REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON BIRTH TRAUMA

INQUIRY INTO BIRTH TRAUMA

CORRECTED

At Preston Stanley Room, Parliament House, Sydney on Monday 9 October 2023

The Committee met at 9:00 am

PRESENT

The Hon. Emma Hurst (Chair)

The Hon. Mark Banasiak
Dr Amanda Cohn
The Hon. Anthony D'Adam
The Hon. Natasha Maclaren-Jones
The Hon. Sarah Mitchell
The Hon. Emily Suvaal (Deputy Chair)

The CHAIR: Welcome to the third hearing of the Select Committee on Birth Trauma inquiry. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the land on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respect to any Aboriginal and Torres Strait Islander people joining us today. My name is Emma Hurst and I am Chair of the Committee. I ask everyone in the room to please turn their mobile phones to silent.

Owing to the nature of this inquiry, I warn those in attendance and those listening to this recording that evidence presented today may contain sensitive content or themes. If you feel distressed as a result of the inquiry's sensitive content and themes, please contact one of the resources available on the Committee's website. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage committee members and witnesses to be mindful of these procedures.

Mrs DULCE MUÑOZ, Private Citizen, affirmed and examined

Mrs AMY MAGEROPOULOS, Private Citizen, affirmed and examined

The CHAIR: I welcome our first witnesses and thank them both for making the time to give evidence today. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Would you like to start by giving an opening statement?

DULCE MUÑOZ: Yes, thank you. I'm going to read it because I get really nervous, and if I get nervous my English goes in and out, as a dyslexic bilingual person. First of all, thank you for allowing us to share our experience. Here we go. I gave birth to my daughter on 13 November 2010 in an inner-city hospital after 72 hours of labour that ended up saving our lives—an emergency C-section for which I am eternally grateful—and that left me with an anxiety disorder and lifelong consequences.

There are three things that went wrong that day. One is that I am a person of colour with a very deep accent who at the time looked really young, with a normal pregnancy medical story and no complications, when my pain and discomfort question was dismissed and ignored by the hospital staff. Two, I felt that there was an animosity between doctors and midwives during the last part of the labour, which created uncertainty and tension. Three, there was a lack of training, communication and compassion about childbirth trauma after the C-section. When I asked the nurse in the recovery room after the C-section about my baby, she told me, "Oh, I can't tell you about it. Just rest," leaving me to create all scenarios possible, including burying my child, taking up juggling and rehearsing my phone call to my dad telling him that his grandchild died.

After two hours, when I saw Victoria—my child—in my mother's arms I was completely in shock and denial. It took me days to realise that I had a healthy baby and nothing happened, but then years to realise also that my panic attacks, my health anxiety and the extreme attachment to Victoria was PTSD from that day. It's funny how an old life like me—a 40-year-old—can be marked by these traumatic effects still. But there were so many positive outcomes that came after that: my life's work, my passion and my vocation. I am here because, for all the incredible work our health system does, I truly believe that there is an underlying racism, sexism and ageism that impacts the way we treat people. I'm here today because for me it is essential that we address these systematic issues to ensure that no other expectant mothers—no matter where they come from, their accent, their age or their medical history—experience the same distress that I did.

I'm also very conscious that I have a very good story because I have a healthy baby and I didn't have lifelong consequences in my physical health. But I'm here to tell you that my story is very similar to the tens of thousands of stories that I heard working with refugees and asylum seekers, especially young mums, who birth in Australia and who feel disconnected. That's why I'm here. Thank you.

AMY MAGEROPOULOS: Okay, it's my turn now. I gave birth to my first child in February 2017. I was part of the midwifery group practice program and I was working as a registered nurse in the hospital in which I delivered. I want to use today's opportunity to discuss a few points: the importance of informed consent, the impact of birth injuries and the importance of women's health physiotherapy. The details of my birth could be typed over pages and pages, but I want to be concise and refer back to my written submission under section B. But to summarise these main points, the position and size of my baby was picked up in the antenatal period but was not discussed with me at any point. I was left to labour for an extended period of time, and my midwife had been on duty for over 16 hours and had left before I was at the pushing stage, handing me over to a midwife who I had never met.

By the time my baby was in distress, again, I wasn't informed that interventions were required. Prior to this there was time to explain the risks; there was time for me to make an informed decision. I was not given that option. There was no informed consent. The midwife and obstetrician would go outside the room for their discussions. I was told by the doctor, "We'll use a vacuum to get the baby out and they may have a bruise on their head." They did try the vacuum over five times, when recommendations are only three attempts. That failed. I then had an episiotomy, which was not discussed, and then the use of forceps to deliver my baby, which again was not discussed.

Following the traumatic birth of my son, during handover the staff would jokingly refer to my birth as "a vaginal caesarean". Despite everyone acknowledging that my birth was traumatic both physically and psychologically, I wasn't provided adequate pain relief, there was no opportunity to debrief and there were no referral pathways for my ongoing issues and injuries. I had to do it all on my own. I felt a burden to my midwives because my injuries and conditions as a result of my birth were quite complex and clearly beyond their scope of practice. Comments such as "Is this your first baby?" from other staff became insulting. It shouldn't matter if it was my first or my tenth. If a patient has a concern, they need to be acknowledged.

I have been left with permanent and life-changing injuries as a result of my traumatic birth, including pelvic organ prolapse of bladder, bowel and uterus, urinary retention—I was unable to pass urine without the aid of a catheter for the first six months of my child's life—bilateral avulsion, pudendal neuralgia, faecal incontinence, PTSD and depersonalisation disorder. I've had over nine surgeries, including a hysterectomy and sacrocolpopexy in 2021, and I will continue to need surgery for the rest of my life in order to be able to function. I'm in pain every day. I'm unable to work full-time. My life is planned around symptom management, my toileting needs and pain thresholds. The rehab and treatment is constant; it's exhausting. It has impacted on my relationships with the people I care for the most—my wonderful husband and my two beautiful boys.

I did seek legal action and, during this period, the hospital openly admitted that they were actively trying to avoid a caesarean, none of which was discussed with me at any point during my pregnancy journey. Without my knowledge, they were enforcing the now-rescinded NSW Health policy of Towards Normal Birth and trying to avoid increasing their caesarean rate. Had I known the risk of an instrumental delivery versus a caesarean, I would have advocated harder for myself. But I was under the impression that I was in the best possible care and the people in that room had my best interests at heart.

The harsh reality is all of my injuries could have been avoided had I been given the option of a caesarean. It is my belief that what's important is informed choice. No program or treatment method is without its limitations. Not every woman can have a "normal" physiological birth, and interventions may be required. These interventions will be performed by obstetricians, no matter what modality of care that woman has chosen. Risk versus benefit needs to be explained by the medical professionals that may be delivering that care. If these risks are identified in the antenatal period, they should be discussed then and not in the delivery suite.

Postnatally, for me, it was a women's health physio that identified my birth injuries and my birth trauma. Women's health physiotherapists are key in diagnosing and treating pelvic floor issues. Their involvement in care is key for early intervention and treatment to prevent more invasive measures down the track. It's not midwives, it's not doctors; it's women's health physios. There should be more subsidies for women's health physio, and all women need to have access to them, regardless of mode of delivery.

It's disappointing that their insights have not been heard as part of this inquiry, as they see firsthand the devastating consequences these injuries have on the lives of women like me. It's not enough for women to simply educate themselves. Health professionals need to ensure that their patients have an understanding. In my own nursing career, I've never witnessed that complete disregard for a patient's concerns until I myself was that patient. If you want to deliver care that is truly woman centred, egos need to be put aside. Look at the research and listen to those that have a lived experience, and make that case for change. Thank you.

The CHAIR: Thank you so much to both of you for coming here today and for your bravery. I will start with a couple of questions. I know that you've both covered this slightly in your opening statements and in your submissions but, as part of this inquiry, we will be making recommendations to the Government about anything the Government can do regarding things like funding and laws. What recommendations would you like to see in that report?

AMY MAGEROPOULOS: As I've mentioned, women's health physio, even in the antenatal period, to assist with that education for a physiological birth, and education. As I mentioned, if you have a vaginal birth without intervention, that's great. You may not know that there will be problems until you're in that labour and delivery suite, but those options need to be discussed. The whole line of, "You can't tell women everything that can go wrong in childbirth"—no, you can't, but there's definitely room for improvement there.

The CHAIR: I think you also mentioned in your submission that the hospital was severely understaffed and that affected the care that you received.

AMY MAGEROPOULOS: Yes.

The CHAIR: Can you talk a little bit more about that, and adequate staffing and good maternity care?

AMY MAGEROPOULOS: Yes. As I mentioned, my midwife, who'd been through with me for my entire pregnancy, was on duty for over 16 hours and I was handed over to a midwife I'd never met before. This is back in 2017, so I can only imagine it's gotten a lot worse now. But there were, I think, over six or seven babies being born. We could hear them crying while I was labouring, and you wouldn't see staff. I was left in the room for hours. That's not an exaggeration. I was left alone for hours with my husband, my sister and my mum. They would come in for a couple of minutes, check in, sometimes not even speak to me. They would come in, touch some buttons on the CTG machine and then leave the room, because they were just too busy trying to help other people.

The CHAIR: Thank you. My original question was what recommendations would you like to see as part of the report.

DULCE MUÑOZ: I think training on child trauma, no matter where you are. After a C-section and 72 hours of pre-labour—after my C-section, in the recovery room, no-one knew what was happening to the baby. You are pumped with drugs, your hormones are going up the roof and you're asking a very basic question, and the answer is, "I can't talk to you about that." It's, like, three hours of recovery where your mind, especially a mind like mine with neurodiversity, goes and resolves things—so I'll bury my child, take up jogging, move from Australia—and then there is a shock.

The other recommendation that I would make is culturally appropriate training. The way people see us still as migrants. I received a lot of, "Oh, but you are so young. Your pain is completely normal." It wasn't normal. It was 72 hours that required some nip and tuck after that, so it wasn't normal. The fact that I was asking questions after my body was completely filled with rashes because of a reaction to one of the drugs—I think there is a lot we have to do to stop racism and ageism and sexism. The fact that we expect that women go through pain, unnecessary pain, is at the root of all this. They're expecting us to hold pain. What were you expecting? What pain is acceptable? So, yes, those are my recommendations.

The CHAIR: I noticed that you said in your submission that there was animosity between the doctors and the midwives, and that created different advice to you. I imagine that would have created a lot of confusion. Can you talk a little bit more about what was happening there?

DULCE MUÑOZ: Sure. I think, as you say, Amy, that there is a push for natural birth. I was a picture-perfect patient. I was young, I was fit, I didn't have glucose, my baby was in a good position—everything was perfect. They pushed, during 72 hours, to do a natural birth, and they even judged me when I went, "I think I need an epidural because something is ripping my hips apart." They were really pushing for it. They broke my waters. They were trying as much as they can for a natural birth when my baby got in distress and my heart got in distress. Then the last thing I remember is a doctor asking me, "Are you allergic to anything?" But between those points, I remember doctors in different shifts coming and saying, "I think it's a lot of time. I think this baby is going to go into distress." The nurses were like, "No, no, no. This is absolutely perfect. She's fine; look at her." I wasn't fine.

AMY MAGEROPOULOS: I would agree with that statement as well. There's almost like this unspoken battle that almost the midwives may feel that they have failed a woman by not giving them that vaginal birth. Personally, I had no preference of mode of delivery. But as I said in my statement, had I known the lifelong injuries I'd be left with, I would have advocated for a caesarean. But I had the trust in the health system, being a nurse myself.

I think health literacy is really important. For some women, when they give birth, it's the first time they ever go to hospital, and it's a completely foreign environment. For me, not so much, because I know what the drip is and things like that. You can become overwhelmed with that alone, never mind that you're giving birth to a child, but the actual environment is quite overwhelming. You might not have the courage to speak up and ask questions. I do feel like there is this push for normal birth, vaginal birth, and then when the doctors get involved, it's almost like they've been defeated. But it's really not about that. You've got to look after the mother and the child. Whatever is safest, whatever poses less risk, that's what everyone should be advocating for. It doesn't happen in other areas of health care. If I had a patient come to me with concerns, I would do my best to address them, and I feel like that's missing in the training in the midwifery and delivery space.

Dr AMANDA COHN: I have two questions, if that's alright. My first one is about that postnatal period. In both of your stories, you talk about the delay between you realising that you needed some extra support in your recovery and actually getting that diagnosis and support—Amy, with your physical injuries and, Dulce, with your psychological injuries. I was hoping you could speak to how that could be better. When would you have wanted that follow-up? Who would you have wanted it from? How could we do the postnatal period better?

AMY MAGEROPOULOS: I think having the option for a facilitated debrief. I know that's going to take a lot of resources, but it is essential. Sometimes just going through the events of what happened could be enough for healing to occur—so, facilitated debrief. They have a pathway for a caesarean—for example, there is set pain relief and pathways to follow. But for my instrumental delivery, there didn't seem to be that. I was only offered Panadol, even though it was a vaginal caesarean, according to them. I know there's some postnatal guidelines being developed. I have seen things about that happening, which is great. It should be similar to how the structure to the antenatal period is, which also needs improvement. But there needs to be the same sort of structure in that postnatal period—a checklist or something. The woman might not need those services but they should be offered anyway because it does take time to realise what's just happened. So there should be some sort of pathway, I think, for the postnatal period.

DULCE MUÑOZ: My injuries were mental health, and you don't know what is normal after giving birth. You think that that stress, that paranoia, that checking if your baby is breathing every three seconds is normal and then you realise when your child is six months that it's not. So I think one of the things is that they check for the health of the baby and they check that you're breastfeeding him and they check if you are feeling blue when you are not feeling depressed; you're feeling something that is insidious and something that you don't know.

I think for me it is about educating women that no matter what kind of childbirth experience you have, you will have consequences. I think we assume that childbirth is still not a life-threatening situation. We are so used to taking women's health for granted. So, yes, check on mums. Make it, again, culturally appropriate. I was so happy to have a partner that could support me so I didn't have to go back to work until I sorted out panic attacks. I was lucky that I live in the city, where I have access to services and I'm able to pay for them. But a lot of people don't, and that will impact economically and physically and mentally for the rest of their lives.

Dr AMANDA COHN: My second question is about the antenatal period. Both of you have spoken to wanting to have had more information about what kind of interventions might be involved. In both of your stories, you've met the obstetricians and you've met the doctors at the absolute eleventh hour, when things are already requiring intervention. If you could have had perfect antenatal care, when and from who would you have wanted to have that information about risks and possible interventions and when would you have wanted the opportunity to meet the doctor?

AMY MAGEROPOULOS: For me, I was overdue. I had what's called a post dates clinic. I was induced at nearly 42 weeks. Even at that point, I met an obstetrician who looked over the ultrasound and there was an argument between the midwife and the doctor as to what date I should be brought in for induction. None of the discussions were had with me. It was like I wasn't in the room. I think towards the end of your pregnancy, you should definitely be speaking to or getting opinions from obstetricians and midwives, whichever you haven't heard from, because there are options. But a lot of it will depend on how you're carrying your baby, how you are and if there's other complications.

So, I think, again, provide the option. If the woman wants to take it up or not, that's up to them. But you don't get any options. And then in my first appointment with the midwife—I remember this clearly—I was given a thick stack of papers and it had everything in there, like, "How to introduce your dog to your new baby", and things like that. But that information pack was never referred to again. I was given it at the first appointment, took it home and after I'd given birth and in the years since I have gone through it and it does mention a few things about labour and delivery but it is never referred to again. It's almost as if, "We've given you the information. That's enough. I can tick that box and move on to the next patient."

