New Zealand
College of Midwives [Inc]

NEWSLETTER

Volume 2 No 5 : February 1990

Joan Donley OBE

Marsden Wagner

Direct Entry Update

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New Zealand College of Midwives
Membership Form

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Type of Membership

Full Member (Registered Midwife Full or Part Time)	$52.00
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Please return completed form (together with money if applicable) to
Local Regional Treasurer
New Zealand College of Midwives
Address:

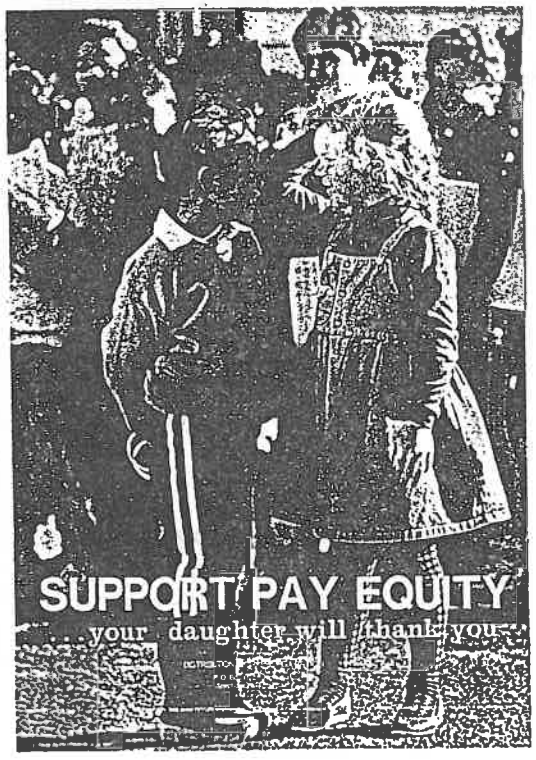
VACANCIES VACANCIES

EMPLOYMENT EQUITY BILL (Labour Select Committee)
This Bill establishes procedures designed to achieve employment equity through:
- the identification of areas of employment with inequality of opportunity for designated groups, and inequality of remuneration for women;
- the promotion of equal employment opportunities;
- the redress of remuneration inequalities for women.

The Bill has four parts, covering the following:
- employment equity commissioner;
- equal employment opportunities;
- pay equity;
- miscellaneous provisions.

The changes come into force on 1 October 1990.

Closing Date for Submissions ***20 February 1990***



MIDWIFE
DELIVERY SUITE
Taranaki Base Hospital

We are currently seeking a Midwife to work in an innovative delivery suite.

The appointee will be expected to work rostered shifts. Either full or part time applications will be considered.

Applicants must be RGON or RCPN and a NZ registered midwife with recent delivery suite experience.

Application forms and conditions of appointment are available from the undersigned.

THE EXECUTIVE OFFICER
PERSONNEL
Taranaki Area Health Board
Private Bag
NEW PLYMOUTH

Enquiries to Kathy Glass, Manager
Women's Health Service
Phone (067) 36139 Extn 7993

DOMICILARY MIDWIFE

Domiciliary Midwife wanted by Fiegling Home Birth Association in Blenheim.

For further information, please write to:

Caroline Carruthers
Marlborough Home Birth Assoc
22 Munro Street
Blenheim

or Telephone (057) 86024

From the Board of Management

Dear Members,

Welcome to the first newsletter of 1990; we hope you are all well rested after the holiday season and ready to support midwifery issues with gusto!

Submissions on the Nurses Act Amendment Bill have now closed and are being considered by the Parliamentary Select Committee. Members of the NZCOM will be speaking to our submission on the 14th March and we are anticipating the second reading of the Bill in April.

Submissions on the Pay Equity Bill do not close until February 20th. This is a very important issue for women, particularly in female dominated professions - there's still time to send a submission supporting the Bill.

1990 has a lot to offer midwives and women with the Nurses Act Amendment Bill, Regional Midwifery Refresher Courses, NZCOM Conference, ICM Japan Conference and a positive public profile. Make the most of these opportunities.

Board of Management

"Pay Heed to the Dignity of Woman"
"Me aro Koe Ki Te Ha o Hine Ahu One"
-Miraka Szaszy, DBE-

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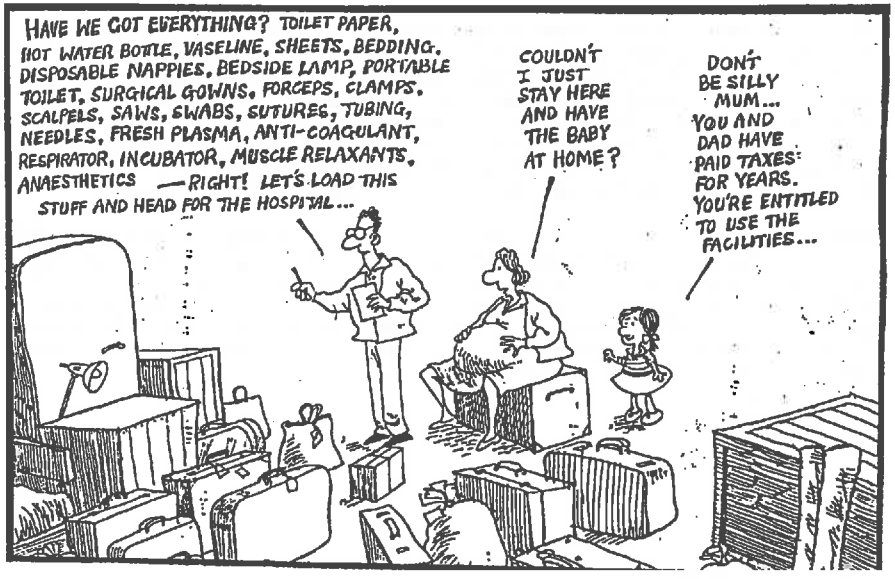

News & Views

Congratulations! Congratulations! Congratulations!

JOAN DONLEY, OBE

This year, Joan's name was present on the New Year Honours List - she received an OBE for services to midwifery.

Joan Donley is the founder of the New Zealand College of Midwives. It was her insight and perception which focused midwives throughout New Zealand into the realisation that midwifery as a profession was under the serious threat of extinction. Her energy and gentle determination motivated and inspired both the women she attended and her midwife colleagues with whom she worked into actively campaigning to get birth accepted by the medical establishment as a normal life event. This wellness model of birth, accompanied by equal involvement of women and their families in the decision making process surrounding birth is the core philosophy of The New Zealand College of Midwives.

Midwives had been discussing the need to have their own professional voice for years but it was Joan who formulated the mechanism by which we did it. She tirelessly researched and documented the history of midwifery in this country and her work has been an invaluable resource to countless midwives, students, teachers, consumer groups and statisticians throughout the world. The Government Departments of Health, Education, Womens Affairs and various Area Health and Hospital Boards have used her research and analysis of systems surrounding childbirth to support changes to our Health Services. She has and does represent the College on many policy making bodies in the last few years as a midwifery consultant.

Joan is the first and only Honorary Life Member of the College and plays a vital part in our ongoing efforts to achieve our objectives. She has re-introduced many of our members to traditional skills that have been almost lost during the last 50 years or medicalisation of childbirth. She has researched, practiced and passed on skills from many cultures including Maori and Chinese which has broadened our scope of practice to the benefit of the women we attend.

Her personal example and deep belief in women's ability to birth normally has given the profession a much needed and valued role model. Joan has been the pivot around which midwifery in this country has been re-vitalised. We believe midwives of the future will look back in history and identify Joan Donley as the woman whose work and dedication gave them back their midwifery profession.

Joan, we salute you.

Traditional Art of Maori Medicine Learned

Helen Scott is the housekeeper at Flanagans Hotel and convenor of the Union's Maori Committee.

One of the "children of the mist" who live in the Tuhoe tribal area from Ruatahuna through to Whakatane-Opotiki, Helen is orginally from Ruatoki.

Helen was taught the art of Maori medicine at the early age of eight years old, when she tended her sick grandmother who passed her own knowledge on to Helen.

Helen writes:

MAORI MEDICINES OF OUR PEOPLE:

One tree we used for curing broken ribs and other illnesses was the bark of the tutu tree. The leaves and the bark from the tutu tree are picked from the sunward side and never the shady side. You boil the bark and leaves at the same time. The leaves you apply on the broken ones and the juice from the bark you drink for other illnesses such as colics, migraines etc.

The tanekaha tree is used for menstruation and birth, and helps bring away the placenta after birth. For childless women who suffer menstrual pains tanekaha is the medicine. Put the bark and broken sticks into the pot and boil. Put only a small amount in a pot when you're boiling the bark. You leave the peelings from the bark to dry first and the longer you dry them the stronger the medicine becomes.

If you need medicine for yourself or for someone who is sick at home then you must give thanks before you go into the bush.

You leave before dawn and when you set out you already know what to collect. If you meet someone don't talk because if you don't talk this person will sense way you're going into the bush. If you're not familiar with the area maybe plants

Helen Scott

you want won't be there, nevertheless you start collecting.

You are also not allowed to eat, drink or smoke while you are in the bush. You are allowed twelve varieties to collect, then you tally up your plants until you reach the required amount.

