

BirthMatters

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Autumn 2012

THE POSTNATAL EXPERIENCE



This issue:

Privately practising midwives on
'collaborative arrangements'

PLUS:

We preview *The Face of Birth*



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

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

Would you like to write for *Birth Matters*?

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

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

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

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

The *Birth Matters* Editorial Team
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Main Cover Photo: Lauren and Monty bask in their 'babymoon'

From the Editor



I have a bumper sticker on my car that reads: “Midwife means *woman*.” I was recently privileged to spend some down time with a couple of midwives who embody that definition.

I was struck by the passion these two women oozed when the conversation turned (as it inevitably did) to pregnancy, birthing and babies. And I found myself, not for the first time, paying close attention to their choice of language and, particularly, its absence of labels. These midwives do not pigeonhole women as ‘high risk’ or ‘low risk’ or categorise them according to the way they gave birth (*the C-section, the homebirth, the breech*). They do not talk about ‘long’ labours or births that ‘went wrong’. Instead, they appreciate that every labour and birth is as unique as the woman experiencing it and acknowledge and embrace the range of changes and contingencies that may eventuate. They do not direct or instruct women in their care to do anything, but provide information, discuss options, consult and refer when needed, and respect choices. They do not ‘deliver’ babies; they “support beautiful, strong women while they give birth.”

Sadly, the gulf that separates the passion, language and underlying philosophy of these midwives from the maternity care so many Australian women still experience appears to be widening.

In a recent radio interview on ABC Brisbane’s *Mornings*, gynaecologist and infertility specialist Dr David Molloy and Director of the Queensland Centre for Mothers and Babies Professor Sue Kruske discussed the safety of homebirth. David warned of the potential for things to go ‘spectacularly’ wrong, claiming—based on an unnamed NHMRC (National Health and Medical Research Council) study—that babies are three to five

times more likely to die during a birth at home, and insisting that Australia has reliable data on the safety of homebirth. Meanwhile, Sue argued that existing Australian homebirth data is outdated and incomplete, explained that the number of women choosing homebirth is rising despite an international push against it, and stressed the need to properly support the women who make this choice. In what was essentially a conversation we’ve all heard before, one of David’s comments jumped out at me:

“The problem is that most obstetricians are acting as advocates not only for the mother because... homebirthing is about mothers—it’s not about babies... the baby really has no advocate there, in that we know more babies will die with homebirthing, we know there are more avoidable deaths with babies with homebirthing. We find it very hard to live with that, we just can’t understand it...”

I’ll not revisit arguments about the lack of current evidence to support David Molloy’s claims, which have been debated time and again by others far more articulate and widely researched than I. But I do want to take issue with the notion that an obstetrician, or any healthcare provider, is a better, fiercer, more qualified advocate for a baby than its own mother. David went on to describe obstetrics as a ‘caring profession’, yet his comment demonstrates an inability to understand—as Ann Catchlove articulated beautifully in our last issue—“that a mother and her unborn child are intrinsically connected

and that you can’t purport to care for the child without also caring for the mother.” The idea that women who choose homebirth place their personal satisfaction before the safety and wellbeing of their babies is insulting and ludicrous. The suggestion that this choice should therefore be eliminated is paternalistic in the extreme. ‘Women-centred’ care cannot exist in a system where these views prevail.

This issue of *Birth Matters* looks at the postnatal period. There’s a mixed bag of stories, but all reinforce continuity, support and choice as the best foundations for confident and capable mothering in the days and weeks after birth. We’re also revisiting ‘collaborative arrangements’, this time from the perspectives of a number of experienced privately practising midwives, who explain how new legislation has affected their practice and the options for women in their care.

As we go to print, *The Face of Birth* is screening throughout Australia. On page 28 co director/producer Kate Gorman explains how the documentary was conceived and shares some of the highlights of producing it. First reports in from MC viewers suggest it is definitely not to be missed—a full review will follow in our winter edition. Information about the film can be found at the official website www.faceofbirth.com.

Until June.

Kylie

In memory of Caroline Lovell

A fund has been established to support Caroline Lovell’s husband and children after the recent loss of their beautiful wife and mother.

If you would like to make a donation to Caroline’s family to help support them through this immensely difficult time, details are as follows.

Caroline Lovell Memorial Fund
BSB: 083841
Account number: 128304978

You can make donations via direct deposit or by going into any NAB branch.

Every little bit helps and any donation, no matter how small, will be greatly appreciated.

With thanks and blessings.

From the President



Ann Catchlove

Welcome to our first edition of *Birth Matters* for 2012. It may be a new year but it seems like we are facing the same old issues!

If I were to be wildly optimistic I would wish for 2012 to be the year where we:

- sort out the federal government’s maternity reforms so that they deliver more Australian women another genuine option for their maternity care;
- get visiting rights for privately practising midwives in all states;
- see a massive expansion of continuity of care models in hospitals across the country catering to all women, not just the lucky ones deemed “low risk”; and
- find a long term solution that ensures that homebirth with a privately practising registered midwife remains an option.

Back in the real world – where do things stand in maternity reform this year?

Commonwealth maternity reforms

The Commonwealth maternity reforms have been in place for well over 12 months now. Across the country a number of midwives have become eligible midwives and women using their services have been able to access some Medicare rebates for their care.

There are, however, some big obstacles to the reforms meeting their potential. As anticipated, the requirement for collaborative arrangements is hampering the ability of women to access Medicare rebates for midwifery care. Even obstetricians who are willing to collaborate are reluctant to make the commitment required by the regulations.

The Commonwealth government has commissioned a review of the reforms and it will be interesting to see whether the outcomes of this review and the appointment of a new Health Minister lead to substantive improvements. MC will be engaging with decision makers to seek improvements.

Another issue is that for most privately practising midwives in most states, hospital visiting rights are yet to materialise. While all states claim to be working on the issue, progress is slow. Without hospital visiting rights woman planning hospital birth with a privately practising midwife cannot receive true continuity of carer.

National agreements and projects

The states and territories through the Australian Health Ministers Conference (AHMC) and other bodies have agreed to work together on a number of maternity reforms.

The National Maternity Services Plan (NMSP) was endorsed by the AHMC in November 2010. The five year vision contained in the plan is one that many of us would agree with in principle:

Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women.

There are a number of commitments in the NMSP that would, if implemented, give women greater choice, continuity and control in their maternity care. One is that governments facilitate increased access for public patients to continuity of carer programs. Some states have set targets for the number of women who receive continuity of care. It will be important for organisations like MC to hold governments accountable for meeting their targets and the commitments that they have made in the NMSP.

Other projects include a national woman-held maternity record, national evidence-based antenatal care guidelines and improved, nationally consistent maternity data collection (including improved data collection on maternal and late maternal deaths).

Homebirth

The future of homebirth with a registered privately practising midwife remains the elephant in the room. At

present it is perfectly legal for a woman to have a homebirth with a registered midwife. The exemption from the requirement for midwives to have professional indemnity insurance for homebirths will now expire in June 2013. It is very unclear what will happen after that date as there is still no insurance product available that covers midwives who attend homebirths. This will obviously be a key issue for MC in the coming year.

An ongoing tension surrounds so called “high-risk homebirth”. For many women this has translated into confusion around whether or not they are able to access midwifery care for a homebirth and, for some, has meant they are unable to find a midwife prepared to care for them. The tension played out in the debates around the Australian College of *Midwives Position Statement on Homebirth*. The current position statement explicitly recognises that women may choose a planned homebirth when this is not recommended by a health care provider and that women should continue to have access to midwifery care whatever their choice. This is consistent with MC’s position.

Confusion also exists at present because the Nursing and Midwifery Board of Australia is yet to endorse the new ACM position statement and still has the old position statement on its website. MC has called on the NMBA to endorse the new statement, which was developed through a transparent process after broad public consultation.

There is plenty to keep us busy in the year ahead as well as a number of other issues we don’t have space to touch on here. Our national committee is committed to keeping you informed about exactly what’s happening and what we are up to, so keep an eye out for updates in future editions of *Birth Matters* and our new electronic newsletter. Please do contact me at president@maternitycoalition.org.au if there is anything you’d like to discuss.

Ann Catchlove

Is your membership up to date?

Renew today. See page 32

Collaborative arrangements – midwife perspectives

By Kylie Sheffield

In the spring edition of Birth Matters we looked at ‘collaborative arrangements’ from the consumer perspective through the personal stories of three women whose care was affected in some way by the requirements of Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2010 and Health (Collaborative arrangements for midwives) Determination 2010. For this follow-up article I asked five experienced privately practising midwives (PPMs) to discuss their views on the legislation and explain what it has meant for them and the women in their care. This is a snapshot of what they have encountered since July 2010 and their varied approaches to moving forward under the new requirements.

Robyn Thompson



Robyn Thompson is a PPM with over 38 years midwifery experience and one of Australia’s leading breastfeeding consultants. Like many PPMs and their clients, she is opposed to collaborative arrangements and believes the 2010 Determination must be rescinded. While she is aware of some PPMs holding ‘effective’ collaborative arrangements, Robyn believes that this is new language referring to the practice of referring and consulting responsibly, just as midwives and medical practitioners have always done. “I really don’t accept the language,” she says. “I object to the term ‘collaboration’ which is hierarchical, political language conceived by legislative writers to bolster the power and control of one profession over another. I feel this language demonstrates total disrespect for me, as a professional in my own

right—imagine a doctor being forced to ‘collaborate’ with a midwife in the same way.”

For Robyn, ‘consult and refer’ is the appropriate way to describe what occurs between a midwife and a doctor when they work together to provide woman-centred care. “This reflects a consultative process with referral back and forth according to the woman’s particular needs,” she says.

According to Robyn, the refusal of public hospitals to support visiting rights for PPMs is also a modern dilemma. She explains that before the insurance crash in 2001, PPMs had professional indemnity insurance (PII) and easy access to hospitals. She was, in fact, involved in setting up the first public hospital admission arrangement with the Medical Director at the Royal Women’s Hospital in Melbourne at the time. “We had no problem accessing the system with midwife and medical colleagues of that era. When I entered a hospital I mostly continued with the woman’s care as part of a consultative team. It was never about ‘ownership’ of the woman or her care—the very reason you enter a system is to seek further advice in the best interests of the woman or her baby. I have had some amazing, mutually respectful professional relationships over the years, not just with obstetricians and GPs but with a range of allied health professionals. The notion that midwives did not consult and refer in the past has no factual basis.”

Another key issue for Robyn and similarly skilled and experienced colleagues is the absence of a ‘grandmother clause’ in the legislation. “No respect for years of experience or wonderful outcomes with women at home. No respect for midwifery as a profession in its own right,” she says.

In terms of how the Determination has affected her practice, Robyn explains that today she offers the same service she has always offered. She chooses not to apply for Medicare eligibility, instead adjusting her fees to make her care more widely affordable and negotiating options for women who are financially disadvantaged. “I continue to work in the responsible way I have in the past and defy modern behaviours and controls. I am a professional who works *with* women. I inform to the best of my ability and I do not make decisions *for* women. I refer and consult wherever necessary, but always

with the consent of the woman and after extensive discussion (except, possibly, in urgent situations, which are extremely rare). My contract is with the woman, not with a doctor or an institution.”

Robyn believes that the new legislation has had a profound effect on the practice of many midwives and on women’s right to choose. “To turn around this modern control of one profession over another will take time and more unrelenting energy. It will likely take another 50 years to unravel the consequences of such legislation and unprofessional control. Most of all it will take the ultimately united, not divided, efforts of all interested women and midwives. But the fight will go on.”

Sally-Anne Brown



Sally-Anne Brown is a midwife in private practice in the Otways, Victoria. She sees collaborative arrangements as a paternalistic attempt by the medical fraternity and government to exercise further power and control over women and midwives. “I find it interesting as a midwife, mother, activist and advocate for women’s birth and human rights that the language surrounding women’s informed consent has shifted strongly towards a submissive state, where mandatory collaborative arrangements in exchange for Medicare dollars is now accepted” she says.

Sally-Anne believes any form of collaboration or referral must take place in a consultative setting, at the instigation and with the full consent, of each individual woman. Health Legislation (Midwives and Nurse Practitioners) Bill 2010 requires PPMs to have a formal arrangement (defined in the Determination) in place with a named medical practitioner in order to offer

Medicare-rebateable care. Women can therefore neither choose the practitioner themselves nor decline medical involvement altogether if they wish to access Medicare benefits. Sally-Anne points out that there is no other referral process she knows of that bypasses the patient in this way. She says: “If I decide I need to see a medical specialist, I go to my GP and ask for a referral, usually to a practitioner of my own choosing. Sometimes the GP recommends a practitioner. It is entirely up to me whether I accept that recommendation and, in fact, whether I see the specialist at all. At no time am I refused the Medicare rebate for my GP visit because I decline the referral. Why on earth should different rules be applied to women who choose care with a midwife? The woman should be at the centre of her own maternity care—*she* decides when and with whom she shares her private information.”

While she understands that (in addition to wanting their clients to benefit from rebates) some midwives see the Medicare provider number as the professional recognition for which they have fought long and hard, Sally-Anne maintains that ‘Medicare for Midwives’ in its *current form* is not the answer, and that collaborative arrangements have served only to obstruct genuine reform. “In reality there are very few examples of successful collaborative arrangements, and the majority of hospitals and medicos continue to cite insurance issues as prohibitive in granting visiting rights to midwives,” she says. “There has been a massive reduction in the number of PPMs who are actually practising—in April 2010 we had around 250 midwives in private practice and now there are about 70. Women were supposed to have improved access to midwives across the nation but, as a direct result of these and other changes, women are more isolated and care is more fragmented than ever before.”

