

BirthMatters

A pregnant woman is shown from the waist up, standing in a field of tall grass at sunset. She is wearing a black halter-neck top and denim shorts, and is gently holding her pregnant belly. The background is a soft, warm glow from the setting sun, with silhouettes of trees in the distance.

Vol 17/2 ISSN1443-7570

Winter 2013

Homebirth transfer
the woman's and midwife's perspectives

**The
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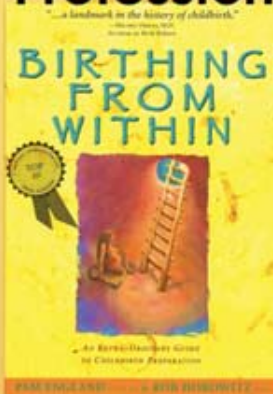
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OUR PURPOSE

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

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

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

GUIDELINES FOR SUBMISSION

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

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

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

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

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

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

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

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

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

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ADVERTISE WITH US!

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

Prices start at \$50 business card sized Ad, ¼ page \$75, ½ page \$100, Full page colour \$150 & includes promotion on our website, Facebook pages, at Choices for Childbirth sessions and through our events, support groups and branch meetings.

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



Welcome to the Winter Edition of *Birth Matters*! As many readers are actively parenting small children it seemed appropriate to include a **Parenting Matters** regular section. As a mother, just 'being with' my baby as he engages in self-directed play, I am reminded of being with women in labour and 'doing *not doing*'. I consciously step back so that my son can be guided by his inner process of exploration and growth, not by what I think he needs to be learning and doing. In the words of midwife Nicky Leap, "The less we do the more we give." This applies equally to parenting and midwifery. In this editorial I would like to touch on five basic RIE parenting principles (1) and then apply them to being with birthing women.

Invite active participation. Babies desire to be recognised and treated as unique, sensitive human beings; not as objects. This can be demonstrated by talking to babies about what is happening, helping them participate in what you are doing together, and verbally acknowledging their experiences and feelings. Equally, birthing women seek to have meaningful involvement in decision making, to understand the process, risks and benefits of any proposed procedures, and to have their thoughts, feelings and concerns acknowledged rather than dismissed or downplayed.

Encourage free, self-directed, uninterrupted play. There is a subtle yet meaningful difference between being present (but unobtrusive) with our children while they play; and ignoring them. When we are present we are open to our child when they wish to engage with us, but we do not direct proceedings. We do not teach them how things should be done. For the most part in labour midwives should sit and "drink tea intelligently" as they quietly observe the labour process; they should be present but unobtrusive (2). This enables the process of labour to unfold in its own way. We do not teach women how to position themselves or how to push; we support the woman to be self-directed and free.

Move birth/life outside and into nature as much as possible. Children seem to feel calm, at ease, safe and happy when they are in contact with the earth, sky, trees and water. Just moving a baby from indoors to outdoors, or into the bath, can be enough to soothe a fussy baby. Environment plays a powerful role in how women labour

too (3). Natural scenes and settings, architectural curves and water all work at a deep level to assist women to feel safe and therefore birth more easily (4). I believe this is one reason why women who birth in a birth centre or at home have a higher chance of normal birth.

Respectful and sensitive communication. Many things people do to children are, unconsciously, disrespectful; things they would never do to another adult like touch a complete stranger or pick someone up while they were mid-activity. A good rule of thumb is to ask yourself, "Would I like it if someone did that to me?" Women in labour are highly sensitive to their environment and this includes the words and touch of those around them (3). Midwives need to sensitively communicate appreciation, reassurance and affirmation (2) while at the same respecting that the woman may need silence and space.

Trust the process. Babies know instinctively what they need to do in order to grow and develop; to reach the next milestone. They are experts at focussing on new discoveries and small tasks until they achieve mastery. Each step leads to the next. We do not need to force milestones; there is a wide variation in normal development. We can trust our babies and trust that the process of development will unfold, in most cases, without the need for exterior controls or prodding (no matter how well meaning that prodding may seem). This trust applies to the body's birthing wisdom which is far greater than our own. When we observe and trust the process we allow that wisdom to choreograph a birth dance that is just right for each woman and her baby. We do not enforce time limits; we recognise there is a wide variation in normal birth.

So what? By actively 'doing *not doing*' with our children and with birthing women, while staying present, we allow the process to unfold naturally. Instead of focussing on the next milestone, and being overtaken by worry about why our baby is taking so long to roll over, sit up, walk, talk etc. we can be appreciative and supportive of *what is happening now*. So too in birth we are best to support *what is happening* rather than what we think *should be happening*. This means being mindfully inactive (if what is happening is normal) or mindfully active (e.g. transferring to hospital, intervening) if

what is happening is not normal. The artfulness of parenting and midwifery lies in knowing when to sit and when to move. I hope this is a starting point in the conversation about **Parenting Matters** and I look forward to receiving your submissions for this new regular section.

References and further information

1. "The surprisingly positive results of respectful parenting – 5 RIE baby basics," Janet Lansbury, accessed May 25 2013, <http://www.janetlansbury.com/2013/01/the-surprisingly-positive-results-of-respectful-parenting-5-rie-baby-basics/>
2. Liz Nightingale, "Birth noises and normal birth: midwifery by ear." *Essentially MIDIRS* 4, no.4 (2013), 17-23.
3. Sarah Buckley, *Gentle Birth, Gentle Mothering: The Wisdom and Science of Gentle Choices in Pregnancy, Birth and Parenting* (Brisbane: One Moon Press, 2005).
4. Maralyn Foureur, "Creating birth space to enable undisturbed birth," in *Birth Territory and Midwifery Guardianship*, ed. Fahy et al. (Sydney: Elsevier, 2008), 57-77

Maternity Coalition

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With the fast approaching Federal Election the MC National Committee have been working on a number of actions and discussions to ensure women's choice and women's rights in maternity care are on the minds of the politicians. Kylie Sheffield and Bruce Teakle are spearheading our campaign and I would like to invite any other interested members to please get in touch and see how you can help.

E: vicepresident@maternitycoalition.org.au

We have has another exciting upgrade with our new memberships database coming online. The committee has been looking at ways to make memberships more appealing to a wider range of people, and we now have a number of membership options. Please if you are due for renewal look over all the options (including a Premium, Basic and Student/ Volunteer option) and please encourage friends and family to join as

'Supporting Members' for *free*! This will help us communicate and receive feedback from a larger number of consumers than ever before. We are always looking for assistance with our National Committee so if you have a skill or talent you would like to share with us, or maybe have some feedback about things we could do better I would love to hear from you.

T: 0417 762 033

E: president@maternitycoalition.org.au



Are you someone who attends MC branch meetings, fundraisers and events? Do you keep up to date with what's happening locally in terms of maternity services? We are looking for an Editorial Assistant from each State and Territory to assist with motivating writers, gathering articles, taking event photos and writing articles. Time commitment would be a couple of hours per week.

Interested in volunteering? please email birthmatters@maternitycoalition.org.au

Letters to the Editor

I was recently sent the *Birth Matters* 'Purpose Statement' and guidelines for written submissions. I was dismayed to read in the purpose statement that Maternity Coalition (MC) was only looking for members to take *political* action. My purpose and passion for writing about birth is to present ideas for debate. I want to challenge the current accepted beliefs about birth, especially medical birth. I want to change the story

about birth so that it does not rest on 'what if something goes wrong?' My intention is to prompt women to take *personal* action, which may or may not include political action.

Knowledge is power! I believe MC should be providing women and their partners with knowledge about natural birth, which the 'powers that be' are not providing. I want to increase the number of women who demand to choose how,

when and with whom they birth. I want women to go to their obstetrician and say no to inductions or caesareans, or even better not engage an obstetrician and instead employ a midwife. There is certainly a place for political action; however the real power lies in the consumer deciding what they want and how they will spend their money.

Lynne Thorsen

www.lynnethorsen.com

A home away from home: new birth options on the Sunshine Coast



Clockwise from top left: Nicole in labour, baby Tyler born in water at the Maternity Care Centre, group photo with Ashlee (student midwife), Belinda (student midwife), Natasha (midwife), Kyle (father of the baby), Nicole, Kyle and baby Tyler.

On Tuesday 9 April 2013, Sunshine Coast Midwifery Maternity Care Centre opened its doors just 200 metres from Nambour public maternity hospital (Queensland). Sunshine Coast Midwifery was established in 2011 and is now operating from brand new premises with a whole team of complementary practitioners.

Bulk-billable private midwifery services

The Sunshine Coast Midwifery Maternity Care Centre was opened by midwife Natasha Oglesby. It provides bulk-billed antenatal and postnatal care by eligible midwives, birth support in hospital and homebirth. The midwives have provided continuity-of-care support in hospital for the past two years and have established good working relationships. Natasha says, "The hospital are respectful of our role as the family's midwife... we are there to advocate and ensure that options are explained in full so that educated decisions can be made and that time can be given to enable those decisions to be made." Like the majority of eligible midwives in Australia, Sunshine Coast Midwifery do not have 'visiting rights' at Nambour hospital, which means they cannot provide clinical care in the hospital setting.

On-site postnatal support

The centre also offers 24-hour on-site breastfeeding and/or postnatal support to well women and babies who have no medical reason to be in hospital. This may suit women who would prefer a family-friendly environment with individualised support for lactation and baby care, rather than the postnatal ward experience.

Home away from home

What's different about the service is that it offers a 'home away from home' for homebirth. The house is complete with a birth pool room, ensuite and family bedroom. This may suit women who live rurally and remotely, who can come to the facility in early labour and wait until established labour before they transfer to Nambour Hospital. Equally, it may suit women who are interested in homebirth but for one reason or another feel that it is not

quite right for them.

My friend Pesha attended the opening and was excited about the potential for the space to meet the needs of her family for their next birth. Pesha had an unplanned caesarean section for 'foetal distress' at Nambour Hospital in 2011. She tells me she has had her eyes opened to the possibility that this may have been unnecessary, or at least potentially avoidable. What she needed was continuous midwifery support to help her manage and ease her anxiety about labour, and an environment that was conducive to normal birth. In other words, Pesha needed an environment where she could feel 'safe, private and unobserved' (1). While Pesha is leaning towards homebirth, her husband has concerns about it, given his previous experience of supporting his wife through a caesarean that felt frightening for both of them. The couple would also like to have their two-year-old son able to attend the birth, in a relaxed way, so that he is free to come

in and out as he feels comfortable. The Maternity Care Centre 'home-away-from-home' option ticks a lot of boxes for this couple, and I imagine that will be the case for many like them who are 'birth-centre minded' but who cannot access birth centre care.

Holistic care

The centre is holistic in its provision of complementary and alternative medicine services, including acupuncture (specialising in fertility, pregnancy and women's health), naturopathy, massage, osteopathy and chiropractic. Many of the practitioners are previous homebirth clients of Sunshine Coast Midwifery. The centre runs regular Hypnobirthing courses, as well as weekly prenatal yoga and meditation sessions, and mums-to-be and mums groups.

Further information

Go to www.sunshinecoastmidwifery.com.au and check out the Facebook Page.

References and further information

1. Buckley, S (2005) *Gentle Birth, Gentle Mothering: The Wisdom and Science of Gentle Choices in Pregnancy, Birth and Parenting* Brisbane: One Moon Press.



L-R: Marion Woodhead (acupuncturist), Janelle Burns (naturopath) with her daughter Ruby, Belinda Kelly-Mandalis (student midwife), Natasha Oglesby (midwife), Beth Newman (midwife), Sarah Farmer (midwife), Chiropractor Fiona Perl far left (not pictured).

Release of national antenatal guidelines: module I

We are pleased to announce that the *Clinical Practice Guidelines: Antenatal Care – Module I* was approved by Australian Health Ministers' Advisory Council on 31 August 2012 and publically released in March 2013. The Guidelines have been endorsed by the National Health and Medical Research Council (NHMRC). The purpose of the Guidelines is to provide evidence-based advice on the care of pregnant women in a range of settings. Module I has a specific chapter on *Antenatal care for Aboriginal and Torres Strait Islander women*.

There are numerous aspects to antenatal care and reviewing the evidence in all areas is a lengthy process. For this reason, the project is being completed in stages. The clinical topics discussed in Module I were selected after a process of consultation designed to identify the areas where specific guidance is required. A draft of Module II will be soon released for public consultation and will be finalised by early 2014.

Module I of the guidelines can be found at <http://www.health.gov.au/internet/main/publishing.nsf/content/phd-antenatal-care-index>



SPECIFIC TOPICS INCLUDED IN THE CLINICAL PRACTICE GUIDELINES: ANTENATAL CARE - MODULE I

Clinical care in the first trimester

- Number and timing of antenatal visits
- Discussing the schedule of antenatal visits
- Planning antenatal visits

Lifestyle considerations

- Tobacco smoking
- Alcohol
- Medicines
- Nutritional supplements
- Oral health

Maternal health screening

- HIV
- Hepatitis B
- Hepatitis C
- Rubella
- Chlamydia
- Syphilis
- Asymptomatic bacteriuria
- Asymptomatic bacterial vaginosis
- Vitamin D deficiency

Clinical assessments.