Dr AMANDA COHN: Just to clarify, Amy, you're talking about the last few weeks of antenatal appointments before delivery? The obstetrician did turn up but not with enough time to actually discuss things in the level of detail that you wanted.

AMY MAGEROPOULOS: Yes, correct.

DULCE MUÑOZ: When I was in my scan in week 20, I was told that my child was going to be born with something called talipes, which is club foot. It is a syndrome that—I don't know if it is a syndrome, but her foot is turned inward and they will need to use certain orthopaedic tools to open it. I remember I felt so confused. I didn't know where it came from. I had never heard about it. But then they gave me all the information that I could need for my child. "She is going to be fine. This is going to happen." A note was made. I felt that everything was about the child. They were there to save the child. I felt so comfortable about that.

But it was never mentioned to me, "What's going to happen to you if something goes wrong?" I didn't meet the people who were going to be in charge at the hospital at that time. I know that there were 72 hours. So that means there were four shifts in and out. But at no point did I talk to a doctor until this lovely man came and told me, "Are you allergic to anything? I'm about to put you to sleep and open you wide." My child was born after seven minutes after 72 hours. Again, I think we take for granted that a perfect pregnancy will be a perfect delivery, and that's not the case.

The Hon. EMILY SUVAAL: Thank you both for being here today and for your opening statements and your submissions. It is really important and will help us make recommendations. I will follow on from the line of questioning from Dr Amanda Cohn regarding the information that you received. If we were to improve this information, what is the best mode that you would recommend to do this? It is online? You mentioned being given a book. How can we better do this? Is it face-to-face classes? Is it apps?

AMY MAGEROPOULOS: Ask the patient. If the patient comes from a CALD background, they might not want written material; they might prefer the face-to-face interaction. I think you need to ask what the patient needs and have those options available. For some, written material may be enough, but for others it won't be. If you want patient-centred care and women-centred care, you need to tailor that care. It's not one size fits all. We do it in other areas of health. I do it at work all the time, so it can be done. We just need to ask the patient and ensure that they have an understanding. If they don't, what's the next step? Do we need to get someone in to explain this a bit better?

DULCE MUÑOZ: I agree with that. There is no one solution. Resources are important. We know that education is not "I present you with a piece of paper" or "I tell you something". I think it should be repeated as much as they repeat how important it is to vaccinate our kids and how important it is to go to meetings. I think it should happen from the moment you're pregnant so you can make an informed decision as much as possible. I think being a mum is to surrender yourself to the uncertainty all the time, but it does help if you know what uncertainty looks like a little bit.

The Hon. EMILY SUVAAL: In terms of the information that we should provide, if we were to do, say, a standardised program, what topics would you recommend be covered? Do you have any suggestions for how we strike a balance between providing enough information or providing too much information that it may be overwhelming or daunting for people?

AMY MAGEROPOULOS: I think there's enough information provided for your baby, as Dulce mentioned. There is very little about the care of the mother, the partner or the husband. I think we educate about the baby well. It is all about the baby, really, at the moment. Women's health physio needs to be included and what to expect in the fourth trimester, as they call it, and what kind of support you might need. What does that support look like and what is available to you? As I mentioned, I had to seek treatment privately. I had to go and find a urologist to help me with my urinary retention. I made the call to find a psychologist because I knew it wasn't just the baby blues or anxiety; it was diagnosed with PTSD. The hospital just washed their hands after six weeks—that was it. So I think there needs be a lot more about the care of the mother and the care of the woman. I think the baby side is pretty well covered.

DULCE MUÑOZ: I agree with that. I would also like to see a lot more about mental health; after the first six weeks of the baby, most of us are just working on hormones. I want to see also information for parents and family. I didn't understand that what was happening to me wasn't normal until my partner pointed it out and, of course, like—you know, the last thing I remember before the C-section is a mobile phone ringing and then, even today, when I get anxious, I hear it all the time. And that's part of your psychosis, and I didn't understand what was happening. Also, support for the parents or the partners of people who are birthing is really important too.

The Hon. EMILY SUVAAL: Thank you. That's really useful. Thank you to you both. Throughout this hearing we have also heard that maternity care needs to be more respectful, including acknowledging when someone is in pain or has concerns. What actions do you think need to happen to ensure this occurs? Could you describe for me a situation when you have received respectful maternity care and what that looked like?

AMY MAGEROPOULOS: We're like the same person. Pain's a difficult one because it is subjective, right. So I think that comes down to your nurses and midwives and doctors in their training. In terms of a positive birth experience, along my recovery I met an amazing pain specialist, who happened to be an obstetrician-gynaecologist as well. I had some surgical procedures that helped me feel a little bit better, and then I felt a bit better and fell pregnant with my second. We were adamant we weren't going to have any more children because of the further risk of injury and all the trauma. He honestly saved my life. I don't think I would have gone through with a second pregnancy had I not met him, because I knew I'd be looked after. So I had an elective caesarean with my second child, partly because of necessity because of my injuries and because of the trauma.

He was just beautiful. He would take my hand and take me off the bed after an examination. When I went into the operating theatre for my caesarean, he introduced every single member of staff. Everyone then knew I had a bad birth experience before, and you could see in their faces that they really wanted it to go well, and it did. We didn't know the sex of the baby. We found out we had another boy, and it was just joyous. And it was just that acknowledgement, "This is Amy. She's a nurse." You know, "We've heard about what happened in your last experience. We are trying not to do that."

That carried right through that whole journey. But that's a cost, and I was fortunate enough to be able to pay for private care. Not everyone has that option. Trauma-informed care—if there is a history of trauma or if they've had a traumatic birth and this is their second, that needs to be asked in the antenatal period. And more training—again—in how you communicate to patients and stop being so dismissive. I get that you have to be healthy, and having a baby is a happy occasion. But, for some women, it's traumatising and it's horrible, so we need to take account of that.

DULCE MUÑOZ: I agree. I decided not to have another child, so I don't have another birth story. But I had kidney infections before having my child. I had it in Australia, and everyone believed me that I was in pain because it was a kidney infection. Everyone was like, "Oh, my god, this is the worst thing that could happen." It's nothing like what I felt—I felt I was dying inside in comparison from—like, Victoria's pain was worse, but no-one believed me, because I am expected to be in pain because I'm giving birth. It was something that—how do we manage pain? I feel that it's because everyone knows what kidney stones and kidney pain feels like, including male doctors, and they were like, "We know how to treat it. You take this." I was in hospital for seven days and I received excellent care for a kidney infection. When I was having Victoria, after 72 hours of extreme pain—and I'm good with pain—everyone was like, "Well, this happens because you're a first-time mum." And you get the question of, "Is this your first baby?" and then they dismiss your pain.

AMY MAGEROPOULOS: During my 20-plus hours of labour, I had a doctor lean over me and say, "It's called labour for a reason, honey." I'll never forget that.

DULCE MUÑOZ: There is no way to measure pain, but it's a way to train people to trust people. I wasn't there for drugs. I wasn't there to make myself a spectacle. I was there to deliver a child, who was safely delivered, but at great cost.

The Hon. SARAH MITCHELL: Thank you both for your submissions and for coming today. Amy, you might have mentioned the role of husbands and partners and support people. How partners or family members are kept abreast of the situation and what is happening has come up with other witnesses as well, particularly for migrant women who have that barrier of communication that I know you said you experienced, Dulce. Are there recommendations we could make around how partners and support people are more involved in the process or informed on behalf of the birthing woman? Is there anything we could do to improve that?

DULCE MUÑOZ: Absolutely. One of the hardest things is, although I have a thick accent, I am highly educated and I come from a comfortable background, and for the first time in my life, ever—and I have lived in many places—I felt racism. I don't know if it was racism because I was a pregnant migrant. I wasn't asked my level of education or where I lived, so it wasn't economic racism; it was racism. It was very strange. My partner couldn't fight it. We didn't feel empowered to say, "Hey, maybe you should listen to her." I honestly think that he saved the life of my baby, my partner.

We were in the delivery room and my child's heart rate dropped completely. He noticed and he was like, "Something is wrong." He went out. The alarm didn't sound—nothing. He went out and looked for it. And I remember going, "It is normal." He was like, "No, no, it's not normal." Then I was rushed. So, yes, I think education should also come to families. Again, we are so comfortable thinking that women should suffer by themselves when they have babies that we forget to educate the rest of the community that surrounds them about what to look for, what to expect, what are your rights and what are your obligations to this person that is birthing.

AMY MAGEROPOULOS: And they know who's going to be in the room. The birth space is very protected, so there's time. They know in advance who is going to be in that room. They knew my husband was going to be there. So talk to them; acknowledge them. I think I was explaining to my husband, at one stage, what the drip rate meant, with my nursing background. I was lucky I had a very good anaesthetist that gave my epidural, so I wasn't in any pain. But I remember the room after my son was born, and I was like, "Oh, he's here," because I was numb. I was a little bit in shock and then I looked at my husband and I was like, "Why aren't you happy?" It took me years to sort of recognise it was the absolute trauma of what happened in that room. It was a war zone. There was blood everywhere, people everywhere. And he was just kind of—wasn't even smiling, and I'm holding our beautiful baby boy and I'm like, "He's here." And no-one was happy. He wasn't acknowledged at any point during that madness, and there was time, yes.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for coming today. I want to ask about the consent process. Amy, you mentioned in your submission that at no stage was consent given. I am keen to hear from both of you, but through your lens as a nurse and understanding how you need to get consent from a patient. I am interested to hear your recollection of the process but also some recommendations.

AMY MAGEROPOULOS: I actually have a background in operating theatres, so I know consent policy inside out and back-to-front. I know that in birth and delivery it is a little bit different because it is considered an emergency situation, but part of obtaining an informed consent is you check with the patient. Do they understand the risks of the procedure you're about to do? And they, on purpose, left out information. It was all about, "You've been in labour for a little while now. We're going to get the baby out. We're going to use the vacuum." But he didn't go on to say what the risks were to me, if I had any other option and, if the vacuum didn't work, what was the next option. They just left information out, and that's not informed consent. That's why I sought legal action. There's time. I know in some instances it is flick of the switch and it's an emergency and it's go time, but, hopefully, with some changes in antenatal education, it won't be as traumatic. But I feel like, again, it's all focused on getting that baby out. They've got to perform the interventions to you, as a person, so you need to ensure there is an understanding of risk to mother and risk to baby, and I don't feel, especially in my case, that that was done at all.

DULCE MUÑOZ: I think in the past few years we have learned a lot about the word "consent", especially referring to women's bodies. Consent comes with education and we are very poorly educated about what happens when pregnancy is not perfect, when childbirth is not perfect. I think consent starts with education and understanding our choices, our rights. That was never explained. The other thing is consent about the levels of pain, maybe, that you are ready to manage. Like, is this it? I was giving my consent to be open, like, "Please, take me", and no-one listened to that. Consent also comes with listening to the patient. That's what I have to say.

The Hon. SARAH MITCHELL: I want to talk about the word "normal". I know there used to be "Towards Normal", which Amy mentioned is not a policy anymore. Certainly what I'm picking up over the hearings and the submissions is that I don't think there really is such a thing as a normal pregnancy and normal childbirth, and maybe we need to look at some of the language and terminology used, because every experience is different and every birth is different. I thought you might have a view on that as well?

AMY MAGEROPOULOS: I would agree. There was nothing normal about my experience. Maybe, in changing some of the language, it might help for people to recognise that they may need—for example, referring to it as an instrumental delivery rather than vaginal caesarean. We change language in health all the time. I think that would be a good suggestion moving forward, yes.

DULCE MUÑOZ: I think in my case normal was used against me. It was a very normal pregnancy. Glucose was fine, baby weight was fine, "You are fine, it's normal." I carried normal. At the end, it wasn't normal. We use that normal—suffering of women is normal, and we need to stop that.

The Hon. EMILY SUVAAL: I wonder if either of you could perhaps expand somewhat on any of your experiences during the whole continuum of care—during the whole perinatal period, I suppose—and if you can outline to the Committee whether there were any positive aspects. What were they, and what can we do as a Committee and as a government to ensure things like those continue to occur?

AMY MAGEROPOULOS: I would say that nothing about my first experience was positive and everything about the second was. That's because I had trauma-informed clinicians looking after me who acknowledged me as a person and were concerned for my health, as well as that of my child. On reflection—and I have reflected a lot—there's really nothing positive that came about from my first experience.

The Hon. EMILY SUVAAL: So better enabling clinicians to have understandings around trauma-informed care, for example?

AMY MAGEROPOULOS: Yes.

DULCE MUÑOZ: I agree with you. I don't have another birth experience, but I do have the incredible experience of working with people who work with trauma and the way they refer to traumatic events. It's not about how everyone will handle a situation. It's the way that situation affects you, and how we are going to put resources in place to make sure that you understand what happened and you can move forward, accepting what happened. I think we still are quite behind on mental health in women's spaces and in family spaces.

The CHAIR: Thank you both so much for coming today. You both have been incredibly brave for sharing your story with us. Thank you so much. It will go a long way in helping us put this report together and the recommendations to Government. Hopefully we can get some changes. Thank you both so much for your time today.

AMY MAGEROPOULOS: Thank you for the opportunity.

Dr AMANDA COHN: Can I ask that we make an exception to parliamentary procedure and give them a clap?

Applause

(The witnesses withdrew.)

Mrs RACHELLE EDWARDS, Private Citizen, affirmed and examined

Mrs LYN LEGER, Private Citizen, affirmed and examined

Ms ELAHE YAZDANI, Private Citizen, affirmed and examined

The CHAIR: Good morning, and thank you for joining us. I will start with Ms Edwards to give a short opening statement.

RACHELLE EDWARDS: Thank you for inviting me here today to give evidence to this select committee. I am sure I speak for the over 4,000 people behind the submissions to this Committee and when I say that something needs to change. I fell pregnant with my son via IVF in July 2020. Prior to conceiving him, my husband and I had sadly lost three pregnancies, and gone through the emotional and physically draining process of fertility treatment. When I fell pregnant with my now son I believed my hardest days were behind me. Firstly, being a plus-sized woman, I was judged by medical staff from the outset. I was not only diagnosed with gestational diabetes but I was actually blamed for it. I was told not to gain any weight during my pregnancy, which left me so anxious that I would be sent to hospital regularly for blood pressure monitoring—almost on a weekly basis towards the end. I was offered an early induction, as ultrasounds showed that my son was going to be huge.

The seventh of March 2021 turned out to be the best and worst day of my life. I was induced at 6.00 p.m. and sent to the postnatal ward with no monitoring. It felt like one big long contraction; however, every time I rang for help with the pain I was dismissed by the nursing staff and not even given Panadol. It wasn't until 9.00 p.m., when the next shift came on and someone believed me enough to place a CTG on, that they realised my son's heart rate was dangerously low and I needed an emergency C-section. My son was born at 11.04 p.m., weighing 3.45 kilos—definitely not huge. He was not breathing and was blue and needed resuscitation at birth. After what felt like a lifetime, he started crying and, with a quick kiss from me, was taken to the special care nursery where my husband followed.

I had returned to my room to recover after my major surgery when, about 4.00 a.m., the lights flickered on. My son was needing urgent transport to a level 3 NICU via NETS, something that this hospital couldn't provide. I knew how important it was and just wanted to see him, but the midwife said they did not have enough staff to wheel me around to go and see him before he left, and it was unlikely that NETS would bring him around to my room before they left. My husband and the paediatrician then decided to wheel me around, despite the nurses' wishes, so I could meet my son.