Sally-Anne objects to the inappropriate use of the term ‘eligible’. “It saddens me that some of my colleagues have chosen to adopt this as their new language. We are, in fact, all ‘eligible midwives’—we are just not all Medicare-accredited midwives.”

Sally-Anne provides care to women in a remote rural area and provides her service at a discounted rate, as many women are financially disadvantaged. “I have adjusted my service fee to give women the money in lieu of the Medicare rebate, and refund them a further \$700 off my fee. This way women receive the financial benefit, I uphold their legal right to informed consent (including right of refusal), and I maintain my practice as a midwife according to the ‘International Definition of a Midwife’, as

is my professional right. Importantly, the woman chooses her own practitioners e.g. a specialist or acupuncturist and, when required, she may ask me to consult with her practitioner/s or ask them to consult with me. This is her birth and her human right.”

Melissa Maimann



Sydney-based ‘eligible midwife’ Melissa Maimann offers a different view of collaborative arrangements. When she and obstetrician Andrew Pesce co-authored a piece for *MJA Insight* in July 2011, they described themselves as “the first private obstetrician-midwife team in Australia to have successfully negotiated a formal collaborative arrangement.” Acknowledging that few other agreements existed but labelling calls for a policy rethink “premature and counterproductive” Melissa and Andrew described a mutually respectful collaboration based on a “similar philosophical approach to maternity care.”

Melissa, who has been a midwife for 11 years and practised privately for the last five, explains that her partnership with Andrew allows her to offer ‘Ultimate Continuity’ which she defines as a model of care involving continuity from a known midwife with medical backup from a known private obstetrician. “Previously, if a woman developed complications in her pregnancy, or had risk factors from the outset, I could attend her in hospital in a support role only. This was not satisfactory to women in my care who wanted continuity from their known midwife. Now I’m able to continue as the woman’s midwife regardless of risk factors, which is a great relief to my clients.” Women in Melissa’s care give birth in Westmead Public Hospital where water birth, VBAC

(including vaginal birth after multiple caesareans), vaginal twin births and vaginal breech births are supported. Based on the data Melissa has collated to date, she reports low levels of intervention and very high rates of normal, drug-free birth.

Because she has a collaborative agreement in place, all aspects of Melissa’s care are Medicare-funded except for intrapartum care at home. She assesses the out of pocket expenses to be around \$3500 per client for private midwifery and back-up obstetric care. For women wanting a natural birth who are happy to birth in hospital; and those assessed to be ‘high risk’ or who develop complications during their pregnancy, Melissa’s service allows them to access one-to-one midwifery care and ensures that the obstetrician who may be called is one they know.

Homebirth is offered to women who have previously birthed vaginally and who are having a ‘healthy, low-risk’ pregnancy. “Andrew sees all women, regardless of planned place of birth, twice in their pregnancy. If it’s necessary to transfer to hospital from a planned homebirth, Andrew provides the obstetric care and I continue as the woman’s midwife in hospital,” Melissa explains.

I asked Melissa how she had negotiated an agreement with Andrew about homebirth given his very public opposition to it. “We came to an agreement through a desire to make it work for women,” she said. “To some people it would seem impossible to have an obstetrician involved and not have them ‘pull rank’ over the care that is provided... essentially I lead the midwifery care of all the women who book with me. A healthy woman who has a normal pregnancy and birth would meet Andrew just twice in her pregnancy—there is no need for further obstetric input. If something happens to increase a woman’s care needs beyond what is considered normal midwifery care, my job is to recognise this and consult with Andrew. He would then become another party to the decisions. Our decision making in this situation is collaborative... we work together with the woman and look for solutions that allow everyone to feel safe and be safe. As a consultant and specialist, Andrew advises on different courses of action and pros and cons of each path. The final decision is with the woman.”



Sheryl Sidery has been a midwife for 26 years and practised privately for the past 22. Her experience with collaborative arrangements has been genuinely positive. Sheryl says she feels fortunate to be working with obstetrician Andrew Bisits, who she had known for some time before the new legislation was finalised. "I was very fortunate to have a good working relationship with Andrew prior to the changes—I'd met him at various conferences where we were both speakers, so when he came to the Royal [Hospital for Women] we knew each other a little."

Sheryl describes Andrew as very "pro midwives and pro women's choice" and explains that even prior to signing their agreement, their relationship was one of mutual respect. "For the past seven years I worked as a consultant in perinatal mental health, so Andrew would sometimes ask me to see women who needed a debrief after a difficult birth or ask my opinion about how he might best communicate with a woman who had complex issues." This information-sharing approach continued when Andrew became the consultant for the Midwifery Group Practice at the Royal, in which Sheryl now works, so she felt comfortable approaching him about the new requirements. "So I didn't put him on the spot, I emailed him and asked if he would 'collaborate' with me," Sheryl explains. Andrew agreed immediately.

"We now communicate in person or I email Andrew when a woman is 36+ weeks to update him on her wellbeing. I then email him after the birth to let him know all is well."

Sheryl describes her collaboration with Andrew as a perfect working relationship and finds Andrew completely open minded and approachable. She adds that she shared a similarly trusting working relationship with obstetrician Michael Webster, but that local GPs she has dealt with have proved to be less respectful of

women's choices, particularly the choice to homebirth.

"Collaboration is very simple with Andrew," Sheryl says. "I never feel I have to explain my position—he knows I'm there totally for the woman and her family. We're both working for the same thing."

Jan Ireland (L) with Kelly Langford



Jan Ireland has been in private practice as a midwife for 25 years and last year teamed up with colleague Kelly Langford to open Midwives and Mothers Australia (MAMA), a private midwifery practice based in Melbourne. Her experiences to date have been varied. While the midwives at MAMA now have collaborative arrangements in place with a number of local doctors and specialists, Jan explains it has required ongoing negotiations and a great deal of perseverance to reach this point.

"Overall we have sent out around 400 letters to GPs and obstetricians asking if they would be willing to discuss signing a collaborative arrangement with us," she says. "Of a total 220 we sent out in one lot, we received six responses—two declined our request, four agreed to meet and talk."

In Jan's experience, willingness to support collaboration depends on the individual practitioner. "While some are making a genuine effort to cooperate, others have been obstructive, particularly in the public hospital setting." Jan differentiates between those who are deliberately obstructive and those who simply don't understand what's required. "Collaboration is essentially a pathway to referral for obstetric opinion when care falls outside the midwife's guidelines for practice," she says. "Some doctors are concerned that if they sign a collaborative arrangement it means they are signing up to support intrapartum care at home. This is not the case—neither insurance nor Medicare apply to birth at home at this point. Some doctors fear that their own insurer won't support or allow collaboration, but once they explain what's involved, there's no problem."

To Jan's knowledge, no public hospital obstetric service will enter into

collaboration with independent midwives. She has found private obstetricians to be supportive provided they maintain the role of primary carer and the woman plans to birth in the private system. "If a woman is seeing a private obstetrician but also seeing me for additional support and advice, a collaborative arrangement means she can receive Medicare benefits for my care. I've found most private obstetricians to be cooperative in that respect." She has also successfully collaborated with a number of GP obstetricians.

"It's an ongoing process and none of it has been easy," Jan says. "I have felt a recent shift in Victoria—things have improved since the Determination was first released. Having said that, resistance from some public hospitals can be extreme. PPMs are being asked to jump through hoops, but then these midwives have always had to jump through hoops."

It is impossible in the space of one short article to represent the views of all affected midwives or to fully expand on the convoluted nature of the laws and regulations underpinning maternity reform. Birth Matters invites you to inform ongoing debate on 'collaborative arrangements' by sharing your personal experiences. Please email birthmatters@maternitycoalition.org.au.

Information on legislation and regulations pertaining to 'collaborative arrangements', Medicare eligibility and PII for midwives can be found on the following websites:

- National Health Practitioner Regulation Law 2009
www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx
- Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010
www.comlaw.gov.au/Details/C2010A00029
- National Health (Collaborative arrangements for midwives) Determination 2010
www.comlaw.gov.au/Details/F2010L02105/Explanatory%20Statement/Text
- NMBA Registration Standards
www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx
- MIGA insurance for 'eligible midwives' in private practice
www.miga.com.au/content.aspx?p=160
- Mediprotect insurance for midwives
www.mediprotect.com.au/MidwifePI.htm
- Medicare eligibility for nurse practitioners and midwives
www.medicareaustralia.gov.au/provider/other-healthcare/nurse-midwives.jsp cause.

Choices for Childbirth goes national!

By Anne Harris and Jess Permezel

Birth Choices Expo (NSW) has merged its energy with the existing Victorian Choices group and we are well on our way to providing a national service for all Australian parents.

Our Mission

Choices for Childbirth was established to provide information and resources to women and their families, so that they can make informed choices about pregnancy, birth and parenting. We aim to provide a healthy balance of up-to-date, evidence-based information along with the wisdom and knowledge of mothers, birth workers and health professionals.

By helping women to achieve a positive birth experience, we can directly affect their enjoyment and confidence in early parenting and can significantly reduce post-birth challenges, including breastfeeding difficulties and postnatal depression. Choices for Childbirth provides women with a toolbox of information and access to local community support networks, helping them to stay healthy and supported from pre-conception through to the crucial postnatal period.

PL and BS have also not been finalised for this reason. For new branches, it would be recommended that funds would be lodged through the national account to circumvent these issues. A cost centre is administered to the branch and money can then be identified easily.

What's happening and how you can spread the word

Choices for Childbirth is now presenting information sessions that cover every aspect of pregnancy:

- Early pregnancy and conception
- Pregnancy, labour and natural pain management
- Newborns and early parenting

We have a new logo—if you would like to add this to your webpage, see the contact details below.



We will be running exciting giveaways on our new Facebook page to encourage people to build our network of support and sharing. You might be the next winner! All you need to do is 'like' our page:

<http://www.facebook.com/pages/Choices-for-Childbirth/354151727945977>

A new stand-alone Choices for Childbirth website went live in February, with details of all the sessions, movies and places and people involved. These sessions are constantly changing, so join our mailing list for updates: www.choicesforchildbirth.org.au

How can you get involved?

You could:

- present a session in your local area—we are always looking to add more areas;
- support an existing area—more support is always welcome;
- become part of an amazing group of volunteers—everyone is welcome.

Contact

Anne Harris: mobile 0433 162 847; email sydney@choicesforchildbirth.org.au

Jess Permezel: mobile 0410 291 572; email melbourne@choicesforchildbirth.org.au

MC MEMBERSHIP EXPIRED? RENEW FOR 2 YEARS & SAVE!!!

You can now renew your Maternity Coalition membership
for two years at a time, and save \$10.

Two year individual membership just \$70.

If you have recently renewed your membership and
would like to take advantage of this, please email
memberships@maternitycoalition.org.au

Leaving well alone in the third stage of labour

By Sarah J Buckley

This article first appeared in Birthspirit Midwifery Journal, 1: 29-34. 2009.



Sarah J Buckley

The third stage of labour is a powerful and mysterious time; more important than we acknowledge and more complex than we know. These thirty minutes or so, which begin as the mother births her baby and finish as she births her baby’s placenta, are usually uneventful compared to the drama of labour and birth, leading many (including many care providers) to think that the birth is already completed. However, enormous changes are happening in the brain and body of mother and baby, all of which are crucial for their survival in the short, medium and long-term. The substantial contribution of the third stage to species survival predicts that evolutionary investment will be high, with substantial sophistication incorporating multiple systems and adjustments.

For the mother, the major adjustment is the shift from pregnant to non-pregnant and especially the sudden separation of her baby’s placenta, which has been intimately associated with her cardiovascular system for the duration of her pregnancy. As the baby’s placenta peels off her shrinking uterine wall, rather like a postage stamp peeling off a deflating balloon, she must seal the blood vessels on her side so that her uterine blood supply, flowing at 1/2 to 1 liter per minute, will not haemorrhage from the torn vessels.

This physiological miracle is accomplished by the mother’s uterine muscle fibres, which begin to contract and retract immediately after birth,

forming “living ligatures” that tighten like a purse-string, kinking and sealing off each maternal arteriole. The uterine contractions that provoke this life-saving haemostatis are triggered by surges of oxytocin, released in a crescendo from the new mother’s pituitary as she gives birth. Ongoing maternal pulses of oxytocin are released as she gazes at and touches her baby, and as her newborn massages, licks, and finally suckles her breast (Matthiesen et al. 2001). Maternal oxytocin levels peak around the time of placental expulsion (Nissen et al. 1995) and, in all mammals, oxytocin plays a major role in switching on instinctive mothering behaviour at this time (Nelson and Panksepp 1998).

Other hormonal systems are also active in the new mother’s brain and body to adapt her to her new maternal role. These include beta-endorphin, the body’s natural opiate and a hormone of attachment, which peaks at birth, adrenaline and noradrenaline, which are elevated in the minutes after birth and ensure that both mother and baby are wide-eyed and alert at first contact (noradrenaline is also a hormone of attachment), and prolactin (Nelson and Panksepp 1998), which reduces stress and augments maternal behavior, likely also beginning its role as the major hormone of breast milk synthesis during and soon after labour and birth (Grattan 2001).

Postpartum elevations of these hormones, which are even higher and more sustained within the brain than levels measured in the bloodstream (Gimpl and Fahrenholz 2001), ensure the devoted maternal care that will optimise offspring survival through to reproductive maturity and that will be replicated by female offspring with their own young (Pedersen and Boccia 2002). Newborn and maternal hormone elevations in the hour following birth also ensure an optimal start to breastfeeding, as initiated by the baby and supported physiologically, hormonally and behaviourally by the mother (Buckley 2009).

