

**Submission
No 232**

INQUIRY INTO BIRTH TRAUMA

Organisation: Western Sydney University

Date Received: 9 August 2023



WESTERN SYDNEY UNIVERSITY
SCHOOL OF NURSING AND MIDWIFERY

Submission to the NSW Inquiry into Birth Trauma

WESTERN SYDNEY
UNIVERSITY

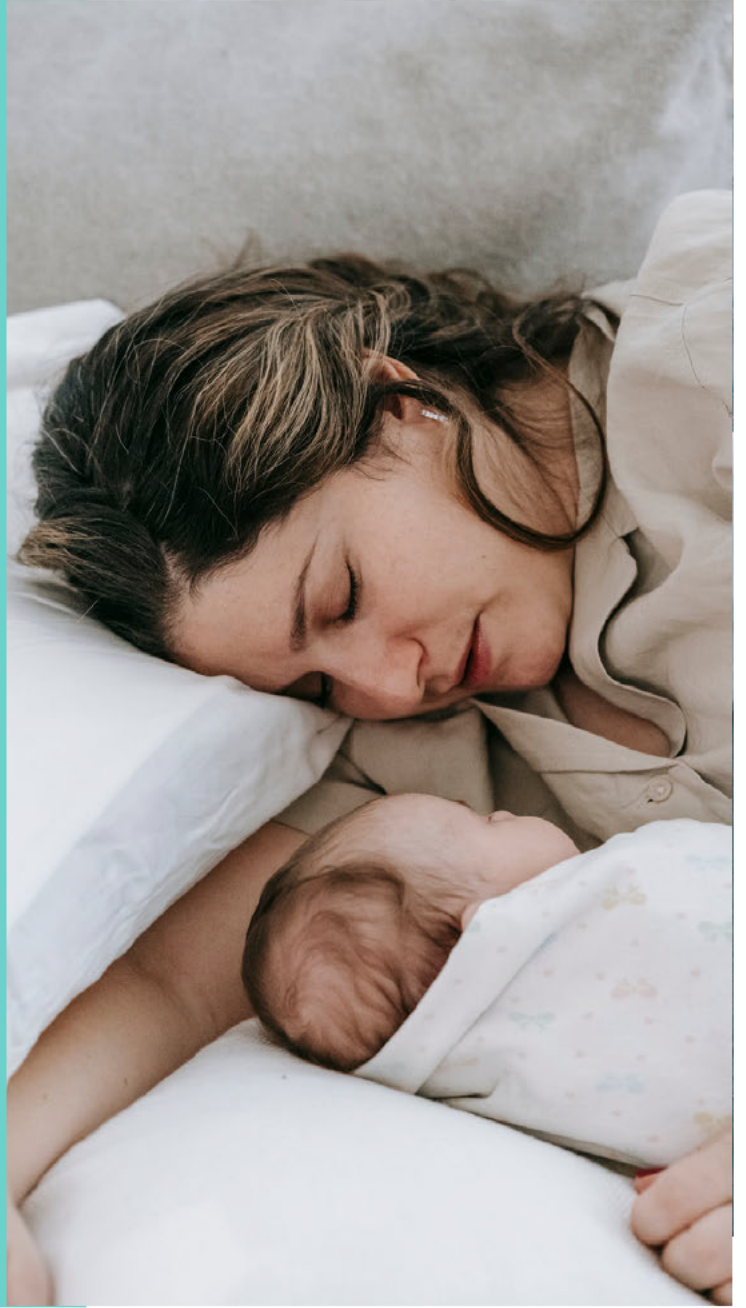


Table of Contents

01

Executive
Summary

02–04

Research Projects

05

Birth Trauma

06

Obstetric
Violence

07

Mistreatment
Index

08

Induction of
labour

09

Mode of Birth

10

Impact on Mental
Health

11

Impact on First
Nations women

12

Impact on CALD
women

13

Impact on young
parents

14

Informed choice

15–16

Maternity models
of care

17

Information for
women

18

Regulation &
Legislation

19–20

Summary

21

Recommendations

22–23

References

Executive Summary

As leading midwifery academics in Australia, in the School of Nursing and Midwifery, Western Sydney University, we, along with our colleagues and higher degree research students, have been involved in research for over 20 years into women's birth experiences and the contributors to birth trauma.

We have led over 100 publications and graduated /supervised over 20 Honours/Masters/PhD students who have completed or are completing research into women's birth experiences and birth trauma and we have further research planned.

In 2020 Professor Dahlen and colleagues published a seminal book, *Birthing Outside the System: The Canary in the Coal Mine*, presenting research from around the world into why women are increasingly being traumatised by their birth experiences and choosing to avoid mainstream care as a result (Dahlen, Kumar-Hazard & Schmied 2020).

The global mistreatment of women during the perinatal period has been demonstrated in research and recognised by the World Health Organisation (WHO). In 2014 the WHO issued a statement which said *'Every women has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care'* (World Health Organisation, 2014). This was followed by a WHO Intrapartum Care for a Positive Childbirth Experience Guidelines which listed recommendations for the provision of care, the top four being:

Respectful maternity care
Effective communication
Companionship during labour and birth
Continuity of midwifery care

This submission will highlight the research we have undertaken over more than a decade in relation to the terms of reference for this NSW Upper House Inquiry into birth trauma. We will focus in depth on recent data from the national Birth Experience Study (BES_t) and in specific present data relevant to women in NSW. This report will conclude with five recommendations to prevent further women experiencing birth trauma into the future.

We commend the work of the Hon. Emma Hurst, MLC and those who supported this inquiry and all the consumers and organisations who have lobbied so hard to have their voices heard.

Senior Lecturer of Midwifery,
Academic Program Advisor Bachelor of Midwifery,
School of Nursing and Midwifery,
Western Sydney University

Professor of Midwifery,
Associate Dean Research & HDR,
Midwifery Discipline Lead,
School of Nursing and Midwifery,
Western Sydney University

Our Research Projects

PROJECTS	DETAILS	PUBLICATIONS
The Birth Experience Study (BEST) 2021 – ongoing	National maternity survey in 2021 with 8,804 responses	<ul style="list-style-type: none"> • Birth Trauma poetry inquiry • Obstetric violence content analysis • What women want content analysis
The Birth in the Time of COVID (BITTOC) Study 2020-ongoing	Longitudinal survey of women's, experiences of maternity services during the COVID-19 pandemic and following 2 years	<ul style="list-style-type: none"> • Vaccine hesitancy • Prenatal stress & anxiety • Positives from disruptive care • Perinatal depression
Clinicians' Perspectives of obstetric violence during childbirth Ongoing	PhD study – Emma Collins Hill – survey and interviews with clinicians	
Midwives' Perspectives of obstetric violence during childbirth 2023	Master of Research study – Emma Collins Hill – interviews with 15 midwives	<ul style="list-style-type: none"> • Thesis
The development of a trauma-informed professional development resource for practitioners caring for women planning a birth after caesarean Ongoing	PhD study – Katherine Young – co-designing workshops and resources for practitioners	
Understanding the Development of Post-Traumatic Stress Disorder Following Childbirth and It's Impact on Women Who Access Residential and Day Parenting Services in NSW Ongoing	PhD study – Madeleine Simpson	<ul style="list-style-type: none"> • Postnatal post-traumatic stress: an integrative review
What are the experiences of midwives returning to work in a maternity unit after they have experienced a perinatal loss? Ongoing	PhD – Wimbayi Musodza – Phenomenology	<ul style="list-style-type: none"> • Scoping review
What determines optimal management of midwifery group practice in Australia Ongoing	PhD study – Leonie Hewitt- Mixed methods	<ul style="list-style-type: none"> • Scoping review • Qaul paper management and leadership MGP • Qual paper thematic and lexical analysis interviews

