

BirthMatters

Vol 18/1 ISSN1443-7570

Autumn 2014

**Homebirth
after two
caesareans**

**Medicare-
eligibility and
women's
choice**

**Excerpts
from a
midwife
in Africa**

**Alexander's
surprise
breech birth**

**Research
on induction
for post-dates**

*IN REVIEW: A Modern Woman's Guide
to a Natural Empowering Birth*

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OUR PURPOSE

Birth Matters (BM) is an annual 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 in hard copy annually in June. **Deadline for submission is the 1st of May.**

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

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

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

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

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

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

Please do not submit advertorials, they will not be published.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

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

CONTENTS

REGULAR SECTIONS

- 2 From the Editor**
- 3 From the President**
- 4 Federal Update** By Bruce Teakle
Medicare-eligibility and women's choice
- 7 Branches Update:** By Tessa Lieberman
Friends of Belmont Birthing
- 8 Maternity Coalition News**
- 9 Parenting Matters** By Kylie Sheffield
Dropping the 'D' word
- 13 Rural Matters** By Bec Telfer
Together midwives and women can make a difference
- 18 Global Matters** By Michelle Steel
Excerpts from a midwife in Africa
- 20 Global Matters** By Lynne Thorsen
Three different countries: three different births
- 22 In Review** By Genevieve Sayers
A Modern Woman's Guide to a Natural Empowering Birth
- 23 Research News** By Jyai Allen
Induction of labour for 'post-dates' pregnancy
- 30 Financial Report**
- 31 Maternity Coalition Contacts**
- 32 Subscribe and Membership Renewal**

FEATURE ARTICLES

- 11 Midwife training in New South Wales**
By Jacquie Svenson
- 14 Turning the tide on unnecessary intervention: education is key**
By Penny Williams
- 27 Why birth is a feminist issue**
By Gaye Demanuele
- 28 Positive birth after caesarean: a quest for adequate support**
By Alexandra Robertson

BIRTH STORIES

- 10 Alexander's surprise breech birth**
By Anna Lake
- 16 Flynn's amazing arrival: a surprise homebirth**
By Jacqueline Powers
- 24 Homebirth after two caesareans: the birth of Sarama Caitrin**
By Erin Quinn

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Main Cover Photo:
Aria birth

Photo by: Rowena of
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Photography



Welcome to the Autumn issue of *Birth Matters*. This is my first run as editor and I would like to take this opportunity to acknowledge all the hard work from the contributors, as well as the Maternity Coalition team, that goes into creating this magazine. The unending support provided which has ultimately gotten this current issue to print has been overwhelming. I consider myself quite fortunate to be part of such a passionate and driven group.

It wasn't until I was pregnant with my first born, nearly five years ago now, that I became aware of the notion of 'birth choices' and how what I had perceived as *normal* (having a baby as simply and naturally as possible, in a setting most comfortable for the birthing mother) was actually contrary to the norm and in actual fact, perpetually under threat!

My grandmother had eight children, all born at home, as was expected at the time. A generation later, my mother had two children via caesarean in the hospital. The first was an emergency procedure, as the baby was breech and she was advised that if she did not go through with it, the baby could die. Panic stricken, my mother consented, and my father was escorted out. The baby was born on a Monday and my mother did not get to meet her child until Thursday. Needless to say, I was a scheduled caesarean, as VBAC was not a consideration for a mother when her obstetrician would claim it to be "certainly not advisable".

Now I have two children of my own, fortunately both born as I hoped and where I wished. When I consider the women before me, I find that this current generation of mothers is caught in a sort of birthing choice limbo. The concept of birth has seemed to transform throughout history from being perceived as a common (routine, even) event to an over-analysed process. Perhaps at one point, the birthing mother was seen to hold more knowledge

than the birthing attendant, leaving her to trust in her body and proceed with ease and confidence.

While we are fortunate to have such advanced medical knowledge and technology in the case of birthing complications; that knowledge has been overly imposed on mothers in a complex and intimidating manner. This is where educating a pregnant woman becomes invaluable. It reinstates the confidence nature intended, and allows a woman (and her partner) to make an informed decision without being swayed by external sources which may or may not be relevant. Penny Williams' article *Turning the tide on unnecessary intervention: education is key*, preaches the growing importance of educating a pregnant mother to find the trust and confidence in herself as increasing surveillance poses a threat to the inward focus and calm necessary for a woman to birth.

I, personally, am now a lot more aware of the choices a pregnant mother is faced with, confident in the choices I made and extremely enthusiastic about advocating the continuing freedom for women to choose what they feel is right for them and their baby.

I invite you to read through this issue of *Birth Matters* and join me in celebrating the determination and achievement of three women in particular: our birth stories contributors. Each woman has managed to make educated, instinctive and confident decisions, stare adversity in the face with great strength and focus and be able to write their birth story as they wanted it to unfold. (Even if it unfolded on the bathroom floor...).



Happy New Year to all our members, old and new. I cannot believe how quickly the first few months of this year have flown.

Over the last couple of years the National Management Committee has been working on many aspects of the organisation and our main focus has been developing Maternity Coalition so it will be a long term, sustainable and well serviced/servicing organisation for members and maternity care consumers in general. There have been many conversations around the great work that has been done in the past and I would like to share our thanks and appreciation with all who have been involved in our organisation at local, state and national levels. Your efforts, no matter how small, have all contributed to the wonderful improvements we have seen in Australia's maternity care to date.

Of course as organisations develop, naturally there are changes. These changes are usually in the best interests of the organisation and its' members. With this in mind, the Committee has been exploring some new and, we think, exciting changes for Maternity Coalition.

Here are the proposed changes, which are all open for discussion and feedback from our members.

Maternity Coalition becomes 'Maternity Choices Australia'

There has always been discussion around the name of the organisation and while it has a long and positive association with maternity care reform in Australia, based on feedback, it also discourages many from becoming a part of what we do as it can sound intimidating or political in itself.

When brainstorming the ideas around the name, the Committee was mindful of the fact that 'MC' is how we are known to many individuals and organisations. For this reason, we hoped to retain this as the shortened version of our official name. The other consideration was not wanting to change so much that we completely lost the wonderful identity we have formed over the last 20+ years. The proposed change will also come with an upgrade in logo but will still utilise the current

logo circles that represent the 'coalition' of women, babies and midwives. The colours will remain purple which symbolises dignity, green which symbolises hope and white for purity. These were the colours of the suffragettes, hence the choice of these colours initially.

The Committee has also worked on revising our current constitution to ensure our statement of purpose, vision and organisational management continue to support and reflect our work in providing consumer representation, advocacy, support and information.

These proposed changes will be sent out to our entire membership for review and feedback and will be voted on in a Special Resolution Meeting on 6 May 2014. We invite all financial members to join in the meeting, and an invitation will be sent to each member in the coming weeks.

This year there will be a change in the way *Birth Matters* is delivered as well. Increased printing and distribution costs have made producing a quarterly copy of *Birth Matters* unsustainable, and we have decided to produce it as a smaller, monthly version online, starting in August. However, we love the hard copy as much as you do, so members who choose a premium membership will also receive a bumper hard copy edition once a year starting in June 2015. If you are currently a premium member you will continue to receive a printed and online version for March 2014, June 2014 and then the Annual edition in June 2015, along with online monthly *Birth Matters* from September 2014. If you are a basic, student or volunteer member you will continue to receive the online versions of each edition.

Being a member of MC is more than receiving a copy of *Birth Matters*. Without a strong membership base MC would find it difficult to lobby for improvements in maternity care. The more members MC represents, the stronger its voice when demanding our maternity system better meets the needs and choices of Australian women. And because of this we thank you for your continued support of our organisation.

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Notice to all Members

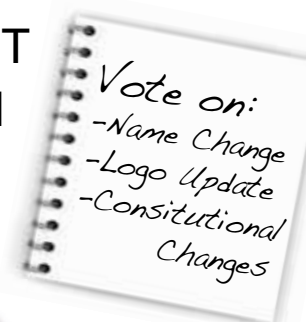
You are invited to attend a Special Resolution Meeting

When: Tuesday 6 May 2014, 8.00pm AEST

Where: In your home, via Conference Call

If you wish to attend, please RSVP:

secretary@maternitycoalition.org.au by 30 April.





MEDICARE-ELIGIBILITY AND WOMEN'S CHOICE



Since 2009 there have been a range of changes to the Australian maternity care system. These reforms have been fundamental and complex, and some elements have created real threats to women's rights to choice, especially regarding homebirth. This has generated a lot of concern, protest, media and political response. There has also been much fear and confusion.

Now that some of the dust has settled, what are the lasting effects on women's options in birth care?

A storm of reforms

In 2010 changes occurred in a range of places in the maternity care system:

- National registration for health practitioners – including midwives
- Requirement for professional indemnity insurance for all health practitioners
- Exemption from this requirement for midwives at homebirths, with conditions
- Creation of the 'eligible midwife', able to provide Medicare-rebatable services
- Commonwealth-subsidised professional indemnity insurance for eligible midwives
- Medicare reforms enabling Medicare Benefits Schedule (MBS) rebates for services by eligible midwives
- Changes to professional guidance for midwives by regulators and professional bodies.

National registration

Until 2010, doctors, nurses, midwives and other health practitioners in Australia were registered by state or territory-based regulators. This meant (for example) that a midwife registered in Queensland was unable to practise in NSW, without

registering there as well. Different states and territories regulated practitioners with different rules and costs.

In 2008 all Australian health ministers decided to move to national registration, so that registration, professional standards, complaints systems, etc. could be managed nationally in a single system. Implementation took more than two years, and required detailed negotiation between all states and territories to develop a system that was acceptable to all governments. This required everyone to accept a degree of change to the rules for health practitioners. As the Commonwealth is unable to regulate health practitioners, national registration required each state and territory government to pass legislation, called the 'National Law', to create the Australian Health Practitioner Regulation Agency (AHPRA) and close the old state-based boards and councils.

Professional indemnity insurance

One highly significant change created by national registration was the requirement for all practitioners to be covered by professional

indemnity insurance (PII). The reality is that people are sometimes injured by negligent practitioners, and there is a strong political desire to see that these injured people receive some degree of compensation.

Most midwives work for organisations (usually hospitals) that provide insurance to employees, so the new requirement for PII did not have an impact on employed midwives. However, self-employed private midwives were particularly affected by the requirement for PII, as no PII product had been available for midwives in Australia since 2001. In Australia, most private midwives provided homebirth care at this time, so the requirement for PII, in the absence of available insurance products, put women's access to homebirth care from midwives at risk.

Shortly before the requirement for PII came into effect, a PII product for midwives was put onto the market by a company called Mediprotect. However, this insurance did not extend to labour and birth care (in any setting), leaving midwives unable to provide insured labour and birth care at home.

Medicare reforms

In May 2009, the Commonwealth Government budget announced a \$120.5 million package of reforms to maternity services in Australia. The centrepiece of these reforms was a plan to introduce Medicare rebates for midwifery services. This was a huge breakthrough, following years of lobbying by consumers and midwives for Australian women to have better access to continuity of midwifery care.

Eligible midwives

Part of the Medicare reforms was the creation of the 'eligible midwife', who is enabled to provide Medicare-rebated

services and to purchase Commonwealth-subsidised PII. The Commonwealth Government decided on a set of conditions for eligibility, which (amongst other things) requires a midwife to have a certain level of experience and to do a course in prescribing medicines.

After development by the Commonwealth, the process of eligibility was handed to the Nursing and Midwifery Board of Australia (NMBA). Midwives wishing to become eligible make application to the NMBA. If successful, this is recorded as a notation to the midwife's registration.

Once eligible, a midwife has no additional restrictions on how she or he (please accept 'she' henceforth in reference to all midwives) practises compared to other registered midwives. Eligibility simply means that she can get a Medicare provider number and purchase Commonwealth-subsidised PII. Once she completes a required course in prescribing and gets the associated endorsement to her registration, the midwife is also able to prescribe relevant drugs, including subsidised drugs from the Pharmaceutical Benefits Scheme (PBS). The midwife isn't required to work in private practice, but will need to maintain her experience across the scope of practice to maintain her eligibility.

Commonwealth-subsidised professional indemnity insurance

Medicare only pays rebates for privately provided health care services. Therefore, to make Medicare-rebatable private midwifery practice possible, the midwives' insurance problem would need to be solved, at least enough to enable Medicare-rebated services to be provided. For this reason, a Commonwealth-subsidised PII product was funded in the reforms.

Because homebirth is such a hot potato, the Commonwealth decided to exclude homebirth from Medicare rebates and subsidised PII. This put women's access to midwifery care in homebirths at risk, because midwives were not permitted to practise without PII (as a condition of their registration), but were unable to purchase a product to cover their practice in homebirths. This problem resulted in a great deal of protest, and was eventually resolved by all Australian health ministers adding a section to the National Law for practitioner registration, exempting midwives from the PII requirement while providing homebirth care. This exemption expires in 2015 and the future of Australian women's access to homebirth will be defined by the way this expiry is resolved.

While the exemption is in force, any midwife is exempt from the PII requirement for the labour and birth care she provides in a home, subject to conditions (her antenatal and postnatal care still need to be insured).

The conditions for the homebirth PII exemption are set out in the *Safety and Quality Framework*, which is available on the NMBA website. The requirements in the Framework apply to any midwife, eligible or not, providing private homebirth care.

Collaborative arrangements

Probably the most inflammatory issue in the Medicare reforms was 'collaborative arrangements'. This is a condition of payment of Medicare rebates and, to a lesser extent, Commonwealth-subsidised PII, which creates a medical veto over women's access to government money for private midwifery care. Consumer, midwifery and nursing groups protested strongly together over this, but were unsuccessful against the powerful medical lobby.

'Collaborative arrangements' became a condition of Commonwealth subsidies for care by private midwives. There are two ways in which this money is delivered: Commonwealth-subsidised PII, and Medicare rebates for care from eligible midwives.

