



JOURNAL

NEW ZEALAND COLLEGE OF MIDWIVES, OCTOBER 1993





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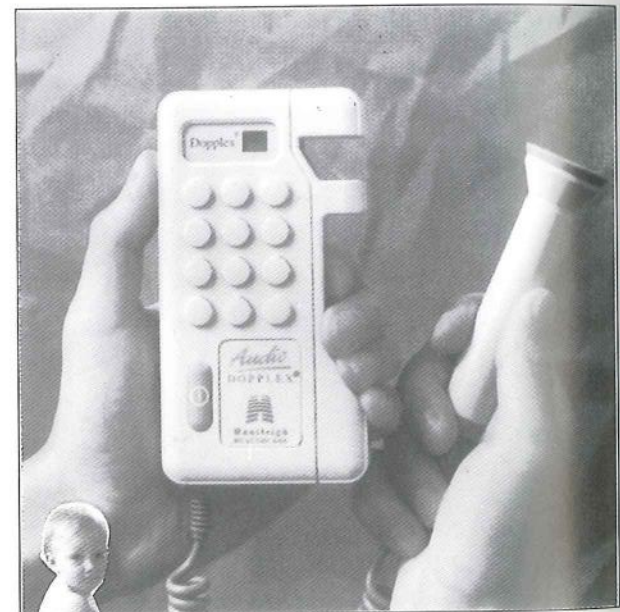
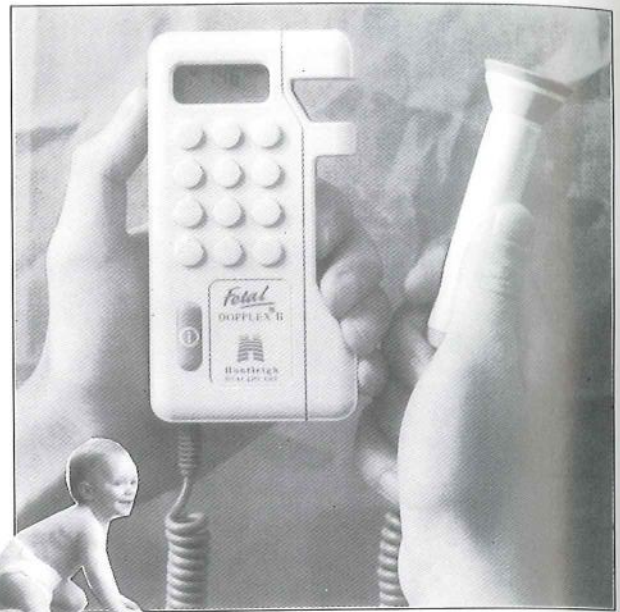
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ISSN 0114-7870
No.9. October 1993

The New Zealand College of Midwives Journal is the official publication of the New Zealand College of Midwives.

Single copies are \$5.00

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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 Sales:

Contact:- 'Advertising',
NZCOM Journal,
P.O. Box 249, Palmerston North.
☎ 06-3581917

Submissions:

Articles and letters should be addressed to:-
The Editor,
NZCOM Journal,
P.O. Box 249, Palmerston North.

Subscriptions:

For subscription enquiries contact:-
Subscriptions,
NZCOM,
P.O. Box 21-106, Christchurch.

Copy Deadlines:

Last Monday in February - for the April Issue.
Last Monday in August - for the October Issue.

Classified Advertisements:

Rates are as follows:-

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

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

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EDITORIAL

This journal is growing from strength to strength. With each issue, the number printed has increased – our last issue was a total sell-out! An increasing number of copies now go overseas. The number of articles requested for reprint is also increasing; M.I.D.I.R.S. has reprinted numerous articles, a few articles have been requested by other overseas journals, and recently the Open Polytechnic has requested the use of six articles for future courses. We are being read!

Sincere thanks must go to all of you that have given us your support – it takes dedicated time and effort to present an article for publication. Most material that is sent in is printed. Sometimes it has to wait for suitable, available journal space though.

This issue is no exception to the high standard that has been set. It includes articles from far and wide from midwives and consumers alike. We are becoming one.

The ICM report gives a first hand taste of the conference. Twenty-five midwives travelled to Vancouver from New Zealand.

Two articles are from New Zealand midwives currently working overseas.

Angela Kearney shares with us her work in Mozambique. Angela began aid work 10 years ago with the Voluntary Service Abroad in Papua New Guinea, and then went to the Sudan with the Red Cross. This was followed by tours with Save the Children in Mozambique, and another tour in Iraq at Christmas before returning to Mozambique.

Heather Jackson was a Nurse Educator at Carrington Polytechnic before travelling to Bristol to work. Heather hopes to return in January 1994. Heather's article is very thought provoking and gives some good pointers.

Sarah Flay has combined her knowledge as a Nurse Consultant in Cardiac Services at Greenlane with her midwifery knowledge. An excellent article.

I.C.M. Conference poster
"Mother and Child"

Artist
CLAIRE KUNJUNDZIC

Jo Coko, Co-ordinator of COM in Auckland makes us aware of the changes to the Nurses Act and its effect on the competitive environment.

Chris Stanbridge has produced a leaflet on SANDS which we hope will be a useful resource for your practice. It is not copyright so you can make copies available to parents/parents-to-be. We hope this will become a regular feature – so if you have something that could be used in this way please send it to us.

Independent Midwife Practitioners are on the increase; talents are being revealed and a real sense of direction has started to emerge. Let's hear from you about your practice – any problems, concerns you may have – or anything of interest you want to share – please write to us.

Another historical midwifery corner has been turned – the views of 'persecution' 'broken' or 'demoralised', shared by parents/midwives have now ceased and we have all emerged stronger, more united and very determined to continue brightening the future of childbirth.

We must continue with enthusiasm – keep ourselves professionally and politically aware, and share our vision and ideas that influence the direction midwifery is taking today.

Val Fleming and Helen Manoharan

LETTERS TO THE EDITOR

Dear Editor,

I am writing to draw attention to a misprint in the article 'Placenta... A User's Guide'. In the section about fat transport the text in the journal reads 'liquids', the intent was 'lipids' or those long chain fatty acids that make up cell membranes.

Yours sincerely,
Kim Wheeler

Editor – Please accept our apology for negating the scientific accuracy of this document.

I hope my children
look back on today
and see a mother
who had time to play.

There will be years
for cleaning and cooking.
Children grow up
while you're not looking.

So quiet down cobwebs,
dust go to sleep.
I'm rocking my baby
and babies don't keep.

Anon.



Suffrage Year

Dear Editor,

I am very proud to be a part of a profession which, in independent practice, has pay equity with doctors.

For one hundred years, New Zealand women have had the right to vote, in 1993 we have only 16 women members of parliament, out of 97.

The unavailability of affordable childcare, the invisibility of women's work and the undervaluation of women dominated professions are as much issues now as they were in 1893.

It is raising the awareness of others of such issues that is the hardest thing. There will always be those who will never stop until it is raised.

Sincerely,
Stephanie McLean RM
Wellington

International Confederation of Midwives

23rd Triennial Congress

Vancouver, Canada

4-14 May 1993



Karen Guilliland
Sally Pairman

We arrived in Vancouver in the afternoon of the 3rd May, 24 hours after leaving New Zealand. Vancouver is a beautiful clean city, wide streets and few people. Mountains with snow on them, trees, rhododendrons and flowers and pansies everywhere. Very friendly people who have a habit of carrying their coffee round in polystyrene cups with lids on them. Every taxi driver in Vancouver knew there was a Midwives' conference on. A major event and we did a lot of networking with the taxi drivers.

The first week of the conference was the council meeting of the ICM. This meeting was attended by two representatives from most of the member countries of the ICM. There were approximately 100 midwife delegates present at this meeting, representing 50 countries.

The first day was difficult trying to understand the process of the ICM which has a very complicated meeting procedure and the necessity for translation into French, Spanish and English meant an inevitable delay in centring the discussions.

The pre-congress meeting started with a ten minute briefing by each country of midwifery's progress or lack of progress within their country, and it was an exceedingly interesting start to a very busy week. Listening to other countries' problems and the restraints and constraints that they work within made us appreciate New Zealand and its advantages and the progress that we have made.

A few examples of some constraints midwives work with internationally: Spain has no midwifery training, nurses practise midwifery without any education. Neither is there any social or professional recognition of midwifery. There is some recognition as there is a shortage of professional people, whatever you may call them, to look after women who are pregnant and in labour. The midwives are working at trying to change society's attitude towards childbirth and for Spanish women to recognise the need for midwives.

Jamaica too has similar problems to Spain in that until recently midwives in Jamaica were called "technical support". They are legalised and there is progress being made towards recognising midwifery as a profession, however they still struggle. They have poor salaries, the training and the education of the midwives have actually been reduced and the midwifery schools are now just a unit within a maternity hospital.

It was with deep sadness that we listened to the German midwives explaining the problems with the unification of Germany and the ramifications of that change to midwifery and to women. East German hospitals have closed, midwives made redundant, obstetricians were taking over midwifery, and there were nine midwifery schools in East Germany which faced closure. These changes were a political consequence rather than women's needs being met.

The Russian midwife who spoke later in the conference also explained the political consequences to the Russian people where there is nothing happening about midwifery. There is no process and no structure, no regulations, no education, and women give birth the best they can without support.

In Sweden midwives are losing their independence and influence because of the number of obstetricians far outweigh the need. Finland has some difficulty with postnatal services, where public health nurses are in the community, not the midwives.

Iceland appears to be making some progress in education, however the women of Iceland are facing real problems because they are required, like the Aboriginal women of Australia, to have their babies in centralised places. These women are displaced from their families and their homes to have their babies and this was a major concern for the International Confederation of Midwives.

The Irish spoke sadly of the erosion of their role. The obstetricians appear to be taking over many normal births, with increased intervention the result. Postnatally public health nurses were taking over the role of the midwife as women were discharged on day three or four from hospitals.

Many countries reported difficulties with trying to keep nursing from overtaking the needs of midwives and women. Malta talked about trying to keep

midwifery independent from nursing. The Norwegians voiced their concerns that nursing sometimes obstructs the profession of midwifery. Italy was another country where nursing needs were identified before midwifery needs. The Association of Radical Midwives and the Association of Supervisors from the U.K. talked about the need to protect the place of birth and protect midwifery from nursing and management.

Australian midwives talked about the struggle for independent practice and the role of the midwife being eroded by other health professionals. They identified the real need to establish continuity of care within Australia. Midwifery schools in Australia were closing and being moved into the universities. There was some concern that clinical practice needs to be protected in this situation.

Indonesia has unique problems because their population is so vast and they have something like 44,000 midwives. Some years ago midwifery education was stopped – to be included into the nursing training – so that, all midwives were nurses and midwives. But, in fact, the Indonesian culture didn't allow this to be a useful way of practising and midwifery was re-established by the Government. However, there were many crash programmes established for midwives to try to fill the need and the Midwives Association was very concerned about the graduates and their knowledge. They will try to collaborate with other international organisations like the American College of Nurse-Midwives to establish a peer review system which maybe would have some influence on the education of Indonesian midwives.

In Japan midwifery is being more and more placed within the nursing frame work. There is an emphasis on post graduate degree programmes and independent midwifery is decreasing. There is much talk about the introduction of male midwives and midwives moving into political placements to influence the policy makers. The birth rate in Japan is declining and more and more maternity units are being mixed with gynaecology units and there is a shortage of midwives to work in these units. The Japanese Nurses Association and the Midwives Association was concerned about these women as they don't get maternity care, they are left alone in labour and the midwives are being utilised for sick patient care instead of normal births.

While some countries are struggling, exhibiting similar situations to the New Zealand scene of ten to twenty years ago, others have exciting stories.

The Norwegian midwifery section has become a lot more prominent in promoting childbirth and as hosts of the next ICM conference is very hopeful midwifery's status will improve.

In Switzerland independent midwifery practices are increasing. There are several birth houses opening with teams of midwives. They also live in a recession, which does have some consequences but they feel that they are holding their own.

In Lebanon midwives are recognised by the Government and have been credited with responsibility for normal birth.

The American College of Nurse-Midwives reports an increase of nurse/midwifery, an increased usage of midwives and the scope of practice has been maintained.

Canada, of course, was the big success story where three provinces now have legalised midwifery and other provinces are working to achieve the same results.

Denmark is promoting midwife schemes and has established alternative birthing centres. There has been an acceptance of the need to educate more midwives.

In Austria, with the extension of midwifery education from two to three years, midwifery enjoys respect as a profession.

