

BirthMatters



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Summer 2013

**How do
French
women
birth?**

**Publicly-
funded
homebirth**

**Accessing
care outside
advice**

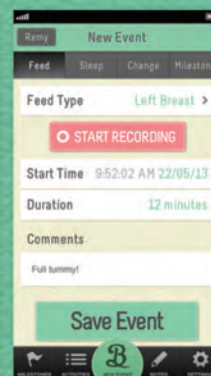
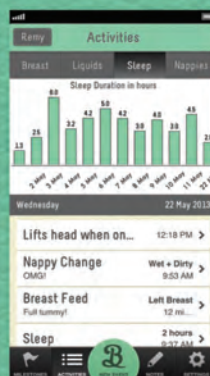
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OUR PURPOSE

Birth Matters (BM) is a quarterly magazine produced by and for members of Maternity Coalition (MC). The magazine provides a forum for consumers and other stakeholders to debate ideas, share experiences, and offer insights into the Australian maternity care system.

It aims to inform members of the challenges encountered and achievements won in maternity care at the local, state and federal levels. It seeks to motivate members to take political action so that our vision—that every woman can choose how, where and with whom she births—may be realised.

It is *your* magazine and without your submissions it will not be able to continue. So please consider submitting an article to share with and inspire your community.

GUIDELINES FOR SUBMISSION

The magazine is published quarterly in March, June, September and December.

Deadline for submission is the 1st of the month prior to publication.

We publish articles that are topical and/or of interest to our readers under the following section headings: *Letters to the Editor, Birth Stories, Features, Federal Update, Rural Matters, Global Perspectives, Parenting Matters, In Review* (Book, Film, and CD reviews), *MC News and Research News*.

All articles should be 250 – 2500 words, prepared as a Microsoft Word document with the File Name: **SHORT ARTICLE HEADING_VERSION_DATE**.

Text should be sized in 12 point, in font Times New Roman. All text should be left justified, single spaced and in block paragraphs for placement. Styles will be adjusted during layout.

In addition to your article please include a short (50-100 word) author biography (just a little blurb about yourself), and photos as JPEG files (minimum 300 dpi resolution).

Please email your article, with photos, and author bio as one zip file attachment to **birthmatters@maternitycoalition.org.au**. For more detailed guidance with grammar, style, spelling, punctuation and referencing; please refer to the **www.maternitycoalition.org.au** under the tab Birth Matters.

Please do not submit advertorials, they will not be published. If you are interested in promoting your business, please contact us via email: **advertising@maternitycoalition.org.au**

If you have an article to submit that is of interest to MC readers, and fits with MC's purpose statement, then we may be able to offer free advertising in exchange. This is at the discretion of the Editor; please contact her directly to discuss **birthmatters@maternitycoalition.org.au**

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ADVERTISE WITH US!

Our readers are passionate about birth, babies and making informed choices. If you want to reach savvy mums-to be, MC campaigners, midwives, doulas and want to support the campaign for improved maternity care services, contact advertising@maternitycoalition.org.au

Prices start at \$50 business card sized Ad, 1/4 page \$75, 1/2 page \$100, Full page colour \$150 & includes promotion on our website, Facebook pages, at Choices for Childbirth sessions and through our events, support groups and branch meetings.

Advertising bookings must be received by the 31st of the month prior to publication; ads must be received by the 15th of the month prior to publication.



As you will read in our Annual Reports section (pages 6-14), it has been a super busy time for Maternity Coalition (MC) all around the country. It has also been very full of activity for me, including the Australian College of Midwives (ACM) conferences, the Becoming A Breech Expert (BABE) course and The Water Birth Workshop. Along with these activities I have returned to full-time PhD study and am, not surprisingly, feeling a little overwhelmed by my commitments. So while I am honoured to have had the opportunity be the Birth Matters Editor for the past 12 months, I am also grateful to be able to hand over the reins to Artemis Horton (MC Belmont branch) in the New Year (see *Meet our new Editor*, page 23).

In August, I attended the Queensland Australian College of Midwives (ACM) State Conference followed by the National ACM Conference in September/October in Hobart. Highlights from both these conferences are featured in this edition of Birth Matters (pages 19-21).

I was one of two consumer presenters at the BABE course held in November, in Sydney. The other consumer was the inspiring and articulate Karol Petrovska who told her personal story of working the system to find support for breech birth. She also hinted at the themes that have emerged from the qualitative interviews she has conducted with breech birthing women around the country (yet to be published). It was a privilege to be a part of the teaching team and so important for doctors and midwives to hear, and really start to understand, how the barriers and limits imposed on breech birth impact women's experiences. My session focussed on 'Setting up the space for normal (breech) birth'. Participants entered a dim, quiet, private space where I acted out being powerfully in labour. I was on my hands and knees on a mat in the corner, rocking rhythmically to the sounds of Deep Forest; the scent of geranium oil permeated the room. I wanted participants to get a sense through what

they saw / heard / smelt / felt, of how peaceful and powerful the birth environment can and should be. After a few minutes I came out of the role and then I presented the theory behind why environment matters i.e. the importance of oxytocin and the ability of adrenaline to disrupt normal birth. These things most of us in MC are so familiar with, but for many health professionals this was new information. The session included video excerpts from my own calm, upright vaginal breech birth that emphasises that ability for the birthing space to remain dim, quiet, and private even in a hospital birth suite, even during a 'high risk' birth. This was eye-opening for many doctors. Every time I give this presentation I am overwhelmed by the response; including things like 'you made me really think about the impact of the birth environment for the first time'.

The next weekend I was busy helping to co-ordinate The Water Birth workshop in Brisbane for over 150 participants (including nine consumers who scored free registrations!) There were fabulous speakers from around the country including midwife Shea Caplice who talked about the benefits and barriers to water birth in hospital, Dr Ted Weaver who shared his experience of supporting over 1000 water births at Selangor Private Hospital on the Sunshine Coast, and midwife-academic Carolyn Hastie who reminded us of how to keep the woman's oxytocin flowing in order to birth the placenta safely following water birth. Alison Harvey, who was featured in the spring edition of BM, shared her birth story and spectacular photos at the workshop. A number of speakers presented Australian research on the safety of water birth and further research is planned between a number of centres in Australia, New Zealand and the United Kingdom to conduct the largest study to date to once and for all settle the question of water birth safety.

I wish you all the best for your end of year celebrations with family and friends.

Letters to the Editor

Dear Editor,

I am writing in response to your article on *Unregistered Birth Workers* by Ann Catchlove in the latest Birth Matters journal. I was quite surprised to find an obviously one-sided viewpoint in support of the belief that any unregistered birth worker is probably practising in an "unsafe, unprofessional or unethical" manner. Lay midwifery, as you know, has worked very well since the beginning of humankind. Just because a birth worker hasn't studied for years in an institutional system, does not mean that they are unqualified to give the utmost care and highest quality attention to women during the childbearing year. Unregistered birth workers often provide even more woman-centred care, as they are not inhibited by the extremely tight guidelines enforced by the medical establishment.

I find this article to go along with the medical system in assuming that any woman or birth worker who is not under their radar, or control, is inevitably making very unwise decisions, and is probably not assisting women with the highest integrity, respect and holistic support. This is amazing. What

of all the incredible traditional midwives in many countries of the world who offer much deeper care, who have learnt from a traditional midwife before them, who have never been 'registered' and who would never pass the registered test because they have learnt so much more than the medical establishment even knows?

This particular topic hits a very tender spot for me. I have been very frustrated by the restriction and persecution of very skilled and excellent traditional and lay midwives in their service to women. And I am also trying to learn midwifery along these ancient ways, but am finding it quite difficult much of the time. I was surprised to read this article but I would also like to say that I usually love every article in *Birth Matters* and all the work Maternity Coalition does. I am involved here in our group in Northern Rivers too.

Anyway, thank you for all that you all do in the cause of bringing more choice to women in birth.

Kind regards,
Taneal

THE FIGHT FOR WOMAN-CENTRED CARE

Jasmijn is a newly graduated midwife from Tasmania. She is currently working as an independent midwife, gaining experience and wisdom from other midwives in North-West Tasmania. In addition, she works part-time in a private hospital. Jasmijn's Dutch upbringing has inspired her to advocate for choice of birth in all settings. She is very interested in the changes occurring already and others that are necessary in the midwifery profession. Jasmijn loves to discuss and to write.

The philosophy of midwifery

Midwifery only exists "to facilitate the optimal experience of birth for pregnant women and their babies" (1). The focus of midwifery care is on the woman and her needs. In addition, each woman is seen as an individual, with different needs and cultural identities to those of others. These three statements form the basis of providing women-centered care.

As a newly graduated midwife, these theoretical statements are still fresh in my mind. It makes sense, of course, that the role of midwife is only possible because humans tend to have babies! I am very grateful that we do and I am profoundly excited by the privilege of being a midwife. In addition, it also makes sense to provide care based on the needs of the individual woman and her family. She knows her body best and can make her own decisions, which should be respected by health professionals.

Providing women-centered care has been an important thread throughout my course to becoming a midwife and I believe it is very true and logical to midwifery to provide care based on this philosophy. However, how often does birth truly happen within this philosophy?

“ Sometimes the best interests of the midwife or doctors involved, rather than those of the birthing women drive the decisions around a birth. ”

The battle for women

Most people have direct knowledge of at least one birth story where the woman was not at the centre of care. I have attended a few homebirths where a woman was determined to give birth at home, or sometimes to free birth, rather than in hospital because of the fear and disrespect associated with her experience of hospital care. This can ultimately lead to risky situations. The fact that some women are prepared to accept those risks to be off the radar and able to birth in the way they want is evidence that much current midwifery practice is not women-centered. In addition, some women who birth in hospital leave without understanding what events occurred during their birth, or why certain interventions were performed. Sometimes the best interests of the midwife or doctors involved, rather than those of the birthing women drive the decisions around a birth.

Unsatisfactory hospital care does not happen to every woman, and there certainly is a place for birth in hospital, *but* the fact is that all issues around the birth should be a decision for the woman and her family. Whether she chooses to birth at home, in hospital or a birth centre, and with or without a doctor or midwife, she should be afforded the respect to make an informed choice. At the moment it is a fight; an unjust battle for women to have the birth they want. Birth is an event to be celebrated, in all types of settings. It should be possible for a woman to choose the birth she wants. She should not have to argue or to produce piles of research evidence to achieve this. It is her choice, and as a midwife my role is to support

her. The term 'birth war' is an accurate term for the issues between women and care providers and the general position of midwifery at the moment.

The battle for midwives

Not only is this a current issue between women and their care providers; the same war also seems to exist between midwives themselves. This year alone, two independent midwives and dear friends of mine have been notified to the Australian Health Practitioner Regulation Agency (AHPRA) by hospital-based midwives. The cases were based on procedural issues and neither had any connection with the actual care given to the pregnant women. In addition, the women involved in each case were determined to support their independent midwives through the process. Thus, instead of simply enjoying their newborn babies, they were involved in a fight to support their midwives. Midwives fighting midwives? If only the principles of midwifery, that the woman is the centre of care, could be reinforced.

Besides the time and effort necessary to defend a case as an independent midwife, the emotional strain and pressure is detrimental. In both these cases the independent midwives were reviewed to have practised correctly according to professional conduct standards and, in fact, the hospital had practised

against policy. No further action was taken, no explanation was given to the women involved and no formal apology was provided to the independent midwives. This event is likely to recur when another independent midwife collaborates with a hospital. It is high risk to be an independent midwife, especially where there is no support (and rather

the opposite) from some hospitals. No wonder independent midwives are so few in Australia.

Reflections

We are currently experiencing a ridiculous fight over birth, between women, midwives and others. Instead of providing care based on the birthing woman's needs, midwifery sometimes seems to prioritise everyone else's needs but the woman's. This is a sad situation. As with all wars, fighting is not the answer and the victims (or women) involved are not actually the focus of the fight: at the heart of this war is a power struggle between different care providers and professions.

As a full-time independent midwife and part-time hospital-based midwife, I experience many different sides and am determined to continue to raise awareness of the current situation in midwifery. A change in the way the original philosophy of midwifery is implemented is essential. This is a responsibility and priority for the whole of society, not just women. I hope to continue to be involved in the many little changes occurring in midwifery and am optimistic that one day soon we will truly provide women-centered care in Australia.

References

1. Guilliland, K., and Pairman, S. (1995). The midwifery partnership: A model for practice. Wellington: Department of Nursing & Midwifery. Victorian University of Wellington. p.41

HOW DO WE GET OUR LOCAL HOSPITAL TO SET UP A HOMEBIRTH SERVICE?



A Maternity Coalition (MC) member recently wrote in asking for advice on how to set up a homebirth service at their local public hospital. I should disclose up front that I've never yet successfully advocated for a public homebirth model, although I have been closely involved in the establishment of a number of midwifery continuity models in Queensland. When the subject of a public homebirth model comes up, I wonder whether we have a public maternity service in Queensland that is ready for this. Letters to the Editor please! From my perspective, there are benefits and risks to public homebirth models, and they need to be built on a good foundation.