For the baby, the major changes during third stage involve the respiratory and cardiovascular systems. These two immediate adjustments, both crucial for survival, are interrelated and both require the extra volume of blood that Mother Nature provides for an optimal newborn transition.

An ongoing supply of oxygen is a physiological necessity, and so, beginning

at birth, blood is rerouted away from the placenta (which is reducing its oxygenating capacity) and towards the newly functioning lungs. Over this time, the pulmonary blood flow increases from 8 percent of foetal cardiac output to 40 percent in the newborn, with this extra blood filling the alveolar capillaries, where oxygenation takes place.

Newborn circulatory rerouting involves the closure of the shunts from umbilical cord to liver and heart, (ductus venosus), from right to left atrium (foramen ovale), and from pulmonary trunk to descending aorta (ductus arteriosus), most of which are aimed at supporting the new pulmonary circuits.

Other major roles of the placenta, chief waiter in the “hotel de womb,” must also be performed by the newborn kidney, liver, gut and skin. These newly functioning organs, whose vascular beds were relatively unfilled in-utero, also require extra blood for optimal perfusion and function.

Mother Nature’s superb design for this time involves a gradual redistribution of blood in the minutes after birth, adding up to a substantially increased blood volume in the newborn, compared to the foetal, body. This haematological top-up, known as the placental (or placento-foetal) transfusion, comes from blood that is temporarily held in the placenta and is transferred to the newborn in several stages.

According to Dunn, during the baby’s final passage through the mother’s lower vagina, pressure on the cord obstructs the low-pressure umbilical vein, which prevents blood returning from placenta to baby and results in an increased blood volume within the placenta. (Dunn 1984). (The higher-pressure artery is not affected, so that blood can flow from baby to placenta but not back again).

This placental back-log may help to delay placental detachment by making the placenta more rigid. Delayed detachment gives the newborn an ongoing source of oxygenated placental blood that is an important back-up, especially if the baby is slow to breathe. Observations that the first five or so newborn breaths are not effective in gas exchange (Ullrich and Ackerman 1972) and that placental respiration continues at normal efficiency for at least 37 seconds after birth (Marquis and Ackerman 1973), underline the importance of this back-up system for all newborns.

As the baby emerges, pressure on the umbilical vein is released and the bolus—around 66 ml—of warm, oxygenated, pH-balanced blood that was back-logged in the placenta enters the baby’s circulation (Dunn 1984). This occurs within seconds of birth, as evidenced by two studies in which weight gain (reflecting incoming blood) has been continuously recorded from birth (Diaz-Rossello 2006, Gunther 1957).

This placental transfusion, also called the placento-foetal redistribution, is augmented by the new mother’s third stage contractions, which compress the in-utero placenta and so push blood towards the baby. Between contractions, blood can return from baby to placenta through the umbilical vein, which closes later than the artery, and which can transport blood in either direction. This transfusion takes place over several minutes, with the majority of blood transferred within three minutes of birth.

The final amount of blood that is transferred from placenta to newborn can vary from 54 to 160 ml (Usher, Shephard and Lind 1963), implying that different babies have different circulatory needs and also suggesting that newborns can self-regulate their final blood volume. This may happen through adjustment of umbilical vein flow or other means. Gunther, who continuously recorded newborn weight after birth, showed a reduction in weight (therefore a transfer of blood back to the placenta) during a crying episode, likely due to increased systemic pressure (Gunther 1957).

The average newborn blood gain following the placental redistribution is around 100 ml. Diaz-Rossello, who also recorded newborn weight gain, showed a final average weight gain of approximately 100 g, equivalent to 100 ml (Diaz-Rossello 2006). This is around one-third of the total blood volume of an average term newborn (250-350 ml), and so represents a major circulatory contribution.

This blood is also rich in protein and nutrients (containing, for example, the

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equivalent iron in 100 litres of breastmilk (Zlotkin 2002), in red cells (delayed clamping increases red cell numbers by up to 60 percent (Yao, Moinian and Lind 1969) and in haematopoietic stem cells, which will migrate to the bone marrow and differentiate into various blood and immune cells. The deliberate withholding of newborn blood for so-called “cord blood banking,” which involves taking all or most of this 100 ml has no discernable benefit to the baby (Diaz-Rossello 2006) and we have not investigated the harm that may result from deprivation of newborn stem cells (Buckley 2009).

The extra blood volume, as well as its components, is also important for an optimal transition. Mercer’s model of neonatal transitional physiology demonstrates the importance of adequately filling the pulmonary capillary networks that surround each alveoli which, when filled with blood, make the alveoli erect, even before lung inflation (Mercer and Skovgaard 2002). According to studies by Jaykka, the pressure needed to inflate the lungs is substantially lower when the pulmonary vascular beds are pre-filled and the alveoli are erect (Jaykka 1957).

The placental transfusion also aids the clearance of the fluid that fills the foetal

lungs, which is optimised by the high levels of plasma proteins associated with a full placental transfusion. Good levels of plasma proteins ensure that the blood colloid osmotic pressure (COP) is high enough to pull the more dilute lung fluid across the alveolar membrane and into the blood stream by osmosis. Both volume and COP effects will optimise newborn lung function and will be compromised, to some extent, by early clamping.

The baby whose cord is clamped immediately after birth, especially within the first ten to twenty seconds, will lose not only the nutrients, stem cells and red cells, but also the extra blood volume and will be hypovolemic, to a greater or lesser extent (Dunn 1984). Diaz-Rozello comments, “For the neonate, it is as if 25% of its volemia is bled into the placenta” (Diaz-Rossello 2006, 559).

Recent randomised controlled trials of early versus delayed cord clamping have highlighted the extra risks of iron deficiency and anaemia in infancy associated with early clamping, compared with a delay of even 30 seconds. A 2007 meta-analysis, published in *JAMA*, suggests that early cord clamping increases the risk of anaemia by five times at one to two days and doubles the risk at age two to three months, compared to late-clamped babies. In this analysis, early-clamped infants also had lower iron stores at six months (Hutton and Hassan 2007).

Concerns about jaundice are often raised in relation to delayed cord clamping. After birth, any red cells that are excess to newborn requirements will be broken down, with red cell haemoglobin being converted to water-soluble biliverdin and eventually to fat-soluble bilirubin. Higher numbers of red cells associated with delayed clamping are therefore likely to cause some degree of jaundice, which occurs among all newborn mammals and is probably an important and deliberate postnatal adaptation. Bilirubin is a potent antioxidant and can protect newborns from the sudden “hyperoxia” that occurs with the transition from low oxygen levels in



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the womb to high levels on exposure to room air (Sedlak and Snyder 2004a).

This “beneficent” role of bilirubin (Sedlak and Snyder 2004b) was confirmed in a 2008 study, which showed that mild to moderately jaundiced newborns have better antioxidant status than less jaundiced babies, which deteriorates when phototherapy is used to reduce bilirubin levels (Shekeeb et al. 2008).

Note that studies do not show an excess of severe jaundice (such as would cause kernicterus, or brain damage) in babies who have had late clamping. Two recent reviews, including more than 1000 late-clamped babies, both concluded that phototherapy or exchange transfusion for jaundice was no more common among late-clamped compared to early-clamped newborns. (Hutton and Hassan 2007; van Rheenen, Gruschke and Brabin 2006).

Jaundice is also mentioned as an outcome in the recent Cochrane Review of the timing of umbilical cord clamping (McDonald and Middleton 2008). The reviewers concluded that jaundice requiring phototherapy may be increased with delayed clamping. This conclusion is counter to the two reviews mentioned above and is critiqued in detail elsewhere (Buckley 2009). Similarly, concerns that “overtransfusion” from delayed clamping will make the blood of healthy newborn babies too thick (polycythemia) and cause “hyperviscosity syndrome,” where extremely viscous blood cannot flow through the small vessels, are not based on good studies (Mercer and Skovgaard 2002). As the authors of the JAMA review conclude: “Delaying clamping of the umbilical cord in full-term neonates for a minimum of 2 minutes following birth is beneficial to the newborn, extending into infancy. Although there was an increase in polycythemia among infants in whom cord clamping was delayed, this condition appeared to be benign.” (Hutton and Hassan 2007, 1241).

Although the above discussion is generally focused on healthy term newborns, it is important to note that premature babies are at even greater risk from early clamping, because the preterm placenta is relatively larger than the body and holds more blood to be transferred to the baby. Guidelines are unequivocal about the importance of delayed clamping in premature newborns (Rabe, Reynolds and Diaz-Rossello 2004).

Compromised newborns may especially need the blood and oxygen that the placental transfusion provides. Ironically this group is especially likely to have their cord clamped early and be taken away for resuscitation, often because resuscitation facilities are further than a cord-length away. UK obstetrician Andrew

Weeks advocates allowing compromised newborns at least one minute for placental transfusion and comments: “In these days of advanced technology, it is surely not beyond us to find a way of keeping the cord intact during the first minute of neonatal resuscitation” (Weeks 2007, 313).

Similarly, babies born by caesarean are very likely to miss their placental transfusion; Weeks recommends that surgical staff “wait a minute” before clamping the caesarean baby’s cord, with the baby kept warm on the mother’s legs (Weeks 2007).

Thankfully, international studies and guidelines are beginning to acknowledge harms from early clamping and promote a normal neonatal transition. Weeks concludes, “There is now considerable evidence that early cord clamping does not benefit mothers or babies and may even be harmful” and recommends a delay of three minutes, with the baby on the mother’s abdomen (Week 2007, 313). The UK’s Royal College of Obstetricians and Gynecologists (RCOG) has also acknowledged possible harms of early clamping on infant iron status and comment, “It is increasingly difficult to justify routine early cord clamping, especially for preterm births” (RCOG 2008).

A recent joint statement by the International Confederation of Midwives and the International Federation of Gynaecologists and Obstetricians, as part of the Safe Motherhood project (ICM and FIGO 2004) also advocates that the baby’s cord should not be cut until pulsation has ceased. The role of oxytocics, which are still advocated under this new form

of “active management,” is discussed elsewhere (Buckley 2009).

A physiological transition for mother and baby would, to my mind, exclude the cord clamp altogether, with the cord cut only after the mother has birthed her baby’s placenta, at which time very little blood is spilled. Non-severance of the cord (lotus birth) is another way to ensure a full physiological transition for mother and baby (Buckley 2005; Rachana 2000).

In conclusion, we can trust Mother Nature’s superb design for mothers and babies in third stage, as well as in birth. For healthy mothers and babies, for caesarean newborns and for babies who require resuscitation, an optimal transition for mother and baby at this time can be supported by leaving the newborn cord intact.

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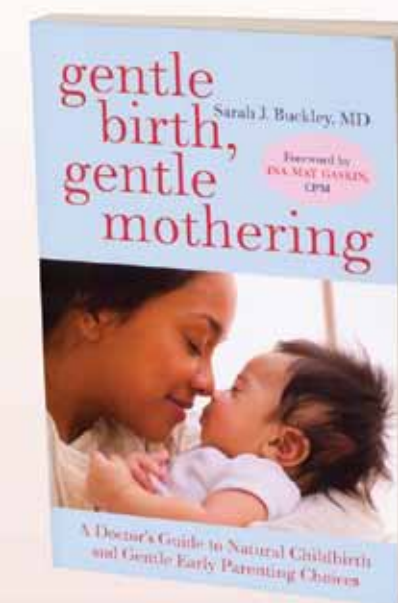
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Depression and anxiety after childbirth

By Debra K. Creedy and Jenny Gamble



Debra K. Creedy



Jenny Gamble

Pregnancy to the first 12 months after childbirth is one of the most important life stages for a woman and her family. Although new motherhood is generally regarded as joyful, this transition can also be stressful. During this time some women may develop symptoms of depression and anxiety. Around 10-15% of childbearing women suffer postnatal depression (PND). While the PND is recognised as an important health issue, symptoms of anxiety tend to be ignored. Although anxiety and depression can occur together, one Australian study identified that another 10% of women had symptoms of anxiety without depression. This article will therefore discuss *postnatal depression, and anxiety*. Postnatal depression and anxiety is more common than often thought with around 30% of women complaining of symptoms. This distress can recur in other pregnancies or later in life, can become chronic (long lasting) and have long-term consequences for the mother, her infant, and relationship with her partner and other children.

Symptoms of Postnatal depression

Around 80% of women experience a change in mood in the days following childbirth. They may become a little teary and this is commonly known as the ‘Baby Blues’. The Baby Blues is considered a normal reaction to the momentous changes associated with childbirth. Sometimes this low mood may persist and signs of more serious depression may occur. Not everyone will follow this

pattern and depression can develop at any time up to one year after birth but it is more common four to six weeks after birth. It is widely considered that postnatal depression is temporary and treatable with skilled professional care and social support.

Women experiencing postnatal depression often describe a depressed mood, tearfulness, lack of drive and enjoyment, social withdrawal, poor sleep, poor appetite, impaired concentration, and feelings of uselessness and helplessness. Some women may feel detached from their baby and show little affection towards other family members. This withdrawal may due to the physical and emotional demands during pregnancy and birth and the dilemma of meeting the needs of the baby and other family members. Some women may also feel as if they are inadequate mothers, causing them to experience guilt and embarrassment. There may be physical symptoms, such as headache and back pain as well as changes in appetite and sleep. Forgetfulness and impaired concentration are common.

