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INQUIRY INTO BIRTH TRAUMA

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Submission to the select committee NSW inquiry into birth trauma and obstetric violence

To The select committee

Firstly, thank you for your time and attention to this issue of birth trauma and obstetric violence. I am grateful that this issue is being addressed and for your commitment to collating the submissions to this inquiry. I do also hope that your yourselves are taking time to debrief what you are learning through the submissions to this inquiry. The people submitting their stories will have been through an emotional journey to submit their words and you will all also experience an emotional journey reading them. My hope is that you are looking after your own mental and emotional well-being during this time. Please know that your work in this committee is going to make a real difference to women in the future. Thank you for your contribution.

My name is Dr Melanie Jackson, I write to you as a midwifery researcher at Western Sydney University, A private midwife providing homebirth services, as an editorial board member for the international journal of birth and parent education and the host of 'The Great Birth Rebellion' Podcast.

My authority in this space of birth trauma and obstetric violence is that I have also completed a PhD on the topic of 'Birthing outside the system' which explored the motivating factors behind women choosing freebirth (intentionally giving birth at home without the presence of a registered maternity care provider) or high risk homebirth (giving birth at home with a registered maternity care provider but with accompanying maternal or infant risk factors that would normally exclude women from the option of homebirth). This research was the first of it's kind in Australia, it was published in 2014 and prior to that there had been no exploration into why women in Australia make these decisions for their birth. These two birthing options were explored together because they both represent a complete rejection of mainstream maternity care options and I was curious to know why women would choose to flee from a maternity care system that is touted as the 'safest' option.

My research discovered that most women who make these choices to avoid the maternity care system are doing so because they have been abused and violated in the system in the past. Mainstream maternity care options are viewed as dangerous and have been experienced as dangerous by these women in the past. Amongst many stories, The women in my research told stories of being held down by care providers and having non-consensual vaginal examinations, feeling like a piece of meat, feeling degraded, bullied and assaulted. To these women, the maternity care system was not safe and the choice to birth outside of the system presented itself as the best and safest option when compared to what they had previously experienced. In my research it was discovered that Birth trauma and obstetric violence is the main instigating factor behind why women view the option of giving birth alone or at home with medical risk factors as a safer option that returning to hospital where they experienced trauma and violence.

The obstetric violence perpetrated against women in hospitals is causing women to make alternative and sometimes more dangerous birthing decisions in an effort to keep themselves safe from violence in the maternity care system.

You have already heard that here in Australia, 1 in 3 women leave their birth with birth trauma and 1 in 10 report being assaulted by their care provider. In this regard, maternity care services in Australia are dangerous to women. We can no longer tell women that it is safe to give birth in hospital, because it isn't. For the most part, women and their babies will come out of their pregnancy and birth experience physically intact, but there is a wake of trauma, and lifelong psychological damage.

This level of trauma after childbirth in Australia is unnecessary and unusual. It is a product of a system that is not equipped to properly care for women. We can see now from research what women have known already. The system is an emotionally, socially, mentally and psychologically dangerous place to be. In my work as a private midwife, the majority of women who seek my services are women who have experienced birth trauma and obstetric violence in the past and who are seeking more respectful care for their next birth. I work with traumatised women every day and have seen the healing that can come from emotionally safe and respectful maternity care.

Thankfully, not only has research shown us the level of trauma that is occurring for women in Australian maternity care services, but also how to stop this from happening. We already have the answers for how to stop women being the victims of obstetric violence and to emerge from their births bold, not broken.

I have inserted an excerpt from my PhD findings below which give evidence-based solutions to the prevention of birth trauma and the instigation of respectful maternity care. These solutions are evidence-based, rooted in respecting the needs of women and represent a humanising way of caring for women. These solutions are the key to providing women with care that will significantly reduce the possibility of obstetric violence and birth trauma.

Implications for the future and recommendations for change

If the Australian maternity system does not change to better cater to the individual needs of women and provide evidence-based care, women will continue to *birth outside the system*. Government and political approaches that seek to limit women's access to homebirth will only serve to further push many women out of the system. If the aim is to encourage women to be more accepting of existing maternity services, then maternity services need to deliver a more satisfactory and acceptable service. A key to successful management of maternity care services is to satisfy consumers' needs and expectations (Gofen, 2012). Efforts to humanise care, expand birth options and monitor freebirth statistics are therefore urgently required.

