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## Maternity Coalition: Australia's National Maternity Consumer Advocacy Organization

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### Introduction

This chapter tells the story of the Maternity Coalition (MC), an Australian advocacy organization which represents an often 'forgotten' strand of the women's movement – the maternalist feminist emphasis on reclaiming women's rights in birth and breastfeeding (Reiger *Our Bodies*). Having originated in the late 1980s to lobby state government inquiries for improved maternity services in the Australian states of New South Wales (NSW) and Victoria, by 2008 the organization was established nationally and was acknowledged as a key stakeholder in the incoming federal government's agenda for improving maternity care. This chapter first examines how the Maternity Coalition developed, its rationale and mothering discourse, and then considers challenges which the organization faces in the early 21<sup>st</sup> century. Developing from a state-based to a national organization, MC faces internal

sustainability difficulties in terms of communicating and managing a voluntary organization mostly comprised of busy young mothers. The external challenges are also considerable—MC aims to change the entrenched system of maternity services but in a cultural context which values technology and professional expertise and a political economic context in which the medical profession holds significant power. Nonetheless, Australia's Maternity Coalition has achieved a national profile and credibility, bringing women's rights to options and optimal care in birth to public attention at a level not achieved in many comparable countries.

### **History, purpose and philosophy**

In the 1980s several developments laid the groundwork for what would emerge as the Maternity Coalition (MC). Childbirth groups supporting normal birth and decrying excessive medicalization in maternity care had been established in Australia from the late 1960s, rapidly expanding in the 1970s in the context of the women's movement. In Australia, and to a lesser extent elsewhere, childbirth education, homebirth and breastfeeding support groups, of mostly white and middle class women, formed a separate 'movement' to the mainstream feminist women's health movement. The movement is best interpreted as maternalist; that is, emphasizing women's embodied knowledge and mothering roles (Reiger *Reconceiving Citizenship; Our Bodies*). MC as an organization went further than support groups, developing a more political role primarily focused on advocacy for improved maternity care. How MC has interpreted that mission has varied locally but reflects its beginnings in political activities around the government reviews of birthing services in the states of NSW and Victoria in the late 1980s. In exploring key factors that have shaped the organization's philosophy and purpose, the following discussion also reveals wider social and organizational challenges facing the international movement to 'reclaim' women's autonomy in childbirth (Goer).

MC began in mid-1988 as a Task Force of a Sydney-based consumer group, Maternity Alliance (MA). MA had commenced in June 1987 in response to the need for effective, rather than tokenistic, consumer input into the NSW review of obstetrics (the Shearman Review). MA's stress was on being a *consumer* organization, reflecting the influence of the recently developed Consumer Health Forum. The Alliance achieved two consumer representatives and a midwife on the NSW review. Responding to the initiative of MA representatives, a specific Victorian group formed to lobby the Birthing Services Review (BSR). The background to the Review already lay in local activism, especially through the direct precursor to what became MC—Mothers & Midwives Action (MAMA). MAMA had gained political support for maternity reform from key women politicians and from feminist health bureaucrats, and problems with perinatal care had been identified by the *Why Women's Health* report in 1985 (Reiger). The Victorian Taskforce of MA initially focused on forming a

flexible umbrella group to prepare a major submission, and succeeded in getting the message out to women that the review team wanted to hear a broad range of voices. A variety of skills and backgrounds contributed to effective action: Gennie MacGregor from MAMA understood the background politics, and Irene Shaw was a member of the Review consultative group but also a childbirth educator and researcher of the birth centre movement. Along with homebirth groups, the involvement of those supporting technological birth, including multiple birth and neonatal death support groups, led to some lively debates over changing birth practices to better benefit women.

In the process of engaging with the Review, the Victorian Task Force moved away from Maternity Alliance (MA) primarily over philosophical differences of opinion about organizational processes. The MA general committee strongly held the position that professionals could not hold office in a 'consumer' organization and also discouraged actual branches, preferring only informal flexible groups. In Victoria, while midwives were not strongly involved in the Task Force itself, they were essential participants in the precursor organization MAMA, which emphasized mothers' and midwives' shared interests in changing the system of maternity care. Maternity Coalition then also encouraged a *coalition* of women and midwives. While it formed as an umbrella group in which smaller organizations retained independence and freedom such as in local networking, MC sought a coherent organizational direction based on advocacy.

