TO:

Maggie Banks
14 Eton Drive
HAMILTON
Subscription has expired.

from:

**New Zealand College of Midwives**
**P O Box 7063**
**Wellington**

# New Zealand College of Midwives [Inc]

# NEWSLETTER

Volume 3, Number 5 : June 1991

**Indemnity Insurance**

**Fees**

# NEW ZEALAND COLLEGE OF MIDWIVES INC.

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## National Committee

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*Parents Centre*
WENDY BROWNE
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Christchurch

*Southland*
LESLEY WATSON
390 Dee Street
Invercargill

*La Leche League*
MARCIA ANNANDALE
16 Shannon Place
Christchurch 5

## New Zealand College of Midwives

### Membership Form

**Regional Information**

Name ______________________________

Address ______________________________

Telephone ____________ Home ____________ Work

Place of Work ______________________________

***Type of Membership***

| | |
|---|---|
| Full member (Registered Midwife Full or Part Time) | $74.00 |
| Full member (Student Midwife or Registered Midwife on Maternity Leave or Unwaged) | $37.00 |
| Associate Member (Other Interested Individual) | $74.00 |
| Associate Member (Unwaged Interested Individual) | $37.00 |
| Affiliated Member (Other Groups, e.g. Parent Centre, La Leche League etc.) | $37.00 |

***Method of Payment***

Please tick your choice of payment method.

- ❐ Subscription payable to College Treasurer (please enclose cheque or money order).
- ❐ Deduction from Salary (please arrange with your Pay Office).

**National Information**

Name ______________________________

Address ______________________________

Telephone ____________ Home ____________ Work

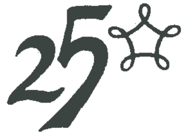
Date of Birth ____________ NZNA member: Yes/No

Type of Membership

Full : Waged ❐ : Unwaged ❐ Associate : Waged ❐ : Unwaged ❐ Affiliate ❐

Place of Work ______________________________

Please return completed form (together with money, if applicable) to your local Treasurer.



## OTAGO POLYTECHNIC

### MIDWIFE : DEPARTMENT OF NURSING

Otago Polytechnic wishes to appoint a midwife who is interested in working in an innovative department.

The position will involve either provision of an independent midwifery service as part of a team of midwives or provision of midwifery education to students.

The position involves working with students and maintaining a high level of midwifery practice.

Applicants should have extensive midwifery experience and post-graduate education would be an advantage.

The appointment will commence mid-July and will be a one-year contract and subject to renewal.

Salary will be dependent upon qualifications and experience but will be within the range of $25,941.00 - $43,005.00.

Job description and application forms are available from

The Assistant Manager (Administration),
Otago Polytechnic,
Private Bag, Dunedin.

Telephone (03) 477-3014. Fax (03) 477-6032.

## FROM THE BOM

It was with regret that we accepted the resignation of Jennifer Sage. Wellington is in the process of selecting another BOM member. Thank you Jennifer for your hard work and commitment.

### PROFILE : MARJORIE MORGAN

I was born in Hokitika and attended the District High School there before nursing at Christchurch Hospital in "the days of long black stockings, starched pinnies, collars and cuffs". As well as nursing qualifications, I acquired a husband in the form of a Canterbury University engineer from the other side of the Avon.

After living in Christchurch, Hamilton and Tauranga (and producing a baby in each city) we spent the next thirteen years in Fiji. It was fascinating to be there as the country moved into independence. Completing my record of delivering babies in a variety of towns and countries, Justine and Kelly were born in Suva's Morrison Maternity Annex. I was involved in the Bayly Clinic which cares for destitute people, and The Pearse Home for The Elderly - but also enjoyed the delights of scuba diving, golf, tropical gardening and bridge.

There hasn't been much of those since our return to New Zealand in 1982. Although it was almost twenty years since I had worked in a hospital, the week after young Kelly started school I was Staff Nursing at Wellington. It wasn't long before I realised that one of the most positive and rewarding things a nurse can do is to support women through childbirth. That led me to Wellington Polytechnic in the Class of 1987 (Midwifery and ADN). My philosophy of midwifery (empowering women, supporting them through their decisions, safeguarding a special place for them in the face of all the Health cuts) is central to my present role as Charge Nurse of the Gynaecological Ward at Wellington Women's Hospital. Having been involved with the College since its beginning, I am glad to be serving on the BOM. The College's success and Helen Clark's Nurses Independent Practice Act have enabled us to get back, in increasing numbers, to the community where we belong. These are exciting times to be involved in midwifery.

