Informed consent and refusal
Your legal rights

This issue:
“Yes I CAN” - women making informed choices

PLUS:
Sarah Buckley on breech birth and the TBT

Our vision: Every woman can choose how, where and with whom she births
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Would you like to write for Birth Matters?

Members of Maternity Coalition and writers for Birth Matters come from diverse backgrounds, ranging from seasoned birth activists, to others who have only recently started thinking about maternity, perhaps with the birth of their first child. Some are midwives, some doctors, some have academic positions unrelated to health, some are in business, and others have no professional qualification but all have something important to say about maternity care in Australia.

All material submitted for publication is considered by the editing team in relation to its contribution to maternity reform. Birth stories are always welcome as first-person accounts of contemporary Australian birth experiences.

Submissions should be no more than 2500 words in length as a general rule and photos accompanying birth stories must be high resolution (300dpi or higher).

Birth Matters offers a personal voice that is not commonly heard in maternity, and other health-related discussions. If you believe you have something to say or an experience to share, please contact us by email, post or telephone.

The Birth Matters Editorial Team
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Main Cover Photo: Melissa McFarlane welcomes fourth child Amber, born breech, at home, in water, gently and without fear.
nothing more from the maternity system in the face of overwhelming opposition. Yet for themselves and their babies, even in this edition. They all have happy endings.

As inspiring as it is to read of women’s refusal to be bullied or coerced into submission, to seek out supportive care givers and to birth their babies in the manner and place of their choosing, it is unacceptable that so many still have to fight so hard to do it. I applaud the strength of women who insist that they can, and look forward to a time, in the very near future, when the births we want are not so hard won.

Note: As Mara finishes laying out this edition, glowing reports are coming in from the MC members fortunate enough to attend the 26th Homebirth Australia Conference, held at Echuca Moama on 15 and 16 May. Timing has only allowed us to include the very brief summary on page 19, but rest assured that our September issue will include a full and comprehensive report of what was, from all accounts, a sensational experience.

Kylie

Meet the team that brings you Birth Matters: Assistant Editor Sonia Bartoluzzi, layout artist Mardi Dower and Distribution Coordinator Bec Telfer.

As a consumer, I just have to keep on believing yes, I can choose to birth where and with whom I want. To do otherwise will send me into a spiral of despair. Many women are still asking, “Can I birth with my midwife come 1 July?”

There is good hope of this.

Three things need to be resolved for women to be certain they can birth with a private midwife of their choice. 1) The adoption of the Quality and Safety Exemption Framework for Homebirth by the Nursing and Midwifery Board of Australia (NMBA are the regulatory body overseeing the legislative changes relating to midwives and nurses).

2) Access to insurance via government or private means.

3) If midwives are prepared and able to work within the proposed system.

At this point we must remind our politicians to keep their many promises that “choices for women will not be restricted by the legislation” coming into effect at the end of June. By keeping up the conversation with your local political representative we have the best hope for the best outcome.

The more the community understands the determination and conviction that women have to seek and find high quality, one-to-one care for their pregnancy and birth, the faster our maternity system will change. There is a level of frustration with the limited visible progress, but Maternity Coalition (MC) can see the reforms have further to go. Members continue to work hard to be actively engaged in the many processes that will determine how proposed changes will affect consumers and the midwifery profession.

Many local branches participated in International Midwives Day to take the opportunity to recognise midwifery as an essential and major part of our maternity system and educate people about the importance of midwifery care for women and their babies.

With continued support from consumers, midwifery will maintain its identity as a discrete, separately regulated profession and become the choice for most childbearing women.

MC remains committed to improving the ability of women to give birth where and with whom they choose.

Thank you to our members who continue to keep the effort to inform, educate and advocate for improved maternity services. Keep being a voice for choice.

Lisa Metcalfe

From the Editor

As I write this editorial, I am 33 weeks pregnant with my third child. It has been a beautiful pregnancy and a time of great healing following the loss of our second son Daniel almost three years ago. I have counted my blessings often over the past eight months — the all-day ‘morning’ sickness, the insomnia and, most recently, this little one’s apparent determination to send me into a spiral of despair.

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Dr Geroing’s Melissa McFarlane (p2) received a very different response when she spoke with her care provider about continuing her plan to birth her fourth baby at home, despite her breech presentation. In Melissa’s words, “There were no threats issued ever ... not a single attempt to undermine my confidence in my own understanding of my own body, my baby, my choices.” Instead, she received reassurance and support from her known and trusted midwife and, as a result, approached this birth as she would any other — without fear. Had Melissa been unable to access the midpoint of her choice, had she been receiving care through the hospital system, or even a more restrictive public homebirth model, her daughter Amber’s birth story might have unfolded very differently.

exclusion criteria — which for birth centres and most publicly-funded homebirth programs typically forbid breech birth, twin birth, VBAC and a number of other real or perceived ‘complications’ — exist to protect mothers and babies, as we are continually reminded by those with the power to veto our attempts to access the care we want. Certainly there are times when birth outside a hospital setting may present greatly increased risks for both mother and baby; but, as Trudy Blakeley’s story (p5) demonstrates, dogmatically applying these criteria with no consideration for a woman’s individual needs, experiences or circumstances protects no one.

From the President

Assistant Editor Sonia Bartoluzzi, layout artist Mara Dower and Distribution Coordinator Bec Telfer.

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MC and the midwifery profession.

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Lisa Metcalfe
Informed choice, consent and the law: the legalities of “yes I can” and “no I won’t”
By Ann Catchlove

The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention ... The decision will be the final stage in showing that consent has been given. It does not constitute the entire information-sharing process, nor does it establish that the consent given is valid or informed.

Informed decision making as a legal right
Competent adults have the right to accept or refuse medical treatment. This principle was articulated by Cardozo J in Schloendorff v. Society of New York Hospital (1914) 105 NE 92 and quoted in the Australian High Court case of Department of Health & Community Services v Re MB (‘Marion’s Case’) (1992) 175 CLR 218.

Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and anyone who performs an operation without his patient’s consent commits an assault.

Consent in the context of assault only requires a consumer to understand the broad nature of the proposed treatment, however a doctor risk provider risks an action in negligence if he or she does not present adequate information to enable the consumer to make an informed decision. The High Court in the case of Re MB [1997] 36 BMR 175 CA the Court said: The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though ... the consequence may be the death or serious handicap of the child she bears or her own death. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.

In the case of St George’s Health Care NHS Trust v S & R v Collins and others ex parte S [1998] 3 All ER 673 the court held that: An unborn child, although human and protected by the law in a number of different ways, is not a separate person from its mother. Its need for medical assistance does not prevail over her rights and she is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it.

Recognition of women as the primary decision makers in maternity care
The legal position on informed decision making and the right of a pregnant woman to accept or refuse treatment is clear. Yet some care providers are reluctant to recognise that decisions about care during pregnancy and birth should ultimately be made by the woman in question. This viewpoint fails to acknowledge the fundamental autonomy of women as protected by human rights instruments and Australian law. It also opens care providers up to a litigation risk. It is therefore in care providers’ own interests to ensure that women are making their own decisions about care and that those decisions are well informed.

All women should be given general information at the outset of their maternity care about the meaning of informed consent and their rights to receive all of the information they need in order to make informed decisions. This should include a clear statement that the woman can refuse to follow advice and recommendations. This information should also be provided whenever a decision needs to be made during a woman’s maternity care.

Signing a consent form does not, on its own, amount to giving informed consent. Informed consent requires a process of dialogue between a care provider and a consumer, and the signing of a consent form should be the final stage in showing that consent has been given. It does not constitute the entire information-sharing process, nor does it establish that the consent given is valid or informed.

Respecting a woman’s decision-making autonomy also means that a woman must not feel that she is being coerced into making a particular decision. Coercion also puts a care provider at risk in any legal claim where consent is an issue. Many women report that they feel coerced into making decisions to have interventions during pregnancy and childbirth. The clearest example of coercion is perhaps when a woman is told that her baby will die or be severely disabled if she fails to agree to a particular course of action. Less obvious examples that nonetheless impact on a woman’s ability to make free decisions include being forced to make decisions quickly in non-emergency situations, or being told she will not have access to a particular model of care if she fails to agree to certain screening tests or other procedures.