Our Research Projects

PROJECTS	DETAILS	PUBLICATIONS
Experiences of pregnancy and childbirth in women who are midwives: A mixed methods study of Australian midwives Ongoing	PhD study – Sharon Coulton Stoliar– Midwives experiences of childbirth	<ul style="list-style-type: none"> • National survey results paper • Integrative review
The use of unregulated birth workers 2021	PhD study – Elizabeth Rigg – interviews then survey of unregulated birth workers across Australia	<ul style="list-style-type: none"> • Interview data • Analysis of submissions to SA Gov inquiry • survey results
The experiences of women planning a VBAC in Australia 2021	PhD study – Hazel Keedle – women planning a VBAC in Australia	<ul style="list-style-type: none"> • Narrative analysis results • Model of care and VBAC Survey • Interactions with HCP
Jordanian women’s experiences and constructions of labour and birth in different settings, over time and across generations : a qualitative study 2021	PhD study – Suha Hussein– review of services in NSW, analysis of recurrence, interviews with women	<ul style="list-style-type: none"> • Narrative review • Qual paper exp of privacy • Qual paper constructions of lab and birth • Qual paper improving birth exp
Experiences of PPMs in Australia who have been reported to the AHPRA 2018	Honours study – Jo Hunter – interviews with PPM who had been reported to AHPRA	<ul style="list-style-type: none"> • Interview results
What attributes do Australian midwifery leaders identify as being essential to effectively manage a Midwifery Group Practice (MGP)? 2018	Masters of Research – Leonie Hewitt – interviews with midwifery leaders	<ul style="list-style-type: none"> • Qualitative paper • Thesis
The Perfect Storm of Trauma: The experiences of women who have experienced birth trauma and subsequently accessed residential parenting services in Australia 2018	Priddis, Keedle & Dahlen – interviews with women who experienced birth trauma and accessed a residential parenting service	<ul style="list-style-type: none"> • Qualitative paper
From Worry to hope: An ethnography of midwife–woman interactions in the antenatal appointment. 2018	PhD study – Alison Teate – Video ethnography of appointment with midwives	<ul style="list-style-type: none"> • Thesis • Qual results from study paper

Our Research Projects

PROJECTS	DETAILS	PUBLICATIONS
Facilitators, barriers and implications of immediate skin-to-skin contact after caesarean section: An ethnographic study 2018	PhD study – Jeni Stevens – video ethnography of women during caesarean	<ul style="list-style-type: none"> • Literature review • Video ethnography methods paper • Facilitators and barriers paper • Impact of clinicians on skin to skin paper
The characteristics, needs and experiences of women choosing to have a homebirth in Australia 2017	Honours study – Heather Sassine – on a national homebirth experience survey	<ul style="list-style-type: none"> • Survey results of 1681 responses
Birthing Outside the System: A grounded theory study about what motivates women to choose a high-risk homebirth or freebirth 2016	PhD study – Melanie Jackson – on interviews with women who had a homebirth	<ul style="list-style-type: none"> • Motivations for place of birth • Perceptions of risk
Experiences of women who have severe perineal trauma, their associated morbidity and health service provision in New South Wales, Australia: a mixed methods study 2015	PhD study – Holly Priddis – review of services in NSW, analysis of recurrence, interviews with women	<ul style="list-style-type: none"> • Autoethnography paper • Risk of recurrence paper • Trends and risk factors • Qualitative interviews
Effectiveness of a complex antenatal education program incorporating complementary medicine techniques for pain relief in labour and birth for first-time mothers 2015	PhD study – Kate Levett – 171 pregnant woman, randomised control trial comparing education with complementary therapy techniques to standard care.	<ul style="list-style-type: none"> • Systematic review • Cost analysis • RCT results • Qualitative results
Women's experiences of planning a vaginal birth after caesarean at home 2015	Masters Honours thesis – Hazel Keedle – Interviews with women who had a HBAC	<ul style="list-style-type: none"> • Qualitative interviews paper • Thesis
The barriers and facilitators of introducing evidence-based practices around the use of episiotomy in Jordan 2014	Masters Honours – Suha Hussein – review of files, interviews and with midwives and stakeholders.	<ul style="list-style-type: none"> • Quality improvement paper • Thesis

Terms of Reference

a The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

Birth Trauma

Birth trauma is the experience of feeling the birth (or throughout the perinatal journey) was traumatic from the women's point of view and can include fearing for their life or their baby's life, a loss of control, perineal trauma/pelvic floor damage, disrespectful care and obstetric violence. The experience and prevalence of birth trauma has been explored in the Birth Experience Study (BEST), Birth in the time of Covid (BITTOC) and VBAC study.

In BEST and BITTOC, 28% of women in Australia experienced birth trauma. In the VBAC study, which only included women with a previous caesarean, the birth trauma rate increased to two thirds of women (Keedle et al, 2020).

“ *I felt ridiculed at times. I felt disempowered. I walked away feeling less like a woman, and left to mother my new baby and my other two young children.*

(Participant from NSW, BEST)

In NSW

In the BEST study we explored the rate of women in NSW who had experienced birth trauma. We found 28% of women giving birth in NSW (similar to the national rate) reported their most recent birth was traumatic.

Birth Trauma



Women in NSW who reported their most recent birth was traumatic

The Birth Experience Study

a The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence")

Obstetric Violence

Obstetric violence is recognised by the United Nations as a form of gendered violence (Simonovic, 2019; United Nations, 1994) and internationally rates can range from 17% to 58% (Perrotte et al., 2020). Legislation in Venezuela recognises obstetric violence as "*the experience in childbirth which becomes dehumanizing, physically and/or mentally abusive, and intrusive*" (Michaels et al., 2019).

The experience and prevalence of obstetric violence has been explored in the Birth Experience Study (BEST).

In BEST we found one in ten women in Australia reported experiencing obstetric violence. The open text comments left by women showed that experiencing obstetric violence left women feeling dehumanised, powerless and violated. Examples included the use of coercive language, a lack of informed consent and a lack of informed choice.

Shockingly, some women described internal vaginal examinations in language used to describe sexual assaults.

In NSW

In the BEST study we explored the rate of women in NSW who had experienced obstetric violence. One in 10 women in NSW, reported obstetric violence, which was the same nationally.



“*Obstetrician pulling my placenta out aggressively without giving me the option to birth it. Telling me to be quiet.*”

(Participant from NSW, BEST)

Mistreatment

Mistreatment of women during the perinatal period is a broad term that includes "physical and verbal abuse, lack of supportive care, neglect, discrimination and denial of autonomy" (Bohren et al, 2015). The Mistreatment Index (Vedam et al, 2019), developed by the BirthPlace Lab in Canada, is a validated survey instrument designed to measure instances of mistreatment from the women's perspective. Each statement refers to a different type of mistreatment and was created through a process of co-design and consumer consultation. The MiST index was included in the BESt national survey.

The Mistreatment Index is a series of seven items identifying disrespect and abuse by maternity clinicians. The item with the highest 'yes' responses (more than 1 in 6 women), was being ignored, refused request for help or failing to respond to requests for help. This was followed by withholding treatment or forcing treatment (more than 1 in 7 women) and being shouted or scolded at by a HCP (more than 1 in 8 women).

Although the other items have fewer 'yes' responses, the fact that 77 respondents in NSW indicated they had experienced physical abuse, such as aggressive physical contact or inappropriate sexual conduct is a cause for concern.

