

Letters to the Editor

From Wellcome

We certainly find the articles in the journal interesting and relevant to our new initiatives in the Pacific and New Zealand region. Thank you for introducing to the Trust your interesting journal.

Dr G.E. Kwan-Lim
Scientific Officer, International Interest Group, The Wellcome Trust

From HRC

You are doing an excellent job with the Journal and it is making a major contribution to the dissemination of health issues and research relevant to the Pacific.

Bruce A Scoggins PhD
Director, Health Research Council of New Zealand

Marshallese births: experiences of an AVA

I am an Australian volunteer abroad (AVA) working in the Marshall Islands as a nurse/midwife. I arrived here 12 months ago with my wife Margot and two children Domenico and Yolanda. The Marshalls have a chequered history, being occupied by the Germans, then the Japanese. After the Second World War, it became part of the Trust Territory of the United States (US). It is in the process of being handed back to the Marshallese in the form of The Compact. Funding from the US are to reduce on a yearly basis till 2001.

There are approximately 60,000 people in the Marshalls, two urban areas, Majuro with 30,000 people and Ebeye with 12,000. The rest of the people live on the Outer Islands, being more reliant on self sufficiency than their urban counterparts. We are based at the hospital on Ebeye. It is 1.5 kilometres in length and 300 metres wide, so it can be a little crowded. Housing in many instances is poor, income is low with the price of commodities becoming more out of reach of the general public.

Water is pumped from the town supply for half an hour on four occasions during the week. This has been reduced in

recent months because of decreased production from the desalination plant. People make as much use as possible of the rain but a lack of catchments and guttering means there is a lot of run off. Power supply is unreliable e.g. over Christmas we spent almost eight weeks having continuous six hour power outages. The irony is that the US base Kwajalein Missile Range, less than 10 kilometres away, is the total opposite to Ebeye. It is ten times as big as Ebeye. It has manicured lawns, housing and subsidized food, reliable 24 hr power and water. It accommodates 2,000 US personnel.

The birth rate for Ebeye is currently 350 each year, so the population is growing quickly. In many ways I have found the Marshallese quite unique in their birthing ways, a lot of what follows is anecdotal. I believe that the women here have really captured an essence of birthing that we all could learn from.

Ebeye Hospital: There are 34 beds, 4 allocated to maternity. The hospital itself is in poor condition, partly due to past typhoon damage as well as poor maintenance. Water, when it is on, is certainly not potable. No linen or food are provided. Air conditioning is generally quite poor. There is a new hospital being built down the road, everyone is eagerly awaiting it's completion.

We have a resident Obstetrician Gynaecologist. She arrived from the Philippines shortly after our arrival. She is low key and happy to accept midwifery care as primary care. Prior to my arrival the nurses handled all the deliveries as part of their normal work load. This can be difficult especially when there is only one nurse rostered on for a shift. I am the only registered Midwife on island and have attended over 250 deliveries to date.

There are several Traditional Birth Attendants (TBAs) on island. One in particular who attends approximately three quarters of the deliveries at the hospital is Neijok. She is over 70 years old and comes from Rongelap. This is one of the outer islands affected by the American nuclear testing back in the 50's and 60's. Neijok can remember the snow like flakes that fell on her island during the tests. Fortunately she doesn't seem to suffer from any ill effects.

Nuclear Claims: Unfortunately nuclear claims are still an ongoing battle here in the Marshalls. Many outer island communities are still dispossessed from their land and compensation deals are still being negotiated with the United States. It seems that even after 50 years there are many issues yet to be resolved.

Homebirths: Most births occur in the hospital. I believe this is the mother's and their families' choice. Since the island is so small and the hospital is located in the middle of the atoll most find it accessible. The homebirth rate for 1996 was 12%. Of these the majority are because of very fast labors, rather than a genuine desire to have the baby at home. We usually

get a call at the hospital when there is a home delivery. I grab my gear and find whatever transport I can, anything from the hospital vehicle to the local police car to my bicycle. I even had the fire engine come to pick me up on one occasion.

