Submission No 943

INQUIRY INTO BIRTH TRAUMA

Organisation: Maternity Consumer Network

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www.maternityconsumernetwork.org.au

Introduction

Maternity Consumer Network is a leading maternity consumer organisation in Australia, with over 1000 member and member organisations. We have been heavily involved in strategic direction and reforms in the maternal healthcare including: working with the previous government to develop a Woman Centred Care Maternity Strategy, the Medicare Review of Participating Midwives, ANMAC Midwifery Standards, presenting to the Stillbirth Inquiry and providing evidence-based solutions to inform the National Stillbirth Strategy, and state-wide strategies for maternity services including Queensland's Normal Birth Strategy, ACTs Public System Maternity Plan, and many research projects.

Submission

Women experience high rates of psychological trauma during childbirth in New South Wales, with estimated 1 in 3 experiencing a traumatic birth, and 1 in 10 resulting in PTSD, and the number rises for women who have assisted or caesarean births. Women's trauma is often dismissed with the long-standing narrative "all that matters is a healthy baby", however women's and babies' health are intertwined.

The consequences of psychological trauma during childbirth for women include the development of mental health problems, which may persist for many years into the future, difficulties breastfeeding, difficulties bonding with their baby, disrupted sleep, and breakdown of their relationship with their partner. This in turn is associated with poorer growth and developmental outcomes for babies, including emotional and behavioural problems that can persist until adulthood. The Maternal Health Matters 2020 survey found that 20% of responses indicated that their birth experience negatively affected their relationship with their baby. 30% reported that their birth experience negatively affected how they felt about themselves, rising to 50% of women who had a caesarean section.

Mistreatment by care providers is a particular risk for experiencing psychological trauma during birth: it is reported as the cause by two thirds of women who had a traumatic birth. The largest birth experience survey to date revealed that over 1 in 10 women are able to identify mistreatment from their care providers, which is indicative of a much larger problem: it is likely that many more do not recognise being mistreated. Common themes of mistreatment reported by women published in Reed et al 2017 are:

- Care that prioritises the care provider's agenda [over the woman's health]
- Lies and threats
- Assault

We receive a large volume of complaints from women with the same themes. As a not-for-profit with no funding, we simply don't have the resources to keep up with supporting and advocating

for all these women.

A national survey in 2021 called the Birth Experience Study (BeSt) collected women's experience who'd had a baby in the previous 5 years. There were over 8500 submissions. From the valid 8,546 responses, there were 991 (11.6% of the BESt survey cohort) respondents who identified "yes" or "maybe" to the question on Obstetric Violence. There were three main categories of comments from women: "I felt dehumanised," "I felt violated," and "I felt powerless." Women reported bullying, coercion, non-empathic care, and physical and sexual assault- obstetric violence. Disrespect and abuse and non-consented vaginal examinations were the subcategories with the most comments.

Women report that they do not receive enough information to make informed decisions during labour and birth, or receive information biased towards their care provider's preference, resulting in them agreeing to interventions that do not align with their preferences. Informed consent to procedures is an essential element of respectful maternity care, yet a study in 2010 by QCMB revealed that only 27% of women provided informed consent for induction of labour, 52% for planned caesarean, and 12% for unplanned caesarean. Yet another study showed that maternity care providers had poor understanding of their legal responsibilities and women's rights to informed consent during childbirth,42 and many policies and guidelines contain coercive language that precludes informed consent. When clinicians fail to obtain informed consent to interventions during childbirth, it is considered medical battery and negligence.

There are many alarming stories published of lies and threats being used to bully women into complying with interventions in childbirth. When women attempt to exercise bodily autonomy, have researched what they want for birth, or want to refuse certain medical treatment, they are often met with threats These include "shroud waving" or the "dead baby card": "Do you want a dead baby? Your baby will die unless [you comply]". Women may be threatened with being reported to children's services.

Women report very traumatic stories of being assaulted during maternity care; they report being held down by clinicians, having clinicians' put their hands inside them against their will, and being cut or stitched without consent or pain relief. The language women used to describe these actions is similar to that used for sexual assault; and indeed the consequences of such treatment is similar for women. One woman we interviewed for our Faces of Obstetric Violence social media interview series had such significant PTSD her marriage broke down and she was unable to maintain custody of her daughter. In 2022, women of Wagga Wagga approached MCN for advocacy support. Subsequently, over 30 women wanted support to make a submission to the HCCC about their mistreatments. We believe without the assistance of Minister Hurst and media, these complaints would have been overlooked and dismissed. Media here.

