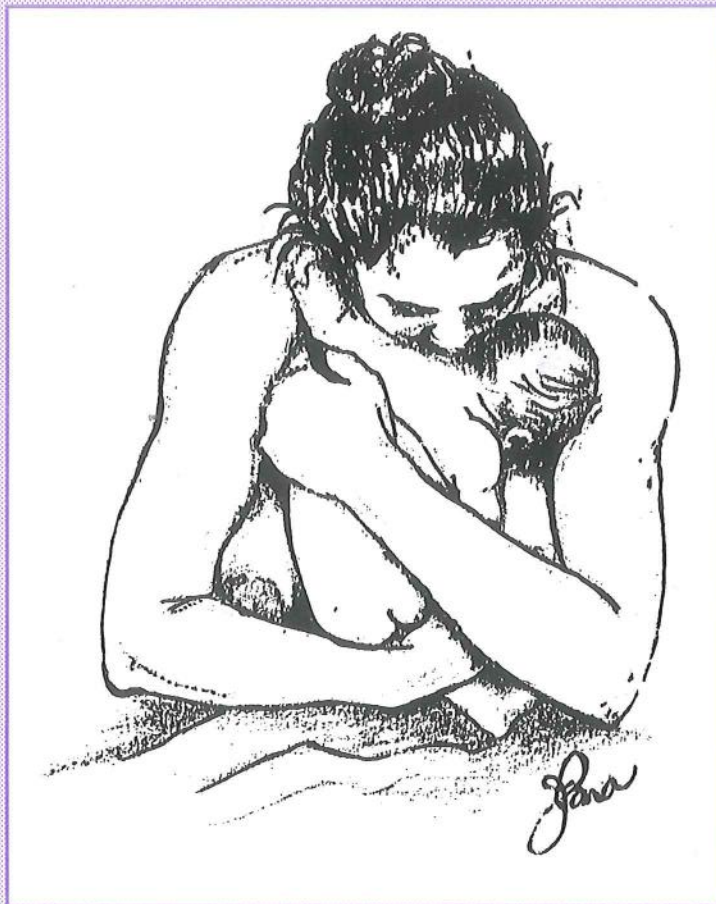




JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, JUNE 1992



CONTINUITY



CHALLENGE

CHOICE

NEW ZEALAND COLLEGE OF MIDWIVES CONFERENCE

Research has shown that CONTINUITY of midwifery care results in a lower intervention rate and greater consumer satisfaction with birth experiences.

In New Zealand the Nurses Amendment Act 1990 acknowledges a woman's right to CHOOSE her care givers.

The CHALLENGE is developing a service that reflects:

Partnership with women.

Knowledge that allows women real choice.

Strength and unity within our profession.

AUGUST 28, 29 & 30
1992

VICTORIA UNIVERSITY
WELLINGTON

Contact: Conference Committee
PO Box 9600
Wellington
New Zealand
Ph 04 388 6592

C O N T E N T S



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Philosophy of the Journal:

- * Promote women's health issues as they relate to childbearing women and their families.
- * Promote the view of childbirth as a normal life event for the majority of women, and the midwifery profession's role in effecting this.
- * Provoke discussion of midwifery issues.

Advertising Rates:

We are developing a new section in this journal for classified advertisements.

The rates are:-

- \$20 for a block of 25 words or less
- \$15 each additional block of 25 words or less (GST included).

Payment please with order (cheque, bank cheque, etc.)

Interested ??

Contact 'Advertising',
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Closing Date for receipt is 31st. October.

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EDITORIAL

On February 14th 1992, a special General Meeting was called to make constitutional changes allowing the structure and function of the College to respond to both individual midwives, and the needs for a more effective service to its members.

Since the College was founded, just two years ago, the demand for information, both regional and national consultation and support, has reached a level where a voluntary structure could not maintain the activity required to function efficiently. It was obvious we needed a physical base and someone employed to co-ordinate and

administer the College business.

The decision to provide Professional Indemnity Insurance also required someone to administer the work associated with such a service. Two years ago, I doubt even the most optimistic amongst us envisaged the rapidity of change, and the magnitude of achievements, and that such a workload was sustained on a purely voluntary basis, accentuates the commitment of midwives and women, to the belief that midwifery does make a difference to the outcome at birth. However, we cannot expect that sort of voluntary workload to continue indefinitely. Increasing the subscription acknowledges our professional responsibilities to support ourselves. I have agreed to take up the part-time Co-ordinator position. Consequently, I will be stepping down as President in August at the A.G.M. As we become

more financially secure, it is expected the Co-ordinator will be a full-time position. The office and National Midwifery Resource Centre will be in Christchurch, and Canterbury/Westcoast midwife representatives Kathy Anderson and Karen Barnes, will take up the two Board of Management positions. Margaret Stacey will provide secretarial support and administer the membership list.

We are looking forward to a busy year and your support. We hope this new structure will not only give us the mechanism for increased energy and commitment for promoting midwifery, but also for protecting women's choices in childbirth.

Karen Guilliland
President

LETTERS TO THE EDITOR

Research

Dear Editor,

We would like to hear from any midwives/researchers who are interested in submitting their recent research (e.g. post 1990) in the form of a chapter for a book.

It is our aim to compile an annual review of NZ research for National, South Pacific, and International markets.

We would consider accepting research concerning Midwifery Issues around clinical practise, education, theoretical models; Maternal-Child health; Developmental Psychology (under 5s); and Parenting.

Research submitted would be reviewed by a panel of referees and recommendations for inclusion made. A final decision would be at the discretion of the editors.

If any members of the N.Z.C.O.M. are interested, please write to either:

Val Fleming, Lecturer
Nursing Studies
Massey University
Palmerston North

or:

Gillian White
Research Officer
Dept. of General Practice
University of Auckland

and enclose an abstract of your research.

Gill White and Val Fleming



The Birth Traditions Survival Bank

Dear Editor,

I am in the process of setting up the Birth Traditions Survival Bank which is a database of information about birth traditions worldwide. I want to contact as many people as possible who may be interested in it, and am particularly keen on finding individuals who either through individual experience or their professional work come in contact with birth traditions who could send me details about them for the Bank. I would also like to build up subscriptions to the Birth Traditions Survival Bank Newsletter as it is through this that the Bank will be supported financially. If you have any queries or would like further information or have any information for the Bank do contact me.

Thank you for very much indeed for your help.

Yours sincerely,
Dr. Jacky Vincent Priya
Private Bag,
Mtunthama,
MALAWI.
Central Africa



Congratulations

The NZCOM offer our sincere congratulations to Dr. Gillian Turner who has recently accepted the Postgraduate Chair of Obstetric & Gynaecology in Auckland.

NZCOM representatives Glenda Stimpson, Jan Carew, Joan Donley, and Judi Strid were given an opportunity to

meet and attend a seminar addressed by Dr. Turner prior to the appointment and noted:

- Her seminar dealt with the real issues that exist in the real world of New Zealand maternity services today.
- She believes that midwives and doctors can work together – symbiosis – she called it and we were interested in her 'risk assessment card' system.
- She discussed the need to improve communication – people skills. We felt that she demonstrated her ability to communicate clearly, confidently and concisely. Not only did her body language convey confidence and compassion, she demonstrated the skill of listening and seemed able to quickly grasp the essence and uniqueness of the NZ. scene.
- She had obviously done her homework.
- We feel that this commitment, combined with her astuteness would enhance her ability to evaluate clinical competence.
- We feel that she showed a determination to grasp the nettle and deal with any controversial issues.

The NZCOM representatives, unanimously recommended Dr. Turner's appointment and feel that this will enhance the health status of women and their babies.



THE FOLLOWING IS PART OF THE COMPILATION PRODUCED AT THE NZCOM EDUCATION Workshops held at Victoria University on the 12-14th February 1992.

There were 39 participants representing a wide cross section of midwifery and consumers of the maternity services. The workshops were founded in part by the Workforce Development Fund (Dept. of Health), the NZCOM and the generosity of the participants themselves.

The impetus for such a gathering came from the changes to maternity services initiated by the Nurses Amendment Act 1990. It was seen as imperative that midwives take a proactive stance on the myriad of issues which have arisen as a result of midwifery independence.

An exciting and affirming three days which was very productive. N.Z. midwifery owes a debt to those participants who gave three days of their energy and time to further midwifery's future.

Introduction

The Code of Ethics of the NZCOM (Inc.) serves a number of purposes.

It is a statement for midwives, women and the general public and identifies the beliefs that midwives hold about midwifery.

It is a statement from which the midwifery profession develops its standards and identifies ways in which NZCOM members can understand the nature of responsible practice.

The Code of Ethics sets in place a system for the profession and the public to be able to judge both individual practitioners and midwifery services.

The NZCOM acknowledges that the Code of Ethics incorporates a social as well as an individual ethic, because of the influence of institutional policies and practices and broader social factors on the welfare of women.

The NZCOM is committed to high professional standards. It expects its members to act responsibly and with integrity and to develop and maintain appropriate levels of competence.

Responsibilities to Clients

- (1) The midwife works in partnership with the woman.
- (2) The midwife accept the right of each woman to control her childbirth experience.
- (3) The midwife accepts that the woman is responsible for decisions which affect herself and her family.
- (4) The midwife upholds the woman's right to free and informed choice and consent throughout her childbirth experience.
- (5) The midwife respects the importance of others in the woman's life.
- (6) The midwife has a responsibility to ensure that no action or omission on her part places the woman at risk.
- (7) The midwife has a responsibility not to interfere with the normal progress of pregnancy and childbirth.
- (8) The midwifery relationship is a privileged one. The midwife holds information in confidence in order to protect the right to privacy. Confidential information should be shared with others only with the informed consent of the woman, unless there is a danger to her, or her baby's life.
- (9) The midwife responds to psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances.
- (10) When the midwife has reached the limits of her expertise, she has the (professional) responsibility, to refer.
- (11) The midwife is accountable to the woman for her midwifery practice.
- (12) The midwife has a responsibility to be true to her own value system and professional judgments. However, the midwife should not deprive any woman of her choice of health care.

Education Workshop

Victoria University Wellington
12-14 February 1992

Responsibilities to the Wider Community.

