

# Birth Matters

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Spring 2012

A photograph of a woman lying on a hospital bed, holding her newborn baby. The woman is looking up at the baby with a joyful expression. The baby is wrapped in a pink blanket and has a red hospital band on its wrist. The woman's arm is visible, wearing a blue hospital gown with a colorful pattern. The background shows a hospital setting with blue drapes and medical equipment.

Caesarean sections - not all the same!

**NEW:** Regular columns on childbirth and the law and rural and remote birthing

## This issue:

Cas McCullough on the Birth After Caesarean randomised trial

## PLUS:

Consumer representation - why bother?



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

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**Contribution closing date for December/Summer issue of *Birth Matters* is Monday 22 October.**

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

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**Main Cover Photo:** Elizabeth Guthrie welcomes daughter Adia, born gently by caesarean section.



# From the Editor



On 10 September the *British Medical Journal* published the results of an Australian study into the rates of obstetric intervention among low-risk women. The study, which involved almost 700,000 women, looked at the rate of obstetric interventions for women giving birth in public and private hospitals in NSW. All forms of intervention, including caesarean sections, were higher in the private system<sup>1</sup>.

This on the tails of an Australian randomised control trial into the effects of continuity of caseload midwifery care on caesarean section rates, again in low-risk women. Published in the *British Journal of Obstetrics and Gynaecology* in July, this study found that women allocated to caseload care were less likely to have a caesarean section, more likely to have a spontaneous vaginal birth, less likely to have an epidural, and less likely to have an episiotomy; and that babies born under this model were less likely to be admitted to special or neonatal intensive care<sup>2</sup>.

Earlier this year, responses to the Queensland Centre for Mothers and Babies *Having a Baby in Queensland* survey suggested that it is doctors' recommendations, rather than women's choices, driving the rising caesarean rate in that state—particularly in private hospitals, where 47.9% of births are done surgically. Of the women who gave birth by planned caesarean in public and private Queensland hospitals, only half (52.4%) reported making an informed decision, while just one fifth (19.9%) of those who gave birth by unplanned caesarean felt their choice was properly informed<sup>3</sup>.

Australian women will join the dots that link these studies; the conclusions they draw will help inform their birthing choices. But there is no guarantee those choices will be available or supported until providers, public and private, use these same findings to inform their practice.

## References

1. Dahlen H, Tracy S, Tracy M, Bisits A, Brown C, Thornton C (2012), Rates of obstetric intervention among low-risk women giving birth in private and public hospitals in NSW: a population-based descriptive study. *BMJ Open* 2012;2:e001723 doi:10.1136/bmjopen-2012-001723.
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midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *BJOG: An International Journal of Obstetrics and Gynaecology*. doi: 10.1111/j.1471-0528.2012.03446.x

3. QCMB research examines myths behind Queensland's rising caesarean rates, January 18 2012, [http://www.qcmb.org.au/media\\_releases/menu/media\\_items](http://www.qcmb.org.au/media_releases/menu/media_items).

Kylie

## ARTICLE SUBMISSIONS DEADLINE:

SUMMER - MONDAY 22 OCTOBER  
SUMMER THEME: ANNUAL REPORT EDITION

State and branch reports  
Annual financial report  
AGM report  
The year that was and the year ahead

Articles should be a maximum of 2500 words and be accompanied by photos where possible. Please email submissions to [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au) on or before posted deadline.



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# From the President



Ann Catchlove

I sometimes get a little smug when some new study is released that looks at the advantages of vaginal birth or the disadvantages of caesareans. Of course such smugness is a little misplaced for me. While I had an intervention free vaginal birth for my son (he was even born in his caul), his big and little sisters were both born by caesarean.

My two caesarean births have taught me that not all caesarean births are the same and that the way we treat caesarean mums and babies makes an enormous difference to the experience.

A big difference between my caesarean births was that the second was very necessary while the first was not. It is not, however, that needless caesarean that still makes me cranky over five years later. What fills me with anger and pain is the needless separation from my daughter, Isabelle, for the first hours of her life, due to hospital protocol. I never knew there was any alternative—it was just presented as what had to happen. It was a long separation of one-and-a-half hours for a perfectly well mum and baby. The (expensive, private) hospital was understaffed and it took a while for someone to be available to move me to my room. I never went to recovery, just stayed in theatre while people buzzed around cleaning up. Isabelle was with my

husband, tightly wrapped in blankets, as you can see in the picture below. Her first family contact was with her Dad in hospital scrubs. She pecked at his arm the whole time desperately wanting to suckle.

Thankfully when we were finally together, the midwife was busy and said she would be back to “show us” how to breastfeed shortly. Together, on our own at last, some instinct saw me wave my hungry baby in front of the breast, where she swiftly attached herself and began her long breastfeeding career.

Unfortunately, that wasn't the end of our separation. Isabelle was born just before 7 pm. It was hospital protocol that babies born by caesarean could not room in with their mothers and that fathers could not stay the first night. So Isabelle was taken to the nursery for the night when she was only hours old. I am in tears as I write this because I have just read a part of my hospital notes that I have only skimmed over previously. They say that at 11 pm that night Isabelle was “placed under heater cold.” I never knew that. She should have been warmed by me. We should have been together.

None of this is a unique story. It no doubt happens in hospitals across the country every day. It is “routine care” for many mothers and babies. It's not good enough. These things matter—for women and for babies.

When I realised that my daughter Sally needed to be born by caesarean, the most important thing for me was that we would not be separated. The water birth of my son Dylan, two years earlier, had shown me the beauty of those first minutes of life together and made me realise even more what Isabelle and I had missed. In Sally's case I had to push for it and I'm not sure what would have happened if I had not been very demanding, but we were only separated for a very short time (a minute



Swaddled in the arms of dad Rob

or two at most). We had skin to skin contact on the delivery table. She started to suckle just after they moved me off the table and we stayed together in recovery. We lucked in to getting our own room and the two of us snuggled together all through that first day and night. It was the same outcome but a completely different birth. Of course I was disappointed that the birth hadn't gone to plan but, for me, being together at the start was the most important thing. It made this birth far more like my second birth than my first.

One day I hope that it might be standard care that women having caesareans are not separated from their babies at birth, rather than something that you have to push for. Not something that is dependent on getting sympathetic hospital staff or on whether there are enough midwives working. If we start from the position that all well women and babies should be together after birth then we should put protocols and appropriate staffing arrangements in place to make it happen. From my own experience, I know that it's a worthwhile investment and that it makes a world of difference.

Ann Catchlove



Isabelle's separation from Ann was presented as 'just what had to happen'.



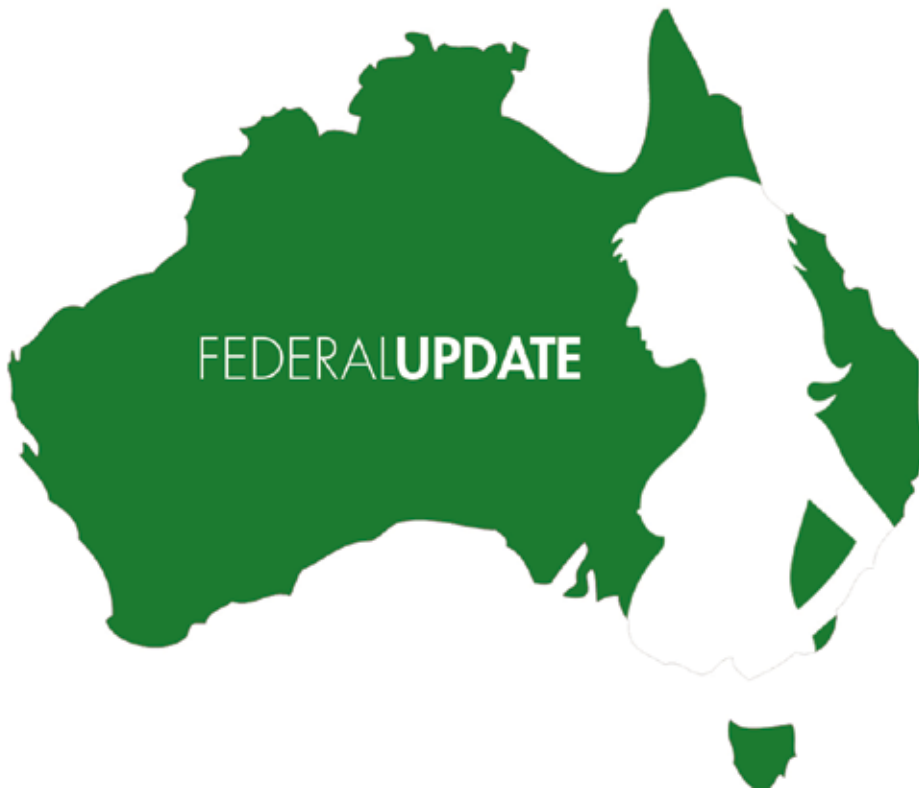
A steadying hand - support from Ann's midwife during Sally's birth



Ann welcomes Sally with immediate skin-to-skin contact

# Federal update

By Ann Catchlove



*After things have been seeming to go nowhere at a Federal level for some time, there has finally been some progress with the Commonwealth midwifery reforms and homebirth.*

## Midwifery reforms

The Standing Council on Health (all of Australia's health ministers) met in August and the Commonwealth agreed that they would amend the requirements for "collaborative arrangements" for eligible midwives. The change means that eligible midwives will now be able to enter into a collaborative agreement with a hospital or health service rather than with a named medical practitioner. This will enable hospital administrators to sign collaborative agreements with eligible midwives and will hopefully mean that it will be easier for midwives to get visiting access to hospitals so that women can choose to birth in hospital with a known midwife. Doctors did have some concerns that signing an agreement would raise liability issues for them. This change should address these concerns.

There is still no requirement for a hospital or health service to enter into collaborative agreements, and there will of course be services that are reluctant to enter into such an agreement. It remains to be seen whether the changes will lead to

a widespread improvement in the ability of midwives to enter into collaborative arrangements.

It's important to note that all Australian health ministers have signed up to the National Maternity Services Plan, which commits that "*Jurisdictions use best endeavours to facilitate the clinical privileges, admitting and practice rights of eligible midwives*" by the middle years, which are now. Queensland remains the only state to have made significant progress on this.

Unsurprisingly, lobby groups representing doctors have been very unhappy with the announced changes, claiming that the safety of mothers and babies is now at risk.

Maternity Coalition welcomes the changes and the willingness of Minister Plibersek to listen to women and midwives about the barriers to the success of the reforms. We are also pleased that the Minister's office has indicated a willingness to consider the issue further if the changes do not improve the situation.

The amendment does not require changes to the legislation but only to the regulation that defines "collaborative arrangements" which is known as "the determination". The Minister's Office has indicated that they will be having a short consultation period for the changes but that they are committed to getting them

through as quickly as possible. Hopefully, by the time you are reading this, the changes will be made.

These changes are purely about access to Medicare benefits and don't affect women's access to homebirth. Despite significant confusion, there is currently no requirement for a collaborative arrangement to be in place for a woman planning homebirth unless she is wanting to access Medicare benefits for antenatal and postnatal care. There is also currently no requirement for a doctor to approve of a woman's decision to have a homebirth.

## Homebirth

Ministers at the Standing Council on Health also agreed to extend the professional indemnity insurance exemption for homebirth care by midwives by two years until 2015. This essentially means that the same arrangements that have been in place since 2010 will continue. Ministers also agreed that WA would develop a paper on longer term arrangements and that this would be presented at the November meeting.

The Commonwealth also convened a stakeholder roundtable on homebirth on 29 June 2012. Maternity Coalition was represented by our Vice President, Bec Jenkinson (and her son Vaughn, who had his poop nappy changed by Minister Plibersek!). The meeting was constructive and was the first consultation focussed specifically on the issues affecting homebirth. At the meeting Minister Plibersek announced that she was recommending to other health ministers to extend the insurance exemption until 2015.

It had been thought that the Commonwealth might consider extending the Commonwealth supported insurance product to cover homebirth, but this has not happened. The extension of the exemption means that the issue of insurance for homebirth is now on the backburner until after the Federal election.

## Going forward?

It seems at this stage that it is most likely that the Labor Party will not win the next Federal election. In order to make sure that the midwifery reforms are not wound back under a possible Coalition government, it is important that local women and midwives start to build relationships now with their local Liberal and National Party members and candidates.