- Gestational age
- Weight and body mass index
- Blood pressure
- Proteinuria
- Psychosocial factors affecting mental health
- Depression and anxiety
- Domestic violence
- Nausea and vomiting
- Constipation

Screening for fetal chromosomal abnormalities

- Discussing screening with women
- Screening tests in the first trimester

Pregnancy, Birth and Beyond MC radio show

In April the *Pregnancy, Birth and Beyond* radio show celebrated its fifth season (two and a half years) of live-to-air broadcasting. It all began when our MC branch presented a screening of Rani O'Keeffe's film *Throwing out the Lies with the Birth Water* in August 2010. We were very inspired to see the presenters of Birth Hour on Blue Mountains community radio share information about natural birth. A month later local radio station 99.9 Bay FM in Byron Bay advertised for volunteers to present their ideas for new show programming. So, with very little time to spare, a team was assembled and the *Pregnancy, Birth and Beyond* radio show was born.

The show's first presenters were midwife Nicole Foder and Anna Aranci, followed by local mum, doula and midwife-in-training Taneal Blake, then two local mums and doulas Lara Martin and Hunna Ovar. Our current team is Lara and Taneal who are now confident enough to run the show solo, so they share the weekly programming by working on alternate weeks.

We are extremely thankful for all the women who have participated in *Pregnancy, Birth and Beyond*. They all work extremely hard volunteering their time and putting together informative and interesting content every week. Without them, all the amazing stories we have heard would not have reached the wider community. I also want to acknowledge the courage and dedication of each of our presenters for stepping into the unfamiliar and technical realm of public broadcasting.

There have been many inspiring interviews during the past couple of years. Interview highlights include: Dr Michel Odent, Jenny Blyth (film maker of *The Big Stretch*), Pinky McKay, Robyn Grille (author of *Parenting For a Peaceful World*), Maha Al Musa (founder of *Belly Dance of the Womb* and winner of the One World Birth National Hero Award), CNN Hero Awards winner, Robin Lim and Attachment Parenting expert Dr William Sears Snr.

The show brings alternative voices to the birthing and early parenting community. *Pregnancy, Birth And Beyond* acts to counterbalance the mainstream media's depiction of birth as a medical process. Instead, the programme presents birth as a sacred event, whether or not it requires any medical assistance.




Radio show team L-R:
Lara Martin, Sally Cusack,
Hunna Ovar, Taneal Blake

Our 'DJ Doulas' Lara and Taneal invite you to tune-in weekly for the *Pregnancy, Birth and Beyond* show every Wednesday from 1 pm to 2 pm eastern standard time. To stream live go to www.bayfm.org and click 'listen'. You can


also 'like' us at www.facebook.com/pregnancybirthandbeyonddradio and catch up on previous shows through our podcast posts.

BayFM have been very encouraging right from the start and have trained up all our presenters. We would be delighted to see other MC branches start up similar projects with their local radio stations. It's a great way to spread the word about the work done by MC and others who support natural birth. Please contact us if you'd like to find out more about how to get your own local radio show started!

As for the future of the show, we expect to use our recently acquired digital recorder to do more recorded interviews at conferences and other birth-related events. We are finding that opportunities keep presenting themselves and, in the meantime, we love the community connections we are making every week.

**Maternity Coalition**

Victoria Movie Nights



BIRTH STORY: INA MAY GASKIN AND THE FARM MIDWIVES captures a spirited group of women who taught themselves how to deliver babies on a 1970s hippie commune, rescued modern midwifery from extinction, and changed the way a generation thought about childbirth. Today, as nearly 1/3 of all US babies are born via C-section, they labor on, fighting to preserve their knowledge and pushing, once again, for the rebirth of birth.

Date:	Thursday 27 th of June	For bookings:	
Time:	7:30pm	Email:	MCmovie@birthattendants.info
Venue:	Northcote Town Hall.	Phone:	03 8677 1881
Cost:	\$10 pre-paid booking \$15 at the door	Web:	www.birthattendants.info

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Protest against changes to the Ipswich Midwifery Group Practice

Consumer perspective

By Daniele Day

Recent changes

Our local midwifery group practice (MGP) now denies many women the opportunity to birth with continuity of carer. Our MGP traditionally focused on providing maternity services to low-risk women aiming for a natural active birth. Under the change, the service was required to prioritise MGP places for high-risk women, including Indigenous and teenage women (under 18-years old). This change in focus left few spaces for low-risk clients to birth with the MGP service.

Cost-shifting

We believe this change was driven by the fact that, in the current Queensland political climate, the Ipswich Hospital has found itself very short of funding. The aim appeared to be to shift all pregnancy care for low-risk women from the State-funded hospital system to the Federally-funded Medicare system, or private eligible midwives. Antenatal midwifery clinics at the mainstream Ipswich Hospital have also been closed recently. This means that low-risk, non-Indigenous women, and women aged 18 years or older, are only offered one booking-in visit at the hospital; no other hospital-based antenatal care is available.

The consumers rallied

Many local families were concerned by this change and there was a considerable local response through a dedicated Facebook page, a petition tabled in parliament, and much letter writing to hospitals and politicians. The Ipswich Community Issues Forum, held on 22 April 2013, provided us with a great venue to stage a protest. The forum panel included: a police representative, Ipswich mayor, Paul Pisale; Federal Member for Blair, Shayne Neumann (ALP); State Member for Ipswich West, Sean Choat (LNP); and a university representative. The forum was hosted by Channel Nine and allowed audience members to ask questions of

panel members. Others present, but not on the panel, included Joanne Miller (State Shadow Health Minister and Member for Bundamba) and Dr Mary Corbett (Ipswich Hospital Board Chairperson).

Our group was the most visual presence at the forum: we wore red and held red balloons, a few signs and many babies and small children. We were able to officially ask three questions during the formal proceedings. Many of our group members also had a chance to talk personally to the politicians and hospital chairperson both before and after the event.

Improvements since the protest

Since we first launched the protest action, there have been considerable improvements in access to the service for non-priority group low-risk women (i.e. a number of women initially refused a MGP place have been called and offered a place). This appears have occurred predominantly as a result of moving under 18-year old women back to their previous non-caseload antenatal care, in a specialised young women's clinic. Despite improvements, without additional staffing, we remain very concerned about the ongoing sustainability of access and whether the current level of staffing will be maintained in the event of staff changes.



Ipswich mothers and babies join the protest

MC perspective

By Melissa Fox

We know that care from a known midwife (e.g. MGP care) is optimum and cost effective for *all* women, whether they are low risk, Indigenous, teenagers, or even high risk (in conjunction with or in addition to appropriate multidisciplinary care). All women, babies and families benefit from having continuity of care with a known midwife during pregnancy, the birth and for six weeks afterwards.

Lack of consultation and poor process

The issue for women and families in Ipswich has been one of process. It is unsurprising that, having experienced the benefits of an MGP service within the community, local families were disappointed and angry to be denied this model of care for current and future

pregnancies. It is not acceptable to take away or limit access to a service that has met women's needs and resulted in high levels of consumer satisfaction. This is compounded because this occurred, as far as I am aware, without any consumer / community consultation.

What about midwives in private practice?

Some argue that low-risk women can access the same kind of continuity of care from a midwife in private practice (MIPP) instead. It is wonderful that the women in Ipswich now have access to a number of skilled, compassionate midwives in private practice. However, there are not enough MIPPs in Ipswich to provide care for all low-risk women. Secondly, it presumes that all low-risk women have the ability to pay a private midwife for consultations in order to then claim the Medicare-rebate; some do not. Thirdly, there will still be a gap that

many people just can't afford (especially with the axing of the baby bonus and its partial replacement with Family Benefit Part A payments over several fortnightly instalments).

What should Ipswich Hospital have done?

Simple: it should have consulted with consumers. When asked, consumers can come up with ideas and efficiencies for health services that meet our needs and that might not otherwise be considered. For example, consumers might have suggested re-arranging existing Ipswich midwifery staff to create several additional MGPs to cater specifically, and in a culturally appropriate way, for groups such as young women and women from a refugee background (as has been done elsewhere). Improving and re-designing maternity services, particularly in this new landscape, is about working together in partnership.

How continuity of care with Ipswich MGP made a difference

Simone is a Mum to Jonathon (2 years and 9 months) and a midwife at the Ipswich Hospital.

Continuity of care during pregnancy, birth and the postnatal period is the 'gold standard'; the ideal. Yet many Australian women cannot get this basic need met during their birthing year. I am lucky in many ways because, as a midwife, I knew the importance of continuity of care even before I had children. This type of care became even more important to me because of my history of depression and the fact that, at 35 years of age, I was pregnant as a single woman (my son was conceived with donor sperm). I booked into the local hospital's Midwifery Group Practice (MGP) before I even had an official blood test confirming my pregnancy – places are that limited!

My midwife, Hazel, was fabulous! We met often during my pregnancy, sometimes for ages, just the two of us, and we discussed my needs and wants. I explained my family dynamic and my worries over the possibility of having no-one to support me during labour. During my pregnancy, I met the back-up team members who would care for me if Hazel was unavailable (e.g. on a day off). We became a strange sort of friends, Hazel and I, during wonderfully supportive antenatal appointments that were flexibly scheduled around my full-time shift work. It was easy to ask advice and to obtain referrals to other practitioners. Here was a woman I could trust, who would live up to the title of midwife: *mid* (with) *wife* (woman), during my birth. Together, we excitedly planned the types of things I could do in labour that would help me to stay active and help bring my baby into the world beautifully. The bath featured strongly in these plans. I could not have experienced this level of support and comfort without the continuity of care that the hospital MGP program offered.

Hazel's support and guidance through my severe sciatica and an unstable pelvis were invaluable, as was a quick and early referral to physiotherapy. As we knew each other so well by this time, Hazel was well aware that it was important to me to continue working for as long as possible before birth. I wanted to minimise my pre-birth maternity leave, as I was determined

to have a full 12 months off, before returning to work, if at all possible.

My waters broke at 34 weeks

I was devastated, to say the least, when, at 34 weeks, I got up and discovered my waters had broken. Denial is an interesting thing: it took me over an hour, and time in the shower getting ready for work, before I admitted that, yes, indeed this *was* amniotic fluid, and I *was* looking at a premature birth and all sorts of things I had never envisioned or thought about. I was completely hysterical as I rang work and then Hazel. I soon met Hazel's back-up midwife in a birth suite to discuss my options and make a plan.

“ I was painfully distressed and it was only my complete trust and confidence in Hazel that had got me to this point, something I would not have had without her continuity on the MGP program. ”

Unfortunately, the obstetrician was a little behind our plans and encouraged me to accept induction there and then due to the 'risk of infection'. The MGP midwife had already discussed the pros and cons of induction with me. I knew that a baby born at 34 weeks would probably be just fine in the long-term, but that early days would be spent in the special care nursery and that breastfeeding could be affected. I hoped that I would be able to make it to 36 weeks, when my baby's suck reflex would be present and he would have had time to develop and grow that little bit more, so that he might not have to spend weeks in hospital. I knew that infection was a risk after the waters broke, but I felt that this risk was worth taking if it gave my baby a bit more time in utero. I was happy to be induced if anything changed with the situation.

I declined induction, not very politely I must admit, and instead requested an injection of betamethasone (steroids). Betamethasone is used to help ready

the baby's lungs to expand (breathe) if they are born before 34 weeks gestation. This can minimise the amount of extra assistance that the baby needs (e.g. oxygen supplementation). I stayed in hospital for 24 hours before returning home to await events. I had regular monitoring on the cardiotocograph machine (CTG) in the birth suite with Hazel, oral antibiotics and checked my pad and temperature often (every 4 hours) over the next week. Hazel was in daily contact, touching base and making sure I was all right, both physically and emotionally. She was a godsend! Our lovely working relationship and the continuity of care I had received meant that she understood my values and what was important to me. I trusted implicitly that she would clearly state if she felt I was making a decision that put myself, or my baby, at risk. We talked about the bath no longer being an option and of the need for continuous monitoring during labour. This was because of hospital protocol: my waters were broken and the labour was likely to be premature.

Sleep didn't happen

A week later, contractions began on a Thursday afternoon and I gave Hazel a call just to let her know something was happening. I told her I planned to take some paracetamol, to have a shower and to endeavour to sleep, and that I would ring her back when things got going a little more. The sleep didn't happen, and I rang her again at about 9 pm. We talked for a while and agreed that it was still early days. I hopped back into the shower. At around 11 pm I rang and told Hazel that I was coming in. As we knew each other so well this was not an issue. Hazel could tell that I needed to be somewhere other than at home; she knew me well enough to be able to understand this.