MiST Statements

- Your private or personal information was shared without your consent
- Your physical privacy was violated, for example being uncovered or having people in the delivery room without your consent
- A healthcare provider shouted at or scolded you
- Healthcare providers withheld treatment or forced you to accept treatment that you did not want
- Healthcare providers threatened you in any other way
- Healthcare providers ignored you, refused your request for help or failed to respond to requests for help in a reasonable amount of time
- You experienced physical abuse, such as aggressive physical contact, inappropriate sexual conduct, a refusal to provide anaesthesia for an episiotomy, etc.

35%

Of women in NSW experienced at least 1 type of mistreatment

18%

Of women in NSW felt ignored by clinicians

2%

Of women in NSW experienced physical abuse

“

The feeling of being forced to remain on my back whilst labouring - being physically pushed down onto the bed.

(Participant from NSW, BESt)

- b** Causes and factors contributing to birth trauma including:
- (i) evaluation of current practices in obstetric care
 - (ii) use of instruments and devices for assisted birth e.g., forceps and ventouse
 - (iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

Interventions – Induction of labour

The experience of birth trauma is impacted by the use of interventions such as induction of labour.

In the BEST study we explored the impact of induction of labour on birth trauma and found significantly higher birth trauma rates for women who were induced compared to a decrease for women who went into labour spontaneously.



“ My labour was induced, it was too hard to handle, they did not ask or listen to the birth plan and I didn't get the physiological placenta birth. They also placed in the synto while I was asleep from the epidural without my permission.

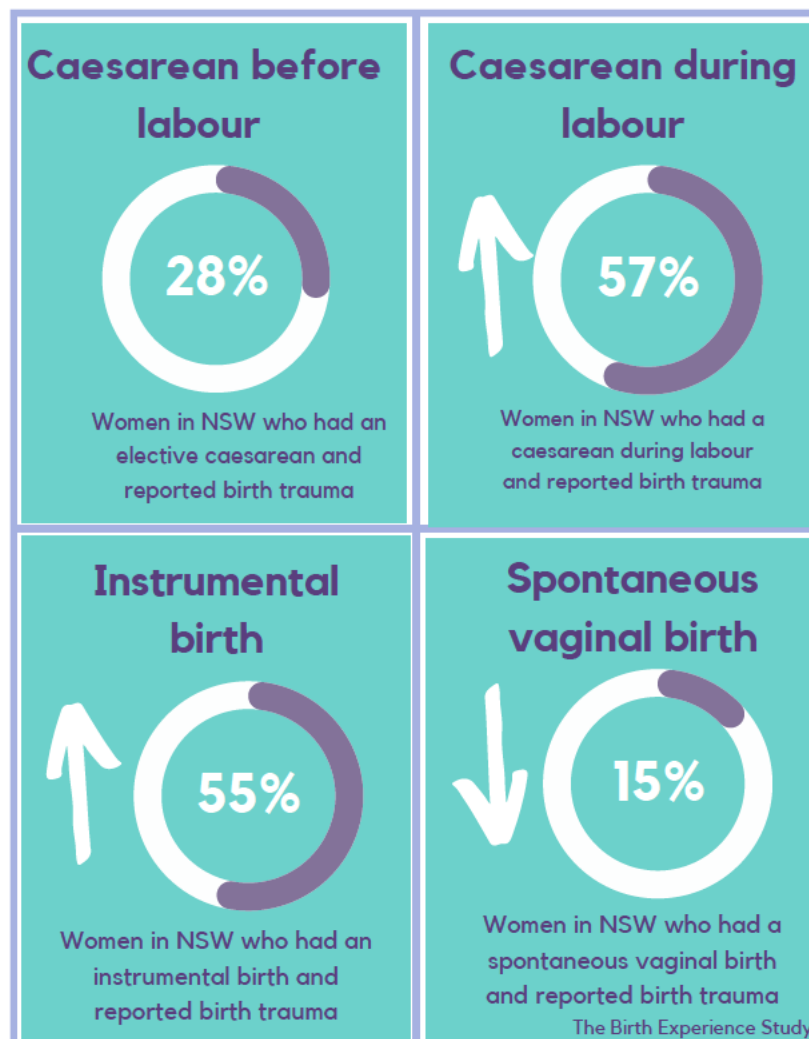
(Participant from NSW, BEST)

- b** Causes and factors contributing to birth trauma including:
- (i) evaluation of current practices in obstetric care
 - (ii) use of instruments and devices for assisted birth e.g., forceps and ventouse
 - (iii) the availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

Mode of birth

The experience of birth trauma is impacted by the type of birth a woman experiences.

In the BESt study we explored the impact of mode of birth on birth trauma and found significantly higher birth trauma rates for women who had a caesarean during labour or instrumental birth compared to women who had a vaginal birth. Women who had a caesarean before labour had the same birth trauma rate as the overall NSW rate of 28%.



My needs were not considered, I felt like a piece of meat with no rights to my body, I was forced into a caesarean when there was no emergency.

(Participant from NSW, BESt)



the physical, emotional, psychological, and economic impacts of birth trauma, including both short and long term impacts on patients and their families and health workers

Impact on mental health

A systematic literature by Simpson et al (2018) at WSU found that having a traumatic birthing experience led to higher rates of developing Post Traumatic Stress Disorder (PTSD). In an International review of the evidence on PTSD beyond 6 months post birth there were higher rates when women experienced instrumental vaginal birth or emergency caesarean section and was least common when women had a spontaneous vaginal birth (Ginter et al, 2022).

In the Birth Experience Study there were increased rates of birth trauma for women who had a previous mental health diagnosis.

Four percent of women received a formal PTSD diagnosis following their birth experience.



I started showing signs about 3 months after the birth, and I still suffer from PTSD 2 1/2 years after. It has strained my marriage and made being a mother 100 times harder. It's made me have to fight the constant feeling of being a failure to my baby.

(Participant from NSW, BEST)

d

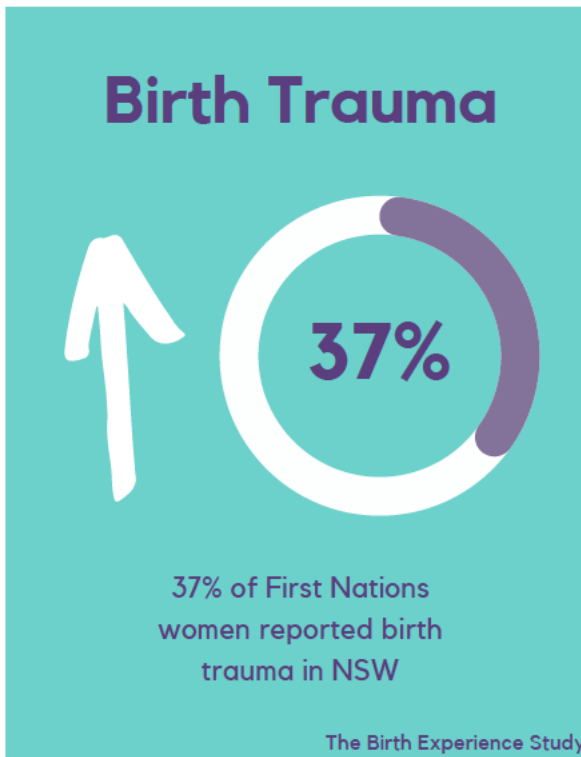
the exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

- (i) people in regional, rural and remote New South Wales
- (ii) First Nations people
- (iii) people from culturally and linguistically diverse (CALD) backgrounds
- (iv) LGBTQIA+ people
- (v) young parents

Impact on First Nations women

First Nations women represent 5% of birthing women in NSW (AIHW, 2023). Across Australia babies of First Nations mothers have higher rates of premature birth (13% vs 8%), perinatal deaths (17.3 per 1,000 vs 9 per 1,000) (AIHW, 2023) and have a lack of Birthing on Country options.

