

BirthMatters

Vol 15/2 ISSN1443-7570

Winter 2011

**Antenatal care - why
our choices matter**

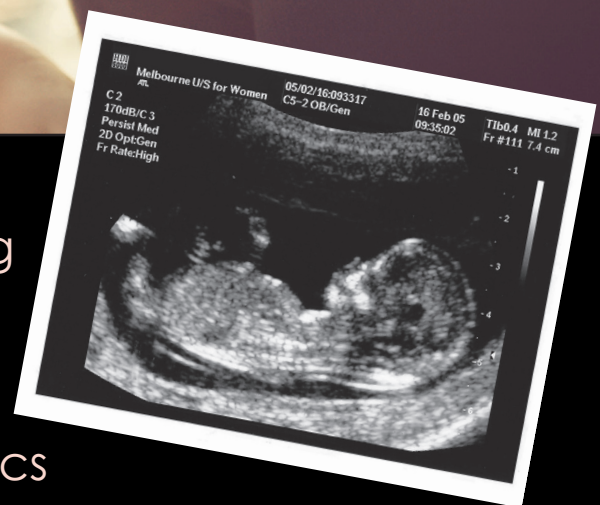
**Sarah Buckley on
prenatal ultrasound**

This issue:

Justine Caines talks prenatal screening
and diagnostic testing

PLUS:

Rhea Dempsey on 'wild card' dynamics



**Maternity
Coalition**

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

Birth Matters is a quarterly journal published by Maternity Coalition. Opinions expressed in *Birth Matters* are those of the authors and not necessarily those of Maternity Coalition. All articles are copyright of the authors unless specifically commissioned for *Birth Matters* and stated otherwise.

Editor: Kylie Sheffield
Assistant Editor: Sonia Bartoluzzi
Distribution Coordinators: Alison Gaffney & Rebecca Telfer
Subeditors: Nicole Carver
Production: Mara Dower and Kylie Sheffield
Advertising: birthmatters@maternitycoalition.org.au
Editorial & Advertising inquiries: birthmatters@maternitycoalition.org.au or PO Box 1190, Blackburn North, Victoria, 3130.

Dates for future issues: **September 2011** and **December 2011**.

Contribution closing date for the September issue of *Birth Matters* is Friday 12 August.

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

Would you like to write for *Birth Matters*?

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

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

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

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

The *Birth Matters* Editorial Team
birthmatters@maternitycoalition.org.au.

Contents

Features

Federal update: recent submissions by Ann Catchlove and Kylie Sheffield	4
Why are birth choices important by Anne Harris	6
2011 AGM	7
Testing times: facing the odds of a less than perfect outcome by Justine Caines	8
Ultrasound: a cause for concern by Sarah Buckley	10
'Wild card' dynamics – emotional work in pregnancy by Rhea Dempsey	13
What is genetic counselling? By Jan Hodgson	16
Preventing postpartum haemorrhage with prenatal care by Michelle McRitchie	18
Birth story: our journey to Rupert by Samantha Roberts	20
Revised information sheets	26

Regular Sections

From the Editor	2
From the President	3
MC news	23
Member notices, MC online social networking and discussion groups	30
MC contacts	31
Subscription/Renew Membership	17, 32



Jaida Meredith listens for baby sister River Lisa, still in utero.
Photo courtesy of Rachele Meredith and Inspired Images.

From the Editor



The timing of our antenatal care themed issue has, quite coincidentally, been excellent. While we were finalising content, the Department of Health and Ageing released the draft National Evidence Based Antenatal Care Guidelines – First Trimester for public consultation and comment. As explained on the Department’s website, the guidelines have been developed in response to Action 2.1 of the National Maternity Services Plan 2010: “Ensure Australian maternity services provide high-quality, evidence-based maternity care”. The website further advises that consistency with the processes outlined by the National Health and Medical Research Council “will ensure the Guidelines are evidence based, reflect best practice and are able to secure professional support for implementation”.

Maternity Coalition has responded to the call for feedback, and a summary of our submission is included in the federal update on page 5. One of the issues highlighted, and certainly one of my own concerns as a maternity care consumer, is the implication of the word ‘routine’ as it’s applied in the guidelines. It’s a word we women hear used a lot on our pregnancy and birthing journeys – to describe everything from the schedule of antenatal visits to the vaccinations offered to our babes once they land earthside. Referring to scans, blood tests and the measurement of body mass index as routine is, of course, entirely accurate. These procedures are widely endorsed and regularly practised. My concern is with how and why they came to be so. The fact that a procedure is habitually performed does not ensure it is based on the best available evidence, woman-centred or safe. Nor does it make it compulsory to anyone.

Too often providers wield the ‘routine’ label not simply to describe, but to reassure, justify or even coerce, which is

unacceptable – no aspect of maternity care should ever be rationalised based solely on its routine standing. If nationally endorsed guidelines are to promote the practice of truly woman-centred maternity care, the language contained within them must consistently reflect women’s right to choose, and emphasise that the role of any provider is, first and foremost, to inform these choices. This is not achieved in the initial draft.

I’m grateful to Sarah Buckley for allowing us to

once again feature an extract from *Gentle Birth Gentle Mothering* (2009). The concerns Sarah raises in her highly relevant article on prenatal ultrasound are drawn from her own experience as a mother, doctor and advocate for natural birth; and meticulous research on the history, uses and safety of ultrasound scans. In challenging the current obstetric dogma that routine prenatal ultrasound is both necessary and harmless, Sarah urges all women to make sure they fully understand the risks, physical and emotional effects, and potential complications before consenting to any procedure.

This is a message echoed by Justine Caines, whose article ‘Testing times’ describes the emotional impact of receiving an ‘increased risk’ result following combined first trimester screening during her pregnancy with youngest child Quinn. Long time advocate for women’s rights in maternity care and mother of eight home born children, Justine is about as informed in all things pregnancy and birth as they come. Many who have seen and heard her in action during media interviews, Senate inquiries and rallies will no doubt be surprised that even someone as hardcore as Justine could end up “on a path [she] did not want to take.” Having trodden a similar path (albeit with a different outcome), I understand how easy it is, in the process of trying to make the best decisions for you and your baby, to find yourself going in a direction other than the one you intended to take.

Prenatal testing is, I think, a lot like a downhill billycart ride. When you start out, you have a firm grip on the wheel, you know where you’re headed and you can see all the way to the end of the track. But once you get going you can pick up too much speed. Sometimes you lose control, veer off course and finally the

wheels fall off. I’m not suggesting that all screens and tests are a bad thing or that women are incapable of making informed decisions about which ones to have. I do believe that these procedures are often poorly explained and that a significant number of women who opt for them do so without having really thought through where it might lead them or what they will do if the result is not the ‘all clear’ they hoped for. And I know from experience how poorly our maternity care system supports women who receive difficult news prenatally.

This is why I asked my friend Dr Jan Hodgson to write an article explaining the role of genetic counsellors in the context of antenatal care. Few women seem to be aware that they can seek genetic counselling at any stage of the prenatal testing process, or that genetic counsellors are qualified to provide specific information beyond that offered by their primary maternity care provider/s. The support of these specialists can benefit not only those who receive an increased risk result or difficult diagnosis, but any woman who is unsure about any screen or test and what it will or will not reveal.

Of course testing is just one part of the antenatal experience – others we cover in this issue include the impact of past experiences on preparing for birth (page 13); how our choice of carer can help prevent the recurrence of previously experienced complications (page 18); and the importance of birthing choices.

Choosing who will care for us during pregnancy and how, where and with whom we will give birth can prove particularly difficult if, like *Birth Choices Expo* organiser Anne Harris (story page 6) your counselling on care options consists of being “handed a list of hospitals and told to make an appointment.” Given the widely acknowledged impact choice of carer can have on how women experience pregnancy, birth and early parenting, surely it is the most obvious of good practice habits to offer every woman written and verbal information on all of her available options at first contact during pregnancy. Here again, the draft first trimester guidelines miss the mark. We can only hope that those responsible for revising them will take our concerns seriously and produce a final draft that is truly woman-centred and based on good evidence rather than mere force of habit.

Kylie

From the President



Sarah with (L to R) Darcy, Finley, Harper and Eben

What a lot can happen between editions of *Birth Matters*. When last we went to print it appeared that we were beginning to see insurance and the Medicare reforms take shape. Since then vexatious reporting of midwives is out of control and women are being left high and dry without a care provider in the final weeks of their pregnancies and going into their births. Why is this happening? Who, primarily, are the ones making these reports? And in a time when every woman has the right to choose where and with whom she will birth (and this is enshrined in law and care provider guidelines), why are midwives still being reported simply for supporting a woman who has made an informed decision about her care?

The most recent example was a situation involving a midwife in Perth who was contacted by the Australian Health Practitioner Regulation Agency’s

(APHRA) “Immediate Action Group” and had her practice suspended because she was supporting a woman to homebirth after caesarean. How did this midwife pop up on APHRA’s radar? Well, simply because the birthing woman made a back up hospital booking.

One has to wonder what the Australian College of Midwives (ACM) thinks of these gross misinterpretations of its guidelines. Where does ACM sit with homebirth after caesarean?

During this quarter the ACM also released for consultation its homebirth position statement (A summary of MC’s response has been published in this edition of *Birth Matters*). There is still much a lack of clarity around what exactly this document be used for.

This is also our final edition before a solution the Professional Indemnity Insurance (PII) exemption for intrapartum care at home must be sourced. Any

woman who conceives post September 2011 and intends to have a homebirth will again find herself in a position of uncertainty. The PII exemption ceases on 30 June 2012.

Finally, this is my last President’s report. After five years on the National Management Committee I have stepped down to focus on my family before we celebrate our last birth. During previous pregnancies I intended to take maternity leave, but inevitably something always pops up (last time I birthed two days before Nicola Roxon’s budget announcement regarding Medicare), and this time I want to enjoy the final weeks of what is definitely our last pregnancy and be able to relax during the postnatal period. MC will nominate an interim president, who will serve from now until the October AGM.

Sarah Kerr



Missed out on advertising in *Birth Matters*?

Book Now to place your ad in September BM!

Contact:

birthmatters@maternitycoalition.org.au

ARTICLE SUBMISSIONS DEADLINE: FRIDAY 5TH AUGUST

Spring Theme – Labour and Birth

- Where do home birthers stand now?
- Experiences with ‘collaborative arrangements’
- Being assertive in labour – can you make yourself heard?
- Birth choices explained

Deadline: Friday 12 August

Summer Theme – Postnatal Care and Annual Report Edition

Deadline: Monday 24 October

Articles should be a maximum of 3000 words and be accompanied by photos where possible. Please email submissions to birthmatters@maternitycoalition.org.au on or before the posted deadlines.

Federal update: recent submissions

By Ann Catchlove and Kylie Sheffield

Professional indemnity insurance consultation

The Nursing and Midwifery Board of Australia (NMBA) recently called for feedback regarding the possible inclusion of a minimum dollar value of *quantum of cover* for midwives in the draft Professional indemnity insurance for midwives Guideline. MC made the following points in its response to NMBA:

- Advice given by the insurance industry is likely to be based on their experience with obstetrics based claims rather than midwifery claims.
- Requirements placed upon midwives (which then flow on to the women they care for) should be evidence based. This evidence should be drawn from outcomes relevant to midwives and the care they provide, not on the obstetric model which invariably carries greater risk due to a greater scope of practice, larger client volume and a wider range of potentially catastrophic complications.
- Requirements for unreasonable/non evidence based quantum cover could significantly restrict midwives' practice, women's options and their right to make informed choices regarding maternity care.

Regarding the *Draft of professional indemnity insurance for midwives Guideline*

- The guideline does not adequately recognise women's rights to informed consent and refusal.
- The Australian College of Midwives (ACM) Guidelines explicitly recognise that women can and do make choices that run contrary to the recommendations in that document.
- The right of women to make decisions about their maternity care including where they will give birth and who will care for them is futile if NMBA produces guidelines that fail to respect this right and fail to acknowledge all of the provisions of the ACM Guidelines when it comes to informed refusal.
- It is inappropriate for "collaborative arrangements" or provision of a care plan to be listed in this guideline as a requirement for midwives exercising the insurance exemption for intrapartum care.

- Sufficient provisions exist in the guideline to encourage midwives to consult and refer as needed. This additional requirement is unnecessary and will only have the effect of limiting women's access to homebirth.

Senate inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)

MC raised the following issues in its submission to this Senate inquiry:

- AHPRA and the Nursing and Midwifery Board of Australia (NMBA) lack the resources to deal with national registration, finalising the details of the insurance exemption and the endorsement of eligible midwives in a timely and transparent manner.
- The process of finalising the details of the insurance exemption for intrapartum homebirth care has led to uncertainty and confusion for consumers.
- The complaint handling procedures of AHPRA and the NMBA are, in many cases, failing to afford procedural fairness to midwives and failing to recognise basic consumer rights, particularly the right of informed refusal.
- Women have a legal right to make decisions about their maternity care including where they will give birth

and who will care for them when they do. This right is meaningless if the NMBA operates in an overly punitive manner when dealing with midwives who respect it.

- The NMBA should be proactive in identifying when notifications are vexatious, frivolous or lacking in substance and take appropriate action to deal with them promptly and appropriately.
- AHPRA should develop guidelines providing for clear and transparent avenues for consumer engagement.

ACM "position statement" on home birth

MC was recently given the opportunity to comment on a draft position statement on homebirth that was being developed by the Australian College of Midwives.

In its response MC stated that the purpose of the document was unclear and that there had been a lack of transparency in the process of developing the position statement.

MC submitted that it is essential that two interconnected principles be at the centre of any position statement, policy or guideline regarding homebirth. The first is the right of consumers to make informed decisions regarding place of birth, including the right to make decisions that do not accord with the document in question. The second is the midwife's duty of care to respect women's decision making autonomy and to ensure that women are not abandoned because of the

choices they make.

In response to a section of the document which stated that homebirth is an appropriate model of care for women deemed to be at low risk of complications MC noted that homebirth is not actually a model of care; it refers to a place of birth. Continuity of midwifery care is a model of care which all women should be able to access. Unfortunately, in our health care system, it is a model of care that is available to very few women. The few continuity models within the health system are almost universally limited to women without any perceived risk factors. This means that for many women their only means of accessing continuity of midwifery care is to hire a privately practising midwife who, at this point in time, can only provide intrapartum care at home. Including a statement like this will make it even more difficult for these women to access continuity of midwifery care. It is essential that the position statement specifically acknowledges that a number of women will choose homebirth in spite of (and often because of) their risk status.