I met Hazel in the hallway of the hospital and we went into the birth suite together. I made a beeline for the shower. At some stage she did a vaginal examination and found I was only three centimetres dilated and had a posterior baby (baby's spine facing my spine). With the trace (continuous electronic foetal heart rate monitor) on, Hazel and I attempted various positions to help my baby to change to a more 'labour friendly' position. This went on for some time, but



Ipswich MGP Simone and baby Jonathon

my contractions were never regular. Hazel attempted to get me using the gas, but I discovered that I am very vocal in labour (I moo) and it is absolutely impossible to breathe in gas and moo like a cow at the same time.

In the early hours of the morning I began to push involuntarily with the contractions. We both knew that it was unlikely, given the nature of my labour to date, that I was ready to have my baby and a quick vaginal examination confirmed this. I was only six centimetres dilated, but nothing we did stopped my urge to push. I was painfully distressed and it was only my complete trust and confidence in Hazel that had got me to this point, something I would not have had without her continuity on the MGP program. My follow-through midwifery student, who accompanied me to my pregnancy visits and was to be with me in labour, arrived at about this time. Hazel and I discussed between contractions what would be best. Eventually I decided that I would have an epidural in the hope that it would prevent me from pushing and causing a swollen cervix.

I almost gave up at this point

An epidural was inserted, but it didn't work for long, so it was topped up quite heavily; a little too heavily. This meant that by the time I was fully dilated, I still couldn't feel a thing. After about 45 minutes of 'passive descent' (allowing my body to bring the baby down, without pushing), I actively pushed for about two hours (maybe more, I am hazy on time frames here). By this time my mother had arrived to help support me. My son's heartbeat remained reassuring through the pushing stage. Soon after I started pushing, Hazel was required to go off shift as her 12 hour working limit was up. I almost gave up at this point. Having done 12 hours shifts myself previously, I

completely understood this requirement, but at the same time I was devastated. After two hours of pushing and not much progress, I was offered a 'trial of instruments' (vacuum or forceps) in the operating theatre. The trial part meant that, if it didn't work, then I would have a caesarean. I had had many conversations with my mother and follow-through student during pregnancy about the birth plan I had developed with Hazel. They were able to support me to continue pushing and, eventually, I birthed my dear little boy into my arms. I was ecstatic! My baby Jonathon had arrived and I had avoided intervention by giving birth to him myself.

Being an advocate on my son's behalf

The continuity of care continued after this birth as I was seen each day in the hospital for the seven days Jonathon and I were inpatients. I wanted to stay in hospital while he was in the special care nursery. Hazel's support and information regarding the pros and cons of various treatments for Jonathon was invaluable. I will always be grateful for her time and input during such a stressful period. The support I got from Hazel helped me to be a strong advocate on my child's behalf.

Hazel and I have kept in a loose sort of contact, both of us having changed employment. I now work in the hospital at which I birthed. Hazel has continued into private practice with My Midwives, Ipswich, who now have a license agreement with Ipswich Hospital. I am currently trying to conceive my second child with the same donor. I have already touched base with Hazel, so that she can provide my care for that pregnancy and birth. I totally want to continue that beautiful, empowering and fabulous relationship that enabled me to birth my precious boy and supported me to make informed decisions in relation to his care and treatment as a premature baby.

Is your membership up to date?

**Renew today.
See page 32**



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Crafting a life of wholeness and belonging: craft, continuity and care



I met some of you through The Crafting Womb at the Home Birth Conference in Hobart last year (2012); where together we clicked and clacked a multitude of squares that have become blankets for Hamlin Fistula Ethiopia (Australia) Ltd. I still wonder at the marvel that has become The Crafting Womb (TCW) since her 'birth' with you all in Hobart.

'Knitting myself back together'

An example of how craft may be used to facilitate 'continuity of care' came out of a connection I made at the Home Birth Conference with Tessa Kowaliw, who was, at the time, the coordinator of CARES. CARES Incorporated is a South Australian, not-for-profit organisation that aims to help women to make informed and empowering choices about caesarean birth and vaginal birth after caesarean (VBAC). CARES supports women and families to work through any issues surrounding caesarean birth and its implications for future births. After hearing me speak about my personal experience of healing through craft, Tessa was keen to offer a crafting process to the women of CARES who attend a coffee morning.

It was through my own experience with craft, as I recovered from illness, that I felt the power of craft as a healing process. For six weeks, each week, I attended a class in crochet, sitting at the same table with the same teacher and the same group of women. Each week, I re-remembered how to crochet, and watched as the lines of my crocheted squares increased. Each week, I noticed that my ability to see the 'light' around me increased. I found myself smiling, and I found myself with more energy and a greater desire to connect with others.

Going to that class and making that connection began a process of re-connection to myself. In time, I was well. I was also well on the way to creating my first crochet blanket! I am still working on that blanket and I'm not sure I will ever complete her. She is like a continuing

creative reminder of what is possible. The journey of crafting was part of the process of my return to wholeness. When you craft, what you are crafting is an outer manifestation of yourself, as you are at that particular time; but it's not the product of your crafting that is important, so much as your connection and engagement with the creative process.

“... it's not the product of your crafting that is important, so much as your connection and engagement with the creative process.”

Nurturing connection

I have seen crafting provide women from a refugee background with an inclusive and nurturing environment for connection. Working with our hands, we become synchronised with our hearts, and synchronised with the next person, and the next. It is a special way to connect. This 'therapeutic' way of connecting provides a non-verbal outlet for women to work through their trauma, creating safety and a place of home.

The Crafting Womb has offered Sacred Crafting to various events and conferences around Australia. Last year, at the Red Tent Dreaming Events in Brisbane, Melbourne and Sydney, TCW offered *Moonstick Magic* within The Crafting Womb space. Hundreds of women participated in the reclaiming of their menses and offered up prayers/wishes to themselves, their communities and to the Earth, creating a crafted moonstick within the process. At the Gaia Goddess Conference on the Gold Coast, participants crafted *Prayer Flags of Transformation*, stitching representations of their personal relationships to transformation, which hung, side by side, connected to those of the other conference participants.

Integration

The process of crafting is a process of 'integration'. Each time I circle with another group of women, some pregnant, some in anticipation of conceiving,

some with babes in arms, some already mothering, or grand-mothering, or mothering themselves, I see how 'touching in' between the crafter and the crafted offers the opportunity for integration. Integration balances, organises and coordinates the nervous system. The nervous system being that which handles the input of diverse sensory information: all the fragments we receive in our day-to-day lives. When these fragments are integrated, we can breathe. We feel balanced and whole. Craft is significantly connected to this process of integration. In my personal experience, my weekend crafting on the couch is my way of consciously sifting through my week, weaving it in, making sense of something that has occurred, coming to new awareness around it, integrating, creating wholeness one stitch at a time.

Certainly my experience of crafting whilst pregnant, knitting and stitching fireside, rocking in my rocking chair, breathing with my babe, could also be understood as "integration, coordination and... sharing of information between (mother and baby)" (1). Crafting develops a special connection of heart and hands: two hearts synchronising whilst crafting a magically imbued gift for the arrival of your newborn. It is a blanket that wraps your newborn within the love of your collaborative creation.

This year TCW will travel to the Being Woman Gathering on the North Coast of Queensland, the Seven Sisters Festival in Melbourne, The Passage to Motherhood Conference on the Gold Coast, and to the SquatFest in San Francisco, USA! I am excited for what is to come, and honoured to hold the space for what that may be.

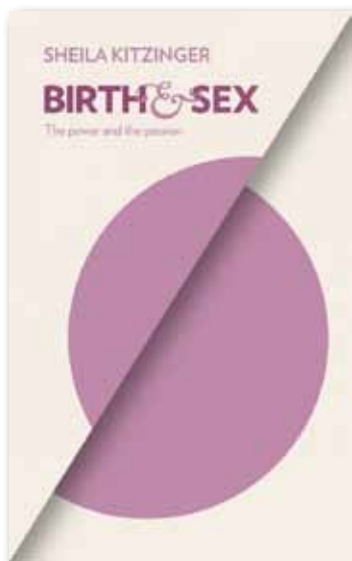
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1. M. Gulliford, S. Naithani, M. Morgan. *What is 'continuity of care'?* (Royal Society of Medicine Press, 2005).

Author Bio

Conceived on Bougainville Island; born in Brisbane, Australia. My nomadic childhood included ten years in the USA. A shamanic experience in Central Australia lead me to Steiner education, to my husband and to homebirthing my two sons. Homebirth lead me to Jane Hardwicke Collings and to her school of Shamanic Midwifery, of which I am now a graduate and an apprentice. I live in a star-studded rivulet in Tasmania.

Birth and Sex (The Power and the Passion) by Sheila Kitzinger



Released late last year, this book is the latest in a long line from the very popular and well-known British birth anthropologist, Sheila Kitzinger. It caused

quite a stir, because people somehow formed the idea that the author was saying that all women should be having orgasms during childbirth. Detractors argued that this book added to many existing expectations around birth and could lead to women feeling resentful and cheated if their experience was different. In reality, the book is not about that at all. Kitzinger notes that birth and sex are not usually discussed on the same page, despite the fact that essentially the same organs and hormones are involved during both acts. Her point is that there is potential for women to experience the same rush of ecstatic energy during childbirth as during lovemaking, given the right environment and conditions.

So Kitzinger is encouraging women to explore, and become familiar with, the anatomy of their sexual organs and to discover how they function similarly during both sex and birth in harmony

with the mind. She covers at length how birth has been de-sexed, particularly since the advent of the obstetric profession and the move to hospital birth. There have been accompanying changes in care philosophies (active management and, a prime example of this, episiotomy), in the portrayal of birth in our society, and in the language used around childbirth. Several chapters explore birth dance, water birth, song, homebirth, midwives and doulas, all of which can be used to help women to create an environment in which they are free to follow their instincts and to be confident in their body's ability to give birth. Kitzinger also has a detailed chapter on *Sex after the baby comes*, a topic not often covered in much detail in other reading material. In all, I found this book a very informative read and I would highly recommend it to others as a 'must read' in preparation for birth.

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Women-centred Care: Does it really exist? Panel with Jillian Clarke (RM) & Bridget Roache (IBCLC) \$19.99

What is it and what does it mean in practice? Do women actually want it? What needs to change to make it possible? These questions and more explored in a constructive panel format!





Renovation of Stanthorpe birth suites (QLD)

In Queensland, Stanthorpe maternity consumer group Mothers Unite for Maternity Services Stanthorpe (MUMSS) were thrilled with the announcement on 1 May by the Darling Downs Hospital and Health Service (DDHHS) that they would fund a \$1.1M renovation of the Stanthorpe birthing suites. The renovation will include two ensuites and a birthing pool. MUMSS began researching and campaigning for an upgrade to maternity facilities just over 18 months ago and has been working with the newly formed DDHHS Board and Stanthorpe Hospital obstetric staff to ensure that the designs would meet the needs of mothers, while being practical for midwives and obstetric staff. MUMSS will continue to engage with the DDHHS to ensure the renovation meets the expectations of Stanthorpe mothers. Work is expected to commence in the new financial year.

Birth care in the Kimberley region (WA)

Great things are happening in maternity care in rural Western Australia. Last year the Kimberley region received a substantial grant to improve the way maternity care is delivered to local women. Each of the three birthing centres

(Derby, Broome and Kununurra), were encouraged to devise a model that would best suit local women, taking into consideration their staffing configurations. These areas are prone to high staff turnover due to their location, so the models had to be position specific, and easily transferrable to a new midwife.

Derby's maternity catchment area includes Fitzroy Crossing and Halls Creek. The new model in this area has provided a midwife from the hospital to travel out to these areas two days a week to support the community midwife and to develop a rapport with the women. A midwife also visits the Aboriginal Health Service in town to provide antenatal and postnatal care to women. Even in the short time since these simple changes came into effect, benefits to the women who birth there have been noted.

Originally, there were to be no extra midwifery positions created, but the Aboriginal Health Service has been so pleased with the results of having a midwife two days a week, that they have taken over the cost! Population Health has also agreed to fund a midwife for two days a week. The hospital is now funding a midwife to travel to another very remote community one day a week and administer the project one day a week. All

together this equates to an extra full-time midwife for their region.

Consumer input in Ballarat (VIC)

Maternity Coalition members from Ballarat BaBs in Victoria continue to be very active in their community. As well as running weekly BaBs support groups, they have been informally liaising with some of the midwives from the hospital. They have been discussing routine procedures that are not necessarily in the best interest of the women who birth there. The BaBs members hope that input from consumers will help to sway management to create a more women-centred birthing facility. Sandy Tai, President of Ballarat BaBs, has also been asked to speak to the Diploma of Midwifery students about the consumer's experience of midwifery care.

Further information

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

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Making A Difference

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Continuity and change at the Queensland Rural Birth Summit

Sarah is an active Maternity Coalition member who lives in Stanthorpe, Queensland.

