

# BirthMatters

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Winter 2012

## THE POSTNATAL EXPERIENCE



### **This issue:**

Privately practising midwives on  
'collaborative arrangements'

### **PLUS:**

We preview *The Face of Birth*



Our vision: Every woman can choose how, where and with whom she births

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**Contribution closing date for September/Spring issue of *Birth Matters* is Wednesday 1 August.**

Advertising bookings must be received by the 1st of the month prior to publication and ads must be received by the 15th of the month prior to publication.

### 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  
[birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au).

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**Main Cover Photo:** Homeborn water babes Sunday Florence Hammet (R) and Sylvie Pearl Hammet (L) with dad Andrew.

# From the Editor



Looking back at previous editorials, it seems I'm always banging on about the many ways (and there *are* many) in which maternity care providers and policy makers continue to fail Australian birthing women. It's easy to forget that along with the frustrations and disappointments, there're also great things happening. Here are some of those.

Back in March *The Face of Birth* premiered and screened to sold-out venues all over the country, and I'm yet to hear anything but praise for what is, pretty simply, an honest, balanced and real portrayal of birth in contemporary Australia. It's a must-see for any Aussie woman considering how, where and with whom she will give birth, and a must-have for advocates of informed choice (see our full review page 30).

Midwife Marg Phelan has continued her journey and, as I write, is less than 600 km away from her Darwin homecoming on Saturday 30 June. The *Go Girl Australia* ride has taken Marg and her campaign for information, access and choice twenty thousand kilometres, from Darwin to Darwin, through every Australian state and territory. As one of the fortunate women whose life has been touched and changed by knowing her, I'm proud and enormously grateful that so many MC-ers have supported Marg on this incredible journey. We'll have a wrap of her homecoming (sure to be a hoot—that Darwin mob knows how to throw a party!) and an interview with the *Go Girl* herself in our spring issue.

Held in The Hague, the Netherlands from 31 May to 1 June, the Human Rights in Childbirth Conference brought together midwives, obstetricians, paediatricians, neonatologists, lawyers, academics,

anthropologists and consumers from all over the world. Particularly inspiring is the fact that the event was organised entirely by unpaid volunteers. A number of participants have generously allowed us to print works they contributed to the collection of pre-conference papers. These articles and letters are highly relevant to the current challenges facing birth reform in Australia, and fit beautifully into this issue's theme: 'The bigger picture – what's happening elsewhere in the birthing world?' Hermine Hayes-Klein, a key conference organiser, is currently creating

a three-volume work on Human Rights in Childbirth which will expand on many of the topics covered at the conference. We'll provide an update on its release.

In our September edition we'll be looking at the 'who' and 'why' of Australian women giving birth by caesarean section. If you'd like to share your experience, send your story to [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au) by the deadline of 1 August.

Keep warm until then.

Kylie



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## ATTENTION ALL WRITERS, EDITORS AND LAYOUT/DESIGN ARTISTS

We are looking for enthusiastic, motivated and passionate people to fill the upcoming volunteer vacancies of Editor and Layout/Design Artist for *Birth Matters*.

If you care about choice in pregnancy and birth for all women and have expertise in these areas, we'd love to hear from you.

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# From the President



Ann Catchlove

I am writing this report not long after arriving home from the *Breathing New Life into Maternity Care* conference in Melbourne. It was a great conference and there were many thought-provoking presentations and opportunities to connect with others interested in the future of maternity care.

One issue that emerged for me was how we provide women across the risk spectrum with choice and support in their maternity care. It seems that we focus a lot on giving options to 'low-risk' women and largely ignore 'high-risk' women until we are chastising them if they choose to birth outside the system. Hannah Dahlen gave a couple of thought-provoking presentations looking at recent research into why women choose freebirth or midwife-attended homebirth with risk factors. She questioned why we blame the women for their choices and don't instead ask what is wrong with a maternity system that provides such limited options and inspires such fear that women make these choices.

During the conference I attended a presentation reporting on the findings of a randomised control trial comparing caseload midwifery care with standard hospital care for low-risk women. The findings in terms of women's satisfaction were really impressive and hopefully will help lead to the expansion of these models across the country. But I couldn't help but question why so many women (those

not deemed to be 'low risk'), who could most benefit from a known midwife, are excluded from these models.

This presentation was in the same session as my own presentation on *Woman-centred care when the care is against guidelines or advice* and there was some discussion at the end of the session around whether midwives should only be providing care for women having normal births. Bec Jenkinson made a very valid comment in response to this. She noted that, in other areas of health care, the more complex a patient's care needs are, the more valuable continuity of carer becomes. Continuity is important to women regardless of risk status and complexity. Even when women need tertiary care, they still need primary care as well.

A few presentations lifted my spirits and reminded me that there are some really positive things happening in maternity care. Kate Dyer from the Royal Hospital for Women's Department of Maternal Foetal Medicine talked about a midwifery continuity of care model that they have introduced for women who have the very highest-risk pregnancies. It provides midwifery care for women 'when nothing is normal'. It was so wonderful to hear recognition that continuity of care is vitally important for women with complex pregnancies.

Another midwife, Jane Raymond, gave a presentation on a program for obese pregnant women run through St George Hospital in Sydney. A key part of the program is to provide women with supportive antenatal care and access to continuity of midwifery care. Again it was very heartening to hear of continuity models that weren't solely directed at low-risk women.

If continuity of care can be appropriate for the very highest-risk pregnancies, then surely women planning VBAC (vaginal birth after Caesarean) or those with other risk factors should be able to access it as a matter of course. Yet frequently women

with risk factors are excluded from continuity programs. These excluded women will be giving birth in the same hospitals with the same access to medical backup as their low-risk sisters. They will all receive intrapartum care from midwives. The only difference is that the higher-risk group will be denied the opportunity of being cared for by someone that they know and trust. It doesn't make any sense!

Of course some women aren't just excluded from particular models of care, they struggle to gain any respect for their right to make a choice about how they will give birth. A couple of presentations at the conference looked at women's experiences of having breech babies. Danielle Freeth, a midwife from Western Australia who had a breech baby herself, gave a presentation titled *Coercion or consent? Factors affecting the decisions women make regarding the delivery method of their breech-presenting babies*. She looked at the enormous difficulties women face in even becoming aware that vaginal breech birth is an option. Even then, there can be huge difficulties in trying to find a supportive care provider or a hospital that will 'allow' it. How can you 'freely consent' to a Caesarean for a breech baby when you are not given any other options?

Choice, continuity and control should not only be the domain of low-risk women. We need to be pushing for all women to have their choices respected and to have access to continuity of midwifery care if that is what they choose. We should be questioning services that exclude women from continuity models and asking why they can't provide women across the risk spectrum with access to gold standard care. Perhaps then we might not see quite so many women making the choice to birth outside of a system that offers them such limited choices.

Ann Catchlove

## ARTICLE SUBMISSIONS DEADLINES:

**SPRING - WEDNESDAY 1 AUGUST 2012**

**Spring theme: Caesarean sections - who, why and at what cost?**

**Summer theme: Annual report edition**

**Deadline: Monday 22 October**

Articles should be a maximum of 3000 words and be accompanied by photos where possible.

Please email submissions to [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au)

**on or before the posted deadlines.**

# 2012 AGM

## Notice of 2012 Annual General Meeting Saturday 13 October 2012 Time: 4 pm Australian Daylight Saving Time

The Annual General Meeting (AGM) will be conducted via conference call. Members who wish to arrange a connection to the meeting, or submit nominations for a committee position please contact Secretary Georgia Hodges [secretary@maternitycoalition.org.au](mailto:secretary@maternitycoalition.org.au)

### The business of the AGM is to:

- confirm the minutes of the preceding AGM,
- receive from the Committee reports upon the transactions of the Association during the preceding financial year, and
- declare all committee positions vacant and elect office bearers and committee members of the Association.

### All members are invited to join in the AGM.

Please consider how you can support the ongoing work of MC by assisting or nominating to fill one of the committee or office bearer roles.

The management team has been developing a system of mentoring members. We would warmly welcome people to participate in the Committee in an assistant role. This means you learn the ropes as you go, building on the knowledge of existing committee members. The aim is to make the transition to a new committee as successful and smooth as possible.

Below is a quick outline of key responsibilities for each position. Please contact the Secretary for more information or to nominate for a position.

**President:** provides leadership, usually chairs meetings, in consultation with the Secretary, ensure that notices / minutes of meetings are distributed to members in a timely and appropriate fashion and acts as the spokesperson on behalf of the MC. Provides reports to the Committee quarterly on action and representation during the preceding quarter.

**Vice President:** assists in leading the organisation, fills in for President as chair and spokesperson. Liaises with committee members, branch presidents, currently responsible for social network site.

**Secretary:** is the principal administrative officer and needs to make and keep a correct record of all proceedings and resolutions at meetings, including the names of those present and those who tendered apologies, distribute minutes to members of the committee, oversee preparation for and notice of meetings, assist other officers with the preparation of reports for the AGM. Communication with the committee shall be, wherever possible, by electronic mail.

**Treasurer:** to collect and receive all monies due to the MC, to make all payments authorised by MC, to keep correct accounts and books showing the financial affairs of MC with full details of all receipts and expenditure connected with the activities of MC, provide a quarterly profit and loss statement and organise audit of the finances of MC.

**General Committee Members:** assist with specific actions arising from meetings. Take on specific projects to develop the organisation.

**Membership Secretary:** responsibilities include send out renewal reminders, provide annual summary of membership, process and update membership requests, and receipt membership payments and post to recipient.

### Current Management Team Office Bearers

President: Ann Catchlove  
Vice President: Bec Jenkinson  
Secretary: Georgia Hodges  
Treasurer: Jen Egan  
Assistant Treasurer: Jo Askham

### General Committee Members

Bruce Teakle  
Jess Permezel  
**Membership Secretary**  
Bec Telfer

### Birth Matters Editorial Team

Kylie Sheffield (Editor)  
Sonia Bartoluzzi (Assistant Editor)  
Mara Dower (Design and layout)  
Bec Telfer (Distribution)

# Birth in Colombia: a technocratic model in a collectivistic culture

By Laura Tolton

From 'kangaroo care' to soaring Caesarean rates, Canberra-based mother and academic Laura Tolton explores the culture of birth in Colombia.



Laura Tolton

Colombia: the country that pioneered 'kangaroo care' in the late 1970s<sup>1</sup>, was cited more recently in a World Health Organisation (WHO) report as having the ninth highest unnecessary Caesarean rate in the world.<sup>2</sup> A male Colombian colleague tells me that these two things, Caesareans and kangaroo care, fit easily into one cultural ideology about birth. But somehow I feel there is a serious contradiction between the two.

I'm a junior academic, originally from the United States, and my academic loves are women's studies, Spanish, and Hispanic culture. I live in Australia, and, another love of mine, our 18-month-old daughter, was born here. Our birth experience did include emotional trauma and has led me to decide that my new research project is going to be about birth... but not in Australia, in Colombia, where I lived the first five years of my adult life. The most interesting reading I have done about birth, to prepare for our daughter's birth and for this project, has been the work by anthropologists Sheila Kitzinger and Robbie Davis-Floyd.

The anthropological literature establishes a clear relationship between birth and culture. In no culture is human birth regarded "as a merely physiological function. On the contrary, it is everywhere socially marked and shaped".<sup>3</sup> Davis-

Floyd delves more deeply into this idea: "through explicit enactment of a culture's belief system, ritual [such as birth] works both to preserve and to transmit that belief system".<sup>4</sup> In fact, "in any society, the way a woman gives birth and the kind of care given to her point as sharply as an arrowhead to the key values in the culture".<sup>5</sup> I have to wonder: if birth is a cultural ritual that enacts a society's key values, how might birth in Colombia relate to Colombian culture?

Based on the five years I lived in Colombia and the Colombians I have known in the United States and Australia, it is easy for me to understand the connections between kangaroo care, the Colombian practice of medicine and Colombian cultural values. Kangaroo care, the key part of which is skin-to-skin contact, began as a low-cost alternative to incubator care for low birth weight babies. Today kangaroo care is recognised in the literature as having certain benefits over incubator care, including facilitating breastfeeding, accelerating weight gain, functioning as an analgesic, and even improving sleep organisation.<sup>6</sup> It seems natural that such a warm and loving culture would establish the benefits of skin-to-skin contact between mothers and infants. However, I find it harder to reconcile the high Caesarean rates with Colombian culture and the human values of the Colombians I know personally. Unfortunately, the Caesarean rates resonate much more with the stories I have heard from women who have given birth in Colombia.

Doctors in Colombia often provide seemingly 'non-medical' solutions. Through my own experience, and that of friends and family (urban middle-class experiences), I am aware of Colombian doctors recommending, for example, the benefits of taking B-complex vitamins, soaking rolled oats, lowering stress levels, exercising, and clearing your sinuses with salt water and a syringe. I even had a doctor give me a recipe for a revitalising soup! In my mind, this kind of a health philosophy fits very well with the fact that kangaroo care began in Colombia. Kangaroo care is humanising; it uses human contact and provides better mother-baby bonding than incubators.<sup>7</sup>

This is what I would expect from a culture in which *confianza* (trust), *calor humano* (literally 'human warmth', meaning 'kindness' or 'affection') and *vínculos* (links between people) are vitally important.<sup>8</sup>

Extremely high Caesarean rates, on the other hand, suggest that a medicalised model of birth in Colombia is quite prevalent. There don't appear to be official Colombian statistics on Caesareans, but in one publication a doctor reports that rates in private clinics are nearly 90%, and Caesareans constitute 70–80% of births in university-affiliated clinics.<sup>9</sup> Unnecessary Caesareans in Colombia are estimated to cost USD\$75 million per year,<sup>10</sup> and they are known to increase the risk of maternal and foetal death.<sup>11</sup>

How could this happen in a country that seems concerned with keeping health costs down by using natural methods? There is a prevalent view in the Latin American media that the high Caesarean rates are due to women who are 'too vain to push'. That is, that these women are worried about disfigurement as a result of vaginal birth, or afraid of labour pain. It seems more likely that, as in Australia, a complex set of social structures and influences would lead to so many unnecessary Caesareans.

Perhaps Colombia's high Caesarean rates are due in part to the cultural influence of the United States. In parts of Latin America, "Western biomedicine has not only taken over childbirth but is redefining its very nature".<sup>12</sup> The medicalisation of birth is accompanied by a large-scale acceptance of the corresponding ideology, at the centre of which is "the technocratic model of birth".<sup>13</sup>

*"This model encompasses the technocratic imperative—if it can be done with technology, it must be done with technology—an imperative heavily embraced in the developing world, which has suffered at the hands of Western technologies and now looks to them for progress and equalization."*<sup>14</sup>

This technocratic model tends to value technology over science in matters of mothers' and babies' physical and emotional health.<sup>15</sup>

The Colombian women I am closest to tell painful, more personal, birth stories, which are all too similar, in terms of



emotional trauma, to those I have heard in Australia and the United States. They don't speak directly of humanisation or medicalisation but instead of aloneness, roughness and belittlement. When we were preparing for the birth of our daughter in Brisbane, my Colombian best friend told me about her birth experience in Colombia as a way to help us. We have continued talking, as we attempt to understand these life experiences. She has given me permission to write about her story here.