Maternity care is no different to any other area of healthcare. Pregnant women have the same human rights and legal rights as everyone else. They have the right to give or refuse consent to medical procedures and to be given the information that they need to make their own informed decisions. Care providers (and women themselves) must have a comprehensive understanding of these concepts, not only to ensure that rights are respected and the law followed, but so that women are able to make the best possible decisions for themselves and their babies.

Author Bio
Ann Catchlove is a solicitor, mother of two and the President of the Victorian branch of Maternity Coalition. Her interest in informed decision making stems from her own poorly informed decision to consent to an emergency caesarean for her first birth. She made an informed choice to have a VBAC with her second baby.

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The road to receiving Adele

By Trudy Blakeley

The recent experience of one Alice Springs family is a clear example of what can happen when medical professionals trade common sense and compassion for dogmatic adherence to doctrine and refusal to offer individualised care. Here Trudy Blakeley tells of the unnecessarily traumatic lead up to the birth of her third child Adele.

The whole of my third pregnancy was just like my first two — wonderfully normal. Aside from suffering the usual morning sickness in the first three months I thoroughly enjoyed being pregnant.

My first appointment at the local MGP (Midwifery Group Practice) clinic was at around 15 weeks. We discussed my obstetric history and I was told how ‘lucky’ I was — the MGP had only just been granted permission to take in VBAC (vaginal birth after cesarean) women into the program. I smiled politely at this because at one time I had been looking into having a homebirth with my MGP midwives in attendance.

In preparation for my appointment, I learned that the new MGP policy had been developed based on the South Australian Perinatal Practice Guidelines and the Policy for Planned Birth at Home in South Australia. So I accessed both of these documents and read them through. Still there was nothing I could find to explain why I must birth my baby in hospital. The backbone of every policy seemed to ultimately acknowledge significant individualised care, based on the woman’s circumstances and right to choose. Even the Royal Australian College of Obstetricians and Gynaecologists guidelines, while not supporting homebirth, acknowledged and recommended that a woman receive the care of a qualified practitioner if she elects to birth at home.

While she was supportive, she explained that a homebirth might not be possible for me this time, even though I had previously attended. She suggested I seek a homebirth midwife if I didn’t want another hospital birth — what we really wanted was another homebirth for this baby. I couldn’t agree more at my next antenatal appointment.

For weeks before the start of my third pregnancy, I had a lot on my mind. I had felt that I was discriminated against. My prior C-section had been born naturally at home, and we had attended a home VBAC with the support and attendance of experienced midwives in attendance. During that labour I was supported and encouraged by those closest to me. Our labour and birth were not difficult or complicated and, ultimately, it was a truly memorable occasion (and a wonderfully empowering experience) for me, my husband, my daughter and even my mother, who also assisted. When I was 36 and 37 weeks before I finally started to contemplate the pending labour and birth. After reflecting on both of our prior experiences, my husband and I decided that if we didn’t want another hospital birth — what we really wanted was another homebirth for this baby. So I decided it was time I met with my midwife at my next antenatal appointment.

While she was supportive, she explained that a homebirth might not be possible for me this time, even though I had previously attended. I was just one of those who managed to feel the most of experience one. At the time of my second birth, the MGP was under the operational guidance of Community Health. We received a shift to hospital control (under Acute Care) had resulted in some policy changes which stated that anyone with a prior C-section must birth in hospital. Of course, I was keen to know if this was really the case. I wanted to know the possible medical concerns and listed at least seven potential situations where we agreed to deal with birth in hospital.

Finally, with a combination of medical concerns, I was ready. Everyone I spoke to felt that my individual circumstances made for a strong case, so I began to feel really good about it. Even so, on the day I was very nervous.

I think our meeting started well, but should I have been talking to another friend to come along with me for support? That might have helped me to stay focused and perhaps be clearer in my communication. In short, the Head of Obestics told me that I “could not” choose to birth at home because I was a VBAC. When I referred to the South Australian Guidelines as the basis for MGP policy, she admitted that she had not read them and had not discussed, and agreed to a documented list of exceptions to my prior C-section. It had, however, been adopted as force by our MGP. I asked to see the policy document, but was told it could not be found on the LAN (Local Area Network). She did, however, search under my name and, when it became clear that we would be unable to reach any common ground. At this point, I was overwhelmed with emotion. I cried. I thought it was out of frustration, because, despite having no complications in this pregnancy, despite having already proved myself in my prior labours and births and a comprehensive birth plan.

I was simply told that I could not, “It’s okay, we can do it here anyway — without them.” I smiled at him, but the words didn’t really sink in until later. As this was my third attempt at a VBAC, my midwife asked me what I planned to do when labour started. I answered her honestly: “I’d love to try a homebirth.” Lack of experience, with ‘homebirths’. I began to cry. I thought we were going to have a homebirth.

Some contractions were becoming more intense and I felt like I needed someone to talk to me through them. My husband would feel so badly if anything went awful. I was told midwives were going to show in the shower. It was great in the shower and I soon found myself resting on my hands and knees while he gently sprayed hot water on my back while I kept my eyes closed. I was improving. I then told the midwife that I felt like I needed to see someone in person. So I called the midwife, who said she would come straight away.

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At this point, I’m embarrassed to say, I broke down. I felt like I had to have a homebirth. I am thankful that everything went well (and there was no reason why it shouldn’t), but even now, when I reflect on my experience, I can’t help thinking, “what if?” What if something had gone wrong? It certainly wasn’t my intention to birth without a midwife (despite my husband’s fluctuating commitment to the idea), but I would never recommend it. Personally, I would have much preferred for our midwives to be present. There were a number of times when I felt like I had failed my child. Being admitted into hospital was the last thing I wanted to do. I had to wait for over a week, but then a call from my midwife told me a meeting had been scheduled between MGP and the hospital. I was told by the Head of Midwives that I was unable to save time and finally I felt like I had generated some interest!

I recalled my midwife had talked about the idea of a meeting, but then a call from my midwife told me a meeting had been scheduled between MGP and the hospital. This was a meeting that was going to last an hour, and it was an emotional meeting. We spent the next two weeks in hospital, and I had to wait for over a week. I was never told why. I thought it was out of frustration, because, despite having no complications in this pregnancy, despite already proving myself in my prior labours and births and a comprehensive birth plan.

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Breech birth – making an informed choice


Caesareans are the only choice offered to pregnant women carrying breech babies in most parts of the world. Doctors have justified their refusal to offer vaginal breech birth with reference to the Term Breech Trial (TBT), a large international study that showed increased risks for women birthing breech babies vaginally under study conditions, compared to women having a planned caesarean.

In this study in 2000, women were offered drugs to prevent labour, planned vaginal delivery, or a caesarean section, with no differences in outcomes. In the TBT, at term, women who had no pain allowing them to be involved in the study (one of whom was a twin — twins were supposedly to be excluded — and one of whom was actually head down) and one baby who obviously died from a congenital abnormality (babies with lethal congenital abnormalities were supposed to be excluded) were two. Healthy babies who died at home after hospital discharge were also included. Although inclusion of these two babies is scientifically correct, a further analysis excluding those babies would have been important.

Even with these provisos, however, the TBT actually shows that the risk of a poor outcome for most breech babies is very low. With a well-positioned baby — frank breech, with straight legs — a skilled attendant, and a smooth and drug-free labour and birth, there is, according to TBT data, over 97% chance of a good outcome for mother and baby. (In the TBT, “good outcome” means a live mother and baby who are well for the first four to six weeks after birth.) Choosing a caesarean increases the chance of this outcome a little to 98.5% according to TBT figures, but in weighing up this risk, all the other risks of caesarean birth for mother, baby and subsequent pregnancies must be considered.