Whilst there is currently more awareness about obstetric violence, disrespectful treatment, and abuse in the maternity space, it has taken large efforts with the media. Bowser and Hill's landmark report in 2010 (below) identified 7 themes of abuse and breach of human rights, consistent with the same abuse of women in the NSW Maternity system. These 7 themes of disrespect and abuse have been instrumental in raising awareness with the WHO and UN, and provided inspiration for the development of White Ribbon's Respectful Maternity Care Charter.46

Types of D&A, Corresponding Human Right, respective sub-themes based on literature in the EMR

Types of D & A	Corresponding Human Rights	Sub-themes identified from the EMR (Khalil, 2020)
1. Physical Abuse	• Freedom from harm and ill treatment	• Overuse of routine interventions • Hitting • Insufficient pain medication

2. Non-Consented Care	• Right to information, informed consent, and refusal • Right to have choices and preferences respected • Freedom from coercion	• Hierarchical care and limited decision-making power • Limited information for decision-making and consent • Unconsented routine interventions
3. Non-Confidential Care	• Right to confidentiality and privacy	• Lack of physical protection of patient confidentiality • Overcrowding
4. Non-Dignified Care	• Right to dignity and respect	• Verbal abuse • Dehumanized care
5. Discrimination	• Right to equality, freedom from discrimination and equitable care	• Personal characteristics • Language
6. Abandonment	• Right to timely care • Right to highest attainable level of healthcare • Right to companionship	• Lack of companionship • Neglect
7. Detention	• Right to liberty, autonomy, and self-determination	• Culture of bribes and Informal payments

White Ribbon Alliance's Respectful Maternity Care Charter addresses the issue of disrespect and abuse toward women and newborns who are utilizing maternal and newborn care services and provides a platform for improvement by:

- Raising awareness for women's and newborns' human rights guarantees that are recognized in internationally adopted United Nations and other multinational declarations, conventions and covenants;
- Highlighting the connection between human rights guarantees and healthcare delivery relevant to maternal and newborn healthcare;
- Increasing the capacity of maternal, newborn and child health advocates to participate in human rights processes;
- Aligning women's demand for high-quality maternal and newborn care with international human rights law standards;
- Providing a foundation for holding governments, the maternity care system and communities accountable to these rights;
- Supporting healthcare workers in providing respectful care to women and newborns and creating a healthy working environment

Despite this, there is a lack of willingness for maternity providers to uphold this charter, undertake training, or make this available to women so they understand their rights. It needs to be embedded in midwifery and obstetric training and appropriate feedback collected from women to rate staff's ability to uphold the charter. There are several surveys from The Birth Lab that can measure women's autonomy, respect and mistreatment- The Mother's Autonomy on Decision Making, The Mother's on Respect Index and the Mistreatment Index. Despite data collection on other outcomes such as gestation, method of birth, baby's birth weight and other interventions, collecting data on the way a woman is treated in birth has not been prioritised by government. This data needs to be captured, published publicly and easily available for women to help choose her place of birth and for care providers to reflect on practice.

Maternity Consumer Network has created training with Human Rights in Childbirth and a Perinatal Psychologist specialising in birth trauma to bring the RMC charter to hospitals in Queensland with our "Better Births with Consent" workshops. It has been endorsed by the QLD Birth Strategy and currently 14 maternity hospitals to date have completed the training. Survey results from the training, along with anecdotal evidence from hospital administration are that this workshop training is having a positive impact on improving the culture of disrespect against women in childbirth, staff are more enthusiastic about upholding a woman's right to informed consent and women's are feeling safer.