# 2012 AGM

## Notice of 2012 Annual General Meeting Saturday 13 October 2012 Time: 4 pm Australian Daylight Saving 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](mailto: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, and
- 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

President: Ann Catchlove

Vice President: Bec Jenkinson

Secretary: Georgia Hodges

Treasurer: Jen Egan

Assistant Treasurer: Jo Askham

### General Committee Members

Bruce Teakle

Jess Permezel

### Membership Secretary

Bec Telfer

### Birth Matters Editorial Team

Kylie Sheffield (Editor)

Sonia Bartoluzzi (Assistant Editor)

Mara Dower (Design and layout)

Bec Telfer (Distribution)

# In hindsight – the caesarean births of Jackson and Lleyton

By Nicole Seamons



Lleyton in special care

*Having delivered her second daughter Bellah by emergency caesarean, Nicole Seamons wanted to attempt to birth her twin boys vaginally. Maternity staff at her hospital had other ideas. She shares the story of her boys' arrival and explains why she feels it could have been different.*

## The birth

It was a morning like any other. I was 35 weeks pregnant with a few weeks left until our twin boys were due to arrive, and was rushing around getting my six-year-old daughter ready for school. To have reached the later stages of pregnancy with everything going well was a milestone for us after suffering a few previous losses. For a twin pregnancy everything was going as smoothly as we could have hoped, though hospital staff were talking about an early caesarean because twin 2 seemed to have stopped growing at approximately 31 weeks.

On the way home from school I went to my next door neighbour's house with our three year old Bellah. Whilst there I went to use the toilet and discovered I was having what I presumed to be my show. As I had never had one before that I was aware of, I rang the hospital

to confirm. The hospital wanted me in right away for observation. Upon arrival I was immediately admitted and hooked up to the CTG machine.

Contractions were well on the way. They were regular but mild, registering between 30 and 40 on the CTG machine and lasting around 30 seconds each. As the intensity and frequency of my contractions grew, I knew this was it, the real deal. I would be meeting my boys soon.

Because twin 1 was breech and twin 2 was head down, the hospital had already informed me they would not allow me to attempt a VBAC, despite my initial goal to birth the twins vaginally.

The contractions were getting stronger and things were really kicking up a notch, but time after time I was told that I wasn't dilating and to get some

sleep. My body couldn't rest. My body knew I was in labour despite what I was being told. My husband had been told to go to work since they didn't think anything would happen in the next few days—he was working in a remote area more than an hour's drive from the hospital.

After staff shift change, a nurse came in to find me leaning over the bed, mid contraction, panting and gripping for dear life. I had been given a vaginal examination just an hour earlier. She asked how long the contractions had been like this and I told her quite some time. I explained that I had tried to tell the other nurses that this was 'it' but because I wasn't dilating they kept telling me I wasn't in labour. This nurse was fabulous. She looked at my file and said, "No wonder you aren't dilating—the positioning of the babies will make that difficult. If the last nurse had read this she would have been able to help you." She immediately rang to organise the surgeon and called my husband to tell him to come—the boys needed to be born as soon as possible.

Two hours later I was prepped for surgery and wheeled into theatre, still

without my husband Lloyd. At the very last minute just as the surgeon had said to close the door, Lloyd, came racing in. Within half an hour I was a mother to four children. Our boys were born on 6 May 2011 at 7:07 and 7:09 am.

## Afterwards

It took just over 16 hours for me to meet my twins. I needed a blood transfusion after surgery and they were both very sick and admitted to the special care nursery. So I had a lot of time to process the events of the birth and just how much it differed from my original birth plan.

I felt upset, angry and let down by the hospital. I had known I was in labour and tried to tell my carers that. But they had ignored me. My body knows more than any textbook and my body was telling me it was time. I felt disappointed that I wasn't allowed to attempt to birth the boys naturally. I had known for weeks that twin 1 would remain breech as they literally had no more room to move, but I had read up on breech births, watched videos of births involving a breech baby, including some involving twins. I was confident enough that my body could do it, so why weren't the hospital?

It took me quite a few weeks to accept that the birth had gone so wrong. I became depressed. All I had wanted was a VBAC (vaginal birth after caesarean) and my hospital had not allowed it. I was made to feel guilty for wanting one, told my babies would have died and that I was being selfish and stupid for wanting to risk the lives of my unborn in such an irresponsible manner. These accusations made me furious. I had educated myself, spent hours upon hours, days upon days, month after month reading and learning about VBACs with twins—my doula and I had many conversations and I felt confident.

So many things made me angry about the birth; it was hard to enjoy our new arrivals. Obviously it takes a lot of getting used to premature babies and life in special care, but deep down that wasn't my problem. My problem was that the one public hospital I could birth at had failed me. Would it have been different if it was just a straight forward vaginal birth and not a VBAC? Would it have been different if it had been a breech singleton? Would it have been different if it was a head down VBAC of a singleton baby? All these



Lleyton and Jackson with mum Nicole and dad Lloyd

taking you down for surgery now." There seemed to be no question of my consent. What if I'd said 'no'? Could I have refused the caesarean and demanded they prove the twins lives were at risk? When they decided on surgery there was no fetal distress and my babies' heart rates were stable. How far could I have gone exercising my rights to birth my babies the way I wanted to?

In reality I think the hospital staff were intimidated by the situation presented to them. Not only was it a twin pregnancy, but it was a pre-term labour, a breech baby and a mother with a previous caesarean. It was easier and within the comfort zone of the staff to do a surgical procedure instead of letting nature take its course. If we had hired an independent midwife who had experience in similar

births, I still feel we could have had a positive, empowering experience. Of course now we will never know.

“

*So many things made me angry about the birth; it was hard to enjoy our new arrivals. Obviously it takes a lot of getting used to premature babies and life in special care, but deep down that wasn't my problem. My problem was that the one public hospital I could birth at had failed me.*

questions were spinning around; none of them could be answered.

I have been left yearning for the 'perfect birth', the empowering one. I felt the twins would be that. Birthing twins vaginally with one breech would have been a major accomplishment in the current system—a birth to correct how terribly wrong the birth of our three year old went. I wanted to fix that, to feel as though my body was capable instead of feeling like it failed again. I was left feeling empty and deflated.

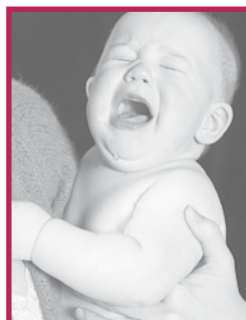
My husband, too, felt disappointed. He had believed and trusted the medical professionals who assured him nothing would be happening anytime soon. He was very emotional at the thought that had he been just a minute later, he would have missed the birth of his sons. Nobody would've been with Lleyton as they had to fight to resuscitate him, while I fought my own battle downstairs after losing almost two litres of blood during the surgery.

Now, if I could go back in time, I would look for an independent midwife who was willing to let me at least attempt to deliver naturally—one who was experienced and equally confident in what my body can do. Financially it would've been a blow to us and would have required many sacrifices. This is why we went against the plan initially. If there is a 'next time' we will certainly be hiring an independent midwife. A VBA2C would give the hospital ever greater reason to object.

Thinking back, I'm not sure I really felt empowered to confront hospital staff when I disagreed with their procedures. It's the way they word things: "We are



First 'twin feed' at two weeks



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# When the personal becomes political

By Genevieve Sayers



Genevieve Sayers

*Genevieve is a mother of four who has experienced care and given birth across all sectors: private, public and home. Her first two births were caesarean sections; these were followed by two vaginal births. Genevieve battled for her choice to have a vaginal birth in her third pregnancy and then, in her fourth pregnancy, was denied the right to access publicly funded midwifery continuity of care. Informed by her personal experiences, Genevieve decided to survey other women about their motivations for and experiences of homebirth after caesarean (HBAC) and here, in an abridged version of her original presentation to the 2012 Homebirth Australia conference, she presents the results.*

The fundamental human right for women to have autonomy over our own bodies means that we should be able to make informed choices as to where, with whom and how we give birth. This is not the current reality in Australia. When I sought publicly funded continuity of care midwifery for my fourth birth, I already knew, from my birth-reform activity, that women with a history of caesarean section were on the exclusion list for entry because they are deemed to carry more 'risk' than normal. I went ahead anyway, because change will not come about unless consumers make their voices heard.

My consultant's decision to refuse my choice of the care that I thought would bring the best physical and emotional outcomes for my baby and for me was

not an evidence-based assessment of risk. It was not possible to put a figure on my supposed 'risk', because consultants have little experience with birth in women like me. This consultant also noted that shared care with my GP would not result in the best possible outcomes for me and for my baby. In doing so they ignored the facts that (a) I would have birthed in the same maternity unit as everyone else, with the same access to emergency care and facilities, (b) I have experienced completely normal, uneventful pregnancies, and (c) I am a well educated, intelligent woman quite capable of making my own decisions. This consultant turned me down, without even assessing my individual circumstances, and would only offer 'a trial of vaginal birth as per the hospital policy', knowing full well that the only other option for one-to-one midwifery care was that provided by an independent midwife and a homebirth.

Given the political changes over the last couple of years, it is becoming increasingly difficult for women in my situation, and indeed for women who have had only one prior C-section, who want to have a subsequent vaginal birth, to make an informed choice, particularly if that choice is a homebirth. For me, the personal is political, because I am astounded and offended that, if I were to have any more children, my right to choice about birth is being eroded.

I believe that women don't decide to have a homebirth lightly. The vast majority of them, particularly those who supposedly carry higher 'risk' than normal, consider their options very carefully and thoughtfully. In an effort to provide evidence about the attitudes and experiences of women who choose HBAC, I have carried out a survey of 53 such women. I asked them about what motivated them to choose VBAC (vaginal birth after caesarean) at home, what obstacles they encountered and how they prepared for their births, as well as how they feel about losing their right to make those choices and what they are prepared to do about it. The results of the survey are presented below.

The survey was distributed through email lists, newsletters and websites such as the Facebook pages of Maternity Coalition and Homebirth Australia, calling for interested women who had planned a HBAC to participate.

## SURVEY RESULTS

### Previous births

All 53 women who responded had planned a HBAC. Of those 53, 43 had had one previous caesarean section and ten had had two previous caesarean sections.

### Age

No one was over 40 or under 25 when she made the decision to HBAC. Overall, more than half (60%) of the women were aged 30 and over. Twenty-one women were aged 25–29 years, 31 women were aged 30–34 years and one woman was in the 35–39 years age bracket.

### Education

More than half (64%) of the women had obtained a university degree or higher. One woman's highest level of education was the end of year 10; three had finished year 12; 15 women had completed education to a certificate/diploma level and 20 to degree level. 14 women had completed postgraduate studies as their highest level of education; none had a PhD.

### Main reason for planning HBAC

The main reason women gave for electing to HBAC was a previous traumatic birth (42%). This was followed by 29% of women who cited being fed up with obstetric care, and 25% who cited the ability to have a midwife of their own choice. Lastly, 4% cited HBAC being recommended by family and friends. There were an additional 16 comments, which centred on not wanting to have another unnecessary caesarean section, the wish to have their choices respected and the desire not to be pressured to adhere to non-evidence based hospital policies.

### How did you come to make the decision to HBAC?

The women appeared to consult widely and to consider a broad range of issues: 49 women stated they weighed up their risk factors; 47 conducted research via books, internet, magazines etc.; 45 consulted a midwife; 30 women weighed up the distance to the nearest maternity unit; 25 considered the time elapsed since their prior caesarean section; nine women had discussions with their GP; six consulted an obstetrician; and one person thought HBAC was a good idea without any other consideration. Fifteen women provided

additional comments. A common theme through the comments was that women talked widely to other women through various organisations about birth experiences and also considered where they were more likely to successfully have a vaginal birth.

#### **Did you encounter any negativity about your choice to HBAC?**

Of the 53 respondents, 49 women reported that they had encountered negativity about their choice and four said that they had not; 34 women said that they lacked support from other family members; 26 lacked support from their GP; 20 lacked support from friends; 18 from their obstetrician; eight suffered from a lack of understanding from their work colleagues; and five from their partner. There were 13 other comments provided by the respondents.

