

# BirthMatters

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Autumn 2013



Continuity of care - where you can get it!



## This issue:

How can we deliver choice, control and continuity?

## PLUS:

Birth stories across the spectrum

New Sections: Interview, In Review, Research News



Maternity  
Coalition

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

# Australian College of Midwives 18th Biennial Conference

30 September - 3 October 2013 | Hobart

Life, Art & Science in Midwifery

**Hobart, Australia** is the host city for the Australian College of Midwives 18th Biennial Conference. Hobart is one of the most beautiful cities in Australia. Its serene harbour, renowned historic buildings and proximity to heritage areas combine to make it a unique destination.

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Australian College of Midwives  
18th Biennial Conference  
30 September - 3 October 2013 | Hobart  
Life, Art & Science in Midwifery



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## OUR PURPOSE

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

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

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

## GUIDELINES FOR SUBMISSION

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

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

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

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

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

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

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

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

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

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**ADVERTISE WITH US!**

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

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

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



Continuity of carer is as old as birth and the profession of midwifery. Women have always helped other women give birth in their communities. As the place of birth transitioned to hospital, the relationship between the woman and a midwife was lost. Care became predominantly fragmented, supplied by multiple providers throughout the course of pregnancy, birth and early parenting. Continuity of carer was limited to women who employed private midwives for homebirth.

Private midwifery care is still a strong preference for many women, as expressed in this edition's **Birth Stories**, including Kate Anbeek's 'Big belly homebirth'. Publicly funded homebirth services have been few and far between. In the **Feature Article**, Pip Brennan shares a little about the history of the longest running publicly funded homebirth program in Freemantle. These programs are now becoming more widely available. Midwife and mother Sarah Vlal offers her experience of both working in, and receiving care from, the Mullumbimby Birth Centre

caseload program, while Kylie Sheffield describes her experiences with the Darwin Community Health Homebirth Service.

In the last few decades the demands of women for access to continuity of care models within the public health system have seen the proliferation of services across the country. In our new section, **Interview**, I ask researcher, midwife and grandmother Donna Hartz to identify Australia's best examples of continuity of carer. These programs are predominantly in the form of Midwifery Group Practices (MGPs). Today these models provide women care in hospital birth suites, birth centres, and at home. A number of women have shared their unique experiences of hospital birth with MGPs in **Birth Stories**, including 'Lotus birth...with Ryde MGP' by Chand Somaiah, and 'Two birth journeys... Casey Hospital's caseload program' by Lily Fetter.

Unfortunately, there are not enough of these programs, particularly in rural areas. In this edition of **Rural Matters**, Bec Telfer highlights some shining examples of rural and remote continuity of care. Alecia

Staines shares her story of two births with midwifery continuity in rural Queensland in 'Tin hut on the river and Queenslander on the main street.'

Where continuity models are available, demand outstrips provision; women consistently come up against tight inclusion criteria (many are 'low risk' only models) and there are often waiting lists or a ballot system of entry. Bruce Teakle writes about the challenges and opportunities offered by eligible midwives in our **Federal Update**, and we celebrate the opening of My Midwives Beenleigh.

In our new regular section **Research News**, we summarise current research evidence that midwifery-led care is beneficial to women and babies, while the way women negotiate the Australian maternity care system and make 'savvy choices' is the topic of the book reviewed in this issue's **In Review**. I hope you enjoy this issue of *Birth Matters*. Feedback about this issue or any issues relevant to MC are welcome and will be included in the new section **Letters to the Editor**.

Jyai Allen

## From the President



by Bec Waqanikalou

2013. It is shaping up to be a busy year!

There has been a lot going on behind the scenes for Maternity Coalition over the last few months, and it does not look like slowing down any time soon.

As President, my goal this year is to work with the Committee on the organisation's structure and to reconnect with our local branches, state branches and of course our members. There have been a number of big issues over the last few years and now things have eased off a little, we have the opportunity to review what we do well and where we need to improve to continue the important work we do.

During the last quarter the National Committee have been working on the new Maternity Coalition website ([www.maternitycoalition.org.au](http://www.maternitycoalition.org.au)) which is now LIVE! It is a work in progress, but overall we are really happy with the results so far.

Any feedback would be appreciated, both positive and constructive, or if you have an interest in IT and would like to assist in its future development please contact me.

I would like to congratulate Kylie Sheffield on becoming the new Vice President for the National Committee. Many of you know Kylie as the previous Editor of *Birth Matters*, and now she has passed the reigns over to Jyai it has allowed her to step into the VP role. Kylie's focus will be on the upcoming Federal Election scheduled for September. She will be the Maternity Coalition representative on the ground in Canberra and will be on the tails of the politicians to ensure women's rights and choices in birth are heard and respected. If you would be interested in assisting Kylie and others in the Political Lobbying over the coming months, please get in touch via email

[president@maternitycoalition.org.au](mailto:president@maternitycoalition.org.au)

Look out for our new printed materials in the coming months. We have been fortunate enough to secure a grant towards new printed materials including business cards, bookmarks, flyers, info sheets and other promo materials. We will be distributing these as they roll off the press.

While I have the opportunity I would like to congratulate three amazing women from our National Committee on the arrivals of their babies.

Jess Permezel and her family on the arrival of Milo, Ann Catchlove and her family on the arrival of Theo and Jen Egan and her family on the arrival of Joshua.

I welcome any feedback, ideas or suggestions on the above and look forward to speaking with, emailing and meeting as many of you as I can.

Bec Waqanikalou

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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.



Follow **birthchoices** or **CaesareanAU** on twitter.com for quick notification of media articles, interviews and behind-the-scenes info about the politics of childbirth.

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# The full spectrum of maternity care: a birth journey 1996–2007



Genevieve's daughter just after birth

young I had no friends who had birthed. A few days' post-dates my obstetrician sent me off for pelvimetry (an X-ray to estimate the size of my pelvis). A few days later, I had an induction of labour with prostaglandin gel. The hospital midwives did absolutely nothing to get labour happening. After the waters broke spontaneously, I remained on a bed nearly all day with mild contractions, which fizzled out by the evening. At this point the obstetrician's information was completely biased towards caesarean section; there was no other decision to be made but to have surgery. I felt like a rabbit caught in headlights.

The surgery itself went fine and the baby was fine. I remember staff talking about their weekend plans etc. during the procedure; no one explained what was going on, and no support was provided. My son was in a crib with me in recovery, but I didn't hold or feed him until the next morning. I recall feeling disappointed with the experience; there was no overwhelming elation and connectedness. My partner, though happy, had not at all enjoyed the caesarean experience, and had felt quite unwell at times. I was in hospital for nine days following birth; we never saw the same midwife twice, and breastfeeding was not going well. After discharge from hospital, we did not see the obstetrician again until the six-week check-up. By this time, I had ceased breastfeeding. At that appointment she told me that I would never be able to have a normal birth with bigger babies (my son had weighed 3.69 kg). The seed of 'once a caesarean, always a caesarean' had been planted!

## My second pregnancy

The same elements that I lacked for my first birth were also lacking in the second birth in 2000. I spent the pregnancy travelling between Australia and the United Kingdom, with very inconsistent antenatal care between several care providers and hospitals. I finally settled in London not long before birth. The option of vaginal birth after caesarean (VBAC)

was never discussed. When I met the obstetrician at the local public hospital, I mistakenly recounted my previous birth story and showed her the pelvimetry report (gosh, what was I thinking?). She recommended we schedule an elective caesarean section a week before the due date. Given that we were in a new country with no family or friends, and with my husband only able to take a few days off work, we felt that this was the probably the best option.

I was mortified when a staff member came in to see me the evening before the birth to shave my pubic hair. She was very nice about it, but no one had mentioned that it would be required. The surgery went well and my baby was fine. During the caesarean the staff interacted with me and explained what was occurring. This time the baby was given to me in recovery for skin-to-skin contact and to begin breastfeeding with midwife assistance. The whole thing felt more like a birth. My partner was not present (due to difficulties finding someone else to look after our eldest son) and he was actually relieved not to be there. Afterwards, on the postnatal ward, I had to wear pressure stockings, which made me feel even more out of place. I had the same breastfeeding problems as last time, and, again, gave it away. My son weighed 3.315 kg.

In the intervening years between babies two and three, I just couldn't understand why I needed to have my babies surgically removed and couldn't birth them like everyone else. I hated sharing birth stories as I had nothing to tell and the reasons for my caesareans sounded really weak. I knew that if I had another baby I didn't want to have another surgical birth. A friend suggested VBAC and she had to explain what it was.

## My third pregnancy

I fell pregnant again towards the end of 2004 and, again, we were on the move to another city, although this time it was only a couple of hours away. When I booked-in at our local public hospital, I mentioned the possibility of vaginal birth to the midwife. She said something along the lines of, "Oh, the doctors won't go for it." At my 20-week obstetric appointment the consultant obstetrician (another woman) said that I would have to have another

*I have put together here my birth journey through four pregnancies and births over an 11 year period (1996–2007). I want to compare what can happen all too easily to birthing women in Australia (especially those hoping for better outcomes by paying for private, obstetric care) with the outcomes that are possible when women can access partial or full continuity of care with a known midwife.*

## My first pregnancy

My birth journey began when I unexpectedly fell pregnant at 19 at the end of 1995. I was a full-time university student in excellent health. I was raised in a family where private health cover was valued and I believed that it gave you 'choice' and 'continuity' of care provider and hospital. I did not find the thought of being cared for by someone unknown (particularly a male doctor) and then sharing a room with one or more women and their babies after birth appealing. So I elected to be treated privately, selecting a female obstetrician for care (unfortunately I later learned she'd had all five of her children by caesarean section).

My obstetrician didn't place any value on antenatal classes, so we didn't go, as we couldn't really afford the additional cost. My preparation consisted of reading all the books that she recommended (all very medically based); that was it. Being very

caesarean. I was a bit taken aback that no reasons were offered as to why it was necessary and that no other choices were even considered. I didn't really know how to respond. As I left I became resolute that, somehow, I was going to have a normal birth. At my next GP appointment, I became a bit emotional when I told her I wanted a normal birth. Not really knowing what to do with me, she advised me to seek another clinic appointment with a consultant.

A couple of weeks later, while out at a baby/children's event, I came across a table with pregnancy- and birth-related information. I enquired about VBAC information. The woman staffing the table said that she had lots, gave me her business card and urged me to contact her to have a chat. It turned out that she was an independent midwife, providing care to women across the childbirth continuum. If I had not met her by accident that day, then I think I would have travelled an all too familiar path to birth. After meeting with her to review my hospital records from my first birth, she confirmed that it was quite likely that my first caesarean had been unnecessary and so, probably, had the second (repeat) caesarean. From that first consultation, she had faith in my ability to birth my own baby, and that instilled much needed confidence. Then we just had to convince my husband, who at the start couldn't understand why I wasn't treading the familiar caesarean path and took a while to come round! The remainder of the pregnancy was spent preparing comprehensively for the birth. I attended two separate antenatal courses, including hospital classes which were too medically-oriented, and community classes facilitated by independent midwives, which were far superior, more intimate and supportive.

I only had a few appointments with my midwife, as our family could not afford the additional cost, but those appointments lasted up to 90 minutes. Hospital appointments with the head obstetric consultant were dreary and draining; they were not supportive of my choice, statistics were overstated, and so much of the focus was on the negative (especially scar rupture and its consequences). The enormous benefits of normal birth for both mother and baby, and the downside of having surgery, were not discussed. The obstetrician said that if I did not agree to the hospital's terms for labour by signing an agreement, I could be refused entry when presenting in labour! How could a public hospital turn

anyone away, yet alone a woman who is supposed to be 'high' risk? He also sent us into a mad flurry, insisting that we obtain my birth record from the UK, to confirm the type of incision made. He intimidated my husband when he attended my appointment post-expected due date (EDD) (the only appointment he ever came to) by going on about being overdue with placenta deteriorating, death of baby, etc. A caesarean section was booked for ten days post-date (even though I had clearly articulated my refusal). The pressure was on: go into labour spontaneously or have surgery again.

Finally, on the eighth day post-date, I went into labour late in the night; our baby was born just after 8 am the next day. All went very well, there was no intervention apart from continuous monitoring (external and then foetal scalp). The on-duty registrar only came in for a few minutes to request that I have a few things done (as per agreement); these I mostly declined and so he left us in peace. I was well supported by my independent midwife at home and she came with me to the hospital, along with my husband. I was on top of the world; I birthed my own baby! My husband also found the birth to be a very positive and rewarding experience. This time my baby weighed 4.09 kg! Breastfeeding got off to its usual difficult start, but my midwife was able to refer me to other health professionals. My baby had a high palate (it is very likely that my older two children did as well, as the symptoms were all the same) and it was treated by a chiropractor; we breastfed for 20 months. I was amazed that I could finally enjoy breastfeeding without wincing pain, severely damaged nipples and blood!

## My fourth pregnancy

When I fell pregnant again in 2007, I balloted for a place in our hospital's new midwifery continuity of care model, knowing that having at least one caesarean was on the exclusion list. I felt it was my right to be able to choose the care that would give me the best outcome, physically and emotionally. Unfortunately, I was right; I was not able to take a place because I was still deemed to be carrying additional 'risk'. The obstetrician admitted that he didn't know what that was, because my situation is very rare. He also admitted that continuity of care with a midwife would give my baby and me the best outcome. I was very frustrated, as I have very normal, healthy pregnancies and women birthing in this model do



Genevieve's four children

so using the same facilities as everyone else with the same access to medical equipment and staff.

After that we decided to have a homebirth, as that was the only way that I could access continuity of care from a midwife, and not have to deal with any pressure from the hospital. At 17 days post-date, I gave birth to our only daughter in the quiet and private surrounds of our home, wonderfully supported and cared for by our midwife and doula. It was fantastic to be at home. She weighed in at 4.25 kg! I had the usual breastfeeding problems, which were soon sorted out by a chiropractor.

Reflecting on my birth journey, I am someone who has longer pregnancies and I am disappointed that our system places such focus on the EDD, when it is just an estimate. I am also upset that there is such a great disparity in midwifery care. (I think more proactive midwives in my first two experiences could have made a significant difference.) This has been a significant life journey, and I might not be in the place I am now without travelling this path and experiencing just about the entire spectrum of birth care.

