Volume 33 - No 2 August 2015

INTERACTION

The Official Publication of Childbirth And Parenting Educators of Australia Incorporated

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INTERACTION

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From the Editor's Desk

Hello everyone and welcome to the August edition of *Interaction*! I am writing this note with the newest addition to my family sleeping soundly next to me. As many of you know I was expecting my second baby since the last edition — and after waiting till 9 days post term (I was feeling very ready by then as you can imagine!!) my little girl made her entrance into the world. A much quicker and simpler entrance than her big brother. My beautiful Poppy Alice was born in the early hours of the morning with my husband, best friend and midwife present. It was a truly empowering, intense and wondrous experience, allowing me to fall in love all over again. I was home as Max was waking up with my parents — all eagerly awaiting us knocking on the door. I have, once again, been overcome with what a powerful role we hold as midwives and educators, and been reminded as to how incredible yet vulnerable women are during pregnancy, birth and beyond…

Thank you to the CAPEA members who have sent their well wishes. And apologies to those whom I haven't contacted or replied to as promptly as normal!! Life has taken on that postnatal haze for me at the moment, especially as I find my feet accommodating a busy active toddler ("I'm a big boy now Mummy") and a newborn. Although my heart has expanded, I find myself wanting and needing more hands and more space on my lap — a feeling I am sure many of you know all too well yourselves!!!

As always, I wish to thank all of our contributors. I feel so lucky to include such fantastic articles for everyone to read. Thanks to Kate Taylor for her article on the 2h Project Safe Arrivals Team — the world needs more people like you in it Kate; Brad Allen for sharing his wealth of knowledge and experience with Supporting Fathers; Chris Teale for her extremely informative and insightful piece on Craniosacral therapy; and Maria Whitmore from the Continence Foundation of Australia for her article of interest on Kids with special needs. I also wish to thank all the NEC members for their support and organising their reports on such a regular basis. And I also bring your attention to the two tributes we are including in this edition. Since our April edition we have lost two remarkable women in the wider antenatal education world, so we honour the memory of both Andrea Robertson and Sheila Kitzinger.

Hope you all enjoy this edition of *Interaction*. And I will see you all in December!!

Take care and happy reading,

Kassie

Web Report

Small recent modifications have ensured that the CAPEA website is responsive to the changing needs of members and browsers. Note the new look home page!

Facebook is the primary social media tool, with a slowly growing number of followers (around 130). The posting informing followers of the recently released link to the *Breastfeeding Handbook for Antenatal Educators* reached 330 people within days.

Feedback, good quality photos of your work, new teaching tips and historical items for placement on our website are eagerly sought with your help!

Lisa Robertson
CAPEA Web Administrator

National President Report

Hello everyone, we are half-way through 2015 already and CAPEA National and the State branches have all been busy with meetings, some great educational opportunities and planning for future events.

CAPEA National has held two teleconferences to date and has ratified the updated Executive Position Descriptions. We now expect that the State branches will be able to use these PDs for their executive positions and hopefully attracting new members to these positions will be made easier.

The National Strategic Plan working party has begun looking at our priorities and the key result areas that will make up the plan. The planning will continue over the next months and we hope to have a draft plan by the next National teleconference in September.

The 2016 CAPEA National Conference is planned for Adelaide, South Australia, October 12-14 and the theme has been determined — Nurture the Primal Instinct. Attending our national conferences is one of the highlights of being a CAPEA member and I urge you all to set aside these dates and make an effort to get to Adelaide for what should be a fun and informative experience!

The Childbirth and Parenting Education community has been shocked by the loss of both Sheila Kitzinger and Andrea Robertson in the past few months. Many of us got to know Andrea well through her years as an advocate for parenting education and midwifery care in Australia and she was amazingly accomplished in many ways, particularly as a trainer and designer and developer of resources we all use today. We were fortunate to have Sheila here as the Keynote Speaker for our 2003 National Conference. She was very generous with her time, not only as a speaker but on an individual basis and it was a real privilege to meet someone who was so influential in the changes to birthing that we take for granted

now. We have posted tributes to Andrea and Sheila in this issue of *Interaction* as well as on the website. We have certainly been lucky to have both of these remarkable women at the forefront of our profession and will miss their continued contribution very much.

Sue Spencer
National President
Susan.spencer@health.nsw.gov.au

Breastfeeding and You handbook

Breastfeeding and You: A handbook for antenatal educators aims to provide information and resources on breastfeeding to antenatal educators, program managers and health professionals who inform and support women, their partners and family. Research has shown that the extent to which a mother commits to breastfeed at this point can impact on the duration of breastfeeding. There are many 'teachable moments' during pregnancy and the handbook includes information on adult learning.

Through the Handbook's Modules educators will be able to support expectant parents to choose breastfeeding, while also recognising that the feeding decision can be complex. The decision to breastfeed belongs to the parents and ultimately each decision — whether to exclusively breast or not — should be respected and supported.

Modules cover Preparing to Breastfeed, the Breastfeeding Experience, Facilitating Groups, Planning and Evaluation Programs, Resources and Activities for Educators and Handouts for parents. Also throughout the handbook are **think**, **reading**, **action** and **tip** icons that may be particularly useful if you are new to antenatal education.

Wide consultation was utilised during the preparation of this Handbook including Australian and US Fellows of ILCA©, UNICEF UK Baby Friendly Initiative, BFHI Australia, Antenatal and Perinatal educators in both Australia and the UK, Childbirth And Early Parenting Educators, Australian Breastfeeding Association, Australian College of Midwives The Royal Australian and New Zealand College of Obstetricians and Gynaecologists and The Royal Australian College of General Practitioners. Both PDF versions with hyperlinks and a Word version for the visually impaired are available at **http://www.health.gov.au/internet/main/publishing.nsf/Content/bay**. The author is Dr Jane Svensson (PhD, MPH, B.Ap.Sci., CM) and the handbook update was funded by the Australian Government Department of Health.

Dates of Publication and Deadlines for *Interaction*

Deadline 28th February
for inclusion in April edition.

Deadline 30th June
for inclusion in August edition.

Deadline 31st October
for inclusion in December edition.

CAPEA Inc website
www.capea.org.au

State Reports

CAPEA Tasmania Branch members enjoyed a lovely lunch and Education Session on Friday 22nd May at Dianne Haworth's home in Launceston. Sharon Riley presented the '*Gestational Diabetes Wellness Research Program*', being undertaken at the Launceston General Hospital in the Antenatal Clinic.

CAPEA Tasmania presented a training workshop with Consultant Psychiatrist Dr Kristine Mercuri on "*Mindfulness in the Perinatal Period*" in Hobart on May 21 and 22. The training was attended by seven health professionals from the private and public sectors. Dr Mercuri took the participants through the *MindBabyBody* antenatal mindfulness program which is currently run over 5-weeks at the Royal Women's Hospital in Melbourne. It was an engaging and practical workshop with participants having the opportunity to experience many of the exercises that are included in the program. There was also discussion and information about common issues when utilising mindfulness with women in pregnancy and in the postnatal period.

For more information about the MindBabyBody program see: Woolhouse et al.: **Antenatal mindfulness intervention to reduce depression, anxiety and stress: a pilot randomised controlled trial of the MindBabyBody program in an Australian tertiary maternity hospital**. *BMC Pregnancy and Childbirth* 2014 14:369.

Dianne Haworth conducted a 2 day Childbirth and Parenting Education Training Workshop at the Mersey Community Hospital in May. 25 Midwives from along the North West and North of Tasmania attended, including one from King Island. Participants ranged from those who had been presenting CBE for many years, to some new graduate Midwives. Evaluations suggested everyone enjoyed themselves and felt more confident to try Child Birth Education.

Marilyn Steers

As I write this report it is hard to believe how quickly the year is passing. I trust it has been a good one for you. It has been a quiet couple of months for CAPEA in Queensland.

Our next teleconference planned for late June / early July will have come and gone by the time this magazine is published. We will be trialling a Monday evening. Check the website for an up-date on minutes from the meeting.