Usually when I arrive the mother is on the floor with the babe between her legs, still attached to the umbilical cord. Occasionally the placenta has delivered. Often there is either a TBA or at least a grandmother in attendance. If the mother is not bleeding I usually attend to the baby first. I give it a check over and give vitamin K and Hepatitis B. If all is well with mother and babe they stay home. If we do not attend them at home then the family usually bring the baby to the hospital to be weighed and checked, in this case we do not usually see the mother. Despite the smallness of the island there is no domiciliary nurse. We have recently initiated a community outreach program but it's early days yet.

I received a call at 6am one morning to attend a home delivery. I went to the hospital and then went with the husband to his home on our bikes. I was ushered past about 4 people watching television with the volume down and a group of six women playing cards for money. I was taken into a small dark room where there were several people of varying ages sleeping. The new mother was in a corner of the room with a TBA at her feet and along with her lifeless newborn, a stillbirth. There was a small kerosene lamp glowing nearby. The mother had not felt any fetal movements for several days but had chosen not to come to the hospital. They all knew that the little boy was dead. One neighbour who was there asked me why does this happen? I replied that we don't really know. She casually replied "That's life".

Traditional Birth Attendants (TBA): TBA and support people feature very strongly in the Marshallese culture. It is the grandmother's role to teach the respective granddaughters, about women's things and then to assist as support person and instructor during labor. They are involved with post partum activities such as burying the placenta and hitting it with a stick to kill it. They arrange and carry out the special bath for mothers to promote healing and reduce blood loss in the postpartum period.

The number of women who attend as support people during labor vary from one up to thirteen but usually around two to three. Occasionally a male will be present being either the husband or even the woman's father but as in many cultures it is a woman dominated affair. The woman's mother usually waits outside till after the delivery. There is usually one woman allocated to care for and clean the newborn. She has usually not been a support person during labor and occasionally is the woman's mother. In-law relatives feature strongly in the support network.

The newborn is cleaned using gauze and local coconut oil. This may be because the water supply is so unreliable. Triple dye is used on the cord and has been in use for the last two

years. Apparently they were losing infants to cord infections previous to using triple dye. They use erythromycin eye ointment on all newborns to prevent gonococcal conjunctivitis. Hepatitis B vaccine and Vitamin K are given routinely at birth. BCG vaccine usually follows within the next day or so. The average birth weight for 1996 was 6lb 8oz (3120 gms).

There is no doubt that the community holds the TBA in high regard. They will either come with them to the hospital or call for them when the labor is not moving along fast enough. There is no formal recognition for the TBA from the hospital's point of view. A senior Marshallese male nurse wants to ban them from the hospital. The reasons seem a bit vague. I have asked Neijok if there is anyone to replace her as she is not getting any younger, but there does not seem to be anyone. Neijok is quite unique in her practice. She is the only TBA who does internal manipulation of the cervix, the others just support the perineum.

Australian Volunteer Abroad (AVA): With many AVA jobs, prior to departure from Australia the actual job description is often vague. My job was to be no exception though people were very flexible. Once was able to write my own. There was a request for some midwifery training of the regular nursing staff with the idea that they would become somehow certified. After explaining that certification was somewhat out of my league, I suggested doing some education sessions with current staff. This I included in my own job description. I also accepted to attend all deliveries when called, attend the prenatal and postpartum clinics, and the well baby clinic.

Delivery Room: The delivery room in Ebeye hospital was a bit of an after thought. The room we use is an operating room that has been blocked off from the rest of the operating theatre. It is a large room with an operating light hanging from the ceiling. When I arrived they were using an operating table as a delivery bed. I noted that all the women were giving birth flat on their backs in lithotomy position but their legs were not strapped to the stirrups.

