

BirthMatters

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**Alison Gaffney wraps
Breathing New Life 2010**

This issue:

The language of birth – does it really matter?

PLUS:

Gloria Lemay on 'Speech Magic'

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

Would you like to write for *Birth Matters*?

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

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

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

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

The *Birth Matters* Editorial Team
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Main Cover Photo: Babes of the North (clockwise from bottom): Erin, Connor, Mikaela, Ocean, Bethany, Fry, Ziah and Toby chill out at Darwin Homebirth Group's July coffee morning.
 Photo courtesy of Dave Krantz.

From the Editor



Kylie, Paul and Gabe welcome Saffron Matilda Vyvette aka 'Saffy'

Our Saffy arrived safely at home on a balmy Darwin evening in July. Let me tell you a little about how she came to us.

I told my husband Paul in October 2009 that we would give it six months max. After a year or so of on again, off again, fairly uncommitted 'trying', we'd finally decided to give it a red hot go. When I tested later that month there was a second blue line... it was faint, but it was there.

A few weeks later Marg Phelan came to visit. She had recently returned from three months on the road for the *Go Girl Australia* test run—the main event would kick off in late April 2010, three months before our baby was due. I did try (albeit rather half-heartedly) to persuade Marg not to disrupt her long-planned adventure for my sake, but she was having none of it. "If you want me, of *course* I'll be there," she told me. She would fly back after doing the first stretch from Darwin to Broome then head off again once our baby arrived. And so I would have my maternity care dream team, Marg and Mo, once again.

Given my experience with Daniel I felt it would be sensible to revisit the prenatal testing issue. I visited my homebirth-friendly GP, who referred me to the Royal Darwin with a request that I be able to see the same obstetrician I had come to know during my previous pregnancy.

On the day of my appointment I saw only my requested obstetrician. I did not have to explain my history to anyone—everyone I dealt with already knew my story. The obstetrician counselled me thoroughly on my choices, supported my decision to decline all early testing, and offered her services should I need them at anytime later in my pregnancy.

As the 20-week mark approached, I

finally decided I would have the morph scan. A foetal medicine specialist had recently set up shop at Darwin Private and I had heard good things about his ultrasound skills. I passed on the opportunity to have the all-singing-all-dancing 3D/4D scan (the bang for your 285 bucks), knowing good ol' 2D would deliver what I needed to see. The scan confirmed what my intuition had already told me: all appeared to be well.

The remainder of my pregnancy was uneventful and entirely lovely. Marg visited monthly and, when she began her epic cycling gig in April, Mo took her place.

The birth itself was surreal. Our girl arrived almost three years to the day after her brother was born into the same little space but, as Marg had said it would be, this birth was unique. My memories of it, so clear and cohesive in the early days of Saffy's life, now come in disjointed glimpses. Our tiny bathroom, dark and hot. The coolness of the wash basin pressed against my forehead as I groaned into the drain. Kneeling on the lounge with Paul and Gabe rubbing my back (and Gabe making *Karate Kid* 'wax on, wax off' gestures). The warmth of the pool, the sound of my mum boiling the kettle, Marg and Mo speaking—always in soothing tones—only to tell me I was doing beautifully. After just four hours, that rock-hard downward pressure. Then the stretching. A head. A chin. The shoulders. The chest. And finally, the little legs and feet. I pulled my baby onto my chest and couldn't understand why it wouldn't come all the way. "The cord's around the neck," I heard Marg tell Mo. No shouting. No panic. Just two highly qualified and very switched on midwives doing what needed to be done. I was lifted from

behind and my baby was tilted, untangled and back on my chest before I even knew what had happened. And then... bliss. "It's a little girl," I heard from somewhere far away.

The spitting image of her eldest brother, Saffy has her Great Grandma's eyebrows, and her Granddad's smile. When she sleeps, she looks just like Daniel. She guzzles rather than feeds and has developed two extra chins beneath the dimpled one she was given. She makes me cry and laugh daily. She exhausts me. She is, along with my two boys, the best thing I've ever done.

I share this story not *just* to indulge my desire to brag about our new babe and her magnificent birth (though I doubt I will ever tire of talking about it), but because the pregnancy and birth care I received—individualised, compassionate and professional one-to-one care from a known midwife (who 'collaborated' as needed)—is surely the epitome of what Maternity Coalition advocates. Not all women want to birth at home (though it is certainly every woman's right to make this choice), but every woman should have the opportunity to access this same level of continuity and receive care that keeps her and her baby always at its centre.

This issue of *Birth Matters* is really late. I always knew it would be a push to get it done with Saffy due just three weeks before the submission deadline. I'd forgotten how all-consuming those first weeks can be. After not quite three months of juggling Saffy's needs and my other commitments, I'm in even greater awe of my fellow MC volunteers and their relentless dedication to the cause. (Our outgoing president Lisa Metcalfe, mother of four, comes to mind—I can't even imagine how many hours sleep she sacrificed to lead us through such a challenging year for MC).

I'd like to say I'm sorry I've been tardy, but the truth is, I wouldn't trade a second of the time I've spent feeding, changing, rocking, bum patting and just gazing at my new babe. With a suddenly very lanky looking 9-year-old in my life, I'm all too aware of how fleeting these chances will be.

Thanks so much to Sonia for taking on more than her share of the content editing and to Mara for her patience with my dribs-and-drabs approach to this issue. I *do* promise I'll try and do better next time.

Kylie



All smiles – Saffy at seven weeks.

From the President



A heroic effort was made by Maternity Coalition members, birth organisations, individuals and midwifery groups to influence the development of the secondary

regulations relating to Medicare for midwives legislation. The final version of the regulations was slipped through Parliament on the eve of the announcement of the federal election.

This underhanded action incensed many women and inspired four women to stand as independents in marginal seats. Congratulations to those women for a fast and furious campaign that brought birthing to the political agenda during election time.

The federal election result of a hung parliament was a result of women voicing their dissatisfaction at the polls and the reality of both sides of politics refusing to listen to women and to act to implement real change in birthing options for women.

As a direct result of the Labor Government following the advice of the Australian Medical Association, women have fewer opportunities to access private midwifery care despite a \$120 million dollar commitment to achieve that aim.

Women must be able to determine their pregnancy and birth care choices. By legislating doctor involvement in every pregnancy and birth in Australia we have reached a new low in women's rights to reproductive self-determination. Effectively, women can no longer choose a midwife for their care without the agreement of a doctor.

A simple way to make the maternity reforms work are to revoke the current secondary regulations and modified them to produce a version that is able to be implemented beyond the private surgeries of obstetric specialists.

Without change to the regulations the enormous effort that has gone into maternity reform will not be realised.

Both sides of politics are promising no more than a review of the situation six months after the introduction of the 1 November Medicare funding. This is unacceptable. We know that birth doesn't wait for political timeframes.

On this journey to solve the indemnity crisis for midwives there have been many barriers and obstacles; the committed work of many people has overcome so many of these. With continued determination this final hurdle will also be overcome.

Thank you to all the committed members of Maternity Coalition and all the wonderful people who continue to keep up the effort to inform, educate and advocate for improved maternity services and work so hard to protect women's birthing options.

It has been a privilege to work with the members and especially the committee of Maternity Coalition. Sincere thanks for all the generous and supportive words and actions from this wonderful community of people. Ann Catchlove will provide excellent leadership as we move toward our AGM, as I focus on working on some challenges within my own family.

Please consider how you can support MC to continue the work of birth reform by nominating for positions at our AGM in October.

Keep being a voice for choice

Lisa Metcalfe



BaBs groups support pregnant women and new mothers to make choices that improve their health, parenting and life skills.

The BaBs program welcomes all women without charge and seeks to assist in health promotion that is sensitive to each person's culture and beliefs.

"I have been coming for a few weeks now and it has become the highlight of the week! I love the fact that we can be so honest with each other whilst sharing our ideas without feeling vulnerable or exposed. Everyone is so supportive of each other"

Jenny

www.babs.org.au

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Group discussions include:

- Adjusting to mothering
- Breastfeeding concerns
- Preparing for labour and birth
- Birth after Caesarean
- Birth Options

To find or start a group, or volunteer go to:
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Or ring:
0422 522 986 or 03 9720 8058

Contact Details:

BaBs Inc is not-for-profit.
Printing of this brochure was contributed to by the City of Whitehorse Community Grants Program.

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For a complete job description please email: birthmatters@maternitycoalition.org.au

A meeting with the Prime Minister

By Ann Catchlove



Ann Catchlove managed a pre-election meeting with Julia Gillard

Like many women, I have been frustrated at how difficult it has been to get our voices heard by the government during the maternity reform process of recent years. It seems that those with the most power and money also carry the greatest influence, and women's voices are ignored. The most recent twist in the reform process, which saw the government enacting a 'medical veto' over women's access to midwifery care, led me to seek out our new female Prime Minister to tell her what I thought.

In the early hours of 29 July 2010 I learnt that Julia Gillard was due in Melbourne that day. I stayed up trying to spread the word and let Melbourne women know that we might have the opportunity to speak to the Prime Minister. I also tried to find out where she was headed.

At 9.12 am I was still at the computer in my pyjamas when the *Campaign Crikey: morning edition* email arrived in my inbox. I eagerly scoured it for clues about Julia Gillard's whereabouts and read the following: "Julia Gillard is heading to suburban Blackburn this morning where she is due to give a speech at 9.30 am." I then completely lost my head and went into a meltdown trying to find the address and let other people know about it. I realised that, even though the PM was due to start her speech in about 10 minutes and Blackburn is about 50 minutes from my home, I had to seize the opportunity and get there myself.

I wanted to print out a document to hand to the PM should I get a chance to speak to her, but of course my printer ran out of ink. I raced around madly getting ready — no time for a shower. I threw a t-shirt on over my pyjama top, got the kids dressed in record time (one still wearing his pyjama top, neither had socks) and raced out the door without my glasses, wallet or nappy bag! After driving for five minutes the fuel light went on. I had

to push aside thoughts about how I was going to get home from Blackburn with no wallet and no petrol. We arrived at Blackburn at 10.20 am. I yanked the kids out of the car, ran to where the action seemed to be and watched as Julia drove by on her way. She waved regally at the children and me as she drove past. I was rather deflated that we had come so close but missed our chance to meet her. Then I saw a photographer waiting at the traffic lights and ran after him (rather difficult with a three-year-old and one-year-old in tow) and asked where they were headed next. He gave me the address and we hopped in the car. If I had been three minutes later we would have missed it all!



Isabelle and Dylan accompanied their mum to meet the PM

We drove to the next venue and saw the media bus and the Prime Minister's car. We parked, unloaded ourselves and settled in to wait for her to leave. I planted myself between the exit and the Prime Ministerial vehicle. Eventually she was coming! John Faulkner walked past and then it was the grand lady herself. I had her all to myself and she was slowly advancing towards me. My stomach dropped and I was petrified, but I stepped forward with Dylan in my arms and Isabelle attached to my legs and shook her hand. I have no idea what I said — it wasn't my smoothest performance. The media had all stopped and there were three television cameras lined up in front of us. I think I started with "I wanted my kids to meet you and to ask about maternity reform." She assured me Nicola Roxon was doing wonderful things for maternity reform. I said something about the reforms not working if doctors could override women's choices. Then I said in a quivering voice "This issue is really important to me and my family." I can't remember how it ended but Jenny Macklin put her arm around me and said in her

most 'caring' voice "We know it is a very important issue."

While waiting for the PM I had eavesdropped on some journalists saying that the next stop was Coles Eastland, so I spread the word to try to get some women there. My wonderful midwife had turned up and she lent me some money so that I could buy petrol to get home.

A little while later I got a call telling me that Malinda Morieson had managed to speak to the Prime Minister at Eastland shopping centre. She also spoke directly to the press afterwards. I got to hear what she had to say that evening on ABC radio's PM program in the opening story:

"Today a midwife managed to get close enough to talk with the Prime Minister."

MIDWIFE: I'm aware at the moment of a couple of private hospitals that actually have in writing on their admission paperwork that they don't want women to bring private midwives in with them because it steps on their toes. Do you think that's collaboration?

JULIA GILLARD: No, well I don't think that's collaboration and if you want to get the details of that through to Mike, we can follow that up.

MIDWIFE: Sure, I'll send that through to you, thank you.

ASHLEY HALL: But Melinda Morrison of the group *Midwives Naturally* says she wasn't impressed with that response.

So it's likely there'll be more protests at the Prime Minister's events over the 23 days until the election."



Prime Minister of Australia, Julia Gillard

Pic Source=<http://www.flickr.com/photos/14670374@N05/4881796497/> Prime Minister Julia

Thank you, Lisa!

By Bruce Teakle

After 17 months being our faithful and steady leader, Lisa Metcalfe has resigned as Maternity Coalition's National President.