At home you divide your plants into those taken internally and those applied externally. You boil each type in separate pots but at the same time. As soon as you have done all this, then you can do the usual things, talk, smoke and eat. While the plants are being prepared a tohunga must recite the proper prayers.

Maori Health Centres

Maori Committee Convenor Helen Scott reports:

We, the Maori people have set up Maori Health Centres (Hui Whaka Oranga) around the country to cater for our own tribal areas.

At the Waahi Marae (Ngaruawahia) health co-ordinator for Marae Health Centres Ramari Maipi mentioned that there is a need for these health centres to continue successfully around the country. Princess Te Puea built Mahinarangi as a hospital for the Maori people for she felt that the health authorities were not meeting Maori needs. People believe the confiscation of land and dislocation of Maori territories were major factors in the downtrend of Maori health patterns. All these problems we are facing today.

These health programmes around tribal areas should be taken up. Let's do something about ourselves and our health and bring into play the spirituality of the body, mind and whanau concept, because our young ones need some guidance. When we look at health issues we just can't look at sickness, we have to look at it from a whole point of view, taking in institutions, employment problems and housing.

Tauranga-Moana (Whai-oranga Health Trust) is run by Onewa Barrett Ohia, who says this health scheme is marae based. The four cornerstones of health are:

- Taha Wairua (Spiritual)
- Taha Hinengaro (Body)
- Taha Tuiaua (Mind)
- Taha Whanau (Family)

Tunohopu (Health Clinic) is run by Health Co-ordinator Inez Kingi, who mentions that the clinic is not Maori based but community based.

The Maori people are prone to hepatitis B and by having these health clinics close to the marae they are accessible and affordable. Clinics on the marae are very important for health education, and if they are in familiar settings the people are more likely to come and use these clinics. The protocol of the marae influences whatever programme you're running. Health education has to be combined with the old wore, the present and future, for this is Maori philosophy. You must have the "spiritual" side whatever facet of life we as a people operate under.

LOGO STICKERS

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14. Caldeyro-Barcia (1978); M. D. Mauk et al., "Tonic Immobility Produces Hyperalgesia and Antagonizes Morphine Analgesia," *Science 213* (1981): 353.
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Congratulations to Lynley McFarland and Feliz Barnett on the establishment of the first Domino Option for Women in New Zealand at Northland Base Hospital. It's great to see more options opening up for women and midwives.

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NEW ZEALAND COLLEGE OF MIDWIVES JOURNAL

The second issue of our wonderful Journal will be available for purchase at the end of March. Journals can be obtained from your Regional Committee. Following the AGM in August, it is hoped that subscription to the Journal will be included in the annual membership subscription.

A number of unsold copies of the first issue have been found. Anyone wishing to purchase this inaugural issue, please write to:

Board of Management
NZ College of Midwives Inc
P O Box 21-106
Christchurch

Cost of 1st and 2nd Issue - $4:00

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TINY PREMIES LIKE BREASTFEEDING

MORE breastfeeding myths bite the dust as premature babies of many low weights and gestational ages demonstrate a facile ability to breastfeed and thrive. Hopefully, hospital nurseries and ICUs that have based their policies and procedures on the following assumptions - none of which have been scientifically tested - will reevaluate on the basis of recent findings.

Myth #1: Breastfeeding is too stressful for babies weighing less than 1,500 grams (about 3.3 pounds). In a 1988 study, premies weighing 1,300 grams (about 2.9 pounds) were observed while bottle-feeding and breastfeeding. Stress levels were monitored by measuring body temperature and transcutaneous oxygen pressure. The results indicate that breastfeeding is less stressful than bottle-feeding and that babies need not become cold outside their temperature-controlled incubators. The babies' temperatures were higher while breastfeeding than while bottle-feeding.

Myth #2: Babies cannot coordinate sucking and swallowing well enough to breastfeed until they reach the equivalent of 34 to 35 weeks gestation. Studies show that the ability to coordinate suckling and swallowing occurs more easily - and sooner - during breastfeeding than during bottle-feeding. The babies studied began breastfeeding at 20 to 50 days of age, equivalent to 32 weeks gestation.

Although able to suckle and swallow regularly and predictably while breastfeeding, given a bottle, their sucking and swallowing patterns became disorganised.

Myth #3: Babies must be able to bottle-feed before they can breastfeed because breastfeeding is more difficult. Researchers have found that babies ready to be fed by mouth experience less difficulty by avoiding bottle-feedings and going directly to the breast. Some premies who are able to breastfeed without distress have shown repeated episodes of heartbeat irregularities while bottle-feeding.

Myth #4: It is impossible to know how much nourishment a premature baby consumes while breastfeeding. You cannot measure the milk, but you can measure the baby if evidence of growth is needed during the early weeks. Whereas mechanical scales may not be sensitive enough to determine how much milk a baby receives during a feeding at the breast, researchers have found that electronic scales can accurately guage these amounts.

Researchers suggest that because the findings listed above differ markedly from standard neonatology recommendations, each baby needs to be evaluated individually. In addition, once breastfeeding is begun, it should not be restricted - as is usually suggested to prevent baby from becoming "fatigued". Premature babies often require a little extra time at the breast to stimulate the mother's milk-ejection reflex and get the milk flowing. Mothers who insist on breastfeeding their premies provide the best nourishment possible - food that is most easily digested, protection from infection, and ongoing physical closeness. (Studies cited in New Beginnings, March-April 1989, pp 50-52).

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MIDIRS - Change of Address

MIDIRS INFORMATION & RESOURCE SERVICE
Institute of Child Health
Royal Hospital for Sick Children
St Michael's Hill
Bristol BSZ 8BJ England

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"COW'S MILK BAD FOR BABIES, SAYS EXPERT"

Babies should not be fed cow's milk, a visiting American paediatrician says.

Professor Frank Oski, chairman of the paediatrics department at Johns Hopkins University Medical School, says dairy products should be removed from the list of basic food groups. "No one in their right mind would give cow's milk to a baby," he said. "Cow's milk is for cows - human milk is for humans."

Dr Oski in New Zealand to present a paper at the national paediatrics conference at Waikato University - said human milk was a much better food for babies.

"There is mounting evidence that breast-fed children are healthier and have less heart disease as adults."

Milk was the main source of iron deficiency in children, since it contained little iron and replaced other valuable foods.

Strong statistical evidence indicated that heavy dairy consumption was the cause of hardening of the arteries and heart disease.

Milk was a poor source of calcium, since the phosporus it contained interfered with the absorption of calcium.

"Only 28% of the calcium in milk is absorbed," Dr Oski said.

Better sources of calcium were seafood and more vegetables.

Many blacks were allergic to milk.

Dr Oski - author of the book *Don't Drink Your Milk* - suggested a racial aspect to the widespread use of milk in the Western diet. "If milk were not white, it probably would never have become popular," he said.

Health Department dietitian Gillian Tustin agreed that human milk was preferable for babies. "We recommend breast feeding wherever possible," she said. But for a mother unable to breast feed, modified cow's milk was an alternative.

Milk was a convenient food that many people could tolerate, though 10-15% of Maori and Pacific Islanders were allergic to it.

Ms Tustin said views about the usefulness of milk had changed over the years.

The Health Department no longer recommended minimum levels of milk consumption.

"No one would come to any harm without dairy products," she said.

A spokesman for the Dairy Advisory Bureau said per capita consumption of cheese and butter was declining in New Zealand.

Consumption of liquid milk had also been dropping, but the recent introduction of cartoned milk might reverse the trend, he said.

From the Auckland Star, August 25, 1988

mother's pelvis) or "failure to progress" in labor.[11]

- The blood and oxygen flow is stronger to the uterine muscle and to the baby, because the heavy weight of the pregnant uterus is kept from compressing the vena cava, a major vein that returns blood to the heart. In fact, pregnant women are advised not to lie on their backs for extended periods during the last months of pregnancy, as this can cause supine hypotension (lowered blood pressure).[12]
- Labor is shorter because contractions are stronger and more efficient.[13]
- Labor is less painful, with less need for painkilling drugs.[14]
- The chance of a perineal tear or need for an episiotomy is reduced.[15]

The upright posture is also better psychologically. Mothers feel more in control; they can see what is going on; and they experience their attendants as being more respectful and caring about them when their faces, and not just their genital areas, are visible.

In thinking about how you want to give birth, be sure to remember the importance of birth posture and to discuss it with your physician or midwife. It is a good idea to make a "birth plan" before labor begins, describing how you expect labor to be managed (see Resources). Your doctor may have been trained to use the "lithotomy" posture, and may feel most comfortable with it. But remember that much medical literature supports the upright posture as being the most scientifically sound position for birth. One physician has said, "Except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery." To reassure your caregiver, provide him or her with the useful resource paper, developed by the International Childbirth Education Association, that explains the major issues and lists medical references (see Resources). It may be necessary to interview several birth attendants before you find the one who supports your birth choices.

Even though every culture takes care of birthing women in a slightly different way, we have seen that women around the world give birth in very similar postures. Just as each kind of animal has its own way of giving birth, so do human beings have a way of giving birth. And it usually involves assuming an upright posture; having trusted, sympathetic helpers; and being in an atmosphere that is caring and respectful. In the small number of cases when something goes wrong, medical intervention is welcome. But it makes no sense to apply unproven and often harmful practices when labor is normal and healthy. As one recent ad for a modern birthing chair proclaimed, "Childbirth is not something to be taken lying down!"