Anxiety and Posttraumatic Stress Disorder

Relatively few research studies have examined the frequency or course of anxiety after childbirth. Some studies about anxiety have examined posttraumatic stress symptoms triggered by adverse childbirth events. While the majority of childbirths are not traumatic, studies conducted in Australia, Italy,

Sweden, UK and US indicate that 2-6% of women report symptoms of posttraumatic stress disorder (PTSD) following childbirth. PTSD is an anxiety disorder. In our research, around 30% of women report that their birthing experience was emotionally traumatic and feared that they or their baby would die or be seriously damaged. In response, women report intense fear, hopelessness or horror about the birth. The main symptoms of PTSD can be clustered into three main groups: persistent re-experiencing of the traumatic event, avoidance of reminders of the event and emotional numbing, as well as physical symptoms (sweating, churning in the stomach etc) when thinking of the birth. A combination of these symptoms from these three groups is needed in order for a diagnosis of PTSD to be made.

Emotional health problems after childbirth are a real burden. Problems persist over time and recovery is not easy. Women who are distressed after childbirth tend to ‘reframe’ normal birth as frightening and dangerous, and may decide to not have any more children, or request an elective caesarean section for subsequent births so to avoid another stressful birth. Other women will avoid reminders of the traumatic birth by avoiding hospital-based services and choose birth centre care or homebirth, including free birth. Even though many women would like more advice and assistance, problems are frequently not discussed or diagnosed and few women receive the help they need.

It could be that events during childbirth itself may contribute to distress. Negative birth experiences can be a result of poor or inadequate care during labour and birth, particularly disrespect or neglect by maternity staff, attitudes and behaviours of caregivers that inhibit women’s choice and/or control, high levels of obstetric intervention, “worst imaginable” pain (with or without epidural), and extreme worry about the baby if they need to be transferred to neonatal intensive care. There is also a link between poor emotional care and development of anxiety symptoms. During childbirth women are emotionally vulnerable and expect staff to be caring, constant, and supportive but instead may experience disrespect, pain and fear.

Experience of Benita

Benita had previously given birth to twins by caesarean section, but planned a normal vaginal birth for this pregnancy. She felt well prepared for the birth and was not anxious. Her labour commenced spontaneously, at 4 pm she was admitted to hospital and her membranes were ruptured, an electronic monitor applied and by 10 pm her cervix was fully dilated. She felt traumatised when the doctor made three attempts to obtain a fetal scalp blood sample and in doing so caused intense pain and discomfort. The midwife requested that the doctor stop. Benita was fully dilated for four hours, fetal distress was diagnosed and a decision made to perform an emergency caesarean section. Benita reported being emotionally unable to hold the baby until the next day. She complained of severe post-operative pain and received a narcotic pain drug, pethidine, for two days. On one occasion the midwife refused to administer the drug upon request because “she didn’t want Benita to become addicted.” Benita signed herself out of hospital after three days and reported being “bitterly disappointed that I didn’t have a natural birth.” She reported being distressed and crying in hospital and said, “they [hospital staff] should have got someone to talk to me.” Benita’s general practitioner subsequently diagnosed PND.

Benita’s experience highlights some important considerations in understanding the development of birth trauma. These include the stressful nature of some birth events, early onset of trauma symptoms, avoiding contact with the baby, and experience of depression.

Our research with over 3,000 women has identified a consistent link between high level of obstetric intervention and depression and anxiety. These procedures are often painful and marked by an increasing sense of fear and lack of control. Childbirth practices in Australia remain predominantly hospital centred and medicalised. There needs to be a review to reduce the use of invasive obstetric procedures. It is also necessary to inform women about these procedures and possible risks.

Women often report that their distress was evident immediately after the birth and was not addressed by staff. While some women may cry others may be detached and numb. It is common for women to want to leave hospital as soon as possible. Within 24 hours of birth, women report the presence of trauma symptoms that continue to be frequent and persist for at least a month. Some women recover completely after a month or so, but for others the symptoms continue, sometimes for several years. Women reported wanting to avoid any reminders of the birth and changed their doctor and hospital. One woman

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Women experiencing postnatal depression often describe a depressed mood, tearfulness, lack of drive and enjoyment, social withdrawal, poor sleep, poor appetite, impaired concentration, and feelings of uselessness and helplessness. Some women may feel detached from their baby and show little affection toward family members.

described “breaking into a cold sweat when driving near the hospital.” Re-experiencing (or intrusive) symptoms may affect a woman’s ability to adapt to the changing demands of motherhood and her relationship with others. Intrusive thoughts about the birth can interfere with decision making and sense of well-being. Disturbingly, our research identified that some traumatised women are emotionally unable to hold their baby after birth. There may be problems because the baby reminds the mother of the emotionally distressing birth. A traumatic birth may hinder a woman’s ability to form a loving bond with her baby and adapt to her new role at mother. Conversely, some mothers may become obsessed with seeking answers about the traumatic episode. They may become excessively anxious and hyper-vigilant about their baby and isolate themselves from other mothers because of their distress.

Providing counselling support

Over the past twelve years our team has developed and tested an approach to counselling to support distressed women. A major challenge in offering counselling and emotional support to new mothers is the availability of trained staff (the right people, at the right place, at the right time). Midwives are well placed to assess and provide targeted interventions to childbearing women but have often been criticised for their lack of attention to emotional care. Furthermore, some midwives have expressed concern about their counselling skill base, lack of time to provide emotional support, and fear of eliciting emotional responses and not managing these. When offered the opportunity, many midwives are keen to learn more skills in order to provide better support to women and their families.

Our first research trial evaluated the effectiveness of a midwife-led counselling intervention with 100 new mothers randomly allocated to receive either counselling or routine care. At three months postpartum, PTSD symptom scores were reduced for women in the group who received counselling. There was also a difference in depression. Only four women in the counselling group but 17 women in the routine care group continued to report significant symptoms. Furthermore, all mothers in the counselling group reported high or very high satisfaction with the counselling intervention. The results of this study were encouraging and we are continuing our work.

Although many postpartum women would like more advice and assistance, emotional health is frequently not discussed and few receive the help they need. There are wide spread consequences of depression and anxiety for women, their children, and families. Postnatal distress is associated with relationship difficulties, poor family functioning and impaired parenting. Children of women who suffer depression and anxiety can have short- and long-term delays to their emotional, behavioural and cognitive (intellectual) development. Women also report fear of becoming pregnant which contributes to a lack of intimacy and conflict with partners and avoidance of other pregnant women.

There is evidence that anxiety and PTSD is often overlooked in routine clinical practice. If anxiety is not recognised in women with depression, then it is likely that counselling approaches that have proven to be effective will not be provided. Trauma that is not acknowledged and dealt with may manifest itself in a variety of destructive and negative ways. Women who have not processed the trauma associated with childbirth may experience continued depression and panic attacks. We need to assist women to work through their trauma and develop coping strategies such as proactive planning, use of a birth plan, and seeking supportive and empathetic care providers helps to regain a sense of control. Importantly, reform of maternity services is needed to de-medicalise and humanise maternity care.

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Something lost – emotional distress after childbirth



Rebecca's Story

When I saw a new mum walking out of the hospital with her baby I used to think, *how wonderful* - what an incredible moment... going home with a baby, a little being you created. Like a special secret, a gift that is all yours. When I left the hospital with my first baby – a daughter – in 2009, I felt like an empty shell, so fragile that the slightest touch might shatter it into a thousand pieces right there in the hospital car park.

It was a very long time before I could even think of it as a 'birth'. It felt more like a surgical removal – somehow 'saving' my daughter when I firmly believed she was in no mortal danger. I remember being wheeled down the hospital corridor to the operating theatre, trying with every fibre of my being not to jump off that trolley and run, really, really far from these people who were about to cut me open. Cut me open and haul my baby out. Cut me open, in fact, like it was just any other day. Actually it wasn't any other day; it was a public holiday and the staff seemed none too happy to have been called away from their family brunches to be there.

I was awake, I'll give them that. But that was about as far as the graces went. With a spinal anaesthetic administered I was laid back onto that skinny little operating table and knew then there was really no escape. The terror I felt was uncontrollable. I was

alone. No kind words. No "it's going to be ok." No holding of hands. No whisper in my ear.

Nothing but cold, clinical blueness. Then a cry.

I knew you were ok, I said to my baby silently. I was angry, so angry at these people for not listening to me.

Meeting my baby was not what I had imagined. She was handed straight to the paediatrician and jabbed in both thighs, rubbed, handled and then bound so tightly all I could see was a squashed little face. I held her for a few minutes in theatre before she was taken to the ward with my husband.

After some time in recovery I was wheeled into the postnatal room where my husband was holding her, our daughter. As soon as I saw her I thought to myself, *how do I know that's my baby?*

That moment was the beginning of the darkest time in my life. I'm sure my daughter was beautiful, delightful at times, but I didn't see it. I looked after her, I feed her, bathed her, held her and felt nothing. I recall no feelings of fondness or affection, let alone love. In fact sometimes I was wildly angry at this little person. Angry that it seemed she had been the root of me being in this state – in pain and bruised and broken. It was her fault I ended up with the Caesar. I was completely irrational – even at the time I knew that – but I suppose I had to have somewhere to direct the blame.

She screamed and screamed. And I screamed inside. Outwardly I think I must have shown little of the blackness going on in my head. I seemed to manage ok. Yes, I was a little flat and teary, but doing ok.

I remember one night, after only a few weeks, my husband went out to play tennis. The baby seemed to scream more when he was gone. That night she sounded like an animal being strangled and was clawing the sides of the pram bassinet in the lounge as I stared blankly at the television. After trying for so long to settle her, I knew it was better to put her in there than to throw her, which was what I really wanted to do. Anything to make her stop. Anything to make her shut up.

I began mother's group. They all seemed

to be coping so well. They cuddled and soothed their babies with ease and tenderness. I felt even more I was losing grip.

I barely let her off my body. She lived in a sling. I was too terrified that if I took her out she would start screaming again, which she often did. After some months I visited the doctor for an infection from retained uterine lining that had gone necrotic. She wanted to do some swabs. I asked her if I could just keep the baby in the sling. She raised an eyebrow but agreed. After the swabs were done she looked me in the eye and asked if I was ok. At that moment everything I had shut inside, all the shame and guilt, came pouring out.

I bawled and bawled.

Then came a search. A search for anything, everything I could find to help myself. I attended a program run by a psychologist for mothers with postnatal depression. It was a revelation that there were other women out there struggling as much, or even more, than I was. That ended after six weeks. Then we went to an inpatient mother and baby unit. It was there that I really began to think of myself as having postnatal depression. I was ashamed. I didn't want anyone to know I was there. We didn't even tell my husband's family. I was there for three weeks. They diagnosed the baby with reflux and put her on medication. I remember one of the nurses asking (while holding my back- arching, wildly screaming daughter), "How on earth have you been managing at home?"

Um, well obviously not so well because I'm here.

After being discharged I attended a Baby Love programme to try and resolve the attachment issues that I had. My daughter also showed signs of the fractured relationship by howling if anyone else handled her, even at four months. Maybe she was afraid I would run away. At times I wanted too. Maybe that's why I kept her so close.

There were dark times. Bathing with her every night became a ritual. Some kind of effort to regain that naked, skin to skin moment lost right after birth. At moments I would imagine letting her slip into the bath and drown. And then myself. The pain I felt was so unbearable at times I didn't want to live. I contacted PANDA (Post Ante Natal Depression Association)

and would sit on the phone sobbing. Sometimes it was 15 minutes before I could even utter a coherent word. They never hung up. Their patience and call-back phone calls to see if I was ok were so important.

I had nightmares and woke up sweating and panicked. I couldn't even drive passed the hospital for some months, let alone walk in there. The mere thought made me want to vomit. The thought of ever having another baby was abhorrent.

I couldn't tell my husband the depth of it. He's not the type. I was afraid he would take the baby from me and I wasn't sure how I would go on, having then truly failed at mothering.

We also attended a day program together. I made me so sad to hear the other women's stories. I seemed to have no shield. All their angst and pain penetrated me like shards of glass and I hurt for them.

Over time my daughter learnt to be separate from me and I learnt to love her and let her be her own person, not see her as a reflection of me. Every day I had to think and try to connect with her. Sometimes it was an effort, a scary place, but sometimes it was enjoyable or even joyous.

I did eventually open up to my mother's group about what I had experienced and they have become my yard stick, my rocks. They all struggle at one time or another and all have their own issues. Mine were profound, however not so different to theirs. Through the counselling, I was able to share with my husband some of what I had gone through and together we began on a journey to find another way. Another way of having a baby. I spent hours, weeks on the internet researching birth and caregivers. I knew if I ever did this again it would HAVE to be different.

After two years I became pregnant again and it *was* different. Having chosen caregivers who supported natural birth, I felt like I was in charge throughout my whole pregnancy. No one told me what to do. It was terrifying at times to feel so responsible for my own baby. But she grew well and I trusted her and that she would be born safely.

My second daughter's birth at 42 weeks was not the home birth I had hoped for but it was the triumphant VBAC that I had longed for. She emerged and was put up on my chest and left there. No one touched her, no one took her away. And holding her there in the delivery suite as the sun came up, just the two of us, was one of those moments in life that you always dream of.

My daughters entered the world in very different ways. I think the second birth

not only highlighted the pain of the first experience but also went some way to healing the old wounds. The joy everyone feels for me for having achieved my goal does make me smile to myself. They knew how much it meant to me.

My first born and I may spend our whole lives trying to repair the damage done in that first day, but I suppose it's the trying that counts.

I am so proud of her strength and resilience and her desire for connection.

