

Birth Matters

Vol 18/2 ISSN1443-7570

Winter 2014

**Memoirs from
a paramedic**

**Siblings
attending
birth**

**Evaleigh's
spontaneous
free birth**

**Fight for
birthing
services in
Katanning**

**Homebirth
insurance
exemption**



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Taming the Tiger 2014

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OUR PURPOSE

Birth Matters (BM) is an annual magazine produced by and for members of Maternity Choices Australia (MCA). 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 in hard copy annually in June. **Deadline for submission is the 1st of May.**

We publish a smaller, electronic version of BM every month. **Deadline for submission to the e-version is 1st of the month prior to publication.** For example 1st March for the April e-edition.

We publish articles that are topical and / or of interest to our readers under the following section headings: *Letters to the Editor, Birth Stories, Features, Federal Update, Rural Matters, Global Perspectives, Parenting Matters, In Review* (Book, Film, and CD reviews), *MCA 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 MCA readers, and fits with MCA'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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Main Cover Photo:

Beautiful water birth of Finn Douglas with Mum Kylie

Photo by: Jane McCrae
Photography



Ladies and gentlemen, you are holding a piece of Maternity Coalition history in your hands at this very moment. Whilst you may be lamenting the decision to do away with the quarterly printed issue of *Birth Matters* (this issue being the last of the lot), you will welcome the news of having BM delivered to you electronically on a monthly basis starting July 2014. In addition, a bumper printed edition will be released annually to satisfy the urge for something more tangible to open and fold as you indulge yourself in a little time to get to know your fellow MC members through each others' compelling stories.

Without further ado, I welcome you to the new face of the former Maternity Coalition, officially renamed to Maternity Choices Australia (MCA). It's never easy to decide on a new name and give an organization a facelift, but management has been working extremely hard at orchestrating the seamless rollout of the new image - the massive effort is commendable. Several additional initiatives have also been afoot across the MCA community, some of which are highlighted in *MCA News*.

Closer to home for me, reporting from my local branch, Friends of Belmont Birthing in NSW, we took the time in May to celebrate some very important women in our lives, the midwives at the Belmont Midwifery Group Practice (BMGP), by way of hosting an open day at the centre for International Midwives Day, providing morning tea and fundraising for an international midwifery charity chosen by BMGP. The BMGP midwives provide continuity of care and offer women the opportunity to birth at home or at the BMGP birthing suites, all publically funded. (Just to throw in a fabulous statistic here, BMGP reported 12 homebirths during the month of February alone!) It is my wish for all women throughout Australia to one

day have access to this option, and it be offered as the norm! Not only does this unique and wonderful service open up the options for pregnant women and their families in the Newcastle/Hunter region, but it reduces the number of healthy birthing women staying in hospital, leaving the beds vacant for those in need. BMGP also boasts a significantly lower emergency caesarean rate than its hospital counterpart. This concept resonates with one of our featured articles this issue: *A letter to the Honourable Rob Lucas* where Tessa Kowaliw asks the health minister to investigate the caesarean section rates and put measures in place to support women who wish to have a VBAC, and is further investigated by Jyai Allen in her article, *Does place of birth affect your chance of having an 'emergency' caesarean section?*

Before I leave you to immerse yourself in the next 30 pages of birth and beyond, I would like to make a simple request: everyone please inform someone you know about becoming a Maternity Choices Australia member. Many mothers-to-be are (not surprisingly) unaware of not only their options for childbirth in this country, but also that these options could, at any given moment, exist no longer. Others are aware of what they *could* have, if only their choices weren't limited by the powers that be. Imagine if each of us informed one friend on becoming a member of MCA, the positive change that would transpire across this nation as the numbers, strength and unity of our voice increased would be astounding!

Whether it is through your membership, active role on the committee, contribution to *Birth Matters* or by simply picking up the magazine and showing interest in what's happening, we would like to express our gratitude for your continuing support of MCA.

WANT TO WRITE FOR BIRTH MATTERS?

We are seeking articles
for our regular sections...

Federal Update, Rural Matters, Global
Matters, Birth Stories, Parenting Matters,
News, Research, Interviews and Reviews

From the President



by Bec Waqanikalou

Hello to our members,

I would like to take this opportunity to thank you all for your continued support of MCA. This last 6 months has been a busy and exciting time for the organisation with some big and small changes, updates and exciting advancements.

For me personally, it has also been a busy year. I have been happily gestating baby #4 and am due to welcome bub earthside in the next few weeks. While I am on 'Maternity Leave' Tish Ryder, Vice President will take over the reigns with the support of our wonderful National Committee and will continue on the path of solidifying our organisational foundations and growing MCA for the future.

I look forward to seeing the interesting and exciting things that will come in the next months for both MCA and also my little family.

Thank you to all.

Warmest,

Bec



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From the Vice President



by Latisha Ryder

As Bec has just mentioned, I will be taking the reins from her whilst she is on maternity leave. I would like to thank Bec for all the hard work she has done so far and I plan on continuing that important work.

Having only been involved in Maternity Choices Australia for a little over eighteen months now, I am so grateful to have the support of our National Committee members who inspire me every day.

Our current maternity services landscape is undergoing continual change and as Bruce Teakle talks about in his essay "What next for the homebirth insurance exemption?" you will see that the impending expiry of the homebirth exemption from professional indemnity insurance has more far reaching implications than just in the context of homebirth. There is much to do and as Australia's leading maternity consumer advocacy organisation, we are in a position to influence the direction that maternity services across Australia go, but we can't do this without your help.

I would encourage anyone who is contemplating getting involved with our organisation to do so now. If I can, you can too.

Like many of you, I'm a mum who juggles raising a spritely two year old, running a business and getting the housework done every now and then. I live in Emerald, a small rural

town in Central Queensland and love the fact that despite my 'remoteness' I can still contribute to such a worthy cause from the comfort of my own home. My interest in Maternity Choices Australia sprouted from the life changing, empowering birth of my beautiful daughter Chloe whom I gave birth to in our local hospital with the support of my husband and my midwife, Donna. I was one of the first women to receive Continuity of Midwifery Care in my town and I was impressed! I was so sold on this service that I would tell everyone (yes, even random pregnant women at the shopping centre) about this wonderful model of care and I made the decision that I would have to do 'something' to make sure that everyone could have access to this model of care. So with a nudge from my midwife in the direction of MCA, my journey to this point began.

I have found my calling and the fire in my belly burns bright for women's rights to choose where, with whom and how they birth.

So, if you think you don't have the time, the skill, the know-how, think again. If you have the fire in the belly, the passion and the will to do 'something', you can be a part of the positive changes in our maternity services landscape.

Looking forward to keeping in touch with you all in our new online version of Birth Matters in the coming months.

Cheers,
Tish



WHAT NEXT FOR THE HOMEBIRTH INSURANCE EXEMPTION?



Australian women's access to midwifery care in homebirth is due for a big shakeup in July 2015, when 'the exemption' expires or is extended. If it expires, homebirth care is likely to be transformed in a way we have never seen before, not necessarily for the better.

What is the exemption, and what might happen next?

BACKGROUND

The 2010 maternity reforms

In 2010 the Australian Government implemented extensive reforms to maternity care in Australia, under the leadership of Health Minister Nicola Roxon. The central element of these was Medicare rebates for women receiving care from eligible private practice midwives. The government was committed to providing women with continuity of care, including labour and birth, so a full range of Medicare items was developed, including a rebate for labour and birth care in hospital.

For private midwives to be able to practice in hospitals (and to provide labour and birth care there), they needed to have professional indemnity insurance (PII). Establishment of the Australian Health Practitioners Regulation Agency (AHPRA) in 2010, also brought a new requirement for all practitioners to hold PII. However, no PII had been available for midwives in Australia since 2001. Therefore a professional indemnity insurance product for midwives was needed.

For these reasons, a Commonwealth-subsidised PII product was part of the May 2009 Commonwealth budget plan for the maternity reforms, recognising the precedent of PII subsidies provided to medical practitioners. An insurer, MIGA, was contracted to provide a PII insurance product for 'eligible' midwives in private practice, at a price set by the Commonwealth, with conditions set by the Commonwealth.

Threat to homebirth – 2010

For political reasons, homebirth was excluded from both new sources of Commonwealth funding for midwifery care: Medicare rebates and Commonwealth-subsidised PII. In itself, exclusion from subsidies was not a problem for homebirth. With the exception of the few public homebirth programs, homebirthing women in Australia have adapted to uninsured midwives and self-funding. However, the exclusion led to a crisis: the potential exclusion of midwifery care from women birthing at home.

National registration required midwives to be insured for all of their practice, but no PII product covered homebirth. Under the conditions that were planned for implementation in July 2010, midwives would not be able to provide homebirth care without breaching their regulated obligations to hold PII.

Consumer and midwifery stakeholders came to realise this problem in 2010. However bureaucrats and advisors did not consider it to be their responsibility, and it took months for the message to get to the Minister. During this time, a great deal of drama and protest were

generated by homebirthing women and families, resulting in some extraordinary statements of support for women's right to homebirth in Commonwealth Parliament. Once the problem was understood at the political level, Minister Roxon acted swiftly to implement a solution.

THE EXEMPTION

Implementing the 'exemption'

The problem was that there was no PII product to cover labour and birth at home, although PII was required by the National Law. The solution was to give midwives an exemption to the PII requirement when they were providing labour and birth care at home.

At a meeting of the Australian health ministers, Nicola Roxon gained a nearly instant, almost-consensus on implementation of an exemption for homebirth. The only way to create an exemption was to amend the National Law for regulation of health practitioners in each state and territory.

One government did not go along with the plan. The Northern Territory, which had not allowed uninsured homebirth midwifery before national registration, maintained its opposition to uninsured homebirth and did not enable an exemption for homebirth. There are still no legal private homebirths in NT (although this is currently under review).

All states and territories, other than NT, amended their National Laws to implement the exemption and to enable women's access to homebirth midwifery. However the exemption was not unconditional or open-ended. It was planned to expire in 2013, providing about three years to find a more permanent solution. Midwives were required to

practice within a set of conditions, now known as the *Safety and Quality Framework for Privately Practising Midwives Attending Homebirths*, published by the NMBA (NMBA, 2011). Conditions include informing women that their homebirth care is not insured and implementing a set of practice processes, including documentation and risk management.

Extending the exemption

In 2012 it became clear that a solution to the homebirth PII problem was not ready for the 2013 expiry of the exemption. The Standing Council on Health (the national health ministers' group) agreed to extend the exemption to 2015. Now, in 2014, women will soon be conceiving babies who will be born after the exemption expires, so it's time for some answers about what will be in place for their birth care.

WILL PII BECOME AVAILABLE?

Commercial PII

PII for homebirth was investigated in detail in 2013 by PricewaterhouseCoopers for the NMBA (PricewaterhouseCoopers, 2013; NMBA, 2013). Several significant obstacles were found to PII becoming available as a commercial insurance product:

- lack of clarity about midwives' practice in homebirth
- lack of data about homebirth outcomes
- lack of data about litigation arising from homebirths
- the small number of homebirths and midwives providing homebirth care in Australia
- the inherent risks of maternity care
- the high potential cost of poor outcomes in maternity care.

None of these problems will change soon, so the problem of PII for homebirth cannot be expected to be solved by the commercial insurance market alone in the foreseeable future. If PII is to become available for midwives providing homebirth care, some sort of government intervention, and probably funding, will be required.

Government intervention

When governments consider particular insurance products to be important enough, they get involved. Medicare is an example of a huge, government-owned and run insurance scheme that supports access to private health care. The Commonwealth also subsidises private insurance products, such as PII insurance for doctors and the new PII system for midwives. There is adequate precedent for government to subsidise PII for homebirth.

OPTIONS AFTER THE EXEMPTION

The decision about what happens after the homebirth PII exemption expires in 2015 sits with the Australian health ministers. They have a range of options, each of which has political implications.

Doing nothing

The first possible option is for the Australian health ministers to do nothing and let the exemption expire. If this occurs, after 1 July 2015, any midwife providing labour and birth care at home will be in breach of her conditions of registration.

We can't be certain how AHPRA would respond to this, but it seems unlikely that they would let midwives continue to practice. *Most private midwives could be expected to cease providing homebirth care.*

The closing down of private midwifery has occurred previously within Australia. When PII providers stopped

insuring Australian midwives in 2001, all private midwives in the Northern Territory were forced to cease practice. Nursing and midwifery legislation there already required PII. This led to the rapid implementation of a public homebirth program in NT, which employed a number of midwives who had previously provided private homebirth care.


Letting the exemption expire at a national level would probably result in loss of access to homebirth care for most Australian women. Some women would have access to public homebirth models, and an increased number of women could be expected to birth with non-registered caregivers or no caregiver at all.

State-based PII

An upgraded version of 'doing nothing' would be to progress without a national solution, with the states each developing their own solution. One solution that has already had some discussion in Queensland is the provision from the state of PII to private midwives.

States/territories could find a way to insure some private midwives in a state-based plan, subject to conditions. For example, contractual arrangements between midwives and health departments or public hospitals could provide PII cover from existing government or hospital insurance.

This option is very risky for both women and midwives. Some states might just not deliver. States that provide insurance could be expected to set different sets of rules regarding women's choices and midwives' practice. Each state would be dealing with a very small number of midwives, increasing costs dramatically. Insurance, when available, could be at varying costs, possibly unaffordable for many midwives. Potentially, different insurers could be involved, without the expertise of the current



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Commonwealth-subsidised insurer. Our experience of the last three and a half years is that a lot of problems arise simply from the complexity of the arrangements around private midwifery in Australia, and the limited understanding of this landscape.

Public homebirth models

An alternative state-based option would be for states and territories to commit to a similar plan to the NT's in 2001. Private homebirth midwifery would cease, and states would undertake to establish more public homebirth services.

Effective implementation of such a plan is not a plausible outcome. The creation of public homebirth models is a complex, clinical, cultural task, requiring cooperation from a range of diverse and often recalcitrant players. Implementation would need to occur in public hospitals that have cultures highly resistant to outside influence and very limited points of leverage from government. Government commitments of these sorts are of limited value, especially when not tied to Commonwealth money. Turning a promise made at a health ministers' meeting into hundreds of functioning public homebirth services, within a limited time, is not a realistic expectation.

If we are left with eight state-based solutions at the expiry of the exemption, we can expect a shambles that will take many years to resolve. Many midwives will be left uninsured, leaving women planning homebirths without care. Again, women could be expected to make difficult, potentially risky, choices.

Extend the exemption

The ministers also have the option of simply extending the homebirth PII exemption for another year or more. This would give more time to further embed private midwifery as part of the Australian maternity care system and perhaps see the development of new provisions that could support the development of an insurance product.

Health Ministers and the NMBA are keen to close this messy gap in the insurance net. Largely, this is because of the risks to women and midwives of leaving homebirth uninsured. When something goes wrong in a homebirth, there is no legal protection for midwives and little chance for women or their babies to receive compensation for the damages that can occur.

The ministers might be more willing to grant some extension to the exemption if it was part of a plan to fix the problem properly. One relatively simple option is available to them.