The experience and prevalence of birth trauma and obstetric violence for First Nations women has been explored in the Birth Experience Study (BEST). First Nations Women had significantly higher birth trauma and obstetric violence rates.



I wanted to have my indigenous midwife with me in the room whilst giving birth. I had my baby late evening on a week day and unfortunately she wasn't there. I have cultural background where each child takes their placenta with them home after birth as it's planted with a tree and it becomes their tree of life. I was told it must go away for testing as they thought my baby was small even though she was born with no complications and was 6 pounds 1oz. Placenta has still not been located.

(First Nations Participant from NSW, BEST)

d

the exacerbating factors in delivering and accessing maternity care that impact on birth trauma

generally, but also in particular:

(i) people in regional, rural and remote New South Wales

(ii) First Nations people

(iii) people from culturally and linguistically diverse (CALD) backgrounds

(iv) LGBTQIA+ people

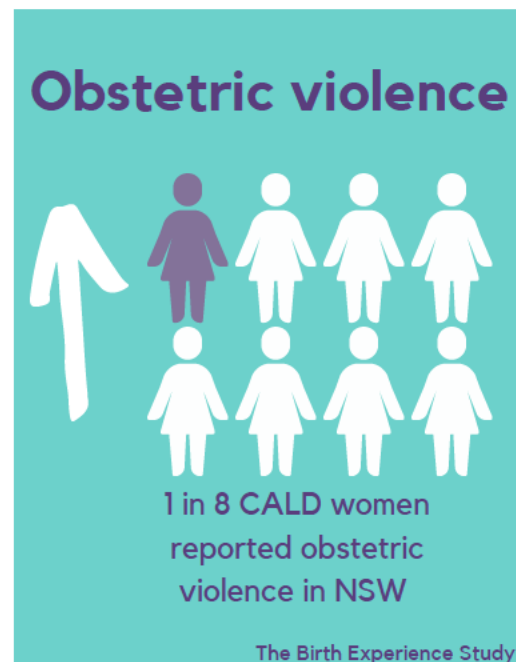
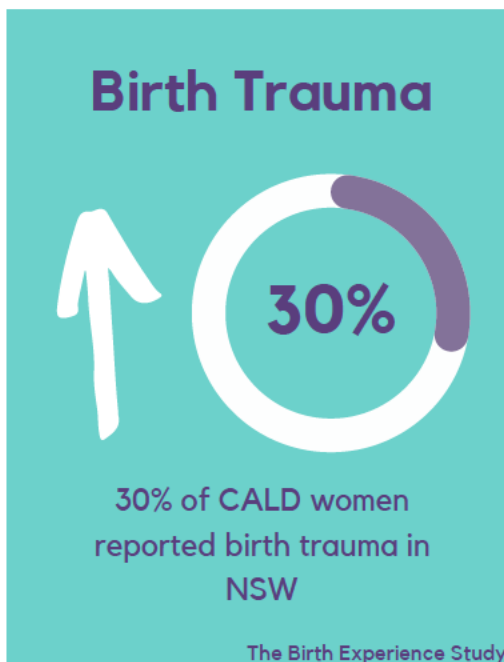
(v) young parents

Impact on CALD women

In NSW 37% of women who had a baby in 2021 were born overseas, with the top four regions being Southern Asia, South-East Asia, Chinese Asia and the Middle East (AIHW, 2023).

The experience and prevalence of birth trauma for women from culturally and linguistically diverse backgrounds has been explored in the Birth Experience Study (BEST). The BEST survey was available in English and seven other languages, Arabic, Chinese, Filipino, Hindi, Persian, Thai & Vietnamese.

Migrant women from non-English backgrounds had slightly higher birth trauma and obstetric violence rates than those from English speaking backgrounds.



“ از نظر فیزیکی و روحی آسیب شدیدی داشتم

I had severe physical and mental damage.

(Persian speaking Participant from NSW, BEST)

d

the exacerbating factors in delivering and accessing maternity care that impact on birth trauma

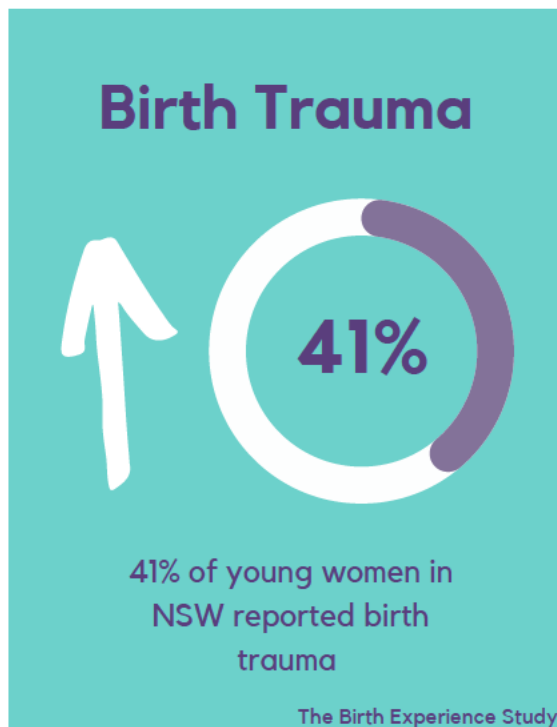
generally, but also in particular:

- (i) people in regional, rural and remote New South Wales
- (ii) First Nations people
- (iii) people from culturally and linguistically diverse (CALD) backgrounds
- (iv) LGBTQIA+ people
- (v) young parents

Impact on young parents

Women aged 24 years and below represent 11% of birthing women in NSW (AIHW, 2023). Across Australia babies of young women have higher rates of perinatal deaths (15.8 per 1,000 vs 8.8 per 1,000) (AIHW, 2023).

The experience and prevalence of birth trauma for young parents has been explored in the Birth Experience Study (BEST). Women aged 24 years and below had significantly higher reported rates of birth trauma and obstetric violence rates.



Whilst I was in labour they refused pain relief and told me I wasn't in labour... wheeled me naked past the front where visitors are to a birth suite... couldn't sleep for 2 days as my son and the midwives kept waking me. I was crying with the lack of support... I received no debriefing...It was horrific... I have a video of the birth and often find myself looking at it and crying.

(18-20yrs Participant from NSW, BEST)

e The role and importance of "informed choice" in maternity care

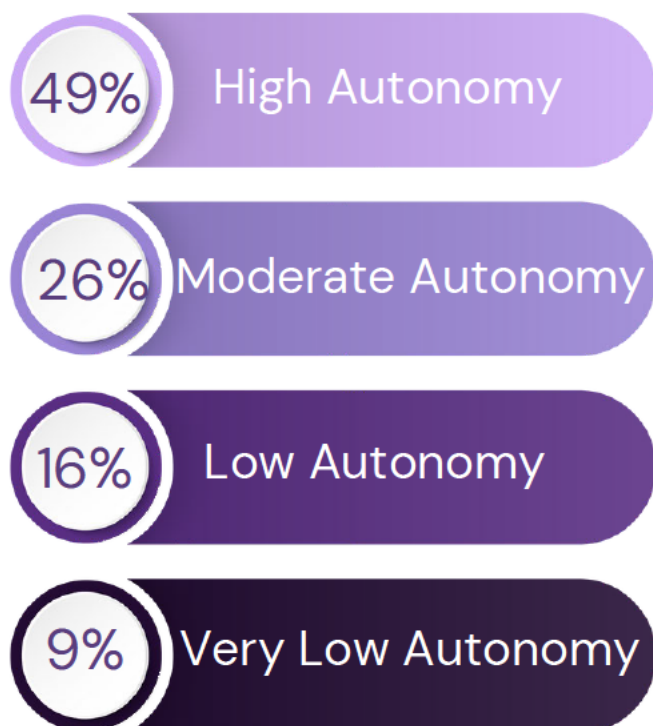
Informed Choice

Informed choice has been defined as "one that is based on relevant knowledge, consistent with the decision maker's values and behaviourally implemented" (Marteau et al, 2001).

