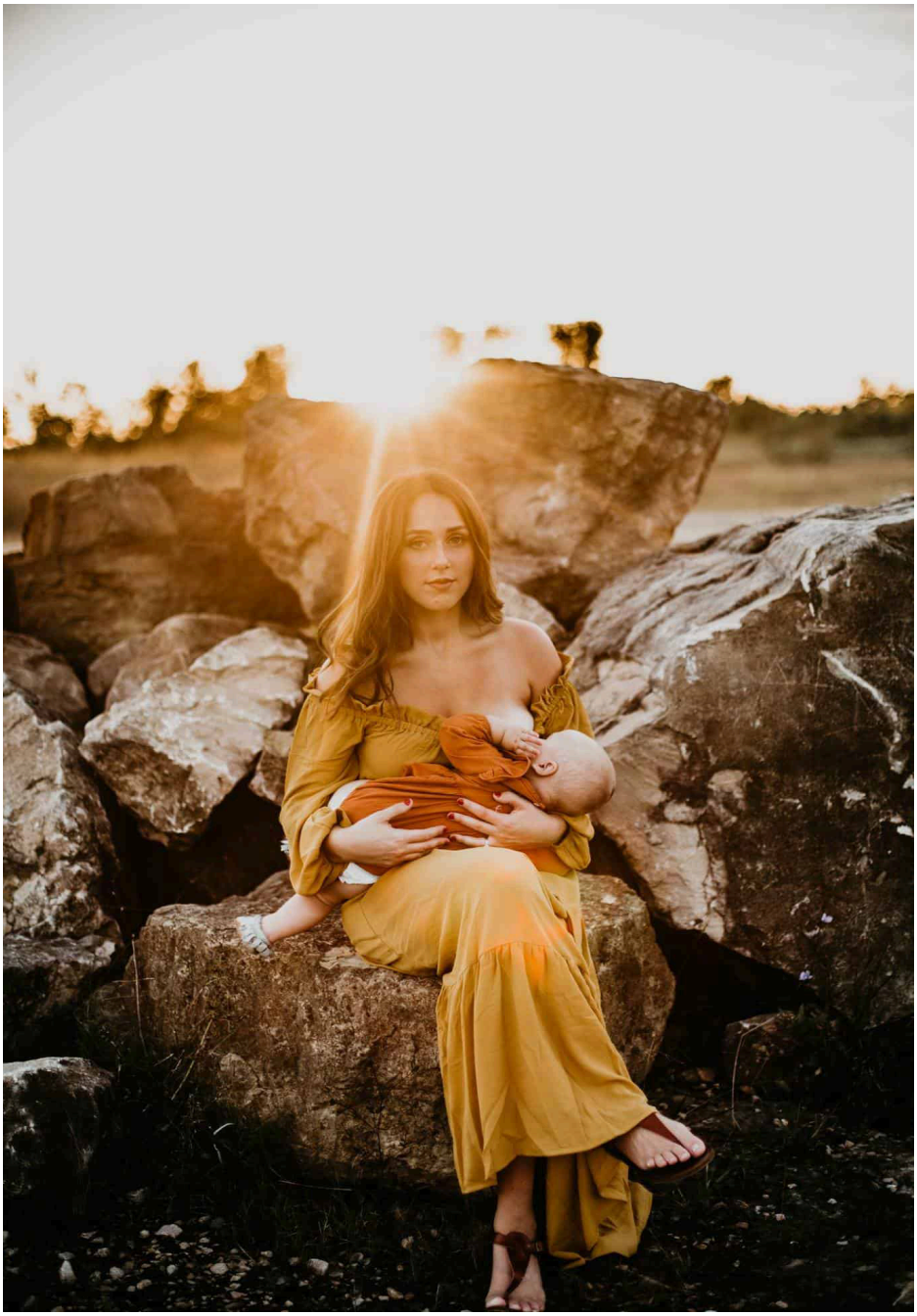
Childbirth Education Association

March 2020
Free

Childbirth Chatter



IN THIS ISSUE ...

High Risk Pregnancy - Gestational Diabetes • Advanced Maternal Age Pregnancy• Going Past Your Due Date

www.ceadarwin.asn.au

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Childbirth Education Association Darwin

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knowledge · confidence · choice

Presidents Message

This will be my last president's report for the CEA newsletter as I've decided to hand the torch on. I've been the president of CEA for a bit over 4 years and on the committee for about 5.5 years.

It's been a wonderful journey. I have learned so much and met so many amazing women. I feel like my involvement in CEA and the women who have come and gone over the years have made me the woman and mother I am today for which I will always be grateful.

I have also been honoured to be a small part of so many pregnancy, birth and parenting journeys. It is now time for me to focus more on other areas in life like homeschooling my eldest (who I was pregnant with when I first discovered CEA) and my business supporting women from fertility and preconception through to pregnancy, birth and postpartum. While I do feel sad about moving on, I am also excited for what the space will allow into my life and excited for the new energy and direction that CEA can take on. I will likely still be taking some classes and courses so I'm not completely disappearing.

Amy Brady Burns will be taking over my role. She is a super awesome human who I know will be amazing for CEA. I'll let Amy introduce herself. This newsletter actually contains the story of Amy's second birth and is what led us to focus on the theme of 'high risk pregnancy and birth'. So many women are given this label as part of their pregnancy and birth journeys and I think it can be helpful to hear the stories of others as well as evidence based information to help feel calmer and more relaxed on the journey, have greater capacity to make informed decisions and make your own assessment and judgement of your level of risk because at the end of the day, risk is subjective and different for everyone.

When confronted with the label of 'high risk', I think it is even more important for women to learn as much as they can so they are well informed and able to make decisions that will feel comfortable into the future. Independent birth education and additional support can make all the difference on a 'high risk' pregnancy journey. Helping women to communicate effectively with care givers, gaining the confidence to ask questions and be true participants in their antenatal care.

Thank you for all of your support over these years, I'll look forward to seeing you around soon.

Bec

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Katie Lucus

Thank you to Michael Gunner and Natasha Fyles for your assistance with printing

Cover Photo taken from www.sarahgraybealphoto.com

All Courses & Workshops Now Online Via Zoom

Birth Preparation Courses

May
Wednesday 6th, 13th, 20th, 27th May
6:00pm to 8:30pm/9:00pm on 27th May

June
Saturday 6th, 13th, 20th, 27th June
1:00pm to 3:30pm/4:00pm on 27th June

Try before you buy. The first week is free - if you like it and want to complete the course you then pay.

Private courses are also available if these don't suit your schedule.