#### **Did you do any of the following to prepare for your HBAC?**

The women undertook a variety of activities to prepare for the HBAC:

- 83% of those surveyed **undertook a birth course** in some form. Of that percentage, 10 attended Hypnobirthing, four Calmbirth, 12 Active Birth, seven Birthtalk course, 23 midwife-facilitated, 10 doula-facilitated, six Childbirth-educator-facilitated, 21 birth-related support group and nine VBAC course.
- 58% of survey respondents attended physical exercise classes and another 9% made sure they got regular exercise, most of which was carried on from pre-pregnancy. So overall 67% of those surveyed **participated in regular physical exercise**. 21 women attended yoga classes, four pilates, four pregnancy exercise and seven aqua aerobics.
- Almost everyone surveyed (96%) **improved their overall education about childbirth**. Fifty women indicated that they read books, 38 watched DVDs, 20 worked through The Pink Kit, 46 conducted research online, and 36 read through magazines and newsletters.
- Overall, 74% of women **consulted a complementary health therapist** in preparation for their HBAC. Twenty-five women saw a chiropractor, 11 a homeopath, 11 a naturopath, 16 an acupuncturist, 14 a remedial massage therapist, two a reflexologist, four a kinesiologist and five an osteopath.
- 71% of all participants **paid extra attention to their diet** during preparation for their HBAC.

- 10 comments were provided about **other preparation**.

#### **What was the outcome of your first HBAC?**

74% of women birthed at home. An additional 9% birthed at home but had to transfer post-birth to hospital. 17% of women birthed at the hospital with 4% being surgical vaginal births and 13% caesarean sections. Twelve additional comments were given.

#### **How might you feel if your right to choose a HBAC with an appropriately qualified and registered midwife was taken away?**

Of the respondents, 41 people indicated that they would be 'angry', 39 'devastated', 20 'upset' and 15 'annoyed'. Eight other comments were made.

#### **If you were not able to HBAC you would...?**

Of the 73 responses given, 41% indicated they would birth at home with an unregistered midwife, 27% would birth at a public hospital, 15% would birth at home with a doula, 14% would birth at home without a care provider or doula and 3% would birth in a private hospital. Fifteen other comments were given.

#### **Is it important to you that you retain the right to choose where and with whom you give birth?**

All 53 participants answered 'yes' to this question.

#### **If yes, what are you prepared to do to retain your right to choose?**

80% of the participants indicated they would attend a rally; 69% indicated that they would visit their local state or federal MP's; 90% would write by letter or email to their local MP; 71% they would lodge a submission to a parliamentary enquiry; 65% indicated a willingness to become involved with a birth reform group such as Maternity Coalition; and 76% said they would become involved with a consumer support group such as Homebirth Australia. No one indicated that they would do nothing. Eight other comments were made.

Additionally, I noted that at least seven women were booked in for hospital VBACs but switched to HBAC at various points during their pregnancies. The common reasons for choosing to switch were being treated poorly / rudely (verbally) by obstetric staff and their straight-down-the-line adherence to VBAC protocols (inflexibility). Two women were in publicly-funded midwifery models but pulled out when it became clear that their

choices were not going to be respected. Several others looked into it but were told they were excluded due to previous caesarean section, so they didn't go ahead and apply.

#### **WHAT DO THE SURVEY RESULTS TELL US?**

The age and education of the women choosing HBACs indicates that these women have good life experience behind them and are also very well educated. Women opt for HBAC because they want to be able to birth in a safe, familiar and comfortable place with a known care provider of their choice who is experienced in normal birth, and who will provide them with evidence-based information and respect their choices. Women do not want to go back to hospitals where they have suffered, where they have not been shown respect for their ability to make informed decisions and where they are cared for by strangers. They do not feel that hospitals are a safe place to birth.

Given their high levels of education, it is not surprising that these women think very carefully about their decision to HBAC. There are many factors to consider and they consult broadly, enabling them to come to an informed decision.

The majority of the women surveyed encountered a lack of support and understanding from family, friends and the medical profession. The prevalence of misinformation and myths in the community about both homebirth and VBACs means that women who seek HBACs, which combine the two, find it a very lonely and unsupportive place. A few of the women who cottoned on to this fact decided not to tell other people about their choice, which enabled them not to have to deal with all the negativity.

Almost all the women who participated spent time in one way or another preparing for their HBAC. So we can conclude that most women take the time to prepare well for their HBACs. One could even say that solid preparation, along with care from a known provider in a comfortable home environment, helps to reduce their supposed medical 'risks'.

The outcomes from these first planned HBACs were very good. Of the women that had to have a caesarean section, none related to the issue of scar rupture. Several women who had repeat caesarean sections went on to have subsequent babies vaginally at home. Two women free-birthed: one with a doula and one without, after they were unable to find midwives willing to take them on.

When asked how they might feel if their right to choose a HBAC with an appropriately qualified and registered

midwife was removed, women clearly expressed a range of negative emotions. This is only natural, given that so many of us have had such wonderful birth experiences at home, after taking great care about making that choice and putting a lot of effort into preparing for it. It is of great concern to me, and should be to all of us, that many women indicated that they would birth at home with an unregistered provider, a doula or no one at all. Although several did say that choosing the place of birth would depend on several factors (including any health issues during that pregnancy, ability to get into public continuity of care models and availability at that time to find an

experienced, registered practitioner). Sadly, a couple of women indicated that they would not have any more children if this option were not open to them.

All the women indicated that it was important to them to retain their right to choose and are prepared to do this in a variety of ways. Some said that, though they wish to become more involved, they just found it too difficult while in the throes of having babies and small children. Some also said that they had done all or many of the items listed but were very disappointed that little had changed and, in fact, the situation had become worse. As someone who has been involved in birth reform work now for a while, I

believe that it is important to encourage people to continue to make contributions and have a say, no matter how small or how infrequently that occurs. It can be as simple as telling other people about your experiences. It is extremely important for all voices, loud and quiet, to join together to make one big noise. It also important to make people aware that birth reform is going to be a very long process. Change happens very slowly and sometimes seems to go backwards, so it is imperative that we are persistent and keep on going.

In summary, life is about balancing risk. It is also about taking into account different points of view when making a decision. Women make decisions for

their children right from conception and have to weigh up risk every step of the way. The women choosing HBAC are well educated, take time to carefully consider their risks, consult broadly, prepare well for birth and choose care providers that they believe will provide the best care for their family resulting in the best possible physical and emotional outcomes.

Medical professionals need to understand that their use of 'doom and gloom' obstetrics and their obstinacy in allowing VBAC woman access to midwifery continuity of care models is pushing women who look to hospital care as their first option, away into community midwifery care. It is very frustrating that they largely care for women on a 'one size fits all basis', when we are all individuals. It is also exasperating that they and many others believe that their medical viewpoint is the only correct one.

Women are unhappy that their right to choose their care provider and place of birth is at risk. Restricting homebirth to 'low-risk' women is completely unacceptable and does not solve the problem, as we have seen that many women will instead to choose to birth without appropriately qualified and registered care providers. They have indicated that, for them, the personal has become political.

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## Child protection and your unborn baby

By Ann Catchlove



Ann Catchlove

A question I am commonly asked is whether it is possible for a hospital, doctor or midwife to report a woman to Child Protection for the decisions that she is making in her antenatal or intrapartum care.

While it is certainly possible for a report to be made, and even, in some cases, for Child Protection staff to initiate and investigation, there is actually no power in any state or territory of Australia for

Child Protection services to take action in relation to unborn children except as detailed below. The legislation is different in each state and territory so this information is of a general nature only.

There are provisions in each state and territory of Australia that enable Child Protection services to intervene in situations where children are at risk of harm and where a child's parents are failing to protect them from harm. While I am not suggesting that any mother intends harm to her unborn baby, this is how third parties may sometimes perceive women's decisions around their maternity care. These provisions do not apply to unborn children. It remains the position in Australia that an unborn child has no legal rights relative to its mother.

There is legislation in most states providing for reports to Child Protection to be made for an unborn child if there is significant concern for the wellbeing of a child *after* its birth. This does not cover the situation before birth and, hence, the

decisions that a mother makes about her antenatal or intrapartum care.

In some states a failure to engage in adequate prenatal care is considered one of the indicators that a child might be at risk of being abused or neglected after its birth. A woman who has not engaged in prenatal care or has not had documented care may find this used as a reason for Child Protection to intervene after birth.

The legal situation changes after a child is born, and there is greater potential for the involvement of Child Protection services. Parents who are being threatened with a report to Child Protection or who have been reported for the decisions they are making about their newborn child's healthcare should seek legal advice as a matter of urgency. The Legal Aid service in your state is probably a good place to start.

*Disclaimer: This information is of a general nature only and does not constitute legal advice. If you need more specific information about this issue you should consult a lawyer.*

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# In the place I least expected it – Adia's birth story

By Elizabeth Guthrie



Elizabeth and Wally as the doctor begins the incision - Elizabeth is 'deeply relaxed'

*When Elizabeth Guthrie found herself preparing for the caesarean she had sworn she would never have, she remained determined to birth her baby as naturally and gently as possible. She explains how a clear birth plan, an open minded obstetrician and a great support team helped her to beat the odds and achieve a beautiful and empowering birth.*

After sustaining a fourth degree tear during the birth of my second daughter and undergoing major surgery soon after her arrival, I was unceremoniously told at my six-week check up that my obstetrician would never support me in another vaginal birth and that I would struggle to find anyone who would. I drove from Nambour to Brisbane in tears and announced to my husband Wally that two children would be it for us because I would never have a caesarean. Ever!

Fate clearly had different plans and in early in 2011 we discovered I was pregnant with our third baby and I was staring down the barrel of that caesarean I was never going to have. I did not like the view! I spoke to four different obstetricians, three midwives, a specialist physiotherapist and an extremely accommodating doula on my quest to find someone, anyone who would tell me I shouldn't have a caesarean. Their opinions were divided. So I read sketchy research until my eyes hurt and ingested so much personal opinion it made my head spin! After a great deal of soul searching I grieved the calm, fearless vaginal birth

checking anything remotely 'natural' or mother/baby focussed at the door. I was at the mercy of the 'system' it seemed. And because I was choosing to have a caesarean, I had no grounds for complaint. I felt this was the message from the medical fraternity but also from women who advocate for birth reform.

I refused to be railroaded into a horrible birth just because it was going to be in an operating theatre. This was the only birth this baby was going to have and while I could do something about it, it was going to be amazing.

I made a list of all the things that were important to me in a birth of any kind and set about trying to find an obstetrician who would help me achieve as many of them as I could. Dr Pauline Joubert was recommended to me by a friend and was everything I was looking for. Passing the first test, she didn't treat me like a complete loony or with contempt when I proffered a whole lot of statistics and information and a copy of a 'Natural Caesarean' video with a Post-it note on the front that said "This is what I want!" From the start Pauline openly admitted many of the things we wanted in our caesarean were a diversion from her usual processes, but she was open to trying new things and had no problem challenging her existing ideas. There was no ego at play and at all times Wally and I felt like we respected and listened to.

At 32 weeks Wally and I met with Melissa Spilstead from Hypnobirth Australia to do a half-day private

I dreamed of having and headed down the caesarean path I had so dreaded.

I quickly learnt that despite the frustratingly slow pace of birth reform in Australia, vaginal births have come a great deal further than surgical births.

Everyone I spoke to seemed resigned to the fact that having a caesarean birth meant

hypnobirthing class, specifically designed for a caesarean birth. Melissa was integral in helping me address and work around my fear of being in an operating theatre to have a baby, and the associated claustrophobia, lights, noise and machines. Not to mention the needles! For the reminder of my pregnancy I practised actively shutting down my mind and my body in deep relaxation and from time to time Wally and I practised our hypnosis scripts.

At 39 weeks, one day before my surgery space was booked, I started having contractions at my local shopping centre. I headed home, parked my three year old in front of the TV, went to bed and hypnotised myself out of being in labour! After months of hoping that I'd go into labour at home and have a baby in 30 minutes on my bathroom floor, here I was talking myself out of labour! Pauline and I had worked so hard to get a great team of people around us to achieve this great birth, there was no way I wanted to mess with that! By evening my contractions had disappeared and I spent the evening dancing my enormous belly around the lounge room with my big girls.

On the morning of Adia's birth Wally dropped our big girls to school, we had breakfast together; I had a shower, put on a nice dress and my beautiful necklace of blessingway beads and we calmly drove 4km to the hospital (via our shop and the bank!). It was so very different (and much stranger) than the amniotic fluid, old t-shirts and manic 100km drive to the birth centre with our other two! It wasn't until we arrived at the hospital that I started to feel nervous. We were shown to our room and given the run down on procedures.