Extend Commonwealth-subsidised PII to include homebirth

As outlined above, eligible midwives are able to purchase Commonwealth-subsidised PII from MIGA, which covers all of their private practice except for labour and birth at home. This product could be slightly modified to include homebirth, without necessarily changing anything else.

Eligible midwives are already insured by MIGA to provide antenatal care, including for women who subsequently birth at home. It is safe to assume that if a woman or baby were damaged by a midwife's care in a homebirth, and legal advice was sought, lawyers would look closely at the antenatal care preceding the homebirth for evidence of negligence. As the antenatal care is insured, there is a potential source of compensation. From this perspective, the Commonwealth-subsidised PII product is already insuring homebirth to a recognisable extent.

Under current arrangements, only midwives annotated as eligible are able to access Commonwealth-subsidised PII. Therefore, if the exemption is allowed to expire and the existing

PII product is extended to homebirth, this would mean that only eligible midwives would be able to provide homebirth midwifery care. Non-eligible midwives providing homebirth care would need to either become eligible or to cease providing homebirth care. This would be a major disruption to the existing homebirth landscape.

Extending Commonwealth-subsidised PII to homebirth faces one huge hurdle: the overwhelming political influence of the medical lobby. Subsidising PII for midwives in homebirth is spending taxpayer money on homebirth. Medical stakeholders have locked themselves into a position of intractable opposition to homebirth, and it would be a brave Commonwealth Government who would cross this line. Still, governments are brave sometimes...

MAKING PII FOR HOMEBIRTH MORE VIABLE

Whether Commonwealth-subsidised, or purely commercial, PII for homebirth becomes more achievable as the inherent risks of maternity care, and the specific risks of homebirth midwifery, are managed and seen to be managed. A range of possibilities are identified in the PricewaterhouseCooper report and the NMBA's response:

- Restricting PII (and thus ability to provide homebirth care) to a specific group of midwives. Eligible midwives are currently the obvious group, but other options are conceivable.
- Group practice requirement. Insuring a group or company of midwives, with good organisation and governance, is regarded as less risky than insuring individual practitioners who may have less structured collaboration, support and backup from midwifery colleagues, and who may have less structured practice processes. It also improves the scale, which decreases costs.



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- Safety and quality frameworks. Agreed, national, clinical guidelines and practice frameworks for homebirth are considered desirable for predictable management of clinical risks.
- Better data collection. Current maternity data systems are inconsistent between states and collect incomplete data. We don't even know how many midwives in Australia provide homebirth care.
- Better relationships between stakeholders. Midwives, their professional college (Australian College of Midwives), their regulator (NMBA), governments, medical stakeholders, insurers and various other players have considerable room to improve communication and shared visions for the profession.
- Collaboration with hospitals. Community midwifery will be safer if midwives have good collaboration with hospitals and their staff. Four years after all states and territories agreed to organise public hospitals to credential and provide access to eligible midwives, only Queensland has any functioning agreements in place.
- Professional supervision or mentoring. The NMBA has recently started a project to develop a system of 'supervision', or professional support, for midwives from expert midwife mentors or supervisors. This is seen as effective in improving practice standards and communication.

WHAT IS THE BEST WAY FORWARD?

Resolving the exemption problem is difficult. Any solution can be expected to significantly disrupt Australia's existing homebirth midwifery arrangements.

The only option that maintains the status quo is indefinite extension of the exemption, leaving homebirth midwifery uninsured. This leaves midwives and women vulnerable when things go wrong, and is not acceptable to governments or the NMBA. A time-limited extension is a possibility, if it is part of a pathway towards proper insurance.

State-based solutions involving insurance from government or hospitals cannot be expected to maintain women's access to private homebirth care. Eight states and territories would be trying out eight ways to solve very challenging problems. A commitment by state governments to provide public homebirth care would not be believable. We just have to look at how ineffectual states and territories have been in implementing relatively easy reforms such as access for eligible midwives.

Extending Commonwealth-subsidised PII to include labour and birth at home would limit homebirth care to eligible midwives, but it would enable private homebirth to continue in a consistent way across Australia, with effective support from an insurer who has significant experience in private midwifery. If the political obstacles could be overcome, this is likely to be the most protective option for women's ability to choose.

My preference would be to have a further extension of the exemption – perhaps to 2017 – with a commitment from the Commonwealth to include homebirth in subsidised PII. The time gained by extending the exemption would enable the implementation of a range of measures, which would reduce the uncertainty, and perhaps cost, of including homebirth in Commonwealth-subsidised PII.

Conclusion

None of the options to resolve the expiry of 'the exemption' are easy or familiar. The best require major reshaping of private

midwifery; the worst bring the end of homebirth as an option for most women.

Women's access to homebirth midwifery is a tiny part of Australia's maternity care system. However it is also a gigantic symbol of women's rights to make choices in their birth care, and midwives' identity as professionals who take responsibility for their own practice. The homebirth subculture has had a huge effect on reforms to maternity services in Australia, and energised much of the consumer representative movement. There is benefit to all birthing women in the retention of homebirth as an option.

It is really important that a solution be found to the PII problem for homebirth midwifery. Consumers and midwives need to be engaged in the political conversation about this now, so that homebirth remains an option for Australian women after June 2015.

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METRO NORTH PERINATAL HEALTH AND MATERNITY SERVICES FORUM

By Belinda Barnett and Ildiko Keogh

Maternity Choices Australia (MCA), in partnership with the Queensland Centre for Mothers and Babies and Health Consumers Queensland, hosted the Metro North Perinatal Health and Maternity Services Forum in late March 2014. Over 120 people attended the Forum, including women, their partners and babies, healthcare providers and policy makers. The Forum provided women and healthcare providers with information about services that support women's physical and emotional health during the perinatal period, as well as providing an opportunity for participants to identify service gaps and to explore strategies for improvement. The consumers' voices were strongly represented by mothers sharing their experiences of maternity care in Metro North Brisbane.

In attendance were the Queensland Minister for Health, Hon. Lawrence Springborg, State Members of Parliament (Kerry Millard, Member for Sandgate, Trevor Ruthenberg, Member for Kallangur and Dale Shuttleworth, Member for Ferny Grove), Malcolm Stamp CBE, Chief Executive of the Metro North Hospital and Health Service (MNHHS), Dr Richard Kennedy, Executive Director, Women's and Newborns' Services, MNHHS and Jeff Cheverton, Deputy CEO of the Metro North Brisbane Medicare Local. The Forum was made possible by a grant from the Medicare Local.

Issues discussed included the benefits associated with women accessing continuity of care during pregnancy, labour, birth and postnatally, and the ways in which women can access this model of care in Metro North. Other issues discussed included services that are available for vulnerable groups of women who may have additional needs during the perinatal period, as well as services supporting women's health during the first 12 months after birth.

Some of the recommendations arising from the Forum included the following:



Metro North Perinatal Health and Maternity Services Forum

- consensus on and consistent use of the term 'Continuity of Carer'
- credentialing of eligible private practice midwives for intrapartum care at all Metro North HHS facilities
- more all risk MGPs and birth centres at all facilities that do not discriminate based on women's geographic location and 'risk' status
- educating GPs, women and families about the models of care available and the benefits of continuity
- consumer engagement at all levels of service design, delivery and evaluation, including consumer involvement in the development of the Metro North HHS Women's Services strategic plan

MCA will prepare a brief report summarising the feedback from the forum and will discuss these recommendations with the Metro North Hospital and Health Service. Video presentations from the forum will shortly be available on MCA's website: www.maternitycoalition.org.au



L-R back row: Christine Percy, Friends of the Birth Centre; Belinda Barnett, Maternity Coalition; Midge Fijac, Sweet Dreams Infant Massage; Jeff Cheverton, Metro North Brisbane Medicare Local; Joanna Molloy, JM Lactation Services; Hon. Lawrence Springborg, Minister for Health; Mr Dale Shuttleworth, MP, Member for Ferny Grove; Heidi Degen, Friends of the Birth Centre; Dr Yvette Miller, Queensland Centre for Mothers and Babies
L-R front row: Melissa Fox, Health Consumers Queensland; Professor Sue Kruske, QCMB; Dr Richard Kennedy, Metro North HHS; Bec Waqanikalau, National President, Maternity Coalition; Odette Tewfik, Health Consumers Queensland



L-R: Ildiko Keogh, MCA Qld Convenor; State Member for Sandgate, Kerry Millard; Qld Health Minister, Lawrence Springborg, and Belinda Barnett

MATERNITY CHOICES AUSTRALIA'S CONSUMER REPRESENTATIVE TRAINING PROGRAM

By Latisha Ryder

Maternity Choices Australia's (MCA) national committee has recently set down a few main projects for the year ahead. One of these is to redesign the Consumer Representative Training Program so that it can be delivered nationally and online.

The Consumer Representative Training Program was initially offered back in 2011 and 2012 in partnership with the Queensland Centre for Mothers and Babies (QCMB) and Health Consumers Queensland (HCQ). It was delivered in a classroom setting in Brisbane over one day, with a strong focus on Queensland consumers and systems. This program was popular and proved very useful for consumer reps involved in the maternity services system.

The need for consumer representation within our health system is an ever-growing one. As Australia's peak maternity services consumer advocacy organisation, we want our

consumer representatives to be as well trained and prepared for their roles as possible, to ensure more effective representation and a more consistent voice for the women and families of Australia.

A working party has been formed to help to bring this project to fruition. We had our first meeting on the 23rd of April. This meeting was a brainstorming bonanza, with the main outcome being a draft blueprint for the new training program. Some of the ideas fired around included: developing the program for Queensland initially, then expanding it further afield after that; using video content (possibly of key MCA members providing explanations of important issues); and running the program over four weeks, with only a couple of hours' commitment required from participants each week. We are very excited with what we have developed so far and we are awaiting feedback on this blueprint.

With requests from prospective and current consumer representatives for training on the increase, we have set ourselves an ambitious time frame to get this program up and running. We can only do this with the help, dedication, knowledge and skills of our passionate volunteers. If you would like to get involved, or know someone who might, please contact Latisha Ryder, Vice-President of Maternity Choices Australia at: vicepresident@maternitycoalition.org.au.

We look forward to keeping you updated on the progress of this particular project. 2014 is shaping up to be a dynamic and very active year for MCA as we grow and adapt.

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REDUCE CAESAREAN RATES, INCREASE HEALTH BUDGET SAVINGS: A LETTER TO THE HONOURABLE ROB LUCAS



Tessa is a teacher, currently on leave, and has been volunteering for CARES in various roles for the past five years. She also runs VBAC workshops locally, combining her passion for teaching and consumer education regarding Caesarean and VBAC.

“ Women choosing VBAC need to be suitably supported, and to have access to good quality, balanced information so that they know VBAC is, for many women, an appropriate and safe choice over repeat Caesarean... ”

12 January 2014

RE: Health budget savings – addressing Caesarean rates to reduce hospital length of stay

To the Honourable Rob Lucas,

On 11 September 2013, I sent the following information to Minister Snelling's office. In October, I received a formal letter of receipt (with a reference number and a promise of further contact), but to date have not been sent a response. This is despite Minister Kenyon's office also promising to follow the matter up on my behalf. I am therefore sending you this letter in the hope that my thoughts might be considered as you prepare policies and party promises for the coming state election.

I believe that it is possible to reduce the length of stay in SA maternity wards if the State is prepared to address our high Caesarean rates, investigate our low vaginal birth after Caesarean (VBAC) rates, and better support women to make next birth after Caesarean choices. A reduction in our Caesarean rates would save the State money and ultimately lead to better outcomes for women and babies.

As a woman who was given a Caesarean for my first birth in 2009, not as a lifesaving procedure, or even as a necessary intervention, but as a result of a cascade of intervention, I feel this is an excellent move to support normal, vaginal birth; I know first-hand that many Caesareans which burden the State's resources could be avoided.

At 33%¹, South Australian Caesarean rates well exceed the upper limit of 15% cited by the World Health Organization², are virtually double the what these rates were in 1981 when I was born (16.9%), and are higher than the Caesarean rates in most other OECD countries³.

Not only is this a budget issue – this is also a public health issue for SA women and their families. Caesarean birth:

- is surgery which inherently increases risks of morbidity and mortality⁴;
- affects breastfeeding rates;
- limits future birth options; and
- increases risks for future pregnancies.

All of these effects increase the length of hospital stay and/or increase the risk of readmission.

For years, Pregnancy Outcome in SA reports have consistently referenced 'previous Caesarean' as the leading cause for Caesarean section in SA – it is clear that helping women to avoid the primary Caesarean is the only way to break the cycle. This would contain costs to the system not only for that birth, but potentially also for that woman's subsequent births, contributing to future improved outcomes both for women and babies, and the State.

I was thankfully able to break this Caesarean cycle for my own subsequent births, however, in order to do this I opted to have a vaginal birth after Caesarean (VBAC) at home with an independent, registered, privately hired midwife. I made this carefully considered choice because I know the context of SA hospitals means too many care providers are not accustomed to witnessing VBACs – the SA VBAC rate for 2011 was 16.9%⁵.

Therefore, on the flipside, I urge you to also consider investigating these poor rates of VBAC in SA. Women who choose VBAC in a well-established, VBAC-supportive environment have a 60-80% chance at success⁶. Each year, approximately 15% of maternity patients in public hospitals (and 22% of maternity patients in private hospitals) are making decisions about 'birth after Caesarean'⁷. If these consumers were better encouraged and supported to break the Caesarean cycle, the SA Caesarean rates could, in turn, quickly decline.

Women choosing VBAC need to be suitably supported, and to have access to good quality, balanced information so that they know VBAC is, for many women, an appropriate and safe choice over repeat Caesarean – a Departmental 'Next Birth After Caesarean' policy could bring some consistency to antenatal counselling, improve VBAC rates and reduce hospital length of stay for these women and babies.

It would be wonderful if the savings which can be made from promoting normal, low-intervention, natural birth could be invested in further reducing the average hospital length of stay by:

- Collating data relating to VBAC attempt and success rates to identify and promote existing good practice (easily done by amending current supplementary birth records to gather this data from all hospitals – a 'Planned VBAC' box is all that is required);
- Expanding existing programmes which support normal birth (i.e. the MGP and government-funded homebirth programmes);
- Opening a VBAC clinic – the King Edward Memorial Hospital in Western Australia has such an initiative established and it achieving great outcomes;
- Creating a more VBAC-friendly "Vaginal Birth After Caesarean in South Australian Hospitals" brochure than currently exists;
- Introducing a "Next Birth After Caesarean" policy for all SA hospitals;
- Addressing the freedom of information issues which prevent women from accessing hospital and care provider Caesarean rates.

I sincerely thank you for the time you take in considering this matter; while I am sad that, regardless of the outcome of the election, the State will need to make cuts from maternity services, the promotion of normal, low intervention, vaginal birth is undoubtedly a good thing for our mothers and babies.

Please do not hesitate to contact me via the details below if you would like to discuss the matter further.