Public homebirth services

Most Australian states and territories have public homebirth services, with Queensland, Tasmania and Australian Capital Territory (ACT) being the exceptions. Overall, these are excellent services, some of them long-established, such as the Fremantle program in Western Australia (which MC used as their model maternity service in the 2002 National Maternity Action Plan).

Most public homebirth services came about as the result of local circumstances: usually much hard work by local champions plus a receptive local hospital culture. The Northern Territory (NT) homebirth program is a notable exception: there was plenty of hard work by local champions, but instead of a supportive hospital culture, they had a political imperative. NT practitioner registration laws did not allow private midwives to practise after the loss of professional indemnity insurance in 2001, so (under strong consumer pressure) government had to provide a public homebirth service instead.

The 2009 Commonwealth Maternity Services Review was quite impressed with the quality of Australia's public homebirth services. Consequently the National Maternity Services Plan, agreed to by all Australian Health Ministers, commits each state and territory to "consider the implementation of publicly funded homebirth models". This is not a commitment to implement homebirth services, but it does require state health departments to put some effort into considering the idea, hopefully including some consumer consultation. Consumers or midwives interested in progressing public homebirth could ask their state or territory health ministers for information about their state department's consideration of public homebirth models under their National Maternity Service Plan commitments.

Why public homebirth?

Public homebirth models have benefits. They are free to women and families. They enable a different group of women to access continuity of midwifery care (assuming that

most homebirth models use a caseload model), along with the benefits of birthing in their own homes. These women may not consider homebirth as an option until it is offered by their local maternity service, or may not be able to afford to pay privately for homebirth care. Some women may also feel safer in a model that is integrated with hospital services.

Public homebirth models also require major cultural development in the public maternity service they are part of

(usually a public hospital with conventional maternity services although, interestingly, the NT homebirth program is not hospital-based). Hospital stakeholders (doctors, nurses, midwives and administrators) need to be able to support midwives in caseload practice, respect women's choices and come to terms with the whole scary idea of birth at home. This is a

“... public homebirth models can be seen as a force for building a collaborative, woman-centred culture in a public maternity service.”

big call for any hospital. So in this way public homebirth models can be seen as a force for building a collaborative, woman-centred culture in a public maternity service.

There are also downsides to public homebirth. Because these models require the agreement of many hospital-based stakeholders, they tend to restrict women's choices and be very rule-based. Midwives are (usually) employees of a hospital, which will insist that their responsibilities are primarily to the organisation, before the woman. This is significantly different from traditional Australian homebirth midwifery, where women have historically had a lot of control over their care and midwives have had a great deal of autonomy (though often in a hostile collaborative environment).

From my perspective, although there are significant risks to women's rights to choice and midwives' professional autonomy in public homebirth models, these models still bring significant benefits, as long as women retain access to other options, especially private midwifery care, which includes the option of homebirth. When well implemented, these models give more options to more women, enhance the professional role of midwives and build a more collaborative culture in the referral hospital.

Pushing for a local homebirth model

If you are considering advocating for a local public homebirth service, the first thing to consider is the existing culture and models of care in the hosting hospital. Does the hospital already have a caseload midwifery model (where women receive most of their care from a named midwife and her partners)? This model might be titled 'Midwifery Group Practice' (MGP).

In most cases a successful hospital-based caseload model would be a prerequisite for a homebirth service. This is because homebirth services are usually caseload based. Establishing a caseload model in a hospital is a challenge in itself, as it requires significant culture changes for most hospitals: recognising the professional role and scope of practice of midwives, and building a culture of collaboration between midwives and obstetricians.

A useful guide to implementing caseload midwifery models is *Delivering continuity of midwifery care to Queensland women*, found at this link: www.qcmb.org.au/media/pdf/Midwives%20Imp%20guide_web.pdf. This document advises on how to implement a midwifery continuity model, with a focus on the key issues: management understanding of caseload midwifery practice, and the need to enable midwives to evolve a practice model that works for them. It also promotes a transparent and inclusive process for developing new models, including consumer representation and stakeholder steering committees. I recommend it for anyone planning to promote a new midwifery model of care, including a public homebirth service.

A new midwifery model of care will depend on having a midwifery champion/s within the system, with the knowledge, commitment and position to push a project forward. Their work

will be easier and more likely to succeed with support from consumer champions: consumers have much greater freedom to advocate within the health system and in the political domain. It is hard for clinicians or managers to progress a project that may be controversial (caseload midwifery or homebirth are both controversial for many people in the system), without being supported by consumer demand.

In short it is important to consider three questions: Are local consumers ready and able to advocate for this (perhaps for years)? Are there midwifery leaders in the local public maternity service who are ready to support this idea? Does the local maternity service have a caseload model with experienced midwives? If you can answer 'yes' to these questions then look at *What you can do* for the next steps to take.

WHAT YOU CAN DO

- Build relationships with hospital management from the top down, starting with the health authority Chief Executive Officer.
- Build relationships with clinicians as well, but remember this is mostly for information; they usually don't have much influence on policy.
- With the hospital authority: insist on high quality consumer engagement in their maternity service, especially consumer representation in their service planning.
- Build relationships with the local state/territory Member of Parliament, especially if you get resistance from the hospital authority.
- Make friends in the Australian College of Midwives in your state branch and get their help and advice.
- Read *Delivering continuity of midwifery care to Queensland women*.



Wishing You A Wonderful Festive Season

On behalf of the Maternity Coalition and the Birth Matters Team, we would like to thank you for your continued support and contributions.

We wish you good spirits, new beginnings and adventures with loved ones in 2014.

PRESIDENT'S REPORT

By Bec Waqanikalou

This report was tabled and accepted at the Maternity Coalition Annual General Meeting on 26 November 2013.

As a new member to the national committee, the last 12 months have been a really interesting experience for me. I have been astonished by what Maternity Coalition accomplishes, considering it is a volunteer organisation run almost completely 'online' by our members with no major funding.

It has been a great year with a lot of internal work going on. The organisation is in the position now of evolving, growing and building on all the hard work that has been done over the last few years, and we hope to see some amazing advancements over the next year or two.

Major events/activities/actions

This year has given us the opportunity to reassess the internal workings of MC. We have been developing a number of procedural changes and setting up positions to support the sustainability and growth of the organisation. We have also been looking at our public profile and interactions with members, other organisations and consumers.

One of the most exciting changes this year was the completion of our new website. With a clean and fresh look, it has been a welcome upgrade. The new website is user-friendly with a number of useful log-ins for members and branches.

We have also seen the implementation of our new membership system, which has been a blessing. There were a few initial teething problems, but it is now running well and has some more features coming online soon that will make our membership procedures seamless. Thank you to our *Webwoman* – David, and Bec Telfer for all your work on the system.

MC now has a Branches Co-ordinator, Tish Ryder, whose sole purpose is to work with new branches as they start up, and with current branches, by supporting them as a central point of contact. As this role develops we are looking forward to seeing more interaction and support for branches and those committees.

We have also introduced a Advertising Coordinator for *Birth Matters*, Jade Farren, who continues to work on building the advertisers and supporting the *Birth Matters'* team.

The federal election felt like a whirlwind, even though it was one of the longest election campaigns ever seen. We worked with a number of organisations, including Australian College of Midwives (ACM), Homebirth Australia (HBA), Australian Private Midwives Assoc. (APMA) and Midwives Australia (MA). We employed the services of Jo Scard, professional lobbyist, with whom we have worked with in the past, on a strategy to get our issues heard. Now with the election over and a new health minister in place, we will be implementing our post-election actions in the coming weeks and months to ensure maternity care issues are not forgotten.

Throughout the nation we have MC members sitting on a numerous boards, committees, advisory groups, and discussion panels as Consumer Representatives and we look forward to supporting others in taking up positions.

Relationships with other organisations

This has been another great year of building our relationships with local, state and national organisations, including ACM, APMA, MA and HBA. We have also had some productive and positive talks with Friends of the Birth Centre Queensland, CARES Inc. (Caesarean Awareness Recovery Education Support) in South Australia and a passionate group of women from Western Australia who have been running the *Women Can Do It 2013* campaign to inspire and encourage women to fight for and speak up for their choices.

On the international stage, this year saw the first *Improving Birth* rallies held worldwide (including two in Australia). Next year, working in conjunction with the Improving Birth organisation, MC will coordinate rallies nationwide to bring more awareness to the needs and wants of Australian women.

Policy

After two years of lobbying by consumer and midwifery stakeholders, the government has finally amended legislation to make 'collaborative arrangements', more achievable for midwives. Under the original definition, eligible midwives had four options:

- a) the midwife is employed by a doctor or entity that employs a doctor
- b) the midwife provides care to a woman referred to her by a doctor
- c) the midwife has a signed agreement with a named doctor
- d) the midwife follows a documentation trail with a named doctor acknowledging care ('midwife's written records').

The recent reforms add another option (e) to this list. This option states that midwives who pass a credentialing process at a hospital employing obstetricians are considered to have a collaborative arrangement in place.

Additionally, a minor amendment to option a) means that, as well as being employed by an entity that employs an obstetrician or GP obstetrician, the midwife can have a written agreement with this same sort of entity. For example, a midwife could have a written agreement with an Aboriginal Medical Service that employs a GP obstetrician.

A further minor amendment clarifies that collaborative arrangements can be with an obstetrician who is in private or public practice.

The future

The National Committee has more exciting plans for MC and we hope to raise public awareness of the need for evidence-based, woman-centred care, as well as more options and more access for women throughout the nation. We hope to see further collaboration with other like-minded organisations and will work towards more engagement. We will also introduce and develop more support roles over the next year and, if you have a special interest or passion in supporting others, we would love to hear from you.

Thanks

Without the driving force of the National Committee, our organisation would cease. This wonderful group of volunteers give up hours each week and month to ensure we can continue to support, represent and advocate for consumers of maternity care. Thank you!

A big thank you to Kylie Sheffield, Vice President. She has been our woman on the ground in Canberra for the federal election and also an absolute godsend for me, providing knowledgeable and balanced advice and support. Kylie won't be returning to the national committee but she will remain the MC contact in ACT and will work on some of the federal issues in Canberra.

Genevieve Sayers, a long-term MC member took over the large task of Treasurer, and now in-house bookkeeper, and has worked tirelessly on the handover of finances. Thank you Genevieve for all your hard work!

Jo Askham continued in her role on the Committee as Assistant Treasurer and Choices for Childbirth Co-ordinator managing our MC Paypal account and running Choices in VIC. Jo also runs regular movie nights. Without her work the VIC Choices wouldn't be as successful as it is.

Bec Telfer, our trusty Membership Secretary, works away ensuring the memberships are up to date and everyone gets their friendly reminders to renew. She also has the important job of ensuring each *Birth Matters* edition arrives safely to each of you.

Bruce Teakle, General Committee Member, continues his work on visiting rights and collaborative arrangements, as well as the important work of consumer representative on a number of working groups, advisory groups and on the Queensland State Committee. Bruce also supports myself and others with his immense knowledge and information on the important issues and work MC does.

Tessa Kowaliw, General Committee Member, joined us this year from South Australia and has been providing feedback and support to the National Committee. Thank you.

Jyai Allen, *Birth Matters* Editor, has done an amazing job with the publication this year. Drafting submission guidelines, putting together an Editor's guide and coordinating the team to produce four great editions. Unfortunately Jyai won't be staying on as Editor next year due to family and work commitments and we will be sad to see her go. Thank you for all your work over the last year!

Also thanks to Sonia Bartoluzzi, the wonderful Assistant Editor and Mara Dower, graphic designer.

For everyone else who has contributed to National Committee work: Thank you!

Finally a *huge* thank you to all our members. We really couldn't do the work we do without you. We appreciate your support in all forms and we do hope you continue to be a member of Maternity Coalition into the future!

TREASURER'S REPORT

By Genevieve Sayers

My thanks to past treasurers, Jen Egan and Nicole Carver, as well as current Assistant Treasurer Jo Askham for their help in transitioning and for answering the many questions I sent their way, as well as to the National Committee for their support during a period of major financial transition for our organisation. My thanks also to the various branches and members I have dealt with this year for their patience during this time.

Late last year the previous treasurer, Jen Egan, and Assistant Treasurer, Jo Askham, recommended to the National Committee that a maternity passionate consumer be engaged to take on a combined National Treasurer and Bookkeeper role, for a fee of \$500 per month. This was to replace the arrangement of a National Treasurer working with external bookkeepers *Figures Are Us* in Victoria at an average cost of around \$600 per month. Under the previous system, the Treasurer was spending about one day a week collating and preparing paperwork that then went on to the bookkeepers. There was much double handling of paperwork with significant communication issues and delays between all parties (branches/treasurer/bookkeeper), resulting in errors and misunderstandings. This made it very difficult for the Treasurer to have timely access to information and to keep abreast of the financial situation of our organisation as a whole. The National Committee agreed with this proposal and I was approached to take on the role.