The New Zealand story was met with great excitement from all countries and we received much congratulation for our achievements, with real interest in our partnership model and the unique relationship that New Zealand midwives and women have identified. Many countries saw this as a model which would allow them to re-establish midwifery as a profession working with women in their countries and providing a maternity system which would meet women's needs.

South African midwives applied for membership of ICM but this was declined at this stage. It was felt important for ICM to follow the lead of other international organisations such as the U.N. in the inclusion of South Africa. However, relationships have been started with the South African midwives and the hope is that by the next conference in three years they will regain their membership of ICM.

Seventeen position statements were put forward for adoption by the council, from various countries. New Zealand College of Midwives put forward the following two remits:

POSITION STATEMENT

The Midwifery Partnership with Women
The ICM believes that Midwifery is a

profession which is based upon a partnership between women and midwives. In keeping with this belief

- i) *The Midwifery profession should reflect the need of women in society.*
- ii) *Women should be involved in the development and maintenance of the Midwifery profession.*
- iii) *Midwifery Associations should encourage women/consumers to participate in the activities of their professional organisations.*

RESOLUTION

Constitutional Change

Constitution para 5

Members of the Confederation shall be

Add new paragraph:

- iii) *In countries where consumers are represented on the Midwifery Association, that association may become a member, provided that*
 - a) *the Association's function is to conduct and promote the objects of the Midwifery profession*
 - b) *the majority of members and office bearers are midwives*
 - c) *the spokesperson for the association is a midwife.*

An association applying to become a member of the Confederation shall Amend to:

- i) *consist primarily of midwives recognised by their government or professional organisation as being competent to practise midwifery.*

The defeat of the proposed constitutional change was no surprise to us and not a concern. We feel that the major coup was achieved with the position statement on partnership with women and that by the time of the next conference the midwifery community would have moved on enough to accept the constitutional change as well. This will allow women to take part in the profession on an equal basis.

Other position statements of note were the acceptance of a position statement on home birth which states that –

the International Confederation of Midwives believes that home birth is a safe option for women experiencing normal pregnancy. We believe that by birth at home unique conditions are created to ensure individualised care and optimum birth outcome. We further believe that home birth has a positive effect on the reduction of unnecessary medical intervention and application of technology. In keeping with this belief –

1. *the International Confederation of Midwives will encourage and support*

midwives who offer the option of home birth to women who choose so and

- 2. the International Confederation of Midwives will work with Governments and national organisations towards elimination of legislation against home birth.*

The intervention in childbirth position statement was finally adopted after some additional work was put in by the New Zealand, Dutch and Canadian midwives.

This position statement now reads that – *the International Confederation of Midwives believes that childbirth is a normal physiological process. Intervention and the application of technology are potentially harmful and are therefore, only justified when it can be shown that their use will enhance the well being and improve outcomes for mothers and their babies. In keeping with this belief the midwife will –*

- 1. promote childbirth practices which enhance the normal physiological process,*
- 2. promote the allocation of resources towards measures which support the basic needs of women and their babies as priorities,*
- 3. continuously evaluate intervention and the use of technology in their practice and will take measures to avoid unnecessary interference,*
- 4. provide information to women and their families which enhances the understanding of birth as a normal life process and enables women to make informed decisions.*

New Zealand’s proposed amendment to the breastfeeding position statement was lost due to procedural problems in running the meeting instead of any opposition to our strong statement supporting breastfeeding. As a result of this, the position statement on breastfeeding was reagennered for later in the meeting. However, we ran out of time and our position was never discussed. We fully intend to encourage, at the next conference, a much stronger position from international midwifery on breastfeeding and its promotion.

The ICM adopted its Code of Ethics which results from considerable work over the last seven years. In her presentation to the Code of Ethics, Joyce Thompson, an American midwife and ethics consul-tant who has been supervising the work on the Code of Ethics, quoted from Bronwyn Pelvin’s article in the *New Zealand College of Midwives Journal*. Bronwyn’s statement that a code of ethics is “a living, breathing embodiment of the spirit of midwifery” touched

a chord for many and gave us considerable pride. It was very pleasing that the ICM has finally adopted its Code of Ethics and as many of you will be aware we used the draft document in the development of our own Code of Ethics which was subsequently adopted by the New Zealand Nursing Council in 1992. ICM was delighted that New Zealand has made such use of its Code of Ethics as the intention was that the code would be used as a basis for other member organisations to develop their own codes.

The new president of ICM is Sonja Sjoli of Norway. Norway will be running the next conference in 1996. The new vice-president is Alice Sanz der la Gente from the Philippines. The Philippines was successful in its bid to host the 1999 International Confederation of Midwives Conference in Manilla. The immediate past president is Carol Hird from Canada. Margaret Peters, from Australia, was re-elected as director of ICM. The new deputy director is Joyce Thompson, from the American College of Nurse-Midwives. The treasurer continues to be the hard working Sister Anne Thompson, from the Royal College of Midwives in the U.K. Our Asia-Pacific representatives will be Judy Brown from the Australian College of Midwives and Mrs Matsumoto from the Japanese Nurses Association – Midwives Section. Karen Guilliland was re-elected as the ICM representative to the United Nations in Bangkok.

One of the contentious issues for the council was the cost of translation into Spanish and French and there was a prolonged discussion about this. As the ICM effectively runs on a shoe-string, it was suggested that it couldn’t afford the cost of translation. The member countries totally disagreed with this, recognising that the only point of an international organisation is that members can speak to one another. Translation is crucial if ICM is to be successful. Consequently, these costs have been retained over the next three years and the congress will continue to have translation facilities.

Following the closing of the council meetings, the ICM safe motherhood workshops for developing countries. There was also a sponsor-a-midwife workshop which we attended with the New Zealand College of Midwives sponsored Fijian midwife, Litia Cava. It was a humbling and often distressing experience to listen to the problems that Third World midwives have in trying to provide midwifery services to women in their countries. One of the most distressing stories came from an Aboriginal midwife who works as a nurse in an accident and emergency clinic in a

community of 1500 Aboriginals. The women in the community are forced to travel to Cairns to have their babies and are removed from the support of their families and the community. Consequently, many women refuse to go and turn up at the clinic in labour. This midwife has no space where the women can give birth except for the shelf in the office. She has one stethoscope which is shared with another clinic 15 minutes away and she told of the lack of running water in this clinic. This in Australia in 1993.

The American College of Nurse/Midwives called a breakfast meeting with the New Zealand College of Midwives and the Australian College of Midwives to discuss ways and means of improving the situation for women and midwives in developing countries. Whilst we have total empathy with the intentions, we felt that our energies must be directed at our own Maori and Pacific Island women who have far less use of the resources in New Zealand than Pakeha women. We came back to New Zealand with an urgent desire for the College of Midwives to start making a worthwhile commitment to bi-culturalism and to improving the status of Maori and Pacific Island women.

The conference itself opened on Sunday 9th May and was followed by a wine and cheese gathering. The conference was attended by 2500 midwives from 80 countries around the world, including 25 New Zealanders. Many of these midwives came to the opening ceremony in their national costumes and the number of midwives was overwhelming.

One of the highlights was meeting and talking to midwives whose names we have read in the midwifery literature. Meeting midwives from around the world, recognising we all share similar beliefs about women and the midwifery philosophy, was uplifting. We felt a real affinity with the midwives of Canada, particularly British Columbia and Ontario. Women like Lee Saxell, Linda Knox and Carol Hird, who have put such energy into developing their midwifery model. There are many, many wonderful midwives and women who are really working hard to make midwifery the profession that it should be in Canada. We met an American midwife, Therese Starling, who works in direct entry midwifery under incredible difficulty. They can’t get access for students in the hospitals so they are forced to send direct entry students to other countries for their clinical experience. Midwives from the U.K. Association of Radical Midwives,

such as Mary Cronk, Sue Downe and Caroline Flint, were inspiring. We met some Dutch and German midwives who were also struggling to maintain the profession of midwifery against increasing opposition from the medical profession. Sister Anne Thompson is a delight and impressive in her commitment to the ICM in her work as treasurer.

There was tremendous excitement at the opening on the first day of the conference when Elizabeth Cull, the Minister of Health in British Columbia, announced legalisation for midwife in that province – the combination of many years of work by women and midwives in British Columbia.

From a New Zealand perspective we felt real kinship with the Canadian situation and real excitement with the direction they have taken. Joan Donley, a New Zealand midwife, has been an advisor in Ontario and has obviously made a significant contribution to the direction that has been taken in that province. We feel that we will have continuing close links with many midwives in Canada. In Ontario the direction of their midwifery education is towards a three-year direct entry degree programme. They have a total commitment to continuity of midwifery care, independent practice and home birth and consumer involvement in all aspects of the profession. Links are already established between this programme and our direct entry course at Otago Polytechnic.

In Vancouver, ICM used the opportunity to support the Canadian midwives in their campaigns. There was a letter written by more than 120 ICM midwives supporting the Canadian midwives stance against a very critical editorial. Memories were stirred for us when we came home and traced the highly controversial reporting by journalists over the state of midwifery in New Zealand. It's some consolation that the media's inability to come to terms with the issues surrounding midwifery is shared by many other countries.

Whilst we were in Canada we were notified that the changes in the Health and Disabilities Act meant the rewriting of parts of the Social Security Act. You know that as the section 51 advice notice. When we received the original fax in Vancouver we were disheartened and worried that by the stroke of a pen we were going to face maybe losing some gains we had made. We worked with Kevin Clay, the College's volunteer lawyer, who happened to be at the conference with his wife Diane, and spent many hours going through the legislation

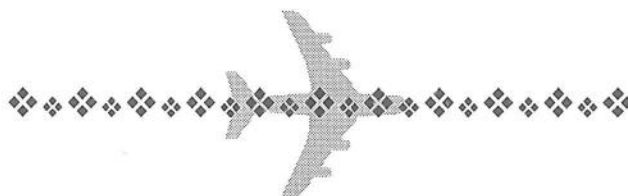
trying to make sense of it. We asked for the support of ICM which was immediately forthcoming and Margaret Peters was able to send on behalf of the Council a congratulatory telegram to the New Zealand Government on its progress so far with midwifery developments.

There was a lot of media coverage of the conference with the conference itself the subject of a television documentary recording the progress of midwives and women in British Columbia. New Zealand was invited to take part in that documentary to give its overview of the changes in New Zealand and to compare the changes and the methods for change that we used with that of the Canadian midwives. Joan Donley gave a press interview, Sue Fesche from Palmerston North was interviewed on national television in a news item, and Karen and Joan were part of the television documentary.


One of the disappointments of being delegates at a conference is that you get very little opportunity to take part in the conference because the demands for meetings, for media sessions, for networking are such that there is no time to

attend the concurrent sessions. Consequently, the only concurrent sessions that we attended were the ones in which we presented papers, both of which we enjoyed. Since returning to New Zealand we have been reading the proceedings and recognise there were many extremely good papers delivered at this conference. The college has copies of all the papers presented at the proceedings and these are available at the Midwifery Resource Centre. However, they are in four major volumes and difficult to disperse and dispense. Some of these papers have been copied and sent to the regions so if you are interested speak to your local chairperson who will follow this through for you. Several New Zealand midwives gave papers and it is exciting to see the body of knowledge we have in New Zealand being shared in such an international forum.

Although the conference was sometimes frustrating in its organisation, it was a very political conference and much was achieved. We carried a real sense of excitement and a real 'high' from having attended this conference, and meeting midwives from all over the world.



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The Gift of a Daughter

Mary Minto
Midwife

I trained to be a midwife in Britain.
I loved to ferryboat on the Thames,
and in my comings and goings to the embankment,
I would pass the statue of Boadicea at Westminster Bridge.
She impressed me.

In my role as midwife in the delivery unit,
I frequently encounter a woman's grief following the birth of a daughter.
One woman told me that her husband (who was not present)
had expected her to deliver to him a son,
because so far he had only one son.
Now she was heaving with sobs,
while holding her newborn, third daughter in her arms.

I wanted this woman to know joy.
But to feel joy she would need enlightenment.
I remembered Boadicea, the handsome, healthy woman,
standing in a chariot at Westminster Bridge,
horses rearing at her command,
and two daughters seated behind her.

Written history tells me that Boadicea was a British queen,
whose husband was a client king under Roman rule.
She was unable to deliver a male heir.
Therefore upon her husband's death, in 61 A.D., his
dominions were annexed,
Boadicea and her daughters disinherited.
Boadicea, said to be a "proud, fierce queen,"
raised the whole of South East England in revolt.
And before the Roman armies could subdue her,
70,000 were massacred,
and the cities of London and Colchester burnt.

