Submission No 1418

INQUIRY INTO BIRTH TRAUMA

Name: Mrs Magenta-Rose KUMAR

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RECOMMENDATIONS:

High risk pregnancy should not remove midwifery components of care and the midwifery group program (MGP) as the focus of obstetrics vs midwifery and the experience of senior midwives and junior doctors are completely different.

MGP should be standard model for all unless the woman and family desire something else.

NICU should be restructured for mother or parent rooming-in as per evidence. The idea that because a baby is unwell or requires more monitoring ensures that the baby is afforded lower quality bonding and care from mothers or parents is upsetting. If it is a place a mother can visit, I don't understand why it's not a place a mother can sleep/stay if desired. If it is not currently possible to do so, alternatives need to be explored such as temporary higher level care for suitable newborns (e.g. increased blood sugar monitoring, warming etc) in an area parents are suited to stay rather than separation.

Breastfeeding education should be given antenatally +++ (benefits and methods, hands on demonstration, should be lead by ABA as they have extensive evidence based resources and staff/volunteers) and lactation support services should be emphasised prior to discharge. Further support of mothers who are unable to breastfeed or choose not to for personal/other reasons should be given due to stigma, personal and societal pressures and importance of safe feeding practices (e.g. suitable equipment, sterilisation etc).

Mothers with support person(s) should be given the option to have healthy newborns in the Post Anaesthetic Care Unit (PACU) without midwifery care – the PACU is due to mother recovering from surgery. Partners and support people are considered competent carers immediately following vaginal delivery. If it is not possible to facilitate recovery in a shared space with support person(s) and newborn, then alternatives such as temporary high-level care with recovery nurse or recovery trained midwife in the birthing unit or ICU should be offered/explored.

Birthing preferences should be extensively discussed and documented during antenatal visits and reassessed during labour, it is unreasonable to expect a woman to give informed consent to interventions under pressure during labour with information provided with time constraints by junior medical staff. Birth plans and preferences should be encouraged, not shamed, with the ability to set expectations and flexibility prior to birth. If explained well, no mother would assume that a rigid birth plan would be able to be 100% adhered to in the face of complications, and they would have a greater chance of being mentally prepared and feeling supported if issues arise.

Interventions and assessments should always be based on evidence of improved outcomes or patient preference rather than “just in case” as there is growing evidence of potential iatrogenic harm. It is naive to assume that healthcare organisations have full awareness of the implications of interventions imposed if not necessary or desired. There is growing evidence recognised by the World Health Organisation that even non-indicated monitoring such as continuous CTG in a low-risk labour leads to greater harm.

More information and access for home birth needs to be provided to mothers open to the idea with a safe home space to do so available.

Support people should have more opportunity for involvement, e.g. not able to attend any antenatal clinic appointments or ultrasounds beyond 12 weeks due to inflexible “no children” policies and only weekday business hours appointment availability.