# Homebirth Legislation Enquiry Submission

# Submission: Birth Healing

### Introduction

It is stated in the discussion paper "Improving Maternity Services in Australia" that Australia is one of the safest countries in the world to give birth, for both maternal and infant survival rates.

This is a fantastic record and one that many women are reassured by and grateful of.

Given this standing as a strong foundation, there are many calling for reforms to be made to the maternity system in this country to expand our understanding of safety to include that of wider physical safety (that is, not undertaking obstetric and surgical interventions unless medically indicated, and understanding the risks involved in these choices) and psychological safety during childbirth. In other words, we need to address birth trauma, which many women will experience.

Many women, when telling others about their traumatic birthing experience, will be told: "At least you had a healthy baby." Whilst this statement is well intentioned, it is insensitive to the needs and emotions that birth trauma can entail. Of course, as mothers, we are overjoyed that our babies are healthy (as they are in a large proportion of traumatic births, although sadly some are not). However, what many women who have sustained birth trauma come to realise, and what wider society also needs to realise, is that is possible to feel very differently about the birth (the process) and the baby (the outcome).

What we feel needs addressing is ensuring that the process of birthing- the psychological component of becoming a mother- is given the attention it deserves, along with the attention given to physical outcomes of birth.

This submission is made on behalf of Birth Healing. The emphasis of the submission will be birth trauma, and how the maternity system effects, and can be reviewed, to address the issue of birth trauma. This issue is one of importance, which is sadly hugely underestimated and misunderstood by many.

Birth Healing is an online forum for support, healing, growth and action after birth trauma. It has been running since January this year, when the site administrator experienced birth trauma and found there were very few services targeted at people who have experienced birth trauma. Whilst it is a relatively new site, plans for the future include forming an incorporated organisation, holding face to face support meetings in various areas around Australia, and counselling services; all in aid of closing the gap where it comes to services for people recovering from birth trauma, and preventing birth trauma from occurring in the first place.

The Birth Healing website can be found at http://birthhealing.forummotion.com/

### Background Information

Birth Trauma is a general term for a range of undesirable psychological consequences following childbirth- this may include Post Traumatic Stress Disorder or the symptoms thereof. The birth process, whilst natural, can often be traumatic, through the unpredictability

of the event, deviations from what is considered to be a ‘normal’ birth are common, and some births may be life threatening to mother and/or baby.

Cheryl Beck, Nursing Professor at the University of Connecticut states: “Birth trauma is an event that occurs during any phase of the childbearing process than involves actual or threatened serious injury or death to the mother or her infant. The trauma can be classified as a negative outcome, such as a postpartum haemorrhage, or psychological distress. Experiencing this extremely traumatic stressor, a woman’s response can be intense fear, helplessness, loss of control, and horror.”

Post traumatic stress disorder (PTSD) is one condition linked with birth trauma. PTSD is an anxiety disorder which is developed after exposure to a traumatic event where horror, fear and/or helplessness are experienced. Symptoms and effects can include nightmares and flashbacks, intrusive thoughts, emotional numbing and character restriction, psychological distress in response to internal or external cues that symbolise the event, physiological reactivity to these cues, avoidance of stimuli associated with the trauma, detachment, sense of a shortened future, hyper vigilance and other symptoms. Obviously, this creates many problems for the new mother.

In one study (Alcorn, 2006), 45.5% of women had traumatic birth events as classified by the DSM-IV (a diagnostic tool for psychological conditions)-that is, partial PTSD, and 53.8% reported their birth as traumatic when asked “Was your birth traumatic?” This study also found that 6.3% of women had full PTSD at 3 months post partum.

Another study (White, Matthey, Boyd and Barnett, 2006), found that co morbidity of PTSD and post natal depression is high.

Maternal distress following childbirth can affect the effectiveness of the functioning of the maternal role, depression and anxiety, adaptation to motherhood, self perceptions, lifestyle, and quality of personal relationships, among other things.

Predictors of birth trauma and PTSD *s*ymptomology include low levels of support from staff and partner, low control of birth and interventions, patterns of blame, previous mental health difficulties, trait anxiety; a high level of obstetric intervention, dissatisfaction with intrapartum care; premature birth, birth of babies then placed in a neonatal intensive care unit, birth of a baby with an illness or disability, women who experienced a medical complication during or soon after birth, or whose baby experienced a medical complication during or soon after birth, women who sustained an injury during the birthing process, women who had their labours induced, those who had caesarean, forceps or vacuum extraction deliveries, who had an episitomy and those who experienced still birth or neonatal death of their baby.

