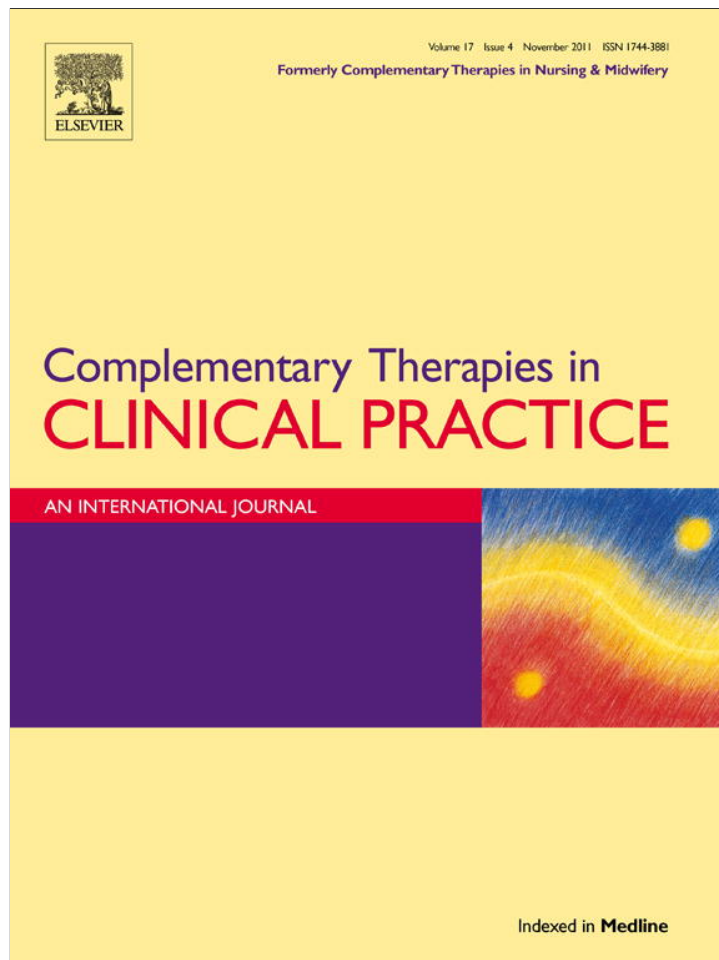


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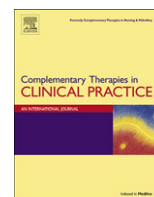
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Editorial

The need to include the subject of natural remedies in midwifery education

The International Confederation of Midwives' (ICM) triennial congress was held in Durban, South Africa, in June 2011 and was attended by over 3000 enthusiastic midwives from all over the world. It was a vibrant and exciting conference and gave much "food for thought".

As the conference was held on the African continent for the first time, there was inevitably a strong focus on safe motherhood initiatives and issues such as HIV/AIDS. This was particularly notable during plenary sessions. Concurrent sessions offered a plethora of subjects to suit all needs and interests and it was apparent that there is a wide disparity between problems facing midwives in first world countries and those in developing countries including Africa, parts of Asia, South America and some of the poorer European states. In the UK, USA and Australia, we bemoan the rising intervention in childbirth and lack of financial and human resources to provide truly holistic care. However, midwives in a number of countries are dealing with basic issues such as lack of clean water or adequate healthcare facilities. This makes it difficult for them to ensure proper antenatal and intrapartum monitoring. In many areas of the world, labour care is undertaken by traditional birth attendants, or a single qualified midwife. Frequently, they have to cover huge geographical areas without ready access to obstetric support. In the west, even if we have difficulty in achieving holistic care, addressing physio-pathological aspects of intrapartum care and psychological and social elements of antenatal and postnatal provision, at least we have the luxuries of time and opportunity to consider these factors.

Midwifery training standards vary between countries. Even in parts of Australia, where distance often makes it impossible to attend courses in person, the emphasis for continuing professional development has to be on ensuring that midwives maintain their skills to deal with emergency situations. Even once trained, employment opportunities for midwives in many countries may be limited; remuneration is poor and personal risks are high. One lecturer, from Somalia, decried the fact that whilst midwives are trained locally, over 80% leave to find work in countries where pay and conditions are better, notably quoting a recent cohort in which, out of 30 students who qualified as midwives, 29 left to work elsewhere.

