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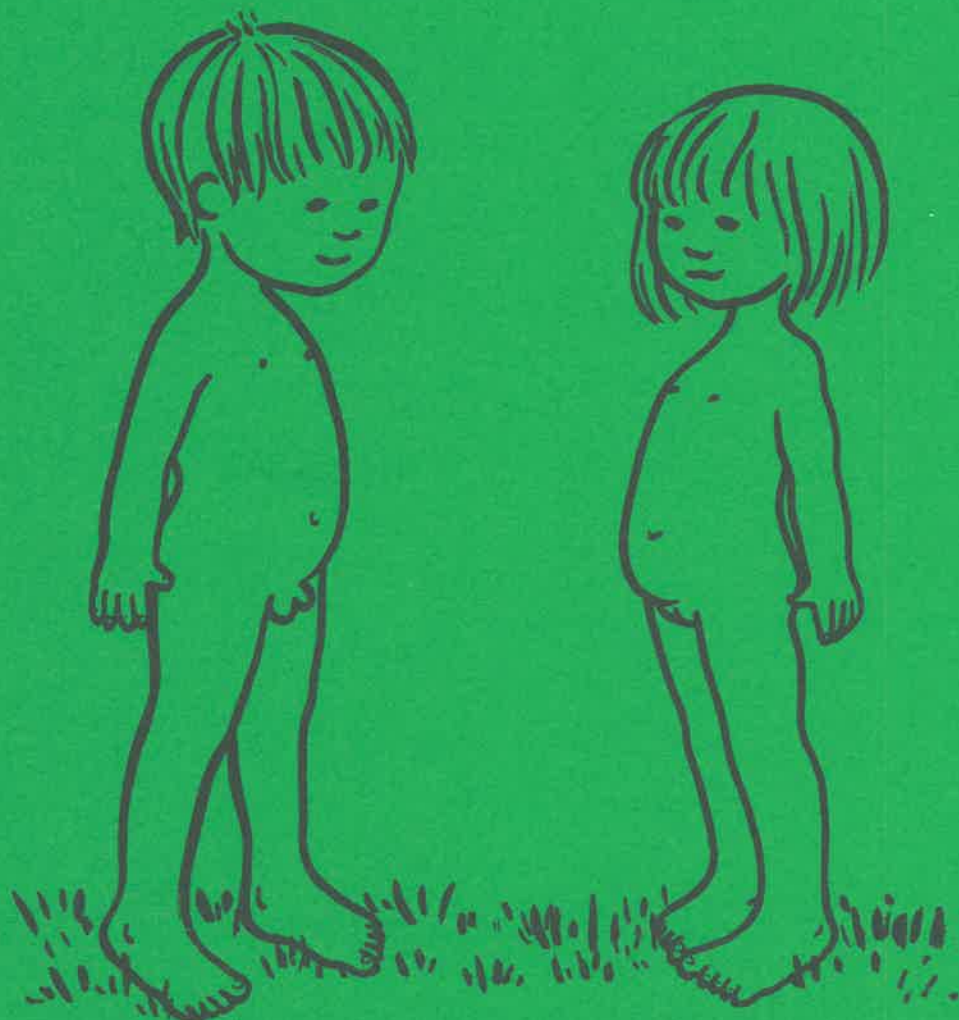

NEWSLETTER • No 57 • AUTUMN '93

AGM AGM AGM AGM

Annual General Meeting of the Auckland Home Birth Association.

Monday 24th May - 7.30pm
Y.W.C.A. - 10 Carlton Gore Rd, Grafton.

Come along and find out what the Home Birth Association has achieved in the last year.

Agenda:

- Reports
- Election of office holders
- Role /direction of the AHBA for the next year

All members welcome
supper provided

New Zealand Home Birth Associations

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THREE LOVES FOR THREE CHILDREN

There is a special love for each child, as this 'poem' which first appeared in Shoret, the Journal of the Israel Childbirth Education Centre shows. (New Generation, March 1992, The National Childbirth Trust).

To the firstborn

I've always loved you best because you were our first miracle. You were the genesis of our marriage, the fulfilment of young love, the promise of infinity. You sustained us through the hamburger years, the first apartment furnished in early poverty, our first mode of transport (our feet), and the seven inch TV we paid for over 36 months. You were the beginning.

To the middle child

I've always loved you best because you drew a dumb spot in the family and it made you stronger for it. You cried less, had more patience, wore faded clothes and never in your life did anything FIRST but it only made you more special. You are the one we relaxed with and realised a dog could kiss you and wouldn't get sick, you could cross the street by yourself before you were old enough to get married, and the world would not come to an end if you went to bed with dirty feet. You were the child of our busy ambitious years. Without you we would never have survived the job changes, the house we couldn't afford and the tedium and routine of marriage. You were the continuance.

To the baby

I've always loved you best because endings are generally sad and you are such a joy. You readily accepted the milk-stained bibs, the lower bunk, the cracked baseball bat, the baby book, barren but for a recipe for graham cracker piecrust that someone jammed between the pages. You are the one we held onto so tightly. For you are the link with a past that gives a reason for tomorrow. You darken our hair, quicken our steps, square our shoulders, restore our vision and give us the humour that security, maturity and endurity can't give us. When your hairline takes the shape of Lake Eric and your children tower over you, you will still be the 'baby'. You were the culmination.

Placenta....... A User's Guide.
by Kim Wheeler.. Midwife.

What's the big deal about your placenta? Well, your baby's placenta is as important to your baby's growth and development as your baby's genetic makeup. Instead of saying "you are what you eat", maybe we'll all be saying in the future "you are what your placenta makes you". In this guide I would like to introduce you to some of the interesting things about the placenta, its range of functions, and to a "user's guide" of terms you might hear about the placenta.

The Third Stage of Labour-the End First.

Soon after your baby is born, the third stage of labour begins. This is where the placenta is born. This stage is generally accompanied by some bleeding, until the muscles in the uterus clamp down and stop the flow of blood. The bleeding continues for several days but should only be as heavy as a period.

Most placenta are round in shape and look and feel pretty solid. Some people think their placenta looks like liver but there are a lot of differences, outside and in. At this time, you'll be able to see the side that acted as an exchange area for the food that your baby gets from your blood. This side or the "maternal" side, is very red and bloody and lumpy looking. The lumps are formed by many tiny clumps of blood vessels that carry the babies blood to the "exchange barrier". This barrier is formed by the cells of the placenta and is where the nutrients from the mother's blood cross the placenta into the baby's blood.

The other side is smooth and has lots of big visible blood vessels. This side is the side closest to the baby. The smooth shining covering which is usually white, is continuous with the membranes that keep the baby in the liquor, amniotic fluid or waters.

You'll also see the cord. The cord has three blood vessels which carry blood from the placenta to the baby and back again. The cord is attached to your baby's umbilicus.

Before Implantation-Back to the Newly Fertilised Egg.

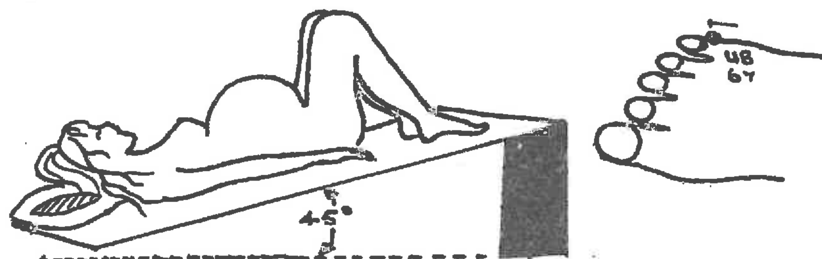
At the time of implantation, which usually occurs around 3-4 days following fertilisation, the fertilised ovum (called a zygote at this stage) is "free living". As the zygote floats down the fallopian tube to the uterus it divides many times producing a solid mass of cells within the original outer layer of the ovum.

The zygote is now called a morula.The morula is covered with a sticky protein layer which means it can stick to the wall of the uterus.

A space filled with liquid develops in the centre of the cells of the morula when it has adhered to the wall of the uterus. The morula is then called a "blastocyst". Inside the blastocyst is a clump of little cells called the inner cell mass, these become your baby.

A layer of cells one layer thick covers the blastocyst and these are the first cells of the placenta - the trophobalst. The cells of the trophoblast that end up closest to the blood vessels that nourish will become the placenta. At this stage the protein layer outside the trophobalst breaks down, its job of helping the morula stick to the wall of the uterus is finished. The process of implantation starts.