MC also expressed its expectation that the document would be made publicly available for comment before playing any role in regulating midwifery practice. Unless this takes place the position statement will lack legitimacy and will risk not being adopted by some midwives and consumers.

Draft National Evidence Based Antenatal Care Guidelines

MC provided the following feedback on these draft guidelines:

- It is essential that all women receive written and verbal explanations of all available care options from their 'first contact' provider – the Guidelines fail to emphasise the importance of providing comprehensive and unbiased information, as early as possible in pregnancy, to facilitate informed choice.
- The woman is at the centre of all 'collaboration' and should drive the collaborative care effort. The definition of 'collaborative practice' provided in the Guidelines omits women from the equation altogether. A more woman-centred definition is provided in the National Health and Medical Research Council's (NHMRC) *National Guidance on Collaborative Maternity Care 2010*, which states that "... collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care" and recognises the woman as an active participant in her care.
- The Guidelines should reflect that it is a woman's right to choose her model of care, including midwife-led care, even if she experiences complications requiring medical or

obstetric support. Women who do experience complications often have the most to gain from developing a relationship of trust with a known carer or carers.

- Terms such as 'usual' and 'routine' should not be applied to procedures and processes to justify their place in antenatal care. Advice should be evidence based and recognise the individual needs and preferences of each woman.
- The language throughout the Guidelines should reflect choice and acknowledge that no procedure, screen or test is compulsory to any woman.
- The advice around the information women are offered before consenting to antenatal screens and tests needs to be specific. A number of evidence-based documents such as *Murdoch Childrens Research Institute Decision Aid (Your choice: screening and diagnostic tests in pregnancy) 2004* and the Centre for Genetics Education's *Fact Sheet 17 (Prenatal Testing – Overview)* already exist to assist providers, yet adequate information is rarely offered.
- If 'companion documents' are to be developed to accompany the Guidelines, they too must be clear, comprehensive and acknowledge that all procedures, screens and tests are a matter of choice.

ARE YOU A MULTI-TASKER?

WANTED: Passionate people to join our editorial team

We are looking for people to join our editorial team later in 2011. If you have experience in the areas of writing, proof reading, editing or design and layout (or have the time and motivation to learn) and feel passionate about the need for an accurate and representative voice on the Australian birthing scene, we'd love to hear from you.

Email birthmatters@maternitycoalition.org.au or call **Kylie** on **0414 494 853** for a detailed role description or more information.



Why are birth choices important?

By Anne Harris



When I became pregnant I did what everyone I know did: I went to my local doctor, booked an obstetrician, had some blood tests, and then asked, “So what now?” I was handed a list of hospitals and told to make an appointment. But somewhere in the back of my mind I knew I wanted a model of care that wasn’t on *any* of these lists. I wanted a woman beside me as I laboured and made the transition into motherhood. I wanted a natural, supported birth and a community of people to help me on my journey.

So began my search for a ‘natural birth’. I googled and read books, but it was extremely difficult to find something local or complete. Finally, I made contact with an independent midwife, booked into a birth centre and completed a 12-week course all about natural pregnancy and birth. The final result was a healthy pregnancy, a four-hour labour and planned homebirth, and the support I needed when I had trouble coming to terms with the challenges a new baby brings.

Many mothers, when the birth is over and they’re tucked up in bed with a new baby, find they’ve arrived there by a very different path from the natural birth they’d always imagined. Getting to that point can

be an amazing journey full of twists and events that you never even knew existed. In Australia you have a 30 to 40 per cent chance of having a Cesarean section; this is well above the 15 per cent recommended by the World Health Organisation.

So why are so many women undergoing major surgery for an event that we might expect Mother Nature, in her wisdom, to have designed to work without surgical intervention? Maybe part of the problem lies in our society’s approach to healthcare: when an illness presents itself, pop a pill, have an operation and remove the culprit. In a more holistic, preventative model of care, if a woman is supported, the ability for her to birth naturally and safely is achievable; evidence-based research proves that this can and does happen.

After the initial stage of getting the hang of juggling being a mother and everything else, I started to look for a way to help other women access the vital information they need to make informed choices about how, where, when and with whom they birth. That’s when I found the *Birth Choices Expo*. They have all the information that you need and the tools to help you become informed, empowered and joyful

about the journey ahead. The expos are organised by a group of women, all of whom are passionate about pregnancy, birth and parenting.

We want to share everything that we have gathered along our own parenting journeys and make other families’ paths simpler and more fulfilling. We want to help you to increase your chance of having a low-intervention natural birth, which will leave you with the energy to really focus on connecting with your new child, to build a safe nurturing environment for yourself and your whole family.

The expos also have a strong emphasis on building community networks, and include community groups that are able to support you on your way. Sometimes you do need extra support to get through the challenges that babies bring. Knowing where to go for advice and information that is in line with your own belief system can help you to feel comfortable about the decisions you make, and empowered as you really are part of the process.

The next *Birth Choices Expo* will be held on 18 September 2011 at Petersham Town Hall, Sydney. There will be a selection of birth centre representatives, independent midwives, doulas and many other pregnancy-related practitioners. Come along to this free community event and explore all your options. Or visit www.birthchoicesexpo.com.au for more information.



Photos are courtesy of Anthony Montalbano

2011 AGM

2011 Annual General Meeting - Change of Date

Saturday 22 October 2011

Time: 4 pm Eastern Daylight Saving Time

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

Secretary Georgia Hodges secretary@maternitycoalition.org.au

The business of the AGM is to:

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

All members are invited to join in the AGM.

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

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

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

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

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

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

Treasurer: to collect and receive all monies due to the MC, to make all payments authorised by MC, to keep correct accounts and books showing the financial affairs of MC with full details of all receipts and expenditure connected with the activities of MC, provide a quarterly profit and loss statement and organise audit of the finances of MC.

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

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

Current Management Team

Office Bearers

President: Sarah Kerr
Vice President: Makayla McIntosh
Secretary: Georgia Hodges
Treasurer: Naomi Campanale
Assistant Treasurer: Jo Askham

General Committee Members

Bruce Teakle
Nicole Carver
Membership Secretary
Bec Telfer

Birth Matters Editorial Team

Kylie Sheffield (Editor)
Sonia Bartoluzzi (Assistant Editor)
Mara Dower (Design and layout)
Bec Telfer (Distribution)

Testing times: facing the odds of a less than perfect outcome

By Justine Caines



Justine welcomes Quinn, completely healthy despite an ‘increased risk’ result following combined first trimester screening.

When faced with the news of my seventh pregnancy and eighth child, I was surprised but excited. I knew our workload would increase, but I was still happy. I also knew many around me would not feel the same, so, despite being very at ease with the prospect of having another child, I decided to conceal the pregnancy. Quite frankly, I did not want the inevitable snide comments.

I spoke to my trusted midwife, and when I saw her fairly early on, we both thought I was presenting much higher than my ‘dates’ suggested. I decided to have a ‘very quick’ early scan, just to check that I had only one baby on board. I had done this with baby number seven and the scan took only about thirty seconds, for which I was grateful. As an obstetrician I know and trust was unavailable, I (stupidly) got a regular referral and was shuffled into a 12-week scan that involved a nuchal fold measurement, commonly

referred to as a nuchal translucency or NT scan. I knew I did not want this. I was familiar with the evidence around early pregnancy screening and I should have declined when asked to have a blood test shortly after the ultrasound. Because it was then clear that I was already on a path I did not want to take. But I kept thinking that this might be a sign; this time there really may be something I needed to know. It was a real challenge and I felt sucked in by it all. I had no local support and, importantly, no one like-minded with whom I could talk this all through. A seed of doubt had been sown. So I meekly consented to a blood test.

The combined ‘results’ of the scan and blood test determined there was a 1 in 9 chance my baby had Trisomy 21, more commonly known as Down syndrome. When the GP called, I told him I understood that this result was not definitive, and asked how the ‘risk

result’ was determined. All I heard was something about a “nose measurement” and “Queen Charlotte’s Hospital in London” – it was clear he had no idea. I felt it was unacceptable that women who receive news of an ‘increased risk’ result go through this angst, yet this practitioner could not adequately explain how the risk ratios were developed.

I was angry with this man but mostly at myself. I know many would find my reluctance strange – just have the test... why wouldn’t you want to know... women do it everyday. For me, the result was unlikely to change the outcome – I knew I would carry this baby for as long as possible and deal with whatever life dealt us. I am pro-choice and I believe in a woman’s right to choose, but I personally could not have terminated this baby unless my life was in danger. I then tried to tell myself again that this was a sign, that I needed to know in order to be prepared. Fortunately I had two friends with whom I could discuss this. One was Kylie Sheffield, and it was very reassuring to hear many stories of women who had received increased risk results following combined first trimester screening, but given birth to healthy babies. I wanted then to turn off and say, “What will be, will be,” but, with a kernel of information, I felt I really needed more.

At this stage I also felt guilt that by wanting to conceal my pregnancy I had caused this. Even though I very much wanted this baby and was comfortable with being pregnant again, the niggle was there.

I decided to have an amniocentesis at 18 weeks. I was terrified of spontaneous abortion (even though the likelihood is low* I kept thinking of how sad it would be if a lost a baby that was totally healthy after amniocentesis). I was rattled.

I felt it was unacceptable that women who receive news of an ‘increased risk’ result go through this angst, yet this practitioner could not adequately explain how the risk ratios were developed.

The procedure was done at a tertiary hospital a 500 km round trip from home. Both of my midwives came with me. I was very well loved and supported. Despite my fear, there was a rather funny side to it. The Registrar who briefed me on the procedure asked if this was my first baby. I casually replied, “No, this is number eight.” Her mouth dropped, so I quickly added, “I have a set of twins.” I was then introduced to the obstetrician who would perform the procedure. She was an Indian woman and I was pleasantly surprised by the calmness and sort of spirituality she exuded.

At this stage I wanted to acknowledge my midwives for the health professionals they are. Neither of the doctors knew them, and I wanted them to see what great care I was receiving. I introduced both of them as my midwives. The obstetrician smiled and said, “Oh, you are from Belmont [midwifery program].” They said they were not from Belmont, and I explained that I had birthed all my babies at home. The Registrar jumped up and said, “What even the twins?!” She nearly dropped the instrument in her hands.

As the obstetrician painted Betadine on my belly (apparently a midwife was meant to be present to do this but hadn’t arrived, so the two doctors carried out the mundane ‘nurse’ functions and were very good-natured about it) I told her I had never had anything like this painted on me. The obstetrician smiled warmly and said, “May this be your only encounter with Betadine.” I was relieved to have such a warm practitioner who was totally unfazed by this homebirth mother of seven.

The procedure started. I visualised my baby sleeping calmly. I did not watch the screen because I wanted to stay totally calm and focus on my baby without

... I was shuffled into a 12-week scan that involved a nuchal fold measurement, commonly referred to as a nuchal translucency or NT scan. I knew I did not want this. I was familiar with the evidence around early pregnancy screening and I should have declined when asked to have a blood test shortly after the ultrasound. Because it was then clear that I was already on a path I did not want to take.

thinking of anything else. My midwife said sometime later that she knew two things as she watched the screen of the ultrasound: that our baby was fine and that ‘it’ was a boy – as the needle penetrated ‘he’ let out a huge kick as if to say, “Stay away! This is my home!”

I was fortunate that John Hunter provided a Fluorescence In Situ Hybridisation or ‘FISH’ result within 48 hours. This is an early result based on analysing the amniotic fluid sample for some, but not all, chromosomal abnormalities, including Down syndrome. In just over 24 hours I had the news that our baby was fine.

Five weeks of angst and costly technology, all because of an initial screening test that can only tell you where you fit on a Bell curve and provide you with an answer based on chance! I wonder how many women understand it in these

terms. I wish I had thought more clearly and not bothered with the scan. I guess I kept thinking, “Gee if we have another set of twins I really will need a footy bus!”

We officially notified our families of the pregnancy in my final week. While this was not ideal, I was glad to have avoided months of disapproval and unhelpful comments.

My story ended beautifully. Our eighth child Quinn was born in the 40th week of pregnancy at a rather hefty 4.5 kg. Betty was right – a big, bouncing boy. A difficult birth considering I had already birthed seven children, but, nonetheless, another calm and gentle home waterbirth, surrounded by loving family and midwives.

**Risk estimates vary from 1 in 1600 to 1 in 200, with “1 in 200 to 1 in 500” increasingly quoted to women in Australia.*

Author Bio

Justine Caines has been a leading advocate and activist for women’s rights in maternity care for over a decade. She is married to Paul and has eight beautiful children. Justine is currently living near Canberra and working as a political adviser.

Is your membership up to date?

Renew today. See page 32

CAN YOU REACH OUT TO AN AUDIENCE?

VOLUNTEER POSITION VACANT

Passionate about choice for women in childbirth, and want to help out?

MC needs to grow so that we can spread the message further. We need to do more work behind the scenes to strengthen our organisation and achieve more of our goals sooner!

Birth Matters is looking for an **ADVERTISING COORDINATOR.**

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



Ultrasound: a cause for concern

By Sarah Buckley



Sarah Buckley

Today the vast majority pregnant women will submit to a ultrasound scan, often simply because they have been told it is a ‘routine’ part of their pregnancy care. In this condensed extract from Gentle Birth, Gentle Mothering (2009), Sarah Buckley explains some of the shortcomings of the procedure and urges women to ensure their choice to undergo this form of prenatal screening at any stage of their pregnancy is an informed one.

Ultrasound is a very common procedure during pregnancy, and many parents enjoy seeing the first images of their unborn babies displayed on the screen. New ultrasound technologies, including 3-D and 4-D (moving) images, are especially compelling. However, it is important to realize that ultrasound technology is very new and relatively untested, in terms of safety, and its main purpose is to test for abnormalities, most of which cannot be treated before birth except by termination of the pregnancy.

This chapter provides essential information for all parents-to-be, and details what we know – and don’t know – about the safety and usefulness of ultrasound during pregnancy.

When I was pregnant with my first baby in 1990, I decided against having an ultrasound scan. This was a rather unexpected decision, as my partner and I are both physicians and had even performed pregnancy scans (sonograms) ourselves – rather ineptly, but sometimes usefully – while training in family practice obstetrics a few years earlier. What influenced me the most was my feeling

that I could lose something important as a mother if I allowed someone to test my baby. I knew that if a minor or uncertain problem showed up, which is not uncommon, I would be obliged to return again and again and that, after a while, I might feel as if my baby belonged to the system and not to me.