I have been a member of Maternity Coalition (MC) for more than seven years, during which I have been active in Queensland, and now in Tasmania, in several different roles.

I graduated from Queensland University of Technology in 1997 with a Bachelor of Business (Accountancy) and became a certified doula with DONA International in 2009.

We purchased the same accounting software package, Quicken Accounts Plus 2013, that *Figures Are Us* had been using, thus enabling us to retain our financial history. This was done at the reasonably significant cost of \$710. This software more than adequately meets our needs and will continue to do so for many years to come. The transition from external bookkeeper back to an in-house role has been a slow process and it is taking time to bring our books back up to date. I hope that by the time MC begins to wind up its activities for 2013, about when the school year commences (early February), the books will finally be current.

Financials

MC continues to operate two main bank accounts: the Commonwealth Bank account for daily banking and a BankWest account that attracts a variable interest rate (currently 2.5%). Interest accrued from this account over the last financial year was \$880.28. The balance at financial year-end was \$20 600.63. The balance of the CBA account continually fluctuates; the balance at the end of the 12/13 financial year was \$7442.27 and the balance as at the time of this report submission was \$9094.83. Expenses associated with *Birth Matters* publication and treasurer/bookkeeping remain MC's largest outgoings, followed by the cost of our insurance, which runs across the financial year. Our main sources of income continue to be memberships

and fundraising from various events and regular activities.

The 12/13 financial year reports will be ready for the AGM at the end of November but will not have been audited at that stage. The Incorporated Associations Act in Victoria (under which MC is incorporated) has changed and, as we fall into the tier with the smallest annual turnovers, we no longer require auditing annually. Hence the National Committee is investigating changing the annual auditing requirement in our constitution. At this stage we are leaning towards having an audit done at least every second year, with the National Committee taking it year by year. We will aim to publish a copy of the audited reports in the first edition of *Birth Matters* in 2014. I will be looking for a new accountant to audit our books, the details of which will also be published in the next edition of *Birth Matters*.

Two branches, Ballarat and Geelong, still actively operate their own bank accounts and have to submit details of entries made at the end of each financial year to be entered into the accounting system. I strongly encourage all branches to record all money in and out, and to submit these records in a timely manner. The new branches pack contains a spreadsheet set-up for branches to use; please contact the MC Branch Coordinator branches@maternitycoalition.org.au. Using this spreadsheet will help branches to have an improved awareness of their financial position, will reduce errors, reduce reliance on the Treasurer and ensure that good quality information is checked and entered into the accounting system. The software allows us to maintain and track separate cost centres for each branch while at the same time incorporating all the data into a complete organisational picture. Please continue to alert the Treasurer to any deposits made on behalf of your group in a timely manner and tag the deposit with a clear, relevant reference.

Several years ago the National Committee decided to levy a 15% administration fee on the profits made by branches. This is important as it helps to cover the costs of maintaining our books (which we must do by law) and also helps to cover the costs of insurance. The National Committee is looking at ways of modifying this so as not to disadvantage smaller branches or eat into the profits of branches fundraising for specific purposes. We hope to finalise this shortly and the National Committee will inform branches of the new arrangements in early 2014.

Insurance

The previous Treasurer began investigating moving our insurance cover because (a) the coverage was not adequate and (b) the cost of our premium was becoming too substantial. I continued her research and, following that, I recommended to the committee that we change insurance brokers. We were able to get a better deal and reduced the cost of our premiums by about \$500. Our new broker is *CRISP*, managed by Willis Australia, a firm specialising in community-related insurance. In seeking out new cover, I compiled a list, to the best of my knowledge, of our all our activities and events across the whole financial year and entire organisation. I will look to keep this up to date every year, so look out for a reminder in April 2014 about this. This amount of detail greatly assists the broker in working out the types of cover we need and the cost of the premiums.

For groups wanting to run events where they expect more than 100 attendees, outdoors events and events where other businesses are involved, please contact me in the *early* stages of planning to check that the insurance coverage will be adequate. Occasionally, it may be necessary to pay an additional charge on top of our existing premium, which branches will need to

factor into their event planning. It is also vital that volunteers assisting with events, stalls, and regular activities are MC financial members so that they are covered by the volunteer worker component of our insurance policy, should anything happen to them while volunteering for MC. Likewise, should any incident occur (involving a member of the public or one of our volunteers) from which an insurance claim may arise, it is essential to notify me as soon as possible afterwards, as I need to pass that information directly on to the insurer. I would like to note here that, as far as I am aware, no claims have even been made against our insurance policies.

PayPal account

MC continues to operate a PayPal account and the volume of transactions going through it has increased dramatically since our new website was launched in May. The new website utilises PayPal for membership payments, a changeover from our previous payment system. Victoria continues to use it for the bulk of Choices and Movie night payments. Jo Askham has remained as the main administrator, with the addition of myself, to enable easy and timely transfers of membership payments over to the CBA account.

Police checks

We recommend that anyone handling money on behalf of MC should be a financial member and have a police check. This will be done at MC's expense.



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QUEENSLAND REPORTS

By Andrea World

What a year for Maternity Coalition Queensland (MC QLD) state branch! It has certainly been a learning curve for me personally, having taken on the QLD President role a little over 12 months ago not really knowing what I was in for. Our QLD management team has benefitted from input this year from many, but the prominent 'short list' has consisted of Bruce Teakle, Belinda Barnett, Ildiko Keogh, Jyai Allen, Melissa Fox, Alecia Staines, Heidi Casey, Tabitha Humphreys, Latisha Ryder, Bec Telfer and, of course, Bec Waqanikalou.

Some days are hard for those of us that 'want change now' and, at times, it can seem as though we can do frustratingly little to enact the changes that we know are desperately needed. It is tempting to feel that our individual efforts do not count for much. But together we are capable of achieving the seemingly impossible!

I am continually amazed at the amount of passion and dedication shown by our visibly active members, but I also appreciate the many financial members who support us in the background. Members who casually mention to a friend over coffee that they do, indeed, have options and choices for their maternity care can forever change that individual's experience of birth. Each and every member plays a valuable part in the improvement of maternity services.

Rural birth summit

It has been a big year for these amazing events. Queensland Centre for Mothers and Babies (QCMB) has done a fabulous job organising the summits that have been held in Toowoomba, Rockhampton, Cairns and Mount Isa, and Townsville. The aim of the summit is to "network maternity stakeholders in Queensland, showcase innovative models and find practical workable and effective solutions to support strong and sustainable rural maternity services". The summits have been well attended by all relevant sectors and we continue to see acknowledgement that improvement is required for rural women, and progress is on the agenda for many stakeholders.

Eligible Privately Practising Midwives

State-wide, the awareness of options (and the need for them) in maternity care is continually on the rise, along with the availability of Eligible Privately Practising Midwives (EPPM). MC QLD is extremely grateful to enjoy a great relationship with the EPPM community. This year we have had a major focus on access to hospitals/visiting rights for EPPM providing continuity of carer models. It is great to see such models working well in Toowoomba and on the Gold Coast. More work

is needed far and wide to ensure that progress continues on this issue. Just recently we have experienced a major change of policy within Logan Hospital (Brisbane). Logan will now permit limited EPPM access from January 2014. This was primarily brought about by women of the community coming forward and reporting directly about the inability to hire an EPPM whilst booked at Logan due to hospital refusal to 'collaborate'. This is an amazing win for the women of Logan. Progress on this issue is ongoing and we are certain more hospitals will be on board with EPPM access soon. Of course this could not have been achieved without the massive support of several driving forces behind the scenes. We are still in awe of the enormity of this achievement and sincerely thank all involved.

Close relationships

Our members have continued to embrace our close relationships with QCMB, Australian College of Midwives QLD (ACMQ), and Health Consumers QLD (HCQ) and have increasingly taken up Consumer Representative positions with several local hospitals, Medicare Locals and the Health and Hospital Services. Positions include birthing services forums, community engagement, steering committees, and midwifery advisory groups, both in Brisbane metro and in various rural locations. It is now quite common to bump into several MC members at any random 'birthy' type event. We are becoming 'part of the furniture' so to speak. MC is also fortunate to have regular meetings with the QLD Health Minister, Lawrence Springborg, facilitated in the large part by Alecia Staines out in Goodiwindi.

Regional Queensland

Regionally, public hospital Midwifery Group Practices (MGPs) are reportedly working well, with many of the rural and regional hospitals establishing the program and the local women singing its praises. MGP is known as the gold standard of maternity care and we are happy to see it in QLD hospitals. There are recent concerns however, particularly in the larger metro areas, that some MGPs may require assistance to continue to progress and indeed, in some areas, remain operational. We will be monitoring this closely and are prepared to step in and provide support for these services wherever we can.

In Stanthorpe, Bec Telfer continued running the local BaBs group until partway through the year. More recently she has shifted focus to implementing a new format and also forging stronger links with the local Australian Breastfeeding Association. Many more first-time mums are now attending meets. Also MC members, Michelle Conkas and Melinda Toms, from the local Mothers United for Maternity Services Stanthorpe, (MUMSS) group have had very heavy involvement in the design of the impending new maternity unit.

Fundraising and grants

Heidi Casey organised MC to host a fundraising supper at a *Birth, babies, breastfeeding and bonding* seminar by Dr. Sarah Buckley in April. The event was a great success and we hope to have the opportunity to repeat it in the future. Special thanks to Chef Kelly Bloye for her generous contributions on the night, along with our other bakers and volunteers. (You know who you are and you are most appreciated. Thankyou!)

MC QLD secured a grant this year and now has some beautiful upright promotional banners to display at events. The banners feature an amazing post-birth image of Heidi Casey, which was captured by the talented Georgia Brizuela. The banners are an amazing visual attractant. No one can walk past them without

noticing the joy in the photo. It has led to many conversations with women about the options for birth. As part of the grant, MC business cards (more accurately, Consumer Representative contact cards) have now been designed and are available to active members for handing out to contacts when attending any relevant meetings. They have helped our profile, boosted the confidence of our Consumer Representatives and added to our professional presence. We will develop more promotional materials for MC Branches use in the near future. MC Polo Shirts are now available and have increased our members' visibility at the many meetings/forums/seminars we attend. This has led to increased connections with other like-minded organisations, as we are now more 'visible' as an organisation. The polo shirts are available for purchase from the main website for any member (from any state) that wishes to stand out in the crowd.

New branches

This year, Latisha Ryder from Emerald and Tabitha Humphreys from Rockhampton have started the Central QLD Branch and are now a visible presence in the extended region. Both have initiated positions on the local Health and Hospital Service committees and also a BaBs group in Emerald. In the last month the new Gold Coast Branch has also come to fruition thanks to passionate involvement from Diahnn Hynda and Karen Travers-Grace from Friends of the Birth Centre Gold Coast.

Hospitals stepping forward

At the end of September we welcomed the opening of the new Gold Coast University Hospital. The birth suites feature beautiful birthing tubs that we hear are already being put to good use. In 2014 the Mater Mothers Hospital will begin its eagerly awaited water birth study, thereby making water birth an option for women meeting the eligibility criteria and choosing to be part of the study. This is a great step forward for water birth access in the Brisbane metro. I am hopeful it may inspire other metro hospitals to follow suit. We are also looking forward to the re-opening of birthing services at Beaudesert Hospital in the first half of 2014 after a birthing hiatus of some ten years or so. This will be a most welcome option for local residents, and we are excited to see some tubs being installed in the new birth suites too.

Hopes for 2014

It has indeed been a big year. I look forward to working with anyone and everyone that shares MC's collective vision during 2014. My personal hope is to be able to forge ahead with creating more connections and getting MC 'out there' in the public arena and part of mainstream conversation on all things birth. I would love to see MC QLD hosting some film screenings and other social and/or fundraising events so we can further engage with local consumers. This way, we can ensure we continue to work towards the needs of all women and their families, regardless of how, where and with whom, they may choose to birth. My sincerest thanks go to all of you who have supported me this past year in my role. I am so grateful to be a part of this amazing group.

FAR NORTH QUEENSLAND BRANCH REPORT

By Rebecca Waqanikalou

It has been a busy year in Far North Queensland (FNQ).

Consumer representation

We have had a number of consumer representatives sitting on committees in our region, including:

- The Midwifery Group Practice (MGP) Steering Committee for Cairns Hospital, which is unfortunately currently at a standstill due to budget restraints on the local Health and Hospital Service (HHS). We hope to see the business case signed off shortly and this crucial service initiated for local women.
- The bi-monthly Maternity Services Committee. Initiated by our reps, this is an ongoing and open discussion around Maternity Services in our region.
- The Cairns Birth Centre continues discussions with the hospital executive around the ongoing plans to build the Cairns Birth Centre.