Kind regards,

Tessa Kowaliw

This letter was written to Rob Lucas, shadow minister for health, ageing, mental health, substance abuse and suicide prevention, in response to an announcement early last September by the Health Minister, Jack Snelling. The announcement was essentially that the Department was looking to make cuts to their budget (because they are terribly broke), and in order to do this, they were reviewing the "hospital length of stay" for patients at our major tertiary hospital. Needless to say, this was a perfect "in" for me, as reducing unnecessary caesarean rates would clearly reduce the burden on the system, both today and in the future.

After initially sending my letter to Minister Snelling in September 2013, I was sent a reference number in response, and then heard no more. Well, that is until the SA government called the recent March election and my local member started cold calling constituents to ask whether or not they had any particular concerns coming into the election. Naturally, I mentioned my letter and the fact I was still waiting for my response from the Health Minister.

Several "letters promising letters about the letter" and six months later, I did finally get the response (right in time for the election). This reported that the local Women and Babies Division had considered my suggestions, and these were also forwarded to the SA Maternal and Neonatal Clinical Network. Other than that, I haven't heard anything more to come of it.

The letter did also reference a "Caesarean Section Pathway" as a key project to reduce the rate of caesareans. So my next port of call will be to investigate that one further as I am keen to know more about what that project exactly entails.

References

- 1 Scheil W, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2011. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2013.
- 2 World Health Organization (2009) Monitoring emergency obstetric care: a handbook. Page 25. See also: "... when caesarean section rates rise above 15%, risks of adverse health outcomes begin to outweigh the benefits." – Einarsdóttir K, Kemp A, Haggard FA, Moorin RE, Gunnell AS, et al. (2012) Increase in Caesarean Deliveries after the Australian Private Health Insurance Incentive Policy Reforms.
- 3 2011 OECD indicators: Netherlands (14.3%), Finland (15.7%), France (20%), UK (23.7%), New Zealand (24%).
- 4 "... this procedure (like any major surgery) carries a risk for surgical or anaesthetic accident, postoperative infection, and even death for the patient (129). A uterine scar increases the risk for uterine rupture in future pregnancies." – World Health Organization (2009) Monitoring emergency obstetric care: a handbook. Page 25.
- 5 Scheil W, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2011. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2013.
- 6 "Most series report a likelihood of vaginal birth (if this is attempted) in the range 60-80%." – RANZCOG College Statement C-Obs 38.
- 7 Pregnancy Outcome in South Australia reports, 2008-2011, SA Health.

“ At 33%¹, South Australian Caesarean rates well exceed the upper limit of 15% cited by the World Health Organization²... ”

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FULL OF GREAT

Melanie Lotfali PhD is a graduate of the Australian College of Journalism in Professional Writing for Children. She is the author of eighteen books of fiction and non-fiction for children and the illustrator of five. Melanie has taught spiritual education classes for children for the past twenty years in five countries and is currently an active animator and trainer of animators for the Junior Youth Spiritual Empowerment Program. She is a qualified counselor and classroom teacher, and for the past six years has facilitated violence prevention and respectful relationships programs in high schools.
<http://michelangela.com.au/books/>

Dolls and crutches

A little girl, poverty stricken, and about to become an orphan, excitedly anticipates the opening of a box of second-hand goods donated to her family. Never having had a doll of her own, she hopes with all her heart that a doll may have been donated. Instead the child finds crutches. Though this child has been taught by her father to find the best in every situation, she struggles to understand how she can be 'glad' about crutches when she wanted a doll. But moments later she is 'glad' again because she doesn't need to use the crutches.

Pollyanna's name has become synonymous with an excessive application of Monty Python's advice to 'always look on the bright side of life'. These days most references to Pollyanna are made in a mocking or sarcastic tone. But the quality that she models in the extreme – gratitude or gratefulness – is one of the most important qualities a child must develop in order to attain contentment, happiness, and joy.

An experiment

One day, I decided to do an experiment on my young children, aged two and four. I had noticed that whenever we left the park – whether we had been there for ten minutes or an hour – they always wanted to stay longer, and begged for more. As part of the experiment I made a decision to stay until they themselves requested to leave. For several hours I endured the tedium of pushing swings, clapping as they tumbled down slides, dusting woodchips off knees, tummies, and tongues, after falls, and so on. Finally, they were ready to go.

Without even realising it in the moment, I was expecting them to have a deep appreciation of the gift they had just been given. Part of me even expected them to verbalise this. However, before we had even buckled the seat belts in the car they were making their request for the next thing they wanted – hot chips. It was at that moment that a very useful phrase was coined: gratitude not greediness.

Gratitude – a quality of the soul

Even very young children can quickly grasp the basic meaning of gratitude (being content and appreciative of what is or of what you have) and of greediness (always wanting more). When we encourage our children to say 'Ta' or 'Thank you' by using the phrase 'use your manners', we are missing

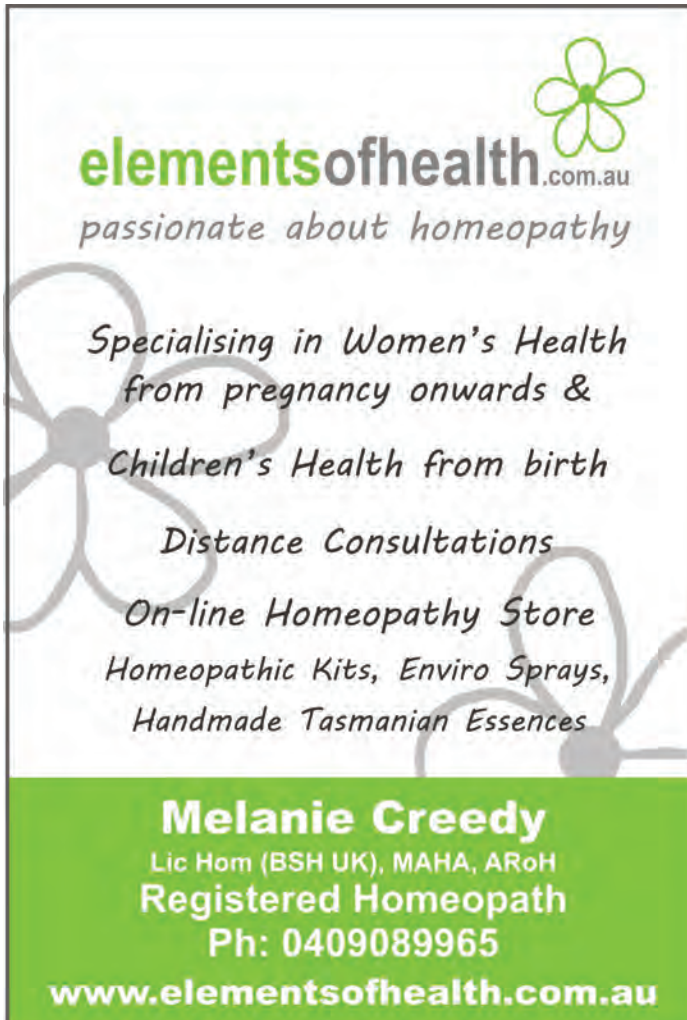
an opportunity to lay the foundation of a profound spiritual quality. 'Manners' are simply imitation of outer social customs. Gratefulness is a quality of the soul that can be nurtured from the earliest months of life and then be constantly refined throughout our lifetime. As our children grow, their ability to understand increasingly complex and subtle aspects of gratitude can be actively fostered by parents. It can be part of almost every moment of every day.

Contrast

Central to developing gratitude is an understanding of contrast. For example, if a child has eaten at least three full meals every day of her life, and all the people she knows have had similar experiences, it is hard for her to feel grateful for a meal. We even tell children they are 'good' for having eaten their vegetables or for finishing their meal. But if a child knows what it feels like to be hungry for an extended period, he will be grateful for food even long after they have guaranteed access to it.

We cannot deprive our children of all the things for which they can be grateful – we will not cripple them so that they can appreciate health, lock them up so they appreciate freedom, starve them so that they appreciate food. But we can constantly engage in conversations that bring attention to the contrast between what is and what could be.

“ Even very young children can quickly grasp the basic meaning of gratitude... ”



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“Manners’ are simply imitation of outer social customs. Gratefulness is a quality of the soul that can be nurtured from the earliest months of life...”

My children and I used to walk one kilometre to get from our home to their Darwin primary school. As we crossed a large grassy area en route, sweating under the tropical sun, we, who had never lived in a war-zone, celebrated the fact that we could walk across the grass 100% confident that we would not step on a land mine. Gratitude for this privilege is fostered through contrasting *what is* for us, with *what is* for many others, or with *what could be*.

Full of great

A child within whom gratefulness is fostered is one who is more likely to experience contentment, happiness and joy. She sees what she has and values it, whether it be a material possession or the love of her mother. She knows that what she has, even a pair of shoes, a safe place to sleep, a school to go to, a comforting hug, represents a privilege to which many do not have access. And on the foundation of this quality she can build a commitment to justice and a life of service for the betterment of humanity. In short, a grateful child is one who will grow to be full of great.

Six tips for growing gratefulness in your great-full child

1. Teach your child the meaning of the word gratitude and the meaning of greediness as soon as they can talk – long before you think they could understand three-syllable words. They will surprise you in their comprehension.

2. Use the language of those qualities, not phrases such as ‘manners’, ‘the magic word’. That is, honour your children for their *gratitude*.

“Thank you Mummy.”

“You’re welcome darling. Thank you for practicing your gratitude.”

Point out, through questioning, when *gratitude* is not expressed or is overtaken by *greediness*.

“I don’t WANT to leave the beach! I want to stay longer!”

“Are you practicing gratitude or greediness?”

3. Expose children to the experiences of others that would help them to appreciate their own privilege. This can be through physical visits, books, television, and conversation that help them compare their experience to the experience of people around them, or people around the world.

4. Use questions to help them to reflect on the practice of gratitude or greediness by characters in their books and television shows.

“Is Thomas/ Cookie Monster/ etc. practising gratefulness at the moment?”

Or “In that story who did you see practising gratefulness?”

5. At the end of each day, ask your child to identify the things for which he is grateful. As he grows, encourage him to recognise the non-tangible and more hidden aspects of his life for which gratitude is warranted.

6. Model the practice of gratitude for all things, big and small, in your daily life.



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MEMOIRS OF A PARAMEDIC

Jason currently practices as a lawyer in Canada. He previously spent twelve years working in pre-hospital care in both Canada and the Caribbean – the final eight-and-a-half as a paramedic. He lives in Regina with his wife and two children.

Before becoming a lawyer, I spent eight-and-a-half years working as a paramedic on an advanced life support ambulance: two-and-a-half years in rural Canada and six in a small Caribbean nation. My paramedic training required me to assist with a number of deliveries in the maternity ward of a hospital and, for the most part, these were nice, controlled deliveries with few complications. On the streets things are much more chaotic.

I will never forget my first field delivery. The downtown crew received a call for a maternity patient. The dispatch information seemed relatively straightforward, but both my partner and I had a feeling that something was off. We were stationed about ten minutes from downtown and decided to offer the downtown crew backup, just in case.

When we arrived on the scene, the downtown crew had loaded the patient into the back of their ambulance. I hopped into the back and asked the attending paramedic if she wanted any assistance. She said they should be OK, and I exited the back and closed the doors. But as they were closing, I heard the other medic shout, "Jason!" I opened the door and she advised me to glove up. The patient was lying on the stretcher and, when I looked down, I saw that the baby was crowning. I had just enough time to grab an obstetric kit (which contained such useful pre-packaged objects as bulb suction, a blanket and umbilical clamps) and put on a pair of gloves.

The next thing I knew I was coaching the patient to breathe and push (when necessary) as the baby was coming. After only a couple of minutes, a healthy baby girl was born. We wrapped her in a sterile towel, clamped and cut the cord, handed her to mum and headed off to the hospital. The mother was healthy; the baby was healthy, and it was a fantastic experience. A year later I ran into that mother in a restaurant and she told me that her daughter was doing well.

That first field delivery occurred about three weeks before my own son was born. Although I had delivered a number of babies in a supervised setting in the hospital, delivery in the back of an ambulance was a different experience. Fortunately, it prepared me for this next event.

About two years after my first field delivery, my wife was pregnant with our second child. I was working a night shift on the ambulance downtown (where the hospital was located) one night in January. My wife called at about 04:00 am to let me know that her waters had broken. My partner and I headed out in the ambulance to pick her up. We transported her to the local maternity ward, arriving at around 04:30 am. As the attending paramedic (and the expectant father) I told the nurse/midwife why the patient (my wife) was there. We were placed into a delivery room to sit and wait.

I advised the nurse/midwife that the patient's contractions had started at about 03:30 am. I further advised her that, during her previous pregnancy, the patient's labour, from start to finish, lasted less than four hours. My wife was about 2 cm dilated and the nurse/midwife opined that there was still a significant

amount of time before the baby would be delivered. The nurse/midwife made note of my comments and returned to the nursing station.

The remaining two hours of my shift were covered by others, and I was able to sit with my wife as a husband, not as a paramedic. However, my paramedic training was about to become highly useful. The nurse/midwife came in to check my wife at around 05:30 am. We were advised that she was dilated to about 5 cm and the baby was still hours away. My wife and I sat and chatted while her contractions intensified.

At around 06:00 am my wife told me that she felt she had to bear down. I went out to the nursing station to advise the nurse/midwife how my wife felt. She told me that the delivery was still hours away and that she would check on my wife in a few minutes. I returned to the room to find my wife experiencing intense contractions. She told me that she felt the urge to push. I moved her hospital gown aside and saw that the baby was crowning.

At that point I went from being husband to paramedic. I quickly grabbed a pair of gloves and coached my wife through delivery of the head. It was at around this point (while I was holding my baby's head in my hands) that the nurse/midwife walked in to check on my wife. Suffice it to say she was quite surprised to find the two of us in the middle of a delivery.

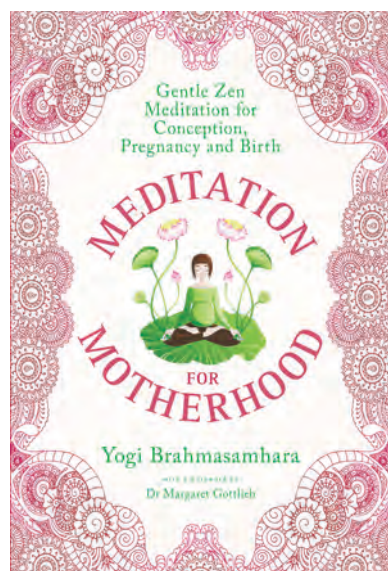
By the time the nurse/midwife had put on gloves, the delivery was nearly complete. At this point I was able to shift from paramedic back to husband. I supported my wife through the remainder of the delivery, and the two of us celebrated the birth of our daughter.

In the remaining three years I spent as a paramedic I had the opportunity to deliver two more healthy babies on the street. The controlled chaos of performing a delivery on a sidewalk by flashlight is something that I never imagined I would experience. Having the opportunity to welcome new life into this world is a rewarding and uplifting experience. Being responsible for welcoming my daughter into this world was unforgettable.



