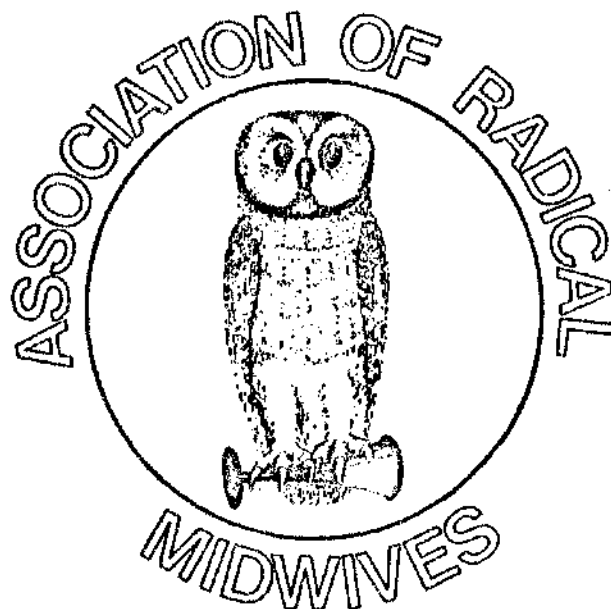


Association of
Radical Midwives



newsletter

April 1980



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CREDITS

Books, Films, Letters Co-Ordinations.....	Liz Winkler
Typing.....	Pat Young
Lay Out.....	Patti and Liz Winkler
Duplication.....	Patti and Jane M. (at Manchester Area Resource Centre)
Cartoonist.....	Fanny

Why a newsletter?

The association of Radical Midwives has been growing rapidly. We have received a high response from midwives and others concerned about the erosion of the role of the midwife and the consequent lack of choice for childbearing women. So we decided it was time to provide a place to share information, news, and to help us organise ourselves to achieve our objectives.

We will attempt to bring out the newsletter four times a year and it'll cover more ground than the minutes from our six-weekly meetings. It will include an editorial, articles, book/film reviews, lists of useful books, addresses etc., and sections on midwifery abroad, organisations and technical information.

Each issue of the newsletter will be put out by a different regional group. Please send all information, comments, letters and graphics to:- NEWSLETTER
c/o Sally Hart, Haringat Women's Centre, 40 Turnpike Lane, London. W4.
We'll be very happy to hear from you and to receive any news, views and information you have to share.

Why 'radical'?

After much discussion about a suitable name for our group THE ASSOCIATION OF RADICAL MIDWIVES was finally agreed upon. We realised that the word 'radical' may alienate many midwives who might otherwise be sympathetic with the aims of our group. We believe 'radical' expresses in its original sense the essence of our group, i.e. relating to roots and origins.

Our overall aim is to restore the role of the midwife for the benefit of the childbearing woman and her baby. We don't see this as going back, but rather as going forward... Our objectives are:

1. to re-establish the confidence of the midwife in her own skills.
2. to share ideas, skills and information.
3. to encourage midwives in their support of a woman's active participation in childbirth.
4. to reaffirm the need for midwives to provide continuity of care.
5. to explore alternative patterns of care.
6. to encourage evaluation of development in our field.

CONTACT ADDRESS:

ASSOCIATION OF RADICAL MIDWIVES, c/o SALLY HART,
HARINGAT WOMEN'S CENTRE, 40 TURNPIKE LANE,
LONDON W4.

ASSOCIATION OF RADICAL MIDWIVES SUBSCRIPTION FORM

.....I would like to subscribe to the newsletter and enclose £2.00 for a year's subscription (£4.00 for overseas subscribers)

.....I would like to become a member of the A.R.M., which includes the minutes of the 6-weekly ARM meeting and enclose £2.00 for a year's subscription (£4.00 for overseas subscribers).

.....I would like to give a donation.

NAME: _____

ADDRESS: _____

Please make out cheques and postal orders to the Association of Radical Midwives and send to Pippa MacKeith, 2 Mount Hooton Terrace, Forest Road East, Nottingham.



EDITORIAL ON NEWSLETTERS

After producing the last Newsletter several people who'd worked on it, felt that it's method of production needed re-assessing. There needed to be investigation into 2 specific areas, time expenditure i.e. sweat and slog, and cost. So this editor collective, acting on a decision made at a National AEM meeting, has looked into other ways of putting the N/L together.

In reference to time expenditure, most AEM people have numerous other commitments and the result is that the N/L is often out late, and this limits it's functions. Although there are varied opinions of what those functions should be, if it is to work as a vehicle for announcements and discussions of recent issues, it must come out on time. Also in regions where members live miles apart, it is more difficult for them to get together frequently. This often leaves one person with the heaviest part of the work and decisions.

The method used in this issue, was typing straight onto paper and reducing-eliminating typesetting (a very long process, though very effective), and laying out. We also chose to eliminate typesets, as they take experience to use without a lot of "fuss".

The other factor in the production of the N/L, that came under fire, was the cost of printing, though everyone agreed, that printing is more attractive and results in a more finished product. This N/L has been duplicated at approximately 1/3 the cost of printing, but involved the labour of 2 AEM members to run it off. We think if people are satisfied with this product, we can possibly reduce the cost of subscriptions as well. If cost is not considered a priority, articles typed on to paper and reduced, can be printed instead of duplicated.

In conclusion these are our options:

1. Typeset, layout, print - as in past newsletters.
2. Type on to A3 paper (large), then reduce to A4 size and duplicate.
3. Type and reduce as in #2, but print instead.

We ask you to consider this N/L as part of a learning process and not aimed to determine finally, future methods of production. We therefore, welcome any ideas, opinions or suggestions, people have to offer.

The North West Region,
Editor Collective.





BOOK REVIEWS



BIRTH AT ROME - Sheila Kitzinger,
Oxford University Press,
£4.5).

Sheila Kitzinger sets out to dispel the myth that hospital is safer than home for childbirth. A prime example is that in many hospitals a paediatrician may not even be 'on-call' so that the midwife would be left to deal with an emergency anyway.

Safety is one of the first arguments used by obstetricians in persuading women to deliver in hospital. But Chapter Three deals thoroughly with this subject, enabling women who are uncertain of their decision to make an informed choice.

There are excellent explanations of the side-effects of various drugs used in labour (to the mother and fetus) which opens up a new dimension for women who are so often shielded from the truth in these matters.