2. Prop up an ironing board at an angle of 45 degrees(Brace the ironing board either side with chairs.)



3. The knee-chest position also works (see diagram.)

Do one of these exercises twice a day for about 20 minutes - on an empty stomach.

Acupuncture

Acupuncture works on the principle of realigning the electromagnetic energy of the body. The macrobiotic dietary factors also realign electromagnetic energy, and the combination of the two methods is generally effective unless there is an anatomical reason why the baby cannot turn.

The acupuncture points are UB 67, in the little toes. It generally takes three or four treatments. I like to do these fairly close together, say within a week. [John Mcdonald, Senior Lecturer in Oriental Medicine, University of NSW, (Australian HBA Conference 1983) claims the Chinese do three treatments in a day].

Moxibustion can be used as an alternative to acupuncture. Moxa cones or sticks are burned over the acupuncture point. These are removed when heat is felt by the person receiving treatment. A slice of ginger or garlic can be placed over the point before lighting the cone.

Homeopathy

The homoeopathy remedy recommended is Pulsatilla 200: two doses two days apart in the 35th week. Even more effective is Tuberculinum 10m. [2]

Good luck!

References:

Weston, Marianne Brorup, *Maternal Health News, (Canada) Vol 8 no 3, Oct 1983*

1. Kushi, Michio and Aveline, *Macrobiotic Pregnancy and Care of the Newborn, p72*

2. de Graaf

Turning a breech baby

Joan Donley, Auckland Domiciliary Midwife

You are planning to have a homebirth but at 30 odd weeks your baby has turned and is now in a breech position. You have been referred to an obstetrician and your hopes for a homebirth are fading. Furthermore, if this is your first baby then your chances of having a caesarian section are quite high!

Breech deliveries are more dangerous because of the possibility of compression or prolapse of the cord, rapid compression to the after-coming head which does not have a chance to mould slowly, and the likelihood of inhaling liquor.

At one time doctors would attempt external manual version (turning the baby by external manipulation) during the antenatal period. Today very few doctors are competent to carry out this rather risky manoeuvre, or to deliver a breech. Their skills are surgical.

A number of domiciliary midwives and homebirth doctors have been turning breeches by acupuncture, generally at about 34 - 36 weeks. We have also found that exercises, dietary changes and homoeopathic remedies can help encourage a baby to turn to a head-downward position.

Diet

According to Michio and Aveline Kushi in *Macrobiotic Pregnancy and Care of the Newborn*,[1] the intake of yin foods can cause the baby's head to become too yin to assume its natural downward position for birth. Excessive yin foods (such as fruit juices, tropical fruits, ice cream, sugar, all sweeteners, oil, coffee) make the baby more yin. Cigarette smoking, drugs, chemicals, and an overly active daily schedule also make the baby yin.

Therefore it is necessary to create a more yang condition. Foods which contribute to this are vegetables, animal proteins (fish, fowl, eggs, meat, dairy products) and miso (taken as tea or in soups).

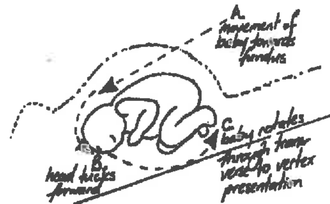
Macrobiotics

Kushi explains that macrobiotics is the art of creating a balance within ourselves and within our environment by adjusting daily food and activities to harmonise with changing circumstances. The neutral macrobiotic diet is:

whole grain cereals	50 - 60%
Vegetables	20 - 25%
Beans and sea vegetables	5 - 10%
soups	5%

Exercises

The following exercise works on the principle of gravity. By angling your body so your head is lower than your abdomen, you are encouraging the baby's head to 'float' up to the fundus. As the pressure builds up at the back of the baby's head it may flex its chin towards its chest and gradually rotate through the transverse (crossways) position to the vertex (head-down) position.



This 'breech tilt' exercise can be done in three ways:

1 Raise your hips about 30cm off the floor using firm pillows.

Implantation.

Implantation begins when the protein coating of the morula breaks down and the cells of the blastocyst stage begin to grow into the tissues of the mother's uterus. The first placental cells, which are already producing hormones, can also produce enzymes that break down the cement like proteins found between the cells of the endometrium or the lining of the uterus. The placenta stops breaking down this cement when it comes into close contact with the blood vessels that feed the tissues of the uterus.

At this point small pools of the mother's blood are formed around the tiny blood vessels of the placenta. The small blood vessels in the area of the placenta get taken over by the placenta. The pressure of the blood coming into the lakes forces the blood that is already there out of the lake back into the uterus. In that way the blood is always being changed for the fresh blood ready to feed the baby. Your blood and the baby's blood never mix and nutrients cross through the cells of the placenta by several paths.

Food for the Baby

The placenta does most of its growing and spreading in the uterus in the first 10 weeks of pregnancy and is fully mature at the end of the first trimester of pregnancy (from this time until the birth, the baby is called a foetus). There are several steps for nutrients to get into the placenta that are in close contact with the mother's blood. The nutrients must then move through these cells to the membrane on the other side of the cell into the baby's blood which is circulating in the placenta.

The baby needs all the nutrients that we do to stay healthy. These are vitamins, amino acids -which are the building blocks of proteins, carbohydrates like glucose, minerals, and fatty acids that make fats and oils.

The baby makes its own stores by assembling them from the fatty acids from the blood. Fats can be used for energy generation throughout the pregnancy. Storage of fats by the baby takes place mainly in the last few weeks of the pregnancy.

The type of fat that makes cell membranes, is transported in large quantities initially. This is so there are sufficient amounts of liquid for the huge number of the cell divisions occuring as the baby grows. Each time a cell divides it needs enough liquid to create a whole new membrane, or coating for the daughter cell.

Also transferred by the placenta to the baby are immunoglobulins, proteins that keep the baby free from disease when it is born. These all come from the mother's blood. The placenta and the baby probably work together to make sure the baby and the placenta get what both need at different times of the pregnancy.

The Paths that the Food Takes

Because the baby's and the mothers blood never mix there is "sieving" effect for the nutrients in the places where the placenta sits in the mothers blood. There are several ways that nutrients get into the placenta and then into the baby. The simplest process is diffusion. This can occur when there is more of a particular nutrient on one side of a cell membrane. Some experiments have shown that the placenta is able to adjust this process. This gives a steady flow of nutrients to the baby by the nutrient moving quickly to the baby so that there is always less on the baby's side of the placenta but often a lot of nutri-

ent in the baby's circulation.

Oxygen in your blood is an example of a small molecule which diffuses quickly across the placenta to the baby. Similarly carbon dioxide produced from the baby diffuses quickly back to the blood from the placenta. A steady supply of oxygen to the baby is very important for the baby's development.

Women who smoke during their pregnancy may limit the amount of oxygen crossing the placenta as well exposing the baby to chemicals like nicotine that are in the blood. Smoking appears to have fairly identifiable affects on the placenta. Placenta from the women who smoke are generally smaller and "gritty" to touch. The gritty feeling may mean the placenta is less efficient and may make the baby smaller than normal at birth. The baby is small because it is undernourished. Some women who smoke don't have smaller babies and this may be due to some compensatory mechanism in the placenta. Ethanol or alcohol, is another small molecule that diffuses easily across the placenta. Drinking alcohol is not recommended during the pregnancy. Although the placenta may not be affected directly, ethanol diffuses straight through to the baby. Persistent use of alcohol during pregnancy can have devastating effects on the baby's mental development. One or two glasses of wine a night is "excessive" in pregnancy.

Some nutrients diffuse across the placenta central "cells" by "facilitated diffusion". This process is where a particular protein binds to the nutrient and carries it across the cell membranes. Examples of nutrients transported in this way are glucose and iron. If all the proteins that carry iron or glucose are being "used" then the extra amounts of nutrients will not cross from the mother's blood into the placenta. Another way the baby gets essential nutrients is by a process called active transport where nutrients are pumped across the placental cells. This uses energy from the cell but does not depend on the amount of nutrient or the number of protein "carriers" available. That energy is recouped by the placenta. The placenta gets energy from the glucose and oxygen in the mother's blood and some glucose may be transported back from the baby for use by the placenta. Just as there are proteins that transport glucose from the mother's blood across the placenta so there have been proteins identified that carry glucose back to the placenta.

The placenta produces lactate from the glucose in the mother's blood. Lactate can be converted back to glucose by the baby. Lactate and fructose, which is another sugar, are transferred by the placenta to the baby. The baby may use these molecules to store energy but may also convert these molecules to glucose to produce energy. The recycling function between the baby and the placenta, as seen with the sugars, has been shown in experiments with some of the amino acids and who knows how often this may happen with other nutrients.