In both the BEST survey and the VBAC survey the Mothers and Decision Making (MADM) scale (Vedam et al, 2017) was included. This scale, produced by Birth Place lab in Canada and explores the level of decision making (autonomy) women felt they had regarding their wishes and choices during the perinatal period.

This has an impact on birth trauma as many women identify a loss of control and choice when they describe their experiences of birth trauma.

In the BEST study we explored the MADM scores of women in NSW. We found less than half of women giving birth in NSW felt they had high autonomy during the perinatal period.



“ I felt like I had no control over anything. Like things were being done to me without asking or even telling me what was going to happen, or after the birth what did actually happen. This has seriously affected my mental health in my current pregnancy.

(Participant from NSW, BEST)



Maternity Models of Care

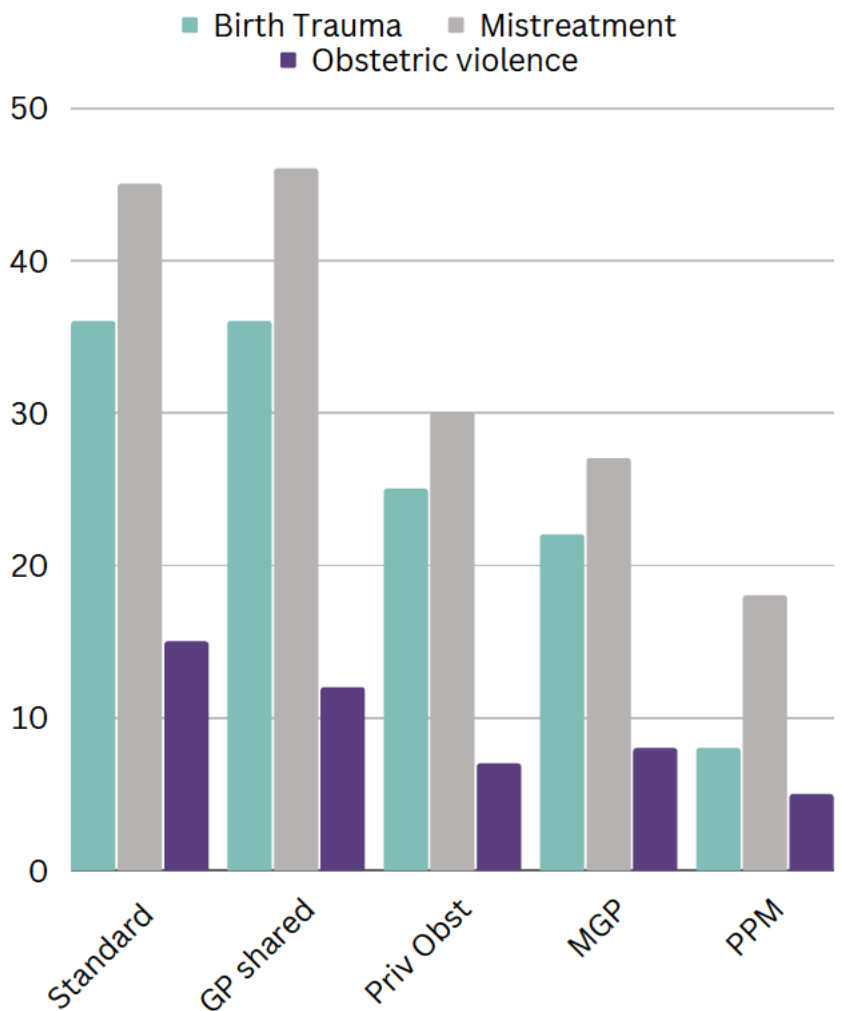
There are a variety of maternity models of care across Australia and in NSW. A categorisation of Australian models of care was developed, validated and adopted by the AIHW (Donnolley et al, 2016;2019; AIHW, 2022). In NSW most women access standard maternity care that is fragmented in nature.

The experiences and outcomes of women in different models of care has been explored in the BEST, BITTOC and the VBAC study. In the Birth in the Time of COVID-19 study (BITTOC) we found the lowest rate of birth trauma when controlling for all associated risk factors was found when women were cared for by privately practising midwives.

In this report we mainly highlight the impact of models of care on birth trauma, obstetric violence and mistreatment from the BEST survey. The data shows that the model of care women have access to has a direct impact on whether they report experiencing a traumatic birth and the level of obstetric violence and mistreatment they experience.

Women who experienced continuity of care modes reported lower rates of birth trauma, obstetric violence and mistreatment, with the lowest rates being for women who hired a privately practising midwife. OV tended to be reported under midwifery care models when consultation/referral to medical care needed to happen.