## Author Bio

Genevieve Sayers is a CD (DONA) practising doula, mother of four children (ages 16, 12, 7 and 5), and active member of Maternity Coalition (MC) for more than six years. She is currently MC Branch President (Tasmania) and the new National Treasurer. To get in touch with Genevieve email [tas@maternitycoalition.org.au](mailto:tas@maternitycoalition.org.au)

# How can we deliver choice, control and continuity to Australian women?



*In 2009–2010 Maternity Coalition (MC) worked really hard representing Australian women while the Commonwealth established major reforms in maternity care funding. Three years later, what's happening and why do so few Australian women have access to Medicare-funded midwifery?*

## **The Commonwealth maternity reforms of 2010**

The Medicare reforms, enabling Australian women to receive Medicare rebates for midwifery services, were a historic turning point in the campaign to give women more choice, control and continuity in their maternity care. These reforms were an outcome of years of intense lobbying by consumers and midwives, which started in 2002 with MC's *National Maternity Action Plan*, and its vision of 'community midwifery' as an option for all women. However, in 2013, more than two years after the November 2010 implementation, very few women are benefiting from Medicare Benefit Scheme (MBS) rebated private midwifery care.

The reforms had several key outcomes:

- a class of 'eligible' midwives who have met a defined standard of competence and experience;

- a range of MBS rebates for women receiving services from eligible midwives in private practice;
- subsidised professional indemnity insurance for eligible midwives; and
- a range of PBS-subsidised drugs which eligible midwives can prescribe.

For women, these reforms have the potential to greatly improve their maternity care options. Theoretically, a woman can choose and employ an eligible midwife, without medical referral, who is directly responsible to the woman.

These reforms give midwives the potential to practice as professionals in private practice instead of as employees. This brings their practice under their own responsibility, aligned with the standards of their profession, instead of just the preferences of local hospital stakeholders. Importantly, in private practice, midwives become more accountable to the women employing them.

## **The obstacles to eligible midwives in private practice**

During the development of the reforms, under pressure from the medical lobby, the Federal Government made Medicare

rebates conditional on midwives having 'collaborative arrangements' with medical practitioners. Despite intense resistance from consumer, midwifery and nursing stakeholders, these provisions stand; however, in late 2012, State and Commonwealth health ministers agreed to relax the definition of 'collaborative arrangement' to enable non-medical hospital management staff to enter signed agreements with eligible midwives. This amendment is yet to be made to the legislation.

I think the Government genuinely believed that midwives would be able to become eligible, move into private practice, and start delivering services to women. They were unable to grasp the scale and nature of cultural resistance from doctors and hospitals to the proposed changes to the professional role of midwives.

The potential of the reforms to deliver improved choice was obscured by a series of problems that put women's choice at risk. The introduction of national registration for health practitioners, including new rules requiring professional indemnity insurance, created the risk that private midwifery care for birth at home, or even non-clinical hospital support from private midwives, would breach registration conditions. Further inflammation came from a briefly endorsed Australian College of Midwives' position statement on homebirth, which raised concerns about abandonment of women with risk factors who chose to birth at home.

These tribulations drew the energies of the birth reform movement and, I believe, obscured the potential for a fundamental re-shaping of the maternity care system we now have.

## **Fortress hospital**

Since 2010, the real action in implementing the Commonwealth maternity reforms has been at the State and local level. Midwives can provide primary care in the community, but their practice depends on their clients having access to more complex care, usually in hospitals. In addition, most women choose to birth in hospital, so for women to receive meaningful continuity of midwifery care, private midwives need access to hospitals and hospital doctors. Without this, private



midwives are restricted to antenatal and postnatal care. For birth at home, or in hospital, the midwife is limited to a 'support' role.

There is extremely limited potential for eligible midwives to gain access to private hospitals. Private maternity hospitals essentially offer a 'hotel service' for private obstetricians, providing rooms, equipment and nursing and midwifery staff to support the obstetricians' care of their clients.

Private health insurers could save a lot of money funding lower-cost models based on eligible midwives; however, for now, private hospitals will be listening to private obstetricians, not women.

Currently, the primary obstacle to Medicare-funded care from eligible midwives is midwives' lack of access to public hospitals. For private midwifery practice to work, eligible midwives need to be able to consult with and refer to public hospital staff obstetricians and other doctors, and admit women as private patients for labour and birth. The need for cooperation between eligible midwives and public hospitals was obvious from the start of the reforms. The Federal Government appeared to believe that the fact that it made such obviously good sense meant that it would happen.

Despite this universal commitment to cooperation by the States who run them, the vast majority of Australia's public hospitals have kept their taxpayer-funded doors closed to eligible midwives and their clients. This is despite government direction, consumer demand, clinical advantages and financial benefits. The internal cultural forces are too strong, and the leverage from government and influence of consumers too weak, for hospitals to change easily.

### Cultural barriers

I see two main cultural forces at work resisting this choice for women: medical/obstetric culture, and nursing culture. These cultural obstacles are a key strategic issue for consumers and midwives seeking to progress reforms.

The obstetric profession is dominated in Australia by obstetricians in private practice. This private-practice culture is business-focused, has limited clinical accountability, and operates in a clinical model where midwives practice more under instruction than in collaboration. For most of this group, the potential rise of eligible midwives in the maternity marketplace is a threat to income and power. Luckily, there are many staff obstetricians in the public system with

very different practice and culture: these obstetricians are collaborative, keen to see primary models with less routine obstetric input and more midwifery consultation and referral, and pragmatic about the need to give women more choice and reduce costs.

The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) has published statements of advice to its members that illustrate and reinforce this private obstetric dominance (available on their website). *RANZCOG Guideline: Suitability Criteria for Models of Care and Indications for Referral within & between Models of Care* does not recognise a private midwife consulting and referring to a public hospital as a supported model. *RANZCOG's Collaborative Maternity Care Agreement between: The Patient, Specified Medical Practitioner(s) and an Eligible Midwife* proposes an impossible model of collaboration, requiring a signed agreement for each woman, requiring the midwife to practice to obstetrically defined guidelines (potentially breaching her own regulatory framework), and enabling the obstetrician to define the midwife's scope of practice. Cooperation between public hospitals and eligible midwives can't happen unless the staff obstetricians are willing to break, to some extent, from their professional tribe, and collaborate in a way that works.

Traditional nursing and midwifery culture also struggles to adapt to new models of midwifery care. Following its 'military-monastic' origins, nursing is adapted to practice as with nurses as employees, in institutional settings, under medical instruction and close surveillance. Until recently, nearly all Australian midwives have been registered and employed as a type of nurse, working within the same practice framework.

Private midwifery practice comes as a shock to this system. Private practice midwives work more as professionals and less as employees. Their clinical decision making is more based on profession-wide guidance, and less on local policies and workplace instructions. In short, midwives in private midwifery practice (including those employed by private group practices) have a high degree of professional autonomy and responsibility; more like a doctor, less like a nurse. This is very uncomfortable territory for many nursing managers, who may struggle with the idea of having private midwives practicing in their hospital, outside of the usual mechanisms of command and control.

### Progress in Queensland

Despite these major cultural obstacles, significant progress is being made in the Medicare maternity reforms. Queensland is way ahead of other States, with four public hospitals (Toowoomba, Gold Coast, Bundaberg and Ipswich) all cooperating with local eligible midwives. In each of these hospitals, eligible midwives have been 'credentialled' (having their competence and references considered by a credentialling committee) in a very similar process to that applied to doctors. They have license agreements that set the conditions for the midwife's use of the hospital's facilities. They also have various deals for 'collaborative arrangements', to meet the requirements of the Medicare legislation. All of these sites are breaking new ground, locally and nationally, so processes and relationships are being refined. However, they work and they are delivering greatly expanded choice for local women.

Toowoomba, a major regional city in South-East Queensland, was the first place in Australia where eligible midwives made a deal with a public hospital. Women can walk in through the clinic door to check the practice out, take a pregnancy test, meet the midwives and start receiving Medicare-rebated midwifery care at their own choice. They can choose to birth at home or in the Toowoomba Base Hospital birth centre; and they can make this choice when they want to.

Toowoomba hospital's cooperation hasn't happened because their managers have an interest in women's choice in birth. Management are responding to significant consumer and political pressure, over a number of years. They are also aware of the major financial benefits of collaborating with eligible midwives. Each woman who is cared for privately by My Midwives, instead of through the public system with Toowoomba Base Hospital, saves the hospital thousands of dollars. The cost of care is shifted from the hospital's State-funded budget, to the Commonwealth budget through Medicare, and to the woman's out-of-pocket costs.

### Political forces for change

For consumers and midwives wanting to increase women's access to these models, it is essential to understand how to get change to happen. Support and pressure from the Queensland State government has had a major influence on progress in enabling access to eligible midwives. A coalition of consumers (represented by MC), midwives (ACM) and the nurses'

union (Qld Nurses Union, QNU) have been meeting with the current and previous Ministers for Health to push for hospital cooperation with eligible midwives. Ministers have been informed about eligible midwifery and its benefits, and have been strongly supportive. After a meeting in mid-2012, the Minister wrote to Queensland's hospital boards and encouraged them to get their hospitals cooperating with eligible midwives. With Ministerial support, the Department of Health's Chief Nursing Officer has sponsored a statewide Collaborative Arrangements Steering Committee (including consumer representation), which meets monthly and which has developed documentation to help hospitals collaborate with eligible midwives.

The other States and Territories each have eligible midwives (in smaller numbers than Queensland). However, (to the best of my knowledge) their public hospitals have not yet credentialled midwives to practice privately within their facilities, nor signed access licence agreements to use their facilities, nor entered 'collaborative arrangements' with eligible midwives. In these circumstances eligible midwives can still operate, but their practice, and women's options, are severely constrained. Perhaps most frustratingly, women birthing in hospital may only bring their eligible midwife for support, not midwifery care, requiring doubled-up care from hospital midwives, and setting a harsh line between support and midwifery practice, which the midwife must not cross.

### Risk at the Federal level

Lack of progress in the maternity reforms increases the greatest risk to women's choice: a new Federal Government discarding or winding back Medicare for midwifery. Conservative governments have traditionally been more sympathetic

to the hard-line medical lobby, and a new government can be guaranteed to come under intense pressure to scrap the reforms introduced by Kevin Rudd's government.

Losing or restricting Medicare rebates for midwifery, and/or Commonwealth-subsidised professional indemnity insurance for eligible midwives, would be disastrous for women's choices in birth. The national registration scheme is almost certain to remain in place, retaining all the insurance and registration difficulties of recent years. Consumers would lose the leverage we currently have to push for change in hospital culture. Midwifery could be pushed entirely into a hospital-employed status.

The only effective strategy to minimise this risk is to embed eligible midwives into the maternity care system as much as possible, as soon as possible, to make a reversal of the reforms as difficult as possible.

### Consumer advocacy

Considering that the Commonwealth has set this up with \$120 million, the States have already agreed to do it, and the States and hospitals can profit from it, consumer advocacy can be the spark that lights the boiler.

Consumers have a range of effective places to ask for better access to care from eligible midwives. Most important are State Members of Parliament, who are able to raise community concerns with both State Health Ministers and local hospital boards. For most MPs, the model we are proposing is attractive: community-based, primary health care; popular with women and families.

State MPs will generally pass matters of this sort to the State Health Minister. Ministers are likely to be supportive in principle; however they tend to be inactive on issues that aren't being raised to their

attention. Ministers are also, like nearly everyone else, confused about how private midwifery works and why progress isn't happening. Ministers also want to know that this model has the support of the midwifery profession (including whether midwives want to work this way).

### Conclusion

Australia's birthing women currently have their best opportunity in decades to reshape maternity services and gain more choice and control over maternity care. Maternity Coalition, as the group that gives birthing women a voice in the political world, has significant expertise in the reforms and is able to support and network consumer representation. Consumers and their midwifery partners can work with MC to realise the potential we now have.

### More information

For an overview of how eligible midwives and Medicare works see the DoHA website: <http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda#10>

The Chief Nurse's office in the Queensland Department of Health has developed a set of documents explaining how to implement collaboration with eligible midwives. These are not yet available online but are available on request.

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# Informed consent

'Informed consent' is a term regularly used in maternity care (and other healthcare settings). There does, however, appear to be a lot of confusion about what it actually means and what obligations it carries.

## What is informed consent?

Under Australian law, healthcare practitioners have a duty to give adequate information to patients to enable them to make decisions around particular procedures or proposed treatments. Under the law of negligence, a practitioner has a duty to warn a patient of the 'material risks' inherent in a proposed treatment. A risk is material if a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This can extend to risks that are actually quite rare if a patient or client has given some indication that they are important to them.

Although the High Court of Australia has expressed some concern about the terminology, this is commonly referred to as informed consent. The information given should include the risks and benefits of a proposed treatment, alternatives and the likely consequences if the proposed treatment is not carried out.

## Does a woman have an obligation to give informed consent?

No. The obligation is on the healthcare provider to give the required information. The woman does not have any legal obligation to seek out information or to be 'well informed'.

“The information given should include the risks and benefits of a proposed treatment, alternatives and the likely consequences if the proposed treatment is not carried out.”

## If a woman is really well informed and has done a lot of reading, does the care provider still have to advise her of the risks?

Yes. The care provider must themselves explain the risks. They should not make any assumptions about how much the woman already knows or her ability to seek out information for herself. Again, informed consent is the responsibility of the care provider, not the woman.

## But birth is not a 'procedure' or a 'treatment'; do you have to give informed consent to undergo a normal, physiological process?

Yes, particularly if there are risks relating to place of birth or having a vaginal birth. A woman planning a homebirth, for example, should be advised of the risks (alongside the benefits) of that choice.

## If a woman is really determined to choose a certain path (e.g. to have a homebirth) does a care provider still have an obligation to advise her of the risks, even if they are certain the woman will not change her mind?

Yes. In such a case it is especially important to give a woman unbiased and balanced information and for the practitioner to document, in detail, the advice that has been given and any recommendations that have been made for consultation and referral.

## There are so many different understandings about what constitutes safe maternity care, how do you know what sort of information women must be given in making decisions?

Philosophies of maternity care can be polarised, and this leads to differences in how providers present information about risk. Referring to established guidelines is probably the most effective way of ensuring that women are receiving appropriate information, and for care providers to protect themselves in the event of legal action or disciplinary proceedings.

If there is debate around a particular approach, or if the evidence is contested (e.g. the safety of vaginal breech birth), a care provider should make sure that they

explain the alternative approaches and the reasoning behind each.

Women should feel clear that they understand the reason behind a particular test or intervention and feel confident to ask questions about it. Women can also refuse any tests or interventions that are recommended or proposed.

## I signed a consent form; does that prove that I gave informed consent?

Not necessarily. A signed consent form can be evidence of informed consent, but the process needs to be more than just signing a form with a list of risks on it. Informed consent requires a process of dialogue between a care provider and a woman, and the signing of a consent form should be the final stage in demonstrating that consent has been given. It does not constitute the entire information-sharing process, nor does it on its own establish that the consent given is valid or informed. That said, you should not sign a consent form unless you understand what it says!

## If I have given informed consent, does that mean I cannot take action if my care provider is negligent?

No. Your care provider still has a duty of care and can be liable for negligent conduct in treating you. Giving informed consent does not remove the care provider's legal obligation to meet the appropriate standard of care in their care of you.