The chapter for fathers is a welcome approach in a Book on Birth. Paternal post-natal depression is a very real issue especially when the child is born in hospital. The obstetric-team is of the utmost importance within such an institution but the father is 'allowed and sometimes even welcomed, but he is not necessary'. He is treated as an inanimate object to be spurned by the staff and reprimanded for touching sterile areas. Sheila Kitzinger contrasts this with the help a husband gives his wife w/o labours at home and shows the true picture of how emotional support plays such an important role in childbirth.

The book is obviously biased towards home-births, but not without advice to those women who should have hospital deliveries.

Stress is laid on the importance of parents making a well-informed decision although the persuasive argument that fewer 'flat' babies are born at home is used, due to the use of fewer or no drugs at all during labour.

Sheila completes the book with such sound advice as 'the parents should put aside time to spend alone with their baby without interference from relatives and friends.'

This book should be read and digested by all the professionals who deal with child-bearing women to cure some of the complacency which they are clouded by.

Belinda Ackerman.



PREGNANCY-MONTH BY MONTH A Consumer Publication from the Publishers of WHICH,
The Consumers Association,
14 Buckingham St.,
London.W.C.2. (or from booksellers)

The stated aims of the book are: "To set out what happens and what can happen throughout the 3 stages of pregnancy and afterwards. Knowing the facts helps parents-to-be to meet and understand pregnancy problems if and when they arise". At first glance this book presents itself as a clearly laid out Chronicle of Events during pregnancy. There is a very good CALENDAR OF PREGNANCY, which explains week-by-week, exactly what to expect, when to book the tests that are necessary etc., Thereafter, each chapter expounds, month by month, with detailed information, what the pregnant woman's choices are - the care, the facilities and the entitlements available. As reference, or Directory, this book would be quite useful. It is easy to read and quick to find what you want. But...My criticism is, there is not enough information supplied. I think that a Consumers Association should not produce a book that only tells you what to expect from the NHS and from the medical profession, but does not tell you how to go about getting what you want; i.e. a critical look at what you are getting.

FOR INSTANCE

Where to Have a Baby.

It states "At present, a woman is advised to book a hospital bed even if there is no reason why she should not have a normal pregnancy and delivery". WHY? It really doesn't say. This is confusing for a woman planning a home delivery. She might act on this advice and be refused a home delivery because she has already booked in at a hospital and it's too late to change: It doesn't tell her what she must do to get a home delivery, if she has decided, that is, what she wants.

It states, about choice of hospital: "However doctors do have discretion to refer patients to an alternative hospital...She should tell her G.P. and she should expect a sympathetic response." In fact, the woman herself can demand or even book with the hospital of her choice. Supposing she doesn't get a sympathetic response? No advice about further action.

Description of Hospital

You are looked after by a 'hierarchy of doctors' and it lists them. This is fairly realistic in view of the diminishing role of the midwife. But it goes beyond BRIGGS in implementing the decline of the midwife - she is not even mentioned: The midwife has been described as some appendage in the background who has 'shared care' of the case with the G.P. There is no description of the role of the midwife.

Description of Home Delivery

Is enough to put anyone off with a description of 2 serious emergencies which might arise and which "can only be treated satisfactorily by trained medical staff" - Presumably in hospital? The main advantages of home delivery are described as "privacy and comfort." This would not be applicable to a large family in a small council flat and not the main reason for choosing a home delivery anyway.

It is stated that your home delivery will be supervised by a midwife who has helped in your ante-natal care. This is NOT the case. There is about 3 in 8 chance of getting the midwife you know.

"Emotional Reactions during Pregnancy."

This section is so negative and brief that I feel it would be better not to deal with this area at all, in such a book, in such a way.

Problems of the Unsupported Mother.

Suddenly at 4 months - or rather at last, or at least - we have the problems of the unsupported mother. Presumably she has been considering abortion up till now and now she is just given another piece of patronising information.

"It is very difficult for an unmarried woman, to think in terms of having a baby as opposed to being pregnant and therefore no decision is made about what to do with the baby before HE is born." (How do they know they are all boys?)

Drugs & Equipment Offered.

I think this is where the Consumer Association could really come up with a critical view of these things.

Pethidine - or the 'Drug of Choice' in present use today is not reviewed at all. Every woman knows you get a needle if you can't cope. But we want to know what exact effects and side effects it has, so that we can make an informed choice. Many midwives are reluctant to use this in late first stage which means at least a discussion between the midwife and the mother about its use, or alternative methods of pain-relief.

Monitoring - is "quite harmless to the mother and baby".

It has not been proved conclusively harmless yet, and it does not mention the discomfort caused to a woman having to remain in a dorsal position for a long time, which can also be related to foetal distress. But also, what is at question is the routine use of these procedures in labour and the use of which is undermining the midwives' skills.

Position "The choice depends largely on the particular skill and preference of the M.W. or Dr." Why should it? Why cannot the woman position herself according to her preference? Breast Feeding "Even if you want to B.F. your baby, you may NOT be able to" if you have retracted nipples or insufficient milk."

I think most midwives, and mothers with retracted nipples would have a lot to say in disproof of this and this is extremely negative and inadequate information.

From my experience as a Midwife, of women's problems with bookings, and from the contact with the Association for Improvements in Maternity Services, National Childbirth Trust & Patients Association, it is apparent that there is a great need for information and advice about how to proceed. For instance, women should put their preference in writing and have their requests clearly inserted in their notes in order to ensure what they want.

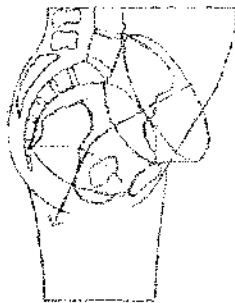
Sadly, on the whole, this book gives a very poor description of the choices available, and in some areas it is misleading and negative. The advice which is offered is inadequate. There is a great need for a consumer's guide to the Maternity services, but it needs to be better researched. It needs to list options and their consequences as well as how women can get the options of their choice. It needs to take a less accepting view of medical orthodoxy and make more use of the information available from Association for Improving Maternity Services, the National Childbirth Trust and Association of Radical Midwives. Then we would have a guide of value to consumers.

I wrote this for Hackney C.H.C. and a shortened version appeared in C.H.C. General Newsletter. Since then the editor of "Which" read the review and wrote to me to say she thought "I had hit the nail on the head:" and would I like to re-write the section on choices available: I have replied that I'd be delighted but would like to do it with members of A.R.M. Any Offers, please phone me. (01-254-8029)

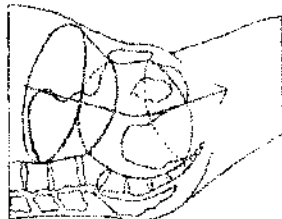
Jo Robinson.