Lisa took the role of President in March 2009, when she stepped forward at our national committee workshop in Brisbane. Two months later Medicare for midwives was announced in the May Federal Budget, and Lisa has been holding the reins through the remarkable ride we have had ever since.

Lisa is one of the "old guard" committee members, who went through the NMAP campaign in 2002, and who brought Maternity Coalition into its role as a national organisation with a focussed reform agenda. Lisa has been a persistent consumer representative in NSW, state wide and with her local services, and has been a member of the national committee for most of the time since she joined. Through this time she has brought her considerable intelligence and steady hand to her work with us all.

Lisa has resigned to attend to her family at a time when she is needed there. Ann Catchlove has stepped up as Acting President until the AGM (thanks Ann!).

Thanks to Lisa for all your hard work and commitment, at such an important time in our work. Thanks also to Lisa's husband Andrew who has supported Lisa during this time, and her four children who have shared her time and energy. We all wish the best for you all.



Marching to Parliament House at the Mother of All Rallies



Lisa addresses the 3000-strong crowd at the Mother of All Rallies in September 2009



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The language of birth

This article is based on a talk by Jennifer Watkins and Cheryl Glenie presented to ACMI National Education Forum From Here to Maternity, held in Adelaide in September 2002. It is included with the permission of Birthrites Healing After Caesarean (www.birthrites.org), where a longer summary of the talk can be found.

We began by introducing each other in obstetric language and then in (wise) women's language.

This is Jen: As a primip experiencing a normal pregnancy Jen was allowed to deliver in a public birth centre with the permission of the obstetrician at the booking in visit. The delivery was managed by an independent midwife who had visiting rights at the hospital. Jen is a doula, helping women through delivery and supporting their husbands. Over the past four years she has had births in public and private hospitals and even at home.

Jen's introduction of herself as a woman and mother: I gave birth to my son five years ago, on all fours, with my partner and a community-based midwife by my side, and it was a powerful life-changing experience. I gave birth and now I know I can do anything. I have the enormous privilege of being with women as they give birth in the place of their choice.

This is Cheryl: After three normal vaginal deliveries, as an elderly grand multi 10 years ago, Cheryl was not considered a low-risk candidate for a trial of labour in the birth centre. She found an independent midwife willing to take the risk of delivering her at home, and has since had three deliveries at home, without needing to transfer to hospital.

Cheryl's introduction of herself as woman and mother: I am a mother of six beautiful children. I have enjoyed six sets of arms and legs growing and moving inside of my now ample belly. I have breastfed for more than 12 years and am still breastfeeding although now my baby sits lower on my lap to reach the nipple than her older siblings. My first three children, now all adults, were born in hospitals. When I was pregnant with my fourth child I already knew how to birth, and being told I was too old at 34 to birth in a birth centre (my heart was not strong enough so the young obstetric registrar told me), I needed to find a better alternative than a labour ward. We found a wonderful midwife and birthed our fourth, fifth and sixth children at home, with all their older siblings around them. I know how life changing birthing is. I know how important midwifery is.

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Women rely on communication with their midwives [or other care givers] to understand what is going on, to make decisions, and then to understand what happened during birth.

Why is the language used with women important?

Women rely on communication with their midwives [or other care givers] to understand what is going on, to make decisions, and then to understand what happened during birth.

Language gives clear messages about power relationships.

Language gives messages about attitudes and ideologies.

Language affects how women feel about themselves and their birth experience.

Much of the language around childbirth is very disempowering.

Changing language around childbirth is an evolving process. It cannot change immediately. Habits are difficult to change, as are deep feelings about wanting credibility with colleagues who use different language. It is not useful to jump on people who slip up. It is the attitude, the intention behind the words that is far more important. We want the language of birthing to be reconsidered.

What language is appropriate?

These are questions you could ask yourself about how you communicate with and about the women who birth with you.

- Does the language put the woman, as a whole person, at the active centre of her experience?
- Are the words ones that she would use? Are they technical words she does not understand, or do they patronise her?
- Is she being manipulated? Are assumptions being made about her social situation?
- Is the language suggesting that she needs help? Does it suggest that she has failed, or that she is a failure?

We have six categories of words that we think need reconsidering:

- Doing or Being Done
- The Power of Name
- Using Women's Words
- Pulling the Rug Out – Guilt or Manipulation
- Baby Talk

Doing or Being Done

Think about who is giving birth, who owns the birth experience.

- “I had a woman...”
- “The midwife who delivers you...”
- “She had 200 births last year...”
- “I did 100 deliveries...”
- “I had 100 women...”
- “My lady, my woman, my baby...”
- “We like to have the placenta delivered within 20 minutes...”
- Manage, conduct, allow, permit
- Educating women
- Empowering women (giving power to someone else is a problematic idea)
- Helping, supporting, assisting, looking after (midwives work WITH women)

The Power of Name

How do we talk about women? What do we call them?

- Lady (Historically this term was for the landed gentry, ladies and gentlemen, and depicted a woman of class and substance. We are not suggesting that we women are not classy, substantial and some of us even land owners, but we do want to distance ourselves from the inherent power and social injustice implied in the word ‘lady’.)
- Girls, dear, love, lovey, darling, sweetie
- “You guys” (Did you hear about the antenatal class where the educator referred to everyone as ‘you guys’ for the whole class?)
- “The induction in room 16...”
- Elderly grand-multi
- Patient, consumer/client

Using Women's Words

- Jargon/abbreviations/acronyms
- Foetus (NO woman has a foetus, even when the baby is tiny in early pregnancy.)
- Spontaneous abortion (A woman has a miscarriage.)

- “We want to see progress of the presenting part.” (What is a presenting part?)
- Primagravida, multiparity (Even as a mother of six I don’t know what these mean.)
- VE (I do know what a VE is because with my last three pregnancies I did not have one.)
- CPD (This stands for cephalopelvic disproportion but I have no idea what it means, it sounds like a venereal disease.)
- Rupture of membranes, EFM, PND
- Do not presume that women and their partners understand. Always take the time to explain to ensure they understand.

Pulling The Rug Out

This is language that undermines the woman.

- “Still...” “Only...” “Still only...” (This negative language makes women feel inadequate and could be laying the foundation for intervention. Women need to be encouraged and to feel they are doing well, not undermined.)
- Normal (What is normal?)
- Low risk/high risk
- Favorable outcome/poor outcome
- False labour (not considered in labour until changes happen to the cervix)

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Changing language around childbirth is an evolving process. It cannot change immediately. Habits are difficult to change, as are deep feelings about wanting credibility with colleagues who use different language.

- Estimated date of confinement/due date
- Incompetent cervix, failure to progress
- Placental inadequacy/insufficiency
- Dysfunctional labour
- Faulty placement of the placenta
- Untried pelvis/trial of labour sizeable pelvis

There are many others: intrauterine growth retardation, blighted ovum, abnormal hemoglobin, hormonal insufficiency, management of

breastfeeding, inadequate milk supply/insufficient milk, average, normal etc.

Guilt and Manipulation

Guilt is often used in our society.

- “You’re happy with this aren’t you?” (This does not give the women a chance to really answer the question in an informed manner.)
- “Well, it’s your choice, but I’ve seen babies die from this..”

Baby Talk

When a woman is pregnant she is having a baby not becoming one.

- Bub, bubbly, bubs, tummy, tum pains
- “Dad, you can cuddle bubs while Mum hops up and has a wee” (No personal pronoun used.)

- Hubbie, down there, private parts, birth canal, inside bottom (Euphemisms - don’t be afraid of the big V word!)
- Hop up, pop into, (This is trivializing of the woman and the birth experience.)
- “It won’t take long...”
- “Just a little prick...”
- “We’re just going to...”

We are not persecuting. This should be fun. We all make mistakes and that is how we learn. We would like to break some language habits. We would like there to be ongoing discussion about the language used to describe pregnancy and birthing and we would like the discussion to include women, midwives, GPs and obstetricians.

Birthrites

Healing After Caesarean

NOR Support Group
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I'm 'overdue'!

By Michelle McRitchie



Michelle and family (L to R): Keenan, Michelle, Marty, Milly and Karlie

After three babies my 'success rate' of birthing before or on my due dates is 1/3... if it was a test I would have failed. So whenever I see the term 'overdue' used now I automatically feel frustrated: it's a word that took me down a path of unnecessary intervention and that prompted me to learn how to educate myself about childbirth. Let me briefly take you on that journey.

I was 22 years old when I became pregnant with my first child. She was wonderfully planned for my husband and me and we were thrilled about having a baby join our family. I read all the books I was recommended, including Miriam Stoppard's *Conception, Pregnancy & Birth* and the classic *What to Expect When You're Expecting*. I attended the hospital's antenatal classes and, as we did not have the internet, the only experiences of pregnancy and childbirth I heard about were from friends and family. I cannot remember hearing much that was negative and I don't remember 'fearing' birth, but I do now see that I was very naïve and compliant in my pregnancy care with my obstetrician.

I was using the public system in a small country town and seeing an obstetric GP, in the days when GPs could offer obstetric care all through pregnancy. My obstetrician was wonderful, a very caring young man, but unfortunately he was planning a holiday when my baby was due and so I would see another doctor then. My 'due date' came and went and I

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My husband and I left the doctor's office and... I immediately burst into tears and sobbed about my impending induction and 'long labour'. My husband wasn't sure what to say and felt completely powerless in the whole process, as I did. We had lost our continuity of care and felt we had to trust this doctor, but she herself would not be there at our birth as we would have whoever was rostered on at the hospital at the time.

began to get anxious, as I was hoping to go into labour naturally myself. At 41 weeks I visited the substitute doctor, who did an internal to see if I was close to being ready for birth. She told me that I wasn't and that I would have to be booked into hospital for an induction. There was no discussion about the risks of induction or any suggestion that I could choose to be monitored and wait a little longer. The doctor phoned the hospital there and then, as my husband and I sat in front of her. She told them to book me in for the next

night as I would have to first have gels and then be induced the next morning, as it would take more than gels to get me into labour. She emphasised that the induction would need to start early in the morning as it was my first baby and I would be in for a long labour.

My husband and I left the doctor's office and got into the car. I immediately burst into tears and sobbed about my impending induction and 'long labour'. My husband wasn't sure what to say and felt completely powerless in the whole process, as I did. We had lost our continuity of care and felt we had to trust this doctor, but she herself would not be there at our birth as we would have whoever was rostered on at the hospital at the time.

I went into hospital the next evening. Before the gels, I underwent a horrendous stretch and sweep carried out by a male doctor with no bedside manner who lacked the skills to pick up on my complete fear and vulnerability. I remember squeezing my husband's hand and crying in pain as the doctor tried to get my body ready for induction. I was then given the gels along with a sleeping tablet and left to try to sleep in readiness for the morning's next set of interventions.

The following day (at 41 weeks and 2 days) at 7.30 am the induction started with ARM (artificial rupture of the membranes) and then a drip. I was in established labour by 8 am and by 10 am was asking for pain relief. I was given pethidine, followed by some maxalon to help the nausea caused by the pethidine. As my baby crowned the obstetrician on duty carried out an episiotomy. My labour was only just over five hours (established) and I wanted to phone the doctor from the day before to tell her that she was wrong and there was no long labour. I felt pretty proud of myself as one of the midwives told me that it was a 'textbook birth' and wished she had taped it to show her antenatal classes. Little did I know then that I would learn years later that being a 'textbook' birth didn't make it a good birth. My daughter screamed for the first three hours of her life in the world, and then continued to scream for around two months and not sleep. I was a mess and nothing seemed to go smoothly for me as I adapted to parenthood.

When my daughter was 12 months old my husband and I discovered we were expecting again. This time, even though I was anxious about going 'overdue' again, I didn't have to worry for long as my son came exactly on his due date

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When we became pregnant with our third child we decided on a home birth with an independent midwife.

We started to discover just how powerful language is in pregnancy and birth. When it came to my due date again, my midwife did not even use the term 'overdue' and continued to remind me that the baby would come when he or she was ready.

and was welcomed into the world with a fairly smooth labour of 10 hours (despite a postpartum haemorrhage). This birth was a quite different experience from

my first, and the presence of my own natural oxytocin allowed me to establish a good breastfeeding relationship and strong bonds, very different to the short breastfeeding relationship and struggles I had with my first experience of motherhood.

Fast forward now nine years to when my husband and I decided to add to our family again. This time around, with access to the internet, I discovered many more options for birth. I had also been on a personal journey with my health, discovering options other than traditional medicine, and finding that I could actually refuse the advice given and seek different treatment routes if I wanted to.

When we became pregnant with our third child we decided on a home birth with an independent midwife. We started to discover just how powerful language is in pregnancy and birth. When it came to my due date again, my midwife did not even use the term 'overdue' and continued to remind me that the baby would come when he or she was ready. Although I was again anxious when my due date came

and went, my midwife made it clear that she didn't even want to discuss induction until at least 42 weeks, and that even then I had the choice of what I would do at that time. I learnt that full term is actually between 37 and 42 weeks and that some women gestate for longer than others, so for some 44 weeks might be 'full term'.