Jason on duty - taken one month after delivering his daughter

BOOK REVIEW: *MEDITATION FOR MOTHERHOOD*



Author:
Yogi Brahamasamhara

Foreword:
Dr Margaret Gottlieb

Published 2014

I am scrambling to get myself, my four-year-old son and my one-year old daughter ready and out the door. As I'm shoving snacks, water bottles, nappies and other typical paraphernalia into my bag, my son repeats a question ad nauseam: "Mum, can you help me draw a three? Mum...". I shut him down quickly with a cranky retort, then turn to see him scribbling away in pen all over the front cover of *Meditation for Motherhood*. Not a big deal, right? It's just a book and the scribbling doesn't impede its readability. But I am caught up in the moment, with a zillion other things on my mind, and so I start digging into the poor fellow. Before I get regrettably carried away, my husband walks in, surveys the situation, and slides the book towards me: "Keep reading," he says.

The old adage says 'don't judge a book by its cover', but I can't help it! I was enraptured by Yogi Brahamasamhara's *Meditation for Motherhood* the minute I opened the package and saw it: The tasteful, yet ornate, border surrounding a very Zen-looking Thumbelina-reminiscent figure with a baby belly is cute and it makes me want to be a) pregnant again and b) sitting on a lily pad surrounded by towering greenery.

Before I start reading from page one, I follow a bit of a ritual: I read the Foreword (this one by Dr Margaret Gottlieb) and flick through to the end. Immediately, the layout of the book strikes me as appealing. In my opinion, a self-help book lends itself to being far more helpful when it can identify its key concepts and highlight them in list form, in text boxes or in short, manageable paragraphs. *Meditation for Motherhood* has it all, so I'm looking forward to getting further into it already.

The book is divided into two sections: *Part One, Zen Meditation: Preparing and Practices*, and *Part Two, Putting Your Meditation into Practice*.

In the *How to Use this Book* section (p9), *Part One (Preparing and Practices)* is referred to as "your textbook". It is set up in

exactly that fashion, complete with photos, and serves as a handy reference. The information is easy to read and uses simple, clear, even colloquial, language without a whole lot of confusing jargon. Brahamasamhara (Brahm) concludes *Part One* by summarizing the main message that "...the practice of meditation and visualization during your pregnancy, as a minimum, will give you delightful moments of true rest, calmness and peace." Even if you happen, like me, to read this book whilst in a different stage of motherhood, i.e., not 'conceiving', 'pregnant' or 'birthing', you still come away from it equipped with the skills necessary to begin a meditative journey. Tension release, focused breathing and the various other key meditative techniques he explores here are useful regardless of where you are at in life, but he manages to easily maintain the focus of the book title and tie in how these key points and the practices described can apply specifically to labour and birth.

Part Two is undeniably the section of the book that gives it its title. Brahm takes the foundation set in *Part One* and puts it into practice, providing a month-by-month meditative landscape of a pregnancy, eventually delving into life with a newborn. Brahm's compassion for mothers is clearly evident in this section as he addresses and offers advice on a myriad of new-mum topics (such as the 'breast or bottle' dilemma, sleep solutions, and comfort and crying). I can't help but to feel here that the book

takes on a slight tendency to morph into another What-To-Expect-When-You're-Expecting-style reference manual, rather than maintaining a trajectory that more closely reflects the tone of the rest of the book.

This book, overall, serves well as a spiritual guide for expectant mothers, providing a good foundation for understanding the basics of Zen meditation and how to

incorporate it into real life situations.

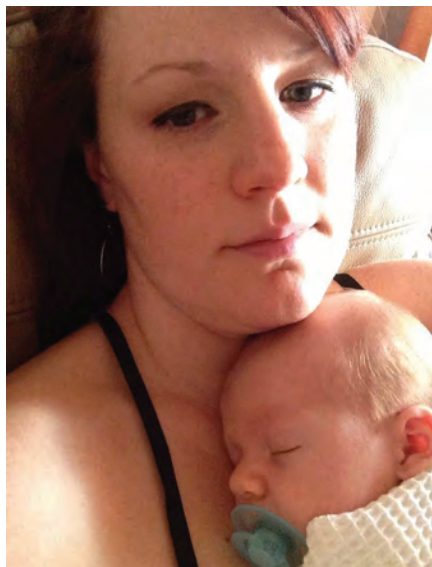
Now every time I look at the front cover of *Meditation for Motherhood* and see my son's handiwork all over it, I find solace through calling upon *Chapter Four, The First Essence: Letting Go Tension...* breeeeaaaathe...

“... the practice of meditation and visualization during your pregnancy, as a minimum, will give you delightful moments of true rest, calmness and peace.”

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CHARLIE, ME AND PND (POSTNATAL DEPRESSION)



Jessica and Charlie learning to cope with PND

Jessica is wife to David and mother to Charlie. Jessica originally hails from Vancouver, Canada as the third eldest of eight children. She has lived in Newcastle, NSW for the last 12 years. Jessica is a stay at home mum, who writes for her personal blog www.peachykeenmumma.blogspot.com.au

"I used to work as an office manager for a psychology practice. I remember one of the pregnant psychologists once said that if she ever developed Post Natal Depression (PND) she

would start medication for it straight away. She wouldn't hesitate. Forget the judgement and stigma of others: she would simply work on getting better by all means. How did I forget these important words years later when I had my own newborn? I was struggling to stay afloat in a sea of sleep deprivation, breastfeeding battles, lack of support and my baby's silent reflux. When you're drowning the world gets really small and blurry and it starts closing in on you."

I can see now that it began in the hospital, although I couldn't see it then. There's no switch that turns on in your head saying, "This is the beginning of your PND battle – beware!" I bonded with my baby Charlie; we had an hour of skin-to-skin time right after his birth. I would look down at his little jaundiced body and tears would spring to my eyes. I felt I was the most incredibly blessed person in the whole world to be his mum. He was mine; this beautiful seven and a half pounds of fleshy goodness, with ten fingers and ten toes.

Charlie took a very long time to breast feed, and the midwives who saw us thought that I was a very confident new mum, who was coping really well. That's what one of them told me. She said I was known on their ward as the woman who rarely buzzed for help. I thought I was doing an OK job, until my nipples started turning red and sore. Then the three-day baby blues and sleep deprivation hit. On my final day in hospital I begged to see the lactation expert before I had to leave. She came into the room and told me right away that my baby wasn't latching properly. So over the next couple of weeks I worked my butt off to make sure that he latched well. I would have to re-latch him over and over again. He really struggled. My nipples healed quickly, but the feeds were still long and arduous. Being new on the job, I didn't know how long it was *supposed* to take to feed your baby or how long to go between feeds.

From seven days old, if Charlie wasn't breastfeeding he was usually screaming or needing to be rocked to sleep in my arms. On day ten my little Charlie bear would just not stop screaming and we ended up in the ER that night. After a few hours there, and a blood test, the Doctor recognised that my son's weight was way below what it should have been and suggested that we

might need to mix feed him (breast and formula). The doctor wanted to keep us in overnight to wait on blood test results (as Charlie was still a little jaundiced). I, however, was a sobbing, exhausted mess, and my husband was also struggling to cope with Charlie, me and his job (having returned to work only a few days after the birth). I begged to go home so that we could all have a bed.

We came home and, at around 2 am, I got into a warm bath with Charlie, tears streaming down my face, trying to feed him again before we went to sleep. Thankfully, the next day I had a routine scheduled home visit from a nurse, and she said that I would have to continue mixed feeding as I must be having low milk supply issues. She also said to limit my breastfeeding times to 45 minutes, for my own well-being, and to begin pumping regularly after the feed for 10–15 minutes a side. I began taking a herbal concoction as well as starting a prescription medication to boost my supply of milk.

So continued my life on the lounge, breastfeeding and pumping and holding my baby while he slept. On top of all this, Charlie would wake up whenever he was not in my arms, so I was constantly holding him to get him to sleep. I had not been taught the subtle baby tired signs either, and I am sure that Charlie was also getting sleep deprived and over tired. I think I became a bit obsessed with my desire to breastfeed him. I never expected to feel so passionately about breastfeeding, but the mix of hormones and instinct had taken over, and my husband was extremely supportive and pro breastfeeding as well.

A friend wrote to me and suggested that perhaps Charlie might have posterior tongue-tie and be having trouble sucking and pulling with his tongue when he feeds. I'd only heard of the obvious kind of tongue-tie. I did a bit of research, checked under Charlie's tongue and thought that maybe this was the issue and, therefore, perhaps it was the solution. After all, I had never been completely convinced that I had a low supply of milk. When Charlie was 5 weeks old I called his paediatrician and asked whether he had heard of posterior tongue-tie. He hadn't, saying, "Did you get this information from an actual medical website?" He dismissed me. Then a couple of days later he had a very quick look at Charlie's tongue, said that there were no problems with it and that I must be the issue, with my low milk supply. I still don't understand why he didn't refer us to a specialist in posterior tongue-tie if he had never heard of it.

The weeks passed very slowly and I felt very alone. I seldom had visitors and felt that I was retreating into myself and my dark lounge room. I really wanted visitors who could bring a meal, or wash the clothes, or clean the bathroom, and not need to be entertained by me or my baby. I called my mum long-distance several times, crying into the phone and begging for her to come to visit me from Canada. The excuses were endless and empty and left me feeling hurt and even more alone. My mother-in-law lives a 40 minute drive away and, with her own large family, including an eight-year-old foster child, she could rarely help me out. Everyone else's lives were full and busy. Who could I call?

Through another distant friend, I learned the symptoms for silent reflux and worked out, with Charlie's GP, that this was why he was always screaming and could never be put down. Finally, we had a solution for Charlie's pain and part of his sleep problems. He started a prescription of Zantac and, when that didn't work, he began the adult pill of Losec, which was very tricky to administer.

At seven weeks in I called my friend Helen, crying, and told her I was struggling so much because I could never put Charlie down in his own bed. I just needed a break from holding him all day! David and I had decided early on to go to Canada and visit my friends and family when Charlie was 8 weeks old, and I became increasingly anxious about how I would even pack for us. Helen came over the next day, took one look at Charlie and said that he needed to be swaddled more tightly. She put him down in his bed, showed me some settling techniques, and he went right to sleep. After 20 minutes of silence from the bedroom she told me to go to look at him. He was asleep! I sobbed all over Helen's shoulder in disbelief. So began a new routine that Charlie fitted right into, and people had told me it couldn't be done with such a young baby. By the end of the week I had packed and cleaned my home and we were headed to Canada. I was feeling a bit more confident too.

In Canada, the mixed feeding worsened. Charlie wanted more bottle and less breast. At a party for Charlie, I slipped away to feed him and my eldest sister came to watch. She has a baby girl only a few months older and breastfeeds exclusively. I was telling her that I had milk, I was full, but Charlie wouldn't stay on at all. I remember saying, "Please tell me how could this be a supply issue? I have milk right now." My sister tried to get Charlie to feed from her and he wouldn't. She told me how she had just been looking into posterior tongue-ties, not even knowing my story, and suggested that this could be the issue. She told me about the top specialist tongue-tie dentist in the Vancouver area. I called their office and explained that we were visiting from Australia. They gave us an appointment for that week.

As soon as the dental assistant looked in Charlie's mouth she confirmed that he did have posterior tongue-tie and also a lip tie. I discovered that he had inherited both from me. My own never stopped me from breastfeeding as a baby, but they were still present, I just never knew it because I hadn't known what to look for. I thought the underneath of everyone's tongues would be the same (except for those with obvious ties out to their gum lines). My immediate response was anger at the paediatrician. Now Charlie was almost 12 weeks old and had little to no interest in the breast. At 5 weeks old we could have done something to help him feed. We went ahead and paid a very high fee for him to have both ties laser cut by the specialist dentist. I discovered that this dentist sees about two babies a day with the same issues. He said that most paediatricians and GPs do not know enough about posterior ties or lip ties and do not consider that this could be a problem with feeding. They often misdiagnose the mother with low supply.

Because Charlie was in pain all that next week he would not breastfeed at all. I was crushed. I had raised my hopes that this would work for us, but it seemed too late. I saw a lactation expert the day before I left Vancouver. She was exceptional and helped me to get Charlie back to at least mixed feeding.

Throughout our time in Canada we found that the routine Helen put Charlie on helped us to be quite social. We got out almost every day to see friends and family. I even bought some clothes for myself. I did, however, have huge dips in mood and days when I didn't want to go anywhere. A benefit of being on holiday was that I had my loving husband with me every day, battling with me to help our baby feed. He saw everything I had gone through on my own and could really empathise. I was also staying with my best friend, who was a great support. She also had a newborn a month apart from Charlie. I watched her feed her baby with ease, and she donated a whole lot of her pumped-milk to us so that Charlie could drink less formula. Motherhood seemed so easy for her, even with her three kids. I wondered

what was wrong with me that I couldn't cope as well as her.

When we arrived back in Australia, Charlie was terrible with his jet lag. By the end of the first week back I was a complete mess again. I could barely think straight. My thoughts were scattered and I found it hard to remember basic things. My closest friend in Australia tells me now that she felt she had to walk on eggshells around me. She said I was unpredictable, would get fixated on particular things and wasn't myself at all. I always seem to have an onset of terrible anxiety when I am sick, extremely tired or stressed. Perhaps I should really call what I was going through PNA, Post Natal Anxiety. The less sleep I got, the more anxious I became; the more anxious I was, the less I could sleep. I was caught in a downward spiral.

Over the course of those first months I had very regular visits with Charlie's GP, who monitored me closely for PND. After a couple weeks back I had a stint at a Tressillian family care centre in Sydney with Charlie. David returned to work. It didn't seem to help me much with the lack of sleep. The psychologist there suggested I go on anti-depressants. I called David to let him know. He was in denial about it, as I was. We just kept saying over and over to each other, "If you/I just had more help, more support and more sleep then you/I wouldn't be anxious." My GP told me that if I had a village to help me raise Charlie I wouldn't be experiencing all the difficulties I had, or at least I would be coping a lot better with whatever came along.

After five months of ignoring the fact that I did indeed have PNA, I finally took my doctor's advice and went on a low dose of anti-depressant. He warned me that most people aren't lucky with the first medication they try and that it could take weeks to get it right. Thankfully, after everything I had been through, the medication worked within a matter of days. I started sleeping more, I stopped hearing phantom baby crying, I started napping in the day a bit more often and thinking a whole lot more clearly. My edgy, anxious persona was slipping away.

So why didn't I do this sooner? Well, I think in my blurry mind there were two main reasons. The most obvious one to me was my belief that, if I just got sleep, I would be fine. This was true, but I would never get the sleep I needed when I was so anxious. The other was the stigma and 'hush-hush' associated with Post Natal Depression. I didn't want everyone thinking that I was on medication because I wanted to harm my baby. Unfortunately, I cared what people thought way more than I did about my own sanity, and that tore me down for a lot longer than I should have let it. I regret that.

Charlie is now 10 months old. I feel great. I just feel like my old self with a wonderful baby attached. I still wish he would sleep through the night, like any other mother. I am doing things for

me. I started blogging, cooking creatively as I used to, and really just enjoying being a stay-at-home mum, while sharing the joy of motherhood with other mums. I am still on medication because the chance of relapse is quite high in the first year, but I really don't care anymore who knows. The day my husband looked at me and said, "I feel like I have my wife back" was when I knew for certain that I made the right choice for all three of us. Next time I will trust my own instinct when it comes to my and, my baby's, health.



