

# BirthMatters



Vol 17/3 ISSN1443-7570

Spring 2013

## Childbirth and the Law:

unregistered birth  
workers

## Freya Isobel's breech birth

## Research News:

water  
immersion  
and birth

## Attachment parenting:

from being abused  
to gentle parenting

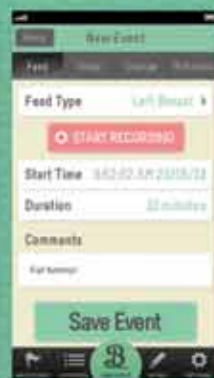
## Government weakens medical veto over Medicare for midwives



# — THE — Baby DIARIES



ON SALE NOW  
for just \$2.99



FOR A LIMITED TIME ONLY



Available on the iPhone  
App Store

[thebabydiaries.com.au](http://thebabydiaries.com.au)

## OUR TEAM

**Editor:** Jyai Allen

**Assistant Editor:** Sonia Bartoluzzi

**Production:** Mara Dower

**Distribution:** Rebecca Telfer

**Advertising:** Jade Farren

## OUR PURPOSE

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

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

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

## GUIDELINES FOR SUBMISSION

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

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

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

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

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

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

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

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

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

# CONTENTS

## REGULAR SECTIONS

- 2 **From the Editor:** *Reflections on a pond*
- 3 **From the President**
- 3 **Letters to the Editor**
- 4 **Federal Update** by Bruce Teakle  
*Government weakens medical veto over Medicare for midwives*
- 8 **Branch Update** by Genevieve Sayers, Tasmanian President  
*What's happening in Tasmania?*
- 10 **Parenting Matters** by Stephanie Hutton  
*How an abusive childhood led me to attachment parenting*
- 14 **Childbirth and the Law** by Ann Catchlove  
*Unregistered birth workers*
- 15 **In Review** by Genevieve Sayers  
*"Birth Story: Ina May Gaskin and the Farm Midwives" Film Review*
- 16 **Rural Matters** by Bec Telfer  
*Midwives ready for rural and remote work*
- 17 **Rural Matters** by Alecia Staines  
*Meetings with the QLD Health Minister*
- 23 **Global Matters** by Lianne Schwartz  
*A birth centre in Bali: Bumi Sehat*
- 24 **Interview** with Robyn Thompson
- 26 **Research News** by Alecia Staines  
*Hypnosis for childbirth: a research summary*
- 27 **Research News** by Jyai Allen  
*Water immersion in labour and underwater birth*
- 31 **Maternity Coalition Contacts**
- 32 **Subscribe and Membership Renewal**

## NEWS

- 6 **Letter Campaign**  
*Do you want your own midwife?*
- 7 **MC NEWS** by Melinda Toms  
*Re-designing hospital birth suites: the importance of consumer representation*

## FEATURE ARTICLES

- 18 **TEN THINGS** you might not know about Maternity Coalition  
by the National Management Committee

## BIRTH STORIES

- 20 **Freya Isobel's breech birth** by Sarah and Dan Fallon
- 28 **Amelie's birth in water** by Alison Harvey

**ADVERTISE WITH US!**

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

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

Advertising bookings must be received by the 31st of the month prior to publication; ads must be received by the 15th of the month prior to publication.





## REFLECTIONS ON A POND

*While researching the history of Maternity Coalition (MC) for our feature article **10 things you might not know about MC**, I was lucky enough to be connected with Irene Shaw, one of the founding MC members and original Editor of Birth Matters. Irene shared several historical documents with me, including the first editorial she published from her typewriter in 1997. Reading it, I was struck by how much has recently begun to change (Medicare eligible midwives, increasing access to continuity-of-carer programs, publically funded homebirth), and yet how many things sadly remain the same (climbing rates of intervention, including caesarean section rates above 30% in the public sector and above 50% in the private, medical domination of midwifery practice, medico-legally driven hospital policies). I have reproduced excerpts from Irene's original editorial below to invite your own reflections.*

Mothers and midwives have, over many decades, often felt unable to find an appropriate forum to voice their feelings about childbirth. Many women have felt silenced. Midwives have often spoken of being intimidated when voicing their concerns about attitudes and practices [...] some believe being directly outspoken places their jobs in jeopardy. Mothers, too, may often feel unable to question what happens to them when they are having a baby [...]

Unfortunately, consumers are all too often ill-informed about the potentially negative side effects of certain procedures and pharmaceuticals, and the risks and benefits of certain diagnostic techniques [...] It is sometimes said that mothers, in the pursuits of the perfect baby and the perfect birth, have fuelled the recently seen increase in the caesarean section rates of women in the modern world.

Doctors, feeling the pressure of consumer demand for the perfect baby, and fearing litigation, may feel obligated to intervene in the birth process. This approach may be contrasted with the earlier practice of obstetrics summed up as 'a good obstetrician was someone who knew how to sit on his hands and whistle Dixie'.

Evidence suggests that increasing rates of intervention such as caesarean sections appear to parallel costs of medical care and women's access to private medical insurance, rather than any desire on the part of one of out of four women (25%) to undergo major abdominal surgery. It would seem also that litigation or perhaps more correctly 'fear' of litigation has led to defensive medicine: 'when in doubt – cut it out'.

More positively, there has also been a trend in some birth settings for providers and administrators to listen to the consumer voice and provide maternity care which is more sensitive, humane and responsive to women's needs [...]

**Childbirth in the twentieth century has been marked by several key transitions. The place of birth moved from home to hospital, the professional practice of midwifery was subordinated to that of nursing, and responsibility for care was transferred from midwives to doctors. A high-touch approach to birth has been replaced by one of high-technology. Birth now most often takes places in strange surrounds and the mother is surrounded by strangers – individuals the mother is most often likely to meet for the first time when she enters hospital.**

Care provided during labour will depend upon the midwives who are 'with-women' as they labour to give birth [...] Even when women can afford private health insurance, it is still extremely difficult for the majority of women to access a midwife of their choosing for care during

pregnancy, birth and the weeks after the birth of their baby. Midwives, too, find they are faced with providing optimum support for individuals they are meeting for the first time... Is there a better way?

Several recent reviews of birthing services suggest there might be and it is both safe and cost effective... Team midwifery and midwife-run birth centres have the potential to provide continuity of care in a range of settings [...] this model of care may become more widely available. A major obstacle [...] is the lack of Medicare rebates for care provided by midwives during the childbearing year.

So where to from here? Lobbying for Medicare rebates for midwives would be a start to address the lack of equitable access (either through Medicare or private health insurance) to a midwife of one's own choice, but how do we address the other issues raised above? [...]

Given the premise in the first part of this editorial that women's voices are often silenced, how about documenting the concerns of women and midwives as well as others who are most intimately involved in the childbearing process? How about working together to reflect upon women's cares, anxieties, concerns, satisfactions, joys, and experiences, as mothers and as midwives. And for good measure, how about conveying these expressions [...] to those in key positions: those who makes critical decisions affecting us all; politicians, hospital administrators, Medicare and private health insurance funds, medical practitioners, educators and so on. Would any of these strategies work?

It sounds like a tall order, doesn't it? But then again, once women didn't even have the vote and look at us now! Working together as mothers and midwives and interested individuals, we can help to educate each other and share our knowledge together and with others [...] We cannot continue to feel that injustices continue without taking personal action. We have to take responsibility for what is going on and not leave decision making to others who have not taken 'our accounts into account'.

Irene Shaw



Welcome to the Spring Edition! By the time you read this the 2013 Federal Election will have been and gone, and for MC, now is the time for action. No matter the outcome, MC will continue to work towards more choices and access for more women.. We have been developing an action plan for a post-election campaign and are looking forward to implementing this.

Maternity Coalition is currently expanding with a number of new branches

opening in Queensland and New South Wales, with potential branches also in South Australia and Western Australia. Visit our website to find out where the branches in your state are and if there isn't one close by, get in touch with our Branches Coordinator on [branches@maternitycoalition.org.au](mailto:branches@maternitycoalition.org.au) for some more information.

The National Committee Annual General Meeting is also approaching and we would love to hear from anyone who

would be interested in getting involved. We are always looking for passionate people to help move the organisation forward, and next year is already looking to be a big one. If you would like to know more about getting involved, please feel free to email me on [president@maternitycoalition.org.au](mailto:president@maternitycoalition.org.au) or call me on 0417 762 033.

Thank you, as always, for your support of Maternity Coalition,



Are you someone who attends MC branch meetings, fundraisers and events? Do you keep up to date with what's happening locally in terms of maternity services? We are looking for an Editorial Assistant from each State and Territory to assist with motivating writers, gathering articles, taking event photos and writing articles. Time commitment would be a couple of hours per week.

Interested in volunteering? please email [birthmatters@maternitycoalition.org.au](mailto:birthmatters@maternitycoalition.org.au)

## Letters to the Editor

Dear Editor,

I was very pleased to read Jenna's story (Autumn 2013) of her positive and natural birth experience with a private obstetrician.

Unfortunately, as we all know, this scenario is very rare; what usually happens, as was the case in my first labour, is that the woman who wants to opt for a natural and intervention-free birth is deceived into believing that this

choice will be respected, when in fact there is never any intention to do so.

I'm not sure if you are aware of the petition that I started at the beginning of this year on [change.org](http://change.org): 'Stop human rights violations in Australian Maternity Care.' At the moment it has around 470 signatures. Unlike Lynn Thorsen, I believe that political action is needed, although I agree with her that women need to know that they have a choice in the first place.

At the moment maternity hospitals

across this country are getting away with pretty much anything in my view. They don't even shy away from threatening a pregnant woman openly via a phone call by telling her that her written consent / refusal to medical procedures will not be legally binding (this happened to me before Keira's homebirth after I booked into Frankston public hospital as a back-up).

Best wishes,  
Tanja

# GOVERNMENT WEAKENS MEDICAL VETO OVER MEDICARE FOR MIDWIVES



The Commonwealth has at last made amendments to legislation, making it easier for women to receive Medicare rebates for midwifery care, and making it more achievable for midwives to work in private practice. This is a significant event politically and should make some improvements to women's access to more options in maternity care.

## Background

In 2009 the Commonwealth Government committed \$120 million to a set of reforms for Australia's maternity care system. The focus of the reforms was to "improve choice and availability of a range of models of maternity care for Australian mothers." The centrepiece was the creation of the 'eligible midwife', who was enabled to purchase subsidised professional indemnity insurance and provide Medicare-rebated care to women.

The reforms met strong and influential resistance from medical stakeholders, who are committed to maintaining doctors as the 'gatekeepers' to the river of taxpayer money that flows to Australian healthcare. Under this political pressure, the Government made Medicare payments conditional on midwives having 'collaborative arrangements' with medical practitioners.

Consumer, midwifery and nursing stakeholders protested and lobbied with a united voice, asking for a definition of collaborative arrangements that was achievable for midwives. A Senate review interviewed stakeholders (including Maternity Coalition) and considered the problem. However, the Commonwealth put in place a definition that offered obstetricians an effective veto over women's access to Medicare rebates, and that made private practice difficult to achieve for most midwives.

State, Territory and Commonwealth governments agreed in August 2012 that amendments were needed to improve women's ability to receive care from eligible midwives. For several months now, the Commonwealth Department of Health and Ageing (DoHA) has been working on a new deal.

## Requirements for collaborative arrangements

Until the recent amendments, eligible midwives had four options for collaborative arrangements (see text box). To see the legal versions of these definitions, see *Further information* below.

The recent reforms add another option (e) to this list. Option (e) says that midwives who pass a credentialing

## PREVIOUS OPTIONS FOR COLLABORATIVE OPTIONS

- a) the midwife is employed by a doctor, or by an entity that employs a doctor
- b) the midwife provides care to a woman referred to her by a doctor
- c) the midwife has a signed agreement with a named doctor
- d) the midwife follows a documentation trail with a named doctor acknowledging care ('midwife's written records').

process to provide private midwifery care in a hospital are considered to have a collaborative arrangement (the hospital must employ obstetricians).

In addition, option (a) has a minor amendment. As well as being employed by an entity that employs a doctor (obstetrician or GP obstetrician), the midwife can have a written agreement with the same sort of entity (other than a hospital). For example, a midwife could have a written agreement with an Aboriginal Medical Service that employs a GP obstetrician.

Another minor amendment clarifies that collaborative arrangements can be with an obstetrician who is in private or public practice. This appears to be in response to some hospital lawyers who claimed that these reforms weren't meant for public hospitals (making you wonder who has lunch with whom).

## What does this mean for women?

These changes won't be a dam-buster, but they will be helpful in some situations, mostly in Queensland where eligible midwives are already collaborating with public hospitals.

Option (e) gives hospital-credentialed midwives an automatic collaborative arrangement. This makes it easier for hospitals and midwives to do deals, and harder for hospital obstetricians to create roadblocks. For example, some hospitals in Queensland have invested significant money and effort towards collaborating with eligible midwives, but have stalled when obstetricians have refused to agree to signed agreements for collaboration (option c).



As an example, option (e) will be helpful for the eligible midwives collaborating with the Gold Coast Hospital. These midwives are credentialed to practice at the hospital, but do not have a signed agreement (collaborative arrangement) with the hospital. This means that, for each woman, the midwives need to have either a referral (option b), or follow the midwife's written records (option d) for women to receive Medicare rebates, both of which involve significant effort.

Four Queensland hospitals currently credential eligible midwives to provide private care, with more planning or considering implementation. These changes are scheduled to come into effect on 1 September 2013.