We continue to liaise with Longreach Hospital and are hoping to run our next rural workshop there in August/early September. Confirmation of location, and further details, will be available on the website and will be emailed to Queensland members.

We invite Queensland members to contact us with ideas and thoughts on how, as a branch, we can be of more service to you and how we can promote CAPEA more effectively to increase membership.

Jacqui Morrison

The South Australian branch committee has met twice in April and May to discuss planning for the Bi Annual National Conference next year. We have designed and distributed our logo. The venue has been booked and the process of quotes and proposals from conference organisation companies and individuals is being looked at, this will be reviewed and decided upon at the next meeting in June.

We met at the Womens and Childrens hospital in May and Lisa Masters presented on the Power of Words for the Childbirth Educators. Lisa has also written an article for the April Interaction but it was great to hear her and have the opportunity to discuss the topic. Her Clinical hypnosis training and the different communication styles are useful concepts for all educators and we are lucky to have Lisa share her knowledge.

Our next meeting is scheduled for the 6th July at the Womens and Childrens Hospital. There will be an education session as well as our conference planning committee meeting.

Mary-ann Baker

Greetings Victorian CAPEA members, colleagues, and friends. Our next Victorian Branch event will be Sunday 13th September, and will incorporate our AGM. Please see the CAPEA Website for details. We look forward to seeing you all then!

We also encourage you to join us on Facebook. Look out for details of our celebration of Childbirth Education Week, and keep Monday 9th November free to join us.

Krystelle Tarburton

Save the Date

NURTURE the Primal Instinct

Brought to you by CAPEA-SA

October 12th - October 14th 2016

at the Sanctuary (Adelaide Zoo)

We are in primary stages of planning but we are very excited about how the conference is coming together and want as many as possible to be able to attend. It will be heaps of fun!
So book time off and we look forward to seeing you
October 2016

CAPEA Membership Secretary's Report

We now have 240 members on our database as all the members who have been unfinancial for a year have been removed. I apologise if anyone who has paid their membership fees has been removed but unfortunately we are still receiving payments and do not have anyway of identifying who the payment is from. Renewal notices were sent out in May and June for the renewal in July and for those members whose email bounced back or who don't have an email a letter was sent by post. The response has been good. The next issue to address is certification so I will be sending out renewal letters to members who are due for recertification. If any member is not certified and would like to be please logon to the web and follow the directions.

Thanks

Jeannie Lynch
Membership Officer

I apologise for any distress that may have been caused to members who should not have received a renewal notice and to all the members who received 2 reminders by the email sent on the 6th July. This email was generated by the IT personnel of the web system.

Safe Arrivals

Every minute of every day a mother **dies** in childbirth

by Kate Taylor

"Giving birth safely is largely a privilege of the rich"
UN Millennium Development Goal Report 2009

"Women deliver – and not just babies. And if we deliver for women, we change the world for the better"
Ban Ki-moon
UN Secretary-General

Each year more than 536,000 women die due to complications developed during pregnancy and childbirth and 10 million more suffer debilitating illnesses and lifelong disabilities. 75% of maternal deaths occur during childbirth and the post-partum period.

Pregnancy and childbirth are the leading cause of death and disability for women in developing countries — a total of 99% of maternal deaths occur in developing countries. Despite pledges by world leaders, little progress has been made in saving women's lives. **UN Millennium Development Goal 5** — 'to reduce maternal mortality by 75% and to achieve universal access to reproductive health services by 2015' has made the least progress of all MDGs.

At the global level, maternal mortality decreased by 1% per year between 1990 and 2005 — far below the 5.5% annual improvement needed to reach the target. At this rate, MDG 5 will not be met in Asia until 2076 and years later in Africa.

What is Safe Arrivals?

Safe Arrivals is a training program for midwives with an aim to reduce maternal and neonatal mortality and morbidity rates in rural and remote areas of Cambodia. According to the World Health Organisation (WHO) Cambodia currently has one of the worst maternal mortality ratios in the world; 450 deaths per 100,000 live births.

Measuring maternal mortality is commonly underreported or misreported in developing countries – Cambodia's unofficial maternal mortality is estimated to be as high as 700/100,000. In comparison Australia's ratio is 7/100,000. A pregnant woman in Cambodia has 83 times the chance of dying in childbirth or from complications relating to birth than a woman in Australia.

Nearly 90% of Cambodia's women are assisted in labour, delivery and the immediate postpartum period by a Traditional Birth Attendant (TBA). Most of these midwives learn their trade by observing other birth attendants — or by trial and error.

Take Sroun Narom, she's 51 years old and has been a TBA since 1971. Over many years she has helped deliver hundreds of babies. She has had no formal training, in fact she learnt to be a TBA from her sister when she was just 11 years old and her sister was 13.

The 2h Project is a not for profit Australian development organisation working with local communities overseas to bring help and build hope for the poor and disadvantaged
www.the2hproject.com

Safe Arrivals acknowledges the vital role that TBAs play and the connectedness that they have with their local communities. However, we also recognise the importance of training and education in helping bridge the gaps in understanding and knowledge.

Increasing the availability of skilled health workers means more women survive childbirth and more children live through infancy. A 10% increase in skilled health workers corresponds to a 5% reduction in maternal deaths.

The Safe Arrivals Training Program understands that tradition will continue to touch lives; training can help save them.

Where did Safe Arrivals come from?

Hearing a young Cambodian woman recall saying goodbye to her pregnant mother as a small girl led Kate Taylor to enroll in the University of South Australia's Bachelor of Midwifery. "The woman remembered when her mother began having strong labour pains how the birth attendant of the village gathered the family around their pregnant mother. As a small girl she joined her father and siblings in hugging their mum and saying 'goodbye'. The young woman explained she didn't understand why they did this. That afternoon when she returned from school she was met by her Grandma who told her that her mother had died in childbirth. With tears in her eyes she said she would never forget her mum — now she was pregnant herself and scared at what might happen".

"What could I possibly do to leave the world a better place?"

Completing her study in 2005 and spurred on by what she describes as the '*Goodbye Story*' Kate established the **Safe Arrivals Training Program** in 2007. With the help of past students and lecturers from UniSA as well as current educators and health professionals Kate has developed a growing team of volunteers committed to delivering this life saving program.

"The **Safe Arrivals** program is one of the best experiences I have had in my 40 years as a midwife. Knowing that I am working with midwives and birth attendants to help achieve Millennium Development Goal 5 is a humbling and truly memorable experience. Safe Arrivals is making a powerful difference to the lives of mothers and babies in Cambodia." Dr Pauline Glover, Associate Professor, School of Nursing and Midwifery Flinders University Adelaide.

What's been achieved?

Safe Arrivals is now in its eighth year of delivering quality, women centred health training, effectively touching thousands of women, their families and their communities across Cambodia.

The story so far ...

Since its inception the **Safe Arrivals** program has been conducted in a total of ten Cambodian provinces; Kompong Speu, Prey Veng, Takeo, Pursat, Battambang, Pailin, Kampong Chnang, Kampot, Svay Rieng, Kratie, Preah Vihear and Kampong Thom. The number of trainees has included 2,627 Traditional Birth Attendants and 714 Skilled Birth Attendants — 3,341 in total; representing maternal health services to a combined provincial population of over 5.6 million people.

In consultation and with the full endorsement of the Cambodian Government's Ministry of Health **Safe Arrivals** continues to deliver a strategic response to the least progressed of the Millennium Development Goals — 'Improving Maternal Health'. With the poorest maternal and infant health outcomes in the region the Cambodian Government acknowledges the pivotal role of the program and welcomes its ongoing assistance.

Dr Chea Sokhim Deputy Director of International Cooperation wrote, "We appreciate **Safe Arrivals**' approach which will be integrated into our own health system… to further medical care/

prevention in undeserved rural areas, particularly for the vulnerable women and children".

Measuring the outcomes

In 2010 **Safe Arrivals** incorporated an analysis of the program's effectiveness in linking the Traditional Birth Attendants with the existing health infrastructure. Does our training improve the referrals to the Health Centres for antenatal care?