Early Parenting

28th April 5:30pm to 8:30pm,
27th May 6pm to 9pm
27th June 1pm to 3:30pm

Active Birth Workshop

Saturday 30th May 1pm to 4pm

Infant Sleep & Settling

Saturday 16th May 11am - 12noon
Just $10.00

Birth Preparation Course Outline

Session One: Pregnancy & Creating Your 'Mind-set' For Labour & Birth
Welcome
Pregnancy - nutrition, self care, building your support group for early parenting
Birth Planning - a useful birth plan is not your ideal birth written down on paper
Informed Choice
Thinking about Pregnancy & Birth - not an ill-ness or 'risk' but a normal healthy life event
Cultural Ideas Around Pregnancy & Birth - how this influences us
Fear Release Work
HypnoBirthing Explained
The Hormones of Labour
Rebozo for Pregnancy
Why Normal Birth is Important
The Importance of Your Due Date
Role of Your Birth Support Person
Roles of Care Providers - OB's, Midwives, Doulas
How/Why Does Labour Start? Physical/Emo-tional/Spiritual
Question Time

Session Two: Labour
Recap of Week One
Relaxation Meditation Practice
Induction - your choices around this, why, when, where, what to expect
The Cascade of Intervention
Hormones & Induction
Why Your Birth Environment Is Important
Creating Your Ideal Birth Environment
How Contractions Work
First Stage of Labour
Using Natural Birth Tools To Manage Labour
Active Birth Positions/Movement
Medical Pain Relief Options
Water
TENS Machine
'Birth Media' - every birth is unique
Question Time

Session Three: Birth
Recap of Week Two
BRAIN Decision Making Tool
Instrumental Birth
Gentle C-Section
More Labour Tools - soft touch massage, rebozo at birth, breathing, supported holds, vocalisation
Second Stage of Labour (Birth)
Directed Pushing vs Instinctive
Avoiding Tears
Post Partum Haemorrhage
Third Stage (Birthing Your Placenta)
The Importance of The First Hour After Birth

Session Four: Early Parenting Workshop - The Fourth Trimester For Baby, Mother & Family (3 Hour Session)
What Babies Need -
Physical, Emotional & Developmental
Your Baby's Experience Of The Fourth Trimester
Baby-Wearing
Breastfeeding
Baby & Parent Sleep
Developmental Milestones
What New Mums Need
Understanding Hormones
Brain Changes
Traditional Postpartum Practices
Mum's Experience Of The Fourth Trimester
Physical Recovery from Birth
Partner's & Team Building
Maintaining Your Relationship
Question Time

Check our website for on-line booking forms... www.ceadarwin.asn.au
or email the office ...
info@ceadarwin.asn.au

Like our facebook page for dates of future events & courses along with regular posts about birth, parenting and

Birth Education Classes

Birth Preparation Classes are held over two or four weeks and encompass body, mind and spirit. Includes breastfeeding information.
Cost: $220 for two participants

Active Birth
Teaching mothers and birth companions techniques for comfortable and satisfying birthing through positioning, movement, vocalisation and special breathing. Workshops are held quarterly in one three hour group session.
Cost: $120 (Includes up to two support people)

Private Birth Classes
You may prefer a more personalised course. Incorportating specific elements of our other courses. One that fits with your and your birth partners schedules.
Cost: Dependent on time - approx. $80/hour

Early Parenting Workshops:
Designed to give parents-to-be knowledge and skills to enhance those first precious hours and weeks with your newborn. Topics include: normal infant behaviour, sleep and settling, breastfeeding, the infant microbiome, self care, team building for new parents and much more.
Cost: $120 (includes partner or support person)

Please email the office for more details regarding any of these courses. info@ceadarwin.asn.au

Pregnancy Yoga Classes

Pregnancy Yoga: An antenatal yoga class with asanas appropriate for pregnancy. relaxation techniques, visualisation, pelvic floor exercises & strength work are included. The library will be open after the class.
Classes are held Saturdays 11.30am - 12:45pm

Mother & Baby Yoga Classes

This gentle yoga class allows you to nurture your self & restore body, mind and spirit through the early months of motherhood. Fridays 10am to 11:30am

Cost: For either Yoga class $12 or buy a 5 class pass for $48.00

Nurturing Newborns Morning Teas

(Suitable for Babies from Newborn To Toddlers)

A chance to meet with other parents in a relaxed environment, have a cup of tea and share a delicious Petra's Raw Food Cake.
Topics for each session are posted to facebook
Please see the schedule later in this Newsletter.

Last Tuesday of every month 10am to noon
Nightcliff Community Centre
Cost: Free

CEA Library

Our library has an extensive collection of books, magazines, DVDs and CDs covering a wide range of subjects such as Pregnancy, Labour, Birth, Parenting, Vaccination, Exercise, Nutrition, VBAC, Waterbirth, Twins, Toddlers, Crying/Sleep, Special Needs Babies, Grief/Loss, Alternative Therapies, Fathers, Grandparents, Midwifery, Stories and more!

What Is A High-Risk Pregnancy? & Tips To Reduce Stress If This Is Your Journey

A high-risk pregnancy is one in which the mother, her baby, or both are at higher risk for health problems during pregnancy or labour than in a typical pregnancy.

For example, women who have chronic health problems prior to pregnancy such as high blood pressure or diabetes may be considered to have high-risk pregnancies even if the condition is well controlled. Other factors such as infections, injuries and disorders of pregnancy can also change a normal pregnancy into a high-risk pregnancy.

Women whose pregnancies are considered high-risk may need specialised care or treatment to have a healthy pregnancy and delivery. The specific type of care needed will depend on the specific risk factors, as well as the overall health of the mother and the baby.

In this edition of Childbirth Chatter we will have a closer look at some of the most common reasons that women are categorised as high-risk when they did not suffer from any pre-existing health conditions and explore these scenarios.

1. Gestational Diabetes
2. Advanced Maternal Age Pregnancy
3. Postdate Pregnancy (Pregnancy that has continued beyond 41 weeks gestation)

If you find yourself placed in a high risk category here are some tips to help you manage the possible emotions and stress that can come with that label.

1. Get an emotional support team together of people you trust and who have your best interests at heart. They should be people who will let you talk about your emotions and debrief your fears and anxieties. If no-one in your family or friends circle is appropriate try using a professional Doula.

2. Find others who are in a similar situation. Having a connection with others facing a similar situation takes away the fears that what you are gong through is unique. There is solidarity in knowing there are others who are dealing with the same fears and worries. People in a similar situation may have information for you or have useful questions that you hadn't thought to ask before.

3. Don't Google. Google can often result in you finding a lot of worst case scenarios and you may end up with more fears and worries than you had when you started. If you do Google make sure you write down all the questions that arise from your research so you can also ask your 'real life' health professionals for their perspective.

4. Adjust your mindset to expect more appointments and tests along the way. It may be necessary to speak to someone at your workplace to let them know what is happening. Don't take on extra stress trying to meet obligations that are no longer realistic.

5. Find a doctor/ob who you connect with and feel safe with. A big part of navigating a high-risk pregnancy is managing feelings. A doctor who does not rush you and explains things well will help make the process much easier. If your birth environment does not adequately provide for one-on-one care create your own one-on-one scenario and engage with a Doula. They will be able to come to appointments with you and help you to debrief feelings and emotions that arise.

6. Take time to research your situation using evidence-based resources. Take ownership of what you can do to help your condition eg. if you have gestational diabetes follow the special diet recommended and engage in other lifestyle recommendations to manage your blood sugar levels.

Always remember - just because a pregnancy is considered high risk does not mean that a problem will definitely occur.