After my son was transported with my husband is when the failings of the system really started to show. I was denied another support person to stay with me due to COVID restrictions, my dad and stepmum only being allowed in after I begged my obstetrician and he went and spoke to the NUM again. It was about six hours I was left alone in my room with no person for support, when my buzzer had dropped to the floor and no-one came in to see how I was going. I was not taught how to express milk in the absence of my son and not given any breastfeeding information at all. I was not helped out of bed for the first time by the nursing staff. My stepmother, who has never had children, was left with this gruesome task.

I was told that I was a challenging patient by my midwife, and I was also told that I'd soon want to be away from my infant son because he would be annoying me. I was told by this same midwife that I was a burden. I was denied mental health and social work support, even though I requested it several times. I was encouraged to self-discharge by the nursing staff and to get into a car with my father less than 24 hours after a major abdominal surgery. I tried to speak to the NUM to express my concerns and was told she was too busy. The most hurtful thing is that I was told I was not a priority to transport to the other hospital and it could be days before I was moved. Due to my extensive experience previously as a nursing case manager, I knew how to advocate for myself, but I struggled as I found myself tangled in a web of systemic failures at one of the most vulnerable times in my life.

However, because of my experience, knowing someone in patient transport New South Wales and the tireless support of the social worker at the hospital my son was at, I transferred late in the evening of the eighth. The hospital I was at, I was told, had not even started looking at booking patient transport for me. My son survived and is now a happy, healthy two-year-old. However, I need to see psychologists regularly and struggle to seek medical attention when needed for myself. I made a complaint to the Health Care Complaints Commission, and an internal review at my hospital was conducted. I received an apology. My biggest message I want to get across today is: Women are just as important as the babies we birth. Please hear us.

LYN LEGER: I have a birth injury—bilateral avulsion of the levator ani muscle as well as three-compartment prolapse. I want to focus on two key points today: the extent of the impacts of my injury and the prevalence of avulsion. I also want to provide my recommendations. Firstly, the impacts. I would like to table this mind map that I've put in front of all of you. It was part of my submission. It shows how my birth injury, which cannot be seen, impacts every aspect of my life—everything from the physical aspects of the injury, managing a pessary and fitting in the required ongoing rehabilitation to my work, home and social life; my mental and physical health and wellbeing; my relationship with my husband, children and extended family; and my ability to look after my own children.

At one stage the impacts became so completely overwhelming that I got to the point of contemplating suicide, yet I was told by more than one practitioner during the time of diagnosis to stop catastrophising. As I age and go through menopause, there is only one certainty, and that is that my condition will worsen. In fact, it already has since I was diagnosed five years ago. This causes me great anxiety about my future. With longevity in the family, I have potentially many decades to survive and manage this injury. Currently, I use a pessary and work hard every day to build and maintain my strength and conditioning to ensure I can be functional and independent for as long as possible, but who knows how long this will last?

Moving on to prevalence, since I was diagnosed, I have read many articles from peer-reviewed journals in an effort to understand my injury. I have been horrified by the statistics around avulsion. Approximately one in five women sustain avulsion during their first delivery. Some articles suggest this number could be as high as one in three. Between 10 and 15 per cent of women sustain avulsion after spontaneous vaginal deliveries. Avulsion has been found in up to 66 per cent of women after forceps deliveries, and 36 per cent of women with prolapse have underlying avulsion.

Realising how common this injury is, I thought, "Surely there's a surgical fix for me," and searched for more information. However, I discovered there is no surgical solution for avulsion. At best, surgery for avulsion is considered experimental. Additionally, while prolapse surgeries are relatively common, they have a high reoperation rate—between 19 and 29 per cent—and my urogynaecologist explained to me that for women with avulsion, the failure rate of prolapse surgery is much higher, around 70 to 80 per cent. To say these statistics were shocking to me is a gross understatement. Listening to the news on the radio one day, hearing about endeavours to send spacecraft to Mars and establish communities on the moon, I got incredibly angry. How is this fair? Somehow millions, probably billions, of dollars are poured into R&D for these activities in space, but we can't fix a woman's vagina after she gives life to another.

So now my recommendations: First, immediately undertake a study into the economic burden of levator ani avulsion. Considering the prevalence of avulsion and the various types of impacts, as I have shown in my mind map, the economic burden of avulsion must be huge. On another women-focused issue, endometriosis, the total economic burden has been estimated to be between $7.4 billion and $9.7 billion. Endometriosis affects one in nine Australian women and has a similar range of impacts. Approximately one in five and possibly up to one in three women have avulsion, which is almost double or three times that of endometriosis. Secondly, ease the ongoing financial burden on individuals, one of the key impacts of avulsion, by working with the Australian Government to put in place Medicare-funded care plans focused on birth injury and trauma. These would likely be similar in nature to eating disorder treatment and management plans, which provide for comprehensive treatment from both psychological services and allied health professionals.

Thirdly, urgently invest in research and development for women with avulsion, in three key areas. First—this one is the most important to me—research to develop permanent surgical fixes for avulsion. Additionally, where experimental surgeries are occurring outside Australia and showing reasonable results, provide funding for our Australian surgeons to learn these techniques, improve on them and make them available to women in Australia. Secondly, research to improve outcomes and longevity of prolapse surgery for those of us with avulsion. A 70 to 80 per cent failure rate is not acceptable. Thirdly, research to develop new and better pessaries that work for all women with avulsion, potentially using imaging and 3D printing or other innovative techniques. We need this while we wait for improvements in prolapse surgery and development of permanent fixes. As one of hundreds of thousands, possibly into the millions, of women in Australia with this injury, I need your help to put all these recommendations on the public record and ensure that they are implemented. Thank you for listening.

ELAHE YAZDANI: The first thing, I apologise about my English.

The CHAIR: Don't apologise.

ELAHE YAZDANI: I'm here to tell some of my story and also talk on behalf of my community, refugee people and all multicultural women. I came to Australia in 2020 by myself, alone and on a protection visa. I just found I am pregnant after six weeks I was in Australia. It was such a big shock and also happiness for me, and also it was a miracle for me. I arrived alone, and I experienced many, many forms of trauma, mistreatment and also abuse before I came to Australia. This pregnancy was on top of all that trauma for me. I was happy I was pregnant, but also I was alone and I didn't know how I would have to do that.

I didn't have any support during pregnancy. I wasn't offered any support or any information in my own language. I had to listen to everything in English and, because I was very new and listening was so hard for me, it was so hard to understand everything. It was the first thing—the first trauma. And also I had no-one. I had no friends and no family here.

The other thing I just recently found out was that I could have a midwife during pregnancy and also after to support me, help me and inform me. But I wasn't even offered to have someone. My birth experience was one of the worst experiences. I still feel so bad. I feel sad. I feel anxious sometimes. I try to forget my birth but I can't. It has been three years. I still have to see a psychologist every week. I have a happy, healthy son but I am not okay. I am not happy sometimes, and it is so hard. With all the wonderful support I got from community and people, I still sometimes got panic attacks. I got anxiety, crying, nightmares and all of these things with me. I never thought how a birth could traumatise me.

I was forced to have an induction when I was 41 weeks, and I didn't want to have it. I asked them, "If it's something necessary, just please give me a reason why I have to do induction." They didn't give me a good reason. I could remember the midwife was laughing and even not looking at me. I was so nervous. I was crying. I said, "I don't want to have an induction." She told me, "I think your baby is not growing enough." I remember that I just fainted. I start crying and I said, "Okay, if you think the baby is not growing enough, why don't you do an emergency caesarean section?" She just laughed and said, "No, no. I mean maybe." I said, "You scared me and now you say 'maybe'." You cannot talk like that to a woman who is pregnant and is here without any support. Even if you have lots of support with your family, it's not the way to talk to a lady who is pregnant.

With force and with pressure, I agreed to do induction. They start induction in the morning at 8.00 a.m. and I was in labour with lots of pain and lots of different things for 12 hours. Finally, I couldn't have a natural birth. The baby got distressed and they took me for an emergency caesarean section. In just 10 minutes, they did an epidural. The person was trying to do an epidural and I remember she tried three times to do an epidural. When they were moving me to the operation room, I told them my neck and my head is heavy and in very bad pain, but nobody cared about that. They told me that they did a caesarean section. They took me to the ward.

The day after, it was afternoon, a lady came, she was a midwife, and she asked me to have a shower. I said, "I cannot walk. Could you help me?" There was a bed rail. She took it off and she said, "You can go and have a shower," and she just left the room. When I was at the shower, I couldn't move and I had very bad back pain and neck pain. I started screaming and they came and they took me to the bed and I couldn't move. When the doctors came, they said, "I think the epidural had leaked." I couldn't move. They told me, "You are not allowed to move." They take my baby and I couldn't see my baby for 24 hours.

I was in pain, screaming, crying, and I got ignored. Nobody cared. Nobody came to the room. I even couldn't reach through the bars to ask them to give me pain relief or even some food or some water. I remember a lady was in the room with me and the midwife was coming regularly to look after her. I asked her to help me to give me some water and to give me pain relief and she told me, "There is another midwife assigned to help you." She didn't do anything. She didn't get the midwife to come to the room. They did a blood patch the day after for me and I was in the bed for three days without any moving. I couldn't move. I have to stay in the bed and I get ignored. It was very bad treatment. Nobody came to the room. I could remember that the baby was crying, but I couldn't reach to take him and I couldn't change his nappy. I was so thirsty.

After around four hours, I buzzed the button to ask for help and nobody came. Finally, I start screaming and crying and asking for help. When the midwife came, I told them, "Why do you ignore me? Why do you think I'm nobody here? Because my hair is black? Because English is not my first language? Because I am a refugee? Because my skin is brown? Why don't you care about me? I'm here like any other patient. Everyone comes to this room looking after the other lady and, when I ask about help, no-one cares about me. What is the reason?" After I talked to them, they came and just tried to look after the baby. They brought some food for me. It was the way I was treated. It's been three years and I still feel I was nobody in that hospital. Nobody listened to me. Why do they treat people like this? Why is there racism in the hospital? Why do we have to treat like this?

They asked me to sign the papers. Even when English is your first language, when you are stressed, when you are under pain, it is hard to understand medical things. They asked me to sign the paper. I even didn't know what I'm signing. I asked them for an interpreter and the interpreter over the phone was explaining for me—she was telling me the wrong thing. I was an ICU nurse in my home country. I could understand that she is telling me the wrong thing. I had a little bit of medical experience and I could understand. Imagine people in that hospital without any English background.

I believe I was racially discriminated against because I was brown and I was refugee. It was a very bad experience for me. They didn't care about my pain. The blood patch was very painful. Nobody informed me what's going on. They didn't tell me what they want to do; they just took me to the surgery room and they asked me very badly to do the position to do the blood patch. I was in lots of pain. I think sometimes being kind—it doesn't matter about your position, it's just being kind, because we are human. It doesn't matter who you are or who am I; it's just that we are human. For me, having the birth was one of the worst, one of the saddest and one of the—I don't know—big experiences in my life. I am still dealing and trying to cope with that, but it is hard.

Last year I remember I saw a psychiatrist for a while because still I had nightmares about my birth. I think it is very important in this country. Australia is a multicultural country. When people come to this country, coming to this country as a refugee, it doesn't mean we are a victim. We are not a victim. We had a life. Some of us, we had a beautiful life in our country, and qualifications. If we come to your country, we bring all our culture, qualifications and everything for you. You have to be thankful. I'm sorry for talking like this here. I recommend that the doctor, the nurse, the midwives in the hospital have to have trauma-informed training. It is very important to people like me coming to this country. I think all the refugees, when they come to this country, they had lots and lots of trauma. Even people who decided to immigrate to another country, they have got lots of bad experience, and I think it is very important.

The second thing is that the hospital staff needs to have anti-racism training. It is very important. Being treated racist in the hospital, it is the worst thing in this country. And we have to care about that. And also, for the people coming as a refugee and the English is not first language for them, I think having a medical interpreter is very important. It is very important. I think interpreter over the phone is not a good idea. I think the interpreter needs to be in the room. Also I think they need to care about people like me—single mums, no family, no friends in this country, and very new in the country. They need to do plans for more support and also they need to do plans for the multicultural people and other languages people to have training in their own language for them.

The CHAIR: Thank you all for those opening statements and for coming and being so vulnerable to share your personal stories. We really do appreciate it.

The Hon. MARK BANASIAK: I have just one question for you, Ms Yazdani. Being a refugee with no family or friends here, would you have liked the hospital or a community organisation to provide a support person to be there during the birth? To get proper care, do you think it would have assisted to have someone there to advocate for you?

ELAHE YAZDANI: Yes. I think it is very important. As I said, I recently found I could have a midwife with me during pregnancy and after, but I wasn't even offered to have someone. Yes, I had a support worker from Red Cross and other organisations, but they were not professional about having birth, and it was so hard for me. Absolutely, I think it is very important to have someone.

The Hon. EMILY SUVAAL: Thank you all for appearing today and for your opening statements and submissions. My first question is to you, Ms Leger, if you are comfortable answering. In your submission, I noted that you mentioned you would be grateful to be given the opportunity to present to the Committee and to explain each impact in your mind map in detail. Thank you for providing a nice A3 version for us. Would you like to do so?

LYN LEGER: Yes. To just explain a bit further the mind map, my experience was that as I started to go and see a range of practitioners, most of them hadn't heard of avulsion. So not only was I struggling to learn about it myself, I then found myself in the position where I was having to educate these people, not on the actual injury, but then also how it was impacting me, because, like I said earlier, I was told to stop catastrophising. But when you see the scale of the impacts, it kind of is a catastrophe.

The Hon. EMILY SUVAAL: Who were the clinicians that you saw?

LYN LEGER: The first one that told me to stop catastrophising was actually a GP. Needless to say, I don't see that GP anymore. I was also told that by one Women's Health physio. So, yes, I guess one of my other recommendations is that there is appropriate training on all of these birth injuries for all of these practitioners who have to deal with people with birth injuries and, considering it's so prevalent, it's really important that happens. Just going back to my mind map, I did it at a point in time, so as the injury and the impacts of that progress, and my children age and my work changes and things like that, I would effectively need to redo this. This is just a snapshot in time that is from a year or so ago.

So the first part about understanding the injury, that just sent me down into a really dark place. It was hard to find information. Like most people who end up with birth trauma, you do a lot of googling because there isn't that information out there. I got told to go to bed, when I found out I had prolapse. At the time, I had a newborn and I had a 15-month-old, and it was pretty much impossible to just be in bed. So my husband had to stop work and things like that. But I went into an absolute panic because, as soon as I read about avulsion on the internet, I just knew that I had that, because that's what I was feeling. I can't even tell you how many appointments I went through. It was hell. I was going to appointment after appointment, having to juggle the babies. Then I started to figure out what questions I should be asking. But even that was traumatic in itself, because you obviously don't know what you don't know. So it's really hard to ask the right questions to get the right kind of information.

Then, obviously, I went down the mental health hole and there was the uncertainty about what was happening to me and how it would affect my family. I couldn't look after my children. We had to get my parents in-law to fly over from France and, basically, stay with us to help me in the interim so my husband could go back to work. We had to pay for my mum to come back from a holiday so she should help out. I felt like I was a massive burden on my family, especially my husband, as I couldn't look after my children. So when I did go back to work I had to basically have help, even on the days that I was at home, to help me carry my children and be able to move around. I couldn't go out; I couldn't socialise. I couldn't do a whole lot of sport in those early days. I was actually told not to do sport to start with, until I could increase some of my strength and learn to use a pessary.