In the early-mid 1990s MC's main focus was on promoting the outcome of the Victorian review. The review report, *Having a Baby in Victoria* (1990) gave strong policy support to implementing the concept of women-centered and family-friendly care, such as through family birth centers and an increased professional role for the (then nurse-trained) midwives staffing the hospital system, as well as the few working independently in community-based practice. Midwives had begun to develop new professional networks and heightened consciousness of the need for system change and to practice more autonomously than as obstetric nurses. Nationally, maternity reform was also given formal legitimacy during the 1990s, first in NSW and Victoria, then later in Western Australia and South Australia and at federal level (Reiger, *Neoliberal quickstep*). While Queensland came later to this process, it was home to important advocacy groups, especially the Home Midwifery Association which developed a complex network of homebirth groups. In sum then, the mandate of MC was to promote change within the maternity care system and to use community gatherings to bring attention to problems faced by women as new mothers. In its role of watchdog over the slow implementation of reform, MC in Victoria developed not only as a support group but also as a formal organization which was increasingly seen by health managers and bureaucrats as credible and representative in lobbying. MC remained small in terms of direct membership, but the largely Melbourne-based group developed a constitution in 1991, and incorporated as a charitable organization which provided the basis for later geographical expansion.

The working committee of MC was bound by commitment to the social value of mothering, as both physiological and social process. Close personal ties were forged over several years: as a community with a shared interest in women's lives as mothers, MC brought old and new members together, more babies arrived, toddlers grew into teenagers, marriages dissolved and families re-formed, and women's paid jobs had to be juggled. Informal monthly meetings were held over weekend lunches, often in a members' home or later in community locations, in a largely unsuccessful effort to become more socially inclusive. MC membership however, has unfortunately remained predominantly white middle class, albeit with the goal of working for improvements to benefit *all* women. Regular MC meetings were eventually arranged to overlap over lunch with meetings of Midwives in Private Practice, bringing some midwives and MC mothers together in a shared agenda. Compared with the emphasis on 'intensive mothering' common in some homebirth and breastfeeding groups, a fairly pragmatic approach to styles of mothering and managing paid work became accepted in MC, possibly reflecting diverse interests of professional women, including midwives. Commitment to promoting normal physiological birth and to supporting breastfeeding has remained the taken-for-granted basis of MC's philosophy.

By the mid-1990s the goals and philosophy of MC were formally articulated, becoming refined over time as follows:

*Maternity Coalition is a national non-profit, non-political and non-sectarian consumer advocacy organization in Australia. The organization acts as an umbrella to bring together support groups and individuals for effective lobbying, information sharing, networking and support in maternity services across Australia. It works to unite women in their efforts and to share skills and resources to achieve beneficial changes in the health care system in the interests of improving birthing services. It was developed to support both consumer and midwife participation at all levels of health policy planning, decision-making and service delivery.*

The philosophy of the Maternity Coalition is to:

- *encourage a woman-centered approach to the birth process;*
- *regard pregnancy and childbirth as normal physiological processes, not illnesses;*
- *stress the social, cultural and psychological factors influencing childbirth;*
- *support midwives as the primary caregivers for women in normal birth;*
- *emphasize women's rights to make informed choices about their caregiver and place of birth;*
- *promote continuous assessment and critical evaluation of technologies used in maternity care;*
- *support the development of services sensitive to women's varied cultural and physical needs. (Source: [www.maternitycoalition.org.au](http://www.maternitycoalition.org.au))*

As the organization grew into the later 1990s, the MC journal *Birth Matters* was inaugurated in April 1997 by founding member Irene Shaw to offer a steady flow of information-sharing as a base for further advocacy action. Early issues, in a similar way to more recent ones, report frustration at the difficulty of changing hospital practices in spite of MC submissions and contributions to government consultations and committees. They have also regularly included birth stories and articles on what is often now termed 'gentle' or 'natural' mothering. New people coming onto the MC committee increased the passion and energy for political advocacy efforts, soon seeking to expand MC's work beyond Victoria as networking increased. In a cultural environment where health awareness was becoming more common, then president Robyn Payne established the 'Choices for Childbirth' public birth information series in Melbourne in 1999, with similar programs emerging in other areas. Under Robyn's leadership the governance of MC continued to be reviewed to maintain a range of skills and interests in the organization, including balancing mothers and midwives in formal positions. For many years, MC successfully managed the possible conflicts between their interests, involving midwives on the committee such as Jenny Parratt as treasurer and Joy Johnston in editing *Birth Matters*. Although the MC Management Committee recognized that a more socially and culturally diverse community base of women was desirable, MC's mandate was an umbrella group to advocate at various levels for improved maternity services. To this end, bringing new members on board slowly was regarded as important, allowing them to become familiar with the enormous and increasing range of information about birth and maternity care, the local policy context, and the culture and principles of MC which had gained it considerable legitimacy with health professionals and bureaucrats.