Ironically, four years later the TBT researchers published their two-year follow-up study, which showed no difference between the caesarean and vaginally born children in terms of physical and delayed developmental, at two years of age. This turn around in outcome was mainly because most of those vaginally born babies who had appeared very unwell after birth, had recovered with no lasting disabilities. As Canadian obstetrician Andrew Kotsanis has highlighted, the use of a “shunt” has been misleading in this study.

Unfortunately, by 2004, when this follow-up study was published, many hospitals around the world (including most of Australia) had already abandoned a policy of routine caesarean delivery for breech birth, and there has not been, in most places, a review of policy. This is despite much international criticism of the study and of the impact that it has had on women carrying breech babies.

In January 2006, the American Journal of Obstetric and Gynecology published a scathing critique, Glazerman noted: “In a substantial number of cases, there was a lack of adherence to the inclusion criteria. There was also a large inter-institutional variation of standard of care; inadequate methods of antepartum and intrapartum fetal assessment were used, and proportion of women were recruited during active labor. In many instances of planned vaginal delivery, there was no attention of a clinician with adequate expertise.” He concluded that “Most cases of neonatal death and morbidity in the term breech trial cannot be attributed to the mode of delivery,” and recommended that the TBT be withdrawn.

Further publication of studies showing good outcomes for breech babies, are shifting the balance towards vaginal breech birth in many parts of the world.

For example, the large European PREMODA trial found that 71% of women planning a vaginal breech birth (who had met certain conditions) were successful, and concluded “… in places where planned vaginal delivery is a common practice and when strict criteria are met before and during labor, planned vaginal delivery of singleton fetuses in breech presentation remain a safe option that can be offered to women.”

In Canada, the Canadian Society of Obstetrics and Gynaecology has revised its guidelines to encourage case selection and labour management in a modern obstetrical setting may achieve a level of success in the presence of strict criteria. This is supported by the American College of Obstetricians and Gynecologists (ACOG) in their 2006 guidelines since they have particular serious morbidity in association with placenta previa and in subsequent pregnancies.

In the UK, in 2004, the Royal College of Obstetricians and Gynaecologists (RCOG) in their 2001 guidelines state: “While it is true that women with breech presentation at term most often will be delivered by caesarean section, management should be individualised. The term breech trial did not have the statistical power to meaningfully analyse subgroups, some of which are likely to be pregnancies that do extremely well with breech vaginal delivery.”

The RANZCOG list the following factors that may favour a vaginal birth.

1. Reduced fetal risk from planned vaginal delivery:
   • Continuous fetal heart monitoring in antenatal labour is required.
   • Immediate availability of caesarean facilities if necessary.
   • Availability of a suitably experienced obstetrician.
   • Presumed favourable fetal presentation (e.g., position of body or average size, no placental insufficiency, frank breech, appropriate gestational age, further analysis of liquor levels).
   • Favourable maternal circumstances, e.g., adequate pelvis, maternal cooperation with pushing, multiparity.

2. Increased risk from planned caesarean section:
   • In particular, this would include women planning a large family (who have a prior breech or breech presentation at term with a possible prior caesarean section), management should be undertaken wherever possible.
   • Vaginal breech birth is a safe option in most circumstances, and in here in Australia is supported by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). A case for breech carries some extra risks to the mother, including risks to herself and her baby in subsequent pregnancies. If your baby is in a breech position, I suggest you inform yourself of all your options so that you can make the best decision and have the best birth possible for you and your baby.

References


Sarah Buckley is a GP, mother of four, and currently a full-time writer on pregnancy, birth and parenting.

Joyce Chilton Pearse, author of Magical Parental Magical Child

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If your baby is breech
By Sarah Buckley

1. Get a second opinion if there is any doubt. A quick ultrasound is the most reliable way, if there is any uncertainty and if significant interventions are planned e.g. a caesarean. Remember that any baby can change position at any time, and a pre-surgery scan has sometimes found a head-down baby and avoided a caesarean. (You can also ask your doctor to double check immediately before surgery.)

2. Talk to your baby in whatever way feels good to you. You can tell your baby, out loud or internally, that being breech can make things more complicated, at least for your caregivers. Explain what may happen and what would be different if he/she was head-down.

3. Talk to your care providers and see what your options are, both to turn your baby and for birth, if your baby is still breech.

4. Explore options if you decide you need to turn your baby to get the best birth. Inverted positions (which get your baby out of your pelvis and free to turn); acupuncture (often using the herb moxa); chiropractic (and specifically the “Webster manoeuvre”); and homeopathy may help. You can also use visualisation (e.g. of your baby’s ideal position, of the birth you want) and drawing, and again talking to your baby.

5. Look at medical options. In particular, “external cephalic version” (ECV), which involves a skilled carer gentle manoeuvering your baby to head-down. This is ideally done using drugs to relax your uterus and with ultrasound guidance. At a minimum, regular checking of the baby’s heart is necessary every few degrees to ensure no harm from cord entanglement. There is a 1-in-200 chance of needing an emergency caesarean after ECV. Success rates vary from 40 to 60% and are higher for women who have previously given birth.

6. Consider your options for birth if your baby is still in a breech position close to your due date. If you think a vaginal breech birth is ideal for you, ask around to find a skilled breech attendant, which may involve changing carers, hospitals, or even moving cities. Andrew Bissetts at John Hunter Hospital in Newcastle has extensive experience. Remember that you cannot be forced to have a caesarean, and if you insist on a natural birth, it is highly likely that the hospital will find a skilled practitioner for you.

7. Look for support if you want a vaginal breech birth. There may be hospital midwives who will be your champions, or you may consider engaging a private midwife or doula to support and accompany you. You can also contact your local Maternity Coalition branch to get support and information about your choices.

8. If you are having a caesarean, make it the best possible experience for you and your baby. Again, enlist supporters (doula, midwife) and talk to your doctor about having your bay skin to skin as soon as possible and for as long as possible after birth. See resources for more information.

9. Include your partner through all of this. He will be your main supporter, before during and after the birth. Talk to him and offer him books and stories to read, and remember that he may need support himself.

Resources


For Amber
By Melissa McFarlane

I have four children, and was blessed with the care of the same midwife for all four pregnancies and births. Summer was born in December 2002 in the Geelong Family Birthing Unit (FBU). She was breech at 38 weeks and again at 40 weeks and was turned both times with manipulation in Chinese medicine technique where locally applied heat from burning moxa sticks is used to stimulate the baby’s movements and encourage it to turn). Neaturing the 42-week exclusion from the FBU, I self induced with castor oil on a day when I knew my favourite midwife would be on. Summer was born head down, in water, at nearly 42 weeks, after an eight-hour labour (with just one hour in hospital) and weighed 3.5 kg.

For my second pregnancy I planned a homebirth and in March 2004 I birthed Luna Rain at 20 weeks. It had been confirmed by ultrasound that my baby had died and I went into labour naturally and birthed at home. In June 2005, after a powerful 3.5-hour labour, I gave birth at 42 weeks to Lukas, a 4.5kg boy, born gently, at home, in water.

This birth story was written for my fourth child, my daughter Amber.

Amber von Asterkas McFarlane born 3.17 am, 5 February 2008

You called down to me, and I was already waiting for you, my heart and body ready and open to welcome you. Your dad agreed to try for one more child, and straight away there you were. When the pregnancy care visits began with our midwife, there were two apprentices: Summer and Lukas. While I delighted in the children knowing our midwife and being involved in the process, I did arrange one or two visits at times when they were not there, so I could have a different quality of visit with our midwife, all by myself. During one of the early visits with our midwife, she asked me in what way I could improve on Lukas’s birth; in what way, if any, I would like to do things differently this time. It took me a while to think of it, because his birth was so very good, but it came to me strongly and stayed with me that my heart’s desire was not to have a preference for one way over the other. I had no fear, because whatever your position, I could have my birth at home, in water, with our midwife. I trusted you and I trusted my body and I trusted that all would be fine. And I was supported in this gorgeous state of acceptance and trust by a skilled and attentive midwife.