# Tin hut on the river, Queenslander on the main street: my experiences with midwifery group practice



Alecia Staines with her two children (L-R) Tully and Lawson

In mid-2008 I was well into my third year of employment at the local high school as an agricultural science teacher in the border town of Goondiwindi. I was enthusiastic. I had a love for education and all things 'ag'. I was also expecting my first child. To say I was rather clueless about pregnancy and birth was, in hindsight, an understatement. All the same, I was overjoyed at the prospect of becoming a parent.

Whilst I considered myself reasonably intelligent, I really hadn't given much thought to, and didn't have much knowledge of, birth. I had put that on my 'to do' list, amongst my work pile of curriculum endeavours, workbook marking, cattle grooming and running the Agricultural Department. All I knew was that there seemed to be a big difference between what I had seen growing up on a farm watching sheep and cattle birth, and the horror stories I had heard from well-intended friends and relatives about human birth. It wasn't until a staff

morning tea one day that a quick-witted fellow teacher, when asking me about my intentions for birth, said, "You do know that baby has to come out somehow?" I wasn't exactly unaware of that fact, I had prided myself on the delivery of the odd sex education class, and also covered animal anatomy and physiology in my agricultural science lessons, but I really

**“** I developed a great attachment to my midwife and the others that were in that little hut. I really looked forward to my appointments. I was even impressed with the offer of six week postnatal home visits, which, I was to learn, was a godsend. **”**

was putting my thoughts on my own impending birth on the backburner.

## I was afraid of birth

It dawned on me that my colleague was right: not only was I not acknowledging the fear I had of birthing, but I really needed to get my skates on and put thought into where I would have my baby. I began frantically searching the Internet for not just 'what happens during birth' and 'who to choose as a care provider', but also the 'whys'. I wanted to know why I should choose a particular service and *how* it would benefit my baby and me. I had decided that I wasn't having a horror story birth; I was going to have a positive birth story to tell.

Fast forward a few months, and I was becoming one well-researched mother to be. Continuity of care was something I had previously never even heard of. There seemed to be quite an exodus from my local border town of Goondiwindi, to birth in the bright city lights of Toowoomba and even Brisbane. I even had a good friend quip, "Well, I'm going to Brisbane, as I get wine provided in the maternity ward there." Clearly we had different priorities when it came to welcoming our babies into the world.

Little did I know then, but Goondiwindi was paving the way for maternity care in Queensland. The local Goondiwindi Midwifery Group Practice (GMGP) was what I had my sights set on. All the articles I could find on continuity of care described great outcomes for mothers and babies and pointed me in the direction of having a birth story that I would be happy to tell.

## Appointment in a little tin hut on the river

At my first appointment, I was excited and beaming with pride at myself for becoming educated and actively seeking out a local service that hadn't yet reached its first year of service. I would later discover that continuity of care was a service that women across Australia were really crying out for. The appointment was in a little tin hut, down by our local river, the McIntyre. The midwives all wore bright green polo shirts and warm friendly smiles. I developed a great attachment to

“She was only ever a phone call away and was there for my physical and emotional wellbeing. She became a confidant over a very short period of time.”

my midwife and the others that were in that little hut. I really looked forward to my appointments. I was even impressed with the offer of six week postnatal home visits, which, I was to learn, was a godsend.

I took maternity leave and had a whole two months before my due date. During this time I really embraced the concept of birth being a normal, natural physiological process. Some HypnoBirthing classes also ensured I was busy practising relaxation, visualisation and breathing techniques daily. I wanted a great birth, just as I had wanted success in all my endeavours throughout my life. My philosophy on human birth was that we are just another animal, so why should we have traumatic birthing experiences? Cattle and sheep really do drop their calf or lamb, give it a lick and keep walking, chewing their cud and lovingly nudge their newborn to help them on their wobbly legs.

## One rainy Friday afternoon

Lawson Max arrived one rainy Friday afternoon, in late February. I had called the midwife earlier that day, as I was a little confused as to whether I was having contractions (as well-researched as I had become, I should also have known that nothing is ever ‘textbook’). By the time I had made my way to the hospital, I was pretty sure I was in labour. As the car pulled up, a nurse friend peeped in the window and saw my one leg up on the dash. “That baby is on its way, you really need to go inside,” she laughed.

I met one of the GMGP midwives inside and was a little puzzled at the look she gave me during my vaginal examination. I had agreed to have the examination as I was hoping like hell that I was in labour and wouldn’t have to return home for things to progress. She asked, “How many contractions have you had since leaving home?”

“Well, I had three in the car.”

“And how far away do you live?”

“About 10 minutes.”

She looked at me again. “Where do you live?”

“Down by the river, on the other side of the bridge.”

“That’s only two minutes,” she smiled.

I was excited; I was eight centimetres dilated and knew that I wouldn’t be far away from meeting my son. Lawson arrived less than three hours after arriving at hospital. Two hours of that was birthing or “pushing” in medical terms. Whilst easy wouldn’t be a term I’d associate with Lawson’s birth, I’d also think referring to it as labour is also a stretch. What a supportive team of midwives and what a lovely environment to have my son brought into this world into.

I spent an amazing five days in Goondiwindi Hospital, not a word you would typically associate with a hospital stay. Whenever I fed Lawson, I would call in one of the midwives to watch and help. I had so much trouble initially with attachment and grazed nipples that, without their support, I would have given up.

The day after our discharge, my midwife called to check on us and arrived with scales to weigh Lawson. She presented me with all my booked appointments for the next few months. It really was one less thing to worry about. It was great to sit down and chat about how I was going, check on my breastfeeding and Lawson’s progress. Soon enough, I told her I was happy for her to just give me a call to check in.

## My Midwives in Toowoomba

To say I was sold on ‘continuity of care’ was an understatement. I had temporarily

relocated to Toowoomba when I was pregnant with my second child, a daughter, Tully May. I was quite shocked at the lack of options for maternity services in Toowoomba and actively sought out continuity of care. My mum found an advertisement in the local paper for the recently opened My Midwives, a private midwifery practice. I was very interested, and got myself along to the information evening they were holding the next week.

It was a far cry from the usual medical facilities offering maternity care that I had seen before. Inside a renovated Queenslander with a warmth and charm of yesteryear, the crisp white wall and soft lighting were a background for comfy leather sofas sprawled with bright, coloured cushions. It could easily be mistaken for someone’s home. I was greeted, shown around and met a midwife who was to become my primary carer for the next few months, with home visits or me dropping into the clinic. She was only ever a phone call away and was there for my physical and emotional wellbeing. She became a confidant over a very short period of time.

I was going through a very tough time: my marriage had broken down and I was now facing the prospect of being a single mum, raising two babies alone. My circumstances were very different to when I had birthed Lawson in 2009. Now I was staring into 2011 and an impending birth alone. I really cannot thank my midwife enough for the support she gave to me when I was pregnant with Tully,

## Raffle to support FreMO Medical and Birth Centre Nairobi, Kenya

Michelle Steel, lead midwife to the Refugee Maternity Service and award-winning quilter, is going to Kenya!

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The quilt will be drawn on 2 May 2013.

Learn more about FreMO at  
[Vicki-chan.blogspot.com/](http://Vicki-chan.blogspot.com/)



The quilt is made from hand-dyed and hand-painted fabric, its 180cm x 180cm large, in pastels pink, lilac, and blue



both during birth and also postnatally. I really felt as if my world had come tumbling down and, even now as I type this, it's hard for me to hold back the tears. Without that continuity of care, I would have struggled through my pregnancy and birth.

## I wanted an induction of labour

Early in February, I was at the 42 week mark and had decided that I wanted an induction of labour. It certainly wasn't my first point of call – I had spent hours with a chiropractor, reflexologist, using the HypnoBirthing techniques and even homeopathy. I was spent. I had had a turbulent pregnancy emotionally, and just wanted my baby in my arms. My midwife was very honest and open with me and we had lengthy discussions about the things that can go wrong with induction and why she really didn't want me on that roller coaster ride. I think deep down she knew that I was pretty stubborn and had started to get rather anxious that my daughter hadn't been born yet. My midwife still reminds me that Tully was only her second induction in 17 years of practice, which speaks volumes about the advocate she is

for birth without intervention.

Birthing Tully May was very quick and soon enough the memories of my induction were erased from my mind as I was cuddling my rather chubby, dark haired little girl. My midwife held my hand as I birthed Tully, whilst my mum later cut the umbilical cord. It really was a special time, to be able to have my own midwife and birth in the local public hospital. Still a concept so many women have yet to hear of, let alone experience.

I enjoy catching up with all the midwives who were involved with birthing my children. Whether I drop into the clinic and say hello, run into them at the local supermarket or catch up with them for lunch. I enjoy catching up as much as they do, seeing these tiny beings that entered the world only a few years ago grow and develop into real little people. It has expanded my network and exposed me to the amazing world of pregnancy and birth.

## Loud and proud advocate for continuity of care

I have obviously since become a loud and proud advocate of continuity of care

and also run my own HypnoBirthing classes. It is a far call from the boot-wearing, cattle-wrangling schoolteacher I was five years ago, but motherhood changes us all. Thankfully, I had such positive experiences from continuity of care midwifery that my life has taken a whole new direction for the better.

## Author Bio

I am a 29 year old school teacher, from the QLD/NSW border town of Goondiwindi. I have a 4 year old son, Lawson and a 2 year old daughter, Tully. I grew up in a rural community called The Gums, population 50, about 1 1/2 hours north of Goondiwindi. I have a real passion for Agriculture and rural issues in general, which now encompasses rural maternity issues since becoming a mum. Two years ago, when I birthed my daughter Tully, I was one of the few maternity consumers in Queensland who had accessed continuity of care midwifery publicly and privately in a hospital setting. My positive experiences have certainly led me to pursue an active role in educating and advocating for continuity of care midwifery in Queensland.

# Research News by Jyai Allen

## Continuity of care and carer – does it really make a difference?

There is mounting evidence that continuity of care works for women and babies. The 2008 systematic review of midwifery-led models of care summarised the results of 11 randomised controlled trials which included more than 12 000 women. Nine of the studies were of midwifery teams, two of the studies were specifically 'caseload midwifery', and not all studies were restricted to 'low-risk' women (1).

Women randomised to midwifery-led care were less likely to experience 'regional analgesia' in labour (e.g. epidural), episiotomy and instrumental birth; they were more likely to experience no analgesia in labour and spontaneous vaginal birth, and to initiate breastfeeding (1).

The authors concluded that "most women should be offered midwife-led models of care and women should be

encouraged to ask for this option" (1).

In 2012, Australian researchers released the results of the COSMOS study, a randomised controlled trial of caseload midwifery for low-risk women. This study echoes many of the findings of the systematic review (2).

Additional findings include that women randomised to caseload midwifery were less likely to experience caesarean section or separation from their babies (by admission to a neonatal nursery) (2).

Hot on the heels of COSMOS was the M@NGO trial (Midwives At New Group practice Options), which included Australian women of 'all risk' who were randomised to caseload midwifery care or standard care (3).

This study focussed on caesarean section as a primary outcome, and included a comprehensive costing analysis to

determine whether caseload midwifery is an affordable or perhaps even cost-saving strategy for health services (3). The results of this study will be published later this year.

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## Continuity of care: developments in rural Australia



While women in metropolitan areas may have to actively seek out a continuity of care model for their maternity care, those in rural areas often find there is no choice; their community is serviced by just one model of maternity care. It can take years of lobbying by consumers for a change in the model of care to occur.

In September 2011, *Birth Matters* reported on the plight of birthing women in Burke, New South Wales (NSW). Their birthing service had closed two years earlier, due to a lack of staff. Since that time women had travelled four hours to give birth in Dubbo. A group of consumers formed the **Burke Birthing Action Group (BBAG)** and campaigned to have local birthing services reinstated. Four years, and many babies, later the BBAG is pleased to report that Burke Hospital will resume birthing services using a midwifery-led model of

care in March 2013. Korina Ivatt, who has until recently been leading the group, said she felt that "The group was influential as we gained regional and national media coverage on the subject. There were obviously a lot of hurdles to jump and the staff at the hospital have worked hard to get the unit opened, but that little push from the community [lobbying] certainly helped get things moving and it is wonderful that women from this area will no longer be forced to leave their support network to birth their babies." *Rural Matters* looks forward to hearing the stories from women accessing this new continuity of care model.

On 16 January 2013 the **Bunbury Regional Hospital in Western Australian (WA)** officially launched its new Midwifery Group Practice (MGP). The new service in Bunbury came about as a result of ongoing consumer action for almost a decade, coupled with supportive midwives who were keen to see a new model in their hospital. The turning point was gaining support from a GP Obstetrician who was keen to see this type of model adopted. Unlike many other MGPs, their service offers a homebirth option as well as the option to birth in hospital. This service will run parallel with the regular maternity services offered by the hospital. Low-risk women can self-refer to the MGP. Women who are not low risk can access the service if they have been referred by a GP; but

they are not eligible to have a homebirth attended by MGP. Although WA still only has a homebirth rate of between 0.7–0.8%, this is more than double the national homebirth rate (1). This could be due to the groundbreaking publicly-funded Community Midwifery Program in Perth.

Kalgoorlie, WA may be about to start its own marathon campaigning effort to establish a continuity of care model. The private midwife, who provided the only option of continuity of care in the region, has recently left the area leaving local women with no choice. A passionate MC member, Kirra Bird, has started the ball rolling. MC has connected her with the manager of the Community Midwifery WA. Kirra has already established a good relationship with midwives at the hospital and, together with some like-minded consumers, they will be contacting their local Member of Parliament about the need to focus on continuity of care.

The **Friends of the Birth Centre (FBC) in Rockhampton** (Queensland) continue to be active. They hold monthly meetings for mothers at the hospital, and hold market stalls to promote the cause of developing a birth centre. Rockhampton Council provided them with a \$1000 grant for printing, which they have used to produce brochures to distribute throughout the hospital and at GP clinics. Even though a birth centre is their ultimate goal, the FBC recognise that a change in model of care is of greater priority at the moment. Currently, as happens in many maternity services, antenatal care and birth care are separate entities, with no continuity. Fortunately the FBC report that they are working with two committed midwives at Rockhampton Hospital who would like a change in model too.

After the Stanthorpe Hospital's Medical Superintendent and Director of Nursing attended the **Queensland Rural Birth Summit**, there has been renewed vigour to achieve the previous State Government's goal of 100% continuity of care for maternity services with less than 200 births a year by the end of 2013. Consumer group MUMSS were happy to be invited to a staff meeting of midwives and medical staff to discuss proposed changes to the delivery of antenatal care. The antenatal clinic has traditionally been run from the outpatients department at Stanthorpe

“...that little push from the community [lobbying] certainly helped get things moving and it is wonderful that women from this area will no longer be forced to leave their support network to birth their babies.”