Our reps also engage in regular conversations with the rural hospitals in our region about the needs and wants of local women. We hope to work on developing and training some more consumer reps as our local health services are engaging more, and asking for women to join their committees, which is very encouraging.

Community engagement

As a fairly new branch, MC FNQ has been working to establish our presence in the community. This year we have attended a local expo to increase our profile and arranged a number of movie nights.

Future

We have some new members interacting and getting excited about engaging more in the New Year. There is talk of more rural and remote services opening in our region, namely Cooktown and potentially Weipa in coming years. We hope to support the local women in gaining and engaging with these services. There has also been the initiation of discussions with James Cook University Cairns to present consumer stories and experiences for the nursing, midwifery and medicine students. We hope to start this in the New Year also.



NORTHERN RIVERS BRANCH REPORT

By Sally Cusack

Film screening *Birth Story*: 5 May

Together with the Mullumbimby Birth Centre, our branch presented a screening of the new documentary *Birth Story: Ina May Gaskin and The Farm Midwives*. This event was held as a triple celebration of the International Day of the Midwife, the first anniversary of the homebirth service that operates from the Mullumbimby Birth Centre, and the launch of the Friends of the Mullumbimby Birth Centre. We managed to achieve good coverage in the local media in the lead up to the film screening, including the eight-minute documentary available here: <http://www.echo.net.au/2013/04/giving-birth-at-home/>

We were thrilled to welcome over 350 guests to the event. Two local musicians, Annie Bryant and Dani Ilich, opened the afternoon with an acappella duet. After screening the film we presented a panel discussion on the practice of midwifery in our region, emceed by the Clinical Midwifery Consultant from the Northern NSW Local Health District, Cathy Adams. The three panellists were former Northern Rivers branch President and newly graduated midwife, Vicki McAllister, independent registered midwife, Bron Moir and registered midwife from the Mullumbimby Birth Centre, Sarah Vial, who had just had her first baby with the homebirth service. The local community were very interested to hear these women's different experiences and unique perspectives.



Our discussion panel of midwives after the film, chaired by Cathy Adams

We were very lucky to have the expertise of local photographer Sophie Myburgh capturing the spirit of the day on film; Sophie donated her time and photographs of the event. She has since started up a new branch of Maternity Coalition in Lismore. More photos are on our Facebook page.

Rally to improve birth on the Gold Coast: 2 September

We took over the first *Rally to improve birth* on the Gold Coast, just three weeks beforehand, after Hannah Wildman, who started it up, had to step down. This took a fair amount of effort, as there was much to do from our remote distance 90 minutes south of the event. However, we were very lucky to have the help and local know-how of Diahnn Hynda and Karen Trevers-Grace from Friends of the Birth Centre, Gold Coast.

We held the rally at a beachside park at Palm Beach and approximately 80 mums, midwives and other birthing professionals turned up. We were very lucky to have local musician and mum of four, Maryen Cairns, sing for us, followed by speeches from Rosie Blyth (independent midwife from My Midwives Gold Coast), Sigal Golan (childbirth educator and doula visiting from Israel), Karen Trevers-Grace (local mum from Friends of the Birth Centre Gold Coast) and Kate Tully (mum and author of *Peaceful Birth Peaceful Earth*). The story is at: <http://www.nbnnews.com.au/index.php/2013/09/02/mums-rally-for-birth-rights/>

We also received a fantastic collection of prizes for a raffle and we were also very lucky to have Michelle Byrne, from Michelle Byrne Photography, donate her time and photographs of the event.

Setting up new MC branches

I have been keen to see new branches open up in our region as the Northern Rivers region is huge and too big for just one branch. So I've been quietly on the lookout for interested members who show an interest in birth choices. It has been really exciting to see MC Lismore and MC Gold Coast open up in the last couple of months. The next region I'm hoping will soon have its own branch is Tweed Heads. Let us know if you live in that area and would like to contribute to the work of informing families of their birth choices! There's plenty of support available and you could start out by simply running a Facebook page. This quickly becomes a great central hub for the birthing community to share their services and for women to find them.



The audience were visibly moved and captivated by the film



The crowd gathers to listen to speakers at the Gold Coast rally

Ongoing consumer representation

I have been attending bi-monthly meetings at Tweed Hospital as consumer representative for the implementation of the NSW Health's *Towards Normal Birth* policy at that hospital. I'm also providing consumer input relating to the move of a local hospital service within the district. The purpose of my involvement is to ensure preservation of the current maternity service enjoyed by the community.

Pregnancy, Birth and Beyond radio show

Our weekly radio show on local community radio is going from strength to strength, and is entering its sixth season. It has even attracted a programme sponsor, which is a great endorsement for the show as well as being of financial benefit for the radio station. The show (which is looking at changing its name: ideas anyone?) continues to be brought to air each week by Lara Martin and Taneal Blake. The most recent event they attend was at Southern Cross University's Midwifery Forum on 8 November. The radio show can be streamed live each week on Wednesdays 12–1pm from www.bayfm.org. Look for them on Facebook!

Pregnancy, birth and parenting professional's forum

In the past three and a half years in my role I have had many conversations with many inspiring people with offerings in the pregnancy, early parenting fields. They all have so much to offer, but they face many challenges in getting the word about their work out to the general public, and in gaining recognition for the value of their work. Through these conversations, I have come to see a role that our branch could play in bringing these professionals together to find ways to meet their challenges through networking and sharing ideas.

Emma Grant and Natasha Hain from Red Tent Yoga in Byron Bay (www.redtentyoga.com.au) have created a wonderful enterprise in bringing together services for women, and they were willing to let us use their space for free for professionals to gather and discuss issues of interest. We held our first meeting on 7 December 2012 and we now meet monthly. Local professionals are very interested in this concept and really appreciate the support from our branch and from Red Tent Yoga. Already more connections and cross-fertilisation between compatible businesses seems to be developing.

www.maternitycoalition.org.au/northernrivers

www.facebook.com/MaternityCoalitionNorthernRivers

www.facebook.com/RedTentFestival

HASTINGS BRANCH REPORT

By Macca Sheldrick and Leah Zvirzginas

The Hastings Maternity Coalition was established in July this year. We are a group of women passionately involved in birth, mothering, health and wellness, and united as active listeners in our community. We endeavour to facilitate change by advocating for local women in the Greater Port Macquarie Region.

We have had an incredibly busy and productive four months. Our first community event was a well-received screening of *The Face of Birth* with the producer Gavin. The screening also provided the opportunity to introduce ourselves to the community. We then held a second screening in September, with a larger audience, and initiated fundraising for our local activities.

We have held monthly meetings and gone from strength to strength, evolving our identity and core. The Hastings Maternity Coalition has established a positive working relationship with the regional hospital and we were invited to provide input and develop an educational pamphlet on water birth.

Our current fundraising is aimed at providing equipment for the hospital maternity unit so that water birth can be a choice for women. We have established a Facebook page and launched our webpage on 8 October. We have defined roles within our wonderful committee members, but these roles are never static and we all juggle work, life and family to remain committed to our goals. Recently, we held a stall at the monthly foreshore markets. Our presence at these markets offers the community an opportunity for face-to-face dialogue and to keep abreast of current projects and upcoming events.

We would also like to thank the National body for their ongoing support as we find our feet in establishing our branch. Merry Christmas everyone!

www.facebook.com/hastingsmaternity

www.hastingsmaternitycoalition.com



WAGGA BRANCH REPORT

By Wendy Harper

Our BaBs group has continued to meet fortnightly, with a variety of topics including *Yoga for Families*, *Budgeting for Babies*, *VBAC*, and *Mothering the Mother* (a very popular pampering session with local therapists donating their time).

This year we have further developed our relationships with local health facilities and tertiary institutions and continued to provide support to women in the local community. Representatives of Wagga MC have been actively involved in planning for the maternity unit in the new public hospital being built in Wagga within the next five to ten years. We have had input into the room plans and their fittings, and continue to be consulted by the staff involved. We look forward to seeing the finished result! We continue to lobby for access to continuity of care with a known midwife. Progress in this area is slow but we think it is also inevitable.

We were very excited to host a visit from renowned birth educator, attendant, counsellor and author Rhea Dempsey in October. Rhea presented a fabulous workshop *Boosting Birthing Capacity: what hinders, what helps, what heals?* She also launched her book *Birthing with Confidence*. All those who attended were inspired by her presentations and re-energised to make birth better for women in our region.

Also in October, Wagga MC representatives were asked to provide consumer input into the ANMAC *Review of Midwifery Accreditation Standards* at a focus group. We emphasised the importance of continuity of care, and how it makes a difference in both the students' learning and the experience of pregnancy and birth for the women the students are following.

We intend to continue supporting local families next year with information sharing on our website and our Facebook page, friendly get-togethers and consumer representation at a local level. Our website can be found at www.waggababs.com.au, and our Facebook page at www.facebook.com/groups/waggaBaBs/
Email: info@waggababs.com.au



AUSTRALIAN CAPITAL TERRITORY REPORT

By Kylie Sheffield

While no formal MC branch currently exists in the ACT, a couple of interesting things have happened here this year.

In early June representatives from MC, the Australian College of Midwives (ACM), the Australian Private Midwives Association, Home Birth Australia and Midwives Australia met in Canberra for a strategic planning workshop facilitated by local political advisor and communications consultant Jo Scard. I attended in person, while Bruce Teakle joined us on the phone. The aim of the workshop was to discuss how, as organisations that advocate for women-centred and evidence-based maternity care, we can work more closely together to achieve our aims given the (then) imminent change of government. It was a great opportunity for us all to reconnect and put faces to a few new names. We came away from the meeting agreeing that much can be achieved if we are viewed increasingly as a 'sector', with shared goals and philosophies, rather than as individual entities who happen to want the same thing. We have since met by teleconference and maintained regular email contact, something we plan to continue. Our first joint project (currently in the final design stages) is the distribution of a postcard promoting the evidence-based benefits of receiving care from a known midwife.

A project is underway at Canberra Hospital to enable the ACT's first hospital credentialing system for eligible midwives. The necessary amendment to the ACT Health Act, which will allow health facilities to convene a committee for midwife credentialing, was passed in October. Canberra Hospital's Nursing and Midwifery Advisor Ann Burgess advises that a

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consultation and advisory group has been formed (including an experienced consumer representative) but that there is still considerable work to do before setting a firm implementation date. Ann and I have planned monthly meetings, so MC will be kept in the loop and have the opportunity to offer additional consumer comment.

Local media reported in early November that plans for a birth centre with the capacity to care for around 200 women a year will go ahead at Calvary Hospital despite a 'government promise' to study the feasibility of a free-standing centre for Canberra. Chief Minister Katy Gallagher has reportedly said that she has agreed to the study, but current capacity issues demand that the opening of the co-located birth centre at the Calvary goes ahead as planned.

Despite inheriting the roll of ACT rep from the capable and motivated Emma Davidson almost two years ago, my focus on Federal issues has prevented me from spending much time on what's happening locally. My goals for 2014 include connecting with MC members in the ACT and nearby communities, getting a better understanding of the local birthing scene, and keeping my eye out for consumer rep opportunities.



CHOICES FOR CHILDBIRTH REPORT

By Jo Askham

After the previous year focusing on our new website and branding, this year was occupied in getting our workshops up and running on a regular basis and continuing to offer great information and presenters. Our information sessions ran seasonally in January, April, July and October and brought in an annual net income of about \$600. Sessions included: *Pregnancy, Labour & birth* and *Early parenting*.

This year we also saw a community need for some more regular gatherings for pregnant women in the form of a sharing circle, held and supported by an informed facilitator. This began with our *Pregnancy conversation* sessions in August. It has been well received and is gaining a beautiful flow of momentum. These sessions are currently run twice a month, but we are seeking to increase this to a weekly basis. *Pregnancy conversations* are relaxed sessions of sharing and connecting, but with a loose structure covering important information around choices in pregnancy, birth and parenting.

MC MOVIE NIGHTS REPORT

By Sarah Goldberg

It has been a fantastic year at the movies both in Northcote and Elwood, touching on important and vital topics that relate to current issues around childbearing. Elwood movie nights is now celebrating its one year anniversary and has successfully planted itself firmly in the community. Northcote too continues to have wonderful turnouts of both regulars and new faces.

The films screened were: *The Face Of Birth*, *Behind The Mask* (PANDA), *The VBAC Dilemma*, *Birth Story: Ina May Gaskin and the Farm Midwives*, *More Business Of Being Born Explore Your Options*, *My Body My Baby My Birth*, *Labouring Under Illusion*, *Birth Movement*, and, to finish off with, the recently released film *Midwife*.