Anecdotal evidence from the Birth Healing website reveals that common themes in birth trauma include loss of control, birth and health care professionals who lack adequate listening skills, post partum haemorrhage, induction of labour, caesarean, forceps or vacuum delivery, episiotomy, frequent and/or forceful vaginal examinations, artificial rupture of membranes, being isolated from support people and loved ones, a lack of support and attentive health care post natally, and a lack of dignity afforded to the birthing woman.

**Reflections on Questions Posed in the Discussion Paper** ***(As related to birth trauma- some sections have not been responded to due to the scope of the submission)***

*Inequalities*

Most notably, from anecdotal evidence, the inequalities experienced by members of the Birth Healing Website have been unequal access to independent midwife care, and misinformation and provision of biased information by medical professionals antenatally and during birth. The access issues to independent/community midwifery care include the failure of these services to be included in the Medicare Benefits Schedule; the lack of indemnity for these services; the costs of these services in relation to those covered by the two above schemes (even a private obstetrician is more affordable through private health cover); and in some cases the shortage of midwives in the local area. These issues will only be exacerbated by the changes made to the Baby Bonus system in which this payment will be given in instalments, meaning it is no longer possible to pay independent midwives with this payment, which was the case for many choosing homebirth and independent midwives in the past.

One member who lives in regional South Australia had no independent midwives in her region, and therefore she was unable to organise a homebirth as desired. She was forced to travel to Adelaide very late in her pregnancy to have a homebirth (that is, in a rented cottage), however this late stress added to her vulnerability to intervention. She was eventually coerced into a caesarean for no medically indicated reason, leading to distress and exacerbation of previous birth trauma. During this time she was forced to leave her other children at home, one of whom was still breastfed.

*Intervention Rates*

The rate of obstetric intervention in this country is unacceptably high. Only 56.6% of women go into spontaneous labour, 10.8% have either a forceps or suction assisted birth, and 30.3% have a caesarean delivery. This is in conflict with the World Health Organisation's recommendations that caesarean sections should only be necessary between 3 and 10% of births. This shows that birth is being led by a medical, rather than woman-centred, natural model.

In an investigation by Gamble and Creedy (2000), it was found that the way in which a doctor offers caesarean can inaccurately create a view that caesarean is a benign alternative, and this can have a significant effect on the woman's decision to have a caesarean. Furthermore, risks often overlooked when discussing caesarean with a patient, include placenta accrete, placenta previa and hysterectomy in subsequent pregnancies.

The vast and unacceptable gap between the World Health Organisation's recommended rates of caesarean and the actual rates of caesarean show that reasoning behind caesarean delivery in Australia is far more sociocultural than medical. This may include the institutional culture of a hospital, the philosophy and practice of the practitioner, availability of the intervention, convenience, and greater demands placed on the mother in a less connected society and increasing maternal ages, among other things.

Disturbingly, statistics show that the higher the socioeconomic status of the birthing woman (and arguably therefore her access to more health care options, and level of education), the more likely they are to have an induced rather than spontaneous labour, or opt for no labour at all and have an elective caesarean. This could be interpreted as an unhealthy societal belief and trend that caesarean is preferable in the majority of cases, instead of only in genuine medical emergencies, and that an unhealthy class paradigm has emerged.

The “Rocking the Cradle” report into childbirth in Australia states: “The difference in Caesarean interventions between women with private insurance and women without it is particularly disturbing, given that women in the former group are likely to be healthier and generally at lower risk than those in the latter group.”

Common misperceptions about caesarean include: caesarean being painless; having no long term ill effects (in fact it increases the chance of psychosocial issues, difficulty breastfeeding, higher risk of post natal depression and PTSD, and greater risk of complications in the next pregnancy); that caesarean is safer for the baby (there is actually a greater risk of neonatal respiratory distress); that caesarean has a lower risk of maternal mortality (it is actually two to four times higher).

In 2005, only 16.5% of mothers who had had a previous caesarean section had a vaginal birth, despite the fact that 70% to 80% of women can birth vaginally safely after caesarean. Those who choose to homebirth with a midwife have the greatest rate of successful vaginal birth after caesarean.