In the years since then I have had three more unscanned babies and have read many articles and research papers about ultrasound. Nothing I have read has made me reconsider my decision. Although a prenatal scan may sometimes be useful when specific problems are suspected, my conclusion is that it is at best ineffective, and at worst dangerous, when used as a screening tool for every pregnant woman and her baby.

What Is Ultrasound?

The term ultrasound refers to the ultra-high-frequency sound waves used for diagnostic scanning; these waves travel at one to twenty million cycles per second, compared to one to twenty thousand cycles per second for audible sound.

Ultrasound waves are emitted by a transducer (the part of the machine that is put onto the body), and a picture of the underlying tissues is built up from the pattern of echo waves that return to the transducer. Hard surfaces such as bone will return a stronger echo than soft tissue or fluids, giving the bony skeleton an opaque or white appearance on the screen. Ordinary scans use pulses of ultrasound that last only a fraction of a second; the machine uses the interval between pulses to interpret the echo that returns. In contrast, Doppler techniques – which are used in specialized scans, fetal monitors, and handheld fetal stethoscopes (sonicaids) – use continuous waves, giving much higher levels of exposure than pulsed ultrasound. Many women do not realize that the small machines used to hear their baby’s heartbeat in pregnancy, and for monitoring during labour, are actually using Doppler ultrasound, although with fairly low exposure levels.

More recently, sonographers have begun using vaginal ultrasound, in which the transducer is placed high in the pregnant woman’s vagina, much closer to her developing baby. This is used mostly in early pregnancy, when an abdominal scan can produce a poor picture. However, with vaginal ultrasound there is little intervening tissue to shield the baby, who

is at a vulnerable stage of development, and heat may be transferred to the baby. Having a vaginal ultrasound is not a pleasant procedure for the woman; the term “diagnostic rape” was coined to describe how some women experience this procedure.

Another recent application for ultrasound is the nuchal translucency (NT) test, in which the thickness of the nuchal (neck) skin fold at the back of the baby’s head is measured at around three months. A slight increase in the thickness of the fold makes a baby more likely, statistically, to have Down syndrome. When the baby’s risk is estimated at more than one in 250 to 300, a definitive test is recommended. Around nineteen out of twenty babies diagnosed as high risk via the NT method of testing turn out not to be affected by Down syndrome, and their mothers will have experienced several weeks of unnecessary anxiety. An NT scan does not detect all babies affected by Down syndrome. Nonmedical ultrasound, using 3-D and 4-D (moving) images, has also become popular as a way to “meet your baby before it is born.” This “keepsake” use of ultrasound has been criticized as potentially harmful

by the American Institute of Ultrasound in Medicine (AIUM),¹ the European Committee for Medical Ultrasound, Health Canada,² the Canadian Society of Diagnostic Medical Sonographers,³ the American College of Obstetricians and Gynecologists,⁴ and the U.S. Food and Drug Administration (FDA), which views it as an unapproved use of a medical device and suggests that consumers report organizations that offer nonmedical ultrasound.⁵

Information Gained from Ultrasound

Ultrasound is used for two main purposes in pregnancy – either to investigate a possible problem at any stage of pregnancy or as a routine scan at around eighteen to twenty weeks.

If there is bleeding in early pregnancy, for example, ultrasound may predict whether miscarriage is inevitable. Later in pregnancy, ultrasound can be used when a baby is not growing, or when a breech baby or twins are suspected. In these cases the information gained from ultrasound can be very useful in decision-making for the woman and her caregivers. However, the use of routine prenatal ultrasound (RPU), also known as a morphology or

standard scan, is more controversial, as this involves scanning all pregnant women, whether they have complications or not, in the hope of improving the outcome for some mothers and their babies.

RPU is designed to check the size and integrity of the baby. The timing of RPU (at eighteen to twenty weeks) is chosen for practical reasons; it gives a reasonably accurate due date, along with a reasonable chance of finding most of the abnormalities that scanning can detect.

The assessment of the baby’s due date, which is based on size, is most accurate at the early stages of pregnancy, when babies vary the least in size. For example, the estimated due date (EDD) calculated by a scan at seven to eight weeks will be accurate to plus or minus three or four days.⁶ At eighteen to twenty weeks, the due date is accurate to around one week on either side of the given date, and some studies have suggested that an early examination, or calculations based on a woman’s menstrual cycle, can be as accurate as RPU.^{7,8} Note that a later scan cannot give an accurate due date because of the large variation in size: after twenty-eight weeks, for example, a due date is only accurate to plus or minus three to four weeks.

At eighteen to twenty weeks, the baby is also big enough to detect most of the abnormalities that can be diagnosed with ultrasound. However, this is also not infallible: RPU actually detects between 35 and 80 percent of the one in fifty babies that have significant abnormalities at birth.^{9,10,11,12} Larger centres and sonographers with more experience tend to have higher detection rates, but even major centres will miss around 40 percent of abnormalities, with most of these abnormalities difficult or impossible to detect.¹³ For example, heart and kidney defects are unlikely to be picked up on a routine scan; markers for Down syndrome are also hard to detect; and other major causes of intellectual disability, such as cerebral palsy and autism, are impossible to diagnose via pregnancy ultrasound.

When an abnormality is reported there is also a small chance that the finding is a false positive, where the ultrasound diagnosis is wrong and the baby is less affected or even unaffected. A UK survey showed that, for one in two hundred babies aborted for supposedly major abnormalities, the diagnosis on post-mortem was less severe than predicted by ultrasound, and the termination was probably unjustified. In this survey, 2.4 percent of the babies diagnosed with major malformations, but not aborted, had conditions that were significantly over- or underdiagnosed.¹⁴ Two other studies have shown false positive results in around 10

percent of babies diagnosed with major structural abnormalities,^{15,16} making a repeat scan (preferably by another operator) important in this situation. There are also some conditions that have been seen to spontaneously resolve.¹⁷

As well as false positives, there are also uncertain cases, in which the ultrasound findings cannot be easily interpreted, and the outcome for the baby is not known. In one study involving women at high risk, almost 10 percent of scans were uncertain.¹⁸

This can create immense anxiety for the woman and her family, and this worry may not be allayed by the birth of a normal baby; in the same study, mothers with uncertain diagnoses were still anxious three months after the birth of their baby.

These uncertainties include the so-called “soft markers”: conditions that do not cause problems but are sometimes linked with more serious diagnoses such as Down syndrome. These include choroid plexus cysts in the brain; echogenic bowel and heart foci; short femur; short humerus; and pyelectasis of the kidney. Around 1 percent of babies, for example, have a

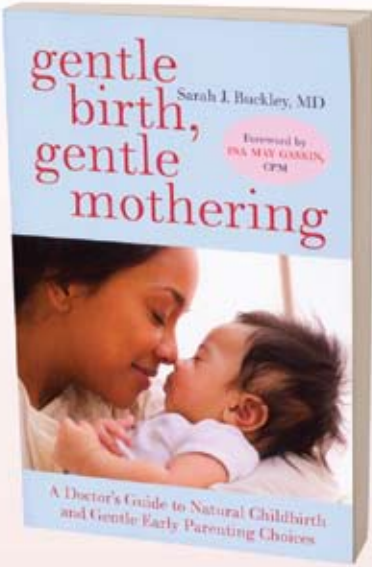
choroid plexus cyst, but only 1 in 150 of these babies will have a chromosomal abnormality such as Down syndrome.¹⁹ Because the diagnosis of soft markers can cause anxiety, and the overwhelming majority of babies with these markers are normal, some experts have suggested that soft markers should be disclosed to only those women at high risk of abnormality.²⁰

In cases in which a chromosomal abnormality is suspected, the doubt can be resolved by further tests such as amniocentesis. In this situation, there may be up to two weeks of waiting for results, during which time a mother has to decide whether she would terminate the pregnancy if an abnormality is found. The process of amniocentesis also carries an additional risk of miscarriage. Some mothers who receive reassuring news have felt that this process has interfered with their relationship with their baby.²¹

In addition to estimating the due date and checking for major abnormalities, RPU can also identify placenta previa (a low-lying placenta) and can detect the presence of more than one baby at an early

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

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



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

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

Gentle Birth, Gentle Mothering RRP\$24.95 ISBN:9781587613227

Available from www.sarahjbuckley.com and wherever books are sold

stage of pregnancy. However, almost all women who have placenta previa detected on an early scan will be needlessly worried; studies have shown that the placenta will effectively move up and not cause problems for 80 to 100 percent of women.^{22 23 24 25} Some researchers have even suggested that a low-lying placenta seen on an early pregnancy scan does not require a follow-up scan.²⁶ Furthermore, detection of placenta previa by RPU has not been found safer than detection in labour.²⁷ No improvement in outcome has been shown for multiple pregnancies either; the vast majority of these will be detected before labour, even without RPU, with no difference in outcome found for mothers or babies.²⁸

Conclusions and Recommendations

I would urge all pregnant women to think deeply before they choose to have a routine ultrasound. It is not compulsory, despite what some may say, and each mother must consider the risks, benefits, and implications of scanning for herself and her baby, according to their specific situation. If you choose to have a scan, be clear about the information that you do and do not want to be told. Have your scan done by an operator with a high level of skill and experience (usually this means performing at least 750 scans per year), and ask for the shortest scan possible. Ask them to fill out the form on page 91, or to give you the information so you can fill it out, and to sign it. If an abnormality is found, ask for counselling and a second opinion as soon as practical. And remember that it's your baby, your body, and your choice.

Note: In her full chapter on ultrasound, Sarah details scientific studies that show measurable harmful impacts from prenatal ultrasound, including damage to cells and effects on laboratory animals and human offspring; and documents the large increases in output from ultrasound machines since 1993, with no research into the safety of these exposures in pregnancy. This section on safety will appear in the September edition of Birth Matters.

References

1. American Institute of Ultrasound in Medicine. *Keepsake Fetal imaging*; 2005.
2. Health Canada. *Fetal ultrasound For Keepsake Videos*. Available at: http://www.hc-sc.gc.ca/iyh-vsv/med/ultrasound-echographie_e.html.
3. Canadian society of diagnostic Medical sonographers. *Position on the use of diagnostic ultrasound for nonmedical purposes*. Available at: <http://www.csdms.com/docs/02.pdf>.
4. American College of Obstetricians and Gynecologists. ACOG Committee Opinion. Number 297, August 2004. *Non-medical use of obstetric ultrasonography*. Obstet Gynecol. Aug 2004; 104(2):423-424.
5. United States Food and Drug Administration. *Official Statement on*

Ultrasonic Fetal Imaging. Available at: http://www.fda.gov/ FDAC/features/2004/104_images.htm.
6. Richards DS, Cornwall G. *Accuracy of ultrasound dating*. Available at: http://www.obgyn.ufl.edu/ultrasound/MedinfoVersion/sec6/6_6.htm.
7. Kieler H, Axelsson O, Nilsson S, Waldenstrom U. *Comparison of ultrasonic measurement of biparietal diameter and last menstrual period as a predictor of day of delivery in women with regular 28-day cycles*. Acta Obstet Gynecol Scand. Jul 1993; 72(5):347-349.
8. Olsen O, Aaroe Clausen J. *Routine ultrasound dating has not been shown to be more accurate than the calendar method*. Br J Obstet Gynaecol. Nov 1997; 104(11):1221-1222.
9. Stefos T, Plachouras N, Sotiriadis A, et al. *Routine obstetrical ultrasound at 18-22 weeks: our experience on 7,236 fetuses*. J Matern Fetal Med. Mar-Apr 1999; 8(2):64-69.
10. Saltvedt S, Almstrom H, Kublickas M, Valentin I, Grunewald C. *Detection of malformations in chromosomally normal fetuses by routine ultrasound at 12 or 18 weeks of gestation- a randomised controlled trial in 39,572 pregnancies*. BJOG. Jun 2006; 113(6):664-674.
11. Grandjean H, Larroque D, Levi S. *Sensitivity of routine ultrasound screening of pregnancies in the Eurofetus database*. The Eurofetus Team. Ann N Y Acad Sci. Jun 18 1998;847:118-124.
12. Crane JP, LeFevre MI, Winborn RC, et al. *A randomized trial of prenatal ultrasonographic screening: impact on the detection, management, and outcome of anomalous fetuses*. The radius study Group. Am J Obstet Gynecol. Aug 1994; 171(2):392-399.
13. Chan F. *Limitations of Ultrasound*. Perinatal Society of Australia and New Zealand 1st Annual Congress. Freemantle, Australia; 1997.
14. Chan F. 1997.
15. Borsellino A, Zaccara A, Nahom A, et al. *False-positive rate in prenatal diagnosis of surgical anomalies*. J Pediatr Surg. Apr 2006;41(4):826-829.
16. Martinez-Zamora MA, Borrell A, Borobio V, et al. *False positives in the prenatal ultrasound*

screening of fetal structural anomalies. Prenat Diagn. Jan 2007; 27(1):18-22.
17. Saari-Kemppainen A, Karjalainen O, Ylostalo P, Heinonen OP. *Ultrasound screening and perinatal mortality: controlled trial of systematic one-stage screening in pregnancy*. The Helsinki Ultrasound Trial. Lancet. Aug 18 1990; 336(8712):387-391.
18. Sparling JW, seeds JW, Farran DC. *The relationship of obstetric ultrasound to parent and infant behavior*. Obstet Gynecol. Dec 1988; 72(6):902-907.
19. Whittle M. *Ultrasonographic “soft markers” of fetal chromosomal defects*. Br Med J. Mar 29 1997;314(7085):918.
20. Stewart TL. *Screening for aneuploidy: the genetic sonogram*. Obstet Gynecol Clin North Am. Mar 2004; 31(1):21-33.
21. Brookes A. *Women’s experience of routine prenatal ultrasound*. Healthsharing Women: The Newsletter of Healthsharing Women’s Health Resource Service, Melbourne. 1994/5; 5(3-4):1-5.
22. Khan AT, Stewart KS. *Ultrasound placental localisation in early pregnancy*. Scott Med J. Feb 1987; 32(1):19-21.
23. Chama CM, Wanonyi IK, Usman JD. *From low-lying implantation to placenta praevia: a longitudinal ultrasonic assessment*. J Obstet Gynaecol. aug 2004; 24(5):516-518.
24. Page IJ, Wolstenhulme S. *Does the ultrasound diagnosis of low-lying placenta in early pregnancy warrant a repeat scan?* J R Army Med Corps. Jun 1991;137(2):84-87.
25. Ancona S, Chatterjee M, Rhee I, Sicurenza B. *The mid-trimester placenta previa: a prospective follow-up*. Eur J Radiol. May-Jun 1990; 10(3):215-216.
26. Page IJ, Wolstenhulme S. 1991.
27. Saari-Kemppainen A et al. 1990.
28. Neilson JP. *Ultrasound for fetal assessment in early pregnancy*. Cochrane Database Syst Rev. 2000(2):Cd000182.