When my dear friend first arrived at the clinic in early labour, the doctor who examined her made her lie down and scolded her for coming in so soon. He then did an internal exam "with no consideration, as if he were doing it through a tube or a bag". He sent her off to walk around for a while. That was at 3.30 am. When he saw her again at 5 am, he asked if her waters had broken yet and then refused to believe her when she said yes. He said that, if they had, her legs would be completely wet. She explained to him that she was wearing a pad, then was forced to take it off in front of him and hand it to him for inspection. He told her they'd have to give her medication to induce labour, because her waters had broken but she "still wasn't dilated". At that point her husband was made to leave. My friend changed into a hospital gown, was given medication to induce labour, and went into a large room with eight other women. She ate something for breakfast, but, by the time lunch came around, she wasn't able to eat. They put

everyone's food on a rack near the door, far away from the beds. Anyone having contractions while stuck on her back in a hospital bed could not go and stand at that rack to eat or drink.

In addition to the pain of labour, my friend tells of how hard it was to be alone, on her back, in bed, with no one accompanying her, no one paying any attention to her or helping her at all. She recalls, "I was lying down the whole time. They didn't let me walk or move around (because there was no one to help... in the clinic there was no one [to help] and they didn't let anyone in)". My friend had induced, extra-strength contractions, for 15 hours. Finally, at 3.15 am, her son was born. Hospital staff put the pyjamas that she had been wearing when she arrived back on her, and gave her son to her to feed. The two of them were wheeled into a dark room where other women who had had their babies were sleeping. My friend didn't even get to take a good look at her son until the sun rose and the room became lighter in the morning. At 8 am the staff finally let her husband come in to visit. After him, one by one, the rest of her family was allowed to take a short turn visiting her.

Overall, my friend says, "It was horrible because I didn't feel like I was treated with consideration but instead, truly, like cattle... with minimal attention so that I wouldn't die and neither would the baby but nothing more... no medicine for pain, no emotional support, no possibility of moving... nothing at all".

My dear friend's experience brings to life the cultural influence that Davis-Floyd says has been implemented in Latin America:

*"The massive importation of Westernized modes of birth, including flat-on-the-back deliveries, the prohibition of family members from accompanying women during labor... the withholding of food and drink, and the overuse of pitocin during labor—all this without the pain relief provided by epidurals, which are too costly for most third world hospitals and clinics to employ."*<sup>16</sup>

Other authors agree that it is common in Colombia for women not to be allowed to choose their positions in hospital births, or to have anyone they know with them.<sup>17</sup>

It bothers me that this sort of medical 'care' seems to disregard what I see as the most prominent Colombian values. In Colombia, human connections and relationships dominate daily life, and spending time together is an important part of affirming these relationships.<sup>18</sup> Colombia "lies amongst the most collectivistic cultures in the world".<sup>19</sup> 'Collectivism' in this sense refers to strong ties between people and incorporation into strong in-groups, especially family, beginning early on in life. The Colombian ideology of relationships revolves around the idea that people are sets of interpersonal bonds,<sup>20</sup> and the way people are situated in their own personal social networks gives each individual meaning and importance.<sup>21</sup> My friend's birth experience seems to directly contradict the values of collectivism and people

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'accompanying' one another in life. But then again, if we consider her experience in relation to the Caesarean rates, perhaps it is logical that Caesarean rates would be high in a country where clock watching, induction, a lack of emotional support and the lithotomy position are widespread practices in birth. I continue to wonder: what cultural values lead Colombia to have such a technocratic model? Can it only be a belief in following US ideas?

Davis-Floyd suggests that oppositional paradigms, models of reality based on an inherent tension between two sets of categories, can be used to characterise core cultural values enacted in medicine.<sup>22</sup> For Colombia, then, one side of the tension could include collectivism and *calor humano*, and the other could come from a belief in the superiority of US values and therefore acceptance of the reverence for technology. Considering that an oppositional paradigm has two sets of values, what other values might be represented in these Colombian birthing practices?

A Canadian article suggests that elective Caesareans might offer women a certain feeling of control.<sup>23</sup> I can't deny that some women have an agentive role in Caesarean rates being high; however, perhaps Colombian Caesarean rates are also related to the fact that Colombian culture itself has a need for control. Colombia ranks high on Hofstede's uncertainty avoidance scale, which represents a need to avoid uncertainty and chaos (likely through some sort of control).<sup>24</sup> The people of Colombia have many examples of what happens when chaos breaks loose. Colombia has a history of instability, including, as major examples in the last century: frequent variations in daily life with changes of the political parties in power; power struggles between the drug lords, the military and the police; and the long-standing armed conflict between the government, the guerrillas and the paramilitaries. Both social hierarchy and ritual provide structure to combat uncertainty and chaos.<sup>25</sup> Birth rituals that respect social hierarchy would represent a number of Colombian values at once.

In my mind, one more cultural element challenges the technocratic model: motherhood is honoured and seen as the dominant part of femininity in Colombia.<sup>26</sup> I have observed a certain attitude toward new mothers, including behaviour such as people giving up bus seats for pregnant women, allowing them to go first in queues, opening doors for them, and the enforced 40-day *dieta* during which women must rest after giving birth. In fact, the importance placed on motherhood as part of femininity is evident throughout women's lives. From the time they are

born, girls are referred to as *mamita* (diminutive of *mamá*), emphasising their reproductive capacity.<sup>27</sup> It makes sense that birth, then, might be viewed as a realisation of women's feminine identity.

This honouring view of femininity is not represented in most Colombian birth rituals. If anything, the birth ritual seems to be linked more closely to the religious idea that women are condemned to suffering in birth because of Eve's sin (Genesis 3:16). Suffering is traditionally a feminine virtue within Catholicism and thus most Latin American countries. According to society's beliefs on this matter, suffering makes women into 'good women', and enough suffering can even make a woman saintly.<sup>28</sup> The religious figure most commonly used to represent motherhood in Colombia is the Virgin Mary. Following this ideal, women are expected to be tender mothers, dedicated to the home, and attentive to others' needs.<sup>29</sup> Through real life and the Virgin Mary ideal, motherhood in Colombia is linked to suffering, self-sacrifice and self-denial.<sup>30, 31, 32</sup> Perhaps in Colombian births women are socialised to believe in feminine suffering through the experience of augmented pain with Pitocin, the lithotomy position, being left alone, and, often, surgery.

Both the understanding of suffering as a feminine virtue and the honouring of motherhood come from the religious realm. These two parts of the Virgin-Mother are related to the syncretism present today in Latin American Catholicism, which includes in some part beliefs of the indigenous peoples from many years ago. The 'mother' part of the Virgin-Mother in Colombia is related to the indigenous Muisca goddess Bachué, representing

pregnancy and exuberance, who was so fertile that in each birth she gave birth to four or six children.<sup>33</sup> The celebration of motherhood that I have seen in pregnancy and postpartum could come from Bachué.

Perhaps the conclusion I must come to is that there are dominant values in Colombian culture that I prefer not to accept. Specifically, I'm referring to the view of suffering as fundamental to femininity which is enacted in the birth ritual by women being placed in a controlled environment with a lack of support, which magnifies physical pain and creates emotional suffering. I suppose my colleague is right—such oppositions can fit together into one system of cultural values about birth—the suffering Virgin versus the exuberant Mother Bachué; US technocratic values of individualism and doctors as the holders of 'truth' versus Colombian 'accompaniment' and *calor humano*—these make up a partial set of tensions and influences which represent Colombian culture in birthing rituals. High Caesarean rates and birthing experiences such as that of my dear friend suggest that the suffering Virgin and US technocratic values overshadow women's physical and emotional needs in the predominant Colombian birth model. As I value the less dominant side, I am interested to learn about alternative models in Colombia, birth models which include Colombian human values, as kangaroo care does in postnatal care.

I have found evidence of two Colombian birthing models that bring community and humanisation into the birth experience. One is traditional midwifery, which appears to be strongest in the areas characterised by violence

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and 'abandonment by the state'. The organised group of Colombian midwives visible on the Internet is ASOPARUPA (The Association of United Midwives of the Pacific). According to their website, "ASOPARUPA seeks to conserve ancestral knowledge and the practice of traditional medicine with scientific knowledge, encouraging unity [and] intercultural solidarity".<sup>34</sup> Today, as we in Australia and the US are working to humanise birth, the developing world is continuing to lose traditional midwives and their related knowledge.<sup>35</sup> Traditional midwifery in Colombia should be supported not only as a cost-saving measure, but, even more importantly, to gain more positive emotional and physical outcomes for women and their babies. Another hybrid model of care in Colombia is found in the medical practice *Procrear*. Doctor Mauricio Espinoza, as head of this practice, promotes the idea of a loving birth and trusting in the process of procreation. Interestingly, *Procrear* works to create a community of families who educate one another about pregnancy, birth, and breastfeeding. Perhaps this community-creating model, based on collectivistic culture, will have something to teach us in Australia about the possibilities for human values and accompanying one another in a fundamental rite of passage in women's lives.

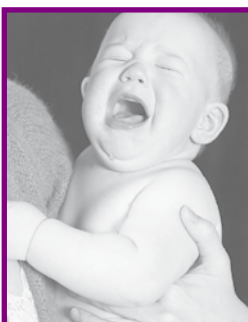
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## Author Bio

Laura is a researcher and lecturer in Spanish, Hispanic Studies and Women's Studies at the University of Canberra. Currently she is working on a project about birth in Colombia. Meeting midwives and birth activists in Australia over the last six months has been exciting for her—what a wonderful group of feminists! You can contact Laura via email at [Laura.Tolton@Canberra.edu.au](mailto:Laura.Tolton@Canberra.edu.au).

# Recovering from birth trauma: finding the silver lining

By Sharon Moloney, PhD

After reading *Something lost - emotional distress after childbirth* in the last edition of *Birth Matters* (Autumn, 2012, p. 14), I wanted to respond with some words of hope for Rebecca and Kim, whose stories of birth trauma may reflect the experiences of other readers. I commend these two courageous women for breaking the taboo of silence surrounding birth/postnatal trauma and for making their heart-wrenching experiences so accessible to us. Women like Rebecca and Kim remind me of warriors lying on a battlefield, shell-shocked and shaken to the core. They have survived the carnage, only to discover that their previous worldview and sense of self have changed incomprehensibly. Their words echo the descriptions of soldiers returning from war zones, who have undergone and witnessed horrors that have changed them forever but which are incommunicable to family and friends. My message of hope is that trauma does not have to mark us permanently. As human beings, we are wonderfully adaptive and, like other species on the planet, we are designed to endure and to recover from traumatic events. In fact, we possess an organic, genetically encoded restorative capacity within our own body that enables us to heal from trauma completely (Berceli, 2008). In this article, I want to share my discovery of this natural capacity, as well as some inspiring stories of recovery from birth trauma drawn from my private practice as a hypnotherapist.

Before doing that, I want to describe a model of the human person that enables us to appreciate why the experience of birth trauma is so profoundly disorienting and destabilising, and also why it has such tremendous potential for transformation (see Figure 1). This model, which takes the form of a medicine wheel, comes from an Indigenous tradition known as the Sweet Medicine Sundance Path (Reagan, 1994). Each aspect on the wheel corresponds to a different direction (north, east, south, west & centre) and each direction is associated with a different element from nature (air, fire, water, earth & void). In

this tradition, it is believed that human beings experience the natural elements in the following way: emotion = water; the body = earth; the mind = air; the spirit = fire; and our sexual soul force energy = the void. The teachings describe the function of the different dimensions of our humanity as follows: emotions flow, the body holds and transforms, the mind receives, the spirit takes determinative action, and our sexual soul force energy, which is right at the centre, is the catalyst for all the other dimensions.

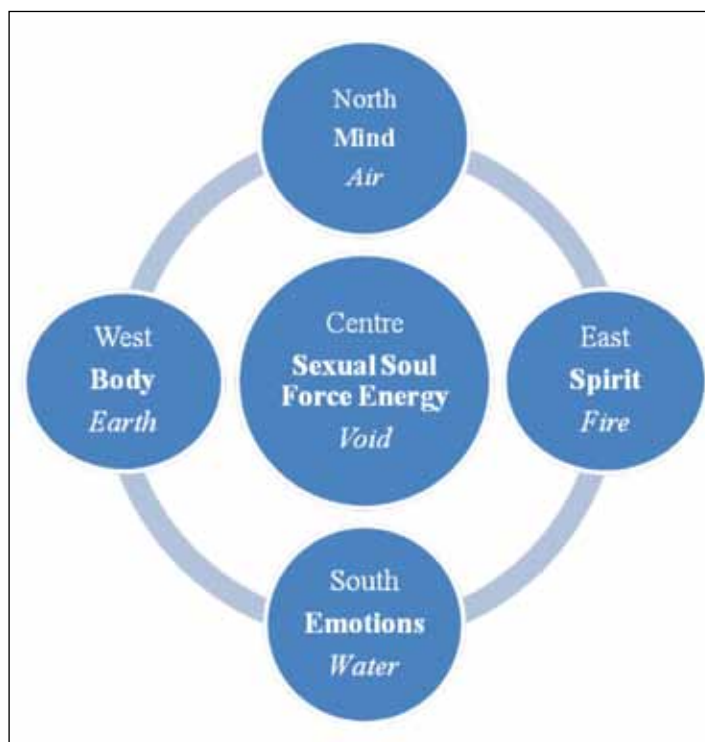


Figure 1. Medicine wheel model of the human person

In this model, our sexual or soul force energy is like a fulcrum upon which all the other elements of our humanity depend. As the animating core, it “literally catalyzes our life and sparks all other aspects of ourselves, giving us our identity as human beings” (Thunder Strikes & Orsi, 1999, p. 196). Birthing is a quintessential sexual experience during which the life force is powerfully evident. This model shows us that it is our soul force energy that is engaged during birth. All the other aspects of our humanity are also significant at this time. The mother’s emotional state plays a crucial role during

labour; fear, for example, can cause the whole process to shut down. The body obviously participates very intensely and actively. A labouring woman’s mindset, and that of her caregivers, can significantly shape the birth experience. And her spirit, her determinative action, can make a huge difference to the outcome. However, all these aspects, which sit at the circumference of the wheel, are catalysed by what is at the centre: a woman’s sexual soul force energy. This is the primary driver that activates and integrates all the other dimensions.

Birth is a threshold or transitional state that bridges visible and invisible worlds. During birth, a door is opened into the integrative core at the centre of the wheel. What is accessed through that doorway is both personal and transpersonal: personal because our core is the seat of our identity, yet transpersonal because we are exposed to the raw, primordial energy of life itself. In many Eastern traditions, the void is seen as the womb of the universe from which everything in creation emerges. During my PhD research, I was privileged to hear birth stories that bore witness to this phenomenon—women describing their births as orgasmic, bliss-filled experiences of oneness with the universe that transformed

their sense of self.

However, by the same token, this powerful threshold experience also holds the potential to be truly devastating because of its extraordinary access into that integrative core. The above model enables us to appreciate how exceptionally vulnerable women and babies are during this time. Caregivers’ words, looks, gestures, attitudes and behaviours can penetrate deeply, with repercussions far beyond what would normally be the case. Damage inflicted at such a fundamental level can be experienced as catastrophic, literally soul-destroying. As a consequence, the sexual soul force energy, which catalyses all our other aspects and gives us our identity, is disrupted and thrown out of balance; the axis of the world begins to wobble. As we read in

Rebecca and Kim's stories, the experience of disintegration from birth trauma is profoundly disorienting and shattering.

The above medicine wheel, in addition to being a wonderfully rich description of the human person, highlights the insufficiency of the bio-medical model and its inability to engage with the complexity and mystery of what it is to be human. Even the bio-psycho-social model now being taught in some universities falls short of the mark when it comes to birth. The medicine wheel also enables us to see why crimes like rape or paedophilia are so deeply violating; they strike to the core of our being, provoking deep, enduring feelings of shame, guilt, anguish and loss of a felt connection to oneself. Women sometimes describe birth interventions as being akin to rape. While it may have been just another day at work for hospital staff, a traumatic birth is something that can continue to affect a woman for years to come. It is often the beginning of a deep soul-searching, in which she looks for a way to call back to herself what was lost during labour and birth. In a very real sense, this is a work of soul retrieval. The result is not a reassembling of the person who began the journey, but rather a transformation of identity, the becoming of an expanded, wiser, more compassionate person.