HIGH RISK PREGNANCY
SOME COMMON FACTORS CAN MAKE A NORMAL PREGNANCY INTO A HIGH RISK ONE.
OVERWEIGHT AND OBESITY.
YOUNG OR OLD MATERNAL AGE.
PROBLEMS IN PREVIOUS PREGNANCIES.
EXISTING HEALTH CONDITIONS.
PREGNANCY WITH TWINS OR MULTIPLES.
LEARN ABOUT REDUCING YOUR RISKS AND HOW TO STOP PROBLEMS BEFORE THEY START.
@SECONDOPINIONTV

Gestational Diabetes

What is Gestational Diabetes? Gestational Diabetes Mellitus (GDM) is high blood glucose (high blood sugar) that develops during pregnancy (ADA, 2018).

To understand Gestational Diabetes, it's helpful to first learn how the body metabolizes sugar. After you eat or drink carbohydrates (often called "carbs"), your gastrointestinal system digests carbohydrates which then enter your bloodstream as glucose (often called "sugar"), which your body must turn into energy.

In order for your body to use the glucose to make energy the glucose must be moved from the blood into cells. Insulin is a hormone produced by the pancreas that helps move glucose from the blood into your body's cells, where the glucose can be turned into energy that fuels your body's functions. Insulin also helps convert extra glucose into fat for storage.

All pregnant women experience some metabolic changes during pregnancy. In a normal pregnancy, hormones from the placenta make it harder for your body to use insulin—you may require up to three times as much insulin to overcome the increased insulin resistance (ADA, 2016). Insulin resistance means that your cells are resistant to insulin moving the glucose into them —it's kind of like if a neighbor (i.e. insulin) keeps knocking on your door (i.e. cell) with gifts of food, and over time, has to knock louder and louder to get you to open the door! In a pregnancy that is not complicated by gestational diabetes, it's harder for insulin to 'open the door,' but the body begins to produce more insulin, this is enough to overcome the resistance.

However, with Gestational Diabetes, there is too much insulin resistance, and the body does not react to produce more insulin (called low beta cell function), or a combination of both (Powe et al. 2016). Some women with GDM have more of a problem with insulin resistance, while others with GDM have more of a problem with low beta cell function (not making enough insulin).

Going back to our analogy, low beta cell function is like if the neighbor who is knocking gets tired over time and knocks more softly. So, with GDM, the door doesn't open because of your high reluctance to answer it (insulin resistance), the neighbor's low intensity in knocking (low beta cell function), or a combination of both factors. You can imagine that with either scenario, the neighbor gives up and takes the food somewhere else. In a similar way, when this happens with gestational diabetes, glucose builds up in the blood until it reaches abnormally high levels, called hyperglycemia.

Researchers think insulin resistance exists to help move more nutrients to the baby (instead of the mother) to promote healthy fetal growth and development (Farrar et al. 2017a). The mother's body is making sure that the baby gets enough nutrition from sugar in the blood, even if food becomes scarce for the mother. This adaptation helped us in the past, but most people today have too much food available—including too many processed foods with simple, easily digested sugars. This situation has led to more people putting on extra body weight, which tends to increase insulin resistance and decrease beta cell function, which further increases the risk of high blood sugar.

The routine tests that are done in pregnancy to identify GDM do not directly measure insulin resistance or beta cell function. Instead, the tests measure blood sugar levels, because it is high blood sugar that can cause problems for mother and baby. If you have Gestational Diabetes, treatment with diet, exercise, and sometimes medicine, is necessary to maintain healthy blood sugar levels.

Today, Gestational Diabetes is one of the most common problems of pregnancy (ACOG, 2018).

Gestational Diabetes has been linked to higher rates of:

- Pre-eclampsia
- Fetal high blood sugar
- First-time Cesarean
- Premature birth
- Higher birth weight/having a large baby
- Shoulder dystocia or birth injury
- Newborn intensive care
- Newborn jaundice
- Newborn low blood sugar
- The mother developing diabetes and/or heart disease later in life

What are the ingredients in the drink?
In Australia, the glucose tolerance test drink is manufactured by Point of Care Diagnostics (product code GTT75) and it will NOT harm you or your baby. The contents are filtered water containing 75g of glucose (Halal, Kosher, Gluten Free), food acid (330) and preservative (211, 202).

Before the test:
In the lead up to the glucose tolerance test, you should:

•Continue to eat a normal diet in the days leading up to the test.

•Consult with your doctor about any medications you're currently taking. Some medications, such as corticosteroids, beta-blockers, diuretics, and antidepressants, can interfere with the results.

•Do not eat any food for at least eight hours before your test. You can drink water, but avoid other beverages including coffee and caffeinated tea as these can interfere with the results.

•Consider bringing something to read or an activity to keep you busy while you wait as the test will take around two hours.

During the test:
•When you arrive at your local Pathology collection centre, a staff member will welcome you and outline the test procedure.

•A staff member will then take a blood sample to measure your baseline glucose level.

•You will then be asked to drink the glucose drink

•You will wait one hour in the collection centre and then a further blood sample will be taken.

•After another one hour in the collection centre, another blood sample will be taken

•Food cannot be eaten during the period of the test as it will interfere with the results. It is ok to have small amounts of water

• Exercise must be kept to a minimum during the period of the test. As mentioned, we recommend you bring something to keep yourself rested and occupied

After the test your test results will be sent to your care provider who will discuss these with you.

After the screening test if you are found negative for gestational diabetes nothing further will happen.

If you test positive you will be given a diagnosis of Gestational Diabetes. You will be asked to join the clinical register of Diabetes in Pregnancy so health care providers can find information and make decisions about treatment.

Most people use natural methods to manage Gestational Diabetes.

• eat healthily
• be physically active
• check your blood glucose levels
• sometimes (around 40%) of people need to take medication such as insulin as directed by their doctor

Receiving a diagnosis of GDM can be stressful for many people. However, the benefits of a positive test result are that you can uncover the potential for health problems before they become a real problem, and take action to improve your health and birth outcomes.

Story taken from www.evidencebasedbirth.com

Table 2: Factors Influencing the Risk of Gestational Diabetes (GDM)
(Moyer and USPSTF, 2014)

Higher Risk for GDM	Lower Risk for GDM
• Being plus-size • Increasing maternal age • History of GDM • History of having a large for gestational age baby • Diabetes in a close relative • Belonging to an ethnic group at increased risk for GDM	• Age younger than 25 years • Caucasian/white race • Weight "normal" before pregnancy (BMI ≤25 kg/m2) • No close relatives with diabetes • No history of glucose intolerance • No history of poor birth outcomes

The Birth of Daisy - a local high-risk birth story

I learned many valuable lessons from my first birth. After 4 gruelling days of early and established labour, I knew that I wanted to...
1.) Enlist the support of birth doula, Bec Ellison (my soul felt she needed to be there),
2.) Read more about working with pain during pregnancy, labour and birthing, and
3.) Get in touch with my birthing body and my growing baby through meditation and mindfulness.

