

ISSUE 1.3

home birth *matters*

HOME BIRTH IN AOTEAROA

spring 2014



FEATURE:

*We speak to
Hermine Hayes-Klein
about birth and
freedom for birth.*



Our editorial.

By Sian Hannagan

Sep 2014

The theme for this issue was intended to be ‘New Beginnings’, a time to refresh as the season does and recentre our vision. As the articles came together and the issue coalesced a new theme emerged, one of its own making. The stories speak of connections, the things that link us together and build the community we have. It is no coincidence that at a time when the buds blossom and the grass grows that we reflect on the grass roots that were our beginning and are our heart. The insightful writing of Carla Sargent draws us to reflect on the connection between midwife and mother, Hermine Hayes-Klein talks to us about the connection we all have on a global scale, Ami McKay connects us to the past and Anna Hughes connects us to our babies. And from these connections we build stories. The stories of a mother denied her birth rights, or the trauma of birth experienced, the story of a midwife caring for a village or the story of midwives and mothers as they journey through birth. Enjoy these stories that we have drawn together for you.

“Story is the umbilical cord that connects us to the past, present, and future. Family. Story is a relationship between the teller and the listener, a responsibility. . . . Story is an affirmation of our ties to one another.”

Terry Tempest Williams, Pieces of White Shell



Our News.

By Home Birth Aotearoa

Sep 2014

Trustee nominations 2014

Nominations were opened for trustees to Home Birth Aotearoa Trust in June. We welcomed nominations from all members of our home birth community. From this we had some warm responses and are excited to see the interest in contributing to the Home Birth Aotearoa trust board. Even though nominations have now closed we will continue to invite interested parties to contact us about joining the trust board, along with some robust discussion at Hui (see the save the date below) around this.

Do you value the work Home Birth Aotearoa do for you? Do you feel you would like to contribute to the future direction of Home Birth Aotearoa?

If you are passionate about Home Birth Aotearoa, and think you can fill a role, please email us at admin@homebirth.org.nz. The future of our organisation is dependent on the support we receive from our community.

For various reasons, most of the women who are part of the current Trust Board have resigned, and we therefore need to urgently fill a number of formal voluntary roles in order to continue operating effectively. These volunteer roles are well supported by our paid staff and require a commitment of approximately 10 hours a month. These roles include:

- Chairperson
- Treasurer
- Board member

We are all aware of the voice and passion that Home Birth Aotearoa has provided to our Home Birth community, including securing funding from the Ministry of Health and the provision of resources. For this to successfully continue, we need a committed and passionate Trust Board which can safeguard and direct the organisation going forward.

We would love to hear from you, and are very happy to answer any questions you may have about what the roles involve.

Trusteeship is a voluntary position, strategically managing the activities of the trust in collaboration with our existing trustees and employees. Becoming a trustee is a valuable and honouring opportunity, where you can utilise your passion, knowledge and skills, whilst meeting new people and gaining new skills. There are opportunities for growth on the board.

Home Birth Aotearoa is the national organisation representing the regional home birth groups throughout Aotearoa. Home Birth Aotearoa would not exist without the regional associations whom it represents and who help deliver our key activities on a regional level.

Currently there are around 25 regional groups, ranging from legal entities to informal groups. All are actively involved in supporting home birth in their regions. Home Birth Aotearoa Trust is a charitable trust which was formed on 26 July 2007. The Trust was formed to enable collective accountability and sustainability of a national home birth organisation via a legally recognised entity. National Hui are convened annually with members of all regional groups invited. The AGM is held at the same time. Regional groups are invited and supported to arrange local pod hui on an annual basis also. A conference is hosted biennially (every two years) by a regional association.

We welcome your application to the board.

Our Goals:

- 1) That home birth is recognised and promoted as an option for the place of birth for the majority of NZ women and their whanau
- 2) To increase the number of New Zealand women and their whanau choosing to birth at home
- 3) To have a strong and flourishing network of active home birth groups throughout Aotearoa
- 4) To have input into maternity strategy and policy- making to enable empowering birth experiences and outcomes, and healthy, thriving families
- 5) To uphold the articles of Te Tiriti o Waitangi

How we work:

The structure of Home Birth Aotearoa has the trust at the core – regional home birth groups contributing to each other and the trust and vice versa. The trust holds the contract for national delivery of home birth coordination and collectively the HBA community has input into the planning and delivery. We use collaborative, consensus decision making to operate.

What does trusteeship involve?

Trustees are responsible for the governance of Home Birth Aotearoa Trust. They are accountable to the national network of home birth associations and support groups (Home Birth Aotearoa) to set and achieve goals which support the goals of the Trust. This includes accountability for financial transactions (including funding, expenditure and assets) and legislative and compliance issues relating to the provision of any services. Further details on who we are, and what we do, are on our [about us](#) page.

Trustees will need to be able to commit to:

- 1) Timely participation in the online agenda of board business
- 2) Regular meetings (4-6 weekly) by teleconference
- 3) Attendance at national Hui
- 4) some trustees have specific accountability e.g.: Treasurer, Facilitator, and/or contributing to initiatives
- 5) thinking at a national level, providing guidance, clarity and direction for long and short-term goals
- 6) nurturing of one pod area (group of regional associations). This involves regular seasonal contact and supporting connectedness.

Trustees will have:

- 1) A passion for home birth, accompanied by 5-10 hrs of investable time per month
- 2) A commitment to supporting and empowering women, their whanau and their communities in their choice to birth at home
- 3) A commitment to Home Birth Aotearoa
- 4) an ability and commitment to expressing their own opinions and perspectives
- 5) an ability and commitment to working constructively with others, sometimes from different backgrounds and points of view
- 6) the support of their families in undertaking a trusteeship
- 7) the support and endorsement of their regional home birth association or support group

Anyone who is a member (or the equivalent) of, and is endorsed by a Home Birth Association or Home Birth Support Group in Aotearoa.

Previous governance or committee experience is helpful but not essential.
An annual honorarium is not currently paid to trustees, however reimbursement for Hui travel is.

The Existing Trust Board:

The trust board is governed by up to 8 trustees, with a quorum of 5, under a trustee deed established in 2007.

Copies of the trust deed are available on request.

Current trustees:

1) Sian Hannagan - Dunedin Home Birth Association, *Interim Magazine Editor:*

Remaining in seat

2) Mayana Sipes - Auckland Home Birth Support, *Group Project Coordinator & PR/Media:* Remaining in seat

3) Sharon Knightbridge - Westcoast Home Birth Association, *Resources:* Term expired, standing for new term

4) Rachel Correa - Home Birth Hawkes Bay, *Facilitator Term expired:* Vacating seat

5) Cecile Tamang - Dunedin Home Birth Association, *Regional Liaison:* Vacating seat

6) Nadia Kersel - Home Birth Hawkes Bay, *Board Secretary & PR/Media:* Remaining in seat

7) Vicki Rogers - Dunedin Home Birth Association: Vacating seat

8) Vacant seat *Previous treasurer:* Seat available

Home Birth Aotearoa Trust is seeking the appointment of 5 Trustees. (one for a 2 year term)

Currently there is no limit on the amount of terms a Trustee can be nominated and elected for.

How to Apply:

Please complete and return this nomination form

[TRUSTEE NOMINATION FORM 2014](#)

via email to: admin@homebirth.org.nz or by post to:

HBAT PO Box 8053 Dunedin 9041

If you require further information, please contact Tess Trotter at admin@homebirth.org.nz

Trustees will be ratified at the National Home Birth Hui in October.



Save the Date! National Spring hui 2014

Tena Kotou,

We are pleased to advise the date for the Home Birth Aotearoa national hui has been set for the weekend of the 10th, 11th and 12th of October. The hui is likely to start on the Friday in the early afternoon and finish around lunch time on the Sunday. The hui will be held in Auckland this year, hosted by the Auckland home birth support group whanau. The event will be family friendly, of course!

As always, we are eager for as many regional representatives to attend hui as possible and have a hui travel budget to support this. Please start this conversation within your regional groups and families.

Registration details to follow.

*“He maiatanga tonu, ta te mahi nga tahi”
Courage arises, where there is unity of
purpose*

Contact:

shazphil@actrix.co.nz



LLL Conference – 50 Years Strong

Don't forget – The La Leche League are hosting a conference in October, this is a great opportunity to be up-to-date with the latest in breastfeeding knowledge and research.

In recognition of fifty years of La Leche League mother-to-mother breastfeeding support in New Zealand, LLLNZ is organising Breastfeeding Support, our Foundation, Our Future Te Tautoko Whakangote: Tō mātou tūāpapa, haere ake nei

We are presenting a diverse array of speakers including our key note speakers Diana West (author of the book “Making More Milk”) and Pinky McKay (author of the books Sleeping like a Baby and Parenting by Heart)

During the celebrations we will be hosting the launch of our history book “ Latching On: 50 years of Breastfeeding Support – La Leche League in New Zealand 1964-2014”

WHEN: Friday 3rd to Sunday 5th October 2014

WHERE: Waipuna Hotel & Conference Centre, Auckland

View programme and register at this link:<http://www.lalecheleague.org.nz/news-a-events/lllnz-conference-2014/312-lllnz-50th-anniversary-conference-2014>



The banner features the La Leche League NZ logo on the left, which includes a green heart and a blue circle containing a white silhouette of a woman breastfeeding. To the right of the logo, the text reads "50 years La Leche League NZ". Further right, the text "Breastfeeding Support: Our Foundation, Our Future" is written in a gold, serif font. Below this, the Māori phrase "Te Tautoko Whakangote: Tō mātou tūāpapa, haere ake nei" is written in a smaller, teal font. At the bottom of the banner, a gold bar contains the text "50th ANNIVERSARY CONFERENCE" and "3-5* October 2014 - Waipuna Hotel & Conference Centre, Auckland" in white, uppercase letters.

Microbirth on a Macro scale

Latest Science Suggests How We Give Birth Impacts Lifelong Health of Children And Could Affect Future of Humanity

Could the way we are born determine our future health and even impact the future of humanity? These are questions explored in a new feature-length documentary “Microbirth” premiering in hundreds of grass-roots public screenings around the world on Saturday 20th September 2014.

Look here on our [calendar](#) for details of local screenings.

Featuring prominent scientists from the UK and North America, “Microbirth” warns that modern birth practices could be interfering with critical biological processes making our children more susceptible to disease.

Recent population studies have shown babies born by Caesarean have approximately a 20% increased risk of developing asthma, 20% increased risk of developing type 1 diabetes, a similar risk with obesity and slightly smaller increases in gastro-intestinal conditions like Crohn’s disease or celiac disease. All of these conditions are linked to the immune system.

“Microbirth” explores several possible plausible explanations. One hypothesis is that if normal vaginal birth is interfered with or bypassed completely because of Caesarean birth, this could alter the “seeding of the baby’s microbiome”, the critical transfer of bacteria from mother to baby at birth. Scientists suggest this could lead to the baby’s immune system not developing to its full potential. Another hypothesis is the actual process of vaginal birth, including the cocktail of hormones produced during labour, could profoundly affect the baby’s immune regulation and metabolism.

Dr Rodney R Dietert, Professor of Immunotoxicology at Cornell University, says, “Over the past 20-30 years, we’ve seen dramatic increases in childhood asthma, type 1 diabetes, celiac disease, childhood obesity. We’ve also seen increases in Caesarean delivery. Does Caesarean cause these conditions? No. What Caesarean does is not allow the baby to be seeded with the microbes. The immune system doesn’t mature. And the metabolism changes. It’s the immune dysfunction and the changes in metabolism that we now know contribute to those diseases and conditions.”

Dr Matthew Hyde, Research Associate of Neonatal Medicine, Imperial College London says, "We are increasingly seeing a world out there with what is really a public health time-bomb waiting to go off. And the research we are doing suggests it is only going to get worse, generation on generation. So tomorrow's generation really is on the edge of the precipice unless we can begin to do something about it."

The film's co-director Toni Harman says, "Caesarean Sections are essential and often are life-saving. However, up until now, no-one has really looked into the long-term impact. This emerging research is painting an alarming picture in terms of future health across populations. There may even be repercussions for the future of humanity. And yet, up until now, I don't hear any alarm bells ringing."

"Microbirth" will be released worldwide on Saturday 20th September 2014.

Are you holding a screening locally in New Zealand? Comment here or [email us](#) with the details of your screening to be added to our website and facebook page. You can share your screening info with Microbirth [here](#)

Screening resources:

[Microbirth How To Hold A Screening](#)

[Microbirth action steps](#)

[Poster Downloads](#)





Election 2014.

Sep 2014

September 20th sees the New Zealand National election. The governance of our nation has a big impact on our health and wellbeing. With this in mind, Home Birth Aotearoa put a range of questions pertinent to our membership to each registered political party. Here we share the answers given.

In some instances these questions were responded to by the party's policy team, in other instances by the health spokesperson, the answers are attributed in question 1. Parties are listed in alphabetical order, and no, we didn't fix any spelling mistakes!

Question 1: What is your Maternal Health policy and what initiatives will you undertake to improve maternal health outcomes for women and babies in Aotearoa?



Kia ora,

My name is Julian Crawford, I am the Leader of the Aotearoa Legalise Cannabis Party (ALCP). ALCP's Health policy will have significant benefits for mothers and babies. Medicinal cannabis can be used to treat morning sickness and reduce the pain of labour. At the moment, medical professionals such as midwives are prevented from accessing medicinal cannabis. Some forms of cannabis may also be used to help treat post-natal depression. Endogenous cannabinoids are naturally present in breast milk and are vital to the baby's development. "Endocannabinoids occur naturally in breast milk and have been found to trigger the first suckling, appetite, swallowing, digestion, sleep, and so

forth in newborns. They continue to aid in appetite, food cravings, enjoyment of food, sleep regulation, growth, and more through childhood, adolescence, and adulthood. They even protect against certain kinds of newborn brain damage and feeling the full impact of digestive pain.” –

<http://flcalliance.org/resources/cannabisresearch/breastfeeding/>

ALCP will also maintain existing government spending on maternity services.



Katherine Ransom, Vice President

Social Issues spokesman, Waikato electorate candidate

Democrats for Social Credit (DSC) core policy is a comprehensive reform of the financial system so that money is created and managed by our publicly owned bank for the public good. That means that the care and nurture of mothers before, during and after birth will not be restricted due to funding constraints.

Improvements will be the full resourcing of social services, who will not be competing against one another for funding, and who will be encouraged and incentivised to work co-operatively.



Green Party's health spokesperson Kevin Hague

The Green Party has a comprehensive Maternity Services policy within our Health policy (available at home.greens.org.nz/policy/health-policy). Specific policies within it include improving funding for postnatal services, ensure all women have access to an adequately funded and staffed information helpline such as Plunketline, improve inpatient and community support services for women with postnatal depression and other mental health disorders, and ensure women have a choice of LMC providers that reflects cultural and ethnic diversity, and that LMCs are appropriately funded and resourced to meet the needs of women.



Health Spokesperson Annette King

Labour has a number of initiatives. We believe that there is a compelling case to ensure that New Zealand is the best place in the world to raise our children. It is important that all women and babies have equal opportunity to have optimal maternity outcomes.

A high quality Maternity Service is necessary to ensure a positive influence on the health status and social wellbeing of the mother, baby and the community. New Zealand is 6th of the top ten countries in the world to be a mother, a Save the Children study found in May, 2010 (12th Annual State of the World's Mothers

report).

It is understood that implementation of the Maternity Action Plan over the last two years has focussed on workforce development, quality assurance and maternity new-born information system development. We support those initiatives as they were identified as being a high priority in 2008.

Pregnant women are currently entitled to a free GP visit in their first trimester with 'at-risk' women being entitled to a further GP visit with their Lead Maternity Carer (usually a midwife) in each of the following trimesters. Pregnant women's pregnancy-related healthcare is free via their Lead Maternity Carer.

However, pregnant women must currently pay for primary health treatment that isn't directly pregnancy-related. In practice, fees vary widely with some GPs giving free or discounted care to pregnant women, and others not.

That means expectant mothers can be hit by unexpected health costs and stress. Labour believes there should be no bar to expectant mothers getting all the care they need.