Unfortunately keeping equipment clean is not one of the staff's strengths. There are no cleaning staff except for some janitors, therefore it is up to the staff to keep their own areas clean. The operating table had a lot of old blood, caked on in layers. The vinyl cover of the mattress on the top of the table had been torn long ago and the spongy inside was also blood impregnated. Fortunately I was able to discard the table and replace it with a relatively new gynaecology table. We have a mat on the floor in one corner and a bed in another corner. Privacy is taken care of by bed screens that my wife skillfully sewed. We have soft lighting as well as fluorescent lights. We resort to Florence Nightingale lamps on the frequent occasions that we have power outages. We now have a backup generator so that has improved the lighting situation.

By far the majority of women choose the gynae couch to have their baby on, with only a few opting for either the bed

or the floor. Either location they always deliver flat on their backs. I have tried on the occasion to introduce either all fours, left lateral or squatting but have always met with resistance. On questioning the traditional birth attendants, there is some history that on the outer islands squatting was practiced. Being on your back is the accepted position these days. During labor there is very little if any vocalization from the mother and on the odd occasion that a woman has groaned, let alone screamed, she is usually reprimanded by her support people.

Traditional Medicine: Local medicines are used but are given or taken in secrecy, no doubt because of mainstream opposition to them. From what I have been privileged to see they are very mild. I believe they add considerably to the psychological well being of all concerned. The most common remedy I have seen is the rubbing onto the women's abdomen a herb, with or without oil. Occasionally they use a herbal tincture as well as sprinkle it onto other parts of the body. Less frequently they drink a very weak herbal tea. I witnessed one grandmother rub an egg on a woman's abdomen. She then cracked the raw egg into the mouth of the woman, who happened to be in second stage of labour at the time. My understanding is that these remedies are used to enhance or speed up labor. Another time a medicine man was called to attend to a multipara. He rubbed a herbal tonic onto the women's abdomen and then waited for her to deliver in half an hour.

I have come to realize in Ebeye is that there is very little tolerance for labors that take longer than a few hours. The family usually expect the woman to have delivered within 2 to 3 hours of her arriving at the hospital. If she does not then they expect you to do something. In general they do end up delivering within an hour or so after arriving, especially the multigravidas. The laboring women usually present to the hospital when they are 6 to 7 cms dilated. Unfortunately with primigravidas who present earlier, this is often not the case. If they are only 1 to 2 centimetres dilated, they are encouraged to return home but are often reluctant to do so.

Pushing Too Early? The hospital staff complain that women are encouraged to push before they are fully dilated, some as early as 1 to 2 cms. It is often the TBA who encourages this. From what I have seen, it makes little difference whether a TBA is there or not because the family will encourage it anyway. We have tried many ways to stop laboring women from pushing till they are fully dilated but have constantly failed. I accept that this practice does actually shorten labor with little if any ill effects to either mother or infant. There have been many cases where I have had to assist the TBA in holding open a very swollen cervix to allow the presenting part to come through the birth canal. Neijok will stretch the cervix using internal manipulation, occasionally this causes discomfort but generally the act is very well tolerated. The families do not seem content to just wait for usual dilation. I witnessed Neijok stretch a multigravida cervix

from 1 - 2 cms to around 8 cms in just over an hour and the women wasn't even having contractions.

The staff claimed that all this early pushing was just tiring the mother out and causing them to need caesarean sections. Whilst the pushing does tire the mother out, whether or not there is any link with any associated problems is difficult to answer. I have yet to see any evidence to support their claim. The opposite could even be argued, that the TBA play a crucial role in keeping the rather impressive caesarean rate at 1-2 per month. This equates to 5%. The doctor had decided to do a caesarean on one occasion, but the family went and got Neijok. Within 15 minutes of Neijok arriving the infant was born without any problems.

I now encourage early pushing, though with a multigravida not until she is around 6-7cms and with a primipara when she is 8-9cms. It is an individual thing and depends on how the cervix feels. There really needs to be a study done, to prove or disprove that it shortens labor and that there are no adverse effects for both mother and child. I am certain the Marshallese women will continue with the practice.

Fast Labors: What continues to amaze me is the speed with which some of these mothers can dilate. This speed does not only apply to multiparas, there was a primipara who was 3 cms at midday and then delivered at 2:40 in the afternoon. I had a multipara that went from 4 centimetres to delivering in 20 minutes. They do not use the term precipitate labor here. I am yet to see any adverse effects from these fast cervical dilations and labors, perhaps the opposite could be argued.