I believed I was all set the first time, having done a lovely hypnobirthing course, supported by homebirth midwives, and partnered by my wonderful husband…. and, although my baby was born vaginally, healthily, and we walked out the following day, I knew that I wanted 'more' out of my next birthing experience. Spiritually, physicallyand without the aid of an epidural. So this time I worked to learn more about birth, and surrounded myself with people I felt drawn to. Then, I believe, the Universe did her thing and put key people there to support me along the way.

To say this second pregnancy was stressful is an understatement.

At 10 weeks I was advised by my GP that the D antibody was in my blood. 'No worries', I said, 'I had needles for that last time which will fix it again.' Correct, but apparently they hadn't worked last time, and this was a major concern because I couldn't receive the anti-d again. By 12 weeks I had an appointment with the specialist obstetrician at RDH, who advised us all of the risk factors of this pregnancy, and that this was now a high risk pregnancy. Although I couldn't birth at home, I was so relieved to have the continuity of care from the homebirth midwives throughout. I cannot overstate my support for continuity of care. I also asked Bec if she would be my doula early on, prior to knowing the risks of the pregnancy, as I instinctively knew I'd need her there.

What was to follow were regular hospital visits, toddler in tow most of the time, for monthly blood tests and fortnightly ultrasounds. By week 25 I couldn't take the stress of the fortnightly scans any longer. I had a bad experience with a sonographer who was quite forceful, followed by a Dr who was learning sonography and taking her time, and it got me questioning how beneficial this all was for the monitoring of my baby. So the obstetrician and I agreed to move scans out to every 3 weeks. But, over the next 3 week period, I decided I wasn't going to get another one until the end of my pregnancy (we agreed on 33 weeks). I would maintain the regular blood tests, which would indicate any spike in antibody levels, but I just felt compelled to protect my baby at this point. So, I expressed these concerns and held my right to take control of my care against some medical advice.

This baby moved significantly more than my first child (and still does), so I knew I would be able to tell if the baby was becoming unwell, because lack of movement would be a clear indicator.

So skip to 33 weeks, with routine blood tests and midwifery appointments in between. At a 33 week scan I confided that perhaps baby had started to decrease movement, which we decided to keep a closer eye on with weekly scans and blood tests. At the 34 week scan, baby was starting to show mild signs of anaemia. But the worrying concern to make us consider a caesarean 3 days later was that my blood antibodies had shot from 1 in 200 (sitting at 1 in 64 most of the pregnancy until recent) to 1 in 4000. Yep, 4000. Shit got real. We booked the Caesar, and the following day I was in the hospital receiving a steroid injection, as baby would only be 35 weeks at delivery, and wouldn't have the pressure of a vaginal birth to push fluid off the lungs.

Following the injection, I felt highly anxious and fell into a very deep depression. I came to the realisation that I didn't respond well to strong medication such as this, and such medication was needed post caesarean (endone etc). I started to question my scheduled caesarean in two days.

That evening, as I put my 21 month old to bed, I laid next to her stroking her hair and appreciating one of the last moments we'd have just the two of us. I reminisced on her long, arduous labour as I looked at her gorgeous face in the moonlight, and remembered how strong I was for the duration. I considered all of the preparation

I had done during the past 8 months to prepare me for this birth. Notably the books I'd read (Ten Moons and Birthing With Confidence, thanks to my doula), I had sought the support of a birth doula, I had been connecting with my baby regularly during mindfulness and meditation, I had prepared with the homebirth midwives and with my husband. I was ready. I was going to birth my baby vaginally next week, and I was going to achieve my goal of not utilising pain relief.

I was surprised to have my husband's full support when I came down to tell him. So, the following morning I woke up early to write out the pro's and con's of my decision. I thought of 13 pro's for induction, and only one con – I took this to the hospital to support my decision. My doula suggested post birth preferences, as well as our birth preferences, which is something I hadn't thought of and will be forever grateful for. The following day I went in to begin my induction, my parents having only just arrived that morning on an emergency flight back from their dream holiday in Europe to support us and be with our first love. Sunday morning I had a last minute rescheduled mother's blessing, led by my doula. These women didn't know it then, but each of their faces came to my mind during labour, with their heart felt intentions strengthening my every being. Sunday afternoon I went to hospital and declined the oxytocin gel, and opted for the oxytocin tape – I had learned in my first pregnancy during the hypnobirthing course that this could be removed if baby started to stress. I felt my cervix moving overnight and was happy with my internal progress, though medically the next morning I was encouraged to insert the gel – I again declined.

I practiced yoga in my room and diffused calming oils. I kept the tape in for the allowable duration of 24 hours, as my intuition told me not to rush this baby. Late that evening, I was told that the balloon would be a good option, which I accepted. The following morning it fell out, which was great news; I was 2cm dilated (note only 35 weeks gestation). Again I practiced yoga, and later that morning when my husband visited, we danced and held each other to build oxytocin and feel each other's support in this tense time. I wasn't 100% aware, but that morning at 11am I had my waters broken (which I thought was all that would happen), and the oxytocin drip started. It was on. Here we go.

We set up the birthing room and hung up sarongs to dim the midday light. We hung my favourite birthing affirmations everywhere, even in the shower, fairy lights, and diffused clary sage (which I had alternatives for, as it later makes me ill).

Compared to my first labour, which took DAYS to properly establish, this was hard and fast. We called my doula to come a couple of hours later, as labour progressed, and I felt I needed some extra support. Soon after Bec's arrival, the shower was a welcome support, as I was unable to use the pool / bath during this birth.

My birthing playlist was also something that was well thought of; I took note of what annoyed me last time, and created a soul inspiring playlist. Being almost constantly hooked up to foetal heart monitoring was a challenge, and potentially it was providing inaccurate readings, so I agreed to have the scalp clip inserted to replace the band currently on. While down there, they declared I was only 4cm dilated – what the actual f.

I felt as though I'd run a bloody marathon and more. I got pissed off. My husband's constant asking if I wanted Powerade annoyed me, as he'd made me some beautifully refreshing labour aide that I'd requested! So in the end I told him to go for a walk and get himself a bloody Powerade if that's what he wanted. Lucky he didn't, because I was birthing our baby unexpectedly within the next 15 minutes. I had been told less than an hour ago I was only 4cm, so we were all totally unaware that I was currently in transition.

Minutes later the student midwife was asking me what was going on, as I was reaching down and holding my baby's head as it started to come out of my vagina. My body knew what to do. My body knew that it had to get my baby out safely. The student midwife hit a button to call for more staff, and out came our baby. It was the ejection reflex that I'd heard of. I didn't even realise, but photos show that the paeds team and additional midwives were standing around, assessing my baby as it came into the world.

Because optimal cord clamping wasn't beneficial in this instance with the blood antibody attacking the baby's blood cells (another difficult conversation had with the paeds team prior to birth), my baby's cord was cut by my husband, and handed up to me. All I could say was, 'I did it, all by myself, I did it.' Because moments before I was defeated saying 'I can't do it', thinking I needed an epidural, unaware that I was in transition. 'You haven't even checked to see what sex it is,' a voice remarked as I took in my baby's arrival earth side.