Photo: © Suzanne Arms

Notes

1. George J. Englemann, *Labor Among Primitive Peoples* (St. Louis, MO: J. H. Chambers, 1882; reprint, New York: AMS

using the "lithotomy" posture for difficult births. To illustrate this, the author used a drawing showing a man placed on a table for a gallstone operation (lithotomy means "cutting for stone"). This posture eventually became common even for normal births.[4]

By the early 20th century in America, the supine, or flat-on-the-back, posture was rapidly becoming the position of choice for obstetricians. Soon most American women were giving birth with their backs resting flat on a narrow, raised delivery table and with their legs tied wide apart into stirrups. The woman's face and upper body were no longer visible to the doctor, and she was often unconscious and strapped down. Because of the effects of the anesthesia and the unnatural posture, her baby would have to be pulled out by the doctor's forceps. Her husband and friends were banned from the delivery room. When she woke up after the birth, she would have to be told that she had given birth. This 20th-century image of the birthing woman as passive and dependent is quite different from what we find throughout history.[5]

Is this progress? Some physicians believe that to pay a price for the life-saving techniques of modern medicine, women must give up their desire for a pleasant, in-control birth experience. But in fact, many studies have shown that the routines practiced in modern hospitals do not actually contribute to better birth outcomes.[6]

Beginning in the late 1940s and 1950s, many women began to rebel against the American system of "knock 'em out, drag 'em out" birth, and gave rise to the "natural childbirth" movement. This eventually resulted in the return of husbands to the birth room and the use of psychological techniques (like the popular Lamaze method) rather than drugs to cope with labor pain. By the 1960s, a small but significant number of people were giving birth to their babies at home or in birth centers, assisted by midwives.

Freedom to choose the most comfortable birth posture has always been an important element of the new "alternative birth." Studying birth postures of the past, and following their own inclinations, women have chosen to give birth sitting up in bed, on hands and knees, on a homemade birth stool, or in a supported squat, leaning on a helper or on a "labor bar."

> "It is becoming easier to find physicians and hospitals willing to accommodate the mother's wish to give birth in the posture of her choice."

Many members of the medical profession now recognize that the upright posture for birth is better. It is becoming easier to find physicians and hospitals willing to accommodate the mother's wish to give birth in the posture of her choice. Many hospitals now have special "birthing beds" or birth chairs to help the mother assume a comfortable sitting-up position. These are most often found in the "alternative birth room" suites that many hospitals have set up in an attempt to duplicate some of the benefits of a homelike setting for birth.[7]

An illustration from the makers of a birthing bed shows the mother, father, nurse, and obstetrician assuming a very Classic Birthing Pose as they await the baby's birth.

The Upright Posture

Primitive women instinctively assumed upright postures for birth. Medical science and the childbirth movement have now learned that upright postures are best for childbirth, for several very important reasons:[8]

- The angle of the mother's pelvi bones facilitates the baby's passage through the birth canal.[9]
- The mother is better able to use her abdominal muscles to assist her uterus in pushing the baby out. (Imagine trying to have a bowel movement while lying flat on your back with your legs in the air! You'll see how this can also be a very difficult position for childbirth.)[10]
- The force of gravity also assists delivery—since the baby moves down, rather than up, to be born. There is less need for forceps delivery or cesarean caused by cephalopelvic disproportion (baby's head too big for

Future Events

[1] ANNE WILSON SCHAEF PUBLIC LECTURE

01 March 1990
James Hay Theatre
Christchurch

Topics : The Living Process
Addiction and Co-dependency
Spirituality

Cost : $12.50

[2] AUCKLAND AREA HEALTH BOARD SCHOOL OF NURSING 1990 CELEBRATIONS

21-25 March 1990
Auckland

Programme includes - Graduation Ceremony
Historical Display
Reunion Dinner
Reunion Breakfast
Grand Ball
Chrurch Service
Picnic

Contact : Nursing Celebration
P O Box 137
Glen Eden
Auckland 7

Please reply by 28 February 1990.

[3] THE USE OF SELF IN PROFESSIONAL PRACTICE - A WORKSHOP FOR HEALTH PROFESSIONALS

27-28 March 1990
79 Bealey Avenue
Christchurch

The aim of this workshop is to develop work styles that are effective and deeply tuned to both your agencies purpose and your own personal purpose. Whole work systems and areas such as ethnics, authority, inter and intra agency relationships, case-load management will be explored experimentally.

Workshop for Health Professionals, cont'd

The workshop will be taken by Walter Logeman, a social worker and psychotherapist.

Times : Wednesday 28 March 4.30pm-6.30pm
Thursday 29 March 9.30am-4.30pm

Cost : $80.00 ($30.00 deposit)

Confirmation: Forwarded as soon as possible.
Limited to 14 persons.

APPLICATION FORM

NAME : .....

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Please enrol me in "Use of Self in Professional Practice" 28-29 March 1990.

Enclosed is $..... (deposit/full fee)

Please make cheques payable to Walter Logeman

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[4] MIDWIVES WORKSHOP

28-29 April 1990
Manawatu Polytechnic (Hokowhitu Site)

Topics include : Midwife Autonomy
Legislative Update - Nurses Act
Young Mothers and the Childbearing Process
Cultural Aspects of Maternal and Childcare
Caring for High Risk Clients
Current Trends in Breastfeeding
Homebirth - Boundaries of Practice
Homeopathy

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SITTING, STANDING, SQUATTING IN CHILDBIRTH

JANET ISAACS ASHFORD

Why do American women give birth lying on their backs? Is this how women have always given birth? We know that "primitive" women have most often used upright postures—sitting, standing, or squatting.[1] But should we copy birth practices of the past? Hasn't medical science made improvements in the way women give birth?

These are among the many questions facing prospective parents as they wend their way through the maze of childbirth choices offered today. Parents hear childbirth activists calling for a revival of the squatting posture, while physicians warn against a return to primitive ignorance. Who is right? A brief look at the history of birth posture can help us understand these conflicting claims.

A sculpture from ancient Greece shows a mother reclining on a birth chair, with a woman helper holding her up from behind and a midwife in front, receiving the baby. I call this a "Classic Birthing Pose," because these three figures, arranged in this close, supportive pose, are seen again and again across time and cultures. Many thousands of miles away, in ancient Peru, we find a birth scene on a clay pot with the very same Classic Birthing Pose of three figures—mother, helper, and midwife.

During the late 1800s, American physician George Englemann recorded the birth postures of American Indians and other native peoples around the world. His book, *Labor Among Primitive Peoples*, was published in St. Louis in 1882 and included his finding that most "primitive" people throughout the world gave birth in upright postures. Margaret Mead has said that whenever we see the same custom being used by many different peoples, it probably is based on some "very stubborn species-characteristic element that is worth following up."[2]

The European birth tradition has long included the use of the upright posture, especially using a birth stool. In an illustration from one of the oldest midwifery textbooks, published in Germany in 1513, the figures are again in a Classic Birthing Pose of three—strikingly similar to the Greek sculpture and the Peruvian pot.

With the rise of science in Renaissance Europe, birth posture began to change. Male physicians gradually came to replace midwives at births, and these physicians found that a flat-on-the-back posture was more convenient for them, especially when using instruments like the newly invented forceps.[3] A French surgery textbook from 1573 recommended

continued on Page 29

ing out to grab all of the new perinatal technology without realising that very much of it was unproven, if not harmful. Present at the Perinatal Conference in China was the Deputy Director of the Regional Office for the Americas, Dr David Banta, an American. He had just finished a five-year stint as the Chief of the Office of Technology Assessment for the US Congress, and he was very sensitive to the issues of appropriate technology. Now that he was working for WHO he and we felt that it might be an idea for the European Region and the Region of the Americas to combine together in a series of conferences looking at appropriate perinatal technology. This is how the three conferences were set up, and this is why the first two were in Washington and Brazil, and the third was in Trieste - all three meetings were a combination of these two Regions.

These three conferences are the subject of the book that I have just now completed in draft form and which hopefully will be out by the end of this year. This book will go into great detail about how these three conferences were run and in great detail about exactly what the final recommendations were and how they came about. They were run essentially on the "consensus conference" model in which we gathered all interested parties together, we reviewed the world's literature on each technology, and we then had an open debate at the conference until consensus was reached on each technology. (Birth recommendations reproduced from page 7.)

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[11] AUSTRALIAN COLLEGE OF MIDWIVES 7TH BIENNIAL CONFERENCE

16-18 September 1990
Perth
Western Australia

Theme : Birthdays Birthdays

[12] 2ND INTERNATIONAL HOME BIRTH CONFERENCE 1992

Sydney
Australia

Calling for ideas and input.

Enquiries : Jane Thompson
12 Thornton Street
Fairlight
NSW Australia

Homebirth champion now OBE

N.Z. Herald 30.12-89

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Mrs Donley, aged 73, said she was not as busy as she used to be, because more domiciliary midwives were practising in Auckland now.

The new year promises to be busy for her, however, with many midwives on leave and a number of due babies on her books. The first is expected on January 8.