Each of the Medicare items which pays a rebate to a woman for services from an eligible midwife is conditional on the midwife having 'collaborative arrangements' in place. There are a range of options for collaborative arrangements (easily found online), which were slightly relaxed in 2013 when a new option was added: credentialling with a hospital.

Collaborative arrangements are a condition of each Medicare rebate, not of eligibility. Thus an eligible midwife is not obliged to have collaborative arrangements to provide private care if her clients pay the full cost of care.

Commonwealth-subsidised PII is also conditional on collaborative arrangements. However, there is a path around this (otherwise the insurance product wouldn't work a lot of the time). Eligible midwives, with Commonwealth-subsidised PII insurance, who cannot get collaborative arrangements for a woman's care can satisfy their insurance conditions by 'communication of a care plan' to a public hospital for that woman. The insurer sets out the requirements for this, which include booking the woman at the hospital, sending in clinical information and confirming that the hospital has received that information.

Professional guidance for midwives

While government has been shaking up the midwifery profession with the Medicare reforms and the nationalisation of practitioner registration, the effects have flowed on to the professional guidance for midwives' clinical practice.

The primary players in the midwifery profession are the Australian College of Midwives (ACM) and the Nursing and Midwifery Board of Australia (NMBA), which is a part of AHPRA. As a professional body, the College can develop guidelines about what good midwifery practice is. As a regulator, the NMBA will refer to those guidelines when judging whether an individual midwife's practice meets the standards of the profession.

Probably the most important guideline developed by ACM is the *National Midwifery Guidelines for Consultation and Referral*. This advises midwives on when they should consult with or refer to an obstetrician (or other caregiver). Importantly, this guideline is a statement that Australian midwives can provide primary care to women on their own responsibility, and that midwives are able to decide when a woman needs medical care. This idea is poorly understood by most of Australia's maternity care services.

The ACM guidelines include a section advising midwives how to respond when women make choices out of line with the guidelines or against the advice of clinicians. This is really important to get right, if caregivers are to respect women's rights to choice.

These consultation and referral guidelines have been hotly contested by obstetricians since the Medicare reforms. Obstetric organisations have attempted to replace the ACM guidelines with an obstetric-approved version, an effort successfully resisted so far by ACM.

The reforms have prompted ACM to develop new guidelines, most importantly the ACM's *Position Statement on Homebirth Services*, and associated guidance. The current 2011 document replaces an earlier version, which could be interpreted as

advising midwives to withdraw care from women who make particular choices, and which initiated a lot of conflict.

All this professional guidance applies to all midwives, whether the midwife is eligible or not, whether the care she is providing is Medicare-rebated or not, and whatever PII insurance product she is using.

Does being eligible restrict a midwife’s ability to respect a woman’s choices?

In itself, being eligible does not limit a midwife’s ability to respect a woman’s choices in maternity care. However, in practice, eligible midwives may work in a cultural context that may create challenges to midwives respecting women’s choices.

Firstly, some eligible midwives (currently only in Queensland) are credentialled to provide labour and birth care in a public hospital. This creates a level of accountability to the hospital for the care they provide within the hospital. This can be expected to have a cultural flow-on to their private practice in the community. Credentialled midwives know that they will need to interact and collaborate with hospital staff, and they may need to justify their decision-making if this is significantly different from what is normal. This is not completely different from non-eligible midwives without hospital credentialling: all midwives need to collaborate with hospitals to some extent, and this always brings scrutiny and the risk of criticism or complaints to the regulator.

Secondly, many eligible midwives (including all midwives who provide labour and birth care to their private clients in hospital) have Commonwealth-subsidised PII. As described above, this requires either collaborative arrangements, or communication of a care plan as a condition of the PII product. Either of these exposes the midwife’s practice to a higher level of scrutiny than she might otherwise experience, which, again, may influence her practice. These requirements also could create difficulties providing care for a woman who was strongly unwilling to book into hospital or consent to communication of her clinical information.

It is important to recognise that the above issues are primarily cultural influences on a midwife’s practice, due to a higher level of exposure and accountability in a medically-dominated culture with limited recognition of women’s rights to choice. This is definitely a problem. However it is also important to recognise that this negative influence on the midwife is balanced by a positive influence on the hospital she is working with.

To me, one of the biggest benefits of the Medicare reforms is the huge cultural influence this brings onto hospital culture. Collaborating with eligible midwives requires hospitals to

dramatically reframe their understanding of midwifery: recognising the midwife as an autonomous practitioner, who is accountable for her own practice, and who will decide when her clients should be advised to receive medical care. When credentialled to practice privately in a public hospital (as committed to by all states and territories, but only implemented in Queensland), eligible midwives admit women to hospital under the midwife’s name as the responsible practitioner – a symbolically huge change in a hospital.

If handled well (by both sides), the increased exposure and accountability of the eligible midwife’s practice forces hospital clinicians to consider issues of evidence-based practice, and women’s rights to choice that normal hospital care ignores. This of course puts significant demands on a midwife’s skills in communication and requires her to be really clear with herself about why she practises the way she does.

Consumer representation

It is totally unrealistic to leave this relationship-building and culture-changing task on the shoulders of private midwives alone. Hospitals are highly hierarchical in their power relationships, and midwives are traditionally low in the power tree. Consumers and consumer representatives are game-changers when they engage with hospitals and push for what they want. The new national health service standards make consumer engagement a key performance indicator for hospitals, and thus offer consumers a new opportunity to get in there and ask for what they want.

Successful expansion of women’s access to eligible midwives will depend on consumers engaging effectively at the hospital and state level. Protecting women’s rights to choice will depend on consumers engaging with hospitals, ensuring that women’s rights to choice are recognised and monitored, and keeping up the pressure in the long term. There isn’t any other way out of this; the system will not fix itself.

Lack of respect for women and their choices, and lack of respect for midwives as responsible practitioners is a big cultural problem that affects all birthing women in Australia, including those who have sought to birth as much as possible outside the system. I see the Medicare reforms and women’s increasing access to eligible midwives as the biggest opportunity in generations to improve hospital and professional culture around maternity care. If midwives and consumer representatives work effectively together, we have the opportunity to increase women’s power and choice in their maternity care.

FRIENDS OF BELMONT BIRTHING

Our group, Friends of Belmont Birthing, began informally as a response to cuts to the number of midwives working at Belmont Midwifery Group Practice in 2012. Belmont Midwifery Group Practice (Belmont) offers Medicare-funded homebirth and birth suite births at Belmont Hospital to women in Newcastle, Maitland and Lake Macquarie. It has a used a caseload approach to midwifery care with a one-to-one care arrangement, but currently operates as a small ‘midwifery group practice. It started in 2005 and has offered homebirths since 2008.

Our consumer support group organised a picnic for supporters of this service in October 2012 and met with Hunter New England Health a couple of times during that year. Inspired by these actions, a Belmont mum and web developer determined to create a website for the group that would refer local families to Belmont. This website has been highly successful in increasing the visibility of a service that is often referred to as Newcastle’s ‘best kept secret’. We hope it will not be a secret for much longer! We also created a Facebook page to advertise the picnic, and this continues to attract attention and to be a useful forum for promoting events.

At a meeting with the midwives early in 2013, we realised that funds were needed for continued promotion of the service. A midwife suggested that a ‘Meet the Midwives’ market stall held at various local markets would be a great way to increase the profile of the service and to reach expectant mothers. We were more than happy to host the stall, given that Belmont is unable to advertise directly to the public. Our first market stall at *Hopscotch Sundays* generated direct referrals to the service and

also many happy Belmont mums coming up to say hello to their beloved midwives. We will host our second market stall this November.

As a loose group of Belmont supporters, it became clear that becoming a branch of Maternity Coalition would provide us with easier access to resources and assist us to grow. As a formal group we hope to have greater longevity, plus the capacity to legally raise funds to promote Belmont. We held our first major fundraiser in October 2013. With the assistance of Natalie Brazil from Golden Chair Yoga (who offers prenatal yoga classes locally) we held the Newcastle premiere of *Birth Story: Ina May Gaskin and the Farm Midwives*. This proved a great success; we had over 100 people in attendance, including our captivating guest speaker, Professor Maralyn Foureur, and her colleague Cath Whelan (they started the first independent midwifery group practice in NSW 30 years ago); we raised over \$1500. We were grateful to a wonderful group of volunteers on the night who donated refreshments and made sure it all went seamlessly.

We are now selling gorgeous *Friends of Belmont Birthing* T-shirts and tote bags and I’m a Belmont Baby tees. In 2014, we will be working on strategic planning to see how best to direct our energies to increase the uptake of the Belmont service. We already have plans to publish a local birth stories booklet and to hold a social event for Belmont families. Local mums are welcome to contact us to find out more about or group.

Contact: www.friendsofbelmontbirthing.org.au or email contact@friendsofbelmontbirthing.org.au



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METRO NORTH BRISBANE

It has been an eventful 18 months for Maternity Coalition (MC) consumer representatives in north Brisbane.

With the establishment of the new Hospital and Health Services (HHS) Boards in July 2012, it was challenging for Metro North to establish whom our key contacts would be and then to secure meetings with them. I met with my State MP, Ms Kerry Millard, MP for Sandgate regularly from late 2012 and through 2013, and, together with Bruce Teakle and Ildiko Keogh, met with Jeff Cheverton, Deputy CEO of the Metro North Brisbane Medicare Local in early 2013. The purpose of these meetings was twofold: firstly to discuss MC's objectives to improve local women's access to continuity of midwifery care, and, secondly, to seek assistance in obtaining introductions to the new HHS Board members. Through my attendance at the Medicare Local planning charrette in early 2013, we finally secured an introduction to the Metro North HHS Community Engagement Manager and obtained contacts for the HHS Board secretariat from my State MP's office. We subsequently sent the HHS a list of questions regarding their performance addressing the National Maternity Services Plan (NMSP) priorities. It took some time for them to respond to our questions and their eventual response in June 2013 regarding progress towards the NMSP continuity of care priorities was disappointing.

Since then, however, MC's engagement with the Metro North HHS has improved significantly. With Friends of the Birth Centre (FBC) Qld representatives, we met with the Acting CEO in June, and Women's and Newborn Services at the Royal Brisbane and Women's Hospital (RBWH) re-established their quarterly Birthing Services Forum in August. MC and FBC Representatives also attended the Metro North Board Engagement Forum in August, where we met some of the HHS Board Members and the new Metro North HHS Chief Executive, Mr Malcolm Stamp. Malcolm has since met with MC and FBC representatives twice more, with another meeting planned in April 2014.

In August 2013, Bruce Teakle and Belinda Barnett were invited to be consumer representatives on a steering committee at the RBWH to establish visiting rights for eligible private practice midwives (EPPMs). The RBWH launched the first phase of the EPPM project in December 2013, which enables a small number of credentialed EPPMs to provide antenatal and postnatal services to women. While Phase 1 has credentialed EPPMs for provision of antenatal and postnatal care only, RBWH intends to move to Phase 2 in the near future. This second phase will enable credentialed EPPMs to also provide intrapartum care for women at RBWH. We are hopeful that both Redcliffe and Caboolture Hospitals will also credential EPPMs in the near future, enabling more women in north Brisbane to access continuity of midwifery care.

The RBWH has also recently announced plans to establish an all risk continuity of care midwifery group practice for Aboriginal and Torres Strait Islander women. The pilot is due to commence shortly and it is expected that approximately 140 women will access this service annually.

While often it feels as if we are making little, if any, progress with our efforts, the incredible support and encouragement of the MC Queensland President and other Queensland Branch members, the MC National President and Committee members enables us to persist, despite the setbacks. While we are not certain why consumer engagement with RBWH has improved

significantly over the last six months, we think the appointment of the new HHS Chief Executive has played a key role. Malcolm Stamp expresses strong interest in improving patient outcomes and experiences, consistent with Standard 2 of the National Safety & Quality Health Service Standards (Partnering with Consumers). We are also fortunate to have good relationships with many other organisations that are also passionate about improving women's perinatal health and access to continuity of care. For example, Friends of the Birth Centre Qld has an active and dedicated President and Committee and we have appreciated working with them, and many other organisations, on initiatives such as the Metro North Perinatal Health and Maternity Services Forum.

METRO NORTH PERINATAL HEALTH AND MATERNITY SERVICES FORUM

MC, in partnership with the Queensland Centre for Mothers and Babies (QCMB) and Health Consumers Queensland, recently won a small grant from the Metro North Brisbane Medicare Local to hold a Metro North Perinatal Health and Maternity Services Forum. The aim of the Forum is to provide women and healthcare providers with information about innovative services that support women's physical and emotional health during the perinatal period. The Forum will also provide an opportunity for participants to identify service gaps that impact on women and their families and explore potential strategies for improvement. Both the State Health Minister, Hon. Lawrence Springborg MP, and Malcolm Stamp, Chief Executive, Metro North HHS have agreed to be guest speakers.

I prepared both grant applications (we were successful in the second round) and Ildiko Keogh, MC Qld Convenor, is doing a great job as project coordinator, having previously coordinated five Rural Birth Summits for QCMB. We are especially grateful to Professor Sue Kruske for the support that QCMB has provided in the lead up to the Forum and for facilitating on the day. We would like to thank the many organisations and individuals that supported our grant applications. They include Metro North HHS, Queensland Centre for Perinatal and Mental Health, FBC Qld, Peach Tree Perinatal Wellness, Women's Health Queensland Wide, the Australian Breastfeeding Association, Homebirth Australia, Embrace Life, Young Parents Program, Ms Kerry Millard MP, Tiny Toes Midwifery Practice, Serene Births and the Australian College of Midwives (Qld Branch). Many of these organisations will also display information about their services at the Forum.

We plan to record the presentations and make these available on the MC website for people who are unable to attend. A report will be prepared summarising the Forum recommendations and will be submitted to the Metro North HHS Chief Executive for his consideration. For more information about the Forum please visit www.qcmb.org.au/metro-north-perinatal-health-and-maternity-services-forum.

If you are based in the north Brisbane region and would like to attend, please RSVP by Wednesday 19 March via <http://www.qcmb.org.au/metro-north-perinatal-and-maternity-services-forum-rsvp> or phone 07 3346 3084.