The most heartbreaking one for me has actually been the inability to look after my own kids. Even now, my son, he can't ride a bike, and he keeps asking me to take him down to the local oval and teach him, but I can't. I just can't run. I can't be at that angle with him to push him on his bike. It seems like something so simple, but it is something that I always thought that I would be able to do. So I can't be the mum that I want to be. My husband—I am sure he won't mind me talking about it, but our sex life is now crap. I have to take the pessary out to have sex. I don't want to be taking it in and out every day, because I find that traumatic in itself. So it has taken away that—it has changed our relationship; it has lost intimacy. And it's mainly because I don't feel that I understand my own body. I feel like I just have this part of me that is foreign. You know, I can't see it. I don't know what it looks like. All the diagrams in books, that's not what my insides look like any more.

My extended family has been a really hard one. They've tried to help, but they're very practical people and it's really hard for them to—I have an injury that is, effectively, an invisible disability. They can't see what I am experiencing, even to the point that, one day, I was on the beach with my kids, and my kids wanted me to dig a hole. That position, for me—of digging a hole—is actually a really hard position to be in, and my mum said, "Why don't you just get down and dig the hole with your kids?" I just thought, "I have told you everything. How can you not understand how that makes me feel?" It doesn't make me feel good that she doesn't understand, but it also doesn't make me feel good that I feel like I am letting down my kids again. So I, effectively, have stopped telling them how I feel.

I have, effectively, made new friends. It is really hard to talk to lots of my male friends from uni about my vagina, and I really struggled, in those early days particularly, to make mum friends, because I couldn't take the kids out on my own. My work has had to change, and I guess I have been lucky enough to be able to apply for a different kind of role at work, but that's actually meant loss of my technical skills. And then, I guess, there's my home life. I can't really look after my house properly. Every morning—I think this was mentioned in the session before—I have to prioritise myself and my bowel movements over everything. Basically, mum's coffee and breakfast and lots of water comes first before the kids get anything. So I often have to get up quite early to make sure that happens before I go out, because if I don't do that then I can feel the prolapse, because of the avulsion, as well, all day. I could go on and on about this, but that's probably enough because I know other people need to say things too. But thank you for asking the question.

The Hon. EMILY SUVAAL: Thanks you for sharing.

The CHAIR: Thank you.

The Hon. SARAH MITCHELL: Thank you for being so open and honest. I think you're the first witness who we have had actually talking about some of those physical traumas that many women unfortunately do experience. I wanted to ask two specific things. You mentioned potentially having access to the same supports as someone with disability and you talked about having "invisible disability", whether it's parking and that kind of thing, which to me seems like a really commonsense thing that the Committee should be recommending. Thank you for that. I don't know if you want to add anything to that?

LYN LEGER: Yes, I could just tell you about one experience I had really early on. I got to the supermarket—I'd seen all the other mums going to the supermarket with their kids and thought, "Surely I should be able to do this." I parked the car in the normal parking—there was no pram parking or anything—and realised that there was no way I could carry my two children, because they were both fairly close in age, over to a trolley. Then I would have to get the double pram out of the car and put them both in it, which also at that stage I was not doing the double pram on my own. I would have had to do the double pram on my own and put my children in, but then I wouldn't have been able to have my shopping in the pram around my children. I was kind of just stuck there.

I went and parked in the disabled parking. I remember just sitting in the car thinking, "If I get out and walk over and just put my kids in the trolley, could I then go and park the car?" It was that moment where I realised

I need—even if it's just temporarily for a few years to get through this period where my kids can't walk—to be able to access that disabled parking. Even now, being able to carry heavy shopping and thing likes that, if it's not a supermarket where you've got access to a trolley—even the rolling-bag things. If you can't fit it in that, what do you do? There are so many aspects. It is something that is probably quite common in consideration for a person with a disability, but because we're not classed as someone with a disability we have these enormous hurdles that stop us getting back out into the community and being able to do normal things to look after our families and ourselves.

Dr AMANDA COHN: My question is for Mrs Leger, because she touched on this in her submission, but I would be open to answers from all three of you about the financial cost implications of your injuries—the cost of care and all of the changes you've needed to make in your life over these years.

LYN LEGER: Yes, I know I'm going to forget stuff because this is just so massive. I guess it's important to think about the fact that there is the cost in the early days of the diagnosis, attending all of those appointments and having to have my husband off work. It is family financials rather than necessarily just the direct financial impact to me. With the cost of all of those appointments, I'm fortunate that I was able to seek care through private means as well—I have private health—but as soon as I got my first pessary and started to try to figure out whether I could claim for that, I was immediately shocked that I can't even claim for a pessary under BUPA. BUPA, you should be ashamed—on the record—because I know that some others do.

So there was all of that cost in the early days, and then I had to have, effectively, someone with me all the time. I couldn't rely on my family for that, so they were nice enough to let an au pair stay in the granny flat—they lived not far from me. Basically I had that au pair there. Every day that I was off work, that au pair was with me helping me care for my children, doing all the lifting, getting the pram out of the car and all of that kind of stuff. That was a huge expense. Then COVID hit and we were stuck at home. I also went through the stage of then realising I couldn't clean my own house. I couldn't do my own shopping. I couldn't do all these other things. My husband had to do the shopping. We had to get a cleaner.

And then, from managing the physical aspects alone—well, let's say physical and mental—I have lots of GP appointments. I have psychology appointments. I have women's health physio appointments. I have weekly appointments where I do exercise physiology for strength and conditioning and Pilates. The Pilates is something that I think I've put in my submission that that has been taken off private health. That is the number one thing that I need. It is so damn expensive to have a one-on-one session and I really need that attention because I am learning about a new body. I have a new body to learn about. Every single movement I do is new. I need to learn how it functions to be able to do all of the movements that I do on a daily basis safely so I don't make my problem worse and it can last as long as possible. Everything, just on my annual, monthly and weekly appointments, currently adds up to—I think I put in the submission $10,000-plus, but I would say it's way more than that.

Looking to the future, I've been told that I might need changes to my laundry. We're getting into really functional, simple stuff, but occupational therapy-type stuff where you look at how you manage your laundry—taking bits out to the line one at a time, or changing the laundry situation so you can pull stuff out of the laundry. It's super simple stuff but it greatly affects how I can manage this in the longer term. Cleaners, yard maintenance—just absolutely anything. To be honest, I have had massive breakdowns over the thought of my husband dying before me because I have no idea how I would cope. One day driving home it just kind of hit me that if he hops on a plane—I know this sounds pretty extreme, but if he hops on a plane and the plane crashes, what the hell happens to me? I rely on him so much. He is my absolute rock. He does everything for me. He lifts everything. I honestly don't know how I would survive without him.

RACHELLE EDWARDS: With the cost of mine, I live in a small rural community. I see a psychologist nearly weekly. It's costing me about—now that my mental health support plan has finished, which you only get the 10 for, it's costing me about $240 to $250 a week in mental health support. I am very lucky that I can afford that, but it is a huge burden on myself and my husband. When I was looking at transferring to another hospital, because of my background I reached out to a private company to transfer me. That was going to cost like $2,000, $3,000. It's all implicated, I guess.

Dr AMANDA COHN: It's really extraordinary. I'm just thinking about the impact that this sort of injury would have on someone without the financial means to actually seek all of those supports. It is quite astounding.

LYN LEGER: Absolutely. I guess that was one of my reasons that I put in my recommendations about the government care plan. At least as a start, you can access more allied health professionals. But we need to look at exactly what is required, and it is totally individual. Everybody's injury impacts them in a different way, so they need a difficult range of practitioners.

RACHELLE EDWARDS: I was just going to say that, short of pursuing legal action like one of the other witnesses does, there is no way that most people can afford to fund this kind of recovery. Also, the mental trauma that going through legal action and the dragging out of the worst moments of your life, not just at that point in time but prior to that—they'll drag you out through everything because they want to avoid paying. Really, you're in a no-win situation.

LYN LEGER: Yes, and you also then have to go through a lot more appointments.

RACHELLE EDWARDS: And they're just dragging everything out.

The CHAIR: I recognise we're running tight on time, but I've got one quick question for Ms Yazdani. You called for specialised maternity care for refugees and women from other countries. Can you talk a little bit more about what you would hope that would look like?

ELAHE YAZDANI: I think the hospital needs to have a program or something like that. When a pregnant lady from a multicultural background or refugee background goes to the hospital, they need to refer them to that ward and they make a plan for them. I could remember they referred me to the social worker. They gave me a card and they asked me to call her. I called her. I introduced myself and I asked about help and any support. She never called back to me—and she was the social worker. She was there to help me, to support me; it was her job. She gets paid to do that, but she never got back to me. I think we need to do something about that to the hospital to follow the people like me, the people who English is not their own language. Some people need more information before birth, having birth training, and we need to do that in their own language for them.

Also I could remember—after birth, I still have back pain. It's been three years. I need to use pain relief every single day. Without pain relief, my life is like nothing. I cannot do anything. I remember for a few months after birth I was crying to do my normal things, and I didn't have any support. No-one was at my place to look after my baby, to take me for the appointments. I think they need to do something about that to look after those people. The other thing I want to mention is I remember I asked them to—I cannot clearly remember what I asked the midwife, and she was telling me, "If you need this one, go to the private hospital." I was thinking, "This is not my answer—go to the private hospital."

RACHELLE EDWARDS: Can I just say something on that?

The CHAIR: Yes.

RACHELLE EDWARDS: I birthed in a private hospital. I would have preferred to birth in a public hospital.

The CHAIR: Can you expand a little on that?

RACHELLE EDWARDS: I don't feel as though—well, I was moved to the public hospital eventually, once my son needed a level 3 NICU. But when I was birthing in the private hospital, I was subject to poorer ratios. I was also part of a burnt-out, monetised system. They just did not have the expertise, nor did they have the mental health resources, like a social worker or any kind of mental health support to deal with a complex situation that I found myself in. They probably haven't seen it in years. They didn't know the next steps to move me to the next facility. They had no idea, and I don't work as a registered nurse anymore; I'm an early childhood educator now. But my background was complex case management, and they had absolutely no skills in it. I was left in the hospital bed doing my own complex case management to get myself moved to my son.

ELAHE YAZDANI: Excuse me, may I say something else? I think the nurses and the midwives in the hospital need to care about people. They need to be respectful. They need to be responsible. I was a nurse; I worked as a nurse for eight years in my own country. I know how to care about people and I know how they have to treat them. I think it is very important. It doesn't matter which colour your skin, which colour your hair and which colour your background. It is very important to do your job, your responsibility and your everything for everyone. We are all humans, and hopefully someone can hear us.

The CHAIR: We have gone over time, but I do have a question for Rachelle in regard to being separated while your son was rushed away. I know one suggestion has been that mothers are able to sleep with their sons if they're in an emergency space. Is that something that you would like to see as a recommendation? Is it something that you've heard of happening anywhere?

RACHELLE EDWARDS: Absolutely. NICUs are tight. My son was in a level 3 NICU, so this is where the sickest, most premmie babies in the whole entire State are. There's not a lot of room for me to sleep down there, but I guess my recommendation is that—most hospitals that we birth in don't have a level 3 NICU; there are only a couple, I think, in Sydney—if it is warranted that the child needs to be moved, the automatic response is that the mother is moved as well. Because the trauma that I went through because my son was on the other side of Sydney and my husband was there—I had nothing. I felt the most alone I have ever felt in my life, and those nurses just did not care. They told me that I was a burden because I fought for myself, because I didn't lie down and take it, and I'm here today because I'm not lying down and taking it anymore. I'm never going to have another child because of this, and it's their fault, and I hold them fully responsible. I can't go through the legal system; I don't have it in me. But I can stand up here today and say what happened to me should not happen to a single other woman in New South Wales.

The CHAIR: Thank you, all of you, for coming here today. It's very brave of you all to come and share your stories. We've run out of time in this session, but there might be some questions on notice. If there are questions, the secretariat will be in contact. Thank you again so much. The evidence that you gave today has been heard here, and it will go towards the recommendations from this inquiry, so thank you.

Applause

(The witnesses withdrew.)

Ms EMILIA BHAT, President, Maternity Consumer Network, sworn and examined

The CHAIR: I now introduce Ms Emilia Bhat from Maternity Consumer Network. Would you like to start with an opening statement?

EMILIA BHAT: Yes. I just want to thank the Committee for inviting the Maternity Consumer Network to give evidence today. The Maternity Consumer Network is a not-for-profit organisation founded by Alecia Staines and other consumers in 2015. We are a maternity and birth advocacy organisation. We are now one of the largest consumer organisations in the country and have successfully advocated for the creation of the national woman-centred care strategy. We are involved in trying to implement Medicare for midwives, and we liaise with other maternity organisations. Most of our work comprises of advocacy, support and referral services for women who are victims of obstetric violence or need help navigating poor maternity care and understanding their rights.

The CHAIR: Thank you. You mentioned in your opening statement and also in your submission that you created a training workshop program, Better Births With Consent. It has now been endorsed and is being used in Queensland. Can you tell us a little bit more about that course, why it's important and if it's something that is missing in New South Wales?

EMILIA BHAT: Absolutely, I do believe it is something missing in New South Wales. I believe our founder, Alecia Staines, made a submission to the Governor in Queensland under women's safety to get funding for this training. Basically, it's run with a lawyer from Human Rights in Childbirth, Bashi Kumar-Hazard; a perinatal psychologist, Heather Matter, who has midwife training; and then Alecia Staines does the consumer side of it. It covers, from the consumer perspective, how birth trauma and obstetric violence affects them. Then we have the psychologist go through, again, how it affects them from a psychological standpoint, and then we have Bashi, who covers women's human rights and basically understanding that women can have the right to decline care and maintain their bodily autonomy. That is the course in a nutshell.

Why I think it's important is that, even with feedback we have gotten from the course, and relevant to New South Wales, we find a lot of clinicians do not understand consent. I think it's a societal problem that comes into medical care. A lot of them think that women lose their bodily autonomy when they are pregnant and that, in an emergency, they don't have the right to say no. This is despite the fact that NSW Health does have a very thorough consent manual in section 6 and section 10 that does outline women's autonomy. But, as an advocacy organisation that has helped other midwives and nurses, when I mention it to them, their response is usually, "What manual? New South Wales has a consent manual?" They are very surprised to find out that women can say no to certain things. So, yes, we really endorse this training to help them understand consent and women's human rights and, when those rights have been compromised, how it can affect women.

The CHAIR: We have heard quite a bit of positive feedback about Queensland generally in terms of reforms they have made around maternity care and informed care. Is there anything in Queensland that you believe is working well that we should be implementing in New South Wales?

EMILIA BHAT: Sorry, could you repeat that?

The CHAIR: We have heard quite a bit of positive feedback about some of the reforms that have been put into place in Queensland around maternity care. I'm just wondering if there are any that you had noticed that you feel are missing in New South Wales.

EMILIA BHAT: The hospitals that have engaged our consent training have been giving us feedback that it has had a positive impact on their workforce and that the clinicians are actually making efforts to make sure they have respectful communication and get women's consent. And then some of the feedback that we have heard from women is that things have changed for them. They are finding, at least in antenatal care, that they are being given better information and providers are careful to actually get their permission on things. That is, I would say, one reform I've seen that's better there. Others I'm not so sure about. I might have to take it on notice.

The CHAIR: That's okay. Through this inquiry we have heard a lot about continuity of care. Some of the submissions say that continuity of care can never be guaranteed in the public health system and that it's a gold standard but it's not feasible or possible. I want to get your thoughts or your response on that because I think in your submission you actually suggested a goal of 80 per cent of public hospitals to have continuity of midwifery care by 2030. I am just wondering if that is an achievable goal and how we get there.