I knew that my woman would need Boadicea's courage.
I knew she would need her fearlessness.
And I knew she would have to go her own way.
And to her I said,

"There are great women who have lived on this earth.
They have battled to retain their property.
They have suffered that we may vote.
And they will be angry with you,
for crying at the gift of a daughter.
But they understand your struggle,
and will be with you every step of the way."

Eventually she stopped her crying,
and gave her smiles,
to her baby.



*Written as my venture, as a midwife, to commemorate
the Centennial of Women's Suffrage in New Zealand.*



Peripartum Cardiomyopathy

Sarah Flay
Midwife

Peripartum cardiomyopathy is a rare condition occurring in healthy women with no history of cardiac disease. Unfortunately for those affected, there are few warning signs. The etiology remains unknown and reoccurrence in subsequent pregnancies may occur. The clinical manifestations are easily confused with the normal haemodynamic changes of pregnancy, which often leads to misdiagnosis and subsequent delay in appropriate medical therapy. The prognosis appears to depend on the rapidity with which the heart returns to normal size. Some women recover completely, others require medication or cardiac transplantation, others do not make it that far. As midwives it is important that we are able to recognise the symptoms that may lead to early diagnosis and treatment. The effects on the woman and her family can be devastating. The midwife plays an important role in providing support and education to both the woman and her family throughout her treatment and recovery.

Peripartum cardiomyopathy is defined as the development of heart failure in the last month or within the first five months postpartum. The criteria according to Demakis and Ramitoola (1971) is:

1. *Absence of determinable etiology for the cardiac failure.*
2. *Absence of demonstrable heart disease prior to the last month of pregnancy.*

Thus, congenital or acquired heart disease such as cardiac lesions from rheumatic fever are presumed absent. There is usually no family history of cardiomyopathy. The incidence varies geographically occurring in approximately 1 in 1300 to 1 in 4000 deliveries (Homans, 1985). There is a much higher incidence in Black African and African-American women. Older women with multiple parity appear to be affected more commonly. In Demakis's study of 27 women between 1947 and 1967, 48% of women were 30 years or older and 71% were in their third or subsequent pregnancy. Other risk factors include multiple pregnancy, postpartum hypertension and gestational proteinuria hypertension.

The etiology remains unknown. Many causes have been suggested including; nutritional deficiencies, viral infections, hormonal changes and autoimmune responses to the fetus. Homans (1985) also suggests possible sub-clinical heart disease in these women that does not cause any symptoms until the last month of pregnancy when the body is under added strain. This does not explain, however, why some women are not affected until their third pregnancy and others are affected in one pregnancy and not subsequently (Demakis, 1971). The most popular theories currently centre upon a viral infection or an autoimmune response. The diagnosis, however, is still made after other possible causes are excluded, often leading to misdiagnosis.

Exogenous factors have also been implicated in some cases. Sanderson and colleagues studied 48 women from Northern Nigeria where peripartum cardiomyopathy accounts for 10% of female hospital admissions during the hot humid months of the year. All the women had carried out the Hausa tradition of taking food rich in added salt and lying on heated beds for at least 40 days during the postpartum period. It is suggested that the combination of hot humid weather and the Hausa ritual may cause these women to develop a volume overload leading to heart failure. This type of cardiomyopathy is somewhat different from that seen in our culture as it has a relatively favourable prognosis and responds well to diuretic therapy.

Most women do not present with peripartum cardiomyopathy in the third trimester. The onset usually occurs in the first three months of the puerperium. On the contrary, heart failure in patients with congenital heart disease or valvular disease usually develops during or before the third trimester (Homans, 1985). This can be an important factor in making the correct diagnosis.

The most common presenting clinical manifestations are related to pulmonary oedema caused by left ventricular failure; dyspnoea, cough and orthopnoea. Chest pain and palpitations may also occur due to added strain on the myocardium, and abdominal pain may indicate hepatic congestion. Physical examination would reveal moderate respiratory distress, elevated JVP and a ventricular gallop rhythm. Blood pressure may be initially elevated, normal or reduced (Homans, 1985). A chest X-ray would show cardiomegaly and pulmonary venous congestion and an ECG would reveal left ventricular hypertrophy. There may also be atrial or ventricular arrhythmias. In the most severe cases a cardiac catheter and biopsy would be necessary which may reveal

cellular hypertrophy and degeneration. Myocardial changes include; disintegration of heart muscle fibres causing a pale flabby heart, four chamber dilation, endocardial thickening, mural thrombi and myocardial fibrosis; strangely enough heart valves remain normal (Schmidt, *et al.*, 1989).

For women affected in the third trimester, the main concern is reduced blood flow through the placenta caused by low cardiac output. Therefore, optimising and monitoring maternal haemodynamic function is fundamental. A period of hospitalisation is usually necessary to establish the severity of the condition and initiate drug therapy. The woman's response to this and any change in her condition needs to be carefully documented and reported to medical staff. Fetal wellbeing should be assessed at least twice weekly with either ultrasound or cardiocography (Pitkin, 1989, pg 62). Mothers should be well informed about the importance of a kick chart to monitor fetal movements. According to Demakis (1971) and Homans (1985), the practice of prolonged bedrest for three months after heart size returns to normal as emphasised by Burch *et al.* in 1971, is of questionable benefit and difficult to maintain. The woman should, however, be encouraged to rest as much as possible while she is showing signs of heart failure and exertion should be kept to a minimum.

The principles of drug therapy are to optimise cardiac function. Digoxin and frusemide may be used in pregnancy if levels are closely monitored to avoid toxicity. The use of immunosuppressive therapy has been shown to be affective in those women with myocarditis and cardiomyopathy in the puerperium (Midei, *et al.*, 1990).

Walsh *et al.*, (1965), observed that up to 53% of peripartum cardiomyopathy cases are complicated by thromboembolic disorders. Therefore, Heparin 5000 units subcutaneously is usually administered twice daily, prophylactically. Midwives should be aware of the increased risk of haemorrhage in these women. Elastic stockings and leg exercises are also useful in preventing thrombus.

Labour and birth are stressful times for a woman with peripartum cardiomyopathy. Her already overloaded system is subjected to an even greater haemodynamic load. Her cardiac output must be intensively monitored with the use of Swan Ganz catheters and arterial lines. Labouring in the left lateral to minimise impairment of venous return and the use of oxygen may be helpful. Pain can further increase heart rate and impair the failing heart. Pethidine may cause cardiac depression, and so epidural anaesthesia and the possibility of forceps to shorten the second stage may be necessary (Pitkin, 1989; pg 55).

The long-term prognosis appears to be related to the rapidity with which the heart

returns to normal size (Demakis, 1971). If the heart size has returned to normal in six months the outlook is good, with most women resuming active lives. For these women, peripartum cardiomyopathy does not usually reoccur. Demakis (1971) found that eight patients whose heart size returned to normal had 21 subsequent pregnancies. There was temporary deterioration of cardiac function in only two women during three pregnancies. Six women whose heart size did not return to normal also had subsequent pregnancies. In three women, there was no change in cardiac function but the other three women suffered severe deterioration resulting in death. Death usually occurs from progressive heart failure but may be attributed to pulmonary or cerebral emboli and ventricular arrhythmias. Death has been reported to have occurred as long as eight years after the initial episode (Schmidt, 1989).

For those who show rapid deterioration with little or no improvement, cardiac transplantation may be the only option. Since the Cardiac Transplant Programme was established in New Zealand in 1987, there have been approximately five referrals for women with peripartum cardiomyopathy. However, only one has had a transplant to date. In the Australasian Registry 1992, peripartum cardiomyopathy accounted for 1% of patients undergoing cardiac transplantation.

The following case study follows the diagnosis and treatment of a New Zealand woman with this condition.

Jane, a 32-year-old gravida 2, para 1, presented in labour at 35 weeks with a 2-3 week history of shortness of breath. Her first pregnancy, two years earlier had been uncomplicated and she delivered a healthy baby boy. This time she was initially thought to have asthma and was treated with ventolin. On admission to the delivery suite, however, she was clearly in heart failure. She had no past history of cardiac problems or rheumatic fever. An echo-cardiogram revealed dilated, poorly contracting left and right ventricles. Her labour over the next 48 hours was sporadic but she eventually delivered a baby girl by normal vaginal delivery. Jane was stabilised on Digoxin and diuretic therapy but only to the state where she was not short of breath at rest. She remained in hospital where, despite aggressive medical therapy, she continued to deteriorate.

She was then referred for transplantation. A donor heart became available shortly after her referral to Greenlane Hospital. Jane had a heart transplant approximately six weeks postpartum. Following her transplant, she progressed fairly well and was able to resume full parenting activities and begin to make plans for the future for herself and her family. She was able to return home three months later. A report from her cardiologist at one year stated that she

was continuing to manage well.

In conclusion, it can be seen that this condition may have few warning signs. The rarity of this disease makes the likelihood of misdiagnosis high. However, a perceptive midwife may detect subtle warning signs that may prompt an early diagnosis. Continuity of care throughout pregnancy and the puerperium allows the midwife to come to know the woman more fully and so detect any changes quickly. This is also important throughout her recovery; to monitor the woman's response to treatment or to detect any change in her condition.

Another fundamental role of the midwife is as support person to both the woman and her family. This condition is devastating for the whole family who will require much explanation and time to work through this major crisis. The midwife will need to co-ordinate involvement of other support services who can assist more fully in accessing financial support and counselling services. The woman will require education about her condition when she is ready. This needs to be consistent and reinforced by all members of the team, particularly those in whom she trusts and confides.

Although peripartum cardiomyopathy is a rare and devastating condition, the midwife's role is integral in ensuring the best outcome for both mother and baby.



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Mozambique

In June 1993, Angela received a Gallantry award from Save the Children Fund. The award is one of only seven presented to New Zealand aid workers. Angela is in Mozambique working as a nurse manager to develop a health programme for members of the disbanded Renamo Army.

Angela Kearney

Midwife

The Ministry of Health in Mozambique encourages and facilitates the training of traditional birth attendants. During 1991 in Zambezia Province, the government midwives were trained in the provincial capital, Quelimane, to train TBAs in courses of three weeks' duration.

In Morrumbala district a study was undertaken to examine the Knowledge, Attitudes and Practices of the TBAs before and then six months after their training courses.

This article examines the findings and recommends that TBA training continues as a priority to improve the maternal and child health care to the rural disadvantaged.

Before Independence a high percentage of the population of Mozambique was excluded from formal health care and many people were assisted by traditional healers and traditional birth attendants (TBAs). After Independence, the Ministry of Health introduced the concept of Primary Health Care with programmes in Extended Programme of Immunisation and Maternal and Child Health (MCH), and the extension of the health care system into rural areas with construction of health facilities at provincial, district and community levels. With these changes a greater number of the population benefited from organised health care programmes.

At present, 30% of pregnant women in Mozambique give birth in a hospital or health centre. More specifically in the province of Zambezia, in central Mozambique, only about 14% of births are attended by a trained midwife.

The TBA already exists in the traditional society and holds a prestigious position. She is the Primary Health Care provider for the majority of mothers in most districts. Recognising this, the Ministry of Health has

attempted to improve the quality of care provided by TBAs, by enhancing their understanding of childbirth and the puerperium, and increasing the attention paid to cleanliness and hygiene.

Training of the TBAs is undertaken by the Ministry of Health as a means of extending the health care system beyond the hospital and health centre level to rural communities.

On the 10th of June 1991, the first, three week, training course for 5 TBAs began in Morrumbala. Theoretical and practical instruction took place at the Maternity Unit during the daytime and after the first week of training the TBAs slept overnight in the maternity unit to gain practical experience by observing and participating in "institutionalised" births. The TBAs were supervised by the Maternal and Child Health (MCH) nurse (who has three years' training) or an Elementary Midwife (who has one year's training) or a Hospital Attendant (who has no formal training besides day-to-day experience of working with the MCH nurse). The overall aim of these night stays was to show the TBAs how to assist a "clean birth".

Hygiene and Disease

People can become sick because of lack of cleanliness in the home or surrounding environment, dirty water or because traditional spirits sometimes bring disease; for example, in the case of a woman who lives with a man who is not her legal husband, she ought to take part in a traditional ceremony to appease the spirits, but if she chooses not to do this she will become sick.

TBAs know that many diseases are caused by bad hygiene habits and can encourage personal and home cleanliness. It was easy to convince them to wash their hands both before and after the delivery. Unfortunately, during the evaluation phase of this study it was not possible to assess the cleanliness and maintenance of

their birth kits, as they did not bring them into the health centre for re-equipping. The monthly bar of soap they receive is seen as an important part of their equipment and vital for their work.

Role of the Man and Woman

The man is always the boss in the home and can give orders in the home, in the fields, etc. The main work of the man is to maintain sexual activity with his wife to make her pregnant.