### What does this mean politically?

These reforms are politically significant. The medical lobby has been highly resistant to any reform of Medicare rules

to enable midwives to compete more easily in the maternity care marketplace. Obstetricians have lobbied hard and have been successful in delaying these amendments until the Federal election was almost upon us. Considering this, the Government has been bold to act contrary to the demands of the medical lobby, and pass these amendments. Given that consumer and midwifery lobbying on the Medicare reforms has been relatively quiet on this issue, this is a good outcome for us.

### Looking forward

I believe the Medicare-midwifery reforms of 2010 offer the biggest opportunity in a generation to increase Australian women's choice, control and continuity in maternity care. They also offer midwives their biggest opportunity (perhaps ever) to re-define themselves as professionals who work to professional standards, rather than employees who work to medical

instructions. It is essential that consumers and midwives work hard to bed these reforms down as much as possible while we have a sympathetic government. These amendments will make that task a little easier, but there is still much work to do.

Maternity Coalition is supporting women's access to care from private midwives with the letter campaign (see Page 6). I encourage women and midwives to work to get as many of these letters sent in as possible.

### Further information

To find the recent amendments, Google: 'Health Insurance Amendment (Midwives) Regulation 2013'.

To find the regulations which this amendment amends, Google: 'Health Insurance Regulations 1975'. The version available (as at 8 August 2013) did not yet have the amendments incorporated.

# DO YOU HAVE A PASSION FOR NATURAL BIRTHING?

Hypnobirthing Australia™ is looking for some *very* special individuals, with a *passion* for positive birthing, to join our team as Certified Hypnobirthing Australia™ Practitioners.

If you have an interest in natural birth, and would like to create an affordable, flexible business that you are passionate about, then this course is for you. Phone 0439 737 739

**BOOK YOUR PLACE NOW AS PLACES ARE LIMITED!**



## COURSE DATES

**Sydney:** 22-24 October 2013

**Melbourne:** 26-28 November 2013

**Perth:** 9-11 December 2013

**Adelaide:** 16-18 January 2014

**Gold Coast:** 11-13 March 2014

COME AND JOIN US! Finally we have an Australian Hypnobirthing Course that is up-to-date and specifically designed for Australians & our models of care!



[www.hypnobirthingaustralia.com.au/practitioner-training/](http://www.hypnobirthingaustralia.com.au/practitioner-training/)

# DO YOU WANT YOUR OWN MIDWIFE?

- **Do you want more control in your pregnancy birth and postnatal care?**
- **Do you want care in your community or in your home?**
- **Do Australian women deserve government-funded midwifery care?**
- **Download and send MC's letter to your hospital and your MPs: <http://www.maternitycoalition.org.au/women-want-midwives.html>.**
- **Use our letter to help you ask for the pregnancy, birth and postnatal care you (and all women) deserve.**

## A new option for birth care

Australia's State, Territory and Commonwealth governments have all committed to giving women access to Medicare-funded care from midwives in private practice. Changes were made to health funding laws in 2010 to give women this choice.

The new arrangements enable women to receive their pregnancy, birth and postnatal care from their chosen private midwife, with access to obstetricians and other medical care whenever needed. Pregnancy and postnatal midwifery care can be provided in community-based clinics or in women's homes and women can go to the local public hospital with their midwife for birth. This type of care is very popular with women, is common in other countries, and is at least as safe as traditional care.

## Why can't I access this choice?

The Medicare items have been ready and available for nearly three years (since November 2010), but only a tiny number of Australian women have access to this choice. Doctors' groups have been highly resistant to the entry of midwives to the birth care marketplace, and most State and Territory governments have failed to act to give women access to public hospitals for birth care with a private midwife. Only the Queensland Government has put processes in place to help women access public hospitals with private midwives, and that's why Queensland has the only four hospitals in Australia with visiting access for private midwives.

## Is it safe?

The research is clear: maternity care from a known midwife, well supported by the hospital system, is as safe, or safer, than normal maternity care. It also feels safe for women.

## Is it expensive?

Medicare funding makes private midwifery care affordable for women. Women can choose their own caregiver at much lower cost than private obstetrics, and still have access to obstetric care when they need it.

Private midwifery care also saves public hospitals and state governments thousands of dollars for each woman who makes this choice.

## So why don't hospitals and state governments support this choice?

Governments have all agreed that women should have this choice and hospitals and governments stand to receive big benefits. However, hospital managers are resistant to change and not particularly interested in women's choices; unless women speak out.

## WHAT CAN WE DO ABOUT IT?

When women speak out together, governments and health services listen.

- Download a copy of Maternity Coalition's letter
- Edit the letter so it tells your story (you don't need to be pregnant)
- Find postal or email addresses for your members of parliament, and your local maternity hospital
- Send them your letter
- Email MC to let us know what sort of response you get  
[info@maternitycoalition.org.au](mailto:info@maternitycoalition.org.au)



choices for  
CHILD BIRTH

Victoria Winter Sessions 2013

Date: Saturday 19<sup>th</sup> and 26<sup>th</sup> October, 2013

Venue: Northcote Town Hall

For booking and more information

Phone: 05 8677 1881

Email: [melbourne@choicesforchildbirth.org.au](mailto:melbourne@choicesforchildbirth.org.au)

Website: [choicesforchildbirth.org.au](http://choicesforchildbirth.org.au)

Sessions include:

Labour & Birth – Dynamics w/Rhea Dempsey

Labour & Birth – Mechanics w/Lael Stone

Pregnancy w/Catrina Adams

Early Parenting w/Jess Permezel

Reasonable pricing and student options



# RE-DESIGNING HOSPITAL BIRTH SUITES: THE IMPORTANCE OF CONSUMER REPRESENTATION



Consumer Representative  
Melinda Toms

It can sometimes seem too hard or too time consuming to bring about change, but if you can identify a need for change and engage your community, it is amazing what can be achieved. 'Community' is powerful: it begins with you, grows into your family, friends and peers and broadens into the wider community of people who will support actions to achieve change for a better future for all.

Two years ago a small group of Stanthorpe women identified the need for improved birthing facilities in the local public hospital (in rural Queensland). The rooms there have not been updated for decades (apart from a coat of paint), there is little room to move, soundproofing is inadequate and, most disturbingly, if a labouring woman needs to use the bathroom she has to leave the labour room and access a bathroom via a public corridor. The voices of many local women who had birthed at the hospital were collated and presented to the region's Hospital and Health Board. The women who shared their stories painted a powerful image of their satisfaction they felt for the care they received in contrast to their dissatisfaction with the *facilities* and how they limited their labouring choices.

The bringing together of the stories was time consuming. To be effective they needed to be statistically collated. Here lies the importance of coming together

as a group using members' expertise. Everyone can contribute, not just those who feel able to be spokespeople: there are roles for collecting information, writing press releases, fundraising and generally raising the profile of the issue to the wider community.

The argument was compelling and the Hospital and Health Board agreed that the existing facility was not in keeping with current expectations. \$1.1 million was allocated in the 2013/14 budget to refurbish the birth suites.

This brought with it another level of commitment by Consumer Representatives, who were invited to attend Steering Committee and User Group meetings. The Steering Committee holds monthly high-level meetings with the architect, Director of Nursing, Darling Downs Hospital and Health Service management and consumer representatives to ensure the project stays on time and on budget. The User Group, consisting of the architect, Director of Nursing, consumer representatives, midwives, Occupational Health and Safety (OH&S) representative, doctors and hospital management; will be working intensively during August and September to finalise the design.

The Mothers United for Maternity Services Stanthorpe (MUMSS) made it our goal to bring solutions to the table, not just problems. Being on the outside of the health system means we can offer an alternative viewpoint, especially where there is resistance to change. We have found it is best to have two representatives at the meetings.

Midwives in other regions have been happy to talk to us about their birth suites, and to allow us to take photos and share their feedback at the meetings we attend. Many people have difficulty visualising a design from a plan. We used photographs to illustrate to the group the atmosphere we want the birth suites to have: a warm, comfortable space in contrast to a cool medical space.

The new birth suites will be larger, with attached bathrooms, soundproofing, streamlined cabinetry and dimmable lighting. The larger birth suite will have a birth pool. The birth spaces will be modern with a welcoming, comfortable 'home-like' atmosphere. Hospital

midwives have commented on how much they are looking forward to caring for women in the new birth suites.

Our lives have certainly become busier since we started this project. Meetings are time consuming: it takes time to prepare for them properly by researching information and maintaining the connection with the consumers we represent. The understanding of our children and partners is a key factor in being a successful consumer representative. It is important to teach our children the value of service to their community, and there is no better way to do this than to demonstrate by example. We share the responsibilities by rotating through the meetings, caring for each other's children and holding our MUMSS discussions usually via email. We have a clear, shared vision and look forward to proudly celebrating the opening of the birth suites in 2014. The members of MUMSS would like to thank the families of Stanthorpe and district for their stories and ongoing practical support during this project.

## Author Bio

Melinda lives with her husband and two sons on a sheep property west of Stanthorpe. She became a Maternity Coalition member after joining the Stanthorpe BaBs group during her second pregnancy and is a Consumer Representative at Stanthorpe Hospital.

**Is your membership  
up to date?**

**Renew today.  
See page 32**

# WHAT'S HAPPENING IN TASMANIA?

We continue to have only a couple of active members, so our activities remain small and infrequent, but at the same time we are still managing to maintain a voice for consumers in the state. The big happenings in the last six months have been the official launch of the Midwifery Group Practice (MGP) at the Royal Hobart Hospital (RHH) and the first of our *Birth Story: Ina May Gaskin and The Farm Midwives* film screenings.

## MGP Launch

Kelly Madden and I were both invited to, and attended, the official in-house launch of the MGP at RHH in early July, where Kelly had the opportunity to speak on behalf of consumers. The MGP began just over 12 months ago, after much groundwork, including an initial committee looking at midwifery continuity-of-care options for Tasmania on which Kelly was the consumer representative. Following on from a 12-month trial at the Mersey Community Hospital, it was decided to establish an MGP out of the RHH. The extremely capable and driven Ana Navidad was employed as the project officer to get the scheme up and running. We could not have had a more ideal person to carry out this role. As Ana acknowledged on the day, an enormous amount of work took place behind the scenes across many departments of the RHH, as well as within the State Health Department and by external organisations such as union bodies, to enable the MGP to come into being and to run successfully for 12 months.

Congratulations to Ana in particular, and to her team of midwives (12 in total), on completing their first year of providing an excellent standard of continuity of care to families in the Hobart city area and beyond. Their survey results have indicated a very high level of satisfaction with all aspects of the service, as well as continued high demand for access. As the hospital CEO, Jane Holden (a New Zealander), said on the day, it made sense to offer a service such as this that better meets the needs of consumers and that also costs health services less to run. On the weekend immediately following the launch, a public picnic was held in the suburbs for more than 300 families who

have accessed, or who are accessing, the group practice. A project officer has also been employed to develop an MGP in the north of the state in Launceston.

## Birth Story: film screenings

In mid-July we ran the first of our *Birth Story* screenings. This turned out to be an afternoon of hiccups, beginning with a major one that could have totally ruined the event. I went to collect the key and to pay for the hall hire at the nominated address 40 minutes before the start time only to find no-one there. *Oh my gosh, what to do?* I drove around the corner to the hall (Taroona) to tell my equipment person and another helper the bad news: we had no access. My helper, Ashi from Sandy Bay Natural Therapies, quickly saved the day by offering a large room in her house in the next suburb. Ashi then remained at the hall

“ ... it made sense to offer a service such as this that better meets the needs of consumers and that also costs health services less to run ~

Jane Holden,  
CEO of Royal  
Hobart Hospital

”

redirecting attendees while we drove down to her house to set-up.

Once there, we discovered a screen had been left at home, so we moved a dining table to use a clear wall. It was a very sunny afternoon in a north-west facing room, so we needed to draw all the blinds



mamashanti  
yoga for birth :: birth support

a unique and contemporary approach to  
**Yoga for Pregnancy and Birth**  
lovingly crafted to help you cultivate calm, lift your spirits  
and consciously create new ways to weave birth  
preparation into your daily life

classes :: retreats :: workshops

Melbourne & Central Victoria

[www.mamashanti.com.au](http://www.mamashanti.com.au)





Hobart MGP: Project Midwife Ana Navidad (front centre, scarf), Kelly Madden (back right, necklace), and Genevieve Sayers (front right, T-shirt)

and throw a sheet over the one nearest the screening wall to darken the picture. Then we had trouble getting sound, solved by a call to a husband who found that we were connecting the wrong cable to the wrong place. After moving chairs upstairs and tea/coffee equipment, and other setting up, we were finally ready to go at 2.10 pm, just 40 minutes after our original start time. Everyone really enjoyed the film, despite the hiccups, and found it a good opportunity to network and chat with a diverse group of like-minded people. I didn't do a head count as I was so flustered, but we had 25–30 attendees in the end, many of whom hadn't been to one of our screenings before. (I had more luck getting media releases published this time, which is how about half the people found out about the screening.) I was also fortunate to be able to line up an ABC local radio interview in the week before the event.

Given that we can use the licence several times for smaller events, and that several people I knew were unable to make it on the day, I have approached the monthly cinema held in my local town hall (Cygnet), which is more than happy to screen it for us in early September. We will also try to organise another screening in the Hobart city area.