Author Bio
Sarah Buckley is a GP, mother of four, and currently a full-time writer on pregnancy, birth and parenting.

‘Wild card’ dynamics – emotional work in pregnancy

By Rhea Dempsey



If you are a card player, follow tennis or even politics you will be familiar with idea of ‘wild cards’. A ‘wild card’ suggests high potency, high effect or high skill combined with unpredictability. You don’t know when it will be played, but when it is you know it will have a significant impact. This article applies the idea of wild cards to birthing.

I first began to think about wild cards many years ago at the birth of a little girl, Janey. She was the second child of a couple whose toddler boy had died of a childhood cancer eighteen months previously. The mother carried unrelieved ‘causal guilt’ (guilt characterised by a feeling of responsibility) because she believed that a chemical insect eradication treatment used on their house before their son became sick was the cause of his illness. Whether or not this was the case, it was the anguished reality of this mother’s belief. She had therefore taken great care during this pregnancy to minimise any possibility of carcinogenic or synthetic compounds affecting this baby’s early formation and development. She was highly motivated to have a normal physiological birth, as she didn’t want her baby subjected to any drugs or synthetic hormones during the labour itself. Although she had an epidural in her first labour, she did not want one this time. She also felt that her husband’s emotional distress might prevent him from providing the support she needed, so she invited me to attend the birth to ensure that she didn’t succumb to an epidural.

This will be straightforward, I thought – a highly motivated mother, clear about what she wants. I had little awareness then of such things as grief attacks, resistance, regression, triggering, cathartic release, of the potential for unconscious processes to sabotage conscious intentions, or of the importance of bearing witness. Over the hours of this labour I received a crash course.

In late first stage, after getting through some fear- and resistance-fueled crises, the triggering of this mother’s grief for her son culminated in the explosion of a cathartic rage. I had been breathing with her through the contractions, assisting her to stay on track with her original intention. But now she was in (I now realise) a full-blown grief-fueled cathartic release. She pounded against my chest, pleading for

“
Thus my idea of wild cards was formed: particular life circumstances, issues and patterns carry a potent, unpredictable dynamic. We cannot know when they will play out in the birth or postnatal period, or exactly what their effect will be. We just know that they will arise in some way, coming out of left field and often blind-siding birth intentions or hijacking postnatal bliss.”

an epidural, roaring at me repeatedly, over and over that: *You are so cruel. Get me the epidural! How can you be so cruel?* I was quite shaken: it took me (and her, I found later) completely by surprise. Knowing the likelihood of her later mental anguish if she *did* have an epidural, I tried to hold to her previously expressed intention for her longer term well being. But she was overwhelmed by the distressing present moment. Gradually I caught on. She was pouring out her grief, raging at me as a stand in, as a proxy for god, death, her son (for abandoning her), and the whole damn universe. She raged at the cruelty of her loss with the hallmarks of ‘grief work’ at

its most raw.
With this realisation (and after checking with the midwife that the mother’s and baby’s vital signs were stable), I steadied inwardly. This woman had had to live through the death of her son: the least I could do was hold firm and ‘bear witness’ to her pain, grief and rage, whilst honouring her original request of me. And so we went on together, breathing, stomping, rocking, until finally the rage was spent, the tears of grief were shed and she came to a quiet place of readiness for her new baby. The wonder of her birthing body took over and, just as she had intended, her baby girl was born into her welcoming arms – not caught in her past grief or her future fears – as she became fully present to this baby and the life to be lived.

Thus my idea of wild cards was formed: particular life circumstances, issues and patterns carry a potent, unpredictable dynamic. We cannot know when they will play out in the birth or postnatal period, or exactly what their effect will be. We just know that they will arise in some way, coming out of left field and often blind-siding birth intentions or hijacking postnatal bliss. I’m not talking here about medical risk factors, requiring medically necessary interventions. (Although, if not adequately understood and supported, the flow-on effects of wild card dynamics can eventually necessitate medical interventions.) I’m referring to psycho-social risk factors that form part of the unconscious matrix: the often invisible factors at work in birthing and mothering – emotions, thoughts, fears, desires, yearnings, personal history and relationships.

Some years ago I presented a seminar on pregnancy and birth art to a group of art therapists, none of whom had a medical understanding of birth and only some of whom had personal experience of the birth process. We explored artwork from pregnant women who attended my pregnancy group, to which I added some information about their life circumstances. The art therapists were able to predict with a great deal of accuracy the eventual birth pathways of these women – whether they would go overdue, have long or short labours, straightforward or complex births, whether or where in the labour they might become ‘stuck’, and whether they would need medical interventions to complete the birth.

What psychological underpinnings did these art therapists base their predictions on? Firstly, they were trained in ‘psychological thinking’, which posits that everything has meaning. Secondly, they believed that unstructured art expression can tap into unconscious processes and were curious about the ways in which previous life experiences live on in our present. Many of our thoughts, behaviours and life patterns are reflective of unconscious processes and deeper impulses, which flow, in the first place, as instincts, but also, more individually, are shaped by the life we’ve lived. When you add the holistic notion of mind-body connection to these art therapists’ curiosity and fortify it further by including insights from recent brain science research, then their capacity to predict birth outcomes becomes understandable.

When I make similar presentations to midwives, they too, if they are experienced and especially if they are working in ‘known midwife’ settings, can predict the pathway of a woman’s labour based not only on medico-obstetric factors, but also by viewing birth through a bio-psycho-social lens. The current obstetric view of birth, which reduces it down to bio-medical risk factors, can leave us believing that it is dangerously unpredictable; that women’s bodies are faulty; that surveillance and strict ‘one size fits all worst case scenario’ protocols are necessary; or maybe that only good or bad luck makes a difference. However, when we view birth through a holistic, women-centered, humanistic lens – a bio-psycho-social lens – we can marvel at the wisdom and responsiveness of the birthing woman’s body to her internal and external circumstance; sometimes in line with her birth intentions, but sometimes not.

One must, however, be mindful of delicate sensitivities in any exploration of these wild cards, because understanding their dynamics requires delving into the birthing woman’s life situation and psyche. Unless this is done with a respectful delicacy in the context of supportive care, we can appear to be blaming the birthing woman in the same way that a simplified view of birth culture can lead to blaming caregivers. The reality is more layered, nuanced and intricate than such uninformed blaming would suggest.

When I ask midwives whether they feel that most birthing women know that their life’s journey can be as predictive of the pathway their birth will take as medical considerations, they say no. Most women do not realise that any of a myriad life experiences can act as wild cards, predicting complexity and difficulty in

labour: a relationship with a parent or partner; guilt about a termination; the residue of a traumatic childhood; grief over a family death in childhood; the loss of previous babies through miscarriage, stillbirth or adoption; the distress of living far from the support of family. Why not?

Perhaps this lack of awareness arises because it is easier to discuss physical and medical matters than psychological ones, especially when, as is often the case, the birthing woman and the midwife are strangers. When trying to understand or explain why a labour has stalled, or the baby is not moving down into or through the mother’s pelvis, or the mother’s blood pressure is up, or the baby’s heart rate is compromised, it is less intimate and confronting to offer explanations in purely physical and medical terms than to

“

Women who carry pregnancy losses, or other painful life wounds and circumstances, in their pregnancies and into their births, need courage and attuned, psychologically aware support for the work ahead. Ideally this will be done in care settings where they can access known experienced caregivers, one-on-one, throughout labour.

engage in more psychological explorations that, unless sensitively handled, may be confronting and experienced by the mother as judgments. It is easier to suggest that a mother is exhausted, than to try to talk about a tension and lack of support between the birthing woman and her partner. It is easier to suggest that a woman’s pelvis is too small or her baby is too big, than to explore whether the rigidity in her body that is restricting her baby’s ability to move through her pelvis and vagina is a result of ‘triggered’ pain from previous traumatic body experiences. Wild card dynamics are not discussed widely enough, yet for the ‘willing women’ – a birthing woman who wishes to work with her body towards a normal physiological birth –these understandings are essential.

The discussion that follows seeks to open up awareness of the life experiences and mind-body connections that can affect birthing potential. If we don’t find a way to name and sensitively explore some

of these ‘wild card’ issues, then many willing women, full of resolve and focused intention, may find themselves blind-sided during their labours. In our present medicalised birth culture we use screening tests, foetal and maternal surveillance, timing protocols and routine practices to watch over and control medical risk factors. Why not encourage the willing woman to reflect during her pregnancy on wild card dynamics and gain support for them to better maximize her birthing capacity?

It might be argued this is less necessary for a birthing woman who is not strongly motivated towards normal physiological birth – medical interventions can generally offer solutions to the disruptions that wild card dynamics may create during labour. Nonetheless, since wild cards can also play out in postnatal life, it remains useful to have a handle on them. In this article I focus on wild cards specifically associated with pregnancy loss.

Socially negated loss

Pregnancy loss is often socially negated loss – loss for which there is a lack of social recognition. Such silenced stories of grief can lead to social withdrawal and isolation and a lack of opportunities to process the grief, leaving the necessary ‘tasks of mourning’ incomplete. Buried feelings about terminations, unprocessed feelings about miscarriages or still-born babies and, particularly in contemporary IVF situations, loss of frozen embryos, can all present psychic pain that may become a resistant and unpredictable wild card dynamic in future births. Even when pregnancy losses are acknowledged, the grief may still be silenced due to well meaning comments along the lines of ‘but you can get on and have another one’.

Tasks of mourning

Psychologist and bereavement researcher William Worden identifies four ‘tasks of mourning’: to accept the reality of the loss; to experience and process the pain of that loss; to adjust to the environment without the loved one including external ‘day-to-day’ adjustments, internal ‘sense-of-self’ adjustments and spiritual ‘assumptive world’ adjustments; then finally to relocate and memorialise the loved one. He calls this, as do other grief counsellors, ‘grief work’ – the active work of mourning, grieving and adapting to a loss. Completion of these mourning tasks enables mourners to reach a place where they can continue to have connection with the person who has died – a continuing yet transformed love for the deceased. However, if this grief work is incomplete, ongoing growth and development can be impaired.

Some of the dangers of uncompleted tasks of mourning with regard to subsequent pregnancy, birth and post-natal experiences are described in the following sections.

Impact on relationships

Different styles of mourning – active grief work styles, or passive ‘time will heal’ styles, externalising expressive styles or internalising ‘stiff upper lip’ styles – can place strain on relationships, leading to a lack of nurture, intimacy and support between a couple. Sexual difficulties may arise from misunderstanding the link between sexual connection and the longing for intimacy.

Loss can shake our ‘assumptive world’ – our fundamental view of the world, our values and philosophical beliefs – which may then reveal crucial differences between a couple. For some couples these strains may eventually lead to separation or divorce. While others may, too hastily, decide to have a ‘rescue baby’ before all their feelings are worked through, in an attempt to save their relationship.

Many other couples find that shared conscious grief work strengthens their couple bond and prepares them for any new possibility.

Fear of future pregnancy and birth

Some women fear being submerged in another grief and may choose not to trust another pregnancy. This can compound their grief: they grieve not only for this particular baby, but for the family they dreamed of. For other women, a subsequent pregnancy can raise rational fears about potential repeatable contributing factors to the previous loss. Clinical assessments and tests may be useful to minimise such fears. However, uncompleted grief tasks can lead to fears about grief being retriggered, leading to free-floating anxiety. Fear can cause a mother to consent to medical control mechanisms in the next birth in an attempt to control any perceived risk. Mothers may also be very psychologically controlled within themselves, and within their relationships with caregivers. Increased levels of fear, anxiety or psychological control affect the mother’s hormonal balance, during both the pregnancy and birth.

Replacement baby

Mothers who have not completed the mourning task of relocating and memorialising their dead baby are in danger of seeking a replacement baby – one who is not psychologically differentiated from their previous child. Acknowledging, grieving and possibly naming the baby who has

been terminated, miscarried or died becomes important in helping to find an appropriate place for the dead baby in their emotional lives, enabling a separate dream and separate identity for any subsequent baby.

Guilt

Unresolved grief can leave mothers, fathers or siblings with distressing feelings of guilt. Things done or not done; thoughts expressed or not expressed; feelings shared or not shared – sorting through these is the task of grief work. If this grief work is not undertaken an unnecessary burden of guilt can be carried into the next pregnancy or on throughout life.

This guilt can take many forms: recovery guilt (guilt at getting on with life with a new baby and a sense of dishonouring the memory of the lost baby), moral guilt (the feeling that some moral transgression in present or earlier life caused the loss), causal guilt (a feeling of responsibility for the death), or even sibling guilt (arising from the normal resentment of a new sibling). All of these can result in complex grief reactions and colour the relationship with any new baby.

Displaced anger and blame

When we experience the loss of any loved one, there can be a tendency to regress and to feel helpless, abandoned or rejected by the deceased. These feelings, unconsciously activated, not consciously formed, arise from our deepest survival needs for security. The death of a loved one shakes our belief in our world as a safe place, potentially triggering panic and anxiety, which can then turn to frustration and anger towards the deceased who caused our distress.

These feelings of frustration and anger at our helplessness need to be consciously identified and appropriately targeted towards the deceased for dying – for shaking our sense of a safe world and for leaving us bereft. Otherwise the anger may be displaced and directed towards ourselves or others at hand, leading to either acute self blame or the search to find someone else to blame.

The need to displace and deflect, to find a scapegoat to relieve our feelings of helplessness, frustration and anger, to find any other recipient but the deceased for this anger, is especially strong in the case of the loss of a baby or child. After all, how could we possibly be angry with the innocent child, angry that they didn’t fulfil their part of our dream, that they have abandoned us and left us bereft – how could we blame them for dying? If this anger is not understood and resolved, and the grief and helplessness that generally lie beneath the anger expressed, they can all

be brought into the next birth experience, which can lead to high anxiety, controlling behaviours and interpersonal tensions with partners and caregivers.

Reactivated grief

The experience of the death of an attachment figure (mother, father, grandparent, older sister, etc) in early life, known as a ‘broken attachment’, is understood to be an especial risk factor for postnatal depression and also can present as a wild card in labour. The grief of such broken attachments can also be reactivated in any current loss experience, so for a mother who has suffered an earlier broken attachment and also a pregnancy loss, the experience can reopen the old wounds.