DROPPING THE 'D' WORD



Our three-year-old, Saffy, has recently taken to announcing to people (some of them complete strangers) that she has a brother called Pemba and that he died. Sometimes she's more delicate and euphemises with 'passed away', but her tone is always matter of fact and carries no hint of reverence or finality. This is because Pemba is one of Saffy's many imaginary friends who joined our family around five or six months back and who has since then been, variously, run over by a car, bitten by a snake, snatched by a quoll and attacked by kookaburras. He dies and is resurrected almost daily, which is handy given Saffy's intention to one day marry him.

It's probably no coincidence that Pemba's deaths often mirror those of animals Saffy has known. Interestingly, she seems to understand that, while he can die and be reborn to play another day, real people can do no such thing. While some are uncomfortable with our littlest one's tendency to suddenly drop the 'D' bomb, I don't find it odd or disturbing. It is not the result of too much age inappropriate TV (as an outsider might mistakenly suspect), nor does it come from any deliberate effort on our part to 'prepare' her for life's harshest and most inevitable truth. It's just that we're a pretty open mob and I'm really not sure what the alternative would be. How would we explain to her what happened to some of the people in the photos on the wall and in our family albums? Where would we tell her they have gone? I have neither the patience nor the smarts to concoct a story fit to satisfy the likes of Saffy and I can't imagine that lying to her would lead to anything but resentment and confusion in the long run.

A dear friend once told me that, when he was very young, his mother had a baby who lived for just a few hours. He and his siblings were never told the baby's name or whether it was a boy or a girl. His only lasting memory of the time was of the tiny coffin brought to the house on the day of the funeral. Even at age 70 he regretted that he was never given the opportunity to comfort his mother as she grieved, or to express his own confusion and sense of loss.

Saffy has never experienced the loss of someone close to her first hand. Her current take on death is based on her observations of *our* responses to it. Because we speak openly about our dead loved ones, she does too. She sometimes repeats things we say and imitates our outward expressions of grief. She has cried at times and said she misses her Grandad, Pop

and older brother, all of whom died before she was born. Just mimicry perhaps, but the only way she is currently able to share in an important family experience.

I'm under no illusions that our frankness will lessen Saffy's pain when she personally experiences the death of a friend or family member. No matter how many different fatal scenarios she acts out with Pemba or how many times we rehash the circumstances surrounding the deaths of late family members, her first real loss will devastate her. But I'm not sure her ability to freely talk about and play out scenarios involving death and dying is all about how *she* feels. I think it's also about how she will respond to others who experience a loss.

Though we've come a long way since the death of my old friend's baby brother or sister, as a society we still broach death awkwardly and often insensitively. I'd like my kids to be a bit more comfortable with the subject. I want them to develop empathy for others who are suffering a loss and not resort to platitudes or stunned silences. I want them to know that death is scary and sometimes awful, but as much a part of the natural circle of life as birth. Most of all, I want them to know that they can talk to and ask us about anything, and as many times as they need to.

I'm sure Saffy will outgrow her long-suffering mate Pemba and her fascination with death. At the very least I hope she stops accosting strangers in the checkout queue and at the park with tales of her tragic losses. In the meantime, we're happy to play along and show her the same compassion we'd like her to show to others, and to hope she doesn't take it too hard when we explain that it's really not OK to marry your brother.

Author Bio

Kylie Sheffield is a mother and a passionate advocate of informed choice in all aspects of healthcare and parenting. She lives in Canberra with her husband and children.

WANTED ADVERTISING COORDINATOR

Would you be interested in volunteering with Maternity Coalition?

Jade is unable to continue in the role of Advertising Coordinator next year, so we are looking for someone who can work with the *Birth Matters* team. This exciting role has very flexible hours and all possible from your own home. Email: info@maternitycoalition.org.au

ALEXANDER'S SURPRISE BREECH BIRTH



Alexander enjoying skin-to-skin time

Anna Lake is wife to Chris and mother to Elizabeth (2 years) and Alexander (10 weeks). Anna is a paediatric ICU nurse and lactation consultant (in training) who is becoming more interested in birth choices!

Continuity of care

My first pregnancy was an incredible journey for my husband and myself. Our daughter was born at a birth centre at a major public hospital in Brisbane with two out of three of our midwives and our midwifery student present. We developed a great rapport with all of them during my pregnancy and I really valued their continuity of care. When I became pregnant with our second child, I felt blessed to be accepted by the same birth centre again and placed with the same team. I requested a student midwife again, as I had found this a great experience last time, for both the student and me. During my first pregnancy I put on nearly 20 kg, taking me into triple figures, which meant that I was unable to use the birthing pool (due to weight restrictions). So, before I got pregnant this second time, I contacted a dietician who began re-educating me about healthy eating. As my pregnancy progressed I tracked along very well and, by the time I went into labour, I was under the limit.

Unexpected labour

When I went into labour at 37 weeks and three days, it took both me and my husband by surprise. Although I'd had a feeling that I might be going early, I had ignored it. That evening I found that I could fit my whole hand between my ribcage and my belly and, a few hours later, my waters broke! We called my midwife and, given that I hadn't had any contractions, I decided to wait until morning before coming in unless something changed. Contractions really kicked off only 45 minutes later, at around midnight. After arranging for our daughter to be picked up, my husband and I tried to rest as much as we could before

labour really took off. I ended up needing my TENS machine fairly soon after the contractions started; by around 3 am they were coming hard and fast and my husband was calling my midwife again requesting that we come into the birth centre straight away. The car ride was painful, and walking through the hospital to the birth centre was interesting as I was contracting all the way. Thank heavens it was the middle of the night!

Our lovely midwife greeted us there and took us to our room, where I continued to labour. Once our student midwife arrived, we found the baby's heart beat with the Doppler way down low, and my midwife couldn't feel a head and thought that it must be well engaged. I was feeling hiccups in my bottom in between contractions, another indication to me that things were progressing nicely! Just after 4:30 am, I asked if I could use the pool as I was starting to struggle with the intensity of the contractions. Once it was filled, my midwife asked if I would like an internal examination, which I very nearly declined as I just wanted to get into the water! My husband convinced me that it would be a good idea to see where we were, so I reluctantly agreed. Just after a contraction, I quickly laid down on the bed, and felt incredibly uncomfortable being on my back. I was visualising sinking into the water when I heard my midwife's voice interrupt my thought: "and baby's breech". "WHAAAAAT!!!" was my verbal reaction. Another contraction hit immediately and I flew out of the bed to get through it. By this time I was using every tool I could think of to distract myself from the pain, but the word 'breech' was starting to make me panic. I kept saying, "It can't be breech! It just can't!" I thought this meant that I would be taken for a caesarean and the thought terrified me! I am a nurse myself and had done a lot of research into birth; I knew that a caesarean was not ideal unless it was an emergency.

A one-sided story

I had noticed that my midwife had popped out of the room, presumably to inform the medical staff that accompanied her back when she returned. She said that we needed to take a little walk over to the birth suite about 40 metres away. As we all (slowly) walked across, my first image was a wall of light blue scrubs and a very bright room. There seemed to be quite a few people in there, and my worry increased. I was hooked up to CTG monitoring while they did an ultrasound to confirm my baby's position; the swoosh swoosh sound of the heart beat was a little bit reassuring. The obstetric registrar came to my bedside and began to explain my options. She told me that none of the staff in the room were experienced with breech births, and that her consultant recommended an epidural and preferably a caesarean. In between my contractions, she explained the risks of a vaginal birth, including the possibility that my baby could get stuck or die. I felt that I was being given no real choice (and, afterwards, my husband said he felt the same thing). I felt powerless. I understood that if my baby needed a surgical birth then it was truly necessary; but was it really necessary now?

The registrar continued to say that she couldn't force me to do anything I didn't want to do. I started to search for my midwife and found her at the back of the room, shaking her head as the registrar talked further about an epidural. Seeing her shake her head, I felt confident enough to ask to try gas and air first, rather than go straight for the epidural. I was then told that, "This isn't about pain relief; it's about the safety of your baby".



Anna, Chris and baby Alexander

I nearly crumbled and, in a last ditch effort, called out for my midwife and asked her opinion, as I really wanted to hear from someone I truly trusted. She confirmed for me what was already in my head, but hadn't heard from the registrar: there were risks in having the epidural, which could slow down labour and lead to further interventions such as a caesarean (a new set of risks in itself). She then explained to me the favourable parts of my situation: my labour had been progressing very well; this was my second baby; at two and a half weeks early the baby was unlikely to be over four kilos; and bub was a complete breech. She also said that she was experienced in breech births and told me that I could do this naturally: I just needed to get up on all fours and continue. I think there may have been a little pause in the room before I made my decision. I decided to put all my trust into my midwife and my body and give natural birth a go. As soon as I said that, I felt better and slightly calmer, although very apprehensive in wondering if I was going to be able to birth this baby backside first.

Can I do this?

They put an IV in my hand, and then my midwife encouraged me to get upright and lean over the bedhead to help progress my labour. I kept asking if I was allowed to push yet, as the contractions were so close and overwhelming that I wanted to push to get some relief! On being told I wasn't allowed to push, I requested some gas and air to help me through the last of the contractions. I felt awful on the gas, and the pain was still there, but I no longer felt that I wanted to push. I started to lose faith in myself at one point, and called out to my midwife asking her, "Can I do this?" Calmly and confidently she replied, "Of course you can!" It was the encouragement that I needed. Things were a bit fuzzy for a short while, but after another request from me to push, my midwife asked to examine me to check for any cervical lip and ensure that I was fully dilated. Thankfully I was able to remain upright, and as she checked me my body took over and I remember apologising as I pushed because I just couldn't help it! My midwife then told me to listen to my body and go with it. All I wanted to do during those contractions was push; it felt so good to be doing something! As I was pushing, I felt my baby descending really well, but I wasn't sure if that was just in my head. I do remember when bub was halfway out thinking how much it was stinging and my heart sunk, realising I still had the head to go. However, much to my and everyone else's surprise, a couple of pushes later our first son, Alexander, was born! That split second of relief was replaced by 'OMG I can't believe I just

did that!' and he was then passed to me through my legs and into my arms. Euphoria took over. I laughed in disbelief at what had just happened, so happy that my baby was here safely, that I'd been able to have him the way I wanted with the people I wanted. By the time I was able to turn around, the 'wall of scrubs' was gone, and the only people who remained were our midwife, our midwifery student (who had never seen a natural birth let alone a breech) and another midwife from the birth suite. An hour later, we were taken back to the birth centre to recover and just enjoy our new baby.

Just 12 hours later we prepared to take our baby home, having had no complications. Thankfully (despite feeling that I had split in two) I came away with an intact perineum and was feeling very spritely! As we were preparing to leave, I looked over the birthing pool and saw that it was still filled. I was so disappointed at not being able to use the pool, but it was for clear reasons and I was happy with that. My dietician and I had worked so hard for me to use the pool, but when I couldn't I found something else to be positive about: on leaving the birth centre I was back to my pre-baby weight, something I never thought I would ever be able to achieve.

Reflection

During the next couple of weeks, I spoke to all three of my midwives about my experience during their home visits and/or phone calls. Through this I was able to start reflecting and processing my birth. My first thought was that, as a nurse, I understand informed consent and felt that the registrar did not give me complete information to allow me to make an informed decision. I also felt disappointed as I found that the consultant who supported this registrar did not support natural breech birth, which meant the registrar had no support herself. I then had another thought: perhaps it would be a little selfish of me to be disappointed that none of the doctors had congratulated me, but I was truly upset that they didn't thank or congratulate my midwife!

Since having Alexander, I have been finding out more about breech births and have joined a Facebook page to further my research and to give support to those who are having/had a breech baby (www.breechbirth.net). I have found that there is a severe lack of skill and knowledge about breech birth, not just in the professional area, but also amongst the public. On hearing my birth story, many people have exclaimed, "You mean you didn't have to have a caesarean?" This confirms to me that more awareness is needed to avoid women being cornered into a single option. Women should understand that it is their body, their baby, their birth, and they have a right to make an informed decision and be supported in that decision. I was incredibly blessed to have an experienced person caring for me, but also she was someone who encouraged me and supported me in every way. I would love to hear birth stories in future of women who have whatever birth they choose, with someone whom they know and trust, and who come out of it feeling that they were in control, informed and that their birth was a great experience. My midwife fought for me and, although she shouldn't have had to, I am forever grateful that she did, not only for me, but to also show those who were inexperienced that it can be done. I sincerely hope that those doctors present were able to learn from my midwife, and perhaps be able to give other breech births a chance at a natural delivery when requested and where possible.



MIDWIFE TRAINING IN NEW SOUTH WALES

I dedicate this article to my two Hunter New England Area Health Services midwives.

Did you fall in love with your midwife?

The first time I fell in love with a midwife I was groaning, bent head-first over the bath, at the John Hunter Birthing Centre. I had just asked, in a small, hopeful voice, whether maybe now was a good time to get the pain control out. I had decided before the birth (as so many of us do) that I wanted to do without any of that. I wanted my baby to enter the world and to meet his parents for the first time free of a drug fog. I figured that the new sensations of sight, sound and touch would be overwhelming enough. But now here I was, 12 hours into what felt like the most monstrous period pains on earth, with dawn nearing. Narcotics were starting to look like a deliriously good idea. My midwife leaned down to me and said in her low, sensible voice, “Now, Jacquie, you said you didn’t want to do that, so let’s not, eh?”

For someone else, at that time, in that situation, those words could justifiably have sounded bossy, ideological, or just downright mean. But for me, right then, that was exactly the steel my backbone needed. Though I didn’t have it, my midwife did. I’m not a medico, but the easier, certainly socially sanctioned, option for her at the time no doubt would have been to call the anaesthetist. This might have made for a quicker and easier labour for her, and less moaning from me. But she didn’t. She stuck with me. It made the world of difference to my baby’s first few minutes of life, and to my experience of them.