We have had a fantastic line up of guest speakers to accompany each film, making for well-rounded evenings of movies, talk and tea! A very big thank you to our volunteer guest speakers who generously gave of their time and knowledge to enlighten and discuss the matters related to the films. They were: the tireless Rhea Dempsey, birth attendant, childbirth educator and author of a new book *Birth with confidence: Savvy choices for a normal birth*, who endlessly goes above and beyond to support the MC cause; film maker Kate Gorman; independent midwife Belinda Henkel; obstetrician Dr Guy Skinner, who enlightened us about VBACs (a personal highlight) and was accompanied by the lovely independent midwife from Midwives Naturally Helen Brown; lactation consultant/ paediatric nurse Sue Shaw; body movement therapist Susan Maling; counsellor family therapist Kaye Hutchings (who, supported by Rhea, provided a very in-depth panel discussing issues of postnatal depression and families experiencing difficulties with their new babies); Catina Adams, birth attendant and maternal and child health nurse; Lael Stone from About Birth; Erica Munton, doula and childbirth educator; Sarah Miller, dance teacher; and Nina Isabella, prenatal yoga teacher and doula.

I would like to also thank all the gorgeous volunteers who give their time to come early and stay late to help set up and pack down; it's such a help! Finally, an enormous thank you to the lovely Joanne Askham, who has been tirelessly committed to the running of the Northcote MC movie nights over the last four years and who has held my hand whilst setting up Elwood. Thank you!





CHALLENGES FOR RURAL BIRTHING WOMEN

Earlier this year another rural birthing unit closed, this time in Casino, NSW. Casino is 25 minutes drive from Lismore, which can cater for women with high-risk pregnancies and births. I spoke with a midwife at Casino hospital who told me that once one of the GPs stopped offering an obstetric service, the hospital was downgraded to a Level 2 birthing unit and could no longer offer inductions or cesarean sections. She also reported difficulties in replacing midwives when they left. This midwife believed that having the surgical ward attached to the maternity unit, with the midwife required to care for these patients too, prevented people from wanting to apply for a post there. There was some interest expressed by newly graduated midwives, but she had dissuaded them as they would be working alone, often without a doctor even on-call for obstetrics in town, which was in her view "asking for trouble" with their level of experience.

The closure of this unit is in contrast to the Queensland Government's commitment to reopen Beaudesert's Birthing Services in June 2014 and the Health Minister Lawrence Springborg's pledge to reopen birthing services in Weipa and Cape York. Why can Queensland justify reopening a low-risk birthing service like Beaudesert just 35 minutes from Logan Hospital when one in NSW closes not much closer to a larger hospital?

According to the Queensland Government Health Services website, Beaudesert Hospital has already managed to attract a full compliment of midwives, even though birthing services are not yet available at this site. Could this be related to the fact that antenatal care and postnatal care is provided in a Midwifery Group Practice model? The future of some small rural maternity units looks grim unless they are willing to embrace some of the changes that are happening in other parts of the country. A unit with a medicalised model of maternity care with little autonomy for midwives is unlikely to attract experienced midwives, who would then be available to mentor new midwives.

I recently met a woman in my town who is planning a vaginal birth after a caesarean (VBAC). She is currently 38 weeks pregnant, and until quite recently was planning a repeat cesarean section (CS) as our local hospital does not provide a VBAC service. To have a VBAC she needs to travel to Toowoomba, a two-hour drive away, which will involve significant disruption and costs to herself and her family. Ideally, she would like to birth locally. Without being happy about it, I can understand the risk analysis the local hospital has undertaken. Women who have had a previous CS have a greater chance of having (although not necessarily requiring!) a further CS, with rates of successful VBAC varying widely (1). Therefore, a facility that relies on on-call theatre and extra medical staff is not an ideal facility to birth in from a medico-legal point of view. When I have spoken to the

doctors at our local hospital, they tell me that by far the majority of the CS they perform are for repeat CS, as would probably happen in urban areas, but are these rates higher in the country? Rural women need to have incredible determination, family support and finances to make a VBAC a viable option.

Anecdotally, I have heard of excellent VBAC rates for women who birth at home, far greater than any I have seen quoted for hospital births. This makes the recent closure of the homebirth VBAC service offered by Darwin Community Midwifery Program even sadder. Any labouring woman will benefit from the continuous support of a known midwife or doula, especially a woman having a VBAC, and even more so a woman having a VBAC who is in a town far from home. I have had difficulty finding any information about rural women's experience of VBAC and would welcome any feedback from Maternity Coalition members about their experiences. Are there programs in tertiary hospitals providing known midwifery support to women having a VBAC, especially those who are from out of town?

Maternity Coalition is always available to assist consumers and midwives with advice and support to achieve their community's goals in order to improve local maternity care. For any further information about rural birthing issues or to report developments in your local area please contact me at rural@maternitycoalition.org.au.

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YOUR FUTURE, YOUR CHOICE!

NORTHERN TERRITORY BIRTH CHOICES CAMPAIGN



Supporter of choice for the women of Darwin

In August this year, the Obstetric Department at Royal Darwin Hospital withdrew support for women who had experienced a previous caesarean to attempt to birth at home under the care of midwives from the publicly-funded Community Health Homebirth Service – the only remaining service in Australia to provide this option. Those who led the push to return choice to the women of Darwin describe their campaign journey so far.

In late August, Childbirth Education Association Darwin (CEA) and Darwin Home Birth Group (DHBG) received official confirmation that restrictions had been placed on the publicly funded Community Health Homebirth Service (CHHBS). CHHBS is the only maternity service that offers homebirth in Darwin, where midwives are unable to practise privately due to legislation specific to the Northern Territory (NT). We were first alerted to the new restrictions when hospital staff advised a CHHBS client at her routine obstetric appointment that her option to homebirth after caesarean (HBAC) was no longer available. CEA and DHBG immediately contacted CHHBS and the Department of Health for clarification. This news signalled the beginning of a concerted campaign to reverse restrictions.

While the initial decision meant the immediate withdrawal of support for HBAC, a further extension of the ban prohibited women who had experienced a previous caesarean from accessing the only model of continuous care from a known midwife (one woman, one midwife) available in the Northern Territory. This meant that a woman who had previously given birth by caesarean could no longer have her antenatal care, birth care or postnatal care provided by CHHBS regardless of intended place of birth, an unprecedented move in Australia. CHHBS had been caring for Vaginal Birth after Caesarean (VBAC) and HBAC women since the inception of the service in 2005; indeed it specifically addressed this service provision given the lack of access to privately practising midwives (PPMs) in NT.

CEA and DHBG were initially advised that this blanket decision was made by the Department of Health based on legal advice and both organisations questioned the completeness of information and evidence used, arguing that a blanket application of restriction denies every woman's right to have an individual discussion around her risks and particular needs.

Another key point made by both groups was the exemplary care provided by the CHHBS for seven years, including for women intending to VBAC. In that time there have been no adverse outcomes relating to VBAC, due to the professional and collaborative care provided as required through ACM guidelines. The decision was made despite a wealth of recent evidence from credible studies that one-to-one care from a known midwife is both cost effective and results in better health outcomes for mothers and babies.

Both organisations were very concerned that women who have previously experienced birth trauma, and those vulnerable to postnatal depression, were being denied the support available to help ensure a positive psychological outcome during subsequent births. This decision means that women who have previously had a caesarean are now restricted to only being able to access the fragmented care at Royal Darwin Hospital (RDH), as they are also unable to access the Birth Centre.

Representatives of CEA and the DHBG initially wrote to the Chief Minister, the Health Minister and relevant Health Department staff. The NT News, ABC News and radio picked up a media release and there was a great turn out to the first public gathering on Father's Day, held at Sunset Park, Nightcliff. A further rally was then held on the steps of Parliament House with about 70 women in attendance. ABC radio and television, commercial television news and The NT News again picked up the story. The event had an amazing turnout and show of support by women for women and their families. Leader of the Opposition, the Hon Delia Lawrie MLA spoke very strongly in support of reversing the decision.

Forty affected community members also wrote to the Minister expressing their concern and explaining the importance of one-to-one care for their birth journeys; some shared deeply personal and painful experiences to highlight this. Women who were directly affected by these restrictions visited every government MLA in Darwin, raising the issue and explaining why choice matters.

CEA and DHBG subsequently met with the Health Minister and the CEO of the Health Department, resulting (we believed at the time) in a Ministerial Directive in regards to the final affected client of the CHHBS, stating she be allowed to remain under their care and to birth at the Darwin Birth Centre if she so chose.

Unfortunately, it seemed the decision was in fact placed back in the hands of the Obstetrics Department at Royal Darwin Hospital (RDH). They directed that the birth must take place at RDH in the general maternity ward, a setting without water for labour. Access to the Birth Centre (on site at RDH and close to theatre as required by RANZCOG guidelines) was denied. We believe this was an arbitrary decision made for a woman who was previously assessed as safe to birth at home and who had also already had a natural birth since her caesarean. It was made



Spiral labyrinth preceding the adjournment of parliament

despite her being assessed as suitable for HBAC by an obstetric GP, based on follow-through care in accordance with ACM guidelines.

The Minister also invited a submission from CEA and DHBG on Birth Choices solutions, answering our call for consumer consultation on this important matter. The submission was prepared following consultation with CHHBS team members, DHBG committee members, the support of key national Maternity Coalition members, national and international evidence around best practice and documents outlining national direction in the provision of maternity services.

KEY SUBMISSION POINTS TO THE NT HEALTH MINISTER

- Legislation to enable privately practising midwives (which creates a safe model in which women can access care to attempt vaginal birth after caesarean at home);
- Legislation to enable privately practising midwives, in tandem with respect for and protection of the Homebirth Service as it currently exists;
- Interim options for women who desire to VBAC through the continuity-of-care model;
- Future increased access to the current and any future birth centres for all women;
- Access to water during labour for all women birthing at Royal Darwin Hospital; and
- Consumer representation at all future decision-making forums in regards to maternity services provision.

Our submission (see text box) was ambitious, but we hoped that the Health Minister's office would be committed to helping parties come together for a respectful resolution. We spent nearly three hours discussing our proposals with the Minister's senior representative, who promised to work through both the needs of individual clients (with haste) and our submission. The vibe seemed good. However, the goodwill appears to have been short lived. The cynics amongst us would say that the meeting was a ploy designed to maintain a level of non-public action whilst a potential leadership spill was imminent. The message we received at the end of our meeting was that the Health Minister was definitely interested in privately practising midwifery legislation enactment in the NT; however the silence became deafening.

There was no further contact for two weeks: phone calls went unreturned, emails unanswered. Birth was becoming imminent for an affected client of CHHBS with no resolution of Birth Centre access. Both organisations wrote a strongly worded email demanding a response and a timeframe for answers. The reply was, "The Northern Territory Government takes very seriously the health of women and will do whatever it takes to save lives." *Thanks very much and go home* was our interpretation. Community anger was further compounded by the Health Minister's response to the forty or so personally written letters she received. Each letter told an individual women's story, explaining the value of one-to-one midwifery care in her individual circumstances and asked a specific question in regards to the current issue. The reply letters were blunt, generic and many signed by bureaucrats. It was unclear whether the Minister had even read these very intimate and heartfelt letters that women and men had taken much time and emotion to write.

During the campaign thus far, we had been very strongly supported by our local opposition MLA Natasha Fyles. Our next step was the presentation of an adjournment in Parliament by Natasha in conjunction with a peaceful vigil to express our determination. The adjournment presentation meant that the Health Minister was required to specifically answer concerns raised. The presentation of the adjournment was also supported by Government MLA Keziah Purich, who had also spent considerable time exploring the issue with us.

The vigil was amazingly beautiful on a cloudy night with a storm threatening. The turnout was small but passionate. A glorious spiral labyrinth was built from leaves, stones, flowers and candles in the forecourt at Parliament House steps. The vigil coincided with a break in sittings, so many politicians came to talk and observe. The skies opened just as we entered Parliament house to hear Natasha Fyles' adjournment speech. The speech articulated the issues in the very best manner; it was well evidenced and focused on the right to choose for all women. The women of the NT thank Natasha for her support and presentation of Birth Choices rights. In her response, Health Minister Hon Robyn Lambley acknowledged the complexity of issues, and made an apology for her response to the personal letters. She went on to commit the NT to implement privately practising midwifery legislation. It was a late night for the mothers of small babies in the public gallery but worth it, as we are now on our way to having access to PPMs and a choice like all other women in Australia.

The following day was a whirl of more media via radio; we embraced the decision to enable PPMs but voiced our ongoing concerns at the service gap for VBAC women to access one-to-

one care. The campaign has highlighted a complexity of access issues for women in the Top End region wherever they choose to give birth including: a birth centre with a 'ballot' system and a statistical average of two births per week; many restrictions of access to both the Birth Centre and Homebirth Service for VBAC women; a lack of clear pathways for women needing one-to-one care for a variety of reasons; and lack of access to water during labour for women birthing in RDH. CHHBS is clearly at risk of losing its community-based one woman, one midwife midwifery-led model. There are strong concerns for the rights of women to make informed choices about care, decline care on an evidence- and a risk-based approach, and retain access to programs.