And I am proud of myself for not just letting it go. Not accepting that experience as normal or ok. And doing everything in my power to change it for the better.

Kim's Story

Nearly 10 months ago I did something that I had dreamed of doing for my whole life. I gave birth to a beautiful, healthy baby boy. This story is not about my birth experience. That would take far too many pages, and I would shed too many tears. Instead it is a story of how my dream of happily luxuriating in motherhood was overtaken by tears and anxiety. How Birth Trauma stole those first precious months with my baby, put incredible strain on my relationship with my partner and isolated me from my friends.

My pregnancy was relatively uneventful. I enjoyed being pregnant, feeling the baby move inside me, reading up on the amazing changes that were taking place within my own body. I read everything I could on the topic of birth. I knew about the benefits of being away from a hospital, of avoiding intervention, of feeling safe and loved during the birth. I had plans (a three page birth plan on

green paper to be exact) of how my labour would be. I am strong and capable with "a good, roomy pelvis". I did not doubt my ability to give birth vaginally and without pain relief. I attended 'Calmbirth' classes, I prepared myself with meditation and breathing techniques. I could handle the pain. I would *breathe* my baby out. We would have beautiful skin to skin contact, gaze into each other's eyes, and the bond would be immediate.

However, after nine months my baby was not ready to come. My hopes for a gentle labour at home – just popping in to the hospital to deliver the baby at the last minute, or even staying home for a last minute homebirth – with my partner and our independent midwife (a wonderful woman) by my side began to dwindle as the days past my 'official due date' slipped by. I had tried everything to encourage labour to start naturally. I could

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Interventions were numerous and invasive. I was assigned a hospital midwife who actively worked against me and was hostile towards my partner and independent midwife. My wishes were essentially ignored and I got (as a counsellor later called it) a 'Susan's Labour' where 'this goes with that'.

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write a book on the topic. Castor oil, curry, orgasm, nipple stimulation, acupuncture, and two ‘sweeps’ of my membranes. I took long walks, I jumped up and down. Nothing.

Finally, after fourteen days, and having pushed the hospital, and even my independent midwife, to the outer limit of what they consider ‘safe’, my labour was chemically induced. Interventions were numerous and invasive. I was assigned a hospital midwife who actively worked against me and was hostile towards my partner and independent midwife. My wishes were essentially ignored and I got (as a counsellor later called it) a ‘Sussan’s Labour’ where ‘this goes with that’. Prostaglandin gel led to my waters being artificially ruptured. This in turn led to an oxytocin drip being administered and constant monitoring, followed by an epidural (for reason of extremely high blood pressure) and, after four and a half hours of directed pushing, to an eventual assisted delivery in a theatre where three doctors attempted to wrench my baby out. I am only thankful that they finally managed to get him out before a caesarean was necessary. The damage to my body was incredible, and will be long lasting. My baby still bears the scars on his nose where the forceps broke his delicate skin.

Initially I seemed okay. I was in pain, and suddenly had a baby that I did not feel coming into the world. But, as my midwife pointed out, there is only so much a woman can bear. I spent a night in the hospital, too tired to think about going home, before discharging myself first thing in the morning. I could not put enough miles between myself and the place that had crushed my gentle birthing dreams.

We sent a message to our friends and family to herald the arrival of our new son. The usual stuff: name, weight, length, etc. We also asked for visitors to give us a couple of weeks to settle in to our new life before coming by to admire the most gorgeous boy on the planet. Most were respectful of this wish (my mother not included). Once home it wasn’t long before the cracks began to show. I was crying constantly. This was not the ‘baby blues’, this was something else. Images and memories of my birth experience haunted me. I felt like a failure. The hospital sent out domiciliary midwives to check up on us in the first few days. I saw four different women in the space of a week. I felt no connection with them. They asked how I was coping, and I just smiled and said fine. The lack of continuity baffled me. How was I supposed to open up and tell someone I had known for 30 seconds what was going on? I believe this

is something that hospitals need to work on.

Thankfully I had continuity with my independent midwife. She was a frequent visitor in the early weeks and months and was deeply concerned. She dropped everything when my partner called and said that things really weren’t going well. She arranged for specialist birth counsellor Rhea Dempsey from Birthing Wisdom, to come. Within days Rhea was sitting in my lounge room, listening while I debriefed and cried. She diagnosed Birth Trauma and said that if I allowed myself to really have a big cry I would begin to feel better in a month or so, but that I would probably never really get over what had happened to me.

“

What if I had just asked for five minutes alone to discuss things with my partner and independent midwife? What if I had refused to have constant monitoring when the hospital insisted? What if I had been stronger and just kept pushing? This doesn’t help. The reality was that with only 30 seconds between contractions I barely had time to regroup before the next one overcame me, let alone the wherewithal to discuss medical procedures and options with doctors who had an agenda. Quite simply a labouring woman cannot fight the hospital system.

Rhea said something that really resonated with me. She told me that ‘closure’, a word so many people bandy about and expect you to be able to achieve after a traumatic experience, is a concept not really heard of before *Oprah* and *Dr Phil* hit the small screen. That really, there is no ‘closure’. This experience will always stay with me, the pain will become less raw, the memories less vivid, the flashes less frequent. Eventually I will not think of it every hour, then every day, but when I do think of it I will still be saddened. I believe her. Other women (who now have adult children) I have spoken to have had similar experiences to mine, and are still brought to tears when they speak of their own birth trauma.

During this time my partner was incredible. Thankfully she had several weeks off work to help us adjust. She took our children for long walks so that I could rest. She reassured me that I was loved. She allowed me to talk constantly about my birth experience and never told me to “get over it.” She never told me, as so many others have: “Oh well, you have a healthy baby and that’s all that matters.” In spite of all of this love and support, my grief remained. I could not rest, because the minute I closed my eyes I would relive the experience over and over. I would just lie in bed and cry. I could only sleep when I was completely exhausted – too tired to move let alone remember. I had a beautiful baby who was a complete dream. He almost never cried and was content to be cuddled and fed. Even now he just smiles all day with just the occasional grizzle to let me know he is hungry or wet. I loved him, I knew he was mine, I would have died for him. But it wasn’t how I thought it would be. There was no overwhelming sense that this was my baby. I truly believe this is because I did not feel him coming in to the world. I was in terrible pain, then I was numbed up and a baby was yanked out of me and pushed onto my chest for less than a minute before being taken away to be checked and so I could be ‘repaired’. It was not until he was over three months old that I really fell completely in love with him. I will forever lament the loss of those first few months. There are scarcely any photos of my newborn boy. I, chief photographer in our house, was too tired and sad to take photos of him sleeping, or of his tiny wrinkled fists. I went through the motions. Feeding him, caring for him, doing all the right things, but usually with tears in my eyes, and such heaviness in my heart.

Rationally I knew that there was nothing I could do to change how things had gone. It was too late. But this hasn’t stopped me questioning everything that happened in the 30 hours that was my labour. What if I hadn’t gone back to the hospital after the first round of induction? What if I had just asked for five minutes alone to discuss things with my partner and independent midwife? What if I had refused to have constant monitoring when the hospital insisted? What if I had been stronger and just kept pushing? This doesn’t help. The reality was that with only 30 seconds between contractions I barely had time to regroup before the next one overcame me, let alone the wherewithal to discuss medical procedures and options with doctors who had an agenda. Quite simply a labouring woman cannot fight the hospital system.

My birth experience has had a profound impact on my life and my family. I used to be the ‘good time girl’ always up for a drink, a chat, an outing, sex. Now, the thought of alcohol does not appeal, I feel little connection with my old friends, and as for sex, please, I can’t imagine ever wanting to be touched again. I am damaged, I am broken, I am undesirable. Maybe, in time, this will change. I am considering going to see a counsellor. I know I need to. I am still hopeful that in time the pain will fade. Like the death of a loved one, it will always be sad, but over time the grief is less raw, the thought of them less constant.

Usually, when a baby is born, friends and family rally around. Meals are prepared, gifts delivered, help offered. We had made the rather unusual request to be given time alone as a family. Apparently to many of our nearest and dearest this equated to not needing help in any way. Only a few wonderful people brought a meal over. There were virtually no cards or presents. People only seemed to want to give gifts or help if they could get something out of it. A cuddle of the baby. A cup of tea, a piece of cake, a catch up. I could barely speak to my partner without crying let alone hoards of guests coming to admire the baby and ask about the birth.

My son is nearly 10 months old now. I have stopped the constant crying, although I still shed a quiet tear most days, and on the days that I haven’t it is only because I have managed to suck them back in. The birth isn’t the first thing I think of each morning, although it is often the last thing I think of at night. I still look with envy at pregnant women thinking that they will get a chance to do it ‘right’. My GP told me that there is no such thing as ‘the right way to give birth’ that every birth is different. I know this, but I don’t agree. I believe that hospitals intervene too frequently, and sometimes with dire consequences. If I had been left to go into labour naturally would things have been different? I will never know.

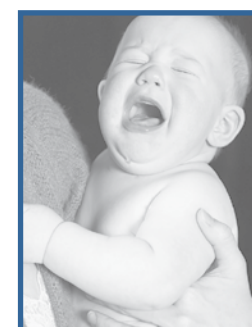
I have some advice for those of you who may know a mother suffering after a traumatic birth. The arrival of a baby is an intensely personal experience. Regardless of how a birth pans out – whether it goes to plan or completely up the creek – families need time to absorb what has happened. Women need time to just be with their new baby, soaking up those first precious days. Friends, families, grandparents, please help! Bring meals, take older siblings to the park, drop a card or a gift in the letterbox. Don’t invite yourself to tea, or come in expecting to hold the baby or have a conversation with the new parents. Remember that you

don’t know how this family is coping, not really. Your love and best wishes are still welcomed and appreciated. When people are ready they will let you in. If the new parents want to talk about their experience, listen, but don’t bring out the platitudes. Don’t tell a mother that because she isn’t dead, and her baby is healthy that everything is great. Just hear her.

Eventually people will stop talking about their birth trauma, they know that their partner is sick of hearing about it, they know that friends and family are thinking “this happened months ago, get over it,” they know that life has to go on and they can’t wallow forever in their grief. This doesn’t mean that they

aren’t feeling just as sad as they were at day one. They may be feeling better, but it may just mean that they are crying alone somewhere, or constantly biting back the tears that threaten to flow all day. Recovering from Birth Trauma is hard. It requires patience and strength and those who have suffered from it should know that they are not alone.

Note: *My independent midwife, Kelly Langford, has recently opened a Midwifery Centre in Kensington (Midwives and Mothers Australia – MAMA). She works closely with Jan Ireland. There are a range of support services available to women both pre and post birth, including counselling.*

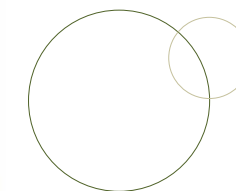


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Lotus birth - not *just* for home

By Sarah Thomson



Have placenta will travel - Fry takes a ride with placenta in tow

When Darwin mother and Homebirth Group President Sarah Thomson's third baby arrived via repeat caesarean, she was determined it could still be a positive and empowering experience. With the support of her husband and midwife, and the cooperation of hospital staff, she became not only the first woman to lotus birth within the Northern Territory hospital system, but also the first to do so post caesarean. She shares what she recalls of her LBAC (lotus birth after caesarean) experience.

I'd wanted a lotus birth for all of my babies, but it wasn't until number three arrived that it was able to happen. My first baby was a planned homebirth resulting in a transfer to hospital and an emergency caesarean section. After a 14-hour labour, meconium stained liquor and a baby stressing out and in deep transverse arrest, a lotus birth was out of the question. My second (16 months after the first) was a planned Homebirth after caesarean resulting in yet another emergency C-section. I laboured lovingly at home for 16 or so hours in and out of the birth pool in my lounge, until my membranes ruptured showing slight meconium stained liquor. I pushed for another hour or so before my babe started showing signs of distress, at which time my amazing midwife advised that it would

be best to make the (awfully awkward and uncomfortable) journey to the hospital. So after another tiring labour, another seemingly stuck and distressing baby, and another emergency caesarean, a lotus birth was again impossible. I've kept the placentas of all three of my babies. The first two were taken home from the hospital by my husband hours after the births; the third came home three days later, still attached to our son. Having neglected to talk about it during my antenatal care, while I was being prepped for theatre, I reminded my midwife (who'd supported me with both of my other babies) that, if possible, I'd like to lotus birth with this baby. Somewhat surprised, and perhaps a tad nervous to ask, my trusty midwife approached the surgeons and passed on my request to keep my baby and it's placenta attached (provided there was no complications that would prevent it of course). Although neither surgeon, nor any of the theatre staff had ever even heard of a lotus birth, they were more than happy to see that it happened for us. So they dug my baby and his placenta (still attached to him) out of my belly, wrapped them both up (individually) and handed them to me! It was a little awkward getting used to juggling the two bundles, but no more awkward than learning to handle a newborn for the first time with it's cord already severed. We dressed our son's placenta with a disposable nappy. Every time we changed our son's nappy, we changed his placenta's nappy too! We doused it with salt and fragranced it with lavender oil. As the days wore on, his placenta slowly dried and shrunk. No one had lotus birthed in this hospital before, and those staff members who'd heard of it had never heard of a placenta being kept attached after a C-section before. We were apparently THE big news on the maternity ward, with every staff member from every shift coming in to see what all the fuss was about. It was like our

baby (or perhaps his placenta) was some sort of celebrity! Relatives and friends were curious to see the placenta when it was being changed, resalted and oiled. It was a good experience for everyone to have the chance to explore what is such an integral part of a baby's life. Undoubtedly, had we not been so vigilant in the salting and redressing of the placenta, we may have copped a whiff of the smell would have become unpleasant some hours or days after birth, especially as we were in the tropics! We went home three days post partum and juggled with the extra little bundle for another two days before he (our baby) appeared to grasp the cord like a wishbone with his little finger and yank it away from his belly with a big sigh of relief.