Mrs Donley with her 679th home delivery, one-month-old Jerome Webby. PICTURE: OLIVE FEELEY

Theme : Breastfeeding

Contact : National Secretary
P O Box 38-406
Howick
Auckland

[9] INTERNATIONAL CONFEDERATION OF MIDWIVES 22ND INTERNATIONAL CONGRESS

7-12 August 1990
Kobe, Japan

Theme : A Midwife's Gift - Love, Skill and Knowledge

Full Papers: Deadline 30 June 1990

Registration Fee : Y50,000 - before 15 June 1990
($581.00)
Y55,000 - after 15 June 1990
($640.00)
(Exchange Rate of Y86 = NZ$1 on 07/02/90)

Estimated Total Cost to attend Conference including registration, all fares, accomodation, food : $3600

In order to obtain reduced air fares through group bookings, we must know the number of people attending the Congress by the 28 February 1990.

Information and Enquiries : Regional Chairperson

or Board of Management
NZ College of Midwives Inc
P O Box 21-106
Christchurch

[10] FOURTH INTERNATIONAL CONGRESS ON WOMEN'S HEALTH ISSUES

8-10 November 1990
Massey University
Palmerston North

Theme : Women as Health Providers within a context of Culture, Society and Health Policy.

Enquiries: Fourth International Congress on
Women's Health Issues
Department of Nursing Studies
Massey University
Palmerston North

been only 1 or 2% homebirth, but in the last several years this has been on the increase and there are places in Denmark now where the homebirth rate is approaching 10% - although there are places in Denmark where it is still closer to 1 or 2%. Now for all the other countries in Europe - at least in western Europe, the homebirth rate is around 1 to 2%. The exception is the Soviet Union and Turkey where there is homebirth in the rural areas where there are not the possibilities of putting them in the hospital.

Let me make a side comment with regard to homebirth. We have been actively collaborating with a group in Canada in the northern Hudson Bay region of Quebec where the local Inuit Eskimos have requested that the women no longer be flown 1,000 miles south to give birth and we have also consulted with some Eskimo groups in Alaska who are also concerned about this business of flying women far from their homes to give birth. The Eskimos and Indians feel that this is destroying their culture because in the first place it means that the traditional midwives have lost their key role in the community. It also means that there is no one left who is in fact a real native of their own village.

They have this very interesting experiment in Quebec in this one area of the Hudson where the women are no longer being flown out and are being attended by trained midwives who are also training some of the traditional local empirical midwives. Together they are conducting the births without flying them out unless there has been a complication during the pregnancy. By the way, they are doing these births where there is no possibility for Caesarean section should there suddenly be a problem and there is no way to get these women out to a hospital for a C-section should there be a sudden emergency. So this is a very courageous and very exciting experiment. I bring this up because we feel that this issue is valid wherever in the world there are indigenous people living long distances from so-called "western perinatal services" and we believe this would be relevant to your Aboriginal people in Australia.

You have spoken and written a great deal about the importance of women retaining control over childbirth and their own bodies, and the need to control the proliferation of childbirth technologies. Do you feel these are the most critical perinatal issues facing women in developed countries today?

I guess I would first answer this question generally by saying yes, that those are probably the two most urgent issues in the developed countries. Of course, with regard to the issue of the women having control, my feeling is that the way to get that control is through informed choice - but the informed choice is basically a part of that control issue.

There are other issues which are also perhaps on my list of important issues, although I would not give them as high priority. For example, there is a really urgent need to set up perinatal epidemiology systems in the various countries to monitor the practices and the outcomes, and feed the information back to the public as well as the health practitioners. So this is another important thing that is needed, although I don't believe it is as high priority as the other things.

I also think there is a need, for example, to completely reconsider the obstetrical/gynaecological profession, since I feel that combining obstetrics with gynaecology was a disastrous mistake and that these two should be once more separated into two different professions. You need a gynaecological profession to take care of the pathological problems of women's female organs. But exactly what we need in the way of an obstetrical profession I am not certain about. There are really two possibilities here. One is that we have a separate obstetrical profession whose tasks are totally limited to the management of complications - pathological complications - of pregnancy and birth.

The other possibility - which is a more radical possibility - is that there would be no obstetrical profession, and that pregnancy and birth would be managed by midwives who would have family doctors as back-up. Then if there is a need for a surgical procedure such as a Caesarean section, you would call in the surgeon for that purpose,

ing out to grab all of the new perinatal technology without realising that very much of it was unproven, if not harmful. Present at the Perinatal Conference in China was the Deputy Director of the Regional Office for the Americas, Dr David Banta, an American. He had just finished a five-year stint as the Chief of the Office of Technology Assessment for the US Congress, and he was very sensitive to the issues of appropriate technology. Now that he was working for WHO he and we felt that it might be an idea for the European Region and the Region of the Americas to combine together in a series of conferences looking at appropriate perinatal technology. This is how the three conferences were set up, and this is why the first two were in Washington and Brazil, and the third was in Trieste - all three meetings were a combination of these two Regions.

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Mrs Donley with her 679th home delivery, one-month-old Jerome Webby. PICTURE: GLENN JEFFREY

DIRECT ENTRY MIDWIFERY UPDATE

Final results of 1988 DE questionnaire (includes late replies)

The Save The Midwives Organisation with the assistance of a financial grant from the McKenzie Foundation distributed a questionnaire in 1988 as part of a study to assess the feasibility of establishing Direct Entry Specialist Midwifery Training Programmes in New Zealand.

691 replies were received, including replies from individuals, midwives, nurses and organisations. The replies indicated a strong support for Direct Entry, both from women wishing to participate in this form of training, and from those who support its availability as a training option. We would like to take this opportunity to thank all those who participated.

Total Responses - 691

85% (585) were unhappy about midwifery training

80% (551) believe that midwifery is separate from nursing

95% (654) would like to see midwives recruited to meet special cultural needs

88% (607) agree that an autonomous midwifery profession is essential for a high standard of midwifery care

96% (661) agree that midwives are essential in the preparation of positive parenting

80% (554) strongly urge the establishment of a 3yr Direct Entry midwifery course, to be available in accessible areas

61% (107/175) would apply for a DE course, if available

57% (99/172) would have done a DE course had it been available (331 answered both sections of Q7)

HAVE YOUR SAY ABOUT DIRECT ENTRY TO MIDWIFERY

The Save The Midwives Direct Entry Midwifery Task Force, in conjunction with the Carrington Polytechnic School of Health Studies & with the endorsement of the NZ College of Midwives invite you to comment on a **Discussion Paper and Draft Proposal** for a Direct Entry Midwifery Course.

If you would like to receive a copy of this 32 page document, please send a self addressed & stamped envelope (long 40c size) to:

Judi Strid
Save The Midwives
Direct Entry Midwifery Discussion Paper
RD 3
Wellsford

(All STM members will receive a copy automatically)

Marsden Wagner

Dr Marsden Wagner has been the Director for Maternal and Child Health for the European Region of the World Health Organization since 1978. He is a neonatologist and epidemiologist who formerly lectured in paediatrics and public health at the University of California, becoming the Director of Maternal and Child Health for the State of California. Marsden is based in Copenhagen, and has four children.

A key figure in the development of the WHO's recommendations on appropriate care and technology before, during and after childbirth, Marsden co-authored the two publications which arose from the WHO's review of European maternity services: Having a Baby in Europe and Searching for Better Childbirth.

Why did the World Health Organization decide to investigate childbirth practices in Europe?

In 1979, the International Year of the Child, the 32 countries in the European Region asked the WHO European Office to investigate perinatal services because they were concerned about these services in their countries. They were finding that these services were getting more and more expensive, even though they were having fewer and fewer babies born and they couldn't understand why it had to be so expensive. They were also beginning to feel that all of this high technology was perhaps somewhat out of control. But it was the Member States who came to us and asked us to do this investigation.

It was then my responsibility to carry forth this work and since I was in fact a paediatrician, neonatologist and epidemiologist but not an obstetrician nor midwife, I did feel that I needed to gather some expertise around me in doing this job. That is why I formed the Perinatal Study Group, which as you know includes what we hope were all interested parties. We worked for five years gathering all the information.

What did the Perinatal Study Group find?

Having a Baby in Europe is the final report of that group and everything that is in that book is what we found. (See "Reviews".) Very briefly summarising it, we found that there was an enormous variation in the amount of prenatal care given without any relationship to the perinatal outcome. Furthermore, there was very little or no information on what the actual content of the prenatal care was, and very little information on what parts of the care were of value, and what parts of prenatal care are not of value.

With regard to the birth we certainly found that there were all kinds of obstetric interventions going on at birth with very little or not scientific justification. In other words, we found that the birth technology seemed to really be out of control. We also found two very important facts: first of all, the midwives had been seriously suppressed and lost very much of their role in many of the European countries. The other thing was that the control of choice around birth had really been lost and that women were very much losing any possibility to have any say about their own birth.

We also found that the information that was being given to the women was biassed and inadequate, and that there was only one country in the whole Region that was really doing an adequate job of monitoring their perinatal services. We found that there were alternative perinatal services in all of these countries.

What led to the series of Conferences and recommendations on Appropriate Technology before, during and after birth, and will there be more?