- (1) The midwifery profession in New Zealand honours the principles of partnership, protection and participation as embodied in the Treaty of Waitangi.
- (2) The midwife acknowledges the role and expertise of community groups providing care and support to childbearing women.
- (3) Midwifery resources should be available in the wider community.
- (4) Midwives should encourage public participation in the shaping of social policies and institutions.
- (5) Midwives should advocate policies and legislation that promote social justice, improved social conditions and a fairer sharing of the community's resources.
- (6) The midwife acts as an effective role model in health promotion for women throughout the life cycle, for families and for other health professionals.



Responsibilities to Colleagues and the Profession

- (1) Midwives support and sustain each other in their professional roles and actively nurture their own and others sense of self-worth.
- (2) The midwife takes appropriate action if the action of her colleagues infringes standards of midwifery.
- (3) The midwife acknowledges the role and expertise of other health professionals providing care and support to childbearing women.
- (4) The midwife actively seeks personal, intellectual and professional growth throughout her career, integrating this into her practice.
- (5) The midwife is responsible for sharing her midwifery knowledge with others.
- (6) The midwife is an autonomous practitioner regardless of the setting and is accountable to the woman and the midwifery profession for her midwifery practice.
- (7) The midwife has a responsibility to uphold her professional standards and

avoids compromising them for reasons of institutional expedience.

- (8) Midwives should adhere to professional rather than commercial standards in making known the availability of their services.
- (9) The midwife ensures that the advancement of midwifery knowledge is based on activities that protect the right of women.
- (10) The midwife develops and shares midwifery knowledge through a variety of processes such as peer review and research.
- (11) The midwife participates in education of midwifery students and midwives.

References

- * ICM Draft Code of Ethics 1991/92
- * NZCOM Standards of Practice, Service & Education
- * NZ Association of Psychotherapists
- * Principles and Guidelines for Informed Choice and Consent DOH 1990
- * NZ Nursing Council Standards of Registration for Midwives.

Diploma in Midwifery (3 year Direct Entry)

AUCKLAND

*Jackie Gunn – Programme Leader
Auckland Institute of Technology
School of Nursing & Midwifery*

THE DIRECT ENTRY MIDWIFERY PROGRAMME at the Auckland Institute of Technology, School of Nursing & Midwifery, began on 10th February 1992 with twenty students.

January was very busy as applicants were interviewed, selected and notified in time for the beginning of the programme. A short list of 56 applicants were interviewed for the 20 places. There were three applications from Maori women. Auckland and Carrington Schools have co-operated so that all interested applicants had an opportunity to be considered for the

programme. The quality of the applicants selected and a significant number of those who were unsuccessful was outstanding. The 1992 class, therefore, is exceptional.

The students will study with the Diploma of Nursing students for the first semester. This semester is Foundation Studies of non discipline subjects. There are five papers: Human Biology, Communication Studies, Health and Psychology (including Developmental Psychology).

The second semester is Introduction to Midwifery. It includes 10 weeks of clinical practice and focuses on Women's Health, Midwifery and the Woman's experience of childbirth. There is a significant emphasis on the acquisition of technical skills in this semester.

Self-directed and self-paced learning are a feature of the curriculum. Regular primary tutorials (initially three per week) are held to focus students and to assist their learning. The midwifery students' primary tutor is a midwifery teacher.

At the beginning of the programme, all

new students were welcomed onto the Campus with a powhiri.

An afternoon tea was held specifically for the direct entry Midwifery students in the first week of the programme. This was attended by a number of midwives who welcomed the students to the profession and wished them well.

A shared lunch was held the following week to enable both classes (DEM & ADN programmes), to meet each other. This was attended by Jilleen Cole and Joan Donley who had been in Wellington at the NZCOM workshops the previous week. It was a warm and exciting event.

As has been their custom for some years, the local College of Midwives will donate a suitably inscribed copy of the NZCOM Standards to each student. A local domiciliary midwife, Karen Connolly, has offered to donate a copy of the NZCOM's new Breastfeeding handbook to the class.

We are excited and motivated to ensure the success of this programme.



1992 First Direct Entry Midwifery Class
including Jackie Gunn, Joan Donley, Jilleen Cole & Debbie Payne.

OTAGO

Sally Pairman
Otago Polytechnic

Course Supervisor in Midwifery

The first class of direct entry students commenced on 22nd March 1992. This is a group of 20 women, all of whom are very committed to midwifery and will bring a great deal to the profession. They have been waiting to do midwifery for a long time and their enthusiasm is exciting and contagious! (At present they are fundraising to take most of the class up to conference!)

Two students are full fee paying students from overseas – one from Canada and one from the Solomon Islands. The remainder come from throughout New Zealand and includes one Maori student. Two students are doing the course part-time, one of these women has just had a baby! Approximately half the students have children and the group have been very supportive in helping each other with childcare arrangements. At times we have babies and small children in class.

In the first year of the course, the students take eight papers, six of which are shared with nursing students. These are foundation papers and include Bioscience, Behavioural Science, Therapeutic Skills (half paper) Practice Skills, and The Family in the Community (half paper).

The remaining first year papers are Women in Society (half paper), People of this Place, Midwifery Research (half paper), Midwifery Knowledge (half paper) and sharing the woman's experience of childbirth. This last paper is experiential where students act as support persons for one woman and her family throughout the childbearing experience. The focus here is on the woman's experience and is a foundation for the midwifery practice papers which begin in the second year.

The midwifery knowledge papers provide an opportunity to think and reflect on midwifery knowledge which in the past has been shared orally between midwives. It gives us an opportunity to develop new ways of focusing on the fundamental issues in midwifery.

Second year papers are mainly focused on midwifery practice and include midwifery knowledge (half paper), Midwifery Research (half paper), The Normal Experi-

ence, Unexpected Outcomes of the Childbirth Experience, Developing Practice in the Hospital Setting, The Midwife and Childbirth, Lactation and Infant Feeding (half paper), Bioscience related to Midwifery, Women's Health (half paper) and People of this Place.

The third year again focuses on practice but by this stage there is little additional theory and the majority of time is spent in practice. The papers include Midwifery Knowledge (half paper), Midwifery Research (half paper), The Rural Experience, the Continuity Experience and Electives.

The only papers which are shared with nursing students after the first year are People of this Place and Women's Health which is an optional paper for students in the nursing degree programme.

The midwifery students will be assessed for registration at the end of the course and will also be awarded a Bachelor's Degree in midwifery on completion of the course.

We anticipate developing some 400 level (Honours level) papers at a later date and expect that the first course will enable our students to enter Master's programmes in various universities.

It is great to have the first course going but as expected we have a few teething problems which we are working through.

Most students have received credit and exemptions for some papers in acknowledgement of their prior learning and experience and we have more work to do in this area.

It is very different running a degree course to running the diploma courses. Timetabling is a nightmare! However, I am finding it really exciting and challenging and, given support from the midwifery profession, I believe this course will be successful and will produce the midwives we want for the future.



Students from both 1992 Midwifery Classes

New Zealand College of Midwives Maternity Benefit Survey

Carey Virtue
January 1992

Background

Initial discussions with the Department of Health following the Nurses Amendment Act, highlighted the need for information on what services midwives were providing and the payment they were receiving.

Aim

To obtain accurate information on what services independent midwives in New Zealand provide, how much time is involved in each area of work and what costs are incurred by the midwives.

Purpose

To set up a data base on the work of independent midwives for use in benefit negotiations and to support the role of midwives in future maternity care provision.

Survey Design

Questionnaires were sent to 100 midwives throughout New Zealand who were thought to be practising independently. Names were obtained from: the college membership list, the domiciliary midwife's society and regional representatives of the college. A selection was made to provide a convenient sample. The questionnaires sought information on four main areas of concern:

- (a) Type of practice i.e. independent midwifery care or midwifery support where there is medical supervision.
- (b) Does the practitioner attend home births or hospital births or both?
- Information on the client group of each midwife in terms of:
 - Ethnicity
 - Socio-economic status
 - Parity
- Information on services provided over an eight week period from preconception advice to postnatal care.
- All services provided for each of the last eight women including birth outcomes.

Results

A very encouraging 67% response rate was recorded. This provided information about the practice of 67 midwives and a total of

536 clients.

Of these clients 465 (86.7%) received continuity of midwifery care while 71 (13.3%) only received ante and postnatal care. Results have been documented in the form of descriptive statistics.

- (a) Midwives mostly work out of usual working hours:
 - 50.8% at night
 - 35.1% during weekend hours (this is only reflective of this particular eight week period).
- (b) In this sample 46% of midwives offer midwife only home births and 34% offer midwife only hospital births (and this is just 12 months since the Nurses Amendment Act!).
- (a) Midwifery services were used by a range of cultural groups. Of the midwives surveyed:
 - 55% have 5-20% Maori clients
 - 35% have 5-10% Pacific Island clients
 - 22% have 5-10% Asian clients
 - 83% have 80-100% Pakeha clients
- (b) 30% reported that women receiving benefits made up 20% of their client group.
- (c) Approximately 40% of women receiving care from independent midwives, were primigravidas and 60% multigravidas.
- (a) Within the 8 week period, antenatal visits for 321 women were provided. The remaining 144 women did not receive antenatal visits.
 - 42.7% of visits took more than one hour
 - 57.3% of visits took 30-60 minutes
- (b) 33% of midwives reported spending time on telephone consultations dealing with miscarriage cases:
 - 7% reported actively managing miscarriage cases.
 - 16% reported making home visits related to this.
- (c) The number of births midwives attend in an 8 week period varied greatly:
 - 26.6% did not attend any births

- during this period
 - 12.5% attended 1-3 births
 - 35.9% attended 4-8 births
 - 23.4% attended 9-16 births
 - 1.6% attended 51 births
- (d) Within the 8 week period, 67 midwives made 1408 phone calls to clients:
 - 54.7% took 15 minutes
 - 43.0% took up to 30 minutes
 - 2.0% took 30-60 minutes
 - 0.3% took more than 1 hour
 - (a) Birth outcomes:
 - 85.14% Normal vaginal birth
 - 6.83% forceps delivery
 - 6.83% Caesarian performed
 - 4.62% Labour induced
 - 10.24% Epidural used
 - 3.6% Labour Augmented (A total of 98.8% as some returns from the midwives were not complete.)
 - (b) The time midwives spent with their clients in labour was on average less than 6 hours:
 - 45.98% of labours required less than 4 hours midwives time
 - 65.66% of labours required less than 6 hours (accumulated %)
 - (c) 51% of postnatal visits were between 30-60 minutes duration
 - 31% were up to an hour and a half
 - 12% were over one and a half hours
 - 6% were less than half an hourMost midwives made 7-12 postnatal visits per woman.
 - (d) 42% of the clients were at home under the care of the midwife the day of the birth
 - 61% by the second day

Conclusion

This survey represents the first attempt to collect information on the work of independent midwives in New Zealand.