Jessica with husband David and son Charlie

OBSERVING THE MIND: THE KEY PRACTICE FOR MANAGING EXPECTATION AND SUFFERING DURING PREGNANCY AND BIRTH



Lauren Horton is a prenatal/postnatal yoga teacher, a doula (birth support person) and also prepares women for birth through birth workshops and energetic healing. She resides on the Central Coast, NSW with her photographer/yoga teacher partner and three-and-a-half-year-old son. She regularly writes about birth and pregnancy in her blog and is generally very passionate about women feeling good about themselves. www.singingbirdyoga.com

During pregnancy our thoughts are dominated by our expectations of how we should birth, how we will feel afterwards and how our bodies will perform. Our minds tend to overthink and put pressure on our performance in daily life too. We plan our days in advance and become frustrated when we don't get enough done, or when things don't go the way we expect. Most pregnant women will admit that they've contemplated their 'ideal' birth outcome at least a few times, sometimes more. This is not necessarily a bad thing, unless you become so attached to one outcome that you pin all your hopes and dreams on a single possibility.

It is all too easy for projected ideals and expectations to lead to suffering in one form or another. Suffering around birth often arises when the mind creates a version of our identity based on what we don't have or didn't get or do. We say things like: "If I had just... I would be happy." "If I had only done this... my birth would have been different." Or "Birth is going to be really painful. I don't think I can do it." By becoming attached to these phrases, mindsets and thoughts we start to believe in them as absolute truths, even though they may not be.

Seeing and hearing of friends, relatives or colleagues experiencing short 'pain free' labours, successful breastfeeding, easy postnatal recovery and a baby who sleeps through the night at six weeks, fills us with hope and positivity. However, it can also lead our minds to attach to these as 'ideals' for our own birth and baby. Similarly, negative stories often lead to an attachment to negative thoughts and outcomes.

Have you ever said or heard yourself say any of the following? "I want a natural birth and I don't want to use drugs." "I am not having a caesarean." "I am not using an epidural." "I am using an epidural as soon as I get to hospital." "I won't be able to handle the pain, I have a low pain threshold." "I'm scared of the pain of labour." "I can handle labour, I'll just breathe through it." These are some phrases that, as a doula, I hear often. These statements create expectations that are set in stone. This fixed mindset can have a detrimental effect and can potentially derail labour before it even starts.

It is easy to forget that birth is not just a physical experience. It is mental, spiritual, emotional and intense, in ways you may not have experienced before. Birth outcomes are influenced by a multitude of factors: emotions, specific events occurring during the pregnancy, muscular tension, pelvic alignment, fears, caregivers, birth location, past and present relationships, to name but a few.

The question is: How can we let go of expectation and have a satisfying birth and smooth transition into motherhood, regardless of the outcome? Labour is a unique experience in that you have to focus on one thing for up to 36 hours and sometimes longer. The key to managing expectation and suffering is to *practice observing the mind*.

For some people the practice of sitting in meditation and listening to all the thoughts arising in their head seems like torture. For others, meditation is something that they can't do, because they feel that it's 'impossible' to still their mind. Unless you are meditating for 24 hours a day, then stilling the mind is impossible for long periods of time. However, stilling the mind for moments at a time is definitely possible and an important practice for labour and motherhood.

The point of 'observing the mind' during meditation is simply to watch your thoughts, without judgement, and then let them go. To reap the benefits and notice a difference, observing the mind should be practiced on a regular basis, daily even. It can be a practice as short as five minutes a day, or maybe more. You can start slowly, sit comfortably, breathe naturally with your eyes closed and observe your mind.

During the practice of 'observing the mind' you may start to notice a pattern of thoughts or a regular line of conversation with yourself. A thought should not define you, tell you what to do, or tell you who you are. When we are more conscious and aware of our thought patterns and habits, we can start to determine what is just 'thought' or 'fear' and what is really the 'truth'. You can imagine how this practice could be beneficial during labour. In between contractions is usually a time when the mind runs wild, telling you: "I can't do this." "I can't handle the pain." "When will this be over?" Having a practice in place whereby these thoughts are just observed, rather than 'bought into' and believed, prevents them from holding any weight and lets them cause less concern. It is when a thought is believed that it comes true to you. This practice is challenging, and sometimes confronting, but vital to coming back to focus during labour, again and again, for however long it takes.

So if *you* find you are attaching to a particular birth outcome, perhaps stop and ask yourself what it is about the opposite of that 'ideal' outcome that is so unappealing, or not, for you. What does that thought say about you? What is it that you are avoiding? What expectations are you putting on yourself to have this outcome? Observing the mind, and noticing when you escape from the present moment, is key to unravelling and getting to know the deeper you. The best preparation for childbirth is to get to know yourself, and don't let your mind tell you otherwise.



KATANNING FIGHTS FOR REINSTATEMENT OF BIRTHING SERVICES

Katanning in Western Australia is another rural area where consumers are working hard to have their maternity services reinstated. Katanning is a regional centre in southern WA with a population of about 5000 people and a surrounding population of 5000. Two years ago the hospital maternity department was closed due to the 'departure of GP workforce required to maintain a 24-hour on call GP-Obstetric roster' (1). Since that time, women have been forced to travel at least 100 km to reach birthing services. Antenatal and postnatal care is still offered at Katanning Hospital.

I spoke with Paula Bolto, who has been leading the campaign in Katanning to have birthing services reinstated. Paula's first three children were born in Katanning, but her fourth was born last year in Albany due to the closure of Katanning's birthing unit. She said she felt she needed to do something pro-active about the loss of such a great service to her community. After Paula met with the Federal Liberal candidate for O'Connor, Rick Wilson, last year, a petition was drafted and subsequently signed by 4676 people before being tabled in the Western Australian State Parliament. It is still before the Committee of Environment and Public Affairs. Social media has also helped spread the word about the closure, with 1600 people liking the Save Our Maternity Ward at Katanning Hospital page. This Facebook page has made disseminating surveys and information simple.

The closure of Katanning Hospital attracted the attention of the researchers involved in the development of the Australian Regional Birthing Index, who visited the hospital in late February 2014. This project has been funded by a grant from the National Health and Medical Research Council with funding running from Jan 2012–Dec 2014. The aim of the project is to create a model aimed at helping health planners to make decisions about where to locate birthing facilities in regional areas (2). The team suggested that Katanning has the numbers of births that could support birthing facilities.

The costs to women and their families of having to birth far from home are not just financial: the emotional and social costs are great. Paula reported her greatest fears about birthing in Albany were birthing her baby in the car on the way to the hospital or the possibility that her partner might miss the birth if her labour progressed quickly. As it happened, she ended up having to spend three weeks away from home with her husband making regular trips to Albany while running their own business. It became so stressful for the children to be separated from her for an extended period and be cared for by other people that she took them out of school and brought them to Albany, so she could care for them. After waiting in Albany for almost three weeks, she chose a medical induction for her labour, so that the family could return to Katanning.

Another woman, pregnant with her first baby, was advised to head to Albany when she presented to the Katanning Hospital after her waters broke. She reported being 'close to having her baby in the car', which she found 'intense and scary' (2). Her baby arrived just 10 minutes after her arrival at Albany Hospital. In both this woman's situation and in Paula's, it was extremely lucky that there were no complications. Surely these two situations involving women with low-risk pregnancies and births could have been managed in a low-risk maternity unit in

their home town?

Staff at Katanning Hospital recommend that women go to either Albany or Perth at least two weeks before their estimated due date. For many, this is prohibitively costly and inconvenient, so it is not uncommon for some to wait 'until something happens' before commencing the drive to Albany (3). The Patient Assisted Travel Scheme (PATS) contributes to the financial cost of accommodation, providing \$40–\$75 per night (3), but this goes nowhere near meeting the real cost of relocating to birth. Paula reported that, in the preceding six months, there have been ten babies born at the Katanning Hospital while the maternity unit has been closed. One of these births was attended by the local GP obstetrician, while the others were attended by midwives. The women who birthed there were said to have 'presented pushing so they couldn't be turned away'. Of the women who have been transferred to Albany in labour, Paula reports three or four in the last couple of months have been born in the back of an ambulance.

Women in Beaudesert, Queensland have begun to birth again at their local hospital, ten years after birthing services were withdrawn (4). It is operating as a Midwifery Group Practice for women with low-risk pregnancies. The Newman Government continues to promise the reintroduction of similar services in Cooktown and Weipa (4), towns that are at least as remote as Katanning. Armed with the knowledge of what is happening in Queensland, Paula is preparing to visit her local State Member of Parliament to suggest they investigate what their Queensland counterparts are achieving!

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

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SIBLINGS ATTENDING BIRTH



We've been waiting a long time for this day, Mum, Dad, Bea, Janie and me. Mum's got pains in her tummy and that means her baby is ready to be born... Bea and Janie both saw me being born, but I've never seen anyone born. Mum has told me that she might make a lot of noise but I mustn't worry because that's what it's like when babies are born. She'll feel better if she yells and screams... Suddenly there's a little, red, scrunched-up face! "Hello, baby," I say quietly. "Hello."
(Hello Baby, Julie Overend)

This time last year, my husband, my eighteen-month-old daughter and I were in the last months of preparation for the arrival of our second baby. As all of our plans were coming together, one decision kept floating around that we were unsure just how to approach: where was our daughter going to be, and who was going to look after her? We were planning a homebirth, and our parents don't live around the corner, so the idea of letting her stay seemed a fairly natural one.

I quickly realised that few of my friends had more than one child, and probably fewer had planned second births like this one, nor, I suspected, given a great deal of thought to having older siblings around. So, whom could I ask?

A quick Google search will turn up plenty of opinions on the topic, from both extremes and everything in between. Some suggest that asking a child to witness a labour and birth is traumatic and cruel; others advocate for a child's involvement and ability to process what is going on. It may be that these opinions are heavily influenced by the holders' own views or experiences of birth.

The positives

Reading *Hello Baby*, I couldn't help being swept up in the cosy, heart-warming atmosphere of the whole family welcoming a new baby together. But it would seem the positives are not limited to simply a nice feeling. Most of the opinions and experiences that favour having siblings attend a birth seem to revolve around a key idea: children need to feel included, informed and that the adults are being honest with them. Some proponents suggest that, in a world where most popular culture representations of birth are of an entirely awful, traumatic and dramatic event, it is a wonderful opportunity to educate children from a very young age about how (potentially) beautiful, peaceful and normal birth can be. Others talk about small children being able to cope with more information and bigger concepts than we give them

credit for. Still others talk about being more honest with children who may otherwise invent terrible, and even more traumatic scenarios, in their heads about exactly how this baby is going to get out of Mummy. Some suggest that giving a small child tasks (like bringing Mummy washers for her face) that make them feel important and included is an incredibly empowering thing, while others tell of their own experiences of feeling very much excluded (and harbouring angst) when other people got to visit their baby brother or sister before they did.

The negatives

There are plenty of people who couldn't think of anything worse to inflict on a child than making them endure their mother's labour and birth. The reasons for this seem reasonably straightforward: if labour and birth are seen as painful, traumatic and possibly dangerous events, it would logically follow that this is not the kind of thing one would want to expose a child to. This would seem like a wise decision if this is your experience and view. However, it would also seem logical that if you are considering having your older child at the birth of a new baby, the chances are your previous birth experience/s, your plans for your next birth and your understandings of birth in general, are not be such negative ones. Even so, there are some potential issues that require some careful consideration.

The first is to consider your own needs as a labouring woman. A bored, needy, hungry or tired toddler or child could drain your energy or be extremely distracting and may affect your labour negatively. Secondly, even the calmest, most peaceful of births can still be extremely intense, possibly noisy at times, and involve plenty of blood. It is entirely possible that your child may react badly to this. Older children may find it extremely confronting to see their mother in such a primal state. Also, if you add your child/children and someone to look after them, your birth space may begin to feel quite crowded, especially if at your first birth you only had yourself, one support person and one caregiver most of the time, as I did. This 'audience' in itself could create 'pressure to perform' and, again, affect your labour negatively.

It is also prudent to consider the small chance of an emergency situation, realising that the presence of a child presents an extra layer of considerations including possible emotional trauma for the child and the practicalities of care and/or transportation.

There are also personal considerations. Kate, a 33-year-old mother of three, considered having her older children at the birth of her youngest: "I ultimately decided that each child deserved their birth to be just all about them and I wanted that space to focus on welcoming that child and the siblings could meet them later... and I am glad I did it that way."

Does the hospital allow children?

According to *Birthplace* (<http://www.havingababy.org.au/birthplace>), a resource for expectant parents providing a range of information on hospitals and birth centres across Queensland, most facilities accommodate 'other support people' including siblings during labour and birth. A small number do not allow children, and some mention conditions, for example that negotiation is required, that they are allowed during labour but not birth, or that an adult must be present to look after them.

As with all plans for your labour and birth, it is best to talk your ideas through with your caregivers, regardless of the 'official' hospital policy. Explain what you would like to happen, and listen to their advice/experiences with children at birth. If your caregivers are not agreeable to your ideas, you may find the stress or possible conflict outweighs the potential benefits to you and your family. It would also be worth including your wishes in your birth plan, if you have one, especially if you do not have continuity of care/in the event of having caregivers you haven't met before.

Other tips to make it work:

- Prepare and communicate: talk about it openly and honestly before, during and after the birth. One of my midwives suggested role-playing with my daughter using positions, actions or sounds I might use during labour. We also read books, talked about birth and watched a few birth videos online. Perhaps the most important part is to *listen* to your child (even if they are not particularly verbal yet) and to what they are *not* saying, and let them know that it is OK not to want to be there or to see what is going on. One particularly memorable story I read was from someone who had witnessed the birth of her baby brother at age five. She says her parents prepared her with books, photos and plenty of communication, and that the birth was natural and uncomplicated, but that she still found it extremely traumatic to see her mother in pain, a baby blue and screaming and the placenta. She felt unable to communicate at the time, nor for many years after the fact, that she had felt scared and wanted to leave, as others talked about what a great experience it was. She still wishes she hadn't been there. Perhaps the lesson here is to give your child plenty of opportunity to opt out, and not to let your own plans and dreams get in the way of your ability to listen.
- Have a dedicated caregiver: tied in very strongly here is a need to assign one person whose only responsibility is to take care of the child/children. In fact, some hospitals require this as a condition to having children present. Some careful consideration needs to go into choosing this person – it must be someone with whom your child is very familiar and comfortable, and that you feel is able to do much of the necessary listening on your behalf. Equally importantly, it needs to be someone *you* are comfortable with in your birth space, and whom you feel will respect that space. Your child may need to be fed, put to bed, entertained (perhaps quietly), taken out for a while etc., especially if your labour is long; each of these things needs to be planned for.
- Be flexible: as with all of your plans for labour and birth, it is wise to be flexible. It is OK to plan for something to happen and then have it turn out differently at the last minute. And it is OK for people (including you) to change their mind at the last minute. The time of day or night that you labour and birth may also require slightly different planning.

How did it go for us?