On 5 December 2012, the Queensland Centre for Mothers & Babies (QCMB) hosted its first Rural Birth Summit in Toowoomba. The regions were very well represented by consumers, midwives, Directors of Nursing (DONs), medical officers, students, lecturers, policy makers and State government, with the Minister for Health, the Honourable Lawrence Springborg, attending as a guest speaker.

Two themes emerged throughout the summit: 'continuity of care' and 'managing change'. Speakers provided guidance for, and real-life experience of, the continuity of care model. They also acknowledged that resistance to change is the largest impediment to its successful implementation.

Challenges and resistance

The summit sustained a positive mood throughout. Speakers presented evidence that the continuity of care model is effective and delivers better outcomes for mothers and babies. Interestingly, the size of the facility does not seem to be a factor in determining success. Important evidence was presented to demonstrate that birthing in small rural areas does not increase or change the rate of perinatal death, even where caesarean sections are not available.

Guest speakers and motivational leaders who had overseen the implementation of continuity of care models in regional centres in Goondiwindi and Proserpine, gave clear instructions and examples of how to overcome the challenges and resistance they met. These challenges included staff rostering and initial budgetary strain during implementation.

The consistent message given by medical experts, midwives and consumers was that improvements can be achieved providing there is strong leadership and a willingness to change. This was reinforced by the Minister for Health, who insisted that resistance to change would not be tolerated under his administration.

Pioneering continuity of care models

The strong focus on continuity of care echoed throughout the day. The regions that have pioneered this approach recognise that every region and hospital needs to learn from their lessons and


“ Important evidence was presented to demonstrate that birthing in small rural areas does not increase or change the rate of perinatal death, even where caesarean sections are not available. ”

find a system that works for them. The presentations culminated in round-table discussions, where pioneering DONs provided one-on-one advice to other DONs in the hope of overcoming the physical barriers. Larger representation from midwives from these areas would have been helpful here, and the My Midwives speaker highlighted the fact that they had received around 160 applicants wanting to work in their clinic under the caseload model.

The Stanthorpe consumer group Mothers United for Maternity Services Stanthorpe (MUMSS) was humbled by the support shown by maternity leaders in government and by other centres. Quite a number of clinical staff remarked that they lacked real consumer input from consumer groups. They even suggested that this leadership could overcome the resistance they encountered from other clinical staff and management. Increased empowerment of groups such as MUMSS could be the key to real and lasting change. Consequent networking strengthened this positive feedback, leading to a commitment from Jenny Gamble, Professor of Midwifery at Griffith University, to visit the Stanthorpe hospital DON to discuss opportunities for student training in the continuity of care model.

Further information

QCMB is planning a series of Rural Birth Summits around Queensland. More information is available on the QCMB website: <http://www.qcmb.org.au/ruralbirth>



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The protection of midwifery practice in South Australia



In early 2013 the South Australian Government released a consultation paper seeking responses to a proposal to restrict the practice of midwifery in South Australia (SA) to registered midwives or student midwives. The discussion paper is titled 'Proposal to Protect Midwifery Practice in South Australia (1)'. This proposal was in response to recommendations in a coroner's report from 2012 into the deaths of some babies related to homebirths (2). If implemented, the proposal would outlaw the provision of midwifery care in South Australia by people who aren't registered caregivers. Health practitioner legislation in Australia is organised by the states and territories each agreeing to having the same (or almost the same) legislation, so changes of this sort in SA would be likely to affect laws around Australia. Maternity Coalition responded to the consultation paper in February 2013, with the submission below.

Maternity Coalition supports women's access to choice in birth, and to care from registered midwives in whatever setting women choose. The protection of midwifery practice in South Australia (SA), or nationally, may provide some protection to women from some practitioners holding themselves out to have midwifery skills, but whose practice is unregulated and uninsured. We believe

however, that the goal of protecting women who choose to birth at home is likely to be poorly served by this action in isolation, and that a broader view is needed to deliver the goals identified by the SA Coroner and the Minister.

Women will choose to birth at home

A proportion of women choose, and will continue to choose, to birth at home. This should be recognised and accepted by all levels of health policy and service delivery. We consider arguments about the safety of this choice to be relevant to inform women's individual choices, but they should not restrict service provision. A harm minimisation approach should be taken to maximise the safety of women and babies when birth at home is chosen.

Access to midwifery care

The safety of women choosing to birth at home and their babies must be protected by access to safe care. This will generally be midwifery care, but safe midwifery care depends on collaboration with obstetricians and other providers. The safety of women birthing at home is dependent on their access to midwives with appropriate skills, supporting processes and lines of consultation and referral.

Lack of access to care

Many women choosing to birth at home do not have access to midwifery care from registered midwives with appropriate skills and supports. This problem has increased with the move to national registration and the requirement for professional indemnity insurance. It appears that the use of unregistered caregivers, and the choice of 'freebirth' without a trained caregiver, has been increased by a reduction in access to registered midwives. Any attempt to improve safety will be futile if the obstacles to women's access to appropriate midwifery care are not urgently addressed.

Collaboration and support from public hospitals

Midwives providing private birth care in the home need collaborative support from public hospitals and their staff. This is for the safety of women choosing to birth at home and their babies. Appropriate collaboration and support from public hospitals is frequently denied to women choosing to birth at home, greatly increasing risk to women and babies. The national agreement to address this problem, in the National Maternity Services Plan, has not been effectively progressed by most states, and in the one state where it has been progressed (Queensland), most hospitals are not collaborating with local eligible midwives.

Access to hospital care with a private midwife

We observe that where eligible midwives have visiting access to public hospitals, fewer women choose to birth at home with risk factors (currently unpublished data). Women are able to maintain continuity of care with a trusted midwife, whether birthing at home or in hospital. Enabling this model of care as a choice for women must be a primary risk management

“ A harm minimisation approach should be taken to maximise the safety of women and babies when birth at home is chosen. ”

strategy for the safety of women and babies in the context of women's choice of homebirth.

Limits to effectiveness of protecting practice

Protection of midwifery practice, in itself, is ineffective in preventing women's use of unregistered caregivers. We observe that in states where midwifery practice was protected before national registration, unregistered caregivers practised illegally because there was demand for this service, coupled with inadequate access to registered midwives to provide care to women choosing to birth at home. It appears that unregistered birth caregivers are predominately an artefact of the marketplace, and may not be much affected by practitioner registration laws.

Traumatic experiences of birth care

We observe that traumatic experiences of birth care contribute to some women's choice to receive pregnancy, birth and postnatal care outside of mainstream services. We strongly object to the trivialisation of women's experience of birth trauma in the discussion paper (1). High rates of trauma arising from maternity care are indicated by research, including Australian research, and have deep and lasting effects on women and their families (3). We believe that the goal of ensuring the safety of women and babies cannot be met without acknowledging the negative experiences of many women, and addressing the causes in current services.

Professional indemnity insurance

Midwives providing homebirth care are currently unable to purchase professional indemnity insurance (PII) for this element of their practice. Homebirth is excluded from the scope of Commonwealth-subsidised PII. This is due, in our opinion, to Government reluctance to offend medical stakeholders who object in principle to women's choice to birth at home. Women are thus unable to receive compensation in civil law for outcomes of care in homebirths, whether their caregiver is registered or not. Providing registered midwives with PII would provide another marketplace incentive for employing a registered midwife. We propose that homebirth care is included in the Commonwealth-subsidised PII product.

Freebirth

A very small proportion of women choose to birth outside of hospital, without

a trained caregiver. While some women make this a philosophical choice and we defend their freedom to do this, we observe that in most cases women do this in desperation, usually due to problems accessing care in which they feel safe. While the rate of freebirth is unknown, we note that in Queensland's perinatal statistics, the rate of 'born before arrival' (which may include freebirths) is several times the rate of planned homebirths (4). It is important that laws restricting midwifery practice do not cause harm to women purposely or accidentally birthing outside of hospital without a trained caregiver, or those people supporting them.

Summary

Maternity Coalition supports the goal of the South Australian Minister for Health in seeking to maximise the safety of women and babies, especially when women choose to birth at home. We support the protection of midwifery practice insofar as it may help to achieve this goal. However we note that the scope of the Coroner's investigation and report does not include the root causes of women's choice to birth with unregistered caregivers, or women's choice to birth at home with complex clinical needs. We consider that a range of other actions must be taken to ensure the protection of women and babies.

References and further information

1. <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/>

KEY RECOMMENDATIONS:

- Respect women's freedom to birth at home.
- Recognise women's need for midwifery care for homebirth.
- Recognise that women's access to private midwifery care is inadequate.
- Act urgently to enable women to access eligible midwives with hospital access.
- Recognise that women's experience of birth trauma is real and significant; it may drive women's birth choices.
- Support extension of Commonwealth-subsidised PII for eligible midwives to include homebirth.
- Protection of non-practitioner support people in any legislation protecting midwifery practice (to protect birth support people such as partners, friends, doulas etc.).

legislation/proposal+to+protect+midwifery+practice+in+south+australia

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Gentle birth in a country with a 52% caesarean section rate



Australian midwife Lianne, Carol, and water born Luisa

They were in Bali. The contractions started while she was asleep. Carol got out of bed in silence so that he didn't wake up. After going to the toilet, she realised her waters had broken. She decided to take pictures of the rice paddies in her backyard, knowing (or thinking) that she still had a long time before the baby came. After taking some photos, the contractions became stronger. She started to walk in circles for minutes, or hours; who knows? She lost track of the time. When her husband woke up, she still didn't want to call the midwife. It wasn't yet 5 am. "It's too early; let's wait until six," she said. Fifteen minutes later she grabbed the phone, "Lianne, she's coming, but don't hurry, we still have some time." Not even five minutes after that her husband telephoned Lianne, "Hurry up, my baby is almost here!" When midwives Lianne Schwartz and Robin Lim arrived, the first thing they heard from Carol was, "Morphine!" She was already six centimetres dilated. Fortunately, her husband had already prepared the bathroom for water birth. Laughingly, they took Carol into the tub where she birthed her baby Luisa soon afterwards.

According to Lianne, what helps Luisa be such a calm and happy child is that she has never experienced any stress, "there was no trauma or separation." For a Brazilian family who believe that birth is the first challenge of life, having a homebirth was a natural choice. "If I don't let my daughter overcome the first obstacle in her life, what am I teaching

her?" Carol said. She explained, "in my first child's birth, the obstetrician tried so hard to make me have a caesarean that he lost me to a midwife." The decisions this family made to have a gentle birth in Bali are an exception to the Brazilian birth culture back home.

“Traditional midwives continue to play an important role in maternal and child health care, mainly among the poor in Brazil's rural areas and Indigenous communities in the forest.”

Brazil's world record in caesareans

How we are born matters; birth matters. The French obstetrician Michel Odent coined the term 'perinatal roots of violence' to explain the correlation between a violent (instrumental/surgical) birthing culture and societal violence. He goes so far as to say he wouldn't walk down the street late at night in a country that has a high percentage of caesarean births (1). In 2010, Brazil reached the world record national caesarean section rate at 52% (2). To put this in perspective,

the World Health Organization (WHO) recommends a national rate no higher than 10–15% of all births (3). Perhaps it is not a coincidence that Brazil is the sixth most violent country in the world. In Brazil, over 80% of all private hospital births are caesareans and 64% of caesareans are planned (4). Within Brazil's public health system, a caesarean birth costs around R\$402 (US\$217), while a natural birth costs R\$291 (US\$157). In public hospital births the caesarean section rate is around 30%. It is important to note that public hospitals in Brazil are inadequately equipped and doctors are poorly paid in those establishments (around 50% of private hospital wages). Brazil's public health system has been ranked 125th out of 191 countries (5). In its seven biggest cities, at least 171,000 patients are on a surgical waiting list; they may wait up to five years if the operation is not considered urgent or life-saving (6). While there are an unprecedented number of unnecessary surgical births in Brazil (with associated cost to the health system), there is also a population desperate for general surgery (6).

The risks of a caesarean section

When truly necessary, caesarean section can save lives. Unnecessary caesarean section, however, *unnecessarily* increases the risks for women and babies. For the woman there is increased risk of postpartum haemorrhage, postpartum infection, hysterectomy and death; for the baby there is increased risk of preterm birth, neonatal breathing complications, and death (7). A Brazilian specialist in prenatal and perinatal care believes that a caesarean brings not only physical risks, but also emotional and psychological ones (8), which can affect mother-baby bonding and attachment.

The pregnant woman at the centre of the process

The alternative to caesarean section is gentle birth (or 'humanised birth' as it is referred to in Brazil). The main character is the pregnant woman, not the doctor and the 'disease/disorder' that requires hospital-based treatment. During gentle birth, the obstetrician and/or midwife accompanies the woman during her pregnancy but only intervenes when



High rates of elective caesarean section in Brazil

necessary. The clinicians provide all the information the woman needs to make decisions about what's best for the health of herself and her baby; not what the doctor thinks is best or most convenient (e.g. planned caesarean section).