What had happened is that the Perinatal Study Group in Europe had more or less wound up their work and we had gone to China for a meeting with China's perinatal authorities because we were very concerned that in China they were rush-

New Zealand College of Midwives

National Conference
August 17 to 20, 1990
Knox College, Dunedin

Information on presentation of papers and workshops

Those wishing to present a paper or workshop should return along with the interest form the following information: topic, brief outline of content, presentation time, audio-visual and other requirements. This must be received no later than **February 28, 1990.**

Guidelines for presentation of papers and workshops

Papers and workshops will be published in the Conference Proceedings by November 1990. Completed papers and workshop outlines should be sent to **Rhondda Davies, Conference Committee** and must be received by **July 15, 1990.** These will be reproduced for publication by photocopier and must be originals of reasonable quality. They should include references and be presented as follows: A4 size paper; 2 cm top, bottom, left and right margins; 1.5 or double spaced with a 10 point type size for the body of the text.

Conference Committee
New Zealand College of Midwives
Otago Region
P.O. Box 6243
Dunedin North
New Zealand

Books Books Books

The following books are available in bookstores throughout New Zealand.

THE MIDWIFE CHALLENGE

---

edited by Sheila Kitzinger, Pandora/Unwin Hyman 1988
$24:95 (Paperback)

For centuries, midwives have been the guardians of normal childbirth until the field of obstetrics became dominated by technologically-orientated male obstetricians. This is a critical investigation of midwifery care in different parts of the world and establishes common issues for midwives and consumers. Highly recommended.

WORKING YOUR WAY BACK TO WORK

---

by Alison Kuiper & Judi Pattison, Heinemann Reed
$19:95 (Paperback)

This highly practical book encourages women to consider what paid employment will add to their lives, to identify and market their skills, and to approach the business of finding a job in a systematic way. Sensible advice is also offered on managing the dual roles most women must cope with when they take on a paid job.

SECOND OPINION

---

by Phillida Bunkle, Oxford University Press
$25:00 (Paperback)

This informative and hard-hitting selection of essays forms a kind of history of the Women's Health Movement in New Zealand in recent years. As such, they should be read by every woman and her doctor.

THE MOTHER EXPERIENCE

---

by Jenny Phillips, Penguin
$19:95 (Paperback)

With two best-selling books on motherhood to her credit already, Jenny Phillips puts the focus on New Zealand women, sharing, in their own words, their experiences as mothers. The result is open and warm, and often startling.

THE POLITICS OF BREASTFEEDING

by Gabrielle Palmer, Pandora/Unwin Hyman
$24:95 (Paperback)

This powerful and provocative book shows that breastfeeding is much more than a matter of personal inclination. Women all over the world are being tricked into feeding babies artificially and this affects us all - our health, our environment and the global economy.

WOMAN'S EXPERIENCE OF SEX

by Sheila Kitzinger, Penguin
$21:95 (Paperback)

Exploring the subject in a way other books rarely aspire to, Sheila Kitzinger examines the emotions, relationships and physical aspects of a woman's life - from babyhood to old age.

THE CRYING BABY

by Sheila Kitzinger, 1989
$18:95 (Hardcover)

This book addresses the difficulty of dealing with a child that cries a lot. It gives parents valuable information to gain self confidence so that they can enjoy their baby.

The following books are available through
ICEA Bookmarks
P O Box 20048
Minneapolis
Minnesota 55420
USA
Please quote code numbers when ordering.

TRANSITIONS

by Sylvia Reichman, 1988 $9:95 Paperback
Code : MI6103

This book focuses on the lives of eight midwife pioneers of recent history who have collectively been involved in setting up birth centres, worked to pass midwifery legislation, been arrested, spent time in jail, written books, participated in statistical studies and helped midwifery become a visible and viable alternative for birthing families.

New Zealand College of Midwives

Consumerism Feminism Midwifery

National Conference — Women in Partnership
August 17 to 20, 1990, Knox College, Dunedin

Keynote Speaker
Dr. Marsden Wagner
Regional Officer for Maternal and Child Health, WHO

Programme

Friday 17		Annual General Meeting (evening)
Saturday 18	*Consumerism*	Opening Ceremony, Cocktail Party (evening)
Sunday 19	*Midwifery*	Conference Dinner (evening)
Monday 20	*Feminism*	Closing Ceremony

Those wishing to present papers or workshops should inform the Conference Committee before February 28, 1990.

Conference proceedings will be published after the Conference and be available for purchase from the College in November 1990.

New Zealand College of Midwives — National Conference
August 17 to 20, 1990, Knox College, Dunedin

☐ I will be attending the Conference, please send me a registration form.
☐ I would like information on accommodation / creche facilities.
☐ I would like to present a paper / workshop (please see reverse).

Name _____
Address _____
_____
_____

with specific detailed guidelines, can be found in herbal literature. Interestingly, not one modern pharmaceutical is recommended to increase milk supply, although some commonly used drugs produce breast enlargement and milk secretion as side effects.

Herbal remedies are also used to treat sore nipples. Warm compresses of goldenseal or comfrey often provide relief. The juice of the aloe plant, now commonly used in creams, lotions, and shampoos, can also be applied to an irritated nipple.

For trying moments when new mothers feel anxious and overworked, a calming brew of chamomile or catnip tea will help. Chamomile, known in Latin America as *manzanilla*, is also good for mild stomachaches and is soothing for both mother and child. Other antispasmodic agents for mild stomach disorders include peppermint tea and fennel tea.

Two herbal remedies effective for constipation are cascara and senna, but these are *not* recommended for the breastfeeding mother because they can cause diarrhea in the infant. The safest remedy for breastfeeding women suffering from constipation is exercise and whole uncooked natural foods.

Gingerroot tea is a good remedy for nausea and motion sickness. Simply steep about one teaspoon of scraped root of ginger in a cup of warm water for five minutes.

Strong sage tea, which suppresses lactation more effectively than some modern pharmaceuticals, is commonly used by women wishing to wean their children. Sage (*Salvia officinalis*), best known as a spice for sausage and turkey stuffing, has also been prescribed since antiquity for female disorders. It is either the estrogenic substances in the herb or the sage flavoring it adds to the milk that is responsible for the decreased suckling. Other herbal lactation suppressants include betel pepper, sassafras, and periwinkle. Naturally, breastfeeding mothers who do not wish to suppress lactation will want to avoid using these herbs.

Native Americans understood the blood-purifying effects of echinacea root, or coneflower. This herb continues to be used as a folk remedy for increasing resistance to infections and for treating bites of poisonous reptiles. Echinacea root may be used, with guidance, by breastfeeding mothers wishing to treat or prevent illness.

Alexander Pope's "Essay on Criticism" states: "Be not the first by whom the new is tried nor yet the last to lay the old aside." Among the 2,000 plants that have been traditionally used for medicinal purposes, some have continued in popularity, others have had their day and are currently out of favor, and still others have been superseded in medical practice by either more potent or more effective therapeutic agents. Breastfeeding mothers need to be cautious when choosing a remedy—be it herbal or pharmaceutical.

Notes

1. Madeleine Pelner Cosman, "A Feast for Aesculapius: Historical Diets for Asthma and Sexual Pleasure," *Annual Reviews of Nutrition* (1983).
2. M. Shatat, "The Effect of the 'Hlactation Promoting Factor' on Human Lactation," *Fouad Ist University of Cairo: Proceeding XI*, vol.2 (1974): 513–519. An address presented at the International Congress of Pure and Applied Chemistry, London.

For More Information

Duke, James A. *Handbook of Medicinal Herbs.* Boca Raton, FL: CRC Press, 1985.

Grieve, M. *A Modern Herbal*, vols. 1 & 2. New York: Dover, 1971.

Kloss, Jethro. *Back to Eden.* Coalmont, TN: Longview Publishing House, 1969.

Millspaugh, Charles F. *American Medicinal Plants.* New York, Dover, 1974.

Simmonite, William Joseph, and Nicholas Culpepper. *The Simmonite-Culpepper Herbal Remedies.* London: W. Foulsham, 1957.

Tierra, Michael. *The Way of Herbs.* New York: Pocket Books, 1983.

White, Gregory, MD, and Mary White. *Breastfeeding and Drugs in Human Milk: Veterinary and Human Toxicology.* Manhattan, KS: Ag Press, 1984.

Paul M. Fleiss, MD, MPH, FAAP, is a pediatrician practicing in Los Angeles. He has a BS in Pharmacy and is a member of the Professional Advisory Board of La Leche League International.

IMMUNISATION: THE REALITY BEHIND THE MYTH

by Walene James, 1988 $12:95 Paperback

The underlying theme of this book is freedom of choice. It covers the history, theory and myths of vaccination. The stated purpose of the book is not to fill minds as much as open them. Parents and professionals need to hear both sides before making their minds up.

You are the midwife of my hopes.
I'm not just talking about the safe world contained in the snapshot
of the new baby on the new blanket
(or the cleanly-typed story ready to mail)
Or the picture of you and the parents
looking tired,
looking triumphant

But the times
when no one's taking pictures,
when you're alone beyond
the light of the lamps
in someone else's bedroom
the guide in someone else's
dream.
And, alternately, you taste
the sweetness of their faith,
and the sour mask of their fear.

"Take me to the hospital,"
says the mother.
"I want drugs," she says.
She looks out of her pain
and into you and says,
as I have said,
(so many times)
"I'm not strong enough."
"I can't do this".

Everyone says,
"Yes, you can, you're doing fine."
but there are few poets as good as you
who can make language enter the blood
and touch the heart.

I don't know how you do it.
You say the same words others say

But your words carry the conviction
of having passed
through muscle and bone,
success and failure

"You are strong," you say,
"You are strong."