There were no threats issued ever. There was not a single attempt to undermine my confidence in my body, my baby, my choices. Unwavering support. Unconditional care.

Welcome Amber

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I had learned a thing or two by now, and when people asked me my due date I added two weeks to the date that was calculated. Our midwife and my support people knew the actual date, but I gave myself a blissful window of time free of any outside pressures or drama about being ‘due’ or ‘overdue’. I was absolutely accepting of whenever you chose to be born and had let go of any concern or expectation about dates.

In the later part of my pregnancy, when our midwife felt my tummy for your position, you were breech. By about 35 weeks, I was worried that having a breech baby at the time of birth may impact on my options, on being at home, on being able to be in water. So I asked our midwife if she would support me to birth a breech baby at home. She said she would be happy to. I asked what it would mean in terms of being in the water — would I still be able to get in the birth pool? She said, “Melissa, if your baby is still breech at birth, I would prefer you to be in the water, as water helps support and assist the baby to complete the rotation needed to be born easily.” With these reassurances from our midwife I was able to completely and absolutely let go of any concern or attachment about your position; it simply did not matter at all, and I didn’t even have a preference for one way over the other. I had no fear, because whatever your position, I could have my birth at home, in water, with our midwife. I trusted you and I trusted my body and I trusted that all would be fine. And I was supported in this gorgeous state of acceptance and trust by a skilled and attentive midwife.

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My circle of women drew in close around me towards the end of my pregnancy. They were all women who were attuned to my wishes, who had spent time with me in pregnancy, talking through my aspirations for my birth and what I wanted their role to be. They blessed and celebrated me richly at my blessingsway, and they committed to nurture and nourish me and my children and partner in the month following the birth.

About four days out from my expected due date of 42 weeks, I was in a bit of a frenzy, trying to clear the space for you, trying to finish up last-minute tasks before you arrived. I spent the full day

For Amber
I was feeling so tired that rocking and leaning on the edge of the pool was much for me. I thought that maybe I could tie dad down and have a rest, so your dad fetched a mattress and put it right beside the pool. One attempt at a contraction, I was lying down and I was up on my knees. As soon as that contraction finished I leaped up undressed and got into that pool. Ahhhhh, such sweet relief, such warmth and support and space to move and find any positions that might help.

I asked that the women be called and they came, one after the other, quietly materialising out of the dark, and another one pressed to me. I was in a quiet, dark space with an ever-present circle of support that was there to meet my every need and wish and which held me without touching me.

I was becoming so tired that rocking and leaning on the edge of the pool was much for me. I thought that maybe I could lie down and have a rest, so your dad fetched a mattress and put it right beside the pool. One attempt at a contraction, I was lying down and I was up on my knees. As soon as that contraction finished I leaped up undressed and got into that pool. Ahhhhh, such sweet relief, such warmth and support and space to move and find any positions that might help.

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I was lying down comfortably. There was nothing to lean over and rest on, and it was not working for me. I wandered out, was feeling drawn to be near my three-year-old full birth pool, and other women who had shared meals with me in the last 24 hours or so if they felt alright. It got worse in the late afternoon and I decided to feed the kids and go to bed with them because I was feeling so lowly. As I was preparing dinner, Luka came in to ask me something and I was really short tempered with him. A few minutes later I found myself leaning against the kitchen bench for support while I was gripping the edge of the pool filling. It all felt leisurely and I texted our support people to let them know.

I then witnessed my first ever bloody show. We decided to wait and monitor. The labour picked up so that I couldn’t speak. “I wanted to know if your head was still there — perhaps it was hanging down. I could hear your words by the phone and I needed to know where your head was.” I asked the midwife to tell her I thought things were moving along. I had a need for intense dark, so went around the house and blew out all but a very few of the candles I lit with such care earlier on.

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You will never be able to birth vaginally again.” These were the words of the obstetrician an hour after the birth of my first child. Just nine little words, but they haunted me for the next 10 years and shaped the birth of my second child.

My first pregnancy was very straightforward until I was 41 weeks, when I was told that I must be induced. Being 22, with no knowledge of the birthing culture within the hospital system, I listened carefully to what the staff told me and believed that they had my, and my child’s, best interests in mind. So I was induced. My birth involved one medical intervention after another, with my son’s shoulder becoming wedged behind my pelvis. The final moments consisted of a panicked obstetrician pulling down on my son’s head, my screaming, and another obstetrician having to take over.

The final physical result: my son was delivered with Lo’s Palsy (paralysis of the arm caused by damage to the nerves surrounding the shoulder) and I had a partial third-degree tear.

The second appointment was also a major disappointment. I was told that my chances of having a repeat shoulder dystocia birth were very high; that at 32 weeks my baby was already “quite big”, and that second babies are always bigger than the first.

So I made an appointment with Ina May Gaskin’s approach to birth blew my mind — it was nothing remotely like what had happened to me in hospital. (I also read that she had developed a manoeuvre to help in moving shoulder dystocia births.)

At about 32 weeks, I felt needed an expert opinion about whether it might be possible to birth this baby vaginally. So I made an appointment with Ina May Gaskin’s approach to birth blew my mind — it was nothing remotely like what had happened to me in hospital. (I also read that she had developed a manoeuvre to help in moving shoulder dystocia births.)

At about 32 weeks, I felt needed an expert opinion about whether it might be possible to birth this baby vaginally. So I made an appointment with Sue. She gave me a number of books to help me prepare for this birth. I found their approach and extremely pompous. I was told that my labour would never tell me where their information came from. To me they seemed distrustfully ‘cliché and daggery’ in their approach and extremely pompous. Sue gave me a number of books to help me prepare for this birth. I found their approach and extremely pompous. I was told that my labour would never tell me where their information came from. To me they seemed distrustfully ‘cliché and daggery’ in their approach and extremely pompous. Sue gave me a number of books to help me prepare for this birth.

My pitch and volume as things started to ramp up. I found Sue’s presence incredibly reassuring. She kept telling me what a great job I was doing, and I felt really happy with my progress. After a few hours it was suggested that I hop out of the pool; I was at risk, so I had no choice but to get a handle on it as the contractions came thicker and closer together.

I was having a homebirth and preparing them for what it might be like, especially our seven-year-old daughter. Sue gave me a copy of the children’s book Hello Baby, which is a story about a homebirth. It is still her favourite book and she has now renamed all the characters — in her mind the midwife in Sue’s birthday is Sue. My eldest was cool with the idea of Mum having a baby at home, but he wasn’t interested in or interested to witness it. Just a few days after hitting the 42-week mark, my pre-labour began. I had not experienced this before and it was all very new to me. Sue came around very early on day two, stayed for a few hours, then told me to rest and save my energy for later. She went to grab some sleep and planned to return in a couple of hours. When she did, she could hear me moaning from the ceiling above and she was quickly awake. "You're having a homebirth, and that is what it should be! You're not sick, you're pregnant. Why should we have to go to a place full of people who are unwell? I will support you on this.” She had found his first birth experience with our daughter unsullied and had lost respect for the state of maternity care in hospital. Having him behind me was a huge boost to my confidence and this was the start of our homebirth journey with our midwife Sue Cookson.

Sue was an invincible support. She was extremely open and backed up all her information with the names of studies. The obstetricians during my second pregnancy would never tell me where their information came from. To me they seemed frighteningly ‘clash and gag’ in their approach and extremely pompous. Sue gave me a number of books to help me prepare for this birth. I found Birth from Within by Pam England and Gentle Birth, Gentle Mothering by Sarah Buckley to be ideal. And I had a transfer at this point, feeling that I had failed and that maybe the doctor from my son’s birth was right. It was a very dark place to go to and I was raw. Standing in my upper bedroom, striped bare of all presence, I felt very small, very vulnerable and very scared. In those moments I looked in on myself and viewed the form of a broken woman. I had been beaten by the system both the first and second times and was now looking down the barrel of another medicalised birth. It felt like I was back on the bed at my son’s birth, being screamed at by the doctor as he pulled him out of my body with such force he broke us. In my bedroom I screamed the same scream from 10 years earlier, and it scared me.