Labour will:

- Ensure all women will have access to free antenatal classes, with a focus on first time mums and those who would benefit from them the most.
- Antenatal assessment available to all women by 10 weeks' gestation, with targets for District Health Boards to deliver on this.
- New mums' programmes targeted at parents who need the most help
- Extended Well Child/Tamariki Ora visits so families in the most need get extra support before baby even arrives
- Assist families to get the help they need by registering new mums with GPs, Well Child/Tamariki Ora provider, the immunisation register, and a dental health provider.
- Introduce free GP visits for all pregnant women.
- Make prescriptions free for all pregnant women.
- Introduce free dental care for all pregnant women
- Increase funding for maternity services and health NGOs by \$20 million per year.



Dr Helen Potter | Senior Advisor/Researcher

MANA Movement of the People

The priority health focus of MANA is to improve the standard of living for women in whanau who are struggling financially - to raise incomes via raising the minimum wage to a living wage (currently calculated at \$18.80 per hour) and raising benefits to liveable levels (including extending all infant and child tax credits to parents on benefits), to build 10,000 new state homes per year for low income whanau to rent or rent-buy, and to undertake a major overhaul of the tax system to make it much fairer and to significantly increase the tax take to invest in

public health and education, housing, job creation, and whanau wellbeing including addressing family violence, addictions, and mental health issues. Maternal health, and particularly home birthing, is best supported when women enjoy good health and wellbeing and when their whanau have a good standard of living.

More specifically, MANA will invest in the development of a high quality, prevention-focused public health system which is free and accessible for all. We support the work of the midwifery profession and would undertake a review to increase their remuneration as a priority task. MANA will also work to ensure family planning advice and contraception are available free of charge.



Barbara Stewart MP, Spokesperson for Health

New Zealand First would facilitate the improved co-ordination and integration through PHOs and other organizations of community health, maternity, and a number of other public health services and overcome the effects of a health system that lacks cohesion and common standards of delivery.

Ensure that safety considerations are paramount in funding decisions relating to maternity care services and require improved provision of ante-natal classes, maternity services for rural, Maori and Pacific Island women, and the improved monitoring of maternity services.

New Zealand First would also remove the GST off food, this would make healthy food more affordable for all.

The National party chose to send us a statement rather than answering the questions posed. This statement is published at the end of the questions.

Question 2: Do you support the mission of Home Birth Aotearoa? Would your party continue to contract, via the MOH for National Home Birth Coordination Contract, services for the promotion of Home Birth in Aotearoa?



Yes, ALCP supports the mission of Home Birth Aotearoa and would continue to contract with them via the Ministry of Health. ✓ Yes, ALCP supports the mission of

Home Birth Aotearoa and would continue to contract with them via the Ministry of Health.



DSC doesn't have specific policy on this issue, but our overarching mission statement is: Whatever a community deems socially and environmentally desirable, and is physically possible, will be financially affordable. We wish to promote true democracy.



The Green Party will improve information and support for home births for low-risk pregnant women, and our policy supports more choice for women. Home Birth Aotearoa has a valuable role to play in helping mothers make fully informed and safe choices and guiding them through their birthing experiences, which we support. Integration of services is a key principle of our health philosophy, but we don't have specific policy on specific contracts, as our policy gives us enduring values and principles to make specific decisions over time, while contracting decisions are usually dependent on a range of factors we can't pre-determine.



Yes, the percentage of women having home births has not increased. Services need to be accessible, coordinated and integrated into the family care services support environment. In some areas Family Health Units should be available when women need respite care or Lactation Consultant intervention to maintain breastfeeding.

Labour will ensure community based facilities are developed by the District Health Boards in conjunction with Midwives, GPs, Plunket, La Leche League and Social Workers



Yes, and yes. MANA is fully supportive of the kaupapa of home birthing.



New Zealand First believes that our current system needs some refinements to ensure interoperability and a focus on patient needs. We would conduct a full

review of maternity services to ensure the best possible start for mother and baby.

Question 3: What do you view as the key areas of concern in maternal health?



The use of alcohol during pregnancy is a huge concern. Many women are drinking alcohol before they even know they are pregnant. Fetal Alcohol Spectrum Disorder "...is linked to primary disabilities, those that are the direct toxic effect on the developing brain and other organs, such as birth defects, cognitive impairment and memory problems and secondary disabilities such as mental health disorders, educational and social failure when learning and functional needs are not adequately addressed." -

http://www.fan.org.nz/fetal_alcohol_spectrum_disorder



Poverty and inequality, the underlying causes of poor health, family violence, substance abuse and crime, are the most damaging to maternal health.



We are increasingly understanding scientifically what midwives have known intuitively for a long time- the profound effect of the in-utero and even pre-conception environment and experience on human development and even epigenetics. The earlier that LMCs can get in touch with women and support their health in a holistic way, including wrap-around social support and risk factor reduction, the better the outcome for the child. There must be no logistical or financial barriers to care for all women, but especially for women with the highest need, where support makes the biggest difference (low income, rural, Māori and Pasifika, younger mums, socially isolated mums, those with pre-existing chronic health problems etc.)

We are seeing higher and higher burdens of preventable chronic disease at younger ages that have an impact on the child as well as the labour process itself, and result in expensive interventions. We have developed comprehensive action plans on two of the most prevalent chronic diseases that cover social risk factors, food environments, education and primary and tertiary care. They are available online; diabetes and heart disease.

Generally, we take a holistic approach to health that looks at the determinants of

health status that often lie outside the health sector, and will boost investment in changing these drivers of outcomes- in the long run, prevention is more effective and costs less than cure. It is also frustrating for health-sector workers on the ground who have to perform in challenging environments with constrained mandates- when clients are in insecure and inadequate housing, for example, women are not empowered to choose the full range of birthing options that they should, and midwives have to deliver more acute care, without necessarily being able to help the cause of the problem. Our campaigns have prioritised tackling the causes of preventable disease, like the 'Warm Healthy Rentals' initiative, and our 'Home for Life' package as part of our \$1 billion commitment to reduce child poverty

Finally, it is a sad fact that New Zealanders suffer a high burden of mental health related illness, which is particularly prevalent in women of child bearing age, and accounts for a large proportion of post-natal maternal deaths. We recognise that in real terms, public health funding has been cut year on year under the National Government, and that DHBs are feeling the squeeze on any 'moveable funding', which is usually fixed term community contracts. Mental health and addiction NGOs are suffering under this pressure, when they are often the organisations delivering essential front-line care. We have committed to reprioritising Nationals' election spending to fund the real needs of health for up to 3.085 billion to 2018. We have also committed that DHBs should pass on sustainable, full and fair funding to community health-sector NGOs.



Labour has identified a number of areas we'd like to see progress made in, and top of the list is ensuring health care, for the mother and baby, is affordable and accessible.



Our principal concern is whanau wellbeing; that too many women are living in poverty and are not able to enjoy good health or have sufficient family support. As outlined above, MANA's key priority is to address poverty and inequality and ensure all families are able to enjoy a quality standard of living. As a necessary part of this, we will ensure there is appropriate levels of funding for agencies dealing with family violence and addictions, that there is good support and funding for mental health, and that communities have the power of veto over where and when pokie outlets and liquor stores can operate to help keep women and whanau safe.

MANA is also concerned about the increasing medicalization of birthing and supports the ability of both independent and hospital wives to (continue to) play

a lead role in birthing, including the promotion and support of home birthing. We will also seek to better value their work, including the huge role they play in promoting and supporting public health alongside maternal health, through undertaking a review to raise their remuneration.



New Zealand First believes there needs to be a complete maternity services review, infant mortality is on the increase, as is the number of 'potentially avoidable' infant deaths, in a country with a first class health system this is completely unacceptable

Question 4: How would you personally improve these areas of concern?



Overseas evidence shows that the legalisation of cannabis leads to around a 10% reduction in alcohol abuse. This has been attributed to the availability of cannabis providing a safer alternative to alcohol. "Researchers found that fatal car wrecks dropped by 9% in states that legalized medical use, which was largely attributable to a decline in drunk driving."

-

<http://healthland.time.com/2011/12/02/why-medical-marijuana-laws-reduce-traffic-deaths/>

The less alcohol consumed by society, the less alcohol-culture will impact pregnant women.



DSC will establish a guaranteed basic income for every NZ resident regardless of age. This will enable low income families to afford good food, better housing, warmer clothing, dental care and other necessities they have lacked for too long. Women of childbirth age will be healthier and better equipped not only to carry to term without complications, but also to bring a new family member home to less stress, violence and drug addiction.



See above (answer to question 3)



Labour believes there should be no bar to expectant mothers getting all the care they need.

As mentioned above, we will make health care more accessible and affordable by introducing free GP visits and prescriptions for all pregnant women.

Labour will introduce reduce costs further by introducing free dental care for all pregnant women. This will improve the health of both the mother and baby.

The earlier in pregnancy that medical and social assessment can take place, the sooner intervention can occur if it is necessary. Labour will require District Health Boards to set a key performance indicator for pregnant women to be booked in for an appointment with a midwife or another Lead Maternity Carer for an antenatal assessment by 10 weeks gestation. This will be introduced as a national health target, starting with a target of 80% by 2015 and lifting to 90% by 2017.

Under Labour's Health Policy all children will be enrolled with a Well Child provider before birth. The Midwife or Lead Maternity Carer is contracted to provide visits in the first six weeks postpartum. Flexibility around transfer will ensure that no gaps in service provision occur, therefore minimising the risk of family violence, child abuse and neglect.



Answer covered in previous question.



New Zealand First would conduct a Maternity Services Review.

Question 5: Do you have children yourself? Can you tell us about your experience with birth?



No, I don't have children.



I have three children, two born by caesarean. I am now a grandmother, old enough to remember a more caring and inclusive age, when inequality wasn't so extreme, and the public health system was better funded. I still didn't like being in hospitals to have my babies, but I accepted that my particular situation made it necessary.

NB. I had my first child in a US hospital, a widely different experience from NZ, where the babies were taken away from the mothers, and breastfeeding was not a priority.



I have an adult son, but consider his birth story his to tell rather than mine! Birth is something that touches everyone in society on a profound level, often throughout their lives, and I am no exception to that.



Yes, my experience is 40years ago when few fathers attended the birth, hospital stays were 8/10 days, GPs delivered babies, Plunket visited home every week for the first three months after the birth, there was universal family benefit and ante natal classes were free to all women. Some things are better (the involvement of midwives as LMCs, more involvement of fathers) but many things need to be improved.



yes

Question 6: Do you support an increase of paid parental leave? If so, what is your party policy in this regard?



ALCP do not have any policy supporting increased paid parental leave. However, we would maintain existing paid parental leave.



DSC supports paid parental leave for the meantime, although it benefits only those who are in work, and not the poorest and most disadvantaged families. DSC will establish a guaranteed basic income for every NZ resident regardless of age. This will enable parents to make their own arrangements, and manage on a single income as we were once able to do.



It is Green Party policy to extend paid parental leave, in line with the Families Commission recommendations of September 2007, to ensure parents are provided with a total of 13 months paid leave.



Yes. Labour believes new parents deserve more time to spend with their babies. As part of our Best Start package Labour will extend paid parental leave from 14 weeks to six months.



Yes. MANA supports the extension of paid parental leave to 12 months.



New Zealand First supports an increase of paid parental leave. We do not have a specific policy on this topic at this time.

Question 7: Our medical system in Aotearoa has an emphasis on informed choice. Do you regard this as playing out well in reality, and what could be done to improve this?



There needs to be more information made available and more choice offered by the health system. At the moment many dangerous drugs are being used on patients, sometimes without their informed consent. For example, patients are not made aware of the benefits of medicinal cannabis but are encouraged to consent to potentially dangerous pharmaceutical drugs. They are presented as the only option, while natural drugs are ignored.

Democrats
for social credit

DSC regards 'informed choice' as a euphemism to disguise the privatisation of a once-public social service. Behind 'informed choice' are profit-making enterprises such as insurance companies, private clinics and ad agencies, and less funding for public health care. Long surgery waiting lists and people arriving at emergency rooms because they are unable to afford a doctor visit are just the tip of the iceberg of symptoms that indicate the system is not working well.

Green
Green Party of Aotearoa New Zealand

As doctors and nurses are required to deliver more and more acute care in shorter periods of time, their workload eventually has ethical implications for our health system. There are systems now inside hospitals starting to monitor safe staffing levels which look promising, but the workforce needs to be properly funded. Outside of hospital, health literacy is an essential part of informed consent, and needs to be improved right from primary school. Our school hubs plan provides a dedicated school nurse for every decile 1-4 primary and intermediate school. Generally speaking, developing a 'culture of consent' in society has an impact on women's control over their decisions and bodies, and our Women's Issues spokesperson Jan Logie has been working hard to gain funding for promotion and education.

The Green Party supports the LMC model of care for pregnancy and birth and

believes that it serves women and their whanau well in educating them about their birthing choices and options.



Ensuring information and services are available is important and can still be improved. This is part of the reason we believe services need to be accessible, coordinated and integrated into the family care services support environment.



People need to have a decent level of health and standard of living to be able to have choice. People also need to be able to have a reasonable level of literacy to be informed enough to make an informed choice. The key focus of MANA is to raise living standards and improve health and wellbeing, and to invest in schools as community hubs which will include home-school partnerships and family and adult literacy programmes.



New Zealand First believes that our current system needs some refinements to ensure interoperability and a focus on patient needs. We would support a review to ensure the current level of informed choice is meeting these needs.

Question 8: The rate of caesarean section operations continues to increase year on year, not only in Aotearoa but across the western world. Why do you think this is, do you see it as problematic and what do you think could be done to change this outcome for women and babies?



Yes, it is problematic to both mothers and babies. There is growing evidence that the guidelines used by doctors, in the western world, are causing caesareans to be performed too early, before the pregnant woman has had a chance to complete a natural labour. There needs to be a significant increase in the amount of time

spent trying for a natural labour before resorting to a caesarean section.



DSC policy as mentioned above will improve the general health of our population including reducing obesity from malnutrition, which may affect the birth outcomes. However, this writer privately wonders if the rising average age of women bearing a first child could also have something to do with the increase in Caesars.

We know that student debt and rising house prices in Auckland are factors that put off a couple's decision to start a family. So if older first-time mothers are more likely to have caesareans, and our debt-based system is a contributing factor, then DSC's economic reforms may contribute to more natural birth experiences in younger women.



It is Green Party policy to support research into rising intervention rates and caesarean sections, and initiatives that will help address this. See above on our plan for preventing chronic disease. Rising health costs are driven by changing population demographics, worsening health status and access to expensive new technology-but with limited health dollars we need to open up a national conversation about the values we want underpinning our health system. Our strong feeling is that New Zealanders want value for money and to keep people well before they need expensive interventions. It has also been noted that economic factors are causing families to have to delay having children, and older average maternal ages are having an impact on birth outcomes. We will tackle macro-economic factors like housing and student debt to allow women to make the choice to have children when it right for them, rather than having to make impossible economic choices.



There appears to be a number of reasons for the increase in caesarean births internationally including concern with birth going wrong and fear of suing (but not in NZ where medical accidents are covered by ACC), choice, convenience and genuine medical reasons. I would like more information and leadership regarding the risks of Caesarean sections and how the number can be reduced.



It's indicative, in part, of rising poverty and inequality levels and the huge impact this has on maternal health (obesity, diabetes, smoking, alcohol) and the need for emergency caesareans as mothers and babies struggle with birthing. Improving the living standards and health of women and whanau is THE key priority for MANA.



New Zealand First agrees with a recent report which has shown that the cause for the rise in the occurrence of birth by caesarean sections in New Zealand is unknown but it thought to be a number of different factors. This is problematic if it is causing harm to mother or child. This increase would be given consideration if we were in a position to conduct a National Maternity Service Review.

Question 9: What is the single best thing your party is committed to doing to improve the health and wellbeing of children in Aotearoa?



We will legalise pediatric use of medicinal cannabis. For example, over 10,000 children have epilepsy in New Zealand abut very few can access potentially lifesaving cannabis oil treatments such as Charlotte's Web, THCA or CBD. Many of these medicine have the psychoactive components removed.



DSC will establish economic reform, so that we can restore our public health system with full funding, establish a basic income for all to wipe out poverty, fund the building of affordable eco-housing and lend at cost so low income families can buy them, with ways to set repayments at affordable levels (rent-to-buy, length of term, etc.)

We will also restore and fully fund our education system so that school 'donations' are unnecessary.