Our birth plan was of great interest to almost every nurse who opened our file and we received all kinds of comments, ranging from "Wow I wish I was assisting with this birth" to "You realise you won't be able to do most of this?" Wally calmly explained to each one that Pauline, our anaesthetist and our paediatrician had approved everything and we just needed them to be aware of what our requirements were.

About an hour before I changed in to my own gown, which was specifically designed for surgery with snaps down the back and access to the shoulders, (but was pretty and smelled familiar), Wally began to read my preferred hypnosis script and



I quickly fell into a deep hypnotic state. Things didn't quite go to plan when Wally inadvertently bought me out of the hypnosis at the end of the script (perhaps a little more practice would have served us well!) and I 'awoke' a stressed screeching mess with only 10 minutes until we had to head off to the operating theatre. We asked Pauline for a little more time to gather ourselves and Wally (nervously) set about re-hypnotising me. This time he didn't wake me up! When it was time for us to leave our room, I was calm and alert but not at all afraid or nervous (and not even a tiny bit stressed and screeching).

Hypnosis works differently for everyone but for me it acted like a buffer zone between my subconscious and my conscious mind. Hypnosis allowed me to acknowledge the things that frightened me and then use deep breathing to move past the fear (or pain).

When I walked into the operating theatre my first thought was "Wow they actually turned off ALL the lights – that's better than I expected!" I saw the bed (and thought there was no way I would fit on it, it was way too skinny!), the chair for Wally, an IV pole and Pauline. It wasn't until I looked at the photos afterwards that I realised there were about 10 other people in the room and a myriad of equipment that I just hadn't registered. I was relaxed and chatty and remember making a few jokes about everyone's outfits!

When our anaesthetist, Mike, helped me up onto the bed I was immediately quiet and fell into a zone which felt similar to being deep in labour, when all you can concentrate on is relaxing before the next contraction (only minus the contractions). The lights were still low and Janet Rabin's Birthnotes was playing. The familiar music helped me breathe through any fear and keep my body completely relaxed. As various drugs were administered I rattled off my name and date of birth in a monotone and with my eyes closed. Wally says there were a few strange looks being passed between the theatre staff at that point, especially as it looked like I was asleep at the point where most people start crying and shaking! The spinal needle went in quickly and easily and as the drugs started to take effect, Mike helped me lie down and a low drape was put up around the level of the bottom of my ribs (low enough that I could have lots of space to do skin to skin with my baby). I'm quite claustrophobic and the idea of having high drapes over my face was something I was that frightened me. I'd initially asked for no drapes at all but

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*I did not end up in surgery by way of grief or trauma. I did not go in to a caesarean after days of labour with my baby or myself in a critical condition, afraid or in crisis. Both my baby and I were healthy. However there are a few things that I believe are fundamental to any birth that are glaringly absent from 'standard' caesarean births, be they planned, unplanned or an emergency. These are consultation and trust, respect for the birth space (quiet voices, respectful conversation), immediate skin to skin contact (unless medically unachievable) and the presence of more than one personal support person.*

realised as soon as I was in surgery why Pauline had insisted they be there—it's a pretty cosy work space down there!

Despite the room being full of people, everyone was so incredibly quiet, calm and respectful of our birth space. Yet at the same time the room was charged with an amazing energy. I felt that things were happening slowly and in progression and nothing was being rushed. The overhead operating light was switched on and as theatre staff prepped me Wally was seated behind me stroking my hair and speaking softly to me. Mike, our anaesthetist was quietly explaining to me what was happening and telling me what I could expect to hear or feel before it happened. I knew that hearing the suction start and

knowing the incision was being made, would be my first major challenge. I managed to take a huge breath and drop to a deeper level of relaxation.

Pauline started to quietly describe what she was doing. As she made the incision a huge gush of amniotic fluid sprayed up into the air and was followed almost immediately by a bottom! We'd planned to have Pauline slowly 'walk' Adia out rather than pulling her quickly—that would allow her to be born calmly and slowly whilst encouraging her lungs to squeeze out the amniotic fluid in a similar fashion to a vaginal birth. Adia had other ideas and was in quite a rush to get her bottom out into the world! Given her breech presentation, Pauline was able to ease her legs out and then drape them over my right side, which enabled gravity to pull the rest of her body and head out very, very slowly. I thought I would want to watch my baby being born but when the time came I felt so safe and comfortable in my 'zone' that I simply just stayed where I was, breathing deeply, listening to the music, with my eyes closed and one hand on the drape! The tugging sensations of Pauline helping her head out were strange but as soon as they stopped I knew my baby had been born and I immediately came out of my hypnotic state and opened my eyes.

The next few seconds happened in a blur. The drapes had been completely lowered and I looked up to see Pauline holding our (enormous) baby curled up in her hands and smiling at me with tears in her eyes, saying, "You did it!

Your beautiful baby is here!" I burst into tears and started sobbing, "Look what I made. I made a baby!" I looked over to our student midwife who was taking photos and video and she was in tears. I looked at Wally and he was in tears. Mike was holding my hands to stop me from instinctively reaching down to bring my baby up to me! Whilst Adia had her cord cut and was handed to the midwife, Wally and Mike helped unsnap the shoulders of my gown so she could be placed straight on my chest, skin to skin. Our paediatrician, David, checked her on my chest and she was given oxygen and her apgar tests from there. Almost instantly she closed her eyes and went back to sleep (as if being born had just disturbed her for a moment). No other weights or measures were taken until the next day.

Adia stayed on my chest the entire time I was in surgery and only went to Wally for a few minutes whilst they moved me from the theatre bed to the bed that would be my 'home' for the next few days. She was back on my chest in recovery where she had her



Elizabeth and Adia in recovery



first (text book, baby led) breastfeed and stayed for the next 24 hours or so.

I am keenly aware that most people don't have the luxury of choosing to have a caesarean birth with the benefit of time and resources to plan the intricate details. I did not end up in surgery by way of grief or trauma. I did not go in to a caesarean after days of labour with my baby or myself in a critical condition, afraid or in crisis. Both my baby and I were healthy. However there are a few things that I believe are fundamental to any birth that are glaringly absent from 'standard' caesarean births, be they planned, unplanned or an emergency. These are consultation and trust, respect for the birth space (quiet voices, respectful conversation), immediate skin to skin contact (unless medically unachievable) and the presence of more than one personal support person.

Our "natural caesarean" birth showed that with very little effort, but a whole lot of open mindedness, these fundamental things are very easy to achieve.

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*Despite the room being full of people, everyone was so incredibly quiet, calm and respectful of our birth space. Yet at the same time the room was charged with an amazing energy. I felt that things were happening slowly and in progression and nothing was being rushed...as theatre staff prepped me Wally was seated behind me stroking my hair and speaking softly to me.*

We change the face of birth one baby at a time. I hope Adia's birth helps just one woman to have a calm and empowered

birth they may otherwise have missed. Pauline now offers many of the things on our birth plan as standard practice in her planned caesareans and, when I last spoke to her, was considering integrating some of them into her emergency caesarean births.

My anaesthetist was fascinated at how hypnosis and drugs could work together to produce such awesome results. And our paediatrician continues to advocate for immediate skin to skin as optimum for every birth.

When I picture the 'perfect birth' I have to admit I still don't imagine an operating theatre. What I do imagine is low lights, quiet voices, respectful and trusted medical staff and support people, my husband's arms wrapped lovingly around me, my baby being gently welcomed into the world in an atmosphere of joy and love. I imagine feeling strong and calm and fearless. I feel so very blessed that I have experienced such a birth. I feel so very blessed that I found extraordinary joy in a place I least expected to find it.

## 'Look into my eyes'... Hypnotherapy for caesarean birth

By Melissa Spilsted

Birth is the end result of a very complex process: the birthing mother has already done most of the hard work involved in creating a new life—months of growing limbs, organs, eyes, even hair follicles. Actual birth is 'the icing on the cake'. Birth is a miracle and can be transformational, and I believe that each woman, *however* her baby comes into the world, is entitled to have a beautiful, calm birth experience as she meets that precious baby for the first time. I passionately believe that this is each woman's own birthright.

Sometimes, caesarean delivery is the safest route out for babies, and the safest route for the mother. We are very fortunate to have a wonderful quality of medical care in Australia and lucky to have options. However, unfortunately, there can be stigma associated with birthing via C-section. The judgement of 'too posh to push' causes untold upset to the women who need to birth this way as a result of all types of special circumstances, both physical and emotional. As a clinical hypnotherapist, HypnoBirthing childbirth educator and natural birthing advocate, my philosophy is *positive* birthing—whatever way our babies come into the world.

Knowledge is power. When parents are armed with knowledge, preparation and some tools and techniques to assist them in their journey, the caesarean birth of their baby can be one of the most magical, beautiful experiences in their lives. It is important for mothers to feel a degree of control over the circumstances of the birth. If a mother feels disempowered, this can have physiological effects on her body and mind, sometimes affecting her entire life. To this end, I have developed a special *Preparation for Caesarean Birth* program that incorporates the same techniques that I have taught over the years for natural birthing: relaxation, breathing, visualisation, *self-hypnosis* and education. This program also informs parents of possible birth choices (that can be negotiated with their caregivers) for a more family-friendly caesarean birth.

At this point I should probably explain what hypnosis is. The common public perception of someone saying, "Look into my eyes... you are feeling sleepy", carries connotations of weird external control. But, in fact, all hypnosis is self-hypnosis and we are all in a hypnotic state many times every day—it is a natural state of relaxed concentration and focus. What



an individual experiences in hypnosis is similar to the daydreaming or focusing that occurs when they are engrossed in a book, staring at a fire, or driving a car. They are still fully in control, but their mind is focused on something else. This is a modified state of consciousness—a mild hypnotic trance. Hypnosis enables us to focus our attention on a particular point through eye fixation, progressive muscle relaxation, visualisation or the retrieval of a pleasant memory.

A number of studies have shown that hypnosis can reduce the perception of pain. These studies have included PET (imaging the brain with position emission tomography) and MRI (functional magnetic resonance imaging). Some researchers believe that hypnosis prevents information from reaching the higher cortical regions of the brain that are

responsible for the perception of pain. Others believe that it permits a better response to pain by activating pain-inhibiting paths more effectively. Perhaps it is a combination of the two. According to Professor Fabienne Roelants from the Department of Anaesthesiology at the Cliniques Universitaires in Brussels, Belgium, "There is still a lot of debate around the exact mechanism that allows hypnosis to reduce pain perception; but what it absolutely clear is that it does so." (See <http://www.sciencedaily.com/releases/2011/06/110613012819.htm>). It is clear that, for caesarean births, this can be of great advantage during the administration of anaesthesia, during surgery and throughout the recovery period.

I use hypnotherapy to assist a mother to release any fears that she holds, so that she can approach her birth without reservations, thus reducing and/or eliminating stress and tension. We are all familiar with the effect that tension can have on our body and mind. After a very difficult day, for example, you may become aware of physical indicators of stress such as a sore neck or shoulders, a headache, grinding teeth, or a churning stomach. Whenever we have a thought, there is a corresponding physiological change in our body. If a woman is stressed and tense leading up to and during her caesarean birth, this will have an effect on her mind, body and her baby. Similarly, when we are fearful and scared, the 'fight or flight' response is triggered and blood is redirected to our defense systems. If this happens in a birthing woman, oxygenated blood is directed away from her uterus and her baby. Whatever type of birth a woman experiences, it is important for her to remain calm and continue to breathe.

During hypnosis, the body relaxes and thoughts become more focused. Hypnosis lowers blood pressure and heart rate and changes certain types of brainwave activity. With these deep relaxation techniques, mothers can be more relaxed when receiving spinal or epidural anaesthesia and awake and calm throughout the birthing process. In this relaxed state, mothers are highly responsive to suggestions from their birth partner. In the time leading up to the birth, I teach the birth partner to 'condition' the mother with 'anchors' (where the mother instantly relaxes to a particular type of touch), trigger words/phrases and other hypnosis scripts/visualisations. These can then be used pre-surgery, during the birth and afterwards.

My approach enables mothers, at the moment of birth, to completely shift their focus to fully experience all the

intense feelings and sensations of the miraculous moment and begin to bond immediately with their baby. I find that these techniques result in babies who are very calm and alert from birth. I believe that a gentler and more positive birth experience for the mother is sure to have an effect on the newborn. A positive birth experience also sets the mother up well for parenthood. There is much debate surrounding this issue, but many experts suggest there is a strong correlation between traumatic birth experiences and postnatal depression.

Breathing and relaxation techniques can also be of great benefit after surgery to assist with recovery. Many mothers who have used these techniques have reported a need for less pain relief after the birth than usual.