In a six month 'before and after' comparison of October-March, the 2010 training resulted in an 11.5% increase in the number of referrals to the Health Centres. Deliveries at Health Centres and Hospitals had also risen significantly in both the provinces where the training was conducted.

Safe Arrivals program consultant Dr Lois McKellar from UniSA's Division of Nursing and Midwifery observes, "If you lose the TBA you lose access to women. They are the link. Do away with the link and you do away with improving maternal health".

Christine MacArthur Professor of Maternal and Child Epidemiology from the University of Birmingham notes, "Although a skilled birth attendant for all women is obviously the ideal, ... it may be years before this is a feasible option". MacArthur goes on to say, "In one trial, the most promising interventions for reducing perinatal mortality and morbidity were training traditional birth attendants... and strengthening linkages".

What does Safe Arrivals do to reduce maternal mortality?

The two three-day training clinics present basic skills, new concepts and safe techniques. Transportation, meals, three day's wages (since 'time out' means loss of income), training & teaching aids and resourcing of basic birthing equipment are included for each midwife who attends. The program covers sexually transmitted diseases, contraception, nutrition, sanitation, breastfeeding, immunisation as well as the specifics of pregnancy and childbirth. And the benefits to the community are numerous; HIV awareness, birth control and child spacing, less chronic and acute illness, decreased infection, and reduced infant and child mortality rates — just to list a few.

For Cambodia's TBAs reading about the latest birth technique in a research journal

isn't an option. They don't have access to the Internet or a local library; and even if they did; the majority don't read or write. So it's hands on training or it's nothing at all! That's why the **Safe Arrivals** program is learning based; not teaching based. And to help the hundreds of TBAs learn the all important lifesaving skills that they need in everyday life; the program offers an array of 'hands-on' learning.

Our dedicated volunteers

What's so amazing about each of our team is that on top of everything else (jobs and families) they give up their time; money and energy to be a part of the **Safe Arrivals** program. Not only do they pay their own way and use their holiday time to be there; they've each met a fundraising target to make sure the training goes ahead! Here's what some had to say:

"The enthusiasm to learn simple initiatives to ensure a safe birth for both mother and baby was tremendously encouraging"

Beth Grinter; Program Director/
Course Coordinator Midwifery
UniSA

"Life changing"

Kate Shadiac
Midwife, Lyell McEwin Hospital

"You go thinking you're going to change lives. You have no idea the extent that the Safe Arrivals program makes a difference, or the amazing way these beautiful people will change your own life"

Suzie Tucker
Midwife, Women's & Children's Hospital

"A mother's love for her baby is unconditional. A safe birth is a rite that we take for granted"

Tania McKenzie
Midwife and Lecturer UniSA

Why do mothers continue to die?

Complications during pregnancy and childbirth include uncontrolled bleeding, obstructed labour, infection and high blood pressure. Societal factors include gender discrimination and social, cultural, legal, economic and logistical barriers that deny women lifesaving health care.

"Many health problems among pregnant women are preventable, detectable or treatable through visits with trained health workers"
UN MDG Report 2009

What is the impact?

Critically linked to issues of maternal health is the fourth MDG — Reduce Child Mortality. As the UN records 'Approximately two thirds of infant deaths occur in the neonatal period' and are 'related to care during delivery'. Cambodia is the only country in its region to record an increasing infant mortality rate; 106 deaths per 1000 live births (Australia's rate is 4.7).

Safe Arrivals 2015

In 2013 The 2h Project was successful in expanding its Memorandum of Understanding with the Cambodian Government. The revised MOU extended the training until 2016 and includes some of the most remote locations in Cambodia. An additional six provinces have been incorporated; Banteay Meanchey, Otdar Meanchey, Preah Vihear, Stung Treng, Kratie and Svay Rieng — taking the total **Safe Arrivals** coverage to 14 of the country's 24 provinces.

The cost of this year's training is approximately AUS$58,000 and includes wages, transportation, food and accommodation for each of the trainees as well as take home resources. To train one Traditional Birth Attendant will cost $120. One birth attendant will assist approximately 70 deliveries in the following 12 months.

The 2h Project receives no Australian State or Commonwealth Government funding to run the Safe Arrivals training. Neither does the Cambodian Government make any financial contribution to the program.

Every donated dollar will directly offset the training costs; no monies are used for administration, organisational or team personal expenses.

Will you consider making a tax-deductible donation today?

Without the **Safe Arrivals'** innovative and effective training program countless mothers and babies will continue to die unnecessarily. Every minute of every day really does count.

safe**arrivals**

Safe Arrivals is an initiative of The 2h Project

Safe Arrivals Bank Account Details
People's Choice Credit Union
BSB - 805 050
Account No - 0428 9104

The 2h Project
ABN – 84 814 621 404
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Supporting Fathers

Brad Allen has 33 years of nursing experience, working with families in the paediatric and midwifery arenas. Holding roles from level 1 through to level 3 in the clinical, management and education spheres. He has been involved in providing a **father specific antenatal class** for the last ten years and is currently working as a private lactation consultant and parent educator in his own practice that he started almost 4 years ago. Brad is also employed part time in the private sector as a midwife, and casually in the public sector as a Child and Family Health Nurse. Brad has been married to Cathy for over 25 years and has a son, Ned who is almost 17 years old, to both of whom he is eternally grateful for providing him with the opportunity to experience the joys and challenges of his most important roles of husband/ partner and father.

Brad Allen Lactation Consultant and Parent Education Services
Email: bradleyallen5@bigpond.com

The rapid growth in fatherhood research in recent years indicates an increased acceptance and understanding that responsible fathers play a vital role in their children's development. Fathers do make a difference, they bring a special way of nurturing and bonding that must be encouraged and affirmed for the benefit of the children, the mother and the father.

In the following paragraphs I plan to look at some of the research and how we can inspire men and assist them to be more effectively involved in the lives of their children. Also I will look at some of the challenges and factors that influence father involvement.

In 2002 Allen and Daly compiled a summary of the research that examined the impact of father involvement and children's developmental outcomes, the co-parenting relationship and development of fathers themselves. Then in 2007 they updated that review by examining approximately 150 new research studies in these same areas. According to "The Effects of Father Involvement: An Updated Research Summary of the Evidence" (Allen & Daly 2007), responsible father involvement is good for children's:

Cognitive Development

- ★ Better school performance and staying in school longer
- ★ Problem solving abilities

Emotional Development

- ★ Locus of control, less impulsive
- ★ Appropriate management of emotions
- ★ Self acceptance, less depression

Social Development

- ★ Positive peer relations
- ★ Less aggression more tolerance
- ★ Empathic concern

Simply put father involvement is a supportive and protective condition for healthy child development and resiliency.

What does the term involved mean? What does an involved father do, what does it look like?

Three common father involvement measurement themes that come from the research were, time spent together, quality of the father-child relationship and investment in the paternal role. Time spent together is more than just being in the presence of each other but participation in routine physical care routines i.e. settling, changing, dressing, reading to and playing with. There is a quality component to this measurement in that how mutual and reciprocal the interactions are. It is just as much about the quality of the interaction and how the father is emotionally available and attuned to the child's state. It is through play and care that fathers bond with their infants, and infants develop a secure attachment with their fathers. This is about fathers responding to their infant with their brain and heart turned on, taking time to learn the unique personality and temperament of the infant. The terms used to describe the interactions and thus the relationship between an involved father and child include caring, nurturing, comforting, affectionate, warm, close, sensitive and encouraging.

How well do these descriptors fit with the classic male stereotype?

I honestly believe that one of the challenges for men during their transition into fatherhood is moving some of that left brain problem solving thinking to the right brain to incorporate and become receptive to their nurturing abilities. The good news is that infants are great at encouraging this and this is part of the wonderful development that also can have positive flow on to other aspects of father's lives. Allen and Daly in their summary of research found evidence that involved fathers are more likely to exhibit greater psychosocial maturity, be more satisfied with their lives, feel less psychological distress, and be more able to understand themselves, empathically understand others, and integrate their feelings in an ongoing way.