One of the Green Party's three priorities this election is to deliver a fairer society where every child has enough to thrive. As a part of that we have a billion dollar plan to reduce child poverty. It includes creating a new top tax rate of 40 percent above \$140,000, with the revenue being invested in a new Children's Credit to give an extra \$60 a week to families currently missing out, a non-discriminatory Parental Tax Credit of \$220 a week in the first weeks of life for the poorest children, and a \$500 million per year investment in children's health and education to reduce the harm caused by poverty.



We're putting the needs of children at the heart of policy making because we're committed to giving all of our children the best start in life. Our Best Start package will focus on the first five years of a child's life and help families struggling to meet the rising costs of living.

It will give 59,000 families with new-borns a \$60 a week payment through to their baby's first birthday. That investment will continue for parents on modest and middle incomes until their child turns three. There will also be free antenatal classes for all first time mothers and early home visits. Free early childhood education for three, four and five year old children will be expanded from 20 to 25 hours a week, and paid parental leave will be extended from 14 to 26 weeks as set out in Sue Moroney's Member's Bill.

For more information about Best Start, please visit

<https://www.labour.org.nz/sites/default/files/issues/policy-beststart.pdf>



MANA has a plan to eliminate child poverty in 5 years: set a plan, monitor, and make it a priority for the investment of public funding – raise incomes, quality housing, employment, public health and education including food programmes in all low-decile ECEs, kōhanga reo, and schools.



New Zealand First would introduce the Teen Health Check Bill to require DHBs to make provision for health checks on all Year 9 students and other measures to ensure no young person enters secondary school with health problems likely to be a barrier to their learning.

Question 10: How do you envision the principles of Te Tiriti o Waitangi intersecting with our health system in a positive way for Tangata Whenua?



ALCP's core principles support te Tiriti o Waitangi, this encourages Tangata Whenua to increase tino rangatiratanga when intersecting with the health system. <http://www.alcp.org.nz/principles>



DSC will ensure that all Maori health needs are met, as determined by each community, and in forms the community decides are appropriate. We will restore our public health system for the good of all, including systems and services that are culturally sensitive and inclusive. Personally, I would like to see an investment in the study of traditional Maori medicine, with funding for research and development of effective, home-grown remedies.



A key principle of our health policy is acknowledging te Tiriti o Waitangi and the status of health as a taonga. We will work with Māori to manage their own health needs and provide Māori specific services, increase accessibility of health services to Māori through increased provision of community and marae-based services, ensure Māori representation and consultation at all levels of the health service, and support rongoa Māori practitioners and practices.



Labour acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand and accepts that Te Tiriti should be honoured in government, society and the family.

Labour's vision for health is to build a nation where all New Zealanders are able to live longer and healthier lives because they have the knowledge to make more informed health decisions with the support of a strong and adequately funded public health system. Labour is committed to adopting an approach to health, which takes into account physical health, mental health, the family, culture and community environment, and the socio-economic determinants of health. Our

system must take into account all these factors if it is to be truly effective. Labour has a vision of a just society where health outcomes are not predetermined by location, ethnicity or ability to pay. We believe access to good health care is the right of every New Zealander. From efforts of the first Labour government which established our public health system to the significant primary health care reforms of the Fifth Labour government, Labour has always been focused on bringing this vision about. Through a focus on equality, access, and fairness in the health domain, through an unquestionable commitment to the integrity of the public health system, and by providing tools, information, and incentives for people to make good health decisions for themselves, we can make New Zealand a healthier nation for all.

MANA

The key here for MANA is the development of equitable access to non-discriminatory, quality health care. To achieve this our policy priorities are to:

- Eliminate institutional racism in the health system through greater ethnicity-based auditing, a more effective governance system, the expansion of Māori health provision including rongoā Māori and the protection of traditional practices, and health workforce development to address the racism of health care workers and systems.
- Achieve pay parity for healthcare workers employed by Māori and iwi health providers.
- Institute a renewed focus on improving health statistics for Māori.
- Support Maori health programmes with proven outcomes, including initiatives in mental health, and use these as a benchmark for a national roll out of initiatives.



In relation to the Treaty of Waitangi, New Zealand First considers that the Treaty should be a source of national pride and unity and not used to expand the separate rights of Maori or anyone else. Too often the Treaty now divides, polarizes and isolates us. New Zealand First believes in the concept of a fair go for all New Zealanders.



The following statement may be attributed to the National Party:

We will be announcing our health policy closer to the election, which will build on National's strong record of improving public health services.

Over the past five years, while many developed countries around the world froze or reduced health funding; National has invested an average of \$500m extra each year in public health services.

Health funding is already targeted to high needs groups. Almost one in three New Zealanders can already access low cost doctors' visits, 98% of under 6 year olds can visit their GP for free, and get their prescriptions filled for free. National's careful management of the health budget has meant we are able to extend this successful scheme to under 13 year olds from July 2015.

If National is re-elected, next year our Vote Health budget will reach \$15.6 billion, the most ever. We're making each dollar go further, delivering 1500 more doctors, & 3200 more nurses, with 1000 fewer back office staff.

We've had five years of record increases in elective surgery – since 2008 we have lifted the number of patients receiving elective surgery by 40,000. Under Labour, despite a doubling of the health budget; we not only saw no real increase in elective operations but 30,000 people were cut off waiting lists.

National supports having affordable and accessible contraception, which is why we already heavily subsidise many available contraceptives. In July 2010, Pharmac began funding long term contraceptive Jadelle.

We have expanded access to the emergency contraceptive pill, and pharmacists can now dispense this without the need for a prescription.

The National-led Government has made substantial investment in resources to help new mothers suffering with post-natal depression and other mental illnesses Budget 2013 included an extra \$18.2 million over four years into dedicated maternal mental health beds and new specialist community services around the North Island for around 650 mothers and their babies a year.

National supports the provision of choice in maternity services.

National is committed to doing our part to give children the best possible start in life and as part of this we are investing an additional \$171.8 million over four years to enhance parental leave provisions. We are extending paid parental leave from 14 to 18 weeks, making it easier for parents to take more time off work to spend with their new-born child if they wish.

We are extending paid parental leave to 'Home For Life' parents and others with similar permanent care arrangements such as those with parenting orders. We are extending parental leave payments to more workers – in particular, to people who have recently changed jobs, seasonal and casual workers, and workers with more than one employer.

Our changes will ensure New Zealand's parental leave framework better reflects modern working arrangements and today's diverse family structures.

We've seen great results in our drive to have all our children immunised and healthy, 91% of 8-month olds are immunised and we are continuing to work towards the target of 95% of 8-mth-olds immunised by 2017. It is an important part of our plan to deliver better care for families. In 2007 under Labour, just 67% of two-year olds were fully immunised.

New Zealand has gone from having one of the lowest immunisation rates in the world to levels that are comparable with other OECD countries, including Australia. Additionally, 2014 is New Zealand's third year in a row in which over one million doses of seasonal flu vaccine have been distributed

Maternity services continue to improve thanks to strong clinical leadership by health professionals.

Protecting and growing the public health service for New Zealand women is part of our priority to deliver better public services. This Government has provided not only record funding, but record results. This is what careful financial management can deliver to Kiwi families.

There's always more to do, and we will continue to invest in our health services as part of our commitment to deliver better, sooner, more convenient healthcare for New Zealand families.

Our election is on Saturday September the 20th, although you can vote before this if you need to. You can enrol to vote up until the 19th of September.

Enrol to vote: <http://www.elections.org.nz/voters/enrol-check-or-update-now>

Voting in the election: <http://www.elections.org.nz/voting>



Theory versus Reality – Rights in Childbirth.

*By Carla Sargent
Sep 2014*

Many would argue that New Zealand women have a better deal when it comes to birthing rights and birth care than anyone else in the world. We have the right to decide where, how and with whom we give birth, and we can choose our midwife and have her care free-of-charge right through pregnancy, birth and up to six weeks after. These birthing rights were fought for by a community of strong, committed women who came before us. Thanks to them we are, indeed, very fortunate in our birthing freedoms. But despite our envied maternity care system, many women, and their midwives, are dissatisfied with the incongruence between legislative rights and birthing realities. The pervasive medicalised birth culture infests the birth care many of us receive, rendering our rights to informed choice and to autonomous birthing as little more than a feminist joke. While many of us in the home birth community can see through the misogynist poison that seeks to oppress birthing women and their rights, it still manages to seep into our experiences, and those of our midwives.



This article explores the midwife-woman partnership within the New Zealand maternity care system, and relates it to the experiences of home birth women and their midwives. It examines the challenges that women and their midwives face in exercising their rights and responsibilities, and it provides some insight into why it's not always as simple as 'supporting women's choice' when it comes to midwifery care. Suggestions are given as to how we can achieve a more positive birth culture for the generations that follow.

Jane had a traumatic first birth experience in hospital. She felt disempowered and damaged by a system of care that failed to support her most basic rights, and which coerced her to undergo unnecessary medical procedures that essentially led to the caesarean delivery of her baby.

Two years later, Jane is pregnant again. This time she is determined to avoid hospital. Her midwife had told her, when they first met, that she would support Jane to give birth at home. At 39 weeks of pregnancy, it is discovered that her baby is settled in a breech position. Jane does her research and decides that she wants to continue with her plan to birth at home. Her midwife, however, says she is uncomfortable with supporting a breech VBAC (vaginal birth after caesarean) home birth, and that if Jane chooses to birth at home, she will need to find another midwife.



Within the New Zealand home birth community, scenarios such as the one above are not particularly uncommon. Choosing to birth at home runs counter to mainstream birthing. To have made such a choice suggests a high degree of investment in seeking a specific type of birth experience – one that upholds an holistically safe and loving family-centred journey. It also implies a greater sense of self-determination than many other birthing women possess. As New Zealanders we are in the fortunate position of having had the right to autonomous birthing won for us by past activists, but there is more at play than legislative entitlement when it comes to women’s birthing rights. The relationship between a woman and her midwife is a key aspect of how the woman’s birth unfolds.

At the core of every woman’s decision-making surrounding her birth, is the need for a safe outcome for her baby and herself. The fact is that no one can definitively determine what course of action (or inaction) will result in the safest outcomes for a mother and her baby. There is no one ‘right’ answer. Safety is a subjectively determined experience, one that involves more than just perceiving ourselves and our babies as physically safe. To be safe, we need to have our emotional, mental and spiritual selves protected from harm, too. Keeping that in mind, it is the well-informed mother who is most capable of determining the safest options for her pregnancy and birth. No one is more invested in a safe outcome than she is!

So, what may appear to the well-meaning family member, friend, midwife or doctor, as a mother making a dangerous decision regarding her birth, will almost always have an undercurrent of valid reasoning in its wake. If we use Jane's example from the beginning of this article, the harm that was done to her through her hospital birth experience was so damaging that the risks of birthing her breech post-caesarean baby at home were less than the risks associated with birthing in hospital. However, to someone who does not know or fully understand Jane's history, her decision to birth at home may seem unreasonable.

Since the beginning of the medicalisation of childbirth some 90 years ago, women have been coerced into believing that doctors and their tools and technology are better determinants of safe birth processes than well-informed women themselves. New Zealand, though, has enacted a maternity system that seeks to challenge such an oppressive dogma. The 1990 Nurses Amendment Act which allowed midwives to practice autonomously reflected years of political activism by women and midwives. Guilliland and Pairman (2010, p.17) note, "This shared personal and political activity gave birth to the New Zealand midwifery model of partnership."

Recognition of birthing women's rights and competencies in determining their birth processes is demonstrated in the philosophical and ethical underpinnings of this midwifery partnership model of care. Amongst the concepts that define this partnership are the following:

The midwife acknowledges the woman's autonomy in her own life and respects the decisions she makes for her childbearing experience.

Midwives accept the right of each woman to control her pregnancy and birthing experience.

Midwives accept that the woman is responsible for decisions that affect herself, her baby and her family/whānau.

Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience. (Philosophy and code of ethics, 2014)

Such an ideology is congruent with the philosophy of home birth. In 1994 the Waikato Home Birth Association developed a comprehensive booklet for maternity consumers and workers, titled 'Have you considered a home birth?' The section 'Qualities we expect in a midwife' includes the statement, "The midwife must at all times respect a woman's right to make informed choices over her birth. It is the woman who is in charge of her birth...and it is the woman who delivers her own baby." (Waikato Home Birth Association Inc, 2014, p.11). As well, the Health

and Disability Commission (HDC) produced legislation which states that every health care consumer has: “The right to make an informed choice and give informed consent.” (The code (full), 2014)

To further meet the needs of birthing women, as defined by women themselves, the New Zealand midwifery profession adopted a unique approach to all their organisational, regulatory, disciplinary and educational functions. The midwifery profession defines and implements each of these in partnership with women, both the woman and the midwife being recognised as expert and equal (Guilliland and Pairman, 2010).

Given that New Zealand midwifery acknowledges a woman’s right to autonomy in childbirth, why was it that Jane’s midwife (using the example provided at the start of this article) declined to support Jane’s decision to birth at home? As logical, empowering and positive as the partnership model of care appears to be, putting it into practice is occasionally a tricky balancing act, one that may find women and their midwives precariously walking a tight rope. Like any partnership, there will be instances where the needs of both parties will clash. Clearly Jane’s needs ran counter to those of her midwife. When faced with such ‘conflicts of interest,’ how well does this partnership model equate to birthing autonomy for the woman?

In this partnership of equality and shared responsibility, the woman has the right to choose where and how she gives birth, but equally, the midwife has the right to decline to continue caring for the woman. Although the midwife has a responsibility to be honest about her views and limitations regarding the care she provides, the withdrawal of care at the end of pregnancy puts home birthing women in the uneasy predicament of having to decide between three unsatisfactory options: 1) to give birth at home unassisted, 2) to give birth in the hospital, or 3) to find another midwife who will support her to birth at home, and attempt to develop a trusting rapport with her in a very limited time frame. This clearly undermines a woman’s right to determine her birth process.

Home birth midwife, Maggie Banks, views such withdrawal of care as a safety concern and says she would not discontinue care, but rather, “...continue to work with her, as birthing without professional support would, potentially, only compound any complication.” (Personal Communication, 26 May 2014). Similarly, Home Birth Aotearoa trustee, Sian Hannagan, believes that, “Having a midwife attend a risky birth is still better than a risky free birth [a birth with no midwife in attendance]” (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014).

By failing to support a woman’s choice to birth her baby at home, regardless of the midwife’s own view on the degree of safety, the midwife is feeding the

patriarchal beast that seeks to subjugate all birthing women. Whether she means to or not, a midwife who drops her care of a woman late in pregnancy (or threatens to), not only sends the message that what the woman is choosing for her birth and her baby is wrong, it also coerces that woman into choosing an unsatisfactory birth option, the very thing that she was trying to avoid by taking ownership of her birth and opting for a home birth midwife in the first place.

In defense of Jane's midwife, there was more to her decision to stop caring for Jane than just 'feeling uncomfortable' about the home birth option. Jane's midwife was scared that if she supported Jane and the baby died during the birth, there would be a difficult battle to fight that she would almost inevitably lose, and that irreparable damage may be done to her career. Although the midwifery profession recognises a woman's innate entitlement to determine her birth process, the medical community and our society in general are slow to adopt this understanding. In her protection of women's birthing rights over the past 30 years of home birth midwifery practice, Maggie Banks has had complaints instigated against her from paediatricians, obstetricians, midwives, neonatal nurses and maternity managers, all of whom, she states, "...do not, or did not, understand that women have a right to control their own health decisions" (Personal communication, 26 May 2014).



Despite some advances, we continue to live in a society that bestows god-like status upon the white coats with MD affixed to their name, and crucifies women

(including midwives) for being self-determining and supporting one another. In order for mutual safety to be achievable for women and the midwives who support them, each needs to support the other, especially in the event that things do not go to plan. This is no small task when faced with adversity, for even when this partnership of trust is upheld, midwives and women are still vulnerable pawns in a misogynistic society that does its best to maintain authority over women, especially those who threaten its power base. New Zealand College of Midwives (NZCOM) midwifery advisor, Norma Campbell, pointed out that a coronor investigating a baby death will find midwives at fault much more readily than when a baby dies at the hands of a doctor. "Doctors are listened to differently than midwives," she said. (Personal Communication, 24 July 2014).