However a baby enters the world, their birth should be a positive experience for all involved. By creating this program especially designed for caesarean birth, I hope that more women and parents will have the opportunity to experience just how beautiful and transformational the birth of their baby can be, making it an experience they will never want to forget.

*The Preparation for Caesarean program is available to parents everywhere via personal Skype sessions or in person. Contact Melissa Spilsted—HypnoBirthing Australia for more details.*

*Melissa's popular relaxation childbirth CD Surge of the Sea also helps to prepare mothers*

*for a calm, positive birth experience (natural or caesarean). In addition to this, Melissa is releasing a new CD in November this year that is specifically dedicated to caesarean birth: Caesarean Birth—Calm and Relaxed. These CDs can be used for relaxation throughout pregnancy, during birth and for recovery afterwards.*

*Albums are available for mp3 download through iTunes or [www.hypnobirthingaustralia.com.au](http://www.hypnobirthingaustralia.com.au). CDs are available for retail purchase and for retail stock/distribution. [melissa@hypnobirthingaustralia.com.au](mailto:melissa@hypnobirthingaustralia.com.au) Ph: 0439 737 739*

### Author Bio

Melissa Spilsted is a Clinical Hypnotherapist (Clinical Member of the AHA), qualified Teacher (B.Ed, B.Arts), HypnoBirthing Childbirth Educator (HBCE) and founder of HypnoBirthing Australia. She runs a busy Hypnotherapy and HypnoBirthing Practice based in Brisbane and the Gold Coast. Melissa is married to Stephen and they have three beautiful boys (aged 3, 4 & 7), who were all birthed using hypnosis techniques. She has lectured midwives and midwifery students in universities and hospitals and her work has been showcased at the Royal Society of Medicine in London. In addition to this, Melissa has recorded popular childbirth hypnosis albums, the most recent being 'Surge of the Sea', which is available on iTunes.

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# The ICARIS Trial: Impact on Caesarean Section Rates Following Injections of Sterile Water

By Natalie Dos Santos

One in three women will experience continuous lower back pain in labour (often referred to as 'back labour') that may persist during the normal resting phase of labour contractions and be severe enough to significantly influence the women's choice of analgesia. For many women options such as narcotics and epidurals may not be acceptable due to actual or perceived side effects, cultural considerations or availability. Sterile water injections (SWI) are used in some hospitals to help relieve back pain in labour. SWI has been shown in a number of studies to provide significant relief from back pain for most women. SWI are a simple and non-pharmacological alternative that provide effective pain relief for back pain in labour, and apart from the initial pain of the injections, it is free from side effects for mother and baby. Sterile water injections were first demonstrated to provide analgesia in the late 19th century, but fell from use with the development of modern analgesics. The procedure was 'rediscovered' in Northern Europe in the 1970's and adapted for relieving back pain during childbirth. However until recently, the procedure remained largely unused outside of Scandinavia. The mechanism for the pain relief is likely to be related to 'gate-control' theory, whereby stimulating one set of nerves blocks the pain transmission from another.

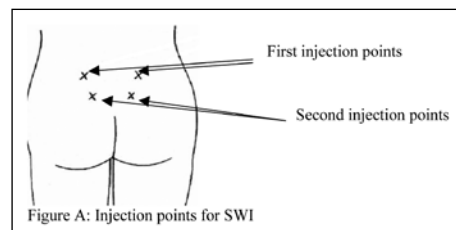
## Pharmacological Analgesia

Although epidural anaesthesia remains the most effective form of analgesia available to women in labour, substantial evidence links epidural use to labour complications such as the baby remaining in an occipital posterior position (i.e., the baby's spine facing towards mother's spine) and subsequent slow progress in labour requiring augmentation of labour with oxytocic drugs. Epidural anaesthesia relaxes the pelvic floor muscles, disrupting the normal birth mechanisms that would otherwise help a fetus to birth normally. Another complication of epidural anaesthesia is urinary tract infection (UTI) due to the requirement for catheterisation. Furthermore, injectable pain relief such as pethidine and morphine can sedate both mother and baby. Alternately, sterile water injections are a non-pharmacological option that can provide back pain relief during labour without the issues related to epidural and narcotics.

## Sterile water injections as pain relief for lower back pain in labour

SWI into the lower back can provide pain relief to women experiencing lower back pain during labour, although there is still uncertainty about the effectiveness of this intervention on the improvement of clinical outcomes. A sterile water injection, results in a brief (15-30 second) but significant painful sensation that is generally well tolerated by women. The onset of pain relief follows almost immediately in the majority of women and can last for up to two hours. The procedure can be repeated a number of times.

The procedure involves injections of very small amounts of sterile water (0.1 ml) under the skin at four points surrounding the lower back (see diagram A). SWI has not been associated with any adverse side effects and does not affect the fetus. SWI can also be safely used alongside any other form of natural or medical pain relief.



## The ICARIS Trial

The ICARIS trial is being conducted by the Midwifery research Unit, a collaboration between The Mater Medical Research Institute and The Australian Catholic University funded by the National Health and Medical Research Council (NHMRC). The study aims to test the effects of SWI on the rates of caesarean section birth. Some previous studies have suggested that women who receive SWI may be less likely to require a caesarean section, although it is not clear if this is because they received SWI or because of other influences in the labour process. A large study, such as the ICARIS trial, will help to answer this question.

Previous research suggests that the best approach is to compare SWI to a placebo such as normal saline (a weak salt water solution), that is commonly used to mix medications given by injection. When used in a similar way to SWI, normal saline provides only a very brief period of pain relief, or the woman in labour may not experience any pain relief at all. We are using normal saline as a placebo because

it has been used successfully this way in previous SWI research. Comparing groups who receive a 'real' treatment (sterile water) to those who receive no treatment, or a placebo (normal saline) is considered the best way to assess if a treatment works, or if it has a particular effect.

The study will involve 1866 women presenting to the birth suites of six hospitals across QLD and NSW (i.e., Mater Mothers' Hospital Brisbane; Royal Brisbane and Women's Hospital; Nambour Hospital; Townsville Hospital; Ipswich Hospital; and Royal Women's Hospital - Randwick). Women in labour, at term, and experiencing back pain during their labour will be invited to participate in the trial. Following informed consent, women will be randomly allocated to receive either the SWI treatment group or the Saline (placebo) group. The study is a randomised, double blind trial, which means that midwives, doctors and researchers will be unable to choose the group or, have knowledge of which treatment is received. Pain scores will be measured prior to and at regular intervals for two hours following injection using a visual analogue scale (VAS), a 10cm line representing "no pain" at zero centimetre and "worst pain imaginable" at ten centimetres. Follow up questionnaires will also be administered the first day after the baby's birth, and two months later.

The ICARIS Trial will be the first clinical trial large enough to determine if the use of SWI will assist in the reduction of Caesarean Section rates. There is limited information about analgesic and epidural anaesthesia use following sterile water injections in labour. Finally, we will also look at whether use of SWI can reduce overall costing for the birthing process.

It is expected that the ICARIS trial will make a significant contribution to the evidence supporting SWI and through providing a best practice, evidenced based technique for SWI offer an effective alternative to the relief of back pain in labour that is free of side effects and will assist in addressing consumer demand for low intervention analgesia strategies.

If you would like further information on the ICARIS Trial please contact:

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# Vaginal breech birth in Australia

By Rhonda Tombros



Rhonda and baby Matilda,  
her inspiration for BBANZ

If you have recently learned that your baby is presenting breech (when the buttocks or the feet are at the bottom of the uterus rather than the head), you are likely to be feeling upset and confused. Regardless of how straightforward your pregnancy has been to date, your maternity care providers are likely to offer only planned caesarean section (PCS) at 38 or 39 weeks if your baby does not turn.

I have first hand experience of the 'breech situation', having learned in the 32nd week of my first pregnancy that my baby was breech. I was new to Australia and I had already established that my own understanding about the best way to approach childbirth conflicted with the highly medicalised system here. However, I had experienced a 'normal' pregnancy and I was expecting a 'normal' birth and so I assumed that the conflict I sensed would never manifest. I was extremely upset when I realised that if my baby did not turn, I would thereafter be treated as 'high risk' and that a PCS would be recommended.

I attempted all the usual tricks to turn my baby (see [www.spinningbabies.com/baby-positions/breech-bottoms-up](http://www.spinningbabies.com/baby-positions/breech-bottoms-up)), unsuccessfully. Then, at 37 weeks, External Cephalic Version (ECV)—a procedure in which a doctor attempts to turn a baby manually from the outside—was attempted and failed. I realised that not only would I be offered PCS but that no provision was in place for my refusal—Australia's largest specialist maternity hospital simply didn't cater for planned

vaginal breech birth (VBB). This was particularly frustrating as I learned that there were several obstetricians on the staff who were supportive of and experienced in VBB but that these people could not be on call for me. If they were there on the day, I might be allowed a trial of labour. If not, I would probably be pressured into a caesarean section.

Whilst VBB has traditionally not been seen as problematic, in the latter part of the 20th century, the practice has become rare. This is especially since the Term Breech Trial (TBT), a multi-centre randomised controlled trial, which supported the practice of PCS for breech presentation. The TBT quickly led to a change in obstetric policy throughout the world (despite the fact that the follow-up study two years later showed no long-term differences between the PCS and planned VBB groups, leading the authors to conclude the PCS does not lead to a reduction in the risk of death or neurodevelopmental delay at the age of two).

However, despite its profound impact, the TBT was not the last say on the management of breech presentation. It has been criticised in terms of its methodology (including VBB in conditions which were too risky), its conclusions (attributing neonatal harm to mode of delivery rather than to inappropriate management), and the way it has been applied to obstetric policy (automatic PCS rather than improving VBB conditions). Furthermore, other studies have shown that for good candidates, the outcomes of carefully managed VBBs are usually as good as those of PCS. One often-cited study, PRE-MODA, which had larger numbers than the TBT and was better controlled, showed no significant difference in neo-natal outcomes between planned VBB and PCS. And, importantly, women still demand the opportunity to give birth to their babies vaginally.

Part of the reason few maternity care providers offer VBB is that they do not possess sufficient skills and experience with VBB and are therefore unable to support it safely. In a large maternity hospital, for VBB to be 'on offer', a significant number of staff need to be trained in it. It is generally accepted that the safety of VBB is affected by the skill of the birth attendant, who should know not to intervene in the birth unless absolutely necessary. If assistance is necessary, the

birth attendant needs the judgment and skill to assist in just the right way. VBB has traditionally taken place with the woman in lithotomy position (on her back with legs in stirrups), with an automatic episiotomy and a forceps delivery of the after-coming head. Although it is now thought that this is not the best way to deliver breech babies, unfortunately, very few birth attendants have received training in modern breech birth technique.

It is clear that VBB is a better option for the mother in terms of recovery from the birth, ability to care for her newborn and, most importantly, for her future pregnancies. Caesarean section also carries a small risk of maternal death, which appears to be under-acknowledged. Also 'swept under the carpet' by the focus on short-term risk to the fetus is the impact of PCS on the mother's psychological wellbeing. Some studies also suggest that babies benefit from the experience of labour. Taken together the research supports the view that VBB may be a good option for some women, but only if a supportive and skilled care provider can be found.

The factors which are often cited as making somebody a 'good candidate' for VBB include frank breech (bottom-first, legs extended) or complete breech (bottom-first, legs crossed) presentation, flexed or neutral fetal head, estimated fetal weight of 2500-4000g, normal amniotic fluid volume, normal pelvic proportions and no other contra-indications to vaginal birth. Some care providers will only support VBB for second or subsequent pregnancies. However, assessment should be individualised as birth is a complex phenomenon (which is the basis of one criticism of the TBT) and so these factors should be seen as guidelines and not criteria. Management in labour typically involves continuous electronic monitoring, and requirements that progress is 'normal', and that the active second stage (in which the woman is pushing) takes no more than 60 minutes. Induction or augmentation of labour are inadvisable for breech presentation and so in the absence of spontaneous labour, or if the labour is not progressing well, it is common for a caesarean section to be advised.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists takes a fairly open approach. Its statement on the

management of breech presentation maintains that “while it is true that women with breech presentation at term will most often be delivered by caesarean section, management should be individualised. The term breech trial did not have the statistical power to meaningfully analyse subgroups, some of which are likely to be pregnancies that do extremely well with breech vaginal delivery.” It is disappointing that this approach is not followed through in practice, as few hospitals or obstetricians offer individualised assessment of suitability for VBB.