Pain

Even if a woman has worked to heal or lessen the impact of any grief in her life, old grief can still reactivate with surprising potency during labour itself, adding a deeper layer of emotional pain, as in Janey’s birth. If old grief has been avoided or not adequately worked through, then increased labour pain would also be expected. A woman carrying an unresolved guilt burden may experience labour pain as punishment, making it difficult to normalise the intensity of their body working.

Support

Women who carry pregnancy losses, or other painful life wounds and circumstances, in their pregnancies and into their births, need courage and attuned, psychologically aware support for the work ahead. Ideally this will be done in care settings where they can access known experienced caregivers, one-on-one, throughout labour.

Author Bio

Rhea Dempsey is an independent birth educator, attendant, counsellor and trainer. Her experience of birth work spans over thirty years and includes birth preparation for couples, birth support in home and hospital settings, birth attendant and childbirth education training and counselling on birth related issues. She also presents regularly on birth and counselling themes at conferences, seminars, and workshops. This article is taken from a chapter in Rhea’s forthcoming book.

Rhea can be contacted via her website www.birthingwisdom.com.au or by calling (03) 9513 9164.

What is genetic counselling?

By Dr Jan Hodgson



Dr Jan Hodgson

"Genetic counselling is a communication process, which aims to help individuals, couples and families understand and adapt to the medical, psychological, familial and reproductive implications of the genetic contribution to specific health conditions. This process integrates the following:

- Interpretation of family and medical histories to assess the chance of disease occurrence or recurrence.
- Education about the natural history of the condition, inheritance pattern, testing, management, prevention, support resources and research.
- Counselling to promote informed choices in view of risk assessment, family goals, ethical and religious values.
- Support to encourage the best possible adjustment to the disorder in an affected family member and/or to the risk of recurrence of that disorder"

(Resta 2006)

Genetic counselling

Genetic counselling is a relatively new profession that arose out of the recognition that people often need assistance in understanding complex genetic information. Genetic counsellors are employed across a range of healthcare settings and in many public hospitals genetic counsellors work as part of a multi-disciplinary team providing clinical genetic services. Most genetic counsellors have a background in science and have completed a recognised training course in genetics and counselling. After a period of supervised practice and submission of a professional portfolio, counsellors are eligible for certification by the Human

Genetics Society of Australasia (HGSA). Working within a framework of ethical professional practice, Associate and Certified genetic counsellors participate in ongoing professional development and reflection.

Prenatal testing

All pregnant women are at risk of having a baby with a chromosome anomaly; the most common of these is Down syndrome, for which risk increases exponentially with maternal age.

Screening tests are offered to pregnant women during the first or second trimester of pregnancy. Both tests involve analysis of a maternal blood sample. The results are combined with other pregnancy information (and for first trimester screening, an ultrasound measurement of nuchal translucency) to produce an individual risk figure for Down syndrome (trisomy 21) and Edwards syndrome (trisomy 18). Second trimester screening also produces a risk figure for neural tube defects such as spina bifida. Women who are considered to be at 'increased risk' may be offered invasive diagnostic sampling procedures such as chorionic villus sampling (CVS) or amniocentesis in order to access fetal genetic material for further testing and obtain a diagnosis.

In addition, many pregnant women are routinely offered an ultrasound examination at 19 to 20 weeks. This is frequently perceived as a time to 'see the

Genetic counsellors can facilitate informed decision-making at all stages of this process by talking with women and their partners in order to ensure that they understand any risks associated with testing and by encouraging them to consider whether the available tests will provide them with information that they wish to know.

baby' and women may be unaware that this seemingly 'routine' test may detect or suggest an increased risk for a range of fetal anomalies that may lead to an offer of invasive diagnostic testing. As both CVS and amniocentesis increase the risk of miscarriage it is very important for women and their partners to carefully consider whether they wish to have diagnostic testing.

When diagnostic testing reveals a fetal anomaly, such as Down syndrome, women are usually offered a choice about continuing or terminating their pregnancy. For many women and their partners this

is a difficult time, especially if they were unprepared for this outcome.

The role of the prenatal genetic counsellor

Throughout the prenatal testing journey genetic counsellors can provide information and education – about different prenatal tests, the conditions that are being tested for and the options that will be available following a diagnosis. In addition, counsellors provide support for women and their partners throughout this often challenging time. Most importantly, genetic counsellors can facilitate informed decision-making at all stages of this process by talking with women and their partners in order to ensure that they understand any risks associated with testing and by encouraging them to consider whether the available tests will provide them with information that they wish to know. Following a diagnosis of a fetal anomaly genetic counsellors offer support in decision-making about continuing the pregnancy and beyond.

In summary, prenatal genetic counsellors can provide information and support for women and their partners who:

- have a family history of an inherited condition;
- may be at increased risk for fetal anomaly, either because of advanced maternal age or as a result of a screening test;

...many pregnant women are routinely offered an ultrasound examination at 19 to 20 weeks. This is frequently perceived as a time to 'see the baby' and women may be unaware that this seemingly 'routine' test may detect or suggest an increased risk for a range of fetal anomalies that may lead to an offer of invasive diagnostic testing. As both CVS and amniocentesis increase the risk of miscarriage it is very important for women and their partners to carefully consider whether they wish to have diagnostic testing.

- receive a diagnosis of / are concerned about their risk for a fetal anomaly;
 - have questions about any of the above.
- Access to clinical genetics services and genetic counselling varies throughout Australia according to location. To locate a

genetic counsellor call your nearest public hospital or visit www.asgc.org.au.

To learn more about prenatal tests that are available during pregnancy you may wish to read *Your choice, Screening and diagnostic tests in pregnancy* which can be found at: www.mcric.edu.au/Downloads/PrenatalTestingDecisionAid.pdf.

References

Hodgson, J., Gillam, L., Sahhar, M., & Metcalfe, S. (2010). "Testing times, challenging choices"; an Australian study of prenatal genetic counselling". *Journal of Genetic Counselling* 19(1), 22-37.

Resta, R., Biesecker, B. B., Bennett, R. L., Blum, S., Estabrooks Hahn, S., Strecker, M. N., et al. (2006). A new definition of genetic counselling: National Society of Genetic Counsellors' task force report. *Journal of Genetic Counselling*, 15(2), 77-83.

Author Bio

Dr Jan Hodgson is a Lecturer and the Research Coordinator for the Master of Genetic Counselling course at the University of Melbourne and the Murdoch Childrens Research Institute. Jan's PhD Research, "Testing times, challenging choices" explored the process of prenatal genetic counselling and women's experiences of being at increased risk for fetal anomaly (Hodgson et al 2010). Her particular research interests include reproductive decision-making and communication about genetics. She can be contacted by email: jan.hodgson@mcric.edu.au

MC MEMBERSHIP EXPIRED? RENEW FOR 2 YEARS & SAVE!!!

You can now renew your Maternity Coalition membership
for two years at a time, and save \$10.

Two year individual membership just \$70.

If you have recently renewed your membership and
would like to take advantage of this, please email
memberships@maternitycoalition.org.au

Proudly sponsored by
Today's the day BLACKMORES

itti*bitti

SYDNEY PREGNANCY CENTRE

BIRTH CHOICES EXPO
Supporting you and your baby, naturally...

PETERSHAM TOWN HALL
CRYSTAL STREET
PETERSHAM
3rd April &
18th September
1-5pm

FREE ENTRY
LUCKY DOOR PRIZES
FACEBOOK GIVEAWAYS

TALK SESSIONS
ON SALE 1st MARCH

www.birthchoicesexpo.com.au

Preventing postpartum haemorrhage with prenatal care

By Michelle McRitchie



really 'with it', so we decided to transfer to hospital two hours after the birth. The hospital experience wasn't fantastic, but the blood transfusion I consented to made me feel much better than I had after my second birth with no transfusion.

When I fell pregnant with my fourth baby, I considered the choice of midwives in my area and

When I set out on the journey of planning our fourth baby, I knew I would be labelled 'high risk' by the medical profession due to previous postpartum haemorrhages (PPHs) during my second and third births. My first two births were in hospital. I was induced for the first and, as a consequence, then experienced further interventions. My second birth, 21 months later, was spontaneous and largely intervention-free, but with a managed third stage. I suffered a large PPH of 950 ml (only noticed during a routine check a few hours after the birth, although I had probably been bleeding slowly since my baby was born) and, three hours after the birth, I was whisked off to surgery for a dilation and curettage on the assumption of retained placenta. I was already suffering from the blood loss and was very 'out of it' before corrective action was taken.

When planning my third birth with my midwife – this time after a nine-year gap – the issue of my last PPH came up. We assumed that it had been a result of my third stage being managed and, therefore, that there was a good chance another PPH would not occur. I also hoped my choice of a homebirth would reduce the possibility of negative outcomes.

I enjoyed a lovely pregnancy and birthed my baby in six hours. Once again I started to bleed slowly after birth, but this time my midwife monitored me closely and, with my consent, administered a shot of syntometrine an hour after the birth. While this stopped the bleeding, my blood pressure remained abnormal due to the amount of blood already lost (more than a litre). I still felt very sick and not

decided my best option was to remain with the midwife who had cared for me during my last homebirth. She advised that another homebirth was possible, but said she would prefer to manage the third stage from the start. This was not something I was keen to do – having experienced postnatal depression (PND) with my first baby, I was aware of the importance of not interrupting the high natural oxytocin levels that are present in the first hours after birth. While I really respected my midwife and was happy with how she handled the situation with my PPH, I did not want a managed third

stage. I also had a feeling that I needed something different for this birth, though I wasn't sure exactly what.

When I met with my midwife at five weeks, I expressed my wishes for a natural third stage, explained that my confidence had grown in relation to childbirth and said that, if it turned out my pregnancy was multiple or a breech presentation, then I might need to look for another midwife. She was happy with this, and we started out on the journey for my fourth baby.

As the weeks passed I became increasingly uneasy about my midwife and still felt I needed something different for this birth. Around 14 weeks into the pregnancy I felt very stressed and confused. Because it was a busy time of year, I hadn't yet had my official first appointment with my midwife. I contacted another midwife from Melbourne and discussed possible alternative midwives who might travel to support me in my birth. I learnt of one who lived an hour from us who might consider travelling to care for me. I phoned her the next day and immediately sensed a peace coming from her that felt 'right'. She agreed to meet me two weeks later to chat about my ideas. From the start of this meeting we clicked. After two hours of debriefing my births, discussing my desires, her philosophies and how they all fitted together, I knew

she was the right midwife for this pregnancy and birth.

By this time it was mid December and, because my new midwife was going away in January, we made our first appointment for the start of February when I would be 24 weeks. I felt good about this timeframe, as I wanted fewer appointments during this pregnancy and, at this stage, wasn't ready to fully 'enter into' the pregnancy. I wasn't disconnected from it, but I was at peace with where I currently was and needed to remain there for a while.

When February came around I was ready and excited finally to be starting the journey. At our first appointment the PPHs were top of the agenda and we discussed what we could do to reduce my chances of another one. My midwife knew my wishes for a natural third stage and supported this, unless I bled quickly or the bleeding would not stop. I agreed that I would definitely want her to take any necessary steps to ensure my safety if I had a quick bleed (which was not in my history) or if my bleeding continued. We also discussed various alternatives to reduce the chance of bleeding, such as using certain herbs; breastfeeding sooner after birth (I did not feed my third baby until more than an hour after birth); creating a quiet, dim and uninterrupted birth space; and ensuring that I could quickly access the toilet to empty my bladder and get onto the bed to get comfortable after birth (all things that were missing from my third birth). My midwife also suggested exploring possible emotional/psychological reasons for the bleeds as I progressed through the pregnancy.

We continued our appointments every few weeks and, by 31 weeks, I was feeling very tired and unwell within myself. My midwife challenged me about my overall health and suggested I start to see an acupuncturist to work on my blood and energy levels and a chiropractor to work on my back, which had been sore for some time. I was also conscious of the fact that I had been diagnosed with pregnancy-induced osteoporosis four months after the birth of my third baby, when I experienced two spinal fractures. This had caused me to lose 4 cm from my height. It dawned on me that I only had nine weeks until I was 'due' and that I needed to really step up and take control of my health, not see out the rest of my pregnancy feeling out of control and in pain.

At 32 weeks my midwife found the baby in a transverse position, which again motivated me to get on top of my health. I knew it was still early, and that transverse presentation at this time was quite normal in subsequent pregnancies, but the height I had lost since my last birth put some 'unknowns' around positioning

and room for the baby to move. I saw an acupuncturist at 33 weeks and a chiropractor at 35 weeks.

The acupuncturist advised that my blood was not looking good and she needed to work on balancing it out to reduce the chance of bleeding at the birth. She also noted the transverse position and did some work on encouraging the baby into a head down position. After my first visit my energy started to increase. I continued to see her fortnightly right up until the birth.

By the time I saw a chiropractor at 35 weeks, my baby had already turned head down. The chiropractor just worked on my pelvis, which she said was restricted by 3 cm. She was surprised I had not had any pelvis pain as yet, only back pain. She adjusted it gently and then made two follow-up appointments to take me up to the birth. When I returned to see her two weeks later, I was still without back pain and feeling great – my pelvis had stayed in the right position and there was no need for me to come back unless I had pain again.

The next week I finished work and was still feeling great. This was very different to my last pregnancy, when I took sick leave and finished six weeks earlier than planned because I was so tired and in so much pain. I felt confident about the changes that were happening with my health, and this gave me hope that this time we would be able to birth at home without a transfer and enjoy the time after birth, for the first time since the birth of my first child, 13 years before.

I started reading Shivam Rachana's *Lotus Birth*, which really spoke to me and helped me to start exploring the possible emotional/psychological aspects of my two PPHs. I thought about the depression I had experienced after the birth of my first child, which was still there after the birth of my second, and wondered whether my PPH was a way of trying to stop the pregnancy ending, so I didn't have to move onto the next step of being a mother. Even though it had been years since my PND, and I had done a lot of work to find healing from it, I acknowledged that my body could still be reacting in the same way. I also wondered whether I could feel the same way with my fourth baby. (Even though I did not experience any PND with my third baby, the back fractures I suffered when she was four months old resulted in chronic pain for a long time afterwards.) I wondered if choosing a lotus birth could be a way of slowing the birth, embracing the placenta and not feeling pushed onto the next stage so quickly.

I discussed this with my midwife at my next appointment and she agreed that it was a good idea. She was very familiar

with lotus births, having supported many over the years. My husband was not as comfortable with the suggestion but, when I explained the reasons behind it, he soon agreed that it was my decision, as I felt so strongly about its place in our plan to reduce the chances of another PPH.