Birth trauma, mistreatment and obstetric violence % across models of care in NSW



f Barriers to the provision of "continuity of care" in maternity care

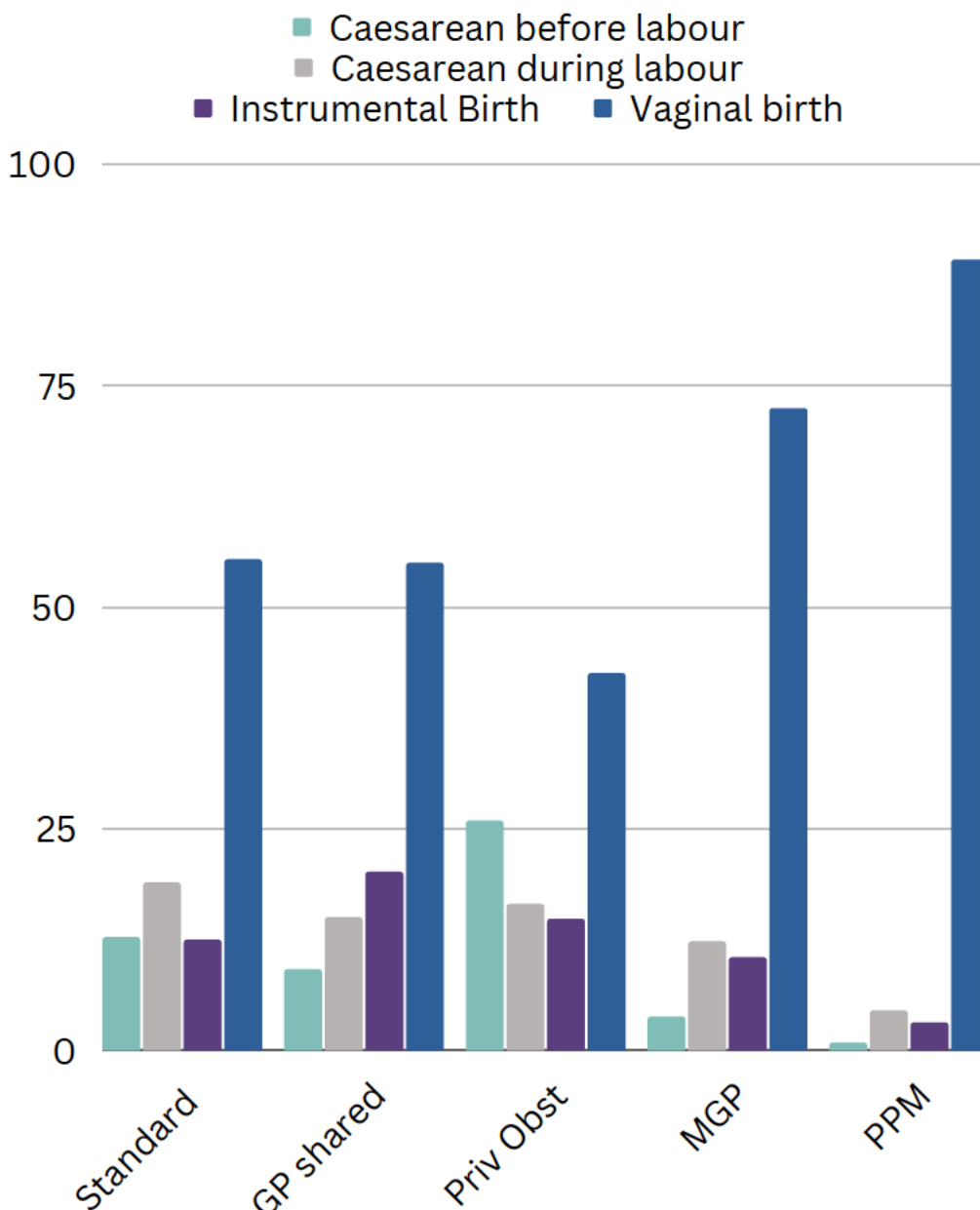
Maternity Models of Care

In this report we have shown how the type of birth impacts birth trauma and obstetric violence, specifically that caesarean during labour and instrumental births is associated with higher reported rates of birth trauma. We can also explore the rates of types of births across the different models of care.

Standard care and private obstetric care have higher rates of caesarean during labour and private obstetric care has higher rates of caesarean before labour compared to the other models of care in NSW. Private obstetric care and GP shared care have higher rates of instrumental births.

Midwifery group practice and Privately Practising Midwife care have higher rates of vaginal birth compared to the other models of care and NSW reported data. The same results are seen in the BITTOC data even when adjusted for level of risk and demographics. As identified earlier in the report, vaginal birth is associated with lower reported rates of birth trauma.

Types of birth % across models of care in NSW





The information available to patients regarding maternity care options prior to and during their care

Information for women

There is a variety of information sources and resources available to women before and during the perinatal period. In the Birth Experience Study (BES_t) we asked women what sources of information they found most useful for pregnancy and birth.

There were a variety of options but the resource with the highest reported usage was the maternity care provider. This was followed by websites, friends and family, childbirth education classes and apps with childbirth and pregnancy information.

Top 5 sources of childbirth and pregnancy information

- 1 Maternity Care Provider
- 2 Websites
- 3 Friends & Family
- 4 Childbirth education classes
- 5 Apps

h

Whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma
(i) any legislative, policy or other reforms likely to prevent birth trauma

Regulation and Legislation

In the Birth Experience Study (BEST) we asked women whether they made a formal written complaint about their birthing experience.

We found 409 women were unaware of how to make a complaint about the care they received. There were many women who did make a complaint, with most of these directly to the hospital.

Comments from women highlighted the lack of knowledge about the complaints process and the challenges of navigating this process.

“

I've been pretty disappointed in the complaint process. The responses I got from the hospital and obstetrician direct were not helpful: the hospital claimed "just following doctor's orders" and "not enough staff The Healthcare Complaints Commission has honestly been pretty crap too - the part with the obstetrician has been stuck on "still deciding whether or not we will hold a panel of experts to review the decision making for your case" for almost 6 months, while bouncing the case around a number of different case managers.

(Participant from NSW, BEST)

Number of women answered complaints question
(multiple responses were possible)

2391

No, I don't feel I needed to

409

No, I didn't know how to

126

Yes, to the hospital / LHD

3

Yes, to AHPRA

11

Yes, to HCC

2

Yes, to Human Rights Commission

9

Yes, I involved a lawyer

In Summary

This report has identified four groups of women, three obstetric interventions / types of birth and two models of care that have the highest rates of birth trauma and obstetric violence in NSW.






They are listed below in order of highest reported birth trauma rates.

- 1 Caesarean during labour
- 2 Instrumental birth
- 3 Younger Women
- 4 Induction of labour
- 5 First Nations Women
- 6 Standard fragmented care
- 7 GP shared care
- 8 Women with previous mental health diagnosis
- 9 CALD Migrant Women

In Summary

This report has also identified specific labour trait, one type of birth and three models of care that have the lowest rates of reported birth trauma and obstetric violence in NSW. However, private obstetrician care also has the highest level of obstetric intervention of any model of care in NSW, increasing cost and length of stay for women.

They are listed below in order of lowest reported birth trauma rates.

-  **Privately Practising Midwife**
-  **Vaginal birth**
-  **Midwifery Group Practice**
-  **Spontaneous labour**
-  **Private Obstetrician**

Recommendations

1 Make respectful care a reality, not a mantra

- Get consent from women and respect refusal. Don't coerce, punish or give women inflated risk data or ultimatums
- Uphold maternal autonomy and advocate for women
- Provide women with judgement- free, evidence- based information so they can make informed decisions and maintain trust in the maternity service and health providers
- Provide culturally sensitive information and care, including more midwives of colour. Support and celebrate cultural diversity by being open and curious rather than ignorant and nervous
- For Indigenous women, remember that connection to country and cultural traditions carry deep significance and must be respected. Cultural safety is paramount to positive experience

3 Support women's access to their chosen place of birth and model of care

- Every woman should have access to a known midwife where trust can be developed across the childbearing continuum, regardless of her obstetric risk
- Provide environments that promote, facilitate and respect physiological birth
- Enable and facilitate access to homebirth that is equitable and available to women who request this option
- Make sure transport and transfer from home to hospital is seamless and formalised handover expected and respected.
- Expand birth centres that are both standalone and alongside hospitals

5 Get the framework right and the rest will follow: policy, guidelines, education, research, regulation and professional leadership

- Explicit international human rights treaties and country based legislation is needed to protect women's reproductive rights including care during pregnancy and childbirth
- Include women in service and policy development, guidelines and research from inception
- Design funding models focused on women and involve women in the design of these models
- Sustainability and fiscal responsibility need to be considered in the debate on place of birth and model of care as the long term implications on society of birth trauma are unknown
- Clear documentation processes and living flexible care plans and pathways are needed for women who make 'off- menu' choices
- A respect for birth plans is urgently needed as these are often laughed at and dismissed.