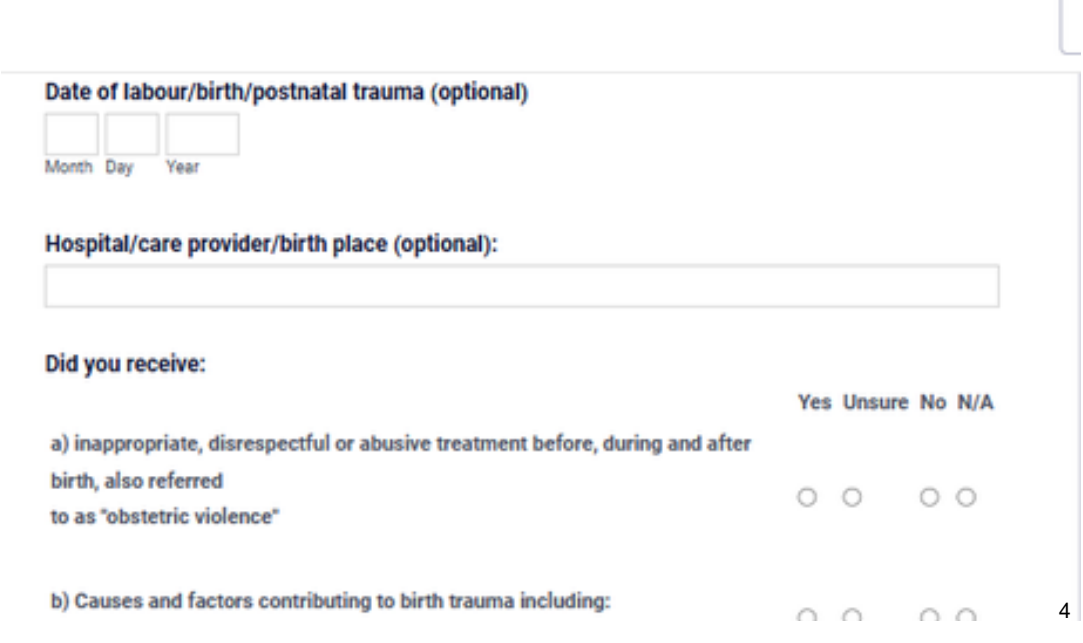
A UN report on the Violence and Disrespect of women in Childbirth warned against “the widespread and systematic phenomenon of violence towards women and girls in reproductive services” and urges services to “address the structural problems and root causes of violence against women in reproductive health services, with a focus on childbirth. Through the submissions received and other resources, the Special Rapporteur identified manifestations of gender-based violence in reproductive health-care services and during facility-based childbirth. Over 40 submissions from NGOs highlighted the lack of informed consent.

The recommendations from this report need to be applied to New South Wales maternity services: it is something we have been constantly asking for many years. Some specific recommendations adaptable to New South Wales as a matter of urgency are:

- Commit to ensuring that all clinicians practicing in Australia have a working understanding of women's right to informed consent to procedures during childbirth (we address this in our Better Births with Consent training).
- Review all policies and procedures and ensure they enshrine structural support for women’s informed consent
- Ensure that data collected on the percentage of caesarean sections, episiotomies, induction of labour, and other relevant procedures performed in a service or by individual private clinicians is published in a manner accessible to women
- Review complaints procedures in all jurisdictions such that women receive fair investigations into allegations of mistreatment during childbirth
- Ensure that clinicians who are found to have mistreated women undertake adequate measures to avoid repeated incidents
- Ensure that women who are found to have been mistreated are provided with adequate restitution.

To make the Inquiry submissions more accessible to women, we converted the TOR into a jotform online form. This was shared on social media and had over 600 submissions.

The results are tabled below, including 67% of respondents agreeing they had received inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to obstetric violence. Sixty-five (65%) of women reported not having informed consent in their maternity care and 59% did not receive continuity of midwifery carer. The common themes align with the same themes of disrespect and abuse outlined by Bowser and Hill and the Respectful Maternity Care Charter.



Date of labour/birth/postnatal trauma (optional)

Month Day Year

Hospital/care provider/birth place (optional):

Did you receive:

	Yes	Unsure	No	N/A
a) inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as "obstetric violence"	○	○	○	○
b) Causes and factors contributing to birth trauma including:	○	○	○	○

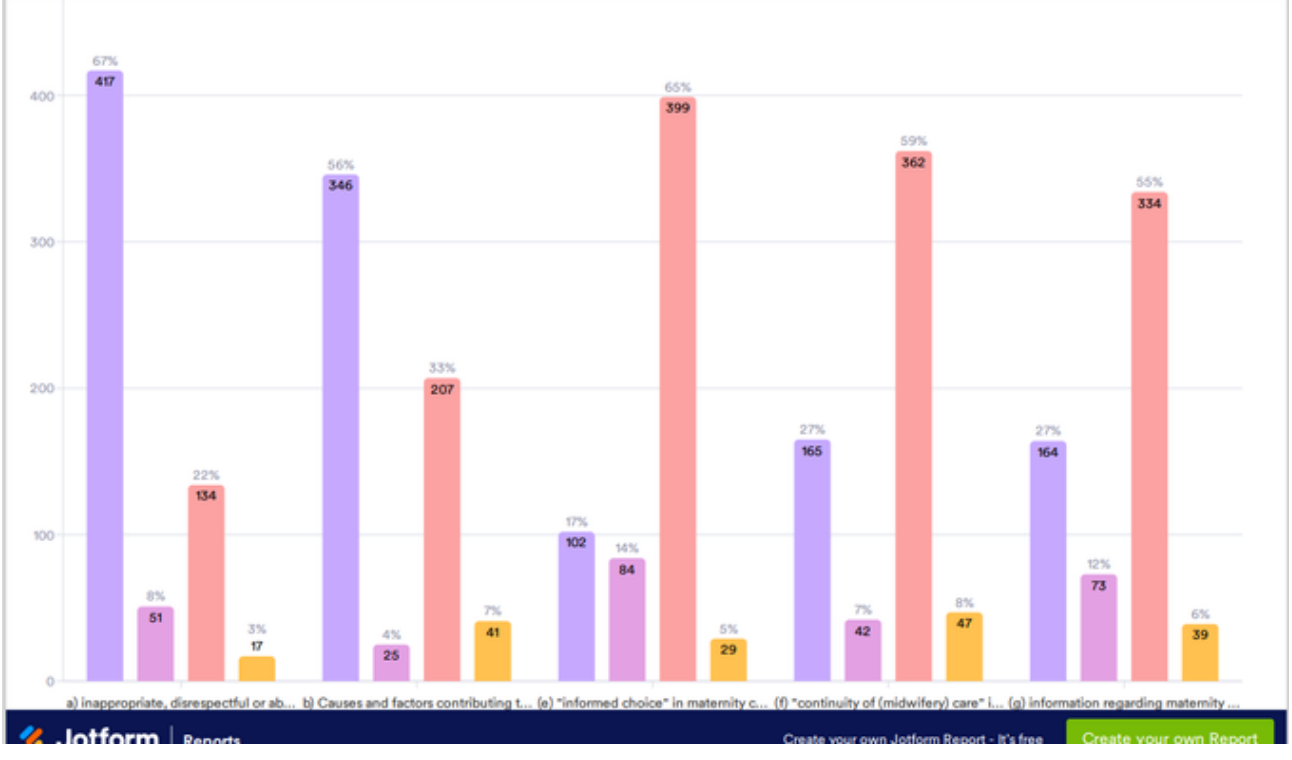
(ii) use of instruments and devices for assisted birth e.g., forceps and ventouse