At 37 weeks I experienced a beautiful Blessing Way organised by a dear friend of mine. This time was very special, with candles lit, prayers expressed, births shared and my friends and family sent home with their own personal prayer request for my birth, which included a prayer asking for a normal birth with minimal bleeding.

At 39 weeks I went back to my acupuncturist who commented that I actually had 'too much' energy and she needed to balance me out the other way a bit more! I was getting up every morning at 8 am and going non-stop until 11 pm at night before I dropped into bed. This was unprecedented for me: I usually crashed in the last trimester, needing afternoon sleeps most days. That night I was quickly exhausted and, over the next few days, was very tired and needed to sleep in the afternoon again. This had me worried, so I emailed the acupuncturist to make another appointment for the following week. But my energy levels improved, so I decided to cancel the appointment.

By the Wednesday of the next week I finally felt 'ready' to have the baby. I knew I had done everything necessary in the prenatal period to fully prepare for the birth, and I was very confident that we had a great chance at not experiencing another PPH. Now it was time to wait until my baby was ready to come. It turned out we did not have to wait long. On the Friday night I went into labour and our fourth baby was born early Saturday morning with only a 550 ml loss after birth.

I am so thankful that I trusted my instincts and continued to look for another midwife, who really helped me to prepare physically, emotionally and even spiritually for a normal birth. I am also thankful for my beautiful husband who supported me at every turn, even when I didn't make much sense to him and he wasn't sure exactly why I needed a different midwife or a lotus birth. He now understands why and has expressed his admiration for my decisions. He is in awe of the way I birthed, finally doing it completely my way.

You can read the full story of Michelle's fourth birth in our next edition of Birth Matters, which will focus on intrapartum care.

VICKI CHAN AND LYNNE STAFF
showcasing the audio-visual magic of Nic Edmondstone

present

BETTER BIRTH: THE WORKSHOP



Bring Better Birth to a town near you!

More info: betterbirthworkshop@gmail.com betterbirth@bigpond.com
Tel: Lynne 0458 180 008 or (03) 6363 2007 Vicki 0402 140 769

Birth story: our journey to Rupert

By Samantha Roberts



Rupert, one week old

Daniel and I began trying to conceive five years ago, but when I underwent surgery to remove an ovarian cyst I discovered that my Fallopian tubes were so damaged that I would never conceive naturally. We then embarked on modified natural IVF, which resulted in a pregnancy on the fifth cycle that sadly ended in a miscarriage. Six months later we discovered I had diminished ovarian reserve and was possibly close to an early menopause. We were advised by our IVF doctor to try a couple more cycles before considering egg donation. Against all hope, I became pregnant again on the 15th cycle.

My waters broke 41 weeks and 5 days later, at 5 am on Sunday 17 April. We had planned a homebirth, but after 15 hours of strong labouring at home with Daniel, faced with suspected meconium in the waters and dehydration from constant vomiting, we followed the advice of our independent midwives and transferred to the Royal Women's Hospital. Although my dehydration could have been addressed at home, no-one could do anything about the meconium. The chances of my baby swallowing some meconium and then becoming sick were only 5%, but if it did happen we would need help immediately following birth. Daniel drove me to hospital and our

baby's head), my contractions began to diminish and dilation slowed at about 7 cm with little progress for the next four hours, despite strong contractions and labouring for most of that time.

As one of the reasons for the transfer to hospital was my dehydration, we asked for an IV. We told the hospital midwife I had ketones in my urine, but they said they would need me to urinate again in order to establish their own confirmation of the test my midwives had already done at home. Of course, this was impossible given I was severely dehydrated. Then followed a Monty Pythonesque situation: they couldn't confirm I was dehydrated because I was too dehydrated to provide the evidence of my dehydration! I soon started vomiting again so they got over it and just set up the IV. My primary midwife tells me I set a new standard for the amount of vomiting during labour – an unwanted honour I assure you!

We were under constant pressure from the consultant obstetrician and registrar to consent to various interventions and it took a lot of effort to delay and/or decline them. Thank goodness Daniel and I understood the hospital's timing protocols and had our midwives there to provide additional advice, support and strategy tips. Timing protocols are based on an 'average' labour, but recently even these have been shortened due to the demand and stress placed on our hospital system from a growing population outpacing the growth in health services. For any woman whose labour is not 'average' – me and nearly everyone else – the threat of a Caesarean section to shorten the birth process is immense.

The first intervention to which I agreed was constant foetal heart rate monitoring with telemetry, to ensure my baby wasn't distressed. The telemetry allowed me to keep moving around and to labour in active upright positions. It was difficult for the hospital to find an intact machine and someone to set it up, and this became my first non-negotiable point: I did not want to be confined to a bed with a fixed/regular constant foetal monitor, as this would not assist the labour. It took a while, but, finally, they found their equipment and worked out how to use it! We later discovered that foetal heart monitoring is only 50% accurate anyway.

After labouring for a total of 24 hours, and with my cervix dilating from only 7

cm to 8 cm over the course of 7 hours, I consented to syntocin to help speed up the contractions, an epidural for pain relief, a foetal scalp electrode monitor and, much later, a foetal scalp blood test to be 100% sure whether my baby was in distress or not. Despite constant pressure to deliver by Caesarean section, I was determined to give birth vaginally and at no stage did my baby show any signs of distress, despite, as we realised later, the epic journey he was slowly undertaking.

My baby's position in utero was right occiput posterior/lateral, instead of left occiput anterior. My baby's head was also asynclitic (asymmetrical – tipped towards one shoulder). The head therefore had a harder time passing through the narrow part of my pelvis: the ischial spines. My baby also took the long route via my back instead of the short cut around my front. Labour with an asynclitic baby is often lengthy and often ends with a Caesarean section, according to the statistics. Dilation often takes longer and there can be a delay in progress at about 8 to 9 cm or 9.5 cm for many hours. Thus my labour was always going to be longer and harder than average for both of us, but we didn't really know this at the time.

Once fully dilated, I negotiated an extra hour to push (the protocol is one hour only). After two hours of pushing I was very close, but the medicos arrived with a trolley to take me to theatre as they had tired of our requests for more time and wanted to 'take charge of the situation'. The birth suite became very crowded and in the pandemonium we obtained an additional 10 minutes, by which point I managed to push my baby's head down enough for it to be seen.

Somewhat disappointed, the medicos agreed that going to theatre was unnecessary, abandoned the Caesarean plan, and most of them departed with their trolley. I then pushed my baby out in a couple of big contractions with the help of the ventouse/ vacuum suction cup. My baby entered the world healthy, alert, bright pink and in the perfect position, showing he had been doing a lot of work himself, even though he had decided to take the long way around! Our midwives agreed that, given another half an hour, I would have probably pushed him out without any assistance.

So, on the full moon at 3.03 pm on Monday 18 April 2011 at the Royal Women's Hospital in Melbourne, at the age of 40 years and 8 months, I birthed our baby boy. We didn't know his gender in advance, so it was a real surprise to discover this firsthand. We named our son Rupert Alexander Scoullar.

We avoided a Caesarean section by the skin of our respective noses. We did it

together with the support of Daniel and our independent and hospital midwives. I recognise there was a good helping of luck as well as a lot of hard work and great support. I sustained a vaginal tear and a second-degree perineum tear (minor), which were quickly sewn up. Apart from the usual soreness of labour, I survived relatively unscathed. Most importantly, I felt empowered by the birth. In spite of the hospital's timing protocols, I avoided an unnecessary Caesarean, negotiated more time and consented and compromised when medically (or pragmatically) necessary in order to birth my son in the way I knew was possible. I really just

“

Once fully dilated, I negotiated an extra hour to push (the protocol is one hour only). After two hours of pushing I was very close, but the medicos arrived with a trolley to take me to theatre as they had tired of our requests for more time and wanted to 'take charge of the situation'. The birth suite became very crowded and in the pandemonium we obtained an additional 10 minutes, by which point I managed to push my baby's head down enough for it to be seen.

needed more time than the norm due to his position.

We are now at home enjoying our beautiful little boy, surrounded by (natural) oxytocin (the love hormone). This is our 'babymoon' and the three of us will enjoy it together for the next month while our independent midwives continue to visit us daily.

I realise how many people are involved in such a personal event and want to thank the large community of disparate individuals who helped us create and bring Rupert into the world. These include:

- Professor Robert Norman at the University of Adelaide for responding to my email and helping us connect with our eventual IVF doctor.
- Dr Lyndon Hale, Justine, the nurses, doctors, scientists, lab and administration staff at Melbourne IVF for accommodating my wishes

to do Natural IVF and encouraging us to continue when we had lost hope. Lyndon's warmth and humanity, not to mention his good humour and grace in always accepting whatever academic research paper on the subject of natural and mild IVF I had ready to discuss with him, will always be fondly remembered.

- The many researchers, academics and scientists who promote natural and mild IVF, including the International Society for Mild Approaches in Assisted Reproduction, some of whom responded to my emails regarding their research.
- My sister Tiffany for offering us her eggs should the last two cycles not succeed. The second to last cycle resulted in Rupert and I cannot help but wonder if in part the success was due to my reduction in stress thanks to Tiff's incredibly altruistic offer.
- The good citizens of Australia who subsidized 60% of the total cost of undergoing IVF through our wonderful universal health care system Medicare, without which, we could not have afforded to do it.
- Emily Howie at the Human Rights Legal Resource Centre for taking up my case *pro bono* against the state government's mandatory introduction of national police criminal records checks and child protection order checks for all IVF patients in Victoria. Emily continues to seek either domestic or international remedies to challenge this discriminatory legislation.
- Charmaine Dennis, Gina Fox, Amy O'Brien, Peter Slipper, Yudhika Naidoo, Jodie Williams, Sue Halliday, Narelle Gahan and the staff at Fertile Ground Health Group for nurturing me in so many ways.
- My colleagues and the Board of Management at Arts Project Australia for being so supportive and understanding during 18 months of gruelling infertility treatment. In particular, I want to thank my colleague and office mate Sim, who always listened with great respect and care to an account of all 15 cycles and who even dreamed about giving me her 'egg'.
- Paul Gough from ABC Radio National's Quiet Space for the personally chosen music he sent me to play while I was in labour.
- Rhea Dempsey, Child Birth Educator extraordinaire, for her wise counsel.

- The Maternity Coalition for their commitment to the advancement of best-practice maternity care for all Australian women and their families.
- The father of attachment theory John Bowlby and all the psychotherapists and psychologists who followed him, including Sue Gerhardt and Oliver James for their incredibly important work on what babies and children need in order to become emotionally robust adults.
- The Australian maternal feminists who inspired me to extend my feminism to include maternalism: Associate Professor Kerreen Reiger and Anne Manne.
- All the natural childbirth activists: Dr Sheila Kitzinger, Janet Balaskas, Dr Sarah Buckley and Pam England, who inspired me to see birth as a normal physiological life event and to give birth naturally and at home if possible; and for reaffirming for us that pregnancy and the manner in which a baby is birthed can have profound consequences for their future physical and emotional health and well being.
- My personal counsellor who has remained an unstinting support these past four years and who continues to provide me with much comfort and reassurance.
- Our couple's counsellor who sensitively guided us through our infertility and slow journey to

- eventual parenthood.
- Our friends and family, many of whom have listened with great respect to our ordeal and supported us in our decision making. I want to pay particular thanks to my dearest friend Miriam and her daughter Ilana for her referral to our midwives. To Helen, Sarah and Ilana for donating their newborn baby clothes (all of whom happened to be boys.)
- Our fabulous independent midwives who practise their profession in an ever increasing hostile political environment in Australia. They are the true guardians of normal physiological birth. They believed in my ability to give birth naturally and without unnecessary medical intervention from the start, despite the obstetric profession categorising me as 'high risk' due to my age, method of conception (IVF) and a borderline moderately shortened cervix at 20 weeks, which increased my chances of a premature labour (instead I was nearly 2 weeks post dates). My pregnancy proceeded uneventfully. I remained fit and healthy throughout as I continued to eat a wholefoods vegetarian diet, walk, swim and practise yoga.
- Our two fabulous Royal Women's Hospital midwives, both of them recently arrived from Manchester, who were likewise guardians of normal physiological birth and

who encouraged me to keep going and to push Rupert out. Both our independent and hospital midwives made for an indomitable team, without whom I would have succumbed to the medical pressure. I also appreciate the RWH doctors who, despite the pressure to have a Caesarean, respected my wishes in the end and assisted with the ventouse to finally get Rupert out. The maternity ward midwives who supported my early attempts at breastfeeding when we were both exhausted from such a long labour are also due thanks.

- Daniel's mother, Jenny. I was amazed to learn that, when Jenny was pregnant with Daniel some 31 years ago, she read the original version of Sheila Kitzinger's *The Experience of Childbirth*, the updated version of which I read during my pregnancy. Thanks to Jenny for being so supportive of our approach to the pregnancy, birth and the way we want to parent Rupert. As the sole grandparent, we understand that Jenny will hold a very special place in Rupert's life.
- I would also like to thank my own mother for birthing me 41 years ago. Although she died prematurely at the age of 32 when I was 5, and therefore will never know her grandchild, I will keep her memory alive in the imagination of Rupert.

Maternity Coalition News

Central Coast MC

By Selena Maloney and Lisa Kim

Planning, travel and birth, 2011

Phew! What a busy few months we have had on the Central Coast. March saw us out of mischief with plenty of organising and planning. Our local member, Selena Maloney, had just returned from speaking on the forum at the *Beautiful Birth Festival* in Adelaide with Dr Andrew Bisits, Dr Sarah Buckley, and Lucy Perry. And the early arrival of our newest little member definitely made for exciting moments. Congratulations to the whole team for each of your achievements.

Beautiful Birth Festival



The Beautiful Birth Festival forum panel discuss achieving a beautiful birth.

On 27 February this year I was privileged to sit on a panel at the *Beautiful Birth Festival* forum in Adelaide (as a consumer of maternity services and mother of two beautifully born babes) alongside some highly regarded birth and health professionals: Dr Andrew Bisits (obstetrician and gynecologist); Dr Sarah Buckley (GP and author); Dr Pauline Hall (clinical psychologist); Tracy Semmler-Booth (mental health nurse practitioner and midwife); Dr Belinda Maier (midwife and midwifery advisor to the Chief of Nursing Officer in Queensland); Jodie Benveniste (psychologist, author, parenting expert and director of *Parent Wellbeing*); Lucy Perry (birth attendant, childbirth educator and author), and Pru Davey (midwife and prenatal yoga teacher).