Humanise maternity care

Past experience of traumatising and disrespectful care was one of the major motivators for women choosing to *birth outside the system*. Therefore, humanising maternity care and providing respectful woman-centred care is needed to enhance women's satisfaction with existing maternity care options. A move towards humane care is a move away from biomedical models of care. Moreover, humane care valorises the midwifery profession and prioritises social models of birth (Rattner, Abreu, Araujo, & Santos, 2009). The provision of humane care would require some maternity care providers to effect a complete philosophical shift in how they care for women (Rattner, Abreu, Araujo, & Santos, 2009). The 2014 National Institute for Health and Clinical Excellence (NICE) recommendations suggest that all care providers should create a culture of respect for each woman as she undergoes 'a significant and emotionally intense life experience' (p. 38), and to ensure that she is listened to, in control and cared for with compassion (NICE, 2014). If women are provided with a dignifying and compassionate experience in the system, they may be less inclined to choose *birth outside the system* for subsequent births. Components of humane care include non-invasive practices, respect for women's autonomy, providing evidence-based care, the valuing of family-friendly environments, a focus on relationships between the woman and her care providers, respecting the privacy of women and ensuring that they have adequate birth support (Rattner, Abreu, Araujo, & Santos, 2009). Humane care is thought to be key to preventing complications and emergencies during pregnancy and childbirth (Rattner, Abreu, Araujo, & Santos, 2009). Humanising birth can be achieved in a number of ways, including the use of one-to-one midwifery care during labour and birth, women-centred care and reducing the use of routine interventions.

One-to-one midwifery care during labour and birth

Continuous care by a known provider has been shown to improve rates of spontaneous vaginal birth, reduce the use of pharmacological analgesia and improve infant outcomes. It also increases the likelihood of women reporting a satisfying birth experience (Hodnett, Gates, Hofmeyr, &

Sakala, 2013). Implementing continuous care models will reduce the levels of disappointment and trauma associated with the birth experience. This in turn will likely minimise the need for women to consider *birthing outside the system*. The 2014 UK NICE guidelines for intrapartum care recommend that women in established labour be provided with one-to-one care and not be left on their own except for short periods with the woman's consent (NICE 2014).

Woman-centred care

Allowing women autonomy in their birth choices and supporting them to have the birth that they believe is best and safest may help to protect the safety of women who choose high-risk homebirth or freebirth. One way to promote autonomy for birthing women is for practitioners to provide woman-centred care, which prioritises treating each woman as an individual and respecting her wishes (Brass, 2012). Woman-centred care in childbirth is a process in which the woman is actively involved, makes choices and has control over her care (Maputle & Donavon, 2013). If women can be provided with woman-centred care, they may have a more satisfying first birth, preventing them from considering *birth outside the system* for subsequent births. In addition, if a woman who has chosen to *birth outside the system* knows she will receive woman-centred care while attending her GP or local hospital, she may choose to access timely and necessary medical care when needed. Providing this type of care means that maternity care providers cater to the woman's needs and desires by respecting and facilitating her choices. This may also require providers to exercise a certain flexibility and latitude in relation to hospital policy and procedures. The 2014 NICE recommendations suggest that care providers ensure that the woman is involved and in control of what is happening to her (NICE, 2014). Key aspects of woman-centred care include providing education to promote informed consent (Maputle & Donavon, 2013), while also allowing space for informed refusal as an acceptable option.