When I learned that my baby was breech, I spent a lot of time researching VBB. The idea that I would plan a caesarean birth simply did not gel with me. I do understand that caesarean section is normally a very safe procedure and can save the lives of women and babies in certain circumstances. But in my view, it is a procedure that should be kept for emergencies. I did not consider myself to be facing an emergency—my baby was simply presenting bottom-first. In fact, apart from the fact that it was my first pregnancy, I was an ideal candidate for VBB. I felt let down by the public health system, which I believed (and still believe) should have gone to greater lengths to support me in my choice to birth my baby vaginally. I felt alone—like I had somehow fallen through the support net, having not taken the ‘usual’ route of PCS. I cannot put into words the level of stress my husband and I felt towards the end

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*I felt alone—like I had somehow fallen through the support net, having not taken the ‘usual’ route of PCS. I cannot put into words the level of stress my husband and I felt towards the end of my pregnancy. And it was completely unnecessary. I should have been supported in my (very well informed) choice to labour spontaneously and all going well, to birth vaginally.*

of my pregnancy. And it was completely unnecessary. I should have been supported in my (very well informed) choice to labour spontaneously and all going well, to birth vaginally.

In the end, we found a private obstetrician who would support my choice to attempt a VBB. It was a huge relief but I resented the need to transfer to the private system at 38 weeks and the fact that I had to pay to avoid unnecessary surgery (we were uninsured and paid out of pocket for both the obstetrician and the private hospital, with borrowed money). I vividly remember the public hospital calling me up to book my caesarean section (in three days time!) and replying that I was going

to give birth vaginally. I wonder how often that happens? Not often enough. If women before me had taken a stronger stand, perhaps I wouldn’t have been in the predicament I was in.

I went into labour at 41 weeks plus three days after five days of pre-labour. I was in active labour for just under seven hours and my baby was born safely and in good condition. However, instead of feeling proud or happy, I felt partly defeated, shocked and appalled at the reality of the experience. (in the words of a good friend, I was ‘too hard core’ to accept any pain relief) and partly relieved the whole unnecessary stress of the ‘breech situation’ was over. *Finally*, I thought.

I formed Breech Birth Australia and New Zealand (BBANZ) when my baby was about three months old as, to my surprise, I was still very upset about my experience. It started with a Facebook group ([www.facebook.com/groups/breech/](http://www.facebook.com/groups/breech/)), through which I attempted to connect with other women who had been through a similar experience. It did not take long before the group took off and we now have a lively discussion forum related to breech presentation.

It is interesting learning the different choices women make and the different options made available to them in different parts of Australia. Some of our members have transferred to the nearest tertiary hospital for support in their choice to attempt a VBB. Others, like me, have moved from a tertiary hospital to a private obstetrician or to a smaller public hospital.

## Breech Birth Australia and New Zealand



Social support and information for women with babies presenting by the breech or who have given birth to breech babies

[www.breechbirth.net](http://www.breechbirth.net)



In some parts of Australia, hospital options are too limited and so women have found midwives to support them in breech homebirths. Some women who join BBANZ do still choose a PCS but they do so with the knowledge that their choice was fully informed and the best option for them. Like any labour, not all of the attempted VBBs are seen through to the end. Some of our members have ended up with a caesarean birth after an attempted VBB. However, by and large, these women are positive about the fact that they were supported in their choice, grateful that their babies were not born before they were ready and satisfied that the caesarean section was necessary. We also have members with very sad stories about forced caesareans, something which should never happen. Each story is unique but each contains an immense personal struggle as well as a struggle with 'the system'. We have shared some of our birth stories on our website [www.breechbirth.net](http://www.breechbirth.net).

The BBANZ website also includes links to a wide range of internet resources (including personal blogs and birth stories) and books on the topic of breech birth, policies of different obstetric bodies, medical studies and articles analysing the respective options of PCS and VBB, and advice about the steps to take if you find out that your baby is breech. Importantly, the growing network can help connect pregnant women with others who've been in the same situation and to put them in touch with maternity care-providers for second opinions on whether they make a suitable candidate for a VBB.

It is my hope that women in the future, including my own daughter, do not have to go through the same struggle that I did for the opportunity to give birth to their breech babies. I am looking forward to change.

*Note: The first Australian breech birth conference will take place in Sydney on 29-30 November 2012. The conference is organised by Women's Healthcare Australasia and a team led by Dr Andrew Bisits, who is well known for supporting women in their choice to attempt VBB. For more information see [www.breechbirth.net](http://www.breechbirth.net).*

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## Author Bio

Rhonda Tombros is the founder of Breech Birth Australia and New Zealand, the Australian chapter of the Coalition for Breech Birth. By profession she is a lawyer and currently works part time in a Melbourne city law firm. Rhonda holds a doctorate in law from the University of Oxford, on the topic of 'Security and the Right to Security of Person', as well as a masters degree in human rights law and undergraduate degrees in law and politics. A New Zealander in origin (and at heart), Rhonda has been in Australia since November 2010 after an extended period in the United Kingdom. She lives with her husband Michael (a GP) and daughter Matilda (now 17 months old), a breech baby who was born vaginally.

## Heads Up! Breech Conference

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# A look at what's happening out bush, outback, and in our most outer reaches

By Bec Telfer



Bec Telfer

Welcome to the first Rural Matters column. With this column we aim to increase the focus on the needs of rural and regional birthing women, and report what consumers and midwives are doing to improve maternity care in their local areas.

While researching this column I was disheartened to hear of the closure of the Know Your Midwife (KYM) program at Kilmore District Hospital in Victoria in August. This program had offered a continuity of carer model to 100 birthing women per year. Now, birthing in Kilmore will return to the fragmented system in place two years ago. *The Northern Central Review* on 1 August 2012 reported that the KYM program “never reached its full capacity (of six midwives)” and hadn’t attracted “midwife only” staff as it had hoped. Surely axing the program

will not help with this! In an age where universities are (thankfully) putting increased emphasis on preparing their midwifery graduates to be able to work in continuity-of-care models, according to the international definition of the midwife (University of Queensland) one would think these programs would be supported in every possible way. Armed with a belief in the benefits of continuity of care, the BMid graduates will hopefully be keen to seek out these type of models. If rural and regional hospitals are not able to offer them, there will be no incentive for these new midwives to work in rural and regional areas, which threatens the future of their maternity services. If Kilmore is going to have any chance of re-establishing this popular service, there will need to be some determined consumers



Members of Mothers Unite for Maternity Services Stanthorpe. L to R, Bec Telfer, Melinda Toms, Anita Campbell with baby Boyd, Sarah Reeves and Michelle Conkas.

and midwives working together. Unfortunately, at the moment, I am aware of only one consumer who has tried to fight for the service and who tells me the midwives are afraid to speak out and join her. MC is available to offer support and guidance to women who find themselves in similar situations.

Although it may seem trivial in comparison, a group of women in Stanthorpe Queensland called Mothers Unite for Maternity Services Stanthorpe (MUMSS), are currently gathering information from local women to build a strong case to request funding to provide a toilet and shower in the labour room. The maternity unit has not been updated for over 30 years and labouring women need to cross a corridor and into the back of the assessment room in order to access a toilet or shower. MUMSS action has been covered in the local papers and has also attracted attention from local ABC radio news.

MUMSS believes that although Stanthorpe is lucky to still have a low-risk birthing service in their town after the closure of so many small birthing units over the last ten years, if acceptable facilities are not offered to women, then a substantial number will continue to vote with their feet and birth in Toowoomba, where they have greater access to privacy and comfort. If birthing numbers drop in Stanthorpe, there is no guarantee that the birthing unit will continue to operate in the future. Modern facilities are also more likely to attract new midwives to the area, something that is increasingly difficult in rural Australia.

In Bowen, North Queensland a group of women is lobbying for the existing antenatal/postnatal care model to be extended to offer continuity of carer. The proposed model acknowledges the need for women to continue to birth in Proserpine, a 45-minute drive away, but

allows for their known midwife from Bowen to accompany them. This model is working elsewhere in the state—one example is in Mareeba—and is a valid option under the Queensland Health Clinical Services Capability Framework. The group has collected 1400 signatures and has support from local midwives.

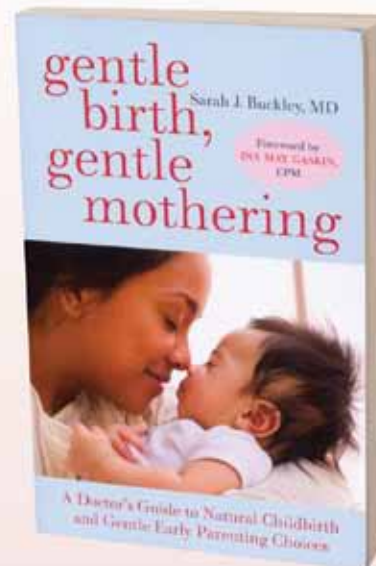
MC has just agreed to auspice a grant for the Mareeba Mothers and Midwives Alliance, who are members of MC. If the grant is successful, the money will be used to fund a project in collaboration with an Aboriginal Women's group called BadJilGal Women's Business Group. The project, which will focus on self sufficiency and healthier life choices, grew out of a critical response to provide ongoing social support and activities for young Aboriginal mothers and their babies living in Mareeba and surrounding districts.

Phase one of the project will be nutritional education coupled with group cooking classes, providing practical support to mothers who are experiencing greater disadvantage in the community. The second phase will develop an edible garden that will provide an invaluable education resource and offer a practical holistic insight into nutrition benefits for the family. The third phase will build upon these engagements with facilitated peer support sessions to support mothers' self sufficiency and healthy life choices for themselves and their children. We hope to report on the progress of their project in future editions of *Birth Matters*.

MC is currently developing a plan to link women from rural and remote communities across the country, and support them in their efforts to improve local maternity care. We welcome your feedback and suggestions. For further information about rural birthing issues or to report developments in your local area please contact me at rural@maternitycoalition.org.au.

## 'Sarah J. Buckley's book is hands-down and easily the best of all birthing books yet.'

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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# Consumer representation: why bother?

By Bruce Teakle



Bruce with wife Erika and children Rose 12, Luka 7, and Jasper 16

*I was asked to speak to a Queensland Health Maternity and Neonatal Clinical Network Forum on 30 May 2012. The audience was maternity and neonatal clinicians and managers from around Queensland. I felt that I needed to take them from where I thought many of them were—why have consumer reps at all? This is an edited version of my talk.*

Firstly I should introduce myself. Our children are Jasper 16, Rose 12 and Luka 7. Our personal family birth experiences are receding into the past, however like all families, our experiences have shaped us and continue (probably more than most families) to shape our lives. My wife Erika is in her third year of a full time Bachelor of Midwifery. My life is currently dominated by all four other members of my little family being in full time education in different schools and all wanting help with their homework and three meals a day with clean bowls and spoons.

I've been involved in consumer representation in maternity care since 2001, when our family birth experiences were fresh and unfinished. I worked with a group of consumers lobbying the state government to give Queensland women more say about their options in maternity care. We wanted women and families to be seen as stakeholders in the system which provides their care and which is funded by their taxes. We worked really hard.

Remember that in those days Queensland had no maternity care policy, no person responsible for looking at maternity services statewide and no consumer representation in maternity services.

The Hirst Review of Maternity Services in Queensland was an outcome of our work, and was the first time Queensland's maternity services had been examined as a system, with a particular focus on how well it was meeting women's needs. The Review's report, *Re-Birthing*, stated that "care belonged to consumers", and formed the basis of Queensland's first policy statement about maternity

services. Government efforts to respond to the Review led to establishment of the maternity unit, the midwifery advisor, and helped shape the clinical network. These in turn led to initiatives such as the caseload provisions in the nurses and midwives' award, Rural Maternity Initiative funding etc.

The Statewide Maternity and Neonatal Clinical Network and its sister project the statewide Clinical Guidelines project, are themselves important statements that maternity services need to be a system, not a scattering of self-contained services, and that system needs decisions about how it works to be informed by a conversation of clinicians and consumers. As Queensland's hospitals move under autonomous Board control, I see increasing importance for the Clinical Network and other statewide agencies to maintain a system-wide perspective. Only seven years since Government first looked at maternity services as being a system, we need to avoid it becoming divided up into hospital-based kingdoms who each do things their own way.

So why have consumer representatives: on the clinical network, on government committees, at the local level? It's because of the expertise they have, the perspectives they bring, and the useful relationships you form.

