**Submission No 235**

# INQUIRY INTO BIRTH TRAUMA

**Organisation:** Homebirth New South Wales

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To the NSW Select Committee on Birth Trauma,

My name is Katelyn Commerford and I am the President of the not-for-profit organisation Homebirth NSW, which is an advocacy group whose vision is for accessible and affordable homebirth options for all women who desire it.

I'm writing this submission for the Inquiry on behalf of our organisation and the members we represent to express our thoughts around birth trauma, its relationship to homebirth, and methods that we can clearly identify that would mitigate the risk of birth trauma by comparing birth outcomes in homebirth to hospital birth.

The NSW Mothers and Babies report released a couple of months ago with data from 2021 showed an increase in homebirthing of 100% from the previous year. Our website receives around a thousand visitors a month, and our social media accounts have 6000 and 7000 followers across instagram and Facebook respectively. We publish a directory of private midwives on our website as one of our income streams that provides a contact form for midwives. On average over the past 12 months, I'd estimate that each of our 23 currently listed midwives receives upwards of 5 enquiries per month from our website alone. These midwives are also receiving their own direct inquiries from referrals, repeat clients, and other marketing avenues. The point to be made is the demand for homebirth far exceeds the supply - Privately Practicing Midwives simply do not have the capacity to take on all of the enquiries they receive.

We can see that homebirth is becoming an increasingly popular birth choice, and our organisation has observed that much of this is to do with women's experiences of trauma within the maternal health care system.

When women complete a contact form on our website to reach a midwife, they can also write a message. Some of them simply share a due date and ask about availability, but it's not uncommon to see a heartfelt and devastating description about prior birth trauma that they have experienced which has pushed them towards seeking private midwifery services and homebirth for their current pregnancy.

I personally receive a handful of inquiries from women a month in my capacity as president of the organisation, asking questions about homebirthing and sharing stories of prior trauma, or occasionally when first time mothers, how they have been impacted by stories of trauma from their friends and family and wanting to birth outside of the system to avoid being traumatised.

This is also backed up by what we hear from the homebirth community at our local homebirth group meets, of which we have around 14 across the state.

Common themes in these stories of trauma include:

- Not being listened to or heard

- Not being involved in decision making

- Not having a relationship with a care provider, and feeling unsafe and unsupported receiving care from strangers at a time of great vulnerability

- Feeling like they have no control over what was being done to them

- A lack of informed consent, or sometimes any consent, around procedures

- Being denied access to alternative options

- Birth complications, most of them iatrogenic (for example, instrumental or caesarean births due to foetal distress after an induction)

- A lack of informed breastfeeding support

- A sense of abandonment either in pregnancy, labour, or immediate postpartum

- Not being given adequate pain relief

The most frustrating thing about hearing these stories of trauma is that we already have the evidence for the best preventative method: continuity of midwifery carer.

Many women come to homebirth for the model of care as much as the place of birth. Private midwifery continuity of care is truly a gold standard - women have prenatal appointments usually around an hour long, and usually in their own homes, they have the direct contact for their midwife and instructions on how and when to contact them, their midwife is the one to attend to them in labour, and they receive in home postpartum care usually every day or second day in the first week postpartum, and then once a week for the next couple of weeks, and then fortnightly until 6-8 weeks depending on the health and wellbeing of the mother and baby.

All women should have access to this level of midwifery care, and this model of care. Birth is a transformative experience, and we cannot afford to see any more mothers entering motherhood broken. Continuity of midwifery care is not only simple, but cost effective. The research is there. Women who are not birthing in hospital save the system money, and women who are under continuity of midwifery care models within hospital save the system money, as they are more likely to birth with fewer interventions and pain relief, and be home sooner.

We also have abundant research that shows women who birth at home suffer from fewer complications than women of similar risk in a hospital environment, and that their babies are as safe as they are in hospital. Yet homebirth remains inaccessible to the overwhelming

majority of women. Even when women are able to find an available PPM, there is still no Medicare rebate for birth with PPMs, and so it is a significant out-of-pocket-cost. We need an expansion of publicly funded homebirth models in NSW, and we need to see more autonomy allowed for the women within those programs. Frequently, women are what is referred to as "risked out" of these programs by eligibility criteria that is almost unattainable. Women who have experienced prior caesarean births make up a significant proportion of homebirthing women (usually due to their trauma and their desire to avoid another caesarean birth - homebirth has the lowest rate of caesarean section, and repeat caesarean section for those with prior caesareans) and this is one of many criterium that sees women excluded from publicly funded homebirth programs. Others include women who gestate beyond 42 weeks, women who have declined particular screening or testing, women who have been estimated to have a macrosomic baby, women who have been determined to have gestational diabetes regardless of whether their sugar levels are controlled or not, and more. These are scenarios where evidence tells us there is no increased risk for the woman or her baby, or that the risk increase may seem significant on a absolute scale when the relative risk is still incredibly low, or where the methods used to make estimations or diagnoses are unreliable at best. This is quite aside from the fact that regardless of level of risk a woman is deemed to have, she still has a legal and human right to make an informed decision about her birth. This should include her right to birth at home with clinical care.

We also want to bring to the attention of the committee the issue of vexatious reporting of midwives. Birth is not a medical problem, it is a physiological event that occasionally needs clinical assistance. Most complications can be managed at home by trained and resourced midwives, and the rare few that cannot, require a safe and timely transfer to hospital. At present, privately practicing midwives (PPMs) are frequently reported to APHRA and the HCCC by hospital staff when transferring women into hospital. This is not only outrageous, but dangerous. Homebirth is only safe when hospital transfer remains possible and straightforward, and when midwives fear being reported for safe and timely transfers of women, transfers may not happen as timely or as safely. We need to see protection from vexatious reporting for our PPMs.

In summary, as an organisation, we can attest to the prevalence of birth trauma and the significant impact it is having on mothers, which in turn affects families, and our greater society. We know that women who choose to homebirth have better outcomes in birth and postpartum, including fewer interventions, fewer complications, higher birth satisfaction, higher breastfeeding rates, and less postpartum depression and anxiety (see attached supplementary file for references). Having access to homebirth for all women who want it would be a huge step in mitigating the risk of birth trauma.

We suggest the following as potential solutions the birth trauma epidemic. We acknowledge that some of these are outside of the State responsibilities, but we bring them to your attention in the hope that you will continue to liaise with your Federal government colleagues on these issues.

- Significant expansion of continuity of midwifery care for women birthing within hospitals, for all risk categories. Women should not be excluded from this model of care because they are higher risk - if anything, those are the women who are most in need of it.

- Significant expansion of Publicly Funded Homebirth programs in metro AND regional areas.

- Expanding the currently prohibitive eligibility criteria for Publicly Funded Homebirth programs.

- Bundled funded for maternity services, allowing Medicare to be used towards homebirth with PPMs.

- Education for clinicians and hospital staff on what respectful maternity care looks like practice and how to provide respectful maternity care.

- Protection for Privately Practicing Midwives from vexatious reporting.

- Reduction of exorbitant 5000 hours required for midwives to gain endorsement to practice privately which would allow for more midwives to enter private practice sooner and meet the current demand.

This list is by no means exhaustive, and Homebirth NSW welcomes any opportunity for further communication with the Select Committee to provide further information or comments.

Thank you for your time, and for hearing the stories of women affected by birth trauma. Many of them may never have had the chance to have someone really hear their story.

Sincerely,

Katelyn Commerford

President

Homebirth New South Wales