## Collaborative arrangements and visiting rights

We have been frustrated with a lack of progress in several areas in Tasmania. In particular these are: consumer representation and consultation, implementation of Federal reforms (primarily collaborative arrangements and visiting rights in public hospitals for Medicare-eligible midwives) and the

State government's position on publicly-funded homebirth. We therefore sent a letter detailing these concerns to the State Health Minister in mid-April and finally received a reply back later in June. The minister strangely gave us a full history of our involvement with the department, which they must think is sufficient, and also failed to address our concerns about the fact that, despite repeated promises by RHH over the last two years, there has still been no consumer engagement in the redevelopment of the Women's and Children's Precinct at RHH, the plans of which must be well advanced by now.

On the issue of Federal Reforms, the minister did not have much to say, apart

from that it is a complex issue, that the department has held preliminary discussions with privately practicing midwives (PPMs) to discuss how the reforms can be implemented here, and that the State's public hospitals are not in a position to provide access at this time. I discussed this briefly with the State's chief midwifery officer at the MGP launch and she suggested that, up until now, we haven't needed to do anything and there is still no urgency to do anything as there are only four eligible midwives, only one of whom is providing care for women across the spectrum in the community. I feel that this lack of progress is acting as a disincentive to midwives who might be interested in becoming Medicare-eligible, as if they cannot collaborate with public hospitals and cannot work their full scope of practice with clients birthing in hospitals what is the point of going through the process to become Medicare eligible?

The only bright light in all this is that the department has employed someone who has worked in Queensland developing policy around visiting rights, so hopefully this means that Tasmania will actually begin making some progress in the near future. The big losers in all this, of course, are women, as our only eligible midwife working full scope of practice can only take on one woman a month due to family constraints and, while there still are several other PPMs, they remain out of reach for many because of cost.

DO YOU BELIEVE IN NORMAL  
PHYSIOLOGICAL CHILDBIRTH?.....

So do we.



The Birthing Symbol – by wearing it you show  
your belief in the power of birth

Available online

[www.blessedbirthforhumanity.com](http://www.blessedbirthforhumanity.com)



# HOW AN ABUSIVE CHILDHOOD LED ME TO ATTACHMENT PARENTING

## Attachment parenting

Attachment parents aim to consistently and dependably respond to their children, in a warm and loving way, so that they feel emotionally safe and secure (1). Attachment parenting (AP) is based on the psychological theory of attachment, in which the quality of the bond between the child and its parent(s) forms the foundation for the individual's future happiness and ability to form loving relationships (1).

Children who are securely attached to their parent/s are more likely to:

- be able to cope with stress
- have satisfying relationships
- have healthy self-esteem
- have good mental health
- reach their full intellectual potential
- have fewer behavioural problems
- have fewer discipline problems.
- have fewer problems separating from parents (2).

The problem with the label of 'attachment parenting' is that people generally assume there is a strict set of guidelines to follow to be a perfect AP parent and to have the perfect baby. I don't think that's the case. I believe AP is about raising a family in a responsive and gentle way; ensuring the needs of all family members are met. Is it easy to do this? No. Does it always happen equitably? No. On many occasions I have put my needs well below my child's needs, but that's part of being a parent. Attachment parenting is about being mindful of my child's needs alongside the needs of my husband and myself.

## How I was parented

I was brought up, by my mum, in circumstances that were not the greatest. I left home at 14 when my mother hit me one night and I declared enough was enough. I had been beaten throughout my childhood, repeatedly raped by my stepfather, bullied by family and peers, abused mentally and emotionally by family and peers, and generally subjected to abuse for far too long. I spent the next year living with my grandparents before moving to Australia to live with my father, stepmother and their children. Together they have ten children, making me the eldest of 12; however I was not

raised alongside them and found the methods of my dad and step mum strange, if mostly understandable with so many children to watch over. The experience of how I was parented had led me to believe that children needed to learn who was boss, that a cry didn't warrant a response, that children weren't the centre of the parent's world, and that parents weren't going to wait on their children hand and foot.

## A more natural way to parent

I was introduced to a more natural way to parent by a friend. In fact I don't even know if she was that at the time, but she sure is now! We went to the same high school, but we never spoke as she was in the year above me. Being a small school, everyone knew everyone, and we were friends on Facebook. We remained that way for a few years until she contacted me when she found out that I was expecting our first child at 21. I admit that, to begin with, I was sceptical about AP, but over the course of my pregnancy my eyes opened. I went from wanting a natural labour, to breastfeed for a short while and to have a child who understood crying didn't work; to wanting a homebirth, extended breastfeeding, co-sleeping, and a gently-parented-well-attached-child. The more I read and the more children I met, the more I realised that being a gentle, attentive mother was what suited me. And, slowly, I convinced my partner too. Some things took time, like co-sleeping, some were a no-go, like homebirthing, and others were something to discuss as and when they arose.



## Birth and breastfeeding not to plan

Our child's entrance into the world wasn't the best, with unnecessary interventions compounded by lying and bullying by the staff. After my waters broke at 9 pm the day before my due date, we went into the hospital for administration of antibiotics, as I had tested positive for Group B Strep (a type of bacteria in the vagina). Evidently I tested negative several times *after* this positive test; this is stated on my notes, but the doctor told us our baby would die if I didn't deliver quickly. I was monitored for 45 minutes, on my side, to get my waters to pool on a machine that was not working properly. Once the staff finally believed that I was in labour, we were told that we must speed things up and get the baby out. They began the Syntocinon drip at 11 pm. We were continually asked if we wanted an epidural, and we consistently

turned them down whilst asking for permission to move off the bed. (I had constant monitoring due to the drip.) I was in agony: the drip caused a constant contraction, with no breaks to recover. I was begging the midwife to turn it down, but she refused, only turning it up and offering the epidural again. When I was finally dilated enough for a monitor on bub's head, my movements were still limited and the midwife insisted that I only sit on the birthing ball.

### **I was pinned on my back and told to push**

I eventually asked for some pethidine and moved back to the bed. I was injected and immediately expressed an urge to push. My midwife asked to check me and I consented. She discovered that I was only eight centimetres, at which point I told her the urge wasn't bad and I could wait. However, she reached inside me and said, as she did it, that she would dilate me the rest of the way. She pushed me from eight to ten centimetres almost causing me to lose consciousness, only stopped by my husband tapping my face as she did so. My husband says he has never heard someone scream in the way that I did then.

The midwife then tells each person in the room to hold either my shoulder or my leg as I am pinned on my back, knees to my chest and told to push. I beg and yell for everyone to get off me, to let me get up, and I am told to shut up and just push. I begin to push as bub's heart rate drops and my husband calls out that the midwife is about to cut me (perform an episiotomy). I tell her to get lost and push the baby out three pushes later. As she is placed on my chest I beg her to make a noise and breath as my husband cuts the cord. They whisk her away and give her oxygen as the midwife gives me a needle to deliver the placenta. She tugs on it twice before pulling it out. I then start calling out for my husband as the midwife reaches inside me and drags membranes from me. She does this again and again. I beg her to stop but she refuses. When she finally does, bub is popped on my chest and I see her properly for the first time. I then feel the midwife move my legs onto stirrups as she informs me that I need some stitches (small labial tears, an episiotomy was not needed after all!) and I ask her to assist me to feed first, but she refuses to and stabs me with a numbing needle before stitching me up. I leave her to it. I no longer care.

My memories of meeting our daughter Rose are scarred with the reminders of how she arrived. We did get a

*“ On top of the usual challenges, I struggled with the abusive parenting I had experienced. It is incredibly difficult to be attached and nurturing to your child when you aren't entirely sure how it feels. ”*

beautiful, healthy, happy baby; but her entrance carried painful memories and breastfeeding was extremely hard. I would bite on a rag to latch her on, screaming and crying through her feeds and, though people told me again and again 'it will get better', it just got worse. I begged midwives and doctors to check Rose for a tongue-tie; I asked for referrals to lactation consultants; neither happened. At 11 days old we gave our daughter a bottle of formula and never breastfed again. She was diagnosed as tongue-tied at seven months of age.

It was at around this time that I started doubting our choices, as neither my labour nor breastfeeding had gone to plan. I wondered if I would ever be able to meet the needs of my child, myself and my relationship with my husband. At that point, to me, AP was about breastfeeding, co-sleeping, cloth nappies, organic food and gentle discipline. I wasn't doing any of that. I was part time co-sleeping, but we weren't meeting those AP goals: the AP rules! Maybe we weren't cut out for this.

### **Postnatal depression**

When our daughter was about three months old, I admitted to my husband that I could not cope. Postnatal depression had hit, and possibly some post-traumatic stress symptoms from my birth experience. I cried whilst my child seemingly screamed all day. Some days I hid behind the sofa whilst she cried for me. I just could not be the mother she deserved. I was convinced I would become my mother and memories of my childhood haunted me. My relationship with my mother was non-existent, I had no mother-in-law, and my stepmother had just given birth herself. I was the first of all my siblings to have a child. I was exhausted with no support.

### **A dawning realisation**

A few days later my grandparents arrived in the country. Their visit

reminded me of why I had left home. It dawned on me that my own childhood was affecting my ability to practice AP with my child. New parents who have not been gently parented themselves usually face challenges, such as pressure from family to do things their way, or insistence from friends that they 'need' to do certain things, such as let their child cry to sleep or 'they will never self-settle'. On top of the usual challenges, I struggled with the abusive parenting I had experienced. It is incredibly difficult to be attached and nurturing to your child when you aren't entirely sure how it feels. If you have been smacked throughout your childhood, it takes a lot of patience, education and self-discipline to not resort to the same. As a child I didn't learn any other ways to respond.

### **Learning a new way**

Now I research, I ask and I implement a system that sees me help my child when she is feeling or behaving in a certain way. I learnt to realise that my child is not being naughty; she is exploring her world and that is OK. I learnt that my child isn't being clingy because I'm doing something wrong; rather, she has a need to be met, but she can't yet tell me precisely what that need is. I learnt that a walk in a carrier was invaluable for settling a teething baby. I learnt that a well-rested mummy doesn't lose her temper. I learnt that taking a deep breath and thinking solved almost any problem. And I learnt that the most valuable thing I had was my instinct, which was always right. This was completely different from the feelings I had when I almost took to the methods of my mum: anger, frustration and a wish to push my baby away from me and punish her. If I started to feel that way again, my brain would kick in and say, "This isn't right. She is just a baby. She doesn't know. She just has a need and you need to meet it. Breathe and think." It always worked and I find I hardly do it anymore.

### **Time for me**

I began to take time for me when I could. A long shower; a lie in; a good book; forgetting the housework and just taking a nap with bub. I realised I wasn't superwoman and that was just fine. Over the months Rose learnt how to crawl and I learnt how to get a few bits done. I was one person, with a household to look after and baby that would grow up oh so fast. I evaluated my surroundings and worked on doing what I had set out to do: to raise a family in a gentle and equal way.





Colin and Rose on Father's Day 2012

bum, not vaccinate and only eat organic; at least that's what they tell you. My experience is that APers are parents who attempt to grow families who are considerate of others' needs, have their personal needs met and who develop well-rounded healthy adults. To me, that's AP. To me, that's what I am. What we are. If there are any 'rules' to APing they are to attend to your child's needs with love and compassion, and to attend to the whole family's needs, including your own, with love and compassion. It is not easy; it presents us with many challenges; but it is more than worth the hurdles on the way.

## Author Bio

Stephanie is a married mother of one, living in Logan, Queensland. The eldest of twelve children, she thought she knew it all before she even had her own! Though parenting has its ups and downs, Stephanie and her husband, Colin, strive to keep the basic AP philosophies of providing a gentle and nurturing environment for the entire family. Stephanie has articles published in other magazines and enjoys offering her work to various 'natural' resources. Writing is a hobby at present but one day Stephanie hopes to publish a book on her childhood experiences.

## References

1. Robin Grille, *Heart to Heart Parenting*. (ABC Books: Sydney, 2008)
2. Australian Association of Infant Mental Health Inc. *Position Paper 2: Responding to Babies' Cues*. 2006 <http://www.aaimhi.org/inewsfiles/Position%20Paper%202.pdf>

## Frazzled back at work

I was back at work when Rose learnt to walk. She had taken steps before, but whilst I was working she became a walker rather than a crawler. Then her first birthday came along and thankfully we were able to have a lovely party due to my pay. However, we soon realised that my not being at home was adversely affecting our mother-daughter bond. My instinct didn't kick in as often. My daughter and I grew constantly frustrated with one another and my husband and I fought constantly through sheer exhaustion. I became a tired frazzled mum, and the only people whose needs were being met were my bosses. This was not what we had set out to do. This was not the right goal for our family. So I quit.

## Our AP family

Now we have our AP family, or our definition of an AP family anyway. We have support through friends who parent like us, through Facebook groups, including a local AP group and through our family finally accepting we do things a little differently to them. I am a happy stay-at-home mum. My daughter is a cheeky, confident and intelligent toddler who loves to explore. My husband is doing well at work, looking at promotion, and loves being the provider for his little family. Attachment-parents (APers) are supposed to breastfeed, co-sleep, cloth

Beautiful & unique toys crafted from organic, sustainable & recycled materials.

NEW Eco Party Range!