So what are some of the factors that influence how involved men become as fathers. Gender and role stereotyping beliefs i.e. only mothers know how to care for infants, men are there as the provider and disciplinarian. Lack of positive father role models, this is an interesting one, most men when they find out they are to become a father look to their experience of being fathered. Research on the impact of role models is mixed, showing that some men use their own father's lack of involvement as a motivator to fuel their commitment to a more engaged

parenting role, while for others, lack of an involved father model is an impediment.

Work is still a significant part of a man's definition of himself, the need to provide for the family vs. the need to be there for their partner and infant. Finding the balance between work and family continues to be a challenge for many fathers. There has definitely been a shift with improved paternity leave and many employers becoming aware of benefits of promoting family time through flexible work hours. Not surprisingly anxiety about work and financial stress has been shown to have a negative impact on how involved fathers were with their children.

The families support network influences how involved the father will be, the more support and value placed upon the fathers role, the more engaged and involved the father is likely to be. This support is the extended family, peers and friends but also very importantly, health and social services. For all of those of you who are employed in these services stop and have a think about how your service values/supports fathers in their role. Are they acknowledged, welcomed, involved and provided any father specific services and resources. Also stop and take some time to explore your own beliefs, attitudes towards fathers of the families in your care.

Mothers are a key influence on the fatherhood role. Fathers tend to be more involved in parenting when their partners are supportive and encouraging (Hoffman, 2011). It is a good idea to talk to mothers about their influence and how they can facilitate their partners involvement in ways that will encourage the benefits for the child, the father and the mother herself. Exploring the mother's belief and attitudes re the father's role is very important when looking at the mothers support network.

Both mothers and fathers also need to understand the importance of co-parenting. Learning to be an effective co-parenting team takes time and effort. The majority of mothers are supportive of the idea of dads being involved with the children – but some may find it unsettling. Having a dad highly involved may be a challenge to a mothers perception that women need to be able to handle everything about parenting. Some mothers show hesitation around a fathers ability to handle the care of the newborn.

So how can we support and encourage fathers to become that involved father with its associated benefits for their family? The best time to reach fathers is when they are experiencing change and looking for support. This happens during the antenatal and postnatal periods. Dads begin to look seriously at their future, their lifestyle, and if they have the tools necessary to raise a child. For many, motivation is high and dads are more interested in accessing services and programs. This gives an opportunity to establish a good working relationship with fathers, which encourages their involvement.

An antenatal dads class provides the opportunity where they learn about the positive impact they can have on their child's development, connect with other fathers, learn the importance of support and communication with their partner, learn about the basics of breastfeeding, infant attachment and some knowledge and skills around, the needs of their infant.

The following is an outline of the antenatal dads class that I present including the resources sheet.

Dads Do Make a Difference

A 2 hour class for expectant fathers to be undertaken when partner around 32-37 weeks gestation

Class Outline

Introductions
Overview of class
Goal – Following class expectant fathers will be aware of the benefits and importance of being emotionally available and involved in their infants care right from the start.

DVD *The Father/Child Journey* (14 min.)
The DVD identifies the important role that fathers play in the emotional development of their children. The images portrayed demonstrate examples of quality interactions between fathers and children. This DVD was produced for fathers who are seeking to learn about their role.

Discussion of DVD

- Role of fathers
- Research re benefits of an involved and emotionally available father
- Attachment theory/ Circle of Security theory
- Psychosocial needs of infant
- Responsive parenting

Father Role Challenges

- Work/family life balance
- Relationship and role stress/ importance of communication and exploration of support network
- The myth of the perfect parent
- Parenting is an apprenticeship involving on the job training

Break for refreshment and opportunity for participants to interact and review some examples of resources from the Father resources handout.

2nd Hour
Education and exploration re practical knowledge and skills re newborns abilities, needs and care.

Breastfeeding:

- Benefits, positioning and attachment, physiology of milk production and let down, supply and demand, challenges. Importance and relevance of fathers supportive role.
- Any questions re bottle feeding.

Sleep:

- Latest research
- amount
- cycles
- safe sleep environment

Settling:

- Massage, safe swaddling / wrapping.
- Various positioning and settling techniques.

Bathing and Hygiene:

- Demonstration relaxation bathing technique
- Discussion changes in stool and urine output. Nappy changing
- Cord care

Illness:
Signs of and when to seek medical review

Discussion of resources listed on resource handout

Discussion of PND:

- Incidence
- Risk factors
- Signs and symptoms
- Importance of early detection and treatment

Resources for further information

Any Final Questions

Father Resources

Books

Perry Lucy, Cheers To Childbirth A dads guide to childbirth support. Pure Publishing 2010 (**www.cheerstochildbirth.com.au**)

Fletcher Richard, *The Dad Factor How father-baby bonding helps a child for life* Finch Publishing 2011

Murray L. & Andrews L., *Your Social Baby Understanding babies communication from birth'*. ACER Press, 2000

Rose L., *Learning To Love*. ACER Press 2000

Biddulph S., (Ed) *Stories of Manhood: Journeys into the Hidden Hearts of Men* Finch Publishing, 2003

Biddulph S., *Manhood: a book about setting men free*. Finch Publishing, 1994

Stevens H. *Safe Sleep Space Book* Rebus Press, 3rd Ed, 2012

Ryan J. *Baby Bliss* Harper Collins Publishers 2009

Gethin A. & Macgregor B., *Helping Your Baby To Sleep Why gentle techniques work best* Finch Publishing 2007

McKay Pinky, *Sleeping Like a Baby Simple sleep solutions for infants and toddlers* Penguin Books, 2006

Websites

www.cyh.com
Child and Youth Health Website

www.breastfeeding.asn.au
Australian Breastfeeding Association website free downloadable e book available "breastfeeding with confidence".

www.aaimhi.org/newsfiles/Position%20 Paper%202.pdf
Australian Assoc. for Infant Mental Health Inc. Position Paper 2: Responding to babies cues.

www.raisingchildren.net.au
Australian parenting website

www.purplecrying.info
The period of purple crying a new way to understand your baby's crying. Information on soothing, settling and sleeping.

www.isisonline.org.uk
Provides information about normal infant sleep based upon the latest UK and world wide research.

www.ngala.com.au
Provider of early parenting and early childhood services with a passion for supporting and guiding families and young children through the journey of parenting. You can download Hey Dad Booklet.

www.howisdadgoing.org.au
This site is from PANDA Post and Antenatal Depression Association with a specific focus on men as new dads.

www.beyondblue.org.au
Can download "Dad's Handbook: A guide to the first 12 months"

www.menslineaus.org.au
Telephone counseling service, supports men who are dealing with family and relationship difficulties. Taking fathering further program.

www.fathersforum.com
Fathers Forum Online — resources for expectant and new fathers.

www.fathers.com
National Center for Fathering — mission is to improve the well-being of children by inspiring and equipping men to be more effectively involved in the lives of children.

What about the dads who do not have access to such a class and particularly those dads who are not thinking about their fatherhood responsibilities?

Do not underestimate the impact you can make with opportunistic education as you interact with these fathers as they move through the antenatal and early postnatal period. The goal is to get them thinking about fatherhood and encouraging the couple to start the conversation about what their expectations and beliefs are re their maternal and paternal roles. A question I recommend fathers need to ask their partner is "What do you need from me to help and support you in developing your role as a mother?" Their partner can also ask them the same question. This can start the all important communication process necessary as they find their way as a co-parenting team.

Other messages that dads need to hear are that parenting is a classic example of on the job training, it is important to get involved right from the start. One of the best ways to get the responsive parenting message across is use of the position paper on "responding to babies cues" from the Australian Association for Infant Mental Health Inc. The other resource that is a must for expectant dads is either the Hey Dad booklet from ngala or the Dads Handbook from Beyond Blue both available as downloads from the websites.