My third baby came spontaneously right on 41 weeks and was birthed at home in six hours. She was extremely content in the hours following her birth and latched on easily for her first breastfeed; she is still breastfeeding strongly at 23 months.

Author Bio

Michelle McRitchie lives in Ballarat, Victoria with her husband Martin and her three children, Karlie (12), Keenan (11) and Milly (2). Michelle works professionally within the welfare sector but her passion is as a birth activist and in seeing mothers form strong bonds with their babies from being empowered in birth and building great breastfeeding relationships.

The Womb

By Joy Johnston

The womb grows quietly, surrounding and guarding the new life within, sealed until the right time.

A single round window softens, its fibres are thinned and taken up, ready for the opening. The womb gives up its charge, silently closing.

The one in the womb grows quietly in a warm, watery world.

Secure in a closed and protected space.

The wee one hears sounds from outside, feels mother's laughter, her song, and her sobs.

Two people: mother with child. They are together, sharing each moment.

The wee one knows joys and sadness, loving and longing; learning life's patterns from within that womb.

At the right time the wee one is guided to a place of readiness.

The round window becomes a vast opening. The womb that held its treasure so patiently finds new strength to powerfully and completely expel its contents.

There is a second womb waiting to receive the wee one.

A womb that is bounded by mother's arms, her loving face, and warm strong body. Within the new womb are her breasts with a bountiful provision.

The child grows, knowing safety, warmth, satisfaction and peace in mother's arms.



Joy and her husband Noel with their family who have recently welcomed two new babies, James and Eve.

Joy Johnston (May 2010)

In writing about the womb I reflected on the language we use to describe the wondrous natural processes of growing, birthing, and nurturing our babies. 'WOMB' is a beautifully rounded, whole word. Even the 'b' gives completion, closure after the fullness of the 'wom' sound. (As I write I am making these sounds.) 'WOMB' is a word that stands alone. I don't know of any derivatives or expansions of this word. Compare 'WOMB' with its technical/medical partner 'uterus'.

When we speak the word 'uterus' there is no similar wholeness, fullness, or beautiful closure. 'Uterus,, uterine,, uteri': sounds like we are having a lesson in the extinct Latin language.

Similarly, what word can be used to accurately describe that amazing part of the womb that holds itself tightly closed, then becomes a vast opening? I have used 'window', yet that is inadequate. I know of no window that performs as this one

does. In technical terms, we refer to the cervix: the neck. It's a sphincter. I wonder is there a better word?

Author Bio

Joy Johnston is a midwife who practises in Melbourne. Joy was a key member of Maternity Coalition and Editor of *Birth Matters* for many years. She is now a frequent blogger and has recently published an e-book *Midwifery from my heart*. Joy's blog can be found at <http://villagemidwife.blogspot.com>

26th Homebirth Australia Conference: Echuca Moama, 15-16 May 2010, Changing Public Views, Rich River Golf Club

By Alison Gaffney



Immediate past president Lisa Metcalfe checks out Justine's latest homeborn babe Quinn

MC members felt privileged to attend the 26th Homebirth Australia Conference at Echuca Moama on 15 and 16 May. Congratulations to the team that put the conference together—the time and effort it took to create such an event would have been enormous. Well done Andrea Quanchi, Helen Grey, Kath Head, Prue Harding O'Dea, Elissa Bowler, Katie Tonkin, Leonie Harding, Jen Atkins and any others I may have missed from the team at Homebirth Australia.

Friday

On Friday night we arrived to the Turkish Bazaar Market and Cocktail Reception. Lisa Metcalfe and Alison Gaffney set up the MC stall and got busy catching up with friends and meeting new and exciting people. The conversations were all at such an advanced level of understanding on the scope of birth issues, it felt so powerful to be in that space and begin to imagine what would be created with so many great minds.

Saturday

We were welcomed to country on Saturday morning, and it was wonderful to hear that the hospital maternity wing was to be named in honour of a local Indigenous midwife. The Hon Sharman Stone (Federal Member for Murray) officially opened the conference.

Our first Keynote speakers were Dr Jennifer Barham-Floareani and Dr Simon Floareani who presented *Well Adjusted Babies*. This was a very exciting presentation which talked about how, essentially, chiropractors have had a

similar standing in health as midwifery—the 'ugly cousin' sort of position, not fully recognised and/or trusted by the more medical of health professionals, though we are seeing some cultural shift.

Jennifer and Simon spoke frankly about their personal birth stories and their journey through loss and grief and the incredible difference the continuity of carer through their many births provided. Simon also announced he has recently been named treasurer for the Allied Health Professions and will be overseeing the money allocated to them in the Budget, which is around \$11 million.

We then attended a Panel Q and A. Justine Caines, Lisa Metcalfe, Jenny Gamble, Marie Heath and Liz Wilkes answered questions for the audience and Simon Floareani asked what was the "overarching vision" of all the groups present on the panel. There was some discussion about this, with all agreeing that we are all aligned with the vision that "every woman can choose where how and with whom she births". (It wasn't 100% clear to me that we are all aligned in where we are aiming.)

Renee Adair spoke very honestly and passionately about her personal journey to becoming a doula and what is available for women choosing to employ a doula. Renee has started up the Australian Doula College, which is the first of its kind to be a government-accredited training facility and looks to continue to grow from strength to strength.

Heather Artuso spoke on the Midwifery Practice Review and the benefits and success of this tool in ensuring midwives are happy and on the right track in the eyes of their peers. The process encourages new midwives to be asking questions and reflecting on their practices. There was a lot of great discussion on the costs and difficulties, which Heather handled beautifully.

The Conference Dinner was so much fun. Too much food

and such great experience and an honour to be a part of the 'Passing Down of Wisdom' ceremony. Dancing went on late into the night—midwives certainly know how to celebrate!

Sunday

Anne Frye was the second keynote speaker, presenting 'Understanding the Pelvic Floor' and she was incredible. Anne had spent the last 12 months creating this animation to explain the physiology of the pelvic floor, showing the individual muscles and their relationships to the bones surrounding.

Two amazing women, Prue Harding O'Dea and Sheana Guthrie, shared their very heartfelt birth stories and their babies' admissions to Neonatal Intensive Care Unit (NICU). Sheana, particularly, was less than encouraged and experienced some very insensitive and down right offensive care. Her baby having to transfer was shocking to hear and painful to listen to, but all the time Sheana was supported by her private midwife. Sheana's baby recovered and, at seven months pregnant, Sheana was proud to announce that she would be birthing again, at home. Since the conference we have heard news from Sheana that she birthed her third baby successfully at home after being told it would be impossible. Congratulations to Sheana, her baby and her midwife Andrea Quanchi!

Carolyn Hastie spoke about the Waves of Change and on epigenetics and explained how six months pre conception our genes



Panel Q & A with (L to R) Jenny Gamble, Justine Caines, Lisa Metcalfe, Marie Heath and Liz Wilkes



The MC Crew

are being defined. This is about how our genes 'dress for the environment' with mirror neurons. (Also, V is for 'vision', U is for 'understanding', L is for 'love', V is for 'values' and A is for 'action'.) We sang a beautiful song which Carolyn had us do as a cannon that was truly magical to hear and be part of.

Becky Banks shared her birth video and told us of her birthing of her twins. Jo Greetham was organised to talk about her experience of birthing twins too, but wasn't allowed to board the plane with two babies!

Robyn Thompson spoke briefly on the Impact of caseload midwifery and how we need to be getting creative to making it work. She is offering her services as a birth consultant and would be willing to mentor new midwives in starting up their own homebirth service. We will need to be creative and connected to share the wisdom of midwifery to continue to birth powerfully, in love and to have good sense prevail in these uncertain times.

Birth announcement

Sheana Guthrie, who inspired us all at the conference with the story of her difficult first birth, emailed this news a few weeks later

I am delighted to announce that Coralie Joy-Ann was born into my hands at 3:04 on Sunday 13 June 2010 after four hours of active labour. She weighed 3.98 kg, with a head circumference of 36cm and was 50cm long... I am still shocked at how quickly it all happened. I'd hoped for a quick labour, thinking 10-12 active would be good... never dreamed it would be four! Feeling fantastic... Not sure what to do with myself or Coralie—I've

never been in the position to make these decisions for myself before! Boobing, sleeping and loads of cuddles.

We have been overwhelmed with the continued messages of support and encouragement following the conference. Thank you all so much.

Sheana

Is your membership up to date? Renew today. See page 32



Behind the scenes...



A family affair: Ali Gaffney's boys Felix, Saige and Magnus help Ali with the mailout for last edition.

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The language of love

By Jeanie Cuskelly

Number two baby was in a hurry and our midwife wasn't. Life partner, lover and friend now faced additional duties as delivery boy. His response was to run out of the room where I was ensconced (wedged) crying (the salty water type) "Don't push!" This piece of untimely advice was as effective as telling the moon not to rise, the visual similarities of the situation being remarkable.

Childbirth truly is one of those rare experiences which Western civilization has not yet tamed, perfected or redeployed in another guise. Childbirth is one of those human states too raw, too gutsy, too frail to discuss without a hint of humour, honesty and, if you're a first timer, horror (at the hands of the Let-Me-Tell-you-about-My-Birth Brigade).

First Trimester: Grandparents gush; partners and Fathers preen and panic, often at the same time; your mother and female friends-with-small-people-at-foot smile sweetly but refuse to meet your eyes, deftly deflecting any opportunities for direct questioning.

Second Trimester: Jokes about your widening girth are still passable (just); footy training nights are enthusiastically traded for Birth Class (he grins and bears down); TV shows on living creatures all end in tears and result in hefty subscriptions to the Save the Wilder beast Society; first kicks are felt, mainly from acquaintances, colleagues and trolley-pushing co-shoppers offering tidbits of womanly advice. The quantity of stitching discussed surpasses even Great Auntie Lena's wartime efforts, and the quality of their suffering would drive fear into the hearts (and nether regions) of even the bravest of men.

Third Trimester: Just as the facts of life are making themselves plain, concerned female friends and family decide to confide in you, sharing stark details about their (up until now) very private body parts—parts you had never even thought about much less put picture to. After offloading their traumas, they reach for the chardonnay with a side serving of camembert whilst your jangling nerves must be calmed in the wee early hours with raspberry leaves and Coon Mild. No time to spit the dummy now, by hook or by crook the only way is out!

The fact is that not one woman sidled up to me during pregnancy passionately spruiking of her intact perineum or uncomplicated delivery. Births without a battering, natural birthing, ordinary births happen. Yet in current literature, medical

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Childbirth truly is one of those rare experiences which Western civilization has not yet tamed, perfected or redeployed in another guise.

Childbirth is one of those human states too raw, too gutsy, too frail to discuss without a hint of humour, honesty and, if you're a first timer, horror (at the hands of the Let-Me-Tell-you-about-My-Birth Brigade).

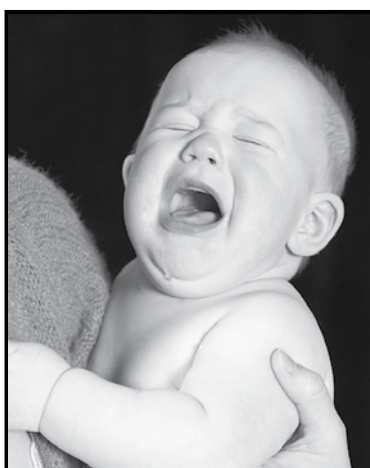
consultation and modern storytelling, a focus on the extraordinary can lead to the ordinary appearing less informed, less caring, less advanced. Yet all of our stories about pregnancy, birth and child rearing matter. They are all part of the ancient language of women. I often ask women what they hope their birth will be like (or rather, I used to). On hearing a women shrug and say, "I'm leaving that to the professionals," I swallow hard. Health professionals are just that. But in passing their birth experience to others, where do women find themselves? Nine months of careful contemplation of sex, drugs and rock'n'roll, only to leave the climax to someone else?

Childbirth is essentially scary because of its unknowable, uncontrollable nature. Having become familiar with predicting, guiding and shaping our major life events,

the discomfort of doubt might seemingly be avoided by passing the decision baby to the professionals. Like a language lost over generations, the story of childbirth is not one, ten or fifty individual stories. It is the language of generations of women from every country and culture and each story holds special meaning because it is part of the whole. As contemporary, informed women we research our home, finance, career and relationship options, choosing the best fit for us from myriads of possibilities. If we 'hand over' our knowledge and decision making to others, we risk losing, or at least reducing, our choices base. In allowing the experiences, wisdom and knowledge of our mothers, grandmothers, friends, family and culture to quietly fade from consciousness, replaced only by 20-minute consultations with not unkind (but unknowable) professionals, are we attempting an unnecessary tradeoff against the anxiety of uncertainty? Why not send Bashful to bed early, track down Mum and ask what you got up to on your birth-day. Let's embrace birth choices—researching, questioning and querying with gusto and enthusiasm, to reinvent what is, essentially, the language of love.