'care for our planet, one step at a time'

[www.ecotoys.com.au](http://www.ecotoys.com.au)



# Homebirth - Own Birth



29<sup>th</sup> HOMEBIRTH AUSTRALIA CONFERENCE

BRISBANE CITY HALL

22-23 MARCH 2014

FOR EVERYONE WITH A PASSION FOR HOMEBIRTH  
& INFORMED DECISION MAKING IN BIRTH

CONSUMERS, FAMILIES, MIDWIVES, DOCTORS, DOULAS, STUDENTS

KEYNOTE SPEAKERS-

SARA WICKHAM & ANDREW BISITS

WITH CATHERINE DEVENY AS MC

With Gold Sponsor



[www.puremedic.com](http://www.puremedic.com)

VISIT - [WWW.HOMEBIRTHAUSTRALIA.ORG](http://WWW.HOMEBIRTHAUSTRALIA.ORG)

FOR TICKETS AND DETAILS

*Photo by Jay Johnson Photography*  
[www.jayjohnsonphotography.com.au](http://www.jayjohnsonphotography.com.au)



# UNREGISTERED BIRTH WORKERS

The basic legal position in Australia at present is that anyone can act like a midwife, but only registered midwives can use the title 'midwife'. There is, however, increasing attention being given to restricting the practice of midwifery. There are also moves afoot to regulate unregistered health practitioners more generally.

Under the Health Practitioner Regulation National Law (the 'National Law'), which commenced in 2010, it is an offence for anyone who is not a registered midwife to use the title 'midwife'. However, there is no law that says that only registered midwives can practise midwifery. Therefore it is legal for an individual who is not a registered midwife to attend births, charge money to attend births, claim to have a high level of expertise in birth, carry out vaginal exams, use a Doppler and 'catch babies', as long as they do not actually call themselves a 'midwife' while doing so.

The legal situation in Australia contrasts with that in the United Kingdom, where only a registered midwife or medical practitioner can attend a woman in childbirth. This means that an unregistered midwife who attends births could be prosecuted. The use of the title 'midwife' is also protected in the UK. The current legal situation in Australia also contrasts with the situation that existed in some Australian states before the National Law commenced.

In the past, individuals practising midwifery without being registered were primarily 'lay' midwives who were not formally qualified and who would not actually meet the requirements for registration as a midwife. In recent times we have seen the rise of the previously registered midwife, who still attends births in much the same manner as they did while registered. They do the same work, but use a different title. They can effectively practise midwifery without regulatory oversight or accountability.

There are also unqualified birth workers, or doulas, who claim expertise in supporting women during pregnancy and birth, and who provide some care that might be considered 'midwifery', including using Dopplers, conducting vaginal exams and providing advice.

There is a legal gap in dealing with these unregistered individuals, particularly if they offer substandard care or behave in an unethical manner. There are limited avenues at present for dealing with a situation where a qualified midwife chooses not to be registered, continues to practice, and then provides extremely poor care. In some cases their actions might amount to criminal conduct, but this can often be difficult to establish. Unregistered individuals cannot be held to account for practice that would amount to unprofessional conduct or professional misconduct (and subject to harsh penalties) for a registered practitioner. Similarly, there is very limited accountability for unqualified birth workers who might engage in unsafe practices or give women poor information. It is possible to make a complaint to the healthcare complaints body in each state, but historically the powers of these bodies have not extended to prohibiting individuals from practising.

In 2012, a South Australian coroner recommended that legislation be introduced making it an offence to engage in the practice of midwifery without being a registered midwife or medical practitioner. The South Australian Government has consulted on a proposal to amend the law, but has yet to introduce legislation. The proposal states that the practice of midwifery will "include all care to a woman across the care continuum of the antenatal, intrapartum and postnatal periods for the mother and baby." If South Australia passes such legislation, it is likely that other states will follow.

There are a couple of difficulties in legislating to protect midwifery practice. The first is how we define 'practising as a midwife'. What specific practices do we say can only be done by registered midwives? Is it checking the foetal heart, conducting vaginal examinations, carrying resuscitation equipment or something else? These would all appear to be caught in the definition of midwifery practice in the proposal. A related concern is how we draw the line between midwifery practice and labour support. Would it be an offence for a doula to attend a freebirth?

New South Wales and South Australia now have legislation that regulates

unregistered health practitioners and that gives the relevant healthcare complaints body the power to prohibit an individual from practicing in certain circumstances. There is also similar legislation before Queensland's parliament.

In June 2013, all Australian health ministers agreed in principle to a single national code of conduct for unregistered health practitioners and for statutory powers to investigate breaches of the code and issue prohibition orders. This legislation is likely to cover unregistered qualified midwives, lay midwives and doulas who are providing some level of antenatal, intrapartum or postnatal care beyond pure support. This will mean that, in all States and Territories, there will be powers to stop an individual from practising if they are engaging in unsafe or unethical practices. The Australian Health Ministers Advisory Council will soon undertake a public consultation on the terms of the first national code of conduct.

The language used to discuss these issues in the context of maternity care is often focussed on protecting midwifery. Instead, I suggest we should be looking at consumer protection: limiting the potential for consumer confusion and protecting consumers from practitioners who claim to have expertise, but whose practice or conduct is unsafe, unprofessional or unethical.

At the very least, women need to know that at present unregistered practitioners have:

- no minimum standard of skills or education
- no requirement to maintain their skills or education or to engage in continuing professional development
- limited accountability in the event of an adverse outcome or misconduct
- no enforceable requirement to comply with professional obligations, such as providing services in a safe and ethical manner, protecting client confidentiality, keeping records and having appropriate insurance (except in New South Wales and South Australia where they are included in the codes of conduct).

# "BIRTH STORY: INA MAY GASKIN AND THE FARM MIDWIVES" FILM REVIEW



In 2012 many of us salivated at the prospect of viewing a film featuring one of the world's most well-known midwives from North America, Ina May Gaskin. Ina May is the author of the hugely popular books "Spiritual Midwifery" and "Ina May's Guide to Childbirth".

I was not disappointed! The directors have put together a down-to-earth and interesting documentary about how Ina May and 'The Farm Midwives' came to be. It showcases their evolving practice using both historical footage and recent footage of the midwives at work. It includes interviews with midwives past and present, and an interview with Ina May's husband, Stephen Gaskin. Ina May comes across as a very practical person with a lot of common sense.

I did not realise that Ina May's first birth took place in a hospital; it did not meet

her expectations and made her question why it had to be as it was. She didn't grow up hearing negative stories about birth and believed that it would be like a test, requiring courage to get through. But she experienced no kindness from her care-providers, and her confidence was battered at such a crucial time. It left her to ponder how difficult it is for

mothers to commence parenting with little self-confidence, and how mothers can regain confidence during such an immense transitional period.

The film-makers have been criticised for 'sugar-coating' midwifery by not including any medical points of view in response to the perceived negativity about hospital births. I disagree. They have shown that well-trained midwives, operating in a community setting, caring for well-nourished, educated women who have positive expectations, can achieve excellent birth outcomes. We already see so much media about highly medicalised and negative birth experiences, that it is pleasing to see the other side of the story. The film is meant to be about midwifery, not obstetrics. Ina May does not advocate that we should do away with obstetrics, rather, that we need obstetricians for

women with complex pregnancies and emergency situations. She says that the issue with obstetrics is that it has become pre-emptive (by using more and more routine interventions); which is rapidly increasing the danger for women. The United States spends more per capita on care for pregnancy and birth than any other country but ranks 50th in the world in terms of maternal mortality.

Some have been disappointed that the film did not delve deeper into the history of The Farm. I think that the film-makers were right not to do so as it would have made the film much too long. Besides, I think their focus was the midwifery clinic; why and how it was established, and why its outcomes were (and are) so different compared to hospital birth. The film includes close-up footage of four births, including a breech baby and a shoulder dystocia where the 'Gaskin manoeuvre' was brought into play. Overall, it is an awe-inspiring documentary for all to watch.

**HAVE YOU SEEN OUR NEW LOOK WEBSITE?? BE SURE TO CHECK IT OUT!**



**[www.maternitycoalition.org.au](http://www.maternitycoalition.org.au)**



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

**Where:** Northcote Town Hall & Elwood/St Kilda Neighbourhood Learning Centre

**For bookings and screening details:**

**Web:** [www.maternitycoalition.org](http://www.maternitycoalition.org)  
[www.birthattendants.info](http://www.birthattendants.info)

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

**Phone:** 03 8677 1881

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

Brought to you in partnership with Birth Attendants info





# MIDWIVES READY FOR RURAL AND REMOTE WORK

Residents in Millicent in South Eastern South Australia have been outraged at the State Government's surprise decision in July to close birthing services at the Millicent Hospital. On 1 August *The South Eastern Times* reported that almost 600 people turned up to a public meeting held on 31 July in Millicent, where the decision was blamed on the fact that the service was unable to offer 24-hour obstetric and anaesthetic cover. This is despite the *10 Year Local Health Service Plan for Millicent and District Hospital and Health Services 2011–2020* stating that it will "maintain and extend the current staffing and resources to cover low risk maternity and birthing." The Minister for Health Jack Snelling did not attend the public meeting, but the Shadow Minister for Health Rob Lucas assured the community that, if elected in March 2014, they would reinstate birthing services.

The decision to close the birthing service at Millicent Hospital means birthing women in the South East now have to travel at least an extra half an hour to reach Mount Gambier Hospital, as Millicent also provided birthing services to Robe and Kingston. Antenatal care will continue to be provided in Millicent. To date, 1326 people have signed the online petition; and *The South Eastern Times* states that another 3000 have signed the hard copy version to be tabled in State Parliament.

Despite accessing multiple media sources, I have been unable to find any suggestion of re-instating the Millicent birthing service with a midwifery-led model. Midwifery-led models in other parts of the country, such as Mareeba District Hospital in Queensland, have proved to be very successful in providing safe maternity care to women with low-risk pregnancies. Maternity Coalition will continue to follow the developments at Millicent Hospital.

There is good news for rural birthing women in Queensland, with a media release from the Minister

for Health, Lawrence Springborg, announcing on 11 June that Cooktown and Weipa may be the next rural areas to have birthing services re-introduced. This was followed by a media release two days later announcing a two-year program for graduate nurses to train as midwives using private midwifery practices to receive the necessary experience. The focus would be on rural maternity care, and would aim to return these midwives to staff rural areas. Mr Springborg said, "The end result will be graduates enjoying proper mentoring by rural health service practitioners, which will result in a midwifery workforce ready for community-based rural and remote employment." Belinda Maier, the former Midwifery Advisor to Queensland Health, is the Project Manager working for My Midwives. She reports the intent of the project is, "to build private and rural capacity for midwives to increase women's access to continuity and private midwifery services."

A new Maternity Coalition branch has started up in New South Wales (NSW), in the Hunter Region. Belmont Birthing Maternity Coalition (BBMC) was formed to support the Belmont

Midwifery Group Practice (BMGP), which provides a low-risk pregnancy and birthing service to women living within 30 minutes of Belmont Hospital. As well as operating from the birth suites within Belmont Hospital, it also provides a publicly-funded homebirth program. Tess Liebermann, the president of BBMC, reported that last year there were cuts to staff numbers that led to the formation of the group. She said, "Our aim as a group is to advocate for the service offered and to promote the service and increase use of the service in Newcastle." The group has produced a website for friends of Belmont Birthing in order to give the service an online presence, which has not been possible for BMGP to adopt on its own, as it has been restricted as part of the broader maternity services system offered by Hunter New England Health.

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



**Rad-Pads®**

**cloth menstrual/  
incontinence pads**

**www.rad-pads.com**  
0408 517 796 info@rad-pads.com

Disposables	....compared to....	Rad-Pads
Ongoing costs		Minimal on-going cost
Big business profits		Woman friendly
Chemicals in manufacture		Organic options
Disposable, into landfill		Re-usable, not in landfill
Comfortable?		Comfortable!
Inconvenient – buy from shops		Convenient – always on hand
Made where?		Australian made
Cost to your health?		Minimum chemicals, no plastic fibres

YOUR FUTURE, YOUR CHOICE!



# MEETINGS WITH THE QLD HEALTH MINISTER

I am rather fortunate to have the current Queensland Health Minister Lawrence Springborg as my Local Member of Parliament. Meeting with him, on behalf of Maternity Coalition, happens regularly and easily: just a quick stroll down the main street of Goondiwindi, to my local council office.

Whilst I believe Lawrence Springborg has a strong commitment to ensuring that woman can access continuity of midwifery care, he is also battling a long-standing culture in our health system whereby many medical practitioners engage in politics and power plays instead of serving the physical and emotional needs of the women and families who fund the health system.

Today, I strolled into the local council office, rather hot under the collar after our Queensland President had called to tell me of some more atrocities facing Brisbane families. Namely, families were being denied access to the public hospital because they had sought antenatal and postnatal care from private midwives. These women were told by practitioners at this particular hospital that it was 'illegal' for them to do so and that they were 'not welcome' to birth at the hospital (which is publicly funded.)

I made it very clear to our Health Minister that this came down to an issue of basic human rights being denied in a Queensland Health Hospital. I reminded him that this certainly does not fit with his commitment for change and his maternity vision for our state. I made it clear that, as a taxpayer, I do not agree to my tax funding such social injustice. I'm hoping that by

next time I write for *Birth Matters* this hospital has had a serious overhaul! (see text box)

I also talked to Lawrence Springborg about Chinchilla, a small town two hours west of Toowoomba, which reached crisis point last year, when its maternity services were abruptly stopped. I will give the Health Minister credit for knowing quite a bit about the condition of maternity services at Chinchilla. It will be the first hybrid public/private continuity-of-care midwifery model in the State, involving My Midwives. From talks to consumers and other stakeholders involved, there is little progress being made on this model. Again, as we are seeing around the State, power, personality and culture are interfering with

families accessing continuity of midwifery care.

The minister has said that he will get back to me on quite a few matters, so watch this space.