Sian Hannagan (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014), acknowledges that there is no black and white answer in solving the issue of protecting women's rights whilst simultaneously protecting midwives careers, but believes there needs to be a more supportive environment for midwives, "...so that they don't carry the blame if they aren't culpable." Despite having a maternity care policy that entitles women to retain autonomy over their birth decisions, midwives who support such policy run the very real risk of having their practice investigated and potentially thrown under the media spotlight. Midwife, Kate Rankin, points out this conflict of interest when stating, "The HDC does support [women's choice] BUT the media and the midwifery council seem to want blood sometimes and the investigations they make can be extremely traumatic for midwives" (ibid.). Such a threat impacts the way many midwives choose to practice. Consequently, it also has an impact on the degree to which women can exercise their birthing rights.

Sadly, vulnerability for midwives who uphold women's choices may also come in the form of judgment from their midwifery sisters. When midwife, Karen Van der Leden/Donald, supported a woman to birth her twins at home, she felt let-down and mistreated by her midwifery community. Karen has felt silenced in being able to celebrate and speak out about that special birth she was a part of, "...because of fear that no one will understand what true informed choice and consent is all about for women and their partners." (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014). Midwives Jan Scherp and Maggie Banks wholeheartedly believe in the importance of depending on *trusted* midwifery colleagues - those whose practice is reflective of their own - in seeking support and guidance for the work they do (ibid.). Unfortunately, for Karen Van der Leden/Donald, there were no such midwives in her region. She was alone in her support of a woman's right to choose her birthing circumstances.

What support exists for midwives outside of their like-minded midwifery circles? According to many of the midwives who commented on the Homebirth in

Aotearoa New Zealand facebook thread (13 May 2014), very little. NZCOM midwifery advisor, Norma Campbell, disagrees. She said that the College receives calls from midwives facing practice dilemmas like those discussed here, all the time (Personal Communication, 24 July 2014). However, not all midwives appear to get the support they are seeking from such conversations. Karen Van der Leden/Donald, the midwife who attended the twin birth, had the following experience:

When I spoke to NZCOM... about my documentation etc, to make sure I was on the right track, I was told that they couldn't advise me and that I was on my own and hopefully it wouldn't get into the papers as another disaster. I did feel abandoned by them, as I did expect more guidance than this. (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014)

Midwife, Jan Scherp, explains why she believes trusted midwifery colleagues are a midwife's only real support source within the midwifery profession. She says, "Midwifery Council are there to protect the public not support the midwife and NZCOM are there to support the midwifery profession but not the individual midwife" (ibid.). Perhaps the NZCOM fears being linked to the support of midwives who care for women that choose to 'stray too far from convention.' Appearing too radical could understandably be damaging to the reputation of the midwifery profession in the eyes of the public. But again, in what foggy undefined space does that leave home birth women like Jane and midwives like Karen?

For some midwives, as it is for Maggie Banks, support from the women they care for is another vital aspect of their home birth midwifery work. The woman relies on her midwife to offer holistic care, including honesty about her midwifery philosophy and limitations, and unbiased information to help guide decision making. And the midwife depends on the woman to communicate honestly and openly, and to maintain responsibility for the informed decisions she makes. Such co-dependence in the midwife-woman partnership necessitates mutual trust, good communication and shared responsibility in order to function effectively. For Maggie, the relationship of trust between her and her clients enables her to feel safe in supporting the choices of the women she works with, despite feeling there is a lack of professional support for midwives outside of their midwifery circles (Personal Communication, 26 May 2014).

For other midwives, though, broken trust has led to a more self-protective midwifery practice. Midwife Kate Rankin shares, "I am a midwife who supports a woman's choice... but I have been seriously let down by women on several occasions" (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014). Such an experience could understandably lead a midwife to conclude that 'if I

can't trust the women I work with to 'have my back', I'll be less inclined to put myself in the position of needing them to.'

Counter to Maggie Banks' personal experience, Norma Campbell revealed that, in her experience, most complaints against midwives come from the women they care for. When a baby death is involved, she said, it is "very rare" that the woman will take responsibility for whatever decisions she'd made regarding her birth. In their grief and anger, says Norma, parents are looking for someone to blame (Personal Communication, 24 July 2014). Knowing this, good clear communication throughout a woman's pregnancy becomes glaringly vital. "Information sharing is what the partnership is all about," says Norma (ibid.). And it's not just about *what* is shared, but *how* it's shared that determines its effectiveness. Norma points out the importance of midwives presenting things to women in pregnancy as *their* responsibility, and she acknowledges the need for the woman's partner and support people to be a part of such discussions (ibid.).

Midwives also have an obligation to communicate the boundaries of their practice. Relating this to Jane's story, perhaps it would have been more appropriate for her midwife to have stated her limitations around supporting Jane to birth at home at the beginning of the relationship. Instead, Jane was only made aware of this when it was essentially too late to opt to change to another midwife. Although it would be impossible to cover the total array of occurrences that could deter a midwife from supporting a woman's home birth decision, it would surely be appropriate and helpful to ask a midwife early on: "Under what circumstances would you be unwilling to support me to birth at home?"

As was the case for Jane's midwife, some midwives won't attend home births due to a lack of experience and confidence with managing more complicated births. Twin birth, breech birth, and shoulder dystocia are some of the obvious examples here. One of the many worrisome consequences of our medicalised birth system is that birth practitioners are becoming less adept at managing these types of births. Women are often pushed to birth their breech babies, their twin babies, and their 'large' babies via caesarean section, resulting in birth workers having less opportunity to watch, learn from, and develop the skills related to, such births. Even women who are supported to give birth vaginally are frequently bullied into agreeing to various interventions, thus hindering their chances of giving birth in a physiological manner. Midwife Karen Van der Leden/Donald sums up the importance of the points being made here:

Midwives need to keep up their knowledge and skills in natural birthing practices, so that instead of making the woman feel uncomfortable with her choices for no scans, or no sonicaid, or birthing a breech or twin, a midwife is able to holistically assess the woman's situation and work with her instead of against

her, working towards making good informed decisions based upon positive information instead of fear based processes which leave a woman detached, [and] more prone to interventions, postnatal depression, and other issues which are becoming more common these days. (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014)

Until society buys into the concept that women have the right to decide where, how and with whom they give birth, then this medicalised birth culture will continue to thrive, further eroding society's view of birth as sacred, women as capable, and midwives as the experts in protecting normal birth. What will it take to get our society to see the light? Birthing rights are undeniably a feminist issue. In my opinion, the way we should look to begin tackling our medicalised birth culture is by strengthening our culture of womanhood. I say this because, as far as I can see, having an empowering midwifery model of care like that proposed by our home birth community and reflected in New Zealand's Midwifery Partnership Model, is only going to achieve what it is meant to if women support and honour one another for the things that make us the strong, capable beings that we are.

At a grass roots level, I believe that more women need to share their birth stories with one another. This needs to be done in an environment which feels safe for women to be honest and open. If a woman's birth has been hard or traumatic, she needs to be able to share her experience without fear of being judged for the choices she did (or didn't) make, or of being told, "At least you have a healthy baby." And women who have had a positive and empowering birth need to share how wondrous birth can be without fear of being judged for the decisions they made around their birth, or of crushing the spirits of those who didn't get the birth they deserved. Because, unless women's traumatic births are acknowledged as damaging and undeserved, unless women know how birth can be, and unless they hear what good midwifery support entails, they may only ever know birth as a horrid and disempowering event that they must suffer through in order to receive their much-wanted babies.

It is encouraging to see a growing number of online birth support forums which respectfully foster the sharing of women's stories. It has been especially heartening to see global woman-to-woman support against birthing injustices (such as forced caesareans, or midwives being punished for supporting women's birthing rights). When we roar with a united voice, we are powerful. Our sisters across the oceans are feeling our embrace, as we feel theirs, and we become empowered in our womanhood. At a national level, we have numerous support groups that honour women as mothers, and mothers as women. La Leche League and regional home birth support circles are two obvious examples. There are also a growing number of birth trauma support networks starting up. Through the learning and support gained by being a part of these groups, women will come to

realise their birthing potential, and they'll trust themselves more, both in their ability to birth their babies without medical interference, and in their ability to make wise decisions about *their* births.

As women, we need to support our midwives, too. We can do this by honestly sharing our needs, expectations, hopes, and fears regarding our births with our midwives, and by maintaining responsibility for the choices we make for ourselves, our births and our babies. It can be scary to make decisions that we feel unsure about, especially when we are making them on behalf of another human being, but they are *our* decisions to make... Welcome to motherhood. We can also support midwives in their learning and growth by inviting student midwives to attend our home births. Far too few midwifery students have witnessed even a single home birth by the time they finish their formal training. Being present at a home birth, especially after having witnessed numerous medicalised births, can be a game-changer for a student midwife who is still developing her own midwifery philosophy. Help to enlighten our future midwives by sharing your gentle and empowering birth experience with a student. And, if you're comfortable to, you might like to consider inviting your sister, niece, or friend to share in your home birth experience, too.

Midwives, you can help strengthen our culture of womanhood by maintaining a philosophy of care which seeks to protect normal birth and be 'with woman.' Your home birth community (and all their yet-to-be-empowered sisters and daughters) are depending on you to enact this philosophy in the important work that you do. As well, you need to support your midwifery sisters, especially students and new graduates, to learn the range of 'normal' that exists amongst the pregnant and birthing population, by not interfering with Mother Nature unless there is a damn good reason to do so. Find midwifery colleagues who share your philosophy, and ensure there is opportunity created for the discussion of midwifery experiences in a non-judgmental forum, then lean on each other for support when you have doubts or fears... or when you want to celebrate another empowered new mother's story. Midwife Karen Van der Leden/Donald notes that, "Midwives also need to know more about informed choice processes and how to practice safely when being challenged by what a woman wants, instead of making the woman fit into a box" (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014). In the current climate of medicalised birth, midwives are only too aware, and understandably protective of, their professional reputations. I'd like to pose the following questions to them: As a midwife, what do you want to be remembered for? What messages do you want to send women and the general public through the work that you do? Do you want to enforce and encourage women's right to autonomous birthing? Or do you want to perpetuate our current medicalised birth culture which reeks of patriarchal dominance over birthing women's minds and bodies?

Strong women fought for the birthing rights of all New Zealand women. Thanks to midwives like Joan Donley and to women like those in our historical home birth community, we now have policies in place that allow us to have much more freedom in how we choose to birth our babies. We are not lucky, we are incredibly fortunate for the hard work of the women who came before us. Let us not take for granted the foundations those committed women laid for us. As has been demonstrated in this article, we still have work to do in ensuring women and their midwives are supported to enact the principles behind the midwife-woman partnership. If you are not a member of your local home birth group, join now! If no home birth group exists in your region, start one up! Be a part of the birthing revolution that will see women and their midwives right across the globe, supported, valued, and respected.

To finish, as women and midwives we rely on each other for support and guidance. We do not always have the backing of those who are lost in the turbulent waters of patriarchal society and its medicalised birth culture, but we do have strength and wisdom amongst us. As Maggie Banks says, “We [home birth midwives] still need to look to each other for support and understanding about our culture.” And from Kate Rankin, “...and we need wonderful women (like the ones here) to love and protect us back.” (Homebirth in Aotearoa New Zealand facebook page, 13 May 2014). The power is within us to ensure that our daughters, and their daughters that follow, have a clear path to empowered birthing. As Margaret Mead so aptly said: “Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.”

References

Guilliland, K., & Pairman, S. (2010). The Midwifery Partnership: A model for practice. Monograph Series, Wellington 1/95 Victoria University.

Philosophy and code of ethics. (2014). Retrieved July 21, 2014, from <http://www.midwife.org.nz/quality-practice/philosophy-and-code-of-ethics>

The code (full). (2014). Retrieved July 21, 2014, from [http://www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act-code/the-code-of-rights/the-code-(full))

Waikato Home Birth Association Inc. (2014). Have you considered a home birth? (3rd ed.). Hamilton, NZ.



Cecile MacNeille's birth art grows out of a deep intimacy and respect for women in the phase of life represented by the mother goddess. As a homebirth midwife, she has been privileged to sit quietly observing many women as they journey through pregnancy, birth, and the period of early mothering. The power and grace of women's physical form during this process has always moved her, and while paintings can never capture the essence of these moments, making images can call up again and again the beauty of birth.

There is some irony in the way that pregnancy and birth are portrayed and perceived in broader context of media and public imagination. Contrary to how they are commonly represented, Cecile sees pregnant women as exuding an incredibly sensual, voluptuous life-force. The intensity of ecstatic birth and the moments of greeting a new baby are the most tangible embodiment of love that we as humans can experience, and the entire cycle of love and birth is inseparable from human sexuality.

Her work can be found on etsy <https://www.etsy.com/nz/shop/lovecycles>

Cycle of Love and Birth
by Cecile MacNeille



Cecile and her family live in Dunedin. She works there as a home birth midwife and an artist.

Her work can be found on etsy <https://www.etsy.com/nz/shop/lovecycles>



Interview with Hermine Hayes-Klein.

By Home Birth Aotearoa

Sep 2014

Hermine Hayes-Klein, lawyer and the director of the Bynkershoek Research Center for Reproductive Rights in The Hague, may not be a familiar name in New Zealand for many, but she should be. Her work as a human rights lawyer has helped define some of the discussions we have around birth and freedom for birth worldwide. She was the guiding light behind the 2012 Human rights in Childbirth conference that was held at the Hague as well as contributing to the Freedom for Birth documentary where she spoke about birth rights for women. She is also the founding program director of the Human Rights in Childbirth movement. Their site [here](#).



Hermine gave birth to both of her children in Holland, and through those births she saw how birth could be.

"I had options. I could give birth at home with a midwife, or at home with a general practitioner. I could give birth at a birth center with a midwife. Or I could give birth in the hospital, with a midwife, or in the hospital with a gynecologist. Like all women, I wanted a healthy birth and a healthy baby. My research into the physiological processes of birth made clear that my body would have the best chance of delivering safely if I felt safe, and supported, during my birth. For me, I knew that the place where I would feel safe and secure was in my home, with a midwife who I could really trust. And so I choose for a home birth, with a midwife, reserving doctors and hospitals for emergency backup."

Opening Address for 2012 Conference of Human rights in Birth



Hermine at the birth of her son.

Hermine now lives in Portland, Oregon, with family. Her work now focuses on legal issues surrounding childbirth, including the defence of midwives and protection of birth rights for women. She has kindly taken time from her work and her life to answer some of our questions.

1. ***When we talk of birth choice, there is a conversation about the difference between the right to decline intervention versus the right to request intervention (eg truly elective caesarians). What are your thoughts on this?***

Hermine: I'd be more comfortable with the choice for elective caesarean if I know that women also have the genuine choice for supported vaginal birth. Women are sometimes told that surgical birth will prevent damage to their pelvic floor- but it isn't vaginal birth that harms the pelvic floor so much as medical vaginal "delivery" with instruments and episiotomies. Simone Diniz of Brazil wrote a great article exposing the contextual nature of "choice" in childbirth: Choice is not choice if it is not informed.

(In this study) when they actively follow these women through the hospital and through their choices they see that the Dr might go into the hall and say to the husband and the woman's mother "it's been 6 hrs it will be safer if your wife has a caesarean" and then they go back into the room and talk to mother and say, your husband wants you to have a c-section, your mother wants you to have a c-section to keep baby safe" and so of course the mother says yes and then it's labelled as mothers choice. This is not choice.

2. ***What would you consider to be the top 5 breaches of human rights in birth internationally?***

1. Unequal access to healthcare, as reflected in racial and ethnic mortality disparities both between nations, and within nations.
2. Violation of every woman's right to be supported in making all the decisions about her body and what will be done to it.
3. Violation of every woman's right to be supported in making all the decisions about her baby and what will be done to it.
4. Legal and systemic enforcement of medical monopoly over childbirth, including the persecution and eradication of midwifery in many places.
5. Imposition of western/colonial/patriarchal models of obstetric care that eclipse woman-centered community traditions, resulting in the loss of traditional knowledge and cultural integrity and repeating the poor practices that are entrenched in the West, like the lithotomy position and the electronic foetal monitor.

3. *What do you think we can do, as an international community to bring the most change to birth rights?*

Hermine: Essentially, protecting Home Birth is a way of protecting all women's birth choices, because when women have alternatives and options in their care providers, they're more likely to have a respectful dynamic with any given provider.