"Women experience their birth journey in many different ways: for some it is painless, orgasmic, and ecstatic. For other women, the process is intense, painful, hard work. More often it is a combination of many states of being. There is not one 'right' way to experience a birth," explains Lianne (midwife). The Brazilian obstetrician and advocate for gentle birth, Ricardo Jones, says that bias towards caesarean birth in Brazil is driven by "ignorant professionals, economic interests and discrimination [towards] women" (9).

It is interesting to note that 80% of Brazilian families have the financial option to choose caesarean birth or vaginal birth. They are educated and have access to information, yet they are predominantly choosing surgical birth (10). Natural births have become taboo in Brazilian society and even wealthy people are poorly informed. Some women even have liposuction during their caesarean operation to shed the weight gained during the pregnancy! Soap operas are the ultimate mass media shows in Brazil. They often show characters (habitually beautiful and polite) screaming and shouting without the usual make up on whilst in labour in hospitals, characterizing pain as the largest part of the birth experience. This is what this society is made to believe.

Traditional midwives continue to play an important role in maternal and child health care, mainly among the poor in Brazil's rural areas and Indigenous communities in the forest (11). According to Paula Viana, coordinator of an NGO working in Brazil, the key to the future is to work together with the traditional midwives to support the health of women, babies and families (11). She affirms that, "the work we develop with the midwives is fundamental for government actions



Baby Luisa enjoys immediate skin-to-skin contact

in reproductive...midwives tend to be important leaders in the eyes of their peers. Our goal is that midwives become (many already are) a connection between public health services and rural and indigenous communities" (11).

Slowly, Brazilian media is starting to bring attention to gentle birth. The 2012 documentary *O Renascimento do Parto* (*The Rebirth of Birth*), directed by Érica de Paula and Eduardo Chauvet, shows different professionals from around the world, as well as Brazilian celebrities, talking about their beliefs and experiences with gentle birth. In a society that still believes that doulas and midwives are for hippies, having a famous actor talk about how he and his wife decided to have a homebirth is a huge step. It is urgent that Brazil starts to rethink its way of bringing children into the world so the next generations have healthier relationships with themselves, others and the environment. May more and more families make decisions like Carol and her family. And may they be supported not only abroad, but also at home.

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Homebirth transfer: Quinn's birth in hospital

A decision I never expected to make

By Kimberley van Megan

I wanted to try for a homebirth, but the decision to do so did not come easily. My husband, Joe, is Dutch and has grown up with homebirth as a norm; he was supportive, but I was fearful of what might go wrong at home. I chose the perceived 'safer' option of a hospital birth through the midwifery group practice (MGP); but my decision never felt right. When my midwife said, "The birth is just one day, it's what happens after that's important," I realised that the MGP wasn't for me. I felt that the birth was going to be an experience that would stay with me for life; it would have an impact on me as a new mother, and would affect the relationship I had with my baby.

A midwife who understood and respected us

At 32 weeks, with Joe's support, I met with some homebirth midwives. I was excited and scared about changing course so 'late in the game', but I wanted a one-on-one care experience where I felt I could trust my midwife. Joe and I both had a good feeling about Sam when we met her: she was on our page, she understood and respected us, and we clicked. I wanted to avoid the judgement and concern I knew would come from well-meaning family and friends, so we decided to keep the homebirth plan to ourselves.



Kim in labour at home

When my baby is ready

Our homebirth secret became increasingly difficult to sustain as the weeks went on. Quinn was very happy inside me and showed no signs of coming once we hit the due date. I did a lot of research to reassure myself that it was OK to wait, and came up with an affirmation that helped me to push away external concerns: "My body will birth my baby when my baby is ready to be birthed." I repeated to myself on days when I felt down, over the pregnancy and doubtful of our decisions. Sam helped me through these moments of doubt, reminding me to listen to my own intuition. She made me feel that I was in control: as long as my baby and I were healthy then it was up to me what to do next. Sam went through all the medical reasons to induce or not to induce; she presented the risks on both sides and encouraged me to make the decision that was right for me.

My first hospital transfer of a client in labour

By Sam Rouse

I am a midwife who studied nursing; I never practised as a nurse. I then studied midwifery through a graduate diploma. Throughout my study, homebirth midwifery was my focus. I sought out opportunities to work in continuity of care programmes and chances to talk with other midwives who attended homebirths. The opportunities were rare and fraught with difficulty, I relished these chances and friendships grew. After a particularly difficult institutional period, I decided to branch out into independent practice. I had found a couple of midwives who were happy to have me be second midwife for them at homebirths. After a few months of being second midwife, I started taking bookings. Kim found me at the end of my first year of independent practice.

Kim booked with me to have a homebirth when she was 32 weeks pregnant. She had been booked with a continuity of care programme offered by the local hospital, but found there was little room for negotiating aspects of care she didn't want to have. Screening tests were offered without rationale, and Kim told me she felt pressured into having them unnecessarily. When I first met Kim she said, "if they are pressuring me now, about these small things, how is it going to be when I am in labour?" I understood entirely. I had frequently seen women labouring in hospital talked into procedures they weren't happy about and that weren't in their birth plan. I had also seen women's confidence undermined and their labours stall as a result. I was determined to help Kim to avoid this happening to her during labour.

A trusting relationship

I believe that one of the things that makes homebirth a safe choice is a trusting relationship between the midwife, the mother and her team of supporters. If a woman books with me late in her pregnancy, I make every effort to see her at least seven times before she births. Kim and I were seeing each other for a visit about every ten days. Kim is a bright and intelligent woman, a researcher, with a lively sense of humour. We got on really well and developed a relationship easily. Our visits were always comfortable and easy. Kim's lovely husband, Joe, was almost always present at our visits. He works for himself and would organise his days so he could be home when I was there. It is a fabulous thing to visit couples at home and to observe their behaviours in their natural setting. Joe is a practical guy; he did not generally sit and listen to Kim and I chatting about the womanly aspects of birthing, but he was always in the room, sometimes cooking or juicing or making tea. Joe would be fully present when we discussed the logistics of birth pools, hoses, tap attachments and oxygen cylinders. He was especially attentive when we had serious discussions about possible reasons for transfer and the qualities of a great birth supporter.

Rest, eat, and hydrate

Kim's pregnancy progressed normally and beautifully. After the usual concerns about going past 40 weeks, and Kim's concern that the hospital would contact her to arrange an induction, labour began gently and slowly 12 days after her due date. I do lots of education with first-time mums about early labour and how important it is to rest, to take things slowly, eat, stay hydrated, not get overly excited and know that this is the beginning of what could possibly be a long, hard road. Kim's labour started gently

I'm having a baby today

I chose to wait for Quinn to naturally arrive. At exactly 42 weeks I woke just an hour after going to bed with strong warm-up contractions (Braxton Hicks). I had a small hind water leak, so I thought this was it! But I had already had a few false alarms, so Joe wasn't convinced. At midnight on Saturday I rang Sam and she confirmed that I was in early labour. After such a long wait, I was too excited to sleep. My first thought was, "I'm having a baby today!" Little did I know how long my labour would take. I let Joe sleep and gave myself mini goals to get through on my own. I lasted four hours, and then I woke him. We were both excited that it was finally happening.

Enjoying the moment

Sam offered to join us, but I felt we were doing OK on our own. After nine hours of early labour, I was excited and ready. We had a couple of friends join us at different times throughout the morning. One friend took over from Joe, applying pressure to my sacrum; as Joe had applied pressure to my sacrum during each contraction all morning, he welcomed the relief. I loved having extra company and chatted between surges. Sam came to check on us. She noticed that the surges were spacing out and said I needed fewer people around in order to focus. Joe and I continued on for a few more hours before deciding to fill the birth pool. The water provided much-needed pain relief. While the labour was intensifying, I really enjoyed this moment: just Joe and I in our home.

I needed it to be over

Around 3 pm Sunday afternoon Joe called Sam, as I was starting to panic and I felt that I needed her. I started to focus more on all the tools that I had learnt in Active Birth Yoga. I had created detailed visualisations that I thought would help during surges, but on the day I found it too difficult to focus and take my mind away. Instead, I used vocalisations. I remember asking Sam in the early evening, "Is it time for Kelli?" (our second midwife), knowing that, if it was, then Quinn wouldn't be far off. Sam said, "No, not just yet." I was gutted; I was starting to feel that I could no longer do it. I needed it to be over.

We were all exhausted

That evening I thought I felt pressure (wishful thinking!) so Sam called Kelli. We all thought we were having a baby that night. Joe was behind me in the birth pool ready to catch her, but the surges started to space out again. Sam and Kelli said I had to get out of the pool and be upright and active to speed labour up. I was disappointed. I was ready and wanted so badly to be at the pushing stage. The pain in my back was too much and I was struggling to cope. Sunday night was long and hard. I laboured in the pool, in the shower, leaning on Joe walking down the hallway, leaning on Sam and Kelli. After falling asleep standing up in the shower we realised I had to rest, but resting provided little relief. I needed help through each surge. Joe lay behind me putting pressure on my hips and lower back, and Sam or Kelli sat by the bed letting me squeeze their hands. Waking every few minutes meant that we were all exhausted.

I chose to transfer to hospital

I became fearful of my ability to get through the labour and

on Saturday evening and she was excited and found it hard to rest, so she was awake most of the night before she established in labour. On Sunday morning I went over to see how she was and to have a listen-in on the baby. Her surges were irregular and spaced out; still early days. She seemed in good spirits and the baby was fine. I encouraged her to rest, eat and hydrate as much as she could. I went home. Joe called me later in the afternoon and asked me to come over.



Kim and Quinn enjoying each other

We were in for a long night

When I arrived at about 3 pm, Kim was in the pool, surging three times in ten minutes (3:10) in a regular pattern. I didn't palpate the surges, but judging by the sounds she was making they were doing a great job. After I had been with them for about four hours, Kim declared she was getting pressure in her bottom! Great news. I called the back-up midwife Kelli. When Kelli had been with us for a couple of hours I realised that my assessment of Kim's

progress had not been accurate. She was not ready to have a baby and we were in for a long night. At this point I did a vaginal examination: 5 cm, thin (fully effaced) with the baby still up quite high in the pelvis (at minus two station). That earlier feeling of pressure had come from the back of the baby's skull being pressed against Kim's sacrum (posterior position). The baby's head was off to one side (asynclitic) which was causing irregular pressure on the cervix, and therefore surges of irregular length and strength. My impression was that the baby was doing a long slow rotation around to a more optimal position for birth (anterior).

She walked, she squatted, we rebozoed, we massaged

We encouraged Kim to get moving. She walked, she squatted, she lay down, she was on all fours, we rebozoed, and everyone massaged, especially Joe. Kim needed constant pressure on her lower back, so we tag-teamed the back rubs. The baby was content through the night and never a concern. At 5 am we were all feeling worn out. Kim was in the shower moving and being upright with the surges, but so exhausted that she was dozing off in between them. Joe was in the shower with her and was at the point of tiredness where he was really struggling to stay awake. Joe expressed concern about dropping Kim as she was leaning on him when the surges came. We were all past the point where we could make clear decisions. We discussed options and opted to do another vaginal examination to help us make a decision. Kim's cervix was still 5 cm, with the baby still high in the pelvis (at minus one station), but the good news was that the baby was now in an anterior position! Progress certainly, but still a way to go. What Kim really needed was a bit of hydration and a few hours sleep. Could we get her that? We discussed transfer.

started wondering about transferring to hospital to get some relief. This was a thought I never imagined that I would have. Sam had worked hard to prepare me for many scenarios that could require me to go to hospital, but I never thought that would be a choice I would make. Although we had agreed that I would not have any internals, Sam asked if I wanted her to have a look. I said, "Yes!" I needed to know. I was hoping for a boost of confidence, a sense of motivation; hoping to hear that we were almost there. It wasn't to be. I was six centimetres dilated and my cervix was inflamed because Quinn's head was sitting crookedly and aggravating it. Sam explained that this would prolong labour further and I would have to actively labour to reposition her. I had no more energy and had already had a few 'I can't do this any more' moments, so I asked Sam's opinion about transferring to hospital. We weren't in an emergency situation, so it was up to me. We discussed the reality of increasing risks and the effect of exhaustion, not only on my body, but on hers. Joe was supportive of whatever I felt was right. My body was sending me messages that it wasn't coping. My legs were shaking uncontrollably after each contraction and I had intense hot and then cold flushes each time. I hated the thought of having to transfer: the reality of labouring in the car, the thought that I was 'giving up' and the fear of what I might face at the hospital. But I knew I needed help, so I made the decision I never thought I would: I chose to transfer to hospital.

Sam could still be a part of it

Sam drove us so that Joe could help me with the surges in the back seat; they were the most painful of the entire labour as he couldn't apply pressure or heat. When the midwives saw how intense my surges were, we were taken straight to a birth suite. Sam knew the hospital midwife, which was great as she could still be a part of it. We were all a little worried about how we would be received, but thankfully everything went smoothly.