Being not quite two years old, I knew there was much our daughter wouldn't understand about what was happening, but I never saw this as reason in itself not to include her. Our midwife and student midwife were very open to having her around. She was included in conversations and activities during all my antenatal appointments, and I remember my midwife saying that (being a homebirth) she shouldn't necessarily be made to leave her own home while I have a baby. When we met with our second midwife at 36 weeks, she suggested role-playing, which I incorporated (to a degree, I could have done more) over the final weeks of my pregnancy. I asked a friend whom my daughter knows well, who has a daughter the same age, and who had a homebirth herself to come and look after her.

I laboured gently through the day and we went about our normal activities. My husband came home early and kept my daughter occupied as he helped prepare the house. Our daughter thought this was the best party ever, with a mattress on the floor that was surely there for her to run in circles over, a movie on and pizza for dinner. We asked my friend to come in the evening to help with bedtime, as labour intensified and I needed more support from my husband. In the event, I birthed just after 11 pm, roaring with each contraction for 15 minutes or so as I pushed my baby out. I can't really remember whose decision it was not to wake her (or maybe just a lack of decision/action), but our daughter slept, just on the other side of the wall, through the whole thing. She did wake maybe 20 minutes later, and I remember it was my husband who suggested we just put her back to sleep, leaving it until the morning to introduce her to her sister, as we probably could do with some quiet time rather than an excited toddler to try to calm down again. It was fine. Ten months after the fact, I still have really wonderful feelings and memories of this birth. I think our willingness to remain flexible helped to ensure that things went smoothly, and I feel satisfied with the decisions we made around supporting and including our daughter.

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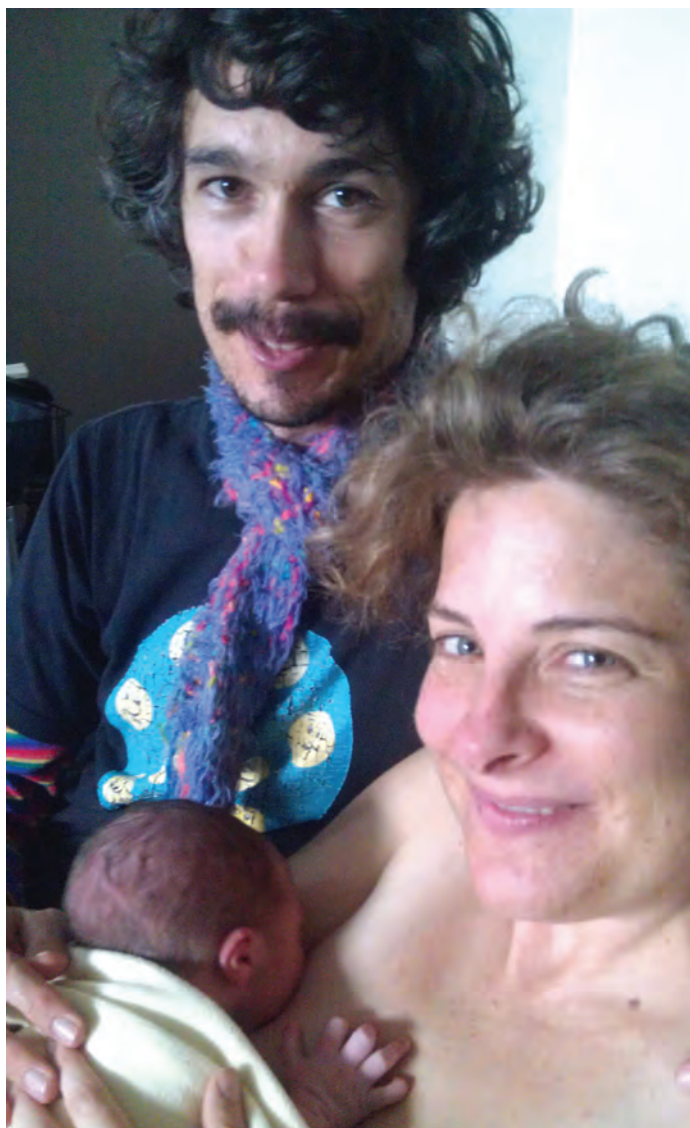
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YOUR FUTURE, YOUR CHOICE!

DEAR HUGO



Jacquie with Oliver and baby Hugo

My brand new, dear, gorgeous baby boy, you are lying on Ollie's knees waving your little arms in a circle, wearing the dark and light blue striped romper that Max wore at the same age. You have a dear little receding-hairline head and wide clear eyes that haven't decided yet whether they are blue or brown. I remember clearly when you emerged, a tiny living miracle squeezed from my body and up onto my chest. You were a minute curled up creature, with the amazing soft squishy head of a newborn, looking up at me in the unrepeatable moment of first seeing each other. I will never get over the miracle of it.

I had been impatient from 37 weeks. Max came 10 days early and so I expected you to as well. But you didn't, you moseyed on in there until 40 weeks two days on 29 June 2012. I had been feeling period-type pains for the week beforehand, so when I started having stronger ones every half an hour or so from 2.30 am on the day that you were born, I didn't think much

of it. Even when there was a mucus plug, I just did that thing I do: discounting it as 'probably nothing', not wanting to get my hopes up that the moment was soon to arrive... I rang the midwife (Margo) and she agreed that you might come today, or next week.

I did feel as though I was in labour though, if only a slow starting one. The three of us walked down to the cafe and, on the way, I rang Mum. I said, tentatively, that I thought something was happening, but it may not be, so, you know, maybe they could come down, but we'd call them later to confirm. At the cafe we sat waiting for takeaways and I continued to have mild contractions that didn't seem to be of any real note. (Georgie, the barista, couldn't believe that I could be sitting there drinking coffee while going into labour, but I said that it could take days, it didn't really mean anything.)

“ I was overcome with joy. I shouted, “Baby! Baby!” because I couldn't believe you had been born and there you were and you were alive and beautiful and ours. ”

By the time we got home, it was 10.30 am and, as I sat on the couch trying to read my book, contractions started coming every 8 minutes. I would get down on the floor and lean against the couch while they were happening, and read my book in between. Ollie asked whether we should call my parents to confirm that they should come and we did so, although I still I didn't feel sure that anything would be happening. My hesitation seems ludicrous now in retrospect! We rang Margo again and said contractions were every eight minutes. She said to come in when they were every five minutes and then, a few minutes later, they were! So we rang Margo again to say we were coming in, rang my parents to ask them to meet us at Belmont hospital, and got in the car.

I had ferocious contractions on the street as I got into the car, and then they came every three minutes all the way there. By the time we reached the car park they were down to every 30 seconds. My parents had already arrived. Passers by in the car park looked on curiously: a woman in natural labour! I felt quite proud! My dad wanted me to hold his arm on the walk from the car park, but I said, “No. I just want to walk.” I had to stop every 30 seconds to lean up against something to moan and then scream.

We reached the hospital corridor and I felt like I had to push. Dad told me later that he could tell by the sounds I was making that the baby was coming *now*. He wanted to get the midwife, but we made it into a lift, then into the birthing room. Then it was clothes off and into the bath. I knew what I had to do this time: push! There was a lot of yelling (by me) and a few instructions from Margo (move your leg to the right, sit back, keep your bottom under the water). She fetched me a straw for the water I was desperate to drink. Then you came out, like a

dream, 30 minutes later. I couldn't believe I was looking down and there was your head, and then the rest of your dear little body, and there you were on my chest! I was overcome with joy. I shouted, "Baby! Baby!" because I couldn't believe you had been born and there you were and you were alive and beautiful and *ours*.

I didn't want to birth the placenta, "Do I have to?" I just wanted to bask in the joy of you! But it came out 15 minutes later, and I got out of the bath and held you on the bed. You fed, and I was entirely wrapped up in the beautiful oxytocin calm of love and contentment.

We lay with you for a while, and then dear Max came in with Mum and Dad and looked at you with thoughtful curiosity. I was so excited to think of the life the two of you would have together. At 39 I had been afraid that the miracle couldn't be repeated twice. Could I really have two incredible, perfect babies, at my advanced age?

With Max's pregnancy I had diabetes and hypertension. The midwives and the obstetrician were watching everything every step of the way from about 28 weeks, with fortnightly trips to the hospital, multiple ultrasounds and a tedious diet. But you did brilliantly in my 39-year-old body. There was no gestational diabetes this time, no need for blood sugar tests when you were born, no need to give you formula to stave off the fear of sugar meanies. You were tiny and perfect. Although you were just two days overdue, by your birth I felt like I had been pregnant for about a year. My tummy seemed too small to fit a human being inside. I kept trying not to bend over too much in case I squashed you! As it turns out, you were the perfect size, as you are perfect in every other way: 3.3 kg, with a dear little head of 32 cm that was easy to squeeze out! (Perhaps I'm simplifying a little, but I have no doubt that it helped.) My body effortlessly produced a human being, to term and without incident.

In your warm soft perfection, all the worries of the pregnancy – listeria; remembering my vitamins; avoiding anything toxic; worrying about potentially toxic things I *didn't* avoid, like the Mortein flea bomb (that failed to get rid of a bird mite infestation in the roof of our new house); sanding the treated

pine fence palings (arsenic!) and then painting them (solvents!); the painting class (ditto); the potential of a car accident; the interminable list of things that could go wrong – all that vapourised, and I felt only the lovely peace that I still feel when I look at you now.

WHAT THE HECK IS A DOULA?

A DOULA is a non medical birth attendant offering support & information to parents during pregnancy, childbirth & the postnatal period.

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"The ADC Doula training, far exceeded my expectations!" Kate Draffen

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EVALEIGH'S SPONTANEOUS FREE BIRTH



Julia and Evaleigh moments after birth



Julia and Rhys with big sister Sorayah and newborn Evaleigh

Julia Bevan is 25-years-old and married with two children. She had her first child, Sorayah Emmanuela, at Belmont Hospital in June 2010 while in her final year of studying radiation therapy at Newcastle University. Her second little girl, Evaleigh Luca, was born at home in April 2014. Both births were under midwifery care and both were very positive, although very different, experiences.

It took until a couple of months into my second pregnancy to decide whether or not to have a homebirth. We had had such a beautiful water birth at Belmont Birthing Centre with our first that we considered trying to replicate the same experience. We were also sharing a house with my two brother-in-laws, and I wasn't sure how comfortable I would feel about asking them to leave if labour were to begin in the middle of the night, although they would have been more than happy to give us the privacy we desired. After talking extensively with my midwife and husband, we started leaning more towards a homebirth, with the birthing centre as our second option in case things didn't work out on the day at home. Homebirth through Belmont Midwifery Practice is publicly funded by the government and cost effective for the hospital. There would be no need to rush to the hospital and I could labour as long as I wanted at home. In the end there were just too many pros not to choose a homebirth.

In preparation, I began to watch and read about the positive homebirth experiences of other women. I found these very encouraging and empowering. They solidified even further our decision to birth at home. I started reading through Ina May's *Guide to Childbirth*, as I had done in my previous pregnancy, just to be inspired again by all the wonderful birth stories and her positive take on birth. I had also written up and laminated birth affirmation cards, which I would read through most nights before going to bed, reminding myself to trust my body and my baby, let go of all the anxiety and fear and ride the waves of the contractions. Amongst the cards, there was a picture I had drawn of a circle with a 10 cm diameter and a caption that read, 'You will become this big, you will see your baby soon.' This had sentimental value to me as I had used it in my first labour.

I was once told that labour is 95% a mental challenge and 5% a physical challenge, so my main focus was on inundating my mind with positive stories, images and video clips, knowing that my thoughts would greatly affect the way that I perceived and managed labour pain. Yet as much as I wanted to remain positive about birthing again, there were still underlying issues and doubts that I needed to face if I were to achieve the beautiful homebirth that I so desired.

I found that I was more anxious about this impending birth than I had been first time around: I knew what I was getting myself into this time. Although we had a positive experience with our first, the unknown, and the possibility of having a different birth experience, scared me. I don't like change. I wanted to remain in control. If I could have chosen the same birthing experience as our first, then I would have, but that's just not how birth works. So it truly felt as though I was preparing myself for another first birth and facing a different set of fears and anxieties than before: the fear of change and letting go of the things I could not control. I would talk openly about my fears with my midwife Kim, who assured me that I needn't be fearful, but should expect my second birth to be easy, quick and wonderful. So these were also some of the words I wrote on my birth affirmation cards, positive and beautiful reminders that I need not fear birth, but could accept whatever may come and embrace the change.

Another challenge I had to face was the possibility of not having Kim around to help me birth, as her rostered shifts and holidays around my date of delivery meant that there could be no certainty that she would be available. I placed considerable value on having her there, and I felt insecure and anxious about the idea of birth with any other midwife. It was my controlling nature, wanting to replicate my first birth and needing Kim's presence and support again this second time around to repeat that first experience. I remember that, at my final antenatal appointment with her, I specifically asked her to affirm to me that it didn't matter who would be at my birth, and that it would be the right person at the right time. She then plainly stated, "The most important people at your birth Julia will be you, your



Evaleigh happy and calm after a quick homebirth

baby, your husband and your little girl.” Powerful words, etched into my memory forever, as that was exactly how our birth story unfolded.

On Sunday 27 April at around 4:20 pm, I was showing Sorayah images of her water birth, explaining to her the beauty of birth, although, naturally, interpreted to a three-year-old’s understanding. I started to relive those images again, tearing up as I was trying to relay the story to her, when suddenly I felt the first contraction. It must have been a combination of elevated oxytocins levels and a ripened baby that triggered labour, but I chose to ignore it and to continue with the slideshow. Shortly afterwards, I had an urge to go to the toilet and I discovered a streak of blood in the mucous. I had a couple more contractions, but I chose to ignore them, although at the back of my mind I was excitedly thinking that this was the start of labour. I didn’t want to be consumed by doubtful thoughts about how long this labour would last or whether it was really labour. Especially as the contractions that I was experiencing were all in my back, completely different to my first labour where they were all at the front and felt more like shooting period pains. This just felt like bad back pain. So I began cleaning the house, folding the washing, doing anything to get my mind off these doubtful thoughts. However, secretly I was excited, knowing that I was going to meet my baby soon.

At 4:40 pm I went to the toilet again and this time I bled much more, experienced closer contractions, and thought it best to let

my husband know and ask my brother in-law to kindly leave the house. I was a lot more certain that this was labour. Rhys was very excited. We were both so happy that I was in labour and we started setting up the candles, music, birth affirmation cards and running the bath. Meanwhile, I had called Kim at around 4:55 pm, explaining to her that I had lost my mucous plug and was having a couple of contractions. She clarified again with me whether I was wanting to birth at home, and I told her that this was definitely where I wanted to birth as I felt safe, loved and supported right here in my own home. She advised us to give it an hour, time the contractions and call again once I felt that I needed the midwives there. However, this baby had other plans: within the space of half an hour my contractions had become 4 minutes apart, so we quickly called the midwives as I felt things were progressing far more quickly than expected.