The data collected, demonstrate that women giving birth, who are cared for by an independent midwife, had good pregnancy outcomes, required few interventions and were on average being cared for at home postnatally within 24 hours.

Midwives practising independently are providing a service that is cost effective in terms of intervention rates and hospital stay, flexible, and responsive to the changing climate in which maternity care is provided.

The data was collated for the College by an experienced researcher. Responses were confidential, only aggregated responses being reported.



FORUM REPORT

Second National Midwifery Forum

Liz Smythe
Midwifery Tutor,
Auckland Institute of Technology

"Issues in Midwifery Today"
La Trobe University, Melbourne
October 31-November 1st 1991

What I learnt from this forum was that Australian issues in Midwifery practice are not the same as New Zealand issues.

My first glimmer of understanding came from the opening address given by a Director of *Nursing*. True, she was a midwife, and did talk about midwifery issues, but it all seemed to be under the umbrella of Nursing. When she talked about the changes in the delivery of health care, and of how the community were being "aggressively consulted", it was all attributed to Government involvement. There was certainly no mention of midwives and women working together as the catalyst for change. She told us of the high dropout rate of midwives from midwifery practice following their training in hospital schools. Because of the current economic situation training positions are about to be cut by about a third. A later speaker informed us that there are currently 16,000 midwives registered in Victoria and only 4,000 practising. It all had a feeling of New Zealand some years ago.

Later in the morning two speakers addressed the Direct Entry Midwifery debate. The speaker promoting direct entry promoted the positive aspects that we have become very familiar with. The second speaker spoke to the negative aspects, and negative they were! It is true that registration is not legally possible at this stage but this seemed to be accepted as being a permanent barrier. It was clear that midwifery matters are still very much dominated by the Australian Nurses' Federation, who are strongly opposed to Direct Entry midwifery, seeing it as further fragmentation of Nursing. A workshop report later in the Conference presented a unanimous declaration that they did not favour Direct Entry for such reasons as:

- that person couldn't work elsewhere in the hospital,
- she couldn't become a Charge Nurse,
- she couldn't become a Director of Nursing.

There seemed to be little understanding of what being a midwife is all about, therefore the concept that you are educated from the beginning to be a midwife did not excite them. I was bold enough to inform the Conference of New Zealand's commitment and enthusiasm for Direct Entry programmes, and was pleased to find people amongst the crowd who shared our view.

One of the interesting aspects of the forum was the large number of midwives engaged in University study at Masters or Doctorate level. Many of the papers were from their research. Louise Sledzid presented an interesting paper in which she looked at how the role of the midwife was described by mothers, obstetricians, nurses and midwives. She found that mothers and obstetricians were best able to describe the role of midwives, while midwives themselves were least specific in describing their role. The major theme that emerged from 144 subjects was that of Caring (stated by 137).

A research paper by Lesley Barclay explored sexuality and pregnancy. She had interviewed couples together three times during pregnancy. Her findings were that sexual behaviour in pregnancy can enhance the relationship, contribute positively to the development of the relationship, or detract from the relationship. It was interesting to hear about the manner in which she conducted her research, and the discussion of her findings.

Other research papers looked at twins, considering how such mothers get effective knowledge during pregnancy, postnatal depression, with an alarming suggestion that it could be associated with breastfeeding (which was challenged from the floor by another research study), and social recovery after childbirth, said to take 6-8 weeks.

Some papers described midwifery practice in Australia. It was interesting for us to realise that what was considered new and innovative is part of our normal midwifery care. For example, one paper described the setting up of a home visiting midwifery service for early discharge, meaning about day four. A Government Birthing Services Review had recently put forward recommendations as to how the birthing services should function. Three midwives described how these recommendations were being implemented in their local communities. I was surprised that such things as flexible birth plans, breast feeding protocols, early discharge, and midwifery involvement in childbirth education should be described as only recent events, and that they should be motivated by Government recommendations. Where were the women and midwives working together on an on-going basis to make such Government Review unnecessary?

At morning tea on the second day, following an address by the National Chairperson of the Australian College of Midwives, a person remarked as she waited in the queue "it seems very political". Goodness knows what she would have thought of a New Zealand conference! It seems midwifery is still very much a part of the career structure of Australian Nurses as they busily collect certificates that will lead them up the promotion ladder. Midwives are still under the umbrella of Nursing, and still refer to themselves as nurses in the terminology they use (e.g. Charge Nurse, nursing care). There are some who clearly recognise the need to break away from Nursing, and see the College of Midwives as the vehicle for doing this, but the barriers are daunting. Each state has its own bureaucracy to fight through before even considering such things as National Standards. They share our dreams. They see us actually making them happen. I was very grateful for the opportunity my colleague Liz Schollum and I had to attend this forum. The Australian Midwives have much to share with us; their academic pursuits, and their concern and commitment to the knowledge of midwifery. Having attended a New Zealand conference the following week (EM Bevis) at which several Australians were present, I am also aware that the perspectives I gleaned were captured in the rarified environment of a conference venue, and may not necessarily reflect reality. I would be intrigued to read the Australian's comments on Nursing Education in New Zealand. Nevertheless, viewing New Zealand midwifery from across the Tasman definitely gives a satisfying rosy glow.

The following papers from the forum are available:

- Direct Entry or Pre-Registration Midwifery. View 1 & 2
- Community Perspectives on Midwifery Practice: Education Implications. L. Sledzik
- Taking Postnatal Care into the Communities. W. Rosier
- Taking Antenatal Care to Remote Communities. C. Slattery
- Sexuality and Pregnancy. L. Barclay
- Twins - Giving Effective Knowledge to Mothers. F. Thompson
- Postnatal Depression. C. Morse
- Social Recovery after Childbirth: An Australian Survey. C. McVeigh

Cost: \$2 PER PAPER plus \$1 post and packaging fee.

Request to:

Liz Smythe
School of Nursing and Midwifery
Auckland Institute of Technology
Private Bag, GPO
Auckland

Direct Entry Midwifery (DEM)

RECENTLY I ATTENDED A LUNCHEON AT THE Auckland Institute of Technology to meet the 20 DEM students – a number of whom had had home births and some of whom had been members of the DEM Task Force (TF). This development is the direct result of the work done by this TF and the good fortune to have a visionary Minister of Health, Helen Clark, who had the courage to make the necessary legislative changes.

The TF evolved from 'Save the Midwives' (STM), which was formed by home birth women, led by Judy Larkin, to fight the Nurses Amendment Bill, 1983. STM declared its intention to 'uphold the rights of parents and to support the midwifery profession'. Not only did the Bill 'erode' the rights of consumers, it spelled the beginning of the end of midwifery in New Zealand' (1), since it allowed nurses, under medical supervision to carry out and supervise maternity care.

STM managed to effect some modification to education clauses and to some of the draconian measures against domiciliary midwives (DMs). Even more importantly, it united the hospital and domiciliary midwives in the battle for midwifery survival – but that's another story.....

When the dust had settled after the passage of the Nurses Amendment Act, STM decided to direct its 'vital energy' to two tasks:

- (1) To improve current midwifery training, which since the graduation of the last St. Helen's class in 1980 consisted of a mere 8-10 week 'midwifery component' within the Advanced Diploma of Nursing course (ADN). Whereas the St. Helen's courses had graduated an average of 130 students each year, the ADN courses, 1980-1982 (inclusive) had graduated a total of 55 midwives.
- (2) To raising public awareness that midwifery is an independent profession. The corollary to that is, of course, direct entry (specialist) training.

DEM training was not a new concept for New Zealand. When the first St. Helen's hospital opened in 1905 to provide a maternity service for poor married women (the deserving poor) and to train midwives, there was provision for two programmes: a one year midwifery training for registered nurses; and a one year training to train as maternity nurses (RMN). The RMN could

then go on to become midwives (RM) if they so desired.

Changes were made to suit medical and nursing interests. In the late 1920s the intake of RMNs was cut back 50% to make room for more RNs to gain a midwifery certificate, while midwifery training was cut back from one year to six months to provide greater opportunities for medical students to do 'deliveries'. Already midwives were being downgraded to maternity nurses, as it was felt that what N.Z. needed was 'a large number of maternity nurses who would work under a doctor' (2).



Photo: Jane Scotts

Joan Donley, O.B.E.

In 1930 maternity nurse training programmes were extended from 12 to 18 months to bring them into line with Britain's training programme (reciprocity), the minimum age limit was lowered from 23 to 18 years and their training was shifted from St. Helens to maternity annexes.

This continued until 1957 when training of maternity nurses began to be phased out, and the content of the course was incorporated into the general nursing programmes. On graduation, nurses gained both RN & RMN. This was seen as 'raising the status of midwifery', in order to attract more RNs into midwifery training as there was a shortage of staff in maternity units.

Before STM could raise public awareness about the status of midwifery in the

1980s, it first had to know what the public believed a midwife to be. A questionnaire, 'What is a Midwife?' was distributed widely through the STM newsletter and at a New Zealand Home Birth Association (NZHBA) conference, asking for feedback. Also women interested in becoming DEMs were asked to contact STM. Research into DEM was started and information and support was solicited from overseas. As files built up it was decided, with continuing support from STM, to set up a separate Task Force under the leadership of Judi Strid (1986) and intensive lobbying was begun.