Hospital, geographically isolated from the maternity unit. This care will now be provided by all the midwives rotating through the antenatal clinic and will be held within the maternity unit.

In January, MUMSS was invited to meet with the A/Director Infrastructure and Planning for **Darling Downs Hospital and Health Service**, as well as the architects and engineers who will be working on a potential new birthing suite. MUMSS was horrified to hear that they had received a brief from the Health Board for two very small ensuites to be crammed into the existing space. MUMSS had told the Board explicitly in October that this was not an option that women would accept; a space incorporating a bath was necessary. MUMSS had enlisted the free help of a local architect and engineer, and were able to provide plans of a more suitable birth suite. The consumer group was very pleased that their ideas were given due consideration and now await costing for the new plans.

Changes in publicly funded health care

“Changes in publicly funded health care seem to occur at a glacial rate; however, without the voices of consumers they would be unlikely to occur at all. As more consumers demand more women-centered maternity care from their local service providers, these models will start to become the norm, rather than the exception.”

seem to occur at a glacial rate; however, without the voices of consumers they would be unlikely to occur at all. As more consumers demand more women-centered maternity care from their local service providers, these models will

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

## References

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## Author Bio

Bec is a midwife who lives in Stanthorpe, Queensland with her husband James and children Eliza 7, Liam 5 and Tom almost 3. She has been a member of MC since 2006, and helped start Stanthorpe BaBs in 2007.

## Feature Article

# My Midwives Brisbane South open a new practice at Beenleigh



Bruce Teakle at the opening event giving his inspiring address

*During the grand opening of My Midwives Beenleigh on 20th February 2013, long-standing campaigner for eligible midwives Bruce Teakle delivered this address.*

Thanks Di, Melinda and Toni [My Midwives Brisbane South] for inviting me today. Thanks to everyone here for coming along and supporting these remarkable midwives in their important adventure.

This occasion, the opening of a private midwifery practice in Beenleigh, is a big deal, it's a historic event. And it's important in several ways, as part of several stories. This morning I'd like to share three of those stories, about what is happening here, with you.

### The first story is a personal story

It belongs to these three midwives, and is about their journeys as people and as professionals. Melinda, Di and Toni are midwives with exceptional commitment

to the women they care for. Everyone wants a caregiver who has both the clinical skills to do their technical work well and keep you safe, and the professional values to care for you, respect your values, and help you feel safe. That's the way these midwives have been determined to work.

However, the needs of women are not at the centre for our maternity care system, where power speaks louder than safety or good care or women's needs. Each of these midwives has found themselves at a point

“Instead of giving up, these midwives have found their mojo, got eligible for Medicare, and set up their own private practice.”



in their career where their professional values has caused them so much trouble, has been so much in conflict with hospital culture and policy, that they must have considered abandoning those woman-centred values. They could have kept going to work, leaving their hearts behind and doing whatever they were told. Or they could have left the profession, as too many good midwives do.

Instead of giving up, these midwives have found their mojo, got eligible for Medicare, and set up their own private practice. They've done this knowing that they can expect no cooperation from their local public hospital, and at significant personal financial risk. This is a story of these women overcoming adversity and their own senses of powerlessness, and taking initiative to provide care to women the way they believe it should be done.

## The second story is a political story

[It is] about a campaign to reform Australia's maternity care system, to rebuild it around the needs of women and their families. In 2001, in the medical insurance crisis, insurance companies withdrew professional indemnity insurance from private midwives in Australia. This looked like being the beginning of the end of private midwifery in Australia, and the end of its crucial influence. When it all looked hopeless, a little birth care consumer group called Maternity Coalition decided that the solution lay in a change of direction for the whole of Australia's maternity care system. They described their vision in the National Maternity Action Plan, and lobbied for years for all women's access to publicly funded, community-based, one-to-one midwifery care.

In 2009 the Commonwealth Government committed \$120 million to implementing reforms that women had been asking for. A range of Medicare rebates was created for women using the services of eligible private midwives, and a Commonwealth-subsidised professional indemnity insurance product was developed for these midwives. These reforms are intended to enable midwives to go into private practice, and deliver care directly to women in their own communities. This practice we are celebrating today represents the opportunities which have been created by the political work of the consumer movement, and the midwifery profession.

These are the most important reforms to Australia's maternity care system in generations. They promise to give women a degree of access, choice and control in

*“ This model of care changes the power relationships in maternity care. It gives women the opportunity to walk in the door, check out the midwives and choose one they like, or walk out the door and try somewhere else. ”*

their birth care which has never previously been possible. They promise reductions to the cost of maternity care, while increasing quality. They expand the professional role of the midwife from an employee, to a professional who is highly accountable to her professional standards and to the women she cares for.

There is a dark side to this story of healthcare reform politics, illustrated in the circumstances of this practice. As I mentioned earlier, this practice is opening without any sign of cooperation from their local hospital.

Allowing women more choice and allowing midwives a tiny share of Australia's river of healthcare money, feels like a loss of power and control for the more insecure members of the medical profession. At the national level, medical stakeholders have worked hard to keep these reforms under medical control, and keep women's choices and care under medical control. At the local level, some taxpayer-employed public hospital obstetricians refuse to provide care to women who have employed private midwives. Clearly this is a turf war, not about safety.

Eligible private midwives provide community-based primary care;

internationally recognised as the gold standard. However this model is dependent on midwives and their clients having consultation and referral to acute care by the midwives and obstetricians employed in our public hospitals. These reforms were set up on the assumption that Australia's public hospitals would collaborate with Medicare-funded private midwives in the same way they collaborate with thousands of private [General Practitioners] (GPs), in the interest of patients. All states and territories have committed, in the National Maternity Services Plan, to doing this. However, despite political commitment, despite consumer demand, and despite the considerable financial benefits to hospitals of cooperating with eligible midwives, only four of Australia's public hospitals are currently doing it. It's time that hospitals were run with recognition that they are there to serve the community who pays for them, not their internal powerbrokers.

## The third story is probably the most important

Too often, the bodies of birthing women are seen as other people's territory in a grab for power, status and money. Today's opening represents another tiny step towards women reclaiming ownership of their pregnancy, their birth and their motherhood. This model of care changes the power relationships in maternity care. It gives women the opportunity to walk in the door, check out the midwives and choose one they like, or walk out the door and try somewhere else. It gives women choice where they have had no choice.

It also represents women's reclaiming of the woman's profession: midwifery. It gives these midwives, and hopefully many more in time, the opportunity to practice to their full level of responsibility and care for women. It gives midwives a place to work where they have the respect they deserve

as professionals.

Thanks for coming today, and for letting me talk for a few minutes. I hope you will all support these fine midwives in their project, which is important for them, for the maternity care system, and for women.

*Photos of the event kindly supplied by Melissa Fox (MC QLD).*



My Midwives Beenleigh (L-R) Diane Tamariki, Toni Randall, Melinda Van Ligten



## Big belly, homebirth and beyond: know your midwife!



Kate pregnant with Tao

*"Guess what? I am pregnant and oh, by the way, can we move into your house and ummm... have a baby in it?"*

*This was pretty much the conversation I had with a friend when I was halfway through my surprise third pregnancy. And, for me, a great deal hung on the answer. With the support of generous friends who opened their doors, and the genuine care of some down-to-earth midwives, my dream for a joyous, intimate and beautiful birth outside of the hospital system became a reality. A birth as idyllic as if it were simply under a tree in my backyard. A gentle birth that I (and I believe my newborn son) drew much strength from when, nine days later, my precious babe became gravely ill.*

### I need a home to birth in

I gave birth to my daughter eight years ago, in a hospital only two and a half hours away. I was lucky to arrive on a quiet evening, and to be greeted by a midwife who enabled me to labour and birth naturally, gently and without intervention. It was an exhilarating triumph. I say I was 'lucky' for, as we know, birth often unnecessarily becomes a

medical process in which woman and babe are treated for malfunction. I know about this first hand. The memory of my eldest son's hospital-centred, induced birth ten years earlier is still fresh in my mind. The joy of that experience comes only from the empowerment of birth itself and of the precious child that emerged at the end of the ordeal.

As I contemplated my upcoming third birth, I was all too aware that traumatic

hospital birth stories were still all the rage. I was not prepared to be treated like a machine again. So I put my ticket in for the local Birth Centre draw, but lost the lottery. In hindsight, the 600 km round trip for weekly antenatal care would have been tiring. There are no practising homebirth midwives anywhere near my small rural town. For me the notion of 'freebirth' was confined to the very real possibility of birthing on the side of the road en route to a hospital, all of which are a two to three hours' drive from my home. Understandably, many rural women choose to stay with friends or relatives in the later weeks or days of pregnancy to be close to their chosen hospital. However, after consulting with many of the 'nearby' birthing hospitals about their procedures and policies (and knowing my womb to be irresistibly cosy beyond 40 weeks), I became terrified of being induced and terribly unhappy at the thought of hospital birth. I joked about giving birth under a tree in my backyard, but the truth was that I did not feel comfortable birthing without an experienced midwife, nor safe in my

small town should help be required. So I needed not just a home to stay in, but a home to *birth* in!

### Know your midwife

Enter my dear friend Ellen: an immensely resourceful, home-birthing, hypno-birthing, wonder-Mama. Ellen shared her knowledge of homebirth midwifery in South-East Queensland. Within the week, I had a midwife (and a back-up midwife) from the private practice group 'Know Your Midwife' (KYM). They were able to care for me throughout my pregnancy in a way that catered for the distance (and our finances). I even had the home! It was a yurt house just out from picturesque Maleny, with sentimental associations, and belonging to some old friends who were planning to be away around the time our babe would be born. My transitory birthing-home was close enough for the midwives to attend the birth. It was only 15 minutes' drive from my friend Ellen, who would become my pre- and postnatal support person. I stepped out of a place of deep anxiety and breathed in that golden light all the way through what became a joyful pregnancy. An aesthetically beautiful, but not superficial, journey filled with gemstones and essential oils, affirmations and music, bonding and growth, opening heart and embracing processes, yoga and laughter, beauty and chocolate éclairs, friendship and red string, Ina-May and belly-casts, raspberry leaf tea and bike-riding, creativity and meditation, hypno-birthing and visions of opening lotus, *Down-to-Earth* Magazine (Birth) education and *The Tao of Pooh*. I even managed to embrace the all-day morning sickness as part of this unique passage. I had honoured my previous pregnancies in similar ways, but what made this journey markedly different was experiencing continuity of care.

I joined the Sunshine Coast KYM's *Circle of Care* programme, held in a special space in Midwife Mary's tranquil home. Here I met with my group (women with a similar due date) and got to know my midwives and the obstetrician. Sitting in the best bean bag ever, soaking up everything that everyone had to share, I would marvel at how natural and nurturing it felt to share and be cared for in this way: void

of bright lights, hours in waiting rooms and uncomfortable sessions with junior obstetricians who were dismissive of my birthing aspirations and fears. When I could not be there in person, I Skyped. Before I moved down to the yurt, my midwives made the 700 km round trip to my home for antenatal care, to meet my family, discuss our birth plan and continue getting to know me. I felt valued. I was being honoured as a birthing mother and the arrival of our baby was genuinely looked forward to by these warm and caring midwives.

## Today is a great day to give birth

My partner, Dutch, had a strong conviction that I would birth at around 42 weeks, as I had with our older children. I settled into the yurt at around 38 weeks (just in case). My son Rhythm (10) and daughter Meisje (8) came with me and we had a marvellous time during our 'birthing holiday'. Every day was a balance between energetically embracing our new and beautiful surrounds and taking time to breathe deeply. It was an intensely bonding time for me with the children, and also for us with the babe inside. We missed Dutch terribly and treasured the sound of his diesel coming up the yurt's driveway when he was able to visit. Each day I felt brave and ready and almost overwhelmed by how wonderful I felt and how much beauty and positivity there seemed to be surrounding me. "Today is a great day to give birth," became my mantra. I welcomed our baby and, when no baby came, I accepted that it was not time.

## Thank you, oh my women

My friend Ellen was my pillar; she was understanding and patient with my ceaseless 'birth-talk' and very sincere in her excitement for the upcoming birth. I was inspired by her trust in the universe and in birth. As the days passed beyond my due date, I began to swing from acceptance to restlessness. I took great comfort in the support of Ellen, my midwives, my circle of women and my daughter Meisje. Rhythm had gone home with Dutch, so it was just the girls, picking fresh flowers every day and lighting candles in the evening, saying, "Come on darling!" But I now had to put some effort into staying positive. I felt my friends probably wanted their yurt home back (it had been four weeks), we missed the boys, funds were running out, the hospital was calling, *everybody* was calling and texting and *every day was a great day to be born!* My midwives and Ellen gently encouraged

me to keep trusting my body and my baby. I did the curries, the pesto, the pineapple, the swing set. I danced and walked and rocked and loved my nipples and acupressed and rubbed on evening primrose oil. I thought about castor oil, but felt it was too unpredictable. I was trying to trust and honour my baby's agenda; my women raised me up when I faltered.

*"I felt valued. I was being honoured as a birthing mother and the arrival of our baby was genuinely looked forward to by these warm and caring midwives."*

## And I danced this baby out!

One beautiful morning, Meisje and I walked and waded around a lake, went with Ellen to a NIA dance class and I surrendered my heart and body (again). We had a swim; I felt joyful. I cancelled my acupuncture appointment because 'today was a great day to be born'; I didn't need to be induced. By the afternoon I was flat. I lay in the empty birth pool, staring at the mandalas on the wall, at the pillows graffitied with my affirmations, at all the beautiful things; "When are you coming?" I fought back tears. I wished I'd had the acupuncture. Meisje and I went to pick flowers. We watched the sunset over the mountains, it was spectacular; my spirit lifted. I danced the *Funky Col Medina* til I was breathless and light-hearted. Next came an attack of despair. My mood swings were giving me whiplash. Totally despondent, I took off my gemstones and told Meisje, "They are a load of crap." "No Mummy, they are working." She was right; have faith. We sat up in bed and in a strong voice I called out some powerful affirmations. There was a pop, like a 'fanny fart'. A sudden urge to pee. I didn't make it. Our excitement was enormous! I



Kate in labour with her daughter's support

rang Midwife Lin, "Not sure if my waters have broken or I have peed myself." I check the colour for her; she is happy; she expects a call in the night. I ring Dutch and tell him to go to bed and sleep; this could be it (of course he gets ready to come). Meisje is suddenly nervous and rings Ellen as planned to share her feelings. She knows Ellen will come over if she feels it is too much for just the two of us. I am still standing in the same spot. I move to the toilet and, "Ohhhh, I see a mucous plug; Yippee." Ellen has bought me a packet of *Depends* nappies and she tells Meisje to hand me one; clever lady. I am not roaring like a lion, I am just over the moon, so Meisje feels safe enough to hang up and go to bed. She is trusting. Dutch and Rhythm are on their way and I ask the baby to wait until they arrive (four hours). The water pump has recently broken, so I flash torchlight at the neighbours; time to fill the pool. I dance around, lighting candles and oil-burners, fill the pool with a hose running to the neighbours tank, waters are gushing (nappies are my saving grace), the neighbour is so nervous it's funny. Happy with the pool and heating coil, he settles into a chair 'to wait' with his wife. No, I am going to bed I say. It is lovely to know they are just over the fence if I need them, but I feel no fear. The contractions feel like an old acquaintance. Like walking in footsteps already made. I lie down and listen to my hypno-birthing for the millionth and last time; so familiar and soothing. Dutch and Rhythm arrive and we debrief about the day. It is 2 am. We all go to bed but I cannot lie down. I busy myself with the pool; it is too cold. I spend some time scooping water into saucepans and heating them on the stove, stopping to ride the surges like a pro-surfer. I am dancing to French folk music.