Reduction in routine interventions

A major source of dissatisfaction identified by the women in this study was the number of interventions used in hospitals to manage birth. The women were opposed to the use of unnecessary interventions, and many chose to *birth outside the system* in order to avoid them. Davis-Floyd et al (2009) argue that the overuse of intervention is a hallmark of birth models that do not work (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). Bringing hospital-based maternity services into line with current evidence may serve to make hospital birth more acceptable and reduce the number of interventions women and their babies experience during labour and birth (Davis-Floyd, Barclay, Daviss, & Tritten, 2009). Major interventions that are unsubstantiated by evidence include routine vaginal exams (Downe, Gyte, Dahlen, & Singata, 2013), continuous CTG where there are no risk factors (Alfirevic, et al., 2013; NICE, 2014), the use of supine birth positions (Gupta, et al., 2012; Priddis H, et al., 2011), repeat caesarean for VBAC (Dodd, Crowther, Huertas, Guise, & Horey, 2013), restricting maternal food and water (Davis-Floyd, Barclay, Daviss, & Tritten, 2009) and early cord clamping (McDonald, Middleton, Dowswell, & Morris, 2013). Basing hospital policy on evidence, and undertaking regular audits of compliance, may reduce the number of interventions used. Providing more access to homebirth with a midwife and the option of midwife-led units would also be an effective way of reducing unnecessary interventions (Birthplace in England Collaborative Group, 2011).

Expand birth options

The women in this study found mainstream maternity care in hospitals to be unsatisfactory; however, not all of the participants wished to *birth outside the system*. Some explained that if they had access to midwifery-led birth centres, publicly funded homebirth, a private midwife or continuity of care with a midwife, they might have chosen one of these options instead. In order for women to access the model of care and location that they believe is best for them and their baby, service providers need to offer a wide variety of options within the system so women are not forced to *birth outside the system*. There are a number of birthing options that are safe and

evidence-based and do not require women to birth in hospitals (Birthplace in England Collaborative Group, 2011; Hodnett, Downe, & Walsh, 2012).

Publicly funded homebirth

In Australia, the prevailing belief is that homebirth (even in the most ideal circumstances) is more dangerous than hospital birth. This is not supported by research. For example, the 2014 NICE guidelines have provided advice that it is safe for low-risk multiparous women to give birth in a midwifery led unit (free standing or along side) or choose homebirth, since these options offer fewer interventions and present no difference in perinatal mortality and morbidity (NICE, 2014). According to these guidelines homebirth may carry slightly more risk than midwifery led units (particularly for primiparous women), however, is still considered a suitable and safe birth choice.

Although publicly funded homebirth is available in some states and territories in Australia, to date there are only 12 such services across the country. There is a need for this option to be expanded so women are able to access homebirth that is affordable and where midwives can be adequately insured. The submissions to the 2009 National Maternity Review (NMR) also mirrored women's desire for funded homebirth, either through the private sector, covered under Medicare, or publicly funded homebirth services through hospitals. The submissions suggested that by allocating funding to these options, women would more readily take them up, as cost would no longer be prohibitive (Dahlen, Schmied, et al., 2011). In addition, recent research into outcomes of Australia's existing homebirth programs has been encouraging (Catling-Paull, et al., 2013), so expanding this option may be feasible and beneficial in the Australian context. New Zealand provides free maternity care to women choosing midwives, even if they choose to birth at home. Given the high levels of satisfaction expressed by the women who utilise these services, this is a model that Australia could emulate (Grigg & Tracy 2013). Furthermore, the Dutch maternity care system has shown that providing homebirth on a large scale is safe and feasible,

with around 20% of the births in the study occurring at home and with good outcomes (De Vries, Wiegers, Smulders, & Teijlingen, 2009)

Birth in standalone or alongside midwifery units

Some women in this study had previously given birth in birth centres because they saw this option as a middle ground between homebirth and hospital birth. Although they were initially open to this as a suitable option, after their experiences they chose not to return. Most birth centres in Australia are annexed to or inside a hospital, with very few standalone birthing units run by midwives. Walsh (2009) suggests that the small-scale approach to birth provided by birth centres and smaller midwifery units, provide women with a reprieve from the production line mentality of larger birthing units. Furthermore, such units also allow midwives to provide care that facilitates the involvement of family (Walsh, 2009). Similarly, the NICE guidelines recommend that women plan to give birth in midwifery-led units (standalone or alongside a hospital) because they will experience fewer interventions, and because outcomes are no different than if they birth in obstetric units (NICE, 2014). Hodnett et al (2012) also concluded that birth centres are associated with lower rates of intervention and higher levels of satisfaction, with no increased risk to either mothers or babies (Hodnett, et al., 2012), making them an attractive alternative to obstetric hospital care.