(e) "informed choice" in maternity care

(f) "continuity of (midwifery) care" in maternity care

(g) information regarding maternity care options prior to/ during care

(Space to explain any of your above answers):



In Australia, there are a variety of maternity models of care that women can access, dependent on location and availability- postcode lotto. The largest model of care is fragmented (40.8%) in nature and results in women seeing different midwives and OBs during pregnancy, labor and birth, and the postnatal period according to AIHW. Women may be able to access continuity of

care with a midwife through a public hospital in midwifery group practices (MGP), with rates of access around 15% according to a Dawson et al 2016 study. Private obstetrics accounts for around 10.5% of births and GP is around 14.6%. Both of these models offer some continuity, but women will not know the midwives who attend their births and very few women are offered postnatal care in these models. We believe in a preventative approach to improve outcomes for maternity care driven by greater access to continuity of midwifery carer. Continuity of midwifery carer is where pregnancy, birth, and postpartum care is provided by a known midwife. It is considered the international "gold standard" for maternity care, 3 and has been shown to result in better outcomes for babies, 4 more satisfying experiences for women, 5 be a more sustainable model of care for midwives, 6 and to be cheaper for healthcare systems. 7 It results in lower rates of interventions, including expensive surgical births via caesarean section8; and reduces the number of stillbirths and babies being born too early. 4

Summary of recommendations

We recommend that Australia's health system do the following to improve access to optimal maternity care. Note that many of these have also been raised in the Medicare Review of Participating Midwives (2018) and Woman Centred Care Strategy.

- Increase access to midwifery continuity of carer. This includes targets and timelines ie. 80% of public hospitals births are via continuity of midwifery carer by 2030.
- Increase and facilitate access to care options that support women's right to choose their preferred place of birth including continuity of midwifery carer.
- Expand funding for programs like Birthing on Country while ensuring that successful programs receive continued funding.
- Review maternity care policies and procedures to:
  - Consider long-term health outcomes for both women and babies.
  - Support women's right to be free from unnecessary medical intervention during labour and birth.
  - Ensure structural support for women who wish to have vaginal breech birth, vaginal birth of twins, and vaginal birth after caesarean.
  - Ensure they enshrine structural support for women's informed consent during childbirth.
- Ensuring that all clinicians have a working understanding of women's right to informed consent to procedures during childbirth. Mandate Better Births with Consent Training.
- Ensure that data collected on the percentage of caesarean sections, episiotomies, induction of labour, and other relevant procedures performed by a service, or by an individual private clinician, is published in a manner accessible to for women to use in decision making. Extend this data collection to include autonomy, respect and mistreatment and publish in a manner accessible to for women to use in decision making.
- Review complaints procedures in all jurisdictions such that women receive fair investigations into allegations of mistreatment during childbirth
- Ensure that clinicians who are found to have mistreated women during childbirth undertake adequate measures to avoid repeated incidents.
- Create laws to criminalise obstetric violence
- Ensure that women who are found to have been mistreated during childbirth are provided with adequate restitution.
- Develop disability identification, data collection and assistance services specific to pregnancy and childbirth.

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