## NEWS & VIEWS

### Direct Entry Curricula

The Direct Entry Curricula are being reviewed at Nursing Council. The NZCOM was asked to nominate two members to the Education Committee to assist with this task. After input from the regions, Marion Lovell and Christine Smith were nominated.

Marion Lovell is a Domino midwife. She has a BA (an Education major) plus experience as a nursing tutor. Currently she is Wellington Region's Chairperson.

Christine Smith also has a wide experience in midwifery and has sound knowledge of the polytechnic system. She is currently working in Balclutha.

It is wonderful to know there will soon be "midwifery" education for midwives.

### Indemnity Insurance

Karen has had discussions with the NZNU and indemnity insurance for approximately $9 per member will be available soon.

NB: We will need to alter our fees to accommodate this.

### Fee Structure

The current fees will need to be reviewed.

Unfortunately, BOM was unaware that they could not just add on GST to the membership fee. Consequently, we caused confusion and incorrect schedule of fees in various places.

For this year we must stay with $74 Full Membership and $37 Associate (as voted at the AGM in 1990).

However, to pay for the running of the College some fee increase will be necessary. A point for us to consider is how much should we charge those who are not full members?


MIDWIFE

SOUTHERN HEALTH DISTRICT
ROTORUA OBSTETRIC UNIT

A modern progressive and family oriented Birthing Unit invites a Midwife to join our team to work full-time rostered duties.

- The Maternal and Child/Whanau Health Service provides a Supportive Professional environment enabling independent Midwife practice.
- The Service is committed to developing a Midwives Clinic and The Domino Birthing Scheme for families in the District.

The Bay of Plenty Area Health Board is committed to, and is working towards becoming an EEO employer. The Board also recognises that biculturalism must permeate all its activities.
We have a smoke free policy.

Job descriptions and Application forms are available from Personnel Office, Rotorua Hospital, Private Bag, Rotorua.
Telephone (073) 481-199, fax (073) 485-136.
Closing date 30 June 1991.

Bay of Plenty Area Health Board
Partnerships in Health

## Contract Specification

### Key Responsibilities

1. The writing of a draft paper presenting the grounds and a proposal for a national framework for nursing/midwifery education.

*NOTE: The committee plans to use such a paper as the basis of a document to be circulated and discussed nationally.*

2. Indepth analysis of papers and report related to the Vision 2000: Project 1991 Forum held in Auckland 14-16 March 1991.

3. Consideration of other relevant literature.

4. Ten photo ready copies of interim report and final draft paper.

**Accountable To:** The Vision 2000 committee.

### Time Frame

1. 1 July 1991 applications close.

2. Before the end of July successful applicant notified.

3. Late July 1991 meeting with at least some of the Vision 2000 committee members for negotiation of terms and discussion of the parameters of the task.

4. By the end of August 1991 interim report to the committee convener.

5. By the end of September 1991 completion of the draft paper.

### Committee's Responsibilities

1. The provision of Vision 2000: Project 1991 Forum papers and report.

2. Liason with the consultant as required.

3. Negotiation of remuneration.

4. Provision of work space in Wellington if required.

*Considerations*

- Money is increasingly difficult for some to find.
- Our commitment to having consumer membership is fundamental.
- The costs incurred by the College are almost exclusively tied up with professional issues. Therefore it seems appropriate to keep consumer/associate members fees down and charge more to those who benefit most.

Let your views be known. This matter will be decided at the AGM on 2nd August 1991.

### Remits for the AGM

Remits are called for. They should be received by the BOM by 12th July. The election of the President will also take place.

### The Future of Health Funding

The future is very uncertain. It is essential that midwives lobby their MPs to ensure they know about midwives and the importance for women to be able to choose their practitioner(s). Area Health Boards also bear watching. Rumours have included:

1. Maternity Benefits to be devolved to the Area Health Boards to pay out.
2. Maternity Benefits being removed totally.
3. Area Health Boards to be reduced to three.
4. Those with salaries over $27,000 will pay for their own health care.
5. Those with salaries over $40,000 will pay for their own health care.

It would seem as if no decisions have been made - a report has been ordered (A White Paper).

*"It's the not knowing that is the worst"!*

## Breast Feeding Handbook

No doubt large numbers of you have seen the draft Handbook. It has caused a lot of interest amongst the membership and quite a stir amongst other interested groups.

The response to reviewing the document was wonderful. Thank you for the effort put in at short notice.

## Student Midwives Research

Some Wellington student midwives requested access to the names of some midwives (a random sample) for a research project.

The National Committee agreed that the student can send their research out to NZCOM members.