The initial statement that once a woman has had a caesarean, she will need a caesarean for all subsequent pregnancies was first made in 1916, however the doctor that stated it gave in the same speech examples of women that had successfully birthed vaginally after caesarean (one, four times). Since then the operation had improved significantly, with a lower, smaller and horizontal incision and superior stitching materials. This suggests that the belief that women who have undergone caesarean need to have future caesareans is outdated.

Whilst obstetric interventions are an incredibly valuable resource when medically indicated, they should only be used in a genuine emergency. A genuine emergency does not include preventative measures. This leads to higher rates of birth trauma, and the “cascade of interventions”.

The World Health Organisation states that the following practices are frequently used inappropriately in care of a labouring woman: restriction of foods and fluids. Pain control by systemic agents, pain control by epidural analgesia, electronic foetal monitoring, repeated or frequent vaginal examinations especially by more  than one caregiver, oxytocin augmentation, moving women between rooms during labour, bladder catheterisation, encouraging the woman to push rather than allowing her to push when the urge occurs, adherence to a stipulated duration of labour, operative delivery, episiotomy (which can cause greater and deeper damage than natural tearing) and manual exploration of the uterus after delivery

Michael Odent states that research is needed into the long term effects on the baby of being born by caesarean, and cites Niko Tinbergen’s research into autism and found higher rates of

the following perinatal events in autistic children: induction of labour, forceps delivery, birth under anaesthesia and resuscitation at birth

Odent also states that a woman's physiological ability to birth and the foetal ejection reflex is inhibited by a lack of privacy, if the woman feels she is being observed or monitored, if her neocortex is stimulated (such as through engaging the birthing woman in conversation), and bright lighting- all of which are common in labour wards around the country!

A study by Jacobsen and Bygdemen found that the risk of violent suicide is higher in adults that sustained perinatal trauma; it has also been found by the Royal College of Obstetrics

And Gynaecology that suicide is the leading cause of maternal death during the first year after childbirth.

Obviously, all of these issues can affect the woman's perception of birth to be traumatic or not.

Despite the safety of homebirth (see next section), only 0.6% of women gave birth at home in 2005,suggesting the maternity system had inequalities, such as informational and funding bias, that channels birthing women into the hospital system, backing up a hypothesis of a medical model in maternity services in this country.

*Breastfeeding rates*

Anecdotal evidence on the Birth Healing website shows that breastfeeding can be made more difficult after birth trauma, for a number of factors including the pain of a caesarean scar, neonatal separation between baby and mother, and inability to successfully bond with the baby after the traumatic experience.

For this reason, by addressing and preventing birth trauma, Birth Healing believes a small improvement will be made in breastfeeding rates. However, it is obvious from the statistics for ongoing feeding that more attention needs to be given to breastfeeding rates regardless, and recommendations have been made thus below.

*Peer Support*

Being a peer support site, Birth Healing fully endorses the investigation the Federal Government is undertaking into the role peer support can play in improving the maternity system. Birth trauma is as yet an often misunderstood and underestimated problem and those who have been through it are best placed to help those in recovery from birth trauma.

Additionally, peer support during birth, such as from an independently hired doula that advocates and provides support for the birthing woman, can impact on the woman's satisfaction of birth, and needs to be investigated as well.

Peer support, such as through forums like Birth Healing, can have its drawbacks however. This warning is posted on Birth Healing:

“I would encourage all our members to exercise caution when using any forum (including this one). The ideologies and opinions of the forum administrators can sometimes effect what is or what aren’t included in the site. Forums may appear to be neutral, unbiased and giving correct and full information, but you owe it to yourself and your little one to do a few more searches and research to make sure any decisions you make, and any lessons you take in (consciously and unconsciously) are the right ones for you and your little ones.

Let me give an example. It is a well known fact that breastfeeding the best, and normal way to feed babies and toddlers. A forum may, however, have a section for breastfeeding and feeding via artificial milks. Perhaps there are far more posts and discussion in the artificial milk section. Perhaps one of the moderators decided early on to formula feed, and because this was the right decision for her, she advocates that women having trouble feeding switch to formula. Perhaps a few members post how they found breastfeeding was disgusting. The culture of the forum starts to become that artificial feeding is normal, and you begin to feel abnormal and unsupported by breastfeeding, and this may affect your decision to wean.