Countless ultrasounds had been performed, and the gender of this baby was never a concern for us, we just wanted our baby here safely. 'It's a girl' I said as I looked down. 'Daisy,' named by my husband. Our baby was here, she was safe, and she was surrounded by support. I was so grateful to hold her for the first 10 minutes, before I willingly handed her to the NICU team, as I could see that she was unwell.

My husband followed them to the NICU ward close by, as I took in this amazingly powerful birth with the midwives and my doula, and cleaned up. Wow. Full on.

Our obstetrician, who stayed away during the birth so that her differing opinion on the method of birth didn't distract me (thank you), came and hugged me emotionally afterwards.

I went to see our baby Daisy before she began her initial treatment of 3 full blood exchange transfusions in her first 12 hours of life. We both went back to visit her hours later at midnight in between transfusions. We cannot thank the knowledgeable, professional staff in NICU and paeds at RDH enough for looking after our baby.

My parents first met her under phototherapy lights with her eye mask on, we could only hold onto her foot as she received intensive treatment. Her daddy got to hold her for the first time on day two, when I also got to offer the breast (as she was nil by mouth prior) and hold her for the first time since birth.

It is not until I begin writing this that I can fully comprehend how hard this time was. I often disregard the challenge, as I know parents in NICU have babies a lot more premature and in need of longer term support. But man, it was an emotionally heart wrenching experience.

I learned to stand my ground as a mama in NICU, and quickly stopped 'top ups' of breastmilk via the nasal gastric tube, and opted instead to encourage feeding from the breast. I was also resistant to leave the hospital, and pleaded to stay close by to my baby, so that we could successfully establish breastfeeding. She was allowed out of NICU on day 5 (to come to the ward

alongside me), which was Father's Day. A wonderful surprise when Daddy and toddler later visited.

Although, only 2 days later, we were told her bilirubin levels had risen again and she would need another 24 hours of phototherapy. I was distraught, and decided I could not leave her side. So on went the sunnies, and under the lights I sat with my babe for the next 18 hours, with an hour break during which my mum and husband, lovingly took my place.

The next morning the blood results were positive, and we were out of the hospital later that day, day 8 of our baby's life – breastfeeding securely established thanks to allowable closeness with my baby.

Stoked is an understatement, and our arrival home was met with welcome balloons and my toddler's beaming face. I had never spent longer than 2 nights away from her. And although she visited almost daily, 10 nights away made my heart hurt immensely.

The days to follow were spent hoping the bilirubin levels didn't rise enough for further phototherapy, and that her weight gain continued with breastfeeding.

At a glance, I look at this birth as such a happy success. Our birthing room was calm (in between Dr checks and medical conversations), I had heaps of support, I achieved my goal of no pain relief intervention, our baby arrived safely followed by the support of trained medical staff, and breastfeeding was able to be established after the 2 days of nil by mouth.

I will, importantly mention, that if this was my first birth I mightn't have been so confident about a lot of things. First being my ability to birth vaginally; I believe I might have looked past my intuition and gone with medical advice.

Secondly, was being told in hospital post birth that I wasn't 'expressing enough', which I ended up politely asking nursing staff to stop asking me about. I had only recently finished breastfeeding my toddler, 5 months into this pregnancy…. I knew I had milk, I knew it would come when I could HOLD my baby.

We have been advised not to try for a third baby. And although a third was not something we wanted to try for, it was quite sad news to be advised by RDH specialists.

Such a multi-faceted story compared to my first birth. But, as mentioned, it is one that I am so proud of and I hope you can take some love and strong feminine birthing energy from my birth story too.

I just want to thank each unique person who played such an important role in Daisy's pregnancy, birth, and post-natal period, because I couldn't have done it without you.

Story by Amy Brady-Burns

The Darwin Homebirth Group is a collective of parents who share the philosophy that pregnancy, labor and birth are normal, natural family centered events.

Our members are passionate about women having real and informed choices in regards to where, with whom and how they birth. This way women can feel supported, safe, empowered and in control of their birth experience.

The fully funded Government Homebirth Service gives women the opportunity to have a known, qualified and experienced midwife care for them at home before and after the birth.

Darwin Homeborth Group is volunteer run and not-for-profit. We offer:

- Monthly morning or afternoon teas
- Access to our library with information on pregnancy, natural birth, water immersion, home birth, breast-feeding and gentle parenting
- Biannual newsletters rich with birth stories, birthing and parenting information
- Ongoing contact with homebirth midwives
- Access to birthing aides and equipment
- Meal provisions for new parents
- Advocating for improved birth choices and women centered care

Darwin Homebirth Group
dhbginfo@gmail.com
0438 888 755

www.darwinhomebirthgroup.wordpress.com

darwin homebirth group

birth choices matter

Find us on

Infant Sleep & Settling Online Workshop

Once you have your baby, sleep and settling become the number one hot topic for every new parent

Ideal for those who have recently birthed or are pregnant

The topics covered include:

* The differences between adult and baby sleep cycles
* Why baby needs your help to sleep and then stay asleep
* Skills to help your baby fall asleep and stay asleep - NOT sleep training
* What a baby's optimal sleep environment looks like
* One size does not fit all - recognising your baby's individual sleep needs
* What changes to expect around sleeping through the first six months of life
* Common ways babies communicate that they are tired and need sleep
* How to respond to well-meaning friends and relatives who have advice about sleep that doesn't fit your philosophy or intuition
* How to stay calm and relaxed if your baby doesn't sleep when you hoped he or she would
* How to get enough sleep yourself through the early weeks and months of parenting
* Where to go for more evidence-based resources

Saturday 16th May 2020
11am to noon, $10:00
online via zoom
book by emailing info@ceadarwin.asn.au

Online May Active Birth Workshop

An Active Birth is instinctive, following the spontaneous, natural progression of labour and birth.

As the term 'Active Birth' suggests, this approach promotes walking around, remaining upright (where possible), choosing positions for labour and birth that improve personal comfort and finding ways to relax that feel right for each individual.

The benefits of choosing an Active Birth include; a reduced chance of medical interventions, a shorter labour time, less painful labour, more satisfying labour, better oxygen flow to the baby, best use of gravity and increased involvement for birth partners.

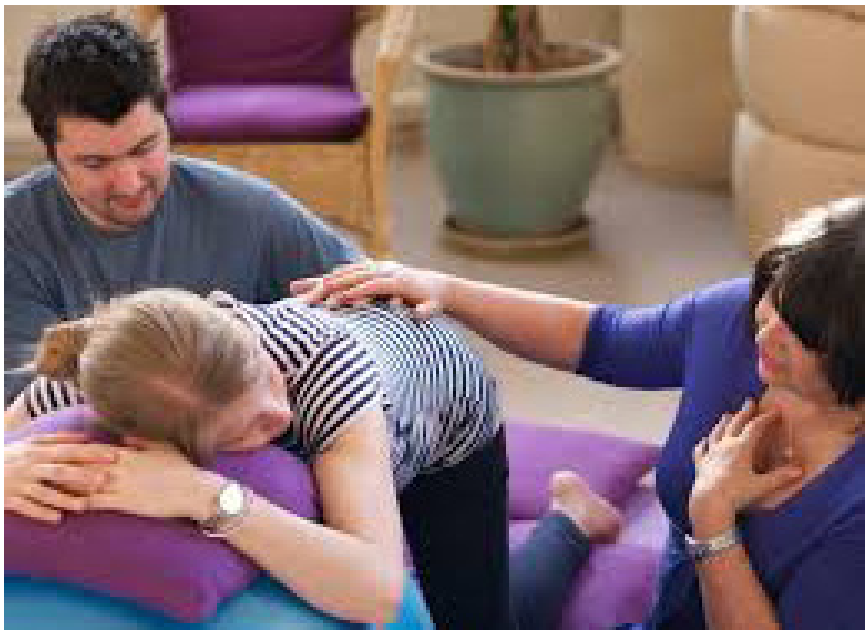
The Active Birth Workshop allows participants to:

* Observe demonstrations and have ample time to practice various birth positions with guidance
* Learn in detail the benefits of positioning
* Review the stages of labour that different positions/activities and breathing exercises suit best
* Understand birthing tools such as vocalisation, movement, stress balls, birth balls, shower, birth pool, massage, pressure points, bean bags & Tens machine
* Learn to work with your contractions and gravity
* Explore how to remain active during foetal monitoring
* Learn how to reduce the risk of tearing by using optimal positioning and breathing as your baby is born
* Birth partners will learn more about their important role – how to encourage, not sympathise, how to help your partner change positions/activities, the use of heat packs, massage, pres sure points and being the interface with others at the birth.

The workshop is suited to:

* First-time parents
* VBAC families
* Those having subsequent babies who would like more skills

Saturday 30th of May 2020 1pm to 4pm. $120 for two
Book online at www.ceadarwin.asn.au - workshops tab or email info@ceadarwin.asn.au



Advanced Maternal Age Pregnancy

Advanced maternal age is now the term for a pregnancy at age 35 or older. It was formerly referred to as a Geriatric Pregnancy

Over the past four decades, there has been a dramatic increase in the number of women having their babies at age 35 and older. This increase started in the mid-1970s and has continued to steadily rise over time. Today, 15% of birthing women are 35 and older, up from 11% in 2002 and 8% in 1990 (Mathews and Hamilton 2014; Martin, Hamilton et al. 2003; Martin, Hamilton et al. 2015).

There has also been an increase in the number of first babies born to women who are 35 or older.

The trend to delay parenthood is happening all around the world. The availability of birth control is partly responsible for women postponing parenthood. However, birth rates in younger women have also gone down in countries that do not use birth control, so we can't isolate birth control as the main reason. It's thought that, worldwide, there are other social and cultural factors that play a bigger role than contraception in the increasing age of pregnant people (Mills, Rindfuss et al. 2011).

Reasons people delay pregnancy and parenthood include:

- Women are reaching higher educational levels (Mills, Rindfuss et al. 2011)
- More women work in male-dominated fields that are not as understanding or supportive of motherhood (Mills, Rindfuss et al. 2011)
- Cultural and value shifts have led towards more women not feeling "ready" to have a child yet (Cooke, Mills et al. 2010)
- Lack of childcare, low benefit levels, and workplace policies that signal to women that they cannot be both a wage earner and a mother (Mills, Rindfuss et al. 2011)
- Divorce, going through multiple partners before settling down, and living together before marriage leads some people to delay parenthood (Mills, Rindfuss et al. 2011)
- Economic or housing uncertainty, unemployment, temporary work, or unstable labor markets (Mills, Rindfuss et al. 2011)

Fertility treatments are another reason that people are getting pregnant later in life. Parents, doctors, and research scientists have been working together to overcome infertility since the late 1880s. As scientists got closer to success, a 1969 Harris poll showed that the majority of Americans believed in vitro fertilization (IVF) was against God's will. But by 1978, the year of the first "test tube baby," another Harris poll found that the majority of Americans supported IVF and would be willing to try it under the right circumstances. And by 2004, more than half a million babies had been born by IVF. So in summary, a combination of fertility treatment options, birth control options, and social and cultural factors have all come together to lead a rise in the rate of women who have babies at age 35 or older.

As a female ages, her fertility—the chance she will get pregnant—is reduced. On average, this decline begins slowly in the early thirties and speeds up in the late thirties and forties. When a female is born, she is born with all of the eggs she will ever have. It's thought the decline in fertility with age is due to a decrease in the number of eggs remaining and a decrease in the quality of eggs (Rowe 2006).

While optimal fertility does occur at a younger age for both men and wmen, it can still be perfectly safe for a woman to have a child after she passes the 35 year mark. While there are some risks that are elevated in an advaced maternal age pregnancy, improvements in medical technology and longer life expectancies are makin this type of pregnancy far more common - and less dangerous - for women around the world. The oldest known successful pregnancy wa actually in a 66 year old woman, nearly twice the so-called cut off age of a geriatric pregnancy.

A person having an advanced maternal age pregnancy will be classified as high risk but there is no reason, if all goes well, a woman of 40 years cannot have a healthy pregnancy and birth.

Risks of Advanced Maternal Age Pregnancy:
Common risks of geriatric pregnancy include a higher risk of preterm labour, Downs' Syndrome, low birth weight, cecarean delivery, Gestational

Diabetes and high blood pressure, amoung others.

Preterm Labour:
There can be a slightly increased risk of very early labour (before 28 weeks) with older mothers, but the rates of preterm labour (before 32 weeks) are not statistically different than in younger mothers. Interestingly enough, perhaps due to better financial, emotional and medical situations, preterm births have a higher survival rate when born to older mothers.

Stillbirth:
While the rate of stillbirth is higher in women over 35, it is not a signficant risk until after the age of 40.

Chromosomal Disorders:
One of the most common misconceptions about advanced maternal age pregnancy is that the risk of chromosomal disorders, such as Downes sydnrome, is much higher. In fact, the risk of Downs syndrome in women over 35 is less than 1%, although that risk does increase to nearly 4% by age 40.

Cesarean Delivery:
Due to the high-risk label care providers will be more likely to advise a cesarean for advanced maternal age births.

Gestational Diabetes:
According to a study published in the European Journal of Obstetrics & Gynecology and Reproductive Biology, Gestational Diabetes rates do tend to be higher in older mothers. Although this form of diabetes is also largely dependent on your lifestyle choices and dietary habits. For older mothers, paying close attention to sugar ntake may be more important to avoid this temporary condition.

High Blood Pressure:
As you age, whether or not you're pregnant, you have a better chance of developing high blood pressure. To avoid hypertension during pregnancy, as well as preeclampsia, you will need to closely follow your recommended diet and fitness regimen.

Table 4: The risk of pregnancy and birth complications in pregnant people of various age groups (data from Jolly et al. 2000)

Outcome	18 - 34 years old	35 - 40 years old	> 40 years old
Gestational diabetes	1%	2.85%	4.56%
Placenta previa	0.26%	0.56%	0.97%
Breech position	2.61%	3.66%	4.57%
Elective Cesarean	4.37%	8.6%	12.67%
Emergency Cesarean	8.65%	11.05%	14.24%
Postpartum hemorrage > 1,000 mL	1.46%	2.19%	3.1%
Preterm birth	5%	6.63%	8.1%
Low birth weight < 5th %	5.81%	6.13%	7.63%
High birth weight > 90th %	10.06%	12.32%	11.96%
Ever breastfed	61.14%	70.08%	66.24%

*Data from Jolly et al. 2000.