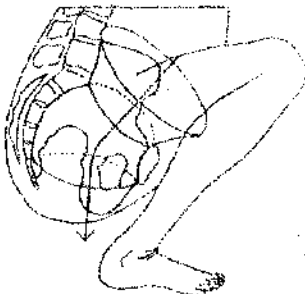
In the standing position the pelvis tilts slightly forward



In the reclining position the pelvis is positioned on its back, so that the child going through it must go upwards against the force of gravity, which demands more effort from the uterus



In the squatting position and other inclining positions the pelvis is almost vertical and the descending child takes the line of least resistance



Have you ever wondered how you would help a woman wanting to adopt a different position in labour when all you have experienced is women lying in labour? This is the book for you. Not too dogmatic or theoretical, just full of practical information.

The book is addressed to pregnant women, but it has been needed for a long time by ante-natal teachers, midwives and doctors. It starts from the premise that moving around in an upright position during most of labour, makes the uterine contractions more effective, reduces pain, shortens labour and improves the blood supply (flow) between placenta and child. It follows this up with how to relax in action i.e. relax into various upright positions. Being able to relax when the body is at rest is not complete preparation.

It also shows conclusively, that squatting is the only position that enlarges the pelvis to its fullest and allows the forces of gravity and maternal effort to have their maximum effect in second stage. The book follows this up with specific exercises to stretch 'civilised' ligaments to adopt this pose. (Left me wondering how many women getting caesareans for failure to progress were needless.)

The goals are accessible. The authors don't expect women to be yoga masters at full term, but they do state that practice from the beginning of pregnancy gives the best results. (Most ante-natal classes start at 32 weeks.) Each exercise is made clear by an accompanying photograph and an explainer given of its direct benefit in labour. Simple but complete explanations are given of the organs, muscles and skeletal systems involved in childbirth and how they function together during labour and delivery. They invite women step by step to examine and explore their own bodies, especially the birth canal before even attempting the exercises.

The most outstanding feature of this book are the excellent clear line drawings. Maggie Nyles could learn a lot from these. They certainly illustrate Midwifery better than any textbook.

Fatti White.



Association for Improvements in Maternity Services
Leaflet No. 3. HOME BIRTH

As it clearly states, this leaflet is for women who have already decided on a home delivery; the important point is made that this is the woman's choice, and that the Area Health Authority has a responsibility to ensure that the confinement is as safe as possible.

The section on booking a G.P. and/or midwife, states the various problems that may arise, and gives useful advice on ways to overcome them. My only criticism is the assumption that there is always a partner, the importance of whom, in getting your own way, gives little encouragement to the single pregnant woman.

Lots of practical 'household' hints are given in the section on requirements and facilities, and there is an account of what should be provided, (in the way of services) if things go wrong. The statutory duty of the Social Services Dept., to provide home help during the fortnight following the delivery is also mentioned.

I was not convinced of the relevance of the short section headed statistics which gives the numbers which define risk factors. Finally a list of useful contacts and books rounds off a generally well thought out and useful leaflet.

Liz Davidson.



USEFUL HERBS



This is just a basic selection of herbs that are quite easy to get hold of. Most of them should be given in the form of a standard brew which is prepared by taking one handful of dried herbs to two cups of water and heating them gently in a pan until boiling point is almost reached. (enamel, steel or earthenware pans are O.K.) Keep on the heat for approximately three minutes, but do not boil. Remove from heat and allow to steep for at least 3 hours before use. Do not strain the herbs; leave them in the pan or pour unstrained liquid into glass jar or pot which should be covered with a cotton cloth... Keeping time is usually three days.

Balm- relieves morning sickness, facilitates release of placenta. Helps with painful menstruation.

Borage- Contains much potassium and will increase milk supply. A great pick me up for deflated spirits.

Comfrey- Leaf compress for sore or swollen breasts. It aids the healing of torn tissues and is of great value as a poultice or in the bath for a torn or sore perineum.

Caraway- Increases milk supply. For colic in infants, a half teaspoon made into tea with hot water. Allow to brew and give before meals.

Catnip- Increases menstrual flow. It is an ancient remedy for expelling wind and curing hiccups in babies. Give one teaspoon of standard brew before meals, sweetened with honey if necessary.

Chamomile- Increases menstrual flow. Used widely in Europe for baby's colic, it's even prescribed by doctors. A standard brew is best, diluted for infants. It will give a lovely peaceful sleep to a newly delivered mother and through her colostrum to the baby.

Dandelion greens- Contain 28 parts sodium. Good for anaemia.



Fennel- Leaves or seeds boiled in barley water increases quantity and quality of milk yield. Contains sulphur, potassium and sodium.

Ginger- To ease labour pains, especially with honey and lemon. For exhaustion following childbirth.

Garlic- The wonder herb: there's not much that garlic won't put to rights. The one relevant use I have found, is a pessaries. in vaginal infections.. only be careful not to lose it: Wrap it in a piece of muslin:

Hops- Increase milk supply. This is perhaps where the beer drinking for nursing mothers comes in. Also nice to have in a child's pillow for inducing a good sound sleep. (not guaranteed)

Levander- Another good herb to have in a pillow. Aids the newborn in getting rid of mucus.

Liquorice Root- Hastens delivery of placenta. Supposed to contain oestrogenic substances and thus aids conception.

Mint- For morning sickness. Apt to diminish milk supply, so should not be taken by nursing mothers.

Raspberry Leaves- The favourite women's herb, Good for morning sickness. Has a specific tonic action on pelvic and uterine muscles and should be drunk daily throughout pregnancy. In a difficult labour, or to bring down a retained placenta, give strong drinks of raspberry leaf tea with one teaspoon of crushed ivy leaves to two teaspoons raspberry leaves, with a bit of honey for palatability and giving strength.

Rosemary- Astringent and antiseptic. Arabs sprinkle it in powder form on the umbilicus of the newborn. Good for nursing mothers.



Shepherd's purse- Contains vitamin K and it's properties in arresting haemorrhage and said to equal those of ergot. It can be given in the form of strong tea combined with bayberry bark or as a fluid extract made by infusing the plant in 12 ozs. water boiled down to $\frac{1}{2}$ pint.

St. John's Wort- To remove after pains.