"It won't be long you tell her
and she believes you even though
she's in that place
where there's no day and no night.
She holds your hand
as another contraction begins
and looks into your eyes:
"It won't be long."

It doesn't always work –
Sometimes the woman goes to the hospital.
Sometimes I choose to fail.
Sometimes you walk through the hospital parking lot
with your head down,
softly pounding your fists on your thighs.
Or we sleep with a space
between our backs;
the bones of sweet words
crumbled in our mouths.

But most of the time it does work.
You know how to wait.
You know the hard, unyielding
business of giving birth
and having hope.

You can't push for the mothers
or for me.
We do it ourselves.
But you are there
hours for her,
years for me.
You drop down beneath our skins
to love and wait

You are the midwife of my hopes.

by Keith Eisner 1986

Written to his wife, Marty Butzen, a licensed midwife in Olympia, Wshington.

Articles of Interest

Midwives Chronicle & Nursing Notes September 1988

THE IMPORTANCE OF THE MIDWIFE:

Women's Memories of Pregnancy, Labour & the Postnatal Period

EILEEN HUTTON, President, National Childbirth Trust (NCT)

AFTER HAVING been elected President of the National Childbirth Trust, I felt a need to acquaint myself with what new mothers were currently saying had been important to them in their pregnancies, their labours and their first few postnatal weeks. I embarked on a series of discussion groups with women who had had babies within the previous year. They took place between May 1986 and February 1987 in various parts of the UK: 18 groups—212 women in all.

I invited the women to talk about their best and worst memories of each of the three phases mentioned above, and left the conversations to take their own directions whilst I took notes. The discussions lasted about two hours.

It did not surprise me, and will not surprise readers of the *Midwives Chronicle*, that the word "midwife" cropped up a great deal in these discussions, but the strength of feeling, which came across so often, made me conclude I had a responsibility to convey some of these messages to you on behalf of the mothers.

Pregnancy: the best memories

By far the greatest number of these centred around being made to feel special—by family and friends, by colleagues and by the public at large. Midwives were mentioned in this context by women who had appreciated the support and attention they had received at antenatal clinics, continuity of care being mentioned specifically.

The other "best memories" most often recalled were to do with the feeling of physical well-being many women had experienced, followed by simply being aware of the baby moving and growing.

Pregnancy: the worst memories

Here we came to the subject most often mentioned: sickness in pregnancy, which had ruined the experience for a great many women. Following that came a mixed bag of ailments or discomforts (which had come as a disappointment to those who had normally felt fit pre-pregnancy). Then, neck and neck, came tiredness, for which most women had been quite unprepared, and feeling worried—most often in a general way but sometimes related to something quite specific, such as the possibility of a second Caesarean section, having been told the baby was not growing, having been scanned at 36 weeks without explanation, and so on. Obviously, midwives figured in a lot of these memories. For instance, one woman said her worst memory was of the midwife saying she would have to have a Caesarean for a breech presentation because "we like to see live babies, dear".

Labour: the best memories

The word that cropped up most often in these memories (10 groups) was the word "midwife" accompanied by such adjectives as: good, great, caring, excellent, friendly, fantastic. Women who had known their midwives before going into labour said how important this had been; those who had felt that their midwives were really interested in helping them to have the sort of birth they wanted were full of appreciation; the feeling of having the midwife's undivided attention was also important and appreciated, special mention being made in three groups of midwives who had stayed beyond the end of their shift until the baby was born. Specifically, midwives were remembered for having given support, explanations, encouragement, progress reports and for having consulted the mother about her wishes. I want to stress that none of this had been taken for granted; it was really appreciated and, as you see, remembered.

Other good memories were, naturally enough, to do with the husband or partner: "support" and "help" were mentioned but just being there was the important thing which left memories of it being a very special time together.

For some women the realisation that they were actually in labour was remembered with pleasure and excitement, whilst for others the actual moment of birth was the best memory of all.

Labour: the worst memories

Here again the word "midwife" cropped up most often (12 groups). Phrases used were "interfering", "asked questions at the wrong moment", "anti-NCT", "persisted in doing an internal during a contraction", "told me it was 'time to suffer now' ". Women recalled being threatened with the use of forceps and with Caesarean section if they didn't make progress. There were a few stories along the lines of being told they were 3 cm dilated two hours after they had been told they were 4 cm, and one woman had been upset by having the midwife and obstetrician disagreeing about her treatment beside her. Discontinuity of care during labour was recalled as having caused distress, although the women concerned accepted that this must at times be inevitable. There were a few bitter memories about lack of co-operation; not 'phoning for husbands and refusing to examine women who felt advanced in labour and unsure whether or not to take drugs.

Obstetricians figured in a few bad memories too, and a further set of bad memories centred around the journey from home to hospital. The pain of labour was only mentioned in five groups; the pain of episiotomy repair in six.

Postnatal Period: the best memories

Quite a few women had good memories in general of their time in the postnatal wards: they found the staff very helpful ("nothing was too much trouble"), thoughtful ("they really thought about the mum as well as the baby";

contains thousands of ingredients, some of which are not found anywhere else in nature. It is very specific in its design for the optimum growth and development of the human infant. When choosing herbal remedies, breastfeeding mothers and infants must be considered as one unit, since both are affected.

Common herbal remedies that are safe for breastfeeding mothers have been gathered from sources worldwide: Native Americans, Chinese herbalists, Indian Ayurvedic physicians, European folklore, and most of all, American midwives. Even in light of the vast knowledge that has been compiled about the use of herbal remedies to cure or alleviate disease, cautionary measures are recommended. Chemical composition may vary with the genetics and environment of the plant and with the preparation of the remedy. When "home brewing" an herbal remedy, it is often difficult to standardize the dose. In addition, proper identification is crucial, as is proper use of the plant's parts. Roots, stems, and leaves of the same plant may stimulate very different reactions. For instance, the seeds of the poppy plant are innocuous, but the milk puree, or latex, of this plant is the source of such potent drugs as codeine and morphine.

The healing effect of an herbal remedy is dependent upon its preparation. Healing qualities are increased when the herbs are grown in a kitchen garden without pesticides or herbicides, cultivated with organic fertilizers, nurtured with loving care, harvested at their peak, stored without irradiation, and brewed with pure water in a clean teapot. Herbal tea remedies prepared from scratch have a healing and fragrant aroma. In medical folklore, detailed preparation is usually included as part of the treatment.

Common Ailments and Herbal Aids

For centuries, midwives have recommended herbal remedies to help increase a woman's milk supply. More than 30 herbs are considered to be powerful galactagogues—agents that promote the secretion and flow of milk.

Perhaps the most widely known galactagogue is fenugreek. Many early-20th-century women were familiar with the proprietary remedy "Lydia Pinkham's Vegetable Compound," whose principal ingredient was fenugreek. This famous cure-all for "women's problems" was available in every American drugstore and widely used as a restorative and possibly as an aphrodisiac. Some innocent people in the modern world get their dose of fenugreek with their Sunday morning pancakes, as this herb is the active ingredient in artificial maple syrup. Dr. Mohammed El Shatat of Fouad University in Cairo, Egypt, reported in 1945 that fenugreek could increase breastmilk production by as much as 900 percent.[2]

Numerous anecdotal accounts testify to the restorative powers of this herb. Janice O. of Berkeley, California, learned about fenugreek when breastfeeding her fourth child. After three experiences in which her babies had failed to gain weight with breastmilk alone, she began drinking fenugreek tea. Four times a day she drank a tea made from one teaspoon of seeds brewed for five minutes in a cup of warm pure water. Her infant thrived. Shirley H. of Encino, California, who had been feeding her adopted baby with a breastfeeding supplementer, was not producing any milk of her own by the third month. Soon after she began drinking fenugreek home-brewed tea four times a day, she was able to feed her infant totally at her breast without supplementation.

Other herbs used as galactagogues include alfalfa, basil, blessed thistle, borage, caraway, cumin, chicory, dandelion, dill, fennel, ginseng, hops, lavender, marshmallow root, red raspberry, wormwood, parsley, milkweed, lanceleaf periwinkle, wormseed, poinsettia, winterberry, teaberry, sea island cotton, star anise, physic nut, bitter lettuce, wild rosemary, balsam pear, African rue, jabviandi, kava-kava, castor bean, potato, chickweed, nettle, vervain, and mistletoe. Additional herbal galactagogues, each needing its own special preparation

Herbal Remedies For The Breastfeeding Mother

Paul Fleiss

Rabbi Moses Maimonides, the famous 12th century Jewish physician, instructed his students saying, "Any disease that can not be treated with diet alone should not be treated with anything else". Heeding this ancient wisdom, breastfeeding mothers are cautioned not to take any herb, drug, or other treatment if healing can be attained by a change of diet alone.

HERBAL PROS AND CONS

What are herbs? They are simply nonwoody plants used as food, remedies and derivatives for drugs. "Drug" in its original Anglo-Saxon usage means "dried herb". The herb category encompasses probably 750,000 plants containing pharmacologically active compounds as well as nutrients and vitamins.

Herbs taken by breastfeeding mothers can have adverse effects. For example:

•Herbs flavour milk. An infant may refuse to nurse after a mother has ingested garlic, onions, broccoli, beans or other plant-based preparations.