### **Maternity Coalition in the 21<sup>st</sup> century**

By the 2000s members from other states were seeking expansion of MC in light of developments in their own states and at federal government level. The midwifery profession was also mobilizing for change through conferences and the nationally funded Australian Midwifery Action Research project. In several Australian states this was a period of major shake-up in the health sector, including closures of rural units, and community concern about the health implications of policies promoting early discharge after birth but with a decline in maternal and child health support. In a conscious effort to expand, the Victorian MC committee supported its relatively new Canberra members Barb Vernon and Justine Caines to attend the annual MC meeting in Melbourne in November 2001. They accepted an invitation to stand as, respectively, MC President and Media Officer, and a new era of development began. A period of major advance for MC as an increasingly national voluntary organization was made possible both by members' increased access to information technologies, and by a political climate in which midwifery was becoming more assertive as a profession and health departments somewhat more responsive to consumer advocacy.

## *Going national: the National Maternity Action Plan*

The first real blueprint for overall reform of Australia's maternity services—the National Maternity Action Plan (NMAP) — was developed by a coalition of groups, notably by MC's revitalized leadership team along with the Australian Society of Independent Midwives, and Community Midwifery WA (<http://www.maternitycoalition.org.au/nmap.html>) The NMAP greatly extended MC's agenda and profile. It strongly emphasized women's right to choose a known midwife to care for them throughout pregnancy, birth and the first few weeks after birth as both the optimal model of evidence-based care (Sakala and Corry) and as a human right of women in reproduction.

Advancing the seemingly radical agenda of NMAP— that is seeking to challenge the obstetric-led maternity care system — attracted professional and political attention and gave MC increased visibility. By the mid- to late 2000s MC was firmly established with a local president and one or more branches in every state and territory, although patterns of local activity varied. In Queensland, local advocacy efforts placed maternity reform on the political agenda for the first time and established MC as an articulate voice. In some states many of the more active MC members were also active members of other groups with a similar purpose and philosophy, with MC acting as an effective umbrella organization, channeling information between state and national levels. This meant easier planning of joint events such as public birth information nights, and shared efforts in promoting normal birth and midwifery care (e.g. at regional Parents & Babies Expos), while state groups could still be involved in national reform campaigns. On the other hand, in other states MC was *the* main organization and benefited from having just one broad membership base. As MC's profile and credibility increased, MC members were also invited by many local health departments, hospitals and midwifery educators to sit on various committees as consumer representatives. MC also gained valuable support in some states from local politicians, particularly women politicians, who were sympathetic to its cause and who offered some opportunities to meet Ministers, or helped MC executive members build their understanding of how to effectively advocate to politicians.

## **Organizational challenges and future directions**

MC continues to face challenges in two main areas: first, the *internal* issues associated with sustaining a national organization run totally by volunteers and, second, *external* issues associated with advocating physiologically normal birth within a professional and political environment which continues to resist fundamental change to the mainstream system of medicalized birth. In view of both sets of challenges, it is hardly surprising that tensions and struggles regarding the focus, philosophy and strategies of the group continue to generate

internal tension and test the strength of purpose and connectedness which motivates mostly mothers, but a few men also, to belong to MC.

### *Internal organizational challenges*

As MC grew beyond the initial one or two states, it faced challenges because its internal organizational processes and structures no longer met the needs of what was becoming a national organization. By 2007 several unresolved issues started to stand in the way of further expansion. Accordingly a small Federal government grant was sought and obtained by then national MC President, Louise Hartley. This allowed MC to bring state/territory presidents and other delegates face-to-face in two workshops to discuss the mission and strategies to move the organization effectively into the 21<sup>st</sup> century. Several structural challenges had to be addressed, especially relationships between national, state and regional branches, with emerging local grassroots entities, and with midwifery organizations.

The 'Choices for Childbirth' public education seminars and, more latterly, the 'BaBS Birth & Babies' mother's support groups were never officially included in the organizational accountability and reporting structures. Furthermore, in states where MC is not the sole maternity consumer advocacy organization, diverse groups often have different philosophical or strategic focus points, such as homebirth advocacy (including the practice of 'free birth'), caesarean birth awareness, or community antenatal education. Their different views of mothering in turn affect their capacity to work together or to attract a broader range of mothers. Some groups, for example, have an additional focus on radical feminist activism, 'attachment parenting' and extended breastfeeding, and on organic foods, natural clothing and natural living. As they vary in their self-identification, some therefore prefer to remain small and independent.