The Placenta Towards the End of Pregnancy

As the baby grows it begins to run out of room in the uterus around the time of the delivery date. At this time the placenta begins to become less efficient at passing nutrients and changing the environment inside the uterus to suit the baby's needs.

The aging of the placenta probably has something to do with the cells not being able to divide and grow and this may be programmed into the placental genes.

So here we are back where the story

THE PREGNANT WOMEN'S HOMEBIRTH BILL OF RESPONSIBILITIES

The pregnant women is responsible for;

- learning about the physical, psychological and emotional process of labour, birth and postpartum recovery.
- learning about good prenatal and birth care so that she may choose the best possible arrangements which suit her individuality and circumstances.
- learning about her practitioner's methods.
- her own physical and emotional well-being during pregnancy.
- attending her prenatal appointments and informing her practitioner if she is unable to attend.
- her own psychological preparation for homebirth in a society which may be unsupportive or even hostile, especially if the pregnancy results in a less than normal outcome for the baby.
- meeting her practitioner's requirements for preparation for homebirth.
- informing the practitioner of any relevant physical, emotional or psychological information which may affect the outcome of her birth. These may include intake of drugs, medications, herbs, allopathic, naturopathic, psychological, or alternative therapies and the obstetrical, sexual or psychological history of herself or her relations, friends or partner which are affecting her attitude towards birth and parenting.
- discussing mutually agreed upon birth wishes/plan with her practitioner in advance of labour.
- choosing a suitable support person or persons for her birth and for ensuring they are emotionally and psychologically prepared for their role at her birth.
- ensuring her support people can carry out her preferences if she is unable to express them during labour.
- the psychological and emotional preparation of siblings for the birth.
- the choosing and preparation of individual support people for siblings acquiring information about breastfeeding and care of the newborn.
- arranging domestic support for herself and her family during the postnatal period.
- evaluating the quality of care she has received and making any dissatisfactions she may feel known to her practitioner or to the Domiciliary Midwives Standards Review Committee.

THE PREGNANT WOMAN'S HOMEBIRTH BILL OF RIGHTS

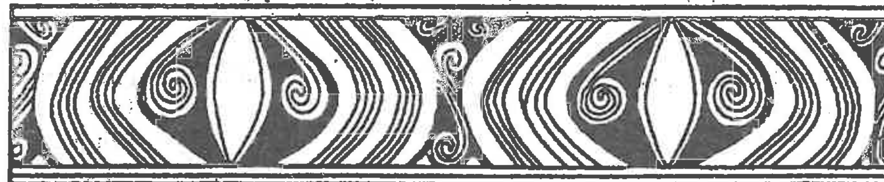
This is a check list prepared by the Manawatu Home Birth Assn. It may be of use to you when planning for your home birth.

The pregnant woman has the right;

- to choose her place of birth.
- to choose her birth practitioner and to be fully informed of her practitioner's qualifications and experience.
- to choose who will be present at her birth and the right to refuse entry or to ask anyone to leave her place of birth.
- of access to literature and information about birth and particularly homebirth
- to know her practitioner's methods and techniques of birth.
- to know the approximate costs (if any) which will be incurred under the practitioner's care.
- to expect any information she gives her practitioner will be confidential and not divulged to anyone else without her permission.
- to comprehensive antenatal care including access to standard tests and procedures related to the well being of mother and child.
- prior to the administration of any drug, medication, procedure or test to be informed by her practitioner of any direct or indirect effects, risks or hazards to herself or her unborn or newborn baby.
- to determine for herself whether she will accept the risks inherent in a proposed therapy, drug, test or procedure.
- to choose how she gives birth and to be treated with dignity and consideration so that she feels free to follow her instinctive reactions during birth.
- to ancillary medical support when needed.
- if transferred to hospital, to be treated with respect and courtesy and to be accompanied by her practitioner (if willing and able) and the support person of her choice.
- if transferred to hospital, not to be separated from her baby except for valid medical reasons.
- to comprehensive postnatal care including support for the establishment of breastfeeding, assessment and care of her newborn baby, and information about relevant screening tests and registration of birth.
- to be informed if there is any known or indicated aspect of her or her baby's care or condition which may cause her or her baby later problems.
- of access to her and her baby's records and to receive a copy of her notes when desired.
- in the event of an unexpected outcome to her pregnancy or birth to receive all the additional support and services that she needs.
- to complain and receive satisfaction from her practitioner. She may also use the Domiciliary Midwives Standards Review Committee in order to lodge a complaint.

began at the third stage of labour! I hope you have a good look at your magnificent placenta. It really is a remarkable organ.

NOTE I wrote this to present some of the most recent research findings in an understandable form for anyone interested in families. I feel this a sadly neglected subject. I am a practising midwife and am researching the human term placenta at a PhD level.
Reprinted from the New Zealand College of Midwives Journal April 1993



Book Review

Talking Past Each Other!?
by Joan Metge and Patricia Kinloch.

Problems of Cross Cultural Communication.
Today when we are all more aware of the different cultures within New Zealand and the need for us all to understand and communicate with each other we often wonder what hinders communication Why is it when we put so much energy into a bicultural or multicultural event that it just did not seem to go so well. This booklet looks at the differences in communication between the Maori, Samoan and Pakeha cultures. This booklet is easy to read and a must for all.

Some of the differences in communication between the Maori, Pakeha and Samoan are:

- Maoris and Samoans emphasize body language more than Pakehas.
- Pakehas are often great talkers and Maori and Samoans tend to tune out as it often seems like trivia.
- Pakehas when talking to someone always look them in the eye.
- Maoris and Samoans consider it impolite to look directly at others when talking to them as they believe it encourages conflict and confrontation and it also cuts others out of the group.
- For Pakehas standing for guests etc. is a sign of respect.
- In order for Samoans to be respectful they need to be physically lower than a superior.
- Both Pakeha and Samoans tend to use the words please and thank you.
- For the Maori these words do not have a precise equivalent and so they express gratitude by and action or a gift or a speech if they are on the Marae.
- The definition of Family, Parent and Child is different for each of the groups.
- The different cultures have different ways of educating their children.

SPOCK RECANTS: BREAST BEST

It is as though the Pope had proclaimed Holy Communion heresy on the grounds that transubstantiation does not work.

After more than 40 years of telling parents that cow's milk is a near-perfect food for the young, Dr Benjamin Spock has changed his mind.

Dr Spock, who will be 90 next year, was at pains not to upset those parents for whom his recantation comes too late. At a journalistic auto-da-fe in Boston he said; "This does not mean that every child that's been on cow's milk is doomed, but breast-feeding is the best milk feeding for babies. I want to urge parents... to use breast milk."

Cow's milk stands accused of causing allergies and digestive problems in some children. It is also said to contain too many antibiotics (derived from cattle feed) and too little iron - so little that over-reliance on it can lead to anaemia. There is also evidence linking its consumption to the onset of juvenile diabetes in youngsters genetically susceptible to that disease.

A team from the University of Toronto reported in July its suspicion that children who develop antibodies to the protein in cow's milk are at increased risk of juvenile diabetes because these antibodies also seem capable of attacking the pancreatic cells that produce insulin.

Dr Spock and his colleagues were also less than enthusiastic about giving cow's milk to older children. They noted that other foods, such as kale, broccoli and fish are richer in calcium and leaner in saturated fats than cow's milk. They did not explain how to make children eat up their greens.

This is not the first bad news for Buttercup this year. The American Academy of Paediatrics withdrew its endorsement of whole cow's milk for infants on the basis that it supplies too little iron.

But a spokesman for the group said that its committee on nutrition is not prepared to make any similar recommendations for children more than a year old, because only a small fraction of the population is adversely affected.

Dr Spock, as ever, has stirred up some controversy with his latest volte-face. The Food and Drug Administration has denied his contention that as much as a third of the United States milk supply is contaminated by antibiotic residues.

It says that only 0.08 per cent of raw milk and 0.02 per cent of pasteurised milk contain trace amounts of these drugs.

NZ Herald November 1992
(reprinted from the Economist)

time can be explained as a time of spiritual reflection and bonding with the baby, not merely an excuse for being lazy for six weeks. Then bring the ideas home; suggest freezing meals ahead of time, having a friend or relative help out, or hiring a doula.

Talk about warming foods, heating pads and belly wraps. Discuss psychological and emotional isolation and how other cultures prevent it.