It is important to note that the students will not know who is in the sample as BOM will do their mail outs.

## Vision 2000

The Vision 2000 Committee continues to meet. They felt unable to include the midwifery framework in their distribution of the Saturday's group work.

The Vision 2000 Committee has decided to contract an individual to work on a national framework (see advertisement in this Newsletter).

The Vision 2000 Committee is aware that the College may ratify and implement the framework developed by practitioners, consumers, and tutors at Vision 2000 Conference.

*International Board Lactation Consultant Examiners Programme*

Certification and Examination will be available again this year. Probably in Auckland or Hamilton.

For details contact Rachel Walker, 41 Halton Street, Christchurch 5, Tel: (03) 352 5872. Fax: (03) 355 9081.


advertisement

VISION 2000 : PROJECT 1992

A draft national framework for nursing and midwifery education.

The Vision 2000 Committee invite applications from interested parties to prepare a draft national framework drawing on:

* a synthesis of papers presented at the national nursing and midwifery education forum held in Auckland on 14 and 15 March 1991;

* the report of the group that met on 16 March 1991.

Contract specifications are available from the Vision 2000 Committee. Applications close 1 July 1991.

The Secretary
Vision 2000 Committee
C/- PO Box 9644
WELLINGTON

__Person Specification__

**Registered as a nurse and/or midwife under the Nurses Act 1977**

**An understanding of current nursing and midwifery trends in the New Zealand context**

**Evidence of professional involvement nationally**

**Demonstrated skills in written communication**

**Acknowledgement of the principles of partnership in the Treaty o Waitangi**

**Understanding of the wider New Zealand social, political and cultural context.**

| | |
|---|---|
| 16-18 September: | *Australian College of Midwives 7th Biennial Conference* Perth, Western Australia |
| 18-19 October: | Hutt Hospital's 25 year Celebrations |
| 5-8 November: | *1st International Congress of Perinatal Medicine (ICPM)* on *Care of the Mother, Fetus and Neonate.*<br><br>Contact: Congress Secretariat, ICPM, c/- Japan Convention Services, Inc, Nippon Press Center Building, 2-2-1 Uchisaiwai-cho, Chiyoda-ku, Tokyo 100, Japan. Tel: 813 508 1213. |
| 14-17 June 1992: | *Reproductive Life*<br>*10th International Congress of Psychosomatic Obstetrics and Gynaecology*<br><br>Contact: Congress Secretariat, CONGREX, International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) - 92, PO Box 5619, S-114 86 Stockholm, Sweden. Tel: 46 8 32 69 00. Fax: 46 8 32 62 92. |
| 4-7 October 1992: | *Second International Homebirth Conference*<br>Sydney, Australia. Reclaiming our Heritage, Creating our Future.<br><br>Contact: Conference Secretariat, GPO Box 2609, Sydney, NSW 2001, Australia. Tel: (02) 241 1478, (02) 247 6940. Fax: (02) 251 3552. |
| 9-14 May 1993: | *International Confederation of Midwives*<br>*23rd International Congress*<br>Vancouver, BC, Canada. |

# NOTICE

## AGM

## 2nd August, 6.00 pm

**Wellington Polytechnic**

**School of Nursing & Health Education,**

**Staff Resource Room**

**If you wish to have billetted accommodation**

**please contact Beryl Davies (04) 887-403**

### Call for Nominations

At the AGM on 2nd August we will have the election of the President.

### Remits

Remits to reach BOM by 12th July

### Selection of Region to be the BOM from 1992

## National Midwives Workshop - Palmerston North

## April 12th-14th, 1991

On this glorious, sunny weekend over 100 midwives, student midwives, nurses and mothers registered for this workshop.

Friday evening we heard Michel Odent's talk entitled: "Birthing in the Post-Electronic Age", disappointing in many aspects, as nothing new was offered.

However, Saturday and Sunday more than compensated! Karen Guilliland made the opening speech - recharging everyone's batteries and providing more fuel for our future journey!

Stimulating stuff - thanks Karen.

Katherine O'Reagan appeared to be very comfortable amongst midwives, gave a thought provoking talk, and took time answering questions.

The remainder of the weekend was spent in small groups in various workshops. Brilliant speakers that allowed the exchange of information and ideas to flow freely, interlaced with excellent food and numerous exhibits to view.

The weekend was a success. Thank you to all those who attended.

*Please note .....*

Taken (by mistake) was a small cardboard box full of packaged cards and midwife stickers. These belong to the Nelson Branch of the College of Midwives for their much-needed fundraising.