The second time I shot straight to Midwife Groupie was more subtle, because there was less time to for my midwife do *anything* noteworthy as that baby nearly came in the hallway at the Belmont Birth Centre, half an hour after I’d called her. As I knelt in a bath, alternately subsiding into it like some kind of mountain listing into the sea and then trying to clamber out, she told me that if I got up out of the water one more time she was going to pull out the plug and make me stand up. These might sound like stern words, but, at the time, unbeknownst to me, the baby’s head was already crowning. If he was to emerge *in the water*, I needed to stay put, for while it was OK to be born head in the water and then lifted *out*, it would not work the other way round! Through the racket of my bull-like roaring as I wondered whether on earth I could pull this off, this was just the black and white information I needed. I knelt down one more time, looked down, saw my baby’s head, and then collapsed back against the wall of the bath yelling (as if this was unexpected), “It’s a *baby*. It’s a *baby*.” She laughed like the Earth Mother she is and took my photo*.

Shortly after that, I decided that midwifery was the career I’d been missing all my life. No matter that I’d been a lawyer for 15 years with no medical training or interest in anything medical to date; becoming a midwife seemed perfectly logical to me at the time. Thankfully for mothers everywhere, I came to my senses, but it occurred to me that I’m probably not the only one who can see the wonder of the prospect. So I thought a bit of a heads up on how to actually *pursue* the dream might be useful.

There are two tracks to becoming a midwife in NSW: enrolling fresh from civilian life (or whatever chequered and relevant/irrelevant past you may have) in a three year Bachelor of

Midwifery degree; or transferring across from being a Registered Nurse (with a Bachelor of Nursing) via a one year postgraduate course. If you want to go the whole hog, you can do both a Bachelor of Nursing and Bachelor of Midwifery as a double degree, or add a postgraduate midwifery year to a Bachelor of Nursing.

The Bachelor of Midwifery is offered by four universities in seven locations in the NSW/ACT region: Newcastle (University of Newcastle, campuses at Newcastle and Port Macquarie), Southern Cross University (SCU, campuses at Gold Coast and Coffs Harbour), Canberra (University of Canberra), and Sydney (University of Technology Sydney and University of Western Sydney). (In 2014 the ATAR entrance score ranged from 91.3–94. It is also possible to transfer in from Open Foundation or other similar alternative entry pathways, as well as TAFE). The University of Canberra and SCU are the only centres that offer part-time study for midwifery. The Bachelor of Nursing is offered at most universities in NSW and is offered part time at many, including Newcastle.

The postgraduate midwifery year to tack onto your nursing degree is available at the University of Newcastle and University of Western Sydney. At present, the Federal Government is so keen on midwife training that students get a portion of their HECS payments back. And it goes without saying that there are great employment prospects.

I realise that I’ve just written down the *academic* aspects of becoming a midwife. Of course, the apprenticeship to that profession requires a whole lot more. I have never been one, but I imagine, just for starters, there’s a dating website list of gorgeous characteristics: a whole lot of patience, steadfastness in adversity, compassion, stamina, grit, pragmatism, truckloads of courage, kindness, and intelligence. On the practical side, a sugar-parent (like so many female-dominated professions, midwives are not well paid), the constitution for shift or on-call work and for surviving heavy-duty bureaucracy, and, of course, a big old sense of humour would probably also be useful. My two darling midwives certainly had all the personality traits; if only we could give them a sugar-ma too.



TOGETHER MIDWIVES AND WOMEN CAN MAKE A DIFFERENCE

There is good news for the women of Chinchilla, Queensland: birthing services at the local hospital have resumed once more after their closure in March 2013 due to lack of staffing¹. For the last 12 months women have had to travel over 80 km to Dalby to have their babies. Now, after the arrival of a doctor with anaesthetic skills, birthing services have been reinstated. Maternity Coalition (MC) had hoped that services might have re-opened using a midwifery-led model of care and, while this has not happened, it would still be possible.

Midwifery-led services in rural areas without direct access to caesarean sections or epidural anaesthesia (such as Mareeba, Queensland²) have been proved to be successful,, so why aren’t there more of them? One answer could be the attitudes of the staff who work in these areas. An investigation into the viewpoints of local stakeholders regarding midwifery-led units in far west NSW was published in late 2013³. The researchers found there were “high levels of confidence” in the evidence-base for midwifery-led care models and in their acceptability for local implementation. Twenty-four stakeholders took part in the research; these included the roles of nurse manager, obstetrician, GP obstetrician, nurse practitioner, remote area nurse, midwife and clinical midwifery consultant, however a breakdown of these clinicians was not provided. The results of their research also suggested that, in order for this type of service to be provided within the far west of NSW, there was a “need for an increased and well-qualified maternity work-force that is retained over time”. The authors of this study concur with Boxall and Flitcroft who argued in 2007 that a change in maternity service delivery was more likely if it came from a “local and grass roots change” rather than a “system-wide change”. They point out that this type of change requires “strong local leadership”. It also should be recognised that the support of consumers also assists (and is often instrumental) in facilitating change in maternity care. A combination of all these factors seems to be required to see a change towards midwifery-led care.

In Longreach, Queensland Health (QH) has been upgrading the hospital at a cost of \$7 million. Within this budget, money has been allocated to the Maternity Unit for a security, fire and IT upgrade. I spoke with a midwife who reported that in early February it was suggested that QH could also do some further work on the Maternity Unit to bring it up to date. However, the Unit was given less than a week to provide a proposal. The midwife was keen to see some major work undertaken to improve the very small ensuite, but felt this may not be supported by QH without the support of consumers asking for the same thing.

Last year, our intrepid consumer representative, Tish Ryder, from Emerald, travelled for 4 hours to speak to the women and maternity staff of Longreach. Unfortunately, none of the women at this meeting were willing to act as consumer representatives at the hospital. Is it only the midwives who believe the women of Longreach deserve better than they are getting? Is it ridiculous to believe that women in rural and remote areas should have access to the same level of service and facilities that women in towns take for granted? Would these women

be more likely to lobby for services if it was on someone else’s behalf, rather than feeling that they are asking for themselves? As a result of the lack of consumer representatives, the midwife in Longreach does not have any consumers ready to call upon, and feels powerless in what she wants to present to QH. MC is working with some contacts from Longreach to identify consumers who would be willing to provide the hospital with consumer representation.

I would like to make some suggestions for both midwives and the women they serve. Firstly, for the women who are receiving maternity care, don’t accept ‘good enough’. In Australia women right across the country deserve to receive high quality care and facilities. Talk with your friends if you don’t feel that this is what you are receiving and do something about it together. Talk to Maternity Coalition: we can help to support and direct you to resolve the issue. Secondly, to midwives, I suggest that you harness the power of the women you work with, especially if you work in a hospital environment, whether you are in the country or the city. Give them a Maternity Coalition brochure or tell them how to find us online. Encourage them to report on their experiences, and put them in touch with like-minded women. Consumers can be mouthpieces for hospital employees, as they are not restricted in what they say, or whom they say it to. Together, midwives and women can make a difference in our maternity care system.

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

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TURNING THE TIDE ON UNNECESSARY INTERVENTION: EDUCATION IS KEY

I come from a nursing midwifery background. I have been involved in parenting education for over 25 years in both the public and independent sectors. I ventured into the field of parenting education early in my midwifery career because of an incident that happened in a delivery suite.

I walked into my assigned room one day to find a young teenage woman in the foetal position in the corner of the room. She was very frightened and in a state of panic. I approached her and introduced myself. This young woman then asked me, "Where is the baby going to come out?" Horrified, I proceeded with a crash prenatal course, simply trying to make this young woman's transition into motherhood as easy as I possibly could. Needless to say, it wasn't an easy birth, but I knew one thing for sure from that moment on: knowledge really is power!

This incident became the catalyst that set things in motion for me to become an educator. I knew that birth had to be a better experience than it was for that young woman. I wanted to help in a skillful way. I discovered my purpose in that moment. I began searching for knowledge that would not only improve my own experience but also that of all I came in contact with.

My searching led me to Peter Jackson, a male midwife and childbirth educator, who helped me to truly understand the link between the mind and the body and its significance in the childbearing year. Peter was the founder of the popular Calmbirth® Prenatal Preparation Program, and he taught me that, to truly prepare for childbirth, the woman and her birth partner need to be prepared both emotionally and practically.

As a midwife, I was already fairly practical, but my Calmbirth® training gave me the skills to prepare couples on a totally different level. Using safe natural techniques that connect the mind and body, an incredible awareness can be developed that works at a very subtle level, strengthening the bond with mother, child and partner.

The relaxations can greatly assist the mother to negotiate the journey from career woman to mother (and back again!). This, in turn, helps the mother to focus her energy where it is needed, rather than indulging anxieties and unnecessary concerns. This enhances a greater connection with her baby, which usually has the wonderful effect of bringing a sense of wellbeing that enables the couple to embrace change and to connect with each other and their baby in very enjoyable ways.

Any quality prenatal education program must offer couples simple down-to-earth techniques that develop confidence in the mother's abilities and provide her partner with practical skills. That not only helps the labour and birth to be more comfortable, but safer as well.

As a midwife, I have seen women naturally go into an inwardly focused state without any formal training. Increasingly however, the birthing room is a place of high surveillance, and many births are so disturbed that the mother cannot possibly achieve the inwardly focused space that is needed for birth to unfold in an optimal way without some help.

I am sure that you are aware that the medical and midwifery models of care that we train with have very different beliefs underpinning them. It can sometimes be a challenge to keep these differing beliefs in balance. These different belief systems are one of the reasons why the atmosphere can become so

uneasy in maternity units and can, eventually, lead to an overly controlling influence of one or other model of care.

My aim with the couples in my care is to help them to achieve the best experience possible, regardless of the model of care that they find themselves in.

The midwifery model views childbirth as a normal physiological event. The medical model is based on risk identification and early intervention. The differing belief systems behind these two models of care can often be a source of tension between medical and midwifery staff. This tension then has the potential to flow on to the birthing families, which, in turn, compounds the cycle of anxiety and fear that is so counter productive to normal birth physiology.

Since that original incident as a very new midwife so many years ago, I have facilitated many prenatal education sessions with couples that have chosen a variety of different models of care. My most successful classes have been the ones that have helped the couples to step up and take responsibility for their own experience.

The medical model tends to blur the boundary of what women can control. Strangers enter her space without permission. Medical equipment and lights create a sense of a need to 'submit' and imply dependency.

In the book *Birth Territory and Midwifery Guardianship* the authors Fahy, Foureur, and Hastie suggest that both midwives and pregnant women are generally usually quite docile in relation to this 'specialist knowledge'. They suggest that one reason for this for midwives is that behaving submissively frees them from the anxiety and worry of taking control of a situation and being held accountable¹.

For the pregnant woman, the authors assert that taking a submissive position avoids the risk of being shunned at a time of great need and vulnerability. Another consideration of becoming submissive during moments of stress is to avoid any 'possible complications' of mother and child. For many pregnant women, their deepest fear is that they will not get the help or support that they need, when they need it the most. And yet this passive dependency is the antithesis of what is required of a birthing woman, who needs strength courage and endurance. This is the minefield that modern birthing couples must negotiate.

When couples share their reasons for choosing to come along to a prenatal class, very often a common theme emerges from these excited but somewhat apprehensive people. They often describe their reasons for coming as: 'not wanting to lose control', and wanting 'tools' to be prepared for what ever unfolds

These sentiments are well known to me as a midwife and childbirth educator. However, on a more personal note, my heart goes out to these couples as I can still vividly remember the unsettling feelings of being overwhelmed and the roller coaster of emotions that I experienced while negotiating such a pivotal life event.

During my time in parenting education, I believe that I have witnessed a shift in the focus among the couples that I come in contact with. In general, they are no longer happy to just have a whole heap of information presented to them. They already have access to that via the World Wide Web. They are no longer happy just to be told what they can expect either, which all too

“The midwifery model views childbirth as a normal physiological event. The medical model is based on risk identification and early intervention. The differing belief systems behind these two models of care can often be a source of tension between medical and midwifery staff. This tension then has the potential to flow on to the birthing families, which, in turn, compounds the cycle of anxiety and fear that is so counter productive to normal birth physiology.”

often is pain and interventions without their input and opinions contributing to their own birth experience.

Increasingly, what the couples that I come in contact with are asking for is knowledge that is more integrated and practical. They intuitively understand the value of self-care. They recognise that pregnancy and childbirth is a very special time in their lives and they really want to enjoy it! They want to know what they can do for themselves. They abhor being treated as a mere number within a system. They want a more personal approach.

Through listening to clients talk about what they need and want, I have come to recognise the value of incorporating self-care into their programs. All of my most successful prenatal programs have, at their core, the recognition that self-care is the most fundamental of foundations. How can these new parents care for their young without first caring for themselves? To me, self-care encompasses all of the healthy things that we can do for ourselves as individuals that improve our experience of things and of life in general.

There is no doubt in my mind that education is the key to turning back the tide of unnecessary interventions, and it is responsible for the current shift in thinking towards what we can do for ourselves, rather than what the medical system can do to us or for us.

It has been said that birth is very similar to a tornado storm. If a woman tries to stay out on the fringes and not take responsibility for her experience she will most certainly become another traumatized casualty of the system. The real task of pregnancy and the transition into parenthood is to stop the abdication of responsibility for ourself, and step into our own real power. To step into the eye of the storm so to speak.

Naturally, this can be very challenging thing to do. However, I always think it is reassuring to know that we can learn from those who have gone before us and that there are things that we can do. Skills can be easily developed to make the experience a whole lot safer, and more enjoyable as well.

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FLYNN'S AMAZING ARRIVAL: A SURPRISE HOMEBIRTH



Jacqueline and Flynn sharing a cuddle after arriving at the hospital

Jacqueline and Matthew Powers were delighted to discover that they were pregnant with their first son Aidan three days before their wedding in February 2010. Three months after Aidan's delivery, Jacqueline lost an ovary to a large cyst, which required emergency surgery. This experience helped them to realise how important building their little family was to them. Just before Aidan's first birthday they discovered they were pregnant with their second child. Sadly, their baby girl Madeline was gone too soon at 21 weeks gestation due to a heart problem. Devastated, the family mourned her loss. She remains a very important part of their lives. Jacqueline's third baby, Flynn, is now one year old. Jacqueline and Matthew thank all of their babies every day for being the best part of their lives.