I am doing this! I am having my idyllic, joyful, aesthetically delightful homebirth!

## Birth

The rushes intensify. (Oh hello, that's right; I have walked here before; you are powerful!) Midwife Lin has arrived. She is peaceful and reassuring. Meisje is in the pool with me; it is lovely. Meisje is drawing; Rhythm is hanging out. I am in control but I think I could easily lose it. I vomit. A lot. It feels fine. Naked on the veranda. The sun is up. Don't care if anyone over the road sees. I am having a baby. Dutch is amazing, he is devoted to me. I sip on grape juice. I want to ask Lin how far up that red line is... but I don't want to know. I am euphoric, but I am tired. My surges are powerful, but I still have minutes between them. I ask instead how it is going. I think I am a bit whiney (secretly I want to plead). Midwife Mary has not arrived so I know there is still a time to go. I want Lin to tell me it will only be a minute. Lin tells me that everything is perfect and happening as it should. The perfect thing to say. I am so grateful she is here with me. She knows me. I make Dutch lie down on the bed next to the pool. The kids are watching a DVD in another room. Lin gently suggests I hop into the pool. She assures me that everyone else is fine, that everything is ready, and that everything is perfect. She knows me. She suggests I get out of my head and into my body. And I do and then it is on! Surge after surge after surge. I am riding a tsunami now. Lin reminds me to breathe that wonderful oxygen down to my baby. I do. I can feel her belief in me as a birthing Goddess. This woman I have only known a few months is essential to me right now. I am too busy in my body to tell her. But I tell Dutch I love him. He tells me I am brave. I am expanding. Golden light, pain dials, opening lotus; oh I am pooing! Lin has her new pooper-scooper out, Dutch is cracking jokes. I want to laugh along but I am not sure where I am. I am with my baby. I speak out, "I am bearing down." I sound like a goat. Oh God, it is more poo. I open my eyes and Lin is right there calmly caring for me. She asks what I can feel but I cannot answer. It is not poo; it is a bowling ball coming out of my bum! My body is shaking. I realise it is my baby. I don't want to split, I want to unfold. I quickly begin my inner-mantra, "My vagina is huge, it's huge, it's huge." The burn comes. I am so wide. I have surrendered to my body and my breath and my baby is here, so gently. I reach down and feel the head emerge. "I have a baby." Lin gently raises the children

from their movie, "Mummy is having the baby now if you want to come quietly and watch." I feel so safe. I see Dutch, Rhythm and Meisje right there. Time is suspended. The body slides out, Lin reaches over and unloops the cord as I pull my baby out of me, out of the water onto my chest. No agony. The kids tell me later that I groaned like a cow. I see Dutch's face; he loves me, he loves his child. The kids are in awe. There is no blood; just creamy vernix. Sunlight streams through the centre of the yurt, tinkling on the water. It's 7.40 am; only 40 minutes of active labour. The kids are desperate to know if the baby is a boy or girl. Midwife Mary arrives. I am surrounded by love and support. The birth has been so gentle. Welcome Tao Mylo Psalm, darling boy. Rhythm, who swore he did not want to see the baby born, asks if I need my 'yonicomb' (honeycomb); Meisje is already writing a song.

## Continuity of care is empowering

Nine days later, back in our own home, Tao vomited. All babies do. Tao, Meisje and I had only been home two days. We had been staying with Ellen, being cared for and nurtured and resting for the drive home. Midwife Lin had seen us nearly every day before we set off; again this made me feel secure and boosted my self-confidence. I was still buzzing from the birth and even with sore nipples and the strange daze of broken sleep, I felt incredible. Tao vomited again and then became upset. Reflux? He was sick during the night. He was sick too many times. He slept for nine hours straight and I calmly freaked out. I rang the local hospital the next morning but needed to wait until the late afternoon to see the GP. Dutch

came home to wait with me. I was scared. We googled baby vomit: reflux, virus, hypertrophic pyloric stenosis. We rang Lin and she guided me to tap right into my baby and into my instincts; it was this advice that carried us through the next harrowing four days. We knew something was terribly wrong with our baby, but it took patience and quiet determination on our part (and eventually Tao's overnight drastic weight loss) for Tao's state to be taken seriously. Three hospitals and two Royal Flying Doctor flights later, Tao underwent laparoscopic surgery for hypertrophic pyloric stenosis. In a nutshell this is a narrowing of the intestine's pylorus valve, causing gastric obstruction. Overnight Tao went from a thriving, alert and contented nine-day-old to a sick and listless baby. Each moment of that time was fraught with intensity; a story all of its own. Our midwives and obstetrician, via phone and text, gave us much support during this intense period (and beyond). The irony of our effort to stay out of hospital, free from needles, pokes and prods, was not lost on us, but we felt that it made all the difference that both Tao and I were so strong and vital from his gentle homebirth. We took our baby home and finally began our 'babymoon'. And it was wonderful!

## Author Bio

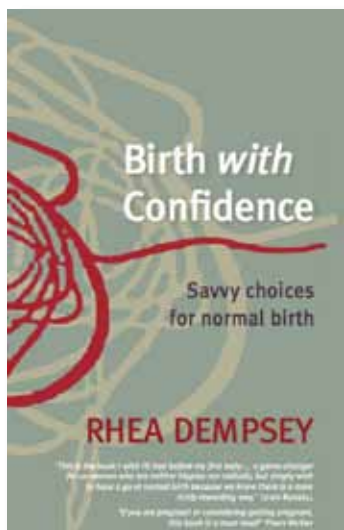
Kate Anbeek is mother to Rhythm (10), Haranii-Meisje (8) and Tao (14 weeks). With her husband Dutch by her side, Kate lives in a small citrus town in South-East Queensland. Kate is a singer-songwriter, a writer, a deferred Arts student, a terrible baker and recently devout homebirther!



Big brother Rhythm with Tao just born



## Birth with confidence - savvy choices for normal birth: new book by Rhea Dempsey



Many women who have attended Rhea Dempsey's birth workshops will whoop with delight knowing that a book full of her birthing wisdom is now available. Now 'willing women' (Dempsey's term for

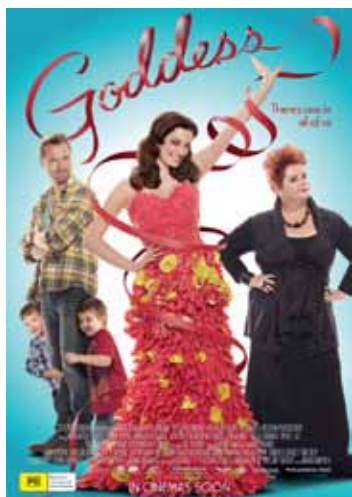
women wanting to achieve a physiological birth), and interested birth workers will be able to share in the authors approach to normal, natural childbirth. It is a warm yet direct resource for current and future generations of birthing women.

In *Birth with confidence – savvy choices for normal birth*, Dempsey intertwines her experiences of working with women as a birth attendant and childbirth educator, along with stories from birthing women. The book sets out to explore the external and internal challenges and obstacles to birthing well in Australia today. This book examines "what motivates the willing woman in the labour bypass era;" and suggests ways we can arm ourselves with a 'circle of support' to get the birth we want and deserve. What makes this book so interesting is her focus on the internal, or mental, challenges for women wanting a natural, physiological birth, within our specific Australian birth culture. She highlights the self-work that women and

their partners need to explore in order to approach birth with confidence. For as Dempsey passionately explains "*simply wanting a normal physiological birth is not enough to ensure you'll have one...to my great sadness and anger – our present birth system is not set up to support normal physiological birth.*"

As I read the book, I can identify that I was an "aspirational and naive" first time mother, with a "wait and see" partner. In regards to achieving and receiving support for a normal birth; this really was a train wreck combination. While I personally navigated emotional suffering in the aftermath of my disturbing first birth, I found Rhea's workshops immensely helpful. For others seeking answers to their experiences of birth, Dempsey's book offers insight, and may help others like myself with the experience of the intense longing for a 'lost physiological birth.' The book then positively paves a way forward to create the best space for the next birth.

## Film Review: Goddess (2013)



It is refreshing to see an original feel-good Australian musical make a successful splash onto the big screen, especially one created by a mum!

*Goddess* tells the story of Elspeth Dickens (Laura Michelle Kelly) who is slowly going crazy stuck at home in rural Tassie with her twin toddlers, while her husband James (Ronan Keating) pursues a career saving whales. Like many other stay-at-home mothers, Elspeth turns to the Internet for some contact with the outside world. She composes and sings her own funny kitchen 'sink songs' about her life into a webcam.

In dream-come-true movie style, Elspeth becomes an online hit and is talent-spotted by Cassandra Wolfe (Magda Szubanski),

who whisks her off to Sydney where she's faced with a choice between career and family.

In similar vein to *Mamma Mia*, this is an exuberant film with a great soundtrack and brilliant choreography: one that really lifts the spirits. *Goddess* is based on a semi-autobiographical one-woman cabaret show created by Sydney mum Joanna Weinberg as a means of retaining her own sanity as she raised young children. There's certainly plenty of keenly observed humour in it that other parents will relate to.

*Goddess* opened across Australia on 14 March, and the soundtrack is already available on iTunes.

# Lotus birth of my little moon Goddess: with Ryde Midwifery Group Practice



Chand, her husband and baby Kiana

*The path that led me to transferring care from a large private hospital in New South Wales (where my partner and I were shelling out thousands of dollars) to being on the waitlist for Ryde Midwifery Group Practice (RMGP) at a state-funded public hospital was serendipitous to say the least.*

## Opposing philosophies of birth

I was five months pregnant and very upset after a conversation with my obstetrician about my birth wishes. "You can't even put two fingers into the vagina, how do you expect a nine centimetre head to come out?" he said. He and I came from two philosophical opposites about birthing. He did not believe that I knew what I was saying when I said I wanted an undisturbed, un-medicated, natural birth (as far as possible). I did not want to be cut (episiotomy); I would rather tear naturally. I did not want to be offered any drugs for pain-relief. I wanted a vaginal birth and was not interested in scheduling a caesarean section when the time neared. He asked me if I knew how many women actually delivered babies without the use of drugs. I said I didn't. Then he proceeded to touch his index finger with his thumb, raising his other three fingers. I offered a response, "three percent?" He

replied, "No. Zero." This might have been the case for all *his* patients, but I knew of a friend's friend who had recently birthed naturally with the assistance of a midwife at another hospital. He told me to write down all my birth wishes and to show them to him at our next appointment. He laughed me off, saying to be prepared to be surprised at how my wishes would change during the actual delivery. I was mortified. I never returned.

I had a conversation with a good friend and her Mum, then she discussed my plight with her best friend and they discovered that one of their mutual friends had birthed with a RMGP midwife and had had a very positive experience. She telephoned me to let me know more

about it. I did a Google search and the Mums@Ryde website ([www.mumsatryde.org.au](http://www.mumsatryde.org.au)) popped up. I couldn't believe that my dream birth place for my baby was only an 11 minute drive from home!

## My beautiful journey began with RMGP

From the get go (from the very first phone call to RMGP's receptionist), I was warmly welcomed. I was treated with respect. I wasn't talked down to or made to feel anxious or panicky about what should rightly be a beautiful journey for all women. Although I was on the waitlist

for some weeks, I was regularly seen by the RMGP midwives and started attending 'Preparation for Parenting' classes conducted by one of them. If I had been unable to get my own caseload midwife in time, I would have had to birth at Royal North Shore Hospital with a midwife on roster there at the time. I was at my office desk when I got the call from my caseload midwife with the great news that we were off the waitlist. My husband and I were elated and called our family overseas to share the good news and thank them for their prayers.

## Getting to know all the midwives

At RMGP, every woman is partnered with a caseload midwife whom she sees regularly for *at least* an hour. I felt so grateful for this unhurried time, especially after being lucky to get maybe 20 minutes, always tense and perfunctory, from the obstetrician. On the first Thursday of every month there is a 'Meet the Midwives' session, which is fun. It provides the pregnant women and their families the opportunity to be introduced to all the nine midwives. This is great, as all the midwives become familiar faces. Should the woman's caseload midwife be on leave or assisting at another birth when she goes into labour, thankfully there will be a known face in the birthing room. This is extremely reassuring and comforting. All the midwives at RMGP believe in empowering a woman to birth naturally and courageously. They trust in women's bodies to birth without unnecessary intervention which, with the phenomenon of (over) medicalisation, has become routine in so many biomedical settings.

Once I had my own caseload midwife she saw me at all my visits and I felt very at ease discussing my birth wishes with her. I wanted a lotus birth for my baby and found my midwife very supportive and helpful. A lotus birth is where there is no severance of the umbilical cord until it naturally separates a few days following birth. This means that the baby, umbilical cord and placenta are left intact. I wanted to do this as I wanted my baby to have a peaceful transition into the world outside my womb. The care we received, even while on the waitlist, was truly exceptional. We were never rushed, there was always time for questions, my

“ He asked me if I knew how many women actually delivered babies without the use of drugs. I said I didn't. Then he proceeded to touch his index finger with his thumb, raising his other three fingers. I offered a response, “three percent?” He replied, “No. Zero.” ”



husband was included in all matters and discussions, there was no desk separating us from our midwife (she was literally on our side), we were given plenty of resources and it was a joy to come to the centre for check-ups. The check-ups are held in the stand-alone birth centre, which is away from the main Ryde hospital building. It felt like home. We felt completely at ease and were able to build a trusting relationship with the midwife.

### I arrived at the birth centre fully dilated!

When it was time, after I had managed my contractions as best I could at home with my Mum and husband, we drove over to the birth centre. When we got there my midwife invited me to do whatever I felt was best. I got on my knees onto a mattress on the floor. We discovered I was fully dilated! I asked if I could get in the birth pool as we had planned on a water birth. She filled it up and I got in. I enjoyed feeling safe, buoyant and at ease in the birth pool. The lighting in the birthing room was low and I felt completely ready and happy. Time ceased to exist. The supporting midwife arrived and introduced herself to me (during the birth each caseload midwife is assisted by another midwife). Although I had met her before, I was in the 'zone' focusing on birthing my baby, so it was lovely that she looked me in the eye and greeted me; very humanising.