If you can locate this box, marked 'Helen Manoharan' on top, please return it to Angela Kennedy, 32 Tamaki Street, Nelson as soon as possible. Thanks.

Also removed from the NZCOM 'table' several T-Shirts worth $160, belonging to the BOM. If you know about - or have any of these - please send cash or contact Christine Griffiths, PO Box 7063, Wellington South, Wellington.

## FUTURE EVENTS

**15-17 July:** Centre for Nursing Research Inc. (in collaboration with the Royal College of Nursing, Australia)

*First International Conference - Nursing Research : Pro-active vs Reactive*
St Peter's College, Adelaide, South Australia.

Enquiries to: Ms Helen Smyth, Executive Officer, Centre for Nursing Research Inc, Bedford Park, South Australia 5042, Australia. Tel: 08-275 9911 Ext 5032. Fax: 618 275 9450.

**18 July:** Auckland Region AGM
5.30pm Oliver's Hutch
National Women's Greenlane Hospital's catering cost $4.

**28 July - 1 August:** *XIV Soroptomist International Convention*
The health workshop will be devoted to Safe Motherhood.

Contact: The Programme Liaison, c/- Soroptomist International Headquarters Office, 87 Glisson Road, Cambridge CB1 2HG. Tel: 44 223 311833. Fax: 44 223 467951.

**15-20 September:** *Symposium on Professional Training for Safe Motherhood at 13th World Congress of Gynaecology and Obstetrics (FIGO).*

Contact: Congress Secretariat, c/- Department of Obstetrics and Gynaecology, National University Hospital, Lower Kent Ridge Road, Singapore 0511, Republic of Singapore. Tel: 65 777 0313 or 65 775 4420. Fax: 65777 3121.

Nicotine poisoning has been recognised in breast fed infants of mothers who smoke more than 15 cigarettes a day. Nicotine poisoning may present as a variety of symptoms, including refusal to suck, vomiting after a feed, grey skin colour, apathetic and flaccid appearance, recurring apnoea following feeding, restlessness, insomnia, diarrhoea and tachycardia.[6] Two classic signs of nicotine poisoning are that infants continually squirm and appear to "tread water". Symptoms are slowly reversed when the mother quits smoking. However some infants also suffer nicotine withdrawal symptoms.

Breast fed infants may have low levels of certain vitamins if their mothers smoke. For example, vitamin $B_{12}$ may be reduced as it is used to detoxify cyanide from cigarette smoke.[6]

Breast milk and breast feeding have known beneficial effects for the infant. But should a mother who is a smoker stop breast feeding to reduce the risks to her baby? According to Labrecque *et al*[5], we just don't know at this stage.

Health professionals dealing with pregnant or lactating women who smoke need to spell out these health problems carefully and tactfully. The best possible outcome is for the mother to quit smoking and continue to breast feed.

*References*


1. Woodward A, Hand K, "Smoking and reduced duration of breast-feeding" Med J Austr; 148: 477, 1988.
2. Lyon A, "Effects of smoking on breast feeding" Arch Dis Child; 58: 378, 1983.
3. Steldinger R *et al* "Half lives of nicotine in milk of smoking mothers: implications for nursing" J Perinatal Med; 16: 261-272, 1988.
4. Nyboe-Andersen A *et al* "Suppressed prolactin but normal neurophysin levels in cigarette smoking breastfeeding women" Clin Endocrinol; 17: 107, 1982.
5. Labrecque M *et al* "Feeding and urine cotinine values in babies whose mothers smoke" Pediatr; 83: 93-97, 1989.
6. Abel E, Marihuana, tobacco, alcohol and reproduction, p107-108, CRC Press Incz, Florida 1983.



Nelson Home Birth Association
PO Box 59
Nelson


Dear College of Midwives

The National Home Birth Conference was held in Nelson on the 17th, 18th and 19th May. A copy of the REMITS and RECOMMENDATIONS passed at the Conference follows. The Conference urges the College to support Direct Entry Midwifery (DEM) programmes as a DIPLOMA of MIDWIFERY.

Home Birth Associations demand direct consumer consultation in the development of DEM Curriculums.

The Home Birth Association of Aotearoa urges you to give this your serious consideration and attention.

Yours faithfully

Brenda Wraight
Conference Coordinator

* * * * * * * * * *

**Remits Passed at the National Home Birth Conference**
**Nelson, May 17, 18 and 19**

1) The Home Birth Associations of Aotearoa strongly recommend that the universal Maternity Benefit be retained. The cost-effective home birth option must remain fully subsidised through the Maternity Benefit.