“We were apparently THE big news on the maternity ward, with every staff member from every shift coming in to see what all the fuss was about. It was like our baby (or perhaps his placenta) was some sort of celebrity!”

While I can't be sure whether it's purely coincidence, or a result of letting our baby and his placenta choose when they parted company, of our three children, our lotus birth baby is by far the most calm and relaxed. Even though it was something we really wanted to do, there was potential for it to be a smelly, awkward experience that we might want to abandon a few days in, especially after hearing of others' experiences of placentas that had stayed attached in excess of 10 days! In hindsight I'm not convinced that our son's easy going nature was coincidence and I don't think I'd leave having a calm and relaxed baby to chance again. Should we add to our brood in the future, we'd definitely repeat our lotus birth experience.

Turning points: the birth of Vaughn Reuben Ryan Jenkinson

By Bec Jenkinson



A family affair - welcoming little 'V'

As spring 2011 really kicked in, I wandered past the 40th week of my pregnancy still feeling mostly calm and content. I was tired and keen to meet my baby, but totally unconvinced that the birth was imminent. Tuesday 20 September was a normal busy day, throughout which I determinedly 'didn't notice' the signs of early labour—I just wondered, and hoped. I promised myself that, when the time was right, I would stop 'not noticing', acknowledge my labour, say goodbye to what would quite probably be my last pregnancy, and enjoy the ride to motherhood for a third time. By dinnertime, I struggled to sit still through our family meal. My focus became deciding when to call our support team. A cast of thousands was planned for this birth: my mum and my friend, Kate, were coming to be support people for my daughters, Indi (4) and Saffi (2), and there would be two midwives and a student midwife. Things seemed to be warming up, and my mum was three hours away, so I decided to call her. Darryl put Saffi to bed, and I rang our student midwife, saying, "There's no need to hurry, but I'm pretty sure that tonight is the night." She noted that I sounded excited, and I was! I was so happy that I was 'in the moment', in touch with what was happening and feeling confident. I also asked Kate to come, after she had put her kids to bed, so that she could be with Indi, tidy my chaotic house and help with filling the pool when the time came. I rang our midwife and we agreed that

she would start the two-and-a-half hour journey to our home. With all the phone calls made, I set about lighting candles, turning on music and generally savouring the moment, happy that I had prepared a beautiful birth space with artwork, cushions, flags bearing messages of encouragement from my blessingway, and fragrant oils. Everything was perfect. I retreated to the bedroom and walked laps around the room and through the adjoining bathroom and wardrobe as, one by one, our support people arrived and got themselves organised. I felt like this unfolding labour had a nice rhythm, and I said to our student midwife how great it was to know that, next time I lay in my bed, I would be snuggling with my newborn. Every time a surge came, I breathed through it, leaning on a wall with someone massaging my back. After a couple of hours though, I started to suspect that my labour was slowing down. I could hear voices as my support people chattered downstairs, making me feel trapped in the bedroom. I wanted them to be quiet, but I didn't know how to ask. I told myself that my body was just waiting for our midwife to arrive and, when she got here, we'd be back on track. When I heard her car in the driveway, I was relieved and a couple of lovely strong surges followed, but, as time passed, it became increasingly clear that my labour just wasn't establishing. Surges would start, but then go nowhere. The time between surges lengthened. Intensity lowered. This wasn't it.

Around this time, I lay down with Indi to help her go to sleep, which confirmed for me that my labour definitely wasn't warming up—quite the opposite. Eventually, our midwife came and asked me how I was feeling. "Sad," I said and wept. We talked about what was happening, what I was feeling, my fear that if I closed my eyes I would fall asleep and wake up tomorrow, still pregnant. This was a turning point all right, just not the one I'd hoped for. We talked about how I could be wrong about labour and be ok. I tried to laugh between the tears, unconvinced. Finally, we sent everyone home (except our primary midwife and my mum). It was about 11 pm as I listened to Darryl turning off the music and blowing out candles. As I blew out the candles near me, I felt as though hope went with them. I don't remember if I was having any surges at all. Darryl came to bed; it was dark, and I was in a dark place, feeling alone with my disappointment. I stayed in bed until I'd heard everyone leave, and until Mum and our midwife were in their respective beds for the night; then I went downstairs and made myself a cup of tea in the dark. Everywhere I looked there were signs of the optimism I'd had earlier in the evening—including mugs laid out ready for tea and coffee for the support team. I took my 'Trust Birth' mug and sat on the front deck sipping tea. The night was still and cool and I tried to talk to my baby. "Is there anything I can do, little one, to help? To get this show on the road?" Whether from my baby, my heart, or the universe, I got the message that I needed: "Trust me. Trust birth. Trust *this* birth." For whatever reason, this was how it needed to be. Another turning point, so I went to bed. I slept, woken occasionally by surges, until about 2 am, when I woke Darryl to ask what the time was—surely it was nearly morning? Nope; not even close. He went straight back to sleep, while I began my 'jack-in-the-box' routine: I lay down until a surge started to build, then tried to get out of bed so that I could rock through it. I wasn't very agile and getting out of bed took too long, so the surge would be in full swing before I was upright and that made me a little bit panicky. I tried waking Darryl again, but he just reached across the bed to hold my hand and went back to sleep. I was unimpressed! At some stage, Indi woke distressed, angrily declaring, "I want our baby to be born right now!" "Oh, I know Sweetie, I'm right there with you," I said. She drifted back to sleep.



Beautiful baby Vaughn

At around 3 am I went to ask our midwife to listen to the baby. I knew the baby was fine, but I desperately wanted her to see me and say that I was now in labour. She didn't. More tears flowed and I went back upstairs to try to rest.

At 4.30 am Saffi woke and came into 'the big bed'. I left her in bed with Darryl and went downstairs. I sat in the lounge room watching the sky lighten while our midwife slept. I knew I was hoping that she would see me, and that, finally, we could agree that *now* I was in labour. I also believed in my heart that the sunrise would bring a change of energy—dawn would be another turning point. Either this would all stop and I could get some sleep, or it would finally, finally, establish. At that point I honestly didn't care which.

Our midwife came upstairs with me again and asked if she could feel the baby's position. It had completely swapped sides in my belly and was now lying on my right, with its head (finally!) well down in my pelvis. Perhaps the long dark night of pre-labour had been to help my baby into a new, better, position? But still my surges weren't in any kind of a pattern: I'd have three close together and be quite vocal through them, but then there'd be ten minutes with nothing and we could chat about what was happening. I was very surprised when our midwife suggested calling our student midwife to come back. I said I was worried about having too many people here too soon, but then our midwife said that, since she was at least 30 mins away, we had better get her on her way. Really? Well, this was news to me... obviously something had changed! I think that was at about 6.15 am.

Around this time, I heard Indi wake up and go to find my Mum and Saffi. Although we had planned to wake the

girls if the birth was during the night, I was relieved that dawn had woken my daughters on this ordinary extraordinary day—a middle of the night waking could well have been a disaster. Perhaps my long, lonely night had been worthwhile,

“

I was pushing strongly now but with each surge I was able to pause as it tapered off and let the baby come down more gently. It took absolutely all my concentration to stay with it. I felt the baby start to crown, and felt stinging, and I was consciously grateful when the surge passed and the baby's head slipped back just a little... the next surge would bring my baby's head.

even if just for that!

Very soon after this, everyone knew that things had changed and that our baby was definitely coming, and quickly. The surges were now extremely intense and starting to get ahead of me. At one point, I was leaning on the bathroom cabinet through a surge—I remember slapping the sink in frustration or irritation at the intensity of it all! “Umm, I seem to be pushing,” I said, surprised that, after waiting all night, now I was suddenly progressing very quickly.

While I laboured on the toilet, our midwife and I heard some kind of popping noise. She grabbed a torch and tried to see if my waters had broken. They hadn't, and I said, “Maybe it was a bone” (meaning that one of my joints had made a cracking noise). We both laughed—I still had my sense of humour, at least between surges. At around this time, she also asked if I could feel the baby yet. I reached down, but I couldn't feel anything.

Our second midwife must have arrived, because I remember her voice too. She had the amazing strategy of putting her hand, almost like a fist, in my mouth to encourage me to open my mouth and breathe over her hand. It sounds like a really 'in your face' thing to do, and I guess at any other time it would have been—but in that moment it was perfect. It felt like another turning point: I was able to stop resisting my baby's descent and relax into the surges. Between surges, I remember saying several times, “I don't want to do this any more.” It was true—this was hard work! I also realised just how close the baby was, and almost yelled, “Get the kids!” Darryl bolted to the kitchen to get the girls, which surprised my mum because she still thought I wasn't in labour yet. Meanwhile, I was still on the toilet wondering how much longer that pool would take to refill. Everyone else had realised that this baby would be born on dry land... I don't even know if we managed to get the previous night's cold water out of the pool.

I was aware of the kids being with me, but I don't remember seeing them with my eyes. I knew I wanted to get off the toilet, but I also knew I couldn't walk. I'd had awful symphysis pubis pain throughout the pregnancy, and it was really painful to move my legs now. I said “all fours” and thankfully our midwife understood that I meant I was going to move from the toilet to hands and knees on the bathroom floor. A nest of towels was hastily assembled and I made this one move. It was all I could manage.

I was pushing strongly now, but with each surge I was able to pause as it tapered off and let the baby come down more gently. It took absolutely all my concentration to stay with it. I felt the baby start to crown, and felt stinging, and I was consciously grateful when the surge passed and the baby's head slipped back just a little. I also knew that the next surge would bring my baby's head. Silently, I said to myself: “The next surge will be it. You can do one more. This is the last time you ever have to do this.” As the surge built, and the head crowned, our midwife said quietly to me: “Just feel that. Feel that burn.” I don't know what she meant me to understand from that. I never would have predicted that I would be so helped by such a statement or that I would value



Saffi gives Vaughn the lick of approval

focusing on that particular feeling, but in that moment, it was perfect—a final turning point. My attention zeroed in on my body, everything else fell away and I was able to consciously decide to just feel it and be with it. It was a sensation of being completely present in that moment and it was exactly how I wanted this birth to be. With an almighty effort, I pushed my baby's head out. I remember reaching down and feeling the membranes still intact around the head, but I don't think I realised yet that my baby was about to be born in the caul.

My midwives help me move so that I was kneeling with one foot flat on the ground, and, with another almighty push, my baby's shoulders emerged, with the rest of him and a gush of fluid. With a

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Just feel that. Feel that burn." I never would have predicted that I would be helped by such a statement or that I would value focussing on that particular feeling, but in that moment, it was perfect--a final turning point.

little help, I managed to catch him and lay him on the towels in front of me. It was 7.35 am, perhaps an hour and half after 'active labour' really established. I brushed the membranes off his face and called him to us, gently stroking his body. Darryl helped Indi to announce the sex of the baby: “I think it looks like a boy,” she said. Yes indeed. I remember hearing Saffi say, “Baby has a gooey head.”

After a few minutes, I was ready to pick my baby up and, once he was in my arms, it wasn't long before I realised that it's pretty uncomfortable kneeling on a tiled floor. With a great deal of help, I stood up and began to inch my feet forward, but after just one or two creeping steps, I realised I could go no further... “Stop! The placenta is coming out.” This surprised everyone, but with quick thinking it was caught in a towel. That sorted, I continued inching my way to the bed.

Much later, it was Saffi's job to cut the cord (with Darryl's help) and then our midwife checked Vaughn over. “Yep, he's definitely a human being,” said Indi. We also weighed him and discovered he was a whopping 4460 g (9 lb, 13 oz). With the vital statistics collected, and everyone safe and well, our care team all departed. Tranquillity descended on our home and we were a family of five.

I will always be a little sad that some of my support team missed the moment of Vaughn's birth, and that my lovingly prepared birth space remained unused. But, in a way, it was Vaughn's message to me: “Make all the plans you like, but I've got my own ideas!” And indeed his arrival has turned our family upside down and inside out in the most delightful way. Welcome, Little V.

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Hold the dose of fear

By Lauren Kaiserman



A settled Monty thanks to continuity and support

I birthed my son on a swag on the living room floor on a Sunday afternoon. By 4 pm our midwives had gone home and a friend had already dropped a warm meal off for dinner. Our midwife Meryl visited our cocoon daily for the first amazingly blurry week with our little one. Monty was slightly jaundiced and didn't feed properly for the first 24 hours. The care we received through the local Homebirth Service ensured that we felt comfortable with the choices we made during this time. We were informed of what was considered 'normal' feeding, advised that there are many variances from the norm and informed of what is not normal so we would be able to recognise it. The feeding sorted itself out. We waited for Monty to get more interested and attach properly. We waited without fear, with the knowledge that he was still healthy and may just need time, with the knowledge of the type of advice we may have received in another setting and with my confidence still intact.

When Meryl visited she would ask us about his colour – had it changed, was it better or worse? Again the jaundice passed without fear, not because we were passively told that he would be alright but because we were informed of what 'alright' meant. If Meryl came by when he was feeding, the feed was never disturbed for any assessment. His sleeping was respected and he was never woken to be weighed or measured. Unlike my antenatal care, during this time it never even occurred to me to tidy the house for Meryl's visits. If she came when I was weepy with my boobs hanging out, then so be it. I am sure that this comfort came from having seven months of home visits where we had the chance to get to know

each other and having her with me for the birth of my son.