While advanced maternal age pregnancy is technically any pregnancy over 35, pregnancy over 40 is another age marker that many people worry about. It is true that the risks outlined above will increase with age but, as mentioned, there are still plenty of women who give birth to healthy, normal children once they reach (and pass) the age of 40. The important thing is to maintain communication with your care providers and focus on all the normal health advise for pregnancy - reduce stress, eat healthy, keep exercising.

The table below is interesting and shows how different the statistics can be for birth dependent on the place of birth and philosophy of the care providers you engage with.

If you are having an advanced maternal age pregnancy and have no other risk factors (apart from your age) you may still wish to have a normal physiological birth. As with any 'high-risk' pregnancy, engaging with a one on one care provider such as a professionally trained Doula can help to navigate your way through the myths and realities of your unique situation.

This article was written by blending two evidence based articles...

1. Rebecca Dekker, PhD, RN, APRN, Mimi Niles, CNM, MSN, MPH, PhD student, and Alicia A. Breakey, PhD. Published March 29, 2016. www.evidencebasedbirth.com

2. John Staughton (BASc,BFA) Feb 07 2020. www. organicfacts.net

Table 5: Rates in first time "low risk" mothers who gave birth in England in traditional obstetric units (hospitals) versus midwifery-led settings (including home birth, freestanding birth centers, and "alongside" midwifery units)

	Obstetric Unit	Midwifery-Led Setting
Augmentation		
Age 30 - 34	31.4%	18.8%
Age 35 - 39	34.8%	21.1%
Age 40+	40.2%	22.6%
Vacuum or Forceps		
Age 30 - 34	25.3%	16.8%
Age 35 - 39	28.9%	19.3%
Age 40+	26.9%	20.7%
Unplanned Cesarean		
Age 30 - 34	15.8%	8.3%
Age 35 - 39	18.3%	10.1%
Age 40+	25.6%	8.8%
Combined perinatal outcome*		
Age 30 - 34	3.7%	2.5%
Age 35 - 39	1.8%	2.1%
Age 40+	7.8%	2.4%

Going Past Your Due Date

Ask any mom whose pregnancy went into extra innings: Right around your due date, the phone calls, emails, and texts start coming: "Is anything happening?" "What does the doctor say?" Playing the waiting game during the last few weeks of pregnancy is hard, but it becomes especially difficult when 40 weeks turn into 41 or 42. But the first thing to know is this: Your due date is just an estimate. In fact, only 5 percent of babies are born on their due date.

"No woman should feel nervous or anxious if she's still pregnant past her due date," says Alex C. Vidaeff, M.D., M.P.H., a maternal-fetal medicine researcher and practitioner at the University of Texas Medical School at Houston. Due dates are tricky because it's hard to pinpoint the exact age of a fetus.

Reasons for this include irregular periods (since due dates are calculated based on a perfect 28-day cycle), sketchy or inaccurate menstrual history presented to the obstetrician, and mistaking spotting during very early pregnancy for a period.

Doctors and Midwives usually use several methods together to make their best estimate of a due date, including:

- Calculation based on your last ovulation (the most reliable method).
- Calculation based on the first day of your last menstrual period.
- Clinical examination of the uterus for size.
- Your first detection of fetal movement (the fetus usually makes its first movements between 16 and 20 weeks).
- Fetal heartbeat (in normal pregnancies, the doctor can detect it between 18 and 20 weeks).
- Ultrasound, which during early pregnancy can estimate fetal age within seven to 10 days (it's not as effective later in the pregnancy).

Even so, the reality is that 80 percent of babies arrive between 38 and 42 weeks of pregnancy, so your due date window is much bigger than you might think. "You might really be 39 weeks when you think you're at 40," says Vidaeff, adding that pregnancy length is, in many cases, genetically determined.

The Risks of Going Past Your Due Date

Only about 1 out of every 10 babies is officially overdue, which means that the baby is born after 42 weeks of pregnancy.

Recent research has shown that delivery after 40 weeks may come with certain risks, and OB-GYNs have responded. "We now change our clinical practices at 40 weeks to prevent potential complications in both mom and baby," says Carri R. Warshak, M.D., an assistant professor in the department of maternal-fetal medicine at the University of Cincinnati.

While they're rare, the risks of having an overdue baby include:

- The placenta's ability to provide baby with adequate oxygen and nutrients may be compromised.
- The volume of essential amniotic fluid may decline as baby grows (this increases the possibility of a pinched umbilical cord).
- The possibility of fetal distress increases.
- The baby could grow too large to pass safely through the birth canal (also known as macrosomia).

At the 40-week mark, your doctor or midwife will become more vigilant about monitoring the overdue baby. "Expect twice-a-week visits if you go past 40 weeks," says Sheryl A. Ross, M.D., an OB-GYN in private practice in Santa Monica, California. Methods that your care provider can use to monitor your post-term baby's condition are:

- Kick count: A "kick count" is a record you keep of how often your baby moves. Your care provider will tell you to contact them immediately should you notice your baby suddenly decreases his/her movements. This could be a sign of fetal distress, which would require immediate testing to determine your baby's condition to assess whether delivery should be initiated quickly.

cont/...

• Nonstress test: This test, a type of electronic fetal monitoring, uses a special instrument to measure how your baby's heart reacts when his body moves. This helps the doctor determine if your baby is in distress.

• Contraction stress test: When your uterus contracts, this test (which is another form of electronic fetal monitoring) measures your baby's heart rate with a special instrument. It helps determine your baby's condition during labor, and allows your care provider to see if there's any fetal distress.

• Ultrasound: Your care provider can determine your baby's size, position, breathing rate, heartbeat, and body movements with an ultrasound. Ultrasound is also useful in determining how much amniotic fluid surrounds your baby. This is important to determine because insufficient amniotic fluid for prolonged periods can cause labour complications. In addition, your care provider can assess the size and position of the placenta using ultrasound. This information is important to know because the placenta provides your baby with life-sustaining oxygen.

40 Weeks Pregnant With No Signs of Labor:
After 40 weeks, if labor hasn't started spontaneously, you'll probably be asked by your health care provider if you want to be induced at 41 weeks—42 at the latest. "If your cervix has started to dilate, odds are in your favor for a successful induction." (However, bear in mind that being induced will impact your normal birth hormones and induced labour is much harder and stronger than a normal labour. You may need medical pain relief to cope.)

In some cases, particularly if your cervix has not started to dilate, induction will not work. If you have had your waters broken and reach the cut off time for safety from baterial infection you will then need to have a C-section.

Midwives tend to wait a little longer for induction than OB-GYNs do. "In our practice, we wait until we wait until 42 weeks for women to go into labor naturally," says Joanne Hasman, C.N.M., a certified nurse-midwife at Special Beginnings Birth and Women's Center in Arnold, Md.