Sue tried to snap me out of it and tell me to relax. "If you're going to hospital it was an option, but my baby and I were not at risk, and it would take just as long, if not longer, before I birthed. I am not ashamed to say that I just wanted the pain to go away. It was unbelievable. I couldn’t get a handle on it as the contractions came one on top of another and didn’t give me time to regroup. Then, with my next contraction, Mat and our midwife moved around the birthing pool to give me as much space as possible. I felt pressure down there and held myself back as I freaked out. I had truly had enough by this point and planned to stand in the way of my having a vaginal birth. I had felt a surge and then just moaning my heart out. I gave Bob Dylan a run for his money during this contraction.

My son’s head was now looking down the barrel of another contraction. It shot down my hips, around my stomach and down my spine — this was on top of the contraction. I was losing my grip and freaked out. I wanted to call it off. Our daughter was in the room with us and I worried that I would scare her, but she laughed at me.

With one leg up on the bed, I pushed with each contraction, but it was so painful that I screamed like a crazy person for one minute, went like a small child the next. Sue did a vaginal exam and discovered a lip that was causing bub to head back up the birth canal. I was seriously considering contracting. It shot down my hips, around my stomach and down my spine — this was on top of the contraction. I was losing my grip and freaked out. I wanted to call it off. Our daughter was in the room with us and I worried that I would scare her, but she laughed at me.

With one leg up on the bed, I pushed with each contraction, but it was so painful that I screamed like a crazy person for one minute, went like a small child the next. Sue did a vaginal exam and discovered a lip that was causing bub to head back up the birth canal.
By Mara Dower

2005 Birth
In 2005, after a wonderful trip away, I came back to find out I was pregnant.

Homebirth was in my consciousness, due to a friend’s birth I attended in London, as well as some other friends who had experienced homebirths here in Australia. But when it came to my own birth, I was a little scared about doing the whole birth thing and proceeded to book myself into what I believed was the next best thing — a birthing unit in a Melbourne hospital.

When my husband and I visited the birthing unit, we found it similar to a hospital ward but with four creatures to help with the contractions and flexibility to assist with the birth. At the same time, we found it clinical, sterile and felt that a hospital (regardless of it being called a ‘birthing unit’) was a place where only sick people went. There was certainly nothing ‘sick’ about me or anyone I knew, and we felt that a hospital should only be needed in an emergency situation. Despite these feelings, we stayed on.

At our very first antenatal class at the hospital, we watched a short video on the labour process. It was pretty outdated (70s, I think), and the woman was birthing in a pool at home. When asked about birthing in pools at the hospital, the instructor (who had not given birth herself) said that due to possible litigation the hospital wouldn’t allow it. The video was a short demonstration of the stages of labour only. She went on to say that it was most welcome to sit in a bath to help with the pain and the contractions, but as soon as full labour began, I had to move back into the birthing unit. I was gathering evidence in my heart and mind that this was the wrong place for me to labour.

In March 2005, on my honeymoon and sitting in a spa bath, I got this gut feeling from my baby that she wanted a water birth. My own daughter was telling me what she wanted, so I had to find a way. It may have been my own desire, but I had a strong intention and purpose.

I had a big belly, was due to give birth in 10 months and had been told by many people telling me what to do, where to birth, and reminding me to make sure to make decisions that would “ensure the safety of my baby.” I was so used to this type of unnecessary stress were instilled in me. I felt scared and challenged by the amount of information and advice I was receiving and unsure who or what to listen to. I decided at that point to just stay in my power and follow my gut instincts. Because I had used natural therapies and been exposed to homebirth, a homebirth was the forefront of my mind.

Determined with new growing and new intentions, I remained in the hospital system due to my fears and conflicting beliefs. Like so many other pregnant women, I was conditioned to have a hospital birth through my past experiences, family experiences and what my power, intuition and intentions were. I was surrounded by a homebirth hospital to keep me there.

So, after the weigh in (9 lb 1 oz or 4036 grams — my smallest baby) and getting myself into my bed, I was joined by my daughter, who wanted to snuggle in bed with Mummy and the new baby like they did in her book Hello Baby.

This was not just a birth for me, it was much more. I learned so much about myself in those hours. Before my daughter was even born she was already teaching me. I will be forever grateful to her for that precious gift.

Though Mat and Sue commented on my determination, I didn’t see it as something extraordinary. It was just a birth. But lately I have been feeling invincible. This birth helped me regain my confidence and boosted my self esteem.

“You will never be able to birth vaginally again.” Yes I can. And I did.

In 2009, after 22 hours of labour, a gorgeous baby girl arrived at home and I just made it to the pool.

The moral of the story: Say “yes” to the birth you want. It’s your power, your instinct, your birth. Say “yes” to everything you hear (even if it’s somebody of authority) and make your own decision. Say “yes” to your power, listen to your instincts and you will be very fortunate with your birth experience.

WE WANT TO HEAR FROM YOU

Would you attend an Australian Childbirth Conference with guest speakers, stall holders and workshops run by experts in the field?

The focus will be around various facets of childbirth and women’s choices.

A survey is being conducted to look at the viability of hosting such a conference.

You responses are needed! Go to: www.australianchildbirthconference.com

To discover ways you can say “YES” to the birth you want, go to www.birthmidagic.com.
I can and I have: one young mum’s success through intuition and continuity

Christine Van Den Berg is the single mother of four children ranging from eight years to two weeks of age. During each of her pregnancies, Christine received antenatal and postnatal care through Danila Dilba’s Child and Maternal Health Service, and planned to deliver her babies at Royal Darwin Hospital (RDH). Each of her birth experiences was unique, and each taught her something about the need to be assertive and informed throughout pregnancy, childbirth and the early parenting experience. This is her story as told to Kylie Sheffield in February, just two weeks after the arrival of her youngest daughter, Aurora.

through intuition and continuity
— I had never missed a feed and there was no need to let me sleep and feed Casey. I remember being really upset and my first reaction being to go to the nursery to let me sleep and fed her without me. An uncomplicated birth, but because she was a very young first-time mother, insisted on meeting someone like Christine who, even as a Grand Multip, had three spontaneous, natural births. I got the impression that they wanted me to control my birth rather than engage with me to provide the care I wanted and needed.

Before going home I asked about the possibility of a water birth, but the young midwife I spoke to advised me that the pool had been removed from the Delivery Suite the weekend prior.

The night I went into labour, I was at a friend’s house. When contractions started, another friend drove me to a close relative’s place to drop off Casey. Phoenix and Azaria. We almost made it to the hospital before I got the urge to push. But opposite Tracey Village [a sporting and social club approximately a kilometre from RDH] I knew we weren’t going to make it.

I squatted on the front seat and out Aurora came, along with my waters, which broke at the last minute. We drove up to the Emergency Department and I was taken straight to the Delivery Suite. Aurora was fine and I delivered my placenta naturally, with no problems.

Having recently read so many stories of young women disempowered and rendered voiceless by our current maternity system, it was both surprising and refreshing to meet someone like Christine who, even as a very young first-time mother, insisted on being heard. Christine attributes her ability to advocate for herself and her children to trust in her own intuition, the continuity and support she has received through Danila Dilba’s maternity service, and the empowering education and advice provided during her pregnancy with Phoenix by her doula Karen.

Christine remains disappointed that she was unable to access one-to-one care through the Darwin HHS for her most recent pregnancy and birth. She believes she would have enjoyed having a known midwife not only during pregnancy and the intrapartum period, but also for her intrapartum care.

References
1. Danila Dilba Health Service is a community-managed organisation providing comprehensive primary health care services to Biluru communities in the Yilli Rreung Region of the Northern Territory. Learn more at www.daniladilba.org.au.

Another beautiful homeborn babe for Justine

Justine Caines and Paul Smith welcomed a son into the world on 30 April 2010 (a full moon).