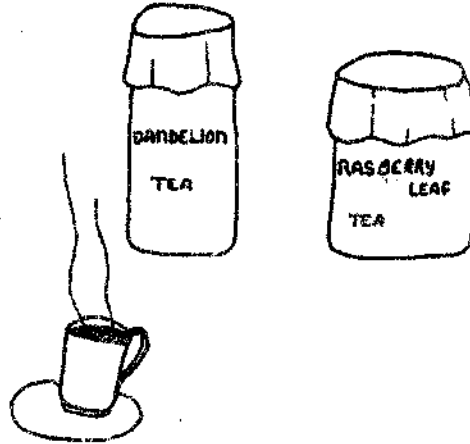
Watercress- High mineral content. Vitamins B&C. Increases milk supply.

HERBAL HANDBOOK FOR EVERYONE..... Juliette de Bairacli Levy

A MODERN HERBAL..... M. Grieve

BACK TO EDEN..... Jethro Kloss

HYGIEIA-A WOMAN'S HERBAL..... Jeannine Parvati.





THE BIRTH CENTRE

9

BIRTH OF THE BIRTH CENTRE

A couple of years ago, Margo Hogan and Kate Russell offered their midwifery services to the growing number of people in London, who wanted to have their babies born at home. A group was set up for the new mothers, where they could offer each other friendship and support. At the office - a room kindly lent by the Community Health Foundation at their "macrobiotic" quarters at Old Street, the phone rang frequently with enquiries. Not from the new mothers: - but from prospective parents eager to get answers to these most frequently asked questions: "Where can I get a Leboyer Birth? Is it possible to have my baby at home?"

The Birth centre - as it was now called - organised itself to meet the obvious need. The office was manned (womanned!) 1 - 4 every weekday, to answer queries in person, by phone or by letter. Information was accumulated, leaflets were printed. The newsletter was started, and a programme of film shows and discussions was initiated, which catered for the growing interest and concern in natural childbirth.

The Birth Centre began to incur expenses - we now had to pay rent on the office at Old Street and this ate hugely into our meagre finances. The programme of films and discussions, though inspired, were not financially viable. The posters, though appealing, were costly. We even attempted to become a Charity in order to raise funds. But this involved forming ourselves into a hierarchy (to meet the requirements of the Charity Commission), and not only did that structure irk, but it felt as if all our energy would be taken up - not with helping people - but in making money. We eventually decided that the Birth Centre could exist just as well without its external trappings, and so we moved it out of its office into our own homes. It was much happier there: Divested of its heavy financial burdens and liberated from Hierarchy, it was now free to pursue the task at hand - which was to help women get the sort of birth they wanted.

THE BIRTH CENTRE TODAY

The Birth Centre feels that present day maternity services are, at best, inadequate. What is lacking is a spirit of loving and caring - qualities which seem an unquestionable and natural part of any birth. It is difficult for the mother to develop the kind of deep and trusting relationship with her midwife, which she needs. The experience, so naturally rich in feeling, is often reduced to a cold confrontation with a machine, and a busy, impersonal staff. And what about the baby? Where is the atmosphere of love and sensitivity, which one instinctively feels is the only right way to greet a new person into the world?

The Birth Centre encourages people not to be afraid to ask for the sort of birth they want. It is only by people making clear what they want and being willing to stick to it, that things will begin to change. We offer guidelines as how a person can best deal, to their advantage, with the Hospital System. (See "How to Have the Sort of Birth you want in Hospital" - price 10p and "Drugs Used in Labour" - price 20p).

Many people are attracted to the idea of a Home Birth, but are deterred by its apparent obstacles. We put them in the picture as to their actual rights, and refer them to various literature available, from us and other organisations, which details the correct procedure to follow. Not only do we want to offer encouragement and support, but we also want to bring to people's attention, that Home Birth is an alternative to hospitals. (See "Home Birth" and "Home Birth - Where do we go from Here?" (price 15p) and Eco-labels "Home Birth Can Be Your Choice:" with design - 65p for 100)

Groups can be that much more effective working on a local level, and we encourage people to set up Birth Centres in their own area. Its role would be to make itself known to the community, and to collect and disseminate information about local facilities. As we have no hierarchy, and each Birth Centre operates independently from each other, we avoid the problems of co-ordinating and communicating at a national level. At present there are 2 Birth Centres in London (North and South), as well as ones in Scotland, Somerset, Gloucester, Oxford and Sussex. We also have a network of sympathetic and informed people around the country. Contact us for your nearest group or person - or to add your name to the list.

Thanks to the changes it has gone through, the Birth Centre is now a healthy, vibrant group with a steadily growing membership.

All enquiries to
Eos Claxton, 16 Simpson Street, London S.W.11.
Telephone (01) 229 - 0224 or (01) 223 - 3026.

Look forward to hearing from you.

Lis Winkler,
Somerset.



IMPROVING THE QUALITY OF LIFE-WHAT CAN WE DO?

The South Wales Midwife Teachers Group of the RCM, held a Study Day for midwives in Penarth, Cardiff in October 1979. The theme was Improving the Quality of Life-What Can We do? The following conclusions were drawn from action group discussions by midwives, and the group specifically asked that the ARM be aware of these.

The Editor Collective felt, that some proposals made at this study day, were very constructive and very much in line with ARM's stated objectives. They are presented here, on the Forum page, to stimulate discussion, and hopefully, some action to follow.

This group may be contacted via Mrs. Ruth Davies,
Secretary, Midwives Teachers Group (RCM),
Maternity Unit,
St David's Hospital,
Cowbridge Rd., East,
Cardiff.

- A. A need for the Better use of Midwifery Skills.
- B. A need for Improvement of Maternity Services through Education.
- I. Better Use of Midwifery Skills.

The Midwife has a comprehensive knowledge of normal pregnancy being wholly occupied in this field as opposed to the Family Practitioner, for whom ante-natal care is a mere 3% of his work load. The skills of the midwife in many areas, are not fully utilised at present.

Suggestions.

- 1). The midwife should be responsible for a large proportion of ante-natal care independently, and/or in conjunction with the doctor.
- 2). The midwife should have access to resources in order to carry out routine tests, such as haemoglobin tests, without reference to a doctor.
- 3). The midwife should be able to refer her patient directly to a Senior Obstetrician when deviations from normal arise.
- 4). The midwife should be responsible for discussing with the expectant parents the individualised plan of ante-natal care. NB. Based on the nursing process model.

Other Factors.

There is a need to decentralise the provision of ante-natal care based on the following observations:-

- (a) Many pregnant women are expected to travel long distances to "centres of excellence" which leads to less than optimum uptake of ante-natal care in those women least motivated and most in need of surveillance.
- (b) The travelling problem militates against early booking and increases clinic 'defaulting.' It is expensive and inconvenient for the user e.g. bus journeys with several children along.