The woman is obliged to clean the house, look after the children, cultivate food, receive visitors in the house, serve her husband, bring water and always be ready to have sexual relations with her husband whenever he wishes.

The Beginning of an Active Sexual Life

A girl should wait for her first menstrual period before beginning to have sex. A traditional healer (curandeiro) holds a ceremony to mark the occasion of the first period. Often the families will choose who will marry whom and this choice can be made even before the girl's first period. The families then need to wait until the daughter's first menstrual period at which time they take her to the house of her in-laws. There is much importance placed on bride price.

Sexual Behaviour during Menstruation

It is forbidden to have sex during a period because it will cause an inguinal hernia in the man. In the local language Sena (S) this disease is called Npuzi and in Lolo (L) the second language it is Ebete.

Pregnancy

It is possible to know that a woman has become pregnant because she will be "more beautiful, with a very pretty face", her abdomen and breasts will increase in size, her naval will protrude and her menstruation will stop. If one counts 10 "new moons" in this state, the woman is nearly ready to have her baby.

Before the training courses TBAs did

not have a lot of contact with the women during their pregnancies. They did not see their role as care givers in the antenatal period, and given family customs and traditions did not actively seek out the pregnant women. It was quite easy to change this and to encourage TBAs to initiate contact with the women during the antenatal period. TBAs already knew that the hospitals and health centres were available to give the anti-tetanus vaccine and so willingly advise the women to go there. Because of the respect and prestige the TBAs hold in the community, the women eagerly listen to their comments and advice following it readily.

Whilst the mother is attending the health clinic for her vaccine she can be seen by the MCH nurse and it is at this time that advice and instructions can be given. Should it be necessary, the midwife can suggest that the pregnant woman returns for further clinic appointments and in the case of a pregnancy of high risk she can suggest to the mother that she ought to deliver in a health centre.

Fetal Development

The baby receives its sustenance from the umbilical cord = *Moto (S) Tecu (L)*.

The placenta = *Peombo (S) Etoque (L)*, has no value.

A woman may continue to have a "normal" sex life until the end of the sixth month of pregnancy, and then she should reduce this activity. When she reaches the eighth month, she should stop having sex or otherwise she could damage the fontanelle of the baby. The women know this danger and readily accept that their husbands will organise other women outside the home to satisfy their sexual needs.

During pregnancy a woman may not cross her legs as it will cause problems in labour, particularly delay progress.

A woman should not relax or sleep to excess during her pregnancy because it will cause the baby to be lazy.

A pregnant woman should not sit underneath a doorway because during her labour the baby will reach the labia but will not advance further, and thus the delivery will be delayed and complicated.

Diet during Pregnancy

A pregnant woman should eat a lot of maize flour sorghum and rice because it helps with the growth of the fetus. It is important to eat plenty of ochre to give the mother strength during the delivery. Some foods are prohibited during pregnancy:

elephant meat - causes delayed delivery
rhinoceros meat - causes malnutrition in the child

eggs - the baby will be born bald

chilli - causes antepartum haemorrhage

bush rabbit - causes the baby to have extra big ears

a special type of fish - causes hydrocephaly.

In Morrumbala district TBAs understand about healthy diet and the need to vary the quantity and quality of food. Nutrition education can be encouraged and TBAs after training gave examples of how they now encourage women to eat eggs in pregnancy and vary the diet with fresh vegetables.

Contacts between Pregnant Women and the TBA

In normal circumstances it is not usual for a pregnant woman to make contacts with the TBA in the community, but it is always necessary to contact the traditional healer (curandeiro). The treatment offered by the traditional healer is paid for with money where possible; if not the family will need to make available some food and other goods. Generally the traditional healers are very rigid and demanding about money payment. Sometimes when the TBA in the community knows that a woman is pregnant she can initiate the contact and even suggest that the woman makes a visit to the health centre or hospital to attend antenatal clinic and be vaccinated.

Diseases of Pregnancy

Sometimes the TBA is also the traditional healer. Each traditional healer has his or her specialty, and they normally only treat specific diseases.

In the case of a woman having swollen feet, hands and face, TBAs believe this is caused by evil spirits. Toxaemia of pregnancy is treated traditionally with special drugs; leaves are crushed and are put in a drink, and the same leaves are also put in bath water. If the disease does not get better, sometimes the traditional healer will send the woman to the government health centre or hospital, or otherwise suggest that the woman tries an alternative treatment with another traditional healer. TBAs believe toxaemia of pregnancy is much more common since the war with Renamo, claiming that at some stage during the war a man from the village had been killed by Renamo and his spirit had passed on to a pregnant woman. It is interesting to note that some TBAs cannot recall seeing this disease before the war and deny even hearing about it from older people within the community.

Convulsions in pregnancy are caused by spirits. It is possible to ask for help from a traditional healer in treating this disease. Very occasionally this disease can be passed on from the mother to her baby and then on to the grandchild. If the disease is genetically transmitted, it can only

be cured by traditional healers.

Sexually transmitted diseases have the following symptoms: blisters, sores on the labia or penis and inflammation. The TBAs usually know that it is necessary to treat both the man and the woman. Some people think that the cause of the disease is because the man had sexual relations with a woman who is not his wife. The traditional treatment varies but sometimes crushed leaves are used. These are boiled in a pot and both the man and woman bathe with the warm water with the leaves floating around. There are also special roots taken in the form of a medicine.

Delivery

The pregnant woman will always give birth in her own home, or the home of her mother or mother-in-law. There will always be at least two or three TBAs present for the delivery. The choice of which TBA should be asked to assist is made depending on the degree of respect and confidence the mother or mother-in-law have with any particular TBA. A woman who has never had a baby herself will never be allowed to be present and it is normal for a TBA to need to assist in many deliveries before she is considered by the community to be reliable and respected.

A TBA cannot herself have sexual relations before going off to help with a delivery because the baby to be born can easily just jump out of the vagina with speed and lack of control. Also, if the TBA is menstruating, she should take away her dressing or pad as it can cause the delivery to be prolonged.

TBAs diagnose the beginning of labour when the woman begins to sweat, has abdominal pains and at times some blood or water can leak from the vagina.

UNICEF supplies a "Birth Kit" to each TBA, and restocks essential equipment as it is easier to encourage hygiene and offer each mother a "clean birth". TBAs were very pleased and excited on the receipt of their supplies and use them at all births they attend. They are aware that many diseases can be prevented by using clean techniques, such as hand washing or boiling up of scissors but are unable to relate poor hygiene to neonatal tetanus. TBA did not understand the relationship between putting unsterile products on the baby's umbilical cord and infection.

Whilst a woman is in labour she is left to lie down quietly on her bed or mat and can wander around her hut to feel more comfortable. Before the training programme the TBAs used to oblige the mother to stay lying down and then they would push hard on her abdomen to encourage the baby's descent.

It is usual to give traditional herbs/medicines to a woman in labour to help

her have more power and as a form of treatment for weakness. When the TBA arrives in the home of the labouring woman she will ask her to lie on the floor. One TBA is positioned behind the mother, crossing her arms across the woman's chest, while the labouring woman places her arms around the neck of a second TBA who is positioned in front.

When the woman becomes agitated and the vagina begins to open a little with the large labia pouting slightly, the TBA obliges the labouring woman to bear down with a lot of pressure. This may well be some time before the cervix is fully dilated. The labouring woman will begin to shake and the TBAs will need to shout and make a lot of noise to encourage the mother to push long and hard.

If the labour and delivery are delayed the reason given is that during the pregnancy the woman had sexual relations with men other than her husband and the TBAs will call a traditional healer for treatment. Alternatively, this delay may be caused by evil spirits. In the case of a complicated labour and delivery, the TBA used to assume the position of judging the mother for some personal behaviour of hers during pregnancy – the suggestion that she has had "affairs" outside her family was the usual reason given for these problems. Sometimes blame was apportioned to witchcraft. The traditional treatments that were given by the TBAs did not seem to be detrimental although it appeared that the mother or mother-in-law of the labouring woman would attempt to physically punish the woman for her "affairs".

Tying and Cutting the Umbilical Cord

The mother of the newly delivered woman should cut the cord with a sharpened piece of sugar cane, wood or other plant, and only on rare occasions will a razor blade be used. The mother will organise a small piece of thread – it could be from a sack or piece of material – and she makes two knots and cuts in between.

If the mother of the newly delivered woman is sick, it is forbidden for her to touch either the baby or the placenta, and in this case the TBA or mother-in-law may cut the cord and help with the child care.

Delivery of the Placenta

After the delivery of the baby the woman needs to help with the delivery of the placenta. She changes to a kneeling position and the TBA who is positioned behind the mother massages the uterus. The mother usually is asked to push a little to help with the expulsion of the placenta.

If the placenta is delayed, the treatment requires using strips of sweet potato which

are tied onto the woman's abdomen. Later, the TBA will beat the back of the mother with a hoe. If this traditional treatment fails, nothing more can be done to assist with the delivery of the placenta.

Disposal of the Placenta

The newly delivered woman needs to take care of the placenta. She will find a traditional clay pot and put the placenta inside this pot. It is necessary to make a small hole in the bottom of the pot to allow the placenta to breathe and also maintain fertility for the mother. The mother then leaves the house and digs a hole – but she should never forget where this hole is because she must return there at different intervals to make sure that the pot and placenta have not been stolen. Each day the newly delivered mother will bathe near the site of the buried placenta until such time that a traditional ceremony has been performed allowing the woman to resume sexual relations.



Typically Angela, mud and all.

Care of the Newborn

A traditional healer (in this case always a woman) is called to arrange some traditional drugs to put in a small pouch tied around the baby's waist with a bit of cord. Either animal faeces, especially those of goat, or special leaves from chosen flowers or pumpkin, or ashes from special roots are placed directly on the umbilical cord.

After the mother has "planted" the placenta in the garden the baby will be bathed with cold water. If the child has a lot of vernix attempts will be made to wipe it off as it means that the child is ugly and men would not be allowed to see such an ugly child. The reasons given for the birth of a baby with vernix are: the mother ate a lot of cassava during her pregnancy or it is the result of sperm that are still near the vagina or entered into the uterus.

When the umbilical cord falls off the mother should bury this inside the house to ensure that the child will not run away from home.

Care of the Mother

There is no special treatment given to the postpartum woman. The TBAs return to their own homes and return daily to visit the mother and the baby. In the case of an ill mother she will be given traditional drugs from a traditional healer. These may well be crushed-up leaves, roots and, depending on economic conditions and availability, the mother will be encouraged to eat chicken or fish to help increase breast milk production and quality. There is no known treatment for postpartum haemorrhage.

Diseases in the Newborn

TBAs know that a newborn baby is sick when it becomes hot, cries a lot and is generally agitated with exaggerated body movements. In this case the TBA will ask a traditional healer to visit the baby and he or she will boil up some sorghum, corn, beans and any other type of food eaten by the mother during her pregnancy. The water is then given to the baby to drink.

Neonatal tetanus is caused by bad spirits. Explanations include: the mother's brother or another direct relation was killed by the bandidos or was eaten by an animal such as a leopard or a crocodile, or someone else in the family committed suicide. The traditional healers attempt to treat this disease with special roots – they are placed in a piece of cloth and then tied to the spine of the baby.

Resumption of Sexual Relations

After delivering a baby it is normal for the woman to wait between one and three months before resuming sexual activity. But this depends on the insistence of the man. On some occasions the woman insists because whilst she is in the celibate phase she is obliged to sleep on the floor with her baby, with or without a mat to sleep on, but usually without a blanket which remains on the husband's bed. The husband will not wish to be too forceful in suggesting sex for fear of contracting a hernia.

Before resuming sexual relations the TBA will be called once more to the family home. She will bring with her some flour for the mother to place in her hand leaving the TBA to take out a small quantity reciting:

*"This is your baby
I was the person who helped you
deliver it
He was part of me
But now I give him back to you."*

The TBA will then leave a small quantity of this flour underneath the mat that the child will later sleep on.

Together with the baby, the people invited to this ceremony include the mother and father, and all the women of the village who helped with the delivery. The father does not actually enter the home until the ceremony is over. If the family has money they will offer a small party, though the war has made this uncommon.

Weaning

Whilst the mother is breastfeeding she should eat a lot of food, especially cassava. If the mother's breast milk becomes "bad" she should express her breasts and wash them with a traditional drug before continuing to breast feed.

The mother should continue to breast-feed until the baby itself decides that it wishes to be weaned. If the mother becomes pregnant again she must stop breastfeeding immediately. To aid this brusque weaning she can either put chilli pepper on her nipples, or use the sap of a certain tree that looks exactly like blood. The child, when shown this "blood" will itself decide to stop suckling.