My rainbow baby, Flynn, was born at home on the bathroom floor, to the surprise and amazement of his family. I had given birth twice before. My first labour was long and hard and I had an epidural. My second was the stillbirth of my gorgeous baby girl, gone too soon at 21 weeks. These experiences, but particularly the loss of my daughter, left me feeling afraid of birthing Flynn.

On New Year's Eve, two and a half weeks before my due date, I started to notice pre-labour symptoms. Over the course of a couple of weeks I had back pains, loss of the mucus plug and most nights experienced manageable contractions, which were painful, about 8 minutes apart, but bearable. These contractions had me convinced that I would soon meet my baby, but each

“ These contractions had me convinced that I would soon meet my baby, but each night they fizzled out, leaving me disappointed and desperate to progress. ”

night they fizzled out, leaving me disappointed and desperate to progress. I tried exercises to position the baby for birth as I assumed the contractions were being caused a slightly posterior engagement. At 39 weeks I had two acupuncture treatments focusing on positioning. A good friend also practiced distance reiki on me to prepare me mentally. Some nights I had very little sleep as a result of the contractions. I found the two and a half weeks of pre-labour very frustrating, like a tease.

On Monday night, at 39 weeks and five days (14 January), my contractions started at 8 pm, as they had each night. They were light, so I assumed this was pre-labour again and continued as normal, although in the back of my mind I knew there was a chance that things could progress. The contractions were about 8 minutes apart. We watched TV and went to bed at about 9 pm. I didn't fall asleep, but dozed in between contractions, sitting in bed to avoid the risk of poor positioning. The contractions were very inconsistent in strength and time. Some were 20 minutes apart and some were 5 minutes. There was some increase in strength, so at 11 pm I called Mum to let her know that things would probably progress early in the morning. She gave me some tips on how to get some rest; this was really important to me given that I hadn't had much sleep in weeks and that my first labour was long and tiring.

Contractions continued but were very inconsistent, so I sent Mum a text at 1 am letting her know that we still had a long way to go and that I was focusing on sleep. I spent most of my time dozing sitting up in bed. At 2 am I woke my husband and told him I thought this might actually be it. I asked him to time some contractions and hold my hand. They still weren't nearly as bad as the contractions I had when I was 3 cm dilated with my son, so we assumed I had ages to go. We giggled and acted normally



Matthew and Jacqueline cherishing cuddles with Flynn after arriving at the hospital

in between these still all-over-the-place contractions. During them I visualised my favourite campsite. The hot sun was the contraction and a cold beer cooled them down. I also focused on a striped dress in my wardrobe and pretended to be blowing it with my breathing.

At 4 am things progressed quickly. I told my husband I wanted my mum to come over and help me get through a few more hours before heading to the hospital. We agreed to wait for 20 minutes and then call her, still thinking we had a long time to go. At 4:20 am I called her immediately after a contraction only to get another one 30 seconds after the first. I had to hang up! After calling Mum back we agreed she would make her way over. Things immediately started to get full on. I needed to go to the bathroom and weeing hurt due to the pressure of the baby's head. I felt a small pop and noticed a small circle of blood. I yelled for my husband, who was packing the car and getting dressed. I suddenly felt immense pressure and the contractions took over my whole body like electricity. I told Matt to run for our next-door neighbour as I felt like pushing, but also told him it was probably a poo! This whole time I was standing in my bathroom against the door.

Matt ran next door at 4:40 am and told my neighbour Sue (a beautiful midwife who does postnatal work and hadn't delivered in years) that I was in labour, had noticed some blood and wanted help. With each contraction I was screaming "Help

“ With each contraction I was screaming "Help me!" and yelling Matt's name as I stood alone in the bathroom. ”

me!" and yelling Matt's name as I stood alone in the bathroom. Deep down I knew Flynn was close. I called the hospital and told them I was in labour. They told me I was in transition but I denied it. I can't believe I was still in denial! I ended up hanging up on the hospital as my body took over. The hospital called an ambulance.

Sue walked into the bedroom at 4:43 am and told Matt to call an ambulance. Matt left the room. I told her, "No, it's just a poo," but in the back of my mind I knew bub was on his way. Sue told me to get in the car and go to the hospital, but I was frozen in the doorway. I couldn't move or go. Seconds later I told Sue I could feel the baby's head coming, almost as if it was in my underwear. Intuitively I went onto all fours with my hands leaning on the toilet and pushed his head out. I did not feel burning or immense pain, just relief, as the pushing felt good. I do think though that my body did most of the pushing. I didn't really think to push; it just happened. I felt my baby's body come and told Sue to please catch him. The membranes were still over his face, so she pulled them off and I saw my waters break in between my legs. Immediately my body again took over and, with one push, Flynn arrived at 4:48 am.

I remained on all fours worrying for my baby while Sue wrapped him in a towel. I was very anxious, so Sue spent the time telling me he was OK, breathing, crying, pink, etc. Matt walked back in and I said, "Matt I have had the baby!" He saw Sue behind me rubbing the baby and started relaying information to the triple zero operator. Sue passed the baby



Proud big brother Aidan holding his precious baby brother for the first time

between my legs and I held him squatting, cord attached, while we waited for help. Matt waited at the front of the house for the ambulance. My mum arrived and Matt told her I had had the baby. Poor Mum ran through the house to find us and hugged me and reassured me. She helped me into a more comfortable position sitting in her lap with Flynn in my arms. The ambulance arrived and the staff checked Flynn while I lay on the bathroom floor. Matt cut the cord. I had a few contractions and remember thinking, "Oh no, no more!" Flynn was fine, so they gave him to Matt and we prepared to get into the ambulance. I stood up with help and felt a large contraction and the placenta coming. Sue handed me some pads and I put them in between my legs to catch the placenta, which she then put into a bag. I was being ridiculously practical, telling everyone not to get blood on the carpet! I walked to the front door with a towel to catch the blood and Flynn and I got into the ambulance. Surprisingly, my two-year-old slept through the whole thing. I yelled to Matt to follow us and to drive safely. The ride in the ambulance hurt. It was so hard to hold the baby, the bumps hurt and I kept rolling around in the bed. I fed him a little on the way, still in shock that he was here and was OK. Upon arrival we were both checked and everything was perfect. I was in shock, but very proud of myself and full of happiness.

I will never forget Flynn's amazing arrival, the extraordinary support of those around us and the incredible strength and beauty of my body during the process. We were home by 10.30 am and Flynn is doing very well. My rainbow baby made an entrance to this world that I will treasure forever. Whilst scary at first, it was the perfect birth for us.

EXCERPTS FROM A MIDWIFE IN AFRICA

Michelle Steel is a midwife who works extensively with culturally diverse women. Last year she took some long service leave and volunteered for 9 weeks in a community clinic in the slums of Nairobi. This an excerpt from Michelle's personal diary telling the story of one woman's birth in the clinic. Names have been change to maintain confidentiality.

Thursday 30 May

There is a couple sitting in the courtyard. They look different to our usual clientele. They are clean, with apparently new clothes. Her hair is recently done and he is wearing a leather jacket. They wait patiently and I nod and "Habari" (Hello) at them. They are still there a while later and I ask if they are being helped. They say that they are. I continue to mooch about and, as it is only early afternoon, I head off to get my laptop and my sewing while I wait for something to do. On my return, Peter, the night-time clinical officer, asks me into the second birth room where I find this same couple. They are Jane and John and I am given handover. I note that Penny admitted them earlier and that Jane was at that point 2 cm dilated and Penny has written 'early labour' in the chart. Penny has commenced the partogram, but there is nothing on it since her admission a few hours ago. I am unsure why the couple are still there. I do a full set of observations and note mild contractions every 8 minutes. We talk about the options. Jane is anxious as it is her second child, which it took her 12 years to get. She wants to have a baby as she has been contracting since 11 pm the night before. She is an educated woman with good English and I talk to her about definitions of labour, latent phase, how to assess foetal wellbeing at home, managing an active upright labour. We agree on a plan that entails internal assessment four hours after Penny's VE [vaginal examination]. At that point Jane is still only 3 cm so she agrees to go home.

I sit and take the opportunity to hem the curtains for the cupboards in the birth room. It is an opportunity to be peaceful and watch the human traffic go by.

Jane returns after a few hours and Peter does the readmission as it is now early evening. She is contracting well and not coping with the pain at home. She is now 4 cm. She wants to stay. I spend some time with her before heading back to the twins who are here for rehydration.

Again I put my nose into the birthing room to check on Jane; she is resting and appears to be asleep. So is John. Peter is attending to another walk-in patient. I go to bed and set the alarm for 2 am to give the twins another feed.

At 2 am I stumble out of my room, not really worried about the security aspect. I go to see Mamu and the twins and again give syringe feeds of EBM [expressed breast milk]. I pop into Jane's room but she is asleep... still.

Friday 31 May

I awake with a start - it's 6.45 am. I am late for the twins' feed and jump out of bed. I am still in my scrubs so run a comb through my hair and dash. I really don't want them left too long.

I put my nose in to see Jane again and she is moving about the bed. I find Peter who tells me she has slept during the night even though she claims to have felt the contractions all night. John is still with her. I am glad he is here to see and understand the difficulty that Jane is experiencing.

Peter is in the pharmacy and communicates that they have decided to leave her to me as she needs assessment and, as it is good to have continuity, I agree. I pop in to see her and discuss the options with her. She is glad to see me in that 'please help me' kind of way. I discuss again the option of ARM [artificial rupture of membranes] if the head has come down. Peter suggests that 8 cm would be a good time to do it. I would be happy if she were 5 cm with a head in the pelvis, which it was last night. She is exhausted. As she is in the middle of breakfast she suggests that she finish that first and then I can assess her. I am happy for that and sit and count contractions and listen to the baby's heart rate. It is fine. I document in the partogram, which hasn't seen a pen for a few hours, and prepare to start the day. It is 07:30 am. John pops out for something. He says he'll be quick. I think he doesn't want to be there for the examination.

Jane jumps from the floor mat saying, "I need to poo." I indicate the commode and she rushes to it. She sits there for maybe 30 seconds and with alarm passing across her face she exclaims that she needs to push. Again I indicate the matt and she is there before I can even help her. She automatically assumes the all fours position and begins to grunt. I scramble for personal protective gear realising that in my rush to get to the twins, I don't have my pack with my eyewear handy. I wipe her bottom



The family unite

and come back to wipe the mucous from the baby's head. The towel is stained green and this is when I realise that I haven't witnessed a SROM [spontaneous rupture of membranes] and Peter hasn't documented it either. More meconium. Not what I like to see. Jane is pushing and asking for her phone. She wants John there to witness the birth. He isn't handy either as I peek out the door. She continues to push... the head keeps coming. Because it has been such a prolonged labour, I think how I would manage a shoulder dystocia when she is already on all fours. For the record, roll her over, push up her knees and start with pulling the posterior arm down into the pelvic cavity. Jane is a typical African woman with a very pronounced backside. I'm sure there is plenty of space there to utilise if needs be. The head continues to come: forehead, brows, eyes and nose... and

finally the mouth but not the jaw. The baby is literally biting on the perineum. I push it back and slip my finger under the baby's chin and sweep it forward. The child sits on the perineum while we await restitution. Please restitute please! Jane keeps asking if she should push. We wait a few moments and finally the urge to push comes. Jane pushes. We deliver the anterior shoulder first and the baby gently and slowly follows. It's a girl. I place her between her mother's legs and go to move her forward, but she doesn't cry. I'm waiting for her to cry as Peter (who has a wonderful knack of just 'being') places the towel on her. I dry her. Jane asks what sex the child is. I rub her. I want her to cry or to breathe. Either is fine. The cord is pulsating and she is moving her arms and legs around. I blow in her face and rub her feet. Please little one just breathe! Then. She opens her eyes, looks around and makes a decision to breathe. I can see it happen. One breath, two and then she cries. Jane is still asking after the sex of the child. I don't want to tell her; I want her to discover. She's still trying to phone John. I push her baby between her legs and Jane sits back and raises her daughter to her chest. She says that now she is ready to dance. She had hoped for a girl to have one of each. Now the chapter is closed.

Kendal was born at 07:55 am. Jane raises John on the phone and tells him the news. Peter translates for me. Jane told John that his daughter was waiting for him to leave. John appears a few minutes later. He sees his woman squatting on a stool with his daughter in her arms. This man cries tears of joy. The placenta comes with minimal effort 45 minutes later. Penny and Teresa are all over the cleaning. I avoid the placenta as I really want to avoid the placenta pit. Jane and John and Kendal prepare for life together but, first, a trip to Kenyatta Hospital for immunoglobulin for Kendal. Jane is Hepatitis B positive. They leave by 11:30 am.



Michelle with mother and baby



Birthing room

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THREE DIFFERENT COUNTRIES: THREE DIFFERENT BIRTHS

In 2001, I had a dream. My dream was to birth my first baby fully naturally in the comfort of my own home. At the time it was quite an unusual dream; most of my friends had already given birth in hospitals with the aid of epidurals and, in many cases, surgical deliveries. Most of them thought that I was crazy and I heard many stories of all the disastrous things that happen during birth and of unendurable pain. I metaphorically stuck my fingers in my ears and sang, “La, la, la”. My own personal beliefs about birth, and prior experiences with hospitals, led me to go against the prevailing birth culture and to choose a homebirth with a midwife. I was determined to see through my dream and I am very grateful that I did. I have three children who were all birthed naturally, at home, with no complications. Each child was born in a different home and in a different country. I have said many times since ‘but for the grace of God, there go I’, for my dream very nearly didn’t become reality. Interestingly, the country that I was in had a significant impact on both the realisation of my dream and on the experience of each birth.