Quinn Thomas, 55cm long and 4.5kg. Another beautiful home waterbirth in the Hunter Valley of NSW. Love and thanks to our very special midwives Betty and Robyn for all the travel and special family care. Thank you also to Connie, homebirth midwife in the making! Quinn is a new brother for Ruby, Clancy, William, Tobias, Majella, Rosie and Riley.

Speaking our language
In the Spring edition of Birth Matters we’ll be looking at the power of language. How does medical terminology around pregnancy and birth affect our confidence in our bodies? Do obstetricians and midwives really speak the same language? How does the way family members and friends talk about birth influence our attitudes and decisions? Do words even matter?

If you have something to say about the language of birth, please email your submission to birthmatters@maternitycoalition.org.au before the deadline of 30 July 2010. Articles should be a maximum of 3000 words.
Canadian birth worker Gloria Lemay visits Geelong

By Kiersten Quinn

On Thursday 13 May an excited group of pregnant women, birth workers, birth enthusiasts and two men* gathered from far and wide to hear Gloria Lemay speak at the Geelong Heritage Centre.

Gloria’s experience and passion as a birth worker spans over 35 years and throughout this time she has built a seemingly infinite source of knowledge, based on practice and experience. If you asked her what she would like written on her tombstone, she would tell you that she wants to be remembered as a mother, birth attendant and someone who spoke up for babies. To sum up some of her key passions more poetically, she is an activist, lactivist, and mother-and-baby intactivist!

I first came across Gloria Lemay’s work when I read an article she wrote which was published in Midwifery Today a few years ago. It was like having a blindfold removed. Although there are many amazing advocates for natural birth, none of their words have touched me so deeply.

Her unwavering support for women and babies in what I will politely describe as very tricky political times is inspiring. When so many voices are claiming otherwise, Gloria Lemay restores faith and builds confidence that birth belongs to women and their families.

Gloria spoke to an enthralled audience for around three hours before we grudgingly took a break. She spoke about a wide range of topics from pelvises through to language and birth. Then there was still time for a birth video and some questions. She was generous with her humour, knowledge and hugs.

Feedback from people who attended from outside the usual diehard birth-enthusiast community was overwhelmingly positive, with three pregnant women (two of whom are planning a birth after a previous caesarean) relating that they had been given a lot of great food for thought about their past and upcoming experiences.

We hope to lure Gloria back for longer next time as it felt like we barely scratched the surface, and we look forward to hearing so much more of her wisdom and experiences about birth. Special thanks goes to Melissa McFarlane, who is an organisational force of nature, and the other wonderful women who made things happen for the night to run well.

Gloria’s prolific blog (http://www.glorialemay.com/blog/) is undoubtedly worth a look. Some of my favourite articles (which can be found easily with a search) include: “Pushing for Primips”, “7 Tips for Creating a Calm, Joyous Homebirth”, “4 magical questions” and “Home VBAC after 2 caesareans”.

*I would love to share how the crafty partners of these men got them to attend but what happens at a Gloria Lemay talk stays at a Gloria Lemay talk.
Federal Campaign Update
By Joanne Smethurst and Bruce Teakle

Bills passed in Senate
The Senate passed the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 on Tuesday 16 March. This legislation should give Australian women greater access to affordable continuity of care with a known midwife by providing Medicare rebates for midwifery services.

What this means
We don’t know how it will all work in practice yet, as Health Minister Roxon still needs to make decisions on a number of things including definitions for ‘eligible midwife’ and ‘collaborative arrangement’, and details around Medicare and prescribing rights are still not finalised.

What we do know is that:
• Consumers, from November 2010, will be able to choose (in theory) their own midwife for their pregnancy, birth care in a hospital, and postnatal care. How intrapartum care in hospital will work still needs to be sorted with visiting/admitting rights. This care will be more affordable as Medicare will be available. This has the potential to increase the numbers of Australian women who can access continuity of care with a known midwife from less than 5% to a New Zealand figure of around 80% or higher.
• Midwives will have access to – Medical Benefits Scheme – Pharmaceutical Benefits Scheme – Professional Indemnity Insurance (excluding birth at home), with the Government also paying any insurance claim that exceeds $1 million.

• Collaborative arrangements is probably the biggest issue. We are hopeful that lobbying by MC and the nursing and midwifery stakeholders will support the implementation of a reasonable and realistic definition.

• Professional Indemnity Insurance for private midwives remains problematic. MC is formulating a response to recently released information about the government-subsidised product. It is essential that women’s ability to make informed decisions about their pregnancy is not put at risk by the policies of an insurance provider. See www.mija.com.au for more information.

• The homebirth exemption framework second draft has been released. MC has responded, proposing that this framework is not an appropriate place to set clinical guidelines for homebirth, that new requirements for midwives need development to enable midwives to comply, and that the Nursing and Midwifery Board of Australia (NMBA) should be given responsibility as soon as possible.

• Eligibility is being defined by the new national NMBA in consultation with the midwifery profession, and appears to be working out well. MC contributed a response to the NMBA’s recent release of a draft standard for eligibility.

What is MC doing?
MC is working hard. We have:
• representatives on all working groups of the Department of Health and Ageing involved in implementing these reforms,
• given evidence at two Senate enquiries,
• attended consultations and made submissions to provide the consumer perspective on maternity issues, and
• engaged in strategic conversations with other stakeholders.

MC and a range of midwifery and nursing organisations agreed on a consensus for collaborative arrangements and took this proposal to the Minister’s office. We’re feeling optimistic about this. Senator Joe Ludwig (ALP) clearly stated in the Senate it was not the Government’s intention in the legislation to give one professional group control over another. We need to keep the Government accountable to this.

What about homebirth?
There is nothing in the Bills for homebirth — they neither support nor outlaw it. However Nicola Roxon has made it clear that she intends women to be able to continue to access midwifery care for homebirths. To hear it straight from the Minister, see this video: http://www.youtube.com/watch?v=ik_V1thEqg4. MC, along with the Australian College of Midwives, developed an alternative proposal for the Quality and Safety Framework midwives will need to work in to order to avoid the two-year exemption from professional indemnity insurance. As the whole purpose of this exemption was to secure women’s access to homebirth care, MC expects an outcome which will work.

The second draft of the framework has been released for comment and MC has submitted a detailed response. We still have major concerns about the framework, particularly its attempt to detail ‘exclusion criteria’ despite the document clearly stating that it is not meant to be exclusionary. We are working to find some straight answers to this and other questions and will let you know when it’s clearer to us.

MC’s perspective of an ideal outcome for homebirth (in terms of what’s going on at the moment) is that midwives providing homebirth care will be:
• registered as a midwife and able to practise;
• exempt from professional indemnity insurance for the first two years of national registration (from July 2010); and
• able to work in much the same way as they do now.

Some homebirth midwives might also choose to become an ‘eligible midwife’ with access to MBS and PBS. In this case they will need to have a collaborative arrangement in place so that their clients can receive Medicare rebates for their pregnancy and postnatal care.

What can you do right now?
If you haven’t written to or visited your Federal MP for a while, get back in touch and tell him/her that birth and maternity care really matter to women and families, and we expect governments to take responsibility for the quality of care and choices available to women. Remind them that they need to find a long-term solution for indemnity for midwives providing homebirth by June 2012 and that the clock is ticking.

Keep up your membership to MC and other consumer and midwifery groups in numbers we have strength with, without you, we are nothing. To renew your membership with MC and/or find out when and where your local branch meets, see our website www.maternitycoalition.org.au.

MC at 26th Homebirth Australia Conference
By Faye Kilcoak and Lisa Metcalfe

MC was well represented at the 26th Homebirth Australia Conference held in Echuca Moama on 15 and 16 May, with members making the trip from NSW, Victoria, QLD and WA.

During the weekend there was opportunity for all attendees to ask questions about current reforms and to express their feelings around the process. Justine Caines (HBA), Lisa Metcalfe (MC), Jenny Gamble (ACM), Marie Heath & Liz Wilkes (APMA) formed the panel for the Q&A discussion. With representation from many key stakeholder groups, we were able to speak openly, raise our concerns and express our thanks for the outstanding efforts to date.