## EDITORS NOTE:

Since going to press there has been a huge win for consumers and Medicare-eligible midwives who access Logan hospital. For further information go to [www.couriermail.com.au/questnews/logan/private-midwives-previously-banned-from-logan-hospital-now-allowed/story-fni9r0nh-1226709828703](http://www.couriermail.com.au/questnews/logan/private-midwives-previously-banned-from-logan-hospital-now-allowed/story-fni9r0nh-1226709828703)

by Rhea Dempsey

Watch Rhea's 'Birthing Wisdom' Facebook page and website for launch dates and purchase options.

Website: [www.birthingwisdom.com.au](http://www.birthingwisdom.com.au)  
Face Book: [www.facebook.com/birthingwisdom](http://www.facebook.com/birthingwisdom)

**Tickets Available Now!**  
**Redeem Your Free Ticket Deal Today**

Book online now to receive:

- Priority Entry
- Your **FREE** Ticket Deal
- Pre-Registration to collect your **FREE Pink Bag** on entry
- Your unique QR code to scan at participating Stands for **offers & competitions.**

Go to [www.pbcexpo.com.au](http://www.pbcexpo.com.au) to claim your free ticket.  
ENTER CODE: **EXNFP**

Melbourne Exhibition Centre  
Friday 25 - Sunday 27 October

**Pregnancy Babies & Children's EXPO**

# TEN THINGS YOU MIGHT NOT KNOW ABOUT MATERNITY COALITION

1

## **We are a not-for-profit organisation**

Maternity Coalition (MC) is Australia's national maternity consumer advocacy organisation. MC volunteers support every woman's right to receive care that is evidence-based and woman-centred, and advocate and lobby for improved information, access and choice in maternity care for all Australian women.

2



## **Most of our volunteers are mothers**

Committed members spend thousands of hours of their own time to bring the consumer voice to Australian maternity service policy makers and service providers. The majority of MC volunteers are also mums (and a few dads). Many have babies or very young children and balance their commitment to MC with careers, study, family and other voluntary positions. It's true what they say: 'If you want something done, ask a busy mother!'

3

## **We have been around for over 25 years**

In the early 1980s, when it all started, MC was a group of mothers and midwives working in various fields, including childbirth education. We formally incorporated MC in 1988 and merged with Mothers and Midwives Action (MAMA), Midwives In Private Practice (MIPPS) and Australian Radical Mothers and Midwives (ARM). Early meetings were held in and around Melbourne in people's homes, culminating in a marathon session completing a written submission to the Victorian Birthing Services Review. The Final Report was titled *Having a Baby in Victoria*.

4

## **Our biggest membership is in Victoria**

We now have branches in every State and Territory of Australia. Victorian members make up 42% of all our memberships, followed by Queensland (28%) and New South Wales (19%). Representation from other states drops dramatically to just 3% a piece for Western Australia and Tasmania, 2% for both South Australia and the Australian Capital Territory, and just 1% in the Northern Territory.



5

## **We have no physical office**

We are an internet-dependent organisation. Committee members (who do most of the work) are spread around rural and urban Australia. Committee members talk monthly (at least) by Skype and correspond daily by email. Maternity Coalition became a national organisation in 2002, just when home internet connections were becoming common. Doing this much work on a shoestring would not be possible without modern communication technology.



## Our slogan has changed, our vision has not

Our very first slogan was 'with women, with child' and our purpose was to improve maternity care. Our current slogan is 'every woman can choose how, where and with whom she births.' This slogan reflects our commitment to improve access to, and quality of, maternity services in all settings. In other words we want 'better options and better care' for all Australian women.

6



## Birth Matters: from typewritten to online

The first ever *Birth Matters* (BM) was typed up by Irene Shaw at her kitchen table in Melbourne. The first issue (Volume 1.1, July 1996) was entitled *New beginnings*; (see the editorial on Page 3 which features excerpts from the first editorial). We are currently printing Volume 17.3 and it is 36 pages including colour advertising. More than 50% of our members choose to read BM electronically. In the future we hope to have BM indexed so that articles that appear online can be found through search engines, shared and referenced by others.

7

## We have more than 2500 'likes' on Facebook

Social media is a forum where we can share news that affects birthing consumers, seek your input into documents for consultation, and seek direction about where MC should place its energies.

8

## A lot goes on behind the scenes

MC has consumer representatives on committees, boards and working groups at local, state and federal level. We also work closely with other groups and organisations such as the Australian College of Midwives, Homebirth Australia and the Australian Private Midwives Association, who share our goal of achieving genuine maternity reform.

9

## We can't do it without you!

Without the ongoing support of our members, MC would be unable to function. There are hundreds of different ways that you can contribute to realising our vision and bringing improved information, access and choice to every birthing woman in Australia. Contact your local MC representative or check our website to find out how you can help.

10

# Freya Isobel's breech birth

## Sarah's story

After twelve years together and eight years of marriage, most of our friends and family had given up asking whether we were going to have children. However, all good things take time and, on Father's Day in 2012, I found out that I was pregnant and due on Mother's Day 2013!

As this event had happened rather quicker than we expected it to (once we finally decided to start trying), our private health insurance waiting period was not yet up and so I was not covered for a birth in a private hospital. This turned out to be a blessing in disguise, as the model of care I chose for my pregnancy (the Midwifery Group Practice, with the same midwife throughout my pregnancy) was excellent. Looking back, I wouldn't have done it any other way.

Although the notes for some of my midwife appointments marked bub's position as cephalic (head down), I suspected that she'd always been breech and that what my midwife could feel down in my pelvis was a bony little bottom. This was confirmed by an ultrasound at 34 weeks. From this date I tried everything I could to turn her: acupuncture and moxibustion, chiropractic (Webster technique), body positioning and inversion (getting upside down); all to no avail. At 37 weeks she was still in a frank breech position and I was booked in for an External Cephalic Version (ECV) at the hospital.



Sarah and baby Freya

## Dan's story

"I think we need to go to surgery." The doctor looks from me back to Sarah. It seems odd, yet comforting: the highly trained professional still seeks approval. My wife is lying on a hospital bed, sweating and panting after long hours of labour. She nods as another contraction begins. There is no argument, no need for persuasion. It is the right decision.

It is early afternoon and we have been in the hospital since 2.45 am. Sarah woke an hour earlier, two hours after we had gone to bed: "I think my waters have broken." After the wishful, inconclusive tests at the start of this pregnancy, my first tired thought is, "You think?" Even groggy and tired, I have enough tact not to voice this. As I wake fully, it dawns on me that this could be it. The house is sorted; the hospital bags are in the car; we are as prepared as we can be, but I'm not sure I am quite ready. She is not officially due for another week and this is time that I had planned to use to 'get my head together'. This is not a false alarm. Excited and happy will have to do instead of ready.

I can find many reasons, both legitimate and ironic, for why this baby is coming now: Sarah had that herbal bath; my intern started today; tomorrow is a huge day at work; we are booked in for our final Spanish lesson next Monday. The only reason that counts, of course, is the one that makes us so happy: our baby is ready.

Our daughter is in a breech position. Despite Sarah's efforts in a range of procedures, our little lady is like Maggie Thatcher: she is not for turning. I think she has adopted the 'wombat defence' (a bottom-first approach to the world) as proof that she is truly Australian. Of course, in her mother's native England, the doctors and midwives tend to have more experience in delivering breech births.

While not ideal, breeches are neither rare nor inherently dangerous. Unfortunately, flawed research indicates a greater risk factor, leading to a discouragement of natural deliveries, leading to reduced clinical expertise in them. Our 'trial of labour' sounds ominous, but isn't: we will try and, if there is a problem, Sarah may need to have a caesarean. We worried about following an arbitrary surgical timetable, but this spontaneous labour means our daughter is coming because she is ready.

After nine hours of steady progress, Sarah has dilated to nine centimetres. Unfortunately, two hours later, there is no change. All signs from the baby are good, but her birth has stopped progressing. In breech position, the options now are limited. The duty obstetrician, a supportive South African, readies herself for a hard conversation. Except that it isn't hard. Sitting on the bed to suit medical convention (rather than walking, or standing in the shower) has disrupted Sarah's focus on managing her pain. Visualising her purring cat helped for a few hours until the contractions got too big even for him. Now, breathing deeply, she is in no mood for discussion. Let's just get it done.

I am so proud of her. The obstetrician tells Sarah how much of an inspiration she is. Surgery is not a failure, and she has maybe helped change some opinions 'around here.' Perhaps



The ECV was uncomfortable and unsuccessful. Bub stayed firmly in place. Until this time all I had been told was that I'd be booked in for a caesarean at 39 weeks if bub hadn't turned head down before then. I presumed this was the only option; however when I spoke to my midwife after the ECV attempt, she told me that I had a choice: I could try to birth this baby vaginally if I wanted to.

## Breech birth or delivery

Being faced with this choice made me very anxious. I had no idea which was the 'best' and safest option for myself and my child. Over the next few days I researched, read books and articles, asked questions and came to the decision that a vaginal breech birth (VBB) was the best option for both of us. I was very lucky that my midwife and her colleagues were supportive of this choice. The obstetricians at the hospital were only experienced in assisted vaginal delivery (involving hands-on manoeuvres of the baby and sometimes instruments such as forceps) where the woman is confined on her back on the bed. There were no obstetricians at the hospital who were experienced in active, upright VBB (which is what I wanted), so the birth would have to be midwife-led. I was told that if there were any complications I'd need to be prepared for a bed-bound assisted delivery, or an emergency caesarean.

## At peace with her breech position

On a Monday night, a week before my due date, I took a bath with clary sage oil and went to bed for the night. As I lay there, I told my baby that I was at peace with her position and ready for her to arrive now. A couple of hours later I awoke to my waters breaking, and contractions followed immediately at three to four minutes apart. Once I was sure that the contractions were regular, I called my midwife and headed into hospital, arriving at around 2.45 am.

At 3.30 am, once I was in birth suite, I was four centimetres dilated. By 7.30 am I had reached seven centimetres and was heading into transition. I was introduced to the obstetrician on duty that day, who was surprisingly supportive of VBB (my midwife later told me that this obstetrician had remarked to her that she was actually quite excited to be present at an active, upright VBB and 'felt like a bit of a hippy').

## The shower was amazing

The contractions were getting more intense and my midwife suggested that I move into the shower to get some relief. I was lucky to be able to do this as, although I was being constantly monitored, it was via wireless telemetry, which was waterproof. The shower was amazing. I stayed in there for most of the next four hours until my next internal examination. I was nine centimetres dilated... almost pushing time! I was given some intravenous fluids as I was becoming dehydrated from being in the hot shower for so long, however, throughout all this, bub's heart rate had been consistent. She was doing just fine in there.

Two hours later I was not feeling a strong urge to push, and had another internal exam: *still nine centimetres*. By this time I'd been in labour for around 12 hours, the last two of those with no progress. It seemed that bub's little bottom wasn't quite large enough to fully dilate my cervix. I spoke to my midwife and to the obstetrician on duty and agreed to an emergency caesarean, as it seemed unlikely that bub would make it out on her own.



Sarah, Dan and baby Freya

her choices may help other women with theirs, or into a position where at least they have a choice to make.

I, however, have felt mostly useless all night, dragged along by Sarah's strength of spirit, offering my encouragement and support where I can. There's nothing like hours of enforced helplessness followed by potentially life-threatening surgery, all after two hours' sleep, to undermine your self-esteem. This, of course, is on the greatest day of my life.

At the moment of greatest drama, I feel most useless. I am all but lost in the bustle to surgery, helped into scrubs by a friendly midwife, and now at arm's length from the woman I love. The same woman whom, the anaesthetist tells me, runs a risk of paralysis or even death from the epidural. On top of my sleepless, fragile ego and impending fatherhood, this is just about too much. I choke up, but no one needs me to speak. I am perhaps a pillow of strength, if not a pillar. In surgery, I hold Sarah's hand and she squeezes back. I'm not sure who is supporting whom.

There seems to be a horde of medicos fluttering around, shifting furniture, and plugging in cords and tubes. It is like frenzied interior decorating around a central surgery feature: quite a conversation piece. After the epidural is inserted, just to draw out the drama, our midwife thinks she sees some extra dilation or movement. Perhaps surgery can be avoided? But no; it is a false alarm. My emotions yo-yo again, but Sarah seems relaxed now the pain is gone and focuses on the midwife's other comment: "You'll meet your baby soon."

Then it begins and before long it is over. I see my little girl held up and hear her cry. She is quiet for the rest of the day, but that first cry is enough. I have to blink back my tears and try not to fall off my chair.

I cannot say yet if I feel love. Relief, undoubtedly; marvel, and wonderment beyond words. I feel, frankly, a little Charles Dickens: 'it was the best of times/it was the worst of times'. After the trauma of the night and day, our baby is now here.



Sarah and baby Freya after caesarean birth

I was happy with this decision. We had given it our best shot: I'd waited to go into spontaneous labour, so I knew bub was ready to come out; I'd laboured for 12 hours and got to nine centimetres; and, throughout this, bub's heart rate was steady and she wasn't distressed. Now I was ready to meet her and, in the end, it didn't matter which exit she came out of.

At 2.34 pm on 7 May 2013, Freya Isobel was born. She came out crying and in perfect health, with an Apgar score of 9. She was long and skinny: weight 3.14 kilograms, length 53 centimetres, and head circumference 35 centimetres. Perfect!