I'm sure you all know the number one source of problems in the health care

system? Of course: the patients. In health care the patients, the consumers and, in maternity care, the women, babies and families are the product. And how do we measure the quality of the product? By how these people feel about the care they receive.

Health care, including maternity care, is about helping people to feel better. Why does perinatal mortality matter? Purely because we know how distressing it is to lose a baby. Maternal mortality matters purely because we know how much suffering it causes to lose a mother and a wife and a daughter and everything else a woman might be. The "hard outcomes" we measure as numbers are important only because they represent soft outcomes which are people's feelings.

Focussing only on the easily measured hard outcomes means missing the whole picture. Women's experiences are not just about life and death. Ask any woman, at any age, about her birth experiences and you will hear a story about how she felt. This is to be expected—birth is one of the most vulnerable and important events in life, for the mother as well as her baby. Frequently her story is dominated by how she felt about the care she received. Were the people looking after her familiar or strange? Kind or uncaring? Did she feel she had control over what was done to her? Did she feel her choices were respected? These things matter a lot, whether she had a normal birth or her care was complex.

A fundamental characteristic of humans is our belief in our own autonomy. The belief that it is our role to choose our actions and control the actions upon us, particularly the actions to our bodies. Our social values and our laws recognise this as a fundamental human need. This need for autonomy is a key to how people feel about their health care, and is a persistent theme in women's experiences of birth. Did I feel in control of what was happening to me? Did I trust the people caring for me in a life and death situation? These questions are fundamental to the experience of safety—which everyone is striving for, and which is experienced by the woman. This applies to us all: control and trust leading to a feeling of safety.

I am endeavouring to answer my own question: why have consumer representatives? The answer is that consumer reps can help you. A key purpose of a consumer representative is to



be the person at the table responsible for thinking about how decisions will affect the women and families receiving this care. How will they feel about it? How does it affect women's need for control and trust?

The need for consumer reps is not because the other people at the table don't care or don't know. Most clinicians at most tables do care and do know, but they have a lot to deal with. They are surrounded by the system all the time, and it is hard in that situation to see the system from the outside. They are employed by the system, responsible to the system, and have limited ability to advocate on matters which are not defined as their responsibility. Consumer representation helps everyone in the conversation to keep checking decisions against the question of "how will this affect women?"

By helping with this question, consumer reps can help with big, expensive, hard outcome issues. Consider litigation, which increasingly shapes practice. According to the Australian Institute of Health and Welfare, by far the biggest group of medical indemnity claims for obstetrics and gynaecology are those related to "consent". These claims happen because of how people feel about their care.

Another big hard outcome measure, maternal mortality, is dominated by how people feel. Suicide is the leading cause of death of mothers up to one year postpartum. Research also shows one third of women show three or more symptoms of trauma following childbirth. Again, the product is how patients or consumers or women feel. These measures also serve to remind us all how vulnerable the pregnant, birthing or new mother can be and the unique opportunity maternity caregivers have to make a positive difference to women at this time in her life.

These are some of the perspectives a consumer representative might bring to a decision-making table.

It's important to define what a consumer representative is. According to Australia's national health consumer body, Consumer's Health Forum:

*A consumer representative is a member of a government, professional body, industry or non-governmental organisation committee who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person is nominated by, and is accountable to, an organisation of consumers.*

CHF also defines the consumer representative's role:

- a) Protecting the interests of consumers, service users and potential service users
- b) Presenting how consumers may think and feel about certain issues
- c) Contributing consumer experiences

“

*Health care, including maternity care, is about helping people to feel better. Why does perinatal mortality matter? Purely because we know how distressing it is to lose a baby. Maternal mortality matters purely because we know how much suffering it causes to lose a mother and a wife and a daughter and everything else a woman might be. The "hard outcomes" we measure as numbers are important only because they represent soft outcomes which are people's feelings.*

- d) Ensuring the committee recognises consumer concerns
- e) Reporting the activities of the committee to consumers
- f) Ensuring accountability to consumers
- g) Acting as a watchdog on issues affecting consumers
- h) Providing information about any relevant issues affecting consumers

What is most important in these definitions is that the consumer rep is a "representative", as well as a consumer. Their lines of representation need to

be clear. For most consumer reps this is via engagement with organisations of consumers, which bring the rep a perspective beyond their personal experience. The consumer rep needs a collective, inclusive perspective informed by the experiences and analysis of many consumers.

What a consumer representative is not, is a consumer who is unsupported by an organisation of consumers, maybe a clinician committee member's friend who had a baby. A consumer rep is also not a clinician, maybe a staff member who had a baby. Being engaged within the system of care makes it too hard to separate out the woman's interests from those of the organisation. The interests of the organisation already have overwhelming dominance.

The other person who isn't a consumer representative is the person who is consuming the services at that moment. 1000 conversations with women while you provide them with their care, will not tell you what you will hear from one of them sitting at the table in a representative role. The clinical relationship between a caregiver and a consumer has insurmountable power differences. You are on home ground, they are in a big, strange and intimidating hospital. You are doing your day-to-day job with its repetitive routines, they have their and their precious baby's lives in your hands. You know how to do your job, they are struggling to work out what you're talking about. They know that you probably know nearly nothing about them and their life and needs and that you probably don't have time to find out. You can learn a

## VICKI CHAN AND LYNNE STAFF

showcasing the audio-visual magic of Nic Edmondstone

present

### BETTER BIRTH: THE WORKSHOP



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Tel: Lynne 0458 180 008 or (03) 6363 2007 Vicki 0402 140 769

lot from the woman receiving your care, but it is very different from consumer representation.

Engaging consumer reps with strong links to community and consumer organisations is not only the right thing to do, it also delivers good value to the decision makers. Having consumer representation inform your decision making helps manage risks. Just having them genuinely at the table manages many political risks. Someone who has a friendly relationship with you on a committee, and who thus has some knowledge about the complexities of delivering health care services, is very unlikely to be writing media releases or letters to Government criticising you. Consider the recent closure of a Birth Centre. The outcome in the end was good, with a review and the hospital taking a really forward-looking direction, but there are easier ways to do it. Keep everyone talking and working together, including consumer representatives.

Consumers are useful to you politically as well. They can be your secret weapon. Consumers may be the only person at the table not employed by Queensland Health. I know this makes many clinicians feel nervous, because consumers seem uncontrollable and could explode at any time. But this is actually good for you. Consumers act as citizens. They aren't restricted to talking only with those directly above and below them in line management. They can get their message, perhaps your message, to Government through the political system, which can be really good for you. Consider the money for rural maternity services through the Rural Maternity Initiative, or the millions now available through Medicare for midwifery care. Consumers will almost always be better than government employees at getting government attention, because Government employees work for Government, while Government works for citizens.

Late last year women in a small Queensland country town spoke to their MP about the birthing room at their small local hospital. They wanted a shower and toilet for the labouring women (are they never happy?). Their MP took it to the Minister, who was interested enough to send someone to have a look. From here the story should go: the Minister's man went back and told the Minister about the poor facilities, and the next day there was a cheque in the mail to the hospital. It doesn't go that way. When the Minister's man went to the hospital, he was told that everything was fine and don't worry about it. Of course the story went back to the women and they are furious and there's no cheque in the mail and their MP is furious and is now the Minister for Health. That

hospital used their secret weapon to shoot themselves in the foot.

Consumer representatives come in a wide range of shapes and sizes. Most are mothers with young children. The proportion who are balding men in their late 40s is statistically insignificant. Most have had some experience which has switched them on and made them want to improve things for other women. Many of them talk about what they want for their daughters. Many of them have had a bad experience in the system and they are the special type of person who decides to put their life's energy into making things better. All need to volunteer huge amounts of time, usually at a really challenging stage of life, to do this work. Amongst all the maternity consumer organisations I've ever seen, there is a unanimous commitment to women's choice and control, and care provided with continuity and collaboration. I personally got involved because I saw

that birth was an experience which could be profoundly empowering, and prepare women and families for the huge task of parenting, or profoundly disempowering, and undermine the social fabric of our communities. Birth is one of the few real turning points in people's lives.

I've spent my available time trying to give you a feel for what consumer representation is about. This is increasingly becoming a government expectation in health care. I strongly encourage you all to see what you can do to build relationships with consumer reps in your own places of work.


## References

Health Consumers Queensland: <http://www.health.qld.gov.au/hcq>

Queensland Centre for Mothers and Babies: <http://www.qcmb.org.au/>. See the Maternity Consumers Representative Training Program page under the 'projects' tab.



**Is your membership up to date?**



**Renew today. See page 32**

## La Bassine Professional Birth Pool



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To hire, contact [ipswich@maternitycoalition.org.au](mailto:ipswich@maternitycoalition.org.au) or phone Ipswich Community Aid on 07 3812 3437 (Major credit cards accepted)

\*a non-refundable \$20 deposit is payable upon booking.

# Breech Birth

## Hands Off the Breech: Evidence & Practice



Day 1: 30 Nov 2012, 8.30am to 5.30pm

Day 2: 1 Dec 2012, 9.00am to 12.30pm or  
1.30pm to 5.00pm



### University of NSW, Sydney, NSW

When faced with a baby in breech presentation, how confident is our maternity workforce to support a woman's choice to give birth vaginally? This two day workshop aims to re-skill our maternity workforce in vaginal breech birth, arming participants with theoretical knowledge and practical, hands on clinical skills.

International experts have been confirmed, who will present alongside experts from Australia and New Zealand to offer the most comprehensive insight into all aspects of Breech Birth currently available!

#### International speakers & trainers will include:

- Professor Frank Louwen, Germany: A Broader perspective of Breech Birth
- Jane Evans RM, UK: Mechanics of Breech Birth
- Professor Lesley Page, UK: The value of normal
- Prof Betty Anne Daviss RM, UK: The Evidence

#### Australian and New Zealand speakers & trainers will include:

- Dr Maggie Banks, NZ: Midwifery...Tackling the Odds
- Dr Andrew Pesce, Aust: Setting up a Breech birth service
- Dr Andrew Bisits, Aust: co Chair and Future of Vaginal Breech Birth: Why does it matter?
- Professor Alec Welsh, Aust: The Evidence
- Dr Gerald Lawson, Aust: The Evidence
- Professor Sally Tracy, Aust: co Chair

Women's Healthcare Australasia (WHA) are excited to be able to offer this exciting **not to be missed event** for maternity healthcare professionals in 2012!

Registrations are open now and places are strictly limited. For the full program, speaker bio's and registration please visit the WHA website at [women.wcha.asn.au/events/insight-forums](http://women.wcha.asn.au/events/insight-forums).



# Maternity Coalition News

## Northern Rivers Branch

By Sally Cusack



Red Tent Festival goddess procession

### Red Tent Festival 2012

Red Tent Festival went ahead on Saturday 31 March in Mullumbimby and was an amazing success, exceeding our expectations in spite of the heavy rain. The spirits of the local community weren't dampened at all and 400 women came through the doors in the daytime and evening sessions. A short film was made about the festival by our local newspaper and a link can be found at the home page: [www.redtentfestival.com](http://www.redtentfestival.com).

For those unfamiliar with the background of the Red Tent Festival, the first one was held in November 2009 in Federal and was also hugely successful; it was initiated by women from the community who sought the support of Maternity Coalition. After the huge success, and correspondingly huge effort, the core group of organising women were not sure if they could ever 'erect' another Red Tent. However the feedback we continued to get from the first festival convinced us that it was thoroughly worthwhile to bring another one to our community.



Red Tent Festival Choir on stage

We also compiled a philosophy for us to follow when we come 'in service' to The Red Tent in order to ensure the effort put into these events is sustainable and doesn't take over our personal family priorities.

If you would like to know about contributing to future festivals see <http://www.redtentfestival.com/get-involved.html>.

This year's festival took place over a day and an evening. The day program consisted of four films (including *The Face of Birth*) and eight workshops, as well as activities such as free weaving, 10-15 minute massages, henna painting and much more. The evening program featured six diverse and inspiring birth stories, as well as music from a range of performers, including our very own Red Tent Choir, made up of women from all ages and stages in life.

As with the first event, the core group decided to restrict entry to women only, welcoming babes in arms and women from 12 years onwards. The reasoning behind is to provide women the rare opportunity to nurture themselves and 'fill their cup'. It was a formula that worked very well and the stillness provided by this space allowed women to form very deep connections with each other and understanding of the content.