Midwives often perform a type of induction called a "cervical sweep," using a finger to separate the cervix from the amniotic sac. This procedure is quite uncomfortable but can **sometimes** kick-start labor. "If the woman is really ready [to go into labor], I'll see her back here in 24 to 36 hours," Hasman says.

Article taken from parents magazine: Nancy Gottesman, Dr. Laura Riley, and Meredith Franco Meyers

Please note: Induction is an involved process with possible pros and cons for both mother and baby. The benefits and risks should be assessed on an individual case by case basis. If you are keen to have a normal physiological birth and are having a low-risk pregnancy your classification of low-risk will change once you reach 41 to 42 weeks. Learning about the various types of induction is important so you are able to give informed consent should these procedures be offered to you.

Making sure your estimated due date is as accurate as possible is important from the very beginning of pregnancy in order to avoid unnessary interventions at the end. If you were not actively planning your pregnancy or tracking your menstrual cycles spend some time before your first medical appointment to narrow down when you concieved. This could make a big difference in how your birth unfolds 40 weeks later.

Important Things To Remember If You Have Reached Your Due Date

Firstly , being 41 weeks is not late at all. The average first time mum goes over 41 weeks before going into labour. Going over your due date does not mean your baby is 'late'. It means your health care provider was not great at predicting your baby's birth date.

Research tells us that babies are healthiest after 39 weeks and before 42 weeks so if your baby is taking a little bit longer than 40 weeks, know that it's normal and healthy and there is nothing wrong with waiting.

Most hospitals will not insist on induction until after 42 weeks so, if you are feeling fine and your baby is also fine, consider the risks and emotional impact of having a n induction that may not be necessary. It is your choice, and there is nothing wrong with saying no.

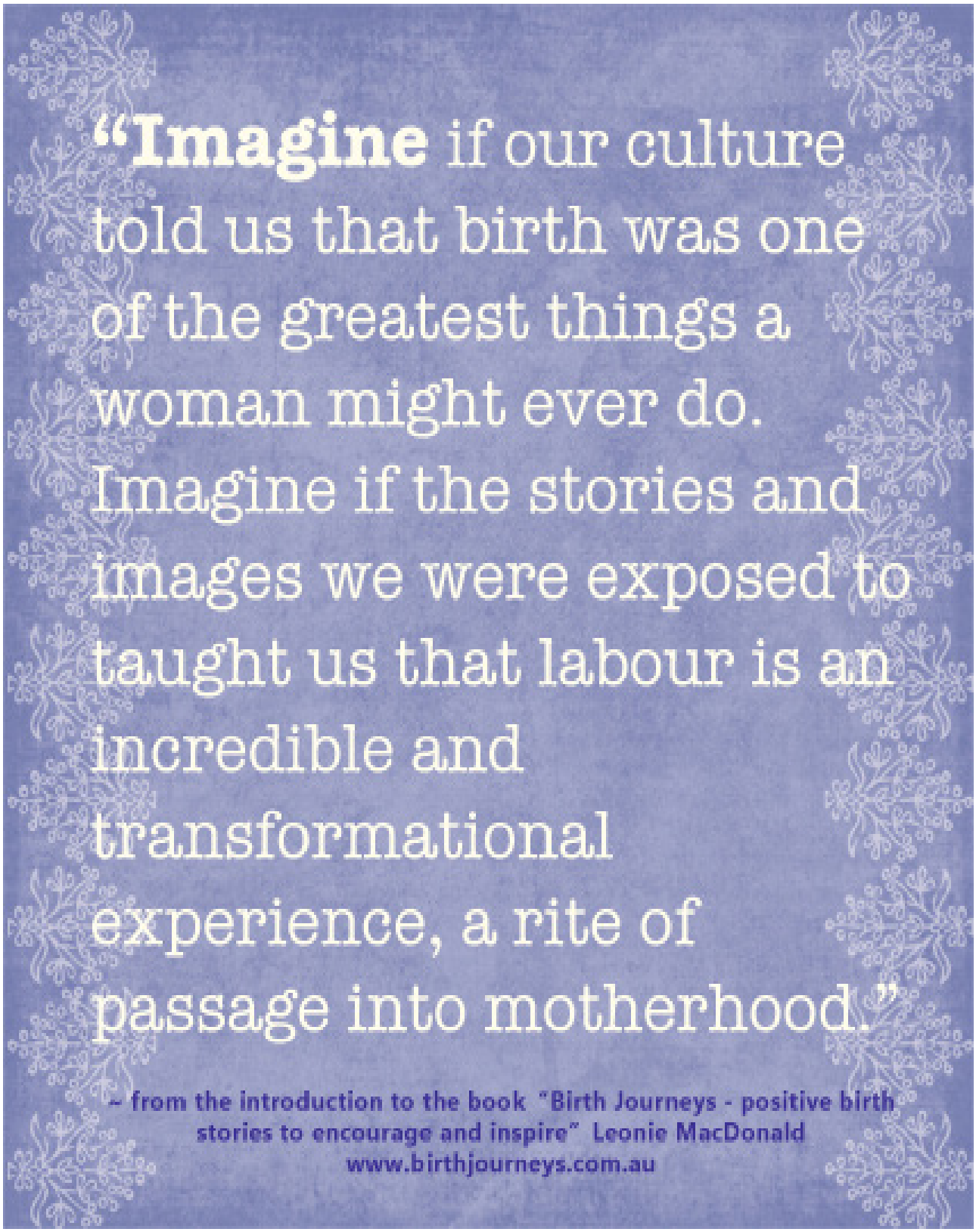
You may wake up every morning feeling disappointed that you didn't go into labour the night before. You may start to dread messages and phone calls from people asking if your baby is here yet. Rest assured that these feelings are normal. Gentle exercise and relaxation exercises will help to prevent you becoming stressed. Now is a great time to get your support person to practice their labour massage techniques and spend time enjoying fine tuning that birth music play-list.

Hold onto the thought that there is nothing wrong with you or your baby. Your care provider will have had the 'past your 40 week due date' conversation with multiple people that day, week, month who are in exactly the same place as you.

When you are being talked to about the option of induction or post-dates testing it may feel like something unique is happening with you and that it's strange. People may start to feel that they are neglectful, irresponsible, if they don't go the postdate monitoring or induction route. Simply waiting for the birth to happen is such a foreign concept in our culture that a pregnant person feels like she is strange for wanting to do so. It is NOT strange you haven't birthed yet, it's common, normal even. Ours is not a culture that waits for anything, nor are we believers in normal birth.

For fearlful family members waiting for a baby may feel less attractive than the sense of control that a scheduled induction can offer. Remind these people of the facts outlined in this article and invite them to read the book "Why Induction Matters" by Rachel Reed

Article taken from Birth Takes a Village.com
The Waiting Is The Hardest Part by Jessica Austin
6/10/2017


"Imagine if our culture told us that birth was one of the greatest things a woman might ever do. Imagine if the stories and images we were exposed to taught us that labour is an incredible and transformational experience, a rite of passage into motherhood."
~ from the introduction to the book "Birth Journeys - positive birth stories to encourage and inspire" Leonie MacDonald
www.birthjourneys.com.au