In addressing the topic *Achieving a beautiful birth*, we answered questions on a variety of issues, including: what to expect from care providers; how to overcome obstacles and avoid unnecessary intervention during pregnancy and birth; how support partners can help; navigating a narrow pelvis; and, ultimately, how to achieve the best possible birth experience for both mother and baby. It was a very informative and worthwhile discussion,

which I was honoured and thrilled to be a part of.

Festival attendees attended seminars and workshops throughout the day, facilitated by the above experts on the following topics: *VBAC*, *Natures blueprint for birth*, *Keeping third stage normal*, *Dads at birth*, *Active birth*, *Woman centred care*, *Maternal mental health*, *Navigating birth choices*, *Blissful pregnancy* and *Achieving family wellbeing*.

They were also treated to some fabulous live music, fantastic food, colourful market stalls, belly dancing, belly painting, art exhibitions, amazing raffle prizes, beautiful maternity/kids fashion and baby wearing. It was an amazing day – a vibrant and joyful celebration of pregnancy, birth and parenting; and an invaluable opportunity to learn from experts, listen to positive birth stories, and meet like-minded others. Hats off to the festival organisers and volunteers who worked tirelessly to bring their vision to life. I would love other states (and the world) to follow your lead!

Caesarean awareness month, April 2011

April internationally recognises *Caesarean Awareness*, which sheds light on the impact of Caesarean surgery on mothers, babies and families. Brigitte Sigl and Kylie Corrigan spent a few days this month talking to women at our local hospital raising awareness about this major abdominal surgery, discussing options and alternatives with many mothers.

Both women welcomed the wonderful support offered by the staff at the hospital, who helped to circulate information to women. Thank you to everyone who became involved and helped to create more awareness about the physical and emotional toll of Caesarean section and the issues surrounding vaginal births after Caesarean deliveries.

International Day of the Midwife, May 2011

The Central Coast Maternity Coalition celebrated the International Day of the Midwife in the Maternity lounge at Gosford Hospital. We held a light luncheon for the midwives to attend before, during and after their shifts. Various heads of the maternity departments attended< including Angela Monger, Divisional Manager Women's, Children's and Family Health. The whole event, including interviews, was recorded by our local TV station, NBN, and aired on the 6 pm news.

Later that evening, Lisa Kim, gave a presentation at the Central Coast



CCMC celebrate the International Day of the Midwife.

International Day of the Midwife's Dinner to help raise awareness about our local branch and our activities. While Lisa Richards, independent midwife on the Central Coast, brought our local midwives up to date with the recent changes to our independent midwifery services.

For the rest of May it will once again be heads down and tails up as we apply for further funding and local grants, so that we are able to continue our efforts locally. Planning for our next *Empowering Birth Stories* is underway for 18 June. So watch this spot for another exciting few months.

Hunter Home and Natural Birth Support

By Chrissy Grainger

Hunter Home and Natural Birth Support members are gearing up for an extremely busy second half of the year, following a rather quiet start to 2011. Our April topic saw members talking about third stage, placenta encapsulation, lotus birth and delayed cord clamping; this topic brought up a range of emotions for many women. It was wonderful to see HHNBS' motto being put into place 'Empowering women to make decisions about and take responsibility for, the health and welfare of their bodies and babies', with members welcoming new information and feeling encouraged to make different decisions in pregnancy and birth. Birth support people, partners, siblings at birth and the role of the doula is the topic planned for June.

The second half of 2011 will see HHNBS hosting a stand at Newcastle's first ever natural parenting showcase, *The Expo for Childhood*, presented by local childhood advocacy group Hunter Alliance for Childhood Inc. We hope to create more public awareness of our group and attract some new members. Also in August is the *Homebirth Australia* conference; Chrissy



WANTED!

Honest and constructive feedback

If you would like to comment on the content of Birth Matters or share your ideas about anything

birth related, please email [birthmatters@](mailto:birthmatters@maternitycoalition.org.au)

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

has been busy preparing a presentation on her birth experiences and how ‘regional boundaries’ could have posed a challenge when she was pregnant with her second child.

October sees International Babywearing Week and HHNBS will once again be teaming up with the local Attachment Parenting group to celebrate babywearing within our community. Plans are still being finalised for Homebirth Awareness Week, which is also held in October.

Even though meeting are only held once a month, members keep quite active on the Hunter Home and Natural Birth Supports’ Facebook page. If you are interested in staying up to date with homebirth and birth news and information please feel free to join us: <https://www.facebook.com/pages/Hunter-Home-and-Natural-Birth-Support/259343047139>

We would love to hear your comments and thoughts on the interesting links that are posted regularly. Most recently ‘likers’ have been discussing: the vitamin K injection, safe babywearing, nuchal cords, informed decision making, as well as preparing an older sibling for a new baby. You are most welcome to share your happy smiley post-birth photo on our wall too.

HHNBS meets on the second Wednesday of every month at 10 am at Carrington Community Centre, 1 Hargraves St, Carrington. For further information please contact Chrissy 0418 237 938 or email hnnbsgroup@gmail.com

Wagga Birthing and Babies Support Group

By Bernadette Anderson

After a summer break, Wagga Birthing and Babies Support Group (BaBs) has been holding fortnightly meetings since early February. So far this year we have had a general catch up at the Botanic Gardens, a Vaginal Birth after Caesarean (VBAC) discussion led by midwife in private practice Lisa Richards from Tumut, and a session about ‘calm birth’ led by midwife Carmel Woods. We have also held a discussion led by local chiropractor and BaBs regular Kate Granger, who shared with the group how gentle chiropractic can be of use in pregnancy and with common childhood complaints, such as recurrent ear infections. The calm birth and VBAC sessions were repeats of topics offered last year, both still very popular with the community and very much geared for our target audience – expectant couples. We have an exciting schedule of meetings planned for the rest of 2011; by the time this goes to print we will have

discussed multiple births and the merits of providing organic foods for our families.

Our meetings provide a space for expectant couples to become better informed about their birth choices and, hopefully, more empowered as they work together with their caregivers. Wagga BaBs can be found on Facebook.



On 5 March 2011 we held a very successful Baby Bazaar at the Wagga Police Citizens Youth Club (PCYC). This was the biggest and best yet, with about 24 stalls and many customers through the door from 9 am until noon on a beautiful autumn day. Prior to the event, Wagga’s free community newspaper, *The Leader*, ran a photo of Hannah Penaluna, *Mama Says Yes!* Wagga representative and her baby Hendrix in his Ergo sling, to promote the Baby Bazaar.

Illawarra Birth Choices (IBC)

By Sonia Gregson

In April IBC members attended the *Birth Choices Expo* at Petersham Town Hall. This vibrant expo provided women with a broad range of information on pregnancy, birthing and postnatal support. The focus and feel of the expo was natural childbirth, and the stall holders reflected the theme with many organic, low-impact goods for mothers and new babies, as well as representation by doula colleges, private midwifery practice, publicly funded homebirth midwives and APMA. The Illawarra Birth Choices MC stall was well attended, with high demand for the



information leaflets, especially birth plan, third stage and water birth. The material was well received and continues to show how well-researched, consumer-friendly material is just what women are looking for.

The *Choices for Childbirth* antenatal classes being held in Wollongong started on Tuesday 10 May and will be almost complete by the end of June. The group will evaluate the effectiveness of these classes as a way of informing and educating local women. Guest speakers cover topics such as: natural birth, all about birth, labour pain, supporting your partner, breastfeeding, sleeping like a baby, homebirth/ water birth and VBAC.

For the International Day of the Midwife on 5 May, Illawarra Birth Choices hosted a celebratory morning tea in the Wollongong Botanic Gardens. This was an opportunity for the local group to thank midwives and publicly recognise all that they do in our community. In the Illawarra we have a number of dedicated private-practice midwives, as well as a hospital-supported midwifery group practice that includes a homebirth option.

Monthly meetings continue to be held at the Russell Vale Community Hall at 10.15 am on the third Monday of each month where we enjoy hearing from a wide range of guest speakers: 16 May – Choosing a care provider; 20 June – Birth plans; 18 July – Helen Gordon, an acupuncturist in Thirroul; 15 August – Traumatic birth; 19 September – Natural birthing methods and natural pain relief options; 17 October – Natural therapies for pregnancy/ baby; 21 November – Homebirth. Our meetings are family friendly gatherings that provide an opportunity to find out about options for maternity care in the Illawarra, to hear birth stories and to gain support from other local families.

Illawarra Birth Choices also has a brand new Aquaborn and La Bassine pool for hire. See our website for more information – www.birthchoices.info.

The aim of the Bazaar is to promote the recycling of popular baby/ kids goods, such as clothing, toys, car seats, potties, toilet seats and books, thus easing the financial burden of parenting. It also provides a space for work-at-home mums, and others with small businesses providing baby-related services and products, to sell their handicrafts (such as cards, clothing, nappies and hairpins). We had a food and hot drinks stall for the first time and a face painting stall, both of which helped keep customers and stall holders happily occupied at the bazaar for longer. This year we have decided to extend the bazaar hours to fill the morning. We had a few lucky door prizes donated by BaBs members collectively. We hold the Wagga Baby Bazaars quarterly, on

the first Saturday of the season; planning for the next bazaar on 4 June 2011 is well underway. To build on the success of the Autumn bazaar, we sought feedback from our stall holders and evaluated what worked well, so we can build on that.

We plan to meet with the nursing unit manager responsible for the Maternity Unit of the Wagga Wagga Base Hospital to examine fundraising ideas we can do in partnership with the hospital, with the aim of improving services to a large number of birthing parents in our community. And this week, we will be celebrating the International Day of the Midwife on Thursday with a morning tea at the Wagga Base Hospital.

As a group of volunteers we achieve a lot by supporting each other as parents, and each contributing what we can, depending on our changing circumstances. Organisational tasks and leadership are shared broadly amongst a core group of ten or more women. We all take pleasure in each other’s company and enjoy building peer support around birthing and babies for ourselves and for others in our local community.

Here are details of Wagga BaBs scheduled for the coming months:

Wednesday 29 June 2011, 10 am to 12 noon: *Conscious conception – How many children are right for your family?* Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Wednesday 27 July 2011, 6.30 pm to 8.30 pm: *Safe use of medications in pregnancy*, by Sonia Lancaster, pharmacist. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Wednesday 10 August 2011, 10 am to 12 noon: *‘Time out’ for Mum and Dad*. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Wednesday 24 August 2011, 6.30 pm to 8.30 pm: *Budgeting for babies*, by Jenny Wallace, financial educator. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Saturday 3 September, 9 am to 12 noon: Baby Bazaar, PCYC, 228 Gurwood St, Wagga.

Sunday 4 September 2011, 12 noon to 2 pm: *Fathers Day Special – Celebrating Dads*. Apex Park, BBQs, adjacent to Lake Albert, Corner of Lake St and Eastlake Drive.

Wednesday 21 September 2011, 6.30 pm to 8.30 pm: *The use of alternative therapies in pregnancy/birth*, by Nicole Hope-Allan, acupuncturist. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Saturday 15 October 2011 5 pm for 5.30 pm start: Movie night *About Dads*. Divine Wellbeing, 10/140 Hammond Avenue, Wagga Wagga. Donations to Living Awareness Foundation.

Wednesday 26 October 2011, 6.30 pm to

8.30 pm: *‘Mumpreneurs’ – Celebrating mums in business*. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Wednesday 9 November 2011, 10 am for 10.30 am start: Walk and talk, around Lake Albert (or part thereof), followed by picnic lunch. Meet at the BBQ/ play area, Apex Park, Lake Albert. Bring picnic lunch.

Wednesday 23 November 2011, 12 noon to 2 pm: *The world of modern cloth nappies*. Ashmont Community Centre, Corner of Tobruk & Blakemore Streets, Ashmont.

Saturday 3 December, 9 to 12 noon: Baby Bazaar, PCYC, 228 Gurwood St, Wagga.

Further information about each session may be obtained from our Facebook site (search for Wagga BaBs), by emailing waggababs@gmail.com or calling Kirsty 0401 523 121 or Jenny 0418 205 262. RSVPs prior to the meeting are appreciated but not essential.

Maternity Coalition Victoria Branch Report

By Ann Catchlove

MC Victoria committee members have been busy maternity consumers during 2011, producing a crop of baby girls who will inspire us to keep fighting for maternity reform for many years to come. Erin Horsley, our secretary, welcomed baby Sylvie in February; my daughter Sally was born on Good Friday; Susan Reddrop had baby Saskia in May and opened her birth themed art exhibition “Urge” just two days later; and Michelle McRitchie, our Vice President, had baby Pepper in May. As we didn’t manage an update for the last *Birth Matters* this one covers the year to date.

Our movie nights have been incredibly popular this year with some great movies and fabulous guest speakers. Elena Tonetti Vladimira presented her film *Birth As We Know It* in February. In March we held a fundraiser for the Bumi Sehat Foundation with a showing of *Guerrilla Midwife*, at which Prem Williams spoke. Pinky McKay joined us for our screening of *Babies* in April and Victoria Marshall Cerins spoke at May’s film Birth Movement. In June we showed *Labouring under an Illusion* with Rhea Dempsey again sharing her insights with us. Many thanks to Jo Askham for the amazing job she does in coordinating the movie nights and to all of our speakers for giving us their time and wisdom.

Our independent childbirth education classes “Choices for Childbirth” have been running again in 2011. There are further sessions running in July and October. Details can be found on the Maternity

Coalition website.

Choices for Childbirth is running a new workshop in July on “*Moving beyond a difficult birth experience*”. Erin Horsley and Jess Permezel have worked with Rhea Dempsey to put together this workshop and we are very grateful to Rhea for running the workshop. Perhaps unsurprisingly, the workshop booked out in less than a week. We will be running another workshop later in 2011. You can register your interest in this by contact Jess at northcotechoices@maternitycoalition.org.au.

Jess Permezel is now a consumer representative on the Victorian Maternity Safety and Quality Committee. The committee provides expert advice on the performance of maternity services in Victoria in order to contribute to improvements in the safety and quality of childbirth.

We have yet to meet with our new Health Minister David Davis but will be stepping up our efforts on this front now that our babies are Earthside.

As always, we are very keen to welcome new committee members and new ideas. Please don’t hesitate to contact me on vicpresident@maternitycoalition.org.au to discuss how you might get involved.

Maternity Coalition Ballarat

By Michelle McRitchie

With a slow end to 2010 due to half our group being pregnant and planning babies, we entered 2011 with a bit more energy and decided to hold a movie night event in early April. We chose the classic *Orgasmic Birth*, as it was a few years since we had shown it and it would attract some interest when advertised in the local paper.