Family Planning

In Morrumbala traditional society it is usual to give traditional drugs to space pregnancies. In the rural areas this involves crushing special roots and leaves and placing them in a small pouch-like cloth and tying it around the mother's waist. These drugs need to stay tied to the waist until the mother wishes to become pregnant again. In the case of the thread breaking the woman must return to the same traditional healer who will organise some more of the same drugs. At times this treatment is not successful and the mother just has to accept her new pregnancy with patience.

Traditionally, TBAs, with help from the curandeiros, offer treatment for family spacing, but often this is ineffective and the mother soon becomes pregnant again. TBAs showed a lot of interest in understanding the different family planning methods available through the health centres and will readily refer women to the MCH nurses at the family planning clinic. Each woman is now encouraged to visit the family planning clinic two to three months after delivery.

Infertility

Infertility has two different causes. Firstly because God decided that a woman should not have children, and secondly because the stomach of the woman has already been burnt. There is some traditional treatment for infertility – roots that are boiled and placed in drinks or a porridge, or special leaves that are burnt, with the ashes placed in a small cloth and tied to the waist with the remainder placed in the bath water. Sometimes the woman will be given traditional drugs to induce vomiting and

rid herself of anything bad inside her which may be killing the sperm.

Childhood Diseases

In Morrumbala the children can eat everything and anything and there are no traditional treatments or drugs needed for a healthy child. But should the child become ill, the family will call a traditional healer. In the case of malnutrition, for example, the parents believe that it is caused by:

- * the mother using salt soon after her delivery or whilst she was menstruating
- * the child bathing at the same time as the other children
- * the child sleeping in the bed with the parents before the necessary traditional ceremony
- * the mother burying the placenta improperly
- * the parents beating the child too frequently.

Malnutrition – though never the result of spirits, can at times be caused by witchcraft. It is more common today than in the past and though traditional healers try to treat it very often the children die and only a few are cured.

Diarrhoea, vomiting, cough, and fevers are frequent childhood diseases and are usually caused by witchcraft and spells. Another reason given for these diseases is that somebody who recently had sexual relations jumped over the child.

Diarrhoea is seen frequently and its causes are many. In a newborn baby the most common reason for this is that one of the parents slept with someone else, or touched the child after having sex but before the traditional ceremony was performed.

Diarrhoea can be treated by asking a traditional healer to prepare crushed up leaves, some to be drunk, with others put into a porridge. Normally a child who has diarrhoea may continue to eat and drink.

Tuberculosis – is caused through the death of a male member of the child's family. The wife of this person did not do all that was required traditionally. For example, during the traditional ceremony she hid some of her husband's goods or money. Later, on remarrying she did not tell anyone that she had hidden these things and the ceremony was therefore not complete. Though the woman is able to sleep with her new husband, the children may catch tuberculosis.

Payment

Years ago each TBA received a predetermined form of payment per birth (for a kilo of rice, a chicken, a litre of locally brewed alcohol), but as the war has affected virtually everybody and the financial possibilities have reduced, the TBA is often

left without any remuneration.

With the proposed visits by the MCH nurses to TBAs it may become even more difficult for the community to understand that the TBA is not a paid worker of the health team.

Summary

With the information gathering and the discussions between the TBAs and the MCH personnel many ideas were shared. One of the main objectives of health education is to change some form of behaviour in the individual. This can be extended to the family and to the community level.

The MCH nurses who are presently working in Morrumbala district displayed great interest in listening to TBAs. They commented on learning many new things, especially related to the health of the mother and child.

The environment for discussions was very open and allowed for easy flow of ideas. Initially the TBAs appeared distant and unsure of their role in the discussions and were embarrassed to speak about some of their experiences. They voiced reluctance to share some of their traditions and customs thinking that they might be criticised or indeed punished over some of the traditional ceremonies and drugs that they use within the community.

This study of the knowledge, attitudes and practices used during pregnancy, labour and the postpartum period will have benefits for the future training of TBAs in Zambezia province. The MCH personnel in Morrumbala participated actively during the discussions and teaching sessions and expressed their surprise at learning so many new ideas, especially about traditional culture and customs. There are many ideas amongst the TBAs which are excellent and should be encouraged and the few that are wrong, and indeed dangerous, require attention to be changed.

Acknowledgements

I would like to thank the TBAs of Morrumbala for their time and honesty in their sharing of experiences, especially related to pregnancy, birth and the postnatal period.

Julieta Agostinho was always present during the meetings and willingly and tirelessly translated.

The other MCH personnel and health workers in Morrumbala gave their time and opinions.

In the Provincial Directorate of Health, my colleagues Antonia Magalhaes, Joao Ausse and Dr. Domingos Diago Dias encouraged me with the work and read the initial draft reports making suggestions. Save the Children Fund (U.K.) funded the project and my colleagues encouraged me and offered moral support.

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Recommendation

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Office and Training Centre Factory:

80 Sunshine Avenue

P.O. Box 10-160, Te Rapa, Hamilton

Hours: Mon-Thurs 8.00 am - 4.15 pm

Fridays 8.00 am - 3.00 pm

I have used this rocker for my clients for several years. It is of great value in coaxing unborn babies into the most suitable position for an easy birth.

If first-time mothers will use it at meal times and when watching television, from 34-36 weeks of pregnancy, and other mothers from 39 weeks, they will definitely increase their chances of an on-time, short-as-possible labour and reduce the risk of post maturity, induction, forceps and caesarian section. It has a totally non-invasive action, so is safe for all mothers to use.

Jean Sutton (Midwife)

Independent Consultant for Normal Birth



The frame of the rocker is in black, with the padding and rockers being a smokey blue colour. The price is \$191.25 GST inclusive. (Freight to your city/town is extra.)

If you would like to find out more about the Maternity Rocker please ring (07) 849-3606 and ask to speak to Barry Wilson or Kirsten Hosking.

The Hamilton Workshops and Training Centre (Inc.) is a non-profit organisation which works in partnership with people with disabilities.

One of our sections is a metalwork and wirework division. Our workers work in teams and are supervised to ensure strict quality control. The Society prides itself on producing high quality products.

Risk Lists – Who's at Risk?

Joan Donley O.B.E.

In August, the College received several documents for comment – usually required yesterday!!

One of these – from the RNZCOG Council – was 'Guidelines for Consultation with an Obstetric Specialist', the other was from Coopers and Lybrand (C & L) which has been commissioned to define 'key issues' surrounding Maternity and Related Services which will be later investigated.

The nine pages of NZCOG risks for referral are predictably based on the medical model. On the other hand, the combined RHAs joint review of maternity services to assess 'the costly conflict over the control of childbirth services', (1) is addressing 'issues relating to quality, access, information and resource allocation with respect to future contract arrangements'. (2)

This will be conducted in three phases of

- * development of a PROTOCOL to be incorporated into a number of service delivery options; (note rigid protocol instead of flexible guideline)
- * costing of a protocol and indicative costings for possible options,
- * development of national communications strategy..... e.g. perinatal data base. (2)

Despite the above, one realistic RHA representative was of the opinion that 85% of women would be eligible for primary health care. (3)

Primary Health Care (PHC) is preventive/community care – the basis of the WHO initiative 'Health for All by the Year 2000'. PHC is not to be confused with primary medical care! Primary medical care means maintaining the doctor as the gatekeeper. Most doctors clinically assess pregnancy and birth, defining slight deviations from the norm as conditions requiring invasive interventions despite clear evidence of general good health status. This is called 'medicalisation'.

The midwifery model based on pregnancy and birth as normal physiological functions has a wider focus. It recognises that environmental factors – poverty, poor housing, workplace hazards, unemployment, junk food, environmental pollution also affects outcomes. Midwives treat minor deviations through preventive and supportive measures instead of getting trapped into routine risk scoring.

Formal risk scoring, placing women into high/low risk categories, frequently results in the medical management of labour leading to an increased incidence of caesarian sections, forcep deliveries and iatrogenic morbidity.

A Guide to Effective Care in Pregnancy (4) says:

Formal risk scoring are a mixed blessing for the individual woman and her baby. They may help to provide a minimum of care and attention where these are inadequate. In other settings, however, formal risk scoring results in a variety of unwarranted interventions. The introduction of risk scoring into clinical practice carries with it the certain risk of dubious treatments and interventions.



Photo: Jane Scotts

The potential benefits of risk scoring have been widely publicised but the potential harm is rarely mentioned in the current literature. Such harm can result from unwarranted intrusion in women's private lives, from superfluous interventions and treatments, from creating unnecessary stress and anxiety, and from allocating scarce resources to areas where they are not needed.

Further, the medical model is reliant on expensive technology. Technology is power and tends to produce a hierarchical distribution of decision making and the transformation of social relationships. It often serves the economic and social interests of élites instead of those of the majority of women in need of care. (5) It is also controlled by men who are unable to have babies and, therefore, understand the process only in terms of short-term outcomes and economics.

This reliance on short-term outcomes and economics was reflected by the C & L agent S. Snively. At a meeting with College members in Christchurch, 27 August, Snively was of the opinion that the economic viability of the CHE had to be maintained. She claimed that this would require that most women (not just the high risk) would have to give birth in these high tech hospitals to justify the expensive technology. But at what cost to mothers and babies and the state?

The Core Health & Disability Support Services for 1993/4 has detailed the 1991 unit costs of various types of birth and care of babies with problems. (6)

Normal vaginal delivery	\$ 2,247
Complicated vaginal delivery	3,710
Uncomplicated caesarian section	4,541
Complicated caesarian section	8,443
Term babes with problems	3,413
Neonates with problems	1,833
Premature babes with problems	15,491

There are three points here:

- the cost of high tech births to the state
- the greater cost (morbidity | social) to mothers and their babes.
- what evidence is there that the medical model results in better outcomes than the midwifery model who are classified as 'high risk'?

There are surveys that show midwifery care of high risk women produces better outcomes.

Doris Haire reports a 1988 summary of 3287 women in New York's Bronx, which has a population 65% Hispanic and 25% Black. In addition to 70% of medically at risk or high risk women there were also 365 (11%) 'walk-ins' (no prenatal care). Yet, 86.1% (2829) had midwife managed spontaneous normal deliveries. Caesarian section rate – 11.5%, instrumental deliveries – 3%, epidurals – 7.3%. (7)

The majority (89.9%) of infants had Apgar score of seven or more; 11.1% required special/intensive care. PNMR = 15.2/1000 live births; stillbirths 7/1000. (7)

More recently, when I was in Canada involved in the Ontario Pre-Registration Programme, I had the opportunity to visit an Inuit settlement – Povungnituk – population 1000, on the west coast of Hudson Bay, just below the Arctic Circle. Here,

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Midwives Raise the Options for Childbirth

Jo Coco

Co-ordinator NZCOM
Auckland Region

The NZCOM Auckland Region notes the comments of Dr. Philip Rushmer and his colleagues as identified by their article in the *NZ Herald* Monday 19 July 1993.

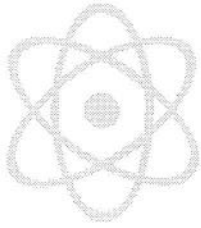
In 1990 the Nurses' Amendment Act again restored independence of practice to midwives. The competitive environment that the change to the Nurses' Act has caused is something that our colleagues in general practice have not been trained to cope with, and, indeed, have not experienced before. No doubt this contributes to their feelings of doubts about their worth and low prestige. Their right to be the primary care givers for well women and babies during pregnancy, birth and the postnatal period had been protected until these changes occurred. The changes to the Nurses' Act allowed a competitor into the area of pregnancy and childbirth and, as with any monopoly, this is a heavy blow. It is feasible to suggest that, with ongoing deregulation of industry including health services, further competitors in other areas of health may also appear on the scene.

Having said that, it is difficult to identify one general practitioner who does not use the services of a midwife, whether women give birth at home or in hospital. As the article points out, general practitioners "carried out the bulk of obstetrics with the help and assistance of midwives". However, because of the limitations of the approach to care that most GPs take this means the women would otherwise be abandoned if they (the GPs) did not employ the assistance of a midwife to continue to provide ongoing care, observation and assessment.

Midwifery care allows GPs the opportunity to carry on with their general practice whilst midwives fulfil the maternity obligations of the GP. There has been little recognition of the costs the state incurs to support this approach to obstetric care. In order for a GP to access the services of the team midwife in a hospital, certain structures must be in place. The midwifery team is composed of a number of midwives. The delivery unit itself houses the latest technology and is supported by cleaning, maintenance, dietary, clerical, and transport staff to name a few. There are also ward house women so that it is not difficult to provide postnatal care, for example. Pre-labour wards and assessment wards provide the perfect answer to having to attend a woman during busy surgery hours – a team of midwives! These services involve teams of midwives who continue to provide the care, assessment and observations of the GP's client. The midwives remain ever diligent in informing the GP of progress and any complications that may arise so that they may prescribe care for the midwives to carry out. The point is that to support GPs in their general practices the state pays dearly. In the community setting, GPs generally rely on the midwives to provide all the equipment and meet the costs of the services provided.