Author Bio

Jeanie Cuskelly is a mother and primary school teacher who lives with her husband and four children aged from 14 to seven years on a farm on the Darling Downs. Three of Jeanie's children were born at home in Toowoomba with a midwife attending. Excellent care and birth experiences being the norm, Jeanie's fourth child was due whilst living out west, necessitating a hospital birth. Happily, the midwives were allowed to work their magic and all went to plan once again.



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As long as it's healthy

An extract from Not Compatible with Life – a diary of keeping Daniel

By Kylie Sheffield



Even the most informed among us can resort to the small selection of well-worn truisms when speaking of pregnancy and birth. But is what we say really what we mean? In this extract from her story of carrying a child with a life-threatening condition, Kylie Sheffield explains the potential impact of even the most harmless of comments.

At no time in a woman's life is she more exposed to scrutiny than when she is pregnant, and no other human condition invites the same relentless onslaught of open inquisition and frank observation. From breast size and weight gain to birthing venues and baby names, suddenly no detail is too intimate to be discussed and dissected in the public domain.

It never occurred to me during my first pregnancy to be put out by the endless comments on my changing shape and frequent questions about everything from my baby's sex to my birth plan. For me, others' interest, albeit a little over zealous at times, was generally well intentioned and a constant reminder of new life's ability to touch all those who encounter it. Carrying Daniel has not made me change that view. It has, however, given me a somewhat unique insider's perspective from which even the most harmless of questions and statements can sometimes appear to be otherwise.

As long as it's healthy. Possibly the most frequently used of all the trite utterances fired on a daily basis at the glowing mum

to be, generally a follow-up to that other all-time favourite, *do you know what you're having?* Popular variations include *as long as it has ten fingers and ten toes*, and *as long as it's got all its bits*. *As long as it's healthy*—I must have said the same thing a hundred times whilst gushing over friends' pregnant bellies. Only since carrying a baby who isn't has the gravity of those five words—innocent enough and always delivered with the best of intentions—truly hit home.

What, after all, is *healthy*? For a newborn babe to earn this all-important stamp of approval, which boxes must be ticked and by whom? Shortly after Daniel was diagnosed, I remember hearing of a baby who, during a routine ultrasound scan, was found to be missing a finger. Despite the fact that no other abnormalities were detected and his organs, as far as anyone could tell, were all present and functioning, the parents were allegedly devastated. As the expectant mum of a baby whose condition is deemed to be lethal, I can't help but feel that the absence of a digit, unexpected though it may be, is nothing to get all worked up about. Is this small anomaly sufficient reason to see a baby as less than perfectly healthy? If so, then where do we draw the line? What of birthmarks, harelips, clubfeet, receding chins and the million other minor anomalies that may be present at birth? If these are justifiable cause for tears and tantrums in the delivery room, then perhaps *healthy* is just another over-used

euphemism and what we really mean when we smile reassuringly and deliver the standard platitude is, in fact, *as long as it's perfect*.

When I was 28 weeks pregnant I met a mum whose baby was diagnosed with Down syndrome shortly after birth. She had undergone no specific prenatal screening so did not have prior warning of a congenital abnormality. On the day we met, her son was three weeks old and fast asleep against her breast. She beamed with pride and adoration as she peeled back the front of his carrier to reveal easily one of the most beautiful babies I have ever seen. His face was completely round, his cheeks pink and chubby, his nose a tiny button. The only outward sign of his condition was an unusually large gap between the first and second toe on each of his feet. Despite a few rough days in hospital following a Caesarian delivery, his mother had persevered with breastfeeding and he continued to gain weight and thrive. Each time I saw them he was fatter and more content, and I wondered how anyone could look at this baby and see him as anything less than perfect. Yet, by medical definition and societal expectation, he was not.

As long as it's healthy. As my pregnancy with Daniel approached its final stages I heard those words over and over again and each time they sounded a little more absurd. My newborn baby would not be healthy. Despite my every instinct suggesting otherwise, science and technology had assured me that once he left the safety of my womb he would be plagued with multiple anomalies that would most likely kill him. Of course no one outside my immediate circle was to know that, and each time someone patted my bump, blew kisses through my belly, even called me 'fatty', it confirmed that I was carrying a new life no less precious or longed for than any other. And whenever the usual string of platitudes rolled off a well-wisher's tongue, it was easy enough to smile and nod even as I placed a protective hand on my belly.

'Do you know what you're having?'

'A boy,' I would tell them.

'Are you happy with that?'

'Of course,' I would say.

'Oh well, as long as it's healthy.'

'He probably won't be,' I would answer in my mind. 'But he will be loved.'

Watch your language!

By Brydie Pereda



Brydie and husband Pat welcome son Ruben Banjo

The power of language is all to clear in this birth story from Brydie Pereda, who traded threats and worse-case-scenario statistics for words of kindness and encouragement on her way to a safe and empowering VBAC.

My period was only one day late, but I knew something felt different. We had just started trying to get pregnant again, and it had taken years the first time around, so it was a bit of a surprise to find myself standing in the bathroom excitedly holding a positive pregnancy kit stick once more.

My first birth had been an 'elective' C-section. Jasper was a breech baby from 30 weeks on; he never wanted to turn around, despite my trying everything 'natural' to turn him along with an ECV (external cephalic version) at 38 weeks. If an obstetrician or midwife had said, "I feel confident in you, and sufficiently confident in my own experience, to give this breech birth a good shot," then I would have happily gone ahead. It was never an option. Nobody was willing to encourage it and, as a first-time mother who had waited so long to get pregnant, I lacked the courage to do anything but have the recommended Caesarean. At 39 weeks and four days and with no pre-labour at all, Jasper was born weighing 4375 grams.

I had grown up reading my mum's copy of *Spiritual Midwifery*, by Ina May Gaskin. Those wonderful hippy pictures and scenes of natural birth from the back of a kombi lodged firmly in my brain and that was what I wanted. I was determined to do everything in my power to get that birth this time around. I decided I wanted the team-midwifery model of care for

what was going to be my VBAC (vaginal birth after Caesarean). I read everything I could get hold of about VBAC—both the good and not-so-good aspects. I wanted to be informed, to know what my options were, to understand what to expect and to find out how best to get the birth that we had planned for our first child.

With the support of midwives from the hospital, my pregnancy progressed beautifully. My body was doing the things it was supposed to do and I was getting excited. After my 19-week scan came a follow-up appointment with an obstetrician. I knew that the consultant might not be quite as supportive of VBAC as my midwives, so I went in feeling a little nervous, but still excited. By the time I left I was extremely upset, confused, and borderline hysterical. I knew that pregnant women are incredibly sensitive to comments and feelings of vulnerability, nonetheless I was floored.

The doctor's behaviour made me uncomfortable right from the start. When he asked whether I had any questions, I delivered my carefully rehearsed list. He answered by saying, "I can tell you the truth as you can't sue me and you can't sue the hospital." What followed were death-rate statistics for VBACs in Africa and horrifying, inappropriate stories. He led me to believe that, if I loved my 21-month-old (who was with me at the appointment), then I wouldn't even consider the risks of VBAC—a torn uterus, stillbirth, or my death and abandonment of Jasper.

I would never do anything to put my children in harms way, and I was extremely upset to be told that I would be doing so if I chose VBAC. My not-yet-two-year-old son and my unborn baby were the most important things to me. My choices were made with them at the forefront of my mind. Extremely distressed and confused, I went home questioning everything I had planned... everything we had planned—my husband Pat was as much involved in this as I

was and was upset at seeing me so very unhappy after a 30-minute appointment.

After much discussion with Pat, reading everything I could and many supportive talks with our wonderful midwives, I made a second appointment with another obstetrician to clarify a few things and enable me to set a plan in motion. I needed to know where I stood with regard to the hospital and its policies.

The second obstetrician agreed to let me go just one week over my due date, with a follow-up appointment at 40 weeks and one day to discuss a repeat C-section if I had not already gone into labour. I was much happier with this arrangement. Although the mere idea of a repeat C-section filled me with fear and disappointment, I had no intention of 'going over'—I just needed the doctor to provide backup support so that I could surround myself with the supportive, positive force of my wonderful team of midwives.

By 30 weeks Jasper certainly knew that there was a baby in my belly. He felt it move and kick. Each night he gave my belly a kiss and said goodnight to the baby inside. I kept telling him that it was still growing and that, when it had finished, it would come out.

Fast forward to 40 weeks one day—the day of my obstetrician appointment. At 1.30 am I woke and couldn't get back to sleep. For the next couple of hours I listened to music on my iPod and had irregular contractions. I tried not to be too

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hopeful that this could be the beginning of labour as I'd wondered over every niggly my heightened senses had detected during the past five weeks. At 4 am the alarm went off for Pat to go to work and he asked if I wanted him to stay. I suggested he went to his morning job but came back in the afternoon, as things felt a bit more serious this time. He decided to stay and promptly went back to sleep. I dozed for another hour and then got up.

I rolled on my Swiss ball and enjoyed the quiet of the morning before the day started. I was using all my mental power to will this baby to keep coming. With a looming deadline, I felt ready to birth this baby. I just needed it to be ready now.

The contractions were coming intermittently, sometimes five minutes apart, and then up to 35 minutes apart. My mum had arrived two days before to be on hand to look after Jasper during the birth. I had been mentally holding on until then, as I felt more confident with Mum around to help look after our little boy. Jasper, Mum and I went for a fast walk to get croissants at 7 am I walked faster than I had done during the whole pregnancy. I felt energised and excited, but really didn't want the contractions to peter out again. I had had lots of pre-labour, on and off, for the last couple of weeks—all feelings and parts of a pregnancy that I had missed out on the first time. More than anything, I didn't want to have to go to see the obstetrician that afternoon to discuss a C-section. I tried to keep an open mind about the birth, and assured myself that whatever happened would be OK, but deep down I didn't believe it. I needed to have this VBAC. I had built up an expectation of what birthing would be like and felt a strong emotional attachment to what it meant to me as a woman giving birth. Another C-section would be a profound disappointment and feel like a personal failure of what my body was designed to do.

At 9.30 am I went for another fast walk with Mum, ran up and down the hall with Jasper and walked up and down our foyer stairs. We lived just 10 minutes away from the hospital, so I felt confident labouring at home for as long as possible, with a quick transfer to hospital when needed. Our midwife kept tabs on us with regular phone support. Her words of encouragement meant a lot. I trusted her judgment and her back-up team to keep me safe. She supported my birth ideals and had, from the outset, been very encouraging of any decisions I made.

By about 12 pm the contractions were finally regular—hooray!—coming about every two minutes and lasting for 50 seconds. By about 1.30 pm they felt a lot stronger and I was starting to get quite

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If an obstetrician or midwife had said, "I feel confident in you, and sufficiently confident in my own experience, to give this breech birth a good shot," then I would have happily gone ahead. It was never an option. Nobody was willing to encourage it and, as a first-time mother who had waited so long to get pregnant, I lacked the courage to do anything but have the recommended Caesarean.

vocal. Jasper had woken up from his nap and I didn't want to scare him at all. Our midwife advised us to come in so, leaving Jasper with a new DVD and Mum, we left for the hospital.

We arrived at 2 pm. Our midwife and a student midwife examined me after I was settled into the room and discovered I was four centimeters dilated. A good start, things were happening!

I felt very cold in that room and I had trouble warming up for the next few hours. My body thermostat didn't know what was going on. After being hot for much of the pregnancy, suddenly I was cold and shivering, and this made the contractions feel more intense. I stood in the last sliver of afternoon sun filtering

through the double-glazed windows, trying to gain its warmth.

The only position I found comfortable was standing or kneeling up against the bed. Sitting was agony and I couldn't bear Pat to touch me anywhere but my hands during a contraction. I got into the shower, and it was heavenly to finally feel warm. I didn't want to get out ever again, but Pat thought I should 'save' it for a little later.

I had a catheter put in as I hadn't been able to wee for a number of hours. Lying on my back to have it inserted during a contraction was horrendously painful.

I had agreed, as per hospital policy, to have a fetal monitor strapped to me. The contractions were still coming regularly and (I thought) intensely, but a doctor read the machine and said they weren't lasting long enough. This sparked a moment of panic for me, as I knew the doctor would have a timeframe of how long they would feel comfortable letting me labour. It was about 6.30 pm. I reluctantly got onto the bed again, so they could see how I was progressing. Lying down for a contraction was horrible. I was 6.5cm. I had ages to go! My waters were bulging though, so they decided to break them. What a warm gush that was. Some of the pressure instantly lifted, but I was still very cold and wanted to be in the shower again.