Possible Solutions.

- a) The provision of a mobile clinic and/or a panel of Obstetric Consultants to provide ante-natal care in health centres and family planning surgeries.
- b) The provision of free bus passes for those designated essential to attend hospital clinic.
- c) The provision of a 'High Street' ante-natal advice bureau with a midwife in attendance. This easy availability of ante-natal advice is seen as educational and convenient for the pregnant shopping woman.
- d) The provision of a 24 hour telephone service "manned" by a midwife.

B. Improvement of Maternity Services through Education.

Improvement in the Maternity Services may be pursued through education, both of those who provide the service, and of those who benefit from them.

SCHOOLS.

Information about the physical process of pregnancy; the services provided, and teaching of parenting, attitudes and skills should be a part of the curriculum for children of all levels of intelligence. Midwives could contribute to this by advising/giving in-service talks to teachers and students.

FAMILY PLANNING CLINICS/OCCUPATIONAL HEALTH CLINICS.

In these, advice should be given on the need for early and regular ante-natal care.

THE MEDIA.

Interest in matters to do with childbearing is increasing. Midwife can contribute by making sure that facts are presented accurately and by encouraging more publicity- e.g. on T.V., Radio etc.

SPECIAL INTEREST GROUPS.

Association for Improvement of Maternity Services, National Childbirth Trust, Birth Centres. These are proliferating. How well or ill informed they are depends to some extent on the relationships between themselves and the professionals who are running the maternity services in an area. Again, midwives can make a valuable contribution to good relationships by their interest, understanding and participation.

ANTE-NATAL CARE.

Midwives are under-used in this field at present. Parentcraft Classes provide education for some families, but the majority of pregnant women do not attend these, so that personal contacts are especially important. Mobile Clinics, home visits and increased responsibility of midwives for normal ante-natal care in hospital and G.P. Clinics, have been suggested as ways of improving the quality of care. Many midwives support the idea of monetary incentives, including free bus passes, to encourage women to attend for ante-natal care, early and regularly. They also recommend strongly, that the number of midwives working in the community be increased to allow for more involvement in ante-natal care, and the continuation of post-natal care up to 28 days.

Education of Midwives.

This is seen to be important to improve teaching and communication skills, and to foster the development of constructive attitudes.

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### SOMALIA

#### REFUGEE SELF-HELP PROJECT

Six-person team needed to work in a refugee camp in the north of Somalia. The team will work with counterparts chosen by the youth and women's associations in the camp, and will provide training in:

preventive medicine, simple diagnostic techniques, simple curative techniques, health education, safe delivery techniques, antenatal and post-natal care,

We are looking for;

1 doctor 1 nurse, 1 midwife, 1 lab technician, 1 doctor or health visitor or nurse,

1 year period of service. Salary will be low and related to local rates.

Pre-departure and other allowances and air fare.

Write with details to: Catholic Institution of International Relations.

(Overseas Section,) 1 Cambridge Terrace, London, NW4.

tel: 01 487 4397.

# GIVING SUPPORT

## PROBLEMS PARENTS HAVE IN BONDING WITH THEIR MALFORMED BABIES

About one baby in forty, is born with some kind of handicap. This indicates that all of us involved in childbirth, will at some point need to care for these babies and their parents. Anticipation of the reactions of mother and family, and ourselves, in this crisis, would help us enormously in giving support, as families often have special problems in investing love in a malformed child.

## NORMAL DEVELOPMENT OF ATTACHMENT

Most mothers develop a very strong attachment to their babies from the moment of birth and over the first days and weeks afterwards. Through an incredible 'to and fro' dance of the senses between both partners, they develop a very intimate knowledge of each other. The mother becomes able to respond to her baby's needs as though they were her own. An example of how mother and babe are keyed into each other:

A baby can see best from 12-14 inches at birth, and has a strong attraction to the human face, especially the eyes. This is balanced by the strong interest of many new mothers in their child's eyes. When holding the baby at breast level, the most natural place to soothe an infant, the baby can best see his mother. We've often seen them gazing at each other like this (falling in love;)

A cyclical pattern of interaction follows....The mother initiates an action such as comforting the baby at the breast. The baby is soothed and gazes up at her. She receives pleasure from the baby's positive response, gains confidence in her mothering abilities, and is encouraged to continue giving them. Her attachment deepens, the baby profits.... etc.,

The growth of this special relationship is dependent on the baby, in a least most ways, fulfilling her expectations, i.e. normal, and constant or prolonged contact with the baby. Both of these factors are altered in some way, when a baby is malformed.

## SPECIAL PROBLEMS

### Physical Property of Malformation

A mother's reaction has much to do with the property of the malformation. Normal interactions may be grossly distorted if a baby, for example, can't suck because of a cleft palate, or cannot see. Mothers have said they feel 'lost'- like 'strangers' with their blind child. She may avoid looking at her infant, which puts obvious barriers to exchange of intimate communication. Yet a disease such as Cystic Fibrosis with no visible scar, may not be recognized. A mother may need several realistic but supportive talks before she begins to absorb that her child will only be with her for a shortened time.

### Threat of Loss

Then the mother may withdraw from freely relating with her baby because of the threat of losing him/her. Even should the child live, it takes months to make up for those days of withdrawal during the optimal period for attachment to grow. Some mothers never re-invest love in their handicapped child, especially when severely malformed or retarded. They represent a permanent burden on the life of the family, and battering and failure to thrive are common. A large number of families breakup under the strain as well.

### Guilt

Feelings of personal responsibility are a big problem with both mothers and fathers. Because of this terrible fear that some action of theirs, or worse, a genetic disorder in themselves, has caused their child's blight. They usually express numerous irrational explanations for the situation. These interfere with attachment in two ways:

1. They consider themselves a potential danger to the child, and are often frightened to touch him/her without permission. Sometimes they won't even enter the nursery.
2. There is an inability to ask medical questions lest the answers confirm that the malformation was caused by them. At the same time, the lack of information perpetuates those fears.