How then, can midwives in these areas ever provide more than essential care for high-risk mothers with complications?

Complementary therapies are often unheard of and it is unlikely that the subject is considered for inclusion in pre- or post-registration education and training. In many cultures, nurturing is often enhanced through the spontaneous use of massage and touch in labour. Although therapies such as acupuncture and shiatsu are popular elements of healthcare in Asian countries, more formal implementation of complementary therapies

(CTs) is an alien concept to midwives in many other areas of the world.

Conversely, however, the use of natural remedies (NRs) is common. Indeed, the use of indigenous plants by pregnant women in countries with poor accessibility to conventional healthcare is rife. Whilst over 80% of women in developed countries enjoy the options of self-administering herbal, homeopathic remedies or aromatherapy essential oils,^{5,1} it is estimated that similar proportions of women in Africa, Asia and South America use traditional herbal medicines to aid childbirth.¹⁷ Limited access to formal healthcare resources, supported by the inherent belief in traditional healing, often means that there is no option but to use plants which are locally available.

The commonality between the developed and developing countries is that there is little, if any, appreciation of the potential risks of NRs, either to the materno-fetal unit, or to the progress and outcome of pregnancy. Furthermore, there is little, if any, real understanding amongst medical professionals of the possible dangers of combining NRs with conventional medicines.

In South Africa, for example, concentrations of the traditional Zulu pregnancy tonic, *isihlambezo*, which contains concoctions of numerous indigenous plants, varies according to geographical locations and has been associated with meconium-stained liquor (passage of fetal meconium into the amniotic fluid, usually a sign of hypoxia) and excessively strong uterine contractions,^{8,15}. Similarly, ingestion of the remedy, *imbelekizane*, by Zulu women in the Transkei region for prolonged labour, may be responsible for several cases of unexplained fetal death as a result of preterm labour.¹⁵ Concern has since been expressed about the need to test and monitor these remedies in order to inform doctors and midwives.^{3,11}

It is interesting to note that when I attended my first ICM congress in Australia in 1984, midwives from Africa were keen to discourage the use of local plant remedies by traditional birth attendants because of their possible risks. This was at a time when complementary medicine was just becoming more popular in the west.

In 1996, I attended the Norway ICM congress and it seemed that midwives in both developed and developing countries were at a stage when they neither actively encouraged nor discouraged the use of herbal remedies. The west had not yet reached the period, as we have now, when large numbers of the population were familiar with CTs and NRs, whilst the developing areas had more important problems to solve. In 2011, I feel that, to a certain extent, the UK, USA and Australia have slipped backwards, since the huge popularity of CTs and NRs has led to real concerns over safety, particularly when used by ill-informed pregnant and child-bearing women.^{6,12}

It has now become a matter of some urgency to address midwives' knowledge of the remedies commonly used by their clients. Midwives in all countries should have a working appreciation of the indications, precautions and contraindications of those plant substances grown and used locally, and their potential interactions with conventional pharmacological preparations so that they can advise women about safety issues such as dosages, side effects and complications.

On the other hand, there is substantial emerging evidence of the benefits of CTs and their value in facilitating normal birth,¹³ many western midwives now wishing to acquire the skills to utilise various therapies in their practice. This is especially pertinent at a time when developed countries are attempting to reduce soaring rates of Caesarean section (CS) and other interventions such as labour induction for post-dates pregnancy. The World Health Organisation recommends a CS rate of around 15%,¹⁶ yet it is approaching 30% in the UK and other westernised countries,² and 50% in China.⁷ Women opting for private maternity care are even more likely to be delivered by CS, one survey of South African private hospitals suggesting a reprehensible CS rate of 67%.⁴

The International Federation of Obstetrics and Gynaecology's (FIGO) definition of a midwife focuses on the responsibilities in caring for women with normal pregnancies, labours and puerperia. However, increasingly midwives in the west are at risk of becoming mere obstetric nurses supporting women receiving care dependent upon medical intervention. It is well known that Caesarean sections (CS) contribute to increased maternal mortality and morbidity; thus, there is a real and urgent need to rationalise the alarming CS rates in order to comply with Millennium Development goal (5a) to reduce rates by 75% by 2015.¹⁴