•Some herbs that are potent as pharmaceuticals appear in milk in doses that may affect the infant. For example: caffeine - found in beverages such as coffee, some teas and hot chocolate - may make an infant jittery.

•Herbal remedies can alter the composition of milk. The delicate balance of nutrients, vitamins and minerals in breastmilk may change with the use of herbs.

•Herbs can influence the quantity of milk. Blood flow to the breast stimulates milk production: 400ml of blood is required to produce 1ml of milk. A cup of Mormon tea made from the herb Ephedra nevadensis provides a dose ephedrine or pseudoephadrine powe. enough to constrict blood vessels, decreasing blood flow to the breast and thereby decreasing milk supply.

Naturally, some health situations will require more than a dietary change. In such instances, selective herbs are an important option for breatsfeeding mothers. Human milk

(cont'd over)

"I had just arrived from New Zealand and they found me a NZ nurse to talk to during the first night") and friendly, and they also enjoyed the support of other mothers. However, the largest number of good postnatal memories centred around getting home to familiar surroundings—to husbands and older children, to own food, own bathroom and own timetable. Having returned home, community midwives came in for a lot of praise; their advice had been gratefully received and their regular visits obviously meant a great deal.

Postnatal Period: the worst memories

The subject most aired as a bad memory of the postnatal period in hospital (11 groups) was conflicting advice, especially on the subject of breast feeding, but also about bathing, opening windows, time to go home, and so on. Lack of sleep in hospital was the worst memory for many, then understaffing, which left memories of waiting 15 minutes for someone to answer the bell; dirty baths and toilets; no one having time to help with breast feeding; jaundice not recognised till 10 days; lack of help after a Caesarean birth. Being back at home had had its problems too: tiredness because there was just too much to do; and visitors who stayed too long.

Midwives and Mothers

I am sure midwives will not be surprised to hear how important they are to mothers. It must be great to know your work and the spirit in which you undertake it are truly appreciated at the time and remembered long afterwards. It must be rotten if you know a mother has had a bad experience and you feel that you contributed to it and know that that will be remembered.

Similarly, it was a delight for me to see the pleasure and animation on the faces of mothers as they related how they had positively enjoyed attending antenatal clinics, and as they attributed all those complimentary adjectives to midwives when they recalled their labours and the support they had received when back at home with their babies. All these things had helped them get off to a good start as mothers.

Sadly, quite different expressions were seen on the faces of women relating their experiences (with silent tears on more than one occasion) of receiving unkind, uncaring and certainly unprofessional treatment which left memories of fear, of physical loneliness and emotional loneliness, of let-down, of anger. All these things were obstacles that they had to try to overcome in starting off as mothers.

It is doubly sad because, in many cases, it would not have taken much to save the situation. For instance: "The midwife apologised when I tore" was quoted as a *good* memory of labour, and so were "The staff were very nice throughout a difficult labour" and "The midwife explained why she had to deviate from my birth plan". Consider these two memories of the postnatal period: one woman's bad memory was of being infuriated by having to wait around for the district midwife to visit; another's good memory was of the midwife asking at what time she should call.

Many women found it difficult to believe that someone to whom they had legitimately turned for support and understanding had failed them so completely. In trying to come to terms with the awful memories, they attempt to find reasons for their "carers" having behaved so uncaringly: "Of course they were very busy that night", "They were badly understaffed".

In an article I wrote for the NCT's magazine, *New Generation*, based on these same discussion groups, I pointed out that I had never heard mothers advance excuses of this sort on behalf of obstetricians who had behaved badly towards them. I wondered if, as women, we found it more difficult to tell other women that their behaviour was unacceptable. I have since wondered if it is partly because we ourselves are viewing midwives as helpers/companions/friends, rather than as professionals whose services we are using and paying for, from whom we expect professional standards and for whom we should not need to make excuses.

We know that, even where delivery wards are staffed at reasonable levels, there are going to be times when they are too busy for comfort, and we know that many hospitals are cripplingly understaffed, with the result that midwives are continually overstretched and exhausted. The high standard of care that many midwives give in the face of these odds earns mothers' enormous respect and gratitude and swells the numbers of those who would like to help midwives receive the recognition they deserve, and who hope that this in turn may draw more women into midwifery and ease the load. Against this I think it becomes inevitable that the unprofessional behaviour—a great deal of which is not related to conditions of work but quite obviously to the unsuitability of the woman to the role of midwife—will inevitably come in for some hard knocks. This will not mean that mothers are withdrawing support from midwives but rather that we are standing by our belief in the rights of women to have skilled, sensitive, supportive care from midwives, and the rights of midwives to have their professionalism recognised.

NCT members were excited by the booklet "The Vision" (Association of Radical Midwives), encouraged on reading the report "The role and education of the future midwife" (Royal College of Midwives) and enthusiastic about the College's policy statement "Towards a Healthy Nation". In acknowledging the importance of the midwife to the mother, the Trust enthusiastically supports midwives in their efforts to improve their professional identity, whilst hoping this will not be at the expense of losing that special relationship with helpers, companions and friends.

MMR VACCINE

A major publicity campaign designed to encourage parents to have their children immunised against measles, mumps and rubella is to be launched this autumn by the Health Education Authority.

The Authority is working with the DHSS to promote the vaccine MMR, which will be available for the immunisation of children from October 1. The MMR programme, already used extensively in Europe and USA, consists of a single dose vaccination, given to children aged between 13 and 15 months. A "catch-up" programme is planned for pre-school children.

Maternity changes "positive" step for Pahiatua Hospital

by Ann Bastby Susan Television 10.10.81

Planned changes in maternity care at Pahiatua Hospital will make the hospital more economical and strengthen its future.

This is the view of Principal Nurse Barbara Pratt, who sees the move towards a smaller, more homely birthing facility and early discharge backed up by staff help for new mothers at home, as an "exciting and positive step."

Major alterations are now being made to the old maternity wing, turning it into a three bed maternity unit at one end and a 12 bed general ward for mainly long-term patients at the other. By working the staff in the two wards to support each other, maternity nurses will be free to provide the service in the home when needed.

Mrs Pratt said that this was the only way to ensure the maternity service offered at the hospital was an economical one.

"I visualise substantial savings because the patient areas concerned are in two adjacent wards instead of scattered through the hospital, and staff will be able to support each other," she said.

Health authorities are continually under pressure to cut costs and the old Pahiatua Hospital maternity unit, with its average daily occupancy rate of 1.7, was considered seriously at risk.

Local medical staff and hospital board members have said how worthwhile they view the hospital and have pledged their commitment to make the new maternity service work.

The new wing accommodating Ward Two and the birthing unit is expected to be open late in November. While the building is being altered, the maternity unit is operating in the outpatients area as a delivery room and a two bed post natal room. The temporary unit is being seen as providing a good trial to evaluate and review the whole concept of early discharge.

Mrs Pratt said the aim of the new look maternity unit was to create a relaxed, homely atmosphere to cater for the whole family. It would provide a short-term hospital stay and return mother and baby to the home family unit, at the same time providing when required immediate support in the home by the maternity staff.

The service will be offered to mothers discharged within five days of delivery and will include a nappy service and home help.

It will be monitored so that it is available to those who have a genuine need. Staff will be encouraging new mothers to use their own resource system, but an open door policy would always apply.

Mrs Pratt said that although there were only three beds in the maternity unit, no-one would be turned away. Accommodation would always be found.

The alterations, started in September, reflect the new maternity philosophy. There will be an ensuite birthing room, with an ordinary bed and bench unit to discreetly store equipment until ready for use. This room, and the two single post natal rooms, will have vinyl up to bedhead height on the walls, wallpaper and curtains.

There will be a family room, with tea and coffee making facilities, a bed settee and comfortable chairs, close to the birthing room and a day room for mothers and visitors.

Service rooms, a small kitchen and staff office lie between the maternity and general areas and service both. Bathrooms in both have been modernised.

The new Ward Two has two single and five double rooms and will open with the old maternity ward day area enlarged to more than twice its former size to make a lounge.

The hospital will be looking to the community to assist in providing additional furnishings required to support the concept of a homely environment.

Staff have been enjoying creating the right atmosphere by choosing colour schemes and materials and the old maternity ward is a hive of tradesmen's activity as the $100,000 alterations take shape.

Woodville builder Roger Hayne is reshaping the interior of the old maternity ward, apart from the work on the large lounge which has been contracted to Rankin and Minnis of Pahiatua.

Women to be Churchill fellows

By SUSAN COOK

Two Christchurch women have received Winston Churchill Fellowships to undertake research projects in Europe early next year.

Maevis Watson and Celia Grigg Sowman are among the 24 New Zealand recipients of this year's fellowships, which enable people to undertake a wide variety of projects that will benefit the community and country.

Ms Watson, a health and safety co-ordinator with the Council of Trade Unions, will visit Britain, Sweden and Finland to investigate problems associated with exposure to solvents in the workplace, and study the impact of health and safety representatives in the workplace environment.

Ms Grigg Sowman will leave on December 20 for eight weeks in the Netherlands and Sweden, where she will compare the public birthing systems in those countries with that in New Zealand.

Ms Grigg Sowman is a family day-care co-ordinator with Barnados, and a member of the Maternity Action Alliance.

She said the rate of home births in the Netherlands is particularly high, with a third of all Dutch women giving birth at home.

MS GRIGG SOWMAN

Research in the Netherlands had shown that home births were not as dangerous as commonly thought in New Zealand, she said.