In my practice as a hypnotherapist, I have supported many clients to negotiate this passage of recovery after birth trauma (names and details below have been changed to preserve anonymity). Danielle came to see me when she was pregnant with her second child. I first met her at a social event and, whenever she spoke about her first birth, she could not stop crying. Danielle had undergone a number of interventions (induction, augmentation of labour, forceps) without being consulted, which left her feeling like she had no decision-making power and that her body had failed her. She was terrified about giving birth to her next baby and clearly showed signs of post-traumatic stress. Hannah also came to see me after a traumatic first birth. She had experienced a strong urge to push when not fully dilated and, despite being given pethidine and an epidural, still had the urge to push. After a very long labour, Hannah underwent a Caesarean section because she felt bullied by two doctors who told her she would kill her baby if she didn't. When Hannah came to see me, she felt angry and resentful towards both the doctors and her son, and, most distressingly, felt no real connection with her baby.

Katie conceived with the help of IVF and, after a good pregnancy, experienced an epidural and forceps during the birth

of her baby. She tore badly, resulting in a fissure, incontinence and other pelvic floor problems, including no sex life. Katie was devastated and wondered if her life would ever be the same. Another client, Tamara, experienced birth trauma for different reasons. During a long labour, she felt unsupported by both her partner and caregivers. When her baby was born blue, there was an emergency resuscitation and he spent five days in NICU. She remembered a specialist making a comment about her to a group of students and the impact of the whole experience had been so shattering she doubted if she would have any more babies.

As these stories show, each woman's experience of birth trauma is unique and yet the resulting consequences are similar: shock, distress, disruption to everyday life, feelings of devastation, anger, resentment and powerlessness. For many women in this predicament, a common tormenting factor is the loss of a sense of connection with their baby, often accompanied by deep feelings of shame, failure and guilt. The analogy of the warrior lying on the battlefield is apt here. If a soldier lay injured and bleeding after having just survived an episode of carnage, no one would expect her to get up and begin looking after a new baby. She would need to be attended to and comforted first; her injuries would need attention and time to heal, the shock subside, an opportunity to tell the story to someone; then she would need support, encouragement and confidence building to find her own way of mothering.

When a birth has been traumatic, for whatever reason, the baby serves as a constant reminder of the ordeal. Yet there is intense expectation from both oneself and others to mother as if all was well, as if there had been no trauma. One of the metaphors I use to describe this double bind is a series of boulders between mother and baby that impedes their ability to connect with each other. When the boulders are moved out of the way, the abiding love of a mother for her baby is free to express itself spontaneously. Hannah was a good example. After her second session with me, she sent an email saying: "To be perfectly honest, I thought you were up the garden path when you talked about associating my baby with the trauma of his birth but I am so glad I went along with you. After my session with you, nothing could get me to part with him, I loved him feeding because when he was feeding I fell in love and bonded with him all over again."

How do we move the boulders obstructing that love out of the way? There are a number of processes that can be effective. Understanding how our brains process traumatic events can, in itself, be helpful. The brain processes millions of bits of data continually. When it is not distressing, this data is sent to the part of the brain associated with memories and feelings, which then connects it to similar experiences from the past; this information in turn is forwarded to another area of the brain where it is turned into a story about our experience (Berceli, 2008).

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Trauma, however, is processed differently because it produces an overwhelming, intense arousal of our whole system. The information is stored as fragments in the sensory part of the brain, where they remain chaotic, compartmentalised and disconnected from the memories, feelings and bigger story. During trauma, the deep structures of the brain activate an alarm response involving the neurotransmitters dopamine, adrenaline and noradrenaline (the catecholamines). Although our system is designed to deactivate after a stressful event has passed, sometimes the 'on' button gets stuck and won't switch off. We then experience anxiety, dread, panic attacks, social aversion and other symptoms of post-traumatic stress. As I describe later, there is a way to switch off this alarm and re-establish the body's natural state of wellbeing.

In my work with clients, I use a number of simple processes to facilitate clearing the boulders between them and their babies out of the way. I listen exhaustively to their story, empathising with their feelings and clarifying what actually happened. Then I guide them into their own deep relaxation response, a well-documented, innate, self-healing mechanism shown to alleviate a wide variety of physical, emotional and psychological conditions (Benson, 2000). Once clients are experiencing the comfort of their deep relaxation response, I then enlist a variety of hypnotherapeutic, neuro-linguistic programming (NLP) and other soulful processes to enable them to reframe and integrate what happened, without being re-traumatised in the process. The brain lock begins to let go, so the fragmented data can be processed. My goal is to facilitate clients' soul-retrieval. They do the healing themselves; I simply create conducive circumstances in which that innate healing can occur. In a way, I act as a midwife to the client's birthing of herself.

When that healing occurs, there is no longer pain at the memory, but rather memory of the pain. For example, after our sessions together, Danielle stopped crying when she talked about her first birth and went on to experience a peaceful, empowering and healing three-hour labour with her second baby. When I saw her to prepare for her third child's birth, she was still going strong. Katie, who had torn badly during her first birth, noticed a dramatic improvement after her first session. She told me she was no longer distressed about the birth and had stopped blaming herself; she was also delighted to have her sex life back again. Tamara, whose baby had spent five days in NICU, arrived beaming for her second

session, announcing that her distress was completely gone: "I feel such a huge difference, I can't thank you enough!" She said she was now planning another baby soon.

I consider it an honour to work with these women. It takes courage to make that healing journey when the time is right; the soul has its own timing and internal logic which need to be respected. In addition to working with birth trauma, I have also used the same processes with other clients (both male and female) to address traumas such as the death of a baby or other loved ones, childhood abuse (sexual, physical, emotional), sexual assault and car accidents.

Recently I came across another approach to resolving trauma, which is invaluable. David Bercei's book, *The Revolutionary Trauma Release Process*, provides a simple, highly effective way of releasing trauma out of our bodies. Bercei identified a precise series of muscular movements triggered by traumatic events that are meant to increase our odds of survival. The flexor muscles in the core of our body—primarily the psoas muscles—contract in response to the neurotransmitters of alarm, the catecholamines. The psoas muscles protect "the center of gravity in the human body, located just in front of the third vertebrae of the sacrum" (Bercei, 2008, p. 39). As part of the fight-flight response, these muscles connect the back with the pelvis and the legs, mobilising us to run or defend ourselves from attack. However, this muscular trauma response needs to be switched off. Chronically contracted psoas muscles hold a pattern of tension that doesn't respond to massage, exercise or a soak in the bath. The most effective way of releasing this deep tension is a series of simple leg and pelvis exercises designed to engage the psoas. This sequence of exercises evokes a neurogenic tremor, a gentle shaking, which is the body's innate way of completing the discharge of energy associated with the trauma response.

Children tremble freely when they experience traumatic events but as adults we have been socialised out of this ability because it makes us feel vulnerable or out of control, and is seen as a sign of weakness. As Bercei observes: "Our body wants to shake to discharge the excess energy, but our mind refuses to let it do so... and our body must then find another way of dealing with this hyper-aroused charge" (2008, p. 49). The gentle tremor evoked by these exercises loosens up the chronic tension stored in the muscles and sends a signal to the brain that the danger has gone and it can now turn off its alarm. I am now incorporating this very useful

knowledge into my client work with encouraging results.

Trauma can visit us in all kinds of different circumstances—it can happen during labour and birth, as it did for Rebecca and Kim and many other women, or it can happen through a car accident, a SIDS death, a flood, a cyclone or the death of a spouse. The experience of trauma is part of life on planet Earth. As adaptable organisms, we are beautifully designed with innate abilities to endure and not just survive traumatic events, but undergo expansion and transformation as a consequence. When the bubble of our previous worldview is ruptured by trauma, it provides an opportunity for self-exploration and self re-invention that can accelerate our evolution. No one wants adversity but, despite how bleak things might look initially, there is a silver lining.

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# On beyond Cambridge: a journey of healing through continuity of care

By Erin Horsley

*From Cambridge, England to her hometown of Melbourne, Erin Horsley shares her maternity care experiences and explains the crucial part continuity of carer played in her journey of healing from birth trauma.*



Erin welcomes beautiful Sylvie

mothers. I read anything I could find by Sheila Kitzinger, and explored natural and active birthing—soaking it all up. I firmly set my heart on a natural birth, which I felt would be best for my baby and for me.

At our home visit at 30 weeks, Jan ran through our birthing choices: I could either have a homebirth or birth in the midwife-led unit at the Rosie Maternity Hospital. I was very keen to have a water birth and the Rosie had a couple of birthing pools. Initially we found ourselves quite confronted by the idea of homebirth. It was a complete culture shock, as prior to this our limited experience had been watching friends select obstetricians and private hospitals. Nine years later it kills me that a homebirth was offered to me on a platter—for free—yet we

chose a hospital birth.

I really appreciated having my visits with Jan; I loved the relaxed nature of her care, and her ability to listen. It was not until I returned to Australia and found out how difficult it was to receive this sort of care in Melbourne that I realised we had accidentally stumbled on the maternity care jackpot!

When I passed into my 40th week and it didn't look as if my baby was quite ready to be born, this first pregnancy turned sharply into a nightmare. I didn't know it at the time, but my experience of this first birth was to lead my life in a different direction: through foggy postnatal recovery with post-traumatic stress and onto becoming a passionate birth advocate. At 41 weeks Jan told me that the hospital would want to set a date for an induction. I was fearful of this, knowing that it could cause a 'cascade of intervention'. Somewhat stupidly, I now feel, I kept positive and thought our baby would choose its own birthday.

At 41 weeks +3 days I reluctantly and very sadly went into the Rosie Maternity Hospital for what I thought would be a check up. Despite feeling sick to the

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*As I began to receive emails from home asking me if I had chosen an obstetrician or hospital yet, we had our first meeting at our local GP's surgery. This GP warmly told us that I wasn't ill, that in the UK pregnancy was considered a normal stage of life, and that my care would be provided by a midwife.*

stomach, I naively believed I would be able to come home afterwards and wait for that exciting first contraction. Sadly, the hospital was keen for me to stay overnight. When I met with the Registrar the next morning, she scheduled an induction, sternly telling me; "At 41+ weeks you don't want your baby to die, do you?"

At 12 pm my first sympathetic midwife Jo suggested we try artificial rupture of membranes (ARM) before syntocin. Unfortunately, there was meconium in my waters. Jo knew I was reluctant to have syntocin and to be strapped to the bed, so she suggested we go for a walk to see what might happen. With nothing but light contractions I was placed on the drip an hour later, feeling shocked, cheated, and emotionally numb. I laboured upright on a birthing ball, tried a Tens machine and remember getting very angry with the foetal monitor. By the second midwife shift I was very uncomfortable and feeling very upset, but unable to express in words why. I had become a 'good patient' on the outside, but with something shifting and becoming rattled on the inside.

The syntocin-fired contractions had no natural ebb and flow and the midwife suggested an epidural. I somehow agreed to it—a place I did not want to go. When I look back now I realise that it was the only thing offered to me at the time. I am disappointed that at that point of distress I was not encouraged to try something

In 2003 we moved to Cambridge in the UK, for my husband to complete his post doctorate. At that time, we were excited to discover that we were taking along a special piece of luggage: I was pregnant with our first child.

We arrived in England somewhat overwhelmed by these dramatic changes, and soon realised that we had stumbled across a very different birthing culture to that of Melbourne. As I began to receive emails from home asking me if I had chosen an obstetrician or hospital yet, we had our first meeting at our local GP's surgery. This GP warmly told us that I wasn't ill, that in the UK pregnancy was considered a normal stage of life, and that my care would be provided by a midwife. The following week we met our midwife, Jan, who came to our tiny flat for the first of many home visits.

Our healthy baby grew and I saw Jan regularly for check ups at the surgery, a short walk away. I was a picture of health as an expectant mother at the age 27. Jan encouraged me to make contact with the *National Childbirth Trust*, who ran antenatal classes, and the Cambridge-based charity *Birthinglight*, so that I could meet other



else—as I had wanted—and couldn't advocate for my needs better. Like many women who have experienced this situation, I am haunted by 'what ifs'.

Four hours later our daughter was born. I was excited to meet her, yet stunned and emotionally numb. She was brought into the world by cold shiny forceps. Not something I had wanted for her. Later I found out they were low and I did not require an episiotomy, only tearing when her shoulders were born—however this birth would continue to haunt me for the years that followed.

The early days with our dear Stella Lily were fraught. The birth had rattled me, yet I wasn't able to understand or express this. I was silenced with the cultural standard of 'Well you should be happy to have a healthy baby and that's all that matters'. This is as rife in the UK as it is in Australia.

Despite my distress, what stands out in my memory is how well the community-based midwifery care kicked in. Friends in Australia were shocked that I was 'allowed home' two days after birth—but they didn't realise that I came home to daily visits from my known local midwife Jan, sometimes twice a day, and in the late evenings as I struggled with breastfeeding. In my determination to breastfeed (there was no way I was going to 'fail' at that, like I felt I had 'failed' at birth), I had hurt my nipples. Jan saw me struggling in a lot of pain, and by that stage she knew me well and understood how much breastfeeding meant to me. So from that point on she stepped up her visits. With Jan's continuing care, by the fourth postnatal week Stella was a thriving fully breastfed baby. It hadn't been easy, and without Jan it might have turned out differently.

After a shaky start we loved our experience living in beautiful Cambridge until well into Stella Lily's second year. The only thing darkening this time was that I had great difficulty understanding and processing her birth. I suffered from nightmares, flashbacks, anxiety, anger and sadness. I was in conflict because, on paper, it looked like a healthy birth—so it was difficult to get help. Friends assumed that, because I didn't have a C-section, I had a good natural birth—but to me it was far from natural. I felt silenced by those who gave me the line about 'a healthy baby being all that mattered'. I felt that my body had failed and, in turn, my body had been ruined by the forceps. I felt I hadn't done enough or been clever enough to get a good birth experience. I was hard on myself and equally ashamed that I had clearly put too much importance on a good birth. I berated myself for not being grateful when other people had lost

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*Despite my distress, what stands out in my memory is how well the community-based midwifery care kicked in. Friends in Australia were shocked that I was 'allowed home' two days after birth—but they didn't realise that I came home to daily visits from my known local midwife Jan, sometimes twice a day, and in the late evenings as I struggled with breastfeeding.*

their babies. I was also terribly angry that I had not been supported enough and that those close to me didn't understand how important birth was to me.

I was lucky to start working on some of this in the UK with Sheila Kitzinger via her birth trauma phone counselling service. The counselling was the first time I felt heard and that my pain was not dismissed. Kitzinger went on to publish some of my artwork based on my birth trauma in her book *Birth Crisis* published in 2006. Helping women with birth trauma was in its infancy in the UK (and also in Australia, I found out later). I struggled on, yet within a year of our return to Australia I felt brave enough to try for another baby.

Pregnant again in 2006, we found ourselves in birth culture shock—but this time in our home town. I was completely flummoxed by the disjointed system in Australia. The first GP I saw assumed I had my own obstetrician and was totally confused by me asking how I could access continuous care by midwives. He proudly told me that it wasn't possible in Australia (clearly feeling midwives were not qualified enough). I left this GP as I felt he didn't quite believe the depth of my distress about my previous birth and told me that a good OB and a C-section would 'fix it'. I didn't want fixing—I wanted a natural birth!