A workshop at 1987 NZHBA conference demonstrated a high level of interest and commitment. There was support from the Maori Nurses Association. Women Labour MPs were supportive, as was Marilyn Waring. Although the TF offered support to the Midwives Section, NZNA in their bid for a one year separate midwifery training, the Section actively discouraged DEM action. However, when the leadership changed (1987) support for DEM was forthcoming.

With help from Joy Foote applications were made for funding. The Cathy Pelly Memorial Trust approved a grant of \$1000 for administration costs (Jan 1988). After discussion with Jennie Nicol in the Department of Health, because DEM was a 'contentious issue', the Roy McKenzie Foundation approved a grant of \$10,000 to carry out a feasibility study to gauge the need for a three-year DEM programme (Feb. 1988).



In May 1988, 4,000 DEM questionnaires were distributed nationally. In response, TFs were established in Tauranga (Anne Sharplin & Pauline Scott) and in Wellington (Thea Roorda & Meta Brand). Playcentre, Parents Centre & NZHBA passed conference remits supporting DEM. The National Council of Women turned it down, the remit not getting past the West Auckland branch.

The results of the DEM questionnaire were presented at the Midwives Conference, August 1988, by DEM Gillian White, who had done considerable work for the TF. From 691 replies, 85% were unhappy about midwifery training, 80% believed midwifery

Continued on Page 17



THE NORMAL NEWBORN FULL TERM BABY WHO IS RELUCTANT TO SUCK DURING ITS FIRST hours and days provides a challenge to its parents and caregivers. Despite this potentially distressing situation a satisfactory breastfeeding relationship should be achievable if the mother and baby receive appropriate and consistent information and support.

WHO/UNICEF have stated that exclusive breastfeeding should be the norm and that mothers should initiate breastfeeding within half an hour of birth (1).

However, the establishment of effective breastfeeding can take significantly longer. Matthews (2) found in her study of 60 healthy newborn babies that, although some effectively breastfed immediately after birth, the average took between 30 and 36 hours to establish effective breastfeeding behaviour and several took between 40 and 48 hours. Matthews (3) found that maternal satisfaction with breastfeeding was influenced by the baby's ability to feed well. The longer babies took to feed the more anxious and frustrated the mother became, especially if it was the first baby. The nurses' reassurances that the difficulties were temporary were initially reassuring to the mothers.

The challenge in this situation is to meet the babies' nutritional needs without jeopardising the breastfeeding relationship by introducing inappropriate practices and undermining the mothers' confidence. Previous papers on this, such as K Titus (4), L. Kutner (5) and K. Auerbach (6) begin to address the problem, but we felt these neglected the parent's role in decision making or relied on devices and regimes that may not be optimal.

This paper describes the care of two home-born babies with delayed sucking and is presented in the hope that it will stimulate discussion.

Case 1

This was a fourth baby, and the previous babies had been breastfed. Problems were anticipated as the mother had been on Doxepin 75mgs at night since before conception. Information about possible effects on the baby was difficult to obtain since much of the data related to accidental poisoning doses. However, an obstetrician said that in his experience the baby might be sluggish and slow to feed but that the Apgar score should not be affected. There were no contra-indications for a home-birth.

The 3.25kg boy was born at term, with an Apgar score of 9/10 after a 6.5 hour labour. He was alert but showed no interest in feeding. He was content to just look around and be held.

Ten hours later he was still not interested in feeding despite being woken and encouraged. He made no attempt to latch on, had no rooting reflex and only a very weak suck. The mother spoon fed him 10ml of hand expressed colostrum. It was decided to offer him the breast two hourly during the day and four hourly during the night, to spoon feed him expressed colostrum and to encourage his sucking reflex by putting a finger in his mouth.

By the second day he was displaying a rooting reflex and attempting to latch on. The parents were optimistic that the baby was making progress, and with the support and reassurance of the midwife, were happy to continue encouraging the baby to feed in his time. His sucking remained weak. He was well but, just to be sure, the parents agreed to a blood glucose test. The result was normal, 5.5mmol/L, which was very reassuring. As the day progressed he began to latch on and suck well for about five minutes on each side. The midwife advised the mother to keep offering the breast 2-3 hourly during the day and to demand feed at night.

By the third day, he was having frequent short feeds and his output was satisfactory. On the fourth day he began to demand feed and the feeds were longer and more vigorous. He was jaundiced but remained alert and responsive. His weight was 150g below his birth weight. By the fifth day he was feeding well. Thereafter breastfeeding continued normally.

Case 2

This was the couple's first baby and it was born at home after a normal, but long 26.5 hour labour. Towards the end of first stage the mother was distressed and

Breastfeeding

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decided to transfer to hospital for an epidural. She requested pain relief before the transfer so Pethidine 50mg. and Phenergan 12.5mg were given intramuscularly. However, before she had left the house she was in second stage and a baby girl was born at home 49 minutes after the injection. The 3.6kg baby's Apgar score was good, 9/10. Despite having a good rooting reflex and looking around she appeared unable to suck. After attempting to feed for some time she went to sleep. Fourteen hours later she still had not fed. She was continuing to look around and had a good rooting reflex but made no attempt to latch on. When a finger was slipped into her mouth she did not suck on it. After discussing various options it was decided to rouse the baby 2-3 hourly and offer the breast, to stimulate the sucking reflex by putting a finger in the baby's mouth, and to express colostrum and offer it on a spoon. The mother was shown how to do this.

By the second day the baby still had not latched onto the breast. She continued to root and licked the nipple but showed no interest in sucking. She was feeding well off the spoon and appeared to be enjoying it and was quite eager for more! During the day she passed urine and meconium twice and looked well hydrated. The mother used a hand pump to express and coped well despite after-pains while expressing. She had excellent support from her partner and both parents had confidence that the baby would eventually learn to breastfeed.

A paediatrician was consulted by phone and he was reassuring and suggested the parents carry on as they were. By the afternoon of the second day the mother was concerned about her supply. A blood glucose was done and the result, without a glucose monitor, was marginal - 2.2mmol/L. The importance of feeding 2-3 hourly was stressed. A La Leche leader came to visit and a Lactation Consultant was contacted by phone and options discussed.

By the second night, the mother was desperate for sleep. Three options were identified. These were to continue as before, to go to hospital for assistance or for the father to cup feed the baby formula four hourly during the night while the mother slept. The parents chose the last option and the baby drank easily from the cup.

After a good night's sleep the mother woke refreshed and was able to express good quantities of colostrum (20-65mls). The baby was well, was passing urine with each feed and had only lost 100g since birth. Blood sugar was measured by a glucometer and it was 3.5 mmol/L. The Lactation Consultant visited in the afternoon and the parents were shown the suck training programme using a periodontal syringe. By evening the baby was sucking very strongly.

During the night the baby was fed on demand with milk expressed from the syringe.

On the morning of the following, and fourth day the baby was put to the breast. After some licking and nuzzling she latched on and fed vigorously for 20 minutes. She came off totally satisfied and never looked back. The breastfeeding continued to go well and the baby thrived.

Discussion

These cases illustrate how the baby's needs can be met without jeopardising its health and the breastfeeding relationship. The important and potentially controversial issues are the avoidance of teats and unnecessary breast-milk substitutes while maintaining the baby's nutritional status.

Both basic physiology and clinical experience indicate that any oral object other than the breast in the first few weeks of life can lead to disturbed sucking patterns in some infants (sometimes called nipple confusion) and they should be avoided (7). There are a variety of methods of feeding a baby who cannot breastfeed e.g. spoon, tubefeeding, fingerfeeding with a tube or syringe, eyedropper etc. (8). Using a cup without a spout is the simplest, most accessible method for parents and is recommended by IBFAN (9).



The use of any complementary fluids is also best avoided unless specifically medically indicated. Giving any other food or drink to a baby under 4-6 months of age is usually unnecessary, compromises breastfeeding and makes the baby more prone to various diseases (1). While it has been recommended that donor human milk is preferable to breast-milk substitutes for babies who are unable to receive their own mother's milk (10), the fear of possible spread of disease and the lack of milk bank facilities in New Zealand at present discourage this option. However, it is still the option of choice for some parents and the parents in Case 2 would have preferred donor human milk had it been available.

When a baby is unable to suck, frequent breast expression (2 hourly during the day and less frequently at night) should be encouraged to provide colostrum, stimulate lactation and decrease likelihood of engorgement. The mother needs information and support as she masters the art of expressing, both about the different options e.g. hand expression, hand, battery or electric pump and about the small amounts of colostrum able to be expressed and needed by the baby. Colostrum is a high density low volume food suited to the specific needs of the new baby. The volume of colostrum avail-

able to the baby increases rapidly over the first few days from an average of 7.5ml per feed in the first day, to an average of 38ml per feed on the third day (11).

Sometimes it is appropriate to consider assessment and/or support from other health professionals or lay support people as happened with Case 2. The Lactation Consultant assessed the situation and suggested a suck training regime. The baby was therefore fingerfed using a periodontal syringe and within 24 hours was fully breastfeeding. Although suck assessment and suck training may be useful techniques as described by Marmet and Shell (12), they have not yet been scientifically evaluated. However, as they observe:

"In many cases, proper positioning of the baby on the breast and proper nipple care are the only interventions that are needed to correct sucking and nipple problems".

Checklists for assessing optimal positioning and attachment of the baby at the breast, such as Ros Escott's, (Appendix 3) can be useful.

Regular assessment of the baby's condition is important to reassure the parents and to determine appropriate management options. This assessment includes:

1. Weight
2. Good skin colour; not grey or pale
3. Alert and responsive baby
4. Urinary output appropriate for age
5. Normal stools for age
6. Baby contented most of the time without being lethargic
7. Serum bilirubin and blood glucose where appropriate

Royal College of Midwives (11)

An understanding of the possible reasons, if known, why the baby may be unable to suck is helpful to new parents adjusting to a new baby with little interest in breastfeeding. Involvement of the parents in the decision making process is important, as is maintaining a positive atmosphere and presenting information in a way that does not undermine their confidence.

Babies born at home should be less likely to suffer from delayed sucking due to the decreased use of analgesia and sedation in labour and less interference in the process of learning after birth. These two factors are described by Akre (13) as being the most common cause of decreased efficiency of the reflexes necessary for breastfeeding. A further advantage for the baby at home is the decreased likelihood of the parents receiving conflicting advice.