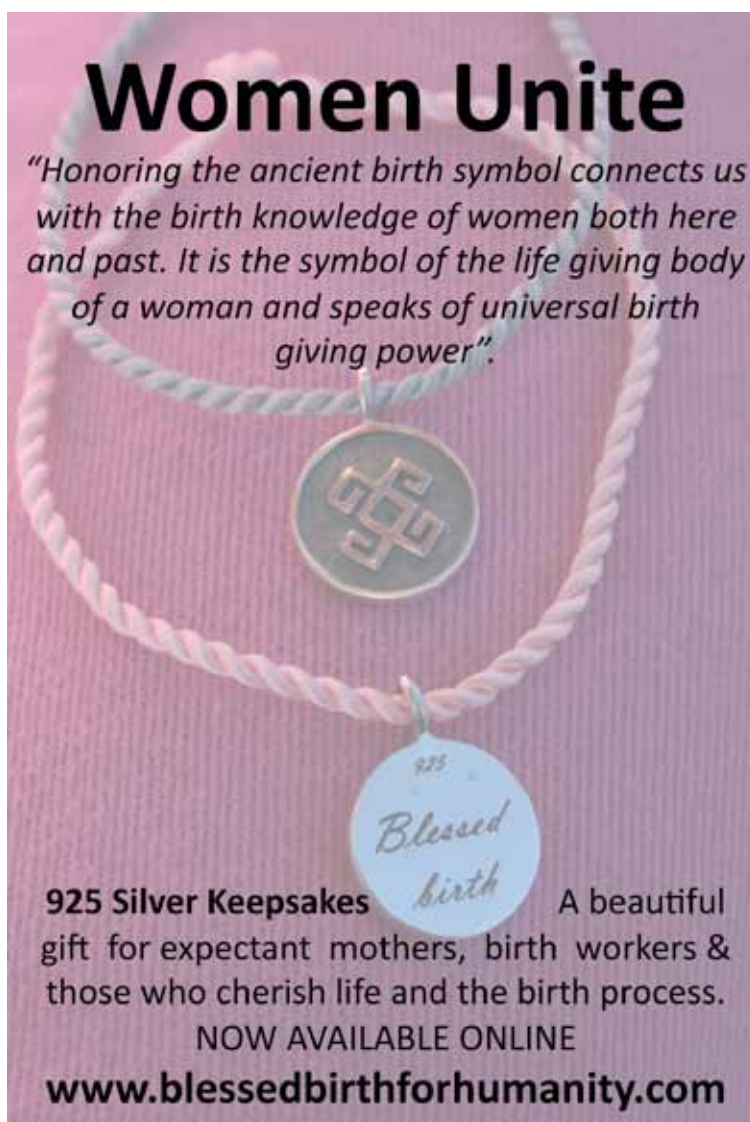
My baby's crown was visible, however she kept sliding in and out. As the birth was not progressing, after some time we decided that I would step out of the water so that gravity could help us. Everyone kept saying words of encouragement to me. The midwives were calm, gentle, supportive and very strong for me. I birthed my baby in a squatting position on a sheet on the floor with my husband sitting behind me on a chair supporting my arms. I was able to birth actively, blissfully and gently thanks to the amazing group support and because I was surrounded by those who respected my birth wishes. I had a natural, unmedicated birth: a dream come true. My baby came into this world sunny-side up (posterior position/face up), caught by my midwife who placed my baby in my arms. I was completely present, thrilled and over the moon! My husband and I cuddled, gushed and gazed upon our baby. The whole universe was suspended in this moment. I was so happy and relieved to finally physically meet my baby; our eyes locked. It was magical meeting each other for the first time. I remember my midwife asking

*"I was able to birth actively, blissfully and gently thanks to the amazing group support and because I was surrounded by those who respected my birth wishes."*

us if we had a girl or a boy. We had the joy of announcing that we have a girl! I birthed my daughter's placenta naturally and my midwife carefully placed it in a bowl beside her. Having my daughter attached to her placenta made us all slow down that much more, and treat her with more gentleness and reverence. When we were ready, some hours after the birth, we brought our baby home for the first time. It was a surreal and very serene experience.

### We buried her placenta

My midwife visited us regularly for the next two weeks. It was very reassuring to know that, even in between those visits, I could message or call her anytime with any concerns or questions, no matter how seemingly big or small. My daughter's sacred and beautiful birth journey was most definitely a big team effort and was possible only because my midwife and the team at RMGP genuinely trust in women's bodies and their ability to birth naturally and confidently. Kiana was eight days old when her umbilical cord, together with placenta, detached on its own. We buried her cord and placenta under a native plant. My family has benefitted enormously from the guidance, expertise and dedication of the RMGP midwives. My daughter's birth was a miracle and blessing for all of my family, especially for those of us who were present and involved during her momentous journey into the world outside my womb.



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## Midwife and researcher Donna Hartz



Interviewee Donna Hartz

### What does the term 'continuity of care' mean?

In Australia, the majority of women have access to continuity of care. They receive care through pregnancy, birth and postnatally; however this may be with many different midwives and/or doctors. What the majority of Australian women don't have is continuity of *carer*. This is provided by eligible midwives, homebirth midwives and some caseload models of care. There is ongoing debate on what continuity of carer means; *basically it comes down to having a known carer at birth.*

### Do you think midwives and women have different understandings of continuity of carer?

Yes, I think that they do. Maternity service administrators, obstetricians and GPs (general practitioners) also have different ideas of what this is.

### Where are some of the best examples of continuity of carer in Australia?

I don't think that any model compares to homebirth or eligible midwife care. This model tends to be the most symbiotic for a woman and her pregnancy and birth. This is not only because the care is mostly provided in her home. I believe that the relationship can have a deeper, more therapeutic, effect for birth and the transition to new motherhood or family life, without the white noise and competing interests of a hospital setting. However, most women in Australia do not have access to a homebirth or eligible midwifery care, or they choose not to access it. The reasons for this are diverse and interrelated; these include government policy, differences in the professional and clinical perspectives of medical doctors and midwives, as well as the socio-cultural expectation of the woman and her family.

“The more women who choose midwifery care in a public hospital, the less 'market share' there is for private obstetrics and GPs.”

### Can you talk a bit more about continuity of carer in hospitals then?

The hospital models that provide the greatest level of continuity of carer, I believe, are a step in the right direction. These are caseload midwifery where the midwives work in small midwifery group practices. Midwifery care at free-standing birth centres such as Ryde maternity service in Sydney (NSW) have high levels of continuity of known carer at birth. The largest of these models is at the Royal Hospital for Women, Randwick (NSW). This model provides care to 40–50% (1500 women) of publicly insured women, irrespective of the presence or complexity of the woman's health issues. Adelaide Women and Babies Hospital (SA) has a long established caseload model that provides care to about 1000 women per year and the Mater Mother Brisbane (QLD) provides care to about 650 women per year. Caseload midwifery models of care have been flourishing all over Australia in the last eight years; however not all of them provides a high level of known carer at birth. There are many maternity services that offer caseload midwifery care, but only a small proportion of women are able to access them; which I'm sure is disappointing to women who want this type of care.

### What makes these models work well?

- Individualised care for each woman.
- Flexibility of care provision based on the needs of the woman.
- The individual midwives' philosophy of pregnancy and birth care.
- The maternity service's commitment to supporting these models within the service.
- Collegial and collaborative relationships with obstetricians providing obstetric expertise to the models and the midwives.

Actually, there are two perspectives to this question. As a mother and grandmother, I believe that reliability

of clinical care, honesty, trust, safety, realistic goals and, in particular, known carer during labour and birth, are very important. But I know different women would have different ideas on what they think makes them work well.

### What are the obstacles to getting more continuity of carer programs?

There is a misconception that the hospital-based caseload models of care are expensive. With money at the forefront of all hospital administrators' minds, this is a common reason not to introduce or expand them. Caseload midwives are paid a 29–35% loading on top of their base wages. The average non-caseload midwife, working shift work, receives approximately 25% loading for shift penalties. So in NSW, where the caseload midwives gets 29%, the 4% extra compensates her for being on-call for extensive periods of time. However, women who have caseload care have fewer interventions and caesareans and often a reduced period of time in hospital after birth. The reduced hospital stay saves the hospital money. Ironically, and unfortunately, hospitals get paid less for normal births than caesarean, so with a decrease in caesarean rates the hospital funding is reduced.

There is a competing private obstetric and obstetrician base with midwife care. The more women who choose midwifery care in a public hospital, the less 'market share' there is for private obstetrics and GPs. Many women do not get the information about options of care when having a first visit with their GP and so will front up to their hospital not knowing there is an alternative to obstetrician or GP care.

Not all midwives have the life flexibility to undertake the on-call component of continuity of carer midwifery. Some midwives do not want the unpredictability of the on-call component. Some may have young children, partners who have absences from home due to work, or are carers within their home for partners or parents.

Many rural maternity services want their midwives to also be nurses, due to the low number of births in their area. Undertaking continuity of carer would not be feasible alongside a roster that requires a nurse/midwife to be on duty in a hospital ward.

## Why are these programs so hard to get into?

Because there are limited numbers of programs and in some areas they do not exist. Also some models restrict women who have health issues from participating. The numbers of eligible midwives are also very low, but they are growing.

## Where are these examples of health services offering continuity of carer to women planning home birth?

The most long-standing homebirth service is the Community Midwifery Program in

Freemantle, Western Australia, which has been providing a homebirth service since 1996. In NSW, St George Hospital was the first to offer publicly funded homebirth in 2004.

## What are the benefits of continuity of carer for birthing families?

Midwives in continuity of carer models are able to support the woman and her family to have the most sensitive environment and care during the most momentous time of their lives. The needs of the woman and family are a priority. In continuity-of-carer models the midwives are strong advocates as they 'know' the woman and her story and place the woman at the centre.

## Does research support continuity of carer as 'best practice' maternity care?

Current research supports homebirth to be as safe as hospital birth, with the support of appropriate professionals such as a midwife or doctor. In Australia the research has demonstrated that hospital caseload midwifery is associated with greater normal births and better breastfeeding rates.

## Interviewee Bio

Donna Hartz (RN, RM, M Mid Studies, PhD (pending), FACM) is a midwife with 25 years' experience as a clinician, educator/lecturer, midwife consultant and researcher.

She has worked at a variety of tertiary and metropolitan maternity services in NSW during this time and as a hospital-accredited independent and homebirth midwife in Newcastle from 1988–2000. In the last decade she has worked closely with Professor Sally Tracy in the implementation and evaluation of the freestanding birth centre at Ryde, NSW. Her midwifery passions are promoting and developing sensitive, women-centred maternity care and the promotion of sound governance frameworks to guide and protect women and midwives within maternity services.

She is a passionate mother and stepmother of six children (two born at home) and a grandmother to four.

Donna is currently a Research Fellow at the University of Sydney and has recently completed her PhD on the NHMRC funded Randomised Controlled trial of caseload midwifery care: the M@NGO project, at the Midwifery and Women's Health Research Unit, based at the Royal Hospital for Women, Randwick.

### PUBLICLY-FUNDED HOMEBIRTH SERVICES

*The following list is provided by  
The National Publicly-funded  
Homebirth Consortium Australia.  
([www.nmh.uts.edu.au/cmcfh/  
research/homebirth.html](http://www.nmh.uts.edu.au/cmcfh/research/homebirth.html))*

#### QLD

None

#### NSW

Belmont District and John Hunter  
Midwifery Group Practice,  
Newcastle  
Midwifery Group Practice,  
Wollongong  
Mullumbimby Community Birthing  
Service, Northern NSW  
Orange Aboriginal Medical Service,  
Orange  
St George Hospital Homebirth  
Program, Kogarah, Sydney  
Tamworth Base Hospital, Tamworth

#### VIC

Midwifery Group Practice, Casey  
Hospital, Berwick  
Midwifery Group Practice, Sunshine  
Hospital, St Albans

#### TAS

None

#### SA

Midwifery Group Practice, Women's  
and Children's Hospital, Adelaide  
Northern Area Midwifery Group  
Practice, Elizabeth Vale  
Southern Midwifery Group Practice,  
Flinders Medical Centre

#### WA

Community Midwifery Program,  
Perth  
Bunbury Midwifery Group Practice  
NT

Home Birth Service, Darwin

Midwifery Group Practice, Alice  
Springs

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# Finding the Holy Grail: continuity of care in Western Australia on the community midwifery program

Open up either Australia's National Maternity Services (ANMS) plan, or look at the new national pregnancy and birth website, and you would be forgiven for thinking that continuity of maternity care models are plentiful. The ANMS plan and website make for pleasant reading; they are all about supporting women-centred care and acknowledging the importance of continuity of care. Take a look at what is available on the ground in Australia in terms of actual birth choices, and it is a very different picture. The disjunct between policy and reality seems vast.

## Community Midwifery Program in Perth

In Perth, there is continuity of maternity care available to women experiencing a low-risk pregnancy through the Community Midwifery Program (CMP). Community Midwifery WA (a not-for-profit organisation) was established in 1996 to be the organisational framework for the CMP. The original vision was to create equity in the maternity care sector so that women could access a publicly-funded homebirth service in the same way that they can access a publicly funded hospital or birth centre birth. That vision was achieved initially with Federal funding, and then State funding, to provide a homebirth service for women living in Perth. The CMP has operated continuously since then; during the 2011–2012 financial year, 301 women had their baby on the CMP.

The CMP's continued operation and slow growth has been achieved against a background of intense scrutiny and pressure, including the insurance crisis and ongoing lack of an insurance product

“The original vision was to create equity in the maternity care sector so that women could access a publicly funded homebirth service in the same way that they can access a publicly funded hospital or birth centre birth.”



Jane and baby Thomas gazing at each other for the first time

for homebirth in Australia. In 2009, the Homebirth Review conducted by Dr Michael Nicholl and Caroline Homer, contained a number of recommendations. By 2012 CMP had implemented all of the recommendations from the Homebirth Review, while WA Health was still to implement recommendations to increase continuity of care models in WA. One recommendation WA Health did implement was an updated Statewide Homebirth Policy. While it is a welcome move to have the model of care 'legitimised' through policy, it has led to a further tightening of the inclusion criteria for the CMP for Perth women.