4. *In your mind, what are some top advocacy statements women can use to protect their birth rights when they are under pressure?*

Hermine: It's about having the conversations BEFORE birth as birth is a moment of crisis. So we need to be having those discussions before we reach that point, prepare for birth, talk about birth choices, have discussions with our lead maternity carers. Bring people to birth who will ensure that our voice is never ignored.

5. *In New Zealand, informed consent is a key part of our healthcare and consumer rights (as I imagine it is in America) yet we consistently hear from women that feel they didn't experience informed consent, or worse, were not even aware of their rights. How do we ensure that true informed consent happens, what needs to change?*

Hermine: We need to try to ensure that women know what their rights are before they give birth, and that providers know too. If everybody understands that the birthing woman is the central agent in her care, then informed consent will be treated as a meaningful conversation instead of a signature on a form. Even when a woman says, "Just tell me what to do, doctor," the woman remains an autonomous agent with the right to change her mind and go against her doctor's advice at any time.

6. *What do you think of the term birth rape, does it help or hinder our cause?*

Hermine: I am addressing this issue in [my next blog post](#), coming out this week! Essentially, most legal traditions recognize non-consented medical intervention as an "assault" or a "battery." When we consider the specifics of, say, a forced episiotomy or hostile, non-consented vaginal exam, as a non-consented intervention on the sexual organs/ vagina, and especially if you recognize childbirth as a sexual event, then it isn't hard to understand how women experienced non-consented birth interventions as sexual assault.

7. *There was an infographic I saw a while ago about the multitude of laws that control a woman's body. Do you have any discussion to offer about how these laws are dictated by social or cultural precedent and how we could build laws that protect women rather than control them. Editors note: This led to a long discussion that ended up in the 'personhood' laws that are appearing in certain U.S states and in Ireland.*

Hermine: In all the countries in Europe, the one country that established personhood laws was Ireland, and this is the same law that is used to force women to have caesarean sections. So a law that is designed to protect the rights of the unborn is the same law that causes actual harm to women. This concept is played out in America with the idea of personhood used to criminalise pregnancy. The southern US states that circumscribe abortion and subject women to criminal prosecution for "endangering" their baby in pregnancy are often the same states where homebirth midwifery is illegal and the c-section rates are the highest in the nation. A woman in Florida who was advised she would be scheduled for a caesarean section with or without her consent. This woman ended up labouring at home and in fear – she then went to hospital and asked for pain relief and they said they would only deliver pain relief if she also agreed to a caesarean. Which is coercion.

Homebirth underground is same as abortion underground, made more challenging and more dangerous. The laws designed to protect people actually harms people. When we have laws that protect the rights of the unborn , we actually undermine the human rights of birthing women because the same law that protects the "rights of the unborn" allows forced caesarians.

8. *The European Court of Human Rights held both that women are the ones with legal authority to make the decisions of childbirth, and that the state cannot use the force of law to take away their options. (Ternovszky vs Hungary) How will this practically affect birth rights globally? Do you think it can make a tangible change?*

Hermine: ECHR (European Court of Human Rights) holdings don't apply to nations outside Europe, and even in Europe, women have a long way to go toward getting Ternovszky implemented. But any state or nation that recognizes a right to privacy as an umbrella for reproductive rights should be able to recognize that reproductive rights apply in childbirth.

"every woman has an interest in ensuring Home Birth is a supported and legitimate choice – because even a woman who chooses hospital, when she has a conversation with her doctor, that conversation will be entirely different if he knows, and she knows she has a choice to walk out"

9. *There is a consistent theme in birth, that a mother and her unborn child are at odds with each other or have needs that are mutually exclusive. How do we pull apart that mythology?*

Hermine: We need to take it head on. Who is, in fact, looking out for the baby? The mother who has been growing it out of her own flesh and blood for 9 months, and intends to birth and raise it? Or the doctor or nurse-on-call that night, the policy-maker in parliament? Always ground this discussion in the reality of the cases you know and are dealing with- because you'll find those mothers were always looking out for their babies, passionately so. Women choosing physiological birth or home birth often do so for their babies, because they recognize a value TO THEIR BABIES of a healthy, gentle birth- a value that the medical system generally refuses to recognize. Similarly, they want to protect their babies from harm from practices like separation of mother and newborn to put baby in "nursery," that the medical system doesn't recognize. A good book to read is Leboyer's "Birth Without Violence."

10. *Coercion seems to be a key tactic for professionals that want to reduce choices or make women comply. Can we/do we take a legal stand on this as well?*

Hermine: What is coercion? It is threats, it is pressure it is saying "do you want your baby to die?" What constitutes coercion varies from professional to professional. To protect yourself from coercion you must have advocates and be your own advocate.

11. *Do you think that human rights in childbirth is getting worse, cases of these nature getting worse, or do you think we are more aware of them because of our online communities and technology in media?*

Hermine: What we find at the moment is that Midwives who historically practised in relative harmony with the system, with no outwards change to laws, are now increasingly being circumscribed. Midwives who practised for years without complaints now have a number of complaints against them and because midwives don't have a legal position they are being accused of practising medicine without license and the law allows for their houses to be searched with raids. Midwives have spoken of having 50 officers outside their house and being ransacked. When midwives are criminalised, women lose choice. Midwives who practice in hostile environments, can't offer support and work in fear. This means that the mother suffers. Midwives can't support the transition to hospitals or communicate with the hospital for fear of their livelihood. Therefore women are left with non choices - a coerced surgical birth or an unwilling free birth.

“When choices are made illegitimate and made underground, then women are put at more risk” Hermine Hayes-Klein

Human Rights in Childbirth are an organisation that protects the rights of birthing women on a global scale. They have created an international support network with representatives in most countries who can offer legal advice, advocacy and education. The local contact in New Zealand is Paul Golden.

For more information on caesarian rates in America this map which has been developed by Hermine’s friend Cristen Pascucci, who is the Vice President of US consumer activist group Improving Birth and has created a facebook page for Birth Monopoly.



Birth Trauma and Babywearing.

By Anna Hughes

Sep 2014

Having had experience in both birth trauma and babywearing, I'm keen to share with you how babywearing can support the healing of parents and babies after an experience of birth trauma.

Our first child was born at home. Six hours of active labour, continuous progress and no sign of heart rate abnormalities. I was in the pool when I felt the first pushing contraction. My midwife asked me to feel for the baby's head at which point I felt a loop of the umbilical cord hanging out of me. Knowing this was life threatening to our baby my partner called an ambulance. Being fully dilated it didn't take long to realise that the quickest way to provide air for my baby was to push him out. This took 12 mins of pushing regardless of contractions, a lot of yelling and an episiotomy without anaesthetic at my demand! We know this because it was all caught on camera. Our baby was blue and limp and attempting to breathe. We transferred to hospital where he wasn't allowed to even attempt to breathe unassisted for another 10 hours. I wasn't allowed to breastfeed him during this time either.

For parents who experience traumatic birth some go on to experience Post-Traumatic Stress Disorder (PTSD). Between my partner and I we had nightmares, panic attacks, flash backs, difficulty sleeping (though don't all new parents!), angry outbursts and a disconnected feeling. For us it wasn't all the time and it wasn't prolonged, but it can be and PTSD can contribute to Post Natal Depression. Birth trauma can also come from a mother's psychological experience of birth as disempowering. A forceps delivery, caesarean or even a hospital birth when hearts were set on a homebirth can cause psychological trauma.

A baby can also experience birth trauma. This is often talked about as a physical thing – damage to the head, spinal cord, nervous system, lungs through aspiration of meconium etc. I'm sure my son struggled psychologically from over 30 mins of struggling to breathe and being in an incubator before being transferred onto his dad's chest. Babies who experience birth trauma may have few symptoms. There are many ways to support your baby post birth trauma. One simple way is to hold them close.



Skin-to-skin contact or Kangaroo Care (KC) has many benefits for both parents and baby. Kangaroo Care was developed in Colombia in the 70's to combat the high infant mortality rate in low birth weight babies, particularly premature babies. It also helped decrease the rates of abandonment. Some (often extremely poor) mothers felt so disconnected from their babies after having them removed from them for specialist care, they simply left the hospital without returning for their baby. KC involves constant skin-to-skin contact with the baby wearing only a nappy, lying in the froggy position, full front torso against their mothers bare upper chest and neck. The baby is secured firmly in this position with a blanket or ideally a stretchy wrap that spreads around the parent's bare torso and is wrapped and tied to hold the baby securely so there is no risk of baby falling. IV lines can be fed around the wrap. Stronger babies may be draped in a blanket and supported to find the breast when they wish. Initially mum is the best person to

practice KC as the physical connection between mother and baby is important in establishing the breastfeeding relationship. KC can happen intermittently or constantly. Research shows Kangaroo Care models that support more continuous and prolonged skin-to-skin contact provide better outcomes for families regardless of the availability of high tech equipment. (Hedberg Nyqvist, K. et al. 2010).

Benefits of skin-to-skin contact for the baby are huge. When we feel unsafe our 'flight/fight' sympathetic nervous system kicks in, creating stress and putting all unnecessary energy outputs on hold until we feel safe again. For a baby their innate safe place is their mother. She provides a familiar voice, smell and food needed for survival. When in skin-to-skin contact with a parent (not necessarily the mother when food is not needed) a baby regulates their temperature, breathing, and heart rate to their parent. Their cortisol (stress hormone) levels drop. The parent's salivary cortisol levels also decrease. Babies held in skin-to-skin contact during painful procedures were found to have a decreased pain response. There have also been observations of improved sleep patterns, improved brain maturation and benefits for brain development.

A healthy, full term infant's brain is still only 25% of the adult size it will become. All babies benefit from being "In the safe and ideal environment of the mother, the "physiological set points" are efficient and economical, and allow maximum use of energy to be directed towards growth." Providing skin-to-skin contact for babies who have experienced damage through birth trauma, offers the conditions necessary for the parasympathetic nervous system to provide rest, and growth through feeding and digestion. Put another way, instead of burning calories to keep them warm a baby held skin-to-skin can use these calories for growth.

"When a baby is touched with warmth and care, the brain is flooded with hormones. These enable the child to form the brain connections he or she will need to develop feelings of warmth, love and empathy towards others."
(Brainwave Trust Aotearoa).

Of these hormones oxytocin or the 'love hormone' is beneficial for both baby and parents. Skin-to-skin contact through babywearing provides oxytocin to parent and baby, closeness for eye contact providing more oxytocin, and confidence for parents in providing the "...intimate care that can improve baby's health and wellbeing." (March of Dimes). Mothers who practice skin-to-skin experience greater breastfeeding success as their babies have easier access to the breast, their cues are picked up on quicker, and the oxytocin itself stimulates milk production. Breastfeeding success builds the confidence of a new mother.

Fathers experience closer and quicker bonding through skin-to-skin contact and ongoing babywearing. Babywearing provides fathers with a tool to easily get their baby to sleep. In my experience it allowed me to have a break. I could easily relax knowing that my baby was content and secure, firmly strapped to my partner. Many fathers have found babywearing empowering, fulfilling an innate need for their baby when only mum can provide the essential need for food.



Babywearing allowed me to exercise in environments that I love - off road, often in the bush, places where pushing a pram would not have been practical. Exercise releases chemicals that positively affect mental health, "...exercise, particularly mind-body and low-intensity aerobic exercise, has been shown to have a positive impact on the symptoms of depression and PTSD [Post traumatic stress

disorder].” Of course parents can exercise while pushing a pram, too. Wearing your baby can provide the double dose of oxytocin release from close contact (ideally some skin-to-skin) and endorphins released during exercise.

Kangaroo Care, skin-to-skin and ongoing babywearing are beneficial to the whole family. Feldman and Weller, et al (2003) found that “Following KC, mothers and fathers were more sensitive and less intrusive, infants showed less negative effects, and family style was more cohesive.”



For the birth trauma my family experienced and the subsequent level of post-traumatic stress, skin-to-skin and continued babywearing was incredibly positive and helpful.

NB: The physical and psychological trauma that families may experience during and after the birth of their baby is very individual. Skin-to-skin, KC and continued babywearing are not a complete treatment for birth trauma. Professional help should be sought for cases of post traumatic stress and postnatal depression.



Anna Hughes is an energetic contributor and luminary in the babywearing and natural parenting world. Her approach of being an advocate for conscious parenting, and providing a community to support other parents in their journey has been invaluable. Anna has written about and presented on babywearing for many years and is a key contributor to the babywearing community in Aotearoa. Her knowledge and wisdom has shaped our approach to healthy and achievable babywearing. Anna Hughes is also a huge supporter of Home Birth and birthed both boys at home with hypnobirthing. Anna and her husband Wayne of Pizzini Productions have created this video to bring babywearing to the wider community. This is a huge body of work which represents hours of mahi and research.

We're giving away a copy of Anna Hughes DVD 'Wearing Your Baby' to readers of this magazine. Write a letter to the editor with your thoughts and you could win a copy of your very own. Letters to editor@homebirth.org.nz.

A PIZZINI PRODUCTION, NEW ZEALAND

A woman with her hair tied back is smiling warmly while carrying a baby in a vibrant, multi-colored striped baby carrier. The baby is also smiling and looking towards the camera. The background is a soft-focus outdoor setting with greenery and pink flowers.

Wearing Your Baby

Techniques for
holding your baby close
and living life

A DVD FEATURING STEP-BY-STEP DEMONSTRATIONS FOR SAFELY USING BABY CARRIERS

The New DVD, Wearing Your Baby is due to be released at the end of July. This video is well constructed with 3.5 hours of comprehensive instruction on how to wear your baby. A real and amazing resource.



Ultrasound: Not Just A Pretty Picture.

*By Erin Young
Sep 2014*

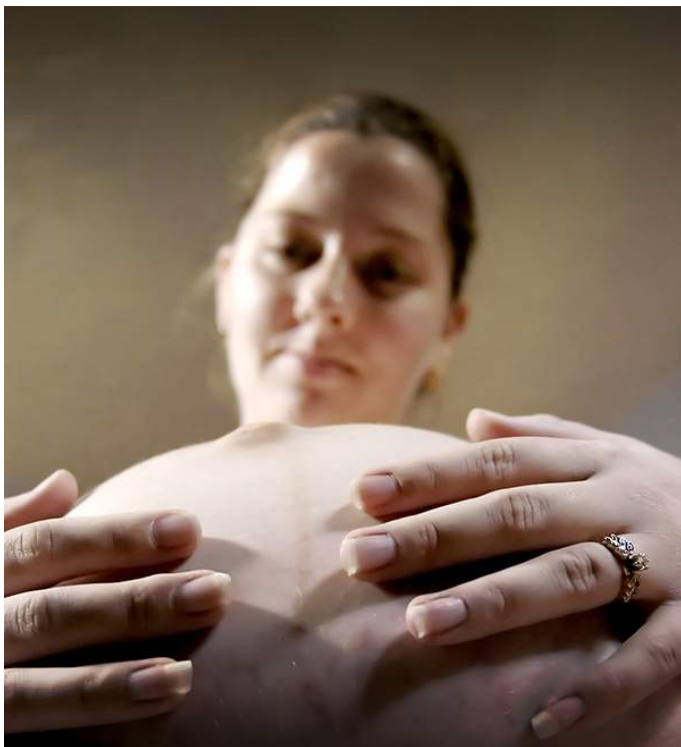
Pregnancy these days can be a minefield of medical examination and testing, from the time you first do the home pregnancy test until the moment baby takes his or her first breath, and even after then. Most women accept the barrage of testing without question, feeling that the more information they can have, the better, whereas others opt out of some or all of them entirely. However, one thing many women don't feel comfortable skipping are routine ultrasound scans.



In New Zealand, the average woman will undergo three different scans during her pregnancy as standard practice: the early 'dating' scan, the 12 week scan to check for risk of Down Syndrome and other congenital abnormalities that may be detectable by that stage, and the anatomy scan performed around 20 weeks to look for any abnormalities in the baby's development. Many people will also use this one to find out the sex of the baby. In certain circumstances, some women will be offered further growth scans if they're deemed at risk of a too-small or too-large baby, or if conditions such as placenta praevia are detected, and yet more if the pregnancy proceeds post-dates to ensure the baby is healthy and happy.