"Support" is an interesting word in forums, especially ones devoted to parenting. Often you are given emotional support, which is welcomed, needed and absolutely necessary. Parenting can be quite isolating and forums are a great way to reduce this. However, please remember there is difference between emotional support, and being provided with accurate and pertinent information. Many times when you are confused and hurting and you post about whatever is going on for you (such as in the woman contemplating weaning in the above example), you receive all the emotional support you need. But to use the example again, perhaps if someone also passed on the ABA's number, posted some links regarding the problem she is having, or shared some information about how to get over the hurdle in some other way, it may "support" the woman and her baby in a far healthier way. Forums are often more focused on emotional rather than informational support, so be aware of this so you do not make a decision you make come to regret later. Take responsibility to do your research.

We are all new to parenting with our first babies, and so are very vulnerable to making decisions in this way. Please do two things: research thoroughly, and most importantly, trust your instincts.”

**Further Discussion**

It can be seen from the above discussion that the needs of birthing women are sometimes far from paramount in the birthing process.

A woman centered model, perhaps most often with a midwife assisting in an appropriate way, shows much promise for reforming maternity services in Australia.

Woman Centred care includes the following principles: focus on the woman’s individual, unique needs, expectations and aspirations; the right of self determination in terms of fully informed choice in line with the World Health Organisation Recommendations, control and continuity of care; attention to the needs of the baby, the family and significant others, as identified by the woman; involvement with the woman throughout pregnancy and the postnatal period; takes into account a holistic approach- social, emotional, physical, psychological, spiritual and cultural needs. It is an urgent need also, that all hospitals come under the Baby Friendly Initiative, and that babies and mothers are not separated in the neonatal period for any reason, especially as is the case after caesarean.

Specific actions that can improve satisfaction of maternity consumers include less testing during pregnancy, short waiting times and flexible appointments with sufficient time during

appointments, continuity of care, sole responsibility in decision making, good communication and listening skills, and consistency of information.

The Maternity Coalition has created a National Maternity Action Plan which is accessible on their website at www.maternity coalition.org.au. Birth Healing fully supports and endorses this plan, which includes the option for all women to have access to a community midwife, that the Federal Government and State and Territory governments work together to eliminate barriers to midwifery care such as funding and indemnity, and prescribing rights for midwives for drugs and tests commonly used in pregnancy, labour and birth.

A number of studies have found that midwifery led care is preferable to conventional care, including in being lower in cost and higher in satisfaction rates (Giles et al 1992, MacVicar et al 1993); short term beneficial outcomes (Flint et al 1989 and Rowley et al 1995); resulting in fewer interventions and shorter waiting times (Flint et al 1989, MacVicar et al 1993); and furthermore, there were no or little difference in maternal and infant mortality between midwifery groups and conventional care groups in all these studies.

Another study (Breslin 1997) found that nurses-midwives utilised fewer medical and technological interventions during birth than doctors- including 9% of nurses-midwives patients being requiring caesarean section against the much higher rates in obstetrician led care- and as has already been noted in this submission, this can help prevent birth trauma, as well as significantly affecting the length of hospital stays and use of resources, meaning birth is more economical- an issue pertinent in public health where the majority of births occur.

In 2005, 99.7% of babies born at home were live born, with 98.5% of mothers going into spontaneous labour. However, only 0.2% of women who gave birth had a homebirth in this year. Attention needs to be given to homebirth as the safe option it evidently is, and to make it more accessible and more affordable to a wider range of women.

Rhea Dempsey, childbirth educator and birth trauma counsellor, states: “The healing process often leads mothers to an awakening of a radicalised consciousness around birth issues. They come to see that if they are to honour their deep desire for fulfilling birth experiences then they must make wise choices in support of their own potent birthing potential. Many of these choices fall outside those offered by the dominant medical model and thus require radical choice.”

On a different topic, it is clear that more research needs to be undertaken to ascertain what services will best address birth trauma, in terms of recovery for those who have experienced it, but of paramount importance, preventing it for all future birthing women.

A poll held on the Birth Healing Website found that women who had experienced birth trauma felt that the following things may have prevented their experience being traumatic in whole or part: continuity of carer (21%); a different birth setting (15%- all of whom birthed in the public hospital system); more information and resources (15%); more control over what happened during the birth (15%); less interventions (21%) and professional debriefing post birth (10%).