2) The Maternity Benefit structure must be reviewed to establish a fee structure that reflects the services being provided by the independent practitioner.

3) The National Home Birth Conference urges the passage of the Health Commissioner Bill in its present form.

4) The National Home Birth Conference expresses its concern at the delay of establishing Direct Entry Midwifery programmes. Home Birth Associations demand an assurance that the Nursing Council will approve acceptable programmes at its next meeting to achieve the target date of commencement in mid-1991.

5) The National Home Birth Conference urges the New Zealand College of Midwives (Inc) to support Direct Entry Midwifery programmes as a Diploma of Midwifery.

Home Birth Associations demand direct consumer consultation in the development of Direct Entry Midwifery curricula.

**Recommendations**

In recognition of Maori as the tangata whenua that every Home Birth Association take responsibility for contacting local Maori especially health and women's groups, to send them information and extend invitations to attend all activities.

That all groups will take responsibility for networking. That there will be a contact person in each group and that the names of the contact persons be forwarded to the National Newsletter Coordinator by June 1st. That information available or required be listed in the National Newsletter. That regional networking meetings be set up and that this networking process be re-evaluated at next year's conference.

The following appeared in *Child & Antenatal Nutrition Bulletin*, Health Dept. of Western Australia/Princess Margaret Hospital, Perth, No 11.

## Smoking and breast feeding

*The adverse effects of smoking during pregnancy have received much attention recently. However, the effects of smoking during lactation have not been clearly spelled out. The following article by **Sue Saunders of the Western Australian Lactation Consultancy (Box 1457, Midland, WA, 6056)** helps shed some light onto this topic.*

There is a general trend showing that mothers who smoke during pregnancy do not tend to breast feed.[1] When women who smoke do breast feed, they tend to terminate lactation earlier than non-smoking women.[2] Interestingly, this phenomenon appears to be dose related: the more cigarettes smoked the less time spent breast feeding.

Smoking has numerous undesirable effects on lactation. For example, nicotine is excreted into breast milk in concentrations that are directly related to the number of cigarettes smoked. In fact, nicotine concentrations in breast milk are higher - and stay higher for a longer period than in serum.[3]

The net effect is to reduce basal prolactin levels leading to reduced milk production.[4] Smoking also releases adrenaline which may inhibit release of oxytocin which is necessary for breast milk 'let-down'.

According to Labrecque *et al*[5] most mothers who smoke during breast feeding have smoked throughout pregnancy. While the deleterious effects of maternal smoking on the infant during pregnancy are well known, the additional consequences of smoking during breast feeding have not been fully assessed.

Breast feeding by mothers who smoke is known to expose their infants to the toxic, carcinogenic and mutagenic compounds in tobacco smoke. In these days of concerns about pesticides, mothers who smoke and breast feed might be alarmed to learn that insecticides (like DDT) are applied to some tobacco crops and may therefore appear in breast milk.

4) *Kreosotum* - yellowish discharge, smelling of rye grain, burning with overall weakness.
5) *Merc sol* - thrush accompanied by acute bacterial vaginitis, offensive thick, greenish-yellow discharge, accompanied by chilly sweating and sometimes recurrent fever.
6) *Nitric acid* - discharge thick and cloudy, burning and excoriating. Fissuring and burning of surrounding skin common.
7) *Pulsatilla* - watery, early cycle discharge with variable yellow-green or clear and white discharge.
8) *Sepia* - offensive, yellowish discharge with dragging lower abdominal and uterine discomfort. Constipation, exhaustion and irritability marked.
9) *Sulphur* - chronic thrush, offensive discharge, associated with diarrhoea, eczema, and all symptoms worse in the mornings.

Babies frequently develop thrush - in the mouth or as a persistent nappy rash. An application of gentian violet generally clears this. A rash on the nipples when breast feeding can also be due to thrush.

**J Donley**

# Childbirth: women urged to take back power

By JOYCE THOMPSON

**Women should unite to regain the power lost to specialists, technology and men during childbirth, according to Britain's leading childbirth educator.**

Sheila Kitzinger, in Sydney to address King George V Hospital's golden jubilee conference, called for a major rebalancing of the relationship between pregnant women and their carers.

"I think many obstetricians see their task as that of managing women's wayward uteruses, as even a conquest over nature," she said.

"The most difficult thing in the world for an obstetrician to do is to keep his hands in his pockets."

She suggested that at the bottom of the problem was an attempt to "forcibly superimpose men's sexual activity upon the female psychosexual process".

"The male orgasm consists essentially of mounting tension culminating in erection and then a single act of ejaculation," she said. The female orgasm was different, consisting of waves of desire ascending to climax and followed by a lull before the next one.