2 Emancipate and support midwifery to emancipate and support women

- Ensure midwifery regulation protects women's rights by not punishing the midwives who support them
- Enable clear respectful pathways of consultation and referral for midwives working in the community
- Make continuity of midwifery care a reality with genuine support given to this model and the midwives who work in it at every level of the maternity service
- Support the development of private midwifery, including giving these midwives visiting rights access to health
- Facilitate the education of more midwives of colour and/ or from culturally diverse backgrounds through targeted pathways and genuine and ongoing support
- Appoint a Chief Midwife in the State as midwifery is not adequately represented by the current structure

4 Offer more flexible, acceptable options for women experiencing risk factors during pregnancy and/ or birth

- Support midwives and obstetricians to develop skills, such as with breech and twin birth within the system so confidence is built in 'complex normality' and more options become available
- When women express their specific needs, be willing to compromise. It is not your body or your baby
- Multidisciplinary clinics and models are needed for women with risk factors who make 'off- menu' choices
- Engage allied health workers when caring for women with social, perinatal mental health and special physical requirements (i.e. social workers, mental health teams, disability teams, physiotherapists, psychologists etc.)
- Midwives and obstetricians need to have more honest conversations about risk and work together to protect the therapeutic alliance with women

References

- AIHW. (2022). Maternity Models of care in Australia, 2022. Australian Institute of Health and Welfare. [Web link](#)
- AIHW. (2023). Australia's mothers and babies 2021. [Web link](#)
- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS medicine*, 12(6), e1001847. [DOI link](#)
- Coulton Stoliar, S., Dahlen, H. G., & Sheehan, A. (2022). Insider knowledge as a double-edged sword: an integrative review of midwives' personal childbearing experiences. *BMC Pregnancy Childbirth*, 22(1). [DOI link](#)
- Coulton Stoliar, S., Dahlen, H. G., & Sheehan, A. (2023). A national survey of Australian midwives' birth choices and outcomes. *Women Birth*, 36(2), e246–e253. [DOI link](#)
- Dahlen, H. G., Homer, C., Boyle, J., Lequertier, B., Kildea, S., & Agho, K. E. (2023). Vaccine intention and hesitancy among Australian women who are currently pregnant or have recently given birth: the Birth in the Time of COVID-19 (BITTOC) national online survey. *BMJ Open*, 13(4), e063632. [DOI link](#)
- Di Paolo, A. L., King, S., McLean, M. A., Lequertier, B., Elgbeili, G., Kildea, S., & Dahlen, H. G. (2022). Prenatal stress from the COVID-19 pandemic predicts maternal postpartum anxiety as moderated by psychological factors: The Australian BITTOC Study. *J Affect Disord*, 314, 68–77. [DOI link](#)
- Donnolley, N., Butler-Henderson, K., Chapman, M., & Sullivan, E. (2016). The development of a classification system for maternity models of care. *Health Information Management Journal*, 45(2), 64–70. [DOI link](#)
- Donnolley, N. R., Chambers, G. M., Butler-Henderson, K. A., Chapman, M. G., & Sullivan, E. (2019). A validation study of the Australian Maternity Care Classification System. *Women Birth*, 32(3), 204–212. [DOI link](#)
- Fanshawe, A. M., De Jonge, A., Ginter, N., Takacs, L., Dahlen, H. G., Swertz, M. A., & Peters, L. L. (2023). The Impact of Mode of Birth, and Episiotomy, on Postpartum Sexual Function in the Medium- and Longer-Term: An Integrative Systematic Review. *Int J Environ Res Public Health*, 20(7). [DOI link](#)
- Gladstone, M. E., Paquin, V., McLean, M. A., Lequertier, B., Elgbeili, G., Kildea, S., Klimos, C., King, S., & Dahlen, H. G. (2023). Prenatal maternal stress was not associated with birthweight or gestational age at birth during COVID-19 restrictions in Australia: The BITTOC longitudinal cohort study. *Aust N Z J Obstet Gynaecol*. [DOI link](#)
- Ginter, N., Takács, L., Boon, M. J. M., Verhoeven, C. J. M., Dahlen, H. G., & Peters, L. L. (2022). The Impact of Mode of Birth on Childbirth-Related Post Traumatic Stress Symptoms beyond 6 Months Postpartum: An Integrative Review. *International Journal of Environmental Research and Public Health*, 19(14), 8830. [DOI link](#)
- Hewitt, L., Dadich, A., Hartz, D., & Dahlen, H. (2022a). Management and sustainability of midwifery group practice: Thematic and lexical analyses of midwife interviews. *Women and Birth*, 35, 172–183. [DOI link](#)
- Hewitt, L., Dadich, A., Hartz, D. L., & Dahlen, H. G. (2022). Midwife-centred management: a qualitative study of midwifery group practice management and leadership in Australia. *BMC Health Serv Res*, 22(1), 1203. [DOI link](#)
- Hewitt, L., Dahlen, H. G., Hartz, D. L., & Dadich, A. (2021). Leadership and management in midwifery-led continuity of care models: A thematic and lexical analysis of a scoping review. *Midwifery*, 98, 102986. [DOI link](#)
- Hill, E. C. (2022). Midwives' perspectives of obstetric violence during childbirth [Western Sydney University]. Sydney. [Thesis link](#)
- Hussein, S., Dahlen, H. G., Ogunsiyi, O., & Schmied, V. (2020). Uncovered and disrespected. A qualitative study of Jordanian women's experience of privacy in birth. *Women Birth*, 33(5), 496–504. [DOI link](#)
- Hussein, S. A. (2021). Jordanian women's experiences and constructions of labour and birth in different settings, over time and across generations : a qualitative study [Western Sydney University]. Penrith, N.S.W. [DOI link](#)
- Hussein, S. A., Dahlen, H. G., Duff, M., & Schmied, V. (2016). The barriers and facilitators to evidence-based episiotomy practice in Jordan. *Women Birth*, 29(4), 321–329. [DOI link](#)
- Hunter, J., Dixon, K., & Dahlen, H. G. (2021). The experiences of privately practising midwives in Australia who have been reported to the Australian Health Practitioner Regulation Agency: A qualitative study. *Women Birth*, 34(1), e23–e31. [DOI link](#)
- Jackson, M., Dahlen, H., & Schmied, V. (2012). Birthing outside the system: perceptions of risk amongst Australian women who have freebirths and high risk homebirths. *Midwifery*, 28(5), 561–567. [DOI link](#)
- Jackson, M. K., Schmied, V., & Dahlen, H. G. (2020). Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia. *BMC Pregnancy Childbirth*, 20(1). [DOI link](#)
- Keedle, Schmied, V., Burns, E., & Dahlen, H. (2018a). The Design, Development, and Evaluation of a Qualitative Data Collection Application for Pregnant Women. *Journal of Nursing Scholarship*, 50(1), 47–55. [DOI link](#)
- Keedle, Schmied, V., Burns, E., & Dahlen, H. (2018b). The journey from pain to power: A meta-ethnography on women's experiences of vaginal birth after caesarean. *Women and Birth*, 31(1), 69–79. [DOI link](#)
- Keedle, Schmied, V., Burns, E., & Dahlen, H. G. (2015). Women's reasons for, and experiences of, choosing a homebirth following a caesarean section. *BMC Pregnancy Childbirth*, 15(1), 206. [DOI link](#)
- Keedle, H. (2015). Women's reasons for and experiences of having a homebirth following a previous caesarean experience [Western Sydney University]. Sydney. [Thesis link](#)
- Keedle, H., Keedle, W., & Dahlen, H. G. (2022a). Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. *Violence Against Women*. [DOI link](#)
- Keedle, H., Peters, L., Schmied, V., Burns, E., Keedle, W., & Dahlen, H. G. (2020). Women's experiences of planning a vaginal birth after caesarean in different models of maternity care in Australia. *BMC Pregnancy Childbirth*, 20(1), 381. [DOI link](#)
- Keedle, H., Schmied, V., Burns, E., & Dahlen, H. G. (2019). A narrative analysis of women's experiences of planning a vaginal birth after caesarean (VBAC) in Australia using critical feminist theory. *BMC Pregnancy Childbirth*, 19(1), 142. [DOI link](#)
- Keedle, H., Schmied, V., Burns, E., & Dahlen, H. G. (2022b). From coercion to respectful care: women's interactions with health care providers when planning a VBAC. *BMC Pregnancy Childbirth*, 22(1), 70. [DOI link](#)
- Keedle, H., & Willo, P. (2022). A Poetic Inquiry of Traumatic Birth Through Bearing Witness. *Qualitative Inquiry*, 28(8–9), 938–945. [DOI link](#)