Standing again under the warmth of two showers, suddenly I felt a contraction that left me wanting to push. But I was only 6.5cm dilated—surely I wasn't supposed to be pushing yet? My husband kept saying it was OK, but I asked him to go and get our midwife. I couldn't hold back, my body wanted to push and nothing would stop it. The midwife took

VICKI CHAN AND LYNNE STAFF

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one look at me and decided to set up the sterile kit. I knelt against the bed on a mat, gripping Pat's hands over the top. These were strong contractions and every ounce of my body was involuntarily pushing. I could feel my hands crushing Pat's, but there wasn't anything I could do. I wasn't moaning now, just deep breathing, and focusing on Pat's eyes. My body wanted to roar like a lion and push with a strength I had never felt before. They quickly took the catheter out so it wouldn't get in the way, which was a huge relief as it had never felt comfortable.

The midwife held out a mirror and said I could see my baby's head crowning if I looked down or feel it if I reached down. But I couldn't; I needed every part of me to concentrate on pushing, and only pushing. The contractions came on top of each other now. I kept waiting for the burning sensation, the searing pain that I had read accompanied the baby's crowning, but I didn't feel anything very bad, so I thought the head wasn't coming yet. Then

I was told to stop and wait, not to push. I could do it; I knew I had to listen. Then I was told to push directing my entire body's energy into my bottom rather than throughout my body. It sounded impossible, but felt so good when I did. The sensation of energy condensing all the way down to one spot felt amazingly powerful: all that vocal energy gathering momentum from my head, harnessing every ounce of energy I had throughout the top half of my body, travelling to my baby to help it come down.

"Brydie, your baby is coming!" Suddenly I felt a weight was gone, instant relief, and my baby slipped through my legs and up to my body. I clumsily clutched at him, sitting in shock. I had done it! I had my beautiful baby in my arms. A baby boy. A perfect baby boy.

Days later, I was still overwhelmed just thinking about his birth. I felt extraordinarily lucky to have experienced what we did: to feel my body being pushed to lengths I didn't know it was

capable of; to see my baby take his first few breaths in this world, clutched at my body. Knowing that my husband was so proud of me, seeing the strength of giving birth, and watching our son being born, filled me with a pride that I had not known before.

I didn't want to forget anything from the birth, and yet I knew the memory and the intense feelings from those moments would begin to fade. Writing his birth story I can't even begin to capture everything that I felt over those first few days. I needed to talk about the birth a lot over the next week. I was so happy with the whole experience—happy with the way my body had performed. I felt I had succeeded as a woman, that I had finally achieved what I had so wanted to do for so many years. By talking and going over the small details with my husband, I tried to recreate the very essence of what we felt on the day of our son's birth. We shed many, many happy tears. It was truly an amazing experience.

With woman: birth language

Optimal use of language ("speech magic") to assist our clients

Midwifery tip from Gloria Lemay, compiled by Leilah McCracken

The only way we can undo the mass psychosis about childbirth in North America is to invent new language and new images. We midwives must make a conscious and disciplined effort to become "speech magicians."

I train my clients to ask for what they WANT rather than what they DON'T want. For example, the client doesn't want an episiotomy = the client wants an intact

perineum. Or a client says "I don't want my baby taken away from me!" = the client says "I want my baby 'Velcroed' to my skin from the moment he/she is born." All my notes in my chart are what the client WANTS, not the "Don't" instructions. This way, I am constantly picturing the image of what is wanted and so are my assistants. When everyone is picturing "Baby Velcroed to skin" then it happens. This technique is particularly effective at hospital births.

Another good way to create what you want with doctors is by using "indirect" hypnosis. For example, the doctor is starting to fidget as the baby's head distends the perineum. He reaches for the scissors and you know he's getting ready to do an episiotomy. So you speak to your client, not to him by saying something like "Linda, you are stretching beautifully; there's lots of space for your baby to come through. Everything is healthy and normal—there's lots of room to stretch even wider. Breathe some oxygen down to your muscles." Everything you are saying to your client is really intended to chill out the doctor. Speaking to him directly is less effective (it makes him more resistant to your message) than speaking obliquely to him through your words to the mother. Once the doctor starts taking deep oxygenated breaths down to his muscles,

you'll see him put down the scissors.

You'll notice that Dr [Michel] Odent does word magic, too. He talks about the "fetus ejection reflex" and the "ancient reptilian brain". I don't think anyone has ever located these things in the physical universe, but they are most useful concepts and ways of 'languageing' that lead to better births for women and help undo some of the fear-based pseudo science that passes for obstetrics.



Gloria Lemay

Author Bio

Gloria Lemay is a private birth attendant in Vancouver, BC.

Is your membership up to date? Renew today. See page 32



Breathing New Life Into Maternity Care: Working together learning from each other, 3rd Biennial Conference, Alice Springs 1–3 July 2010

By Alison Gaffney



Dalby midwife Jane Gately and MC's Alison Gaffney at the foot of the MacDonnell ranges outside the conference venue

Thank you to the people who made it possible for MC to be a presence at *Breathing New Life 2010*—Queensland MC president Rebecca Jenkinson for securing funding from Queensland Health and Belinda Mair from the Office of the Chief Nurse for providing the registration, dinner, tickets to the art show and the stall place. Thank you also to the Australian College of Midwives for making places available for representatives from MC.

I was extremely excited to be attending the conference and, with minimal notice, I was pumped. The intention was to make connections and share with people the work that we do with MC and to gain up-to-date information to share within this community. The outcomes were some new members, the distribution of MC journals and a great deal of valuable conversation about what's possible in the future. I was very fortunate to be able to catch many of the sessions and be truly inspired by how much is going on to ensure that all women are cared for professionally and compassionately in the perinatal period.

I attended one of the four workshops entitled *Normal birth—proactive support of labour*. The *Indigenous cultural awareness* workshop also sounded excellent—it took people out to traditional birthing grounds and talked about birth locally—as did the *Basic ultrasound* workshop and the *Fetal surveillance education* program session.

Paul Reuwer: Normal birth—proactive support of labour (Plenary 7)

The *Normal birth* workshop (to my mind a better description of the program would have been 'A formula for reducing Caesarean section rates within the hospital system') turned out to be a controversial discussion and was also presented in a plenary session. Paul Reuwer's definition of 'normal birth' differs from mine, but I appreciate his intention to collaborate and his commitment to seeing women experience birth as physiologically as possible, with timely

intervention if any is needed. His formula has quite an emphasis on checking cervical dilatation to diagnose labour and monitor progress once labour has commenced. Personally I would be uncomfortable with this, but, apparently, with the women completely informed of this procedure throughout their antenatal sessions, he hears no complaints at all.

Dr Reuwer took us through what he explained were the most common scenarios for 'unnecesareans', which typically result from induction before a woman is truly in labour. These primip Caesarean sections have a great impact on future births, and Dr Reuwer's number one lesson is: get it right for the first birth and you won't have work to undo in future pregnancies.

He gave as the second most common reason for unnecesareans: women being left unattended during labour and mentally losing all faith and trust in themselves, typically (he claims) from badly managed homebirths (!).

Dr Reuwer reported the Caesarean section rate in The Netherlands as 25–35% and said two thirds of these are described as being from dystocia, or 'failure to progress' in a first birth. This description is used too often without definition and makes Caesarean section look like a successful rescue mission instead of the result of badly managed care. Thirty per cent of births are with instruments; 11%

of women in Holland require complete psychiatric care for postnatal stress disorder (PNSD); and 42% show some symptoms of PNSD.

His key message was that birth is a parasympathetic process requiring safety, rest, confidence and security in the woman. A midwife needs to be more of a coach than a physician to provide reassurance, continuous attention, a consistent birth plan, and pre-labour preparation consistent with actual practice. Normal birth in nature is short—less than 12 hours.

Dr Reuwer said that if a woman shows signs of anxiety at 36 weeks this indicates a likely longer time in labour. He talked about 'dark cloud' (or negative) psychology and said that daunting news from professionals is the darkest cloud, especially with tools like ultrasound. The media come a close second with programs like *Births from hell*, of which we saw a snippet (a truly disgusting program in which women are taught to be afraid). Women can create self-fulfilling predictions and the birth team can provide so much more to set the scene as safe and encouraging.

The midwives working in this model of care are apparently also very happy with it and daily peer review is used as a basis for keeping the team effort in place and sticking to the plan. The plan is a commitment to provide care to achieve normal birth—this is written up publicly in a place where everyone can see it, including the families who visit the ward.

I would have felt more comfortable hearing from 'the team', but we only heard from Paul who seemed to have vastly differing statistics about the homebirth situation than those presented in the homebirth study released in 2009. I was left wondering what the midwives are saying.

The basis for this model appears sound. First, collect satisfaction rates from the women. Recognise that it is vital to provide continuous care from a midwife once a woman is in labour, so she is truly encouraged throughout the labour and birth. The woman is given a 'last date of arrival' (42 weeks) as apposed to a 'due date' and only at 41 weeks does anybody use the word 'induction'. The team has agreements on the terminology

used and the definitions of diagnosis and symptoms, so as not to overload a woman before she is even really in labour. I feel that there is real reason for celebration here, however when compared to the Inuit's Caesarean rate of 1% there is still a way to go.

Other sessions I caught included the following.

Kathleen Baird: Women's experience of domestic violence during pregnancy—listening to women's voices

This was very powerful and Kathleen spoke about listening to these women and what works in allowing them to speak. Women need to talk about their experience and be allowed to move through the process at their own rate.

Maggie Redshaw: Maternal emotional and physical wellbeing in the perinatal period

Women in England were surveyed at three months post-birth regarding their experience. Of the 4800 women who participated, most experienced some problems and most felt they were improving, but 6% said they had flashbacks of the birth.

Hannah Dahlen: The role of the doula

In Sydney doulas are becoming quite common, and what they bring to the birth can be difficult for other professionals to deal with.

Christina Lee: Listening to change—a pilot test of having a baby in Queensland survey

Queensland Centre for Mothers and Babies (QCMB) reported on their take on the data that was received. To my mind, the range of respondents wasn't varied enough to make the statements that were made about satisfaction.

Heather Pearce: Pregnancy-related pelvic girdle pain—listening to the voices of Australian women

Management for pelvic floor damage varies, and too many women aren't recognised as being disadvantaged by these pregnancy- and birth-related traumas. This was managed beautifully and deserves more recognition for further assistance for these women with sustained damage to the pelvic floor.

Debbie Slater: Just a consumer (Plenary 1)

Debbie spoke about the role and importance of consumer engagement. The personal is the political, and our experience in birth is never forgotten and will always be an important part of our lives. Debbie shared her personal

experiences, the range of care she received and the difference it makes. Women contribute so much by describing the services from their perspective, so we can provide a wonderful insight and can advocate for better services for all. Great work Debbie.

Eugene Declercq: Improving policy, practice and outcomes (Plenary 2)

Eugene gave us the statistics on birth around the world, showing that Caesarean sections are still on the rise everywhere. The logic is not understood statistically yet, but the evidence shows we are losing the art of normal birth.

Eugene is an excellent speaker and a great advocate for consumer power. He notes that consumers are guided by media, and that YouTube, Facebook and other social networking sites are becoming powerful environments from which women get a lot of their information. TV shows such as *William and Mary*, which is about a midwife and a funeral director, provide interesting ways of getting information out into the public domain. The movie *The Business of Being Born* has been edited to a 30-minute piece that can be shown in schools and could be a powerful tool for educating young people.

For professionals in the UK there is a maternity liaison committee to deal with complaints; the USA has no such thing and the only avenue is to go to court. Providing a non-threatening place to just talk and listen is very valuable. Eugene suggested more tea rooms as places just to be together to chat. Overlapping shifts was another good idea.

Soo Downe: Interprofessional practice (Plenary 3)

Soo spoke on getting beyond the gargantuan struggle: from conflict to collaboration in maternity services. It is a reality that true collaboration can happen

in a broad range of settings and will provide empowered birth experiences, particularly for those requiring rapid transfer and instrumental delivery. The parallel positive effects on staff wellbeing were also discussed.

Hannah Dahlen, ACM; Ted Weaver, RANZCOG; Jeff Ayton, RDA: Moving forward with maternity services reform (Plenary 4)

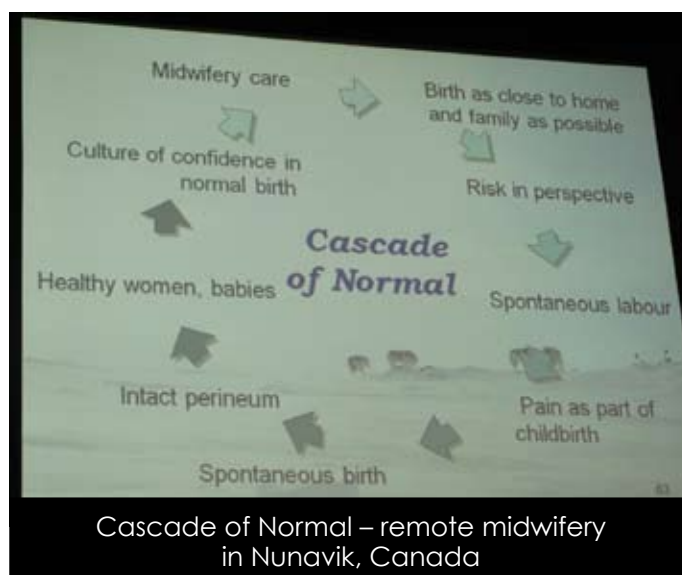
These college presidents discussed and debated how the federal reforms will improve care for women and babies. Questions were asked regarding Indigenous women, commitments to supporting overseas efforts and homebirth. In the final round up delegates promised that the three colleges would support a pilot program for birth on country.