## Community Midwifery WA

CMWA provides services to support the delivery of the CMP, including antenatal education, administrative support, postnatal services and community awareness. Since CMWA is a not-for-profit organisation, it can meet the needs of

women of childbearing age by having a social media presence and a strong online presence. For example, women can book onto the CMP, book a class and hire a pool, all from the CMWA website. CMWA offers its classes and postnatal services to all women, no matter where they are having their baby. We are actively seeking to increase the reach of the conversation about birth choices beyond the usual cohort who are interested in homebirth and all things natural. We believe that there are many ways to have a great birth, and at the core of a great birth is a woman who feels supported, listened to and encouraged.

It is all too easy for consumer representatives like me to stand on the sidelines and criticise. It is important to state that, as I write, this work is continuing to roll out midwifery group practices (MGPs) in public hospitals. A MGP (including a homebirth service) has been established in Bunbury and work



“ We believe that there are many ways to have a great birth, and at the core of a great birth is a woman who feels supported, listened to and encouraged. ”

is progressing in Broome. Many Perth-based public maternity services are also working on the complex human resource (HR) issues inherent in rolling out MGP models of care. With all this activity, I look forward to the day when CMWA's monthly *Choices in Childbirth* presentation can include a long list of continuity of midwifery care options.

## Birth with a known midwife in hospital or at home

As well as offering care with a known midwife to birth at home, the CMP also provides a domino service, where women can birth at selected public hospitals with a known CMP midwife. Of the 301 women who had their babies on the CMP in 2011–2012, 60% had their baby at home and 40% had a domino birth; either electing to birth in hospital from the beginning, or being transferred to hospital during labour.

Other changes to the CMP have aimed to address the challenge of offering a continuity of care model while avoiding burnout in staff, and ensuring that some kind of work–life balance can be achieved. After an early trial of a 'buddying system', it was adjusted to ensure that while there is a lead midwife, the buddy midwife undertakes at least a one hour home visit early in the pregnancy and is sufficiently known to the woman to be able to provide continuity of care in labour.



Jane's third baby, first homebirth

## Jane's third baby: first homebirth

Jane Bigelow arrived in WA having already had two boys in hospital in Orange in NSW. Jane joined the CMP when the buddy system was first implemented, and met her buddy midwives for two appointments each. Jane felt the midwives were all on the same page to support her. Like many women, she was attracted to the idea of a known midwife but was initially unsure about birthing at home. At first she was leaning toward the birth centre option; the CMP offers care with a known midwife at King Edward Memorial Hospital's Family Birthing Centre. However, given that she lived in the hills, Jane began thinking about the option of the Kalamunda birthing rooms. This facility is for CMP mothers not wanting a homebirth. It differs from a birth centre because if a woman needs to transfer for medical assistance, she needs to be transferred to hospital in the Swan Districts. With some reassuring words from her midwife to relax about it all, and some raspberry leaf tea, baby boy number three arrived safely at home just when he needed to; when dad was home and before grandma arrived.

Jane reflected on the contrast between her hospital births and her homebirth. While she has luckily had uncomplicated births with no interventions, for her the strongest contrast came during transition. For both hospital births, when she reached transition and the 'I can't do it' stage, the hospital midwives went into action, ensuring that she was directed to push immediately, almost as if they also felt that she could not do it and a crisis was imminent! Her CMP midwives, on the other hand, beautifully held the space of transition, gently diverting her until the overwhelming urge to push overcame her; a feeling she had not been able to experience in her hospital births. "I was listened to, reassured and gently guided to have the birth I wanted. My midwives believed in my baby, they believed in me and understood the normal effects of transition and helped me to have the birth I always wanted."

## Magret's first birth, at home

Magret Schell reported feeling very empowered and supported during her first birth at home on the CMP, but it was in the vulnerable postnatal period where she felt the continuity of care was especially vital. Magret researched her first birth choices carefully and went to some lengths to have her baby with a known midwife, as many of her friends spoke about how difficult it had been for them



Magret and her first baby

to establish breastfeeding after a hospital birth. When Magret had her first baby, she enjoyed the postnatal care on the CMP of home visits for the first two to four weeks. Because her midwives knew Magret well, and had seen her newborn every day, they were very quick to notice that her baby was not putting on weight. They took quick action, providing support with attachment and the loan of a breast pump to assist with milk supply. "I breastfed him for 22 months. I am so thankful that I was able to keep breastfeeding and it really was because of having my midwives who knew me and my baby," she said.

## Conclusion

The Community Midwifery Program has survived many challenges to its funding and ongoing existence and has seen many upheavals in its 16 years. The hope is that the CMP will be joined by many metropolitan and regional continuity of maternity care models to ensure that all women can access this gold standard, evidence-based care.

## Author Bio

Pip Brennan manages the not-for-profit organisation CMWA, which provides antenatal education, postnatal support services, community awareness on birth choices and administrative support for the Community Midwifery Program (CMP). Pip is a passionate advocate for consumers' rights in maternity care and sits on a number of key committees in WA overseeing policy, planning and service delivery in the maternity care system. Pip is not a midwife, but is very interested in finding funding and supporting women and families in pregnancy, birth and early parenthood.

## Two birth journeys with my midwife Kim: Casey Hospital's caseload program



Lily, Tim and baby Zane just minutes after arrival

*Casey Hospital in Berwick, Victoria, offers a caseload program for women with 'low risk' pregnancies, including the option of homebirth. I was fortunate enough to have my third and fourth babies at Casey with the same midwife. It was continuity-of-care at its absolute best!*

### I knew what I didn't want

In May 2009 I fell pregnant for the third time. Whilst my previous pregnancy and birth experiences would be considered by most as 'textbook perfect', I was dissatisfied with many elements of the care I received. Given my previous experiences, I knew exactly what I did not want this time around. I did not want fragmented care. I view birth as an extremely intimate and private time, so I did not want strangers at my birth. I did not want students forced upon me. I did not want any unnecessary interventions. I did not want the progress of my labour decided by the clock. Being 'low risk' I did not want to receive care from a specialist in 'high risk'. So, with a mixture of excitement and trepidation, I began my search for quality maternity care.

### Disheartened

Initially I booked into the Mercy Hospital for Women birth centre, and attended my first appointment at 12 weeks. The midwife that attended us for the booking-in appointment could not have been less interested in my hopes for antenatal care and birth. I went along expecting this birthing centre to operate in a similar way to the one in which I

had my second baby, 17 years earlier, which was organised as two teams of five midwives. Antenatal appointments were conducted by all five midwives in your team and the aim was for you to meet all of them prior to going in to labour. The only complaint I have about my second birth was that, as things worked out, the midwife that cared for me during labour was the only one of the team that I never got to meet antenatally.

So I was cared for by a stranger, which, for me, was very disappointing. With this in mind, you can imagine my dissatisfaction when I was told that there *were* no teams at Mercy Hospital birth centre, just a large number of midwives who were rostered through. When I specifically enquired about the possibility of 'continuity' I was told it was highly unlikely but that 'maybe', towards the end of pregnancy when I attended antenatal appointments more regularly, I 'might' get to see a familiar face. And so I was placed on the conveyor-belt that is fragmented care!

I returned home feeling very disheartened and got straight on the phone to the Angliss Hospital birth centre to enquire about continuity of care, but was told a similar story. After my own previous birth centre experience, I really felt that large staff numbers on teams or rosters were pointless, as you still received fragmented care. At this stage I felt that I was running out of time and options.

### My caseload journey began

About a week later, I discussed my

disappointment with an acquaintance, who suggested I try to book into Casey Hospital, as they were part of a 'caseload' pilot program. I could not get home and dial the number fast enough! By this time I was fast approaching 14 weeks. When I rang the hospital I was told the caseload program was fully booked, but I could be put on a waiting list. Knowing that places do become available, I was happy to be put on the list. I was also told that a new caseload midwife was starting in a few weeks and she would select patients, so my hopes rose. I then organised transfer of my medical records from the birthing centre to Casey Hospital.

After only three weeks, I received a call from Casey Hospital's new caseload midwife, Kim. She wondered if I was still interested in joining the caseload program. I was elated: *of course* I was interested! And so my caseload journey began.

Dealing with only one person at *every* appointment was so easy – and nice. Kim was calm and easy to talk to. Her philosophy of birth matched my own. There was nothing to fear. And, while I did create a 'birth plan', it was not for Kim. But for other staff in the (unlikely) event of an emergency. It was the first pregnancy during which I felt I could relax, let my guard down and actually trust my carer; all because I knew her and she knew me.

Waiting times for antenatal appointments didn't exist. On just one occasion I had to wait a few minutes because Kim was with a labouring woman. I was happy to wait! Having had my first baby in a tertiary facility, I was accustomed to waiting an average of two hours at every appointment! Appointments with Kim were never rushed. There was always ample time to discuss any issues or concerns. When pregnant with my first baby, I recall being told to discuss any fears/concerns/issues with the midwife or doctor and wondering: which one? Every appointment was with a new face. Every appointment, when I finally got in, was rushed; there was no time for discussions. How could I discuss personal and intimate concerns with a stranger, not knowing what their birth philosophy was and/or how receptive they would be? Even if I did so, it was highly *unlikely* that they would be at my birth. What was the point? I would have to explain or discuss things

“After my own previous birth centre experience, I really felt that large staff numbers on teams or rosters were pointless, as you still received fragmented care.”



all over again with the midwife caring for me. Antenatal appointments through the mainstream public health care system are at the opposite end of the spectrum from antenatal appointments through the caseload program.

Everything with my pregnancy and birth went smoothly and, on 8 February 2010, we welcomed our little boy, Zane, into this world. My only small disappointment was that I didn't get the water birth I had hoped for. Just over 12 months later I was pregnant with baby number four. And this time, I knew exactly what I wanted: caseload and, if at all possible, the same midwife!

Knowing how quickly the caseload program fills up, I called Casey hospital when I was just five weeks pregnant only to be told that the booking system had changed and that I needed to book online. I was confronted with an online form in which I had to answer set questions and could not provide any additional information. I wanted to let them know that I had had a baby just over 12 months before with a caseload midwife and wanted to keep that continuity, but I was dealing with a computer, not a person.

**I no longer lived in the 'catchment area'**

To my horror, about a week later I

*“ It was the first pregnancy during which I felt I could relax, let my guard down and actually trust my carer; all because I knew her and she knew me. ”*

received a letter stating that I could not have my baby at Casey hospital because I did not live within their 'catchment area'. Sometime between having my third baby and falling pregnant with my fourth baby they had become 'strict' and would only accept people within their catchment boundaries. I was mortified.

Discussing my disappointment with a girlfriend, she suggested I use her address, which was within Casey's catchment area. Initially I was hesitant. Being dishonest about where I lived didn't make me feel good but, at the same time, it frustrated me to think that my birthing options were being dictated by where I lived. So I did it. It's not something that I'm proud of, but feeling safe and birthing the way I

wanted to was far more important. I was not going to let anything get in the way of that. Birth is not transient. At the end of the day, I did what I had to do and it was very much worth it.

I was six weeks pregnant with my fourth baby when I went online and completed the online form with my girlfriend's address. When I received the acceptance letter I rang Casey and told them I would very much like to be part of the caseload program again and, if at all possible, would like to have Kim as my midwife again. And so my second caseload journey began.

Again, things went smoothly and on 25 November 2011 we welcomed our little girl, Mia, into this world. Knowing how disappointed I was

about missing out on a water birth last time, Kim made sure it happened this time; another benefit of the caseload program! It was amazing. Had I any idea how much of a difference a water birth makes I would have birthed my first three in water!

## Now a midwife

In November 2008, six months prior to falling pregnant with my third baby, I qualified as a midwife myself. Since then I have witnessed the perils of low-risk women birthing in tertiary-level birth suites led by obstetricians. I cannot recommend the caseload program highly enough. I have heard whispers in the wind that they will be expanding the program to both Monash Medical Centre and Dandenong Hospital. I hope those whispers are true, so that many more women get to experience the awesomeness that is the caseload program – without having to be dishonest about where they live! It saddens me, as both a midwife and a consumer of maternity care, that, with the same breath, we claim to support women's right to choose where, with whom and how they birth, while we also take women's choices away.

In the not-too-distant future, I hope to continue my caseload journey as a caseload midwife myself.

## Author Bio

Lillian Fetter is a midwife with a keen interest in childbirth education. She is an advocate for women's rights in childbirth. She qualified as a midwife in 2008 and is a member of the Australian College of Midwives. With four children of her own, her family is now complete (you've got to stop somewhere!), but she loves the fact that she'll always be around babies and is honoured to see the beginning of new lives and new families.

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Lillian Fetter is a midwife with a keen interest in childbirth education. She is an advocate for women's rights in childbirth. She qualified as a midwife in 2008 and is a member of the Australian College of Midwives. With four children of her own, her family is now complete (you've got to stop somewhere!), but she loves the fact that she'll always be around babies and is honoured to see the beginning of new lives and new families.



MGP Midwife Kim with Mia and Zane



# The real deal: continuity of care and carer with Darwin's community health homebirth service

*Kylie Sheffield felt that continuity of care from a known and trusted carer would help her avoid unnecessary medical intervention and birth her second baby as naturally as possible. She explains how a tatty pamphlet led her to one of Australia's most woman-and family-centred birthing programs.*

For 'low-risk' urban women, maternity care options in Darwin are largely the same as elsewhere in Australia, although the choice of providers in both the private and public sectors is limited. A woman experiencing a 'healthy' pregnancy, who lives within the urban boundaries of Darwin or Palmerston, can choose from a range of services delivering varying levels of continuity of care. The two midwifery-led services offering continuity are: the Community Midwifery Practice (CMP), and the Community Health Homebirth Service (formerly Homebirth Service, Darwin).

The CMP is a group practice employing two teams of three midwives who provide antenatal, intrapartum and postnatal care to women with no medical or obstetric complications. Women get to know each of the midwives in their assigned team, and birth with one of these midwives in the Birth Centre, or, if extra medical support is needed, in the delivery suite at the Royal Darwin Hospital. Early transfer home is possible four hours after birth if there are no complications, and midwives make initial daily home visits followed by postnatal care, including 24-hour on call support, for up to three weeks after birth. There is a waiting list for the CMP and women must first undergo an obstetric check and consent to a foetal morphology scan at 18 to 20 weeks of pregnancy.

The Community Health Homebirth Service (HBS) is unique in that it allows self-referral, offers one-to-one care from a known midwife, and accepts women attempting to birth vaginally following a previous caesarean section. In Australia's only state or territory to legislate against midwives practising without professional indemnity insurance<sup>1</sup>, it is also the only available option for Darwin women wanting to give birth at home in the care of a registered midwife.

I wanted my second baby's birth to be different from my first highly medicalised and traumatic birthing

experience with my son Gabe. I also wanted a compassionate maternity care provider who delivered woman- and family-centred care, something I did not receive from my private obstetrician before, during or after my first son's birth. When a friend recommended the CMP it seemed like a step in the right direction. Then, during my prerequisite visit to the hospital antenatal clinic, I spied a shabby pamphlet advertising HBS, Darwin. I had accidentally stumbled onto one of the few Australian maternity care services that are publicly funded to deliver continuity of care from a known midwife throughout the pregnancy continuum.