These services provided by the state are better employed for the purposes of those who are not well during their pregnancy and childbirth, and for those who choose or need to deliver in hospital. This fact has been recognised by the Minister in his decision to reduce the expenditure on maternity services. When midwives regained independent status as practitioners in 1990, they inherited the Maternity Benefits Payment schedule of fees payable to practitioners involved in maternity care. It was not until this time that the contents of this schedule became public knowledge. Midwives quickly recognised that the schedule did not well reflect the philosophical basis of their care and the midwifery model for practice. Instead, fees were attached to specific tasks with higher fees payable for procedures such as forceps, caesarean sections and other interventions. It remunerated GPs according to the amount of interventionist care.

In addition, it remunerated GPs according to the normal outcomes most often achieved by the diligence of the attending midwives. This differs from the midwifery model which recognises birth as a normal process. It also supported the business overheads of the doctor's general practice while the GP was in attendance elsewhere (namely delivery unit). This practice of double-dipping overlooked that payment was being made for this attendance, irrespective of the location of the service being provided. This cost was again compensated for in the rather extraordinary travel allowance of \$1.60 per kilometre, acknowledging income lost for time away from the practice. Do you know of any other business that pays this sort of compensation?



Midwives did not wish to practise in this way and attempted to negotiate with the New Zealand Medical Association and the Dept of Health to correct these anomalies. This was not well received by the Medical Association who did not wish to have discussions with midwives. Historically, the medical profession has been unwilling to accept the Department of Health recommendations on maternity care payments. The result of this attitude is the expense of Tribunals as was the case in this situation.

A midwife will spend up to two hours with a woman at the first visit. At subsequent visits she will often spend one-half hour. During this time she will be assessing not only the blood pressure, growth of the baby, urine tests and other clinical observations, she will also give much of her time listening to the woman and her partner and answering their questions. In midwifery practice this is the time for education as well as assessment. Postnatally, the midwife will also spend considerable time assisting a woman with breastfeeding and other issues of the postnatal period including ongoing education for parenthood. The Maternity Benefits Schedule pays \$20.65 for any one visit in the antenatal and postnatal period irrespective of the time that practitioners spend. It is little wonder that GPs are concerned about the cost of overheads, and hence the need to rush women in and out of the practices to achieve the desired \$80 to \$90 per hour as stated in their article. It is the team midwives in hospitals that provides the safety net for women in this situation. They hold antenatal classes so that women have an opportunity to receive some form of antenatal education, they provide postnatal care in hospital wards so that the GP doesn't have to contemplate the logistics of providing postnatal care at home while running a busy practice. All of these support services are funded by the state.

Surely the overhead expenses incurred in any business is the decision and responsibility of the business owners and

not that of the state. The fee for service should surely be payable for the job done, not attached to the financial position of the claimant. The article questions whether the far greater overheads of the GP should be taken into account. Simply, 'No!' Midwives who provide services to women in the community are encouraged to do just that; provide maternity care in their home as much as possible. This includes antenatal and postnatal care for those women who choose birth at home. The commitment to time spent providing that care is far in excess of that provided by most General Practitioners and thus the overall hourly rate is significantly less than their article would have us believe. The care that is provided in the community eliminates the high costs of the supporting structures of the hospital setting and as more women choose the midwifery option the costs of maternity benefits overall will continue to decrease. In time it is envisaged that the expensive maternity facilities of a hospital will be available for those women who need more sophisticated obstetric care because of problems with either their pregnancy and/or childbirth. The team midwives will be experienced at providing the intensive care required by these women while continuing to offer a community 'midwifery only' option for those women who choose it. This option is currently available from National Women's Hospital and the NZCOM Auckland Region congratulates these midwives on this initiative.

The College of Midwives supports the Minister's decision to reduce expenditure on maternity services. While achieving this he is able to extend to women the choice of an alternative care giver that may provide the sort of service that she prefers. The truth is that the care giver has not changed, but instead has been recognised for their worth and contribution and finally the payment has been redistributed and paid to the rightful earner. On average, a midwife would gross no more than one-third of those figures mentioned.

In their article the GPs state that the value of the GP is as a gatekeeper. The concept of gatekeeper is a demeaning one to women. It upholds the old stereotype of 'doctor knows best'. It also relies, unwisely in the light of this article, on the impartiality of the gatekeeper to offer honestly to the woman her rights of choice in available options and care givers.


Midwives, irrespective of their area of practice, have their practice reviewed annually. This ensures accountability for care given and negates the possibility of a midwife completing her training and not

attending to ongoing or practice updates on a regular basis. To date no such process occurs in the practice of medical practitioners.

There is much said about community consultation and consumer evaluation in the health services these days. Midwives are the only professional group that actively involves its consumers in its organisation. Consumers are invited to become associate members of the College and to attend meetings and contribute to debate and discussion. The NZCOM pursues feedback from consumers regarding the services provided by midwives. There is no parallel involvement in GP services.

The article asks "is there any evidence that this extra expenditure is leading to significantly improved services?" The NZCOM Auckland Region believes that with the new schedule of fees put in place, a cut in the overall cost of maternity services will be achieved and a redistribution of the monies spent overall. With this is the added bonus of improved choices for women both in childbirth and professionally as midwives. If you want to know if a midwife's service is an improvement on your last childbirth experience ask a friend who chose a midwife. You may also ask your midwife to put you in touch with other women she has cared for.

The NZCOM is disappointed that the GPs who wrote the article – namely Philip Rushmer, Alison Denyer, William Ferguson, John Hilton and Lannes Johnson – are implicating midwives in their argument for more pay and recognition of their worth by the Minister. It is a fact that all of these GPs involve and rely on midwives to provide care and assessment for their clients during pregnancy and childbirth.

We wish to acknowledge the large number of GPs who continue to work in a collegial relationship with midwives, both in the community and in hospitals. 



Reconsidering Breastfeeding Management: One Breast or Both Breasts at a Feed?

Heather Jackson

Midwife

Currently residing in
Bristol, England

Following the recent UNICEF breastfeeding awareness initiative and the recognition of breast milk as the best form of nutrition for infants, there has been an upsurge by health professionals, especially midwives, in developing strategies that promote, protect and support women to breastfeed. However, not all of these have met with the success that had been anticipated.

Many units have introduced guidelines and policies in an attempt to ensure that breastfeeding management has some consistency and mothers are given correct information to enable them to make informed decisions about the breastfeeding experience—a highly desirable development that has the potential to help both professional and mothers. However, what appears to be happening is that these guidelines are becoming inflexible rules to be carried out to the point of extreme insistence. As a midwife and lactation consultant I have become increasingly alarmed at the insistence of many on one-sided feeding or using both breasts at each feed, and at the increasing number of women who have developed breastfeeding problems as a direct result of this. This discussion will consider these issues in light of recent research that emphasises the role which the baby plays in controlling its own rate of nutrition.

The mechanism by which control of human lactation is exercised seem to be simple. Prolactin released from the anterior pituitary was responsible for the milk synthesis while oxytocin from the posterior pituitary was responsible for the release of stored milk. The stimulation from the baby sucking stimulated the release of these hormones to provoke a bilateral breast response. This is what midwives have always been taught and so based their practice on. However, this failed to explain such observations as milk termination in one breast and not in other (Woolridge, 1993). Recent research (Peaker, 1987; Prentice, 1989) offer some explanation for this. They identified another factor secreted in the milk that exerts a direct and local inhibitory action on further milk synthesis. This factor is released into the milk space and inhibits milk production locally as its concentration increases – it exerts a negative feedback on milk production by autocrine control. The action of the local factor imposes a more phasic pattern to milk production, resulting in a peak in production immediately after the breast has been emptied and slowing to minimal production as the breast fills to its natural capacity. It then appears that prolactin is responsible for priming the system and determining the broad limits of milk supply in the first week(s) postpartum, and this autocrine control may exert the predominant control and local factor in the remainder of lactation. If milk is not removed from one breast or both breasts then the inhibitory action of this factor will be sustained, suppressing further milk production. However, it is unclear if the control of milk supply is the only role for this autocrine factor and it may well be that it has additional actions that limit damage caused by overfilling (Woolridge, 1993).

The clinical consequence of this finding is that if breastfeeding fails to be optimised in the early days, breast milk output may be set at an inappropriately low level from which a degree of latitude to increase milk supply may be lost. Any practice that limits potential milk output in the first week postpartum may therefore compromise a mother's long-term output, resulting in an apparent or relative breast milk insufficiency.

Increasingly research shows that the baby also exercises direct control over milk supply by controlling how much milk is consistently removed from the breast. The more fully the breast is emptied, the more efficiency milk will be synthesised and production maintained through lack of the inhibition factor production. Appetite control by the baby will ultimately be the regulating factor.

We know that babies need adequate intake of both fats and calories to ensure adequate growth. It is also known that fat and calorie content increases with the duration of the feed with the foremilk low in calories, changing to a small volume of high calorie hindmilk at the end of the feed. This is a gradual change that occurs throughout the feed and is unrelated to timing or letdown (Hall, 1975). This can be likened to a three-course meal, with the first part of the feed being the soup and progressing to the dessert high in calories. Patterns of management that restrict time at the breast may therefore result in babies never receiving the high calorie milk at the end of the feed. In addition, an infant who is restricted to one breast may never get sufficient calories (get past the soup course) if that particular baby's pattern and mother's physiological makeup actually require the infant to use both breasts at a feed to ensure that adequate supply and calorie content are obtained. In a Bristol study (Woolridge, Ingram & Baum, 1990) mothers who had no breastfeeding problems were asked to follow either of two rigid feeding policies for a period of one week each – either to offer both breasts at each feed, or to try to feed

from one breast at each feed – alternating the breast to be offered at the subsequent feeds. The babies' milk intake (volume, fat content and net fat intake) were evaluated at five and six weeks. There were significant differences in the babies' volume intake in 24hrs and in the fat concentration levels, but overall the net fat intake remained the same. It was concluded that babies were able to regulate their net fat intake in the short term despite significant changes in the quantity and quality of milk, demonstrating that babies were exercising appetite control on the breast with breast milk fat as the currency of this control. For a large proportion of mothers, either pattern of feeding would properly manage to maintain lactation and meet their infant's needs. However, while normal babies in this study were able to stabilise their intakes on alternative extreme patterns of breast usage, mothers whose potential milk supply lay closer to the ends of the normal range would need to be much more flexible in finding a pattern of feeding in order to avoid clinical problems of either over- or under-supply or inadequate calorie intake in their infants. I shall illustrate this by two examples from my own experience.

Case 1

A mother presented with an unsettled baby at six weeks. This infant was feeding frequently, using both breasts at each feeding. Mother felt the baby was hungry and had attempted to increase her supply through switch nursing, increased feedings and hand expression. Mother stated that her breasts felt full, and there had been enormous increase in size and on examination this appeared to be so. There seemed to be no anatomical problems with the breast and they were very heavy and tense, suggesting a good to over-supply. Mother also demonstrated a strong let-down reflex with a very powerful ejection of milk at the commencement of the feed. However, weight gains had been poor and baby had been very colicky, had copious wet nappies and had spat up a lot. On observing the baby feeding he appeared to be correctly positioned and able to remove milk well (as seen by swallowing patterns) and he had good urine outputs but frothing green stools. What was happening here was this baby was getting only the soup course. While the volume was more than adequate, calorie intake was low. The infant was demanding more calories but under the present management got instead more foremilk volume than he could cope with. By altering the management and offering the baby one breast at each feed several things happened. Firstly, the baby was receiving less volume but was able to get more of the

high calorie content as breast content and rate of flow decreased towards the end of the feed. The baby's digestive system was able to cope better and the colic disappeared. As the milk supply was now being regulated to meet the needs of the infant, the infant became more settled with less frequent feeds and a pattern of more or less regular feeding developed, weight gains increased and both mother and baby became more relaxed and happier.