In addition to the many informative and empowering daytime presentations, the Splash of Purple Dinner and Healing Down of Knowledge was a wonderful night, with women sharing their moving and incredible birth stories (including two amazing twin births).

Alison Gaffney and a number of others did a great job on the MC table, ensuring we were a visible presence throughout the weekend.

Overall, there was a sense of hope and a commitment to continuing to work together to achieve much more than just an insurance exemption. The fire still burns — we will get there. Let’s all unite, ALL of us, look after each other and be kind to each other. When it all feels like it could not get any worse, greatness comes.

Note: A full report on the conference will follow in our September issue.
Maternity Coalition News

Wagga Birth Choices Action Group (WBCAG) By Bernadette Anderson

On 1 March 2010 three of us attended a Regional Meeting of the Country Women’s Association (CWA) at Coolamon Golf Club where we spoke about ‘Birthing rights’. We explained what is lacking in Wagga in terms of choice of carer, continuity of care, non-medicalised birth, and the general shortage of midwives and obstetricians both in the public and private hospitals. We helped our audience to relate to these issues by speaking of our own relationships (sadly, in other cities) to relate to these issues by speaking of our own relationships (sadly, in other cities) to draw on. Our attendees is being organised at mothers’ homes on alternate weeks. The meetings venue, the Ashmont Community Centre. During the first half of 2010 we have held an extra meeting to make a decision to join us for a morning of tenderness and sharing as five couples shared their special VBAC journey; and Jane Eager, who was completely empowered by her breech vaginal birth; Cassandra Bell, who found great support in our local private hospital; Eszter Wong, who shared her special VBAC journey; and Jane Eager, who moved everyone to tears with her wonderful homebirth.

Our May meeting’s guest speaker will be Nicole Hope-Allan, an acupuncturist. Nicole spoke at Wollongong Central Coast Health Services to help promote our group throughout the region.

This event again drew many women, beyond birth what was possible, as well as homebirth practitioners Q&A and why?

HHNBS is currently planning a week of Birth Matters 14/2 Autumn 2010 Birth Birth Matters 14/2 Autumn 2010
Maternity Coalition Victorian
By Ann Catchlove

Maternity Coalition Victoria had a stand at the Baby Show in March. Thanks to our volunteers we were able to provide a fantastic independent source of information to women attending the show. Many great conversations were had both with women who were already MC supporters and with many others who had never heard of us. Our information sheets on a range of birthing topics were enthusiastically taken and hopefully provided some interesting and thought-provoking reading amongst all the flures on offer for the latest ‘must-have’ pregnancy and baby products.

In April members of our committee attended a training session on lobbying presented by Emily’s List. We learnt about how community organisations can have maximum political effect with limited resources by campaigning in marginal seats. We now need to incorporate what we have learnt into our planning for the rest of the year and share it with others in MC.

Events to celebrate the International Day of the Midwife were held in Melbourne, Geelong and Ballarat. In Melbourne we had a picnic in the Botanic Gardens.

Felicity Ockelshave is stepping down from her role in coordinating Choices for Childbirth in Melbourne. We thank Felicity for her fantastic work in coordinating the classes and helping so many women to get the information they need to have empowered birth experiences. The next series of Choices for Childbirth will take place in July. Keep an eye out on the website for more details.

Maternity Coalition Northern Territory
By Kylee Sheffield

It’s a missed bag of news from the Territory this edition. On the bright side, our own Mary Phelan kicked off her ‘Go Girl Australia’ venture and is, right now, cycling around Australia to promote midwives and normal birth. In Survival style, she is voicing and choice for women. Members of MC NT, Darwin Homebirth Group (DHBG), Home Birth Service Darwin and many of Marg’s friends and colleagues gathered on the Esplanade in the early hours of Saturday 24 April to put on a BBQ breakfast and send Marg off in style.

A highlight of the event was the unveiling of a line of calico banners, lovingly decorated and put together by heavily pregnant DHBG President Sarah Thompson — with the help of daughters Marshall and Lux, who generously donated their multi-coloured hand prints — and Marg’s friend and midwife-colleague Mo Davy. Each print was labelled with the name of a baby or child whose life has been touched in some way by Marg and carried a message of support for Marg and her team.

Check www.goigaultraustralia.net.au regularly and look for the Go Girl group on Facebook to follow Marg’s journey. DHBG and MC NT members joined local midwives at our favourite beachside picnic spot for the annual International Day of the Midwife celebration. It was a great turnout and a lovely morning was had by all.

Other recent positive happenings include:
• Completion of maternity care options leaflets, which will soon be available to all women through GPs and other providers of early antenatal care, and a corresponding website. For the first time, women in the NT will be able to access current and accurate information on all local pregnancy care and birthing options, education and support groups, and resources.
• Newly established Midwifery Group Practices in both Darwin and Alice Springs are now offering one care for remote women during antenatal visits to town, in labour and birth, and in the postnatal period until they return to their communities.
• Darwin Home Birth Service midwives and clients will soon be able to access the birth centre (albeit subject to meeting the centre’s restrictive criteria). This is good news for women who do not wish to birth at home, but still desire one-to-one care from a known midwife.
• New dedicated Remote Area Midwives positions are being established in a number of remote communities.
• First and second midwives from around the NT have commenced Bachelor of Midwifery studies at the Australian Catholic University — a great first step in increasing the number of Indigenous midwives working in the Territory.

While clearly some improvements have been made over the past twelve months, there is still much to be done.
• Birth centre (Darwin) access remains subject to restrictive criteria, meaning that this potentially excellent facility is largely under-utilised.
• Alice Springs Hospital’s adoption of SA Perinatal Practice Guidelines and Policy for Planned Birth at Home in South Australia has resulted in women who could previously choose to birth at home (under the less restrictive guidelines formerly followed by the Home Birth Service Alice Springs) e.g. women planning a VBAC, now being refused this option.
• Women from remote communities are still being forced to travel hundreds of miles from their homes and families to birth at the nearest major centre. (Even where Remote Area Midwives provide antenatal and postnatal care within the local community, labour and birth must still take place in Darwin, Alice, Katherine or Groote.)
• Genuine continuity of care and care remains available only to the small number of women fortunate enough to access the Home Birth Service Darwin i.e. those who have ‘uncomplicated’ pregnancies and live within the geographic boundaries.
• The NT remains the only Australian state or territory where it is illegal for an independent midwife to practise without indemnity insurance. In 2009 the Territory legislation is changed, the two-year insurance exemption granted by the Federal Government will have no bearing on the NT.
• The Clinical Reference Group formed to address some of these issues along with many other recommendations of the most recent NT Review of Maternity Services has stalled due to a lack of obstetric leadership and bureaucratic and political support (this despite some excellent work from consumers and providers who have

progressed a number of tasks through smaller working groups).

At time of writing MC NT awaits notification of a meeting with Health Minister Kon Vatskalis to discuss these issues.

International News

US Study finds Homebirth Safer

A study of selected US birth facilities published in the American Journal of Obstetrics and Gynecology January found that homebirths are “associated with a number of less frequent adverse perinatal outcomes” when compared to births in a hospital facility.

The study looked at 743,090 births that occurred during 2005 and 2006 for outcomes for babies born in hospitals, birth centres and at home, and found that home and birthing centre births were “associated with less frequent chorioamnionitis [inflammation of fetal membranes due to bacterial infection], fetal and neonatal care, assisted ventilation, neonatal intensive care unit admission and [low birth weight.”


Amnesty International

Shocked by US Maternal Mortality Rate

An Amnesty International report released in March found that 1.7 million US women died of complications related to pregnancy-related complications, and that more severe complications which almost cause death have risen by 25% since 1998. The report entitled Deadly Delivery: The Maternal Health Care Crisis in the US identified those living in poverty, Native American and immigrant women and those who speak little or no English to be most at risk.