EMILIA BHAT: I do think it would be tricky to get there, just because of the way the system is set up. Internally, I'm not sure how they would do that and the reasons they give for not being able to implement it. But giving women access to MGP programs has slowly been rising. Many years ago it was 8 per cent, but I am hearing that it's getting closer to 20 per cent. So it's slowly rising and they are able to do it. I'm guessing that to get it is just to encourage midwives to want to go in there. I believe there is research—I'm not 100 per cent sure—that a lot of midwives when they come out of uni—maybe it was from the survey—were interested in that kind of continuity of care, but that doesn't become apparent for them later down the line. I do think it could grow and it has been growing. Some hospitals in Queensland, I believe, have been managing to do it, but it remains to be seen how they would implement it in New South Wales. I am not sure of the actual number of access for New South Wales specifically, but there is that rise we are seeing.

The CHAIR: With regard to the complaints process and working with the ACCC quite often with your organisation, do you think that that complaints system is working and, if not, what needs to change to support women through that process?

EMILIA BHAT: That system is not working at all. In every complaint I have ever lodged—and I have lodged complaints where there have been some severe acts of violence against women, even with a witness like a doula who has given their version of events. I understand they are not a court of law, but most of the responses I get back recommend no accountability, not even that this midwife go and take some training—nothing. Often I have to warn women, "Look, I can write this complaint for you but you need to be prepared for a very poor response."

It concerns me because this lack of accountability and not even recommending training or even hospitals to do X, Y and Z means that the health services aren't improving their services and this situation continues. We get worried about providers who are very concerning who have done something quite violent to a patient and aren't being taken to court by the Health Care Complaints Commission, and that they are still there being able to do things to patients that they are not supposed to be doing.

That system, I believe, does need a huge reform in terms of accountability and at least making recommendations for changes and staff training and I guess as evidence taking and what to do if they do take some clinicians to court, as I understand. But, no, the system is really poor at the moment and it's pretty demoralising having to have that conversation with women that the chances of anything coming out of that complaint is very low. Group complaints are a little bit different. I do find in some cases, whether to a hospital or to a regulatory authority, that they do tend to yield a better response and make recommendations. I guess there is power in numbers, but I shouldn't have to get a group of women to do that.

The CHAIR: What system would you like to see instead? I know that on day one of the hearing we had a suggestion of a legal clinic set up to support women, and other people have talked about reviewing the policies and the procedures around hospital complaints. What would a change in that position look like to you?

EMILIA BHAT: That's a really good suggestion but I would also—again, doing the complaint process, I find that the investigative officers and the Health Care Complaints Commission don't really talk with the patients to get their perspective or clarify things. As far as I know, their investigation is just looking at clinical notes. If the clinical notes say this didn't happen, it didn't happen. This is even if you have a witness or a couple of them, like the woman's partner and a doula and the woman herself saying X, Y and Z. They don't communicate at all. To get the story, that's at least how it appears that they are investigating. So communicating with patients would be a big one for changes.

I do think that the other suggestion was good. It might be a stretch but I think some sort of government-funded independent service to help navigate them through the complaint processes should be considered. We would do it but we are an underfunded, under-resourced organisation. We can't keep up with it. I do the majority of it. I am one person serving all the women in Australia. Most women I have to turn away and just kind of quickly guide them through the process.

The Hon. SARAH MITCHELL: I have a couple of questions coming from your submission. You said that you have about 1,000 members and member organisations. That is across Australia. It's fine if you don't, but do you know how many are in New South Wales? Is that a big proportion of your membership?

EMILIA BHAT: No, I wouldn't know how much we have in New South Wales specifically.

The Hon. SARAH MITCHELL: That's okay. In your submission you talk a little bit about informed choice and consent. That is quite a common theme, you wouldn't be surprised to know, across some of the submissions and the witnesses that we have had. We have been looking at whether there are things we could do to improve that antenatal period and the information that women get, while not frightening them but making them more aware of what could go potentially wrong or the complications. From the experience of your organisation, what do you think would be some of the things that we could recommend to improve that information that women are getting before they give birth that might help them when they are in that situation?

EMILIA BHAT: I do find that, sometimes by choice and sometimes because of the way the system is set up, there is this inability and sometimes failure for providers to give women informed consent and education, which they are supposed to as per their legal obligations and professional standards and codes of conduct. Antenatal care, as it is, is usually, "Here, take these tests," and there is no communication about why they are doing this or education about interventions in birth or what to expect. That is pretty common, from our organisation's perspective. The problem is that even if the women we find when we get complaints ask for information, we get some women told—I guess it's omitted or downplayed or overplayed or it's from an emotional perspective.

Let's say a woman wants a VBAC and the hospital doesn't support that. They will tell her, "Your uterus will rupture and you will die," instead of having a respectful discussion and saying, "Well, these are the risks of a VBAC. These are the risks of a repeat caesarean," and giving them a resource. That doesn't happen. To help that antenatal period, I do think staff need training on respectful communication and how to give that informed consent, because that is lacking. I guess, understandably, maybe they may have their own trauma and they see something like a bad outcome and that affects them being able to give women information effectively. I think they just need training on how to actually give the information. That's a problem. In some places, I understand—it has been told to us—there are time constraints. At least in the public system, they are seeing so many women that they only have about a 15-minute appointment and then they can't give that information.

I do think giving women information sheets with links and resources can help—that are consumer-friendly. Obviously, things will need to be designed for culturally and linguistically diverse women and women who don't speak English. I do think health providers should also encourage self-education from relevant places, if they can, so women can come back and actually ask questions, because there are some women who obviously trust their provider is doing right by them. In part of our submission, unfortunately, we have had providers prioritise their own agenda, sometimes by choice, sometimes through no fault of their own—from pressures from the system—to schedule an induction, for staffing or something like that. So the women think, "Okay. Yes, there's a real medical reason for this," and that hasn't been the case. So we think encouraging women to ask some questions and encouraging women to also educate themselves, which is important for their own birth, would help in those antenatal appointments.

The Hon. SARAH MITCHELL: And in the postnatal period as well?

EMILIA BHAT: Yes.

The Hon. SARAH MITCHELL: Do you have any thoughts on ways that could be improved in terms of information and care on postpartum issues?

EMILIA BHAT: With the women who access continuity of care, they have two weeks' worth of appointments from their MGP midwives. But unfortunately I find with the community midwife program, which is a general program they send to some women three days post-birth, that is also really quick. So I would also recommend the same: actually sitting with them and talking with them about what to expect and giving that information and numbers to call, but going through it with them, not just throwing the papers at them, so that it's very clear what these services offer.

I know a lot of women—sometimes, in New South Wales, they get this information pack. But how many of them read that or know that these are services to call, or how it is important? I don't know if someone is actually telling them. I think it helps to actually have someone tell them, "Hey, we do actually have these support services. I am happy to help call them for you if you feel you need them," and that kind of thing, to help get that education and that there are all of these support services out there postpartum, early, instead of waiting until they realise there's an issue. That would help, all that communication—but, again, I acknowledge there are also time constraints—to help women get the education and knowledge they need.

Dr AMANDA COHN: In your submission you talk about a trend of focusing on the wellbeing of the fetus over the wellbeing of the birthing parent during pregnancy or birth.

EMILIA BHAT: Yes.

Dr AMANDA COHN: It is something that has come up in other evidence as well. I was wondering if you could speak to that a little bit and perhaps give us some examples that you have heard from your work.

EMILIA BHAT: Okay. So it does go back a little bit to what I said before. I understand, obviously, women want a healthy, live baby out of their birth, but there becomes a problem where we feel that providers forget the woman is their main patient and she actually takes priority. Unfortunately, despite Australian—I guess I understand it as case law. Women's autonomy is paramount and, like I said, with the NSW Health consent manual, women can make a birth decision even if that choice does result in a bad outcome for themselves. The problem we have is, during birth, one of our complaints is, for example, fetal tones were going down on the CTG monitor and the doctor wanted to do a forceps delivery.

The woman has said no and then she is held down by midwives and has that forceps delivery against her will and often without pain relief. This is contrary to what I understand as Australian law and their human rights. They have the right to say no and risk the outcome of refusing that intervention. And I do find a lot of—again, prioritising the fetus over the woman's autonomy is the issue. That's what we are trying to explain with the consent training. Women can make those decisions—decisions you may not like—and that's what we experience. Sometimes it's not a case of the actual fetus being in danger, but women are told they have to make this choice for the sake of their baby.

A provider will tell them the baby is stuck—when it is not—and they have to do an episiotomy. The woman says no, but they cut them anyway, again without pain relief. Then when women complain, they are told they did it to save the baby. Even though women, legally speaking, have the right to make a decision that could result in a poor outcome, I am just going to say not many women are going to make that kind of choice. But it is important: You still have to get their consent in those scenarios and they can say no. I am not sure about New South Wales, because I haven't seen a guideline, but I know Queensland has guidelines on partnering with a woman that declines recommended maternity care. They have advice on what to do in an emergency situation when a woman is declining that life-saving emergency treatment, and that's what we are going over.

The other thing from our organisation's point is we find that the health and wellbeing of the baby is the only thing—I guess they consider prioritising the baby and not so much what the mother wants and her emotional health. For example—I'm trying to think of a good example; it would be similar—a woman is trying to decide things outside of guidelines, wanting to decline certain tests, and it is not going to result in a bad outcome. She is just declining something. Again, she is told, "We are going to call child protection. Are you not prioritising your baby? You are selfish," and these emotional responses, so it's not putting women at the centre of care.

Or we will have women who in later pregnancy are put on a CTG monitor. They might have higher risk factors. They are not told why they are on there for hours and hours on end. When they're asking, "What about me? I want to do X, Y and Z. I don't want to be on these CTG monitors for hours on end," they are told, "All that matters is the baby." That makes them feel like their wishes and needs don't matter. When they try to question that, they are treated like they are selfish or that they want to kill their baby, which obviously isn't true. They have just made that informed decision for themselves, but that's not been respected. So that is what we mean by the fetus being prioritised and the woman not being prioritised.

The Hon. ANTHONY D'ADAM: Thank you for your submission and your attendance today. In your submission you make a recommendation about creating laws to criminalise obstetric violence. Can you first just explain what you mean by that term?

EMILIA BHAT: We follow the UN's definition, and that is the abuse and mistreatment of women in pregnancy, birth and postpartum. My legal understanding is very limited here, but when we say "laws against obstetric violence", it would be specific to pregnancy, birth and postpartum. Simply, in my limited understanding of law, a lot of any kind of medical abuse or negligence cases often mean people have to go to the civil arena. When women are assaulted in childbirth—for example, forced into a forceps delivery when they've said no or had an episiotomy against their will, that is assaulting someone—we do believe women should have an option in the criminal arena under specific laws to try and get justice. I do understand the criminal system has a very high standard of evidence beyond a reasonable doubt, so I'm not sure the particulars of how that would work, but we do think that some of them should be held accountable in that way for a very severe act of violence that has obviously resulted in harm and things like that. I guess that is what we mean by laws against obstetric violence.

We do do police reports for women, but often they don't go anywhere. Often the only place we go to is the police sexual violence unit. If a woman has been assaulted, had fingers inside her against her will, has been given an episiotomy—forced interventions into her genitals—that is where we go. But it is still a bit separate from a sexual assault, and, as far as I'm aware, it hasn't really gone anywhere to court, maybe from a lack of evidence or there's just no specific laws against it to do anything with it. So women have to try and rely on the civil arena. But we do think laws would hold people accountable and understand that it is not okay to assault patients in childbirth.

The Hon. ANTHONY D'ADAM: Why do you think that criminalising obstetric violence, as opposed to dealing with these cases through the civil, would be more effective in terms of achieving outcomes for women?

EMILIA BHAT: I guess it's another way to hold someone accountable, and I guess it's just, you could argue, a commonsense thing. Assaulting someone—just because you're in a medical setting doesn't give you permission. In any other context, if you assault someone, if put something inside their genitals, it's assault or sexual assault. You get reported to the police, and you go through the justice system to be held accountable.

Obviously, that depends on the evidence and what happens there. It should be the same—women should have that option to seek their personal justice through the criminal justice system when that happens to them. It's not okay that it can only be a civil thing just because it's in a medical setting and done by a medical professional. They should be held to, I guess, the same standards that any member of the public is if they do those things.

The CHAIR: Can I just ask a follow-on question from that? I think others have talked about these laws elsewhere. Do you know much about that?

EMILIA BHAT: I know a little bit. I do know they did enact it, I think, in Brazil. If that has had a positive effect or if anyone has been charged with it, I don't know, but they did manage to get it, I think, in Brazil—or Venezuela, pardon me. If it has been effective, I'm not sure, but I believe they did fight for it in that country. I might have to take that on notice to see what effects it has had since then.

The CHAIR: Yes, that would be useful. Thank you. Some of the women in the panel we just heard from talked about how difficult it is to take private legal action and that, for many people, it's not affordable. Is that part of the reason that you think there should be some kind of legislative change so that it's available to women?

EMILIA BHAT: Obviously, going through the civil system is always going to cost a lot of money. I could be wrong about this; I'm just going off a limited legal understanding here. From what the women have told us, a lot of lawyers don't take on their case because—let's say they're upset that a provider did something to them without their consent. A lawyer won't take on the case because the act of the harm wasn't enough; there had to be all these other physical, serious injuries to actually get anything from the civil system. So they have no choice but to go through the complaint process, like the Health Care Complaints Commission, and hope for something. Again, there's that lack of accountability for that provider assaulting that patient, but I am talking about civil cases here. It shouldn't be fair that there has to be all this injury when there has been a wrong done to you. I do think more mental health should be counted because, as a result of being assaulted, they have mental health problems afterwards, as anyone would, after that. From what we've been told, it's not enough for a lawyer to take on in the civil arena.

The CHAIR: I also want to ask about funding. I notice in your submission you mentioned that the Maternity Consumer Network doesn't receive any funding. Do you think that there should be more funding, broadly, for support services for women who experience birth trauma and, I suppose, within a complaints process but also with some of those support networks as well? Is that something that's really missing?

EMILIA BHAT: Absolutely. Just from our organisation's perspective, we obviously get a lot of phone calls to help with complaint processes and to link them up to support services, but most of us are unpaid volunteers, very small; often, many of us are just mums using our free time because we're passionate about helping women. So having, I guess, a specialised service of people doing that would be able to link them up better, instead of—with our limit—having to turn people away or just write a quick email, "You can go here." I guess having good support services that are fully funded, they would be able to properly link up and it would do wonders for their mental health to see that people care and that there are actually services being properly linked to, not just something I've got to quickly write, but having deep conversations with them.

The support services are actually good because sometimes what women are looking for is financially out of reach most of the time, or if they're in a regional and rural area, they can't access the service, so we've sadly got to deliver bad news. What we do in that case, we kind of do a call-out in the community, "Anyone wanting to provide free services, like a doula? Can you cook some food for this mum? Can we give her this community support? She can't afford psychological services, so can she come to your mums' circle and have someone to chat to?" We have to make do like that.

The CHAIR: Thank you. One of your recommendations is to also review all policies and procedures and ensure that they enshrine structural support for women's informed consent. Can you expand on this? How are current hospital policies and procedures stopping women from being able to make informed choices about their birth?

EMILIA BHAT: One of our problems that we have is the term "shared decision-making", because the ultimate decision-maker is actually the woman. Women have given us feedback when they thought that they couldn't make the choice and the ultimate decision actually rests would their provider, and we have to come and tell them, "No, that's only in an emergency, if you are falling unconscious or unconscious. Until then, you can decline or say anything." Some of the language there isn't worded for their autonomy. I do find with the policies and procedures, I reckon there should be a consumer version—there are some, but a lot of the NSW Health policies and procedures that, yes, you can look up are obviously written for clinicians, with a lot of complicated medical lingo. If you're a woman trying to educate yourself or read this policy, it's very long, full of that medical lingo and hard to understand. It would be easier if there is, like, a smaller consumer info sheet on it. They do have some but not for everything.