As we relied wholly on volunteer involvement and sponsorship, we were able to keep our expenses down and therefore offer very reasonably priced entry tickets and allow young women aged between 12 and 18 to enter free of charge.

Meals were cooked and served by the wonderful women from MamaBake.com. All involvement in the festival was voluntary and, wherever possible, everything we needed was sourced from the local community. It proved to be a wonderfully bonding experience for everyone involved and we all got so much out of participating.



Catering by MamaBakers

### Film Screening of *Birth Day* and Publicly Funded Homebirth Petition

We held a screening of Diana Paul's film "Birth Day" about the birth of Mexican midwife Naoli Vinaver's third child in the water at home. This was held as part of a campaign to introduce publicly funded homebirth from one of our local hospitals. Our local area health service had been investigating this option for almost two years, but progress on this seemed to have reached a stalemate. So, we started an online petition to raise awareness of this issue. See [www.ipetitions.com/petition/petition-for-a-publicly-funded-homebirth-program](http://www.ipetitions.com/petition/petition-for-a-publicly-funded-homebirth-program). Within a few weeks we had collected about 500 signatures on paper and online and featured in the local newspapers and on community and ABC radio.

About 65 people attended the film screening, which completely filled the modest venue we had organised. We used posters, Facebook and email to publicise the event. Interestingly, 21 people replied 'yes' to the invitation we sent out via Facebook, which represented 30% of our total turnout on the night—a useful indicator for future events. The film was followed up by the panel discussion with Marion Buchner, local registered midwife, and two local pregnant women hoping for a home birth in a region where Marion is the only registered midwife who attends homebirths.

We are still awaiting a response from the area health service about the publicly funded homebirth program. In the meantime, Marion continues to be the only registered homebirth midwife in the region.

### Welcome Party for Marg Phelan from Go Girl Australia

Back in February we were fortunate enough to have Marg Phelan cycle right into Byron Bay. A group of us met her and support vehicle driver Robyn Thompson at the beach front for afternoon tea. Marg



Marg and driver Robyn with Northern Rivers women L to R Robyn, Julisa Fox and family, Sally Cusack, Marg, Rachel van Raak-Shine, Vicki-Lee McAllister

stayed on for a few days to rest before continuing her journey north. It was a wonderful experience to meet Marg and Robyn. What an inspiration Marg and her journey are for all of us.

### "Pregnancy, Birth and Beyond" Radio Show

Our one-hour radio show on local community radio station BayFM is continuing to grow from strength to strength. Our 'DJ Doulas' Lara and Hunna are doing a wonderful job of sharing the responsibility of bringing diverse and informative content to air each week. The show provides a fantastic forum for bringing issues around birthing and motherhood to the airwaves, as well as helping embed our branch into the local community as we get to know new people each week through the process of interviewing them on air. The show is also a fantastic way to raise awareness of our events, such as the Red Tent Festival!

## Go Girl makes it home

By Marg Phelan



Marg's sons flew from Hobart and China to surprise her. Pictured here with L to R Ann Alsbury, Sue Howell and Marg

*Marg Phelan shares with us the final day of her epic cycling journey.*

### Saturday 30 June 2012

The final day of the ride—Adelaide River to Darwin—was a very exciting and



Kylie and Saffy flew in from Canberra

memorable day. We set off at 8 am. Anne (my sister and fellow cyclist) and I met up with Chris for morning tea at Manton Dam. The road was not too busy and the hills easy to ride. As we approached Noonamah we were both looking forward to seeing the first of the welcoming party. When we arrived it was fantastic to see Susie, Julie, Judy, Peter, Terri and our driver Chris. I was totally overwhelmed and happy to see my boys David and Paul, who had made an enormous effort to get to Darwin (David from Hobart and Paul from Nanchang, China) to surprise me and ride the last 40 km with me. I was in tears as we hugged and greeted everyone. It was the best kept secret of my entire life!

After a lunch break at Noonamah we all rode on to Darwin together (Anne, Susie, David, Paul and me).

The planned arrival to the Esplanade Darwin was between 2.30 and 3.00 pm. Our timing was perfect and we rode in at 2.45 to a fabulous welcome. I rode through a chequered flag to the tune of Helen Reddy's *I am Woman* blasting from a stereo system set up for the event. It was a fantastic welcome from everyone there, including Ali Mills from the Larrakia Nation, who performed a "Welcome

*Home to Country*", Paul Henderson (NT Chief Minister), Katrina Fong Lim (Lord Mayor Darwin), Jeff Moffet (Chief Executive NT Department of Health and Families), Sally-Anne Brown, Kylie Sheffield, Robyn Thompson and friends and colleagues from the Darwin community. I felt so proud to be home and the recognition of Go Girl Australia's 'One Mother One Midwife' campaign was fabulous.

Sincere thanks to all the organisers of the event

including Kylie (website manager), Sally-Anne (media liaison), Susie, Meryl, Robyn, Darwin Homebirth Group and ACM (Australian College of Midwives) NT. ABC radio and TV were there as well as



Marg with DHBG President Sarah Thomson

*The NT News.*

All my Darwin family members (midwives, birthing families, cycling friends and everyone who knew I was coming home) were excited to see us. The afternoon was great fun and I am blessed to have such support. Photos of the event are on our Facebook page (<https://www.facebook.com/groups/341147400756/?ref=ts>) and will be uploaded to photo bucket on our website soon.

The final tally of money raised for the **Rhodanthe Lipsett Trust is: \$5840**. Thankyou to everyone who donated from all over Australia. It was a fabulous result. The money is now available for Indigenous women to apply through the ACM Rhodanthe Lipsett Trust for assistance to help them to complete the Bachelor of Midwifery.

### 30 July

It is now four weeks since we arrived back in Darwin and settling back into work as a midwife in the Darwin Homebirth Practice is going well. The social life is fabulous. I ride most days before work and longer at the weekends, but not 100+ km each day!

After cycling 20,000 km for women, midwives, normal birth and breastfeeding, I was honoured to be nominated for the 2011 Pride of Australia Medal.

## ATTENTION ALL WRITERS & RESEARCHERS

We are looking for enthusiastic, motivated and passionate people to write and research feature articles for *Birth Matters*.

If you care about choice in pregnancy and birth for all women and have expertise in these areas, we'd love to hear from you.

You will receive full training and excellent support from fellow MC-ers and members of the broader birthing community.

Email: [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au).



# Report review: Why the birth after caesarean randomised control trial is good news for VBAC

By Cas McCullough



Cas McCullough

In March this year, the results of the controversial Birth After Caesarean Randomised Control Trial were finally published. There are no big surprises in this report, but there are many questions that remain to be answered.

## What the researchers say the report says

The researchers claim that, on balance, Elective Repeat Caesarean (ERC) has a lower risk of fetal death or serious infant outcome. They cited a 2.4% rate of infant mortality with the VBAC group as opposed to the ERC group. When you put it like that, it sounds like ERC is safer than VBAC, but what do the results really show?

## What the report actually says

More women preferred to at least try VBAC. Of the two groups, the planned VBAC group accounted for 52.8% of all participants.

Only 22 women agreed to be randomly allocated to either a repeat caesarean or a vaginal birth after caesarean, indicating that women had strong preferences about to how they gave birth.

Two women out of 2345 participants sadly lost their babies. Both of the deaths were due to “unexplained stillbirth.” Neither of the deaths was necessarily related to the fact that the women were in the planned VBAC group. In fact, it isn’t even clear if the whether the women involved had a VBAC or emergency caesarean.

In Australia, approximately 1-2 in 1000 births is a stillbirth<sup>1</sup>. So, the rate of stillbirth in the planned (but not necessarily achieved) VBAC group is not any higher than in the general population of all births.

Importantly, the spectre of Uterine Rupture didn’t even factor significantly into the results. The report says, and I quote:

*The risk of symptomatic uterine scar rupture was low for both treatment groups being 0.1% for women in the planned ERC group and 0.2% for women in the planned VBAC group. This risk of uterine rupture related to VBAC is lower than that reported from the NICHD cohort study of 0.7% [4] and lower than the rate of symptomatic uterine scar rupture of 1.2/100 to 3.9/1,000 among women having a VBAC reported in systematic reviews of other cohort studies [9–11].*

So, in terms of Uterine Rupture, this is good news for women wanting a VBAC. You still have far more chance of being hit by a bus.

## What the report doesn’t say

After reading the paper, I have more questions than answers. Firstly, the question of whether the two babies that were stillborn were born vaginally, or by elective or emergency caesarean section, needs to be answered.

Also, given that a very large number of the women in the VBAC group had their labours induced (known to be associated with higher complication rates), had epidurals and other analgesic interventions that could potentially affect the outcome of their births, it would be interesting to know whether or not the two stillbirths involved any of these interventions as well. It would also be good to know if those women who experienced higher rates of haemorrhage ended up with elective or emergency caesareans. This too is not addressed.

The report also fails to talk about the impact of routine “standard” care interventions on women

in the VBAC group. It was very clear to me, when I first reviewed the research methodology back in 2003, that the VBAC women would be set up to fail because of the way their care was managed.

It would be interesting to see a study comparing birth after caesarean with “standard” care to birth after caesarean with “optimal” care, but apparently that is considered “unethical” by the powers that be (even though randomly assigning healthy women to unnecessary surgery is apparently okay).

My hope is that this research will be given the attention it deserves and dismissed as biased by any thinking physician or woman who reads it. However, I suspect that the sad reality is that many medical professionals will jump on this research and use it to coerce women into unnecessary surgery they don’t want.

The entire report of the *Planned Vaginal Birth or Elective Repeat Caesarean: Patient Preference Restricted Cohort with Nested Randomised Trial* can be found at: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001192>

## References

1. <http://www.stillbirthalliance.org.au/fact.htm#Stillbirth%20and%20perinatal%20mortality%20statistics>

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## 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](mailto: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](mailto:secretary@maternitycoalition.org.au) for details. Communication between meetings is mainly by email.

## General meeting dates for 2012

General meetings will be called as required and members given 14 days notice. The 2012 AGM will be held by teleconference on Saturday 13 October at 4 pm ADST.

## 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](mailto: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](http://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](mailto: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](http://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](mailto:dean50@ozemail.com.au) or Lisa Metcalfe at [nsw@maternitycoalition.org.au](mailto:nsw@maternitycoalition.org.au).

**MatCoWA.** For members in WA. Contact Tracey Reibel at [wa@maternitycoalition.org.au](mailto: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](mailto: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](mailto: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](mailto:qldpresident@maternitycoalition.org.au).

Find us on



# Maternity Coalition Contacts

## MC contacts (National)

### Office Bearers 2012

**President:** Ann Catchlove  
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**Vice President:** Bec Jenkinson  
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**Assistant Secretary:** Vacant

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**Assistant Treasurer:** Jo Askham

**Birth Matters Editor:** Kylie Sheffield  
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**Assistant Birth Matters Editor:**  
Sonia Bartoluzzi

### General committee members:

Bruce Teakle  
Jess Permezel

## Other really important people who support our National Management Committee

**Membership Secretary:** Bec Telfer  
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### National BaBs coordinators:

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**Mail forwarding:** Suzie Anderson  
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**Consumer Representative:** Bruce Teakle  
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**General Inquiries:**  
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**CANA inquiries:** info@canaustralia.net

## Branch contacts

**QLD President:** Alecia Staines  
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### Hunter Region

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**Northern Territory:** Lauren Kaiserman  
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**Tasmania President:** Genevieve Sayers  
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**Victoria President:** Ann Catchlove  
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### Peninsula Birth Support

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### Geelong President:

Cherie Nixon  
Geelong MC/ Choices for Childbirth  
0423 189 317  
geelong@maternitycoalition.org.au

**Ballarat President:** Michelle McRitchie  
ballarat@maternitycoalition.org.au

## 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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## Want Extras?

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For bulk orders (500g or more), please contact the Editor for rates. [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au).

Simply visit our website at:  
**[www.maternitycoalition.org.au](http://www.maternitycoalition.org.au)**  
and subscribe online to reduce carbon emissions

Or write to:  
PO Box 1190  
Blackburn North Vic 3130  
to request a brochure.



☐ **Yes, I'd like \_\_\_ membership brochures for Maternity Coalition**

Please send brochures to/contact me via:

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Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

A PDF of the brochure can be emailed upon request. Contact [secretary@maternitycoalition.org.au](mailto:secretary@maternitycoalition.org.au)

# CHILD BIRTH AND THE LAW FORUM



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**ELIZABETH PROCHASKA**

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