Because of all the research I had done on breech birth, I was prepared for the possibility of a caesarean and had thought hard about my preferences (and informed my midwife of these) should this eventuate. I was therefore able to have some precious skin-to-skin time with my little bundle while I was being stitched up, before she was taken away to be weighed and measured. After only two hours of sleep and 12 hours of labour, I was a little hazy to say the least. Holding my newborn baby on my chest made the experience even more surreal. Despite the fact that the birth did not happen 'as planned' (does it ever?), I am very happy with the way it all turned out. I had excellent care throughout, and it ended in the best way possible: with my beautiful, healthy little daughter.

“ At the moment of greatest drama, I feel most useless. I am all but lost in the bustle to surgery, helped into scrubs by a friendly midwife, and now at arm's length from the woman I love. The same woman whom, the anaesthetist tells me, runs a risk of paralysis or even death from the epidural. On top of my sleepless, fragile ego and impending fatherhood, this is just about too much. I choke up, but no one needs me to speak. I am perhaps a pillow of strength, if not a pillar. In surgery, I hold Sarah's hand and she squeezes back. I'm not sure who is supporting whom. ”

I only realise afterwards that I am not even bothered about whether she has the right number of everything. During pregnancy I'd had all the natural fears about my middle-aged sperm, Sarah's ageing ovaries and all the 'thousand natural shocks that flesh is heir to'. Now, all that matters is that she is here, and crying to let me know she is out. Finally! The only problem seems to be the bright lights of theatre that make her blink and stop me staring into her little eyes. They look like mine, and I am hers.

After a first cuddle with Mum, she is cleaned up and handed to me while the surgeons stitch up. I take her to a quiet room where she nestles against my bare chest and even finds her way to my nipple for a first, tentative suck. Pure magic!

Late that night, as I sort out my ticket in the hospital car park, the attendant wishes me a good day. It has already been the best I could ever have.

### Author Bio

Sarah, 34, and Dan, 40, are first-time parents. Freya Isobel, three months, is the child her grandparents had all but given up waiting for.



**Kelly's Cuisine & Catering Brisbane**  
Gourmet catering for intimate events at home, or large gatherings and functions  
Menu designed to suit your taste, style and budget  
Phone for a free quote 0420 480 799  
[www.kellyscuisineandcatering.com.au](http://www.kellyscuisineandcatering.com.au)



# A BIRTH CENTRE IN BALI: BUMI SEHAT



This photo is of the Bidan Gampong (Village Midwives) alongside the Qualified and Registered Midwives at Bumi Sehat Aceh.  
Used with permission from Ibu Robin

On 26 December 2004, approximately 230,000 people were killed by the earthquake and tsunami in Aceh, and about 500,000 were left homeless. The situation for pregnant women was horrific: families were lost, food was scarce and health care non-existent. Healthcare workers from around the world assisted in the aftermath of the disaster.

A team of midwives and healthcare workers from a small rural birth centre in Bali, Yayasan Bumi Sehat, rallied together to go into the disaster zone, specifically to help pregnant, birthing and postpartum women in this ravaged area. The team was set up not only to provide immediate disaster relief, but also to set up programs that would be self-sustaining once the initial aid workers left the country.

Bumi Sehat (Aceh) is a marriage of traditional and modern. In post-tsunami Aceh, birth is not what it used to be: pregnancy hypertension is a common problem; malnutrition makes birth much more high risk than it used to be; even the basic need for shelter is not certain as new lives are still being re-built years later.

Ibu Robin Lim is a midwife, and the

“ Villages had lost so many people. There were bodies still being found. There was no clean water, no food, and nobody looking after the mothers and babies. ”

founder of Bumi Sehat Bali and Aceh. She has centred her life around one essential theme: gentle birth heals mother earth. As we sit together during a quiet phase of a Bali homebirth, Robin reminisces about what it was like in Aceh when the team first arrived:

*‘Villages had lost so many people. There were bodies still being found. There was no clean water, no food, and nobody looking after the mothers and babies.’*

*Beginning in the first few weeks of the aftermath of the tsunami, Bumi Sehat has maintained a clinic for the survivors. We stretched tarps over bamboo and began to see people. We worked with our sister Non-Government Organisations (NGOs) to*

*establish water supply, dig pit toilets, find shelter for people living in the open, and even find recovered bodies.*

*Now we have a fully functioning health and birthing centre. If the birthing woman wants to have her baby at Bumi Sehat, the Bidan Gampong [traditional midwife] calls us (with her trusty donated Bumi Sehat hand phone) and one of the Bumi Sehat midwives, with the ambulance driver, picks up the entire family and the traditional midwife. If she prefers to stay ‘home’ (could be a proper Sumatran-style house, or a new style NGO ‘shack’ or an old tent); the Bidan Gampong calls Bumi Sehat and we send the midwives out to help the traditional midwife. The ambulance stands by, just in case, but out of sight so as not to scare the mum and her family. So no matter where, when or how the woman wants to give birth, she is safe, she is cared for, and her culture is respected.*

*This model works: it saves lives. Traditional midwives stay for three days after the birth, looking after the woman and the family. They are paid 50,000 IDR (around \$6 AUD) for their services by the Bumi Sehat donors. The program by Bumi Sehat of actually paying the traditional midwives began when a woman died after her husband refused to call the Bumi Sehat midwives as he didn’t want to pay the 15,000 IDR (less than \$2) fee to call in the midwives for the birth (preferring to buy cigarettes than pay the money, as his wife had successfully given birth four times before). The woman subsequently had a severe postpartum haemorrhage and died. Following the birth, the baby was taken by the father and eventually died due to neglect, likely due to the now-common illness of paternal depression.*

*When a mother dies at birth, it is more than just her life that is at stake: an entire family is shattered. With so many shattered families in Aceh, both help and hope are needed to bring life back to these communities.’*

“ ... no matter where, when or how the woman wants to give birth, she is safe, she is cared for, and her culture is respected. ”

# INTERVIEW WITH: ROBYN THOMPSON

*Robyn is a mother of three children: Mark (48), Joanne (45), and Melanie (stillborn). She is grandmother to two adorable grandsons: Joshua (20) and Kai (18). Robyn is a midwife, maternal and child health nurse, and breastfeeding consultant in Melbourne. She has 52 years' professional experience, both in public and private practice. Robyn is semi-retired while she is completing her PhD on the factors associated with nipple trauma for breastfeeding mothers.*

## What drew you to midwifery and child health?

I started nursing in 1961 and gave birth to Mark in 1965 and Joanne in 1968. Both were born in hospital - I didn't know any better at the time, both were beautiful births. I spent nine good years at home enjoying raising a young family. I felt the time was right to return to full-time professional life in 1974. I wanted to do something that was an extension of my nursing profession, something that would expand my thinking, and in those days midwifery and maternal and child health were a natural progression.

## You started making waves quite early in your career, didn't you?

That's right. I have really strong principles, certainly from my own birth experiences. I wanted to make sure that women were respected by the people in the system. After studying midwifery I had a better understanding of how the system worked. Within three months of qualifying as a midwife, I was offered a six-month tenure to manage a ten-bed public labour ward for a senior colleague on leave. I was then asked by the Director of Nursing (DON) to complete two specific briefs.

First, she wanted me to create a woman-friendly labour ward environment. So we started making changes. We started encouraging women off the bed during labour. I rostered midwives to be with the woman for the entire labour if possible, they didn't have to go if the birth was imminent. I didn't want the woman to have to have another person walk in on her. I was subconsciously providing continuity of carer, but not really knowing that I was doing that. We didn't call the

doctors either, unless there was a problem of course, the midwives looked after the women.

Secondly, the DON asked me to 'sort out' the antenatal clinic. Her brief was open ended she wanted me to change the 'herd mentality' of the antenatal clinic. The women were called up to the central desk by number, asked to hand over a urine sample, asked to jump on a set of scales, and then sit down until the number was called. When they were again called, they went to a small cubicle attached to the consulting room where they put on a gown and sat waiting to be called inside to see by the doctor. There was no real conversation, they were expected to get up on a couch for a quick assessment, and then they were dismissed to make another appointment and the next woman was called from the next cubicle.

My emphasis was on creating a welcoming, woman-friendly environment by improving the aesthetics and re-organising the service. A booking system was established where the women came to a midwife to book-in; they only spoke to a midwife. No more calling women by numbers; they had appointments with a midwife in the antenatal clinic. I had hand-selected staff and full reign. If all was well they didn't see a doctor. I didn't ask to do any of this, it all just unfolded. If the doctors were late, the woman did not wait, they were always seen by the midwife. There were no time limits on appointments; some women had longer visits if needed. We spaced appointments to reduce waiting times. More about my professional experiences are published in a book (see *Further Information*).

## What was maternity care like in the mid-1970s when you started Midwifery?

This was a large public hospital, women came with complicated pregnancies; most in fact were quite normal. For the first decade of my midwifery experience it was considered best practice to encourage women to achieve a vaginal birth.

Experienced midwives taught me how to midwife. Women gave birth to twins and breech babies without medical assistance. But there were medical standing orders for first-time mothers who were in early labour to have heroin/narcotics, these women often woke up to have a baby without knowing about labour. It was a routine practice.

Caesarean section was considered major abdominal surgery that should be avoided when possible. In the 1970s and 1980s medical assistance was readily



Midwife, maternal and child health nurse and breastfeeding consultant Robyn Thompson

available but only used if needed. There was unwritten reasonable and responsible cooperation between women, midwives and medical practitioners.

The inter-professional relationship changed in the late 1980s when midwife autonomy diminished as the number of obstetric registrars, resident doctors and medical students increased. The autonomous role of the midwife transitioned to the medicalised midwife with increasing induction of labour, and resultant obstetric interventions that enveloped women and the natural labour and birth process.

## Was there a catalyst that drove you into private midwifery practice?

Yes, it was pure chance. In 1984 I was contracted to set up a new midwifery unit at a private hospital in Melbourne. I met a homebirth midwife. She suggested this new unit would be good for transferring homebirth women if necessary. She invited me to a homebirth group meeting with a general practitioner (GP) who attended homebirths. I was very sceptical, and so they invited me to participate in some antenatal care. It was there that a woman asked me to participate in her homebirth. So what happened after that is history. She lived in my suburb [laughs]. I accompanied a very relaxed experienced midwife. I was highly anxious, for example when the baby was born I had the suction turned on (I was kneeling on the end of the bed), being quietly observed by the midwife, and the doctor who happened to be in the background. I was terrified that the baby wouldn't



breathe. I can't believe my anxiety was so high. Then just as the baby took its first breath, the two dogs just outside the bedroom window began to howl...I get goose bumps... two cats on the front doorstep howled and within seconds the neighbourhood dogs were howling. I began to think about the Universe, and how powerful birth is, and how nature communicates. So I was hooked [laughs], and I transitioned into private practice.

## What did you learn by attending homebirths?

Oh, how wonderful women are! How amazing babies are! How they talk to their mothers. How they know how to survive. I was in awe of what was going on between the mother and baby. I never had such strong feelings when I was in the system; I wasn't as sensitive to it. There is something special going on, if you have time to stop, look, listen, smell, see and don't touch!

## So how did that knowing change your practice?

It turned me completely around, I became a midwife in the true sense of the word. I started to practise midwifery but I also had the experience that's required if things don't go right, or if things aren't going to plan. I was the first midwife to have a private healthcare provider number through Australian Unity, women could claim for midwifery services. I was the first midwife to gain private and public hospital access for transfer of women in labour, where I could continue to share midwifery care.

## Can you describe one of your most rewarding experiences as a midwife?

Oh yes. Being the midwife for both my grandsons (all babies are special though [laughs]) and my niece. Yes that was a real privilege. I have had hundreds of wonderful rewarding experiences; how do you explain them all?

## What about one of your most challenging?

It's been since Nicola Roxon [Health Minister] got involved in the Maternity Services Review. Nicola took away our midwifery rights to practise our skills autonomously. She did it in the name of politics, to appease the AMA (Australian Medical Association). I live in her electorate; she was my MP (Member of Parliament). I challenged her all the time, but she'd already come to an agreement. However, the current health

*“ I was in awe of what was going on between the mother and baby. I never had such strong feelings when I was in the system; I wasn't as sensitive to it. There is something special going on, if you have time to stop, look, listen, smell, see and don't touch! ”*

minister, Tanya Plibersek, appears to be more understanding of the role of the autonomous midwife.

## How did you become so expert in breastfeeding?

Having the privilege of being with women; just sensing what mothers and babies do so well. The Darebin In-Home Breastfeeding programme paralleled with my private midwifery practice. Distinctive contrasts in breastfeeding issues were evident between women who delivered in hospital, and women who chose to birth at home. In my experience, the women who birthed at home seemed to have fewer birth and breastfeeding problems compared to women referred to the programme. I wondered why?

## Can you explain your approach to breastfeeding?

I think the most common thing is that I've learnt not to touch (the woman or the

baby) to the point where I now do Skype sessions with women all around the world [laughs], while they're in their own home. I've gone back to basics where the mother and baby know what to do. My role when necessary is to help her fine tune how the baby attaches to avoid painful trauma, which is one of the most common reasons women give up breastfeeding.

## Why on earth would you take on a PhD in your mid 60s?

Through this research and future writing, I look forward to encouraging gentler, mother-baby-friendly breastfeeding practice, and to assist in the review of midwifery education. I also look forward to encouraging midwives and obstetricians to consider how they can participate harmoniously to expand women's self-confidence, and relinquish unnecessary professional interventions in the labour, birth and breastfeeding. Most importantly, I hope to promote how to keep mother and baby together from the moment of birth and facilitate uninterrupted, leisurely breastfeeding for at least the first 72 hours. Ultimately, my desire is to share the study results, and I will have an opportunity to do this next year at the International Confederation of Midwives Conference in Prague, providing I'm still alive [laughs]!