References

- Kluwgant, D., Homer, C., & Dahlen, H. (2022). "Never let a good crisis go to waste": Positives from disrupted maternity care in Australia during COVID-19. *Midwifery*, 110, 103340. [DOI link](#)
- Lequartier, B., McLean, M. A., Kildea, S., King, S., Keedle, H., Gao, Y., Boyle, J. A., Agho, K., & Dahlen, H. G. (2022). Perinatal Depression in Australian Women during the COVID-19 Pandemic: The Birth in the Time of COVID-19 (BITTOC) Study. *Int J Environ Res Public Health*, 19(9). [DOI link](#)
- Levett, K., Smith, C. A., Bensoussan, A., & Dahlen, H. G. (2016a). The Complementary Therapies for Labour and Birth Study making sense of labour and birth – Experiences of women, partners and midwives of a complementary medicine antenatal education course. *Midwifery*, 40, 124-131. [DOI link](#)
- Levett, K. M., Dahlen, H. G., Smith, C. A., Finlayson, K. W., Downe, S., & Girosi, F. (2018). Cost analysis of the CTLB Study, a multitherapy antenatal education programme to reduce routine interventions in labour. *BMJ Open*, 8(2), e017333. [DOI link](#)
- Levett, K. M., Smith, C. A., Bensoussan, A., & Dahlen, H. G. (2016b). Complementary therapies for labour and birth study: a randomised controlled trial of antenatal integrative medicine for pain management in labour. *BMJ Open*, 6(7), e010691. [DOI link](#)
- Marteau, T. M., Dormandy, E., & Michie, S. (2001). A measure of informed choice. *Health Expect*, 4(2), 99-108. [DOI link](#)
- Michaels, P. A., Sutton, E., & Highet, N. (2019). Violence and Trauma in Australian Birth. In *Australian Mothering* (pp. 239-255). Springer.
- Musodza, W., Sheehan, A., Nicholls, D., & Dahlen, H. (2023). Experiences of Maternity Healthcare Professionals Returning to Work Following a Personal Perinatal Loss: A Scoping Review of the Literature. *Omega (Westport)*, 86(3), 744-768. [DOI link](#)
- Perrotte, V., Chaudhary, A., & Goodman, A. (2020). "At Least Your Baby Is Healthy" Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review. *Open Journal of Obstetrics and Gynecology*, 10(11), 1544-1562. [DOI link](#)
- Priddis, H., Dahlen, H., & Schmied, V. (2013). Women's experiences following severe perineal trauma: a meta-ethnographic synthesis. *J Adv Nurs*, 69(4), 748-759. [DOI link](#)
- Priddis, H. S. (2015). Autoethnography and severe perineal trauma--an unexpected journey from disembodiment to embodiment. *BMC Womens Health*, 15, 88. [DOI link](#)
- Priddis, H. S., Keedle, H., & Dahlen, H. (2018). The Perfect Storm of Trauma: The experiences of women who have experienced birth trauma and subsequently accessed residential parenting services in Australia. *Women and Birth*, 31(1), 17-24. [DOI link](#)
- Rigg, E. C., Schmied, V., Peters, K., & Dahlen, H. G. (2017). Why do women choose an unregulated birth worker to birth at home in Australia: a qualitative study. *BMC Pregnancy Childbirth*, 17(1), 99. [DOI link](#)
- Rigg, E. C., Schmied, V., Peters, K., & Dahlen, H. G. (2020). A survey of women in Australia who choose the care of unregulated birthworkers for a birth at home. *Women and Birth*, 33(1), 86-96. [DOI link](#) (Women and Birth)
- Sassine, H., Burns, E., Ormsby, S., & Dahlen, H. G. (2021). Why do women choose homebirth in Australia? A national survey. *Women and Birth*, 34(4), 396-404. [DOI link](#)
- Simpson, M., Schmied, V., Dickson, C., & Dahlen, H. G. (2018). Postnatal post-traumatic stress: An integrative review. *Women Birth*, 31(5), 367-379. [DOI link](#)
- Simonovic, D. (2019). A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence : note / by the Secretary-General. 23 p.
- Stevens, J., Schmied, V., Burns, E., & Dahlen, H. (2014). Immediate or early skin-to-skin contact after a Caesarean section: a review of the literature. *Maternal & child nutrition*, 10(4), 456-473.
- Stevens, J., Schmied, V., Burns, E., & Dahlen, H. (2016). A juxtaposition of birth and surgery: providing skin-to-skin contact in the operating theatre and recovery. *Midwifery*, 37, 41-48.
- Stevens, J., Schmied, V., Burns, E., & Dahlen, H. G. (2018). Who owns the baby? A video ethnography of skin-to-skin contact after a caesarean section. *Women and Birth*, 31(6), 453-462. [DOI link](#)
- Stevens, J., Schmied, V., Burns, E., & Dahlen, H. G. (2019). Skin-to-skin contact and what women want in the first hours after a caesarean section. *Midwifery*, 74, 140-146. [DOI link](#)
- Stevens, J. R. (2018). Facilitators, barriers and implications of immediate skin-to-skin contact after caesarean section: An ethnographic study Western Sydney University (Australia).
- United Nations. (1994). Declaration on the Elimination of Violence Against Women: by General Assembly Resolution 48/104 of 20 December 1993. [DOI link](#)
- Vedam, S., Stoll, K., Martin, K., Rubashkin, N., Partridge, S., Thordarson, D., Jolicoeur, G., & Changing Childbirth in, B. C. S. C. (2017). The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. *PLoS One*, 12(2), e0171804. [DOI link](#)
- Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., & Declercq, E. (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health*, 16(1). [DOI link](#)
- World Health Organization. (2014). The prevention and elimination of disrespect and abuse during facility-based childbirth (WHO/RHR/14.23). [DOI link](#)



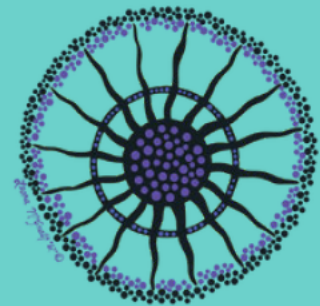
BEST

THE BIRTH EXPERIENCE STUDY

The Birth experience study has been co-designed by representatives from ten maternity and consumer organisations through a consumer reference group. This group informed the design, distribution, funding and dissemination of the study. We would like to thank those representatives for their dedication and support.

BEST has also supported students and visiting scholars with analysing different sections of the study, including seven undergraduate midwifery students on summer and winter scholarships, one medical student, two psychology honours students and a Fulbright Scholar from the USA.

At the time of writing there have been three published papers on the BEST data on birth trauma, obstetric violence and women's wishes for future pregnancies.



Rhodanthe Lipssett Indigenous
Midwifery Charitable Fund



Birth Time



—  —
THE BIRTH EXPERIENCE STUDY
— INTERNATIONAL COLLABORATION —

*10 Research Groups
across the World*



1 in 10

Women
experience
obstetric
violence in NSW

28%

women experience
birth trauma in NSW





We thank the women who participated in our studies by sharing their stories.

We acknowledge the pain they have, and do experience.

We hope this Inquiry finally gives them a much needed voice.

Acknowledgements

This report has been created for the NSW Upper House Inquiry into Birth Trauma.

Written by **Dr Hazel Keedle & Professor Hannah Dahlen**

Data analysis by **Warren Keedle, Dr Hazel Keedle & Professor Hannah Dahlen**

The design of the report by **Dr Hazel Keedle**

August 2023