There is more we can do. We need to be more available and supportive postpartum. For instance, we can make sure to do a six week visit, the one usually put off. We can turn the visit into a celebration of parting of midwife and mother. In addition to discussing birth control and checking the baby over, the mother may want to invite some friends, share some food, tell the birth story one more time, and acknowledge her reentry into society as a "new mother".

(Reprinted with permission from "Midwifery Today" Number 22: Summer 1992)

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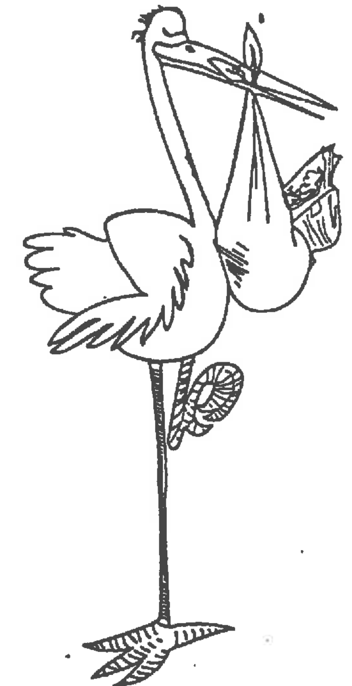

Americans and Malaysian traditional societies, blood is "hot". Thus the loss of blood involved in birthing creates a state of "cold". Chinese medicine holds that one's "chi" or vital force has been reduced, creating the "cold" state. In my practice, we often joke that the pregnant woman has her "personal portable heater" on her belly during pregnancy, because pregnant women so often feel warmer in general, and it is common to watch women experience chills and shakes immediately after birth. Many cultures use some method of heating the mother up, inside and out, after the birth experience.

One method of warming the mother is to feed her only "hot" foods. These foods are classified not so much as to how they are prepared or taste as for the effect they have on the body. Cold foods are to be avoided. Vietnamese and Filipinos caution against sour foods and cold drinks. Malaysians include fruits and certain vegetables in their cold category. In Mexico, avocado, cucumber, cabbage and melon are avoided. Chicken broth or soups, herbal teas and warm drinks are universally accepted postpartum.

MOTHER ROASTING

The practice of mother roasting or literally, heating the mother, exists in many cultures and in various forms. Raven Lang has written of the Chinese practise of moxabustion for the postpartum woman - gently heating the lower back and abdomen with smoke from the moxa stick for a period of 30-40 minutes over several days. In Asia and Malaysia, traditional people may use a "roasting bed" by building a small fire underneath a raised bed where the postpartum mother lies.

The heat of the fire is believed to improve circulation, encourage involution of the uterus, and close up the cervix. A woman would spend from a few hours a day to several weeks on the roasting bed, depending on her needs and time factors. In the Americas, the mother roasting takes the form of the sweat lodge or Temazcal. Traditionally, the steam or sweat baths begin the third day postpartum and continue every three or four days until the 40 days are done. Plants are used both in the water (steam) and directly on the skin. Mexicans believe the Temazcal (steam bath) helps to "eliminate water and toxins, bring down the milk, close up the waist, expel the cold, and return organs to their original place". In Mexico as well as Micronesia, women who are postpartum may be instructed to squat over a bowl of steaming hot herbs to heal the perenium, close up the cervix, and replace lost heat. In Asia and Latin America a small glass cup which contains a small amount of alcohol is ignited and pressed onto the skin, creating a hot suction. This practice of "cupping" is used on the back to "restore the chi" or "close up the bones".

A belly binder also retains heat. Some cultures apply a herbal wrap beforehand to heat up the skin. Cotton leggings and tights serve the same function as traditional leather, cotton or wool wraps.

In modern society, we may feel that we can't indulge ourselves in these rituals, even if they seem so sensible. After all, women and birth aren't recognised as spiritual life changes, deserving of honour. But they could be, if we are willing to change our beliefs and influence society's.

We can start by telling stories. You can tell stories from your own experiences, or of what you've heard of others. Tell your childbirth education classes about postpartum rituals around the world: that rest is healthy and encouraged. The lying in

A CHANCE TO CHOOSE YOUR BABY'S SEX

by David Rorvik with Dr Landrum Shettles

Over the centuries, man has devised at least 500 "formulas" for choosing the sex of his offspring. Aristotle advised the Greeks to have intercourse in the north wind if males were desired, in the south wind if females were wanted. To this day, some European peasants wear their boots to bed when they want to conceive boys, and in some rural American communities men still hang their pants on the right side of the bed if they want a boy and on the left side if they want a girl.

Interest in choosing a particular sex - and anguish over failure to produce it - remains as high among couples today as it ever was. As one young housewife, who has three boys, put it, "My doctor said I was being silly and immature when I begged him to help me have a little girl. He has children of both sexes and can't understand the hurt of always having boys."

X versus Y. One doctor who does understand is Landrum Shettles, an assistant attending obstetrician-gynaecologist at New York's Columbia Presbyterian Medical Centre and an assistant professor of clinical obstetrics and gynaecology at Columbia College of Physicians and Surgeons. Dr Shettles recalls the night in 1961 when he made the discovery that may help millions select the sex of their offspring.

"Medical science had known for some time," he says, "that it is the male who determines the sex of the offspring. If the fertilizing sperm carries an X chromosome, the child will be a girl; if it carries a Y, the child will be a boy." The trouble was that doctors had been unable to tell the difference between "male" and "female" sperm. About all that was known was that the Y chromosome is smaller than the X. Dr Shettles had long felt that this difference should be reflected in the size of the sperm heads. But, under an ordinary microscope, killed and permanently fixed specimens failed to reveal the presence of two distinct sperm populations.

"Then one night," Dr Shettles continues, "I decided to examine some living sperm cells under a phase-contrast microscope." This relatively new type of microscope throws eerie haloes of light around dark objects, revealing details that ordinary microscopes miss. The living sperm cells under the microscope flashed through the field of vision like luminescent eels. Dr Shettles put them into slow motion by exposing them to carbon-dioxide gas - and almost immediately noticed that the sperm came in two distinct sizes and shapes. "I was so excited," he recalls, "that I ran upstairs to find a lab technician. I had to show somebody what I'd found."

Today, after examining more than 500 sperm specimens, Dr Shettles is convinced that the two sizes correspond to the two sexes; small, round-headed sperm carry the male- producing Y chromosomes; and the larger, oval-shaped sperm carry the female-producing X chromosomes. In most cases, the round sperm far outnumber - perhaps by two to one - the oval-shaped.

TIME FACTOR

As soon as he had made his initial discovery, Dr Shettles had only one thing in mind, to find some means of exploiting this knowledge to help parents choose the sex of their children. It seemed fairly certain, he reasoned, that the larger, female producing

sperm, (now called gynosperm) must be more resistant than the other type. Why should there be nearly twice as many of the smaller, boy- producing variety (known as androsperm) in the ejaculation of the average male if not to compensate for some inferiority in coping with the environment beyond his reproductive tract?

To find out what accounts for the greater vulnerability of androsperm within the womb, Dr Shettles began studying the environment that exists inside the vagina and uterus at about the time of conception. He took transparent capillary tubes and filled them with cervical and vaginal secretions. Then he turned millions of sperm loose at the opening of the tubes and watched their activity through his microscope.

"It was a little like watching a horse race," he says. When the secretions in the tubes were more acidic than alkaline, the gynosperm seemed to prevail. But when the tubes were filled with cervical mucous removed from a woman very close to the time of ovulation, the smaller androsperm always won out. Why?

Acid inhibits both gynosperm and andosperm, but it harms the androsperm first and most, cutting them out of competition. The gynosperm's greater bulk seems to protect them from the acid for longer periods.

Alkaline secretions, however, are kind to both types of sperm and generally enhance the chance of fertilization. But in the absence of hostile acids, the androsperm are able to use the one advantage they have over their sisters; the speed and agility that their small, compact heads and long tails give them.

As a gynaecologist, Dr Shettles knew that the environment within the vagina is generally acidic, while the environment within the cervix is generally alkaline. And, he knew, the closer a woman gets to ovulation the more alkaline her cervical secretions become.

All this told him that the timing of intercourse is a critical factor in determining the sex of children. His findings suggested that intercourse at or very close to the time of ovulation, when the secretions are most alkaline, would very likely result in male offspring. On the other hand, intercourse two or three days before the time of ovulation, when an acid environment still prevails, would be likely to yield female offspring. The female producing sperm cells can survive those two or three days, while the androsperm rarely last longer than 24 hours.