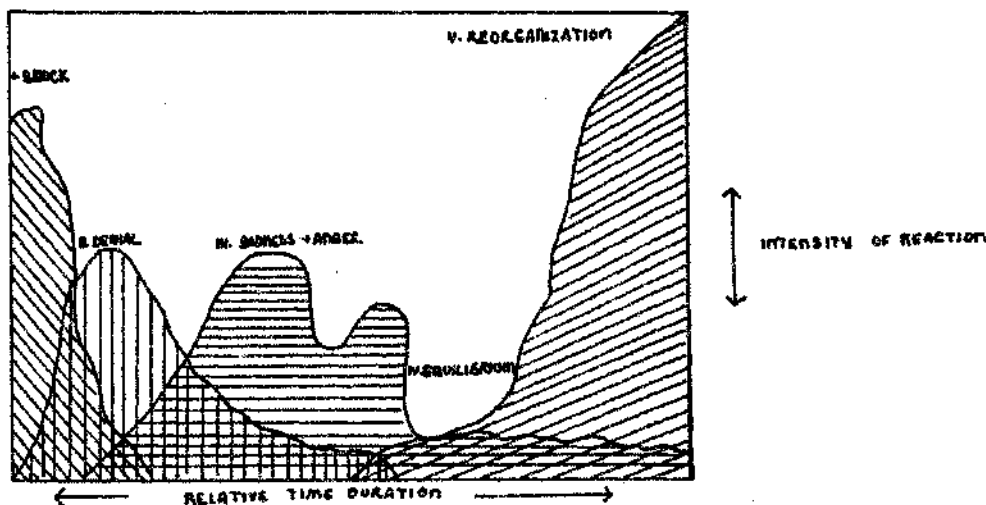
### Separation

As attachment deepens through contact and feedback of sensual information between mother and infant, separation frustrates the mother's desire to nurture her child and she loses confidence in her mothering abilities. Although this separation (usually to Special Care Units) is sometimes vital to the baby's well-being, it's too often due to us attempting to 'hide-away' an unsightly child because of our own embarrassment or desire to avoid questions.

### STAGES OF REACTIONS

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Before discussing specific points of care for these parents in these circumstances, I would like to briefly outline stage of reactions to expect. Although time sequences and depth of reactions vary, there are similar themes running through. The graph below is a generalization of the pattern that emerged from parents discussion of their own reactions (Drolan et al 1975), they are similar to those experienced by persons grieving the death of a loved one.



First stage: Shock characterized by irrational behaviour, crying, helplessness, wanting to flee.

Second stage: Disbelief (denial) characterized by repetition of the same questions to staff hoping not to hear the same answer. Turn to religion I've been bad, if I'm good, my child will be normal again.

Third stage: Anger, Sadness, Anxiety: Anger comes first, directed at each other, God, the baby, the hospital staff. The commonest form is directed at themselves i.e. guilt. Sadness and anxiety usually follow anger. The sorrow may underline the rest of their lives with the child.

Fourth stage: Equilibrium: The parents usually find a facet to love in the child. They feel more comfortable in the situation and begin to believe they can cope.

Fifth stage: Reorganization: The parents begin to deal with arrangements for their child's special needs, getting in touch with organizations, equipping their home, reading books.

Our role is to guide parents through these stages to reorganisation.

SPECIFIC POINTS IN CARE OF PARENTS

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1. Body Language- If we are astute or have built up a relationship with a mother, we can be aware of non-verbal communication, as well as listening to what a mother might offer to say. Changes of expression, evading eye contact, change of posture, can indicate anxiety, despair or satisfaction. Our own body language is important too. Standing above someone indicates authority, and also conveys a feeling of preoccupation with other tasks that are calling one away. Adoption of an unhurried approach sitting on or near the bed is more conducive to offering support.

2. Early and Prolonged Contact- helps the defect seem less alarming than imagined. In several studies, parents have said, they had visions of a nameless mass which when seen was less horrific. Touching, cuddling, caretaking should be encouraged as it reinforces the mother's desire to care for her child and re-establishes her shaken faith in her abilities. Expression of breast milk can be encouraged as a positive contribution to the infant's welfare. If the child cannot suckle from her.

3. Fathers- should be included in all discussions of the baby. He has a heavy task in having to support his wife, explain to relatives and take care of other children in the family. We need to keep in mind that he is frightened and shocked too and needs our care. Keeping in mind that families often break up under the strain of these circumstances, we can help him become attached to his child by including him in caretaking activities. He should be allowed prolonged visiting, so the mother and father can work through their grief together.

4. Avoid Tranquilizers- We may be distressed by parents pain and wish either not to see it, or feel we must 'cure' it by giving drugs. Tranquilizers tend to bury reactions, prolonging the period of mourning, and should only be used if necessary i.e. hysteria. Sedatives for sleep are useful.

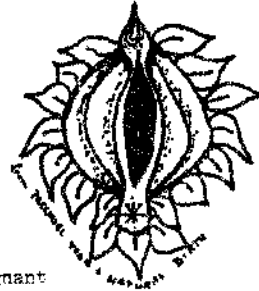
**5. Information and Repetition-** We are instrumental in ensuring parents understand the nature of their infant's defect and teach them the specific physical care needed along with sources of support in the community. Repetition of these facts may be necessary many times in the early stages of shock.

**6. Counseling-** We need to develop our skills in helping parents verbalize their fears and emotions. We can then correct wrong impressions of procedures being done, or unusual explanations they've made for the child's defect. Parents often re-develop feelings of helplessness, depression and guilt, once they leave the safety net of the hospital. This may make caretaking of an already difficult child even harder. The two may become alienated, working out their grief in isolation. So counseling should continue for months after discharge. Encouraged to express themselves in the presence of each other, parents may begin to understand the other's adaptation.

**7. Example-** The most important task is to show parents that their baby is lovable. How we act towards the baby and mother is extremely important, as we are society's first representatives displaying acceptance or rejection. The baby should not be 'hidden away'. The baby's name should always be used (never referred to as 'it'). We can point out positive features of the child....beautiful eyes, how well feeds are taken....if parents find their child lovable, the child can grow to believe that others will love him/her and have hope for the future.

Fatti White.

# kegels



## Exercises of the Pelvic Floor Muscles - For All Women.


I learned to control my pelvic floor muscles, whilst I was pregnant in another country. No doubt, some men there, had claimed discovery or ownership of this particular part of our female anatomy, as these muscles were known in hospital jargon as the Kegel Muscle. My ante-natal teacher, affectionally (I) referred to the exercises I will describe as doing 'Kegels', which is why this article is so named.

The point of this exercise is to be able to contract and release the muscles in the pelvic floor at any time. This ability is of particular importance, to pregnant women, as conscious relaxation in that region aids delivery and prevents damage to the birth canal. Also for women who have recently delivered, lifting and tightening the stretched muscles, aids their return to their original positions. But this exercise is of value to all women, a pelvic floor strength and control enhances sensual experience and if continued into later life, also protects us from getting prolapsed organs and ensures the maintenance of urinary, vaginal and rectal control.