All local groups work to improve maternity services and experiences for women, especially valuing and promoting midwifery services. Although MC started as an explicit collaboration between birthing women and midwives, by the mid-2000s, as midwives established a heightened sense of professional identity, state authorities, and some members, encouraged the discursive positioning of MC more specifically as a health *consumer* organization. Whilst the 'mothers-midwives coalition' remains important, it has therefore become less pivotal to MC organizational identity and the balance between focusing on midwifery interests and 'consumer' issues has remained controversial. The diverse community-based birthing groups have nonetheless continued to work successfully with midwives on many occasions to run public events either under a local banner or under the MC banner. In several locations in 2007-8, shared events included for example screenings of the Ricki Lake documentary film *The Business of Being Born*, and a protest outside the federal



parliament in response to changes to insurance and registration requirements around home birth midwifery access in 2009.

In a country as large as Australia, and with only the limited funds from membership and local fundraising, MC's communication challenges have been considerable. It has been difficult for state presidents to come together or even to meet with regional representatives to build the relationships required for concerted advocacy efforts. The Internet has enabled a shared interactive national online list-serve, and some at local levels, and email and teleconferences also allow office bearers and members to work together more effectively, such as on the national newsletter, although such 'distanced' relationships cannot replace the interpersonal trust and local knowledge of 'real time and space'. Conflicts and misunderstandings, which can become especially acute in the emotionally-laden field of childbirth, can also become amplified in the absence of personal bonds and knowledge of each other.

Sustaining involvement is also a challenge in an organization run by volunteers who are at the same time mostly mothers with young children and families to care for, and often also women in part-time or full-time paid work. Not only are those most active in the organization at risk of finding themselves burnt-out from working a 'triple shift' (mothering & caring work, paid work outside the home, unpaid advocacy work) but for many, activism around birth is part of a life cycle stage, soon replaced by joining kindergarten and school groups as their children grow up. Those with longest involvement have often been midwives, researchers, or activists who go on to doula or midwifery training, finding their involvement to be a great opportunity to 'bond in sisterhood' to work to improve women's lives. The shared commitment to widening women's birthing options, especially birth centers and homebirth, and to improving mainstream hospital-based services has remained MC's central focus, but has also been challenged by the external political environment.

### **Confronting the challenges of political advocacy**

The *external* challenges faced by the Maternity Coalition include the continuing power of the medical lobby and of a biomedical paradigm which diminishes women's agency in reproduction (Rothman *In labour*; Martin) and contributes to the cultural dominance of medicalized birth. The Australian Federal Government's National Review of Maternity Services in 2008-9 generated a key period of mobilization and consumed an enormous amount of MC's time and energy, although with very disappointing and demoralizing results. Auspiced by a reformist Labor government elected in late 2007 as part of its larger health reform agenda, the MSR was responding to several pressures for reform of the maternity system, significantly those put on the agenda by MC via the NMAP in 2002. MC leaders played a key stakeholder role in the MSR process, notably Justine Caines (also

representing Homebirth Australia) who contributed enormously to public media discussion. From the initial consulting period, there was genuine optimism that changes to the power dynamic of Australian maternity care were a real possibility.

MC advocates, and others in related organizations, worked tirelessly to encourage women to write submissions to the Review, providing templates and holding gatherings where women submitted letters 'en masse', advocating for the right to be able to choose their own midwife and birthplace. Following its formal report in February 2009, the MSR resulted in legislation to facilitate new arrangements for midwives and nurse practitioners, designed to enable those of them registered as 'eligible' professionals to access state health insurance (Medicare) rebates and pharmaceutical benefits, along with indemnity insurance. However, as such 'eligible' midwives are now required to work in 'collaborative arrangements' with obstetricians or hospitals, a new form of control has been instituted over both women's choices and midwives' practice. Despite vigorous campaigning by mothers and supporters—a 3000 strong rally to protest outside the national Parliament, letter writing, media work and meetings with politicians—the legislation was passed in 2010. Activism around the MSR has confirmed the power of the medical lobby and hence also revealed the limitations of women's role as consumers and their political effectiveness in changing a mainstream system.