Another GP suggested I try the Family Birth Centre (FBC) at the Royal Women's hospital, Melbourne. This felt right—not quite my own midwife, nor a short walk away, no home visits, but care by a midwifery team. I met an understanding midwife, and then had to be cleared by the OB. This doctor smirked when I explained my distress and told me I would never be 'allowed to go over the due date as much as you did in the UK.' I felt so angry—why

wouldn't anyone believe me and why was it so hard to get someone to care for me? At 23 weeks pregnant I did not feel safe in my health care at all.

I booked into the FBC, however I wasn't able to relax. At my next appointment I was told that the centre was being closed a couple of nights a week, which sent my anxiety levels flying. The midwives were doing the best they could in an unpopular system. I knew then that I had to find another option. I couldn't just leave it to fate, as I had in Cambridge. I had to get to know my care provider and I was determined that this time they would be there for the birth.

We then knew we had to find enough money to pay for an independent midwife. This was the best option for me, where my concerns were heard and plans were put in place to birth my second baby naturally. I finally felt safe and could begin to trust my midwives.

In June 2007 we welcomed our second daughter, Sunday Florence, at home. It was a strong powerful birth. I finally felt connected to all that I had longed for. I felt so strong, so elated and emotionally connected to my body and this birth. I had waited a long time to feel this way, and can't thank my midwives Clare and Nicola enough.

Emotionally I experienced a lot of guilt about this wonderful birth, and realised I needed to further grieve the loss I felt about my first birth. Despite so many people telling me to 'get over it' and 'all that matters is a healthy baby', my experience had shown me just how much my first baby and I had lost.

I am now eight years older and I think I have finally achieved some peace. Many things have got me here, including the guilt-free home water birth of my third daughter, Sylvie Pearl, in 2011. Joining the MC Victorian committee in 2009 and helping to set up our *Moving beyond a difficult birth* workshops with Rhea Dempsey in Melbourne, for women like me, has also helped.

I am grateful for my midwifery care in Cambridge. It gave me such an understanding of the importance of continuity of care. I now understand that first birth better and, while it remains a disappointment, it no longer holds me in such distress. I can see it taught me to follow my heart more, communicate what I want more clearly, and that I needed to fight for the subsequent births I believed I could have. That experience helped to create in me a passion for birthing well and improving the maternity care of other women in Australia. It also made me understand the importance of championing the need for women to grieve the births that have upset them.



# Refugee women give birth in Ontario, Canada: observations of a birth companion

By Brittany Irvine

*Canadian doula Brittany Irvine shares her experiences as birth companion to two African refugee women in Ontario. This piece was originally written for International Settlement Canada and the Centre for International Migration and Settlement Studies and has been edited for use in Birth Matters.*



Canadian doula Brittany Irvine

paper is about my experience with my first two clients, both whom are single women without intimate partners. They are also both refugees from Africa who have chosen to settle in Ontario. Both women gave birth to babies whose Apgar scores were nine out of ten at one minute after delivery, and nine out of ten at five minutes after delivery. I saw these healthy babies come into the light, saw their mothers labour through contractions. I listened closely to the metaphors the women used to describe their birthing experiences. I will discuss each case in turn. I have used the connotations 'Client 1' and 'Client 2' to protect the identities of the women involved.

I met Client 1 for the first time on 23 April 2011 at a café near my home. Going into the meeting I knew that this woman was a refugee, that she was 37 weeks pregnant, and that she was living at a local shelter for pregnant women and very new mothers. I asked her how she was feeling and she said she was okay. Although she was at full term, she did not have a huge belly at that time. It was during this initial meeting that Client 1 told me she had emigrated from Uganda and had been in Canada for nine months. She currently relies on government benefits and considers herself homeless. She mentioned to me that she was really looking forward to the baby being born because she would have someone to talk to. She said that she and the baby would have each other as family. She said that in her first trimester she did not really feel too much connection to the baby and that she experienced morning sickness, which made it difficult to function. But throughout her third trimester she had grown increasingly attached and felt she had bonded with her baby. It was at that point in our meeting that my client pulled ultrasound pictures from her bag and showed them to me. I found it difficult to see exactly the outline of the foetus, but she pointed out the forehead, nose and

lips and said that in the second photo the image showed that her baby had her hand resting on her forehead in contemplation.

My philosophy about volunteering my time with pregnant women who have been deemed vulnerable is that it is best to not ask too many questions, to not pry for unnecessary information. I did ask Client 1 whether she planned to breastfeed, to which she answered a definite yes, commenting that she had seen her mother breastfeed and wanted to do so herself. I asked about her living situation and she told me that she had a private room at the shelter. She said the food being offered there was different from the food she was used to and she was finding it difficult to eat. She had lost five pounds in the course of the previous two weeks. She said she was trying to eat for the sake of her baby. I told her to eat as many fruits and vegetables as she could, and she replied that she was trying, but did not have much appetite.

Mothers with newborns are allowed to stay at the shelter until the baby is three months old, at which point they must move on and find somewhere else to live. If there is a teenage mother on the waiting list for a room, the possibility exists that new mothers will have to move on as early as three weeks postnatal. So my client needed to find somewhere to live. She said to me that she wanted to just have the baby, start her future and find an apartment in the city where she could settle in. She told me that she wanted to become a registered nurse—that she studied chemistry back in Uganda. So I guess I did ask a few questions; however there are also questions I did not ask of her. I felt she would volunteer information freely if she wanted me to know.

On 6 May at 2 pm, my client called me and said that we would leave for the hospital at six in the evening. At 4.30 pm she called back and said that she was ready to go to the hospital at that moment. I called a taxi and rushed to the shelter, where I saw my client was in pain. The taxi took us to the local hospital. It was a slow walk to the Family Birthing Centre. My client stopped walking during her contractions. They were strong and painful for her to endure. She was admitted to the obstetric unit right away as her membranes ruptured during her triage

I began volunteer work as a 'birth companion' in the Canadian Mothercraft Program in the early spring of 2011. I had filled out an application form and was interviewed to join the program; by February 2011 I was attending training sessions. I completed a 40-hour training course designed to help me to learn to be a doula. Once I have seen six live births I will be certified through my local Doulas Association.

Pregnant women who are deemed vulnerable are referred to the Canadian Mothercraft Program by their health care providers. Family doctors, obstetricians and public health agency workers can all make referrals. Once a client has been referred, the Mothercraft Family Outreach and Doula Support Worker meets with the client, documents what issues the client is facing, and then matches the client to a birth companion such as myself.

At present I am supporting six clients, two of whom are in the postpartum period; the four others are set to deliver within the next three months. My volunteer work with Mothercraft is fulfilling and I think it is special. This

cervical examination. My client asked repeatedly for an epidural but it took hours for an anaesthesiologist to reach her room. As her pain continued to rise and fall my client said to me that labour was war.

Very early in the morning on 7 May, my client delivered a baby girl. According to the obstetrician who sewed her up, the name she chose for her baby means 'blessing'. At a postpartum visit later in the spring my client commented that she could never imagine beating her daughter, although she had been beaten by her mother until she was 14, and beaten by her father until she was 20. She said to me that she never once witnessed her father hit her mother though.

I met Client 2 on 16 May. Mothercraft provided me with a little information about her, including a phone number where I could reach her. She was due to deliver her baby on 18 June. I visited her at the lodge where she was living. On this first visit we did not have an interpreter with us, but on later visits the local Women's Immigrant Centre provided a woman to interpret English to Edo for my client's sake. The interpreter was present at the birth too.

Client 2 arrived in Canada from Nigeria in April 2011. I learned she had been living in fear for many years. Her husband was severely abusive. He had induced miscarriages through violence twice. He had circumcised her when she was a teenager. He was going to kill her because she was pregnant. He was the chief of her village and my client's father was given land from this man in exchange for his daughter's hand. This man had locked my client into a room as my client's third pregnancy began to show. She jumped out of the window and ran. She made it to Lagos and an uncle of a friend helped her to buy a plane ticket to Canada. She has large serving spoon sized scars up her arms and down her legs. She has infections in her teeth because her husband bashed her in her jaw. She has a large stab wound under her left breast. The Department of Citizenship and Immigration has made arrangements with the lodge where she currently resides for her to stay on for a while. I asked her if she felt safe and she responded affirmatively. She said that she had asked her lawyer if there was any way her husband could find her in Canada and her lawyer had reassured her that she cannot be traced. My client has other health problems: she has a blood disorder called thrombocytopenia and she has hepatitis B. She had no prenatal care until she arrived in Canada, but since arriving she had been seeing a doctor at the local hospital once a week.

On the morning of 15 June my client called me saying that she had some blood leaking from her vagina. I quickly called a cab, made my way over to her motel,



picked her up and together we went to the hospital. The interpreter met us there. Things did not progress smoothly. My client was given a transfusion of immunoglobulin to help with her platelet counts. As her labour progressed it became clear that she was going to have a 'high-risk' delivery. Because of her thrombocytopenia she was not able to have an epidural—her doctors feared she would bleed too much. At 11 pm on 17 June my client was transferred by ambulance to a tertiary care centre. I had been with my client off and on since the 15th, but once we arrived at the tertiary hospital I stayed with her for the duration of her labour. She failed to progress between 2 am and 9 am, so in the late morning of the 18 June her obstetrician ordered intravenous synthetic oxytocin. This helped to dilate her cervix the rest of the way and by 10 am my client was transitioning into the pushing stage of labour. As she pushed her interpreter held her hand; I applied counter pressure to her foot, as did her nurse. She cried, "Blood of Jesus," many times over. Her baby's

heartbeat decreased with every contraction during the pushing stage, so her doctors cut an episiotomy to help widen the birth canal. The baby was born at 10.40 am with a good heartbeat. He cried right away. My client chose meaningful names for her son. One of his names is a Nigerian word that means 'no human is God'. My client chose this name because when she and her husband would quarrel she would defend herself as much as she could by saying that he was a chief but that he was not God.

I hope to continue my work in the Canadian Mothercraft Program as I treasure these experiences.

#### Author Bio

Brittany Irvine is a professional doula practising in the Ottawa area. Her graduate studies are about the state of the modern obstetrical care system. To learn more please visit her website at [www.necessarydoulas.com](http://www.necessarydoulas.com).

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# Human Rights in Childbirth Conference report

By Ann Catchlove



The *Human Rights in Childbirth* Conference in the Hague on 31 May and 1 June 2012 brought together women, midwives, obstetricians, lawyers, ethicists and many others interested in the legal and human rights of birthing women. Luckily for those of us who live a long way from the Netherlands, there was the opportunity to participate by webinar (web-based seminar) and to follow the proceedings through discussions on Facebook and Twitter.

There was a really impressive range of panellists at the conference, including, among many others, Ina May Gaskin, Robbie Davis Floyd and Michel Odent. The conference was structured around a number of different panels, with several panellists each speaking for five minutes before having time for questions. The first day was focused on international and European perspectives on human rights in childbirth. The panels included topics such as *Safety, risk, costs and benefits: weighing choices in childbirth* and *The rights of the baby: the interests of the unborn child and the power to speak for those interests*. The second day was focused on the legal situation in the Netherlands and included the topics: *Cases on the edge: controversial birth choices in the Netherlands* and *The future of choice in the Dutch obstetric system*. As the organiser of the conference, Hermine Hayes-Klein, commented afterwards, it is amazing how much a person can say in five minutes. The short time limit really made the speakers focus on what was important and allowed a wide range of perspectives to be heard.

The impetus for the conference was the decision by the European Court of Human Rights in the case of *Ternovszky v Hungary* that being able to choose a homebirth is a human right. It was fantastic to be able to hear from some of the key players in the case including Anna Ternovszky, the

mother who took her case to the court. The case sprang from her discussions at the kindergarten gate with a fellow mother who worked for the Hungarian Civil Liberties Union.

Anna Ternovszky's midwife was Agnes Gereb. Despite the victory in Anna's case, legal proceedings continued against Gereb relating to her attendance at homebirths in Hungary. Gereb was a panellist *in absentia* at the conference. In

early 2012, an appellate judge in Budapest upheld a lower court's judgment against Gereb and sentenced her to two years imprisonment, which is being served by house arrest. She is waiting on the Hungarian president's consideration of a clemency petition.

What I found to be both heartening and challenging about the conference was discovering that we are not alone in the challenges we are facing here in Australia. It is easy to feel that our Australian situation is unique in the world at this time. The issue of insurance for homebirth here is certainly a huge hurdle. With no solution in sight at present a midwife attending a homebirth after July 2013 would be in breach of her registration. At the same time, there is an ongoing debate around whether midwives can attend women (at home or elsewhere) who make decisions against guidelines or advice. There is a strong push from regulators and government at the moment to prevent midwives from attending women planning VBAC at home or women with other risk factors. The insurance issue is being used to push this agenda (namely, if we get a government-supported insurance product it might only cover low-risk homebirth or a further exemption to the insurance requirement might have strict conditions).

Listening to the conference participants I realised that women across the world are struggling with these same issues and the impact that they have on their choices. Australian independent midwives are not alone in their inability to access insurance—in many other countries there is also no insurance product for midwives to purchase. Similarly, we are not the only country facing a situation where insurance is becoming or has become compulsory. A compulsory European Union directive, similar to our own legislation, requires all registered health care providers

in member states to hold indemnity insurance. Independent midwives in the United Kingdom, Germany, France and other countries all face a situation where they are required to be insured but have no insurance product to purchase. In Belgium insurance is available, but women planning homebirth must agree that they are accepting the risks involved.

Similarly, we are not alone in struggling with how to ensure that women who choose homebirth against guidelines or advice have access to midwifery care nevertheless. We often look to the Dutch maternity system as one that offers women an excellent level of choice in their care. Yet they also have consultation and referral guidelines, the 'Obstetric manual list', which are used in a restrictive manner to limit women's choices. There is considerable uncertainty about the situation of midwives who support homebirths in the face of risk factors, and several Dutch midwives are facing legal proceedings for supporting women who make decisions against the guidelines. It all sounds very familiar!

The President of the New Zealand College of Midwives was a panellist and New Zealand does seem avoid these issues. Insurance is not an issue because they have a no-fault personal injuries compensation scheme. High-risk homebirth seems to be less of an issue too, not so much because it is encouraged, but because midwives are able to be autonomous care providers for women in hospital. Australia's fledgling National Disability Insurance Scheme is a long way from providing a realistic replacement to our current negligence-based scheme. Similarly, while many hoped that our maternity reforms would see us moving towards a maternity system more like New Zealand's, the reality is that our changes have not gone nearly that far.

So, while it is disheartening to hear that the same stumbling blocks exist in countries all over the world, it is also exciting that these conversations are happening and that there is a network of people worldwide all seeking to find solutions to common problems. I am looking forward to Maternity Coalition becoming part of these networks, learning from others throughout the world and joining the international movement to ensure that birth rights are recognised as human rights.



# Human Rights in Childbirth Conference:

## a selection of pre-conference papers



### Introduction

By Hermine Hayes-Klein

*Hermine Hayes-Klein is an American lawyer, mother and a key organiser of the Human Rights in Childbirth Conference held in The Hague, The Netherlands from 31 May to 1 June this year. She has arranged for us to print a selection of pre-conference papers, including her introduction explaining what led her to this project. In the full text of her intro, Hermine explains that her own 'birth story' begins not with the birth of her first child, but with the reading of Ina May Gaskin's Ina May's Guide to Childbirth, and describes the journey that led her to her Dutch midwife Laura and the natural, gentle and supported homebirths of her two sons in The Netherlands. Because space does not allow us to print Hermine's entire piece, we have focussed on the elements of her story most relevant to the current politics of the Australian birthing scene.*

#### The Personal Becomes Political

In 2008, I started teaching law in the International and European L.L.B. (Legal Studies) program at The Hague University. I worked with students and colleagues

from all over the world. Teaching law in The Hague opened my American perspective on rights, which had been based in notions of civil and constitutional rights, to see human rights. Working with my colleagues and students over the next few years helped me to think more deeply about the legal, economic and social context in which people make choices and in which human rights are meaningful.