Why I believe, also, that policies and procedures need to be reviewed is just to be keeping up with evidence, because, I guess, some policies are not caught up with the best evidence or just need to be reviewed a bit more frequently. I guess what we mean by that is also to have staff training on some of these policies and procedures. Again, we've helped midwives who have come to us. When I do complaint letters, I have to pull up policies and guidelines, and I tell them, "Did you know NSW Health had this?" They were surprised that there's actually a whole clinical guideline or a policy or procedure on it. It's a bit worrying that the staff that work in the system, who have come to us for help, as a consumer, don't even know this. Policies and procedures are great, but then, I guess, they don't mean much if there's no training on them, and that's what we mean by they should be reviewed.

The CHAIR: As part of this inquiry, the Committee will put together a report, with a whole range of recommendations. I'm just wondering what the main top-priority recommendations are that your organisation sees will make the biggest difference if they were implemented.

EMILIA BHAT: We think the biggest thing that would make the difference is some form of consent training, either from us—we have our own—or whatever New South Wales wants to develop, because that's one of the biggest reasons that our organisation gets called: "They did things without my consent. I didn't know I had these rights." I do believe there's consent training, based on the NSW Health consent policy, to the staff about women's rights in pregnancy and their consent, and I really do feel they need an emergency section. It has been a while since I've read it, so if they've updated, then I guess disregard, but when I last checked the NSW Health consent manual, like Queensland, there aren't scenarios for birth, which can be tricky. They have scenarios for other situations if a patient is declining something, but there isn't that scenario for birth. I think they need advice on what to do in X, Y, Z scenario, just like Queensland has. I think that would help, and they can support women's autonomy, be able to respect their consent, and I believe that would help alleviate birth trauma, if the woman has made the choice of her own volition.

The CHAIR: Absolutely. I have one more question. Obviously, your organisation was heavily involved in collating and submitting a large complaint just recently—I think you mentioned over 30 women—for one particular hospital. Are the stories of birth trauma isolated to this one hospital or are issues of birth trauma something that your organisation has been hearing across New South Wales and Australia?

EMILIA BHAT: There's birth trauma that we hear across Australia. I will say what happened with that hospital was one of the worst, just for the fact that it was so many in so little time. Normally, we get lots of complaints about disrespect, but the more severe cases where there has been assault and negligence, we'll get a few here and there around Australia and a couple a year from a particular hospital. But with this particular hospital, it was so many—I do want to point that out—and in such little time. The women had given birth between 2019 and 2022, so that particular hospital and district were concerning. I do understand regional health also, in general—that's where a lot of our complaints come from, regional and rural, as well—do have a lot of issues with, I guess, having as much services or equipment or staff, compared to the city. But we do hear birth trauma stories and obstetric violence stories from all over Australia. When we made that complaint or call-out for women, we weren't expecting that, though, just to be clear.

The CHAIR: I have a follow-up question regarding regional and rural hospitals. It has been briefly mentioned throughout this inquiry, but what sorts of recommendations should we be making that would be specific to regional and rural areas and the support that's required there? I know that there was an inquiry in the last term of Parliament about the impact of staff shortages, and everything was kind of magnified when it came to regional and rural areas. What sorts of specific recommendations would you like to see from this inquiry to support women in regional and rural areas?

EMILIA BHAT: I guess accessible transport services, because I do think a lot of women get risked out. We don't agree with some of the reasons they're risked out, but there's a lot of, I'm certain, bureaucracy on the level of the hospital and what they will take on. And then some of these women that live very far away—300 kilometres or more—are having to make arrangements to go to a hospital, I know, in some cases. I'm not sure if it's specific to New South Wales, but I'll just make a comparison. I know in Queensland, up in Cairns and women in more rural areas like in Cooktown, they have to get on a plane. They get supported to get on a plane at 36 weeks, but they've got to make their own arrangements for accommodation. You can give birth from then on—37 weeks, at term, to 42 weeks or onwards. That's four or five weeks of trying to find accommodation unless the hospital lets you stay there, and they may not be able to because of bed arrangements, so there's not that accessibility.

Some women don't even have that plane service in some places—same in New South Wales—and they've got to make these accommodation arrangements to be near the hospital, and then what happens is a lot of these women are being recommended inductions. It's not for a clinical implication; it's just for convenience. If they're happy to do that, that's not a problem, but then women who are not happy to do that just feel like they have no choice because they don't want to be stuck birthing so far away from a hospital and something going wrong. Some sort of accommodation accessibility service for those women would be the issue in regional and rural health in terms of access and, of course, there is an issue with staffing. I do think there need to be ways to attract staff and midwives, especially to these regional and rural areas, and find out why the staff don't want to stay there or they're having staff attrition or people just don't want to work in these places. So some incentives there, I guess—but for the women, accommodation and transport.

The CHAIR: Fantastic. Thank you. Was there anything else that you wanted to put to the Committee that you felt hadn't been asked in a question?

EMILIA BHAT: No, I'm good. Thank you.

The CHAIR: You did take a question on notice, so the secretariat will be in contact with you in regard to that. If the Committee has any further questions to ask, the secretariat will be in contact. Thank you again for coming in today. I know it was a bit of a trip for you to come into Sydney, so we really appreciate it. Thank you for your evidence.

EMILIA BHAT: Thank you for your time.

(The witness withdrew.)

(Short adjournment)

Ms SHARON COULTON STOLIAR, PhD Candidate, Registered Midwife and Author, sworn and examined

Dr RAKIME ELMIR, Senior Lecturer and Deputy Director Clinical Education Midwifery, School of Nursing and Midwifery, Western Sydney University, affirmed and examined

The CHAIR: Thank you both for coming today. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. We will now start with some opening statements. I might start with Dr Elmir, if that's okay.

RAKIME ELMIR: Before I begin, I would like to pay my respects to the traditional owners of the lands on which we meet and pay my sincere respects to Elders past and present. I recognise their continued connection to the land and the waters of the place and acknowledge that they never ceded sovereignty. I would also like to thank the select committee for the inquiry into birth trauma, which will no doubt shape and change the provision of maternity care in New South Wales. I present my evidence to you today as a Muslim woman, a mother, a midwife with 20 years' experience, an academic, a researcher and an advocate for migrant, refugee and Muslim communities. I am also here to give voice to the forgotten partners—that is, fathers, who are all too often sidelined in the maternity care system.

In 2021 Islam was the second most common religion in New South Wales. According to the 2021 mothers and babies report, women born in South-East Asia and the Middle East accounted for the highest proportion of births. Published and anecdotal evidence highlights the systemic, cultural and spiritual barriers for women and their partners in accessing individualised, culturally safe and sensitive maternity care. We know from existing research Muslim women have been stigmatised and stereotyped as oppressed, uneducated and, most importantly, disempowered from openly and freely practising their Islamic beliefs. Women and their partners are not being difficult; all they are after is compassionate and culturally sensitive care. Our maternity care system needs to understand that when a maternity care provider cares for a Muslim woman, they are caring for the entire family. The woman's family is her community. Her community is her village that protects, supports and nurtures her. We need a system that empowers Muslim women to make informed choices and decisions that are culturally and spiritually appropriate to their needs.

Our hijab, the veil on our heads, is our shield that empowers us and gives us strength and comfort in times of hardship. We feel more at ease donning our hijab, listening to and reciting *Koran*, and praying. Our spiritual needs are nuanced and complex. We need maternity providers that understand and are sensitive to our processes and timelines, particularly during traumatic events such as stillbirths and neonatal deaths. Due to our beliefs surrounding death, time is of the essence. We need to see a Muslim chaplain as a matter of urgency. We need to have family present around us to comfort us, and we need to bury our precious one as soon as practical. We want to see the midwife after we give birth. We want to speak with a counsellor or psychologist and have an opportunity to debrief when appropriate.

Let's not exacerbate grief and trauma for women. We have evidence of Muslim women refusing to book into hospitals due to the systemic bias and previous trauma experienced. We have Muslim women accessing more midwifery continuity-of-care models, such as MGP and private practising midwives, and we have more Muslim women requesting a doula to accompany them at their own births for a more positive experience. Women know what they want. Let's not forgot our fathers now. I have looked at the impact of birth on fathers for the past 10 years. Existing research I have published highlighted that men are not prepared, particularly first-time fathers, for the events that may unfold at the birth, yet they are expected to be present and support their partners. They are excluded from decision-making processes and often feel out of their depth. They feel helpless, emasculated and merely like a bystander, yet they so desperately want to be involved as parenting partners.

For our culturally diverse fathers, they experience additional challenges such as employment, financial pressures and sociocultural expectations, particularly around gender roles and seeking support for what many CALD fathers describe as taboo. These challenges impact on men's mental health and wellbeing and their transition to parenthood. One in 10 fathers experience postnatal depression, but why don't we hear about this? How can we reduce the incidence of depression and the impact of birth trauma on fathers? We need father-inclusive maternity care, where fathers are welcome and support is available for mothers and fathers. Why is it that inclusivity of women and their partners stops at the doors of maternity? How can we reduce the incidence of birth trauma in culturally diverse women? Continuity-of-care models are great, but they need to be publicly funded, accessible and holistic. They need to be equally distributed across the districts.

We need more culturally diverse midwives caring for our CALD women. We need cultural and religious processes and guidelines in place to support women's journeys, particularly in times of adverse events. We need a maternity care system that supports mother, father and baby. We need cultural competence training mandated across New South Wales for maternity care providers, and this needs to start with our midwifery students. We also need support for midwifery students and midwives caring for women to retain our midwifery workforce. Care cannot be optimised when we have skeleton staff and midwives that are burnt out and run down. We need change now, not for us but for the next generation of birthing women and their partners, our children and grandchildren. Thank you.

SHARON COULTON STOLIAR: Before I begin, I take a moment to acknowledge the traditional custodians of the land on which we gather today. I pay my respects to the First Nations people who have cared for this land for thousands of years. I also acknowledge the Elders past, present and emerging, who have stewarded this country and their rich culture through generations. It is a privilege for me to have been able to grow up here in this country since the age of five and make the most of the opportunities available to me. I also thank the brave and courageous women who spoke up and raised their voice and were the catalysts for this inquiry. I honour you deeply.

I must first offer a disclaimer and clearly state that what I'm going to say are my own views. Today I am not representing nor speaking on behalf of any organisations, workplaces or universities that I have previously graduated from or am currently enrolled at. I give evidence here today before you as a midwife and a nurse, a PhD candidate and a Sri Lankan migrant who has experienced birth trauma and clinically diagnosed birth-related PTSD. In my submission I've detailed my personal experiences of birth trauma: having my excruciating, agonising pain ignored and dismissed until it was far too late to prevent permanent damage and lifelong physical and psychological consequences. I wasn't listened to at such a crucial point of my life.

When maternity care providers don't listen to women, there is a cost. The impact of not being listened to, not having my pain addressed properly and not being believed when I complained of pain was that I had an acute compartment syndrome that was left undiagnosed and untreated, causing permanent nerve and muscular damage in my leg. Undiagnosed and untreated acute compartment syndrome almost always results in amputation. I am fortunate I didn't lose my leg. I was highly dissatisfied, disappointed and angry with the postnatal care that I received.

Over the years I have reflected a lot about my experience and even published a book, called *Scars of Gold*, which is about my experience of birth trauma through the eyes of a midwife. I have learnt a lot and read lot of research on birth trauma. I am still learning, but knowing what I know now—particularly about the experiences of childbirth in women of colour—I would like to make some further comments in addition to my submission. Please bear with me, because it is very important that you hear this. Australian research has demonstrated that First Nations, refugee and migrant women from non-English speaking backgrounds have poorer pregnancy outcomes and lower satisfaction with care than women from the general population. In the research, immigrant women have said that health professionals—as in maternity care providers—do not always remember them between visits, do not make an effort to get to know the issues that are important to them, and do not keep them informed about what is happening during labour or take their wishes into account.

A qualitative evidence synthesis of 27 studies, which represented women from 42 countries, of women who gave birth in Australia has found that migrant and refugee women experience hostility and discrimination in our maternity care system. They have described a sense of being unwelcome, talked down to, treated differently from Australian women and made to feel like a nuisance. Anecdotally, there are insinuations made about different groups of women from different cultures: for example, "Oh, she's a typical Indian or Sri Lankan drama queen complaining of pain with a low pain threshold." Call it discrimination or hostility—call it whatever you want—but let's call a spade a spade: this is racism.

Australian researchers also found that maternity care providers often lack adequate cultural knowledge, some hold stereotypical assumptions and the healthcare system in general is not culturally responsive. Even the maternity care providers have admitted to this. In recently published research about refugee and migrant maternal health in New South Wales, maternity care providers themselves have described witnessing displays of judgement and bias in their co-workers. One midwife has been quoted in this one particular study saying, "There's a lot of racism in health sectors. I have seen it quite often working as a midwife."

Whether we like to hear this uncomfortable truth or not, implicit bias and systemic racism exists in our maternity care system. Even though I was a midwife, gave birth in the hospital that I trained to be a midwife at, grew up here, have an Australian accent and am highly educated, I still wasn't listened to and I didn't have my pain taken seriously. I have often wondered if the stereotypical assumptions of people from my cultural background and race played a role in being dismissed and not having my pain addressed.

According to the latest AIHW data, the 10 most common maternal countries of birth were Australia, followed by India, New Zealand, UK, China, Philippines, Vietnam, Nepal, Pakistan and South Africa. Furthermore, of those born in Australia, 5 per cent of women identified as being First Nations. In New South

Wales alone, South Asia, as in the Indian subcontinent—women who visually look like me—was the second largest region for maternal country of birth, accounting for 9.2 per cent of all births in New South Wales. These statistics should illustrate just how many women of colour are giving birth in Australia, specifically New South Wales.

While Australia, however, might hold the largest maternal country of birth, we don't know how many of those categorised as Australian births were second-generation migrant women of colour, whose cultural backgrounds play an important role in their transition to motherhood. To highlight my point, I'm going to share a comment posted on my own social media from a woman who has a very white-sounding name but is a second-generation migrant from Sri Lanka. That means she was born here to Sri Lankan parents. Here is what she says:

> I myself have experienced a racism you speak of, from back when I was a child to even ... I have a running joke with my white husband that I must be invisible because people walk into me, I get ignored by other customers or I'm immediately placed into the category of "I can't speak English and I'm likely uneducated". Even in my care on the postnatal ward the same thing happened. I received better treatment when my white husband was present, but when he left I was ignored and had horrible insinuations made about me.

For data collection purposes, this woman was categorised as being born in New South Wales and still experienced racism in our maternity care system. This experience of racism in the country of her own birth caused birth trauma for her—and she is one of many women like that. According to the latest ABS data on our last census night, more than half of our population in Australia—that's 51.5 per cent—were first- or second-generation migrants. If one in three women experience birth trauma and more than half of our population is made up of first- or second-generation migrants, we really need to begin to talk about colour in maternity care, and we need to consider the importance of culturally safe maternity care to reduce avoidable causes of birth trauma for First Nations, migrant and refugee women of colour. We know that this group of women would benefit the most from continuity of midwifery care.

The last two hearings have made a clear case for midwifery models of care—for continuity, in order to prevent avoidable causes of birth trauma. But although there have been major efforts to increase midwifery-led models of care in the last couple of decades—specifically continuity of care for women—the finding from two consecutive population studies in Australia shows no change to immigrant women's experiences of care. I raise the following questions here to you: Are we encouraging migrant women to choose continuity models of care? Do they know about midwifery group practice? Is our advertising of these models inclusive?