So, with these thoughts in mind and a desire to ascertain the progress of privately practising midwife legislation and other submission requests, CEA and DHBG requested a further meeting with the Chief Executive of the Health Department and the Chief Operation Officer of the new Local Area Network. Results from this discussion held on 25 October were mixed. There is a genuine and unimpeded move towards the establishment of the PPM with both legislative and hospital credentialing currently being explored. Legislation may be enacted as early as April 2014. The entire campaign has sparked recognition that there needs to be increased collaboration and access for women between governmental service providers. The actual clinicians are now sitting down together to work through solutions and interact for the first time in a very long while. The forty plus letters written by women have clearly had an impact on the Chief Executive of the Department of Health, who now acknowledges the fact that women are having detrimental experiences in our system. Consumers will be returned to the process, with early December or 2014 given as the date for the next opportunity to participate.

To date it feels as if there is low value placed on one-to-one midwifery care, wherever women may choose to give birth. There are threats to the CHHBS model, statements around the provision of a 'blue ribbon service' and the notion that a good midwife can establish a solid relationship with a woman even if she meets her for the first time in labour, 'because that's what midwives do'.



Advocates of choice observe parliamentary proceedings

In addition to this, without access to PPMs, VBAC women still fall into a choice vacuum, unable to access one-to-one care through CHHBS and currently only able to access fragmented care at RDH. The Department of Health stands steadfast in its circular argument that the women are accessing a service called 'Homebirth Service' and might have an 'unreasonable' expectation that they will be able to birth at home. No amount of discussion around the fact that historically many women have accessed the service with the primary desire for one-to-one care rather than for homebirth itself has had an impact on this mindset. Nor has there been any genuine consideration of access to the Birth Centre for the final woman assessed as suitable to attempt HBAC in the care of the CHHBS (prior to the new restrictions). The inability to help these individual women hurts the most. We wish them the strength to own their births as much as possible, despite the circumstances.

So we end this story for now with the work really just starting. Now comes the long haul of staying in the room, participating and collaborating with services providers to help them hear the voices and needs of women for real birth choices and strong, harmonious births.



Rally to demand the reversal of the decision

LIFE, ART AND SCIENCE AT THE ACM CONFERENCE

By Genevieve Sayers



It was with a mixture of nervous anticipation and excitement that I welcomed the beginning of the Australian College of Midwives (ACM) conference in my home state of Tasmania. My excitement stemmed from the fact that as a birth 'nut' I would be attending my second conference in just over 12 months. I was also really looking forward to catching up with Bec Telfer, our Membership Officer, and meeting Jyai Allen, our Birth Matters Editor, for the first time while 'womaning' the MC stand.

I was nervous because I had been designated to give a keynote address to an entire room of delegates (about 400 midwives) following Kathryn Gutteridge from the UK, a very difficult act to follow. A glance at the size of main plenary hall on the first afternoon of the conference was enough to give me butterflies, particularly as I had yet to complete my presentation!

Keynote presentations

My presentation, *Midwifery care, affecting women's lives – a consumer perspective* was the only one presented by a consumer. Despite a wobbly start, I relaxed into it and managed to finish within time. Many midwives commented that listening to someone's story was a refreshing change from the many presentations of research. Additionally, midwives said that it was good to be reminded about the simple things that can have a significant impact on a woman's experience.

There were a lot of great keynote speakers and I enjoyed them all. Christine Nixon talked about *Leading, achieving and flourishing*, which I think was particularly apt to the midwifery profession at this current time. I already mentioned Kathryn Gutteridge; her story of transforming a maternity service from being on the verge of shut down to one of the best in the country, in a relatively short space of time, was inspiring. It's amazing what can be achieved with a determined, focused and motivated leader. Kathryn spoke about how much they sought

and valued consumer involvement in designing and improving their service, not just from women, but also from other family members. This is a key lesson for many health services in Australia. One of Kathryn's comments that really stuck with me was around risk assessment. The UK uses positive risk assessment, in contrast to Australia where it tends to be negative. In my own experience this negativity really bothered me: why emphasize that a woman's risk of scar rupture in a Vaginal Birth After Caesarean (VBAC) is 0.5% when she has a 99.5% chance of no scar rupture!

Marianne Wobcke, an Aboriginal Wakka Wakka woman, midwife and registered nurse from Queensland, exhibited a large art installation titled *Perinatal Dreaming* and presented in the keynote session on the last day. I was glad that Bec and I viewed her installation the evening before as we were able to better understand her talk and relate it back to the artwork we had seen. Marianne has been on a very interesting journey as an adopted child into a white family. It wasn't until she began midwifery training that her life dramatically changed and she began having experiences that related to what had occurred to her as a foetus, during her birth and as a newborn baby. Her artwork documents her journey to healing and understanding.

Concurrent sessions

There were so many great sessions on offer that it was difficult to make a choice between them! I ended up in *Understanding our personal agendas that we bring to our work as midwives – an inner exploration* with Jane Hardwicke Collings and Elizabeth Maloney. While some might shy away from this as being 'too out there', I found it to be a very insightful workshop that helped me to understand why I work as a doula and how my agenda might affect the way I care for clients. I would highly recommend this type of exploration to others who provide care to childbearing women.

The session on *Acupressure for the perinatal period* was very practical and I learnt some new skills for my doula practice. I found the entire session on *Giving birth at home*, with four different presenters, to be very interesting. I caught some of the speakers covering caseload midwifery, who presented findings from two significant Australian trials: COSMOS and M@NGO. I also listened to Jane McCrae speaking about birth photography and then zipped over to another room to catch Jyai speak about her vaginal breech birth. Even though I had read her story before in *Birth Matters*, it was great to see it from another perspective on film, with Jyai explaining various aspects while the footage played.

I sat in on the ACM's members' forum (I felt this was a very valuable exercise in giving ordinary members a chance to view their concerns to the National Executive) and Annual General Meeting (AGM). *The Lactits* also gave a performance before the AGM and had everyone in stitches with their singing repertoire, adjusting the words of several hit songs to be about breastfeeding. I only wish I'd caught their full performance earlier on in the conference. Bec really liked the art installation

The Tea Room, where a Tassie midwife had set up an actual tea room space in the Creative Arts Area, which she found an authentic representation of the hospital tea rooms where she had worked.

MC stand

Thanks to ACM for working with MC to enable us to have a stand; it was well worth our while. We were able to have numerous conversations with midwives about how they can engage and work with consumers in their areas to improve their health services and we were able to enrol more than 20 new

members on the spot via the new online system on Bec's laptop! We ran a raffle, which raised a couple of hundred dollars, and I would like to thank the following businesses that generously donated prizes:

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ACM QUEENSLAND STATE CONFERENCE

By Jyai Allen

I was lucky enough to receive a consumer registration to attend this year's Australian College of Midwives (ACM) Queensland state conference in Toowoomba. The day started with an opening address by Professor Jenny Gamble, who listed the challenges for midwifery in Australia: a large private obstetric sector; three levels of government; and nursing subsuming midwifery. At the same time, she reminded us to focus on the gains: the national regulation of health professionals; the national maternity services plan (which drives reforms); Medicare-access for midwives and rebates for families; students being mentored by private midwives in continuity of carer models; and the profile of 'midwife' being raised in the community. She encouraged us, midwives and consumers, to build a critical mass until a tipping point is reached in the supply/demand for private midwifery care.

Birth unit design

Jennifer Fenwick spoke about designing birth settings in a way that facilitates normal birth. The research hypothesis is that a stressful birth environment leads to stress for staff and birthing families, which contributes to a rise in the woman's adrenaline levels during labour, which decreases contractions and increases foetal distress (a common hospital birth scenario). In her study, births in different environments were videoed and analysed and interviews were conducted with staff, the birthing woman and her support people. Jennifer talked about the importance of 'domestic' and 'natural' birthing spaces that give women permission to claim and use the space (unpack their bags, add their special items, use every corner and nook of the room), particularly as women prefer to birth in between and behind furniture. Her recommendations were to: manage the bed (i.e. remove it as a focus); use the space differently (e.g. midwives sit and lie on the floor); use equipment to support women to be active; provide access to water within the room; make sure support people are catered and cared for (e.g. places to sit, take breaks, make food); provide access from the birth room directly to the outdoors; guarantee privacy; and use colours and textures. Jennifer encouraged women to visit the birth room during pregnancy, so that they can start to build a sense of themselves birthing in the space, and feel more attached/able to claim the space during labour.

My Midwives

Next Hazel Brittain of My Midwives Ipswich (MMI) unpacked the practical details of how they support, promote and continue to work in collaboration in an all-risk model of care. MMI is currently made up of two Medicare-eligible midwives (MEMs) along with one new graduate who, given the requirement for three years' experience, is not a MEM and so works in a voluntary capacity! If the pregnant woman is low-risk she does not see the obstetrician. The midwives then follow ACM guidelines for consultation and referral. There is fortnightly case-conferencing with the obstetrician, along with ad-hoc updates via email/telephone. The midwives maintain a duplicate hospital chart for both planned hospital (71%) and homebirth clients (29%). The current statistics are fantastic for an all-risk model when compared to state/national data.

Changing workplace culture in birth suite

The stand-out talk of the day was delivered by obstetrician Dr Anne Sneddon (Gold Coast Hospital). In 2010 a review of maternity services at the hospital made 19 recommendations. In response, the hospital undertook to make significant changes, including to the 'workplace culture'.

1. There is now a shared understanding that 'it's all about the woman'. This understanding drives the communication between midwives and obstetricians, and between clinicians and women. According to Anne, if women consider that freebirth is their best option, then we've failed!
2. Clinical guidelines are woman-centred, and the language used to describe risk has changed from 'black-and-white' conversations to 'grey conversations' that consider the woman's individual circumstances and risks. Conversations *do not force immediate choice* (e.g. vaginal breech birth), instead offering multiple opportunities to discuss and reflect on options.
3. Multiple changes to manage junior doctors' fear. This fear is transmitted to women, and birth becomes fearful for all involved.
4. Embedding reflective practice for medical staff through a weekly audit/discussion of *all births*. These sessions are about reflecting on what happened, with a view to avoiding

unnecessary interventions for future births.

5. The junior doctors are offered more support by their senior colleagues, who just 'hang around at the desk' but are available if needed; this decreases fear for the doctors.
6. There is now consumer engagement at all levels.

Since making these changes to the workplace culture (and little else) the caesarean section rate has gone from 28% to 18%, the instrumental birth rate from 12% to 8%, and the episiotomy rate from 10% to 7%. The caesarean section rate is now the lowest in the country!

Care for Aboriginal and Torres Strait Islander women

Linda Evans, a midwife from Toowoomba, described her midwifery service for Aboriginal and Torres Strait Islander (ATSI) women called Boomagam. The service is supported by the essential role of the Aboriginal health worker who is connected to the community. Linda sees about 100 women per year in their homes for antenatal care and postnatal care up until six weeks after birth. The women birth at Toowoomba Base Hospital with a midwife not familiar to them. The service has received 'close the gap' funding until 2014, but the hospital has not agreed to support the service to continue *despite fabulous outcomes*. The service is measured against close the gap key performance indicators, including that women have:

- more than five antenatal visits (2009 32%, 2012 100%)
- babies more than 2500g (2009 90%, 2012 100%)
- a decrease in smoking during pregnancy (2009 62%, 2012 28%).

Another presentation on an ATSI maternity service was delivered by Sue Kildea (Mater Hospital, Brisbane) and Machellee Kosiak (Caboolture Hospital). They focussed on the findings of their mixed-methods study, which included surveys, interviews and chart audits to evaluate the 'Murri' clinic, an antenatal-only service for ATSI women or women with ATSI partners.

RECOMMENDATIONS FROM THE MURRI CLINIC EVALUATION

- Have a specific MGP for ATSI women
- Improve administrative support
- Improve social support for the women
- Use an Indigenous work-force
- Engage with the community
- Keep the service within Indigenous control



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DUTY OF CARE

In the time that I have been involved in Maternity Coalition, I have often heard the concept of 'duty of care' misused or misunderstood by midwives or supporters of midwifery. For example: *"I had a duty of care to the woman to support her breech birth at home"*; or *"Australia needs duty of care legislation to make sure that midwives can support women with risk factors to birth at home."* In this column I hope to clarify what a duty of care actually is, what it is not, and to shed some light on what duty of care really means for women who choose to birth at home.

What duty of care is

Duty of care is a key principle underpinning the law of negligence. Midwives owe a duty of care to women in their care to exercise reasonable care and skill in the provision of professional advice, diagnosis and treatment. The duty arises both by virtue of the relationship between the midwife and the woman and from the contract between the midwife and the woman or the hospital and the woman (whether it is expressed in a document or implied by the circumstances).