I gave birth in England (2001), Australia (2004) and France (2006), respectively. The culture and social structure of each of these countries are similar, although not the same. Each of my three births was a very different experience and, although my emotional state and personal beliefs contributed in a different way to each birth, the policies, beliefs and birth supporters of each country contributed significantly to both the experience and the outcome.

Of these three countries, England in 2001 was the most supportive of homebirth, which then accounted for nearly 5% of total births. It was extremely fortunate that I was living in the UK for the birth of my first child: if I had been in either Australia or France, my dream to homebirth my babies may have never come to fruition. As it was, I was pleasantly surprised to discover that my local practice in South London had a program of community midwives who supported both home and hospital birth fully covered by the National Health Service (NHS).

However, at 32 weeks, a complication arose: my baby was breech. I was told that, if she remained breech at term, I could no longer birth at home under the community midwife scheme. This threw my whole world into a spin and I madly started researching breech births. For four weeks we tried every natural method under the sun to get her to turn, alas to no avail. We now had a big decision to make: if we stayed with the NHS we would have to deliver in hospital. The most likely outcome being a caesarean, as this is what the NHS recommended for all breech babies. This was due to the recent publication of the *Term breech trial*, a Canadian study that recommended that outcomes for breech babies were significantly better if they were delivered by caesarean section. Most countries, including the UK and Australia, accepted this recommendation, without examining the validity of the trial. My own research found this trial to be severely flawed in both its methods and conclusions. It seemed to me that there was evidence to suggest that, if certain factors were in place, it was perfectly safe to deliver a breech baby vaginally and at home.

Fortunately, in the UK, I was still allowed to choose where and with whom I gave birth. For me the choice was easy, even though the pressure brought to bear was staggering. We found ourselves engaging independent midwives at week 36 for the princely sum

of £2500 GBP (approx 6000 AUD at the time). Ouch! Luckily, we were able to come up with the money.

Our midwives were fantastic and made up for lost time by visiting me twice a week leading up to the birth. They were very experienced with breech deliveries and my daughter was born fully naturally at home. My dream was a reality: I had birthed my baby the way I wanted to with no intervention, drugs, stitches or doctors. I felt at once both ecstatic at the amazing outcome and saddened by the fact that so many other women were missing out on that wonderful experience due to the misinformation being offered and the limited choices available. If I had been in either Australia or France for this birth, I would not have had this choice, as there it was illegal for independent midwives to ‘knowingly’ assist a breech homebirth. In addition, the fear I encountered from friends and family living in Australia about my decision to birth my first baby at home in the breech position was overwhelming, and would have been harder to ignore had I been living there.

My daughter’s successful home breech birth meant that I had little opposition from either the establishment or my friends and family when it came time to birth my second child. Before we moved back to Australia, I was extremely concerned, as I knew how medical the Australian birthing system was and that private midwives had recently been refused the right to access indemnity insurance. Fortunately, we found a wonderful midwife who was still practising. On our arrival in Melbourne we engaged her services for \$2500, a real bargain compared to the UK, especially as we could benefit from all the pre- and postnatal care. This midwife was absolutely lovely from the start, involving our daughter in the whole process. Over the term of the pregnancy she developed a really wonderful relationship with the whole family. I kept my head down, I used hospital services for blood tests and a 20-week scan and that was it. Luckily, I was considered ‘low risk’ due to my health, the test results, the baby’s position and that fact that it was my second baby. If I had had a caesarean with my first baby then I would not have been considered low risk and would have faced much more difficulty in trying to HBAC (home birth after caesarean) my second child in Australia. At the time (2004), there was a strong belief within Australia that once you had a caesarean you needed to have another caesarean without question or trial of labour.

Our son surprised us by coming a week early and arrived with barely any fuss after only two pushes, under the water. I delivered him myself, with the midwife standing by. Once again I had managed to birth my baby at home surrounded by friends and family with no intervention. I was again very grateful to be in the position of having experienced two homebirths instead of two caesareans.

My birthing history became increasingly significant when we, surprisingly, became pregnant with our third child. By this time we were dividing our time between a home in Melbourne and a home in France. My husband was concerned on hearing the news, as not only was he not very keen on having a third child, he was upset that we wouldn’t be able to go to France as planned. When I looked at the dates, I realised that the baby had timed things perfectly and, as long as I could find an independent midwife for a homebirth, we could still go at exactly the time planned.

Birth in France is even more medical than it is in Australia: there are still routine shavings and episiotomies, along with monthly scans, routine electronic foetal monitoring and a high rate of epidurals. I definitely wanted to stay out of the system. If I had had two previous caesareans, I would not have been able to find an independent midwife in France willing or allowed to deliver my third baby at home, due to the strict rules and regulations placed on them by the health system. These same rules and regulations led this, my third birth, to be my most challenging.

Eventually, after a bit of searching, we found a midwife. One drawback was that she lived an hour and a half away from our home, as there are so few independent midwives in France. We met her for the first time in her rooms, when I was 32 weeks pregnant. I was relieved to find her to be very sympathetic and caring, although I was shocked by her performing an internal exam at that initial meeting. This had not been my experience in either the UK or Australia. The second shock was her fee: surprise, surprise, the same number as before, but this time it was 2500 Euros (approx 5000 AUD). I thought this was an amazing coincidence and also a bit expensive, considering there was only going to be one prenatal check up, the birth and one postnatal check up for that cost. This upset me, as I was not expecting it to be so expensive. Communication was difficult and it was obvious that we had very different ideas about what a homebirth should look like. At the time I didn’t realise that this midwife was strictly regulated, and that meant a more medical approach to the birth. I had to supply syntocinen, strong pain medication and a hospital-strength antiseptic in my homebirth kit. The lack of trust around birth was filtering in and, although I had convinced myself that this would be an easy birth, when I went into labour 10 days early I wasn’t really overly prepared for it in mind, body or spirit.

After several hours of labour, it seemed that I was stuck at 7 cm dilation and not progressing. In fact contractions were becoming further and further apart. I felt guilty because I had called the midwife early (her request) and now the birth was not happening in the quick time that I had imagined. My husband and mother, neither of whom spoke French, were unable to act as go-betweens. I felt that I had to do it all by myself. So when the midwife suggested that she should break my waters, if I still hadn’t progressed, I agreed, because I was irritated and just wanted to be on my own with my baby. This was the only intervention I experienced in all three births and I know that if I had been with my UK or Australian midwives, it would not have happened. As is usually the case with augmentation, my contractions then became extremely fast and painful. My second son was born about 40 minutes later with the cord wrapped tightly around his neck and his hand up next to his ear. His face was very blue and the midwife gave him oxygen.

At the time I was happy that it was over and that everyone was alive and healthy. Later, my Australian midwife told me that she would have just advised me to go to bed as this is what she calls the ‘rest and be thankful’ stage, which often presents itself so the mother and baby can rest or another issue can be resolved. I truly believe that my son needed more time to disentangle himself and get in the optimum position for the birth. Breaking the waters meant he did not have that time.

My easiest and most satisfying pregnancy and birth experience was definitely here in Australia. Even though Australia has a highly medical birth culture, there is a small band of independent midwives and consumers who are extremely dedicated to the achievement of natural, empowered, woman-centred births. Many of these same people are members and volunteers of the

Maternity Coalition. My Australian birth was the only birth for which I experienced full ‘continuity of care’; that is, the same primary caregiver throughout the pregnancy, birth and postnatal period. Unfortunately, this model of care is rarely found throughout the world. In countries where it is available, such as The Netherlands and New Zealand, there are much higher percentages of homebirths and lower numbers of caesareans.

Each of my births taught me that personal and cultural beliefs about birth, as well as incumbent regulations and policies, directly affect the experience and outcome of birth. In many countries, including the UK, Australia and France, a battle between independent midwives and governments has ensued in the years since my children were born. It is now far more difficult to access independent midwifery care and homebirths due to the regulations surrounding professional indemnity insurance.

For each birth, I had to sign a waiver form, acknowledging that, due to their lack of professional indemnity insurance, I could not sue my midwives in the event of something going wrong. In each case I was happy to do this. Currently in these three countries, independent midwives now require this insurance to be able to practice legally. Many midwives simply cannot afford to purchase it, limiting the choices available to birthing women. I wonder how much more difficult it would be now to keep myself under the radar and to find birth supporters who are free to support natural, low-technology births.

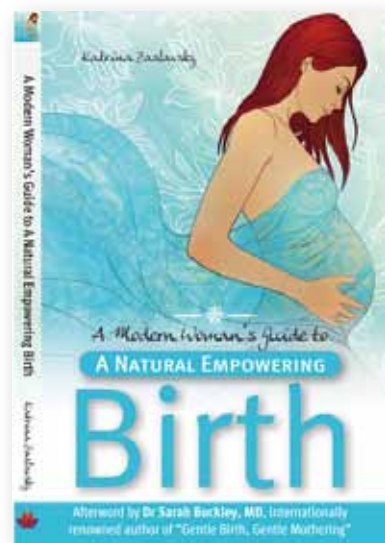
The concern I have is that today my story could have been very different and my dream could have remained just that.

Author Bio

Lynne Thorsen is an intuitive healer, workshop facilitator and freelance writer on self-empowerment, self-healing and natural birth. Lynne is the co-creator of ‘Soul Birthing’, a healing program designed to facilitate the safe and effective release and healing of the life-long wounds of fear, inadequacy and limitation. Her philosophy is based on the belief that we are all in a state of constant creation and it is never too late to create empowered change. Her focus is to provide her readers / clients / participants with the knowledge and tools to create the birth and life that they really want!



BOOK REVIEW: A MODERN WOMAN'S GUIDE TO A NATURAL EMPOWERING BIRTH



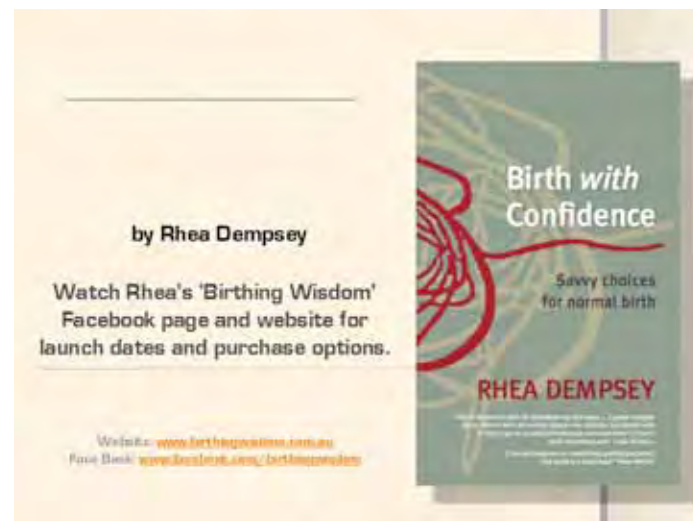
Author:
Katrina Zaslavsky
Foreword:
Dr Sarah Buckley
Published 2011
Available through
Amazon.com

A welcome addition to the plethora of childbirth books out there, this book by Australian author, Katrina Zaslavsky, stands out as one that all women should read as part of their birth preparation. The book welcomes the reader into a special community, where wise women share knowledge and stories in a very positive manner with the aim of informing, inspiring, overcoming fears and ultimately enabling women to empower themselves for positive experiences. It doesn't tell women how they should birth, but rather presents them with options and advice that will help them through their journey. For women who find themselves unable to access natural birth classes or support groups in real time, this is a brilliant book to refer to throughout pregnancy for reassurance, guidance and inspiration.

I really like the way the book is structured: each chapter is called an 'insight' with a birth-related theme and follows a similar format. First, there is an empowering birth quote, followed by commentary from the author about the journey through her experiences in relation to each insight. Then comes *Mothers' wisdom*, being quotes from empowered women who have walked the path. Next is an *Experts say* section that shares birth lessons and tips. Finally, each chapter ends with an inspiring birth story followed by another quote. Each 'insight' (chapter) is short, fitting in nicely with our modern hectic lives. The reader can read in short spurts without losing track of where they are up to. The chapters don't have to be read in any particular order, so you can just select the insight that appeals to you most at the time and start reading. This also makes it easier to process, retain and understand the message from each insight.

Zaslavsky's approach, and comments she makes in the book about women needing to move towards a more conscious and natural lifestyle, sit comfortably with me. However, some of her views (for example, "[my children] have never had any medication in their bodies or seen a doctor for anything and I intend to keep it that way") might alienate some readers and make them doubt the important messages that this book imparts. Worse, some people may be put off reading it all together. This would be a terrible shame. It really is a terrific book and those

readers who might be lost are right in its target readership. If the author were to consider a second edition, I would like to see this aspect of the text toned down, so that it reaches the widest possible audience.



INDUCTION OF LABOUR FOR 'POST-DATES' PREGNANCY

In this 'quick and dirty' research review I hope to answer the question 'What is the evidence for induction of labour at 41 weeks?' For a more comprehensive look at the risks and benefits of induction versus expectant management (waiting for labour to start on its own) see Rachel Reed's excellent blog article: <http://midwifethinking.com/2010/09/16/induction-of-labour-balancing-risks/>

Key concepts

Normal 'term' pregnancy is between 37 and 42 completed weeks. The Australian College of Midwives guidelines for consultation and referral suggest obstetric consultation after 42 weeks for 'post-term' pregnancy¹. Yet more and more often women are being offered induction at 41 weeks of pregnancy. Having an induction of labour (IOL) between 40–42 weeks simply because the estimated due date (40 weeks) has passed is known as induction for 'post-dates'.

A medical IOL occurs in hospital and is defined as "the process of the artificial initiation of labour before its spontaneous onset"². The IOL process usually includes three steps: (i) medication inside the vagina to encourage the cervix to soften and open (prostaglandin gel); (ii) a small hole created in the amniotic sac (artificial rupture of membranes); and (iii) an intravenous drip with a synthetic form of the labour hormone oxytocin (Syntocinon). Each step of the IOL process carries a unique set of risks (e.g. initiating contractions that are too strong and too close together 'hyperstimulation of the uterus'). Ideally, the purpose of an IOL is to start labour when the risks of continuing the pregnancy outweigh the risks of IOL. While the presence of medical conditions (e.g. high blood pressure, growth restricted baby) may indicate an IOL should be considered, this article will focus solely on the research evidence in relation to IOL for post-dates pregnancy.