Many recent publications, e.g. Akre (13), Royal College of Midwives (11) and the

New Zealand College of Midwives Breastfeeding Handbook (in press), provide guidance for those helping mothers with newborn babies who are unable to suck and establish breastfeeding. The last word should go to the Royal College of Midwives: 'Midwives should remember that bottle-feeding does not resolve breastfeeding problems, but knowledgeable, enthusiastic and sympathetic help can' (11).

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Appendix 1

Factors which may cause delayed sucking and difficulty establishing effective breastfeeding

1. Analgesia and sedation during labour.
2. Interference in the process of learning in the period after birth e.g. separation of mother and baby, use of teats, dummies etc.
3. Sick baby e.g. UTI, septicemia.
4. Maternal drugs during pregnancy.
5. Prematurity and low birth weight babies.
6. Congenital abnormalities.
7. Cerebral damage.
8. Severe jaundice.

Based on Akre (13)



Appendix 2

Proposed Guidelines for the Management of Newborn Babies Reluctant to Suck

1. Assessment of baby and mother to eliminate possibility of illness, abnormality etc.
2. No bottles and teats, nipple shields or dummies. Use cup, spoon tube, finger feeding etc. instead.
3. No breast milk substitutes unless medically indicated and expressed breast milk is unavailable.
4. Mother to express frequently.
5. Mother encouraged to put baby to breast frequently.
6. Ensure correct positioning of the baby at the breast.
7. Minimal interference in the mother-baby relationship.

8. Continuing assessment of baby and mother's condition.
9. Communication between parents and caregivers essential so that parents are fully involved in decision making.
10. Maintain a positive environment, avoid conflicting advice and undermining the parents' confidence.



Appendix 3

Positioning and Attachment Checklist.

1. Mother's and baby's clothing adjusted so no restriction.
2. Mother positioned comfortably, well supported, neither leaning back or hunched forward.
3. Baby's whole body turned towards mother, supported behind shoulders not head, which is free to tilt back.
4. Baby's lower arm around mother's waist, body flexed around hers, hips held in close, neck slightly extended.
5. Baby at same level as breast, which is supported by a roll if necessary, mouth centred on nipple.
6. While attaching, compress breasts slightly between thumb and index finger, back from areolar, not between middle fingers.
7. Encourage wide gape, with tongue well down, by tickling lower lip with nipple; repeat till wide gape.
8. Bring baby to breast, not breast to baby; chest to chest.
9. Baby takes a good mouthful of breast as well as the nipple.
10. Check that chin is well in against breast.
11. Baby has mouth wide against the breast, not pursed lips.
12. Baby's lips are flanged out, creating a seal, not rolled in.
13. Baby's tongue is over lower gum, and is sometimes visible, or can be checked by gently rolling down lower lip.
14. Baby should stay attached and not keep sliding on and off the nipple.
15. Breast should not appear stretched or distorted.
16. Fast 'sucking' rate (2+ per second), slowing (to about 1 per second) as milk volume per 'suck' increases after let-down, with occasional pauses; more irregular later in feed.
17. Baby's cheeks should not hollow with each 'suck', nor should there be loud tongue clicks, however, swallowing may be noisy.
18. A baby actively feeding is working hard; jaws and even whole head will move, ears may wiggle.

19. Immediately after baby comes off, the nipple will appear slightly elongated; trauma is indicated by red stripes or blanched areas on nipple, or if it appears squashed.
20. Breastfeeding with good positioning and attachment should not be painful. (From (14)).



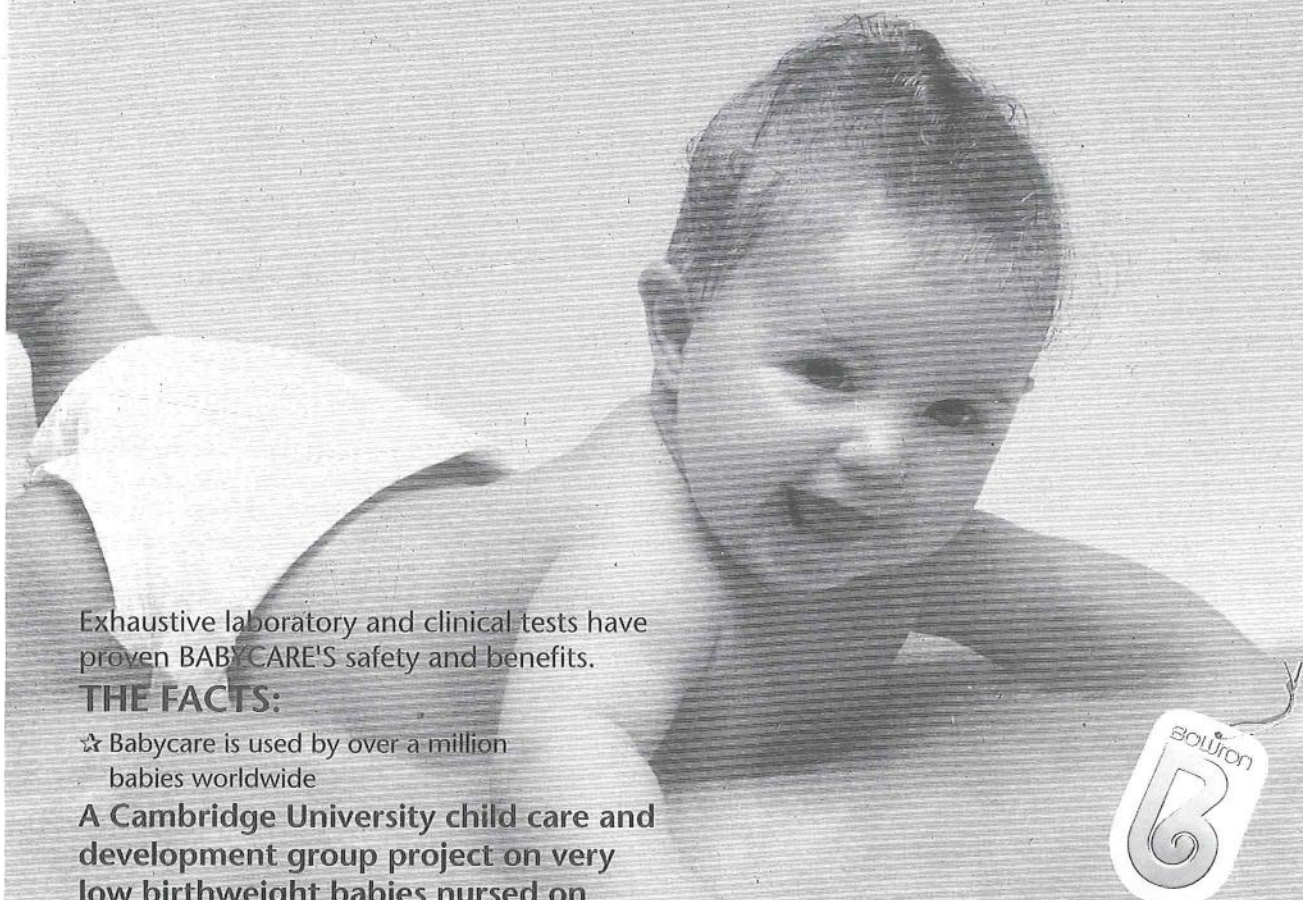
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The International Conference of Midwives – Asia Pacific Region

Judi Strid

WOMEN & MIDWIVES

Forming a Network Towards Safe Motherhood

March 26 -27, 1992
Melbourne, Australia

The conference was hosted by the Australian College of Midwives and an impressive number of countries in the region were represented. Karen Guilliland, Bronwyn Pelvin and myself attended the Asia-Pacific meeting the day before the conference began. This was to deal with the business side of the region, and of particular interest to us, was the discussion on consumer representation. This has been a difficult concept for most countries to deal with although there is already evidence of less resistance, and in Australia increased interest in the prospect of benefits to be gained by actively working with consumers. However, it is necessary to continue highlighting the issue and the value of such a partnership for both women and midwives.

Some of the obstacles preventing full acceptance of consumer representation include apprehension about working with non-professionals, fear that consumers might take over, cultural issues where in some countries health professionals are presently expected to speak on behalf of consumers, and from a practical point of view, issues that are considered to be far more pressing.

The compromise for seeking acceptance for the N.Z. position and keeping the issue on the agenda was that the region agreed for two remits to go forward to the next full ICM Congress. The first remit calls for endorsement of the right of NZ to operate in partnership with consumers. The second one calls for endorsement of this partnership

on a global basis. It was felt that NZ was more likely to get support if the remits were separated in this way.

Listening to the reports from the various countries, it was clear that the NZ midwifery profession has achieved much that is envied. A number of countries are still struggling to become independent from nursing and for some, the status of the midwife is very low.

An overwhelming number of countries have a battle just keeping women alive! It was very heart-warming to hear about the lives of women in countries like Nepal, Cambodia and Papua New Guinea. Women in these countries die at an appalling rate because they have babies too young, too old, too many and too close together. The mortality and morbidity rate for women is absolutely horrific.

The affects of sexism was a common theme throughout the conference beginning at birth with the preference for male children. Women in developing countries with female babies get less food, less health care and have to be much sicker before medical assistance is sought. They are constantly disadvantaged and the demands of bearing children in quick succession further compounds the way in which their health is compromised.

Some 40-60 million women worldwide seek an abortion each year and it is estimated that if women who do not want to continue having children could stop, the birth rate would reduce by 35% in South America and 70% in Africa. Access to contraception continues to be a difficulty in many countries. Maternal mortality is very closely linked to the socio-economic status of the country and the status of women.