> *"One hundred years from now it will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove... but the world may be different because I was important in the life of a child."*
>
> Anonymous

As can be seen from the Dads antenatal class outline, I include information about breastfeeding, there are some very valid reasons for this. Lets look at some of the literature and research on fathers and breastfeeding. Bromberg et al(1997) in A Literature Review of Fathers and Breastfeeding listed 6 key findings:

1. Fathers play an important role in the infant-feeding decision, usually made early in pregnancy, apart from their support of their partners in the endeavour of breastfeeding itself.
2. Expectant mothers' perceptions of their partners' attitudes regarding breastfeeding are powerful predictors of mothers' intent to breastfeed. However mothers-to-be are not good predictors of their partners' actual views toward breastfeeding.
3. Fathers are an important source of support and assistance at both ends of the breastfeeding spectrum. They were shown to be among the most important source of assistance at the first feeds and their support of the mother in breastfeeding beyond 5 months was second only to the encouragement of the baby.
4. Many fathers are not informed about the risks of using artificial breast-milk substitutes and not using breast milk. Research has shown a relationship between knowledge about breastfeeding and attitudes towards it.
5. Fathers want to establish their own relationships with their infants and sometimes see breastfeeding as a barrier to doing so.
6. Fathers sometimes show signs of jealousy toward the breastfeeding pair, either toward the infant who has taken away much of his partner's time and affection and or toward the new mother who can offer the baby nourishment and calm the crying baby in a way that he will never be able to duplicate.

Messages from Research

A number of studies have found fathers influencing mothers' decisions to initiate and/or sustain breastfeeding (for review, see Scott et al, 2001). 'Unpacking' this research it has been found that support from the infant's father through active participation in the breastfeeding decision, together with a positive attitude by him and knowledge about the benefits of breastfeeding, have been shown to have a strong influence on the initiation and duration of breastfeeding (Swanson & Power, 2005; Arora et al, 2000; Bromberg & Darby, 1997). Low-income women in particular suggest that male support is crucial in their decision to breastfeed (Schmidt & Sigman-Grant, 2000).

It is worth noting that mothers' perceptions of their partners' attitudes to breastfeeding – on which researchers often rely – may not be accurate: when the men are interviewed directly, their attitudes can be more positive than expected and reported by their partners (Freed et al, 1993).

An established workplace intervention in the US offers fathers either two 45-minute group classes (which include observing positioning and attachment) or a one-hour, one-on-one coaching session (which includes use and care of a breast pump). A book on breastfeeding and other 'take away' handouts are supplied. The fathers are also invited to attend a men-only fathering session as part of an ante-natal course for couples. All the interventions result in higher-than-average breastfeeding rates, with the outcomes from the fathering session the most impressive. When fathers had attended the fathering session as well as the breastfeeding instruction, 69% of the mothers were still breastfeeding at six months postpartum, compared with a national average of 21% (Cohen et al, 2002).

In Italy Piscane et al (2005) found that teaching fathers how to prevent and manage the most common lactation difficulties had a marked, positive impact on breastfeeding continuation. Only 15% of mothers whose partners had been simply told about the benefits of breastfeeding were still breastfeeding at six months; but when the men were individually coached for just 40 minutes on managing common problems (such as pain and discomfort, fear that baby isn't 'getting enough' and breastfeeding-issues when mum returns to work) the percentage of mothers still breastfeeding at six months was 25%. The impact was particularly strong among women who had reported difficulties with lactation (4.5% v. 24%).

Since high levels of maternal responsibility for household tasks and infant care are significant predictors of breastfeeding cessation, supporting fathers to take responsibility in these areas may contribute significantly to breastfeeding maintenance (Sullivan et al, 2004).

Working with the couple rather than simply with the mother in breastfeeding education is important. A desire for the father to have opportunities to be close to the baby can be a factor in some mothers opting to cease breastfeeding; and an approach that focuses exclusively on the mother-child dyad can result in some fathers feeling excluded, jealous and resentful to the detriment of breastfeeding success (Jordan & Wall, 1993).

In summary it is clear from the research that where fathers are bonded and emotionally available and involved with their children there are enormous implications for fathers on their own path of adult development, for their partners in the co-parenting relationship and most importantly, for their children in terms of social, emotional, physical and cognitive development. The challenge is how to engage fathers and support them to be that involved father. This starts with our own attitudes and beliefs about fathers. Two resources that are well worth accessing are John Hoffman's book of 55 pages titled "*Father Factors: What social science research tells us about fathers and how to work with them*" which can be found on the Father Involvement Research Alliance website (**www.fira.ca**). The other resource is the Father Inclusive Practice Guide that can be found by placing its title in the search box on the Australian Govt. Dept. of Social Services website (**www.dss.gov.au**).

Children, families and society deserve our efforts to encourage men in their role as fathers. The effort will be worth it.

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Arora, S., McJunkin, C., Wehrer, J., & Kuhn, P. (2000). Major factors influencing breastfeeding rates: mother's perception of father's attitude and milk supply. Pediatrics, 106(5).

Bromberg, B-YN., & Darby, L. (1997). Fathers and breastfeeding: a review of the literature. Journal of Human Lactation, (13), 45–50.

Cohen, R., Lange, L., & Slusser, W. (2002). A description of a male-focused breastfeeding promotion corporate lactation program. Journal of Human Lactation, 18(1), 61-65.

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Sullivan, M.L., Leathers, S.L., & Kelly, M.A. (2004). Family characteristics associated with duration of breastfeeding during early infancy among primiparas. Journal of Human Lactation, 20(2), 196-205.

Swanson, V., & Power, K.G. (2005). Initiation and continuation of breastfeeding: theory of planned behaviour. Journal of Advanced Nursing, 50(3), 272-282.

The Father/Child Journey DVD **www.gowrie-adelaide.com.au**

Craniosacral therapy; its history and application to babies and children

Chris Teale is a member of the Australian Physiotherapy Association having qualified in the UK as a Member of the Chartered Society of Physiotherapy before migrating to Australia in 1984.

Chris' initial experience has been in rehabilitation and musculoskeletal medicine, followed by sports physiotherapy working with a variety of sports clubs including the SA Women's cricket team and the Australian under 21's Women's Cricket team.

Chris commenced study in Craniosacral therapy (CST) with the Upledger Institute International in 2000 completing the 4 basic levels before progressing to CST for Paediatrics, CST for Obstetrics and Advanced CST level. She received certification from the Institute in 2012 and from 2006 to 2014 was director of the Upledger Institute Australia.

Learning the art of CST has changed Chris' physiotherapy practice, with her main focus for the last 10 years on babies and kids. Chris returned to study in 2006 and completed a Diploma in Clinical Nutrition, followed by a degree in Psychology in 2013 and she is currently a post graduate student at UniSA.

Introduction

CranioSacral Therapy (CST) is a gentle, hands-on modality aimed at improving the function of the cranio-sacral system; this system includes the cranial bones, membranes, spine and sacrum. CST was pioneered by osteopathic physician Dr John Upledger, following his extensive scientific studies at Michigan State University, during his tenure as a clinical researcher. As an osteopath he was proficient in cranial techniques but through his in depth study of anatomy, he determined that the cranial membranes and spinal dura had a significant role to play in the functioning of the central nervous system.

History

Trained as a surgeon, Dr. Upledger's in-depth investigation into the field of cranial mobilisation was prompted by an observation of the dural membrane during a patient's neck surgery in the early 1970s. After much research, Dr. Upledger theorized that cranial bones allowed for movement into adulthood — a concept previously accepted only for infants.

Dr. Upledger's curiosity on this controversial position led to his research with a team of anatomists, physiologists, biophysicists and bioengineers at the College of Osteopathic Medicine at Michigan State University where he served as a Professor of Biomechanics and clinical researcher from 1975 — 1983. They were tasked with proving or disproving the basic tenets of cranial mobilisation techniques i.e. the movement of cranial bones. By studying fresh cranial specimens and employing various testing means, Dr. Upledger's team confirmed the existence of cranial bone motion and attained precise measurements of the frequency and amplitude of cranial bone movement. Further investigation by Dr. Upledger lead to the hypothesis of the "Pressure stat Model" where the craniosacral dura mater and cerebrospinal fluid were integrated into a comprehensive model of the craniosacral system.