I got mastitis in week two. After an agonising night I went straight to the doctor, came home with my standard script for antibiotics and called Meryl. She came around later with Robyn (another experienced midwife and breastfeeding expert) and they spent two hours of their evening in my living room talking us through all things breastfeeding. On leaving, Robyn told us that we would have a

new baby in 72 hours. I thought this was a huge statement, but, sure enough, things changed. He fed more efficiently, was always full and satisfied, stopped getting stomach upsets and was more settled. My mastitis cleared up (without the drugs) and we all got more sleep.

By six weeks our life with Monty felt settled. By my last meeting with Meryl I didn't have any questions left other than the petty, "When will his rashy face clear up?" Although I missed our weekly catch ups I felt confident enough as a parent not to have our visits anymore.

It was at this stage that I was visited by the local community health nurse. I was greeting her at the door when she stopped mid sentence, said, "What's

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I walked out of these sessions with more anxiety about mothering, having heard so many different ways of doing what had seemed so much simpler before the influx of advice. Overall I enjoyed being able to meet other women who had also just become mothers.

going on in here?" and squeezed past me into my living room. I didn't understand, so I explained that I liked to have my son sleeping close by, which is why he was on a low futon in the living room. She was referring to him sleeping on his stomach. She began a SIDS-safe sleeping lecture before even asking me if I was aware of the risk factors for SIDS. I was gobsmacked that there was a stranger in my home who had assumed my ignorance and was now berating me. When she was done, we sat and continued the box ticking. Somehow I let her convince me to wake my baby so that she could perform a physical examination. He screamed the entire time and I was annoyed at myself for letting it happen. I fed him while she

handed me flyers about other services and fought back the tears while she imparted some anecdotes about improbable ways that she had heard of babies dying. I was relieved when she left.

A month after my son's birth I began attending an informal group discussion of parents of babies up to eight weeks old, facilitated by two community maternal and child health nurses. I only had a few friends with babies and was lacking parenting role models. The explosion of information was overwhelming. There was talk of 'dream feeds', 'expressing', 'settling techniques' and heaps of products and devices, none of which had ever occurred to me but seemed to be central to baby care. It was at one of these sessions where I first spied a disposable breast pad. I had been given a few lovely organic washable breast pads that I used when feeding and had taken to folding little squares of muslin in my bra when I was out. I was always leaking and when I asked people about this problem they would say, "Do you use breast pads?" and I would say, "Yes". I was shocked at my ignorance but pleased with the discovery. I walked out of these sessions with more anxiety about mothering, having heard so many different ways of doing what had seemed so much simpler before the influx of advice. Overall I enjoyed being able to meet other women who had also just become mothers.

Although I found the manner of the community health home visit inappropriate, I appreciated having a local drop-in child health clinic close by. I used it a number of times in the first six months and attended a parent support programme for new families there. The sessions consisted of four different speakers from government and non-government organisations. I appreciated learning paediatric CPR from the ambulance service but I didn't need to hear his stories about horrible injuries that he has treated in infants. I appreciated the water safety talk and the five free swimming lessons (to be used when bub was six months old) however the DVD of distraught

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It seemed that every introduction to services that promoted safe parenting was preceded by a healthy dose of fear. In my vulnerable state as a brand new mother I found it overwhelming and confusing. Who were they trying to convince? My protective instinct over my new baby was more powerful than I could ever have imagined, I didn't need the horror stories to convince me to make safe choices for my new family.

parents talking about their toddlers who had drowned felt unnecessary. It seemed that every introduction to services that promoted safe parenting was preceded by a healthy dose of fear. In my vulnerable state as a brand new mother I found it overwhelming and confusing. Who were they trying to convince? My protective instinct over my new baby was more powerful than I could ever have imagined, I didn't need the horror stories to convince me to make safe choices for my new family. I was also highly emotional and found it distressing. I attended all six sessions.

I am quite analytical and sceptical about most of the services that I attended, it is in my nature and I am also training to be a health professional myself. When my husband came home from work I would say, "The maternal health nurses were handing out free dummy samples and talking about giving formula to fussy babies at six weeks." The services, in general, were pretty good, just probably not for me. Overall I found them

invaluable, mostly because I didn't have anything else to do or anywhere else to go. I had only recently moved to Darwin when I became pregnant so didn't have many friends and the way I used to spend my time was too hard with a baby. I felt pleased waking up on a Tuesday knowing that the programme was on because I had something to work towards... getting out of the house and being somewhere at a certain time. It sure beat staring at the fan going around. Being a new mum was isolating and bouncing around free services for new parents stopped me from going stir crazy.

Even though I am now secure and settled socially in Darwin I continue to attend many of the government and community activities for families. The morning teas and various events hosted by the Childbirth Education Association (CEA) and the Darwin Homebirth Group were an excellent way of meeting people and this is where I developed my wonderfully supportive friendship base. I feel lucky to have started my mothering journey in a place that is so supportive of new parents. I had access to health care when my son was sick, regular child health check-ups (if I had chosen to take him), a huge amount of early parenting support and information about other services if required. It was easy for me to get involved in a couple of active community groups.

As my son gets older there are more and more activities and events that are enjoyable for me and fun for him – story time at the library, 'Fun bus' (free toddlers' activity sessions in the park), the local pool, kids discovery sessions at the museum, mums and bubs yoga at the CEA, the toy library. I know that this is unfortunately not the case for many families who do not speak English or who do not live in town or for many other reasons. This is a shame because I know that having access to continuity of care though pregnancy, birth and postnatally, along with access to early parenting support, was essential for me navigating through the most difficult yet fulfilling time of my life.

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

Please email submissions to birthmatters@maternitycoalition.org.au

on or before the posted deadlines.

It takes a village

By Bec Jenkinson and Joanne Smethurst



Bec and Jo's 'village' L to R: Shannon Morris, Liz Wilkes, Bec and Vaughn, Jo Smethurst, Ildiko Keogh, Kate Walter and Erika Hobba

New mothering by Bec

Mothering in the 21st century can be pretty isolating. In the months after the birth of my second child, while at home on extended (indefinite?) leave from my 'before-kids' career, I found myself pretty lonely. Many of my former work friends were childless, and my network of other mums was pretty small. Like many women today, I live a great distance from extended family who might have been able to help.

On one of the rare occasions I ventured out in those early months with two kids under two, I found myself with my midwife at a homebirth support group in Brisbane. 'How do you know if you've got postnatal depression?' I tearily asked her. It was the beginning of a months-long process, not of treatment for postnatal depression (although, arguably, my Edinburgh Postnatal Depression Scale score might have warranted that), but of realising that there is a range of not often spoken about feelings that come with early mothering. I agreed with a wise friend who said that she felt a significant proportion of 'postnatal depression' might be re-diagnosed as 'lack of social support'.

Fast forward to the birth of my third child a couple of years later and I had become a conscious creator of my own 'village'. It takes a village to raise a child, or so the saying goes. For women of previous generations that village might have come ready made, brimming with extended family members and neighbours who were also at home with young families. For us, our village is an interconnected web of women who

support each other in the early months of mothering a newborn and beyond.

What kinds of support can a woman's village provide? Whatever she needs and asks for! Perhaps most importantly, my village gave me permission to ask for help, something I am not often very good at. In the months after the birth of my third child, I found that mothering as part of a village wasn't nearly as lonely as going it alone and I was a better mum for it! In the early days, I was brought a delicious array of healthy real meals. Visitors came with playmates for my older daughters, or welcomed them to their homes. In both cases, I was relieved of 'hostess' duties as villagers were excellent at making their own cups of tea and making sure everyone was fed and entertained. I could disappear to put Vaughn to sleep (an arduous and time-consuming process!) or a wonderful friend would give my tired arms a rest and rock Vaughn off to sleep. My village was also *amazing* at supporting me to keep family life ticking over in other ways. Loads of washing were hung or folded, floors were swept and meals prepared – or not, if the more pressing need was a cuppa and a chat. One villager took over swimming lessons with Saffi, another came to Indi's circus class so that I didn't have to leave little V on the sidelines. On more than one occasion, I was able to preserve precious naptime by calling on a villager to do the kindy drop off or pickup. Perhaps most importantly, I knew that my women folk were only a phone call or text message away, day or night, to cry with, vent to or laugh with.

As the months passed, and I re-engaged

with MC work, my village once again stepped up. Not all of the people in my village are fellow MCers, but they know how important this work is to me. I call on them to care for my older children while I attend meetings, but in recent weeks they've also taken on a new responsibility: protecting me from my own inability to say no! Jo has become particularly vigilant in helping me to come up with other strategies for getting things done, beyond just doing them myself. In the world of volunteer birth reform activism, that is a really invaluable support to have!

I was so grateful for the support of my village, especially during Vaughn's early newborn days, that I decided to gather everyone together for a special celebration when he was 12 weeks old. I have a friend who calls this first 12 weeks the 'fourth trimester', in recognition of the completely dependent and all-consuming nature of a babe-on-arms through that time. I was inspired to do this by a similar circle that Jo had held to mark her decision to farewell her days of pregnancy and birthing. In some ways it was like a blessingway, I guess – but for a different stage of our mothering journeys. We never did come up with a good name for either gathering, but my village came together to honour the conclusion of my 'fourth trimester' and to celebrate the wonderful journey it had been. It was a chance for me to say thank you, and to hear from those who had been at Vaughn's birth their versions of his birth story. Perhaps such circles, marking various seminal moments in mothering, will become a tradition in my village life, a way of sharing the journey with my women folk.

Older children mothering by Jo

With older children, my village has grown and morphed with their ages and stages. Last year my partner had a very unexpected heart attack (I guess they are all unexpected!) and my village jumped to action. My beautiful MC friends put together a goody basket for the kids and me – activity books and stickers for the kids, a jar of organic trail mix to snack on, some body products for me to stop my skin drying in the crusty hospital (!), a journal and pen to record my feelings or questions through this unexpected challenge and a book about Australia to fuel our joint dream to travel this country.

Not only were my 'old' village supporting me, but I discovered I had been building a new village around me – a local one based on my children's school and kindergarten links. I had more

meals made, mums helping out with pick ups and drop offs while I was ferrying Simon around for countless tests and appointments, and lots of supportive good wishes every day up at the school.

In fact, I am so grateful for Simon's heart-attack. I felt so much love, compassion and support during this time. It showed me I had a larger village than I had realised.

So how did I build my village?

The meals I received back during my 'babymoons' were such delicious reminders of the support and love I felt from my community that I wanted to give back. So not only do I make a conscious effort to cook meals and provide support for my village during their babymoons, but I also include local mums whom I don't really know.

I've baked meals for neighbours, kindy families and old university friends. I've gifted a whole pile of baby clothes, sheets, bassinet, toys and playmats to a woman across the road whom I suspected had some challenges with drug dependency and who was (I suspect) in a difficult relationship. I wanted her to know that if, after her baby was born, she needed support and help I would be there for her.

I live close to school, so I offer my mobile number to lots of families, letting them know that if ever they are running late they can give me a call and I will either wait with their child at school or walk home with them to my house. I make plenty of offers, most of which are never taken up, just in case I'm ever going to need some help in return.

To me, being part of a village means allowing yourself to be vulnerable to others, asking for help, providing help and generally just being a good friend. It's not pretending you can do it all on your own as some sort of Super Mum. Sometimes it feels too hard to give of yourself when you

feel there isn't enough time for the things in your own life, but, as I experienced last year, when things do go wrong, being a part of a supportive, loving village makes the rough weather easier to ride.

In summary, we have built our villages by *paying it forward*. After all, we weren't meant to mother alone.




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Postnatal story: Merryana's breastfeeding journey

By Daniele Day



I planned the birth of my first baby with the public Ipswich Midwifery Group Practice, hoping for a calm natural birthing experience. I went to classes in hypnobirthing and active birthing as well as breastfeeding preparation, and was an active member of the Australian Breastfeeding Association (ABA). At around 34 weeks, we found out that my baby was breech. She stayed that way despite attempts to turn her via External Cephalic Version (ECV), acupuncture, chiropractics, hypnotherapy and various other positioning activities. So I started researching breech babies and breech birth. I attended a screening of the film *A Breech in the System* at the suggestion of my hypnobirthing teacher. After the unsuccessful ECV, I had about three meetings with obstetricians at the public hospital to negotiate terms for a vaginal breech birth. It was heavy going. The final compromise was that I would have a vaginal breech birth in the hospital, supported by my caseload midwife, but also a breech-experienced obstetrician for the second stage. I reluctantly agreed to give birth on a bed, and (after much deliberation, argument, crying and consultation with a private obstetrician who supports breech vaginal births) also agreed to have an epidural at 6 cm to prevent an early foetal ejection reflex. I was never happy with the epidural (or the bed really) but felt that I had to compromise to get the support of the hospital for my vaginal birth.