I recommended Laura (my midwife) to every pregnant woman I knew, and those who followed up with her were extremely satisfied with the care they received during childbirth. One of

these friends was supported by Laura in a home VBAC, after two traumatic deliveries in New York and in Spain. Her third birth went quickly and smoothly, and Laura saw her health and strength in the moment and let her push her baby out at home, instead of going in to the hospital as originally planned. The experience was profoundly healing for my friend and for her husband, and a much stronger and happier beginning to the mothering of her third child than had occurred after her previous births. Laura mentioned to me then that very few midwives in Holland would support a home VBAC. This was when I realized that Laura was not only extraordinary, even by Dutch standards, in her willingness to support her clients on their terms, but that she might be legally vulnerable for doing so.

Around the time that my second baby was born in 2010, Laura told me that she was being called before the Dutch Inspectorate for Healthcare for complaints based on her support of two women who had chosen to birth their twins at home. The complaints were not filed by the parents involved, who were happy and grateful for her services, but by medical

providers who had learned about these births after the fact. Some months after my own baby was born, I asked her to connect me with the mothers who had chosen these births, so that I could hear their stories. The women I spoke with were grounded, stable Dutch mothers. They had made highly informed and embodied decisions that, given the options available to them, the safest choice they could make for the birth of their twins was to labor at home and transfer to the hospital only if a problem arose during the delivery. Both mothers had faced punitive legal consequences for their choices.

I began to research the question, "Is it illegal to give birth to twins at home in the Netherlands?" The legal issue beneath this question seemed to end up at disagreements within the Netherlands about the legal status of the Verloskundige Indicatie List, or VIL, which translates as Obstetric Indication List. The VIL is a professional protocol that defines the indications that, if present, trigger the transfer of a pregnant or birthing woman from midwifery, or "first line" care, to gynecological, or "second line" care. At the risk of over-simplifying a rather long story, the VIL was drafted in professional collaboration between doctors and midwives. The list of indications for transfer grows with each revision of the VIL. Those who write about the Dutch birth system generally write something like, "as long as a woman has a healthy pregnancy without any medical indications present, she can give birth at home with a midwife. If a medical indication arises, she is transferred to gynecological care, and can no longer give birth at home."

These analyses ignore a complex, but important, question: What if a woman chooses to give birth at home, and/or with a midwife, despite the presence of a VIL indication? What does it mean to say that she "can no longer give birth at home?" Is the VIL a law binding on birthing women? Are midwives and doctors legally bound to mechanically follow the VIL, even if, in their experienced judgment, an alternate course of action would be in the best interest of this mother and this baby?

Many within the Netherlands, including those in positions of power within the healthcare system, state that the VIL "must" be followed, and that a midwife who deviates from it should be punished.



When pressed, they will either admit that, “technically speaking,” no medical protocols negate a patient’s human right to refuse treatment or give informed consent to any healthcare service, and that the VIL is no exception to this, or they will claim that the VIL is indeed an exception, because deviation from the VIL compromises the interests of the being-born child, and that this is illegal (or should be). The few midwives who are willing to deviate from formulaic application of the VIL, and who are sought out by birthing women for this flexibility and guarantee that decisions will be based on judgment about their real needs, face legal proceedings on what seems to be the latter argument.

In the course of this research, I learned a lot about complexities and controversies within the Dutch birth system. I spoke with doctors who told me that home birth is a vestige from a by-gone era, and that Dutch doctors have come to view midwives as competitors who control too large a share of the birth market. I spoke with Dutch midwives, who told me that changes in the financing of birth care necessitated the kind of large, busy practice that made it difficult to build relationships with clients, and that this loss of connection, in turn, affected the ever-rising rate at which midwives transferred women to medical care. I read Dutch media articles stating that the Dutch perinatal mortality rate is high, relative to other European countries, and read disjointed debates about whether home birth and midwifery are killing Dutch babies. I came to see that the Dutch birth system is at a cross-road. It may abandon its unique approach to birth as a physiological event, and adopt the medical model ubiquitous elsewhere in the developed world. Or it may change in other ways.

What seemed to be missing from the conversations and controversies within the Dutch birth system was the position of the mother as an active decision maker in childbirth, and a meaningful debate on how women’s choices can be respected at the same time that birth professionals are empowered to deliver care within the boundaries of their expertise and judgment. In recent years, the Dutch birth system has predominately been discussed from a risk/safety perspective, with the usual impasses that this debate meets in other jurisdictions. While at least one governmental organization had brought together midwives and different medical professionals for collaboration, there remains a need to bring care providers together with women, families, and professionals with other relevant perspectives. If the Netherlands is going to make a collectively intelligent decision about the future of the Dutch system, there needs to be an opportunity for all the parties invested in that system—the doctors, midwives, nurses, mothers, fathers, politicians, social workers, lawyers, ethicists, and so forth—to exchange perspectives and ideas about how the system can be optimized to both deliver the highest quality of healthcare while respecting the rights and dignity of birthing women.

#### *Ternovszky v. Hungary*

In December 2010, the European Court of Human Rights made a powerful holding right at the center of the questions I was researching for the Netherlands. In a short and simple opinion on the case of *Ternovszky v. Hungary*, the Court held that legal authority and meaningful choice in childbirth is a human rights issue. There is much in the opinion that can be considered radical, in light of prevailing birth practices

across Europe and around the world. These points briefly summarise the court’s findings.

- The Court located the human rights at stake in the ‘right to privacy’, the source for other reproductive rights across jurisdictions finding, based on its analysis of Article 8 of the European Convention on Human Rights, that “...the right concerning the decision to become a parent includes the right of choosing he circumstances of becoming a parent.” *Ternovszky v. Hungary*, (Judgment) ECHR 67545/09 (14 December 2010) para 22.
- The Court discussed the Dutch birth system extensively, in its quotation of a World Health Organization report on physiological birth (which pointed to the Netherlands as the European system with meaningful choice for home birth) and noted, significantly in light of current trends in Dutch birth care: “There was no evidence that this system of care for pregnant women can be improved by increasing medicalisation of birth.” *Ternovszky v. Hungary*, (Judgment) ECHR 67545/09 (14 December 2010) para 11.
- The *Ternovszky* holding imposes positive obligations on all European States to comply with its basic instructions for ensuring that pregnant women have a genuine choice to birth outside the hospital if they so choose. These instructions came down to two points, in the Hungarian context:
  - a. The State must not sustain a regulatory or legal framework that generates ambiguity about whether home birth is “legal.” It must provide for home birth within its healthcare regulations.
  - b. The State may not bring legal proceedings against healthcare professionals for supporting women in their choice to birth outside a hospital. The Court held that the persecution of midwives for supporting home birth is a violation of the rights of the birthing women who would wish to rely upon such professional support.

I was struck by how little attention this holding had received in the European and International press, in light of its implications for birth politics and existing healthcare systems. And I was fascinated by the implications of this case for Europe generally, and for the very different healthcare systems of Hungary and the



Netherlands, in particular. My research on the legality of twins births indicated to me there is, in fact, significant ambiguity within the Netherlands about the legality of home birth in the face of VIL indications, arising out of uncertainty about the legal status of the VIL itself. And furthermore, I personally knew several Dutch midwives facing legal proceedings for supporting such births, a fact that had the expected consequence of deterring other professionals from doing so and operated to restrict the choice for home birth for many women. Because the Netherlands offered genuine choice for “low-risk” women, the whole issue faced in other countries is shifted, so that questions of authority and support arise around “high-risk” births. But after that shift, the problems look strikingly similar to those playing out in other jurisdictions, which can be summed up with the question: who gets to make the final decision about how a baby is born?

Meanwhile, in Eastern Europe, midwives continued to face prison for supporting any women at all in out-of-hospital birth. The *Ternovszky* case was brought in the face of proceedings against Hungarian doctor-midwife Agnes Gereb, the beloved midwife of the plaintiff, Anna *Ternovszky*. Even after the *Ternovszky* holding, criminal charges against Agnes Gereb went forward. In early 2012, an appellate judge in Budapest upheld a lower court’s judgment against Gereb, and sentenced her to two years in prison. Gereb lives in house arrest pending the Hungarian president’s consideration of a clemency petition in her case.

The only experts permitted to testify to the safety of home birth in the Hungarian trials were obstetrician-gynecologists. As in many healthcare communities, the Hungarian professional ob-gyn organization has long maintained uniform opposition to home birth.

Although it doesn’t use economic terminology, the *Ternovszky* holding is about medical monopoly over childbirth. State-sanctioned medical monopoly over birth care violates birthing women’s human right to choose the circumstances in which they give birth. The case imposes positive obligations on the state to refrain from supporting and reinforcing that monopoly, by unquestioningly legitimizing the self-serving medical claim that all birth belongs in the hospital, and using the power of the state to turn that claim into Law. The significance of its holding extends beyond the choice to birth outside the hospital. *Ternovszky* situates birthing women as the ultimate decision-makers regarding the circumstances in which they bring forth their babies. Women, not

their healthcare providers, have the final say regarding what they do and what will be done to them around the birth of their babies. If birthing women have a human right to choose the circumstances in which they give birth, then nobody can tell them that they “must” lie down on a bed, tether to an electronic fetal monitor, accept induction at 41 weeks, or anything else. They can only be advised, not ordered.

A year and a half after the Court issued its judgment, the rights that it articulates remain an abstraction in most, if not all, jurisdictions. The holding, and its orders, provide a new lens through which to consider how genuinely “woman-centered care” would operate in practice. The cases of twins and breech home births in the Netherlands are important not only for the few women who choose for these births, just as *Ternovszky* isn’t important only for the few women who choose home birth in other jurisdictions. These cases are important because they illuminate the system’s bottom-line assumption about who is the ultimate decision-maker in childbirth. Do birthing women have an obligation to obey their doctors’ orders? Or do doctors and midwives have an obligation to support birthing women on their terms? What is the place of the unborn baby, of its rights or interests, and who has the moral and legal authority to make decisions for it? How do the relationships between doctors, midwives, and nurses support or undermine woman-centered care and protect the rights expressed in *Ternovszky*?

These questions are not academic. *Ternovszky v. Hungary* is law, and any jurisdiction faced with the demands of its female citizens to come into compliance with this law will have to answer these questions, among others.

Holdings of the European Court of Human Rights are binding on all European signatories to the European Convention on Human Rights. Many, if not all, of these jurisdictions could stand to reconsider their birth systems in light of the questions of legal authority and supported choice raised by *Ternovszky*. Moreover, the fundamental human rights discussed by the Court are meaningful in all the jurisdictions in which human rights are meaningful. The European Court of Human Rights grounded the *Ternovszky* holding in the fundamental human rights to privacy and autonomy. These rights are sacrosanct in constitutional democracies, and in particular the United States. Faced with a plaintiff like Anna *Ternovszky*, would an American court deny that pregnant women retain the right to give birth to their children in a way that reflects their family’s personal values? Would

it deny that a pregnant woman retains authority over her physical body? Of course, to deny that women have authority over their bodies, and in particular over their reproductive capacities, has a significant historical context. It is for this reason that all women should be concerned with the protection of *Ternovszky* rights, whatever their own birth choices would be.

### Author Bio

Hermine Hayes-Klein grew up in Lexington, Massachusetts, USA. She attended college and law school at the University of Chicago, receiving her J.D. in 2001. She practiced law in New York and Connecticut for six years before moving to the Netherlands, in 2007. She taught law at the International and European Law L.L.B. program at The Hague University from 2008 to 2012, and became the director of the Bynkershoek Institute’s Research Center for Reproductive Rights (RCRR) in 2011. In the spring of 2012, Hermine moved with her family to Portland, Oregon, USA. She will continue as the director of the RCRR from Portland, and will also return to the practice of law.

## Letter to the Conference

By Anna *Ternovszky*

I am just like millions of other moms who wished to decide—and still hope to be able to do so in the future as well—where and under what conditions I would deliver my two babies. My continuous aim going forward is to help as much as I can, so others like me will have the same right; to make up their minds freely without their decision being determined by others. It is everybody’s right to do so! Right? We shouldn’t even have to talk about rights here, as these issues pertain to the very core of our lives. However, the legal system we live in has such influence and so much power over how we do things. And these kinds of regulations that are trying to control what we know best from our instincts are clear signs that the ancient faith we used to have in women has been lost somewhere along the way. Throughout the history of humankind there was one thing always certain: women knew how to give birth, how to bring another life to this world. And we used to be respected for that. We were trusted and appreciated. But what has all that become? Our ancient wisdom is being doubted; and we, mothers, are being judged - something which deeply saddens my heart.

I hope that by addressing this issue the way this conference intends to, step by step, we will be able to help not only mothers, but also doctors, midwives and



doulas who have dedicated their lives to this sacred goal. I hope our attention to this important topic will bring about the right conditions for them to continue to follow their calling.

Well, I am a mother who decided to give birth to my two little boys at home, surrounded by my family, my loved ones and the midwives and doulas of my choice. It was the best choice I have made in my life. Their deliveries are my most precious memories, something I will always treasure. And I will forever be grateful to those who were by my side at that time, helping me with love and devotion, caring about nothing else but me and my babies. The person to whom I feel most indebted is my beloved midwife, Ágnes Geréb, who spent 20-30 hours helping me relentlessly, giving me her undivided attention, her utmost love and respect, standing by my side as I was giving birth to my boys under the most peaceful and undisturbed conditions. Feeling safe and secure, to me, meant being at home in those situations, surrounded by the well-known scents and lights that are part of my everyday life, having the loving presence of my husband, my siblings and friends, as well as the support of my midwives and doulas.

I remember, I spent 10 hours sitting in the bathtub, and at every contraction my helpers opened the tap and ran some warm water in, they fanned me to feel better, or gave me some drink to refresh a bit; comforted me as I was vomiting. They gave me help and support in every way that one can possibly need in such a situation. Ági knelt on the rough stone floor; massaging my back, singing and giving me compresses, holding my hand tight whenever I asked. I did not feel uncomfortable for a second, not even when I was on my hands and knees, yowling and writhing completely naked. I did not have to “behave,” nobody said anything – I felt accepted. I felt as if I was going to die from the pain, but feeling such faith from them, knowing that they believed I could bear it, gave me tremendous strength, which was a very new feeling, something I enjoyed utterly. I had a chance to experience that I possess the ability to bring my child to this world by myself. I was given an opportunity to have a real meeting with myself and experience the immense power that lies within me. To this day it gives me great strength to recall and build upon that feeling. By being able to focus inward, I was also allowed to pay attention and feel how I was working in sync with my baby. I felt how we fought as a team; when my uterus contracted, and he gathered all his strength, pushing his way outward. I could feel his every movement, and it was simply

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the most amazing cooperation between the two of us. The love that surrounded me as I was pushing him out was also something I will never forget; my sister and my doula were kneeling face to face, their legs formed my live birth chair. My husband was holding me from above, and Ágnes Geréb and Ágnes Király, my two midwives, were massaging my perineum with warm oil, so it wouldn't break. They put hot compresses on my tummy, and that is how my first boy arrived in this world. Ági used her own mouth to suck the amniotic fluid out of my baby's nose and mouth, then she smiled at me and said, “The first kiss was mine.” Then she put him on my body, and I began breastfeeding. Nobody took him away from me, not even for a second. We were able to stay together for hours and days in complete peace. It is something that I will forever appreciate.