Rhea Dempsey gave a talk and, as usual, she was fantastic and really spoke to the varied experiences of women in the room. The night was a big success with some women who had never previously heard of MC. One woman decided to change her birth from hospital to home, while another decided to find a doula to support her in her birth.

The New Year has also seen us finally start a BaBs kind of support group within the Ballarat area, which has only been running for two months now but seems to be growing each week.

We are still looking for a permanent venue, but the group is certainly in demand from women in our area. Our committee in Ballarat is still small and we really do need some more helping hands, but we continue to work hard, despite many of us still having babies and being busy with our ever growing families.

Revised information sheets

The following info sheets have been recently revised. Further sheets on a range of topics can be downloaded from www.maternitycoalition.org.au

INFOSHEET

THE THIRD STAGE OF LABOUR

A review of maternity hospital practice guidelines reveals differences in management of the third stage. Women who are intending to give birth under natural physiological conditions are encouraged to plan a natural third stage, and discuss their maternity care with the person who will be in attendance as the responsible professional when they give birth.

What is the third stage?

The third stage of labour spans the time from the birth of the baby to the birth of the placenta. The third stage is a pivotal time for the health and wellbeing of mother and baby.

In many modern obstetric settings it is standard practice to use drugs that cause the uterus to contract strongly to hasten the third stage, in an effort to prevent haemorrhage. This is called 'active management'. Active management may include early clamping of the umbilical cord, and pulling on the cord to deliver the baby's placenta quickly.

In a spontaneous, unmedicated, uncomplicated birth, it is reasonable to plan a physiological or natural third stage, without increasing the risk of haemorrhage.

In natural third stage the baby's cord is usually not clamped or cut, and the mother and baby stay in skin to skin contact, in a warm, unstimulating birthing environment until after the placenta has been birthed. It is important that the midwife or doctor who has professional responsibility at the time of birth is competent in natural third stage, and does not interrupt the natural process without a good reason.

Why is the third stage important?

Immediately after a baby has been born, a mother meets her baby for the first time and will, if uninterrupted, experience a natural and instinctive behavioural pattern that supports the establishment of confident mothering, early breastfeeding, and a secure bond or attachment between herself and her baby. This natural process includes a surge in the mother's love hormone, oxytocin, which also cause her uterus to contract, and assists in the birthing of the placenta.

What about the baby?

The moments after birth are also very important for the baby, who experiences a series of amazing natural transitions. When umbilical cord clamping is avoided or delayed, the baby receives up to 100 ml of blood that would otherwise be wasted. This blood supports the transition to life outside the womb, and improves the baby's iron stores.

A baby who is well at birth will instinctively begin to search for the breast, often within minutes of birth. The newborn baby's senses,

"Western practices neither facilitate the production of a mother's own oxytocin nor direct attention to reducing catecholamine levels in the minutes after birth, both of which can be expected to physiologically improve the new mother's contractions and therefore reduce her blood loss. The routine practice of separating mother and baby deprives the mother of important opportunities to increase her natural oxytocins release. "

Dr Sarah J Buckley 2009 (page 179)

and particularly the sense of smell, play an important role in early bonding, imprinting, and breast-seeking behaviours.

Mother-baby bonding may be delayed if the baby is separated from the mother at birth. Babies' instinctive efforts may be impaired as a result of drugs that have been given to the mother in labour, and that interfere with the baby's natural behaviour patterns.

Babies who have been born by caesarean surgery, or after medical interventions in the birthing process, who have not experienced natural birth or third stage, need long periods of uninterrupted skin to skin contact with their mothers as soon as possible after birth, to support mother-baby bonding (attachment) and other instinctive adjustments.

Suggestions for mothers who want to plan for natural third stage

- Choose a leading professional carer (midwife or doctor), and other carers who have the skills, confidence, and trust in the natural processes of birth and third stage.
- Plan for an undisturbed birth. This includes maintaining your health throughout pregnancy, spontaneous onset of labour, progress without drugs or other medical treatments to speed the labour or to take away the pain, natural birth of a healthy baby, followed by natural birthing of the baby's placenta without excessive blood loss.
- Prepare a birthing environment where you can be kept very warm and uninterrupted as you welcome your baby.

Please note that a natural third stage may not be appropriate if drugs and interventions such as synthetic oxytocics, epidurals and forceps have been used in labour and birth. .

© Maternity Coalition 2011. Revised April 2011. Date of first issue: 2006 May be copied without alteration for personal use or for free distribution. **Credit:** This *INFOSHEET* is based on the work of Dr Sarah J Buckley , Chapter 8 in *Gentle Birth, Gentle Mothering: A Doctor's Guide to Natural Childbirth and Gentle Early Parenting Choices* by Sarah J. Buckley, Celestial Arts Berkeley CA, (2009) www.sarahjbuckley.com Used with permission.

INFOSHEETS are produced by Maternity Coalition and Midwives Australia. *INFOSHEETS* provide consumer information that is current, accurate, evidence based, women centred, and consistent with maternity practices that protect, promote and support wellness and are in harmony with the natural physiological processes in birth. *INFOSHEETS* will assist women to make **informed decisions** about their maternity care, **regardless of their chosen place of birth or care provider**. www.maternitycoalition.org.au www.midwivesaustralia.com.au

INFOSHEET

A BABY'S TRANSITION FROM THE WOMB TO THE OUTSIDE WORLD

Birth is a time of enormous change for a baby. The transition from life inside the mother's womb requires many important changes. In the womb, the marvellous placenta performs the functions of the baby's liver, kidneys, skin, gut and lungs and after birth the baby's body must be reorganised to do these. In particular, the baby must breathe straight after birth, which also involves redirecting blood away from the placenta and to the lungs. The vital changes take place naturally at birth when mother and baby are well, and undisturbed.

Medical interventions may be needed at this time for babies who are having difficulty, but the vast majority of babies make this transition without help. Some drugs and interventions that are commonly used in maternity settings today, that may have an adverse impact on the baby's transition to life outside the womb include:

- Pethidine and other pain-relieving drugs used during labour can make the baby sleepy and even cause breathing problems especially when given 1-4 hours before birth
- Early clamping and cutting of the umbilical cord deprives the baby around 1/3 of the blood they need for an optimal transition and can cause anaemia in the early months
- Separating mother and baby in the hour or more after birth, even for weighing and measuring is unnecessary and can affect the baby's early breastfeeding behaviour
- Wrapping the newborn is not necessary: babies are warmest when skin to skin with the mother in the minutes and hours after birth
- Suctioning a healthy baby at birth is not beneficial and can cause a slowed heart rate and affect the baby's early breastfeeding behaviours
- Methods of resuscitation of a baby who is not breathing at birth have changed in recent years, in response to evidence. Air is being used in initial resuscitation, rather than oxygen.

Over time many interventions into the birthing process have been adopted. Some interventions in certain situations are life-saving, while others are not based on evidence for improved outcomes for mother or baby.

We encourage parents who are seeking maternity care that supports and promotes health and wellness to discuss these and any other issues that are important to you with your primary caregiver. You can seek to ensure that the midwife or other professional who is attending you in labour will support your plan for the care of your baby during the transition from the womb to the outside world.

Practices that have a positive impact on baby's transition:

No separation of mother and well baby, with uninterrupted skin-to-skin contact
Delayed cord clamping for term and pre-term babies
Breastfeeding when baby is ready, during the first hour or more.

Practices that may have a negative impact on baby's transition:

Drugs to relive pain such as pethidine, and epidural/spinal anaesthetics
Suction of the baby's airways at birth
Separation of mother and baby

Practices that are often used unnecessarily, without evidence to support their use:

Induction of labour
Clamping of the umbilical cord
Suction of baby's airways at birth
Oxygen used in initial resuscitation

Natural birth is a mother's own resource

Pregnancy, birth and breastfeeding are natural biological processes. Most women and babies are well during this time, and will be able to proceed through spontaneous unmedicated labour, and give birth to a healthy baby who breastfeeds and thrives naturally. In fact, unless there is a valid reason to interfere, the natural biological processes are the safest for both mother and baby.

There are many aspects of birthing which are un-knowable, and your birth plan should allow for and support your informed decision making at all times. Women who know and trust their midwife or doctor may be more confident in making decisions than those who do not know their primary carer.

Reference: Judith S Mercer and others, 2007. Evidence-Based Practices for the Fetal to Newborn Transition. J Midwifery Womens Health 2007;52(3)262-272

© **Maternity Coalition 2011** Date of issue: July 2007. May be copied without alteration for personal use or for free distribution.

INFOSHEETS are produced by Maternity Coalition www.maternitycoalition.org.au/ and Midwives Australia www.midwivesaustralia.com.au/. *INFOSHEETS* provide consumer information that is current, accurate, evidence based, women centred, and consistent with maternity practices that protect, promote, and support wellness and are in harmony with the natural physiological processes in birth. *INFOSHEETS* will assist women to make **informed decisions** about their maternity care, **regardless of their chosen place of birth or care provider**.

BIRTH MATTERS IS CHANGING

It's important to us that we bring you a journal that represents the experiences of ALL women and accurately describes the developments and politics of birth in Australia.

- Themes will be announced two to three issues in advance and advertised on our Facebook page.
- We'll endeavour to keep up with what's happening on Facebook and relevant blogs so we can best reflect a broad cross-section of views and attitudes.
- Every edition will include a Federal Update so you know what's happening nationally, what MC is doing about it and what you can do to help.
- We're introducing a section for reader feedback—you can email us or send us a letter to comment on the content of the journal, suggest themes or share your thoughts about anything birth related.

How YOU can help

- Make the deadline! We understand how hard it can be, but we hope the advance notice of future themes will help.
- Keep your eyes and ears open. You don't have to be a Maternity Coalition member or birth reform activist to submit to Birth Matters. Do you know of someone who has a great story to share or is well placed to submit a relevant article? All we need is a name and contact details. We'll do the rest.
- Tell us what you're doing. MC News is a great place to share what's going on in your area. Keep the news coming in.
- Stay in touch. Send us your comments, suggestions and concerns. We care what you think, so let us know.

Email birthmatters@maternitycoalition.org.au or call Kylie on 0414 494 853.

We look forward to your ongoing support as we work to make *Birth Matters* the most current, accurate and representative voice on the Australian birthing scene.

BIRTH AFTER CAESAREAN SUPPORT: ONE ORGANISATION'S OFFERING

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

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

Knowledge Not Fear

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

Won't a VBAC Just Be Better?

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

Empowering and Safe

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

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



ADVERTISE IN BIRTH MATTERS

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

birthmatters@maternitycoalition.org.au

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

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

Member notices

Management committee meetings (National)

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

General meeting dates for 2011

General meetings will be called as required, and members given 14 days notice. The date for 2011's AGM on Saturday 8th October, 2011, 3 pm EST. Full AGM details on page 7.

Midwives in Private Practice (Victoria)

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

Choices Victoria

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

Donations

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

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

MC bank account details

Commonwealth Bank of Australia Branch: Ringwood Victoria
Account Name: Maternity Coalition Inc.
BSB: 063 167
Account Number: 10108586
Postal Address: PO Box 1190 Blackburn North Victoria, 3130, Australia

Infosheets

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

Topics include:

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

Birth announcements note

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

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

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

Maternity Coalition Contacts

MC contacts (National) Office Bearers 2011

President: Sarah Kerr
president@maternitycoalition.org.au

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

Secretary: Georgia Hodges
secretary@maternitycoalition.org.au

Assistant Secretary: Vacant

Treasurer: Naomi Campanale
treasurer@maternitycoalition.org.au

Assistant Treasurer: Vacant

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

Assistant Birth Matters Editor:

Sonia Bartoluzzi

General committee members:

Bruce Teakle
Ann Catchlove
Kylie Nicholson

Other really important people who support our National Management Committee

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

National Peer Support Advisor: Alison Gaffney

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

Webwoman: Emma Davidson & Melissa McFarlane

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

General Inquiries:
info@maternitycoalition.org.au

CANA inquiries: info@canaustralia.net

Branch contacts

QLD President: Rebecca Jenkinson
07 3351 4834

qldpresident@maternitycoalition.org.au
Darling Downs President:

Linda Maguire
lindam99@tpg.com.au

Ipswich Contacts:

Kathy Smith
ipswich@maternitycoalition.org.au

NSW President: Lisa Metcalfe
nsw@maternitycoalition.org.au

Hunter Region

1. Hunter MC: Julia Cook
hunter@maternitycoalition.org.au

2. Hunter Home and Natural Birth Support: Chrissy Grainger
hnbgroup@gmail.com

Central Coast: Mandy Hilaire
mandyhilaire@yahoo.com.au

Coffs Harbour: TBA
coffs@maternitycoalition.org.au

Blue Mountains: Amy Bell
maternitycoalitionbm@gmail.com

Northern Rivers Maternity Action Group:

Vicki-lee McAllister
northernrivers@maternitycoalition.org.au

Wagga and South West Region:
Bernadette Anderson

wagga@maternitycoalition.org.au
Far South Coast: Tammy Glass
farsouthcoast@maternitycoalition.org.au

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

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

ACT President: Emma Davidson
act@maternitycoalition.org.au

South Australia President: Lareen Newman
08 8278 8649

sa@maternitycoalition.org.au
WA President : Tracey Reibel

tribal@dodo.com.au
0439 875 441 or 08 9336 3321

Northern Territory: Kylie Sheffield
0414 494 853

kylesnshef@gmail.com

Tasmania President: Vacant
tas@maternitycoalition.org.au

Victoria President:

Ann Catchlove
vicpresident@maternitycoalition.org.au

Peninsula Birth Support

Sarah Langford
0430 076 428
mcpeninsula@gmail.com

Geelong President:

Cherie Nixon
Geelong MC/Choices for Childbirth
0423 189 317

geelong@maternitycoalition.org.au

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

Branch Information

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

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

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

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

MC online discussion lists and social networking groups

Join an MC email group!

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

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

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

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

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

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

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

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

Find us on



Find us on

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

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.

Simply visit our website at:

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



HOME BIRTH
AUSTRALIA



CHALLENGING THE BOUNDARIES

HOME BIRTH AUSTRALIA CONFERENCE 2011

KEYNOTE SPEAKERS
ROBBIE DAVIS-FLOYD
INA MAY GASKIN

NEWCASTLE CITY HALL
19-21 AUGUST 2011

FOR EVERYONE WITH A PASSION FOR HOME BIRTH
MOTHERS, MIDWIVES, DOULAS, FAMILIES, STUDENTS

WWW.HOMEBIRTHAUSTRALIA.ORG

FOR TICKETS AND DETAILS