Dr Upledger pioneered techniques for evaluating and treating the dural membranes distinguishing CranioSacral Therapy from other cranial techniques which were focused on the osseous elements of the cranium. He also coined the now common title "CranioSacral" Therapy. His development of CST and the work of Upledger Institute International led his appointment to the Alternative Medicine Program Advisory Council for the Office of Alternative Medicine at the National Institutes of Health in Washington, D.C., and his being named in TIME magazine as one of America's "Next Wave of Innovators" for his proven clinical applications of this therapy.

Cranio-sacral system

The cranio-sacral system comprises the cranial bones, the cranial membranes which enfold and separate the two hemispheres of the cortex and cerebellum, the dural membrane which encloses the spinal cord and nerve roots, and the cerebrospinal fluid which flows through the subdural space cushioning the brain, spinal cord and assisting in the removal of waste products. Using gentle touch generally no greater than 5 grams, CST practitioners discover and release restrictions in the system, improving the movement of fluids, the function of the central nervous system and related structures. The movement of fluids is essential to the healthy function of any tissue and organ, whether it be brain, bone or muscle. Fluid is the body's physiological mechanisms to remove metabolic wastes from within cells and from intracellular spaces. Fluid is also the vehicle the body uses to deliver nutrients and antibodies, and to carry messenger substances such as hormones, neuropeptides and the electrically charged ions and particles that are so important to physiological function. CST also uses myofascial techniques to release the horizontal fascial diaphragms of the body including the pelvic floor, respiratory diaphragm, thoracic inlet, the

muscular attachments of the hyoid bone and the cranial base. Due to CST's holistic approach to releasing tension in the body's major zones of restriction, it can help in a wide range of problems associated with pain and dysfunction. Common problems treated in adults are whiplash, headaches and migraines, TMJ problems and bruxism as well as chronic neck and low back pain.

CranioSacral therapy for babies

My own experience with CST has been over 15 years and with a professional background in physiotherapy, the light touch was a very different modality to introduce to my adult clients. Over 8 years I progressed through various levels of training, and evolved from adults to treating children, pregnant mums and babies. CST helps irritable babies to settle; improves cervical movement in babies who have torticollis; assists in restoring symmetry to the babies who have plagiocephaly (flattened head shape) and can improve dramatically the symptoms of colic and reflux. Anecdotally I have witnessed marked improvement in children's behaviour including concentration, attention, increased auditory and visual processing speeds, enhanced sensory integration and ultimately improved activity at school.

To help understand how these improvements occur a brief reminder of anatomy may help. At birth the baby's cranium is soft and pliable, with only the parietal bones ossified to protect the cerebral hemispheres. The remaining cranial bones are partially ossified allowing the head to be moulded down the birth canal, with commonly the frontal and occipital bones compressed under the parietal bone, shrinking the size of the baby's head. Internally the cranial membranes, which are in 3 layers, attach to the under surface of the cranium and form two distinct structures; the vertical or falx cerebri/cerebelli and the horizontal or tentorium cerebelli. It is these fascial layers that maintain the integrity of the cranium through the birth process and allows for the normal cranial shape to be returned after birth, assisted by the baby's feeding, sucking and normal bouts of crying.

Birth process

If the baby's birth is uncomplicated and the head presents posteriorly, the occiput is hyperextend on the baby's first vertebrae; if the baby is allowed to birth itself with only mum's assistance less stress is exerted on this junction. If any intervention is applied on the baby's head with hands or instruments, then the baby's upper cervical muscles will contract against the force and effectively compress the occiput against the first vertebrae; these muscles may stay tight compressing the cranial base onto the first vertebrae. As well as the baby's brain stem protruding from the base of the occiput, 3 cranial nerves and the jugular vein are vulnerable to compression as they exit between the occiput and temporal bone. These are the vagus nerve CN 10, the glossopharyngeal nerve CN 9 and the accessory nerve CN 11. If the muscle tissue remains in spasm, the normal drainage of the jugular vein will be impeded increasing tension on the other structures around it, including the cranial nerves. This will also reduce normal fluid circulation within and around the brain affecting the cerebrospinal fluid, intracellular fluid, interstitial fluid, lymph and blood as well as the reduction in removal of waste products.

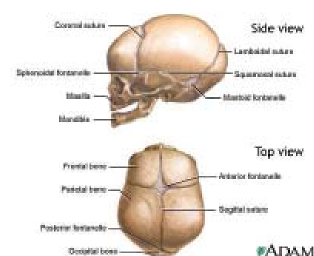
The result of this decreased fluid flow may result in the irritation of the cranial nerves and result in the symptoms I have already mentioned; the vagus nerve key function is the parasympathetic control of digestive functions and if irritated may cause symptoms of colic or "reflux"; the hypoglossal motor nerve controls the muscles of throat and tongue and if irritated may cause problems with attachment and feeding difficulties; and the accessory nerve supplies the upper trapezius muscle and sternocleidomastoid, which if affected may cause muscle spasm resulting in torticollis. Any of the above can be the consequence of a normal delivery.

If labour fails to progress, the choice may be either a ventouse or forceps delivery; each of which adds further strain and compression into the baby's cranial system. The ventouse in particular seems to add the greatest strain as its suction mechanism tractions the parietal bone and the underlying attachments of the vertical membrane system. If you haven't already tried one on your forearm, then I suggest you do as you will have some appreciation of what the baby has to endure. The most irritable and hard to settle babies I have treated have been those born by ventouse; although the obvious bruising and misshapen head from birth may resolve in 48 hours the underlying stretch on the cranial membrane system can continue to irritate the baby from many weeks.

If forceps are used further compression can be introduced into the baby's system through their placement on the sphenoid/temporal region and depending on what guiding force is used or needed to help birth the baby a twist or torsion in the baby's system may be induced. A C-section would seem to have less stress on the baby's craniosacral system, but this is not the case as the baby's system is shocked by the sudden change in pressure when the incision is made, causing the baby's head to balloon and increase the stretch on the cranial membranes. Some babies are also wedged inside the mother's pelvis and need extra intervention.

The shared practice of adding a broad spectrum antibiotic to the mother's drip during the procedure, also allows for the passage of antibiotic into the baby through the placenta and through the mother's milk. The C- section babies are already low in gut bacteria as they do not receive the seeding from the vaginal flora; the antibiotic just adds further dysfunction to their gut. The commonest problem I see for C section babies is digestive colic, with explosive bowels, difficulty with wind, excessive crying which can be quickly resolved by a specially formulated baby probiotic. Another common problem for C-section births is projectile vomit, and is a result of the expanded head, which creates tension around the vagus nerve. This responds very well to CST with often the first treatment resolving the problem.

One the subject of colic, recent research has indicated that some babies whose mothers suffer from migraines, are more likely to suffer from colic regardless of birth intervention. The authors of the study concluded that the babies could be suffering from a type of migraine; this could explain why CST is so effective in these babies (Gelfand 2012).



What does a treatment look like?

For newborns, evaluation and treatment are bound into one with the baby's system releasing with the gentlest of pressures.

Initially the sacrum and pelvic fascia is released, followed by the respiratory diaphragm and thoracic inlet; if there are swallowing or feeding issues special attention is placed on the hyoid bone and its muscular attachments. Next the occiput is released off the first vertebra, allowing for a release of the spinal dura with the occiput cradled in one hand and the sacrum in the other. Once tension is released from the spine, the baby's sucking reflex is checked which helps to stimulate the soft palate; particularly important if the baby was suctioned after birth. Following a ventouse delivery the baby may be too sensitive for cranial work, so treatment is focussed around the sacrum with gentle pressure applied to spinal dura from the sacrum to release tension around the head. These babies sometimes take 2 or 3 session before treatment can be applied on the cranium, and then the focus is to relieve tension on the parietal bones.