A midwife won't be negligent if they can show that they acted in a manner that is widely accepted by a significant number of 'respected practitioners in the field' as competent professional practice in the circumstances. This is referred to as a 'peer professional opinion'. Peer professional opinion is determined by expert evidence from members of the profession, and professional codes and guidelines are also important. In practice, the expert witnesses would be other midwives, particularly those in senior academic positions or senior positions within hospitals.

Midwives also have a duty to warn of the material risks inherent in a procedure or course of action (often referred to as obtaining 'informed consent').

What duty of care is not

People often confuse the term 'duty of care' with a duty to care. Duty of care does *not* mean that a midwife is legally obligated to agree to attend a homebirth or to care for a woman in whatever way the woman wants. Midwives must act in a manner that can be justified at a later date as consistent with good practice and professional standards, as determined by peer professional opinion.

How does duty of care work with consent?

While midwives have a duty of care, a woman has a right to decline consent to any proposed care or treatment. A woman can decline treatment even if this would have serious or potentially fatal consequences for her or the foetus. Midwives cannot provide care that has not been consented to, but they still have a duty of care to provide the care that is given with reasonable care and skill (or to do their best in the circumstances). If a woman has refused care, the midwife's duty of care to provide information will continue and the midwife should be careful to explain the risks, benefits and options as fully as possible and to make good contemporaneous notes of both the content of the discussion and the woman's decision.

Homebirth

Homebirth midwives have a duty of care to their clients. If the care they offer or recommend falls below the standard of care expected of midwives generally and there is a poor outcome as a result, then they run the risk of being liable in negligence. Additionally midwives have a duty to warn of the relevant risks for a woman in her circumstances birthing at home and may be liable if this information is insufficient or incorrect. Midwives who actively recommend homebirth to women with risk factors, or who do not act in accordance with professional guidelines (such as the Consultation and Referral Guidelines), may find their practice very difficult to defend in the event of a claim.

Does this mean that women with risk factors cannot choose homebirth with a midwife or that women must accept every test or procedure that is widely accepted as part of appropriate professional practice? No. Competent women can always decline a recommended care pathway, test or intervention. However, the midwife must at the outset be offering or recommending care that can be justified by reference to professional midwifery standards and must be providing complete risk information.

The Australian College of Midwives Consultation and Referral Guidelines give some guidance on caring for women who decline recommended care. A midwife who sincerely followed these guidelines would be well placed to demonstrate they had acted in accordance with professional standards. Similarly, these guidelines provide that a midwife should not withdraw care from a woman during labour or emergency situations.



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This provision does not negate the duty for midwives to make recommendations for safe care. A midwife would not be protected if they had not first met their duty of care by exercising reasonable care and skill in providing advice and treatment. In a non-emergency situation, the guidelines provide that a midwife can choose to continue care or to discontinue care by following certain steps. If a midwife continued to provide care she could be held to be negligent if she is acting outside of her skills and expertise (e.g. supporting a breech birth with insufficient experience).

It is sometimes suggested that peer professional opinion for homebirth midwives should come from other homebirth midwives. It is possible that a Court may agree with this, but it would be safest to assume that the opinion could come from across the profession.

What about duty of care legislation?

It is regularly suggested in Australia that we need to have 'duty of care legislation' to support women's choices and protect midwives attending homebirths. The United Kingdom is invariably cited as an example of such legislation. In fact, there is actually no 'duty of care' legislation in the UK. Instead, a circular issued by the Nursing and Midwifery Council (which also confuses the terminology) stated that if there is a conflict between a woman's choice and the perceived risks of caring for her at home, the midwife must continue care but can seek support from her supervisor of midwives.

I don't believe that many Australian midwives would want to be obligated to care for women at home regardless of risk. What midwives seem to want is a protection to support women to birth at home without regulatory consequences for the risk factors that they are *personally comfortable with* and have the skills and experience to deal with. For some this extends to Vaginal

Birth After Caesarean (VBAC); for others it extends to breech and/or twins.

If a midwife is not comfortable caring for somebody with particular risk factors or does not have sufficient experience caring for women with those risk factors, then she should help the woman to find care elsewhere. The midwife is not obliged to continue to care for that woman. In fact, she may breach her duty of care by continuing to provide care that is outside her scope of practice. Regardless of a midwife's beliefs and intuitions about a woman's ability to birth naturally, the fact is that many midwives do not have the requisite skills and experience to support women in breech, VBAC and twin births at home.

So what will protect midwives and women's choices?

There is no easy way out of meeting a midwife's legal and professional obligations. Midwives will be protected against liability for negligence by providing care to the standard expected of a midwife. They will be protected by respecting women's decisions to refuse consent. They will be protected by providing unbiased information around women's care options, including place of birth, following professional guidance in supporting women's decision-making (such as Appendix B to the Australian College of Midwives Consultation and Referral Guidelines) and thoroughly documenting the discussions had and the decisions made.

Many midwives feel that they are in a vulnerable legal position. This is often because they are not doing these things. If we could confidently demonstrate that homebirth midwives as a group were practising in this manner then it would be easier to secure insurance for intrapartum homebirth care and resist the push to regulate homebirth more strictly.

MEET OUR NEW EDITOR

ARTEMIS HORTON

Artemis Horton was born and raised in Canada, and currently lives in Newcastle, NSW, with her husband and two fascinating young children. Childhood aspiration was to become an astronaut, but Artemis had to forego such an ambition due to an innate fear of heights and math. She completed a degree in music and was to pursue a career playing the trumpet, but has temporarily had to forego this as well due to her children's innate fear of horns.

Currently, Artemis holds the prestigious title of 'mum' to Alexander (3.5 years) and Madeleine (6 months). As a result of two wonderful birth experiences, through a rare and fantastic birthing service, Artemis has developed a passion for advocating birth choices as well as the services which allow women and their families this freedom.



Artemis with Alexander and Madeleine

JADE FARREN, ADVERTISING CO-ORDINATOR



Jade Farren and her daughter

Jade lives in Victoria, she is mother to one daughter and volunteers as Advertising Co-ordinator for Birth Matters. In this interview she answers 20 random questions about Maternity Coalition, family, birth and life in general.

What's your favourite thing about volunteering for Maternity Coalition?

I love knowing that, in my own way, I can contribute on some level to the improvement of maternity care services in our country. It was important to me to be able to give back to and support the organisation that helped me have the positive birth experience that I did.

What's a day like for you as Advertising Co-ordinator?

Like most other days really, only I spend some time sending and replying to emails. Always one to leave things until the last minute, before deadlines I am usually spending the best part of the day tying up loose ends to make the next publications. Every issue of *Birth Matters* I promise myself I will leave myself more time next time to get the job done! Luckily I work as part of a great team of other volunteering mothers who do an amazing job of juggling their time to get the job done.

When have you been most satisfied in your life?

I feel very fortunate and satisfied with my life at the present. Having my daughter in 2011 has definitely given my life a new sense of meaning and purpose. Creating new life has been a very rewarding and satisfying experience.

What are you passionate about?

I am passionate about sharing positive birth experiences and encouraging others to have the birth they feel is right for them. (www.blessedbirthforhumanity.com is my other little project) I also have a fascination with placentophagia and recently became a placenta encapsulator, which has allowed me to share a part of other women's birth journeys, which I love.

I have loved yoga since discovering it shortly after finishing

high school. I love how a regular practice keeps me feeling healthy and balanced on all levels. I was fortunate enough to complete my teacher training in India in 2010 and I now enjoy guiding others with their practice at a local yoga studio.

How many pets do you have?

We have one cat who we found hanging around our house with all of her kittens when we moved in. We ended up adopting her back from the RSPCA. We also have two ISA brown and three barnacled ear chooks who have free range of the back yard. We also have two Rex guinea pigs, Pip and Squeak.

What did you do last weekend?

I spent three days away in Hobart with my daughter on a mini holiday. We spent the weekend visiting Mona art museum and going on a boat tour of Bruny Island, dolphin and whale watching in the Southern Ocean! (Our weekends are not usually as exciting as that!)

Who is your role model and why?

I think I look to others from all walks of life as a role model in a sense. Everyone has something to teach you in life.

What things do you not like to do?

I don't like putting clean washing away and I hate stacking dishwashers (would much prefer to wash them by hand!)

What book are you reading at the moment?

I have been reading the same book now for *far* too long (and not because it isn't interesting by any means) called *Sex at dawn*, which sounds like a trashy erotic fiction but is actually a book which takes anthropology, archaeology, primatologist, anatomy and psychosexuality evidence to look at human sexuality, monogamy and our innate capacities to love. Interesting stuff, that's for sure!

What's your motto / mantra?

I really like the proverb "this too shall pass". It indicates that all material conditions, both positive and negative, are temporary. The Sufi phrase is attached to a fable of a great king who is humbled by these simple words, which have the ability to make the happy (wo)man sad and the sad (wo)man happy. I remember having this written down as some of my pre-birth affirmations to remind myself that no matter how intense even labour could become, it will pass, and to remind myself to be in the present moment and work through each stage for what it is. (And it really helped!)

What song is stuck in your head?

A Beatles song *We can work it out*. I think it was playing in a shop we were looking in earlier today and it has been stuck in my head all afternoon!

Where is the farthest you have been from home?

I spent the best part of my 20s travelling. I have worked on private yachts in The Mediterranean and have been trekking

up mountains and white water rafting in Nepal, paragliding in Turkey and camel riding in Morocco across the Sahara. All of these places felt as far from home as the next as I didn't have a Facebook account at the time and it often felt like I was on the other side of the universe!

What is the kindest thing anyone has done for you?

Someone literally once gave me the jacket off their back at a festival when they overheard me saying I was getting cold as they walked past. They did this without a second thought and disappeared without giving me the opportunity to say thank you as they darted off into the crowd before I had really registered what they had just done!

Where do you want to retire and why?

I would like to retire somewhere lush and green where the weather is warm... in saying that, this little trip to Hobart has left me feeling like I could live in Tasmania one day too! Such a beautiful place...

Do you collect anything?

I have a wooden dish full of coins from all of the countries I have been to. There are a few paper notes in there too. I also recently collected all of the mini Puffin children's book classics which came with the Herald Sun!

List five goals on your life's to-do list

1. To travel through South America
2. To take my daughter to India to meet her relatives
3. To learn Spanish
4. To host a refugee in my home
5. To build my own home (from scratch)

What is one of your favourite quotes?

"Life is what you make it".

What sound do you love?

I love the sound of rosellas in our garden. I also love the sound my coffee espresso makes on the stovetop when the coffee is brewed!

The best part of waking up is?

Having my daughter give me a 'nose kiss' (Eskimo kiss).

If you could give one piece of advice to birthing women, what would it be?

Knowledge is power! Understanding the birth process will help to de-mystify the experience and hopefully allow you to work through any fears or uncertainties. Knowing it is ok to say what feels right for you is so important too. It is your birth and this experience is something you will never forget, so it is important to listen to your heart and endeavour to have the birth you imagine.

WANTED ADVERTISING COORDINATOR

Would you be interested in volunteering with Maternity Coalition?

Jade is unable to continue in the role of Advertising Coordinator next year, so we are looking for someone who can work with the *Birth Matters* team.

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BIRTH IN FRANCE



Birth is universal, however the manner in which you experience birth, from both the mother's and baby's perspectives, depends upon a number of factors including which country you are in. In this article we are going to look at the experience of birth in France.

Birth in France, is considered relatively safe with an infant mortality rate of 3.3 in every 1000 birthsⁱ and a maternal mortality rate of 8 per 100 000 live births.ⁱⁱ

France has a comprehensive health care system, funded through social charges paid by income tax payers and employers as a type of payroll tax. This means that health care, including childbirth, is accessible and affordable for everyone. Like many things in France, having a baby is entwined with bureaucracy. There are a plethora of forms to fill in and agencies to register with to ensure that you are in the 'system' and can claim all your rights and benefits, including medical refunds, child/family benefits and parental leave.

Once pregnant, a woman must attend seven compulsory and thorough antenatal examinations with a gynaecologist or midwife (Sage Femme). Each examination is recorded meticulously in the Maternity Record Book. If a woman refuses to follow the prescribed course of tests and examinations, she risks losing access to benefits and refunds. At least three ultrasounds will be performed during the pregnancy and some gynaecologists offer a sonogram at each antenatal visit.

The vast majority of births occur in a maternity hospital and will mostly be attended by hospital midwives. Epidurals are readily available and actively encouraged.