The issue of professional debriefing port birth is a contentious one. A study on midwife-led post natal debriefing for women who had recently given birth, found that whilst the debriefing was seen as positive by the majority of women, than there were no significant differences between the treatment and control groups on measures of depression, anxiety, trauma, perception of the birth or parenting stress at any assessment points. Perhaps it could

be a question of debriefing being held by a source more independent to the birth itself, such as a counsellor or a family health nurse.

Another study has found that women consider post natal debriefing a deficiency in their care, especially those who have operative deliveries

A poll on the Birth Healing Website posing the question "What has helped (or possibly would help) you heal from birth trauma?" elicited the following results: counselling, support and contact with other women who have experienced birth trauma, Birth Healing Website and other websites were of the most use to those recovering from birth trauma (perhaps due to misconceptions about birth trauma in the wider community); with doula or midwife support post birth and medication useful to some women; and professional debriefing in the days following birth and a complaint to health care provider also being moderately useful.

**Case Studies**

*Aliases have been used to protect the confidentiality of women recovering from birth trauma. All case studies are as told by the women on the Birth Healing website.*

*"Woman A"*

Woman A had a premature rupture of membranes at 41 weeks. Labour did not begin in the thirty six hours after the rupture, and despite wishing for a natural birth in her local public hospital, agreed to an induction via syntocinon drip after midwife and obstetrician's advice to induce labour to avoid infection to mother and baby.

Due to hospital policy and the nature of the intervention Woman A was required to have continual electronic foetal monitoring and cannulisation which meant her movement was greatly restricted and was mostly required to stay lying in bed. The first attempt of cannulisation failed with blood loss that distressed Woman A.

The induction failed to start labour on the first day. Woman A rested overnight in hospital and a second attempt was made the next day. Labour started on the second day, with intense contractions with very little rest between them. A number of vaginal examinations were carried out during the labour, of which some Woman A requested to cease, but the midwife continued.

No further dilation or softening of the cervix was found after many hours of intense labour from the day before. Woman A began to have grave concerns for her baby but felt the hospital staff did not listen to her. Due to the intensity of the pain Woman A requested an epidural, which after two hours of attempts was unsuccessful. After approximately 12 hours of contractions obstetrician undertook a vaginal examination which showed baby was in a transverse position. Woman A had an emergency caesarean under general anaesthetic after further attempts at an epidural and spinal block. Baby sustained a laceration to the forehead by the scalpel during delivery.

Woman A showed Post Traumatic Stress Disorder symptoms a week after the birth, and was diagnosed with PTSD in the months following the birth.

*"Woman B"*

Woman B went into spontaneous labour at 41 weeks. After labouring overnight in hospital her husband returned home to look after the couple's other children. Woman B was moved

from the birth suite to the maternity ward and was unattended by any staff, and she felt alone and scared. Having not slept for over a day, she was also very tired. This length and intensity of labour was unusual for Woman B. At 1pm she was moved back to the birth suite, and her husband soon returned. A doctor undertook a forceful vaginal examination without Woman B's permission, and then proceeded to rupture her membranes, again without Woman B's permission. Woman B requested an epidural so she could sleep, although she did not want one. It took seven attempts to get the epidural in successfully and Woman B sustained significant bruising to her back. At 2am after many more hours of labour she was given a two hour time limit to birth the baby. At 6am she was given a vaginal examination and during which the doctor stated she could feel the baby's forehead and so a caesarean would be undertaken. During the operation, in which Woman B was conscious but ignored by staff, she felt a strong pull but did not hear her baby cry or see him. A doctor asked "Is it hysterectomy time yet?" to other staff. Woman B was told nothing for some minutes but was then informed her uterus had ruptured. Woman B was quickly shown her baby and then was taken to intensive care as she had lost two litres of blood. Woman B and her baby were separated for some time.