The trust administrator, Ms Joanne Oliver, said each fellow was required to report on their overseas findings on their return.

The findings would be available to the public, and in the past some had influenced Government policy, said Ms Oliver.

Applicants from a broad range of areas including social services, agriculture, tourism, marketing and the arts would be welcomed for next year's fellowships.

The trust would provide all costs of a project's cost, with a limit of $8000.

Midwives see Act amendment as positive

TAURANGA birthing professionals have welcomed last week's amendment to the Nurses Act as a positive move that will give women more choice.

Midwives have won the right to deliver babies without the attendance of doctors for the first time since 1971.

The amendment was passed in Parliament on Thursday.

But according to local midwives, it isn't a move that breaks new ground.

"The amendment brings us into line with professional midwives in the world," Papamoa domiciliary midwife Anne Sharplin said yesterday.

The choice women are offered whether a doctor or midwife attends their childbirth is "reclaiming old ground", as far as medical and public recognition is concerned.

Mrs Sharplin said the change boded well for the health of mother and babies.

"It will give us greater effectiveness in the community," she said.

Prior to the amendment it was illegal for anyone to carry out obstetric nursing unless responsibility had been taken by a medical practitioner. Offenders could be fined $1000.

However in the Western Bay of Plenty there was already some flexibility with that law and doctors and midwives has a fairly good relationship.

When the Te Puke maternity annexe closed, the Tauranga Hospital Board set up a system where midwives cared for mothers antenatally instead of general practi- [illegible] and [illegible] nue, [illegible] inga [illegible] Helen Bridley [illegible].

Dr Ridley thought the amendment was a positive move as long as midwives were caring for low risk mothers.

He disagreed with Health Minister Helen Clark's claim that 85 per cent of births did not need medical intervention, however.

"The figure's probably closer to 50 per cent because at the moment we do 15 per cent caesarians and there are many other abnormalities that require medical intervention," he said.

Dr Ridley didn't anticipate a surge of women opting for midwives because people tended to stick with the status quo rather than try something new.

Mrs Sharplin said the midwives' practice tended more to the normality of childbirth than technology and in time she thought the percentage of medical intervention would decrease when women received appropriate care.

That view was held by women Government backbenchers who described modern childbirth as a "medical model of birth".

One MP said women of New Zealand wanted to claim back childbirth as a natural process and get away from treating pregnancy as an illness.

Tauranga District maternity and child health divisional nurse manager Jan Bear said New Zealand midwives now came into line with the World Health Organisation definition of midewifery and she was delighted with the amendment.

She said the maternity annexe was hoping to start up a "Know Your Midwife" scheme where mothers kept the same midwife right through labour.

The annexe wanted to provide the consumer with what she wanted, which now included midwife care.

However, she stressed that the amendment should not mean the medical profession and midwives should be at odds.

Midwives win sole role

From SIMON COLLINS in Wellington

Midwives have won the right to deliver babies without the attendance of doctors for the first time since 1971.

A simple two-clause amendment to the Nurses Act, introduced in Parliament yesterday, will give mothers an alternative to what Government backbenchers described as the present "medical model of birth."

The bill, introduced by the Minister of Health, Helen Clark, was warmly welcomed by the Opposition spokeswoman on women's affairs, Mrs Katherine O'Regan.

"Many of our mothers would have been delivered at home in this country by midwives who were well respected in the community and knew their skill very well," she said.

"As we see a closure of maternity hospitals under this Government, choices are narrowed for many women, and they may turn in due course to home delivery."

Mrs O'Regan said she trusted midwives to know when a doctor should be called in.

Under the present Nurses Act, it is illegal for anyone to carry out obstetric nursing unless responsibility has been taken by a medical practitioner. Offenders can be fined up to $1000.

But Helen Clark said that 85 per cent of births in New Zealand did not need medical intervention.

"Having a baby is not an illness," she said.

"With the advent of medical technology there has been a trend towards treating pregnancy and labour as an illness.

"This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives' role.

"This has proved to be both costly and in many cases inappropriate."

Mrs Judy Keall (Lab—Glenfield) said the women of New Zealand wanted to claim back childbirth as a natural process.

"That does not mean that we are starry-eyed," she said.

"We acknowledge that some births are difficult and will have the assistance of technology, but we would like the chance for women to experience childbirth as a natural process if it is at all possible."

The Opposition spokesman on health Mr Don McKinnon, said his party supported the bill, but asked whether midwives would be allowed to take swabs and prescribe drugs.

Helen Clark replied that the bill would not change the normal work of midwives which included taking swabs but not prescribing drugs. That would remain the work of a doctor.

The bill was referred to Parliament's social services committee for public hearing of submissions.

The New Zealand College of Midwives applauded the amendment to the Nurses Act, but doctors say the patient will be the loser.

The president of the college, Mrs Karen Guilliland, said: "The midwife has the knowledge and skills to provide safe care through pregnancy, labour and, in the postnatal period, working in collaboration with doctors when she identifies at-risk situations."

But the Royal New Zealand College of General Practitioners disagreed.

The chairman, Dr David Cook, said the obstetrics was best managed by the "team concept," with doctors and midwives working together.

"When care is provided episodically by a variety of people, there is confusion as to who has primary responsibility."

Breast-feeding ruling

PA Nelson

The Human Rights Commission has ruled against the Landmark Gallery's no breast-feeding policy after a complaint from two Nelson women.

Banning breast-feeding in a public place was sexual discrimination because it affected only women, the commission found.

The commissioner, Mrs Ras Julian, said the complaint was the first about breast [illegible] and the long [illegible] sions at research [illegible] settle.

The decision meant the gallery owners were acting unlawfully to ask women to stop breastfeeding in the restaurant.

They were now liable to the settlement requested by the complainants which could range from an apology to a financial payment of up to $2000 for humiliation.

The gallery's owners, Bill and Betty James, said yesterday they had no comment to make about the decision.

They were entitled to appeal against the commission's opinion Mrs Julian said, and the complaint could then be taken further to the Equal Opportunities Tribunal.

The complainants, Ms Veronique van der Warf and Ms Josephine Yellowlees, were "very pleased" at the news.

Ms van der Warf said she expected the decision to go their way.

They would settle for an apology from the owners, and the necessary change of policy, she said.

Ms Julian said the decision would apply to all future cases. It was based on the 1985 equal opportunities decision which had established the basis for sexual harassment rulings.

This was a "gender plus" discrimination case, where the complainant was affected by gender and one other factor, for example the act of breast-feeding.

Bill increases midwives' responsibilities

PA

Wellington

A midwife will be able to take sole responsibility for the care of a woman and baby during childbirth, under a bill introduced to Parliament on Thursday.

Introducing the Nurses' Amendment Bill, the Minister of Health, Ms Clark, said that at present only a medical practitioner was permitted to take responsibility for a birth but under the bill, a registered midwife could do that.

She said that with the advent of medical technology, there had been a trend towards treating pregnancy and labour as an illness.

"This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives' role.

"This has proved to be costly and in many cases inappropriate."

While the expertise of medical practitioners was necessary for high-risk, complicated and abnormal pregnancy or childbirth, the focus of midwives' expertise was the low-risk, uncomplicated and normal pregnancy and childbirth.

Ms Clark said 85 per cent of births in New Zealand were normal and did not require medical intervention as a matter of course.

The bill would give New Zealand women the choice to use the services of either a medical practitioner or a midwife.

The Opposition health spokesman, Mr Don McKinnon, said lack of health funding had put pressure on the Government to establish low-cost maternity services.

He said while the Opposition supported the two-clause bill, he was sorry it was not bigger.

He asked whether midwives would be able to prescribe drugs. Later Ms Clark said they would not. The use of drugs would indicate an abnormal situation in which case a midwife would call in a doctor or refer the woman to hospital.

Ms Judy Keall (Lab., Glenfield) said medical practitioners had attempted to take over childbirth.

An indication was that in 1982, 34 per cent of births were considered "abnormal" and medical intervention was used — 10 per cent being deliveries by Caesarian and 14 per cent by forceps.

"It's very sad when that intervention occurs unnecessarily," she said.

The Opposition spokeswoman on women's affairs, Ms O'Regan (Waipa), said for too long mothers had been left out of the birthing process.

"Every woman who has gone through childbirth knows that while it might be painful, it is not an illness."

"I trust midwives to know when things are going wrong."

The bill was welcomed by the New Zealand College of Midwives.

The bill has been referred to Parliament's social services committee for further study.

Midwives' role

Sir, — As a three cheers for a return to normality. How refreshing to see that midwives are once again being recognised for their true worth in terms of work and skills, and that human birth is actually possible without the omnipresent male doctor hovering by ready to interfere at any moment that he chooses to. I would like to register a particular vote of confidence in domiciliary midwives. Both our sons were born at home because of the courage of my wife and the skills and confidence of the midwife now concerned. As pay equity is now an issue that the Minister of Health wishes to push, maybe she would like to address (or redress) the pittance that these midwives earn and, let us face it, they are saving the public health system considerable sums of money. Birth is an issue that men should play very little part in, in terms of control and decision-making. Doctors will, no doubt, greatly resent the loss of power and control they still desperately wield in the birth process, but let us see this control return to the hands of women, where it more properly belongs. — Yours, etc

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November 12, 1988.