Deciding to have intervention

The first few hours were spent getting a drip in, and I was given an epidural and a catheter. The surges during this time were still intense, but I was glad it wouldn't be too much longer until I had relief. The epidural slowly started to take effect, numbing my feet first and working its way up my legs, taking a while to fully kick in on my right side. Once it was working I felt amazing. It was such a relief to not feel the intense pain of the surges. The midwife then checked and found that I was seven centimetres dilated and Quinn's head had straightened. My surges were irregular and spacing apart to every seven minutes, so we discussed breaking my membranes and having some Syntocinon. It was great to have Sam there to help with these decisions, as I trusted her judgement, knowing we were on the same page regarding interventions. I asked a lot of questions and decided to do it to avoid more serious interventions later. Sam stayed with us until I felt comfortable and that I could trust the hospital midwife. I was happy that, after getting some much-needed sleep, she was keen to come back to the hospital to be there for the birth. The day went by relatively quickly. We told immediate family what was happening, as most had guessed things had started due to our lack of communication for two days and we knew they were starting to worry.

She started to crown

At 3 pm there was a shift change with the midwives. I was a

We put aside our fears

Kim was anxious about going to hospital and unsure of how we would be received after changing care providers late in pregnancy. I was anxious about transferring a client, my first transfer, to the hospital where I had trained. We put aside our fears. We made a plan: hospital, epidural, intravenous fluids, sleep, baby! I called the hospital and let them know we were coming in. We couldn't call an ambulance, as there was no emergency, so we planned to go in my car. It was Monday morning and Kim and Joe live out in the suburbs, so timing was important: if we left it much later than 6 am we would hit the peak hour traffic. The thought of being in the car was hard enough for Kim, without being slowed or observed in heavy traffic, so we moved as quickly as we could. Joe and Kim were in the back seat, with towels, as I was expecting the waters to go at any time and it was my car! Kelli stayed behind and did a beautiful job of tidying the house, emptying the pool, and changing the bed. She even left flowers by the bed. She is extremely good at those important touches.

Warmth and respect

Our arrival at the hospital went smoothly: we went straight through the assessment unit into a birth suite in a very short space of time. I was greeted warmly and Kim and Joe were treated with great respect. There was no feeling of animosity, and no sense of being judged harshly. As we were moving from the assessment unit to the birth suite, a lovely midwife who had been a lecturer and student liaison midwife while I was studying saw us. She was obviously pleased to see me and, having known my leaning toward homebirth as a student, she was excited to see that I was working in the model I believed in. It was so reassuring to see her and to see her face light up. Any reservations I had had about transferring were slowly dissolving and, even though I was exhausted, I was happy with the decisions we had made.

Our plan was in action

Kim got settled in the room at the end of the corridor, we communicated our wishes and, before we knew it, our plan was in action. Kim was aware that the hospital would want to monitor the baby and so was happy enough to have the fetal heart rate monitor (CTG) applied, even though it was uncomfortable to lie down. The anaesthetist arrived quickly and by 8 am the epidural was in and starting to take effect. We were very lucky and grateful that the early-shift midwife was super lovely. She took lots of time to explain everything carefully and was very kind and understanding. By 9 am Kim was ready to drift off to sleep. Joe was already drifting off in the recliner chair. A plan was in place and everyone felt better. After a chat with Kim and Joe, I headed home for a sleep. Luckily I live about ten minutes from the hospital. I crashed quickly and slept until about 12 noon, when I rang to check in. Kim's cervix was now 7–8 cm and that baby was moving deep into the pelvis. All good. I dozed off for another hour, and then made my way back to the hospital just after 3 pm.

Baby Quinn born gently

After a shift change, we were lucky to have another super midwife. The 4 pm vaginal examination found Kim was fully dilated. We waited for an hour to allow passive descent of the baby before beginning active pushing; this is fairly standard hospital policy when a woman has an epidural. At around 5 pm, Kim started pushing, and there was normal progress. The only hiccup at this time was an imminent shift change for the doctors and the associated pressure from them to have a baby before

little nervous about getting a new midwife but both hospital midwives were lovely, respected our wishes and included Sam. An hour later I was fully dilated but didn't feel an urge to push, so we waited another hour. Pushing while numb was strange, but I was determined. I visualised the area and her descending. Once she started to crown they put a mirror up so I could see her progress. It was incredible to see Quinn's hairy little head start to emerge. I was so ecstatic! I was smiling between surges and couldn't wait for the next chance to start pushing. I felt so positive and strong at this point that I found it frustrating that the obstetrics registrar said I would need to have a vacuum extraction if she wasn't out in two hours. Luckily both Sam and the hospital midwife reassured me that Quinn was progressing well. After two and a quarter hours, Quinn was born.



Quinn born in hospital on mum's chest with midwife Sam

It was incredible

It was incredible pulling Quinn up to my chest and seeing her for the first time; she was just perfect. She lay on my chest and easily found my breast for her first feed. I was so happy that I was able to have skin-on-skin contact and delayed cord clamping. A couple of hours later Sam drove Joe home to have some much needed sleep while I went up to the ward. I only slept an hour that night; all I wanted to do was hold Quinn. Joe arrived early in the morning and, after a lengthy check-out process, we were home by lunchtime. It was lovely to come home to a clean house; Kelli had cleaned up and even left freshly cut flowers from our garden by my bed.

Gratitude

It wasn't the environment I wished to birth in, but transferring to hospital wasn't nearly as bad as I thought it would be. I feel fortunate that I had two wonderful midwives who cared for me there. While I ended up birthing in hospital, I am glad that I finally listened to my instinct and attempted a homebirth, as I know otherwise I would have forever asked 'what if'? No words can describe the gratitude I have for my wonderful husband, who was such an incredible support, and for both Sam and Kelli, for their love, care and the experience they shared. I look forward to my next unpredictable and empowering attempt at a homebirth with Joe, Quinn, Sam and Kelli by my side.

handover at 7 pm! Baby Quinn took her own sweet time and was born gently at around 7.30 pm. I love it when a plan comes together.

Delayed cord clamping and skin-to-skin contact

Kim and Joe chose delayed cord clamping, even with the cord blood bank lady knocking on the door! Quinn lay skin-to-skin on Kim's chest and did a beautiful job of latching herself for her first feed. The hospital has huge supply of knitted hats for babies and insisted on Quinn wearing one from the moment she was born. Kim and I had talked a lot about how skin-to-skin is the best way to keep babies warm, and how the smell of the baby is one of the things that triggers the bonding mechanisms in a mother and helps hormonally to initiate the birth of the placenta, so each time the midwife turned away we would whip off the hat and have a conspiratorial giggle.

Staying overnight

Hospital policy is for women who have an epidural to stay in overnight. Two and a half hours after the birth, with Kim and Quinn still skin-to-skin, they were transferred to the postnatal ward. It was way past visiting hours and Joe was so tired, so we said goodnight and I drove Joe home (he had no car!). Joe came back in the morning and, after the mountains of procedures and paperwork were completed, they were discharged and home by the afternoon.

Next homebirth

All in all I was very happy with the way Quinn's birth turned out, and particularly the way we were received at the hospital. There was no drama, no whispering. We were all respected. I am happy with the way decisions were made and more than happy with the beautiful outcome. In the weeks after the birth Kim and I talked over what had happened and it was great to hear from her that her commitment to homebirth hasn't wavered; she would choose homebirth and my care again for their next baby.



Midwife Sam, Kim and baby Quinn enjoy a postnatal home visit

Interview with: Renee Adair

Renee Adair is a qualified aroma and massage therapist, Reiki practitioner and childbirth and parenting educator, and she holds a Cert IV in Doula support services and a Cert IV in Training and assessment. Renee is the founder and principal educator of the Australian Doula College and the College's charity arm: Doula Heart Network. Renee has spoken on Radio National on the subject of Doula support and she presents at conferences, seminars and workshops around the country on all matters related to pregnancy, birth and early parenting. Renee is a regular contributor in a variety of both print and online pregnancy and parenting publications. Over the course of her career she has supported and educated thousands of doulas, women and their partners before, during and after the birth of their babies. Renee lives in Sydney and still attends births on a regular basis.

Can you explain what a 'doula' is and give us a little of the history?

A doula, or birth attendant, is a woman offering non-medical support and information to parents in pregnancy, childbirth and the postnatal period. 'Doula' is a Greek word-meaning slave, which has come to mean 'woman's servant'. A doula mothers the mother, supports her labour and birth wishes, and supports her partner. Doulas in their true form have been the handmaidens of birth for centuries. The word 'doula' was adopted in the US almost 30 years ago and the title was introduced formally in discussions in Australia in various places from around the year 2000. We have had non-professional support people undertaking this role for many years. Doulas are now professional women supporting other women in pregnancy, birth and the postnatal period; they offer continuity of care and support for the family.

How did you come to be a doula?

I had two amazing homebirths under the guidance of the wonderful Maggie Lecky-Thompson. My pregnancy and birth experiences opened my eyes to a whole new world. I had two amazing support people, who were my doulas really, and I felt supported, but others around me were not feeling the same love. It got me thinking about choices, support and the lack of good education that was available to pregnant women generally. I sat in

the Insightful childbirth and parenting education sessions of Marie Burrows and it was her way of educating that appealed to me. Marie was running a two-year traineeship to become a childbirth and parenting educator, so I signed up when my daughter was still a bub. We had to attend births as a part of that training. I loved it. We didn't call ourselves doulas then, as the word hadn't really kicked into Australia at that time. For a long time I called myself a birthing companion. It all ignited a burning desire to go on and assist, support, inform and nurture women and their families during pregnancy, birth and beyond.

What are the benefits of having a doula present at a hospital birth?

By hiring a doula for a hospital birth, parents to be can receive continuity of care. This is a rare commodity in our maternity system today. Doulas get to build a rapport with clients; we listen to their fears and feelings and we can assist a woman and/or her partner with a birth wish list. We offer non-biased information, can inform our clients about hospital protocol and possible restraints and help them to gently navigate the system. We can assist parents to make real informed decisions. According to research undertaken in the US (1), there are many benefits of having a doula at your birth (see Table 1).

TABLE 1: BENEFITS OF DOULA CARE FOR LABOUR AND BIRTH IN HOSPITAL

60% reduction in epidural requests
50% reduction in caesarean rate
40% reduction in oxytocin use
40% reduction in forceps delivery
30% reduction in analgesia use
25% shorter labour

Improved breastfeeding
Decreased incidence of postpartum depression
Greater maternal satisfaction
Better mother-infant interaction

What are the benefits of having a doula at a homebirth?

Having a doula at a homebirth can be of great service to the attending midwife and of course to the family. A doula takes on more of a handmaiden role at a homebirth. I find myself doing some



Renee Adair, Founder of the Australian Doula College

cooking, supporting siblings, filling or emptying the birthing pool and giving the midwife and/or partner a break when labour is long. I love attending homebirth alongside a midwife for the best outcome for the family.

Can anyone call themselves a doula and attend births?

Unfortunately currently anyone in Australia can call themselves a doula. Attending births is a sacred job in any capacity, and I believe good, comprehensive training is necessary for anyone involved in birth. There are some doulas pretending to be midwives. This places doulas, midwives and the women they are caring for in a precarious position. There are also some unregistered and deregistered midwives who are calling themselves doulas, or who are being labelled as such, and this is proving to be a very grey area.

Is this why you started up the Australian Doula College?

Yes, that's one of the reasons. I want to see regulation for doulas in Australia. That's why I got our training accredited. I was also disturbed by the fact that very few women in Australia are afforded continuity of care. I find that a cruel and unusual punishment for women. I was also motivated by our shocking postnatal depression rate here. Women's emotional needs are generally not met in our system today and partners are mostly left wondering what to do, how to help and how to best engage their partner and baby.

I believe in the need for doulas

to provide on-going support and information. We can fill a gap. I also believe that doulas need an organisation to belong to. We need to be accountable.

There is some online doula training that I believe does not provide enough. Like all professions, our clients deserve to know where and with whom their doula has studied and that the person supporting them is supported and keeping current.

What is a typical day in the life of a doula?

That depends greatly on her starting platform. We all come from a different place depending on our circumstances, but with the same passion. That never ceases to amaze me. Some doulas are mothers, some are not, some are working, and some are studying other modalities.

For me, a typical day starts with supporting my kids to get to school and TAFE. If I have students in the College that day, or another working commitment, who knows? I have general back-up plans with the priority being my labouring woman. I eat once my kids are out of the door and my first team member arrives. I make sure that my doula bag is packed, my fridge is full of food and the car is full of petrol. I need to be prepared to leave my life at any time during the on-call period and be available for my clients. I believe it's a good thing to assume you will be gone for 24 hours for labour and pack accordingly.

It's really strange and stressful being on-call at first, but once you have done it several times, being on-call becomes a way of life. It is what it is. [Big smile.]