*"Woman C"*

Woman C was 19 years old and in an abusive relationship with little support. Towards the end of her pregnancy her blood pressure was high and at the hospital's request was induced at 42 weeks. Woman C requested gel rather than syntocinon drip (although she was pressured into this decision as well), which was still applied after she lost her mucus plug overnight. After some hours of contractions she was moved to the labour room, where she was connected to monitoring devices which restricted her body's urges to move. When she did move, the monitor would become dislodged, and was told to "stop moving as it is making our job very difficult". She was soon given the syntocinon drip despite refusing it, and was given hourly vaginal examinations. AT about 20 hours her waters were broken after she reluctantly agreed to the intervention, feeling coerced by the staff. She fainted when allowed off the monitors to have a shower and the nurses asked her partner to bring her back to the labour ward. Her mother was allowed into the labour room against Woman C's wishes and she was then vaginally examined by a male doctor despite having had written in her notes that she would not see male doctors. The staff then inserted an internal monitor onto the baby's head. Woman C had not had any food or water during labour and was in a high level of discomfort because of this. She was then given a blood test by an anaesthetist who missed her vein three times and then re-inserted the saline cannula, missing the vein, causing significant swelling in her arm. She was given a successful epidural by a different anaesthetist on her partner's request. At this point she was given the choice to try to continue with labour or to have a caesarean. She chose to have a caesarean, having been heavily traumatised by labour so far and wishing to find a way to reassert some control. Whilst being prepared for theatre she was dropped onto the floor, in front of a room of medical and nonmedical staff, family and maintenance people. At this time she was naked and had unnecessarily had her public region shaved. She could feel pain during the procedure, although she was told she couldn't by the staff. The baby was not offered to either parent to hold first, but instead to members of the extended family and friends. Woman C had many problems breastfeeding after the birth trauma and is still traumatised from the birth, almost ten years on.

*"Woman D"*

Woman D had a troubled pregnancy with morning sickness through until seven months gestation, pelvic pressure from 15 weeks, recurrent kidney infections and bleeding. Her baby's head engaged at 20 weeks and she went into premature labour at 30.5 weeks. She spent the rest of the pregnancy on bed rest and had tectonic contraction from 38 weeks, as

well as intense back and pelvic pain. She had daily trace monitoring after this time and went into spontaneous labour at 40 weeks. At this time Woman D's obstetrician was on leave and the treating obstetrician decided to augment labour after two hours via syntocinon drip, and told Woman D her birth plan would not be looked at. His rudeness and aggressiveness during vaginal examination caused both the midwife and the midwife's supervisor to apologise for the way she was treated. She asked for nitrous oxide to deal with the intense pain- the baby was posterior with the head flexed- which she had a reaction to and lost consciousness for some time. She was put on oxygen following this occurrence. Four hours after this Woman D requested an epidural which took four attempts to insert correctly. After the epidural passes the obstetrician decides to deliver the baby via forceps. He performed an unnecessary episiotomy against the woman's wishes and following the delivery, heavy bleeding ensued. Woman D passed in and out of consciousness, and during this time the baby was attached by a midwife to the breast, causing nipple damage. Midwives on the maternity ward were concerned about the major vaginal bruising; some of who said it was the worst they had seen. Woman D's episiotomy scar became infected within a week- it had been incorrectly sewn- and also had mastitis. Further treatment revealed her pubic bone had been misaligned by the force of the forceps birth, the episiotomy was third degree, and many internal tears that had not been attended to and grew into marble sized polyps. Woman D had to have reconstructive surgery on her vagina 9 weeks later, and her and her partner have since decided to have no more children, her partner has now had a vasectomy.

*The full versions of these stories and many more birth stories are available at http://birthhealing.forummotion.com*

**Recommendations**

That the Federal Government make urgent reforms to the maternity system to include independent midwives under the Medicare Benefits Schedule, to allow all consumers of maternity services equitable, affordable and appropriate health choices, thus addressing unsatisfactory rates of birth trauma through lack of choice;

That changes are made so that access to an independent midwife is not restricted by financial capacity, and so that those who cannot afford this optimal service are not automatically entered into the current substandard mediatised maternity system;

2. That the Federal Government further support and fund the Australian Breastfeeding Association and other organisations that promote breastfeeding as the normal and optimal mode of feeding babies and children up to and beyond two years, as per the World Health Organisation Recommendations ;

2.1That further research is undertaken into the effects of birth trauma on breastfeeding, and from this, actions undertaken to support women affected by birth trauma to successfully breastfeed;

2.2 Furthermore, that the Federal Government understand that good governance needs to address the low rates of breastfeeding in this country, and to effectively educate the community (including those in the parenting demographic) about the benefits of breastfeeding and the risks of artificial milks;