Absolutely positive now that he was on the right track, Dr Shettles found further confirmation in data on artificial insemination. Doctors who specialise in artificial insemination try to pin-point the time of ovulation in their patients so that fertilization can be achieved on the first try. It occurred to Dr Shetles that an unintended side effect of this practice ought to be an abundance of male offspring. In a series of several thousand births achieved by artificial insemination, he found that the sex ratio was 160 males for every 100 females. In another series, 76 % were boys. His hunch seemed to be correct.

In the course of his early research, Dr Shettles had also noted that a low sperm count seems to be associated with a preponderance of female offspring. Men with a high sperm count, on the other hand, tend to father a greater number of male offspring. This suggested that building up the sperm count through abstinence might be another way of increasing chances of begetting male offspring.

we not give ourselves much "lying in" time, but we also have the other extreme: birth as a video event and women boasting to one another at how quickly they were back on the job or forcing themselves to attend parties.

Many cultures observe a period of some degree of seclusion. Malaysians observe 40 days and Mexicans observe los cuarenta ("doing the 40"). The Chinese "do the month" or "do the moon" at which time the mother and baby stay indoors, observing certain rituals in a "moon room". When the month is up, they invite friends and relatives to a banquet. The Ibo of Africa have a 28-day seclusion period which ends with the baby's naming ceremony.

In Colonial America, the "lying-in" was for four weeks, during which time other women took over the household chores. At the end, a "groaning party" was held for the helpers. The groaning referred not to the noises of labour, but to the groaning of the table and the women - both full of food.

THE FOUR ELEMENTS

The earth element is most easily recognised in the practice of burying the placenta or cord stub, returning it to the earth. The placenta is customarily buried under a tree in the cultures of Apache Indians, traditional Hawaiians, and in many parts of Africa, Asia, Polynesia and Latin America. Planting a tree with or without the placenta underneath to commemorate the birth was or is the custom among the Jews, Swiss, Swedes, Germans, Javanese, New Zealanders, and people of the Fiji Islands and New Guinea. In Mexico, some families who have no garden will bury the cord stub in a potted plant. The Malays believe that the placenta is the child's older sibling and thus entitled to a decent burial.

In many cultures, infants are bathed in soothing waters: Medieval Europeans gave newborns a "sweet bath" of soothing herbs like rose petals and lavender. Mexicans may choose wild lettuce or chamomile. German mothers often use rosemary. Vietnamese would cleanse both mother and baby in cinnamon water. The Onitsha of Africa would give the baby hot herbal baths twice a day for 28 days. Often the bathing was a ceremonial marker of the end of the phase; for example, Northern Plains Indians would have a ceremonial bathing and then the naming ceremony at the end of the 30 days seclusion.

The Catholic baptism, with its ritual dunking of the baby in Holy Water, marks for many Latin Americans the legitimate naming ceremony.

In our own culture the Leboyer and waterbirths are seen as favourable to baby's well-being, while mothers are usually forbidden to bathe during the early postpartum days, and certainly not in cool water.

The Apache Indians believed wind could kill a postpartum mother if it got to her. The Chinese advise the postpartum mother not to be blown by wind, or she will suffer ill health for the rest of her life. Mexicans believe the postpartum woman who gets cold on her back or walks barefoot on cool floors will become ill. This is why, they say, the midwife positions herself in front of the mother during birth so as to "block the wind" and prevent the cold air from entering.

There is a universal belief that after childbirth a woman enters a "cold" state, and heat must be restored in various ways. According to ancient Greek humoural systems purported by Galen (of Heat, Cold, Moisture and Dryness) and still followed by Chinese, Japanese, Egyptians, Latin

POSTPARTUM RITUALS: HONOURING THE MOTHER

by Alison Parra Bastien

"Right after the baby was born and taken care of, my mother started to clean me. After I was cleaned, she started massaging my bones back in place. For 30 days we stayed, my baby and I, in cleaned rags, and did not do any heavy work. I was bathed and given a cleansing ceremony every four days. Mother would wash me then sit me next to the incense so that the smoke would go up my blanket and purify my body. Once the 30 days were over, the baby and I were cleansed, and the child-naming ceremony took place." -Beverly Hungry Wolf, from Ways of My Grandmothers.

Across cultures, the sacred element of transition from girlhood to motherhood is honored by performing various rituals. Unfortunately, rituals which honour this change are conspicuously absent in our western care models. In more traditional societies, there is a common bond of acknowledging the power and specialness of the postpartum period from the mother's perspective.

The obvious common factor is seclusion, otherwise known as "lying in" or "hanging out (at home)." Other commonly performed rituals are based upon a relationship to the four elements of Earth, Water, Fire and Air, and in large part, common sense.

THE SACRED, THE PROFANE, AND RITUAL SECLUSION

Vicky Noble, in her book, Female Blood: The Roots of Shamanism, writes of birth as like the shaman's journey. "A woman about to give birth stands at the gateway of life and death. She peers into the death realm, not knowing for certain she'll come out alive - she enters into an altered state of consciousness, reaches over, and brings through another new soul."

Birth is considered to be one of the ancient Blood Mysteries, because women's major transformations are accentuated by blood - in adolescence there is menstruation, in matrascence there is pregnancy and the absence of blood as the baby grows, and the third is the transformation of blood into milk. These transformations have always been regarded as either Sacred and Holy or Profane and Unclean. The loss of identity and dignity and the separation from our babies and loved ones which occur in the standard medical model may have evolved from the profane perspective on birth.

In primitive societies, rituals of purity observed by divine kings and priests were also observed by mourners, pubescent girls, hunters, fishermen, and birthing women. What they all had in common was the transitional status: direct contact with life and death. For this reason, they were often placed in seclusion and regarded as spiritually dangerous or special for coming so close to the boundaries of being and non-being.

In modern times, we see postpartum rest and seclusion as signs of passivity and weakness, whereas in other cultures it was a sign of reverence. Our isolation postpartum is more often psychological - we feel isolated because there has been no acknowledgment of the tremendous change we as women have undergone; no ritual, no reincorporation into society. Not only do

As a result of all these findings, Dr Shettles has formulated two procedures - one to be used if a female child is desired, the other if a male is wanted:

FOR FEMALE OFFSPRING

1. Intercourse should cease two or three days before ovulation.
2. Intercourse should be immediately preceded, on each occasion, by an acidic douche consisting of two tablespoons of white vinegar to a quart of water. The timing alone might be enough to make female offspring probable, but the douche makes success all the more likely, since the acid environment immobilises the androsperm.
3. If the woman normally has orgasm, she should try to avoid it. Orgasm increases the flow of alkaline secretions, which could neutralize or weaken the acid environment that enhances the chances of the gynosperm.
4. Shallow penetration by the male at the time of male orgasm is recommended. This helps to ensure that the sperm are exposed to the acid in the vagina and must swim through it to get to the cervix.
5. No abstinence from intercourse is necessary until after the final intercourse two or three days before ovulation. A low sperm count increases the possibility of female offspring, so frequent intercourse, prior to the final occasion two or three days before ovulation, cannot hurt and may actually help.

FOR MALE OFFSPRING

1. Intercourse should be timed to be as close as possible to the moment of ovulation.
2. Intercourse should be immediately preceded, on each occasion, by a douche consisting of two tablespoons of bicarbonate of soda to a quart of water. The solution should stand 15 minutes before use.
3. Female orgasm is not necessary, but is desirable. If a woman normally has orgasm, her husband should time his to coincide with hers or let her experience orgasm first.
4. Deep penetration at the moment of male orgasm will help ensure deposition of sperm close to the cervix.
5. Prior abstinence is necessary; intercourse should be avoided completely from the beginning of the monthly cycle until the day of ovulation. This helps ensure maximum sperm count, a factor favouring androsperm.

FAMILY BALANCE

So far, clinical results with the procedures outlined above have been encouraging. In one study, Dr Shettles reported that a group of 22 couples who wanted female offspring took up to six months to conceive by timing intercourse two to three days before ovulation. "Of 22 offspring," he notes, "19 were girls. In a group of 26 women anxious to have boys, the first coitus occurred at the time of ovulation or within 12 hours thereafter. To these women, 23 boys were born."

Of course, Dr Shettles does not guarantee that these procedures will be successful in every instance. But, in his words, "They are safe and simple. There's nothing distasteful about them, nothing that any religious body has objected to. I believe that if a husband and wife are conscientious with the timing and the douche, they can achieve success 85% to 90% of the time."

Some observers believe that the ability

to choose the sex of children may result in an over-abundance of boys. Dr Shettles is convinced, however, that parents will not use his techniques to produce either mostly males or mostly females. "Over the years. parents have expressed one desire," he says. "That is to have balanced families in terms of sex."