When I say "inclusive", I mean doing posters around the hospitals, digital media and information sheets about this model of care. Visually represent the migrant, refugee and First Nations women of colour who could benefit the most from these models of care. Do they know you pretty much need to book yourself into MGP the moment you get pregnant in order to get it? Or is that little piece of knowledge a luxury afforded to those who sit on the lucky ledge, a luxury afforded to those who have health-in-language literacy, autonomy and agency to research the best models of care and navigate the system to get it?

I will be blunt and say that we don't live in white Australia anymore. This is 2023 and we live in a very multicultural and multireligious Australia, but we have a maternity care system that systematically fails to take into account the cultural needs of almost half of the population it serves. We need more maternity care providers who are midwives of colour in our workforce. We need a workforce that can more accurately represent the population it serves, because feeling able to identify and connect with one's maternity care provider is very important if women of colour are to feel comfortable, confident and able to ask the necessary questions about their health care, and if they are able to feel comfortable to express what they want for their pregnancy, labour and birth experience. Feeling able to identify and connect with your care provider, especially when you are in an ethnic minority in a traditionally white country, is very important. As Antoinette Lattouf says in her book, "It really isn't rocket science. It's just social science."

If we work on encouraging and supporting people of colour from different cultural and religious backgrounds to choose midwifery as a profession, then, in the long term, we will see midwives of colour in our workforce. We will see a midwifery workforce that reflects our population. We will have more women being able to visually relate to their midwives, more culturally sensitive and culturally safe care and less avoidable causes of birth trauma. We might even hope to see more midwives of colour in academic positions across universities. But, in the short term, there are easy solutions to this. Basic cultural training and education to maternity care providers would not be difficult to implement.

A recent study of New South Wales recommends that we need to understand the needs, experiences and identities of refugee and migrant women, but, without education and cultural training, it is absolutely impossible for white midwives from western countries to understand the significance of cultural practices, heritage, religion and family relationships for women from different cultural backgrounds, especially when they are becoming a mother. I myself have developed a very basic short course on culturally sensitive postnatal care for women from the Indian subcontinent, and something like this could be very easily expanded into other cultures and used to educate our midwifery workforce. This is just one example of something that's so easy to implement, and we could see immediate changes in how this group of women perceive their overall experience.

To finish, I just want to remind everyone here today that there are numerous examples of community development projects in Australia where well-meaning white project teams have gone into rural First Nations communities with the aim of implementing a health intervention program but found themselves to be unsuccessful. During the planning and implementation stage, they failed to include stakeholders from within the community they aimed to serve. In the same manner, we cannot address this horrible issue of birth trauma in all women and birthing people unless organisations, committees, policymakers and people in positions of power listen to, include and ensure input from women and people of colour who understand the cultural context and nuances of the First Nations, refugee and migrant women.

It's clear that implicit bias and systemic racism exists in our maternity care. Maternity care policies and guidelines created by well-meaning white people in positions of power systematically do not adequately address the needs of women of colour. I urge this Committee to listen with your ears wide open and ensure you seek appropriate involvement and input from women of colour from different ethnic backgrounds during the process of making recommendations from this inquiry. This should include women and people from different religions and faiths as well.

I note here, based on what has been circulated on social media, that the advisers to this Committee did not include any people of colour—not visually at least. I am here only because of the fierce advocacy of Sharon from Better Births Illawarra and Alicia from the Maternity Consumer Network, who both separately wrote to the Committee to urge that I, a midwife and woman of colour with a lived experience of birth trauma, speak here today. I must emphasise again that a failure to seek input from women of colour when the recommendations are made from this inquiry will only further perpetuate the systemic racism and the implicit bias that currently exists in our maternity care system today.

The CHAIR: They were both very powerful opening statements, so thank you both very much.

The Hon. SARAH MITCHELL: Thank you both for your submissions. I echo the Chair's comments: They were really powerful opening statements, so thank you for being open and honest and giving the Committee guidance on some things we can look at. I will start with you, Dr Elmir. In both your opening submission and your written submission you spoke about the role of fathers and greater awareness and support for them throughout the entire process of pregnancy and birthing. What are some of the things that the Committee should look to recommend in terms of how we can better engage partners in the process and inform them about what may happen, particularly when there are traumatic birth experiences? Do you have any suggestions for the Committee to consider?

RAKIME ELMIR: I think that's really important. When we're looking at supporting fathers, it's really important that we look at how we can engage fathers in the maternity space, and it's really important to engage them from the beginning—so antenatal education. A lot of the antenatal education, at present, is at a cost, so that is a financial burden for many fathers and partners. I think that having that accessible for fathers and after hours, because, as we know, fathers work and are breadwinners. So I think something after hours would be quite ideal. Having more consumer organisations that fathers can tap into and are aware that that's a form of support, because, from the research that I have conducted, many fathers don't think any supports available, even though it's come a long way since I first began my research 10 years ago. So there are a lot more consumer organisations. But my recent study around culturally diverse fathers does suggest that there is still really nothing available, or it's not being publicised or advertised that that's something that they can go to for support.

The Hon. SARAH MITCHELL: Do you perceive a gap, particularly around culturally diverse families, in terms of information available to fathers?

RAKIME ELMIR: That's right, particularly when it comes to the availability and accessibility of information in their own languages. So when we're looking at migrant and refugee fathers in particular, they want something as well that's accessible, that they can go online and access and that's really short. I've recently developed some videos in partnership with a consumer organisation. And that's really just short snippet videos that they can just go online and access and have a look at the lived experience of culturally diverse fathers, for example. They're just the sort of innovative ways that we can try and get fathers to really access this type of support.

The Hon. SARAH MITCHELL: I have one more question for Mrs Coulton Stoliar. In your written submission, you spoke about how, when you were at work, in your uniform and badge, you were listened to, but when you were a patient, you were not. And if you, as someone who was educated and knew exactly what you were going through felt like that, how would women who do not have a medical background feel? I thought that was a really pertinent point, particularly in relation to making sure that we have more midwives of colour working in hospitals to get that cultural awareness and continuity of care. I do not have a medical background, but I am curious: What practical recommendations could the Committee make so that midwifery was more attractive to people of colour? Is it scholarships? Is it training? What could we do that you think might help us to get more culturally diverse people into the midwifery career?

SHARON COULTON STOLIAR: There are actually, I think, a few layers to that. Let's just focus on my cultural background. I'm from Sri Lanka, and that's the Indian subcontinent. We need to understand the cultural nuances there as to why we don't have many women like me—from where I'm from—being midwives. So we need to understand how midwifery and nursing is seen in those countries. Migrants are coming here to give their children a better life, generally speaking, so what they know is—your profession, such as being a doctor, an engineer, a lawyer, an accountant. They are going to set you up with a good life, a good future and a good, viable and stable income. That is what they know, generally speaking.

If we're going to try to encourage people of colour, students of colour, coming into the university system to do midwifery, we need to have education out into the communities. I think in the long term it needs to be planned—for example, in schools but also in the community and for the parents of those children and students in the schools to actually present midwifery as a viable option with a decent income and job stability: You can have a great future with it. That's one aspect where that's something we need to tackle.

But I think we also really need to pay attention to the differences in the ATAR cut-off. Midwifery is ridiculously high when you compare it to nursing. We have so much more diversity in our nursing students in universities. If I make a very generalised comment, midwifery is white. Midwifery students generally are white and English-speaking. By default, they have a better command of the English language. When you have such a contrast in ATAR to get into midwifery compared to nursing, if you look at midwifery you are disadvantaging people whose first language is not English, just by default already. We need to look at that.

We need to look at why midwifery is so high and what the difference is. Is this a thing about valuing life? I don't know. I'm just putting it out there. If we want more people of colour—migrants and refugees whose first language isn't English—we do need to implement some kind of access scheme. We need to implement support and education. We really do, because we won't see a change. Our universities and faculties are mostly white as well, in midwifery. There is a lot to think about. There are a lot of things that need to be done if we are going to get more people of colour whose first language is not English going into midwifery.

The Hon. SARAH MITCHELL: Thank you. That's useful.

The Hon. NATASHA MACLAREN-JONES: I have a question following on from my colleague. Do you have any stats on the number of nurses and midwives that are from a non-English speaking background? You may not have it at hand and, if not, you can take it on notice.

SHARON COULTON STOLIAR: I don't think we collect that. I don't think AHPRA collects that. Have you ever been asked that?

RAKIME ELMIR: No.

SHARON COULTON STOLIAR: Me neither.

The Hon. EMILY SUVAAL: Thank you both for coming along today to give evidence to this inquiry and for your submissions. It is a really important perspective for us in terms of making recommendations. You briefly touched on the need for better education for our workforce. If you were to recommend anything in the antenatal period—and I know, Dr Elmir, you spoke briefly about education methods—what would be ideal in terms of the mode of education and how that could be provided? Do you have any suggestions about topics that should be included or how we can improve in that way?

RAKIME ELMIR: Sorry, do you mean antenatal education for partners and fathers or for—

The Hon. EMILY SUVAAL: Generally, with specific focus on culturally and linguistically diverse peoples.

RAKIME ELMIR: I think there is a current module—providing culturally-sensitive care module—for all nurses and midwives to complete, but that is really generalised. I think there needs to be specific training targeting the main populations, the main groups, particularly around spirituality. I think that's a really important factor to consider. Rightly so, many people are not very comfortable; they can't possibly be well versed in every culture and every religion. But I think if you give them the tools and education around maybe the main populations and also some of the cues to look out. As Sharon highlighted, even if they don't have that education, really, do we need education on how to provide just humanistic care? And if you're unaware, when I used to work in a very large tertiary hospital that was very culturally diverse, you would ask the woman and her family, "What are your cultural needs? What can I do that will make you feel comfortable and safe?" I think, beyond training, just ask those questions. That makes a real difference. We really did hear that from our consumers this morning.

SHARON COULTON STOLIAR: In terms of antenatal, I think, if we are going to look at western culture compared to non-western culture—again, I will just deflect to what I know from my culture. We value community and we value family involvement from the beginning. Western culture places a high premium on autonomy, agency, choice, independence and self-sufficiency. So we've got all very good things but, realistically, when a woman has a baby, she wants help, she needs help, she needs support and she needs connection. We've got this maternity care system—I have seen it time and again—with very well-meaning, amazing white midwives telling women from places like Sri Lanka and India, "Now, I know your parents are going to want to come in and get involved and do this for the baby, but set your boundaries and keep them at arm's length." It's not good. That causes so much trauma and conflict. From a western perspective, that's seen as a good thing—to do it all yourself and be independent. But from my perspective we don't see it as a bad thing; we see it as our culture. There's nothing wrong with that.

We don't see it as anything like, "We need to keep our parents away and our sisters and brothers away. We don't need the help. We've got to do it ourselves." That causes such chaos and conflict internally. The damage it can do to relationships and within the family dynamic—and often that's all you've got, your immediate family in this country. If we are being told—and I say "we" as in other women like me. We are coming from a different cultural background. I was raised here but, as a culture, my parents are from Sri Lanka. They are here, but with that culture in my household. I am getting information like "keep them away" because that's good and that's better for you. The conflict is enormous. It's that kind of information and training that needs to go to our maternity care providers, because they don't know this. They don't realise it's causing trauma and harm and issues down the track, because they will just put it out there. Midwives and obstetricians and nurses, we don't go into this profession to cause harm and trauma; it's not what we go to do. I think it's more a matter of educating how the impact of their actions impacts on the women.

We've got this really romantic idea that midwives are equal to women, but the reality is they are not equal to women. They hold so much power over a woman and her family and her life that it can make or break her. When maternity care providers realise that and are made to see that power that they have, that is when change happens. When we engage them from a perspective of kindness and compassion and empathy and have that heart connection with them, that is when change is going to happen. Instead of saying, "You are doing this wrong. You are causing trauma," and instead of painting them all with the same brush—that they are all perpetrators of obstetric violence—I think we need to take it back a step and approach it with kindness and compassion for our care providers as well, because they are stressed, exhausted, understaffed and burnt out. We need to see it from both sides of the coin.

The Hon. EMILY SUVAAL: We certainly heard a lot of evidence earlier on in the hearing about care providers. Nobody goes to work intending to cause harm. I just want to acknowledge, through you, Chair, that the Minister for Health has just walked into the room. Thank you, Minister, for attending today. I just want to ask the witnesses a question about one of their earlier statements. You mentioned the ATAR for midwifery, which is quite high. As we know, ATARs have come about—it's a supply and demand principle. If more people want to get in, there are less spots. Do you have any thoughts or considerations around overcoming that obstacle?

RAKIME ELMIR: At my university where I work, it's not just the ATAR that makes it difficult. It's also based on an interview process. They have to get in based on ATAR or equivalent and also do really well in an interview process, where they sit a number of stations and they are marked on their performance. I think there is always scope to re-look at that type of approach and see how we can have a more diverse group of midwifery students enter our workforce.

SHARON COULTON STOLIAR: I can't speak from a university perspective, but I will echo what Rakime said. I don't know if it is having different pathways to get into midwifery—having more positions open to get into midwifery. There are a lot more positions in the Bachelor of Nursing across the universities. I don't think I can comment further about that from my perspective.

The CHAIR: I thank the health Minister for joining us—he is welcome here today. Both of you have done quite a bit of research in this space and so I want to talk to you both a little bit about some of that research and some of those research findings that you think could be useful for the Committee. Dr Elmir, in regards to your research around dads and support for dads, what are some of the research findings?

RAKIME ELMIR: Sorry, what is it in particular you would like to know—the demographics? How the fathers were selected, or how that—

The CHAIR: More about the findings of your research. With some of those research papers, what were some of those key takeaways from the actual research findings that you think could be useful for this Committee and its recommendations for the inquiry?

RAKIME ELMIR: Yes, sure. Really what interested me in looking at fathers was my primary research, my doctoral work. During the interviews with mothers who had quite a traumatic experience—that was focusing on women who had a severe postpartum haemorrhage and emergency hysterectomy. Throughout the interviews with the women, they were mentioning how distressed their partners were—the fathers. That prompted me to look more into fathers' experiences of witnessing traumatic births. Some of the findings from that research, back almost 10 years ago now, really did highlight how unprepared fathers are when they enter the hospital system. So many want to be present, but they just feel really underprepared. It doesn't matter how much reading they do or how many people they speak to—other peers, fathers they speak to—they enter the room as really an extra person and they don't really feel included as part of the maternity system.

They also did mention that they would like antenatal education classes to be run by male educators. Many parent education classes are being run by females, and some fathers thought that was okay, but that was just one of the recommendations fathers had—that they be run by male midwives or male facilitators. Now, male midwives—females dominate the midwifery profession, so they are very limited, but I definitely think male facilitators are something that could be possible. The other thing was that they really did value peer support and support from consumer organisations. Particularly our culturally diverse fathers, where it is often taboo to talk about birth and show those signs of weaknesses, and them needing to uphold those roles of masculinity and being the protector and the supporter—they did really find a place of solace with these peer groups. And they also suggested that parent support groups don't tend to include fathers because they are mainly female dominated. Fathers are excluded, particularly our stay-at-home fathers. I think support groups tailored for fathers is definitely a need.

The CHAIR: Ms Coulton Stoliar, you are doing a lot of research as well. I am keen to hear about the research that you are involved in.

SHARON COULTON STOLIAR: My PhD research is on midwives' own experiences of pregnancy and birth and how that experience impacts or influences their professional practice. That is what I have been doing for the last seven to eight years. I have published a couple of papers. In one of the papers, one of the findings was that midwives generally have the chance to choose their individual care providers. So 75 per cent of this national survey were able to pick exactly who they wanted, which is a professional privilege that women in general don't get to have. But 45 per cent of the midwives in this survey actually got continuity of midwifery care, whether that was a private midwife or whether that was MGP caseload midwifery.