Babies that present with "reflux" can have any or all of the following; irritation of ANS particularly the vagus nerve, irritation of thoracic nerve roots 6-7 which innervate the gastro-oesophageal junction (GOJ) or tension of the respiratory diaphragm where the GOJ's fibres merge. If CST is unable to resolve the problem then dietary management is advised. As "reflux" can settle v quickly when the tension is released from GOJ, nerves and / or mum's diet or formula is resolved, it seems more appropriate to refer to these babies as suffering from chronic regurgitation. This is confirmed by research that debates the presence of gastric acid in newborns, with the over prescription of PPIs which can do more harm than good (Douglas, 2005).

CST in children

If birth results in compression of the baby's skull and this isn't resolved with normal crying, feeding and growth; it may present later in a child's life. Without a longitudinal study this cannot be confirmed empirically but by carefully questioning the mothers of children I see of their child's birth history and development, common patterns of presentation occur in children with learning difficulties and behavioural issues.

The children commonly referred to my clinic have been independently assessed by an occupational therapist and/ or psychologist. They may present with different issues at school but on testing have a combination of decreased auditory and visual processing, retained primitive reflexes e.g. Moro, Asymmetrical tonic neck reflex, sensory integration problems and limited concentration and attention span.

Common restrictions found in the craniosacral system related to these are, compression of the frontal, temporal and sphenoid bones, tension of the tentorium cerebellum which is particularly important as 8 cranial nerves penetrate the membrane and compression of cranial base. With a few treatments, tension can be resolved in the system with a measurable improvement when retested by their referring professional as well as profound behavioural changes. As one 8 year old boy said to me "I feel like a brick has been taken off my head and my brain has more space".

CST in pregnancy

CST can assist through pregnancy helping to prepare the mother by releasing tension in her pelvis, SI joints, spine and fascial diaphragms as the baby grows. It may also help with pre-conception as the major endocrine organ, the pituitary gland, sits behind the bridge of the nose, within the sphenoid bone and is vulnerable to any extra strains that exist. It is connected to the hypothalamus by numerous blood vessels and communicates directly into the blood stream.

CST is practised by a multitude of therapists including physios, massage therapists, osteopaths and chiropractors. As it has become more popular as a modality make sure to check the therapists training credentials and they have completed both Upledger Obstetric and Paediatric courses before referring any of your mums and babies.

If you would like further information on CST training in Australia or to find a practitioner in your area contact **www.upledger.com.au**.

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If you would like further information
www.christealephysiotherapy.com

The **care** factor: **kids** with **special needs**

Maria Whitmore, a former journalist and sub-editor in regional Victoria, is now a member of the communications' team at the **Continence Foundation of Australia**. As their special projects officer Maria helps promote the Foundation's key message that incontinence is not a normal part of life, but, in the majority of cases, easily preventable and treatable. With nearly one in five Australians affected by incontinence, Maria's principal objective with each of her communications' projects is to offer hope to those affected, and continue the destigmatisation the condition throughout the wider community.

There is plenty of research telling us what most of us already suspected; that parents of children with disabilities are much more prone to stress, anxiety, depression and relationship strain than other parents[1].

We also know that the level of social and community supports these parents receive is a major determinant in how well they fare[3].

The most recent Australian Bureau of Statistics (ABS) census reported that one in 11 children aged between five and 14 had some form of disability - more than half with severe or profound limitations[2]. That equates to about one in 20 children.

The parents of these children make up a sizeable portion of the 2.7 million unpaid carers across Australia[4] who look after our most vulnerable citizens, including the 140,000 who need help with bladder and bowel control[5].

To draw attention to the plight of carers of children and adults with incontinence, the Continence Foundation of Australia has this year turned its focus on carers. The Foundation is about to launch a national campaign, ***Tell someone who cares; phone 1800 33 00 66***, during World Continence Week (June 22-28).

Parents are often overlooked when the term 'carer' is used in this context. Yet the majority (63 per cent) of children's disorders reported in the last ABS census were mental or behavioural[2]. Conditions such as autism, ADD, intellectual disability and delayed development are amongst these — all of which can have implications for bladder and bowel control problems.

Children's continence nurse Janine Armocida, who is also a consultant on the National Continence Helpline, said parents were often exasperated and desperate by the time they phoned the Helpline.

Some of the more challenging behaviours parents sought help for, she said, were when children held on (avoidance) for unreasonably long periods, handled their faeces, soiled or wet themselves well beyond toilet training age, or were afraid to use the toilet.

"We can help parents identify possible causes for some of these problems so they have a starting point from which to take some new approaches," Ms Armocida said.

For example, a painful bowel motion due to constipation was often found to be the precursor to toilet avoidance, she said.

"If you suspect constipation, have your child's bowels checked out by your doctor or continence nurse."

Fear of the toilet may be a sensory issue for children with autism, she said. "They may not like the sound of the flushing toilet, or feel that the toilet seat is too cold, too hot or too hard. By trying to identify the cause of their fear, parents may be able to make a few alterations to the toilet environment," Ms Armocida said.

Explaining to parents why some children might handle their faeces was a significant first step towards modifying their behaviour, she said.

"Some children handle their faeces because they can feel it coming out, or because it feels uncomfortable in their rectum. This too, can often be associated with constipation. Other children play with their faeces because they like the tactile sensation, in which case products like playdo or kids' slime might be introduced to their play."

Ms Armocida reassured parents that there was much that could be done to support parents trying to cope with challenging toileting behaviours.

"We can also put parents in contact with a specialist continence service in their area when they phone us at the Helpline," she added.

"As with all children, it's important to observe your child so you know what may be holding them back; sometimes recording their bladder and bowel habits helps give a pictorial of what is happening. And remember, stay calm, be positive, reward good behaviour and ignore other behaviours."

The Tell someone who cares; phone 1800 33 00 66 campaign is supported by Carers Australia and includes the launch of new resources, dedicated web pages and short videos on the Continence Foundation website that outline the available support services, including the National Continence Helpline (1800 33 00 66).

Ms Armocida recommended a number of excellent resources already available for parents of children with disabilities:

- ★ *One Step at a Time*; a parent's guide to toilet skills for children with special needs available from the Victorian Continence Resource Centre (03 9816 8266),
- ★ Tom's Toilet DVD; available from the South Australian Government (13 23 24),
- ★ *Toilet Training for children with special needs* app from iTunes, and
- ★ *One Step at a time Toilet Tips* from Google Play

For advice about your child's toileting behaviours, information about financial assistance for the purchase of products and referrals to health and support services, phone the free National Continence Helpline on 1800 33 00 66.

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2. ABS 2003 and 2009 Survey of Disability, Ageing and Carers (SDAC).
3. Isa SN et. al., The impact of children with disabilities on parent health-related quality of life and family functioning in Kelantan and its associated factors. J Dev Behav Pediatr. 2013 May;34(4):262-8.
4. ABS (2012) *Survey of Disability, Ageing and Carers.*
5. Access Economics (2010) *The Economic Value of Informal Care in 2010.*

Andrea Robertson

Andrea Robertson was inspired to become a childbirth educator in 1974, following her first birth experience — she felt that women needed better support and encouragement to make informed choices and be actively involved in their labour and birth. She orchestrated many campaigns for the improvement of maternity services in Australia, and initiated many programs of educational services for health professionals and educators related to care of women, particularly during labour and birth. She was truly a leader during the fledgling years of birth and parenting education in Australia, and was the first person to achieve a recognised Graduate Diploma in Childbirth Education in the world (1993-2004).

She has positively inspired many midwives and childbirth and parenting educators over many years through her practical Active Birth and Birth and Parenting workshops, 1-3 day conferences and books for educators as well as expectant parents.

Andrea died suddenly during April 2015, while still maintaining a busy workload. To honour her work, her children request that people and organisations may **donate** to the **Rhodanthe Lipsett Trust Fund** which supports indigenous midwives. She will be greatly missed by all who knew and were influenced by her.