Stephanie Bell: Indigenous maternal health (Plenary 5)

Stephanie spoke about the Central Australian Aboriginal Congress, describing the great work that is happening through this service and the challenges they face.

Vicki Van Wagner, Mina and Harry Tuguluk: Remote midwifery in Nunavik, Canada—outcomes of perinatal care (Plenary 6)

This session described the outcomes of perinatal care and midwifery care in the remote area of Nunavik, Canada. It was truly inspiring to hear from these champions of primary care for Indigenous people. They reported a 1% Caesarean section rate and absolute belief in community birth care. The nearest hospital is 500 miles (eight hours flying time) away, so there are no onsite Caesarean sections and very few transfers. The 'cascade of normal' shows the way that birth is approached in Nunavik.



Sally Tracey: Collaboration in maternity care (Plenary 8)

Sally shared with us how midwifery group practice programs are taking off and women are asking for 'that mango care'. M@NGO (Midwifery @ New Group Options) is a three-year randomised controlled trial of caseload midwifery care at the Royal Hospital for Women, Sydney. The costs of M@NGO compare favourably with standard care. Sally also helped to set up the Ryde Midwifery Caseload Practice in 2004. She said there is a need for:

- no mandated obstetrician involvement
- developed rules of engagement
- shared purpose achieved through a process of interdisciplinary risk assessment
- mutual respect and trust
- ACM guidelines for consultation and referral.

Sally stated that the biggest risk women and midwives face with this model is that they will be satisfied and the outcomes will be better.

Eugene Declercq, Paul Reuwer, Vicki Van Wagner, Soo Downe: Policy, practice and systems of care (Plenary 9)

These speakers formed a panel to answer questions.

Mary-Rose MacColl (facilitator): Collaborative maternity care can/can't work—a hypothetical

This session was a role play of a scenario of birth care for a rural woman who received many differing opinions and conflicting advice throughout her pregnancy. It created a highly stressful situation which ultimately led to her birthing on the side of the road with no professional care. I recognised this story from a report released a while ago called something like "Thank goodness we had a flash light". Mary-Rose stated at the beginning that the woman whose story was told, was actually in the room. I think she was being hypothetical, but perhaps the woman was in the room. The idea that she would have to listen to the laughing and joking made me extremely uncomfortable. As a consumer I found it

very telling of how women are spoken about and listened to from the collective of professionals out there. The team on stage obviously had fun, with people like Ted Weaver playing the privately practising midwife and Hannah Dahlen the private obstetrician. However it was a very powerful exercise to allow us to feel as though we were alongside the woman receiving varied advice and limited care. The woman was only spoken about but the birth sounds were played by Sue Kruske and her experience of fear was heartfelt and truly terrifying. It was a great way to end the conference to remind people about how their care impacts a woman's experience, particularly when they are working towards better collaborative agreements. Many women spoke up after the scenario and told of their own experiences of incomplete and inadequate care from professionals in birth care. The impact on the lives of these women is real and lifelong. I am holding onto hope for a future which is aligned to all women receiving great care in birth and pregnancy based on love, best practice and respect.

National campaign update

By Bruce Teakle



Bruce Teakle on the consumer rep trail with Sarah Kerr and baby Harper

The big bad issue for maternity care reform remains the requirement for midwives to have "collaborative arrangements" with doctors as a condition of Medicare rebates. Since this was first announced on 5 November 2009, it has threatened to give doctors control over the private maternity care marketplace, and

thus women's choice and access. With the requirement for collaborative arrangements becoming law in March this year, the only realistic way to avoid a medical "veto" over women's access to funded midwifery care, has been in the definition of collaborative arrangements, which is set in a regulation (a lower level of law which doesn't need to go through Parliamentary debate). Consumer, midwifery and nursing groups worked together, lobbying the Minister to adopt a reasonable definition, but on 16 July the regulation was enabled, requiring a doctor's permission and giving the medical lobby what they had demanded.

Legislative Instrument -

F2010L02105 (Google this to read the text) sets conditions eligible midwives must meet before women can claim Medicare rebates for midwives' services.

From here on we must take every opportunity to amend the legislation, or the regulation, but the reality is we may have to live for some time with the laws as

they currently are. To make Medicare for midwives work for Australian women, we will need state and territory governments to get moving on collaboration between eligible midwives and public hospitals. This is important for meeting collaborative arrangements requirements, but is also essential if women are to have continuity of midwifery care in hospital births. There are complex issues to be resolved, simply in dealing with issues of public patients, private patients and Medicare funding.

Maternity Coalition has posted a brief on its website homepage to help understand how Medicare for midwives works, and what deals need to be made with public hospitals. This might help members talking with local hospitals, or with state health departments.

Also available on our homepage is a one-page brief for lobbying to remove the medical veto. You can add your local MC branch contact info to the bottom and take it to see your Federal MP, or our first elected woman Prime Minister next time she is in town!

Maternity reform and innovation — ideas and challenges, University of Technology Sydney, Wednesday, 7 July 2010

Mr David Hirsch: Listening to women: learning from medico legal cases and events

By Carol Chapman

In the June issue we featured Ann Catchlove's article 'Informed choice, consent and the law: the legalities of "yes I can" and "no I won't". This issue Carol Chapman explores further legal issues with her take on a seminar by Mr David Hirsch, barrister and Chair of the Australian Lawyers Alliance Medical Negligence Special Interest Group.

As much of Maternity Coalition's present concerns relate to the notions of women's autonomy, valid consent and the right of refusal in childbirth I emailed David before the seminar as follows:

"I am hoping that in the course of your presentation you will be able to speak on the issue of a woman's right of refusal to tests and interventions and the legality of public health services denying care if a woman refuses screening."

I added the question:

"How can screening be mandated and not violate valid consent? How can a threat of being 'released from the program' not be viewed as coercion?"

David responded to my email and considered my questions in his talk but did not (could not?) provide specific answers. Nonetheless, his talk was interesting, entertaining and included useful background information for consumers of maternity services who are concerned that their care is being influenced by clinician's fear of lawsuits.

Tort law versus a no-fault compensation scheme

Tort law aims to provide (a) compensation (that is, put the person into the position they would have been in had they not been wrongfully injured), (b) corrective justice and (c) deterrence. By contrast, the aim of a no-fault scheme is to provide support (that is, provide for the injured person's basic needs).

David showed an image of a man on a metal ladder in a swimming pool attempting to fix a light fitting. He then showed another swimming pool image. This time there were several children who had no arms as a result of Thalidomide,

playing by the edge of the pool. David explained that a no-fault system would compensate these people equally should the handyman be electrocuted—the cause of injury does not matter. Tort law takes the view that the cause of injury does matter and that a victim of negligence has the right to more than just having their medical bills paid; they have a right to restoration.

The indemnity 'crisis'

Indemnity insurance premiums for obstetricians with United Medical Protection (UMP) doubled within a year as a result of several factors: global insurance (including reinsurance) increases following 9/11 and flooding in Europe, inadequate financial management practices by UMP, and the introduction of 'risk rating' (where those with higher risks pay higher premiums) where previously there had been mutual risk sharing. There was also the Calandre Simpson case, in which the claimant was awarded a record \$14 million payout.

Doctors used the 'indemnity crisis' and large payout to lobby for tort reform, claiming that they could no longer afford to practice and that insurance premiums had risen as a result of an increase in the number of people suing doctors, an increase in the number of frivolous but successful claims, and courts awarding higher payouts.

Tort law reform

The call for Tort reform was successful, despite the facts that (a) there was no evidence of increasing numbers of lawsuits (the findings of a federal government review and a Victorian government review), (b) UMP had significantly mismanaged funds, and (c) of the \$14 million Calandre Simpson payout, UMP only paid \$1 million (the rest covered by a US reinsurer). At the end of the day the government bailed out UMP and agreed to pay 50% of claims over \$300,000. David recalled receiving an invitation to an event celebrating this tort reform.

The invitation was emblazoned '*Just what the doctor ordered*'. In the years since the number of claims and the amounts paid have significantly decreased—just what the doctor ordered indeed.

When David began discussing negligence claims following the births of babies with cerebral palsy and the evidence used to defend the doctors, I began to feel really uncomfortable. The evidence used was the same as we birth reformers have used to support our case: the average decision-to-incision interval being 45 minutes and longer, that cerebral palsy rates have remained the same in spite of increased CTG (cardiotocograph) foetal monitoring and Caesarean section. David, as a barrister who acts on behalf of the claimants, pulled the evidence apart, making the case for more prompt Caesareans and more frequent or accurate CTG monitoring in these cases. I don't know what disturbed me the most: that doctors use the same evidence we use to bolster their arguments when it serves them, or that David's refutation of the evidence seemed quite compelling. I also considered that David's work may be pushing in the opposite direction of our own: that is, causing doctors to become risk averse and more inclined towards screening and intervention.

David went on to talk about why people sue, and here his clients and members of MC had much in common.

- People do not sue because of bad outcomes or because they are looking for someone to blame. Largely people accept that tragic things sometimes happen and are no-one's fault.
- People do sue if they perceive that they are being lied to or that there is secrecy surrounding their case.
- People do sue if they are not listened to or respected.

As I listened to this I remembered many negative birth experiences women have told me about in which I heard the same themes.

To summarise, I gleaned the following from David's lecture:

- Tort law *may* be useful to maternity consumers retrospectively, but not protectively. That is, once harmed you can seek justice. However, negligence is very difficult to prove and very expensive to pursue.
- There will be times when obstetricians are negligent and the victims will need and deserve compensation, and we do need some form of deterrent and corrective justice for genuine negligence.
- Fear of a lawsuit is not a justification for defensive obstetric practice, as the fear is unfounded.

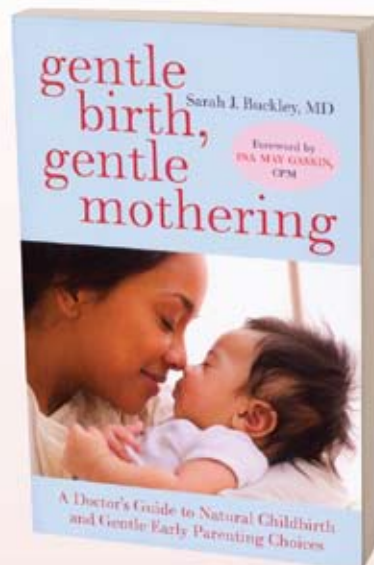
Perhaps David could not answer my question about consent because whether or not valid consent can protect us from coercion or duress through mandated procedures is possibly untested. But I hope that no woman is ever placed in a position, through denial of valid consent, to test it—where she must pursue legal action to feel 'listened to and respected' in her maternity care choices after the damage is done.

Author Bio

Carol Chapman is a long time active member of Maternity Coalition and past NSW president. She has represented maternity consumers on numerous committees and working parties and was heavily involved in the initiation and development of the Midwifery Group Practice and public funded homebirth in Belmont NSW. She continues to be involved in her local MC group and is a consumer reviewer for Midwifery Practice Review. Carol's husband and 'birth activist by association' is Dean. They have three children, Jacqueline 14, Sam 12 and Dominic 10.

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Joseph Chilton Pearce, author of *Magical Parent Magical Child*



'Sarah Buckley's work is unique: as a health professional AND a hands-on mother, Sarah exquisitely demonstrates how science affirms the intuitive wisdom of motherlove as well as how gentle parenting works in practice — not just in theory.'

Pinky McKay, author of *Parenting by Heart* and *100 Ways to Calm the Crying*, Melbourne

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BIRTH MATTERS: DECEMBER THEME

Annual Report Issue

The year that was... December is our annual report issue—we need national, state and branch reports as well as lots of great pics of what MC members got up to in 2010. Birth stories and topical articles are welcome as always.

Please email all items to birthmatters@maternitycoalition.org.au on or before the deadline of **Monday 1 November 2010**. Articles should be a maximum of 3000 words.

Please note: Our editorial and distribution teams would love to have the final edition of the year in your mailboxes before Christmas. Please help us out by making the deadline.



Maternity Coalition News

ACT Branch

By Emma Davidson

I attended the ACT Council of Social Service (ACTCOSS) 'Meet the Candidates' forum in the weeks before the federal election. The forum ran in a different format to most similar forums. Candidates were given five minutes to speak to the group about their priorities, then each candidate moved around the room, spending 10 minutes with small groups of up to six attendees, answering questions.