I try to imagine what it is like for a baby to leave the safety of his or her mother's womb and arrive in this unknown world. How scary and painful the journey must be in and of itself, and when he or she arrives, the temperature changes, the sharp light in the eyes must be devastating, the first gasps for air; everything is new. The only thing that remains the same is the baby's mother. The familiar rhythm of her heartbeat, the warmth of her body, her voice; the only place safe is with her. That is why I feel that it is crucial for my baby to stay with me upon his birth; something that is allowed in some cases in hospitals, yet also prohibited in many situations unfortunately.

Why and how did I turn to the European Court of Human Rights in Strasbourg? When I was pregnant with my second child, Ági's persecution had already begun. There were several cases against her, and it was impossible to know where exactly things would stand by the ninth month of my pregnancy. It became clear to me that the Hungarian law at that time would not allow me to give birth with

medical supervision at home without breaking the rules. That was when I turned to Strasbourg and asked for some kind of remedy. I was scared of many things. I was especially worried that I could get Ági in even more trouble if there were any complications around my baby's birth. I didn't want to have such responsibility weigh on her shoulders, since it was not her, but myself, who made this conscious decision and accepted all risks involved in my home birth. Based on the experience I had at my first child's birth, I knew without a doubt that Ági was the doctor and midwife who would do everything for me and my baby's safety. Strangely, the Hungarian courts and our Medical Chamber gives this benefit of the doubt to all doctors, while assuming that Ági alone wouldn't do everything she could to the best of her knowledge.

Agnes Gereb has assisted home births for 22 years. According to the Hungarian statistics, during that time there were nearly 5500 perinatal deaths in connection with hospital births. There are no guarantees in childbirth, no matter where or how it occurs. Everybody assumes that the doctors involved in those 5500 hospital births did everything humanly possible to save the babies. None of these people have been accused of any negligence or sent to prison as a result. Why was Agnes Gereb subjected to a different set of assumptions, ones that seemed to presume her bad intent? I find her demonisation for having assisted in a birth where a baby died following shoulder dystocia very hard to accept, knowing that babies die in hospitals, in Hungary and elsewhere, every year due to shoulder dystocia. As long as such a double standard is present, which assumes good faith for medical workers and bad faith for midwives, so that the midwives alone face criminal punishment for outcomes that can occur in any birth, home or hospital, how can I choose for home birth, no matter how strongly I feel that it is the right option for me and my newborn?

In addition, at the time of my second pregnancy there were several other charges brought against Ági, which very much reminded me of the witch hunts of the old days. These charges made me fearful for Ági if she were to assist in my baby's birth. I was extremely concerned that I would not have a chance to have my baby at home as a result of the situation, or that even on parole Ági could only be present in secret, so we wouldn't bring any more trouble on her. It was the most undignified situation I have ever been in, for my wish to have Ágnes Geréb and Ágnes Király present at the birth of our second son too, shrouded with secrecy and fear.

I was expecting our second boy surrounded by these fears, so it was natural that I often found myself discussing these issues at the kindergarten with other mothers who gave birth at home. One of the moms was working at the Hungarian Civil Liberties Union as an attorney, and with my rebellious curiosity I asked her if there was a higher court to which people can turn in such situations. She said there was, the European Court of Human Rights in Strasbourg. She explained that it is only possible for private individuals to file a lawsuit, and in such cases it would have to be someone who is pregnant. I was expecting our second baby at the time, and my immediate reaction was that I would love to be that person. When we looked at each other we broke out in laughter, though we both knew I was not at all joking. Things quickly sped up after that, when Dr. Tamás Fazekas, one of the attorneys at the Hungarian Civil Liberties Union contacted me. He had been involved in Ági's case for a long time by then. We met, discussed the details, and soon afterwards we filed the paperwork.

In legal terms, we condemned the state of Hungary for the violation of two articles of the European Convention of Human Rights; the one dealing with one's right to privacy as well as its anti-discrimination regulation.

The state's response to our claim contained a kind of cynicism that I still can't comprehend after all these years. Denying all accusations, their short rejection said that since I refused the health services (hospital birth) offered by the state—which, they added, also violated my child's right to life—I was not entitled to demand any kind of "alternative" healthcare services from them. Of course, by no means was it my intention to refuse health services.

It was a wonderful feeling to learn that we won, and that the Court condemned the state of Hungarian birth policies, ordering my country to create the necessary regulations as soon as possible. The Court's ruling restored my faith, as well as the faith of many people in Hungary and abroad, that something will finally happen, and the long-awaited regulation will be created at last. I was quite satisfied with the fact that the process has started, and the new legislation to regulate birth got passed as a result. However, I continued to have some questions and fears ever since.

The Court had a firm position that one's right to privacy, in itself, included the right to determine the circumstances in which one's baby should be born. According to the judges' reasoning, the section of my

government's previous regulation (which imposed a fine on midwives assisting home births) was violating my rights, as well as the rights of other expecting mothers. The court also stated that the fact that I was under the threat of the imposed sanctions, as well as the lack of special and comprehensive regulations, restricted my decision-making ability in terms of home birth.

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Despite the court's ruling in Strasbourg, Ágnes Geréb was subsequently sentenced to prison for two years, something that deeply upsets and terrifies me. Shouldn't the European Court's ruling on my case mean that a midwife like Agnes cannot be subjected to such extraordinary punishment for supporting home birth?

Following the European Court's decision, Hungary passed regulations addressing home birth, but subjected it to many arbitrary restrictions. The new Hungarian regulation states that the costs of home births are not covered by our social insurance even if the mother is entitled to receive medical services as part of her health insurance. To me this means again that the state looks at me differently from all the women who give birth in hospitals and; therefore, mandates that I pay for what they consider a silly hobby.

This is a terrible discrimination. I personally could not afford to pay the expenses, but even if my financial situation allowed me to I still would not do so, because I feel outraged that such service is not available to everyone on a universal basis. What else can be more fundamental in any country than the healthcare provided for a mother who is giving birth to her baby?

There is another section of the regulation making another home birth impossible for me. One part of the regulation classifies a baby whose expected birth weight is above 4000 grams to be non-eligible for home birth. I have two concerns when it comes to the objectivity of this stipulation; one being that the projection of an ultrasound can be off by as much as 500 grams, and the other being the fact that the mother's size is not taken into consideration in any way. For instance, I am 180 centimetres tall and both my children were born at home weighing over 4000 grams. Perhaps if I underwent some serious weight loss program, it would give me some hope that the state might allow me to bring my third child to this world at home.

Considering all of the above, I continue to believe that the decision is still not in the hands of women. The regulation of home births has began in Hungary, yet under the current conditions I would not be able to take advantage of this option for all the reasons I have just mentioned. As a result, I would be forced to give birth in a hospital, or to do it all by myself at home, without any supervision.

Finally, I would like to express my sincere hope that the process, the change that began in Hungary, will not come to a halt; that it will continue to develop for another twenty or thirty years and represent as well the interest of those mothers who choose to give birth at home. I believe that it is a program which can be done in close cooperation with all participants involved: vocational colleges, doctors, midwives, doulas experienced in home births, the mothers themselves, of course, as well as those who create the framework for our decisions: our politicians.

I hope we are not far from the day when the idea of 'equal rights' will no longer be a simple catch phrase; however, I can also see very well that in order to make such a thing happen, we need to work together in a well-established international collaboration. Let's make Ági's case (and the growing number of these alarming cases surrounding midwifery) serve as a strong wake up call, and use it to guide us through our joint efforts, so finally the right to undisturbed home birth can become available worldwide, regardless of one's background or location.

#### Author Bio

Anna Ternovszky is photographer and ceramist. At the moment she is a mother on a fulltime basis, and she is managing her own business which produces and distributes environment friendly packaging.

# Letter to the Conference

By Elke Heckel

I have joined the panel late as I was in India earlier this year volunteering in a Women's Health Centre. As part of the trip I attended a Conference in Bangalore in January entitled: *Safe and Supported Birth - a Human Right*. When I found out about The Hague Conference my initial response was that I need to tell the conference organisers in India about it, hoping that they can send a representative. My second thought was that there was no independent midwife from the UK on any of the panels. As we are threatened by extinction in October 2013 we need all the help and support this conference can give us. Whilst we are only small in number, the number of women using our service has seen a threefold increase in the last eight years (IM UK data).

I am very pleased to have been invited on the panel of this conference that is bringing so many eminent people of the birthing world together in one place. I truly believe that interested parties worldwide need to work together to enshrine women's rights to self determination and access to safely supported birth and this needs to include homebirth.

## Independent Midwives in the UK – Opportunities and Challenges

Independent midwives in the UK have been in a unique position. We have been practising outside the NHS (The National Health Service, the state-funded universal health-care service in the UK), whilst fulfilling the requirements of our professional body the Nursing and Midwifery Council (NMC). We pride ourselves in working directly with and for the women in our care. These are not necessarily low risk women. Sometimes women with numerous risk factors come to us because they feel their needs are not met by the NHS system. They want to make truly individualised choices. It is fairly unusual for this to happen in an NHS setting due to time pressures, inflexible implementation of protocols and guidelines, a culture of risk-aversion and mistrust and, most importantly, a lack of continuity of carer/s.

Often these women specifically want a homebirth; however others would ideally like us to give them the 'low-tech' care of a home birth within the hospital, where higher-level emergency treatment is more readily available. Yet our lack of Professional Indemnity Insurance (PII) prevents us from taking on a clinical role in an NHS Hospital. We will try to be advocates for the women, but some decide

that hospital policies are too rigid and they will choose a homebirth. Independent midwives in the UK are at the moment still able and willing to support a woman's choice for a vaginal birth of a breech baby, twins or a vaginal birth after caesarean (VBAC), at home.

While we acknowledge that all these can carry a greater risk to the baby, the mother or both, we give the woman and her partner the opportunity to look at the available up-to-date evidence and encourage her to make choices that are right and safe for her. Women are physiologically equipped to carry and give birth to twins and breech babies. Some would argue that their chances to do so are enhanced when the physiology can unfold without unnecessary interference and when the woman is emotionally well supported. 'Shroud-waving' achieves the opposite and often tells us more about the fear of the practitioner than the actual risk to the woman.

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During a physiological breech birth, for example, it is seen as essential to keep the fear out of the birthing room. Anxiety may cause the woman to involuntarily clench her levator ani muscles, a common stress response, and this can impair the progress of the birth (Evans 2012). How realistic is this in most NHS hospitals where the majority of breech babies are now born by caesarean and the remaining ones by breech extraction assisted by obstetricians? Obstetricians in the UK are not the experts in normal, physiological birth; they are the experts in dealing with complications and surgery. How can they therefore be

the experts in physiological breech or twin birth, presentations which some experienced midwives like Mary Cronk would argue present a variation of the norm not an abnormality?

## An Example of Good Cooperation

In an ideal world I would be able to care for a woman at home or in hospital and be able to liaise with a knowledgeable and sympathetic obstetrician if a problem arises. I would like there to be mutual respect for each other's skills and knowledge, but also an honest acknowledgement of professional limitations. The mother needs to be the centre point of our planning, communication and care.

We did achieve this 10 years ago when we had an honorary contract in a London hospital. A 40 year old primiparous woman had chosen to give birth to her twins in the hospital under independent midwifery care. She was hoping to give birth as naturally as possible.

We liaised with a Consultant Obstetrician who offered to be on call for her and us! The babies were born without any use of drugs at 40 weeks gestation. The only obstetric involvement on the day were words of greetings and congratulations. We heard later that his colleagues were appalled by his willingness to agree to the woman's birth plan. Had he not been there on the day and helped us to protect the privacy of the woman, the experience and possibly the outcome would have been very different.

## The Insurance Situation for Independent Midwives in the UK

Since 2002, independent midwives in the UK have been unable to obtain PII due to the high payout that could be required if negligence was proven in the case of a baby with long-term problems. At less than 150 midwives, we are too small a group to raise the money that would be required for the premium.

Whilst this has made us potentially more vulnerable to personal claims made against us, it has encouraged a very special working relationship with our clients. They are made aware of this situation and its implications before they decide to book with us. This also leads to a discussion about the inherent uncertainty of pregnancy and birth and that financial insurance does not protect them or us from a negative outcome. Throughout their care we ensure that we build a relationship of mutual trust and that clinical decisions are made in partnership with the parents.

Until now our search to resolve our insurance situation has been unsuccessful. It is also of concern that the last insurance





premium available to independent midwives in the UK in 2002 was as high as £20,000 per year, unaffordable for most independent midwives.

The EU Directive 2011/24/EU of the European Parliament and of the Council (9 March 2011), on the application of patients' rights in cross-border healthcare, demands: "systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory;" (Chapter II Article 4)

This directive will be implemented in the UK in October 2013, and if we have not found an insurance solution by then it will be the end of independent midwifery.

The previous UK Government ordered an independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional, also known as the Finlay Scott Report (June 2010). It gave the following recommendation that applies to independent midwives: "In relation to groups for whom the market does not provide affordable insurance or indemnity, the four health departments should consider whether it is necessary to enable the continued availability of the services provided by those groups; and, if so, the health departments should seek to facilitate a solution." (Recommendation 20)

The response of the four UK Health Administrations to this was: "We agree with this recommendation and will take forward work on a case-by-case basis where this is appropriate"

This has not provided us with the assurance that we were hoping for.

The NMC and the Royal College of Midwives (RCM) commissioned the Flaxman Report which was completed

September 2011. It looks at many aspects of independent midwifery care and analyses why it has been so difficult for us to find insurance. The conclusion it draws is that if we continue to work as self employed, independent practitioners we will be uninsurable. Independent midwives in the UK have been working on different solutions that are acceptable to women and midwives alike. We have drawn up best practice guidelines. There has been some progress in moving closer towards contracting into the state system. This would make our care accessible to women who cannot pay for it. The restrictions placed on the scheme at the moment make it difficult for some midwives and women to accept. Others feel it is a step in the right direction and exclusion criteria will be changed once the project is rolled out.

Whatever solution or solutions we find, it will change the way we can work. If we do not find a solution by October 2013 we will stand to lose our midwifery registrations. While we have the option to return to the NHS or some other employment situation that offers PII, pregnant women who would have chosen an independent midwife might be unable to get the care that is acceptable to them elsewhere.

There are now real concerns about women deciding on 'free-birthing', not through choice but because they feel this is the only option open to them if they are unable or unwilling to surrender to the type of care that the system is willing or able to provide for them.

### Pressing Questions

Should a woman have the right to choose her midwife and pay for her - after all, she can employ a private obstetrician? Should the midwife have the right to practice her profession autonomously in a self employed capacity?

### My Hope

I am coming to this conference in the hope of getting a step closer to finding a solution for our plight. I hope to be able to link with midwives from other European Countries where appropriate - apparently the independent midwives in Belgium have been able to source PII, though they only make up 2% of the total number of midwives there. I am also hoping to raise the profile of what we as independent midwives in the UK represent and the unique service we can offer to women. With the demise of independent midwifery in the UK a whole raft of skills and experience will disappear as well. I hope that we can all form closer links to ensure that women will indeed continue to have a true choice and the excellent care they deserve.

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- Further Background Information*
- Our Practice Website - <http://londonbirthpractice.co.uk>
- Website for IM UK - <http://www.independentmidwives.org.uk>

### Author Bio

About Elke Heckel:

It was during my pregnancy with my son in my mid-twenties that I first became interested in the field of childbirth. Initially I trained as an antenatal teacher with the NCT and helped at a local Active Birth class. During this time I also co-founded a homebirth support group in Hackney and tried to improve the maternity provision as a consumer representative. Looking back at that time, it was while attending births of friends and women I got to know during classes, that the desire to train as a midwife was born.