## Further information

Vernon, D., ed. 2007. *With Women: Midwives' Experiences from shift work to continuity of care* Canberra, ACT: Australian College of Midwives.



Want to write for Birth Matters Spring Edition?

We are seeking articles for our new, regular sections...

Federal Update, Rural Matters, Global Perspectives, Birth Stories, Parenting Matters, News, Research, Interviews, Reviews

**DEADLINE NOVEMBER 1ST**

# HYPNOSIS FOR CHILDBIRTH: A RESEARCH SUMMARY



Birth in ecstasy using hypnosis and water

## What is hypnosis?

Hypnosis appears to encompass altered states of consciousness, such as daydreaming, meditation or intense concentration, resulting in the failure of normally perceived experiences to reach conscious awareness. Such hypnotic or 'trance' states are characterised by an increased receptivity to verbal and non-verbal communications, which are commonly referred to as suggestions (1).

## How does hypnosis help labour and birth?

"Women's experiences of pain in labour are variable and complex but the intensity of pain can be made worse by fear, tension and anxiety. Techniques such as hypnosis have been proposed as ways to help deal with these fears and anxieties" (2). Marie Mongan, founder of the HypnoBirthing® childbirth education program is perhaps the most famous hypnotherapist working with childbirth (3). The HypnoBirthing Institute International now teaches HypnoBirthing® in 45 countries around the world. This programme comprises five sessions (12.5 hour program) that provide tools for couples to self-hypnotise, visualise and relax, as well as special breathing techniques (3).

## Fewer women require analgesia in labour

An Australian review of research that compared studies of

hypnosis in labour found that hypnosis reduces analgesia uptake in labour (4). The authors suggest three possible reasons for this: those patients who learnt self-hypnosis then engaged a greater sense of control and autonomy; patients using hypnosis for relaxation may have reduced their apprehension of pain, which in turn may reduce analgesic requirements; and, finally, the use of hypnosis might reduce the need for labour augmentation, which may then reduce the need for epidural analgesia. The HypnoBirthing® Institute International reports that women who have undertaken the HypnoBirthing® program have a 66% reduction in the use epidural analgesia for vaginal births, compared to the national US average, and a corresponding 50% reduction in caesarean sections.

## Are there other outcomes from hypnosis?

One case control study reports that duration of the first stage of labour in the hypnosis group was significantly shorter than the control group by over two hours (5). Another case control study reported a significant reduction in

duration of labour for those using self-hypnosis: a reduction of 2.9 hours (first-time mothers) and 0.9 hours for mothers having subsequent babies (6).

A further study involving 600 participants found an absence of postpartum depression in a trial of five 30 minute sessions, as compared to typical rates of 10 to 15% postpartum depression amongst the untreated population (7). Another study reported similar results, with lower depression scores in the hypnotically treated group compared to a control group (8).

While a 2012 review of research reports little difference between women randomised to hypnosis or control groups for (a) additional use of drugs for pain management, (b) the number of normal deliveries, or (c) women's satisfaction with the method of pain relief, there appear to be benefits from hypnosis for birthing women, including less pain intensity, shorter labour duration and shorter hospital stay (3). The review cautions that these results came from a small number of studies with very few women; larger studies are needed.

## Conclusion

It appears that a simple intervention such hypnotherapy, which is gaining popular acceptance, has effects both medically and socially on birthing women and postnatally: "the use of obstetrical hypnosis should be brought back again and used more often, for it is really the valid, simple and safe way to conduct a normal delivery" (8).

“Women's experiences of pain in labour are variable and complex but the intensity of pain can be made worse by fear, tension and anxiety. Techniques such as hypnosis have been proposed as ways to help deal with these fears and anxieties”

# WATER IMMERSION IN LABOUR AND UNDERWATER BIRTH

Water immersion during labour occurs when the labouring woman is immersed in warm water to a depth that enables her to sit in the bath or pool with her abdomen completely submerged (1). Water immersion during the first stage of labour, for comfort and pain management, is increasingly common in Australia. A 2012 systematic review of 12 randomised controlled trials reports that water immersion during the first stage of labour reduces moderate to severe pain across a range of timeframes for those labouring in water (2). Water immersion is also associated with a reduction in the use of epidurals amongst women allocated to water immersion compared to controls (10% less likely) and a shorter duration of the first stage of labour (mean difference -32 minutes) (2).

For the woman there were no differences in instrumental vaginal births, caesarean sections, use of oxytocin infusion (to speed up labour), perineal trauma (in any category) or maternal infection (2). For the baby there were no differences for low Apgar score (less than seven at five minutes), separate neonatal nursery admissions or neonatal infection (2).

## Water birth

Water birth occurs when a baby is born fully submerged in water (for example, in a bath or birth pool) and is immediately brought head first to the surface (1). Qualitative studies, which focus on women's perceptions and experiences of water birth, report the benefits include increased maternal satisfaction due to relaxation (3), ability to change positions easily (4) and a greater sense of control and privacy (1). One trial in the systematic review showed a significantly higher level of satisfaction with the birth experience (2).

## Safety concerns

The most common clinical concerns raised are: water aspiration (breathing in water), infection for mothers and babies, and temperature regulation (1). Three of the 12 trials (including a total of 3243 women) from the systematic review related to water birth (2). The systematic review reports that water birth is not associated with differences in low Apgar score (less than seven at five minutes), admissions to a separate neonatal nursery, or neonatal infection rates.

The largest Australian research study (which included 6144 women) compared five-minute Apgar scores for low-risk women who gave birth in a birth centre and who chose water birth with those who chose to give birth on land (5). This study reports that water birth is not associated with an increased likelihood of a low Apgar score (less than seven at five minutes) (5).

## Why is there a need for more research?

If there was no increase in ill-health for babies following water birth, you might wonder why we need to do more research. The answer is that the existing research has some limitations. None of the studies included in the systematic review were large enough (statistically powered) to accurately measure differences in poor health outcomes for babies (neonatal morbidity) following water birth. In the Australian study some women who were planning a water birth were asked to exit the bath because of concerns about the baby's well-being (e.g. concerns about the

baby's heart rate or meconium). These births were then analysed as land births. This might have the effect of biasing land birth towards poorer outcomes (such as Apgar scores at five minutes), because it includes babies who were showing signs of distress. Furthermore, this was not a randomised trial, which means that there could be differences between the women who chose water birth, compared to those who chose land birth; and these might affect the outcomes for babies.

The systematic review concludes that further research is needed, ideally a large randomised controlled trial that is big enough to measure differences in neonatal morbidity between women randomly allocated to water birth or land birth. Whether this type of study is do-able, and whether women would be happy to take part in it, is yet to be seen.

## References

### Hypnosis for childbirth

1. M. D. Yapko, *Trancework: An Introduction to the Practice of Clinical Hypnosis* (Florence: Bruner-Mazel, 1990).
2. K. Madden, P. Middleton, A.M. Cyna, M. Matthewson, and L. Jones, "Hypnosis for pain management during labour and childbirth," *Cochrane Database of Systematic Reviews* Issue 11 (2012), accessed August 10, 2013, <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009356.pub2/pdf/abstract>
3. Marie F. Mongan, *Hypnobirthing: The Mongan Method*. (Florida: Health Communications, 2005).
4. A. M. Cyna, G. L. McAuliffe, and M. I. Andrew, "Hypnosis for pain relief in labour and childbirth: a systematic review," *British Journal of Anaesthesia* 93 (2004): 505–511.
5. T. M. Harmon, M.T. Hynan, and T. E. Tyre, "Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education," *Journal of Consultant Clinical Psychology* 58 (1990): 525–530.
6. M. W. Jenkins and M. H. Pritchard, "Hypnosis: practical applications and theoretical considerations in normal labour," *British Journal of Obstetrics and Gynaecology* 100 (1993): 221–226.
7. P. McCarthy, "Hypnosis in obstetrics and gynecology," in *The Use of Hypnosis in Surgery and Anesthesiology: Psychological Preparation for the Patient*, ed. L. E. Fredericks (Springfield, Illinois: W.W. Norton, 2001), 163–211.
8. R. G. Roden, "Management of Delivery under Hypnosis," in *Canadian Family Physician* (1970) 77, 78.

### Water immersion in labour and underwater birth

1. K. Young and S. Kruske, "How valid are the common concerns raised against water birth? A focused review of the literature." *Women and Birth* 26 (2013): 105–109.
2. E. R. Cluett and E. Burns, "Immersion in water in labour and birth (Review)." *Cochrane Database of Systematic Reviews*. 2012 CD000111. DOI: 10.1002/14651858.CD000111.pub3.
3. R. M. Maude and M. J. Foureur, "It's beyond water: stories of women's experience of using water for labour and birth." *Women and Birth* 20 (2007): 17–24.
4. H. Richmond "Women's experience of waterbirth." *The Practising Midwife* 6 (2003): 26–31.
5. H. Dahlen, H. Dowling, et al. "Maternal and perinatal outcomes amongst low risk women giving birth in water compared to six birth positions on land. A descriptive cross sectional study in a birth centre over 12 years." *Midwifery* 29 (2012): 759–764.



## AMELIE'S BIRTH IN WATER



Sitting on the birth stool waiting for placenta

*We found out that I was pregnant as we waited to be picked up by a tuk-tuk to go to watch the sun rise at Angkor Wat, outside Siem Reap in Cambodia. I was on holiday with McCoy, my husband of five years, and some friends. I had quietly suspected for days that something was going on, and we found ourselves grinning at each other in disbelief as my suspicion was confirmed in our little bathroom at 4.30 am.*

Soon after we arrived back from holiday, the morning sickness set in. It lasted until 14 weeks, and I found it very challenging. I vomited every day, suffered frequent migraines, fell behind in my work and did very little except lie on the couch. I used acupuncture, various supplements, homeopathy and herbs to get me through this time, with some relief. Fortunately, things picked up and I enjoyed good health (although some back pain) for the rest of the pregnancy. I especially

enjoyed my yoga practice, accessing prenatal classes (which were wonderfully informative as well as nourishing) from about eight weeks, in addition to my regular yoga class.

### Relax and prepare

My work was extra busy, and at times very stressful, so it felt great to let it all go at 36 weeks, giving myself time to relax and to prepare for motherhood. I feel very lucky to have stumbled across some excellent resources before and early in my pregnancy: a friend who'd had a baby at the birth centre (and couldn't say enough good things about it), Sarah Buckley's book *Gentle Birth, Gentle Mothering* and Jenny Blythe's *The Down to Earth Birth Book*, and my prenatal yoga teacher. I was very uninformed about birth, but these resources really resonated with me and I'm grateful to have been influenced by

all of them in making my choices around the type of maternity care I accessed. We booked into the birth centre, even though we were out of their catchment area. Their natural approach, continuity of care model and opportunity for water birth (among other things) were very appealing.

### My own little internal examination

My acupuncture treatments continued into the last weeks of pregnancy to help ready my body for labour; my last one was the day before my due date. I experienced many more Braxton-Hicks contractions than usual that weekend, and I remember saying to McCoy on Saturday (40 weeks plus two days) that I felt that I was closer than ever to going into labour. I realise this was an obvious thing to say considering that it could happen at any time, but I just felt that day that it actually seemed likely. More Braxton-Hicks contractions and some mild back pain on Sunday had me strongly suspecting that there was a baby not far away. I took it upon myself to do a little internal examination, and decided my cervix felt about two centimetres dilated, meaning I was well and truly in 'latent' first stage labour.

### When is a Braxton-Hicks not a Braxton-Hicks?

I'd been stocking the freezer for after the birth and still had a lamb stew to make: this evening would be my last chance. I found myself wondering, 'When is a Braxton-Hicks not a Braxton-Hicks?' My contractions were becoming frequent and definitely making their presence felt, although they were still not particularly painful. We got the cooking done and finally got to bed at around 11 pm, as my contractions were becoming more regular and a little painful. The contractions and my sense of excitement meant that I didn't sleep much past about 1 am. At some point I got up, sat at the foot of the bed and read about labour in one of my books. This was perhaps a little short-sighted; I really should have been reading about how to care for a perineal tear! Eventually McCoy woke up, at about 4 am, and we called our midwife, Corinne at about 6 am. Corinne advised us to stay at home. I experimented with different positions and found standing up was best: being in the shower with warm water on my back

was particularly good. My contractions felt shorter and less painful and the gaps between them felt longer, although, according to McCoy's timing, they hadn't changed.

## The drive was tough

We called Corinne again at around 8 am, wanting to come in to the birth centre. She was very relaxed...of course we knew that we should stay at home for as long as possible, but I really thought that I was well on the way. The drive was pretty tough; I sat in the back with pillows and no seat belt, but it was still very uncomfortable. I only had a few contractions in the half hour car trip from my home to the birth centre, but I remember them being quite painful. We got ourselves inside, into the lifts and up to the waiting room, again with not many contractions. I guess I found it all pretty distracting, especially walking past other people and feeling rather conspicuous.

We got inside the birth centre just after 10 am and Corinne met us there shortly afterwards. I was naturally very disappointed to be only four centimetres dilated at the first internal examination at about 10.30 am, but Corinne said that was enough: she could call it 'active' labour and didn't have to send us home. She also said the membranes were bulging and would break soon. I laboured mostly in the shower, but I did try other places and positions, including resting on my side on the bed, trying to snatch some deep relaxation at least between contractions, given how little sleep I'd had. I was apparently there for maybe an hour (time was a funny thing); with McCoy constantly timing and chatting to Corinne, but I eventually gave up and got back in the shower.