We have been deeply saddened by the recent passing of Andrea Robertson, well-known educator and author. Andrea has been a huge influence on the lives of countless childbirth educators and midwives over more than 30 years - and, in turn, on the lives of so many women and their families across Australia and around the world. She was fearless in her convictions and that passion was passed on to all who knew, worked and studied with her. She will be greatly missed by us all.

Sue Spencer
National President CAPEA

Such a sad loss to the world of midwifery and childbirth education. Both Sheila and Andrea exemplify what the wise women were to society in ages past. I listened to both women speak over the last 20 years and hope that I can take some small part of their knowledge and impart to women in my care. Andrea set me on the path of CBE 17 years ago and I have gained enormous satisfaction from the role. I hope I have helped new parents achieve as normal a birth as possible as a result of her active birth principles.

Jane Knight
National Treasurer CAPEA

Australia has lost a major champion of Childbirth Education. Andrea's influence and innovation in our field will be missed. When parents prepared for childbirth in the sixties the only classes for pregnant women were about care of the baby and mother. These classes were quite didactic even later, when Grantly Dick Read's breathing method (psychoprophylaxis) was embraced, the lessons were conducted in front of a blackboard for mothers alone. Our history is a multifaceted story but the strongest voluntary and organisational push came from The Childbirth Education Association (Melbourne) and Parent Centres of Australia (Sydney) as they passionately defended the right of choice and control over childbirth. Feminism, consumer rights and the inclusion of fathers reformed the way health professionals and the maternity health is viewed today. Andrea was the National President of Parents Centres Australia from 1978-1984 leading many of the public campaigns and educational programs to improve maternity services. In 1985 she started a private consultancy and began training workshops to update educators and health professionals.

ACE Graphics, *her first business, provided teaching aids (even making plastic models herself) books and support for Janet Balaskas' concept of "Active Birth". Her business expanded providing workshops and in-service training for midwives wishing more education experience to spread throughout Australia. Often her innovations were extraordinarily ahead of a safe business model. Fellow educators have failed in attempts to make Childbirth and Parenting Education part of tertiary health degree but Andrea did have her course accredited through the Australian Government Vocational Education and Training Accreditation Board as a Graduate Diploma in Childbirth Education. She conducted training camps for senior educators to step into leadership roles, whilst constructing a training course which involved correspondence, telephone support for those providing distant education, face to face workshops and sponsoring notable visiting speakers.*

Her first book Preparing For Birth (1987) was the first Australian book published in the soft cover format that could be sold as a class handout. This was another innovation making it a best seller at 260,000 copies. This was followed many others: Teaching Active Birth, Empowering Women, Making Birth Easier, and her last book The Midwife Companion - the art of support during birth was republished in 2004. It is hard to imagine how so much can be achieved by one woman and although based in Sydney she travelled extensively around Australia, to the United Kingdom, the United States, South East Asia, Japan, South America, and New Zealand.

This is a very tragic loss for all women giving birth, this includes the many who do not even know of the powerhouse behind the Australian Childbirth Education vocation. I knew Andrea well and respected her ease with an audience, her sense of humour, integrity as a sponsor and pragmatic approach to women's business!

Bronny Handfield
Vic CAPEA

For more about Andrea's professional life, go to: **https://www.birthinternational.com/about/company-information/andrea-robertson** and **https://www.birthinternational.com/about/graduate-diploma**

To donate to the
Rhodanthe Lipsett Trust Fund for indigenous midwives, go to:
http://rhodanthelipsetttrust.com.au and http://rhodanthelipsetttrust.com.au/web-access/wp-content/uploads/2015/01/RLT-How-to-Donate.pdf

Sheila Kitzinger

Sheila Kitzinger, sometimes described as the "high priestess of natural childbirth", died on 11 April 2015 aged 86.

She was a social anthropologist specialising in pregnancy, childbirth and the parenting of babies and young children. She lectured on midwifery but was never a midwife.

She believed women should be able to make informed choices surrounding childbirth and was unyielding in her campaign against its medicalisation. She promoted women-centered care and believed each birth should be a unique and individual experience. She advocated for the acceptance of pain in labour, seeing it as a powerful, positive sensation with a purpose.

She married Uwe Kitzinger in 1952. Her passion for natural childbirth came from first-hand experience of five natural, energizing, empowering labours and births.

Kitzinger became involved in two organisations which were inspired by the writings of the British obstetrician Grantly Dick-Read. In 1958 she joined the advisory board of the newly formed Natural Childbirth Trust (renamed National Childbirth Trust) and was a consultant to the International Childbirth Education Association, in the US. It was at this time she started to cultivate her "psychosexual approach" to birth.

Kitzinger researched styles of parenting and preparation for birth in many societies. She was a childbirth educator and trainer as well as a lecturer. Her book "The Experience of Childbirth" published in 1962 (last up-dated in 2004) brought her distinction in this area as she argued that women's needs and choices during labour and birth should be of vital importance. These beliefs challenged the increasing medicalisation of birth. Many women had similar beliefs to Kitzinger and the book's effect on labour and birth caused women to question 'routine' practices such as enemas, shaving and episiotomies. Women needed to reclaim their bodies. She argued that problems in childbirth could be reduced through education and by using a range of relaxation techniques.

Kitzinger wrote more than thirty books, translated in many different languages, covering women's experiences of antenatal care, birth plans, induction of labour, epidurals, episiotomy, hospital care in childbirth, children's experiences of being present at birth, sexuality, post-traumatic stress following childbirth, breastfeeding, childcare, motherhood and grandparenthood. Her 1980 book Pregnancy and Childbirth, revised as The New Pregnancy and Childbirth most recently in 2011, has sold more than a million copies.

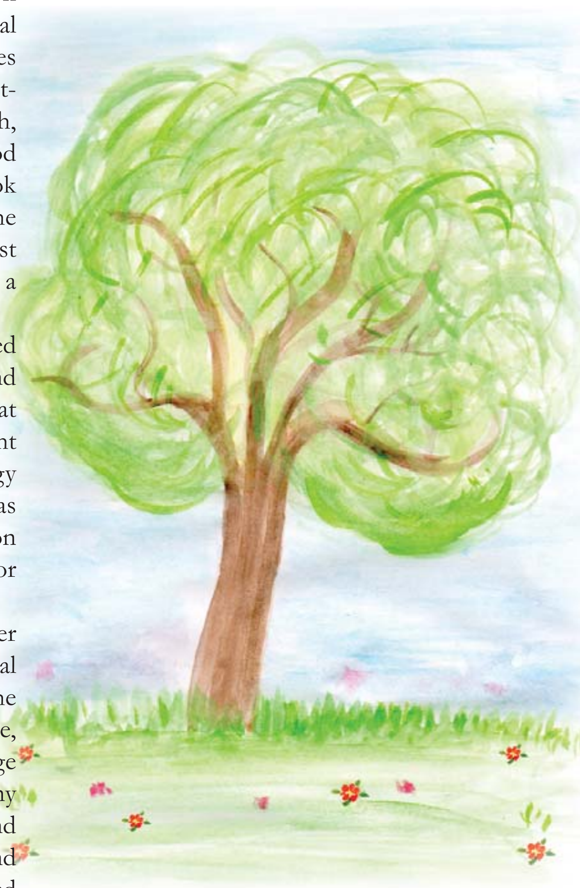
As well as writing books, she continued to research areas of labour, birth and parenting. She was honorary professor at University of West London. She also taught workshops on the social anthropology of birth and breastfeeding and was appointed MBE in 1982 in recognition of her services to education for childbirth.

Sheila was the Keynote Speaker at the CAPEA (NACE Inc) Biennial Conference held in Sydney in 2003. She was an inspiration at the conference, willingly sharing her knowledge and expertise and speaking to many CAPEA members in workshops and small groups. She was friendly and accessible to everyone who approached her, which was much appreciated by all who attended.

Sheila will be greatly missed by all who knew and were inspired by her.

With thanks to the Guardian UK and CAPEA members.

For more about Sheila's professional life, go to **http://www.sheilakitzinger.com/**



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