## Paradox of the Dutch Maternity Care System

By Ank de Jonge

The Dutch maternity care system is unique in the Western world. Independent primary care midwives can provide all maternity care to women who do not need obstetric care, unless risks or complications arise, and homebirth is still common. For many women, this system works well. Women are most satisfied if they give birth at home. In addition, women with a physiological pregnancy who are under supervision of a midwife (in "midwife-led care") at the start labour and especially if they start at home are more likely to have a spontaneous vaginal birth than those under supervision of an obstetrician (in "obstetrician-led care").

Unique as it may be, the system is characterised by an uneasy paradox. On the one hand, other countries, such as Canada, the United Kingdom and New Zealand, take the Netherlands as an example for changing their maternity care systems. In these countries too, midwives increasingly work autonomously and the homebirth rate is rising.

On the other hand, the quality of care of the 'Dutch' way of birth is increasingly put into question. In particular, there are doubts about the safety of the system because of the relatively high perinatal mortality rate compared to other European countries. Comparisons of perinatal mortality rates between countries should be made with caution because of differences in populations, registration systems, definitions, completeness of data and quality of registration information. Nevertheless, the poor ranking in the Netherlands generates a lot of debate.

Concerns about the Dutch maternity care system give rise to new forms of care. For example, birth centres are being built near labour wards where women can give birth in midwife-led care. Further, some call for discouraging homebirth for primiparous women and for involving obstetricians in care for all women, regardless of the presence of risk factors or complications.

In the media, the impression is often given that the debate centres around the interests of midwives versus obstetricians. Personally, I think most midwives and obstetricians ultimately have the same interest: optimal quality of care for women and their families. There may be different points of view, but this does not need to be problematic. In a respectful debate different perspectives will enrich the discussions.

The biggest problem is not the contradictory opinions we hear in the

media, but rather the voices that we do not hear. Those who should be the main persons in the debate are silent. Where are women in the discussions about what our maternity care system should look like?

In many countries, women play a pivotal role in maternity care via strong consumer movements. In the Netherlands, it appears to be very difficult to motivate women to join a consumer organisation.

I am therefore very excited about this conference with a great variety of speakers and, I hope, attendants. It is unique that clients, professionals, ethicists and many others discuss the future of maternity care. The different viewpoints may generate broad discussions in which all of us have to step out of our comfort zones. The idea of a breech delivery at home may be as abhorrent to one as a caesarean section at

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maternal request may be to another.

In the Netherlands, debates have focused too much on issues of risks, professional interests and money. The conference provides a golden opportunity to have discussions that are long overdue on the role of ethics in childbirth and, most of all, on the true meaning of woman-centred care.

## I alone have the right to speak for my unborn baby

By Roanna Rosewood

I've been preparing for the responsibility to speak for my babies' interests since long before anyone else even envisioned them. While my brother play-battled and lined up his cars, I tended my own "baby." I brought her shopping and to the park. I made fancy tea parties for her and her friends - Bear and Lily the Lion. When my mother nursed my newborn baby brother, I sat next to her and nursed my doll, preparing for the day when the baby that I held in my arms would pulse sweet milk dreams and curl his toes around the touch of my fingertips as I rocked him. Twenty some odd years later, my belly was as round as the moon, and I could barely contain my excitement. Parties, movies, and restaurants all dulled in comparison to the thrill of sitting alone with my hands rubbing my belly. "I love you," I told him. I repeated it again and again, not out of doubt, but because I knew, even then, that I would fail him. I would make mistakes. "I love you" was the one thing that I could offer unconditionally. No matter what hardships he would face, I promised he would never doubt my love.

At birth, I surrendered myself to the hospital protocols because I believed it was in my son's best interests. I was wrong. Without explaining their purpose or what I would be charged, the doctor ordered "routine" testing. The nurse hooked me up to an Electronic Fetal Monitor. "It hurts. I need to move," I told her. "It's required," she replied. She did not explain that the "requirement" was her personal preference instead of written hospital policy. She did not tell me that submitting to this machine increased my risk for a caesarean, or that the American College of Nurse-Midwives prefers Doppler monitoring. The nurse had the power to alleviate my pain by removing the tight band around my belly and allowing me freedom of movement. She chose not to.

Eighteen hours later, stuck at eight centimetres, the doctor administered Pitocin. Two hours later she said that my baby was in danger and I needed a

### Author Bio

Ank de Jonge qualified as a midwife in East Anglia, U.K. in 1994. From 1995 to 1998 she worked as a midwife in Nigeria. She did a Master in Public Health in Edinburgh from 1998-2000, while she worked as a midwife in Edinburgh and Livingstone. Since 2000, she has been working as a primary care midwife in the Netherlands. She also worked at the Dutch Organisation of Midwives (KNOV) and at TNO Institute for Applied Research. She finished her PhD on birthing positions in 2008. Since 1 May 2009 she has worked as a senior researcher at VU University Medical Centre. Ank was the first author of the world's largest study into the safety of home births, which had a huge impact nationally and internationally.



caesarean. The doctor did not try reducing or stopping the Pitocin. She said that my baby weighed almost 5 kilograms and my pelvis was too small to give birth. She offered no opportunity to discuss alternatives or my wishes. I didn't know that if I were to simply refuse to stay on my back, if I had followed my own body's demands to move, that this alone might have improved what I would later learn was only mild heart decelerations. I believed that my baby's life was in danger. I didn't know that if it had been a true emergency, the time from decision to incision would have been thirty minutes. "Hang on. They are going to help. I love you," I repeated for one and a half agonizing hours, while they leisurely prepared for the caesarean. I remember watching as they lifted him up over the operating curtain. I caught a glimpse of his black hair. It was the moment I had anticipated my entire life. I expected them to hand him to me. They didn't. They carried him away. He wailed loud, uncontrollable screams, one on top of the other. I wondered how he could breathe.

Every instinct in my body demanded that I get up and go to him, that I sooth him with the same simple words he had heard me repeat since his perfect ears had formed inside of me. I couldn't. I was tied down. My womb was sitting outside of my body. There was vomit dripping down my cheek. I lay helplessly and listened to him scream, repeating "I love you" as if he could hear me. My son was healthy; his Apgar score at birth was 9. There was no reason for our separation. His distress was emotional, not physical. The doctors considered their routine more important than his comfort and well-being. My son's first experience of this world was at the hands of strangers, who disregarded the one simple demand that he made. While he screamed for me, they took his footprints, cleaned him, and measured him. Why must a baby be measured immediately at birth? How much can he grow in an hour? I found out later that the caesarean itself was unnecessary. My son weighed 3.5 kilograms, not "almost 5 kilograms." My pelvis wasn't too small to birth a baby. (I know because I went on to give birth naturally.) The caesarean cost fifteen-thousand dollars. I had to give up maternity leave and return to work so that I could make the payments. I experienced Post Traumatic Stress Disorder. For four years, random sharp pains in the incision site would stop me in my tracks. Nerve damage severed feeling to my belly. Where I used to rub and caress it with love, now it is cold and numb to the touch.

The hospital that performed my unnecessary caesarean was so bloated with

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*The hospitals that performed my caesareans were just fifteen miles from each other. The physical processes that they performed were identical but the experiences were profoundly different. Where the first doctor left me traumatized, the second understood that her fingertips had touched the depths of my body, that my womb was sacred. Just as a baby can be conceived through making love, sex, or rape, so too can a baby be born.*

self-righteous power that they didn't even bother to ask if I was satisfied with their services. They treated my son and I like products, instead of paying customers. I've come to terms with the physical and financial abuse I received at their hands. Dreams of being tied down and cut open no longer haunt my nights. The thing that still wets my eyes today, twelve years later, is the memory of failing my son. The sound of him screaming his first and simplest request to the world will forever echo through my body. A million times, I've tried to make it up to him; I've told him "I love you." But there is no way to heal my son's introduction to the world. His first breath, his first sight, and his first touch were filled with fear, pain, and disregard. With research, I came to understand that my unnecessary caesarean was not unique, that for-profit hospitals perform more caesareans than non-profit hospitals, and that America's caesarean rate is more than double what the World Health Organization advises.

In labour a second time, I knew better than to trust in the doctors. This time (again at 8cm) when the doctor said that I needed a caesarean, I assumed she was lying and I fought back: "No. I need another doctor." When the second doctor told me that I needed a caesarean I said "No. I need another hospital." No other hospital would take me. Though it shames me to admit it, death felt more welcoming than a caesarean. I would have done anything to keep their scalpels and gloved hands out of the depths of my body—anything but risk my son's life. I "consented" to the caesarean. This time, in spite of my belligerence, they were

kind. The doctor explained what she was doing, asked questions and waited for my answers. She treated me with respect and eased my fears. It was not the violent or degrading experience that I had been bracing for. When my son was born, she placed him directly on my bare chest and tented both of us with a blanket to provide soft light for his eyes. We spent ten blissful minutes together. This time, my baby did not scream. Mine were the first eyes that he saw. This time, my son was greeted into this world with the words "I love you."

The next morning, she gently told me about the surgery itself. She explained how, inside of me, she found more adhesions than she had ever seen. They were from the first caesarean and were sticking my uterus to everything around it, holding it in place and preventing me from giving birth. I had tried so hard that I had pulled a "window" in my womb. As I cried, she held me and told me that having a caesarean did not make me less of a mother or less of a woman. The hospitals that performed my caesareans were just fifteen miles from each other. The physical processes that they performed were identical but the experiences were profoundly different. Where the first doctor left me traumatized, the second understood that her fingertips had touched the depths of my body, that my womb was sacred. Just as a baby can be conceived through making love, sex, or rape, so too can a baby be born. Pregnant a third time, I went back to the second doctor. "I want to give birth naturally," I told her. "There are new rules and restrictions," she replied, and a hint of sorrow touched her voice. "The hospital hasn't technically banned VBAC (vaginal birth after caesarean), but essentially it is impossible." "I won't fight you this time," I promised. "I know that I will probably need a caesarean. I only want the opportunity to try." "I wish I could give it to you," she replied. Her training and opinion were irrelevant. People who would never look into my eyes or see my baby's entrance to the world were "tying her hands," just as she would tie mine to the operating table. Their business decisions overruled both her medical expertise and my constitutional right to bodily integrity.

*What should I do?* Even as I asked this question, I was aware that my ability to ask it put me in the privileged few. Because midwifery isn't covered by most insurance plans and is illegal in many states, other women have no choice but to turn their births over to an industry that charges twice as much for maternity care<sup>1</sup> than any other country, while yielding a higher percentage of maternal deaths than forty-nine other countries.<sup>2</sup>



*Who are they to deny us a basic bodily function?* Women have been giving birth since long before there was organized healthcare, insurance or government. These institutions would not exist if we did not bring life into the world. Is medical protocol more important than a mother's informed choice? Should those who question authority, who refuse vitamin K, immunizations and hospital births be overruled by the system?

In answering these questions, we must remember that safety cannot be guaranteed. In the Netherlands, the Dutch Safety Board recently found that three times as many people die as the result of medical errors than die in traffic accidents. If the Centres for Disease Control categorized death due to medical errors like death from diseases, medical errors would be America's sixth highest cause of death.<sup>3</sup> Unfortunately, no matter how diligent we are, some mothers and babies will die around childbirth. If there is a mistake to be made, let it be made by the one who must live with the resulting disability or death for the rest of her life. Let it be the one who will grieve and pray. Let it be the one who has already proven her commitment to this child by willingly putting her very life on the line in choosing to give birth to him. Healthcare providers, insurance companies, governments, and shareholders do not sacrifice for our babies. They make their living by serving us. Mothers are the ones who sacrifice for their babies. We nurse and comfort, we postpone our careers and spend our resources feeding, housing and educating our children. Each of us is here, right now, because a woman opened up and bled for us, so that we may experience life. I am not a religious person, but I know this: institutions had nothing to do with impregnating me. My baby was a gift from something bigger, stronger, and more important than they are. The way that I choose to give birth is between me and the powers that entrusted me with this child.

When I chose home birth for my third pregnancy, some called me a hero; others expressed contempt. I deserved neither. I was just trying to do the best thing for me and my baby. I watched homebirth videos and saw women peacefully and gracefully bring their babies into the world. I visualized giving birth like they did. I thought I would open like a flower and a baby would emerge. I was wrong about birth again. I wasn't graceful; I flailed around the birth tub. I wasn't peaceful; I screamed. My mother said that I sounded like a rhinoceros. I wasn't brave; I begged for drugs. The midwife brought ice chips. If I could have spoken, I would have explained that ice chips aren't drugs.

I wasn't strong enough. I couldn't do it. I gave up. I surrendered and when I did, the most incredible thing happened. If you've ever given birth on your own terms, you will understand: I didn't have to do anything. Birth didn't require that I be tough, composed, or in control. It didn't require that I breathe a certain way or push to someone else's rhythm. Birth happened to me, in spite of me, and with complete disregard for my agenda. Where before there was pain, now there was pleasure. It was the most exquisite pleasure I have ever felt. I wasn't myself anymore. I was part of god and god was me. It wasn't a baby that was moving through my body. It was the

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*Unfortunately, no matter how diligent we are, some mothers and babies will die around childbirth. If there is a mistake to be made, let it be made by the one who must live with the resulting disability or death for the rest of her life. Let it be the one who will grieve and pray. Let it be the one who has already proven her commitment to this child by willingly putting her very life on the line in choosing to give birth to him. Healthcare providers, insurance companies, governments, and shareholders do not sacrifice for our babies. They make their living by serving us. Mothers are the ones who sacrifice for their babies.*

future: generations of children. Everything that they would experience—their entire lives, their joys and defeats and pleasures and glories, I experienced all of them. They were tangible. They converged between my thighs in a shinning black ball of hair. I watched as she whooshed from my body. There in the water was a beautiful blue and purple mer-baby.

I waited for someone to do something. Nobody did. The room was still. I realized that no one was moving because she was my baby and first contact was mine by right. I reached for her; though no expert instructed me to, I instinctively did what every single uninterrupted mother from the beginning of time has done, I held her to my left, to my heart, to where the first sound that she would hear was the steady

and familiar rhythm of her home. I did not smile or cry. There was no “I did it” moment. The midwives, my family, and my ripped vagina, did not exist. There was only my daughter.

Separate, for the first time, from everything she had known, she screamed her displeasure, fully exploring the might of her newfound lungs. Time folded and I did what I had longed to do since the moment that my first son was stolen from me. “I’m here. It’s ok. I’ve got you, I’m here. It’s ok. I’ve got you, I’m here. It’s ok. I’ve got you. . .” This is all that I had to offer and it is everything that matters. The moment her eyes found mine, she quieted. “I love you.”

Women were created to give life and protect the interests of our children. We cannot separate from it. It is who we are. It's in the breadth of our hips that widen on their own volition to cradle them. It's in the curve of our breasts, heavy with milk to sooth them. Every month, our wombs ache in preparation to receive life because, as women, it is our responsibility, honour, and choice to bring new life into the world. We alone have earned the right to speak for our unborn babies' interests.

## References

1. *Deadly Delivery: The Maternal Health Care Crisis in the USA*, Amnesty International
2. *Trends in Maternal Mortality: 1990 to 2008*, World Health Organization, UNICEF, UNFPA and The World Bank
3. <http://www.justice.org/cps/rde/justice/hs.xml/8677.htm>

## Author Bio

Roanna Rosewood is a fierce women's rights and birth advocate. Her upcoming book: *Cut, Stapled and Mended: A Do-It-Yourself Birth* details her HBA2C journey. She lives with her three children, chickens, and cat in beautiful Ashland Oregon, USA. When she's not writing, speaking, or coaching, she can be found working shifts in her café, travelling, knitting, gardening, or curled up with a wonderful book. She looks forward to connecting with you through her website: [www.RoannaRosewood.com](http://www.RoannaRosewood.com).