### **Gaining and maintaining credibility as a voice for women**

While Maternity Coalition gained a heightened public profile during the MSR process, members nevertheless had difficulty representing a coherent public voice. Internal differences emerged within MC itself, between MC and other groups, and within the midwifery community. These continue to reflect longstanding tensions which split the Australian homebirth movement in the early 1990s and which MC had since sought to overcome. Some saw the struggle over the MSR primarily as *ideological*, requiring a huge cultural paradigm shift to remove childbirth, an intrinsically 'natural part of life', entirely away from government or medical control. They draw on counter cultural, and often essentialist, radical feminist imagery to emphasize women's embodied capacities and the importance of rejecting mainstream services. Others instead interpret maternity reform in more pragmatic and reformist terms as using state policy to slowly change a health system to ensure greater equity for socially disadvantaged women as well as offer increased choices and autonomy for all. In spite of some overlap of objectives and shared strategies, both strands within the birth movement are evident within MC, which also faces continued challenges associated with public image. Unlike in the 1970s, 'alternative' birthing is not exactly fashionable in a contemporary technocratic, risk-oriented and celebrity-obsessed culture.

Medical dominance is so taken for granted in Australia that few women question it, or even see that the adverse health outcomes they often experience with birth are caused by the way the system is often set up to fail them (and not to provide, for example, the emotional care and time they need to give birth under their own steam), so that women have no option but instead to 'trust' their doctors, and then blame themselves and their own bodies for negative experiences of birth and early motherhood (Campo). Reflecting the cultural dominance of biomedicine, the media also often derogatively present birth advocacy groups as 'hippies' and 'feminists' driven by ideology and irrational hatred of 'modern' medicine (e.g. Devine). It is usually doctors and their organizations, rather than women and their midwifery advocates, who are then sought for opinion by journalists. As a volunteer-run organization supported by a relatively narrow membership base, MC struggles to compete with the united front presented by powerful medical interests supported by paid executive officers, paid professional media teams, etc. During the MSR for example, doctors lobbied vigorously in favor of supporting the status-quo of medically-led birth. While they claimed achieving low levels of infant and maternal mortality rates as their success, they ignored evidence presented concerning high levels of maternal morbidity – postnatal depression, post-traumatic stress disorder, relatively high levels of caesarean and perineal trauma, and low breastfeeding rates.

Ironically, the constraints of neo-liberal health care provision both open up new possibilities for health care reform, including stress on increased 'choices' in childbirth, but also constrain the agendas (Reiger, *Neoliberal quickstep*). Health professionals and policy advisors with a 'health-risk' rather than 'wellness' attitude to pregnancy and birth provide the main input to the service system design, planning and management, often marginalizing attempts by women as consumers seeking service redesign to be more woman-centered. A decade and more of conservative governments has seen the demise of many feminist-oriented agencies within federal and state bureaucracies, limiting MC's capacity to mobilize support outside of health policy decision-making. However, in advocating for women's needs, MC has benefited from the resources now associated with health consumer advocacy more generally, and from having well-educated members with skills to use the Internet to gather and analyze the same scientific research evidence to which doctors alone traditionally had access. MC has also been supported in this regard by some members whose professional lives in academia (feminist and women's studies, midwifery, sociology, and public health in particular) facilitates informed critique of the status quo, challenges medical views, and highlights research on models of care which give more benefit to women (see e.g. Newman *Why planned attended homebirth, Health care system*). MC has also had support from some professional groups whose mandate includes increasing the provision of woman-centered care, in particular the Australian College of Midwives, and from doctors—more often in the public than the private health system—who support less medicalized models of care because they acknowledge the rights of

women to be autonomous decision-makers in reproductive health care and respect the professional role of midwives

## CONCLUSION

That the Maternity Coalition's advocacy work for Australian women in childbirth can sometimes feel like an uphill battle is hardly surprising in view of the internal and external challenges it involves. Organizations such as MC will have a reason to exist as long as obstetrics, despite increased women entering the profession, continues to act as an institutional bastion of male domination of women, over-riding women's agency in childbirth and maintaining masculine 'medicine' versus feminine 'illness'. The medical, scientific focus remains on mechanistic and reductionist explanations and 'controlling' approaches to childbirth care, while alternative 'birth models that work', emphasizing interaction, holistic care and the integrity of organisms, struggle for legitimacy and support (Davis-Floyd et al). This means that activist mothers need coalitions within a renewed women's movement in order to achieve a paradigm shift to give women their rightful and respected central place in the reproductive process. The many roles that are required to run a national organization mostly of young mothers, let alone to recruit new members and also undertake advocacy, can be very demanding. It is testimony to women's amazing energy, abilities, creative force and passion that women-led organizations such as Maternity Coalition *are* able to exist and continue to remind us that, as Barbara Katz Rothman put it some time ago: 'Birth is not only about making babies. It's about making mothers- strong, competent, capable mothers who trust themselves and believe in their inner strength' (Rothman *Women Providers and Control*: 254).

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