In between contractions, Rhys and I smiled at each other. He would tell me that I looked beautiful, creating a positive environment for not only myself, but for our little girl. She would occasionally come up to me and rub my belly and hug my legs, asking if I was OK, I would explain to her that I was, and that we were going to meet our baby soon. Shortly after the phone call to Kim, my contractions became two minutes apart and increased in intensity. I had a real urge to bear down, dry heaving as I was reaching the peak of a contraction. I constantly felt the need to keep moving, swaying my hips and rubbing my back as each contraction flooded my body. Within the next couple of contractions, my waters broke onto the bathroom floor and the baby’s head immediately started descending. I called out to Rhys, telling him that I could feel the head, he quickly told me to get into the bath, and so I did and continued to birth the rest of her head. I remember Rhys telling me to remain in the water and to push the baby out with the next contraction. I stayed calm and could feel her head in my hand, feeling her neck and making sure there was no cord around it. The next contraction came and we pulled her up onto my chest. That was it. She was out!

Meanwhile, Rhys was frantically calling the midwives who were 10 minutes away, to let them know that I had given birth and to ask for prompt instructions on what to do next. It was surreal. I could not believe that I was holding my baby. Everything happened so quickly. There was just so much to process. We were instructed to put towels on the baby to keep her warm and to rub her vigorously until we heard her cry. Then there it was, a little sputter and gurgle and her first breath, we were overjoyed! There she was, breathing and alive and safe in my arms, our baby girl. I started to cry and to laugh. I was in a state of complete euphoria and bliss! It was beautiful to smell that precious scent of birth on her head, and to hold her warm little body on mine. It was perfection. There we were, just the four of us, amazed with our little addition and the speed of her arrival into our world.

And so we ended up free-birthing our baby girl Evaleigh Luca Bevan at 5:56 pm after a one hour labour, with the midwives arriving shortly after to help deliver the placenta. I felt safe knowing that my midwives were on their way, supported by my husband’s strength, faith and positivity and I had trusted my body to safely deliver our baby girl. It was easy, quick, wonderful and more beautiful than I had ever imagined. I would not change a thing about our homebirth experience, all the right people were there at the right time – just the four of us – and, as Kim kept saying, “That was the way it was meant to be.”

THE HBAC (HOMEBIRTH AFTER CAESAREAN) STORY OF RUBY JANE ASH



Ruby's first moments with mum and dad, Nicole and Matt

The prelude: My first pregnancy was in 2009. I had planned a natural water birth in hospital and we had completed a Calmbirth® course. Unfortunately, my natural birth plans were not to be and, after a 30-hour labour, I agreed to an epidural and artificial induction. This birth was eventually an emergency caesarean, followed by a rather nasty infection, two further hospital stays and a follow-up operation to clean and repair my wound. Needless to say, healing was difficult and I still yearned for a natural birth experience.

At 12 weeks pregnant I began planning my hospital VBAC (vaginal birth after caesarean) with my community midwives. I also enlisted a student doula and began going to prenatal yoga with my doula, Lauren, as my teacher. I also started attending a VBAC support group, where I met homebirth midwife, Lisa, to whom I proclaimed that I could never have a homebirth – too scary!

The hospital staff seemed very encouraging of my VBAC plans, so I was confident that I would experience the natural birth I wanted. Unfortunately, after two borderline (and really only just borderline) tests for gestational diabetes, I was transferred to the high-risk clinic antenatal care. I was no longer allowed the care of my community midwives. I was also to be restricted by hospital policy regarding the use of water during the labour and birth and the 'compulsory' use of a foetal monitor. I debated and debated my case with the midwives, the doctors in the clinic and anyone who would listen, but I simply wasn't being heard and I knew that a natural birth was slipping away from me.

At 33 weeks I felt that I could no longer fight for a natural birth, and I didn't believe that I should have to. Under the care and advice of my doula, I meditated and asked my baby where she wanted to be born. After a short nap, I received a very obvious 'at home' message. After lengthy discussions with my

husband, we decided to meet with Lisa (the midwife from the VBAC group) to discuss our options. At 34 weeks we began our homebirth journey.

During the final six weeks of my pregnancy I had one appointment a week with Lisa; each meeting was as encouraging as the next. It felt natural, normal, and safe. I really started to believe that we'd have our baby naturally and at home. I had a mini-blessingway, belly henna, made placenta plans and got ambulance cover – just in case. We didn't tell many people about our change of plans and it felt nice that it was private and just for us.

The birth

On my expected due date, 14 June, I was woken at 3 am with mild contractions. I continued to doze until 6 am, when I sent a text to Lauren and Lisa saying that I was feeling mild contractions and that today seemed like a nice day to have a baby.

Later that morning we sent our two-and-a-half-year-old son to preschool as usual and I packed a bag for him to spend a day or two at my Nana's house. I had a good breakfast of eggs and toast. My parents were returning home from a two week cruise today and I knew that my Mum could stay at Nana's to help if need be. Subconsciously I think I was waiting for my Mum to get home before having our baby. I knew she was worried about my planned homebirth and I wanted her to know that we were OK. I also wanted her to help my 81-year-old Nana with our two-year-old.

Food is important to me and I love cooking. I had been planning my post-birth meals for a few weeks and, at 10 am, I put a beef and red wine casserole in the slow cooker. I wanted this to be my first 'real' meal after the birth. At 11 am I was tired of having contractions that didn't seem to be doing anything

and so I took a nap while listening to my Calmbirth® CD.

I woke up and had some left-over chicken soup for lunch. Later in the afternoon I cooked a groaning cake for post-birth birth-day celebrations. All day I had been drinking water, walking, napping, eating, cooking... and contractions had continued on and off, becoming regular and then dropping off again. I was feeling a bit deflated, so once again I went to bed and took a nap, this time listening to Shamanic drums.

When I woke I was quite disheartened. I felt that my contractions had stopped again and that I wasn't progressing. The last remaining fears from my first birth were coming to the surface to be dealt with. My husband Matt said he had heard me have two contractions while I was sleeping, but I didn't believe him. Who sleeps through contractions?

At about 4 pm I spoke with Lauren, and she helped me to verbalise my fears about not progressing. I had a bit of a cry and she reminded me to trust myself and my baby. Then Lisa came for our 40-week check-up and I had another little cry. She checked the baby's position and assured me that she was not posterior (another fear which stemmed from the first birth) and that we were all perfectly prepared for the birth. During her visit my parents returned from their cruise and were at our place picking up their car. I could feel my contractions becoming more regular and a bit more intense, but I was still not convinced. I was sure they would drop off again and that I'd be in pre-labour for days!

Everyone left at about 6 pm and that is when my labour really kicked in. I recall having a few quite intense contractions and wondering why Matt was in the kitchen. Apparently he had decided it was dinner time and was cooking sausages and chicken chippees. Each contraction was obvious from my verbalisations, and Matt would come running from the kitchen and put pressure on my lower back. The verbalisations I practised at yoga were amazing at helping me through each contraction, and the counter pressure on my back reduced their intensity by about 50%. At some point I allowed a chicken chippee into my mouth and immediately regretted it. Then I remember thinking, "Why did I let Lisa go home? And why haven't I called Lauren yet?" My labour was real, it was in full swing now and no one was here!

My husband called Lauren and she was at our place within 20 minutes. It was about 7 pm and things were becoming serious. I was labouring in the bathroom, which came in handy when I had to use the toilet! Lauren made me a labour aid drink, but I think I was already too deep in my labour to appreciate it. I kept sipping water, but only because someone kept shoving a straw in my mouth. (Thank you, someone.)

Suddenly... or gradually... I was in transition. I felt completely out of control, yet completely in control, at the same time. I had previously given myself permission to let go and just surrender to the process, so essentially I did not need to be in control. Here my memory gets hazy and I thank the birth gods for all those lovely labour hormones.

I got into the shower and put my head right in the corner against the tiles. As I verbalised my 'ohms', 'haas' and 'ohhhs' I could feel the humming vibrations all around me. I remember thinking, "Yay for wall-to-wall tiling and its wonderful acoustics," although I'm sure my neighbours disagreed.

Somewhere around this point Lisa returned, although I have no recollection of who called her or when. I knew she had arrived, but her arrival was so peaceful and quiet that I barely noticed it. She was simply listening to me labour. I'm sure she also came and checked the baby's heart rate at some point, but I don't recall. I do know that, in the midst of transition when I

almost lost my mind completely, she laid a quiet hand on me and made me feel that everything was going to be all right.

It was about 9.20 pm when my water broke with a very distinct 'pop' and, amongst the labour haze, I was able to stop and say, "My water just broke." It was a very exciting moment for me as it didn't happen in my first birth and it made my experience feel different, defined, positive and uplifting.

I knew the birth pool was full and Matt had suggested a couple of times that we go to it but, during transition, this just felt like too much. I wasn't sure I could have a contraction in the hallway without having a complete meltdown, so I waited. During each contraction Matt had stayed by my side and now, during transition, he never faltered, using counter pressure, encouragement and breathing with me to help me stay focused. His unwavering support is etched in my mind forever.

Although I didn't know it at the time, my contractions had changed and I was getting 'pushy'. It was at this point that I felt ready to get into the pool. So I did the walk and, as soon as I got one leg in the pool, I pretty much jumped in. Lauren had done the most wonderful job of completing our birth space with aromatherapy, music, candles and, most of all, her divine presence and belief in me. The lights were off and Lisa was calmly watching with her little torch at the ready.

As soon as my body was immersed in water I felt the haze lift; transition was over and I was pushing. Each contraction was an opportunity to help bring my baby into the world and I wasn't going to waste a single one. My yogic chanting had had its time and was now gone. In its place was a raw and powerful noise that came from deep within. I felt like a lioness roaring for her cub.

After a few pushes I realised that I had no idea how dilated I was... another fear creeping in. I stopped and said something along the lines of, "I'm pushing. Am I pushing? I think I'm pushing. Should I be pushing yet?" A simple nod from Lisa was enough to help me realise that this was going to happen and that I simply needed to trust my body and go with it. So, back to being a lioness!

I don't recall the pushing being painful at all. I remember the pool being replenished with hot water from pots on the stove, the smoke alarm going off from too many hot pots on the stove, not letting Matt go to fix the alarm because I would not let him out of my bear grip, then one tiny little sting – one little tear – and she began to descend.

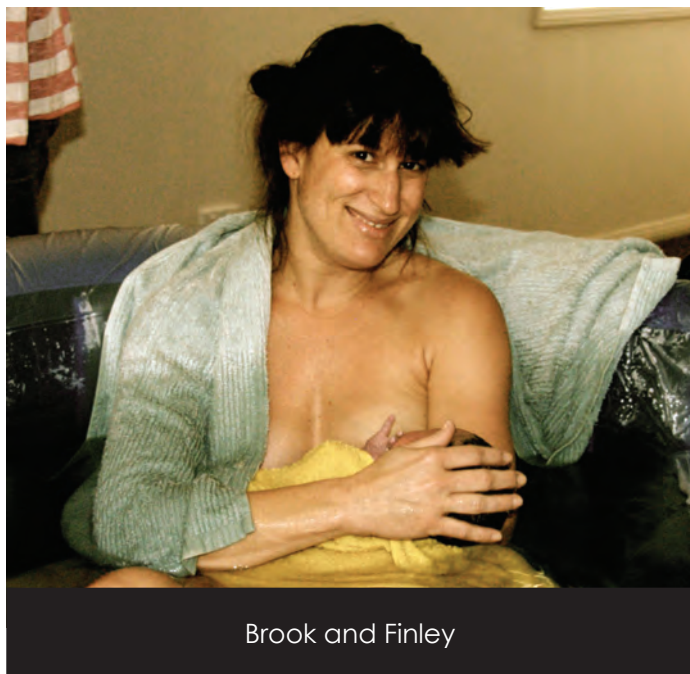
Slowly, during each contraction, I felt the head of my little girl move down and back up again, slowly stretching the space. My pushes became stronger as her head moved further down. I even felt my pelvic bones readjust to make more room and I roared, "Open," to encourage this movement. I also remember stopping at some point to say, "I can so totally do this!" To which everyone smiled and agreed. A short or long time later (time had no meaning) my baby's head emerged, and I took a little break. Then, in a couple more pushes, her body was born. Although we had planned for Matt to catch her, I was reluctant to release him from my grip, and so our wonderful midwife Lisa brought our baby to my chest and I breathed her in, taking in everything I could.

Ruby Jane Ash was born at home into water at 10.34 pm 14 June 2012 weighing 3.9 kg (8 lb 8 oz) and 52 cm long.

The placenta followed about 45 minutes later and Lauren made a few simple prints onto paper. We followed that up with some lovely skin-to-skin time, breastfeeding, a huge glass of milk and a piece of groaning cake. Happy birthday baby!

By 2 am we were all tucked safely into our bed and our house was quiet again. It was truly amazing.

THE BELLA BIRTH OF FINLEY SAMUEL HUMPHREYS



Brook and Finley

Before I begin Finley's birth story, I need to go back and tell you a bit about my first birth. My first pregnancy was uneventful. I felt great and looked forward to welcoming my baby the way Mother Nature intended. I did yoga, ate well, exercised and prepared myself by reading plenty about natural birth and active birth techniques. I skipped the parts about cesarean section: I wasn't having 'one of those'. The thought did not even enter my mind as an option. That turned out to be a mistake. It left me very underprepared for what eventually unfolded: an emergency c-section for distress after 14 hours of labour.

This first birth put me on the path to my VBAC. I started reading positive information about VBAC and joined a VBAC group, where I met some lovely mums, doulas and midwives who were all very supportive. It was so nice to be in a room talking with other women who had experienced what I had. They knew how I felt. They understood. I never really discussed my true feelings with friends and family as I just thought, "Unless you've had a cesarean you can never fully understand how I feel."

We fell pregnant when my daughter was 22-months-old. We were excited! My husband, Nick, and I had been reading plenty of empowering and positive HBAC stories and we were starting to warm to the idea that we could have a homebirth. I'd also been hearing of other women's struggles with the hospital system for their right to birth how they wanted. I didn't want any negativity, doubt or hospital bureaucracy surrounding me.

Sadly, that pregnancy ended in a miscarriage. We took some time out to grieve and, in the time before we fell pregnant again, we decided that, when we did conceive, we would be having a homebirth with an amazing independent midwife and a close friend who is a doula.

Five months later we were pregnant again! We booked our homebirth and never looked back. Our midwife was a constant source of information, support and woman-centred care. It

was very special having her come to our home for antenatal appointments, often for hours, to chat about anything and everything. Our daughter loved her too. She knew us and we knew her. I did yoga every week and I had regular chiro and reflexology. I rested and I ate well. We did a birth workshop and Calmbirth® classes.

We felt safe. We felt loved. We felt prepared.

The final couple of weeks of my pregnancy were tiring. My body was heavy, I had a lot of pelvic pain, many strong Braxton Hicks contractions and a busy 3 year old to look after, but I remained calm and relaxed. I never once doubted that I could birth this baby out of my vagina!

On Sunday 7 April I went to prenatal yoga as usual, then we went about our afternoon as usual. That night my friend came over to do some Reiki on both Nick and myself. My friend left at about 8.30 pm and then her partner came over to watch cycling on TV with Nick. I showered and went to bed at around 9.30 pm as I was totally uninterested in the cycling. I checked Facebook, returned some emails and text messages and turned the light out at around 10.30 pm. I was woken briefly at 12.30 am by the guys' muffled cheering, but went back to sleep quickly.