The report listed several key issues currently impacting the quality of US maternity care, including:
• Lack of health insurance, particularly among minority groups.
• One-in-four women do not receive adequate prenatal care, rising to

one-in-three for African American and Native American women.
• Problems with Medicaid enrolment may delay access to vital prenatal care for those seeking government-funded options.
• Shortage of health care professionals, especially in rural areas and inner cities.
• Many women have no say in decisions about their care or informed about her risks of various interventions (Caesarean sections make up nearly one third of all deliveries in the US).

The number of maternal deaths is significantly understated due to lack of effective data collection. The full report is at: http://www.amnestyusa.org/demand-dignity/maternal-health-is-a-human-right-the-united-states/page.do?id=1351091.

UK Reclaiming Birth Rally

On Sunday 7 March more than 1000 people gathered in London to attend the Reclaiming Birth Rally organised by the National Childbirth Trust, Independent Midwives UK, the Association of Radical Midwives, the Association for Improvements in Maternity Services and the Albany Mums Support Group.

Filling Westminster Bridge as they marched to Downing Street, ralliers called for improved access to midwifery-led continuity models (including free-standing birth centres and homebirth) for all UK families.

For more information on the Reclaiming Birth campaign, see: http://www.independentmidwives.org.uk.

Birth Matters 14/2 Autumn 2010
Book Review: Pregnant with Heart and Soul

By Nicole Carver

Riet van Rooij is a counsellor with a particular interest in emotional well being and spirituality in pregnancy, birth and beyond. This wonderfully inspiring and beautiful book, encourages pregnant women to explore many different areas including visualisation, rituals, dance and art. It comes with a CD guiding the reader through the emotional and spiritual journey that begins prior to conception and continues through to parenting the resulting child. There is also a useful appendix with relaxation techniques and exercises.

Riet’s approach is so warm, nurturing and insightful. She writes beautifully, encouraging expectant parents to connect spiritually with their baby and each other prior to conception and during pregnancy. She has written an excellent chapter about dealing with anxiety during pregnancy and leading up to the birth. She normalises the fear and encourages women to accept it and work through it using a number of different techniques.

Riet helps women prepare for birth using visualisations, affirmations etc. but then encourages them to let go any notion of how the birth will be and surrender to the experience more often with new, more independent forms of being enveloped and nourished. “Riet goes on to give practical advice to help the baby in developing this sense of security. This is a really practical, positive book, which will help women and their support people to embrace the journey of conception, pregnancy, birth and parenting; and enable a fulfilling experience and the building of strong connections between mother, partner, baby and any other children.

Pregnant with Heart and Soul
By Riet van Rooij
Paperback
Published by Binkey Kok
Publications, 2009
Distributed in Australia by Brumby
Distribution:
http://brumbybooks.com.au

CAPERS bookstore Events 2010

Midwifery Update: Using Water for Labour and Birth and Essential Midwifery Skills for Challenging Situations
• Two one-day workshops with Sheba Capicole & Sheryl Sidey
  • Melbourne 4-5 June, Cairns 30-31 July, Canberra 5-6 November and Hobart 12-13 November.

Keeping Birth Normal & Grief and Loss: The Crying Time
• Two one-day workshops with Sheba Capicole and Hannah Dahlen

Breastfeeding Update and Ethics in Lactation Practice
• Two-day workshop with Carol Bartle
  • Brisbane 10-11 July, Sydney 13-14 July and Melbourne 16-17 July.

CEPIS and MidPLUS points available.

See www.capersbookstore.com.au or call (03) 9318 0151

One of the best ways you can support birth reform is to...

ADVERTISE IN BIRTH MATTERS

Our readers are passionate about birth, babies and making informed choices. If you want to reach savvy, informed mums-to-be, midwives and doulas, have a business that fits with MC’s philosophy and want to support the campaign for improved maternity services, contact: birthmatters@maternitycoalition.org.au

ADVERTISING COORDINATOR WANTED

Volunteer Position Vacant

Passionate about choice for women in childbirth and want to help out? MC needs to grow so that we can spread the message further. We need to do more work behind the scenes to strengthen our organisation and achieve more of our goals sooner!

Birth Matters is looking for an ADVERTISING COORDINATOR.

Author Bio

Nicole Carver is a Maternal and Child Health Nurse from Melbourne and the National Treasurer of Maternity Coalition.

Knowledge Not Fear
Birthtalk acknowledges that women and couples planning a subsequent birth after caesarean do have some specific issues to consider. Birthtalk encourages attendees to approach these issues in the context of working towards an empowering birth, where you are making all your decisions based on knowledge, not fear.

The course enables those preparing for a birth after caesarean to receive evidence-based information, and offers appropriate support to attendees so that they can ask questions and have their fears addressed.

Wont a VBAC just be better? Many women wrongly believe that having a VBAC will make their birth a positive event. At Birthtalk we are often asked “Surely a vaginal birth will just be better anyway?” Unfortunately, many of the things that can make a caesarean such a traumatic way to meet your baby are not restricted to caesarean birth. These things include feeling out of control of your birth, feeling ignored or abandoned, feeling fear or confusion, or feeling unable to ask questions. While having a caesarean can increase the possibility of these feelings occurring (simply due to it being surgery where you are on the operating table), having a vaginal birth in no way protects you or eliminates the possibility of feeling this way.

Empowering and Safe
According to Birthtalk, to make your birth a positive event you need to focus on having an empowering experience. The above list of traumatic feelings is, in essence, the definition of a disempowered birth. All women want their VBAC to be an empowering and safe experience, so it makes sense to focus on turning the above feelings on their head. This means learning tools and accessing information so you feel in control of what happens to you, central to the experience, safe and nurtured, and able to obtain information through questioning your care provider. This will increase the possibility of feeling strong, confident and positive about the parenting journey ahead. Birthtalk offers these tools and other ideas at their VBAC course. ©Birthtalk 2009

One of the best ways you can support birth reform is to...
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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 in other branches in its activities and fundraising. For details of financial arrangements including reimbursement of costs upon presentation of receipts, contact the Treasurer.
Terms of Reference of each branch are to be consistent with those of the Maternity Coalition.

MC online discussion lists and social networking groups

Join an MC email group! MC members are able to keep in touch with other members interested in the same issues via Yahoo! email discussion groups. Please use your real name and surname. Messages are archived. All discussion groups are governed by electronic communication guidelines established by the MC National Committee.

Maternity Coalition on Facebook. There are several birth-related Facebook groups. If you are a member of Facebook you can join any of the following MC-related groups: The Maternity Coalition Inc., Caesarean Awareness Network Australia, and Birth Matters Journal. There are also several branch groups. Jump online and explore!

MCNSW
For NSW members and other interested individuals. For an invitation to join, please contact Carol Chapman
president@nswmaternitycoalition.org.au
or Lisa McFarlane at nswmcfarlane@gmail.com.

MailCo. Are you a member of the Midwives Who Write group? Give birth in Australia becomes a reality for the majority of women. To join contact Tracey Johnstone at joy@jake.com.au.

MCMidwives. For midwives, midwifery students and others who are members of MC who are committed to seeing women chooses birth in Australia becomes a reality for the majority of women. To join contact Tracey Johnstone at joy@jake.com.au.

BACliq is for active members of Maternity Coalition in Queensland. Queensland also has two other lists if you don’t want to join the core group but want to stay informed or receive a copy of the Birth Action News newsletter. Contact qldpresident@maternitycoalition.org.au.
Birth rights, rites and writes

A personal voice rarely heard in discussions about maternity services, Birth Matters is a forum for debate and discussion about the issues that affect birthing women and care providers in Australia.

Simply visit our website at: www.maternitycoalition.org.au and subscribe online to reduce carbon emissions

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PO Box 1190
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A PDF of the brochure can be emailed upon request. Contact secretary@maternitycoalition.org.au

Birth Matters

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For bulk orders (500g or more), please contact the Editor for rates. birthmatters@maternitycoalition.org.au.
Maternity Coalition proudly supports Marg Phelan and Go Girl Australia.

Cycling for midwives, women, normal birth, breastfeeding and informed choice in pregnancy, childbirth and early parenting.

Visit www.gogirlaustralia.net.au and follow the journey