There are strict time protocols that are adhered to, inductions occur regularly and electronic fetal heart monitoring is routine. The obstetrician/gynaecologist will arrive to perform all the postnatal tests and examinations. The caesarean rate has increased dramatically from a rate of 6.2% in 1972ⁱⁱⁱ to 20% in 2009^{iv} and is much higher in private clinics. It is still far less than in either Australia or the US. It has been cited that 'doctor convenience' rather than financial incentive, is the main reason for the climbing caesarean rates in France.^v

There are very few birthing clinics and homebirth is exceedingly rare. There are less than 50 independent midwives^{vi} for a country with a population of almost 66 million. Since October of this year, homebirth has been effectively outlawed, as it is only legal if a Sage Femme with legal liability insurance attends.^{vii} The cost of this insurance prohibits

“ For the past 50 years, French women have been mostly content with this clinical, authoritative, type of birth experience, however the winds of change might just be blowing here too with more women seeking autonomy and choices for the birth process. ”

most low paid midwives from accessing it.

Although France has produced several luminaries of the gentle, natural birth movement, such as Dr Frederic Leboyer, Dr Lamaze and Dr Michel Odent, they are the aberration rather than the rule. The majority of women I interviewed or read their birth stories, report that birth takes place in a sterile, clinical environment, bright lights, jarring noises, hustle and bustle and officious rather than gentle staff. The majority of hospital midwives start their training as medical students and end up in midwifery when they do not make the grade to be doctors or dentists. This may go some way to explaining the very medicalised rather than personalised approach of the maternity system.

Christel, unusually, had her first baby at home with an independent midwife. Two years later, she was forced to birth in hospital due to her midwives closing their practice. She describes the fear that she experienced being in a clinical setting, with the sounds, smells and people and her labour did not progress even though her waters had broken. She was told that she would be induced and not allowed to follow her natural

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birth plan if something did not happen quickly. Fortunately for her, there was a shift change and the new midwife offered the support and reassurance that Christel needed and her baby was born, intervention free, three hours later. This midwife also allowed her to take the placenta home with her and leave the hospital after only a few hours even though hospital policy dictates a two to three day stay and disposal of the placenta. Christel states that the 'system', controls the birth process and the labouring woman is given little autonomy due to the rigorous adherence to compulsory medical protocols. They will not hesitate to take over and make all the decisions in regards to interventions, regardless of the couple's express wishes. It appears to be luck of the draw depending on which personnel are on shift as to the experience you may receive. There is a pervading attitude that hospital knows best!

My first two babies were born at home in England and Australia respectively and my third in France. Sebastyn's homebirth was my most challenging, as I felt unsupported by the system and everyone around me expressed fear. My French midwife was very caring, however her methods, essentially forced upon her by the system, were far more clinical and invasive. She performed internal examinations and insisted that I have Syntocinon on the premises in case of third stage complications. She also broke my waters, the only intervention I experienced in three births. The missing element for me was trust, the French system does not trust birth and as a result I did not trust it either.

The one area that France appears to lead the world is in postnatal care. After every birth, a woman is prescribed at least 6 sessions with a physiotherapist to re-educate her perineum to avoid problems with urinary incontinence. I was advised by my midwife, an array of herbal remedies and exercises/practices to assist with healing of the vaginal opening, bringing my stomach muscles back into place and restoring my perineum to full function.

I have noticed that the French people, on the whole, look to government or professionals to be the authority and accept the system without question. Government provides education, healthcare, childcare and many other bureaucratic functions. Birth comes under this umbrella; therefore they accept blindly that doctors know best and that hospitals are the safest place to birth. Although not pleasurable, the birth experience is relatively safe, cheap and doesn't require them to think or make choices.

For the past 50 years, French women have been mostly content with this clinical, authoritative, type of birth experience, however the winds of change might just be blowing here too with more women seeking autonomy and choices for the birth process. They are beginning to ask, "Is there a more gentle, less invasive, and more empowered way to birth our babies?"

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up to date?**


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See page 32**

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Lynne Thorsen is an intuitive healer, workshop facilitator and freelance writer on self-empowerment, self-healing and natural birth. Lynne has had three homebirths in three different countries, England, Australia and France, including a breech birth for her first baby. Her philosophy is based on the belief that we are all in a state of constant creation and it is never too late to create empowered change. Her focus is to provide her readers/clients/participants with the knowledge and tools to create the birth and life that they really want! www.lynnethorsen.com



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THE NATURAL PROGRESSION OF AN EMPOWERING BIRTH EXPERIENCE



Tish, Brock and baby Chloe

I still remember the first phone call I received from midwife Donna Milburn when I was about 30 weeks pregnant. She wanted to know if I'd like to be a part of the new midwifery model of care (MGP) in the Emerald Hospital. At first I was hesitant: What if I didn't like this midwife? What if she one of those hard-nosed old-fashioned type midwives? Would I be stuck with her for the remainder of my pregnancy and birth? I couldn't have been more wrong. From the moment I met Donna I felt immediately relieved.

From scared to excited

Donna encouraged my husband Brock and I to attend antenatal classes organised by the MGP, which proved to be one of the best things we could have done to prepare for our labour. Before I met Donna, I had no desire to 'prepare' for my labour. I was thinking it would be best to just wing it and go with the flow. Knowing what I now know, that was just my way of avoiding the fears I had surrounding birth: fear that my pain threshold wouldn't be high enough to handle it; fear of the unknown. Learning about birth and informing ourselves was the best way to overcome my fears and Donna was integral in that process. Every meeting I had with Donna was well over an hour long, I had plenty of time to talk things through and ask questions and I never once felt rushed or unimportant. Within a few short months, I had gone from being scared of birth to being excited and ready to embrace it!

Baby would come when it was ready

I distinctly remember my excitement when my labour finally started. It was about 10 am on a Wednesday morning and I was seven days past my 'due date'. I had an appointment with the obstetrician at our local hospital booked for later that day to discuss the possibility of requiring an induction. I had not slept properly the night before, going over and over the argument I was going to have with him to let me go over the standard ten days. I was adamant that this baby would come when it was ready and obviously it just wasn't ready yet!

My husband had slept in with me that morning and, in an

attempt to bring on labour, we went for a long walk, or should I say waddle, through a nearby park. On returning home, my husband went to work and I put on my pregnancy yoga DVD for a quick session, then started the housework. I was determined to do everything I could do to get my labour started naturally. I did not want that induction!

Distinct waves, a little excited

As I was hanging out the washing I started to feel some lower back pains. Not wanting to get ahead of myself I just continued doing the housework. When I noticed that the back pain was coming and going in distinct waves every 15 minutes or so, I allowed myself to get a little excited and I called my midwife Donna. As I expected, she said that I should remain at home, try to have a sleep and give her a call at noon to update her and decide whether or not I wanted to see the obstetrician as planned that afternoon. I was expecting this to be a long process being a 'first timer'.

The 'signs of labour' pamphlet

I called my husband to let him know what was happening and, despite me telling him there was no rush, he was home within ten minutes reviewing the 'signs of labour' pamphlet we'd been given at the antenatal class! As soon as he was home I had something to eat and lay down on the bed for a sleep. After tossing and turning for an hour I decided that sleep was not going to happen and that I was indeed in labour.

I got set up: my yoga mat was still on the floor in the lounge room, I got my gym ball out and put on my 'birthing music' playlist full of fun, happy, love songs. I was ready to have this baby and I didn't want my labour to peter out, so I kept active. I walked around and around the house trying all sorts of positions to ease the pain I was feeling. At noon, I called Donna again and told her to forget about the appointment with the obstetrician, I was certain I was in labour and was happy I didn't have to have that argument about induction with him after all. Donna advised us to continue what we were doing and that she would pop over to see how we were progressing at about 2 pm.

We were on our way!

Over the following two hours my contractions became stronger and more frequent. Brock was wonderful; he was diligently timing my contractions and trying to help me in any way he could. Just before 2 pm I felt I was ready for the hospital. My contractions were 3 to 4 minutes apart and I figured that if I didn't get in the car right then, I wouldn't be getting in the car at all. Brock called Donna to see if she was already on her way to our place. When she said she was still at the hospital, I just told her to stay there; we were on our way!

Donna met us as we entered the hospital and helped me make my way to the maternity ward between contractions. It was very reassuring to see a familiar face at the hospital. I immediately felt calm and reassured that Donna was there for me, that I was in good hands and that she knew all there was to know about me. She knew all about my pregnancy, she knew my birth plan, but most of all she knew me as a person – my personality, my



Midwife Donna demonstrating
Chloe's first bath at home

“ She knew all about my pregnancy, she knew my birth plan, but most of all she knew me as a person – my personality, my sense of humour and that my husband and I wanted to do this together. ”

sense of humour and that my husband and I wanted to do this together. It was very nice not to have to explain everything to hospital staff in amidst the chaos of contractions; I could just focus on the task at hand.

As soon as we were in the privacy of the birthing room, I immediately stripped off my clothes; I couldn't stand the way they felt and I just wanted to be naked. Having known Donna for so long throughout my pregnancy, I didn't feel the least bit embarrassed because she wasn't a stranger. I remember Donna asking what I would like to do and if I would possibly like to try the shower to start with. She got everything set up in the shower for us and then gave my husband Brock some guidance as to what he could do to help. Well within about two minutes

of being in the shower I decided it wasn't for me. The dual sensation of the warm water under the shower and the cool hospital air on the bits not under the shower was too much of a distraction.

We found our rhythm

Brock helped me out of the shower and Donna asked if I would like to try the bath instead. I figured I was already naked and wet so it was worth a go. Donna and Brock helped me into the big birthing bath in the next room, which Donna had already filled with warm water when she knew we were on our way to the hospital. As soon as I immersed my lower body in the warm water of the bath I felt immediate relief. I found a position that worked for me and Donna helped Brock get into a comfortable position on the outside of the bath so he could be where I needed him. I was kneeling in the bath leaning forward on the edge holding onto Brock, who was sitting on gym ball on the outside of the bath facing me. It was just what I needed. I would hold onto Brock and squeeze his hands whilst having a contraction and then I would let go and lean on the bath between contractions so Brock could pour warm water on my

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back until the next contraction rolled around; then we would hold hands again. We had found our rhythm and it worked. Brock quickly worked out what I wanted him to do and when to do it, he was there breathing with me through every contraction, helping me focus and providing constant encouragement; he was my rock. I had never felt more in tune with my husband than in those few hours of active labour. I could definitely feel the 'love hormone' (oxytocin) working! Throughout those three hours of active labour Donna was there but she was in the background. She allowed my husband and I to do what worked for us.

Crazy intense love

Chloe was born at 5:05 pm and I'll never forget the moment we held her up onto my chest. Every possible human emotion was running through my heart and soul: relief, amazement, exhilaration, pride, but most of all this crazy intense love that I'd never experienced before. I loved Chloe; I loved Brock more than I ever had before; I even loved Donna! Those were precious moments that we had all to ourselves: no phones, no cameras and no rush. I think I sat around half covered in blood for what seemed like forever because I didn't ever want to move from that moment. I wanted to stay there in that little cocoon of love forever and I felt that Donna would have let us if we'd asked!

The aftercare was nothing short of exceptional. Donna stayed well into the night to make sure I felt comfortable with breastfeeding Chloe and she didn't go home until almost midnight. We went home the next afternoon, with reassurance from Donna that she would be around to visit the next day and that we could call her at any time of the night if we needed. We

were hesitant to go home at first, but it was the best thing we did! There is nothing better than the comforts of home and a dedicated midwife on call if you need her.

Donna proceeded to come around very often in the first six weeks, which was a godsend as I'd had placental membranes retained, was having a few big bleeds and was having trouble with my milk supply as a result. It all finally resolved itself and I went on to breastfeed Chloe for 12 months. The bond that I had formed with Donna since those first few antenatal check-ups has lasted longer than both of us could have imagined. Donna has given me the greatest gift a midwife can give a woman: empowerment to believe in herself, her body and her birth!

Starting a branch of MC

After emerging from the fog of sleep deprivation, I went on to start up a branch of the Maternity Coalition (MC) in my area and to become a Consumer Representative. I want all women in my area (and in Australia for that matter) to have continuity of midwifery care available as an option for them. I want all women to have choices and feel nothing but empowered during their journey to motherhood and beyond. I still carry that empowering birth experience with me every day and I draw from it to remind myself that I am woman, I am a mother and I can do anything!

Author Bio

Tish is a Maternity Coalition Consumer Rep, Branch President of Central Highlands Branch, Qld, and MC National Branches Coordinator (in training)!

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Branch Information

If you wish to become active in MC and there is no branch near you, contact the President or a member of the national Management Committee, who will assist you in setting up your local branch. Branches and participating organisations may be formed in any state and territory of Australia, or in any location that is identified by a group of at least five (5) members.

There may be more than one branch formed in each state or territory.

A branch may be formed upon the authority of the Management Committee. A branch of the organisation is independent of other branches in its activities and fundraising. For details of financial arrangements including reimbursement of costs upon presentation of receipts, contact the Treasurer.

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General Enquiries

Australian College of Midwives
Conference Secretariat

ICMS Australasia

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