In a post-dates pregnancy the theory is that, as the pregnancy continues beyond the due date, the placenta's ability to provide oxygen and nutrients to the baby will gradually but steadily decline leading to the risk of death of a baby in utero (perinatal death). Let's consider what the research says.

Evidence for post-dates induction of labour

The highest quality research evidence is generated through the process of 'systematic review': "a high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer it"³. A 2006 Cochrane systematic review included 22 trials (including over 9000 women) that compared induction of labour versus expectant management (waiting for labour to start on its own)⁴. This systematic review reports significantly fewer baby deaths around the time of birth for women induced at 41 weeks compared to women who experienced spontaneous labour at 42 weeks and beyond. The difference reported is 3 deaths per 10,000 babies (IOL group) compared to 34 deaths per 10,000 babies (expectant group)⁴. While this suggests that babies are ten times more likely to die in-utero if pregnancy continues to 42 weeks and beyond, the risk is still very low in both groups. The risk is so low in fact that 410 women need to be induced to prevent one baby's death⁴. This review looked at other outcomes, including the risk of experiencing caesarean section for women having an induction,

and, surprisingly, reported that the risk of caesarean was about 10% less likely for those induced than those who awaited labour⁴. The risk of meconium-aspiration syndrome (where the baby inhales meconium at around the time of birth that leads to infection and breathing difficulties) was less likely for those babies in the induction group (about 50% less likely)⁴.

So what?

Most hospital guidelines recommend post-dates induction of labour at between 41 and 42 weeks⁵. The responsibility to weigh up the risks and benefits of an IOL, and the decision to accept or decline an IOL, is the woman's to make in consultation with her maternity care provider and significant others. It is a complex decision. The risks associated with induction of labour including the 'cascade of intervention' appear to be infrequently discussed. Furthermore, "...the absolute risk of perinatal death is small. Women should be appropriately counselled in order to make an informed choice between scheduled induction for a post-term pregnancy or monitoring without induction (or delayed induction)"⁴. It may be helpful to ask questions to progress the discussion with your health care provider and, if necessary, seek a second opinion. For ideas on what questions might be helpful to discuss go to: <http://www.qcmb.org.au/media/pdf/Parent%20Information%20Sheet-%20Induction.pdf>

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See page 32**

HOMEBIRTH AFTER TWO CAESAREANS: THE BIRTH OF SAMARA CAITRIN



Mum Erin and baby Samara meet face to face

Erin Quinn lives with her husband and three daughters in the foothills of the Blue Mountains. She is passionate about natural birth and hopes to become a birthkeeper when her kids are a little older. Her eternal love and gratitude go to Sonja, Jo and Nat for their wisdom and support on her HBAC (Home Birth After Caesarian) journey. Birthkeeper: Someone who acts as a guide in a mother's spiritual and emotional preparation for birth. Typically, a birthkeeper acts only as witness at a birth and allows the mother and father the freedom to birth as they wish and encourage them to be the first hands to touch their baby.

My first two daughters were both born by caesarean section. The first was a classic 'failure to progress', or failure to wait. I planned a homebirth with my second but, after four days of labour, my waters broke with thick meconium. I transferred to hospital where labour stalled and, after several hours, the baby started to show signs of distress.

“Both my daughters were big babies. Both went from more favourable to less favourable positions during labour or shortly before. Neither of them ever engaged in my pelvis. I thought that my body was truly a lemon. I could blame the hospital for my first surgery, but, after my second surgery, when I had planned a homebirth and completely trusted the process, I felt the buck stopped with me. I had failed.”

I was scared to conceive again. I was frightened that perhaps I wanted another chance to birth naturally more than I wanted another baby. I was scared of going through the whole emotional journey again, only to fail again.

In the event, Samara got tired of waiting for me to work it out and her conception was a happy surprise for us. I planned a homebirth. Of course I did. I don't have it in me to choose a caesarean. I believe the way we are born matters. Deep in my soul somewhere I knew what birth was supposed to be like. I had to try again, though for the first time I started out with no belief in my body. I was lucky enough to be able to surround myself with three wonderful women (two midwives and a doula) who did all the believing for me. It was an emotional pregnancy: I didn't know whether the birth was going to be my life's high or low point.

I cut out sugar and as much processed food as I could from my diet, though I fell off the wagon at Christmas. I did techniques from Spinning Babies every day to balance my pelvis. My husband bought me a rebozo and we started using it. In the third trimester I began having Bowen therapy and acupuncture to optimise my pelvis. I took warm baths and talked to my baby, asking her to help me to birth her beautifully. Even my three-year-old started saying, "Move down baby!"

At my 35 week prenatal visit, my midwife announced that my baby was slightly engaged. I promptly burst into tears and asked if she was lying. It was a huge moment for me. I had seriously wondered if there was some kind of physical barrier preventing my babies from entering the pelvis! But there she was! Maybe I could do this! Maybe my body wasn't broken!

I felt the first tightenings on a Monday night, while in bed. Nothing too bad and I was able to simply breathe through them. I was a bit teary. I was afraid that I was going to be in labour for days again, and I didn't want to send my kids away. They were going to stay with my parents as, much as I love the idea of siblings at a birth, for this birth I felt the only one who needed mothering was me. But now that the time was imminent, I didn't want to say goodbye to them. I think they picked up on it; my two-year-old was restless, and my three-year-old ended up joining us in bed.

The tightenings stopped once I got up for the day, increasing again towards evening. I expected I was going to have a few nights of pre-labour, as I had done with my others. I sent my husband off to his piano lesson. He insisted I text my birth support people. I sent a message to the effect that I was having contractions, but tonight wasn't going to be the night.

As soon as I tried to go to bed, the contractions notched up. I quickly realised that I wasn't going to be able to rest and decided to have a bath by candlelight. I laboured there for a while, just watching the flames. I tried again to go to bed, still in denial, and then ended up in the shower. I was banging on the wall, counting myself through the surges. I quickly changed to banging on my own thigh, worried I was going to wake the kids.

I began to think that I might need my doula there, but I couldn't call out. My husband read my mind, because he came to check on me and suggested he call her.

When Nat arrived, I was kneeling against the lounge and moaning into the cushions. Later, she told me she could hear me from the street! She asked why we hadn't filled the pool or called the midwives. She proceeded to do so and I heard her say, "She's vocalising quite strongly".



Samara is born

The pool was set up and I got in. Instant relief! I spent most of the time in a kneeling position, leaning over the side. I tried some other positions, because I thought maybe I should, but I realised that the position I had chosen instinctively was the most comfortable one for me. I held on to loving hands through the contractions. I started off deliberately keeping my hands loose, but at some point that strategy was abandoned!

I stayed in the pool, moaning through surges and sleeping in between them. Everyone was very quiet and just held the space for me. I was aware of how present and supportive they were. It helped so much, even though no one was 'doing' anything. I thought I was going to need a lot of guidance and cheerleading, but I didn't.

At some point I was aware of soft voices. I wanted to tell them that they didn't need to whisper, but I couldn't. Almost from the first contraction, I had entered a trancelike state. In the pool I was in my own little world, in a state where I was aware of my surroundings but separate from them. I had random thoughts that I wanted to voice, but in my trance I couldn't verbalise. One of the only things I managed to say was, "I can't do this for four days". Everyone assured me that this was not going to last for four days and that I was in real, strong, active labour.

Dan called my parents. They arrived just as my two-year-old woke up at 5:30. The kids transferred easily from bed to car, with some sleepy glances my way. My mum briefly poked her head into the lounge room to smile at me. After the girls were safely on their way with their grandparents, someone suggested I go for a walk before the sun came up. I didn't want to get out of

“At my 35 week prenatal visit, my midwife announced that my baby was slightly engaged. I promptly burst into tears and asked if she was lying.”

the pool, but I recognised that we were in a lull, and I certainly didn't want to leave the house in daylight.

Somehow, I did get out of the pool and into a nightie. Dan and Nat accompanied me around the block. I remember Nat asking if we got possums, and Dan mentioned the local bat colony. I was vaguely disappointed that we didn't see any bats that morning. I was feeling a bit sulky, thinking of how tired I was; if labour was stalled, I wanted it to stop altogether so that I could sleep. In hindsight, this was probably transition. But I still didn't believe that this baby was really going to come without help.

Nat was encouraging me to walk through contractions, but I kept stopping and moaning into Dan's shoulder. The block seemed enormous to me. We got to the top of our street and our house looked miles away. I finally decided to woman up and walk through the contractions; I think I was just eager to get back home.

I laboured in the toilet for a while. I remember this time as being the hardest part. The contractions were coming harder and faster, and I was finding it difficult to rally myself enough for each new one.

Then I reached down and felt my baby's head, behind a bulging bag of waters, just a few centimetres inside me! Dan felt it too. It was the most wonderful, intimate thing to be touching our unborn baby together. That was the first inkling I had that I might be about to birth a baby vaginally.

I moved into the pool again, but the contractions slowed right down, so I went back to the toilet. I was being encouraged to stay upright, and someone brought a step for me to put one leg up, but the contractions were too intense for me to integrate this way. I dropped to all fours again, where I could surrender to the surges instead of fighting against them. Dan pointed out that the contractions were further apart in this position and I said something rude to him.

My baby's head did get lower, against all my expectations. Someone said it was time to move back into the pool but I didn't think I could after all that. The few metres between toilet and pool seemed to be an insurmountable distance but, with everyone's help and coaxing, I managed to get back in.

I don't remember much of this time. I do remember being unable to avoid blowing bubbles during the surges. I remember being told to push. It was only then that I realised that the enormous pressure I had been feeling at the peak of every contraction for quite some time was a pushing urge. It wasn't what I had expected. I expected it to be involuntary, a relief and a release, as I had heard it described. Instead I felt it as quite a scary, splitting sensation that I did not want to push through. I couldn't. I just wanted to breathe through it. I pretended to push. I asked if my vagina was about to be ruined, and everyone assured me it wouldn't be.

They got me into a supported squat and prepared me to catch my baby. I said I wanted Dan to catch her. Reaching down seemed impossible to me and I wanted him to have the honour anyway. He wanted me to catch her and we actually argued about it for a minute! In the end, we both caught her.

There was no ring of fire. I didn't realise when her head came out, it was just a continuation of the splitting sensation I was already feeling. I remember the sensation of her shoulders rotating. I said something like, "Ooh stop it baby," and someone explained what was happening. Then she was out! My waters broke as she emerged in her caul. I saw her eyes wide open, looking straight at me from under the water as I lifted her out. The cord was short, I couldn't bring her up to my chest as I wanted to. She didn't cry, but she was making little gurgling noises. I was encouraged to rub her back and blow into her face. I wasn't worried. She seemed very present to me and she was fine.

I thought I would have a huge outpouring of emotion when my baby was born. I wanted to have that 'I did it!' moment, but I think I was just too overwhelmed. Finally having the natural birth I had always dreamed of, but never thought I would get, my whole world and self-identity shifted. It was too much to process in a moment. I just calmly inhaled my baby. Now, at the time of writing, Samara is 8 months old, and I have 'I did it!' moments every day.

It was wonderful to have the joy of a new baby unadulterated, without the accompanying grief of an ungentle birth. I cried so often when my older kids were babies. This time the only sadness I have experienced is that I will never get to experience real birth again. It was unquestionably the most

amazing experience of my life. It wasn't painless, nor technically orgasmic, but it was ecstatic. The contractions hurt, but I wasn't suffering or unable to cope. Birthing uninterrupted, feeling safe and supported, allowing my hormones to work exactly as they were supposed to I entered a primal place where the pain was not bigger than me. I feel as if I've discovered the secret of the universe, and that I could do it again and again. How heartbreaking to discover this just as our family is complete. How exquisite it would have been to know this secret on the day I became a mother for the first time.

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WHY BIRTH IS A FEMINIST ISSUE

"Control of our bodies, control of our lives!"

Women have sung out this chant over many years. If self-determination applies to all aspects of women's lives, then childbirth belongs within the full spectrum of reproductive rights. A woman's choice of how, where and with whom she gives birth is as important as her decision to become pregnant, to end or to continue a pregnancy.

The sexist stereotype of the 'good mother' as selfless and uncomplaining has fostered a blanket silence about birthing. In the hard fight for abortion rights (now under renewed right-wing attack) the feminist movement of the last five decades has mostly bypassed women's rights in childbirth. Until recently, feminist discourse has largely ignored them.

A notable exception in second-wave feminism was the Boston Women's Health Collective, which produced *Our Bodies, Ourselves*. This publication gave women information to take control of their own health and reproductive lives. First released in 1970 (now in its 9th edition), its message to women was clear - that they can be 'expert of self':

"We weren't encouraged to ask questions, but to depend on the so-called experts. Not having a say in our own health care frustrated and angered us. We didn't have the information we needed, so we decided to find it on our own." Nancy Miriam Hawley (*Our Bodies, Ourselves*).

Today, reproductive rights advocacy groups around the world still primarily focus on abortion. But there has also been a rise in childbirth rights' organisations. Formed by women, they challenged the technological takeover of childbirth and its questionable science, coining the term 'obstetric violence' to expose the extensive harm this has caused. These organisations demand that birth be 'humanised' and that women have full autonomy in making decisions throughout their pregnancy and birth. November 25th marks *International Day Against Obstetric Violence*.

Childbirth in crisis

Worldwide, childbirth is in crisis. In resource-rich countries, medical interventions are at record highs, with no concurrent gains in safety for mothers and babies. Many women report feeling abused and disrespected in their experience of maternity care. They feel disempowered by their birth experience. In Australia, suicide is one of the leading causes of maternal deaths in the postnatal year. In the United States, the maternal death rate resulting from caesarean section is increasing.