Case 2

This mother presented with a slow weight gain and an unsettled baby at two weeks who fed frequently but at one breast only at each feed. Mother stated that her breasts had never felt really full. This infant was very well positioned at the breast and appeared to suck well but came off the breast after a relatively short time. What was happening for this couple was the reverse – this mother needed more stimulation of bilateral nursing to maintain an adequate supply, while baby needed to use both breasts to maintain adequate calorie intake. When the mother's supply was increased by the baby having unrestricted feeding at both breasts, the problem resolved rather quickly. I also felt that the baby had learned early on that sucking at the same breast further produced little reward and was not worth the effort, so that this baby initially took some encouragement to suck at the second breast. Fisher & Blackburn (1993) both comment on similar experiences, suggesting that infants learn quickly from negative experiences at the breast and modify their behaviour accordingly.



What these cases demonstrate is that neither one or both breasts at a feed is better, but that rather there is a place for both. There must be allowed to develop flexible patterns of breast usage that allow babies to self-regulate their milk supply. Improved outcomes have been associated when breastfeeding is unrestricted and babies are allowed to come off the breast at their own time. Babies should be offered the second breast, so allowing the baby to decide if it has had enough. Sometimes they may take it, while other times they may not – both are acceptable. Only the baby knows when they have had the right balance of foremilk and hindmilk. It is also known that frequent nursing in the early days resulted in reduced infant postnatal weight loss, increase in breast milk supply and intake, increased weight gain, more frequent passage of meconium and lower incidence of hyperbilirubinaemia (Woolridge, 1993; Illingworth, 1985) and that mothers experience less dis-

comfort (Carvahlo M. *et al.*, 1984, Fisher, Renfrew & Arms, 1990). Guidelines that are used for breastfeeding must be those that encourage efficient use of the mammary gland through effective and frequent emptying, as this can also maximise quality in terms of calories and volume. These guidelines must recognise that babies possess an appetite control which, given the right environment, will regulate their own nutrition and milk supply.

Midwives will protect and promote breastfeeding best by correctly assessing positioning at the breast, supporting and guiding mothers rather than doing it for them, and demonstrating feeding management through verbal and written communication. What is required is not a rigid policy but a policy that guides good practice. Midwives must ask themselves on what their breastfeeding management is based, and not continue practices just because that is how they have always been done. Midwives must examine critically and reflect on their practice. Consumers of maternity services have the right to a high standard of care based on research and knowledge. Midwives who cannot demonstrate this knowledge and the skill needed to assist mothers to breastfeed stand the risk of being challenged by the profession and the consumer. Midwives must have accurate knowledge in understanding how lactation is initiated and maintained and not lose sight of the physiological factors, which too often happens. Equal consideration must be given to the baby's fat/calorie intake and attention must not solely concentrate on volume intake.

Acknowledgement must be given that while general principles apply to managing lactation, each woman and infant is unique physiologically and emotionally and that this may require their needs to be met slightly differently while still meeting the general principles of breastfeeding guidelines.

There is no place in caring for breastfeeding women for the imposition of arbitrary rules and regimented feeding policy. There is, however, a place for those with expert skills in breastfeeding management who can share information, help to formulate policy and provide specialist clinical support to mothers, infants and midwives should they encounter problems in the hospital and community setting. The skill is in recognising the individuality of the nursing couple, assessing needs, implementing care, evaluating that care and modifying management if required using current breastfeeding knowledge, research and excellent clinical skills.

References

Available from the author on request.

Pregnancy Chair

The Pregnancy Chair is a kneeling/rocking chair that assists optimal fetal positioning, which helps to reposition a posterior positioned fetus to an anterior position. It offers a positive posture with a safe-proof rock where a pregnant woman may rest with broadly spread knees and an open pelvis.

When the body is rocking with the hips above spread knees, the environment is set for the baby to turn to its optimal fetal position. From an osteopathic point of view 'The Pregnancy Chair' offers correct pelvic tilt and minimal knee stress, enabling long-term sitting. The foot massaging treats the tops and bottom of the feet, while the sides are used for the massaging between the toes.

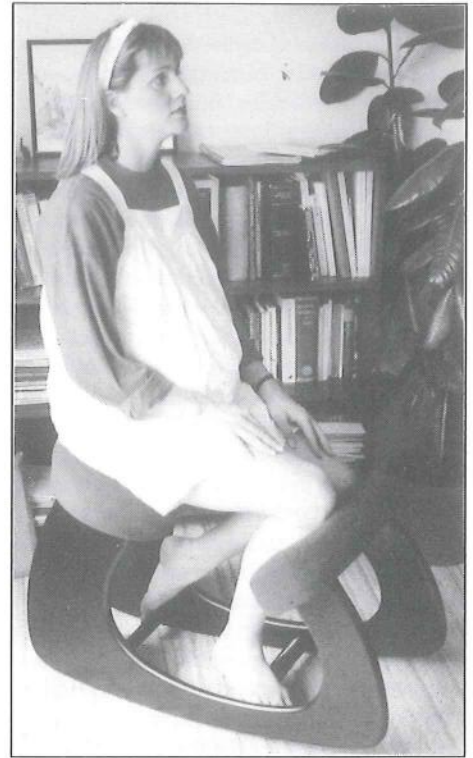
The curves of the chair (based on

the Maori fish-hook design) are simple in form and contribute to a pleasant and child-safe living space. The chair is very stable yet collapses in 15 seconds (into five pieces) for transportation or storage.

The teal coloured fabric is 100% cotton canvas (scotch-guarded). The turned foot massager is oiled matai. The sides are clear sealed. All fabrics and finishes are completely non-toxic. The chair is 100% NZ made.

The Pregnancy Chair can enhance the birth experience of the mother and baby and save time for the midwife by assisting the fetus into the anterior position. The Pregnancy Chair is available at a special price to NZCONJ readers of \$249 + GST. For purchasing details and further discounts:

Ph. (07) 575-8818



Previous model shown

Political Comment (Continued)

there is a 21-bed Health Centre with an attached 4-bed Maternity Unit under the management of three midwives. This Unit provides perinatal care to a population of 3688 Inuit widely scattered in seven villages accessible by dog sled or small plane.

In 1986 when this Unit was established only 30% of Inuit women gave birth in the north. The majority was forcibly evacuated at 37 weeks gestation to Moose Factory or Montreal. The late neonatal death rate was nine times higher than the rest of Quebec, in fact, it was as high as that of Third World countries.

By 1990, 82.1% of Hudson Bay women birthed at the maternity unit. The Perinatal Mortality Rate (PNMR) 1986-88 for Hudson Bay was 7.4/1000 compared to 8.7/1000 for Quebec (1984). (8)

These are high risk women. Parity ranges from 0 to 11; ages of women range from 14-42. Family violence is common; nutrition is generally poor; the incidence of anaemia is 42.7%; 41% of all pregnant women are diagnosed and treated for STD - mainly chlamydia; 87.5% of women smoke. (8) The climate is harsh.

These women are overseen by a Perinatal Committee chaired by a mid-wife. Comprised of two midwives, two doctors, Inuit midwives in training, one consumer, a representative for the other village nursing stations and a member of the Health Centre nursing staff, it reviews all files in the third

trimester. All decisions are ready made by consensus, grading all women A, B, or C on protocols developed by the midwives and approved by the committee.

Women in the outlying villages have their antenatal care at the nursing stations supported by a trained Inuit women. They come to Povungnituk for assessment in the third trimester (or earlier if necessary) and at term, staying with relatives or at special houses. This is subsidised as are the air fares. Partners who wish to support a woman during the birth get a half-subsidised airfare. Occasionally a birth occurs at the village nursing station.

At Povungnituk all antenatal education is provided by the Inuit midwifery students in their native language. Most antenatal care is also carried out by these women under the supervision of the midwives.

As it's an eight hour normal flight to Montreal (\$1400) or six hours by air ambulance (\$10,000), decisions are carefully made. According to one of the doctors, certain risks are accepted with the consequences. The 'risk de milieu' is minimised by giving maximum respect to the normal, antenatal emphasis on prevention, community support, health promotion, team decision making and using little intervention.

Sending women south for delivery is not without risk. Here they are unsupported in unfamiliar surroundings and have language difficulties. They suffer from loneliness and depression. They have a high caesarian section rate. At home, child care is difficult to arrange while the long separation is seen to promote family

discord and violence.

In the adjoining Ungava Bay community of Kuujuaq which has a larger hospital and more technology (including anaesthetic facilities and ultrasound' both lacking at Povungnituk) and where care is in the hands of nurses and doctors (medical), 32% of women are sent to Montreal for birth compared with only 12.6% from Hudson Bay. The Government noted in its Report (8) it is the midwifery care in Povungnituk that makes the difference.

The most recent Povungnituk statistics, 1 April 1992 to 31 March 1993: (9)

Births:

At Maternity Unit	130	
Home (unplanned)	2	
Nursing Stations (unplanned)	10	
	142	
Transfers & Medivacs	20	
Elsewhere by choice	6	
Total Hudson Bay Coast Births	168	
Premature Births - 29,30, 31,		
34 weeks	4	2.4%
Congenital Abnormalities	3	1.8%
Neonatal Deaths - 2 of 3 above	2	1.2%
Stillbirths - 1 IUGR		
- 1 cord around neck		
3 times	2	1.2%

Obviously, the midwifery model/low tech preventive care in pregnancy and birth yields the best results physically, psychologically and economically.

References available from the author on request. ◆

SANDS

Stillbirth and Neonatal Death Support Group (incorporating those with early pregnancy loss)

Loss experienced anywhere along the reproductive continuum (infertility, spontaneous and therapeutic first trimester abortion, ectopic pregnancy, mid-trimester abortion, premature birth, abnormal infant, adoption, stillbirth, and neonatal death) inevitably leave the woman and/or family with a sense of loss and deprivation that needs to be resolved with the painful process of grief. Our greatest support to these people is our humanness. If we have had a significant loss ourselves and/or taken the time to explore our own feelings and thoughts of life and the loss of it, we often have even more to offer these families.

1. It is important that **staff are honest with parents from the outset**. Any dishonesty will be remembered with hostility, and cause unnecessary pain. Say honestly: "We are trying to get your baby to breathe", "The scan shows your baby's heart isn't beating - I'm sorry - your baby has died." The parents will remember the way you tell them this forever.

If the fetal heart has been reasonable up until second stage, and death of the baby has not been expected or verbalised, parents will not be able to believe it *at the moment*. They will be in deep shock, so will not react in any way that the midwife - perhaps working alone with the baby - cannot handle.

It is a different procedure if the woman is admitted and no fetal heart is heard. If she is physically well (e.g. not bleeding heavily in early pregnancy, or in established labour) it is important that **she goes home** to her own environment for approximately two days, where her loss can begin to become real to her, and she can begin to grieve. It does not matter if she does not stay home for long, if she cannot bear it, but it will be helpful to her later if she has been home. The option of **D & C/induction of labour should be explained** to the couple and a contact person and phone number made available to them.

2. It is important that staff try to **ensure that parents can be together as much as possible**. If the father is not available the baby's grandmother or a close friend should be allowed to stay with the mother. Hospitals generally allow the couple to spend all their time in hospital together, e.g. both in the TV room.

This could also be offered those with early pregnancy loss. Because this is often the first major life event for the couple, helping them to share their thoughts and feelings with one another can enhance their relationship. (Marriage breakdown after the death of a child is three times more likely than average.)

If there are other children, and these have been involved in the pregnancy, it is also important for their grief that **the children be allowed to share this time with their parents and the dead baby**. It is for this reason that parents can arrange with the hospital and/or the funeral director to have the baby at home (even after a post-mortem).

3. Parents find it helpful if **you share your tears and distress at the death of a baby**. It shows that others feel bad about their loss too. Expressing your feelings does not imply lack of professional conduct on the part of staff. Comments like "I can't imagine how awful this must feel for you", "I'm sorry your baby has died", or "I don't know what to say", can give parents an opening to talk.

It is good, once contact has been established, to maintain it - **don't avoid the patient** - often they want to talk and/or go over what has happened. Stay with the parents in their grief - accept their tears, anger, guilt, fear, disbelief, anguish - just being there is helpful, a touch or hug when the pain has eased for the time being.

4. Parents in this situation for the first time, may assume that the midwives and doctors they meet are used to the situation. Parents may give disproportionate weight to what is said, and the way it is said to them.

5. It is **normal for parents to want to see their baby**, no matter at what gestation it is lost. However, many will not have seen a dead person before and may need help before they feel able to see their baby. An explanation of baby's appearance is important, and they may be helped if the baby is wrapped in a blanket and placed in their arms with the words "Here is your baby to cuddle". They may find it helpful to know that others have regretted not seeing their baby. Remember **there is no hurry**.

STAFFLINE GUIDELINES

Objective: To promote sensitive care for families experiencing loss anywhere along the reproductive continuum

by:

Remembering:
THERE IS NO HURRY
GIVING OPTIONS
HELPING CREATE MEMORIES
ENCOURAGE PARENTS TO TRUST AND
EXPRESS THEIR FEELINGS

6. There is no hurry: be patient; work at the pace of the family, particularly the woman; wait for the cues - "What do we do now?" "What happens next?"