For many people, these peeks into the womb and the hidden world of the unborn child are gleefully anticipated as one of the most exciting milestones of pregnancy, bringing joy and making women feel more 'connected' and 'bonded' to their growing babe. An entire industry has sprung up in recent years around fetal scanning, with a growing number of couples opting for extra 3D and 4D scans at private clinics - the 'clay model' images providing a startling 'preview' of what their baby looks like at that moment in time. Facebook and other social media sites are often awash with images expectant parents put up to share their growing baby with the world.

So with all this in mind, we must ask the question: how safe is ultrasound really? And how necessary?



The use of ultrasound has increased enormously since its introduction in the 1960s, with technology ever-improving and evolving. The vast majority of women will undergo at least one scan during pregnancy, generally aimed at ensuring the developing foetus is growing normally and is free from the myriad congenital abnormalities that can be viewed by sonography. Generally the view is that the sooner you know about something, the easier it will be to treat and the better the outcome. The use of first trimester ultrasound is also popular for estimating the baby's due date, which many women find particularly useful if they're unsure of their dates, have an irregular menstrual cycle, or find themselves unexpectedly pregnant and aren't sure of when conception could have happened.

However, there is also evidence that for all the good they can potentially do, ultrasounds could possibly be harmful to the growing fetus, being linked in recent years to various neurological problems, intra-uterine growth restriction, and other health problems, and the scans may not even make any significant difference to the outcomes for those infants in whom a congenital abnormality is detected.

There are a number of issues with ultrasound that many women may not be aware of, each of which could be the subject of an entire story – please consider this a mere overview!

Firstly, the level of radiation exposure and dosage of ultrasound used varies across equipment, meaning broad differences in potential levels a fetus may be exposed to. As technology has improved and the detail able to be visualized on machinery has grown, so too have the levels of radiation babies are exposed to in utero – with 3D and 4D technology posing the greatest risks, alongside the hand-held dopplers used at many routine antenatal visits to listen to baby's heartbeat. Many people are unaware that this is a form of pulsed ultrasound with much higher output than other forms, and that there are non-radiation alternatives available on request such as wooden pinard horns (fetoscopes).



It is known that ultrasound can cause thermal changes, where the waves are absorbed by some tissue which causes localized heating (in bone especially, causing potential risks to the brain via the skull), and cavitation, where the ultrasound wave connects with tiny gas bubbles. This can cause them to move, expand, or collapse, resulting in changes at a cellular level in the developing bone and other tissue, the outcome of which has not been properly studied. There are further studies linking ultrasound in pregnancy to left-handedness and to increased risk of dyslexia, and more recently the increased use of routine ultrasound has been connected to the ever-increasing epidemic of autism and Autism Spectrum Disorders, following worrying studies of brain development in mice. As well as all this, and despite the use of ultrasound to monitor fetal growth, there are links between ultrasound and prematurity, and ultrasound and Intra-Uterine Growth Restriction.

Whilst much of this research is fairly preliminary, and some has not been able to be replicated in later trials, there are some very persistent findings that do appear valid – the connection between ultrasound and left-handedness in particular. If indeed the scans during pregnancy are causing changes in the developing brain that lead to this outcome, it begs the question of what other changes are taking place that we aren't aware of as yet?

There are also issues to do with accuracy that can arise when things are apparently detected by ultrasound, that are worth considering prior to undergoing the scan. What happens if, for example, a woman experiences bleeding early in pregnancy and is told after examination that no heartbeat is detected, and termination is recommended as the fetus has died. Many women will agree to a termination to 'speed things along', yet there are plenty of reports of women who have decided instead to allow the body to abort naturally and gone on to continue the pregnancy to term, finding that the fetus was still alive, viable, and healthy.

Likewise, if the nuchal translucency scan finds an increased chance of Down Syndrome, are you likely to want to abort the pregnancy? To go on to more invasive and potentially harmful assessment such as amniocentesis? Or to continue the pregnancy as normal and not worry about whether or not baby does indeed have such a difference?

Then there's the question of whether or not scans are indeed always accurate for detection of growth restriction and babies that are deemed too big or small, which can often lead to increased rates of interventions such as induction or caesarian. Studies have shown that cases of genuine IUGR are missed around 30% of the time, whereas around half of all cases 'diagnosed' by ultrasound turn out to not be IUGR at all. In other words, often things are missed, or the scans have 'got

it wrong', with much depending on the sonographer and their interpretation of the findings and measurements.

There are also studies showing that, despite the prevailing belief that if you find an anomaly early by way of ultrasound, it can improve the outcome for baby during and after birth, there is no difference in perinatal mortality or other outcomes between things being picked up antenatally or postnatally. The WHO note that even when abnormalities are detected, no reduction in adverse outcomes can be found.



Of course, when medically indicated, scans can be extremely useful and have saved lives - there is no doubt that there are times where the possible benefits of knowing something or being accurately monitored for a complication that has arisen likely outweigh any potential risks. In these cases, ultrasound can be a lifesaving intervention and something we can certainly be grateful to have access to in this country. The question is whether or not the targeted screening for at-risk women justifies the routine screening of all women throughout pregnancy, given the possibility of risk to the growing baby.

So what are your rights when it comes to scans in pregnancy?

There are reports from around New Zealand of mothers requesting brief scans of limited duration, or opting out of all but one scan, and being told by the sonographer that they are unable to perform such a brief examination and are

required to 'tick off a list of boxes', despite protests from the woman or her family. These women are then bullied into scans that are of longer duration than they want, causing distress and feelings of anxiety or guilt as a result, despite ultrasound not being compulsory and this being a breach of informed consent laws. It is worth having a conversation with the examiner before going in to the exam room, explaining what your wishes are and agreeing to them together prior to the beginning of the scan. If the person is unwilling to honour your request for a shorter exam, find somebody else. And if you feel at all coerced into a scan against your wishes, you are well within your rights to lay a complaint with the Health and Disability Commissioner.

Ultimately, although it has clear benefits when medically indicated, ultrasound is not something that has ever been proven safe, despite its widespread and routine use in pregnancy around the world for decades, and it has been linked to numerous potential adverse health events in later life. You are well within your rights to decline any or all scans in pregnancy – or to agree to them all. Ultrasound is not compulsory, and the onus is on the individual woman to discuss any concerns with her LMC (Lead Maternity Carer) and to do her own research, and decide how she would like to proceed. Whether this be with all routine scans, or some, or none. While it can be nice to see an image of your growing child, one must ask whether it is always worth the pretty picture.

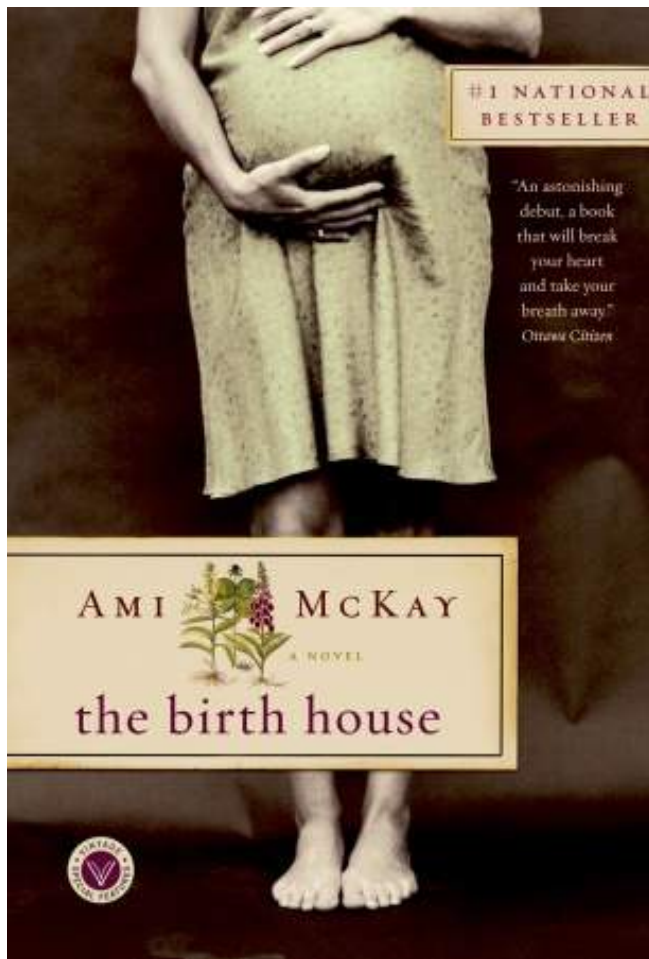


The Birth House by Ami McKay.

By Sian Hannagan

Sep 2014

Dora Rare, the first daughter born in five generations of Rares, was born in the caul, touched by magic, a changeling, a witch. Born out of turn, born a woman, she lives her life caught between her desire for self determination and the close set rules of a rural village community. Set in Scots Bay, Nova Scotia, her journey from daughter to wife, wife to midwife is set against the pre-suffragette backdrop of small town Canada just as the birth of what we now call modern obstetrics begins. As a young woman with six brothers she struggles against her father's expectations and a community that regards with suspicion any woman who does not conform to preset ideals. She is taken under the wing of the village midwife, an Acadian woman called Mrs Babineau who fills a unique space in the village. She is needed and trusted as much as she is spurned and abhorred. Regarded with suspicion, she is tolerated by the men and revered by the women, she is 'other' and sits outside of the common boundaries of womanhood. Mrs Babineau guides Dora on her path to midwifery. Her knowledge on the birthing of babies is steeped in the mythic and the very real. Her wisdom is built from folklore, passed down knowledge and a deep understanding of a woman's body. As the book progresses we see that this wisdom is valueless in the eyes of 'men of knowledge', and as such, Dora's story, woven from the threads womanhood and domesticity, becomes tangled, when a profit driven Doctor comes to Scots Bay to change the face of childbirth.



This story steps through into the secret life of women as they exist in a pre-suffragette patriarchal world, the storytelling is as majestic and otherworldly as it is simple and sturdy. The story, in its simplicity, speaks of how a woman's wisdom and the divine feminine is fragmented by concepts like hysteria, virginity, femininity and infidelity. This story is about a place in time where women did not own their sexual agency and its narrative leads us to question the sexual agency of women today. The concepts raised in an herstorical context are still relevant now. McKay's artful writing draws us into Dora's world and as we read we also reflect on birth as it is for women now. The Birth House is a powerful story that will speak to women and midwives, daughters and mothers. It's not often that a work of fiction manages to be so honestly and sweetly true.

"Our parents and teachers say it's (birth is) a miracle, but it's not. It's going to happen no matter what, there's no choice in the matter. How a mother comes to love her child, her caring at all for this thing that's made her heavy, lopsided and slow, this thing that made her wish that she were dead . . . that's the miracle."

Dora Rare, The Birth House.

Ami began her writing career as a 'closet writer', she spent most of her nights filling notebooks and journals with short stories and ideas for novels, putting her words under the bed where no one else could read them. A thank you note written as a conscious effort to thank people unexpectedly in the year 2000, "the year of writing thank-you notes to people I don't know" led to an appearance on the Oprah Winfrey show and inspired the next step in her writing career. She set about writing 'The Birth House'



Photo credit Ian McKay

Lured to Scotts Bay by a man who recites Byron ("She walks in beauty like the night") years before, Ami found herself living in an old house on the Bay of Fundy.

By spring she was pregnant. As word spread around the community of her “condition” and that she was looking for a midwife to assist in a home birth, neighbors began telling her tales about the history of her home, which was once a midwife’s house. The Birth House. While digging in the garden, she unearthed many relics of the time from medicine bottles to broken china. Her favourite find was an old silver serving spoon: “It was used so often that the edge of the bowl of the spoon had been worn down to an angle. As I stood at my kitchen sink, washing the dirt out of the wheat stalk pattern in the handle, I began to daydream about the woman who had once held this spoon so many days of her life.”

McKay was born in Indiana and taught music in an inner-city Chicago high school before moving to Scots Bay in Nova Scotia in 2000. She has a graduate degree in musicology, as well as writing she worked as a vocal coach. “Finding voice has been an essential part of my life, both as a musician and a writer, there’s something quite magical in helping someone else find theirs.”



Photo credit Ian McKay

Other written work by Ami McKay

- ***The Virgin Cure*** – a novel.
- ***Jerome – the Historical Spectacle***, Play, for Two Planks and a Passion Theatre.
Published by Gaspereau Press
- *Motherhood Unplugged*, Personal Essay, ***Between Interruptions***
- No Shoes Required, Personal Essay, ***My Wedding Dress***
- ***The Birth House*** - a novel
- ***Daughter of Family G***, Feature Documentary for CBC Radio's The Sunday Edition.
- ***Kitchen Ghosts***, Feature Documentary for CBC Radio's Outfront
- *The Midwife House*, Feature Webumentary for CBC Radio's Outfront
- *From Smart Girl to Scat Girl*, Feature Documentary for CBC Radio's Outfront
- *Learning to Box*, Personal Essay for CBC Radio's First Person Singular
- **Magazine credits include:** *Elle Canada, Chatelaine, Canadian Living*



Photo credit Ian McKay



The day of your birth, my best birthday..

*By Samantha Pottage
Sep 2014*

My sister Maia's birth, as told by an older sister.

I wake up to the feeling of my frosty nose this winter morning. Unlike most cold Monday mornings this one is different. With the sunrise of sleepy eyes a bright gleam of light is peering through the gap in my light grey curtains. I can hear the sound of opening and closing ranch sliding doors and water streaming through the pipes. With a big stretch reality dawns upon me, its my birthday. While I sleep my last peaceful sleep of childhood, your occupied by something much more extraordinary. My senses serving their purpose for 18 years now, noticing the light, the sound and the fluttering excitement in my heart. I know what day this is.

Unlike most Monday mornings, this one is different. With a yawn and a rub of my now risen eyes its time to see if my senses are correct with the way they hint the sweet inevitable. Please be today. I step outside with a fresh breath of winters cool air. As I approach the front door my heart races with excitement. Opening the lounge door the warmth of the heat pump kisses my chilly cheeks and frosty nose. As I step inside I feel the warmth on my skin but also this fluttering warmth in my stomach. Its relaxingly dark, with thanks to the grey clouds outside and the thick curtains all pulled around all openings. I peep around the corner knowing what to expect, the objects around me of my loving home and the pool I also expect to see with you resting in it. Everything I had imagined from the dawning of my first glances this morning to the moment I am standing in now. This day, June 30 2014 is the end of my adolescence and the beginnings of someone else's, someone I have been very eager to meet.

I am nervous to approach you, its hard to see you in pain so vulnerable. I notice the strain in your face as pain sets in I can only imagine how intense the feeling must be. Your frizzy scuffed up bun in all places from the humidity of the warm water you're sitting in, sits around your exhausted face. You glance at me and all I can feel is heart warming pride for my beautiful mum. As my chin wobbles with a hard swallow keeping down my tears I ask how you are. You're in a lot of pain by this point and it worries me, I know you will be okay though soldiering on like the strong warrior you have always been through my eyes. Your stubborn certainness has always shown this and the thought gives me comfort every time you let out an uncomfortable moan.

I hesitantly leave the warm room filled with love, excitement and suspense. Unlike most monday mornings, this one is different but I have duties to attend to. I go back to my room and dress for the school day when I am ready i come back into the lounge, your leaning over a chair at the dining table. The one where all 8 of us will sit at in the very near future. Alan has left to help Chloe with the car its just you and me in the lounge I do my best to try and comfort you. I rub your warm back as you sway side to side breathing deeply in attempt to conceal the pain. I have never seen you in this way before the one time I have ever seen you not fully in control of the situation. My hand rubs the center low of your back, its small and narrow I never noticed how little your back is. My attempts to comfort you have shown me a switch in the norm. Its usually you rubbing my back in times of pain and worry and it makes me appreciate all that you have done for me starting from 18 years ago in this exact moment, in my journey into adulthood I can express the same nurturing care that I have learnt from you. I leave you with a love filled kiss on the cheek and two crystals that I know will help you. You accept them thankfully and I'm out the door. This has been a special moment for me.