"The desire to push in second stage (labour) . . . follows this typical female sexual pattern. Yet in hospital after hospital, women are still exhorted to take a deep breath and hold it as long as they can, and push. The female sex rhythms are denied, rejected as not good enough to deliver a baby."

Expulsion of the baby became a race against the clock.

Mrs Kitzinger said that every time a woman succeeded in giving birth without intervention or drugs, "the dominant values of our technological society are undermined".

"This is heresy, this is witchcraft and they warn us we're playing with fire," she said.

For childbirth in the year 2000 and beyond, Mrs Kitzinger offered two scenarios. The first was "isolated pockets of refugees from the dominant obstetric system", huddled together in potentially dangerous conditions because of a poor homebirth service, inadequately trained midwives and lack of hospital backup. The second involved advocates pushing for widespread social and economic changes to make childbirth safe and satisfactory for women everywhere. — AAP

## ARTICLES OF INTEREST

# Mastitis : A New Look at an Old Problem

Many health professionals look upon breastfeeding mastitis as a relatively uncommon experience. Reports of incidence of mastitis in mothers with newborns range from 2 to 7 percent. However, those who work closely with breastfeeding families have long suspected that it occurs more frequently.[1,2] Incidence reports by physicians are based on the number of women who returned to the clinic or hospital for treatment of a breast infection. The possibility that mothers might have mastitis and not seek treatment and thus be unreported has not been addressed.

The traditional school of thought about mastitis holds two tenets: 1) mastitis occurs in the first few weeks after birth, and 2) it is preceded by nipple breakdown which allows a pathogen to enter the body, usually *staphylococcus aureus*. But there are other factors associated with mastitis, including plugged ducts, milk statis, breast constriction (e.g. by underwire bras), engorgement, poor nutrition, and vigorous upper arm exercise.

The major share of medical research on lactation mastitis has focused on pathology, biomedical analysis, and speculations about mastitis classifications. Research has not examined how the mothers themselves describe their experiences with mastitis: how often it occurs, where it occurs, and what women do when they have it.

To redress this omission, I surveyed 91 women attending two international conferences, one sponsored by La Leche League International and one by the International Lactation Consultants Association. Because the women who attend these conferences generally breastfeed for a longer period of time than the average mother and allow babies to wean themselves, they provide a larger window of time to study the natural history of mastitis. Likewise, this group of women is knowledgeable about lactation and, presumably, can distinguish between mastitis and a plugged duct or other breast problem. However, because of their expertise, this group does not represent the general population. Hence, outcomes cannot be generalized to other populations, although the survey explores new information about mastitis.

*Source*

Breastfeeding Abstracts, Volume 10, No 1, August 1990.
A newsletter for health professionals. Published quarterly by La Leche League International.

The survey defined mastitis to the participants as the presence of breast soreness and redness, accompanied by flu-like aching and a fever above 100.4°F. These criteria have been used in previous research studies on mastitis.

The incidence of mastitis among these women was much higher than anticipated. One-third of the women surveyed said they had had mastitis, as defined by the criteria given above, while breastfeeding their last child. The greatest number of cases occurred during the first four months postpartum. One-third of the cases occurred after the baby was six months old, a time when skin breakdown from sore nipples is rare. A few mothers reported very frequent episodes of mastitis.

The mothers ranked fatigue first and stress second as conditions that preceded the development of mastitis. Several mothers described family trips, christenings, and household moves as precipitating mastitis. Other factors that mothers felt were related to mastitis included, in order of their importance, plugged ducts, a change in the number of feedings, milk statis, engorgement, sore, cracked nipples, an infection in the family, and trauma to the breast. Poor nutrition and exercise were rated as least important.

Most women in the survey (63 percent) contacted their physician when they became ill. It is not known how many physicians prescribed an antibiotic, but only 54 percent of women said they took antibiotics to treat their infection. All said that they continued to breastfeed during and after the infection. None reported developing an abscess.

A number of other survey results are worth noting. The upper outer quadrant of the breast was the most frequent site for the infection to occur. Approximately the same number of cases occurred in the right breast as in the left. Only two women said that the infection occurred in both breasts simultaneously.

The results of this study will be of interest and help to health professionals who work with breastfeeding mothers. Unlike the traditional explanation that mastitis is caused by the entry of a pathogen into the breast through cracked nipples, from this survey it appears that mastitis is multifactorial in origin. Mothers who are fatigued and stressed

1) Echinacea tincture, 3-5 drops daily to nourish your immune system.