Fortunately, when I went into labour, I was 10 cm dilated at my first internal exam, so skipped the epidural and had a drug-free birth. I did have a shot of preventative antibiotics prior to the birth as my waters had released before active labour started. My baby and I had a lovely post-birth bonding and breastfeeding time, and I stayed one night in hospital. Initial breastfeeding went really well, using the self-attachment that I had learned at my ABA breastfeeding class. I knew that my baby, Merryana, was at increased risk for hip dysplasia (poorly formed shallow hip joints) as a result of being breech, and even more so as she was vaginally born. Other risk factors for hip dysplasia include a female baby (hormones), a family history (which we have on both sides), and a first-born baby (another tick). I made sure that her hips were assessed before we left the hospital the next morning: one hip was dislocatable and the other clicky. The doctor immediately fitted a Von Rosen brace, which kept her in a frog-legged position, and came up and over her shoulders, preventing back and neck movement. We were told the brace would stay on for at least 12 weeks, and that we would continue to need ongoing reviews for up to two years. Being positioned like this helps the hip sockets to deepen as the baby grows. There is very good evidence that the Von Rosen brace does improve a baby's hip joint, especially if it is applied when they are very young. The brace is worn 24 hours a day. We were told we could only take it off for bathing, although most parents are advised not to take it off at all. We took our baby straight home after the brace was fitted, and then tried our first home breast feed, which didn't go so well. The brace caused quite a lot of difficulties with feeding because Merryana could no longer self attach. She was completely unable to extend her neck. In addition, because she could no longer bend at the waist (and her little legs were stuck straight out at the side) it was very difficult to position her in line with my nipple. My husband suggested I try a football hold, which he had seen at the ABA breastfeeding education class—this helped with positioning her legs, and I started to use a feeding pillow to support her weight. My midwife visited the next day (Day 3), and we discussed the breastfeeding issues, but as Merryana was asleep and we couldn't rouse her, I didn't feed whilst

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she was there. I told the midwife that I had some slight nipple tenderness, but I thought this was probably normal when starting breastfeeding, and I wouldn't have described it as pain. The midwife said that this could mean that we had some attachment issues. On Day 4 it was evident that we had some attachment and positioning issues as my nipples were scabbed over, with cracks starting to form. My midwife helped to improve my attachment by teaching me how to place my nipple into Merryana's mouth (since she couldn't self attach) and loaned me a DVD, which taught the same attachment style. I found this really helpful and it did make a difference, but obviously feeding was very painful now due to the cracked nipples. I searched the Internet forums and found a few people who had managed to breastfeed in a Von Rosen brace, but these babies had not been put in the brace until they were three to six weeks old, so a breastfeeding relationship had already been established. Learning to breastfeed for the first time with the brace seemed to be what was causing problems for us. There is limited published research on the effects of a Von Rosen brace on breastfeeding. One study (Elander, 1986) compared the rates of breastfeeding for 30 babies in Von Rosen splints from birth for 6 -12 weeks with 113 random controls. The frequency of exclusive breastfeeding in the splinted group (around 82%) was significantly lower than in the control group (around 98%) at one week old—but



after this in both groups the breastfeeding rate continued to drop at a similar rate. The paper's discussion implied that the researcher believed that a 'complicated delivery' might be the cause for lower breastfeeding rates in the first week, rather than the splint itself. The paper defined complicated delivery as a breech vaginal birth, Caesarean or instrumental delivery (30% of the splinted babies versus 4% of the control). However, the researcher had developed this study to "clarify the breastfeeding rates of a special neonatal treatment which did not require separation from the mother" as a follow-on from a previous piece of research (which showed that mothers who were separated from their babies due to minor illnesses breastfed for a significantly shorter period than unseparated mothers). As a result her conclusion might be skewed. Elander also found that first-time mothers (and consequently inexperienced breastfeeders) of splinted babies were less successful in breastfeeding; however, this was also attributed to the higher number of 'complicated' births. In my case, my difficulties arose from the physical restrictions on positioning imposed by the brace, rather than my 'complicated' breech vaginal birth. These difficulties were exacerbated by my lack of prior experience in breastfeeding. In fact, I think the birthing 'high' and feeling of empowerment and awe I experienced by having a natural breech birth really helped me to persevere with such painful feeding. I felt that if I could vaginally breech birth in the public system then I should definitely be able to sort out these breastfeeding issues. My midwife continued to visit me daily and helped with attachment and positioning, but also encouraged me to seek the help of a lactation consultant as she had no experience with helping someone to feed with a Von Rosen brace. The mothers she had seen with splinted babies had changed to formula feeding

once the brace was applied. Luckily I live in an area where we have lactation consultant drop-in clinics available three mornings a week, so I went along on Day 5 (the first clinic after all the Easter public holidays). After two visits the lactation consultants said that my attachment looked as good as could be expected given that Merryana could not extend her neck, but my cracked nipples were still not healing. Feeding was extremely painful for the first two minutes of attachment, but then remained very painful throughout the entire feed. Also, I would have to reattach Merryana around 20 times during the one-hour feed—she seemed to be slipping off my nipple. She didn't seem to be covering her bottom gum with her tongue when feeding, but there was no obvious tongue-tie. The lactation consultant referred me to a GP specialising in tongue-ties and, when Merryana was three weeks old, he diagnosed a posterior tongue-tie, which was snipped immediately. This made a huge difference to my feeding, in that I could now feed for 20 minutes without the need to continually reattach. This considerably reduced the sharp initial pain, although moderate pain throughout the entire feed was still a problem due to persistent nipple cracks caused by the lack of neck extension and poor positioning. “
... I think the birthing 'high' and feeling of empowerment and awe I experienced by having a natural breech birth really helped me to persevere with such painful feeding. I felt that if I could vaginally breech birth in the public system then I should definitely be able to sort out these breastfeeding issues.

I clung on to the hope that feeding would improve when we hit the six-week mark. At this time she was due to have a hip ultrasound on Friday, and then to have the brace off for the entire weekend until her review appointment on Monday. The six week mark came and Merryana's hips had improved so much that I was told she would not have to wear the brace any more, but would continue to be reviewed regularly to check her hip sockets. It was lovely to have a snuggly little baby, although it took us a few days to get used to caring for a floppy baby. (We whacked her head into walls a few times while we adjusted to having to give her more

support!) Having the brace off normalised my positioning, but I still had badly cracked nipples and developed a severe case of nipple thrush. Prior to the birth I had taken probiotics in an attempt to ward off thrush, but had forgotten all about these once I went to hospital and then came home with a new baby. In hindsight, I should have realised that the IV antibiotics would place me at risk, but I wasn't aware how awful and difficult to eradicate nipple thrush could be. For my next birth I will definitely have a comprehensive thrush avoidance plan. Nipple thrush continued to be a massive, incredibly painful and stressful battle for me, until improvement began in Week 11 through a combination of medications, an elimination diet, and rigid hygiene/sterilisation practices. I had a lot of difficulty accessing the medications that I needed to get rid of the thrush, as they all advised "not recommended for breastfeeding women" on their packaging. The medications that I could get from a pharmacist were not sufficient to get rid of the degree of thrush I had developed (and I believe my thrush had become resistant to some of the first-line treatments recommended). I ended up using an internet pharmacy and checking the actual effects on breastmilk of the drugs with my lactation consultant. Finally my nipple cracks healed and, by 18 weeks, I was able to stop using the feeding pillow. I also felt confident enough to schedule a camping trip to the Northern Territory when Merryana was three and a half months. Now, at 21 months along, we are going strong with breastfeeding and I am pregnant with my next baby. I am so glad that I persevered and it is lovely to be now able to feed in all sorts of positions—lying in bed without turning on the light, bent over the car seat, bushwalking in the sling. My advice to anyone who is feeding a baby in a Von Rosen splint is to get professional assistance (a lactation consultant or face-to-face ABA breastfeeding counsellor) to check your positioning as early as possible. But, more importantly, establish a supportive breastfeeding community before you have your baby—I was lucky to have the support of my many breastfeeding friends, my husband, the midwifery group practice and the Ipswich ABA group that I had been attending since starting maternity leave. The journey would have been so much harder if I had had to find this support after I was already struggling with breastfeeding. A different version of this article was printed in the Australian Breastfeeding Association's, magazine Essence September 2011 issue.

References

Elander G. (1986). Breastfeeding of infants diagnosed as having congenital hip joint dislocation and treated in the Von Rosen splint. *Midwifery* 2, p. 147–151.

Film preview: Face of Birth

By Kate Gorman

The end of a long gestation for an Australian film about Birth After two and half years, *The Face of Birth* has finally been released. It's taken longer than we ever intended and it's sometimes been hard and frustrating, but also amazing, wonderful and never boring! We filmed during a time when it was hard to keep up with the changes in maternity care, and yet has there been change enough?

I first decided to make a film about birth in 2009 when, pregnant for the third time, I found out from my independent midwife that my choice of homebirth was under threat. My background is in drama, feature film and television, so I rang a friend and documentary producer who said I must meet Newcastle film maker Gavin Banks. Gavin had been passionate about birth and wanting to do a project around homebirth for a long time, so we teamed up and *The Face of Birth* was born.

Moments of pure gold have been captured from Sheila Kitzinger, Michel Odent, Lesley Page, Hannah Dahlen, Rhea Dempsey, Ina May Gaskin and Robbie Davis Floyd, as well as many Australian academics, midwives and doctors. *The Face of Birth* gives a face and voice to homebirth

"Not just a homebirth doco. The Face of Birth offers excellent insight into Australian birthing culture and provides them with the tools and knowledge to get savvy and real about their childbirth choices."
~ Jess Permezel, Choices for Childbirth


mothers, sharing in five women's diverse and beautiful stories. It looks at the issues of choice, safety, empowerment, the rising caesarean rate and its costs. The film also takes us to the Northern Territory. This was a life changing experience for both Gavin and me. We were privileged to share in traditional Aboriginal women's ceremonies and learn about the importance of being able to choose to birth 'on country'. Indeed the film's resounding message is about the power of choice for all women.

We found we didn't really have to do that much to get the film known throughout the birthing community—they have been waiting for this film for a long time and the support has been incredible. Our community screenings have been organised by different maternity groups, with tremendous support from the Maternity Coalition. The challenge for us is getting the film out to a broader audience including women and families who haven't yet begun to think about their birthing choices and are completely unaware about the lack of choice.

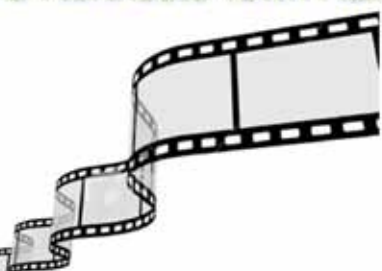
SO if you are coming to a screening, please bring someone with you who hasn't yet given birth. It is everyone's right to choose their place of birth, even those who don't know it yet.

Kate Gorman
Co Director/Producer
The Face of Birth





Movie Nights
@ Northcote Town Hall



Bringing the vision of natural pregnancy, birth and parenting to the community

Where: Northcote Town Hall
189 High St, Northcote, Vic

For bookings and screening details:

Web: www.maternitycoalition.org
www.birthattendants.info

Email: MCmovie@birthattendants.info

Phone: 03 8677 1881

Cost: \$10 pre-paid booking, \$15 at the door

Brought to you in partnership with Birth Attendants.info



faceofbirth.com

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

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

BIRTH AFTER CAESAREAN SUPPORT: ONE ORGANISATION'S OFFERING

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

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

Knowledge Not Fear

Birthtalk acknowledges that women and couples planning a subsequent birth after caesarean do have some specific issues to consider. Birthtalk encourages attendees to approach these issues in the context of working towards an empowering birth, where you are making all your decisions based on knowledge, not fear. The course enables those preparing for a birth after caesarean to receive evidence-based information, and offers appropriate support so attendees can ask questions and have their fears addressed.

Won't a VBAC Just Be Better?

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

Empowering and Safe

According to Birthtalk, to make your birth a positive event, you need to focus on having an empowering experience. The above list of traumatic feelings is, in essence, the definition of a disempowered birth. All women want their VBAC to be an empowering and safe experience, so, it makes sense to focus on turning the above feelings on their head. This means learning tools and accessing information so you feel: in control of what happens to you, central to the experience, safe and nurtured, and able to obtain information through questioning your care-givers. This will increase the possibility of walking away from your birth feeling strong, confident, and positive about the parenting journey ahead. Birthtalk offers these tools and other ideas at their VBAC course. ©Birthtalk2009

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

ADVERTISE IN BIRTH MATTERS



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

birthmatters@maternitycoalition.org.au

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

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

Member notices

Management committee meetings (National)

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

General meeting dates for 2012

General meetings will be called as required and members given 14 days notice. The date for the 2012 AGM will be published in the Autumn 2012 edition of *Birth Matters*.

Midwives in Private Practice (Victoria)

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

Choices Victoria

For details and dates regarding Melbourne, Geelong and Ballarat Choices for Childbirth programs, please visit our website: www.choicesforchildbirth.org.au.

Donations

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

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

MC bank account details

Commonwealth Bank of Australia Branch: Ringwood Victoria
Account Name: Maternity Coalition Inc.
BSB: 063 167
Account Number: 10108586
Postal Address: PO Box 1190 Blackburn North Victoria, 3130, Australia

Infosheets

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

Topics include:

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

Birth announcements note

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

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

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

Maternity Coalition Contacts

MC contacts (National) Office Bearers 2012

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Ballarat President: Michelle McRitchie
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Branch Information

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

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

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

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

MC online discussion lists and social networking groups

Find us on



Join an MC email group!

MC members are able to keep in touch with other members interested in the same issues via Yahoo! email discussion groups. Yahoo! Groups allows files to be stored and retrieved including documents, databases and the like, and messages archived. All discussion groups are governed by electronic communication guidelines established by the MC National Committee.

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

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

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

MatCoWA. For members in WA. Contact Tracey Reibel at wa@maternitycoalition.org.au if you'd like to join.

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

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

Qldcore list is for active members of Maternity Coalition in Queensland. Queensland also has two other lists if you don't want to join the core group but want to stay informed or receive a copy of the Birth Action News e-newsletter. Contact qldpresident@maternitycoalition.org.au.

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