Its time to leave and go to school. With a day uncertain of any particular plan it is all down to the magnificent processes occurring miraculously in your body. Within a few hours its time to come home. A repeat from this morning begins with the racing heart, a warm kiss on my icy face from the heat pump and the soothing sound of Aunty Mel's voice. Its so good to see her. I peer once again around the corner to where you sit in the pool. I nervously sit on the couch you are in extreme bursts of pain that make me feel uneasy. Alan's soothing presence seems to keep you in a calm enough state. He lovingly massages your back with the shower head streaming warm water onto your back. I sit tentatively quite on the couch, some time passes by Kelly and Aunty Mel encourage you in the best way possible. A big sense of girl power is felt so strong. I am so proud of you.

Chloe leaves in a hurry against time. I approach you in the pool shyly kneeling in front of you. Hoping I am not flustering you at this time. You are doing so well and the pain subsides enough to have a chat. You teach me about the fluid that sits on

the bottom of the pool and how its what baby has been covered in during your pregnancy. I am mesmerized by you in labour knowing that soon all of your big belly moments are setting to an end.

Soon your waters fully break, to your happiness the vibe shifts within the room. Its time and we are all eager and excited. I sit across from you and you start to push, this is so exciting and within the time period of no longer than 2 minutes full of intensity of pushing I see waves of little hair under the water. You lean forward and reach your hand down you say “oh my gosh I can feel hair” Tears begin to pool in your eyes and love is felt throughout the whole room. With a few more pushes I see baby’s head I am intrigued and very excited. Moments later Kelly brings her hands into the warm pool and with another push out comes our little trooper. She is brought up to you and has her first feel of the love filled air “I did it” you whimper in a sign of relief. Tears roll down my face she is beautiful. Chloe comes in blubbering she can’t believe she missed out but is here now with all of us, as the new addition to the family takes her first strained breaths. I look around I see watery eyes and trembling smiles in my family’s faces. Chloe reaches down and cuts your umbilical cord. Baby is then passed up to her shirtless Daddy he is in complete awe of his little girl.

Us girls sit in amazement of the events that have just passed us, soaking up the warmth feeling in our hearts praising you finally relaxing in the pool. Its time to birth the placenta. The last part of your amazing progress is coming to a sweet end. Kelly shows us the tree of life that our little sister had been living in. It was amazing and funny to touch.

Eventually you hop out of the pool, we wrap your poor aching body in towels and then your dressing gown. You snuggle comfortably on the mattress with baby in your arms. Absolutely beautiful.



Samantha holds her baby sister.

My niece Maia's birth – as told by a loving sister

I got to your house a little after 1pm. You were in the birth pool and were working hard. You were hot, sweaty and had had enough! Listening to you “ooooooooohhhhhh” your way through contractions struck my heart. If I could have given you a break I so would have!

Alan had the shower head on your lower back. That thing looked bloody awesome. Your midwife's back up was giving quiet encouragement, letting you know everything was fine and as it should be and that it'd be over eventually. I got a cold flannel and wiped your face. And made sure you drank little sips of water. Kelly thought it'd be a good idea to get you out of the pool and onto the toilet for a wee.

You were in your bathroom/bedroom for a while just you and Alan. Kelly talked to me and the girls about if you hadn't made much progress she'd suggest you transfer to hospital. She didn't want to push you too hard and was worried you were exhausted and not hydrated enough. When she came into your room to check your dilation you were 7 whole centimetres! Go uterus! She said baby was in a great position and you had a bulging bag of waters in front of baby's head. You hated lying on your back though. Fair enough, it sucks! She suggested a herbal tea with some honey for a bit of energy so I made a nettle one.

You made your way from the bedroom back to the lounge and stopped halfway to have a contraction by the front door. After it was over I told you I was going to get bossy about drinking water because Kelly wanted you more hydrated. You said ok.

Back in the pool and the relief from the water was instant. You seemed more collected once you hopped back in. I think knowing you had made some progress gave you renewed energy.

Your contractions were very powerful now. You swayed and “ooooooooohhhhhh” your way through them. You kicked arse Darls. You did so well! You stayed calm in between them. You seemed to 'fade off' and only come to a little bit when I offered you water or tea. You kept your eyes closed and breathed softly. When you felt another one coming you would open them and let me know. And I'd say “ok, let's go then”. I hoped you felt my strong presence and support through them.

Your waters broke! You told us all and we all said, good! It can be an alarming feeling. The next contraction had you giving a wee grunty push at the height of it. Kelly asked if that was a push and you said “ I think so!”. I told you your energy might change now. You woke up completely and let the contractions work your

baby down. Then her head was out! We didn't realise her whole head was out though, we all thought just a bit was eased out. You had a feel and said she had hair! Sam and Ashleigh were right by the pool now eagerly waiting. Was so exciting!

Kelly had you lean back in the pool and the next contraction you gave a huge push and she was out! You bloody did it! She was caught by Kelly and passed straight to your chest. You sobbed "oh my baby girl! I did it". Alan said "Just beautiful. Amazing". He was totally in awe of you two. A beautiful moment, thank you. I cried and couldn't speak.

Chloe came home right after and saw you and the baby and she was gutted she had missed it and overwhelmed with emotion. She sat next to me right by your head and cried and I cuddled her.

When it was time to cut Maia's cord, I helped Chloe hold her in the water and she cut her cord. Then she was given to Alan. I bossily told him to take off his top (sorry Alan!), but babies love skin. He snuggled her on the couch under a blanket. Was lovely. She acclimatised to the outside snuggled safe on her daddy's chest listening to his heart. Was such a love filled moment. She was so calm and content.



Baby Maia

You caught your breath in the pool while Kelly showed the girls the placenta and all that stuff. You were happy to just chill for a bit and have a pause before the next huge chapter.

You hopped out of the pool and got in your robe and onto the mattress. Maia was handed to you and there she stayed for ages. when she was weighed we were all

amazed at her size. Who knew you could stash a baby that big? No tears either. What a legend.

Thank you for having me sis. I am so honoured to have been there. Love ya heaps.



Maia and her mama



Papatūānuku.

By Home Birth Aotearoa

Sep 2014

He raupapa toru o ngā wāhine toa

Papatūānuku

Ko tōku tinana, ko ōku kikokiko, ko ōku uaua, ko ōku wheua ngohe, he toka, he one, he paru, he kōhatu, he kirikiri, arā, ngā mea mārō katoa.

Ko ōku kōiwi, he rākau mātātoka, he uaua karanati, koura, hiriwa, he konukura, me ērā konu katoa, mai i ngā pekanga o tōku ira, mai i tōku pūtaketanga hoki.

Ko ōku toto, he rangitoto, he wē toka, he wai māori, he paru koropupū, e nakunaku ana i te poroiwi me te kiko ki ngā momo uaua mārō katoa.

Ko tōku hā, he pungatara, he kāpuni, he hau, he kohu, e pupū ake ana i ngā taumata kiri mārō katoa, he kiri whakahou orange. Kia puta te ora ki āku tamariki, āku mokopuna, tae atu hoki ki a rātau taihuānga maha i puta. Ko ngā ngāherehere ērā, ngā whakatipu, ngā moana, ngā awa, tae atu ki te hunga kararehe, e kākahutia nei au. Ko rātau tōku korowai, e manaaki nei i a au.

Koinei tōku pūrākau.

Ko Rūaumoko tāku pēpi, e ngote nei i tōku ū, he whana, he tākaro pērā i ngā tamariki katoa, kua rū tōku puku, kua wiriwiri tōku tinana, kua tūpato te haere a āku tamariki. I tō māua wehenga ko Ranginui, ka noho ko Rūaumoko ki tōku taha, i te wā i tohua e māua kia puta ki te whaiao, ki te ao mārama.

Kua tae kē ki te wā, hei wehe mō māua. Kua tae hoki ki te wā e puta ai ā māua tamariki ki te ao mārama, kia tipu ai rātau, kia mōhio ai rātau he aha ā rātau mahi. Ka whakaaetia e māua kia wēhea māua e tā māua tama a Tāne, ka takoto me ōna waewae ki te rangi, ki te pana i tōna matua, kia motu ai tā māua hononga.

Ka haere anō ngā mahi whai i ngā kupu whakarite a ngā tīpuna. I ōhakitia mai ki a tātau, hei tānga ki te ngākau wairua, i heke mai i Te Kore, i Te Pō. He taonga aroha ka whakawhiwhia ki ngā hua, kia haere tonu te āwhio o te orokohanga.

Engari ko tā te orokohanga, ko te mamae, ko te whakahere, ko te hāngaitanga, he ōrite ki te wai, me te rā mō te hunga mataora. I tō māua wehenga ka toko te wā hei whakaaroaro – he wā kitenga, he wā o te mana, he wā nō te pūngao whakahou, he wā panoni hoki.

Ko tōku korowai e kākahutia nei i tōku tinana, te tūāpapa, hei tango i te kākano mō āpōpō. Ka whakahaua e Ranginui tāna tama a Tāne, kia whakatōngia te kākano, kia whiria ki ngā muka o te korowai rā. Ka mahia e Tāne te mahi, ka ūhia e Ranginui te kākano rā ki ōna roimata, ka whāngaihia e te rā, ā, kua taea te oati o ngā rā o mua.

Koinei te tīmatanga o tōku haerenga whaimana, ko au hoki te whāea o ngā mea katoa, e hoki mai aua mea katoa ki a au.

Ka whakaaetia e māua kia whakawāteahia he wāhanga i waenganui i a māua, he wāhanga e whiti ai te māramatanga. E tipu ai ngā whakatipu katoa.

Nā, kua tukuna ngā tamariki ki te mahi i ngā mahi, ki te haere i ngā haere, ki te whakaea i ngā māmina, heoi kua wareware ētahi i takea mai rātau i hea.

Engari ka rongu au i a rātau, e tuku karanga mihi ana ki a au, me tā rātau mōhio e kore rātau e wareware. Kua karanga rātau ki te rā hou, ki te whakahōnore i te hunga kua huri ki tua o te ārai, kua karanga hoki rātau ki a māua, ngā mātua o te ao, te matua o te rangi, me te whāea o te whenua.

Ko au te whenua, ko Papatūānuku au.



Papatūānuku

My flesh, muscle, sinew, and cartilage are composed of rock, granite, dirt, mud, stone, sand, and all that is dense and solid.

My bones are fossilised trees, veins of granite, gold, silver, copper, and all precious metals, branching from my core, from the centre of my being.

My blood is molten lava, liquid rock, water, boiling mud, nourishing bone and flesh through a labyrinth of rigid veins.

My breath is sulphur, gas, air, and mist, seeping through countless layers of hardened skin, a skin of regenerating life. Life for my children, my grandchildren, and the countless offspring which derive from them. They are the forests, plants, seas, rivers and creatures which clothe me. They are my wondrous korowai which sustains us all.

This is my story...

My newborn, Rūaumoko, suckles at my breast, kicks and plays as any child, causing my belly to rumble, my body to shudder, and my children to be wary. Rūaumoko stayed with me when I was separated from Ranginui, Sky Father, when we chose to allow light to come between us.

It was the right time for us to grow apart, my husband and I. It was also the right time for our children to grow and understand the responsibilities of becoming all they possibly could. And so we allowed our son Tāne to brace himself against me, to thrust his legs upward, pushing Sky Father away, to sever our embrace.

And the journey of following the unspoken words of our forbearers continued. This was their gift to us, an imprint in our consciousness, handed down from Te

Kore, the nothingness, through Te Pō, the nights. A gift of love which we in turn passed on to our children, to continue the cycle of creation.

Creation requires pain, requires sacrifice, requires possibility and belief, as food, water and light for any living thing. Our separation was a time of inward turning – a time of discovery, a time of power, a time of regenerating energy, a time of change.

My korowai which cloaked my body in the past was also the foundation to receive the seed for the future. Ranginui instructed Tāne, our son, to plant the seed, to weave it into the tapestry of my korowai. And as he did so, Ranginui's tears nourished the seed, so too did light give the seed food, fulfilling a promise from the past.

This was the beginning of my journey as the mother of all, from whom all living things are created, to whom all will eventually return. We had allowed our children to create a space between us, a space which admitted light. Light which allowed growth and the ability to stand tall. And now that our children have been free to create whatever their will desires, some have forgotten from whom they came.

But I hear them calling, a karanga of acknowledgement, of understanding that they will not forget. They call to celebrate a new day, to honour those who have passed to the next world, they call to acknowledge their ancestral parents, Sky Father and Earth Mother.

I am Papatūānuku, Earth Mother.

“The mythological origins of Maori society are laid out in three major myth cycles, beginning with the creation myth of Ranginui, the sky father, and Papatuanuku, the earth mother. The second sequence of myths deals with the adventures of the demi-god Maui, who fished up the land and brought many benefits into the world for humankind. The third series of myths deals with the life of Tawhaki, the model of an aristocratic and heroic figure. The central characters in the myths are gods, their progeny and their human descendants. The stories are narrated in prose form, with the notion of an evolutionary sequence conveyed by the storyteller linking the main characters through the traditional method of genealogical recital. Inherent in the genealogy of earth and sky, the gods and their human descendants is the notion of evolution and progression.”

- Walker, Ranginui, Ka Whawhai Tonu Matou:
Struggle Without End, Penguin, Auckland, 1990.

Content supplied by the Ministry of Education <http://www.minedu.govt.nz/>



Whenua to whenua.

*By Home Birth Aotearoa
Sep 2014*

When a baby is born to the people of this land (tangata whenua), to Maori, it is customary to bury the whenua or placenta in the earth, to return it to the land. Most often the whenua is buried in a place with ancestral connection, and is considered a physical and spiritual link to the place of birth. This act has deep cultural and spiritual importance, as the land is a source of identity for Maori. Being direct descendants of Papatuanuku (Earth Mother), Maori see Maori as not only of the land, but as the land. The living generations act as the guardians of the land, like the tipuna (ancestors) had before them. The uri (offspring/descendant) benefit from that guardianship, because the land holds the link to their parents, grandparents and tipuna, and the land is the link to future generations as well. This tradition comes forth from the idea that tangata whenua were first made from earth, from the body of Papatuanuku, who birthed all creatures and living beings. This leads us to understand why the word whenua has a dual meaning, meaning both the placenta - the tree of life that supports a baby through pregnancy, and also the land that connects us all. From earth people come and to earth they return.

*Ma te wahine ka tupu ai te hanga nei, te tangata;
Ma te whenua ka whai oranga ai.
Whai hoki, ki te tangohia to wahine e te tangata ke,
Ka ngau te pouri ki roto i a koe.
Na, ki te tangohia te whenua e te tangata ke,
Ka pau to pouri ano.
Ko nga putake enei o te whawhai.
Koia i kia ai, He wahine he oneone, i ngaro ai te tangata.*

*Woman alone gives birth to humankind,
Land alone gives humans their sustenance.
No man will lightly accept the loss of
His beloved wife, nor that of his sacred land.
It is said truly that man's destroying passions
Are the love of his wife and love of his land.*



Tree of Life Whenua print - Jil O'Brien

Whenua were traditionally placed in hollowed out hue (gourds), earthen pots or woven baskets and then buried to return them to Papatuanuku. These vessels are called ipu whenua. The whenua and pito (umbilical cord) of the first human created from earth were buried in the earth. This is the origin of the proverb 'He taonga no te whenua, me hoki ano ki te whenua' (What is given by the land should return to the land).

During the colonial period in New Zealand, the practice of placenta burial was taken away from Maori. Placentas were treated as medical waste, and the burial of whenua was considered primitive, unhygienic and superstitious. Whenua burial found a resurgence when in 1984, a group calling themselves Te Whanau o Maungarongo first promoted the idea of recreating ipu whenua. The group was initiated by Paparangi Reid (Te Rarawa), now Head of the Medical School in Auckland; the late Heraina Marsden (Ngai Takato, Te Aupouri, Patukoraha), daughter of the renowned tohunga (expert) the late Reverend Maori Marsden; and kaihanga uku (clay worker), Manos Nathan.

These three championed the idea of ipu whenua coming back to the people, especially when Manos and his wife were entering into the realm of childbirth. "It seemed the most logical thing to do to start creating ipu whenua and

reinvestigate the rituals or practices within Maoridom... The concept of these vessels for whenua (the placenta) is the binding of a person to place, affirming whakapapa (genealogy) and links to turangawaewae.” Manos Nathan

Their initiative encouraged whanau to make ipu whenua in uku (clay) in order to hold the whenua until it could be buried in a place of significance. This practice is now very commonplace, not only with Maori and within the Maori midwifery community, but it’s also gaining ground in non-Maori in New Zealand.