## Focus, breathing and mantra

My waters didn't break, and I was about seven centimetres dilated at my next examination about four hours later. This meant I could get in the bath if I wanted to, and I did; it was wonderfully relaxing. My contractions really slowed, however, and I got out after about 45 minutes and back into the shower. One of my most vivid memories, almost as significant as labour pains, was the state of my feet! After so many hours of standing they were very purple, sore and swollen. In between contractions I tried to rest on all fours in the shower, my knees on foam blocks the staff supplied. During contractions I focused on breathing out very long and slowly, and repeating a mantra in my head, which has pretty much escaped

my memory, but I think it was something along the lines of 'beautiful contractions; beautiful baby', inspired by some birth hypnosis workshops I had done. My next examination was at around 6.30 pm, and I was nine centimetres dilated. Corinne was very surprised that my waters hadn't broken yet and expected them to go at any minute. Most of what I remember from the next two hours (apart from my feet and my mantra) was a feeling of willing each contraction to break the waters, and then being extremely disappointed when it didn't happen. I remember thinking this must be what it felt like to be addicted to buying lotto tickets. This time I'm going to win! No, not this time. But next time! No.

## Disappointed at the lack of progress

At 9 pm I was still nine centimetres dilated, and my waters still hadn't broken. I was pretty exhausted and somewhat disappointed at the lack of progress in the last two hours. During this examination, and while I was still on the bed, Corinne suggested rupturing my membranes. After quick discussion, we agreed, she broke them and I completed dilation. During this time I had two contractions on the bed, which were the most painful by far until this point. I keep telling other women not let anyone make them labour on a bed!

## The urge to push was so strong!

I remember Corinne asking me where I'd like to be, but I had no idea. She suggested the bath, so I said, "Oh yeah, I'll jump in the bath." As soon as I got in I felt the urge to push. This was an entirely new feeling for me, more painful than anything I'd felt thus far (ever!) but very different and the urge was *so strong*! I tried to relax for the first few contractions, but it was too much and I just wanted it over, so I pushed. I distinctly remember thinking, I can't possibly do another five of these contractions, it's going to have to be over in the next three; but of course I must have done at least 30 of them by the time our baby was born.

Aside from perhaps a little moaning in that last hour or two in the shower, this was the first time I really needed to vocalise, and I screamed! Thankfully someone reminded me (and I remembered from my yoga classes) to keep my jaw relaxed and my sounds low. So from then on I roared; the sound was coming out regardless! I remember that, after the first few contractions, McCoy asked Corinne whether this was second-stage labour. I was thinking that of course it was; it was so vastly different to the first stage. But Corinne said, "Well, I'm reluctant to call it

just yet, because once I do we only have an hour to get the baby out before we have to interfere." I couldn't fathom the thought of doing this for an entire hour; but in fact I went well over this time.

At the end, there we were, McCoy and I, in the bath, with mister I-don't-want-to-watch-the-baby-come-out, holding a mirror beneath me (I was semi-squatting, hanging over the edge of the bath) while Corinne shone a torch to see what was happening. I distinctly remember the feeling of the baby descending with each contraction and then slipping back up in between. Even though Corinne said encouraging things like, "Yes, that's great, the perineum is stretching quite nicely," I found it really hard not to be disappointed. After what seemed like forever, and after much pushing and yelling, Corinne called another midwife in to take photos of a baby being born. (I found this very encouraging!) I remember McCoy being amazed the first time Corinne showed him that he could see our baby's head. I also remember the only time I uttered an expletive during the whole ordeal. In between contractions, as the head was crowning, McCoy made a comment and I declared, "It f\*\*\*ing hurts!" Eventually though, the baby's head appeared (at 10.30 pm), photos were taken, and I was asked to stand up out of the water so they could help deliver the body as the shoulders were a little slow to emerge.

## Exhausted, overwhelmed, elated, and emotional

Our baby was born at 10.32 pm and passed (rather awkwardly) through my legs so I could sit back down in the bath against McCoy's chest, with our baby on my chest. We just sat there staring at the purple, sticky, crying little baby in my arms while more photos were taken. We were exhausted, overwhelmed, elated and emotional. It eventually occurred to us that we didn't know whether we had a girl or a boy, so I tipped bubbly over, half-dunking him or her in the water (oops!) and then, with more surprise and excitement, found out that we had a little girl, Amelie.

## The water turned very dark

The next part all happened very quickly. Suddenly I was being told to get out of the bath, and we noticed how dark the water had become. The staff sat me on a birth stool to deliver the placenta. Corinne was trying to get Amelie to breastfeed while Louise (the second midwife) worked on the placenta. We weren't having much



Alison and baby Amelie

success with the feeding. I was told to push, and a placenta appeared, and then I gave consent for an oxytocin injection because they were a bit worried about my blood loss. I was then helped to sit down while the midwives checked out my bleeding and tear. This was perhaps more painful than giving birth! I was advised to have stitches, as a blood vessel had torn (which meant the oxytocin was probably unnecessary, but I felt it was a reasonable precaution).

## Grateful for the birth centre

Corinne signed off and went home and Louise wheeled us around to a birth suite room for suturing by one of the registrars. Seeing that clinical looking room, I was very grateful to have been in the birth centre with its more friendly surroundings as well as its different philosophy and approach. I was about ten times more scared of having stitches than I had been of giving birth. It took all my efforts, and quite some time, to relax all my buttock and pelvic muscles so that the registrar could apply local anaesthetic. In the end, of course, it was totally fine. Amelie hadn't left my arms since she was born, although I still couldn't get her to feed. Once I was wheeled back around to our room Louise helped me into bed and took Amelie for a few minutes (with my permission, and only across the room) to weigh and measure her, etc. We declined the Vitamin K and the Hepatitis B vaccination, but Louise had said there was an extra heel prick blood test recommended for babies over four kilograms. I remember asking,

"Can't we wait until she's been weighed and then make a decision?" But Louise said, "Oh, she's definitely over four kilos!" I had no idea; I thought I was having an average seven pound baby. It turned out that she was nine pounds and nine ounces (4300 grams)! I only know a couple of women who've had bigger babies than that. At Louise's suggestion we compromised and had one blood test instead of the several recommended. She put a nappy on, wrapped our little baby up (McCoy helping and taking notes) and brought her to bed, where we stared at her and at each other and wondered, saying things like, "Can you believe this?" while Louise made us tea and toast. I think we finally went to sleep at around 2 am. We considered keeping Amelie in bed with us, but ended up putting her in the bassinet beside the bed. And there we all slept, until 8 am.

## A long sleep and still not breastfeeding

I was a little freaked-out after such a long sleep with not a peep out of this little baby, who was supposed to be keeping us up all night, from everything I'd ever heard. She was fine, of course, and I think we might have woken her up to try feeding her again. I was a little concerned about her lack of interest in feeding as I'd read about jaundice etc., and about how naturally birthed babies (without drugs) should be alert and instinctively find their way to the breast. But I also had confidence that things would work themselves out. Amelie was bringing up bits of mucous, which might have been

bothering her.

We pretty much stayed in bed all morning, although I did get up and hobble to the shower, which with hindsight I should have had help with, given how weak and light-headed I still was. I almost blacked out. There seemed to be people coming and going all morning: a midwife for a postnatal check, a physiotherapist and a paediatrician I think, all with various bits of advice that I honestly thought I would take in and remember! We knew it was possible to go home as early as four to six hours after the birth, but we now learnt it was important for our baby to get her first good feed before we left. Amelie fed in little bits and pieces (I kept offering) and I think Corinne showed me how to express colostrum and to collect it, drop by drop, in a syringe to feed to her. But we left in the afternoon without having really established proper feeding. I knew I would just keep trying until it all fell into place.

## No postnatal home visits

We had a busy first few days with visitors who stayed too long; I have learnt from this! Being out of the birth centre's catchment area, home visits were not available to us, which meant that we had some running around to do, including back to the hospital. We had known this was part of the deal when we booked in. I was committed to breastfeeding though, and it progressed well despite my being busy.

After getting over the initial shock to the body that is childbirth, I settled into motherhood with relative ease (I think), and became immensely (and increasingly) proud of what I had achieved. Although I had had some minor interventions, the experience left me in complete awe of my body's ability to deal with the pain and my mind's ability to focus. It strengthened my inherent faith that women's bodies are meant to perform, and capable of performing, this amazing task.

Having shared birth stories with a few friends I am now even happier with our choice to have our baby at the birth centre. Many of the negatives from my friends' stories centre around caregivers (in particular meeting strangers during labour/birth) and disrespectful interactions with caregivers. These simply weren't issues for us, and I think this is part of the reason why I had such confidence that everything would be fine, and why everything did indeed go smoothly.



## MC contacts (National) Office Bearers 2013

**President:** Bec Waqanikalau  
president@maternitycoalition.org.au

**Vice President:** Kylie Sheffield  
kylesnshef@yahoo.com.au

**Secretary:** Georgia Hodges  
secretary@maternitycoalition.org.au

**Assistant Secretary:** Vacant

**Treasurer:** Jen Egan  
treasurer@maternitycoalition.org.au

**Assistant Treasurer:** Jo Askham

**Birth Matters Editor:** Jyai Allen  
birthmatters@maternitycoalition.org.au

**Birth Matters Advertising:** Jade Farren  
advertising@maternitycoalition.org.au

**Assistant Birth Matters Editor:**  
Sonia Bartoluzzi

### General committee members:

Bruce Teakle  
Jess Permezel  
Louise McMullan

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

**Membership Secretary:** Bec Telfer  
memberships@maternitycoalition.org.au

**National BaBs coordinators:**  
Erika Munton  
erikamunton@yahoo.com.au

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

**Consumer Representative:** Bruce Teakle  
teakle@maternitycoalition.org.au

**General Inquiries:**  
info@maternitycoalition.org.au

**CANA inquiries:** info@canaustralia.net

## Branch contacts

**QLD President:** Andrea World  
qldpresident@maternitycoalition.org.au

**NSW President:** Rachele Meredith  
nsw@maternitycoalition.org.au

**Hunter Home and Natural Birth  
Support:** Rachel Prest  
hlnbsgroup@gmail.com

**Central Coast:** Lisa Richards  
bellabirthing@live.com.au

**Northern Rivers:** Sally Cusack  
maternitycoalitionnr@gmail.com

**Wagga and South West Region:**  
Bernadette Anderson  
wagga@maternitycoalition.org.au

**Illawarra Birth Choices:** Sonia Gregson  
illawarra@maternitycoalition.org.au

**North West Sydney:** Anna Russell  
nwsydney@maternitycoalition.org.au

**NSW BaBS  
Central Coast:** Veronica Pasfield  
veronica@nunker.com.au

**Tumut and District:** Lucinda Clay  
tumutbabs@yahoo.com

**Wagga:** Wendy Harper  
wendyharper80@gmail.com

**ACT contact:** Kylie Sheffield  
kylesnshef@yahoo.com.au

**South Australia President:** Vacant  
sa@maternitycoalition.org.au

**Western Australia contact:** Kirra Bird  
kirrabb@gmail.com

**Northern Territory contact:**  
Justine Wickham  
jhulands@hotmail.com

**Tasmania President:** Genevieve Sayers  
tas@maternitycoalition.org.au

**Victoria President:** Ann Catchlove  
vicpresident@maternitycoalition.org.au

**Peninsula Birth Support**  
Sarah Langford  
0430 076 428  
mcpenninsula@gmail.com

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

**Ballarat President:** Vacant  
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.



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

Find Maternity Coalition on



# Subscribe/Renew Online Today!

## Birth rights, rites and writes

A **personal voice** rarely heard in discussions about maternity services, **Birth Matters** is a forum for debate and discussion about the issues that affect birthing women and care providers in Australia.

## Want Extras?

Extra single copies of *Birth Matters* are available for \$10 including postage and handling.

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:

Name: \_\_\_\_\_

Organisation (if applicable): \_\_\_\_\_

Street/PO Box: \_\_\_\_\_ Suburb/City: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country: \_\_\_\_\_

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

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



# Australian College of Midwives 18th Biennial Conference

30 September - 3 October 2013 | Hobart

Life, Art & Science in Midwifery

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

The call for abstracts is now open via the Conference website [www.acm2013.com](http://www.acm2013.com) and all submissions are welcome. The theme of the Conference is 'Life, Art & Science in Midwifery'.

The social program will provide a unique opportunity to catch up with friends and colleagues and, at the same time, enjoy fine Tasmanian food and wine.

## General Enquiries

Australian College of Midwives  
Conference Secretariat

ICMS Australasia

GPO Box 3270

Sydney NSW 2001

Ph: +61 2 9254 5000

Fax: +61 2 9251 3552

[info@acm2013.com](mailto:info@acm2013.com)

[www.icmsaust.com.au](http://www.icmsaust.com.au)



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



# Telehealth: Are you ready?

Telehealth is the delivery of healthcare services from a distance using information and telecommunication technology, primarily through online video consultation.

Nurses and midwives can facilitate a telehealth consultation between a specialist and the person receiving care, increasing access and reducing travel time and costs, particularly for people in rural and remote areas.

Learn the skills to be telehealth ready with online training and resources available through any of the websites below.

## FREE RESOURCES

- Standards and Guidelines for Registered Nurses and Registered Midwives
- 4 hour online learning package – 4 CPD hours/points
- Telehealth resources: fact sheets, brochures, posters, checklists