I have found it difficult to assess dilatation on many occasions. Either the cervix has not been well applied to the presenting part or it is very stretchy. Again this can be just as applicable for primiparas as for multiparas. It is not uncommon for women to come in at 2-3 cms and then deliver in 20 minutes.

Ironically the fast dilation is not always associated with manipulation of the cervix. I recall a gravida 16 woman I attended, she had only one support person. Invariably the more births you have the less support people you seem to have. The woman was in early labor and progress was slow, she was around 2-3 cms dilated. We decided to augment labor with some oxytocin to move things along. We have found this to be necessary in multiparas who are greater than para 7, as a general rule. The oxytocin was up and I left the room to get something, was away less than a few minutes. On my return she had just delivered a healthy boy, no problems of course. All this occurred less than 30 minutes.

Because no linen is supplied by the hospital, it is up to the family to supply everything necessary. Old clean dresses are used to place under the mother and to mop up the spills of giving birth. The colors can be quite cheerful compared to hospital whites. As there are no hospital gowns they wear

their own clothes, usually lightweight cotton floral dresses. Post natal stay is usually just one day unless there are any problems with either mother or baby. There are very few post partum complications and infections are negligible. Discharge after four days post caesarean section is the norm.

Episiotomies: We have an episiotomy rate of less than 1%, intact perineums around the 80% mark. The rest are a mix between lacerations, 1st and 2nd degree tears, with one 3rd degree for 1996. There is no doubt that part of Neijok's cervical stretching also involves a component of perineal stretching. I have also seen many women who have had neither and still have intact perineums. One possible answer may be, the slower crowning of the presenting part that I have witnessed on numerous occasions.

Analgesia: In all the deliveries I have attended there has not been any request for analgesia, nor have I felt it was necessary to administer it. There is no Nitrous Oxide available but narcotics are available. Epidurals are usually used for caesarean sections. These women have a high pain threshold. I believe that the culture, with it's laid back island lifestyle also plays an important role in their attitude to birth.

Prenatal: Women often present late for prenatal care, usually the third trimester and a quarter do not have any prenatal care. Three quarters of the women are anemic but do not appear to be grossly affected by this. It is very difficult to try to explain to a new mother, nursing a healthy infant, that she should have had prenatal care. Diabetes is rampant in the Marshall Islands, but only half a dozen have developed gestational diabetes in my time here.

Breastfeeding: Marshallese women breastfed without any difficulties at all. We encourage immediate breastfeeding post delivery but I find many mothers reluctant to start straight away. Many women feel the need to wash their nipples prior to feeding and at times this delays the first feed. I have not however seen any associated problems with the delayed feeding.

Within 24 hours of delivery, the bottles arrive. The price of formula here on Ebeye is around \$24.00 U.S. for a can of powder that only lasts a week. This combined with a lack of water makes bottle feeding a bad move. Sadly there is a genuine lack of faith that breastfeeding alone is more than enough for the majority of babies. Many mothers are breastfeeding as well as bottle feeding at 6 weeks of age. Most of the infants admitted for malnutrition and diarrhea are bottle fed. The initiative for a baby friendly hospital has been started in Majuro but is yet to reach Ebeye. It is hard to deny western influence in this choice to bottle feed.

Infant Mortality Rate: The Marshall Islands has an infant mortality rate of over 30 per 1,000 live births. This compares very poorly with developed countries such as Australia. Many of the deaths are either premature infants, or infants

several months old who develop tuberculosis, suffer from malnutrition or invariably a combination of both.

One infant was admitted at 3 months old suffering from malnutrition, diarrhea and pneumonia and weighed 61b 12oz (3240gms). His birthweight was 6lb 14oz. (3300gms). After three weeks the pneumonia and diarrhea had resolved but he only managed to gain 2ozs, (60gms). We were fortunate enough to be able to foster him for a short time till he was adopted by an American family on Kwajalein. Six weeks later he was up to 12lbs(5400gms) and his hair was starting to grow back. The family history was the classic one of poor social circumstances, with no one prepared to take the responsibility of caring for a young infant. This was one of the more fortunate ones, I have seen many here who have not the opportunity of a second chance. At times it is almost as if no body cares.