So if doulas are present possibly from very early labour until the birth of the baby, how do they manage fatigue?

Good question and never has the answer been more heightened than at my most recent birth. Twenty-five hours straight at the hospital. It is a physical job that requires the doula to be solid of mind, sure of herself and physically well and strong. I think it helps to be aware of your limitations, to do some form of exercise or stretching and to find what natural 'stay up' enhancer works for you. Caffeine over a long period of time does not work for me personally, so I choose a mix of herbs that have been made for me. I also have appropriate, negotiated breaks: my mantras are 'I will sleep in the next life' and my kids favourite 'sleep is overrated.' [Big smile.]

Can you tell me about one of your most challenging experiences?

There have been many. Labour and birth are so diverse and different for every woman. That's what I love about it and it's the challenges that make it amazing. However, I think the most challenging time for me in my role is dealing with midwives and hospital staff that do not respect or understand the role of the doula. Why, oh why, are they so afraid? I just had a midwife tell me that she wanted me to catch the 'infection' that she thought was in the placenta I was taking home (to encapsulate for my client). Sad! Good thing I had been up for 30 hours and all that came out of me was a laugh.

What about one of your most rewarding experiences?

Oh, such a big question! I find it all rewarding and amazing even amongst the challenges. If I think about all the jobs over the years, one of the most rewarding labour and births I was privileged to be a part of was with a young woman whom I supported through all three of her labours while she was in and out of the care of the Red Cross service I used to work for. Her previous two children had been removed from her care and there was a court order to remove her third baby from birth. A challenging experience indeed! What I was able to provide her with was a place

of stability, without judgement. I excused her for her shortcomings, internally I mean, and had time for her. I loved being able to provide her with that. I found this rewarding by giving her choices and a voice at a time when she believed she didn't have either. Her children are all still in care. The good bit is that she is able to see for herself that ultimately that was the best decision. Inclusion, support, love, nurture equals solution!

What's next on your professional horizon?

In the short term on the professional horizon the ADC will continue to educate the general public and professionals on the value of good doula support. We are accrediting some more courses and looking at expanding our membership/mentorship program, and we have just started training in rural areas. I'm doing some writing and, without giving too much away, may have something rather cool in print in the not too distant future.

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1. Klaus, Kennel and Klaus. *Mothering the Mother, How a Doula Can Help You Have a Shorter, Easier and Healthier Birth.* http://www.australiandoulacollege.com.au/what_is_a_doula/benefits_of_having_a_trained_doula.htm



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Consumer Health Forum of Australia: informed consent in healthcare workshop

The Consumer Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers. In 2012 CHF received funding for the Consumers and Informed Consent project, aimed at identifying gaps in information currently available to consumers and developing resources to empower them to make informed healthcare decisions (1). One project initiative was the Informed Consent in Healthcare workshop held in Sydney on 25 March 2013. Bec Jenkinson and Kylie Sheffield attended the workshop on MC's behalf.

While six hours was insufficient to cover the complexities of informed consent and its impact on healthcare consumers, especially given the range of groups and organisations represented, the CHF workshop was an interesting and worthwhile exercise. It allowed us an opportunity to network, raise MC's profile, and hear about how informed consent plays out in many different healthcare settings.

Informed consent in healthcare

Before the workshop, CHF provided a document entitled *Informed Consent in Healthcare: An Issues Paper*. Based on existing literature, research and policy, the paper offers a number of definitions for informed consent and explores various aspects of the issue, including the importance and consequences of informed consent, consumer information needs, mechanisms to support informed consent, barriers to improving informed consent and the role of consent forms and guidelines. The full document is available online (1). It was excellent background reading for the workshop and is a worthwhile read for all healthcare consumers.

Unnecessary 'routine' procedures

The workshop began with a series of presentations followed by questions and discussion. CHF Chair Karen Carey kicked things off, reiterating many of the points raised in the issues paper and acknowledging fragmentation of healthcare (something encountered by many maternity care consumers) as one of the major impediments to informed consent. She also presented some alarming statistics around unnecessary 'routine' practices and procedures; for

example, only 11% of all knee operations are clinically required while just 19% of all antibiotics prescriptions and 30% of prescribed treatments for atrial fibrillation are evidence based. In the absence of current and comprehensive data, we can only imagine how this translates to the many available interventions in maternity care.

“ I found the failure to acknowledge a woman's right of refusal, and the reasoning behind it, extremely concerning. ”

Be less afraid to ask questions

Director of UTS Centre for Health Communication, Professor Roderick Iedema, spoke on provider-patient communication and the need to address the power imbalance within this relationship, while Health Care Complaints Commissioner Kieran Pehm discussed the consumer role in the informed consent process. His closing advice (that consumers should be less 'afraid to ask questions') was probably redundant in a room full of active consumer representatives. The first three presentations, while informative and relevant, did not communicate to me any real appreciation of the consumer perspective, particularly the depth of consumer disempowerment in various healthcare settings.

Audio-taped medical consultations

The final presentation from Professor Martin Tattersall was the morning's highlight. Professor Tattersall is a Professor of Cancer Medicine at the University of Sydney, a cancer physician at the Royal Prince Alfred Hospital, and has also, he explained, spent time as a patient. He has devoted the past ten years to researching ways to improve the quality of cancer consultations. Many of the methods and tools he has developed are highly relevant to maternity care, including audio-taped consultations. Professor Tattersall argues that consultation audiotapes have a number of benefits.

First, they allow patients to play back the conversation, giving them the opportunity to identify areas of concern or ambiguity and to ensure they have heard, understood and retained the relevant information. Second, they offer a useful tool for evaluating the way in which medical information is delivered, and assessing the quality of that information. Finally, in terms of consent, they can assess the extent to which the information provided in a consultation facilitates informed decision making. Professor Tattersall asserts that, in many cases, the very presence of an audio-recording device results in a more patient-centred approach and the delivery of higher quality information.

A question prompt list

Another of Professor Tattersall's initiatives is the question prompt list: a condition or situation-specific list that is given to patients before a consultation to help them to identify and communicate their information needs. While designed for cancer patients, the following sample list is equally applicable to most healthcare scenarios:

- understanding my choice
- finding out more (and being given the time to do so)
- understanding the purpose and background of the proposed treatment/procedure
- understanding the benefits
- understanding the risks
- the difference between trial and standard treatments
- understanding provider conflicts of interest
- right of refusal
- alternative therapies
- own questions

I would personally like to see every pregnant woman receive a tailored version of this list on first consulting her GP or attending an antenatal clinic.

The problem with consent forms

The final issue Professor Tattersall touched on was the use of written consent forms. Expressing his concern that forms have replaced open discussion, he made the excellent point that the person presenting the form, whether a medical professional or an administrator, is often someone who does not know the patient, and who is therefore unable to answer



MC reps Kylie Sheffield and Bec Jenkinson at the CHF Informed Consent in Healthcare Workshop

questions or to respond to concerns the consumer may have specific to his or her background and individual circumstances. An example from maternity care is amniocentesis. Women routinely undergo this invasive procedure with providers they have never met. They rarely know the skills, competence or experience levels of the doctor performing the amniocentesis, and consent forms are often presented immediately before the procedure, leaving no opportunity for detailed discussion.

Informed refusal

Bec posed a question to the panel regarding the right to informed refusal, using the example of a woman who had made an informed choice to refuse foetal monitoring during labour, despite continued pressure from providers. In response, Karen Carey suggested that, in this scenario, the provider was also considering the welfare of the baby. When Bec pointed out that the law is clear in relation to a woman's rights to make decisions for her unborn child, Karen responded that, "it then goes to whether [the procedure] is reasonably acceptable." While we did not have the opportunity to discuss the issue in greater depth, I found the failure to acknowledge a woman's right of refusal, and the reasoning behind it, extremely concerning.

The hypothetical breech presentation at 36 weeks

In the second session we broke into groups to discuss a number of hypothetical scenarios around barriers to informed consent and possible improvements. Our group's scenario dealt with 'Julie' whose baby was in a breech position at 36 weeks and whose doctor had recommended a caesarean, citing a '75% increased incidence of serious problems' in breech babies born

vaginally. Misunderstanding her doctor's advice, Julie believed her baby had a 75% chance of having serious problems and elected to have a caesarean. Unfortunately, it was a scenario with which Bec and I were all too familiar and, interestingly, one of our group members had experienced something similar during her own second pregnancy. The group was unanimous that the doctor's approach did not facilitate informed choice and that informed

consent had therefore not been given. Our discussion was around the accuracy of information provided, the way in which statistics were phrased, and the doctor's failure to provide alternative options or to acknowledge and discuss Julie's right of refusal.

What helps informed decision-making?

The final session again involved small group-work, this time looking at the practicalities of informed consent. Discussion points included consumer information requirements; resources, policies and tools to support effective informed consent processes; and the roles of decision aids and informed consent forms. While some great suggestions came up when syndicates fed back to the larger group, there was inadequate time for questions and further discussion.

So what...

The workshop was worthwhile, largely for the exposure it provided to the issues affecting consumers in other healthcare settings. It was interesting and also disheartening to hear of the many different contexts in which systems and providers are failing to support and respect consumers' rights to informed consent and refusal. For me, the most interesting and valuable part of the day was the discussion that followed the presentations, and I would have liked more time for participants to elaborate on their questions and comments. There was mention in the issues paper of a "growing body of interactive techniques aimed at providing a framework within which consumers and clinicians can discuss, reflect and decide on the most appropriate treatment option." It would have been excellent to hear about other progressive tools and methods such as those pioneered by Professor Tattersall.

In terms of what happens next, there was discussion in the issues paper and at the workshop of developing a national standard or framework for informed consent. MC will continue to monitor the Consumers and Informed Consent project and provide input from the maternity care perspective wherever possible.

References and further information

1. Informed Consent in Healthcare: An Issues Paper: <https://www.chf.org.au/pdfs/chf/Informed-Consent-Issues-Paper.pdf>

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Women's use of complementary and alternative therapies during pregnancy

The majority of women rely on health professionals, such as midwives, general practitioners (GPs) and obstetricians, during pregnancy and birth to ensure that both mother and baby are as healthy as possible. Are these the only practitioners providing care to women during this important time in their lives? New research suggests there are 'others' involved. These other health professionals are broadly defined as 'complementary and alternative medicine (CAM) practitioners', an umbrella term that covers a diverse range of practitioner groups including acupuncturists, aromatherapists, chiropractors, doulas, massage therapists, naturopaths, osteopaths, and yoga and meditation teachers.

The research study

A study undertaken by researchers at the Australian Research Centre in Complementary and Integrative Medicine at the University of Technology Sydney was published recently in *BMC Pregnancy and Childbirth*. The study involved a cross-sectional survey of 1835 Australian women who had recently given birth. It examined their use of CAM during pregnancy, labour and birth. The cohort involved in the study was drawn from the Australian Longitudinal Study on Women's Health, which is the largest, nationally representative study in this field in Australia. The study reports that half the Australian women surveyed consulted with a CAM practitioner for pregnancy-related health conditions. This is the first time that figures from a nationally representative data set have been reported at a national and international level.

Which practitioners did women consult?

The data shows that women most commonly consulted with a massage therapist (34.1%), followed by a chiropractor (16.3%), yoga or meditation teacher (13.6%), acupuncturist (9.5%), naturopath (7.2%) and osteopath (6.2%). Doulas were less common (1.4%), as were aromatherapists (0.6%). (See Table 1.) These findings highlight an additional and previously unexamined element in maternity care in Australia. It is also quite common for women to consult with multiple CAM practitioners alongside their (also often multiple) conventional maternity-care providers (see Table 2). In fact, of the women who consulted with a

**TABLE 1:
WOMEN'S CONSULTATIONS WITH
COMPLEMENTARY AND ALTERNATIVE
MEDICINE (CAM) PRACTITIONERS
FOR PREGNANCY-RELATED HEALTH
CONDITIONS (1)**

Professional group	Total %
Acupuncturist (n=1714)	9.5
Aromatherapist (n=1670)	0.6
Chiropractor (n=1709)	16.3
Naturopath/Herbalist (n=1684)	7.2
Doula (n=1667)	1.4
Massage (n=1743)	34.1
Meditation/Yoga (n=1690)	13.6
Osteopath (n=1690)	6.2
Any CAM practitioner	49.4

CAM practitioner, half of them involved two or more CAM practitioners in their care team.

What conditions did women consult a CAM practitioner for?

The study includes information about the pregnancy-related health conditions for which women consulted a CAM practitioner (Table 3). The list of conditions examined was diverse, ranging from fatigue through to pre-eclampsia, and the CAM practitioner consulted varied significantly depending upon the health condition. Women were most likely to consult with a chiropractor, for example, if they experienced back pain, but more likely to see a massage therapist if they had neck pain or sciatica. Acupuncturists were also consulted for back pain, but in addition they were consulted to assist with preparation for labour. Naturopaths were consulted for conditions such as nausea, fatigue and indigestion.