Although I had to leave early for school pickup, I was able to speak to Senator Kate Lundy (ALP). Senator Lundy has met with MC on many occasions about the right of women to make an informed choice for homebirth with a registered midwife. On those occasions, she has been supportive of our cause in her choice of words, and has written to Minister Nicola Roxon on our behalf. I wanted to remind her of the issue in the lead up to the federal election, hoping that she would remember our persistence and resolve in our meetings with her after the election.

Both Senate seats in the ACT are considered 'safe', and the incumbents were standing for re-election. In addition, the two House of Representatives seats vacated by retiring ALP MPs were predicted to be won by ALP candidates. This may have contributed to the reduced number of minor party and independent candidates at this election. The Greens came very close to winning the second Senate seat currently held by Senator Gary Humphries for the Liberals, a supporter of MC's cause in the past. The Greens candidate for Fraser, Indra Esguerra, had attended a protest rally outside Senator Kate Lundy's office earlier in the year, and was clearly well informed on the midwifery legislation in her speech at that rally.

Our work in the lead up to the election was intended to remind the candidates that our campaign is something that will not go away, by building on the hard work of the ACT branch over many years in attending meetings, writing letters, and attending protest rallies. In the aftermath of the election, ACT Branch of Maternity Coalition will write to each of our elected representatives to remind them of the importance of our issue. We will also write to the Greens, thanking them for their active support for our campaign.

The combined effect of Maternity Coalition representatives attending various forums and protest rallies will be something we can draw on in meetings with our Senators and MPs later in 2010

and into 2011. Every action by an ACT member of Maternity Coalition, no matter how small or infrequent, has added to the campaign flow going into the offices of our political representatives. Every action is important.

Maternity Coalition Queensland

By Bec Jenkinson

Queensland Branch is powering on and, despite our lack of branch reports so far in 2010, rest assured, we have been busy!

On Thursday 15 July, just after 5 pm, the Gold Coast Birth Centre was closed without warning or consultation. The closure occurred after the hospital obstetricians voted unanimously to withdraw their support for the model, citing safety concerns. That news at first trickled, and then flooded, in through social networking sites and text messages. We scored the strategic coup of being the first to draw the closure to the attention of the Deputy Premier/Health Minister's office. Local women on the Gold Coast did an amazing job of contacting media outlets, politicians and each other. Three hundred women, men, babies, midwives and student midwives rallied outside the Gold Coast Health District CEO's office and, subsequently, about 40 crowded into his office to meet with him directly. MC members who had stayed in Brisbane worked the phones all day, talking to the Deputy Premier's office, opposition politicians and the media. By about 8 pm that night, we got news that our lobbying had been successful: the Birth Centre was reopened under normal operating conditions, while a review of the Gold Coast Hospital Maternity Service is undertaken. It was a spectacular example of just how effective consumers and midwives can be when we work together! The feedback has been that we very much took them by surprise! We continue to lobby for the inclusion of consumer representatives on the review steering committee. However, as we have seen on the national scene, this is finding resistance, in favour of 'independent consumers'.

Our next job is to transfer this kind of success to two other situations: Beaudesert and Emerald.

We are currently lobbying government to support the proposed primary maternity service in Beaudesert. Beaudesert women currently travel 45 minutes to Logan Hospital, after the closure of the local

maternity service five years ago. Following a highly successful community forum, attended by over 200 locals, Beaudesert is now set to become the first maternity service in Queensland to re-open. We are now working to convene a meeting of key stakeholder with the Deputy Premier/Health Minister.

Emerald has also been facing a similar loss of service, again due to the loss of obstetric and anaesthetic cover, which would require Emerald women to travel 3 hours to Rockhampton to give birth. In a matter of days, the women of Emerald organised a rally of 300 local women, started a Facebook group (*Save Emerald Birthing*, now with over 1800 members) and got the attention of Queensland Health. Nonetheless it is an ongoing concern.

The Queensland Branch has also been in a fortunate position to fund consumers attending both the ACM Queensland state conference and the *Breathing new life* conference in Alice Springs. On extremely short notice, Ali Gaffney represented us in Alice Springs – see her report in this issue. For the ACM state conference we had the luxury of time and we were delighted to be able to sponsor conference registration, travel and accommodation for eleven consumers from around Queensland. MC Queensland has also launched a blog, *Birth action news*, to replace our widely, if sporadically, circulated newsletter. Because the blog is much more immediate and much less labour intensive, our goal is to maintain an engaging and timely flow of campaign information. Follow us at <http://maternitycoalitionqueensland.blogspot.com/>

Central Coast MC

By Lisa Kim

Application for grant – June 2010

Brigitte Sigl and Lisa Kim both spent many hours filling in forms and writing several event plans to submit with our application to the Southern Lakes Communities for Children C4C Small Community Grants Program. After months of waiting and wondering whether we had simply pondered over too many coffees, we have just been advised our application was successful.

This grant will allow our team to hold several *Empowering stories* seminars over the next 12 months, and also ensure ongoing education for several of our members, helping to raise awareness of who we are and how others can help pave the way for birth change in our local community.

Central Coast Community Congress – July 2010

The Central Coast Community Congress was created in 2000 and started with a conversation about how people with a passion for working with communities might discover, collaborate, celebrate and develop community building on the Central Coast. The Congress event happens biennially and brings together 250 community builders from the Central Coast and beyond to learn together and celebrate what has been happening within their communities. The Central Coast MC was honoured to be invited to speak in the *Real people doing real things* segment and delivered the following overview:

What challenges has your group experienced and how did they overcome them?

One of the biggest challenges for the Central Coast Maternity Coalition is maintaining a high level of commitment from its volunteers. Our members are busy mothers who are dedicated to their families but at the same time passionate about improving local birthing services for other members of the community.

The preparation of events such as the Empowering birth stories seminar, done annually, requires our members to find funding, suitable venues, promote the event, arrange guest speakers and catering, and organise child care for attendees with children. This is all fitted in between caring for our children and families, sleep times, nappy changes, feed times, etc. Often our members are up quite late or very early in the morning organising while our children are asleep. And, more often than not, our children are with us during meetings or as we prepare for events.

As with many other volunteer groups, financial concerns are always an issue. Finding suitable funding or donations is a struggle, but fortunately our volunteer members are highly generous, not only with their time, but in providing refreshments at all events. Local grant applications have also been of great support in the past; however, they are not always available, therefore fundraising events need to be arranged, putting more pressure on volunteers.

Last of all, raising community awareness about who we are, what we do and why is always a challenge. Although our volunteer group is made up of members with a variety of experiences, we lack the knowledge and knowhow of effective marketing, as well as the financial backing to cover the costs of extensive promotion.

What has surprised you most about your work?

One of the most surprising factors we have found is a complete acceptance by women of the interventions and procedures that are offered routinely in most hospitals during labour and birth.

Birth can be a beautiful process, and learning how to have the kind of birth you wish for will help to protect your body and your baby.

It surprises us that many women don't consider where the best place for them to give birth and with whom is. They are quite often unaware of the alternatives offered by our public hospitals, such as birth centres, midwifery-run programs and specialised continuity of care programs.

Knowing and understanding rights in labour, becoming informed about birth choices, and learning about the risks and reasons for interventions and alternatives to them, will help many women prepare themselves and welcome their babies into this world in the best way possible, giving them a beautiful birth tale to pass onto their children.

Further raising community awareness effectively, and gaining the support of more local members who are concerned with our current birthing policies and situations, will achieve changes more quickly, so offering better choices for all birthing parents.

Election preparation – August 2010

In the countdown towards the national election, the Central Coast branch contacted our supporting local politicians, Dobell MP Craig Thomson, and Robertson Independent Michelle Meares. Both of these locals have shown a great interest in offering birth choices and working towards better birthing systems locally, and we wished them both well in the election.

Plans for September, October and November 2010

Spring will definitely see us out of mischief with a busy few months ahead of us. The final planning is underway for our next *Empowering birth stories* seminar on 16 October, to be quickly followed by the *Kids day out* and our local *Kids and baby's market* where we have plans to sell our *Loved, nurtured and cherished* 2011 calendar and help to raise awareness about our local birthing services.

Hunter Home and Natural Birth Support (HHNBS)

By Chrissy Grainger

HHNBS has welcomed many new babies. At the HHNBS AGM two beautiful women with gorgeous pregnant bellies stood down from their positions within our group. Thank you to Amanda Hinds and Amanda Kaldin for assisting with the organisation and duties of HHNBS.

July's *Support people: doulas, husbands/partners and children at birth* was one of our most popular topics by far. A number of

local doulas were in attendance to answer questions.

In August we held a pre-election screening of the new Australian birth documentary: *Throwing out the lies with the birth water*. Many potential federal members of parliament showed their support for true choice in birth by attending and liaising with members of their electorates. Let's hope the message of this wonderful film gets back to parliament.

Our August meeting, on the topic of *Boobs, bottoms and baby wearing*, proved once again to be very well attended. It was lovely to see so many new faces and blooming bellies. There were modern cloth nappies to look at, a number of baby-wearing demonstrations and great discussions about the 'elimination communication' / nappy-free approach to babies' elimination needs and the topic of baby-led solids.

With homebirth awareness week in October quickly creeping up, we are busy planning for this special time of the year. We hope to screen *Orgasmic birth* and raise more awareness about homebirth in our local area.

HHNBS meets on the second Wednesday of the month at 10 am. For further information please contact Chrissy on 0418 237 938 or email hbnbsgroup@gmail.com

Maternity Coalition Victoria

By Ann Catchlove

Michelle McRitchie and Ann Catchlove met with Daniel Andrews, the Victorian Health Minister, in May. It was a constructive meeting and the Minister was receptive to our concerns. We focused on the importance of continuity of care for women and on some of the current opportunities for, and barriers to, giving women access to this. We discussed the implementation of the national maternity reforms in Victoria. We noted that there are some fantastic caseload midwifery programs in Victoria, but that women's access to this model of care is still very much limited by geography and eligibility criteria. We stressed that women deemed 'high risk' are often those who could most benefit from having a known midwife. It was pleasing that the Minister acknowledged that VBAC (vaginal birth after Caesarean) women in particular should be able to access continuity of midwifery care through caseload programs. We also discussed the closure of the caseload midwifery program in Ballarat. Finally, we raised some of our concerns regarding the safety and quality framework for the insurance exemption

for homebirth midwives, particularly issues around protecting women's rights to make informed choices.

We have been active trying to raise the profile of maternity issues in the lead up to the federal election. Our members have been busy on a number of fronts setting up Facebook pages, writing to and meeting with local candidates, writing letters to the editor and even chasing down the Prime Minister!

Choices for childbirth will be starting up again in October, with new coordinators Jo Askham and Jess Permezel. Bookings are essential and can be made by telephone on 0434 968 808 or by email at: northcotechoices@maternitycoalition.org.au.

Our movie nights continue to be popular. In July we had a number of birth movies showing, with guest speakers Vicki Chan and Lynne Staff. On 9 August 2010 we hosted the Australian premiere of the movie *Doula*.

Maternity Coalition Ballarat

By Michelle McRitchie

There have been some big changes in Ballarat since the last branch report for BM. Faye Kricak has resigned from the president's role but has thankfully stayed on as our treasurer. Faye has given an amazing amount of time and dedication to our branch along with all her other commitments. We also have a new secretary, Amelia Flanagan, who has been a godsend in helping to organise all the meetings and minutes, as well as being another passionate contributor to our committee.

Our branch has been very active in the last few months assisting the local public hospital in their plans for maternity services in Ballarat. Unfortunately, they have closed the Primary Midwifery Care Program (PMCP), which is our only

caseload program, and are looking at new plans for team midwifery that will be up and running by the end of 2010. Ballarat MC are saddened by the closure of the PMCP but we are continuing to meet with the hospital to see how we can assist them to make sure women still have access to continuity of care.

We have also been kept busy hosting a local event for International Midwives Day and attending a Rural Maternity Services forum as consumers amongst professionals, government departments and other organisations. We have held a movie night every few months with the lovely Rhea Dempsey coming to speak on the night.

We are *still* waiting for our promised meeting with Nicola Roxon, which came out of the community cabinet meeting in February in Ballarat. Faye has been diligently following this up and now I have continued to do so, but unfortunately with no success as yet.

Notice of 2010 Annual General Meeting

Saturday 23 October 2010, 5 pm Eastern Daylight Savings Time

The Annual General Meeting (AGM) will be conducted via conference call. Members who wish to arrange a connection to the meeting, or submit nominations for a committee position please contact:

Secretary Georgia Hodges secretary@maternitycoalition.org.au

The business of the AGM is to:

- confirm the minutes of the preceding AGM,
- receive from the Committee reports upon the transactions of the Association during the preceding financial year,
- declare all committee positions vacant and elect office bearers and committee members of the Association.