Thus, a sustained and formal effort to educate midwives in developed countries about the use of CTs could be a valuable means of reducing intervention, particularly since relaxation therapies are known to reduce stress hormones such as cortisol which suppresses the oxytocin levels required for normal progress in pregnancy and birth.⁹ Furthermore, improving midwives' understanding, worldwide, of the issues related to women's use of indigenous plants should alert caregivers to possible risks and interactions and possibly go some way towards educating women about appropriate and safe use of their traditional remedies. This education should, accordingly, be included in pre-registration midwifery training, as well as being offered as continuing professional development courses for qualified midwives.

Expectancy is the world-leading provider of accredited complementary therapies education specific to midwifery practice and maternity care. *Expectancy* offers courses and study days for

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References

1. Babycentre.co.uk. *Survey on the use of herbal medicines in pregnancy*. Viewed online at: <http://www.babycentre.co.uk/midwives/natural-remedies-survey>; 2011. 12 July 2011.
2. Black C, Kaye JA, Jick H. Caesarean delivery in the United Kingdom: time trends in the general practice research database. *Obstetrics and Gynecology* 2005;**106**: 151–5.
3. Brookes KB, Smith AN. Cytotoxicity of pregnancy-related traditional medicine. *South African Medical Journal* 2003;**93**(5):359–61.
4. Fokazi S. *Experts call for cut in C-section birth rates* Independent Online. Viewed online at: <http://www.iol.co.za/lifestyle/family/birth/experts-call-for-cut-in-c-section-birth-rates-1.1029667?ot=inmsa>; 2010. 12 July 2011.
5. Hall HG, Griffiths DL, McKenna LG. The use of complementary and alternative medicine by pregnant women: a literature review midwifery, Viewed online 17 January 2011.
6. Holst L, Wright D, Haavik S, Nordeng H. The use and the user of herbal remedies during pregnancy. *Journal of Alternative and Complementary Medicine* 2009;**15**(7):787–92.
7. Lumbiganon P, Laopaiboon M, Gülmezoglu AM, Souza JP, Taneepanichskul S, Ruyan P, et al. Method of delivery and pregnancy outcomes in Asia: the WHO global survey on maternal and perinatal health 2007–08. *The Lancet* 2010;**375**(9713):490–9.
8. Mabina MH, Moodley J, Pitsoe SB. The use of traditional herbal medication during pregnancy. *Tropical Doctor* 1997;**27**(2):84–6. 1997 Apr.
9. McNabb M, Kimber L, Haines A. Does regular massage from late pregnancy to birth decrease maternal pain perception during labour and birth?—A feasibility study to investigate a programme of massage, controlled breathing and visualization, from 36 weeks of pregnancy until birth. *CTNM* 2006;**12**(3):222–3.
10. Pinn G, Pallett L. Herbal medicine in pregnancy. *Complementary Therapies in Nursing and Midwifery* 2002;**8**:77–80.
11. Refuerzo JS, Blackwell SC, Soko RJ, Lajeunesse L, Firchae K, Kruger M, et al. Use of over the counter medications and herbal remedies in pregnancy. *American Journal of Perinatology* 2005;**22**(6):321–4.
12. Tiran D. Complementary therapies in labour and delivery. In: Walsh D, Downe S, editors. *Essential midwifery skills: intrapartum care*. London: Elsevier Science; 2010.
13. United Nations. *Millennium development goals*. viewed online: <http://www.un.org/millenniumgoals/maternal>; 2010. 12 July 2011.
14. Varga CA, Veale DJH. Isihlambezo: utilization patterns and potential health effects of pregnancy-related traditional herbal medicine. *Social Science and Medicine* 1997;**44**(7):911–24.
15. World Health Organization. Appropriate technology for birth. *Lancet* 1985;**2**: 436–7.
16. World Health Organisation. *Fiftieth session of the WHO regional committee for Africa Ouagadougou, Burkina Faso, 28 August–2 September 2000*. Viewed online at: <http://www.afrolib.afro.who.int/RC/RC50/en/AFR-RC50-17-Final-Report>; 2000. 13 July 2011.

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