Another interesting finding was evidence of the co-treatment of many of these conditions between both CAM and conventional care providers. For some conditions, such as back pain and gestational diabetes, a substantial number of women consulted both conventional and CAM practitioners. Women were most likely to consult a CAM practitioner *without involving a conventional care provider*

**TABLE 2:
DIFFERENT CAM PRACTITIONER
PROFESSIONAL GROUPS CONSULTED
BY WOMEN FOR PREGNANCY-
RELATED HEALTH CONDITIONS (1)**

Practitioners	Complementary medicine† (n=1629) %
0	54
1	25.7
2	13.1
3	4.8
4	1.8
5	0.5
6	0.1

† Complementary medicine practitioners includes acupuncturists, aromatherapists, chiropractors, naturopaths/herbalists, doulas, massage therapists, meditation/yoga classes, and osteopaths

in their treatment for other conditions such as neck pain, hip pain and sciatica. In fact, the only condition for which no women *worked with a CAM practitioner without involving a conventional care provider* was pre-eclampsia. The only condition for which *women did not engage with both a conventional and CAM practitioner* for management was high blood pressure. This means that some women are involving CAM practitioners in the management of health conditions that have a significant impact on the outcome of the pregnancy and birth for both mother and baby.

The woman's health care team

An issue of concern is whether these practitioners are working together, or whether they are providing treatment and recommending interventions without knowledge and awareness of the other practitioners. We do not currently have evidence about this and the situation may depend on the practice philosophy of the conventional care provider or the birth setting. One element identified through the study was a relationship between CAM practitioner consultations and visits with conventional maternity professionals.

TABLE 3:
PATTERNS OF CONSULTATIONS WITH HEALTH PROFESSIONALS BASED ON PREGNANCY-RELATED HEALTH CONDITIONS (1)

		All women				Only women with pregnancy-related condition		
		CAM practitioners				Level of integration between CAM and conventional care		
		Chiropractor	Acupuncturist	Naturopath	Massage	CAM practitioner only †	Both CAM and conventional practitioners ‡	Conventional practitioner only §
	%	%	%	%	%	%	%	%
Back pain	39.5	11.3	4.1	1.7	0.5	2.2	61.8	32.1
Tiredness	35.4	0.4	1.0	1.2	1.0	6.0	2.3	26.0
Reflux/Indigestion	34.7	0.2	0.3	1.0	0.1	6.0	1.9	51.3
Nausea	32.9	0.4	1.3	1.6	0.2	5.0	4.6	48.2
Sciatica	22.1	5.3	1.3	0.2	6.6	40.4	16.3	22.7
Preparing for labour	21.9	1.0	2.4	0.9	0.9	11.0	13.7	72.1
Hip pain	20.9	5.0	1.1	0.1	4.5	35.4	17.5	25.3
Neck pain	12.4	5.7	0.4	0.2	5.9	74.6	5.3	5.3
High Blood Pressure	6.6	0.1	0.2	0.0	0.0	0.8	0.0	93.4
Gestational diabetes	4.9	0.0	0.1	0.1	0.0	6.7	22.2	64.4
Pre-eclampsia	3.2	0.1	0.1	0.2	0.0	0.0	5.2	93.1

† Women who only consulted with a CAM practitioner for the designated pregnancy-related condition. This includes chiropractors, acupuncturists, naturopaths and massage therapists

‡ Women who consulted with both a conventional and CAM practitioner for the designated pregnancy-related condition

§ Women who only consulted with a conventional practitioner for the designated pregnancy-related condition

A trend was evident with doula care: women who consulted more frequently with a midwife were also more likely to engage a doula in their maternity care. Women who consulted more frequently with an obstetrician, however, were less likely to also involve a doula in their care team. These relationships may reflect the attitudes of the maternity health professional, or they may be reflective of the birth setting, or the preferences of the women themselves.

What does this mean for women?

If some women do consult a CAM practitioner and a conventional care provider simultaneously for the management of the same condition, without disclosing this to either practitioner, this may create risk for mother and/or baby through possible pharmacological interactions between treatments, or broader conflicts between the treatment goals of the two (or more) practitioners. It is important, for this



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reason, that women ensure that all practitioners providing support during pregnancy or birth are clearly informed about the involvement of other care providers. This requires practitioners not only to be aware of the inclusion of others, but also that to be aware of the treatment interventions and recommendations being offered to the woman.

What does this mean for maternity health professionals?

All health professionals, whether providing conventional maternity care services, practising CAM or integrating both approaches, need to be aware of some of the significant trends identified through this study. Primarily, it is important that a health professional caring for a pregnant or birthing woman is aware that they may not be the only practitioner involved in that woman's maternity care team. In fact, with half of all women consulting a CAM practitioner during pregnancy *it is more likely than not that a CAM practitioner is involved!* This also means that health professionals need to conscientiously enquire about women's use of CAM and engagement with CAM practitioners, as a

standard element in their history taking. Likewise, should the involvement of a CAM practitioner be identified, it is vital that maternity care providers open the lines of communication and encourage clear disclosure of practice, treatments and interventions from both sides of the divide.

So what?

The involvement of CAM practitioners in the care of women during pregnancy and birth is clear. For the sake of the health of the mother and baby these practitioners need to move away from their place outside the conventional maternity care system and be more effectively included in the woman's chosen maternity care team. This is the safest option and the most woman-centred approach. There may be some barriers to overcome to achieve this, but it is a goal deserving of the attention, energy and commitment of women using CAM during pregnancy and any health professional providing maternity care.

To read more about this study please access the full article (free to all) at: <http://www.biomedcentral.com/1471-2393/12/146>

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Author Bio's

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Jane is a herbalist living in the Blue Mountains in NSW and mother to her three-year-old boy.

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Jenna and baby Lelia

Like most women, my preconceptions, or should I say misconceptions, of birth and labour were not positive. It's funny how quick women are to tell you horror stories, almost as if there's a competition for the worst birthing experience. So you'll understand when I say that it blew my mind when my neighbour told me that she really enjoyed her birthing experience, that it was 'just lovely', and that it was all completely natural without drugs (thanks to HypnoBirthing!) As of that day, my ideas about birth were never the same again. I guess this was the starting point for us in our pregnancy and birthing journey.

Like most first time couples, we had no idea where to start. We knew that we wanted to look into HypnoBirthing and also that we wanted to have a private obstetrician for peace of mind and reassurance. We weren't sure that the two would mix together well though. And that turned out to be the case with the first obstetrician we saw. After two visits, we realised that, if we wanted to try for a natural, intervention-free birth, we would need to find another obstetrician. Since midwives seemed to be the most supportive of HypnoBirthing, we asked around a few midwives for a recommendation. (We figured any obstetrician recommended by a midwife

would definitely be good!) They all pointed us in one direction: obstetrician Dr. Warrick Smith. We immediately formed a positive impression of him. We were upfront about our desire to do the HypnoBirthing course and asked if he would be supportive. It is so important when embarking on this journey to make sure that you have the full support of your professional team.

'Training' for birth

About three months before our baby was due, we spent two weekends with Melissa Spilsted, from HypnoBirthing Australia, learning about natural childbirth. We learnt that birth is not something to be feared, but something that can be a beautiful and an empowering experience for both you and your baby. She taught us (from her personal experience of three wonderful births) that a woman's body is perfectly designed to give birth and much fear comes from doubting this innate ability. She also taught us that there are things you can do in preparation for birth to allow your body to do the job effectively and efficiently. She taught us techniques, including relaxation, breathing and visualisation, which we could 'train' with before the birth. Most importantly, she taught us to trust our instincts and

our own bodies. Although most of us were first-time parents, that didn't have to mean that we wouldn't know what was happening in our bodies or that we should trust them any less. HypnoBirthing is not something you can learn about once and then just hope it works on the day! You need to be focused and practise regularly (daily) in the lead up to your birth. The more comfortable you are with the techniques, the more they become second nature, and the easier it is to access these skills and strategies on the day. And, let me tell you, *they work!*

I had been listening to the affirmations CD daily for over a month, and practising the relaxation techniques, probably every second day, for some time before the birth. I started getting much stronger practice contractions (Braxton Hicks) on a Tuesday and all through Wednesday. They didn't bother me, so I just kept active, spending plenty of time outside walking the dog and listening to my affirmations. On Thursday morning I woke up at 7 am and asked Nathan to look at his watch, as I thought that perhaps the contractions were finally in a more regular rhythm. They were about three minutes apart, so we took the dog for a walk for an hour. By the time we got home, my contractions were a minute long and only two minutes apart. I thought I'd better shave my legs and put some makeup on at this point before driving to the hospital!

We arrived at the hospital at about 10 am. The staff told me that I was four centimetres dilated and, as this was my first baby, I could go home again as it would probably be another nine or more hours before anything would happen. I felt

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Jenna, Nathan and Lelia

disappointed by this, but I kept reminding myself of one of the birth videos I had seen where the woman went from three centimetres to fully dilated and ready to birth in just 15 minutes. That was all I kept focusing on in my mind. Nathan went to move the car, while the hospital staff did some monitoring and, by the time he came back (a bit after 11 am at this point), I stood up and all of a sudden said to him, "I need to push. This baby feels like she's going to fall out!" Nathan encouraged me to remain calm, thinking it was all still a way off, and wanting me to conserve my energy. The midwives came in with the same misconception, until they checked me and then frantically started calling Warrick to tell him the baby was on her way out *now*!

Wavering

I found my breathing techniques made the surges/contractions much more bearable. There were a couple of surges/contractions at the point where I started to feel the need to 'push' where I was a little panicked and forgot about my breathing and, far out, the difference! They hurt a lot more! I could see how it would be very easy to become panicked and caught up in the 'pain' if you didn't have the preparation and a support person to get

he could tell and would put his hand on me and gently remind me to relax, which would allow the process to happen. He encouraged me and reminded me about how wonderful this was, in between contractions, and how excited he was to finally be meeting his baby girl. He gave me so much strength.

I don't want to make it sound as if my birth didn't hurt or wasn't very hard work: it was all of that as well. But my experience was that it was never out of control. There were times, particularly towards the end, where I wavered mentally and just wanted my baby out already. This was the part where Warrick really helped. He respectfully asked Nathan's and my permission to talk me through the very last part of birth. Up until that point I had been more than okay with just Nathan talking to me and encouraging me to remember what I'd practiced and to relax my body. But for that last 30 minutes or so, when it was hard work, I appreciated the guidance Warrick gave me a great deal. It made me feel confident again and was just what I needed.

We were extremely pleased that we took the time to choose an obstetrician who was willing to support us in the birth we wanted. For the most part, he

you back on track and know all the right things to say. Despite my belief in the value of the HypnoBirthing course and the importance of choosing the right carer, this wouldn't have had the same effect if I didn't have a wonderful, supportive husband by my side. It's absolutely crucial, if you are going down the HypnoBirthing path, that your partner or support person does the course with you and is a hundred per cent on board. Nathan and I practised the relaxation techniques together, and this enabled him to be really tuned in to all that was happening in my body on the day. When I was tensing up,

just let Nathan and I do our own thing, offered encouragement when I needed it, and told me I was doing a wonderful job and that our little girl would be here very soon. He didn't interfere in the natural birthing process and was very gentle and calm about explaining a couple of things to us throughout the labour (for example, there was meconium in my waters). My waters exploded over everyone only right before my baby was born. (I didn't laugh at the time, but in my mind I found this amusing.) We had asked Warrick, during our regular appointments, not to release my waters unless absolutely vital. So I was really happy that right at the end this happened naturally. I think we only spent about an hour in the actual birthing suite before our lovely little Lelia Rose was born at 12.50 pm.

We cried; we laughed

Once Lelia was born, Warrick placed her on my chest straight away. She was incredible. She crawled her way to my breast with very little help, started feeding within minutes, and hasn't stopped since! The midwives were wonderful; after they'd done some tidying up of everything, they just left the three of us there together to bond and be alone for the next three hours while we cried together, laughed and just stared at the perfect little baby girl who was ours. It was an extraordinarily special time. It was lovely not to be rushed and just to be able to enjoy each other and the amazing experience we were having. We called our families and shared our excitement with them. Lelia stayed on my bare chest the whole time, feeding and sleeping. Then I got to have a nice long shower while Nathan enjoyed some skin-on-skin time with our baby girl for an hour.

There is no doubt in my mind at all that it was the techniques we learnt in the HypnoBirthing Australia course, choosing the right carer, having a wonderfully supportive husband and the prayers of my family, that led to an incredible three-hour birth, without drugs or fear. (Oh, and Raspberry leaf tea! I highly recommend it, I think it helped too!) Everything about Lelia's birth was joyous. I was amazed that, even though I was completely focused and in my own little world with my eyes closed the entire time, I've never in my life been more aware of absolutely everything going on (in the room and in my body). Afterwards I felt so proud of myself and the very next day I actually said to Nathan that I'm looking forward to next time already!

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Branch Information

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

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

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

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