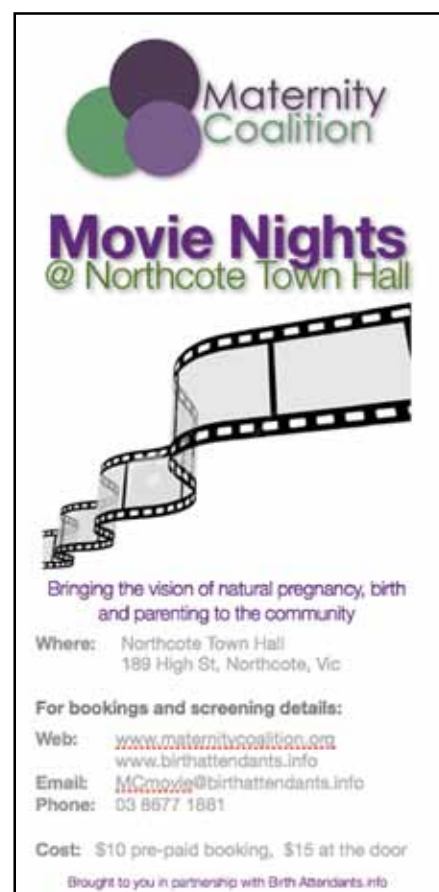
A few days after I contacted the HBS, a midwife named Marg came to our house. Just 15 minutes into the hour-long visit it was clear that we were already experiencing a completely different kind of maternity care. Marg explained how the service worked, and answered our many questions (including some pretty left of field ones from my six-year-old son, Gabe). She also asked about Gabe's birth and how I felt about it. Whilst the GP, obstetrician and hospital midwife I'd seen earlier in my pregnancy had all glossed over the details of my first birth, Marg acknowledged my feelings of disappointment and regret, and understood my need to pursue a better birth for this baby. By the time she left, we'd made our decision. I self-referred to the HBS the following day.

My antenatal appointments took place at home. They were nothing like my first antenatal experience, which I recall as a series of brief encounters with multiple

providers who checked, prodded and scanned my belly and were generally reluctant to discuss anything in too much detail, particularly the evidence base for their practices and procedures. Under Marg's care I felt informed, supported and understood. I was particularly grateful for her non-directive approach when it came to making decisions about prenatal screening and testing. When Marg offered me the available tests she also provided information on their potential risks, benefits and complications and, importantly, explained what each test could or could not detect. At no stage did she attempt to persuade me to do or not to do anything. I valued her guidance, but did not ever feel that she would judge or chastise me if I chose a different path from the norm or from one she recommended.

HBS midwives practise according to the *Australian College of Midwives National Guidelines for Consultation and Referral*. If specialist care is required at any stage, the midwife consults and refers accordingly, then works collaboratively with other providers while continuing

“Whilst the GP, obstetrician and hospital midwife I'd seen earlier in my pregnancy had all glossed over the details of my first birth, Marg acknowledged my feelings of disappointment and regret, and understood my need to pursue a better birth for this baby.”



The poster features the Maternity Coalition logo at the top, consisting of three overlapping circles in green, purple, and blue. Below the logo, the text 'Maternity Coalition' is written in a green, sans-serif font. Underneath that, 'Movie Nights' is written in a large, bold, purple font, followed by '@ Northcote Town Hall' in a smaller, green font. A graphic of a film strip with several frames is shown below the text. At the bottom of the poster, there is a block of text providing details about the event, including the location, contact information for bookings and screening, and the cost.

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For bookings and screening details:

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Email: [MCmovie@birthattendants.info](mailto:MCmovie@birthattendants.info)

Phone: 03 8677 1881

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“ Because I had come to know Marg well and trusted her implicitly, I gave birth naturally, unselfconsciously and without fear. My husband and son felt respected and included. ”

as the woman's primary carer. When complications with my own baby's health were detected, Marg collaborated with my GP as well as obstetric and other specialist staff at both the public and private hospitals to ensure I had the most appropriate care. In a difficult time, the support of my known and trusted carer was invaluable.

As its name suggests, the HBS exists to care for women who want to give birth at home. Once under the care of her known HBS midwife, a woman can decide at any stage of her pregnancy or labour that she would prefer to birth in hospital. In this case her HBS midwife will accompany her and continue in the role of primary carer, working collaboratively with obstetric staff and the midwives on the labour ward. Women birthing at home are attended by their primary midwife and a second midwife, whom they will meet and get to know in the final month of their pregnancy, though many HBS clients will have already met their second midwife by this time.

As impressed as I was with my care to that point, it was only during labour and birth that I fully understood its true value. Because I had come to know Marg well and trusted her implicitly, I gave birth naturally, unselfconsciously and without fear. My husband and son felt respected and included. Most importantly, I felt completely safe (even when making what they referred to as my 'dying cow' noises). After our son Daniel and his placenta were born, and after checking that we were all safe and healthy, Marg and my second midwife Mo did the best possible thing they could do; they reassured us that they were just a phone call and a short drive away, and they left us in peace. Their care was compassionate, competent and always respectful of my needs and the needs of our family.

My first week after Gabe's birth was spent in a private hospital where the nice room and good food failed to make up for the impersonal approach of the midwives and the confusion that resulted from their frequently conflicting advice. Marg's

postnatal visits were daily for the first week and weekly for five further weeks, but, basically, she was available whenever I needed her. Again, her approach was both woman- and family-centred and very much about ensuring that we were all okay. I have since birthed my third baby (daughter Saffy) with the HBS, and received the same exceptional care throughout pregnancy, birth and beyond.

Unfortunately, when I birthed my son in 2007 the HBS was largely under-utilised for a number of reasons. The service was poorly promoted, with women rarely receiving information about it from their GP or the hospital antenatal clinic. Like me, many discovered it quite by accident, usually through word of mouth from 'someone who knew someone' who had given birth at home. The generally negative media portrayal of homebirth, along with the NT Government's banning of independent midwifery, had contributed to a public perception that homebirth was an unsafe and irresponsible choice. Additionally, nominated geographical boundaries prevented women who lived outside Darwin and its immediate surrounds from using the service (though it was possible for women to appeal this restriction). There was no provision for women living in the Territory's rural or remote Top End to birth at home or even within Community Group Practices, making continuity of care impossible.

By the time Saffy was born, some positive changes were underway. In 2009 the Darwin Midwifery Group Practice (MGP) was created to care for Indigenous women from some of the Top End's most remote communities. These women

are required to travel long distances to Darwin for antenatal care and to give birth, necessitating separation from their families and communities at a time when they are most vulnerable. The MGP offers women care from one known midwife during antenatal visits to Darwin; while they are in Darwin awaiting their baby's birth; during labour and birth; and for several days postnatally, until they return to their communities. For women who have traditionally seen numerous different care providers, none of whom is well known to them, this is a tremendous improvement.

In 2011 a long-awaited policy change finally enabled HBS midwives to take on clients who desire continuity of care from one known midwife but who wish to give birth in the Birth Centre rather than at home. While homebirth remains the service's primary focus, and hospital policy dictates additional prerequisites and restrictions for Birth Centre clients, this is a positive step in increasing access to what is surely one of Australia's best examples of continuity of care and carer.

## References

1. In 2002, the Northern Territory government introduced legislation forbidding midwives to practise without professional indemnity insurance (PII), effectively outlawing independent midwifery. There has been no amendment to this legislation despite the PII exemptions granted to midwives in other states and territories.

## Author Bio

Kylie Sheffield is a mother and former Birth Matters editor. She is passionate about informed choice in all aspects of healthcare.





## Dreams come true: Mullumbimby Birth Centre's home birth program

I have been very privileged to experience both being a caseload midwife to women for their journeys through pregnancy and birth and also having my own midwife throughout my pregnancy and birth.

I started working as a caseload midwife at the Mullumbimby Birth Centre in October 2011. After seven years of working within a fragmented system in various hospitals, this was a dream come true. I had wanted to work in a birth centre in a continuity model ever since finishing my midwifery studies, but had not had the opportunity to do so. This was partly because I travelled a lot, but also because there was a lack of opportunities in Queensland, where I was based. So, when I was offered a job at Mullumbimby, I was completely stoked. My husband and I moved from Brisbane to Mullumbimby, which was a challenge in itself.

The job was very daunting and challenging to begin with for two reasons. Firstly, I needed to learn how to fit into a close-knit, very experienced team of midwives. Secondly, I had to work out how I could best support my new clients, sometimes working very long hours, whilst also fitting work in with my family life. This new way of working, however, was much more rewarding than my previous jobs and made everything worthwhile.

My passion for continuity deepened: it is now the only way I want to work. I enjoyed being with clients whom I had met many times before, knowing their preferences for their birth before there was any sign of labour. This was made possible by the fact that I had already established a trusting relationship with them, and they with me. It was a privilege to share such an amazing journey in people's lives from start to finish, rather than in just a small window. It made all the sleepless nights, being on-call, and time away from my husband, worthwhile.

### Serendipity

After hoping for a baby for a few years, we found out we were pregnant in February 2012. I knew immediately that I wanted a homebirth and to have Ti as my midwife. Fortunately, Mullumbimby had just started a publicly funded homebirth trial program for just two women per month. Serendipity smiled on me and I was one of the lucky ones to be pulled out



Sarah, Dave and baby Jarrah

of the ballot (for which I wasn't present!). Having worked with Ti for a few months, I really respected and admired her skills, dedication and relationship with her clients. I had supported clients through some very sad experiences, as is the nature of birth; this made it very difficult to not have fears for my own pregnancy and birth. Throughout my pregnancy Ti and I became closer and she helped me to work through many of these fears. Ti was able

to help me focus on the most important concerns and she supported any decisions I made.

I spent my pregnancy doing as much preparation as I could, including yoga and walking, nutrition, osteopathy, homeopathy, acupuncture and using herbs. I knew that physically, emotionally and mentally I had to be prepared for whatever might happen during labour. I had to be as healthy as I could to give our baby the best start. It was challenging at times, as I was still working full-time until 34 weeks. Sometimes it was very tiring going to a birth in the middle of the night, but the beautiful new families that were being created were always a great motivation and made the exhaustion much easier to handle.

When it came time for Jarrah to be born at almost 41 weeks, my support team and my midwives were all on the same page for what I wanted. I didn't have to remind anybody of anything. I started contracting

“ I will always remember the love and support that I felt from Ti's strength and trust in me and my body. There is no way I would have done this with a midwife I had just met. ”

“ I know first-hand that the hospital staff in a fragmented system do care deeply, however it goes to another level when you know a family closely. ”

irregularly at 3 am, and by 11 am was in established labour; however I still thought I was very early. My twin sister had led me through some beautiful yoga and meditation throughout the morning, and helped me to stay grounded and focused. I started bleeding slightly at around 10 am, but had no worries at all as the baby was moving quite a lot; speaking with Ti reassured me further. When I rang my husband Dave at 1 pm, I told him to take his time. I wanted him home, but knew we were going to be in for a long night. Dave arrived home at 1.30 pm with some beautiful flowers. His workmates had wanted him to hurry up, but Dave told them that it normally took about three to four phone calls with my clients who were having their first baby before I met them in the birth centre. Since it was only my second call, he also thought that the baby was a while away. I continued to bleed slightly, so we rang Ti to come over and check the baby. I thought she would leave after she had done this because my contractions were losing intensity when I sat down, and I felt there was an immense gap in between them. In retrospect, this just shows how ‘not present’ I was!

## Transition

Ti arrived at 2.45 pm, by which time I was in transition. When I first saw her I fell into her arms and cried and cried. I will always remember the love and support that I felt from Ti’s strength and trust in me and my body. There is no way I would have done this with a midwife I had just met. I asked Ti if she thought I was even in labour, and she just laughed and said ‘yes’ and that I was doing great.

After Ti checked the baby, Dave and I jumped into the shower. I remember feeling that Ti might think that I was close, but that I didn’t. So I told Dave that we still had a while to go, that Ti was wrong, and that we were going to be here all night. My loving husband told me kindly that it was all okay, to take as long as I needed, and to travel to the stars to bring back our baby. With the next surge I felt myself travel out of the bathroom window and up to the clouds and blue sky, and then come back down to earth and to my body. I think it was the following surge when my waters broke, and maybe the one after that that I started pushing. It only took two contractions and I could feel the baby’s head on my perineum, so I quickly headed to the pool, which was just ready. Thankfully the baby’s head went back up in the next break and gave me a chance to catch up with everything. It finally dawned on me that my baby was very close and would be in my arms very soon. I completely let go and opened to the next sensations, which were pretty intense, and her head was out. I then started to celebrate the fact that I had not only gone into labour and would not need any intervention, but that I was having a

homebirth and was not going to The Tweed Hospital (which had been one of my fears). Ti told me to back-up on the celebrating and first to birth my baby. She suggested that Dave and I needed to push to bring out the baby. So, after a big

baby girl was born at 3.32 pm. I picked her up out of the water and cried over and over, “My baby. my baby.” The feeling of this moment cannot be described in words. It was amazing and euphoric and intense; so powerful and strong. To hold my baby in this world for the first time is the most amazing experience I have ever had!

She needed a little help to breathe, but Ti had everything completely under control with a little facial oxygen and a strong back rub. Baby Jarrah’s voice soon filled the air. My labour was so quick that the back-up midwife didn’t make it, so when they both arrived it felt like a party to me. We all celebrated with some champagne sitting on the floor in my kitchen!

I know that being so well supported by my midwives and family, and birthing at home, were the main reasons I had such an amazing birth. I consider Jarrah’s birthday to be one of the best days of my life. I really felt that people who cared deeply about the wellbeing of my baby and myself surrounded and supported me. I know first-hand that the hospital staff in a fragmented system do care deeply, however it goes to another level when you know a family closely. It builds a partnership and a trust that is unique to the birthing experience, and something I believe completely enhances the joy of the journey for everyone. Having worked in all areas and different styles of midwifery, I feel very passionately that it is every woman’s right to know her midwife before her birth, and to be supported to birth however she feels best for her and her family. From everyone’s point of view, it is so much more rewarding: a dream come true.

## Author Bio

Sarah is mother to Jarrah (4 months) and lives with her husband Dave in Ocean Shores, NSW. She is currently on maternity leave from her job at a Mullumbimby Birth Centre as a caseload midwife, which provides continuity care both at the birth centre and at home. Sarah has been a midwife for seven years and first became interested in the profession after working as a renal nurse and seeing much sadness in people’s lives. Sarah decided she wanted to share the happy and joyous parts of life, which are found abundantly in birth. Now that she’s not working, Sarah is spending her time loving her family, the beach, great food and new friends.



Midwives Ti Harrison, Michelle Poppel, and Suzanne Weir



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