The muscles at the front of the pelvic floor are best identified by attempting to stop the flow of urine, midstream. The muscles at the back of the pelvic floor, can be identified by drawing up and closing the anal outlet. These muscles should be tightened, and held for a few seconds, then relaxed. Then done in a series of 5, several times in a day.

At first, the sensations may feel vague and very much the same, but eventually awareness of the separate muscles develops, along with strength and control. For this reason, pregnant women should be encouraged to begin the exercises at the beginning of pregnancy.

The exercises can be done, at anytime, without having to alter the day's activities. While standing in a queue, sitting in a bus or car, listening to a boring lecture. In fact, 'Kegels' can fill in, the dull spots in your life.



# A Woman's Story

## SUCCESSFUL BREASTFEEDING WITH COMPLETELY INVERTED NIPPLES

I had always intended to breastfeed my children, but knew that my having inverted nipples might well make this difficult if not impossible. On my first antenatal visit to the hospital, I mentioned this problem to the doctor who advised me to discuss it with my doctor and midwife at the local clinic I was to attend for the next few months. This I did, and my doctor told me to obtain nipple shields from the chemist. The midwife examined my nipples, shook her head and said if I wanted, I could try nipple shells, but she didn't really hold out much hope of their correcting my completely inverted nipples. (see editor's note)..... My mother had mentioned my problem... to a midwife in her neighborhood. She offered to help. She examined my nipples, showed me how to encourage them to come out by rolling them between my fingers and how to express colostrum, which she felt was a good idea in my case. She confirmed that nipple shields might help..... Well for the following nine months, I wore the shells all day. By evening, my left nipple was usually well drawn out, but quickly retracted again, once the shell was removed. My right nipple remained little altered. I was able to roll the left nipple between my fingers..., but this was more difficult with the right. I also contacted the local N.C.F. breastfeeding councillor. In conversation.. and at (N.C.F.) meetings I attended, I learnt how nipple shields and a hand pump may help if my nipples remained inverted after the birth of my baby. During this time, neither the doctor at the clinic, nor the hospital, enquired as to my progress in preparing to breastfeed.

When my baby was born, I immediately put her to the breast, but neither then nor when they brought her to me later, was she able to suckle.... We did manage for the following two days.. with the aid of nipple shields.... but not very successfully. With the nipple shield, the baby is sucking on the teat and not stimulating the areola, so the milk only flows very slowly. Even after sucking for up to half an hour each side, she had not emptied my breasts. She was tired, but her hunger was not really satisfied. She lost 10 ozs. and the staff began to talk threateningly about the likelihood of jaundice setting in. Although several of the sisters were sympathetic with my determination to breast feed and gave me a lot of practical and moral support, they all advised giving complementary feeds. Reluctantly, I gave in deciding that the more quickly I fattened her up, the more quickly I would be discharged. At home I could do as I wanted... I did during this time also attempt to get my baby to suckle directly from my breast, and succeeded on only a couple of occasions... She usually ended up crying and frustrated, leaving me feeling equally frustrated and upset. In fact, I found I kept putting off trying for fear of failure again.

When I came home, I continued using my nipple shields, feeding for about 20 minutes each side. Then using a handpump, I expressed the remaining milk and fed this to her in a bottle. I was happy that my baby was once again having breast milk only, but this was very tiring and I doubt I could have kept it up for very long.

The happy ending to my story is largely due to the help I received during the next couple of weeks from my midwife. She gave me every encouragement, although she admitted later, that she didn't think I would really succeed, not only because of my inverted nipples, but because my baby had become used to a teat, both on the nipple shield and on the bottle. She advised giving the milk... in a spoon or cup. This seemed very simple when she did it, but I only succeeded in pouring the milk all down my baby's front. She also encouraged me to persevere in putting (her) directly to the breast. Some days we failed altogether, which was very disheartening. Some days I could manage but only with the midwife's help, or sometimes only at one feed, or.... one side. But gradually, it became easier and we seemed to manage on our own, both sides, for sometimes two or three consecutive feeds, until after two weeks, I was breastfeeding normally all the time.

At the time of my writing this article, my baby is ten weeks old and I am still breastfeeding. Vigorous sucking seems to have almost corrected my left nipple. My right nipple, however, is still completely inverted. I find this breast on the whole is less efficient than the other. It is never as full and the milk doesn't... flow as freely. My baby seems to find no difficulty in latching on.. but with there being no nipple to centre the breast in her mouth sometimes she is sucking on one side of the areola and extracting the milk very slowly. My left breast, I assume, must compensate for any difficulty in the right, as my baby is well contented and gaining weight steadily.

Editor's Note: This woman had great difficulty obtaining breast shells. Apparently, assistants at chemists are not frequently asked for them. She experienced some very embarrassing circumstances of having to explain their purpose in front of a shop full of customers. She found in the end, they are sold under the brand name of Woolrich Shells or Meredith Breast Shells..... for our future reference.

Jackie.

# Letters

Dear ARM,  
(Newsletter FORUM)

I would like to make a contribution to the topic brought up in the Forum in the January issue - 'Midwives and Abortion' - by J. (?). I am not a midwife, but perhaps the following can be taken as good enough 'qualifications' to write on this subject: I have given birth to four children (three at home), had one miscarriage, am a member of a birth group here in Edinburgh and their Newsletter Editor (but am not in this letter representing the group's opinion), and am hoping very much to be accepted for midwifery training soon; I also n e a r l y had an abortion case.

There are so many aspects to the problem abortion, it is hard to know where to begin. Perhaps you will bear with me if I recount a personal story: I was 20, single and a foreigner in this country, working illegally without a work permit, when I became pregnant for the first time. I didn't think I wanted this baby, nor did the father who was anyway due to leave Britain for good within the next months. So what was the solution? Everyone knew it and told me so: have an abortion. This was not something that tallied with my personal philosophy, but nevertheless, under the pressure of my environment, my financial situation and so on, I managed to convince myself that it was O.K. I went to my GP, a kind and sympathetic man, told him a few lies about previous bouts of depression and not having anywhere to go with the baby, and he gave his agreement to an abortion 'on psychological and social grounds'. We soon found a clinic, together scratched up £20, and I would have had my 'solution' had I not at the last minute - already in the clinic bed - had a sudden and shattering intuition in which it became quite clear to me that it had all been a big lie and I really did want this baby. I left the clinic, already expecting my tummy to be growing bigger... it became the happiest day in my life. The following seven months were not easy, the birth - in hospital - was lonely, but I had a beautiful daughter, and she has since led me on ways which I would never have gone without her and which I have never regretted going.