Many couples have told Dr Shettles that they had initially planned a family of two children, hoping for one of each sex. But when both offspring turned out to be of the same sex, they made a third attempt - and so on. It is not too far-fetched to envision sex-selection making a significant contribution in the effort to control the population explosion. How much better would it be to achieve the ideal family balance in two conceptions rather than three or four, or more - or never.

Not everybody had agreed with Dr Shettle's findings, and he does not claim scientific infallibility. But he does stand on his record, on observations he has made in the laboratory and, most important, on his results to date. So, it appears quite possible that for the first time parents may have the opportunity to make a scientific attempt at determining the sex of their children.

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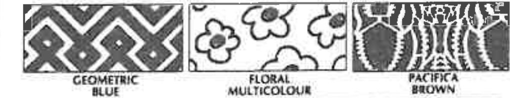

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" Suzanne tells me this between contractions and the tears well up for me too, a sudden, deep emotional connection, childbirth linking my mother and me, her only daughter. The second stage of labour lasting an hour and a half, I found the most difficult. I had plenty of energy left and felt clear-headed but mentally I had to really extend myself to accept the pain of pushing. Each time a lull ocurred between those clamouring urges to push I would think, oh my god I'm going to have to do that again and again. My poor bottom was all I could worry about. Sian was kneeling on the floor in front of me as I sat on the birthing stool, with Geoff and Diana supporting me from behind. Sian acknowledged that yes, it did hurt and that yes, I would now have to give 110%. Somehow her saying this made it easier to go on. Jan, my doctor, who had arrived for the finale said quietly into my ear for me to push through the pain. Unbelievably I found myself doing what she said and with that particular push I felt something give. Where do we women get all this strength from? In the next breath I was up on the bed, totally consumed by that burning sensation as Sian massaged me with wheatgerm oil to ease Oscar's head into the light of day. "He's trying to say something", said someone as his little head, covered in wet black hair, waited for the rest of him to arrive. One last push and he was out - waving with his hand instead of a shoulder, causing me one small tear only. What a glorious climax this was - tiny Oscar had arrived, eyes wide open, looking around, nestling at the breast within seconds and hardly a sound. A gently passage into life and our welcoming arms. In the photos taken my face glows with elation and satisfaction - no drugs, no hospital. That's the hardest thing I have done in my whole life, I remember thinking immediately afterwards and that no, I was never going to do it ever again. But of course as nature began to work its magic those feelings faded fast.

Thank you to my partner and friends and to Sian, whose management of the labour was so empowering of me.

Rose Yukich

Thanks to Kate and Rose for sharing your birth experiences.
Birth stories for publication are always welcome. Please send yours to A.H.B.A. - P.O. Box 7093 Wellesley St, Auckland 1

Birth Notices

MIDWIFE: ADRIENNE BELL

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
21.12	Sally-ann Reddaway	M	Peter	3500	2	Vos M/W
06.01	Veronica Niewenbroek	M	Nicholas	4200	2	Kearney M/W
20.01	Corene Walker	M	Nicholas	3300	1	Kearney M/W
12.02	Jocelyn Murray	M	Tasman	3000	2	Kearney M/W

MIDWIFE: MAUREEN KEARNEY

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
13.01	Louise Legget	M	Edward	3595	3	
08.02	Esther Stewart	F	Jasmine	3500	2	Bell M/W
17.02	Joy Sexton	M	Gene	3500	1	Bell M/W

MIDWIFE: JOYCE COWAN

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
09.01	Lianne Porter & Kiu Muller	M	Karsen	3765	2	M/W only

Joyce also attended 2 hospital births

MIDWIFE: JAN THOMPSON

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
12.12	Diane & Mike Kelly	M	Jacob	3250	1	Hoare M/W
19.12	Tracy & Peter Nuske	M	Samuel	3500	1	M/W only & Peter's sister - Aust. M/W
12.01	Annie Munro	F	Kelly	4000	3	M/W only

Jan also attended 2 births ant Warkworth Birth Unit, 2 hospital births & 2 women for postnatal care only.

MIDWIFE: RUTH DAVISON

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
08.02	Robyn & Robert Edwards	F	Laura	3500	1	Cox M/W
23.02	Brigid & Alan Hilford	M	Caillan	4600	2	Vita M/W

MIDWIFE: FIONA CLEMENTS

Date	Parents' names	Sex	Baby's name	Wt	Baby no.	Doctor
12.01	Kerry & Harold Watson	F	Sydney	4030	1	Bilton M/W

MIDWIFE: VERONIKA MULLER

04.10	Hiraina Tuhiwai & Tim Green	F	Chloe	3770	3	Hilton
06.10	Shirlene & Paul Johnstone	M	Bruno	4480	1	Hilton
04.11	Lisa & Tui Eves	M	Jackson	3180	1	Hilton
13.11	Marie & Tim Reilly	F	Anna	4460	2	Hilton
19.11	Elizabeth & Theo Boogaard	F	Saskia	3200	1	Hilton
22.11	Audrey & David Sorrell	M	Connor	3490	2	Denyer for Hilton
17.12	Jennie & Jeffrey De Varga	F	Isabelle	3520	1	Hilton
05.01	Trish & Brent Johns	F	Bianca	3150	1	M/W only
10.01	Helen Cox & George Lindsay	M	Connor	3260	1	Hilton
27.02	Carlene Judson & Dave	F	Ayla	3940	3	Hilton

MIDWIFE: JENNY MCDONALD

28.12	Tara & Jim Wafer Water birth	F	Emerald		1	Hodson M/W
31.12	Cassie & Nigel Marsters	M			1	Maclaurin
10.01	Wendy & Craig Kendall	F	Ella	3700	1	Maclaurin
19.01	Moira & Steve Waite	F	Alexander	3250	3	Groom M/W
28.01	Jodi Scott	M	Dylan	3550	2	Peters
14.02	Michelle Porter	M	Felix		2	Groom M/W
20.02	Veiushlca & Richard Kalenjuk	F	Nikita	3430	1	Maclaurin
25.02	Linda & Paul Simpson	M		3450	3	M/W only

MIDWIFE: HEATHER WAUGH

14.01	Helen & Paul Parmentier	M	Marcel	4335	1	Copland
15.01	Deneke & Mark Jansen	F	Aretha	3150	2	Copland
05.02	Tea & Vao Malo	F	Atogaugaaletui-toga	4300	3	Gulbransen
14.02	Alison Sutton & John Benseman	F	Caitlin	4175	2	Copland
18.02	Louise Dowling	F	Gabriella	3775	1	Raymond
02.03	Jaqueline Clarke & Brian Harris	M		3700	1	Copland

Oscar's Birth-Day

I was enjoying the 40th week of my pregnancy - a warm, lazy time of year - my favourite for relaxing in. On the due date I was to be seen swimming at Takapuna Beach and lounging under a pohutakawa tree, feeling nothing like the beached whale I had imagined I would by this stage. So I was somewhat irritated when 7 days later on Saturday morning I woke about 7am with diarrhoea, cursing the fact that my diet had been less than perfect the night before. While Geoff lay in bed I wandered about outside and watered the garden, hoping to cure my tummyache with some early morning exercises. By mid-morning this ache resembled a period pain - nothing much to me. I was trying not to over react. Looking back I think I expected labour to be intensely painful from the outset, not having done this before. I'm not in labour, I thought. "Yes you are", said Diana, mother of three and one of my support people who had turned up in anticipation. Suzanne had also arrived to be chief cook and telephone attendant. These two and Geoff began recording the frequency of the "pains" I was having. A kind of party atmosphere was brewing in the house. "I hope you're not all going to be disappointed". I said still feeling very "normal" as food preparation got under way and cups of coffee were consumed. I walked around the house, chatting and planning how I might plant some fresh petunia seedlings in my terracota pots in the afternoon. At midday I did ring Sian, my midwife. "You'll have the baby tomorrow", she said, when I told her I was experiencing these vague pulling sensations every 20 minutes. But that's not what Oscar had in mind, nor Diana who was convinced he would arrive today and insisted I eat something substantial for lunch. Well, if this was 'it', the weather was perfect, overcast and no humidity and we all had a good night's sleep behind us. Still not quite believing that this was the real thing I did some last minute checks in the birth room to which Geoff and I had put the final touches the week beforehand and cast a glance at my hospital bag in the hallway, packed just in case. I went into the study and started reading. By 2.30pm while lying on the couch I felt a new sensation inside me followed by a quiet trickle of water onto the study floor. Not for the last time that day I found myself outside my body, a neutral observer of what it was doing; my body didn't need my mind to carry out this physical process. One of the others rang Sian again - it looked like I was going to fulfill the promise of the day after all! Sian arrived by 3pm exactly at the moment I had my first strong contraction leaning against the dining room table. For the next 4 1/2 hours I entered into a mental and emotional twilight zone as my wonderful body, bless it, went onto automatic, quickly and efficiently. Geoff, Diana, Suzanne and Sian enveloped me in support and encouragement with Sian, the ringmistress(!) keeping up a variety of approaches to the labour, helping me and Oscar to maintain the momentum. I remember lying in the bath, sitting on the toilet, being on the bed, kneeling on the floor, sitting on the birth stool....The breathing consciousness I had acquired through Tai Chi and antenatal classes made the contractions much easier to deal with as did making noises, something which I did spontaneously, no preparation required! "Your mother's just rung. I told her you were in labour and when she started to cry so did I.

of my back with each contraction. I squeezed people's hands to the point where probably they could have used medical aid, and the whole thing just went on interminably.