In Australia and the United States one in three women now have their babies 'delivered' by caesarean section, that is, via major abdominal surgery. The caesarean section rates in the United Kingdom and Europe are not far behind this. Fifty percent of women have their labours induced and/or sped up with synthetic hormones, which disrupts the release of labour hormones that naturally prime mothers and their babies for love. Women report being coerced through fear-based language to consent to procedures and interventions they do not want. At other times women are denied the procedure of their choice (for example, water birth). Rather than feeling empowered through their experience of giving birth, many women are left to cope, or not, with the effects of physical and emotional trauma. Women who speak out can be demonised as selfish, as putting their birth experience above their baby's safety. Who could care more about her baby than the woman herself?

Medico-legal control

Obstetric practice is heavily influenced by risk aversion, and dictated by the concerns of insurance underwriters. More women are facing legal action, accused of acting against the 'rights' of their foetus. By putting its trust in technocracy instead of in the birthing woman, the maternity care system is *failing* women.

Midwives and doctors who support women's autonomy can be similarly persecuted. Midwives are penalised, fined and, in some countries, imprisoned. Agnes Geréb, a Hungarian midwife and former obstetrician, remains under indefinite house arrest awaiting re-trial, after two years spent in prison for the 'crime' of supporting women in their choice to birth at home. Several North American midwives await trial, having been charged under state 'foetal personhood' laws. In Australia, the UK and Ireland, independent midwives who have continued to support birthing women whose choices fall outside of guidelines are severely sanctioned. In poorly resourced countries, traditional midwives are demonised as dirty, ignorant and dangerous.

Where women's choices go against the obstetric norm, they may also feel shamed and penalised. It is not unheard of for women who stand up for themselves to be reported to child protection authorities or threatened with legal action. In a few cases women have been forced to undergo court-ordered procedures (for example, caesarean section). Alicia Beltran, from Wisconsin in the US, was recently arrested and forced to undergo treatment that she did not want or need under that state's 'foetal protection' law. Alice's 'crime' was giving an honest answer to a question during an antenatal health check. She disclosed that she had suffered a *past* dependence on pain medication. A lawyer was appointed to represent her foetus, however she herself was not entitled to a state-appointed lawyer. There are similar cases across the US. The slippery slope is edging closer in Australia, with similar laws being proposed here (i.e. Zoe's law).

Take back power

Women's human rights are violated by a system that deems women incapable of making 'good choices'. Few groups connect the dots of:

- the right to make decisions in pregnancy, childbirth and parenting
- the right to safe abortion
- the right to direct the course of their lives.

Radical Women sees this connection as vital for the feminist movement and its capacity to win equality and justice for all women, be they mothers or not.

Author's note: The terms 'woman', 'women', 'mother' and related pronouns have been used throughout this article. The writer respectfully makes recognition that some people who give birth may identify with another gender term.

Author Bio

Gaye Demanuele is a formerly registered midwife, birthworker, reproductive rights activist, mother and grandmother. She lives in Melbourne, Australia. She is a member of Radical Women (RW), a socialist, feminist, grassroots, activist organisation. She represents RW in the Campaign for Women's Reproductive Rights (CWRR), based in Melbourne. Email: ixchel@iinet.net.au

POSITIVE BIRTH AFTER CAESAREAN (PBAC): A QUEST FOR ADEQUATE SUPPORT

Preparing for birth after one or more previous caesareans can be a very emotional, frustrating and empowering journey. The key factor to ensure a positive experience for this next birth is support. Support for your body to birth, support for your birthing conditions and for your birth choice. We often think of birth support as consisting of the husband/partner, midwife and/or obstetrician and possibly a close friend. For a woman planning a birth after a caesarean, very many more people affect her decision making, her understanding of her birth choices and associated risks, and her emotional preparedness for birth. In addition to a strong birth support team, the woman also needs support from the health system and from ‘outsiders’, those who will not be in the birthing environment, such as family, friends, co-workers, community and the media.

De-briefing the first caesarean

The journey of a positive birth after caesarean (PBAC) woman does not start when she falls pregnant after her caesarean birth; it starts immediately after that first caesarean. This is where all the support should really begin. Surveys have identified that, by approximately six weeks after having a first caesarean, most women have decided whether they will pursue a vaginal birth (VBAC) or book in for a repeat caesarean section (RCS) for their next baby. A tiny proportion of women decide not to have another baby at all as a result of their experience. Anecdotally it seems many women do not have a full postnatal debrief following a caesarean; perhaps with the exception of those in midwife continuity-of-carer programs.,

I myself was not in one of those programs. Three days following my son’s birth (emergency caesarean due to failure to progress and baby distress); no doctor or midwife involved in my caesarean had been to see me. The midwife on shift asked me whether I might just have the ‘baby blues’. Are you kidding me? It is not unreasonable to want to hear how my surgery went, how my son was positioned, and whether there was anything that could have been done differently. Later that day I spotted the midwife who was with me at the start of my labour (whom I really liked). I bombarded her with questions, fears and tears. She assured me that things would go differently next time around and that around 75% of women have vaginal births after a caesarean (VBAC). She also advised me to do my own research, as there are many requirements to follow under VBAC policy, which can be negotiated before the birth. I wonder how many women get such a pep talk after their first caesarean.

Even though this was invaluable advice, there wasn’t really any support for my grief about the vaginal birth that I did not have. You need support to nurture you while you grieve for the loss of the birth you expected, while also caring for your newborn. This is an area truly lacking in the system. It is very hard to find out whom to contact for help, besides a psychologist or psychiatrist, whom may not be specialised in pregnancy, birth or postnatal trauma.

The support of other women

Knowing where to find other women who shared similar feelings would have helped me immensely in processing my experience and in finding out about what options really were

available next time around. I needed support for the emotional decision of planning my next child and birth. Would the journey be the same next time? Would it be different? Would my birth choices be limited? Would I be labelled ‘high risk’ and miss out on certain aspects of the journey I wanted? I had so many questions, worries and emotions from my first experience of labour and birth. Healthcare providers could answer these questions, but would they truly understand my fears? Wouldn’t it be great to talk to women who had been through this and find out how their journeys ended up?

I did not come across such a support network until I was pregnant with my daughter. What a difference it was to talk with fellow women who understood exactly how I felt after having a caesarean. To talk to women who understood how it feels to be disappointed about missing out on the entire journey of labour and birth; rather than outsiders who expect the outcome of a healthy baby to override this disappointment.

“It was a battle at every prenatal appointment for my VBA3C [VBAC after three caesareans]. Every prenatal appointment I was armed with knowledge, so if they said to me, “Your chances of rupturing are...”, “Your baby could be too big” etc., etc., I hit back with statistics I had memorised. I remember the first appointment I was asked, “How will you feel if you have a stillbirth?” Well how the hell do they think I’d feel? When I got home my eldest daughter said to me, “Did they tell you the risks of another caesarean as well?” and no, not one mention of the risks of another surgery...” PBAC support group member.

Support in the health system

Having a supportive care provider is vital, especially one who follows the woman from pregnancy to labour, birth and beyond. Despite being in the ‘Next Birth After Caesarean (NBAC) midwife team’ I was surprised to find out I only saw the same midwife during my antenatal appointments. During labour and birth I would have a midwife I had not met before. Similarly, after birth their was not follow up from my antenatal midwife. Once I understood this, I hired a doula to provide me with the constant care I wanted. She helped me to have the confidence to really push for the birthing conditions I wanted; so that there was less ‘fighting’ once I was in labour. Fortunately for me, as a result of my negotiations with hospital management, I was offered my NBAC midwife to attend my birth (yes, thanks!), so during my labour and birth I felt truly supported and I trusted everyone in my birthing environment. I even had full trust in

the obstetrician who checked on me, as I knew my midwife was sending away doctors who would not support my birth plan and only allowed this one in.

On top of the emotional battle with your own fears and uncertainties, one is also faced with rules and restrictions in the health system. A key to being supported by women who have been through their PBAC journeys is finding out that you have a right to accept or decline any procedures/conditions that are expected of you (see text box *Standard hospital vaginal birth after caesarean policies*).

Most of these conditions are negotiable, but it depends on the hospital and how early in the pregnancy you start negotiating. Many women are not aware of these conditions until half way through their pregnancy, and they are often presented to them as being non-negotiable. It should be our right as birthing women to determine our own approach to birthing, and we should not be forced into anything that we are not comfortable with, nor should we have to follow any extra ‘rules’. I believe that with adequate support, even if birth after caesarean does not go to plan, women will still have a positive experience because the birth happened on their own terms.

Homebirth after caesarean (HBAC) support

Some women with the confidence and the funds to do so give up on the fight for birthing conditions in the health system and opt for homebirth with an independent midwife (IM). Why is it that you can have a water birth without continuous monitoring at home with an IM, yet have to negotiate time off the monitors just to get under the shower in a hospital? Even with strong and unwavering support from an IM and partner, most women find that family and friends are unsupportive, either to their face or behind their back. Unfortunately, in our society, women choosing to homebirth in general encounter this issue; it is even more problematic when you add the ‘fear’ of a past caesarean to the outsiders’ view. Many HBAC women will (a) avoid talking about their plans with their family and friends, (b) lie about their plans, or (c) try to educate others with their plans. Any of these options is exhausting and can often cause them to question their decisions, even though they have done their research and found an awesome support team. Even though the outsiders will not be there for the birth, their negative comments, fears and questions can have a major impact on the

STANDARD HOSPITAL VAGINAL BIRTH AFTER CAESAREAN POLICIES INCLUDE:

- limited access, if any, to the birthing centre facility
- limited options, if any, to have a VBAC after two or more caesareans, or VBAC with a breech baby, or VBAC with twins
- no access to publicly-funded homebirth
- continuous baby heart rate monitoring which may then place further restrictions on using a bath or shower; and moving about freely(although this is changing with the introduction of wireless, waterproof monitoring in many hospitals)
- having an intravenous cannula inserted into your arm
- having a blood sample taken (in the event of needing a blood transfusion)
- limited opportunity for midwife continuity-of-care due to not being deemed ‘low risk’ (although this is changing as some programs are becoming ‘all risk’ models).

“I had a ‘failed’ VBAC attempt resulting in a repeat emergency C-section under GA [general anaesthetic], and the emotional recovery from that was made much worse by the fact that I was being cared for by midwives who didn’t know my journey or how strong my desire for natural birth was. The system really just spits you out without really following up. I found that there is immediate ‘support’ provided but I was honestly too shocked/numbed/overwhelmed by the experience and busy recovering physically, on top of caring for a new baby and my three year old, that the gravity of my experience didn’t set in until weeks later, when all the care providers are long gone...” PBAC support group member.

parents’ emotional preparation,. Some of their fears or questions may pop up in labour if it does not progress as expected, and may contribute to a stalled or prolonged labour leading to a not-so-PBAC.

Improving birthing options after caesarean

Birthing options for women after one or more caesareans vary across the country. As outlined above, hospital policies include common limitations on VBAC women. In the Hunter NSW area our PBAC support group intends to become involved in improving birth choices for VBAC women to allow for:

- water birth
- birthing centre access, and
- access to midwife continuity-of-care programs

The NSW Health Policy Directive *Towards Normal Birth* requires all health providers to implement policies to increase the rate of normal birth by 2015, and specifies expanding VBAC options, which, in effect, will give VBAC women the choices our support group is keen to campaign for. I hope they carry it out.

Author Bio

Alex is mum to three-year-old old Jack and 15-month-old Isla. She joined the Hunter PBAC Support Group two years ago and set up the group’s Facebook page last March. At the beginning of this year, Alex volunteered to coordinate the group following the retirement of Tina Wilkie, who originally started the group ten years ago.

FINANCIAL REPORT

Maternity Coalition Inc. ABN 82 691 324 728
Independent Auditor’s Report to the Members

Report on the Financial Report

We have audited the accompanying financial report, being a special purpose financial report of Maternity Coalition Inc. (the association), which comprises the Statement by Members of the Committee, Income and Expenditure Statement, Balance Sheet, notes comprising a summary of significant accounting policies and other explanatory notes for the financial year ended 30 June 2013.

Committee’s Responsibility for the Financial Report

The committee of Maternity Coalition Inc. are responsible for the preparation of the financial report and have determined that the basis of preparation described in Note 1, is appropriate to meet the requirements of the Associations Incorporation Act of Victoria 2012 and is appropriate to meet the needs of the members. The committee’s responsibilities also includes such internal control as the committee determine is necessary to enable the preparation of a financial report that is free from material misstatement, whether due to fraud or error.

Auditor’s Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We have conducted our audit in accordance with Australian Auditing Standards. Those Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor’s judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the association’s preparation of the financial report that gives a true and fair view, in order design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the association’s internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness accounting estimates made by the committee, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our audit opinion.

Auditor’s Opinion

In our opinion the financial report presents fairly, in all material respects, the financial position Maternity Coalition Inc. as at 30 June 2013 and its financial performance for the year ended in accordance with the accounting policies described in Note I to the financial statements, and the Associations Incorporation Act Victoria 2012.

We have noted that the association has not been audited for the financial year ended 30 June 2012 and have taken this into account when prior year comparisons were necessary.

Basis of Accounting

Without modifying our opinion, we draw attention to Note I to the financial report, which describes the basis of accounting. The financial report has been prepared to assist Maternity Coalition Inc.’ to meet the requirements of the Associations Incorporation Act of Victoria 2012. As a result, the financial report may not be suitable for another purpose.

Signed on: 21/2/2014

Brian Orr, Auditor
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Branch Information

MC has branches in all states and territories at both local and state levels. If you wish to become more actively involved in MC, you can get in contact with the President or Branches Coordinator on branches@maternitycoalition.org.au, who can assist you in finding your closes local or state branch or look into the option of setting up a local branch in your area.

New branches 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) financial members. There may be more than one branch formed in each state or territory. A branch of the organisation is independent of other branches in its activities and fundraising. You can find about more about starting your own branch on our website www.maternitycoalition.org.au/start-a-new-branch

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