Midwifery-led continuity of care

As detailed in the background section of this thesis, midwifery-led continuity of care has better outcomes for mother and baby compared to standard fragmented care in hospitals (Sandall, 2012). Under midwifery-led continuity of care, women experience fewer interventions, greater satisfaction, positive birth outcomes and a heightened sense of confidence and achievement (Fahy, et al., 2008; Homer, et al., 2008; Leap, et al., 2010; Sandall, et al., 2013). Continuity of midwifery care is also cost effective (Tracy, et al., 2014), and it has been successfully expanded in

New Zealand (Grigg & Tracy 2013). Models of care that maximise partnership and relationship-based care need to urgently be expanded in Australia.

Midwifery care for high-risk women

A major problem in Australia is that women with risk factors have little choice but to birth in a high-acuity setting under obstetric care, or else birth at home with the assistance of a midwife who risks being reported to the regulatory body if an adverse event occurs. Providing other options – such as continuity of midwifery care – for women with risk factors will broaden the possibilities, and lessen the sense that women are faced with an either/or quandary.

An Australian study published in 2013 reinforced the benefits of a midwifery continuity of care model for women of all-risk levels (provided that a collaborative approach to care is prioritised). The randomised controlled trial included all-risk pregnant women, who were randomised to either standard care or caseload midwifery care (under a continuity model) (Tracy, et al., 2013). The authors concluded that 'for women of any risk, caseload midwifery is safe and cost effective' (p. 1723). The authors encourage other maternity care providers to consider adopting this collaborative model, as it would allow higher-risk women to have access to midwife-led care (Beasley, Ford, Tracey, & Welsh, 2012).

Access to VBAC

Access to VBAC was a significant contributing factor to women's choice to *birth outside the system*. Some women *birthed outside the system* because their local hospital did not offer the option of VBAC. Women who did not want a repeat caesarean section had no choice but to travel the distance to a hospital that would provide the option of a VBAC, choose a private midwife to attend them at home, or opt for freebirth. Furthermore, policy restrictions around VBAC in hospital, such as requirements for continuous electronic fetal monitoring and venous access, deterred some women from giving birth in hospital. If more women were offered the option of

VBAC, and if policies regarding care during labour were rendered more flexible, women may be more willing to accept mainstream maternity care.

Enhanced support for private practice midwifery and private homebirth

The majority of women who chose to freebirth explained that they felt backed into a corner and forced into this situation by the fact that there were no other acceptable options. One way to cater to these women would be to ensure that women have greater access to privately practising midwives (Newman, 2008). Australia needs to make practising as a private midwife less daunting, encouraging more midwives to pursue this professional path. Currently, there is a great deal of cultural and medical hostility towards, and political unrest around, private midwifery practice. As a result, midwives are giving up practicing. Therefore, women who want a midwife at their birth are experiencing difficulty locating an appropriate person. Furthermore, vexatious reporting of private midwives (by other maternity care providers) to legislative authorities is making midwives scared to refer complex cases, rendering the practice of private midwifery less safe for women. Policymakers, regulators and government should be making private practice a more welcoming option for midwives by, creating a supportive environment, facilitating access to hospitals, providing adequate professional indemnity insurance and offering adequate medicare funding.

Encouraging women to birth inside the system cannot be achieved by a heavy-handed approach. Rather, providing women with what they believe is the best and safest (in this context, trained registered midwives to attend them at home) will reduce the numbers of women who choose to *birth outside the system.*

Monitor freebirth statistics

Freebirth rates are not captured easily in current data sources. In the future, it would be ideal to record the numbers of women having freebirths. This would allow monitoring of variability across geographical regions, and to determine whether rates are changing over time. If *birth*

outside the system is an indication of women's dissatisfaction with mainstream maternity care options, then perhaps as maternity care evolves in a positive direction, the number of women planning freebirth will reduce. Currently, however, there is no way to assess this due to the lack of accurate data.

Thank you for your time in reading my lengthy submission.

I would welcome any questions you might have and would happily offer further insight if you would like clarification on anything in my submission.

I would also welcome the opportunity to come and speak with the select committee on this issue if you feel my contributions would add value to this inquiry.

Kindest Regards

Dr Melanie Jackson