We changed position various times to try and get things going, did nipple stimulation etc. etc. but it just took forever. People kept saying, "It won't be long now," but I could feel the baby's head at least 3 cm up, with no sign of moving down, for at least two hours. Liam went to sleep and was woken at midnight when we thought the birth was imminent, but it wasn't.

Finally I began to understand that the only way out was through it, since I wasn't going to be miraculously levitated to NWH for an epidural. So I just tucked my chin down, stopped mooing and pushed like a bulldozer and it was about 5 good contractions later that the head came.

As there had been a little meconium in the liquor Lesley suctioned on the perineum and Joyce worked quite hard turning the shoulders. Deborah said later she was glad I hadn't seen the shoulder-turning, as I might have worried about how big they were and how much effort Joyce had to put in to turn them.

Unlike with Liam I really had to push the body out (Liam had just seemed to slither out once I'd done the head), but this fellow was big and really needed the push. Of course he was a real mango-head, quite moulded from his long stay in the birth canal, and Lesley suctioned a bit more before I could hold him (seemed to take forever - my arms were aching to hold him). It was ten to two, about 8 hours after I started.

By this time, after hundreds of changes of position (it seemed), we had settled on my being on the birth stool on top of the bed, cast of thousands supporting and/or being squeezed by me. It was only a moment later (according to me) that the stool was gone, and I was leaning back on the big cushions looking at him.

Liam and Rob cut the cord, and after a while I got into a supported squat and pushed the enormous placenta out, and a fair amount of blood (500 mls) and then we could get on with admiring him. Lesley said "Looks like you've got a nine-pounder, Kate." But I said, "oh, no, we don't do nine-pounders in my family." (Liam was 6 pounds 15). He was 8 pounds 15 near enough to it.

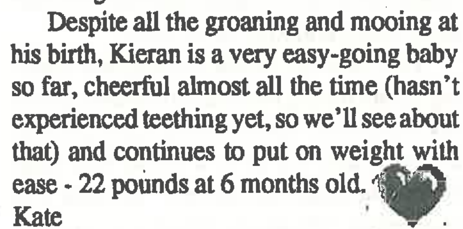
I took a lot of arnica in the next several days, and the Weleda haemmorhoid compound, and used their cream as well. After a week or two, and icepacks and sitz baths and a lot of very conscientious pelvic floor exercises everything came right, and I know now that I needn't have been so fearful of the pushing, that piles can be cured without surgery - if you're patient, and lucky.

This baby was two pounds heavier than my first one, and 4 cm longer, and more importantly, his head circumference was 4 cm bigger too.

Because of the amount of time it took for second stage, and the amount of noise I made (I could feel the vibrations in my sinuses - it felt as though the windows were rattling!), I didn't feel the same joyful triumph that I felt with Liam, that it was hard work but I'd do it again as soon as I recovered and rested awhile....This time I felt very humble, very impressed with all the women who have babies without the untiring encouragement I had.

Despite all the groaning and mooing at his birth, Kieran is a very easy-going baby so far, cheerful almost all the time (hasn't experienced teething yet, so we'll see about that) and continues to put on weight with ease - 22 pounds at 6 months old.

Kate



MIDWIFE: CAROLYN YOUNG

18.12	Sam Mitchell	M		5050	1	Railton
01.01	Fiona & Richard Hailstone	M	Gareth	4240	2	Railton
04.01	Cheryl Houston & Leo Vestegan	M	Jes	3260	2	Nash
07.01	Emery Pia & Rua	F				McGarry
08.01	Karla & Grant Mitchell	M	Brooke	3120	1	McGarry
11.01	Julie Smith	M	Leroy	3700	1	Gulbransen
03.02	Carla & Dave Ross	M	Kane	2800	1	Gulbransen
10.02	Karyn & Ian Dobson	M	Rafferty	3940	1	Nash
21.02	Lyndall & Parbhu Mitha	M		3560	4	Nash

MIDWIFE: RHONDA JACKSON

08.12	Margaret & Keith Whitten	M	Tieman	3740	2	Nash
08.12	Eva & Klaus Wellnitz	F	Sophia	3540	2	Nash
16.12	Caroline Bree	F	Rosie	4790	2	Kerins M/W
18.12	Joce & Chris Williams	F	Claudia	4770	3	Hilton
13.01	Michelle & Peter Berends	F	Amy	3400	1	Hilton
15.01	Paula Beverstock & John Henderson	F	Gemma	4080	2	Gulbransen & Sara M/W
22.01	June & Keith Swasbrook	F	Abigail	4140	3	Railton
18.02	Judy Lawless & James Gibson	F	Lily	2670	1	Eason

MIDWIFE: MARGARET FALCONER

7.02	Wendy & Graeme Downey	F	Jessica	3600	2	McDonald
19.02	Debbie & Fletcher Tetlow	M	Issac	4200	3	Whittaker
02.03	Meg & Russell Davidson	F	Catherine	3300	3	Nealie

Margaret also attended 7 births at the Helensville Birthing Unit & 3 women for postnatal care only.

MIDWIFE: BARBARA HARVEY

29.07	Rayna & John Reihana	M	Creedence	3750	3	Churton M/W
15.08	Terri & Dick Cassidy	F	Waimarie	3220	1	Churton M/W
28.09	Anna & Matè Dragicevich	F	Ellen	4220	2	Hilton
05.10	Maylene Mill & Steve Benseman Caught by Steve!	F	Carole	3470	3	Denyer
05.10	Fiona Patterson & Alan Bell	M	Zeph	3620	3	McGarry

Thanks to Cathy Davies.

Barbara also attended 10 DOMINO births and 4 women for postnatal care only.

MIDWIFE: GENNY THOMSON

23.01	Metiria Turei & Paul Hartley	F	Maya	2530	1	Ansell
22.02	Patrica & Warren Wilson	M	Barry	3020	3	Wormald & Hinson M/W's
22.02	Clairlene Muller & Albert Fraser	M	Johan	3675	3	Barlow M/W

PLEASE ACCEPT OUR APOLOGIES FOR ANY ERRORS OR MISSPELT NAMES.

TRANSFERS TO HOSPITAL:

Of the 65 planned home births listed in this edition 17 resulted in transfer to hospital for the following reasons:

1) Transferred at onset of labour ? asymmetrical growth retardation - monitored by obstetrician who reccomended base hospital delivery after 42 weeks gestation. Mother and baby fine - home after 3hours.
2) Transferred for slow progress - L.S.C.S.
3) Transferred for lack of descent - L.S.C.S.
4) Transferred for slow progress - forceps delivery.
5) Transferred for slow progress - N.V.D.
6) Prolonged S.R.M. - O.P. - failure to progress - L.S.C.S.
7) Transferred for slow progress - epidural - Meconioum liquor - N.V.D.
8) Antenatal transfer - post mature - induction - N.V.D. - immediate discharge.
9) Transferred for lack of progress - epidural - Neville Barnes forceps.
10) Transfer in 2nd stage - O.P. not progressing - Keillands rotation and delivery.
11) Antenatal transfer - post mature - N.V.D. - baby in S.C.B.U. 5 days then O.K.
12) Transferred for pain relief - epidural - O.T. - Keillands rotation - forceps delivery.
13) Antenatal transfer - breech presentation & C.P.D.- L.S.C.S.
14) Tranferred - no progress - epidural - synto - N.V.D.
15) Transferred - P.R.O.M., P.O.P. - no progress - L.S.C.S
16) Premature labour - 36 weeks - epidural - N.V.D.
17) Antenatal transfer - GPH - induction at 37 weeks - NVD.