In an effort to reduce maternal mortality the World Health Organisation (WHO) Guidelines state the need for:-

- *emphasis on female literacy*
- *access to information*
- *access to good nutrition*
- *access to good health care for women*
- *an improvement in the status of women*
- *access to family planning by all couples*

- *referral for women at risk*
- *access to antenatal and postnatal care.*

The WHO has stated that the health plans of countries must include strategies to prevent maternal death. Some of the strategies being used are:

- *promoting equal treatment of girls and boys (to eliminate discrimination)*
- *raise the marriage age of girls*
- *increase education opportunities for girls*
- *primary health care approach with acceptance of midwifery care at all levels*
- *improving referral centres*
- *promotion of family planning services so women have choices*
- *arrangement for transportation so women can access the care they need*
- *proper recording and reporting of statistics (it is estimated for every maternal death there is an estimated 50 morbidity cases!)*

It was also ironic to hear how western countries are working to reclaim childbirth from the medical arena. Developing countries are becoming increasingly infiltrated by the policies and practices of western medicine. Midwives from all countries are actively working towards improving the education and training of midwives and traditional birth attendants who work alongside midwives.

In conclusion, it was heartening to hear a number of speakers refer to the inappropriateness of the over emphasis on safety and control of decision making for professionals. Indeed, as one midwife claimed, there needs to be a goal of health enhancing motherhood. The opportunity to meet and talk with midwives from so many countries and with so many perspectives and with so much collective wisdom was stimulating, and affirming for the direction of NZ midwifery.

Judi Strid
COM Representative
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White Spots – What Are They?

The Mysterious White Spot

Mary Hammond, Midwife

THIS IS THE TITLE OF A SECTION IN CHAPTER 6 (Breast infections or mastitis?) in Maureen Minchin's book *Breastfeeding Matters* (1985). I am very grateful that I had a copy of her book to refer to when I had the problem outlined below. The 'white spot' problem is something I had never come across or even heard of in my midwifery practice, and speaking to colleagues I find most have not heard of it either. As non-recognition of this problem could easily lead to the giving up of breastfeeding due to a full-blown breast infection I would like to share my experience with other readers of this journal.

About a month or so after my daughter was born I developed what I thought was a blocked duct in my right breast (a hard, lumpy, tender area; no redness, no fever). Despite trying different feeding positions, hot packs, hot bath, shower, massage, expressing by hand and with a Kaneson pump, I could not unblock the duct. Over the next few hours the whole half of my breast became rock hard and excruciatingly painful. I could hardly bear to raise my arm because of the pain. My baby, Sophie, was still able to latch on but unable to clear it with her suck, and I could only express a few drops by hand or with the pump. I even got my partner, with his stronger suck, on to the job - to no avail, although the attempts had us both in fits of laughter despite the pain I was in.

After looking through all the books I had on breastfeeding and finding Maureen Minchin's description of the white spot I took a close look at my nipple - and there it was - a minute white spot that I almost needed a magnifying glass to see. I was unable to squeeze it out but managed to dislodge it by carefully using a needle. It was tiny, like a grain of sand, but with a soft fatty consistency.

Milk immediately began dripping out and then with a few squeezes of hand expression milk shot across the room. It had obviously been under a lot of pressure behind the fatty plug. I then got Sophie to suckle and the relief was instant as she gulped the milk down. The area softened

quickly as she fed and I was left with a residual tenderness in the area - no doubt from the over-distended tissues - but this soon disappeared.

The problem recurred three or four more times (sometimes only days apart) in the first two months but I was able to find the white spot each time and remove it. Sometimes the spot was not immediately visible, being further down the duct, but it would appear as I squeezed the nipple, and disappear when I stopped squeezing.

Sophie is now four months old and I haven't had any problems for the last two months. I wonder if my problems were related to being too busy and overdoing things at the time combined with not taking enough care latching her on, but it seems that no one is exactly sure why these white fatty plugs occur in the first place. Minchin quotes Ruth Lawrence who has found that "the condition dramatically improved by limiting the mother to polyunsaturated fats and adding lethicin to the diet as well".

Although I briefly altered my diet and added some lethicin, I cannot say with any conviction that this cured my white spot problems because over the last few months I have had my normal moderate intake of saturated fats and no extra lethicin - and no problems!



Minchin queries whether nipple creams could be associated with white spots. On rare occasions in the first few weeks I used a small amount of Weleda Rose and Calendula cream, but I was not using any at the time I had the problem.

I would be interested to hear comments from anyone who has had experience of 'the mysterious white spot'. ■



Further to "The Mysterious White Spot"

Kath Ryan, BPharm PMS IBCLC

MARY'S ARTICLE RAISES THE OPPORTUNITY TO discuss the existence of white spots and plugged or blocked ducts and their relationship to mastitis in general.

Several suggestions have been made to account for the occurrence of this phenomenon. Some women describe the blockage in a milk duct as a fatty plug which is often stringy in nature and may feel gritty when rubbed between the fingers. Others describe a discrete hard granule. To my knowledge no-one has analysed these plugs from women, although Dr. Audrey Naylor told me during her recent visit to New Zealand that a PhD student in San Diego may be interested in such a project. Let us hope that help is on the way.

In the meantime we may find a clue in the scientific literature reporting work done in dairy cattle. In "Bovine Mastitis" (1) there is mention of *corporea amylacea* which resemble starch grains but may be of mixed chemical composition. Epithelial cells lining the ducts are continually being sloughed into the lumen and together with milk residues these *corporea amylacea* or similar structures could make up the plug. I know of women who have found such 'plugs' and 'granules' dozens of times, sometimes in conjunction with a breast infection, sometimes not. A further theory is based around the possibility of thrush (*candida albicans* infection). Several points need to be made here. Theoretically it is possible that thrush in the milk ducts could cause a thick exudate to be produced which would then lead to blockage, but no work has been done on this. It has been accepted in practice that thrush within the breast tissue (both ductal and interstitial) may cause shooting pains throughout the breast both during and between feeds. This pain may even be felt as far away as the back and shoulder blade considering the nerve supply to the breast. Research work is still needed to verify these empirical findings.

The traditional treatment when thrush is suspected is mycostatin oral suspension for the mother's nipples and the baby's mouth. Where the candida is superficial (i.e. on the nipple) this treatment is effective.

However, it is difficult to imagine how topical application of an antifungal preparation can be effective on an infection deep within the breast tissue.

Two alternative treatments are proposed in this situation. The first was recommended to me by Maureen Minchin and involves the administration of a course of oral nystatin. Theoretically this is hard to explain since it is known that nystatin is not absorbed from the gut. However, Maureen says that in practice it appears to be effective and suggests that clearing the gut possibly enables the body to handle other infection sites.

The second alternative is the use of an antifungal agent, such as ketoconazole, which is absorbed systemically. This treatment is used in Australia and the United Kingdom but ketoconazole can only be obtained by specialist recommendation in New Zealand. Results are generally obtained within a week thus avoiding prolonged treatment and the likelihood of unwanted side effects which may occur with longer dosage regimes. Once again, this is all empirical knowledge derived in practice and has not been explained or tested with regard to the lactating breast.

Jan Riordan (2) has reported a higher incidence of plugged ducts during the winter months and suggests that this may be due to restriction of milk flow by heavier winter clothing.

Mary describes a method of manually removing the 'plug' from the duct at the nipple. Some women describe a small blister which requires popping. Others are lucky enough to have the baby dislodge the blockage during feeding. This can be encouraged by altering feeding positions so that the baby's tongue and lower jaw are adjacent to the location of the blockage. The application of heating to the breast will offer some relief

from pain. Simultaneous hand massage from behind the plug towards the nipple may help to move the 'plug'. Whatever method is employed to unblock the duct all mothers describe the relief as instant.

In all cases prevention is better than cure and mothers who suffer from recurrent blockages need to be aware of possible causes such as a tight fitting bra; pressure from clothing, a baby pack or sling, car seat belt, the 'scissors hold' when presenting the breast to the baby; pressure from breast pump flanges; missed feedings; fatigue and stress.

It is commonly believed that an untreated blockage may lead to full-blown mastitis as infection develops in the banked up milk. Certainly Mary describes what might be termed a 'caked breast' when a whole sector or half of the breast becomes involved. The cause and effect relationship has not been proven, but neither have any of the 'causal factors' in mastitis.

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International Confederation of Midwives

We are delighted with the recent appointment of NZCOM President, Karen Guilliland, as the International Confederation of Midwives representative to the United Nations Economic Commission. The role of the Economic Commission is to service programmes and procedural relationships between non-governmental organi-

sations. The Commission is fully involved in all major projects in respect of funding and resources. Karen's input will be related to midwifery and women's health. She is to share representation to the Economic Commission, Asia & Pacific meetings with the Australian nominee Miss Pamela Hayes at the Commission headquarters in Bangkok.

American Midwifery Links

The American College of Nurse-Midwives are keen to explore a formal liaison role with the N.Z. College of Midwives. We, of course, welcome a closer link and envisage major advantages as both countries progress towards an effective midwifery service.

Continued from Page 10 (Joan Donley)

to be a separate profession and 80% urged establishment of a three-year DEM course.

In view of this support, coupled with the dissatisfaction with midwifery training expressed in the Department of Education in 1987 evaluation of the 'midwifery option' within the ADN, and lobbying of the MPs regarding midwifery education in general and DEM in particular, intensified.

In reply to a Question in the House, Minister of Health, David Caygill replied that there appeared to be no fears about the quality of midwifery, only its relative scarcity, and announced that separate course leading to midwifery registration would commence in 1989.

Seething with energy, the TF embarked on preparation of a Discussion Document and a draft curriculum with Jilleen Cole, tutor, Carrington Polytechnic (CPI), who expressed willingness to establish a DEM course if approval was obtained. It was also agreed Jilleen visit places and people in the U.K. and the Netherlands in preparation of the Discussion Document. When completed, 826 copies were distributed by the TF.

In June 1990 CPI submitted the first formal proposal to the Nursing Council for approval to offer a DEM course. Marie Burgess, Executive Director, declined the offer as the Nursing Council is philosophically opposed to DEM.

In response to the Nursing Council's obstructive tactics, when introducing the Nurses Amendment Act 1990, Helen Clark amended Section 39 of the Nurses Act 1977 allowing Council to consider approval of establishment of DEM pilot courses with the approval of the Minister.

As midwives reclaim their profession DEM is the training of the future. In U.K. there are 12 courses offering DEM in England, 1 in Wales and 8 starting in Scotland this year.

This year N.Z. has two pilot DEM programmes underway - one at Auckland Institute of Technology and the other at Otago Polytechnic - we wish them every success.