The next thing I was aware of was waking up with a slight cramping feeling. I think I must have been having a few cramps in my sleep. I glanced up at the clock: it was 2.55 am. I closed my eyes and waited. Again, I felt a period-like cramp creep in. I glanced at the clock again and it was 3.10 am. I started to wonder... Again I closed my eyes, only to feel that cramping sensation once more. I looked at my phone: it was 3.22 am. Hmm... I think today is the day!

I opened my contraction timer app and timed a few more 'cramps'. They were coming pretty much every 12 minutes. After about an hour, I still hadn't been able to go back to sleep. I think I was too excited. Nick was woken by the light from my phone and I told him that I was having mild contractions. He brought me a hot water bottle, which felt good and eased the sensations. I wanted to stay in bed for as long as possible, as I didn't know how long this was going to take and it was the middle of the night anyway, so I put my earphones in and listened to my positive birth affirmations.

Two hours passed; it was now 5.15 am. I decided that it was time to text the midwife, Lisa and doula, Lauren. I said to Nick that I thought it was a decent enough hour to wake them. I can't believe now how concerned I was – I'm pretty sure, given their job titles, they're used to being woken at all hours! Oh what strange things a labouring woman worries about.

Over the next 45 minutes my contractions moved to 9 minutes apart and started lasting for about 60 seconds. I was still listening to my birth meditation. It was 6.05 am. Lauren and I texted back and forth a bit more about how I was going. I was still lying on my side breathing through the waves. Lauren talked about Mina being at kindy that day and that's when I thought, "There's no way she's going to kindy today. We won't be driving anywhere." I knew it would be soon. The last message Lauren sent was at 6.30 am. I didn't reply to that one. I was now unable to lie on my side and instead I was on my knees, head down over a couple of pillows. I was putting all my focus into my contractions. Over the space of 25 minutes they

had gone from 9 minutes apart to about 4 minutes apart!

I had Nick call Lisa, as we hadn't heard back from her yet. (It turned out that she had sent me a 'dream' text!) He casually told her that my contractions were about 7 minutes apart, but he wasn't even timing them! As I bent over the pillow next to him I crankily said that I'd just had two in the time that he'd been talking to Lisa and another as he hung up! They were definitely about 3 minutes apart now. I told him to call her back and ask her to come now. I was concerned that it was after 7 am and, by the time she got ready and left she would get stuck in school traffic (it was Monday morning) and her usual 30-minute journey might take even longer. Lisa and Lauren were both now on their way.

By 7.05 am I was leaning over pillows propped up on the side of the bed. I spotted Mina at the bottom of our stairs looking a little shocked. She'd just woken up and came up to see what was happening. I was vocalizing by this point with 'ahhhs' and 'ohhhs'. I asked her to come up and told her that Mummy was having the baby today. We had prepared her well for this, so she knew what was going to happen (to some degree).

I don't really recall times from now on, but I now had the urge to use the toilet, so I made my way through to our ensuite and sat down. I couldn't go. Now that I was upright things ramped up again. I had the longest contraction whilst sitting on the toilet. I'm sure it lasted about two to three minutes! I got up and ripped off all my clothes. I felt hot, clammy and flustered! I went straight onto my hands and knees; the cool tiles were heaven! Lauren had arrived at this point and kicked into action by putting pressure on my back with each contraction and bringing me drinks. It felt great! I was very relieved when she arrived, as Nick was running around trying to finish blowing up the pool (apparently it wasn't firm enough, but I didn't care and just wanted to get in!), filling it, reassuring Mina and putting pressure on my back every two minutes! I felt irritable and hot and asked for a face washer. He lovingly tried to wipe my brow, but I snatched it off him, wiped my whole face roughly and threw the washer back at him! My wrists were hurting from leaning on the hard tiles, so Nick brought me two pillows to put under them. I put one under my hands and threw the other out of the door, frustrated. I was in transition. I started to feel pushy at the end of each contraction and, only for a minute, wondered how dilated I was.

Lisa arrived at around this time. She slipped in and it felt as if she'd been there all along. I was relieved that she'd arrived and I think I relaxed a bit knowing she was there. I had a few more contractions on the floor, then Lisa suggested we move to the pool; it was ready. I think it was about 8 am.

With Lisa's help, I walked back into our bedroom and eased myself into the pool. For a split second I thought, "Oh no, it's too hot. I feel claustrophobic." But then that feeling left as quickly as it had appeared. Ahhhh! It was bliss. It really felt as I'd imagined it would. The feeling of the warm water felt just as it was described in all the birth stories I'd read. I had a few more contractions and then, during a break, opened my eyes. The fog had lifted and labour-land seemed clearer. I looked at Lisa and said, "Hello!" Apparently (I was reminded later) I also commented on how beautiful Lauren looked! I gazed around our bedroom and my birth space looked calm, serene and birthy! Lauren had done a wonderful job in setting it up: candles lit, music playing, birth flags hung.

My husband, my daughter, my midwife and my doula: all there supporting me, nurturing me, pouring warm water on my back, stroking my arms, kissing me, talking to me, bringing me

drinks and wiping my face. All of them there; all for me. I was a birthing goddess!

Lisa noticed that I was glancing at the clock after every couple of contractions, so she suggested that it was turned around. I don't really remember taking much notice of the time, but it was in my view. I got back to the task at hand!

All along Lisa, Lauren and Nick echoed their reassuring words around the room. At this point Lisa suggested that I feel down for my baby's head. I was hesitant at first, but then, after the next contraction, I put my fingers inside and felt a squishy head! Oh my, what a feeling! I was doing this! From then on I couldn't keep my hand away. During each contraction I felt him coming closer and closer. My body was extremely powerful. I couldn't believe the intensity of what it was doing. I didn't consciously push, not once – my body did it without instruction, it was unstoppable! This baby was coming down and out of my vagina! It was overwhelming at times, and at one point I even tried to get out of the pool and push my baby's head back up! What was I thinking? I could feel the pressure of his head. I could feel the burning as he, little by little, made his way out.

I was vocalizing quite loudly during the whole pushing stage and used all sorts of noises that at any other time would make me feel very silly. But there, in that pool, in our bedroom, surrounded by my birth team, it felt right. I felt empowered and I was uninhibited. I was vocalizing with the word 'open' when Lisa gently said, "I think you should use 'down' now Brooke. I'm pretty sure you're 'open'!" This made me laugh. It was great to be reminded to laugh and smile.

I had been leaning forward over the pool since I got in and I felt ready to turn over and lean back with my arms over the side of the pool. I wanted to see my baby being born. I'm not sure how long it had been, but I had relaxed a bit by now and had my eyes closed. Lisa had let Mina use the torch and, once she saw the head starting to emerge, she called out 'baby' and stripped off her clothes ready to jump in. I asked Nick to get her to wait until the head was out, as I was really focusing on getting through that. Not long after, I felt his head come through. What a relief that was! I put my head back on the pool, thinking I'd have a little break before the next contraction brought his body out, but bubs had other plans. He kept on coming and swam quickly into his daddy's hands! He was out! I did it! I just birthed my baby out of my vagina! Nick passed him to me (we didn't know the sex at this point) and I brought my baby to my chest and kissed him and talked to him as I cried and smiled and cried! He let out a cry and Nick kissed me and we looked to find that we'd had a beautiful baby boy. We watched in awe as he pinked up and cried and stared at us in wonder. His eyes said, "I know you, you're my mummy!" I was in love!

We stayed in the pool for about half an hour drinking in our new 3.43 kg 50 cm baby boy. He was just perfect. His cord was quite short, so I got out of the pool got cozy in bed. About 45 minutes after he was born, Nick and Mina cut his cord and we snuggled up for our first feed. Mina and Nick had cuddles whilst I was birthing the placenta.

I ended up spending one night in hospital due to a bleed, but I was home in my own bed the next day snuggled in with my beautiful boy and celebrating our daughters third birthday.

I'm extraordinarily grateful to my amazing birth support team. In my opinion, they are the most important part of a woman's VBAC journey. I am forever thankful to my amazing husband Nick, our beautiful daughter Mina, my wonderful midwife Lisa and gorgeous doula Lauren.

Most of all, to my son Finley, I thank you for being born.



DOES PLACE OF BIRTH AFFECT YOUR CHANCE OF HAVING AN 'EMERGENCY' CAESAREAN SECTION?

A MCA member recently reported that the 'emergency' caesarean section (CS) rate at her local birth centre was less than 10%, compared with more than 20% at the local birth suite. She wondered why this statistic alone wasn't enough to convince women that the birth centre is a better place for most women to give birth. Here a 'quick and dirty' review of the literature examines the evidence that has been published about CS rates in birth centres and birth suites.

Background

The term 'emergency' caesarean is problematic for two reasons. First, it conjures up fear in the public imagination. Second, it is commonly used to refer to any CS that occurs *during* labour. Caesareans during labour are rarely an emergency and are commonly performed in response to 'poor progress' with or without immediate concerns about the mother or baby's wellbeing. Therefore in this article I will use the term 'unplanned CS' rather than 'emergency CS'.

While birth centres differ from each other, they have two defining features: continuity of midwifery care and a birth environment that promotes normal birth (dim, quiet, private, with access to warm water immersion).

The *New South Wales Health Policy Directive – Towards Normal Birth* outlines a number of strategies that health services can adopt to reduce the rate of CS (both planned and unplanned) to 20% or less overall. A specific target for unplanned CS section has not been set.

Method

I set out to conduct a quick review of the literature around CS rates in birth centres as compared with birth suites. To do this, I used the terms 'birth centre' and 'outcomes' in PubMed (www.pubmed.com) and limited my results to the following: studies undertaken in the last 20 years; studies carried out within resource-rich countries such as Australia; publications in English; studies providing a result for CS in the abstract of the article. Naturally, these limitations may have caused me to miss some relevant articles.

Evidence for place of birth

In research, the highest level of evidence is considered to come from 'systematic reviews'. Systematic reviews select and analyse results from a number of the strongest randomised controlled trials (RCTs). In an RCT participants are randomly selected to have either a particular intervention (in this case, a birth centre) or the control (in this case, a birth suite). I initially imagined that I would be unlikely to find an RCT for this particular intervention, as I thought it would have been deemed unethical to restrict birth centre access through the use of a RCT, but I was wrong!

In 2008 a systematic review was published that included six trials. In total, 8677 women were randomised to 'alongside' birth centres (within the hospital) or conventional birth suites (1). This review did not report on unplanned CS; it did, however, report that birth centre care was associated with a slightly higher chance of spontaneous vaginal birth (surprisingly, this was only 3% more likely) (1).

In 1997 *The Stockholm Birth Centre Trial* (2) included 1860

women who were randomised to birth centre care (n=928) or usual care (n=932). The unplanned CS section rate was not significantly different between the birth centre group (5.3%) and the usual care group (6.5%). Interestingly, the rates of induction of labour (IOL) (2.7% in birth centre vs. 4.6% in usual care) and epidural in labour (12.1% in birth centre vs. 15.1% in usual care) were similarly low in both groups. These rates are remarkably low when compared to Australian benchmarks. As we know, IOL and epidural analgesia are both associated with unplanned CS. Is it possible that these birth centres reported generally low rates of unplanned CS because women having IOL and epidural were excluded?

After systematic reviews and RCTs, the next most reliable research evidence comes from 'cohort studies'. A cohort study includes people who may or may not have been exposed to something (in this case, birth centre care) which we think might influence a certain outcome (in this case, unplanned CS). Importantly, people in cohort studies choose the exposure they receive (in this case, birth centre care).

A large US cohort study (3) included 2555 women who chose to birth in a birth centre and 9382 low-risk women who chose to birth in a standard delivery suite in the same hospital. The researchers adjusted for differences between the two groups of women (e.g. background characteristics such as socio-economic status). After adjustment, the birth centre group had fewer unplanned caesarean sections. Those who were having their first baby were 31% less likely to have an unplanned CS and those who were having a second or subsequent baby were 66% less likely to have an unplanned CS, as compared to those who gave birth in a standard delivery suite. The authors concluded that

Another large US study (4) compared outcomes for women who received birth centre care (n=827) to all women who received usual care in the same time period (n=61,071). They only controlled for those confounding variables that could be identified by reviewing birth certificates (such as, difference in age, marital status, ethnicity, class). This study concluded that

"Midwife-led comprehensive care with the same medical guidelines as in standard care reduced medical interventions without jeopardizing maternal and infant health."

~ Gottvall, K., Waldenstrom, U., Tingstig, C., Grunewald C.

women who received birth centre care were less likely to have a CS. However, I am not confident in these findings. Unlike the previous study, in this study the authors did not know (and therefore could not adjust for) all those significant differences between the women who chose birth centre and usual care (e.g. smoking, drug use, medical history) that are not recorded on birth certificates. Thus these differences could have affected the outcome, rather than exposure to birth centre care.

Slightly less reliable (in terms of the evidence hierarchy) are those cohort studies that have no comparison group. One US study (5) included 15,000 women who chose to birth across 79 different birth centres; there was no comparison group. The

analysis was 'intention-to-treat', which means that, once women were booked into birth centre care, they were analysed as birth centre even if they transferred to the delivery suite. This study reports a low rate of in-labour transfer (12%) and a 6% rate of CS overall, which is remarkably low.

Another study from the US, but this time from an Amish birthing centre (6) reported on the outcomes of 927 births, including an overall CS rate of 4%. In both these US studies the women included met a strict, low-risk criteria. It is not surprising that the CS rate was low – it should be!

Discussion

It is difficult to compare birth centre outcomes to birth suite outcomes. Birth suites include all the women who are at higher risk of CS section because they have had an induction of labour (7) as well as women and babies who may be less able to tolerate labour due to poor health (e.g. high blood pressure, diabetes, poor baby growth, prematurity). This is not to say that birth centres can't make a difference – but a fair comparison needs to be made between similar groups of low-risk women in either birth centre or birth suite.

There is surprisingly little evidence to say that birth centres reduce the rate of unplanned CS. However, systematic review reports that both continuity of midwifery care and access to warm water immersion have a number of benefits for women, including reduced chance of having regional analgesia (epidural) (9, 10), shorter length of first stage labour (10), less chance of episiotomy (9), less chance of instrumental birth (9), and more likelihood of having a spontaneous vaginal birth (9).

So what?

The difference in the rate of caesarean section commonly seen between birth centre and birth suite is likely to be associated with the characteristics of the women that choose (or are excluded) from one or the other. However, the continuity of midwifery care and access to non-pharmacological pain relief that is offered by birth centres has a number of other advantages that women should consider when choosing their place of birth.

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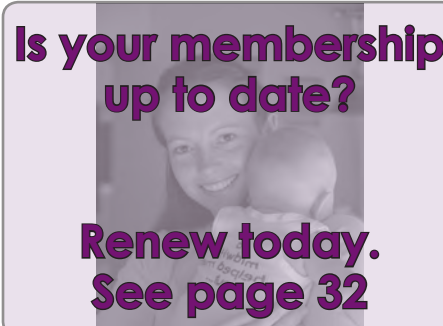
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