3. That the Federal Government play a directive role in ensuring a major paradigm shift occurs in the maternity system to see birth as a natural event, not a medical event that needs to be 'managed', and therein medical intervention only occurs when medically indicated and not for convenience or to shorten the duration of the birthing process as this leads to birth trauma and the cascade of interventions;

4. That such changes are made by the Federal Government to facilitate for continuity of care for pregnant and birthing women by appropriate health care providers (including midwives and doulas), therefore creating a safer physical and psychological environment for maternity consumers;

5. That action is taken to address birth trauma, how it can be prevented and how women suffering from birth trauma can best be supported to recovery;

5.1 That the following services be funded to address birth trauma: post birth doula and home assistance programs for women suffering from birth trauma; free counselling for those experiencing birth trauma; face to face birth trauma support groups; and the Birth Healing website and other websites (such as Joyous Birth) that assist women experiencing birth trauma, at a time where due to the responsibilities of motherhood, are often at their most isolated;

5.2 That the Federal Government runs a community education campaign aimed at pregnant women and their partners, and those of child bearing age, of what birth trauma is and how it can be prevented;

5.3 That the Federal Government runs an education campaign aimed at health care providers in the maternity system (including obstetricians, midwives, doulas, general practitioners and other professionals) about issues surrounding birth trauma;

5.4 That the Federal Government fund a network of organisations that address the needs of women with birth trauma, and those who prevent birth trauma, nationally, and that these services are made accessible to women with very young children;

6. That the first contact being made with a pregnant woman (or a woman considering pregnancy) the health care provider is required to provide the woman with written contact details for all birthing options (including independent midwives and homebirth) available in the region in an informative, non judgemental way;

6.1 That this information is complemented with a booklet about pregnancy and birth, in which birth is addressed as a natural event, with the benefits and risks of all birthing options, and accurate statistics therein, in line with the World Health Organisation recommendations;

6.2 That this booklet also addresses birth trauma and the role different birthing options may play in it;

6.3 That this booklet also addresses breastfeeding, bonding with a new baby, and other issues pertinent to healthy psychology of the mother and baby;

7. That maternity services are urgently expanded to offer more midwife run birth centre style options, where an appropriate, comfortable and private space is made for women to birth in, supported by midwives and/or doulas, in a way conducive to natural birthing, and that medical and other interventions are available in a timely way- when medically indicated (which will not be necessary in most births and should only happen in line with World Health Organisation recommendations);

8. That the Federal Government runs a community education campaign targeted at pregnant women and their partners, those of child bearing age, and health professionals, addressing homebirth and other 'alternative' options as safe and workable;

9. That the Federal Government takes action to see that more doulas are trained and made affordable and accessible to women, in an effort to provide support to women in traumatic situations, and to help guard a psychologically and physically safe birth space.

10. That the Federal Government adopts all recommendations of the Maternity Coalition's National Maternity Action Plan.

**Conclusions**

It is evident, that while the maternal and infant mortality rates (and also to some extent injury and morbidity rates) in this country are excellent, there is something lacking in the maternity system in this country. Birth Healing congratulates the Federal Government for recognising this shortfall and taking the first steps in improving maternity services in Australia.

Birth is an undeniably significant event both in the lives of women and babies, and to society as a whole. The way we treat our birthing women and our newborn babies has numerous physical, psychological and psychosocial implications, many of which are at the edge or beyond our consciousness.

We need to ensure, with urgency, and with huge importance, that women are given respect in this process. All actions and outcomes will fall in line if this one value is upheld. Whilst the maternity system in its current state relies of facts and figures, objective monitoring, medical skilfulness and a one-size-fits-most ethos, there is little room for intangible ideas such as respect.

We must make a paradigm shift to make these more intangible things as valued as those things that are easier to record, observe and analyse. Respecting women means providing them with the full gambit of information, in an unbiased, intelligent way. It means allowing women to make choices to suit the individual needs of themselves and their family in a way that is healthy and positive. It means communicating with labouring women in a sensitive, serving way and allowing the woman to labour privately and with dignity and in the way that feels right for her. It means supporting services and individuals that truly support women. And it means, whenever possible, that the connection between mother and baby should not be interfered with.

Perhaps, above all, we need to take the "system" out of the maternity system, and respect women for what they are: individuals, with an instinctual wisdom for what is best. Let's not stand in the way of that any longer.

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