Language: Language barriers have been a problem and I have been somewhat slow in getting a grasp of the local language. I have no problems with shouting "katiok" which means to push and "kakigi" which means to relax at the appropriate times. I found the women here very accepting of my assistance and now request my attendance at the deliveries. Quite often post delivery, food and drink are offered to those who helped. I have been impressed at the outset with the support that these women give to their laboring women. In many ways I find myself redundant, only being called upon at the end to receive the baby as it nears the end of it's journey, or assist if there are any troubles.

Another interesting point is the speed with which some of these women recover from giving birth. Whilst not always the case they mostly get up within half an hour of delivering and walk into the maternity ward unassisted. I have even had several women get up within five minutes of delivering, then they have started to clean up after themselves.

Conclusion: My experience here has only confirmed that we as midwives should be taking more responsibility for normal deliveries. The skill comes in recognizing problems before they turn into disasters. I admire the Marshallese and their birthing ways. Despite adverse surroundings and conditions they have managed to maintain their unique way of giving birth. It has been a privilege to have witnessed first hand, the quickness of their labors and the excellent support given has been a worthwhile experience. There is a lot to learn about giving birth, part of that learning is being open to alternative ways of doing things. Working with TBA in the Marshalls has been invaluable and confirmed the important role they play.

We are returning to Australia all the richer for our experiences here. I look forward to sharing what I have learnt here and to continue to practice midwifery in Australia.

Peter L Malavisi
 PO Box 5792, Ebeye, Marshall Islands.
 Current Address: 51 Johnson Street, Thornbury, Victoria 3071,
 Australia.

NZ Aids Foundation

The New Zealand AIDS Foundation is deeply concerned by some comments of Ati George Sokomanu, Secretary-General of the South Pacific Commission, in the "Guest Editorial" of your September 1995 issue. In his editorial Mr Sokomanu states:

" Much work remains to be done to improve knowledge of sexuality and bridge the gap between cultural taboo and the obvious over practice indicated by the high rates of STD, population growth, prostitution, and extra-marital intercourse. The apparent increase of homosexuality, child abuse, rape and domestic violence are worrying indicators. "

Leaving aside the loaded moral tone of the first part of this paragraph – which we would argue has no place in a scientific discourse about HIV and AIDS in the Pacific – the inclusion of homosexuality in a list of crimes of violence is extraordinarily homophobic and highly offensive.

The inclusion of comments of this kind seriously undermines your journal's credibility amongst organisations working in the field of HIV and AIDS. It also leaves us with substantial concerns about the policy directions that the South Pacific Commission may take on the AIDS epidemic.

It has been recognised by the World Health Organisation that discrimination against those at risk will only increase the likelihood of transmission of HIV. This understanding is formalised in Resolution WHA 41.24 (1988).

To conclude, we are extremely disturbed by the inclusion of these comments in the journal and request that you specifically dissociate yourself from them in the next issue.

Charles Chauvel (Chair) and Harold Samu (Trustee)
 NZ AIDS Foundation

Editor's response. This letter just recently surfaced and I apologise for the delay. A copy has been forwarded to the Secretary General of the South Pacific Commission.

AIDS is a moral issue as well therefore 'a moral tone' is part of scientific discourse – which itself is not value free. The list you are concerned about has inadvertently offended your heterophobia but has not undermined the credibility of PHD. From our perspective you should be more disturbed about racism and more overt discrimination against Pacific people with or without homosexuality. □

Type II diabetes (non-insulin dependent) is most common among adults who are overweight or who have a history of diabetes in the family. It is common in urban areas and mostly above those older than 35 years. People suffering this type of diabetes can produce insulin in their own body, but the amount they produce is not enough.

**In Food, Drinks and Non-Communicable Diseases,
 University of South Pacific, 1990**