It is important that *the baby is not taken away from the parents* unnecessarily. The baby can be washed by, or in front of, the parents. They may like to dress the child in the clothes the mother brought in. (She can easily be changed later if necessary for post-mortem).

Parents need time to get to know their baby, often several days. Some will need longer, especially if it was an operative delivery, or involved a general anaesthetic. As a rule, babies should not leave the hospital before the mother (except to go to and back from possible post-mortem). Miscarried babies should remain available for the parents to see, until the mother is discharged.

Even if the baby is grossly deformed and unattractive to staff, the mother will find her baby acceptable.

If baby is ill or premature and on its way to the neonatal unit, parents should be helped to feel they have done as much as possible for the baby themselves. Give them a photo of their baby while they are separated from it. *Parents value having held their baby while she was dying.*

7. Ask the parents for the baby's name. Then the staff should refer to the child by name. It is important to the mother that the baby is still a person.

8. *Help create memories*: memories help establish the reality of their babies and ease the way for future grieving. Be careful your own distress (for example with a macerated or deformed babe) doesn't influence parents needs. Colour *photographs of the baby should be available* to the parents. Include a family photo and one with each parent, sibling, and/or grandparent. Any photos the parents don't want at the time should be kept in her files. A lock of hair, a duplicate bracelet, hand/footprints, Plunket book with baby's measurements, are also important tangibles for the parents in the months of grief ahead.

9. Mothers should be given a choice, but most prefer the privacy of a *single room when they are moved*

to the postnatal area. (Make sure they do not feel isolated - visit them frequently; ask if they want their door open or closed etc.). After a perinatal death, if a mother is adamant she doesn't want to go to a postnatal ward, support her to visit the area before discharge so she has begun to overcome the fear of seeing and hearing live babies and pregnant women.

10. The mother will deeply appreciate the frequent visits of staff somehow connected with the delivery of her baby, e.g. the antenatal staff, and especially of those present at the delivery and/or death of the baby.

Although she will feel distressed without her baby and full grief family and other close friends should be encouraged to visit these people will will her supports in the succeeding weeks and months and it helps if they have been involved in the intense periods of her grief).

Often parents who have themselves suffered a loss previously can be of assistance. Such people know the fears and the course bereavement must take. These parents are available to be called anytime. Stillbirth and Neonatal Death Support group (also) for those with spontaneous and therapeutic first trimester abortion, ectopic pregnancy, and mid-trimester abortion).

11. Offer lactation suppression (it may be needed from as early as 8 weeks gestation).

12. The longest walk is the one along the corridor going home. The loneliest drive, the emptiest house is ahead. It will help women to know when they first go out that their view of the outside world may feel distorted and that they tend to notice pregnant women and small babies.

13. Parents attach much importance to the postoperative \ post-miscarriage \ postnatal visit, and expect to receive a great deal of information and assurance about future pregnancies. It usually marks the end of official recognition of their baby. The combination of high expectations and the termination of their relationship with the hospital frequently leaves parents feeling depressed. Acknowledgement of this by staff can be of assistance.

14. A survey has shown that women who have their next child within 16 months of the death of their baby, are more liable to have difficulty accepting the new baby for itself, and may start grieving anew for their dead baby. Parents should be especially warned about starting a new pregnancy three months after a stillbirth. It would usually be too soon anyway, and would lead to term around the anniversary following early pregnancy loss are best left until a normal menstrual cycle is re-established and the parents, particularly the mother, feels physically and emotionally ready.

SANDS therefore suggests that *parents wait a minimum of six months before attempting to start a new pregnancy*. Although this seems to leave a women in great emotional pain, it does help the parents to work through their grief before anticipating/dreading a new baby.

15. *The pregnancy following pregnancy loss is always an anxious one*. This anxiety needs to be recognised, accepted and aired.

Many parents benefit from speaking to others who have had similar experience. Not only in the first days after the baby's death, but also at the 3-4 month time, when the rest of society assumes they will no longer be grieving; during any subsequent pregnancy; and after the birth of the next baby.

16. SANDS parents are available to support staff who are caring for families who have experienced the loss of a baby. *It is not a failure to lose a baby*. Parents may focus anger or blame on you, your hospital, or your colleagues - review what they say and accept legitimate criticism, and realise that you also may be the focus of the family's displaced grief.

Remember -
**THERE IS NO HURRY
GIVE OPTIONS
HELP CREATE MEMORIES
ENCOURAGE PARENTS TO EXPRESS
THEIR FEELINGS**

COLLEGE OF NURSES AOTEAROA (N.Z.)

In August 1991 a group of nurses met in Palmerston North to discuss the feasibility of setting up a College of Nurses. Seven people formed a project team which developed a vision, philosophy, purpose, structure and criteria for membership. As a result of the Team's activities, the College of Nurses Aotearoa (N.Z.) has become a reality. It is now a legally incorporated society.

The College of Nurses Aotearoa (N.Z.) has been established to maintain and promote EXCELLENCE IN NURSING, to encourage research in nursing by nurses and to monitor standards of nursing practice, in a negotiated partnership with the Tangata Whenua.

The College will not be involved in any industrial or contract bargaining activities, but will provide a strong professional focus for nurses who are currently covered by a range of different industrial bodies, bringing nurses together into one professional affiliation.

Subscription is \$100 for a Member and \$120 for a Fellow. This carries a one million dollar indemnity insurance and free subscription to Nursing Praxis of New Zealand.

The Council of the College of Nurses Aotearoa (N.Z.) comprises four Maori and four Pakeha nurses.

President:	Jenny Carryer
Vice-President:	Kamiria Gosman
Secretary:	Kathy Wilson
Treasurer:	Pauline Hill
Office of Academia:	Dr. Judith Clare

Councillors

Mary Wade
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For more specific information about application for membership, write to:

College of Nursing, P.O. Box 1258, Palmerston North.

HEALTH CARE HAWKES BAY WAIROA HOSPITAL STAFF MIDWIFE

Applications are invited from Registered Midwives for the above position based at Wairoa in Northern Hawkes Bay on the sunny East Coast of the North Island.

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If you wish to be part of a select team providing this service please contact the Personnel Department, Health Care Hawke's Bay, Private Bag 6023, Napier, New Zealand, for a job description and application form.

Phone 0064-6-8359241 or fax 0064-6-835 666.

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The working environment of both Units is progressive and innovative, our staff friendly and motivated and the surroundings pleasant and comfortable.

If you can demonstrate a commitment to professional midwifery practice, are willing to share your knowledge with women, primary care givers and midwife colleagues and have excellent communication and interpersonal skills, you are the midwife we want to join our staff.

Closing date: Open.

Please contact Anne Manley, Personnel Officer, phone (09) 486-1491 ext 2543.



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COMING EVENTS

Midwifery Conference 1st December 1993
Royal College of Nursing, London. Contact - Margaret Storer, 20 Cavendish Square, London. WIM OAB. U.K.

The First World Congress of Labour and Delivery. 3-7 July, 1994. Jerusalem, Israel. Contact - Secretariat: Eshed Productions Ltd, 6, Pinaless St., Tel-Aviv, 62265. Israel.

Launching The International Year of the Family 1994
'Promoting Families for the Well-Being of Individuals and Societies' Mediterranean Conference Centre, Malta 28 November - 2 December 1993
Contact - IYF National Committee, Ministry for Womens Affairs & Social Development, St. Venera, Malta.

The Parent & Child Show
29-31 October 1993
NZ Expo Centre, Auckland.
Contact - Donna White, XPO Exhibitions Ltd., 5 Cheshire Street, Auckland.

VIDEO REVIEW

Title/Topic: BREASTFEEDING
Duration: 26 minutes
Produced/Sponsored by: Mead Johnson
Cost: complimentary copy for the Midwifery Resource Centre
Reviewed by: Chrissy Fallow, March 1993.

This video is presented by an Australian Lactation Consultant, Mary Langly of NSW, and features a hospital setting (a lactation team/clinic is referred to in the dialogue). It consists of two parts:

1. The presenter focuses on one-to-one counselling - assisting a first-time mother to position and latch her baby on to the breast. The mother demonstrates first what she has been doing (with the consequence of sore nipples) followed by corrective suggestions by the lactation consultant.

What is particularly commendable is the hands-off approach adopted by

BOOK REVIEW

Book Title: Water Birth
Authors: Janet Balaskas/Yehudi Gordon.
Publishers: Unwin Paperbacks
Date Published: 1990
Country Published: U.K.
Price: \$32.95

'Water Birth' is a very appealing book, full of diagrams, photos and very interesting information. It is written for expectant parents and their birth attendants. The book obviously revolves around the theme of waterbirth but covers many topics including the use of water in pregnancy, birth and postnatal care.

The book begins with essays on the ideas and philosophies behind the use of water for this part of life and creation. A portion is given to philosophy of labour and the physics of water use for labour, and its help in reducing and alleviating pain.

In pregnancy, water can be used for aromatic baths including massage, relaxation and meditation. Water exercises can also be done during pregnancy and diagrammatic examples are given on this topic.

There is a good section on labouring in water; answering all the questions you probably ever had on this topic. There are heaps of photos and much discussion on

the benefits and possible drawbacks of it all. The best part of the book covers the time after birth with clear information on breastfeeding and baby care. Information on baby massage and introducing baby to swimming is included.

The last section of the book focuses on the practicalities of obtaining, setting up and using a pool and covers the questions of monitoring the fetal heart, 'protecting' the perineum, birth underwater, body excretions, risk of infection, haemorrhage, etc. There's even a bit on protecting the midwife's back and preparing the room surrounding the pool.

On the whole, I found this a very stimulating and exciting book. It stressed the need to be open-minded and that having prepared the pool, the labouring woman may not want to use it once in labour. They also point out that used too early some labours peter out, and many women labour in water but spontaneously leave the pool for birth.

This is a book I would thoroughly recommend to all midwives, doctors and anyone contemplating a pregnancy or labour in water.

*Reviewed by Karen Barnes
Midwife, Christchurch*



the helper, the woman achieving the corrected positioning and latch-on by herself, thus finding subsequent feeds less sore. During the entire session, relevant and complementary information about the basics of breastfeeding, milk ejection reflex, fore/hind milk balance, etc. is provided.

2. The second part is a group discussion, consisting of the lactation consultant and a small group of mothers (of varying parity) and babies, in a postnatal ward setting for a 'Question and Answer Session' on breastfeeding. Information shared included a further review of the basics, particularly lactational physiology, positioning, latching-on, supply and demand concept, supply variation over 24 hours, through to the commonest cause of sore nipples, nipple care, and what to expect when going home what services are available in the community (N.B. Australia).

There is quite a bit of repetition throughout as the video emphasises the important points, yet limits inclusion of

other relevant information. Some editing was obvious in the "Question and Answer" section so not all questions from the women received fully elaborated answers (as per the video), in fact, some responses came across as rather arbitrary. However, this deficit could be easily rectified by anyone showing the video to a group, stopping the tape and elaborating more fully on some aspects as required.

Although the role displayed here featured a lactation consultant, it is certainly that of the midwife - particularly in this setting. It is heartening to note though that the NSW hospital involved refers to a having a lactation team/clinic available when presumably other practitioners such as midwives have reached the limits of their expertise in a particular situation.

Despite it being a Mead Johnson sponsored video, it was gratifying not to see promotion of breastmilk substitutes inserted.

This video may help complement antenatal class presentations and/or group discussions in the early postnatal period by midwives and their clients; and perhaps be of value to beginning practitioners.

New Zealand College of Midwives

Membership Form

B.O.M.
P.O. Box 21-106
Christchurch

Regional Information

Name _____
Address _____
Telephone Home _____ Work _____
Place of Work _____

Subscription Enables:

- * A Professional Midwifery Organisation
- * Establishment of an office and a National Midwifery Centre
- * Employment of a Co-ordinator for the College
- * Professional Indemnity Insurance

Type of Membership

Self-Employed Midwife **\$255.00**
Full Member (Registered Midwife Full or Part-time) **\$155.00**
Full Member (Student Midwife or Registered Midwife on
Maternity Leave or Unwaged) **\$50.00**
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La Leche League, etc, and other interested individuals) **\$30.00**

Method of Payment

Please tick your choice of payment method.

- Subscription payable to College Treasurer (Please enclose cheque or money order)
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Telephone Home _____ Work _____
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Claiming on Maternity Benefit Schedule: YES/NO

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Please return completed form (together with money if applicable) to the National Committee member for your area.

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