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The Unseen Scars

Mary Wood

Midwife

*I did not die in childbirth,
at least not for good,
I did not die in childbirth
But I also did not live.*

Marion Cohen 1979.

AN UNPLANNED CAESAREAN SECTION IS KNOWN to have negative implications for the woman and her partner, risking damage to the woman's self esteem and self concept which is widely acknowledged in childbirth literature. My intention in this article is to discuss these implications, and how they can be minimised through appropriate and loving support offered by midwives.

As a twenty-two year old primiparous woman, with no previous hospital experience, I underwent an unplanned caesarean section. As a young teenager, I experienced violent sexual abuse. In many respects, the feelings I experienced during and after my caesarean section were the same as those I also experienced as a rape survivor (writing this is also a way for me to let go of some of my "demons".)

The shock of an unexpected caesarean section can be overwhelming, and without adequate support or after-care can precipitate a crisis situation (1).

The Implications

Women who have had unexpected caesarean sections may have to come to terms with the loss of the 'ultimate experience' they may have been planning and waiting for, for months. Often the expectations of those around her reflect the attitude that she should 'be happy that her baby is healthy', and that the end justifies the means. I have yet to meet, or read about, any woman who wasn't happy that her baby was born safely, however, as discussed in the book *Silent Knife* (2), caesarean mothers often experience 'long term feelings of bitterness, frustration, confusion, sadness and pain'.

How do we justify this 'assumption', that the joy over the safe arrival of the baby,

should somehow negate the myriad of negative feelings that may have erupted over the mode of delivery?

Nichols *et al* (1), discuss the guilt often felt by woman who have been disappointed and dissatisfied over their birth experience, stating that this guilt is compounded by the attitudes and 'well-meaning' comments of those around them. This grief and guilt go hand in hand for many women, the more grief they feel about the birth, the more guilt they experience for feeling grief, and so on. Another common experience for women who have had caesarean births is loss of control over their bodies, their lives, and their maternal roles. I remember apologising to the obstetrician the day after the birth of my daughter, for 'behaving badly' during my labour and delivery, for 'losing control'. After a caesarean birth, the woman may have feelings of incompetence, perceive that her body doesn't function properly, that she couldn't 'do it right', she had failed somehow. All of these factors can lead to loss of self esteem and impaired self concept. Nichols *et al* (1-p. 308) review various research studies concerned with maternal responses to caesarean birth, and say that "the ability to function with control is an important determinant for maintaining self esteem, and that when there is a loss of control, the risk of maternal role failure is increased."

If a woman's self concept is impaired by her caesarean experience, and if, according to Stuart and Sundeen, (3), sexual identity cannot be separated from self concept, and, if we accept that birth is indeed a sexual experience, then it is easy to understand why so many who have caesarean sections report difficulty in readjusting sexually after giving birth (2).

Jealousy of women who have had vaginal birth experiences may be another unwelcome feeling for the post-caesarean section woman. She may be really struggling to cope with the effects of major abdominal surgery, coupled with the stress involved with having a new baby, particularly a first baby. I can remember very clearly, feeling somewhat in awe of women who had 'walked' to the ward from the delivery unit, when I could hardly get out of bed unaided for several days.

Another implication for the woman who has had a caesarean section is the potential risk to the mother-infant relationship. The mother is most sensitised to be responsive to her baby during the first three hours after the birth according to Sweet (4). How then, is the bonding and long-term relationship affected when the mother doesn't get to see or handle her child, sometimes until the next day? Available literature has suggested that one of the long-term effects of early separation may include the 'Battered Child Syndrome' (2 p.38), stating bonding failure

is related to the pregnancy, labour, delivery and the amount of separation the mother and baby has endured.

My daughter was born just before midnight, with the use of a failed epidural analgesia that led to a general anaesthetic. When she was wheeled into my room the following morning my feelings were of 'unreality'. She could have been anyone's baby and it was several unhappy weeks before I felt any true connection or bond to her.

"The father in the caesarean delivery room may make the difference between a successful surgical procedure and a happy meaningful occasion for both parents and their baby." (Donovan 6 p.122).

Who could better support a woman during a caesarean experience, to hold her hand and reassure her, to be the first person to tell her about the baby, than her partner? This is often the most appropriate place for him, for both of them, rather than an empty waiting room, filled with helplessness, and anxiety.



Strategies

It must be acknowledged that for some women, caesarean birth is wonderful, and can be an enormous relief after a difficult labour. Perhaps because of my personal experience, it has been difficult for me to understand how some women prefer caesarean to vaginal delivery. What is it then that makes the difference for some women? It is my belief that the support she receives during, and after the birth, plays a large part in determining how a woman comes to terms with the experience. If we choose to be midwives, to be 'with women', in the true sense, we must acknowledge the implications of an unplanned caesarean section, and strive to minimise the negative effects. Flint (5), gives a wonderful account of how to achieve this - stressing the importance of talking the woman through the entire ordeal, repeatedly telling her what she is going to see, hear, and feel. The maintenance of her sense of control and dignity is very important. Flint (5) p. 121 states:

The more the mother is taken through the whole experience, the less shocked she will be by it, and the easier she will find it to assimilate.

It is so easy for us, who may spend our days in a hospital environment, to forget that for most people this environment is totally alien. Imagine how I, as a rape survivor felt, lying helplessly on a cold table, paralysed from the waist down, one arm strapped down, partially stripped, and very afraid, while strangers with masks over their faces

did incredibly invasive things to my body.

Flint (5), also talks of the midwife going to see the woman the next day to talk her through the experience, and tell how the baby was born, what baby looked like and did. Photos can be of great benefit. This could be of great value if there had been little time for detailed explanations prior to surgery. She needs to be reminded that she is not a failure, but a heroine, willing to have major surgery for the wellbeing of her child. Tell her so, over and over.

Let her know that it's perfectly normal and very common to feel grief over the loss of the birth experience she may have wanted so badly. It is sad, it's a great disappointment, but it is not a failure, and she needs to hear that from us. Stuart and Sundeen (3 p. 397) say that:

Positive self concepts are the result of actual positive experiences that lead to perceived competence.

To make a rapid and emotionally uncomplicated recovery from an unplanned caesarean section the woman needs to come out of the experience with her self concept intact. I see it as part of our role as midwives

to strive to make it an empowering experience rather than a disempowering one. We can do this by assisting the woman to perceive herself in a positive light, while at the same time validating her sadness over the losses involved.



Conclusion

I have discussed many of the implications that may arise for women who have unplanned caesarean sections. However, for every woman who has had this experience, there are issues that arise which are quite individual, and as such the care of the woman should always be individualised. In practice it is all too easy to become 'task orientated', and focus only on the physical dimension, especially within a system that forces us to care for more than one labouring woman at a time.

When, during the course of a labour, a caesarean section becomes necessary, there may be nothing we can do to change that, but there is a lot we can do to help the woman cope with the situation. The strategies I have discussed are focused on emotional support, empathy and helping the

woman accept the outcome of her labour in an adaptive way. Part of our role must be to minimise the emotional trauma felt by women after the experience of an unplanned caesarean section, those so profound and lasting, unseen scars.

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Abridged.



Exercise For Two

Liz Weatherly

Midwife

THE RISKS AND BENEFITS OF AEROBIC EXERCISE IN PREGNANCY.

Aerobic Exercise - Sustained exercise that requires continued oxygen uptake(1)....

In the high tech world of the 1980s and 90s the advantages of regular exercise are being recognised. Fitness and exercise have experienced a boom time - gymnasiums are proliferating in New Zealand, and amongst their clientele are many women of childbearing age - both pregnant and non-pregnant. This paper will examine the relative benefits and dangers of aerobic exercise during pregnancy. It will also outline some practical recommendations for pregnant women who wish to maintain or improve their physical fitness and establish that in doing this they can positively influence their experience of pregnancy.

Many women exercise because of the beneficial effects on their physical and mental wellbeing. Today, health professionals

and lay people alike recognise that regular exercise is one of the keys to combating the effects of our predominantly high-stress and sedentary lifestyles. Whether a woman's pregnancy is planned or not, she will more readily accept her changing body image if she is able to maintain a daily routine that is as normal as possible - including exercise if that is her norm.

Elizabeth Cady-Stanton, mother of seven in the nineteenth century, speaking of her first child's birth, said "My girlhood was spent in the open air. I would walk five miles before breakfast, or ride ten on horseback. So, in pregnancy, I dressed lightly, walked every day, and took proper care of myself. The night before the birth I walked three miles. The child was born without a particle of pain" (2). Unfortunately, the availability of wide open spaces is limited in our modern society of cities, and horseback riding in pregnancy is frowned upon, so the pregnant woman of the nineties is likely to be seen at her local fitness centre, recreation

centre or YMCA. A multitude of gyms are adding pregnancy fitness programmes to their current options.

Before commencing any organised or informal training programme, the pregnant woman should discuss her current fitness and physical health with her practitioner. The aim of this would be to determine any pre-existing contraindications to exercise such as hypertension or resting tachycardia (over 140), hypertension or pain. An individualised exercise programme for each woman will ensure that she progresses at a rate that is comfortable and safe for her and her baby. The recommended aerobic exercises for pregnancy are swimming, cycling and walking (3). Some programmes also recommend low resistance strength training of the arms, legs and abdomen on a rowing machine.

Exercise in pregnancy has the advantages of increased muscle tone, stimulated circulation and improved joint flexibility (4). Therefore many of the minor disorders

of pregnancy, such as joint and ligament pain, varicose veins and muscle cramps are reduced. Posture improves, as does pelvic floor control and abdominal strength. A decrease in mental tension improves sleeping patterns and general wellbeing. These benefits occur when the aerobic exercise is maintained for 12-15 minutes or more, two or three times a week (5).

Concern has been expressed among health professionals that the combined effects of the normal physiological changes of pregnancy of strenuous exercise could have detrimental effects on both the mother and the fetus. Kaufmann and Hall (1987) studied the effects of aerobic exercise on pregnancy in terms of the eventual outcome for mother and fetus. Factors which were considered were placental flow and fetal responses during exercises, gestation, length of labour, birth weight and apgar scores. They concluded that moderate exercise has no significant adverse effects on the pregnant woman (and her fetus) - the author's parentheses (6).