Photo of ipu whenua generously gifted by Robin from Seed of this Land Photography. <https://www.facebook.com/seedofthisland>

Making your own ipu whenua can be a simple and loving activity, undertaken whilst pregnant as preparation for the journey of labour and in honour of welcoming a new child into the home. For a tutorial on how to make your own, easily constructed and price conscious placenta vessel, [this tutorial](#) is a great place to start.

You can also make a vessel out of clay, and because the ipu whenua does not need to be fired, very little equipment is required – some clay, a plastic mat and

some shaping tools at the most. Some regions have workshops available. Lisa Kelly of Te Ha Ora has offered some photographs from the workshops she runs in Eastern Bay. These workshops which are focused on kaupapa Maori, offer an antenatal and parenting education programme for hapu mama and whanau. Phone 0272293086 for bookings or enquiries.







A couple crafting their own vessel out of clay.



We follow midwifery students.

By Home Birth Aotearoa

Sep 2014

Lian Pansino - Midwifery Student 3rd Year



The nomadic student lifestyle has brought me to the Western Bay of Plenty - and although it lacks the warm weather of the tropics, it still manages to boast unbelievable fruit! The last few months have been a stark contrast to my previous placement in Rarotonga. In the Bay I've been living and breathing midwifery!

My base has been in Katikati where I lived with Trudy Hart and family. Trudy is what I would describe as a wise woman; one of many wise women I've come to know in these parts. She has a wide breadth of knowledge which has helped inform me on topics like breastfeeding, vaccinations, and knitting. Along with her sharing of knowledge Trudy has kept me fed and in clean clothes, something that may have been unachievable if I were left to fend for myself on this busy placement. Busy it was, in 14 weeks I attended 30 births with Katikati Midwives! This involved births at home, the primary unit in Waihi, and Tauranga hospital. I had the pleasure of working with wonderful women and families from a variety of socioeconomic and ethnic backgrounds who had one thing in common, they had gorgeous physiological births and became outstanding breastfeeders! Unlike in

Rarotonga, this placement has involved babies enjoying immediate skin to skin with their mothers, delayed cord clamping, and choices for mothers throughout pregnancy, birth, and post-partum.

The majority of these women were with the midwife Veronika Muller, another wise woman who happened to be my preceptor! During my time with Veronika I was exposed to her knowledge of naturopathy, acupuncture, and 30+ year's midwifery experience. Besides an overwhelming number of normal physiological births (yay!) this placement was marvellous because she really allowed me to be 'the midwife.' By providing a space where I could be myself has meant that I feel confident and prepared for my new graduate year. Also, my understanding of physiological birth has grown tremendously, making me feel assured that next year I will be able to support women through pregnancy and onto normal births. The number of births I attended could not have been achieved without the generosity of women working with midwives Judy Bellamy and Glenys Perry. I am so grateful for the experience I gained and for these midwives' teachings. I'm going on now to my final placement with yet another wise woman, Anne Sharplin. Her knowledge and experience with birth at home is going to be a valuable addition to my learning. I look forward to the new experiences that await me in Tauranga and the beautiful families and babies I'm about to meet!

Christie Grace-Beck - Midwifery Student 2nd Year



Now two-thirds of the way through the year and the idea of second year ending makes me very excited! My list of assessments and exams is slowly shrinking and the sun shining outside is tricking me that its almost summer. The last few months have been incredibly busy for my husband and I as we have been competing in a cooking show for TV. I know I'm mad..somehow juggling 2nd year midwifery and suddenly deciding to be a TV personality! But I've decided that if my classmates can juggle children and this degree then its pure lazy for me not to have my hands full.

During one of our photoshoots the special effects man strikes up conversation..

"I hear you're studying to be a midwife?"

“Yes, I am, I love it!” I respond, meanwhile trying to maintain my composure as the cameras pan around.

He then continues on to inform me that he delivered both his children at home, all by himself. He is beaming with pride at this.

It is another moment in my life where people share their experiences, wanting nothing but to share their joy and give appreciation for midwives. How wonderful to be in a profession where there is so much love and support, even from tough men.

Aside from that, the course is getting increasingly harder and it is necessary because we have the lives of women and their babies in our hands. As much as I love the aspects of midwifery that allow us to sit back and observe and leave women to birth in peace, there are scenarios where we need to have all the knowledge necessary to cope with what falls outside of the norm. This is the hard part and what I keep my head buried in books for.

Midwifery is a roller coaster and I’m not particularly fond of roller coasters but the ups of this course are thrilling and with the end in sight I know that the Polytech will do everything to ensure we graduate as a class of very competent midwives. Bring on exams and then 3rd year!



Eggplant Parmigiana with a Little Twist.

*By Sian Hannagan
Sep 2014*

Eggplant parmigiana is traditionally a summer dish, made with aubergines in full harvest, it is a rich, nourishing meal that makes best use of fully ripe tomatoes, fresh basil and summer produce. This version is a little lighter, making use of spring vegetables from the garden for a fresh tasty treat. It's a little early for eggplant but some of the earlier lightly speckled or white varieties will be showing up in the markets soon. If you can't find eggplant then zucchini, new season fennel bulbs, cauliflower or Jerusalem artichokes are all good alternatives. Other tasty additions are seared ramps, bell pepper or spring onions.



In Italy, eggplant parmigiana (or Melanzane alla Parmigiana) is a classic southern Italian dish that originated Naples, the version we know today, with its parmesan cheese and tomato ragu, first appears in print in Ippolito Cavalcanti's *Cucina teorico-pratica* published in 1837. Much more recently this dish has gained notoriety for bringing women to labour if they are past their expected due date. There is nothing in this dish that has been associated with the hastening of labour and along with the Home Birth ethos we tend to let nature take its course. However this is a deeply comforting and nourishing dish that can be gifted to new mothers or frozen down for eating later.

In the traditional dish, the eggplant slices are crumbed and fried, this is labour intensive (excuse the pun) and can end up with a very greasy final result. In this recipe the slices are flash grilled in a hot pan or griddle or even oven baked for a less greasy result. A lot of older recipe books call for eggplant to be salted and rinsed before cooking, this is usually unnecessary as eggplant varieties are now a lot less bitter than they historically were. To prepare your eggplant, all you need to do is slice into thick slices and grill as desired.

This dish is made from three primary components and then baked. It takes a while and is best done on a sunny afternoon when you can open all the doors and windows and let the beautiful cooking smells tempt the neighbourhood.



Ingredients

2 large onions

1 whole head of garlic

1 litre or more of tomato passata (or oven roasted tomatoes)

Fresh or dried oregano (or both)

Chilli flakes to taste

1 teaspoon smoked paprika

Olive oil

Stale bread (or fresh if you have no stale)

Fresh herbs from the garden

Parmesan cheese (any hard cheese will do, even tasty cheese at a pinch)

Ricotta (cottage cheese will do)

Mozarella cheese (edam will do)

Eggplant (or cauliflower, or zucchini, or whatever else you feel like)



Breadcrumbs

The breadcrumbs are an essential part of the dish, bringing it together and giving extra crunch on top. The best breadcrumbs come from stale bread. A thrifty household stores any old bread heels and crusts to turn them into homemade bread crumbs. If you don't have any stale bread, then toast will do.

In your food processor toss in chunks of bread or toast with a lug of oil and some fresh herbs. Blitz until it forms coarse crumbs – you'll need a cup or two so be generous. If you don't have a food processor then a blender can work, or making good use of a broad bladed sharp knife. To add more flavour you may want to toast the crumbs gentle before adding to your dish.

Marinara Sauce

If you're in a hurry, you can skip this step and just use plain passata or tomato puree, but the final dish won't have the same depth of flavour.

In a heavy bottomed pot warm some olive oil and very gently sauté your finely diced onions, once they are translucent add in a whole head of crushed garlic. If peeling garlic makes you heave a heavy sigh, then check out this [amazing hack](#) that will change your life when it comes to garlicky goodness. Stir in some paprika and a pinch of chilli flakes, then add your passata. Once it has heated through add your oregano and then turn down to a low heat for 30-40 minutes. Season with salt and cracked pepper to taste.

When I make eggplant parmigiana I make a few dishes at once, and that way I can freeze a few meals for another day. If you want to do this you'll need to double or triple the marinara sauce quantities.

Grilled Vegetables

Traditionally eggplant was used, but as discussed, any vegetable with 'body' can be used as a base for this meal. I made one with golden kumara last winter that was delicious. A griddle pan is ideal, but any cooking surface that can reach high temperatures is ideal. Slice your vegetable into 1cm thick slices and grill or char until the surface is seared. To prevent sticking you'll want to brush the surface with a layer of oil before frying. Coconut oil is a good option to prevent denaturing of oil at high temperatures.

A note on cheeses

Obviously as this dish originated in Italy the cheeses used are common to that country, proper mozzarella, parmiggiano and ricotta are much harder to get here in New Zealand at a reasonable price. Luckily, this dish is very forgiving, and almost any cheese can be used effectively. Feta would add a nice sharp fresh bite to it, creamy havarti would make

it a much more luscious flavour and there is nothing wrong with using the cracked old heel of cheese lurking at the back of the fridge.



Parmesan and Mozzarella cheese.

Optional

Traditional versions of this dish include sliced boiled egg, this is a perfect spring addition if your chickens have just taken up laying again or free range eggs are readily available in stores.

Building the dish

In the bottom of the dish add a smear of marinara sauce before adding your first layer of eggplant. On top of this sprinkle a few breadcrumbs and some cheese. Then add another thicker layer of marinara sauce. At this stage you can add any fresh herbs or wilting vegetables you'd like. Sauteed spring onions or ramps are a delicious addition. Repeat your layering until you are 1 cm away from the lip of the dish (over filling will result in spillage) The final layer should be cheese and then a good generous sprinkle of breadcrumbs.



Baking 2-3 at once saves on labour and keeps the freezer stocked.

Bake in a 180 oven until the dish is bubbling around the edges and bleeding through the crumb layer (about an hour). Ideally you wouldn't serve this dish hot, but just above warm. It's even better reheated the next day.

This dish is delicious served on its own or with a fresh salad and fish or lamb.



The final dish. Mmmmm





Spring.

By Juliet Batten

Aug 2014

The shutting down and huddling in of winter is over! Spring is the season of awakening and regeneration. New shoots push themselves through the earth, vibrant green leaves open in the sunlight and bright flowers adorn the gardens and streets. The warmth of the sun draws us outside to walk, play, and run barefoot on the grass or beach.



Image of Kiokio supplied by Juliet Batten

Open your senses

SMELL the sweet fragrance of flowers. What can you smell in the garden? Maybe freesias, magnolias, daffodils, bluebells, violets . . .

What native flowers can you smell in the bush? – maybe the honeyed fragrance of mahoe, tarata or karo.

LISTEN to the birds, for this when they return from winter migration. Can you hear the riroriro trilling in the trees? For Maori, the riroriro (grey warbler) was singing a wake-up call, reminding everyone it was time to plant. The koekoea (long-tailed cuckoo) sings ‘koia! koia!’, ‘dig! dig!’ The pipiwharau (shining cuckoo) sings ‘kui! kui!’—‘no food! no food!, because the stored crops were now running out.

Tohunga used to put their ears to the ground, and listen to the earthworms awakening.

TOUCH the earth, and feel how it is warming, and making a home for seeds to sprout in. Feel the grass under your bare feet.

SEE new growth everywhere. Look for kowhai, manuka, creamy clusters of rangiora or fresh white puawananga (clematis) flowers.



Image of Kowhai blossom supplied by Juliet Batten

Spring picnic

To celebrate as a family, you might like to hold a picnic, with fresh food of the season: green food, such as asparagus and salad is ideal, (though not always the favourite of little children). Maybe you can serve honey cakes and dye eggs in honour of Eostre, goddess of the spring: use beetroot for pink eggs, onion skins for orange, spinach for green. (If you can find white eggs, they will dye much brighter than brown ones.)



Image of decorated eggs supplied by Juliet Batten

The Green Man and dancing

In old Europe a Green Man, representing the spirit of nature, would appear and dance at the spring festivals, bedecked in so much greenery that his face could not be seen. Maybe a Green Man will come out of the trees and dance at your spring picnic.

You too can dance to welcome spring. Find some bright music, maybe flute music, or songs that make you want to move lightly, with joy. You might make spring crowns to place on each other's heads and then dance around a tree, remembering the maypole dances of old.



Image of maypole supplied by Juliet Batten

Digging and planting

To celebrate the arrival of spring, dig a little patch of earth and plant some seeds—maybe some mustard and cress, or radish—and watch them sprout and grow. If the weather still feels cool, you can plant the seeds inside, in a pot, or sprout some wheatgrass in a dish lined with blotting paper and watch the bright blades as they shoot up.

Before planting, ask the children to think of a wish, something hopeful that they would like to happen in their world. Then plant and water the seeds with the intention of watering this wish, this hope. As you watch them grow, feel that hope is growing as well.

Spring Festivals:

September 23: Spring equinox, when light and dark are equal, Eostre, Te Koanga.

October 31: Flowering and Sap-Rise, Whiringanuku, Beltane.

Note: 'Flowering and Sap-Rise', the time of peak greening, is often overlooked because we have superimposed the northern hemisphere festival of Halloween upon our southern season of spring. What can be done about this? I will be posting a Seasons Newsletter on the subject in the weeks to come.

You can sign up to receive the Seasons Newsletter on my website www.julietbatten.co.nz

For further spring activities for children and communities, see my book, *Celebrating the Southern Seasons*. The revised edition, published by Random House in 1995, includes additional material for each of the eight seasonal festivals of the year. You will learn when to plant kumara, how the word 'bonfire' got its name, and why the Celts lit bonfires in high spring.

The sequel, *Dancing with the Seasons*, published in 2010, includes further activities as well as stories for the seasons. There you will discover why spring equinox is the time to dye eggs, and why Easter is a spring festival.



To check out my books, go to www.julietbatten.co.nz

<https://www.facebook.com/JulietBattenBooks>

Or my blog www.seasonalinspiration.blogspot.com

© Juliet Batten 2014

Please give photo credit for any images used.



What's Happening in Spring.

By Home Birth Aotearoa

Regular Catch Ups for the Regions

Dunedin Homebirth Association meet monthly at the Hub, first Tuesday of every month. Bring food to share. Anyone welcome.

Otepoti Dunedin Babywearing meet twice a month - last Wednesday of the month 10-12 at the Hub - Babywearing Library and experienced babywearers available. For folks with their own carriers meet every 3rd Monday of the month 10-12 at the Hub - no library use on this day.

CHOICE BABY -Nelsons Natural Parenting and Home Birth Group meets monthly in Nelson, second Monday of the month. For more details see their website [here](#).

Tauranga HB support circles every 1st and 3rd Tuesday of the month. Where: Maungaarangi Kindergarten/Whanau Centre. 22 Esmeralda Street, Welcome Bay. What: Bring your lunch or a healthy snack to share Children welcome - play area available.

Manawatu get-togethers are open to anyone interested in Home Birth. Get-togethers take place on the 4th Thursday of each month, 1.30-3.30pm. Please see our blog for more details.

Natural Birth Southland meet on the 4th Friday of each month at the parents centre rooms @ 25 Exmouth st 10.30 - 12.30. We would love to see you there.

Waikato Home Birth monthly support circles are held on the 2nd Tuesday of each month at Parents Place in Boundary Rd, 10am - 12pm. Join us on facebook

Positive Birth Wellington We hold regular discussion meetings on the third Tuesday of every month, open to pregnant women and their partners, new mums, birth partners, midwives and anyone wanting to support a positive birth community. 7.45 -9.15pm 137 The Parade, Island Bay, Wellington,

What's Happening in Spring?

Events Calendar -- Homebirth in Aotearoa

September 2014

Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23 Te Koanga	24	25	26	27	28
29	30	31				

October 2014

Mon	Tue	Wed	Thu	Fri	Sat	Sun
		1	2	3 LLL Conference	4 LLL Conference	5 LLL Conference
6	7	8	9	10 Homebirth Hui	11 Homebirth Hui	12 Homebirth Hui
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31 surprise Beltane		

November 2014

Mon	Tue	Wed	Thu	Fri	Sat	Sun
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

To submit events to appear on this calendar please email editor@homebirth.org.nz

For more information on events check out our website www.homebirth.org.nz

Home Birth Matters

Homebirth in Aotearoa