2) Pau d'arco which has anti-fungal properties is available either as chips or as a tincture from most health food shops. Pau d'arco is obtained from the inner bark of the Brazilian lapacho (tajiho) tree (family Bignonicaceae) which grows high in the Andes. It is a legendary remedy of the ancient Incas and is credited with cancer-curing properties, as well as being a wide-ranging antibiotic which also attacks viruses. The bark chips are made into a decoction (one heaped tsp in 4-6 cups of water, boiled for 5 minutes in a glass or porcelain container. Brew for 20 minutes). Drink freely on an empty stomach. It can also be applied topically.

3) Gentian violet 1% aqueous solution applied topically is effective but messy.

4) Suppositories made from either golden seal, yellow dock, chick-weed or slippery elm. Combine with cocoa butter, form into two inch oblongs on waxed paper and cool in the fridge.

5) Garlic is anti-fungal as well as antibacterial. Insert either a garlic capsule or a small clove of raw garlic into the vagina. (Both 4 & 5 are recommended by Paavo Airola, *Everywoman's Book*.)

6) Cider vinegar 1:5 solution eases itching.

7) Vegetables belonging to the mustard family (cabbage, turnip, brussel sprouts, mustard greens etc.) should be eaten liberally.

8) Don't use soap, and wear cotton panties - or none at all.

Homeopathic remedies (Trevor Smith, *A Woman's Guide to Homeopathic Medicine*)

1) *Alumina* - for chronic thrush, thick clear or white discharge with itchy burning symptoms worse in progesterone (second) half of cycle. Vulval soreness, constipation.
2) *Borax* - where discharge is thick and gelatinous like clear egg white.
3) *Graphites* - thin watery discharge which burns.

Crook discourages use of foods which contain or are made of yeast - not because these feed the candida, but because candida victims tend to be allergic to yeast-producing foods, e.g. yeast breads, mushrooms, cheese, peanuts and brewers yeast.

On the other hand, brewers yeast is not only a high protein food, it is also an excellent source of B vitamins which the normal gut synthesises, along with vitamin K. The colonised gut is unable to provide these vitamins. Vitamin B is necessary to stimulate production of Hcl which activates pepsinogen to produce pepsin which digests protein. Impaired protein absorption results in a B12 deficiency. If you are allergic to brewers yeast you will experience gas and bloating. Because of its high protein content, brewers yeast should be taken on an empty stomach (to fully utilise the stomach acids). Also because of its high phosphorus content it should be taken with calcium, e.g. in orange juice.

There is a combination of digestive amino acids including Hcl available at health food shops, useful if B12 levels are low.

The cell salts nat mur and kali mur play a role in the production of Hcl. Marijuana suppresses the production of Hcl. It is also advisable to take kelp daily - powder or granules on your salads or in your soup, or a kelp tablet daily. The iodine in the kelp keeps your thyroid healthy and a healthy thyroid is essential in the production of B12.

Cell salts improve your general health. Refer to *Biochemic Handbook* by Dr W H Schuessler. For specific discharges the following cell salts are helpful:

| | |
|---|---|
| Calc phos | for albuminous discharges; |
| Kali sulph | for sticky yellowish discharges; |
| Kali mur | for thick, white fibrinous discharges; |
| Nat mur | for watery discharge with accompanying rawness and soreness. |

As well as improving your nutrition by eating a diet high in vitamins and minerals, e.g. vit A (cod/halibut liver oil) for healthy mucous membranes; vit B to aid digestion; vit C to support your immune system, there are a number of herbal remedies that can help to relieve local symptoms.

## MEDIA WATCH

# Women 'frightened out of homebirth'

**NELSON (PA) — The medical profession frightens women out of choosing a homebirth by refusing to attend and falsely claiming it is dangerous, a domiciliary midwife says.**

Bronwen Pelvin, chairwoman of the Nelson-Marlborough region of the College of Midwives, said the medical profession used the issue of safety as a red herring to take power away from women.

However, Nelson GPs spokesman Dr Jim Jerram said homebirths could be disastrous for some "at risk" women and the lack of backup services for homebirths was of concern.

### Choice

Ms Pelvin told the National Homebirth Association conference here at the weekend that giving birth at home should be the choice of every woman, but it was not because the medical profession had taken over the responsibility and refused to allow choice.

Increased technology in childbirth, including the introduction of ultrasound, forceps, caesarian births and drugs, had created a dependence on the hospital for women and midwives.

Even though the 1990 Nurses Amendment Bill allowed midwives to deliver babies on their own, many still did not offer homebirth services, Ms Pelvin said.