Some of the problems associated by the pregnant woman can be:

- (a) fetal hypoxia due to diversion of maternal blood supply to peripheral organs.
- (b) increased circulating catecholamines which cause vasoconstriction and subsequent reduction of uteroplacental blood flow.
- (c) fetal bradycardia or prolonged tachycardia due to hypoxia.
- (d) fetal abnormality due to maternal hyperthermia i.e. greater than 1.5 degrees Centigrade above normal core temperature in the first trimester. (7)
- (e) pre-term labour due to increased uterine contractility to epinephrine and norepinephrine released during strenuous activity.
- (f) haemoconcentration and risk of maternal thrombosis due to dehydration.
- (g) ligamentous and musculo-skeletal injury in the mother due to physiological joint and connective tissue laxity.

The intensity and nature of which can be regarded as "safe" exercise is under scrutiny, and in response to a widely varying body of opinion as to what is "safe", the American College of Obstetricians and Gynaecologists formulated the following guidelines:

PREGNANCY AND POSTPARTUM

1. Regular exercise (at least three times a week) is preferable to intermittent activity. Competitive activities should be discouraged.
2. Vigorous exercise should not be performed in hot, humid weather or during a period of febrile illness.

3. Ballistic movements (jerky, bouncing motions) should be avoided. Exercise should be done on a wooden floor or a tightly carpeted surface to reduce shock and provide a sure footing
4. Deep flexion or extension of joints should be avoided because of connective tissue laxity. Activities that require jumping, jarring motions or rapid changes in direction should be avoided because of joint instability.
5. Vigorous exercises should be preceded by five minutes warm-up. This can be accomplished by slow walking or stationary cycling with low resistance.
6. Vigorous exercise should be followed by a period of gradually declining activity that includes gentle stationary stretching. Because connective tissue laxity increases the risk of joint injury, stretches should not be taken to the point of maximum resistance.
7. Heart rate should be measured at times of peak activity. Target heart rates and limits established in consultation with a physician should not be exceeded.
8. Care should be taken to gradually rise from the floor to avoid orthostatic hypotension. Some form of activity involving the legs should be continued for a brief period.
9. Liquids should be taken liberally and after exercise to prevent dehydration. If necessary, activity should be interrupted to replenish fluids.
10. Women who have had sedentary lifestyles should begin with physical exercise of a very low intensity, and advance levels gradually.
11. Activity should be stopped and the physician consulted if any unusual symptoms appear.

Pregnancy Only

1. Maternal heart rate should not exceed 140 beats per minute.
2. Strenuous activities should not exceed 15 minutes in duration.
3. No exercise should be performed in the supine position after the fourth month of gestation is completed.
4. Exercises that employ the Val-Salva manoeuvre should be avoided.
5. Caloric intake should be adequate to meet not only the energy needs of pregnancy, but also the exercise performed.
6. Maternal core temperature should not exceed 38 degrees C. (8).

Although every woman will approach her exercise programme with different expectations there are some practical guidelines to increase the safety and comfort of her activities:

CLOTHING - Comfortable clothing is essential, it must be non-restrictive, and the breasts should be adequately supported, particularly during impact exercises (such as jogging). Footwear

should be appropriate for the exercise environment, but in general should be light, supportive and have adequate cushioning to protect against jarring.

LIMITS - Once exercising, if the woman is so short of breath that she cannot hold a conversation, then she has exceeded the safe limits of activity (9).

She can learn to monitor her own pulse rate, and adapt her rate to keep heart rate within the optimum range.

RELAXATION - A short period of relaxation following a normal workout can be a bonus. Added to the physical benefits she can go out to her daily routine with a harmonised body, mind and spirit.

Caution - before commencing any form of new exercise, the pregnant woman should discuss her plans fully with her midwife or health practitioner in conjunction with current information about her health status. A written certificate from her health practitioner will assure fitness instructors that she is able to participate in a training programme safely. Beware if the centre does not demand proof of medical clearance!

So we see that exercise, undertaken with careful planning and supervision, and adapted to the individual needs can add to the comfort and wellbeing of a woman during pregnancy, contribute to a better experience of labour and birth, and quicker return to normal body shape postpartum. Over-exercise can pose risks to the fetus and mother, but if undertaken with careful planning and supervision the gains can be considerable.

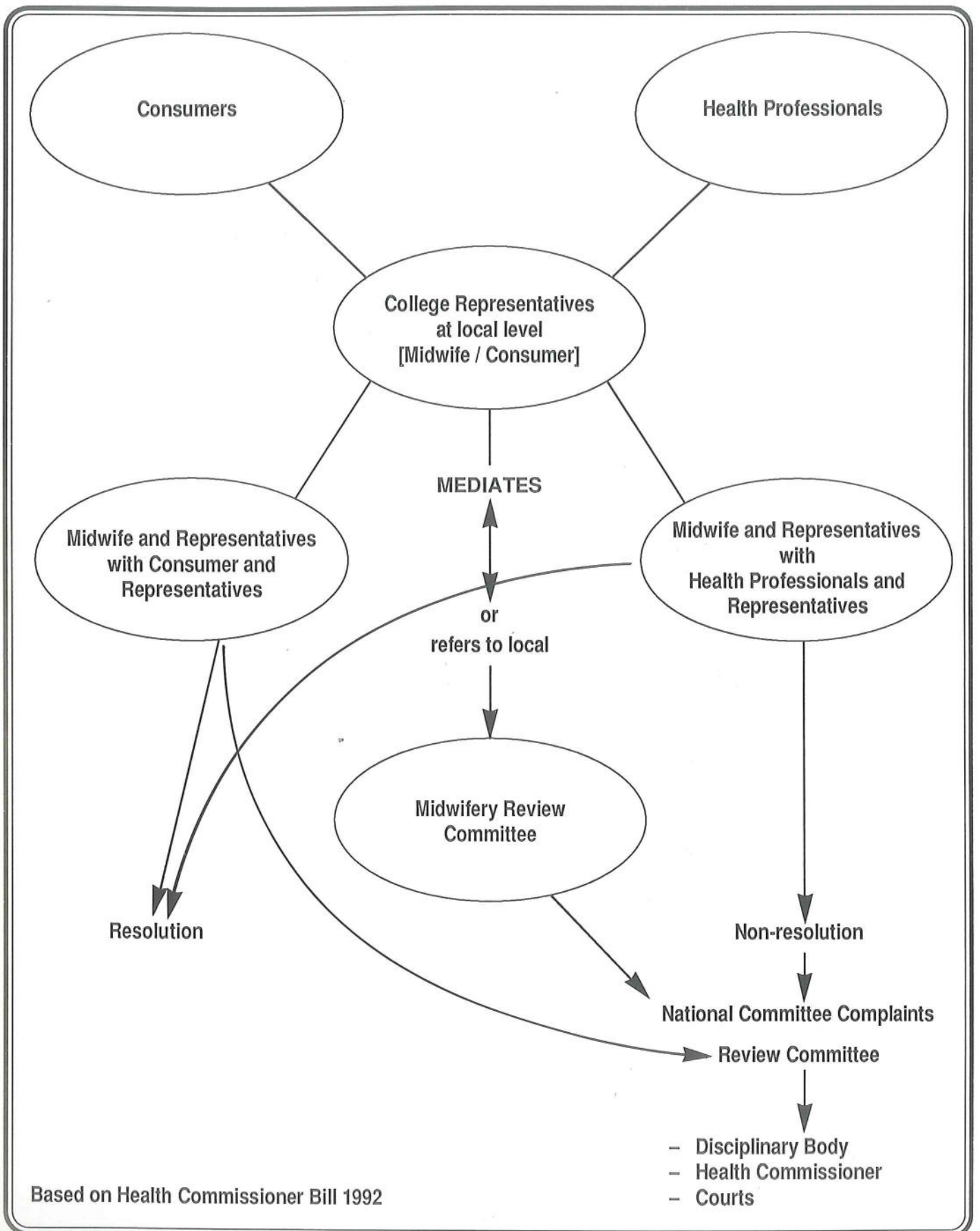
Fitness centres and gyms offer a wide range of programmes, but a woman must be wary that she receive expert advice and is not putting herself or her baby at risk through over-exercise.

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Midwife to Midwife

Mary Hammond
Midwife

Support of the Perineum and Control of the Head

IN THE INTRODUCTION TO MICHEL ODENT'S BOOK, *Entering the World*, Dora Henschel, an English midwife, writes about a visit to Pithiviers. She says,

During the birth the nurse-midwife neither supported the perineum nor controlled the emergence of the baby's head.

As a student midwife I was taught to do both—support the perineum and control the baby's head. It is only after years of experience and observation that I realised that most of the time this is not necessary. We do it out of habit and it makes us feel that it is this control of the head or support of the perineum (usually with the co-operation of the mother) which has prevented or minimised tearing.

Recently I was supervising a student midwife in hospital with her first delivery. The woman about to deliver was a primigravida, lying on her side and breathing on Entonox (having firmly declined my suggestion that she give up the mask). She was very relaxed and the head was coming down beautifully without any active pushing; so I suggested to the student that although she should have her hands at the ready, she did not need to be touching the

head or perineum. She should simply watch and talk quietly to the mother as necessary.

Then the woman's doctor arrived (made it just in time!), put on his gloves and proceeded to give the student totally opposite instructions. "You must always control the head like this," he said, placing a big gloved hand over the head "You can ease the perineum over the head like this" (proceeds to demonstrate) "There, the head's out; no tear."

The student, needless to say, was very confused by this contradictory advice.

Although I concede that it is sometimes necessary to have this hands-on approach, I believe that if we have gained the woman's trust, she feels safe and confident and is going with the flow, she will be able to breathe the baby's head out in a slow and controlled fashion by herself, with the midwife supporting with gentle quiet encouragement or just silence. In some situations the woman might be offered hot towels to soothe stretching tissues, but this is more for comfort than control.

To watch a baby's head gradually emerge without "doing" anything is one of the most beautiful sights imaginable.

Mary Hammond
Midwife

Jan Pana Cards

Jan Pana is the sole La Leche League Leader in the Solomon Islands and is involved in exciting projects there:-

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