All members are invited to join in the AGM.

Please consider how you can support the ongoing work of MC by assisting or nominating to fill one of the committee or office bearer roles.

The management team has been developing a system of mentoring members. We would warmly welcome people to participate in the Committee in an assistant role. This means you learn the ropes as you go, building on the knowledge of existing committee members. The aim is to make the transition to a new committee as successful and smooth as possible.

Below is a quick outline of key responsibilities for each position. Please contact the Secretary for more information or to nominate for a position.

President: provides leadership, usually chairs meetings, in consultation

with the Secretary, ensure that notices/ minutes of meetings are distributed to members in a timely and appropriate fashion and acts as the spokesperson on behalf of the MC. Provides reports to the Committee quarterly on action and representation during the preceding quarter.

Vice President: assists in leading the organisation, fills in for President as chair and spokesperson. Liaises with committee members, branch presidents, currently responsible for social network site.

Secretary: is the principal administrative officer and needs to make and keep a correct record of all proceedings and resolutions at meetings, including the names of those present and those who tendered apologies, distribute minutes to members of the committee, oversee preparation for and notice of meetings, assist other officers with the preparation of reports for the AGM. Communication with the committee shall be, wherever possible, by electronic mail.

Treasurer: to collect and receive all monies due to the MC, to make all payments authorised by MC, to keep correct accounts and books showing the financial affairs of MC with full details

of all receipts and expenditure connected with the activities of MC, provide a quarterly profit and loss statement and organise audit of the finances of MC.

General Committee Members: assist with specific actions arising from meetings. Take on specific projects to develop the organisation.

Membership Secretary: responsibilities include send out renewal reminders, provide annual summary of membership, process and update membership requests, and receipt membership payments and post to recipient.

Current Management Team:

Office Bearers

Acting President: Ann Catchlove

Vice President: Makayla McIntosh

Secretary: Georgia Hodges

Treasurer: Nicole Carver

Assistant Treasurer: Naomi Campanale

General Committee Members

Bruce Teakle

Sarah Kerr

Membership Secretary

Bec Telfer

Birth Matters Editorial Team

Kylie Sheffield

Sonia Bartoluzzi

Mara Dower

Financial information for the year ended 30 June 2009

The following extracts are provided for the information of members. For further information, please contact Nicole Carver at treasurer@maternitycoalition.org.au

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MATERNITY COALITION INC

BALANCE SHEET AS AT 30TH JUNE 2009

	2009 \$	2008 \$
ASSETS		
Current Assets		
Cash and Cash equivalents		
1110 - Geelong Bank	4,182.07	3,605.25
1000 - BANKWEST-National Acct-5121-7	34,497.66	32,689.84
1050 - FBC Canberra Branch NAB	220.65	0.00
1100 - CBA Ringwood-National Acct-8586	15,504.78	38,049.70
1115 - Bendigo Bank East Gippsland 541	1,038.22	776.72
1124 - Petty Cash- Ballarat Branch	-25.73	0.00
1125 - Bendigo Bank Ballarat Branch819	3,391.40	1,039.10
Total Chequing/Savings	58,809.05	76,160.61
Accounts Receivable		
1200 - Accounts Receivable	4,680.00	285.00
Total Accounts Receivable	4,680.00	285.00
Other Current Assets		
1500 - Prepayments	0.00	200.00
Total Other Current Assets	0.00	200.00
Total Current Assets	63,489.05	76,645.61
Fixed Assets		
1600 - Office Equipment		
1620 - Office Equipment at Cost	9,403.60	8,542.08
1650 - Less Provision for Depreciation	-6,294.00	-5,832.00
Total 1600 - Office Equipment	3,109.60	2,710.08
1700 - Furniture and Fittings		
1720 - Furniture and Fittings at Cost	107.20	107.20
1750 - Less Provision for Depreciation	-107.20	-107.20
Total 1700 - Furniture and Fittings	0.00	0.00
1800 - Capital Grant funded assets		
1820 - Grant Funded Assets at Cost	9,943.00	0.00
1830 - Less Provision for Depreciation	-2,292.00	0.00
Total 1800 - Capital Grant funded assets	7,651.00	0.00
Total Fixed Assets	10,760.60	2,710.08
TOTAL ASSETS	74,249.65	79,355.69

Financial information for the year ended 30 June 2009

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MATERNITY COALITION INC

BALANCE SHEET (CONTINUED)

	2009 \$	2008 \$
LIABILITIES		
Current Liabilities		
Other Current Liabilities		
2010 · Sundry Creditors	920.00	0.00
2150 · CANA Money held in Trust	496.81	441.81
2170 · MIPP money held in trust	6,012.89	1,365.84
2300 · Income Received in Advance		
2330 · Capital Grant -Comm Ben fund Q	8,573.00	0.00
2350 · Unearned Revenues	4,505.00	3,230.00
2370 · Grant Income received in adv	2,079.00	33,642.41
Total 2300 · Income Received in Advance	15,157.00	36,872.41
Total Other Current Liabilities	22,586.70	38,680.06
Total Current Liabilities	22,586.70	38,680.06
TOTAL LIABILITIES	22,586.70	38,680.06
NET ASSETS	51,662.95	40,675.63
EQUITY		
1110 · Retained Earnings	40,675.63	47,410.83
1111 · Transfer CANA held in trust	0.00	-441.81
1112 · Transfer MIPP held in trust	-3,657.05	-1,365.84
3000 · Opening Bal Equity	0.00	50.00
Net Income	14,644.37	-4,977.55
TOTAL EQUITY	51,662.95	40,675.63

This is a true statement of the financial position of this Incorporated Association as at 30 June 2009.

Financial information for the year ended 30 June 2009

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MATERNITY COALITION INC

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF MATERNITY COALITION INC

I have audited the accounts, on Pages 2 to 7, being the Statement of Income and Expenditure, Balance Sheet and notes to and forming part of the accounts of the Maternity Coalition Inc and of the economic entity for the year ended 30th June 2009.

The association's committee is responsible for the preparation and presentation of the accounts and the information contained therein. I have conducted an independent audit of these accounts in order to express an opinion on them to the members of the association.

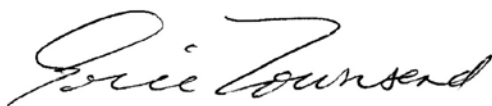
My audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance as to whether the accounts are free of material misstatement. My procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the accounts, and the evaluation of accounting policies and significant account estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the accounts are presented fairly in accordance with Australian Accounting Standards and statutory requirements so as to present a view which is consistent with my understanding of their financial position and the results of its operations.

The audit opinion expressed in this report has been formed on the above basis.

AUDIT OPINION

In my opinion, the financial statements give a true and fair view of the financial position of the Maternity Coalition Inc as at 30th June 2009 and the results of its operations for the year then ended.

DATED: This 21st day of April 2010

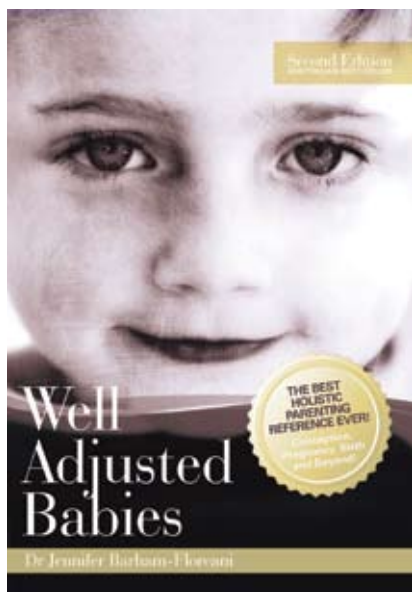


**ERIC TOWNSEND
E TOWNSEND & CO**

**35 MEREWETHER AVE
FRANKSTON, VIC., 3199**

Book review: Well Adjusted Babies

By Mara Dower



Well Adjusted Babies

Second Edition

By Dr Jennifer Barham-Floreani

Paperback

Published by Vitality Productions,
Pty Ltd 2010

Copies available in Australia at:
<http://welladjusted.me>

Dr Jennifer Barham-Floreani is a mother of four, a chiropractor, business owner and author of *Well Adjusted Babies*. Now in its Second Edition, I don't know how she fits in her extensive research and time to write with four boys and her husband Simon – it's awe-inspiring.

Written from her heart both at a personal and professional level, this well informed and easy-to-read book will encourage families, parents, individuals and health professionals to raise healthy and well adjusted children.

The journey for well adjusted babies begins with the health of both the mother and the father. Dr Jennifer discusses fertility and infertility, and the focus a baby needs from day one. Miscarriages are discussed in detail, routine procedures and testing during pregnancy (including anything invasive), birth preparation including hiring a private midwife, and the role of the partner.

The journey continues then to birthing, the stages of labour and overdue babies. She also covers induced labours, drugs, other interventions, and c-sections (including how to plan for a positive caesarean).

The baby is born, and Dr Jennifer explores self-care, breastfeeding and

formulas. Then the challenging decision whether to vaccinate or not to vaccinate – Dr Jennifer covers this topical subject including ways to building a healthy framework for the entire family.

As the baby continues to grow into a toddler and then a child, *Well Adjusted Babies* has a comprehensive chapter on healthy food options to support immune systems and development.



With her chiropractic upbringing and background, there's continual reference to the health benefits of chiropractic adjustments for individuals, the pregnant mother and to babies and children. Dr Jennifer's husband Simon Floreani, is our family chiropractor, and I'm testament to the wonderful benefits this treatment has had on my health as well as my children's.

What I love about Dr Jennifer's approach in *Well Adjusted Babies* is that her information is practical and empowering, leaving the decisions and choices in the reader's hands for their own wellbeing as well as their children's.

Author Bio

Mara Dower is a mother of 2, author of *Childbirth Magic*, a Doula and a client at Vitality Group.

Central Coast Maternity Coalition

Presents

Empowering Birth Stories

Come along for an
inspirational morning of
warmth and tenderness as
five couples share their
birth journeys.

Guest Speaker: **Anna Russell**
Doula, Birth Educator.

Where: Berkeley Vale Neighbourhood Centre

When: 09:30-12:30 Sat 16th October, 2010.

RSVP: 8th October (if you need childcare)

Cost: No Charge

Ph: 4362 3990 or 0418 656 221

E-mail: ccmaternitycoalition@gmail.com

**Morning tea and crèche facilities
provided**



NEW SOUTH WALES
AECG
INCORPORATED

This activity is supported by the
Southern Lakes Communities for Children Project.
Communities for Children is supported by the
Australian Government.

BIRTH AFTER CAESAREAN SUPPORT: ONE ORGANISATION'S OFFERING

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

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

Knowledge Not Fear

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

Won't a VBAC Just Be Better?

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

Empowering and Safe

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

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

ADVERTISE IN BIRTH MATTERS

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

birthmatters@maternitycoalition.org.au



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

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

Member notices

Management committee meetings (National)

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

General meeting dates for 2010

This year's Annual General Meeting will be held by conference call on Saturday 23 October at 5 pm Eastern Daylight Savings Time. See the notice on p24 for more information. Other general meetings will be called as required, and members given 14 days notice.

Midwives in Private Practice (Victoria)

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

Choices Victoria

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

Donations

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

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

MC bank account details

Commonwealth Bank of Australia Branch: Ringwood Victoria

Account Name:

Maternity Coalition Inc.

BSB: 063 167

Account Number: 10108586

Postal Address:

PO Box 1190 Blackburn North
Victoria, 3130, Australia

Infosheets

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

Topics include:

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

Birth announcements note

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

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

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

MC online discussion lists and social networking groups

Join an MC email group!

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

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

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

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

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

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

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

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

Find us on



Maternity Coalition Contacts

MC contacts (National)

Office Bearers 2009

President: Lisa Metcalfe
president@maternitycoalition.org.au

Vice President: Makayla McIntosh
vicepresident@maternitycoalition.org.au

Secretary: Georgia Hodges
secretary@maternitycoalition.org.au

Assistant Secretary: Vacant

Treasurer: Nicole Carver
treasurer@maternitycoalition.org.au

Assistant Treasurer: Naomi Campanale

Birth Matters Editor: Kylie Sheffield
birthmatters@maternitycoalition.org.au

Assistant Birth Matters Editor:
Sonia Bartoluzzi

General committee members:

Bruce Teakle
Melissa McFarlane
Sarah Kerr

Other really important people who support our National Management Committee

Membership Secretary: Angela Wallace
memberships@maternitycoalition.org.au

National Peer Support Advisor: Alison Gaffney
mungomagic@dodo.com.au

Mail forwarding: Suzie Anderson
suebert@optusnet.com.au

Webwoman: Emma Davidson & Melissa McFarlane
webwoman@maternitycoalition.org.au

Consumer Representative: Bruce Teakle
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Branch Information

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

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

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

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

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