Generations of people who believed the medical profession that hospital births were safer and the reduction of the midwife's role to one of a doctor's assistant, had made women scared to choose a homebirth.

Ms Pelvin said homebirths were "safer" than hospital births because as well as domiciliary midwives having the skills to cope with complications, they built up trust and helped women to relax.

### Alternative

At present only 1.7 per cent of women in New Zealand had homebirths. There would be more if women were freer to choose.

Dr Jerram said homebirths were a viable alternative for well-informed "suitable" women who had good support services, but for others it was not appropriate.

He confirmed there were doctors who refused to attend homebirths and said there were some he would not attend.

Women "at risk" such as diabetics, those with high blood pressure, a multiple pregnancy, babies facing the wrong way and a bad childbirth history, would be safer in hospital, he said.

A team of a doctor and a midwife was the safest choice for a woman, he said.

Contined from Previous Page

appear to be at the highest risk, especially when fatigue and stress are accompanied by plugged ducts or a change in the infant's feeding pattern. This survey points out important questions which should be asked in future studies of mastitis in order to expand the limited body of knowledge we have about breastfeeding mastitis.

**Jan Riordan RN, EdD**
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2. Riordan, J . *A Practical Guide to Breastfeeding.* St Louis: Mosby 1983.

12 The Evening Post, Tuesday, June 4, 1991

# Course limits could result in midwife gap

Midwives could be in short suppply following a Government decision to fund only two new programmes next year, says Jeanie Douche, a spokeswoman for the College of Midwives.

Ms Douche said there had been a substantial increase in demand for midwife-only care since changes to legislation last year gave registered midwives power to deliver babies without a doctor present.

Independent midwife Christine Griffiths said nearly half her practice was midwife-only care. During the next six months, 31 of her 68 expectant mothers had chosen not to have a doctor present at birth.

There are five courses offering a diploma in midwifery after completion of a nursing degree. Seventy-six women became registered midwives last year.

Five or six polytechnics nationwide, including Wellington, are preparing to submit proposals to the Nursing Council of New Zealand to run pilot programmes in direct-entry midwifery. The Education Ministry has agreed that funding will not be provided for more than two courses. As experimental programmes, there will be a single intake at the beginning of the three-year course.

A direct-entry midwifery programme is a course of study in midwifery without first having to complete a nursing qualification.

Domino midwife Marion Lovell said there had been a steady increase of women choosing the midwife-only option in her practice since the legislation. She said she had to take on fewer women because midwife-only care demanded more antenatal visits by the midwife.

Ms Lovell said that, as the Government was looking at ways of cutting costs in the health area, pregnant women might find themselves having to pay for their maternity care. In that case, many more will probably choose the midwife-only option because of its economy.



## Thrush, Monilia, Candida Albicans

Whatever you call it, it itches!

Candida albicans is a yeast or a sac fungus* that normally resides in the gut. As long as you remain healthy, candida is a casual resident in the yeast form. However, when the body gets out of balance, candida exploits the condition to become a coloniser, changing to the vegetative, mycelial form. The mycelium absorb nutrients (your nutrients) and secrete enzymes which are toxic. These toxins paralyse the T cells undermining your immune system; they upset your hormonal system and your central nervous system (CNS). Proliferating yeast produces ethynol which is a CNS depressant and results in a depressed condition known in Europe since the 1950s as the 'drunken yeast syndrome'.

Predisposing factors that provide candida with the climate to make a take-over bid are antibiotics (which destroy the friendly intestinal flora), steroids, the pill, stress, a diet high in refined carbohydrates which leach out your minerals and vitamins, iron deficiency and pregnancy combined with any of the above.

Therefore, one of the first steps in reversing the condition is to restore the lactobacillus population of the gut. One of the best ways to do this is to eat yogurt. You can also apply it to the vagina with an applicator.

William Crook (*The Yeast Connection*) advises a diet high in protein and fat with minimal carbohydrates. As candida thrives on carbohydrates, the idea is to starve them out over a period of six weeks on the diet - but sugar has to be given up for life!

Sugars are present in all sweet foods and include natural sugars such as honey, maple syrup and dried fruits such as raisins, dates, figs, etc. Refined (white) sugar and all products made from this (lollies, soft drinks, cakes, biscuits, alcohol, etc.) not only feed your thrush but leach out valuable minerals and vitamins.

* The sac fungi family (ascomycetes) includes powdery mildews, blue and green moulds on cheese and citrus fruits, baker's and brewer's yeast, edible truffles and morels. Also the fungi from which LSD is obtained and that which causes ergot on rye.