Abbreviations:

L.S.C.S.	Lower segment caesarian section
N.V.D.	Normal Vaginal Delivery
O.P	Occiput Posterior Position
S.C.B.U.	Special Care Baby Unit
O.T.	Occiput Transverse
C.P.D.	Cephalo - pelvic disproportion.
P.O.P.	Persistent Occiput Posterior
G.P.H.	Gestational protienuric hypertension

Kieran's Birth

The birth of my second son, Kieran, was a good lesson for me to learn, as an advocate of home birth for many years. He's the 9th baby I've seen born, and by the time he came along I was getting a little complacent about women's ability to give birth naturally.

I've been saying if you have the right support you can get by without analgesics for so long that it was really good for me to realise that if I'd been offered some serious pain relief at some stages of my labour, I might well have been tempted to use it, good support and attitude or not!

I had had a little preview a few days before the labour began, waking up early with some tightenings which lasted an hour, but were not painful - just enough for me to tidy up a few loose ends that I wanted to do before the baby came.

Then on Saturday morning, more interesting sensations, and a little bit of a "show", but nothing to slow me down.

At 6 pm after a bit of gardening in the afternoon I felt tired and had a rest, but found a few sensations beginning to interfer with my concentration on a book I was reading to Liam (my 4 year old). I told my husband and ate some dinner, but without much appetite.

By 7 pm I decided it was a good plan to get into a hot bath, and I spent the next couple of hours in there, with the contractions really cranking up quickly.

I lay in there awhile reading and relaxing (a rare luxury) but had to stop and splash my belly every few minutes. Liam got into the bath too, but after a while Rob rang Joyce (the midwife) and told her what was happening. We got my friend Gael to come and look after Liam, as I couldn't really appreciate his patting my shoulder while I was having a contraction.

When Joyce arrived it looked pretty good, it seemed like we could be all done in an hour or so, and she even asked did I want to get out or have the baby in the bath. But by then my splashing wasn't enough, I wanted pressure on the small of my back, and although Rob seemed willing enough to kneel at the side of the bath and press, I felt his back wouldn't hold out, and the bathroom really isn't big enough for more than one or two people.

So I started for the bedroom and realised how difficult things could be, because of the piles I had developed in the last month or so, probably flaring up from Liam's birth years before.

When I got to the bedroom someone rang Deborah (student midwife) and it all sounded like hurry, it's going fast. By this time I was closing my eyes for each contraction.

I spent the next few hours avoiding pushing (for fear of those piles) while seeming to all onlookers to be just about to get the baby out. I made a HUGE amount of noise, like a herd of buffalos in the bedroom.

By now it was getting late, about 11 pm, and I began to apologise about taking up people's time, keeping people up and so forth. The second midwife, Leslie, had been summoned, another friend, whose baby I'd seen born had arrived, and so there were 6 adults and a child cheering me on, while I called for hot cloths for the various parts of my anatomy, including perineum, piles and top-of-the-pubes.

Rob was still pressing hard on the small

Support Group News Continued....

Central Auckland

The next series of classes in Central Auckland will be commencing on **Wedensday 2nd of June** with meeting each Wedensday evening for six weeks. The Venue is the Y.W.C.A. in Grafton. For more information - or to book for these classes phone:

Shelly Cruikshank - 620 4685

Mothers Group meeting at 869 New North Rd, Mt Albert
Last Thursday of every month at 10am

We are a group of women with babies approximately 1 year old. We wish to welcome mothers and those expecting new babies to join us to share friendship, support and our experiences of motherhood in an informal atmosphere.
For more information about meetings please contact:
Claire Greig Ph. 378 6279.

South Auckland

Our group has not arranged the usual series of meetings this year. Numbers have fallen as mothers concerns change from birth / health issues to preschool / education issues and they wind up on Kindergarten Committees etc. The group is now about one third the size of two years ago.
We have begun a new activity involving a postnatal support network. One of our members has put a great deal of effort into setting up such a network, which supplies a few meals to new mums at home in the first few weeks after birth. This will be a great way of establishing contact with folk both to offer them a contact for company, especially in those vital first few weeks and to interest them in our group. So far we have contacted midwives in the area for names of women due to give birth at home and wanting to take part.
If anyone else in South Auckland is interested in taking part in this network, on either the receiving or giving end please contact ***Marguerite - 267 1940 or Glennys 298 1880.***
We had morning tea together in March and will do so again at a later date. As numbers build up again we will arrange more meetings of the type held in the past. Glennys remains co-ordinator of the group and holds the library and videos for borrowing.

Hibiscus Coast:

The next series of classes are due to start in July at the Community House in Orewa for details contact **Sue Lee Ph. (09)424 0169**

DOMICILIARY MIDWIVES CURRENTLY ACCEPTING HOMEBIRTH BOOKINGS

Central Auckland:

Ann Becker	623 2913
Sian Burgess	846 1801
Jenni Churton	846 5824
Jilleen Cole	630 7638
Joan Donley	828 7759
Jackie Gunn	626 3970
Irene Hogan	629 0620
Maureen Kearney	638 9009
Rhondda Kerins	376 4551
Angela Keown	529 2741
Chrissie Sygrove	378 1993
Heather Waugh	524 0424

North Shore

Marijke Cederman	418 4126
Jo Coco	(09)426 4122
Janette Cox	404 6395
Ruth Davison	443 3574
Margaret Falconer	(09)420 5321
Amanda Greenwood	489 9190
Suzanne Innes	(09)420 5509
Rhonda Jackson	480 2422
Mary Wood	483 6544

West Auckland

Anna Barlow	817 8703
Karen Connolly	416 6026
Aileen Coppock	846 2319
Maggie Cropper	846 2313
Barbara Harvey	818 5629
Joan Miller	833 6823
Veronika Muller	817 4880
Carol Newton-Smith	411 8616
Carolyn Young	836 2770

Midwives - continued

East Auckland

Joyce Cowan	534 9163
Lesley Hinson	534 1276
Gillian Jenkins	570 4681

South Auckland

Fiona Clements	299 8847
Adrienne Bell	275 8898
Chris Likeman	579 8871
Genny Thomson	267 6092
Rose Vos	827 6559
Jenny Woodley	292 8404

Waiheke

Libby Groom	372 7748
Jenny McDonald	372 7350

Warkworth

Jan Thompson	(09)425 8795
Sally Wilson	(09)425 8127

Pre-Conception
Early Pregnancy
Active Birth
New Parent

Sally Morison. Ph 522 0408
Birth & Parent Educator

PREGNANCY EXERCISE CLASSES

Gentle stretching with breathing and relaxation.

Suitable for women at any stage of pregnancy.

Cost - $5 per class

Please phone Brenda 378 7614

SUPPORT GROUP NEWS

West Auckland

Our first set of classes took place at Henderson House and started in February. We ran this course for 5 weeks which seemed to be acceptable for all who took part. Feedback has been positive, and our **next set of classes** will start on **June 1st** at the same venue, and again for 5 weeks. We are also arranging a coffee morning for our first group of mothers and babies to be held in July.

If anyone is interested in helping with these classes, please contact either Chris , Kath or Margaret.

Our thanks go to Kathy and Trish for their help and support they have given for our first series as co-ordinators, and to our guest speakers, Carolyn Young, John Hilton and William Fergusson.

Chris - 827 2763 Kath - 818 8547 Margaret - 818 8199

East Auckland

East Auckland is still looking for someone willing to organise Home Birth Antenatal classes for the area. We will still continue our monthly **coffee mornings on the first Monday of the month at the Sylvia Park Plunket rooms.**

We received a tribute from Mary Hammond, our midwife who moved to Dunedin two years ago. She says she has yet to meet a group of women as strong and enthusiastic about home birth as the East Auckland group, and hopes to see us at Conference in Gore in May.

Joyce has been quite busy of late, Gillian has a new daughter who is keeping her busy in a different way from before. Deborah, one of the student midwives Joyce was taking along, has qualified, but is herself expecting a baby in late August, so it looks as though Joyce and Lesley will be busy for a while yet.

Thank you again, Joyce, Leslie and Deborah for your excellent care during the birth of my second son, Kieran.

Kate Jaunay Phone 579 8573

North Shore:

For information of the meetings held in Takapuna please phone
Joanne Walker - 415 8248

Warkworth:

For information on the meetings held in Warkworth please phone
Stefanie Mann - (09)425 7733

Waiheke:

For information on Waiheke support group please phone **Terisa Tutte 372 7307**