Is your membership  
up to date?

Renew today.  
See page 32

# Maternity Coalition News

## Ballarat MC

By Michelle McRitchie

Ballarat got off to a big start this year with the screening of *The Face of Birth* in April. The screening was held at the Regent Cinema and our original goal was to half fill a theatre that could seat 120 people. (Our normal movie nights were lucky to pull in 20 people, a number we were happy with given our motto: 'Even one women who learns she has choices in birth is worth it'.) So 60 people would have been fantastic result and allowed us to break even (something we never usually do). In the event, we were surprised to find that tickets sold quickly, and a week before the event the cinema decided to move us into a bigger theatre as it looked as if we were going to sell all 120 seats. We were thankful for this decision as our end result was around 150 tickets sold and a great night had by all! A local state MP came along to the night, as did a junior Labor member, who was very challenged by the film and agreed that it was an issue that needs to be addressed.

It is always hard to measure the impact of this sort of event on the individuals who attend, but we did receive some feedback on Facebook about an opportunity for some women to thank their midwives, some to enter into a journey of healing from their births and others determined that their next births would be very different. Again, if it makes a difference for one woman and her family then it's all worth it!

This event was coordinated by Jade Farren, one of our newer members. Jade was herself energised by attending one of our movie nights in 2011, which allowed her to discover that homebirth was an option locally and saw her change from a hospital-planned birth to homebirth half way through her pregnancy (her first baby was born gently at home in October last year). Jade was amazing and advertised the night far and wide, even getting sponsorship, raffle prizes and donated items for 'goodie bags' to give out on the night.

Our BaBs group has continued to grow, with a membership of over 20 mums enjoying the information sharing that happens so freely with this group. Our committee continues to be challenged by the need to engage more people to help out. We have just decided on a new way of approaching membership to our BaBs group, which will hopefully generate additional support for our committee, so that those people who help out every time don't get burnt out, as has happened in the

past. I would like to say a big thank you to Faye Kricak who has just stood down from the position of Treasurer and welcome Jade Farren who has taken on the role. Our committee is now myself (Michelle McRitchie) as President, Amelia Flanagan as Secretary, Jade Farren as Treasurer and Yvette Knights as BaBs Coordinator. We also have a few committee members who continue to support our committee well.

## Hunter Home and Natural Birth Support/Hunter MC

By Rachel Prest

The New Year saw a new committee elected for HHNBS and a merge of branches with Hunter Maternity Coalition: Rachel Prest (Coordinator), Jenny Cherry (Secretary), Jo Lin (Treasurer), Danielle Stenson (Librarian), Lindsay Hinchey and Jane Jenkinson all form part of the management committee, a great mix of new and old members. Thank you to our outgoing coordinator of the last three years, Chrissy Grainger, for all her efforts and also for being an active voice on homebirth issues locally. Thanks also to outgoing convenor of Hunter Maternity Coalition, Julia Cook, for her involvement with birth advocacy and maternity consumer representation in the Newcastle/Hunter Valley area over the last few years.

In February, we welcomed Go Girl Australia, cycling midwife Marg Phelan into Newcastle on the East Coast leg of her trip back north. Group members and their families met Marg and heard of her adventures whilst feasting on an afternoon tea picnic in the leafy King Edward Park. Donations were made to the Rhodanthe Lipsett Trust, a scholarship fund developed by the Australian College of Midwives to help Aboriginal and Torres Strait Island women to study to become midwives.

Our support group has continued to meet monthly, 10 am - 2 pm (every second Wednesday) at our new venue—New Lambton Uniting Church Hall, 10-14, Grinsell Street, Kotara. Facilitation of discussion topics has been shared between group members and has been warmly received. Topics covered so far have included: *Big brother, big sister—siblings at birth*, *Natural ways to cope in labour* and *Birth plans and transfers*, which was facilitated by Lisa Richards, a privately practicing midwife servicing our area. We



165 attended Newcastle's *Face of Birth* screening

also held our first positive birth sharing morning where three members shared their most recent birth experiences.

In March, HHNBS hosted the Newcastle screening of *The Face of Birth*. Following the screening, guest speakers Dr Andrew Bisits and filmmaker Gavin Banks addressed the 165-strong crowd. Thanks to Chrissy Grainger for her tireless efforts and to our community of members for assisting in the delivery of a very successful and professional event.

Once again our support group won the Babes In Arms—Babywearing Grant. The grant was used to purchase an Aquaborn professional birth pool for pregnant women in our community to hire. It is wonderful to be able to provide this service to our members for use during labour.

The month of May saw the celebration of the *International Day of the Midwife*, where we held a celebratory morning tea for all midwives with plenty of home-cooked goodies. Midwives spoke about why they chose the vocation of midwifery and members spoke about why they chose midwifery-led care.

Please email all enquiries to [hnbgroup@gmail.com](mailto:hnbgroup@gmail.com). Check out our Facebook page for further advocacy and birth related links [www.facebook.com/HHNBS](http://www.facebook.com/HHNBS)



HHNBS members Danielle Stenson and Ro Morrison (with baby Lyla) help spread the word



# Film review: *The Face of Birth*

By Kylie Sheffield

On 7 September, 2009 I stood among a crowd of 2000 on the lawns of Parliament House, Canberra demanding safe and equitable maternity care for all Australian women, including those who choose to give birth at home. Also in that crowd was film maker Kate Gorman, pregnant with her third babe and collecting footage for 'an Australian film about birth.' In March this year, I returned to Parliament House to see that film.

*The Face of Birth* tells the story of birth in Australia just like it is, through the very different pregnancy and birthing journeys of ten Australian mothers (including Co Director/Producer Kate herself), and interviews with an impressive cast of experts including Sheila Kitzinger, Ina May Gaskin, Michel Odent, Robbie Davis Floyd, Andrew Bisits, Sally Tracy, Rhea Dempsey and many more.

The "moments of pure gold" Kate wrote of in our last issue are many. For me, the first comes when the ever-articulate Hannah Dahlen discusses the notorious *cascade of intervention*: "You're a low-risk woman, healthy pregnancy, you walk into the doors of our institutions, what you do is embark on a cascade of intervention that often takes you in a direction you never anticipated." Hannah's description of what that cascade entails is so spot on she could have been telling my eldest son's birth story. Also beautifully articulated is her explanation of how, during a homebirth, a known and trusted midwife is able to quickly identify developments necessitating transfer to hospital. In a calm birthing environment, she says, variations from normal are easily recognised—"the tiny ripple you see because the water is so calm."

Then there are the birth stories. It's impossible not to be moved by actor and mother Noni Hazlehurst and the sheer joy with which she recalls the homebirths of her two sons. Every pregnant woman should hear at least one story like Noni's. She speaks of feeling strong, supported, empowered—a story that instils confidence rather than fear. She also makes a crucial point about the perception of 'risk'. Despite the commonly held view that homebirth was a dangerous option, Noni felt that hospital, with all its inherent interventions, posed a greater risk to her and her baby. Interestingly, Noni's mother, who she describes as a highly conservative woman, completely supported her daughter's choice having come from the UK where homebirth was the norm.

Journalist Emma MacDonald also felt

positive and empowered during the births of her two children by caesarean section. I found the inclusion of her story valuable for a couple of reasons. First, it confirms good support and informed decision making, more than place or 'type' of birth, as the major determinants in women's birth experiences. (Milliner Vicki Car echoes this sentiment, attributing her positive emergency caesarean experience to the continuity of care she received from her known midwife and the fact that the care providers present respected her wish to create a quiet and calm birth space for her son). It's also a great reminder that not all women need or want the same kind of birth, and that judging rather than accepting another's decisions can only serve to undermine the achievement of genuine choice for all women.

Of the many poignant moments among the birth stories and expert opinions shared in this film, it will not surprise regular readers that the entire segment shot up north is the highlight for this ex-Darwinite. Yolgnu elder and Manager of Yirrkala Women's Centre, Djapirri Mununggurritji, gives a passionate and moving description of 'birth on country' and its significance to Aboriginal women. Absolutely priceless is the segment featuring sisters and traditional Indigenous midwives Lena and Rosie Pula of the Arllparra Urupuntja community in Central Australia, who describe using traditional massage to gently guide the baby on its birth journey, enabling it to come out "straight" and "quick." Kath Mills (Auntie Kath) expands on this in one of the film's most stunning depictions.

*They sing the baby out, they sing the baby which way to go, they feel and they guide that baby, because they know, they've been through that channel... they know every little turn and twist so they tell that baby it's safe to come... No, go back that way, come this way... because they've already been on that journey themselves.*

It's now almost four years since more than 2000 of us stood in the rain outside Parliament House, and yet so many Australian women are still unable to make informed and supported decisions for themselves and their babies. Previewing her film for Birth Matters, Kate Gorman appealed to us to spread the word beyond the already-aware birth community. So take a friend to a screening or pass around your copy of the DVD. Contribute to setting the scene for more birth stories like Noni's. Despite the never-ending obstacles.

faceofbirth.com

FOR THE LATEST INFORMATION ABOUT THE FILM, RELEASE DATES AND OTHER DEVELOPMENTS

Follow our filmmaking journey  
online with comments, updates  
and other tidbits...

YouTube Facebook



## BIRTH AFTER CAESAREAN SUPPORT: ONE ORGANISATION'S OFFERING

It can be hard to find evidence-based information and caring support when beginning the journey towards another birth after caesarean. One organisation working to change that is Brisbane-based BirthtalkTM, co-founders of the Caesarean Awareness Network Australia (CANA).

Women birthing after a previous caesarean often have special needs and considerations. There may be issues surrounding whether to have a repeat caesarean, or a vaginal birth after caesarean (VBAC). There may be relevant emotional issues surrounding 'what happened' last time that need to be addressed. And it can, at times, be difficult to access evidence-based information and support that would help in decision making and processing of options. Brisbane's Birthtalk runs Australia's only eight-session VBAC Course, which includes information about both VBAC and empowered birth after caesarean (EBAC). Birthtalk also offers support and understanding in issues surrounding healing from a previous birth.

### 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 so attendees can ask questions and have their fears addressed.

### Won't a VBAC Just Be Better?

Many women initially assume 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 immediately more vulnerable), 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-givers. This will increase the possibility of walking away from your birth feeling strong, confident, and positive about the parenting journey ahead. Birthtalk offers these tools and other ideas at their VBAC course. ©Birthtalk2009

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](mailto:birthmatters@maternitycoalition.org.au)

Our advertising sponsorship packages start from as little as \$50 an issue for a business card size ad. We also offer full colour advertising on our inside and back covers. If you sponsor us for 12 months, we'll promote your business on the MC website, at Choices for Childbirth sessions and through our events, support group and branch meetings.

*Birth Matters* is distributed in hard copy to approximately 700 members (including approx. 20 organisations with their own membership bases) nation wide and is available online via the Maternity Coalition website as a PDF (online complete issue in full colour).

# Member notices

## Management committee meetings (National)

The committee meets monthly, or as required, via telephone conference call. Dates and times have been set to optimise the involvement of members who are separated by great distances and time zones. All members are welcome at these meetings. and are advised to contact [secretary@maternitycoalition.org.au](mailto:secretary@maternitycoalition.org.au) for details. Communication between meetings is mainly by email.

## General meeting dates for 2012

General meetings will be called as required and members given 14 days notice. The 2012 AGM will be held by teleconference on Saturday 13 October at 4 pm ADST.

## Midwives in Private Practice (Victoria)

MIPP is a participating organisation of MC. To request a MIPP brochure, or for other information including membership inquiries please email [mipps@maternitycoalition.org.au](mailto:mipps@maternitycoalition.org.au). MIPP meetings are held monthly. Midwifery students who are members of MC are welcome at MIPP activities.

## Choices Victoria

For details and dates regarding Melbourne, Geelong and Ballarat Choices for Childbirth programs, please visit our website: [www.choicesforchildbirth.org.au](http://www.choicesforchildbirth.org.au).

## Donations

MC thanks you for your generosity to our organisation. Your donations fund our important work and help us to get one step closer to reform of Australia's maternity services.

MC's book keeper, Meredith, would like to request that any donations made by members be accompanied by an email to [accounts@maternitycoalition.org.au](mailto:accounts@maternitycoalition.org.au) to let Meredith know the amount that has been deposited into the bank account and the reference. This is so she can make sure funds are allocated to the appropriate sub-accounts.

## MC bank account details

Commonwealth Bank of Australia Branch: Ringwood Victoria

Account Name:

Maternity Coalition Inc.

BSB: 063 167

Account Number: 10108586

Postal Address:

PO Box 1190 Blackburn North  
Victoria, 3130, Australia

## Infosheets

The Maternity Information Initiative was established in 2006 to "develop a series of consumer information sheets on key maternity topics." Infosheets are designed to assist women to question and communicate with their care givers, and make informed decisions in their maternity care. This will help ensure that care offered is appropriate for the woman, her pregnancy, her goals and individual circumstances. Infosheets are available on our website to download free of charge.

## Topics include:

- A healthy pelvic floor after childbirth
- The third stage of labour
- Pre-labour rupture of the membranes
- Induction of labour
- Births after caesarean
- Labour in water
- Bearing down or directed pushing?
- "Who cares?" Choosing a model of care
- A baby's transition from the womb to the outside world
- Preparing your birth plan
- Breech birth

## Birth announcements note

It is our policy not to publish the names of homebirth midwives due to the current situation in which these midwives work. Homebirth midwives have no insurance and are often targeted by regulatory authorities despite providing excellent care.

As such we feel it is our duty to support those midwives that continue to provide care for women who want the opportunity to birth at home with a trained professional by respecting their need for privacy.

If you want to name your midwife in your birth announcement or birth story, you first need to seek their consent to have their name published. Once you provide written consent from your midwife, we will publish their name if you desire.

## 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. Yahoo! Groups allows files to be stored and retrieved including documents, databases and the like, and messages 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!

**OZBIRTHING.** An open group that can be joined (or unsubscribed to) via the [maternitycoalition.org.au](http://maternitycoalition.org.au) website. Just log on and follow the prompts!

**MCNSW.** For NSW members and other interested individuals. For an invitation to join, please contact Carol Chapman [dean50@ozemail.com.au](mailto:dean50@ozemail.com.au) or Lisa Metcalfe at [nsw@maternitycoalition.org.au](mailto:nsw@maternitycoalition.org.au).

**MatCoWA.** For members in WA. Contact Tracey Reibel at [wa@maternitycoalition.org.au](mailto:wa@maternitycoalition.org.au) if you'd like to join.

**MCmidwives.** For midwives, midwifery students and others who are members of MC who are committed to seeing woman-centred birthing in Australia become a reality for the majority of women. To join contact Joy Johnston at [joy@aitex.com.au](mailto:joy@aitex.com.au).

**BAClist.** A discussion and action group dedicated to issues, media and research about birth after caesarean and caesarean surgery. It is moderated by Caesarean Awareness Network Australia representatives. Contact [info@canaustralia.net](mailto:info@canaustralia.net) to join.

**Qldcore** list 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 e-newsletter. Contact [qldpresident@maternitycoalition.org.au](mailto:qldpresident@maternitycoalition.org.au).

Find us on



# Maternity Coalition Contacts

## MC contacts (National)

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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.

Terms of Reference of each branch are to be consistent with those of the Maternity Coalition.

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