What I am trying to bring across with this story is the following: It is all very well saying that a fair proportion of pregnant ladies would not be pregnant if free abortion on demand were available. I would, however, counter this by my own assumption: that a fair proportion of ladies who do get abortions, would not want them if a free 'counselling service' were available.

In other words: I think many women get abortions too easily, without ever being told about all the possible consequences, or being helped to see ways in which even an 'unwanted' pregnancy could turn into something very much treasured. I don't think I am alone with these feelings as I have heard and read about countless women who experience their past abortions as heavy burdens, or shadows, in their lives.

It is here that I could see a link between the problem area 'abortion' and the role of the midwife. For, contrary to J., I see the midwife as a guardian, not of 'women's rights', but of unfolding life within the womb. Thus, in the case of an unwanted pregnancy, the midwife could c o u n s e l

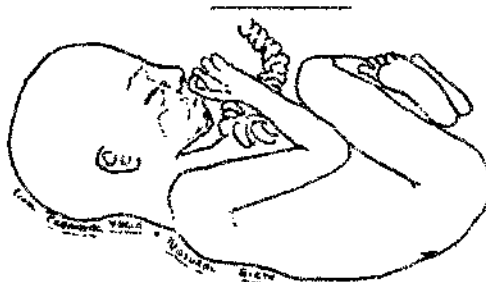
the woman, and perhaps in co-operation with a social worker attempt to resolve existing psychological/social/financial problems.

I totally agree with J. that health professionals do not have the right to make moral judgements; nor, to tell outright lies to 'their patients'. But then, should they have the right to conceal the t r u t h s about abortion? How many women, do you think, have any idea that 'therapeutic abortion' is not just a matter of drawing a clot of blood from their uteruses? How many women under going the suction method (or any other method with subsequent B&C) are told about the possibility of cervical incompetence and its consequences for a future pregnancy? Or about any other health hazards? Or, that their fetus (read baby) will come out in pieces which will then be 'reassembled' to make sure that no tiny hand or foot is left behind? Or, that their baby will be slowly poisoned by salt injected into the womb? How many women getting rid of an unwanted 'fetus' by Section in the 20th week or so, are afterwards told that their baby was born alive and crying but was dropped into a bucket and left to die? Perhaps J. and her like-minded colleagues didn't know these details either? Perhaps they would like to go and work in an abortion clinic for a while...

No, I am not in the least surprised that J. doesn't want to discuss the 'rights of the fetus'. I am nevertheless amazed at how glibly the argument of the woman's 'right over her own body' can be brought up again and again - should not midwives know best that in pregnancy, we are dealing not just with our own body, but with a separate human entity that has happened to choose our body for a temporary living space.

In conclusion I would like to say that I am glad to know that there is 'disagreement amongst ARM member's' over this issue. In that case, however, I find it totally wrong that J. and her friends use an ARM banner for their participation in pre-abortion marches; surely, to be fair, they must accept that they cannot do this?

Yours,  
Beatrice Carline, Edinburgh, Scotland.  
P.S. Although I totally disagree with J. on almost all the questions raised, I do nevertheless recognise her genuine concern and admire her courage in bringing this topic up at all!



Dear (Editor),

I note that in the January Newsletter it is stated that the maternity unit provision in St. Mary's, Paddington "is being halved". May I put the record straight - the two St. Mary's units were amalgamated at St Mary's Barrow Road W9 from 1st December 1979 on a temporary basis (approx. 24 months) whilst St. Mary's Praed Street, W2 Aleck Bourne Maternity unit is upgraded to form the District unit.

The same number of deliveries - 2,200 per year are being undertaken at St Mary's W9 which has had spare labour ward capacity and an empty ward for some years. An increased number of early transfers home are being encouraged to take account of the reduction in beds from 77 to 64.

The change in maternity services in this part of London is intended to provide a better clinical service by concentrating available resources in one unit rather than two and is not related to the current economic difficulties in the NHS in Central London.

I trust you will publish this factual statement to correct any wrong impressions readers have gained.

Yours sincerely  
S. GREENWOOD (Alice)  
Divisional Nursing Officer  
Midwifery  
St. Mary's



SCOTLAND

I would like to apologise to Scottish members of A.R.M. for my rather abortive attempt to get a regional meeting organised. In case we have another awful winter, I think we should aim to meet in April and I will write to individual members nearer the time.

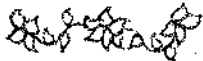
Thanks very much  
Hilary Pender  
(Scottish regional representative).



A.T.M.S.

Dear (A.M. Sisters),  
There is always space in the A.M.S. newsletter (well as long as I'm editing!) if anyone wishes to write a blurb about A.M.S. or, indeed, aspects of maternity care. It would be very welcome.

Christine Hurley,  
Lansdowne House,  
5 Lansdowne Square,  
Hove, Sussex, BN3 1BE.



FOR THE SOCIETY OF ASSISTANT MIDWIVES

**WORKSHOP**



THE POLITICS OF MIDWIFERY.

On February 24th I spoke on behalf of ARM at a Science and Society, History workshop sponsored by the London University Extra - Rural Department.

I spoke on the Politics of Midwifery: Past and Present in a Politics of Procreation workshop. The two people I spoke with, presented papers on population control and the neo-Malthusian doctrines of modern governments; and abortion as a personal/political/medical experience. For my presentation, I relied mainly on an analysis of the history of midwifery and how that compared to the developments in obstetrics here, and to midwifery on the continent. Our three talks blended well and our workshop was well attended and well received..... Belinda did a marvelous job of running the creche.

Melody.

SHEILAH JONES HOME

SHEILA KITZINGER

April 25th, 1980:

Sheila Kitzinger, author of a number of books on childbirth, and related issues, including "The Experience of Childbirth" and "Birth at Home", explores the reasons why, after the almost complete elimination of home births, women are again seeking birth at home in a relaxed, family setting.

While supporting every endeavour to make hospitals more like home, she believes that home birth has unique qualities and that we should be building today a high standard home birth system so that women can make informed choices between alternative birth styles and places. Home is not the second best place for birth. For many women, and their babies, it is the right place.

Starts 7.30.p.m. Admission 20.00.  
There will be a bookstall.

Venue: Conway Hall,  
25, Red Lion Square,  
London. WC1R 4SL.