What we can see there is that with those numbers—and most of them, I think about 86 per cent, birthed at hospitals, so 11.2 per cent had homebirths, which is so much higher than the general population. Even with the majority birthing in hospital, we had a normal birth rate of 66 per cent—16.3 per cent had instrumental births and 16.8 per cent had a caesarean for medical reasons. Big differences, really, to the general population, but again that all comes down to having a known and trusted care provider, because these midwives in this survey chose those care providers based on having a prior professional relationship or a personal friendship, but they had already established a trusting relationship, which is continuity by default.

That is one of the papers. I am in the middle of publishing a couple of others. I can't give out all the details yet, but in terms of birth trauma, PTSD and postnatal depression rates in this cohort of midwives, those numbers I am seeing are much higher than what we are seeing in the research for the general population. When that paper comes out, it will definitely come with recommendations. It is something that we do need to think about because if we have—so we've got midwives who are traumatised by witnessing trauma, but if we have midwives who have birth trauma from their own experience and then are coming back to provide care to women, we need to look at the impact of that on midwives because there is nothing really in place at the moment to help midwives process, debrief, bracket their own experience before they provide care to the wider population of birthing women. There is some need to look into midwives' own wellbeing when they come back to work after giving birth.

The CHAIR: Thank you. If that paper is published before this inquiry completes, I invite you to submit it to the Committee as well.

SHARON COULTON STOLIAR: Absolutely, if I can get that done.

The CHAIR: I have one more question. You have spoken online about the intersections between systemic racism and birth trauma, and you touched on it as well in your opening statements. Can you unpack that a little bit further for the Committee, around some of your observations regarding racism? We have also talked a lot about education, but are there other recommendations you would like to see from this inquiry? I put that to both of you.

RAKIME ELMIR: I think that education is really important. I go back to your point—education and training. I mean, we live in such a culturally diverse country and we are so inclusive, but for some reason in maternity that tends to change. It is just really a continuation, and you'd think at the most vulnerable time in a woman's life, in a partner's life, things tend to change. Definitely education—and just being inclusive of different practices. We really should be embracing diversity in our maternity settings, and the diversity that women and different cultures and religions bring. I think that is really important. In terms of processes and guidelines, there needs to be clear processes and guidelines for certain adverse events around death and dying, particularly in maternity. And there needs to be more support for culturally diverse communities because that is really diverse in terms of how different communities process, really, the processes around that.

SHARON COULTON STOLIAR: I don't think there has been a lot of research done in Australia in terms of racism specifically in maternity care, but discrimination, hostility, it all comes down to it. There is research in the UK and the United States specifically talking about this very explicitly and these are other traditionally white countries with a large population of different people of colour, different ethnic backgrounds, so I think we can start to look at some of that. That research is showing that women of colour—black, brown women—are experiencing birth trauma at a higher rate than white women. It is there. I didn't refer to that in my speech today because it's not Australian research.

But I think also just what Rakime said, even if we take race out of it, we take culture out of it, I think the bottom line is common sense, and I think it needs to come down to conscious maternity care, which is what I talk about in my book. It is really just common sense. We're conscious about our eating, we're conscious about everything else in our life, and maternity care providers need to remember their actions and their words, their non-verbal cues, non-verbal communication matters. They will forget what they do and go home and come back to another set of women and families the next day but the women that interacted with them will remember that interaction for the rest of their lives. I think it's just about, again, education, but it's commonsense education.

They need to be aware of their own biases, beliefs and fears and their own concerns, realise that their words matter. Every single word that's uttered in that room, the facial cues, the expressions, they all matter because that's how women will remember that experience. They need to mind their body language. The frustration—yes, they're burnt out and, yes, they're exhausted and that is a system issue but on an individual basis, maternity care providers can make little changes immediately that can see big changes for women immediately as well. Most of all, they need to remember empathy. They need to think about how they would feel receiving the care that they are providing, I think. I think education on that to maternity care providers is absolutely crucial, and I think it could be done really easily and fairly quickly, and we'd see changes immediately.

The CHAIR: And would you advocate for funding for research in Australia so that we can get some of that data?

SHARON COULTON STOLIAR: Absolutely. Absolutely, funding; it goes without saying, or maybe I should say it. We need funding to look at birth experiences of women of colour, different cultural backgrounds, ethnicities, races, and see what it is, especially if of the Australian population 51 per cent is first or second generation migrants. I think it's really time that we look at that.

The Hon. EMILY SUVAAL: I noticed you spoke earlier about the continuity of midwifery care, which is something that has come up a bit in this inquiry. How would you define continuity of midwifery care that you would like to see provided?

RAKIME ELMIR: For me it's one maternity care provider providing care for the woman and her partner from pregnancy right through to the postnatal period, and so the same care provider and potentially hopefully in a few years from the same culture as well. I think that would be wonderful.

SHARON COULTON STOLIAR: I would echo what Rakime has said, but I would say that it should go up to six weeks at least. Those are such crucial weeks and really that's when the mother has become the mother. That's when she needs that support, that extra support, and we know it's always better from the same care providers. So, really, privately practising midwives would be amazing, or if we could implement some kind of model of care that sees women get that all the way through, even within a hospital setting because, let's face it, 97 per cent of women in Australia give birth in hospitals. So while it would be absolutely ideal and amazing to have MGP, private practising, all throughout, we need to see what we can do now in the hospital as it is right now to make change now and not just in the long term when we do one day get all of those ideal models of care in.

The Hon. EMILY SUVAAL: I think you both raise very important points, and in a perfect world it would be the same maternity care provider throughout and, indeed, from the same culture. We have heard other evidence in this inquiry about some of the complexities with midwives being unable to work the requirements of a 24/7 on-call roster, which is, as you would know, a requirement often with the midwifery continuity of care models. In terms of recommendations, how would you propose that we kind of balance both of those, respecting midwives' personal caring commitments—they're often working mothers themselves—and their caring commitments and work-life balance when, in order to achieve that goal, it would require them working an on-call roster?

RAKIME ELMIR: I think you would look at a shared model. I work really closely with our midwifery students and I facilitate their clinical placements across New South Wales, including rural and remote, and many of them want to be placed in the continuity of care model because they want to experience what it's like. I always have a debriefing session with them and brief them beforehand just so that they are aware of what the model involves, and many are not aware that they need to actually be on call pretty much 24/7 and so that's just a bit of an eye-opener for them.

But in terms of addressing your question, I think there is definitely a need for this and we heard this from this inquiry, but potentially a shared model would work well. We know our culturally diverse communities often see their GPs because they speak the same language, they're from the same culture, but the only barrier there is that loss of continuity when they enter the hospital system. So potentially having our GPs enter that hospital system so that the woman sees a familiar face would work quite well. Otherwise in our MGP models I think on call or working in a shared model may be the way to go.

The Hon. EMILY SUVAAL: Sharon, did you have anything to add?

SHARON COULTON STOLIAR: No, not in addition. I agree with Rakime there.

The CHAIR: Wonderful. Thank you both for coming today and providing your evidence. It has been very powerful evidence and very, very useful for the Committee, so thank you both so much for your submissions and also for coming in today. If there are any questions that the Committee has to give to you on notice, the secretariat will be in contact. Thank you both again.

(The witnesses withdrew.)

Ms JASMINA BAJRAKTAREVIC-HAYWARD, Community Services Coordinator, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, affirmed and examined

Ms DEBORAH GOULD, Senior Consultant, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, affirmed and examined

Ms YUSRA METWALLY, Advocacy Liaison, Zamzam Mums and Bubs, sworn and examined

Ms SALTANAT BORA, Co-founder, Zamzam Mums and Bubs, sworn and examined

Dr FATIMA EL-ASSAAD, Director, The Still Nest, and Senior Research Associate, University of New South Wales, before the Committee via videoconference, affirmed and examined

The CHAIR: I now welcome our next witnesses. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. I now open to witnesses wanting to give a short opening statement.

JASMINA BAJRAKTAREVIC-HAYWARD: STARTTS would like to thank the New South Wales select committee for undertaking this inquiry into birth trauma and for the invitation to provide evidence to the Committee today. We have been supporting survivors of torture and trauma in the context of organised violence and State terrorism since 1988. The majority of our clients have arrived to Australia under the refugee and humanitarian program and in over three decades we have assisted over 80,000 individuals through our different services. You have our submission, so today I will just take a moment to discuss a case study of a client. Their name and identifying details have been changed, but it is an example of something that has happened.

Zara is a young woman who is seeking asylum in Australia. She has witnessed violence, experienced persecution herself, and has experienced numerous accounts of sexual abuse. Zara is the mother of two children. Her first pregnancy took place in Indonesia, where she was living alone. During her pregnancy she had intense fear of birth. She feared that she would die at birth and worried who would look after her baby if she were not to survive. For eight months Zara lived in Indonesia alone with her son. The two of them resided in an unhygienic and unsafe room. Zara did all she could to support the needs of herself and her baby to survive. Since then, three years have passed and Zara became pregnant again. This time, she was resettling in Australia—or residing in Australia. During this pregnancy, Zara began to recollect the fears and anxieties of her first pregnancy. When attending appointments for her pregnancy, she would feel uncomfortable when male practitioners were present, due to her previous experience of sexual assault.

Zara's history of trauma, isolation and stress manifested in high anxiety and low mood throughout her perinatal period. For Zara, there was lack of awareness or consideration made to her previous experience and trauma, as this was not reported to her pregnancy-care professional. They were not aware of Zara's previous experience of trauma and she was not aware of how the health system works in Australia. For women like Zara and other clients of STARTTS, the experiences of traumatic events often occur over prolonged periods of time. These experiences of trauma are compounded by the impact of loss, grief, dislocation and cultural dissonance.

Therefore, in addition to the recommendations we made in our submission, we further recommend to the Committee the need for the implementation of trauma-informed care for all those accessing maternity care, including refugee clients. There is a need for a robust system to be put in place that ensures that the principles of trauma-informed care are adhered to in practice. This will ensure that those accessing maternity care have the capacity to freely and clearly communicate with healthcare providers, where they have informed choice and control, and it will ensure health professionals and care providers have an understanding and capacity to respond when faced with interconnected or compounded experiences of trauma, including birth trauma. Thank you.

SALTANAT BORA: I would like to first acknowledge the traditional owners of the land, the Gadigal people, Elders past, present and emerging. I thank you, the inquiry Committee, for inviting Zamzam Mums to this hearing. My experience in this space comes from being a founder of a grassroots mothers' group. It also comes from being a mother of four myself. In 2019 two fellow mothers and I came together to create a support group for Muslim mothers in south-west Sydney. We believed there was a gap in support services for women from this background.

Data from our own research, which we show in our submission, shows that 80 per cent of the women that we surveyed had not attended a playgroup at all. Although it was also a playgroup—activities were organised for children—primarily, the group focused on creating a safe space for mothers to share their experiences of pregnancy, birth and child rearing, in each monthly session. More than this, however, we wanted to engage in discussion of issues mothers face, in an honest, sincere and meaningful way. To achieve this, we engaged professionals in the field to discuss a wide range of topics such as nutrition, motherhood, positive parenting, balancing religious practice with parenting and so on.

Sessions included dhikr at the onset, which is a recitation of religious litanies to connect to our Muslim identity. Each session was an open discussion where we sat in a circle on the same level with mothers rather than speaking down to and throwing facts at them. Mothers were welcome to contribute to the topic in a conversational manner. As each session wore on, we found more and more women sharing candidly their experiences of birth trauma, of neglect in postpartum care, of a lack of knowledge about the physiology of birth and breastfeeding, of the purpose and consequences of intervention.

Most women expressed dissatisfaction with their birth providers, sharing heart-wrenching stories of bullying, of cultural and religious values not respected, and of experiences with postpartum depression due to these incidents. Not only did women feel safe in this space to share these stories but individual experiences of birth trauma were validated by what they shared with each other. This brought women back, month after month. This helped the process of postpartum healing, acting as a tool for mothers to find support in this often neglected time. Some months into the project, however, we realised that it was not enough to support mothers in this postpartum phase. There were too many ongoing issues of birth trauma being shared, and it was at this point that we realised that expecting mothers, first time or not, needed a support group of their own. To this end, we created a second monthly session entitled "I'm Expecting! Let's chat …", which aimed to provide birth education support to expecting mothers.

These sessions focused on understanding or educating women about the physiological stages of birth, partnering with pelvic physiotherapists to speak to women about pelvic health and how to prevent prolapse, the importance of focusing on a positive mindset going on to birth, discussing birth plans and so on. We also discussed how to advocate for our specific cultural and religious needs as Muslim women. We engaged doulas and other professionals in the field. It gave mothers an opportunity to connect with these professionals and some of the mothers who attended our sessions went on in their births to hire these professionals and had more positive birth outcomes.

Then, after they gave birth, they attended our mothers' session, so it was like a full circle experience where we were able to help mothers in their pregnancy in their expecting phases and then afterwards after they had given birth. These sessions emphasised the importance of birth education that was framed with a positive rhetoric, not one based on fear that focused on the dangers and risks of birth. A core message we wanted to deliver to attendees was that having a healthy baby at the end of the birth was not the primary goal and that the health of the mother, her emotional and physical state, was just as important.

Unfortunately, with the disruption of COVID and a lack of funding and volunteer base, Zamzam Mums has not been operational at its former capacity. We believe that community services such as Zamzam Mums can provide culturally specific care and detailed and empowering education to birthing mothers who are not receiving supportive, positive and culturally nuanced knowledge and care from public and private hospitals. Furthermore, community groups such as Zamzam Mums can work in conjunction with hospitals to help provide this culturally specific training. We have seen that a systemic change in the broader public and private health model is required to address birth trauma, as most women who came to our groups who had positive birth outcomes sought help outside of the system.

The term "Zamzam" comes from the well of water that God provided from the dry desert for our mother Hagar, Abraham's wife, in the valley of Bakkah—or Mecca, known as today—after she ran from hill to hill to find help for herself and her infant son. It represents our spiritual connection to a mother who did not give up in the harshest situation to provide for her son. With her efforts and unfailing faith in God's mercy, the spring of life-giving water which still runs today was made hers. Although our situation as birthing mothers today in New South Wales appears dire—the thousands of submissions to this inquiry is proof of this—we take strength from our ancestral mother and believe that unfailing effort and faith in the humanity of people will overcome the lack of political will, embedded systemic challenges, and a skewed and damaging view of birth to lead mothers and society to a place of life-preserving, life-treasuring care that upholds the status of women as life bearers and deliverers. Thank you.

YUSRA METWALLY: Good afternoon. I'd firstly like to acknowledge the traditional owners of the land on which we meet, the lands of the Gadigal people. On behalf of Zamzam Mums I'd like to thank the select committee for reviewing our submissions and for inviting us to present to you today. We are sharing today the experiences of culturally and linguistically diverse women based in south-western Sydney, and we are grateful for the opportunity to be able to share and highlight stories that have been shared with us for the very first time by many women as part of this inquiry. We acknowledge the physical, emotional and psychological trauma that many women and their families have experienced during birth and the re-traumatisation that women are facing as they share their stories with us as part of this inquiry.

Standing here today, I'd also like to acknowledge the birth trauma faced by my mother in birthing me in a south-western Sydney hospital as a migrant in a new country without many supports. I did think of her throughout the hearings shared by migrant refugee women today. Seeking support for trauma does indeed have an element of privilege in understanding the very nature of birth trauma that is only available by virtue of education and informed consent. We welcome the Government's commitment to hosting this inquiry and to better understand the nature of birth trauma, especially for culturally and linguistically diverse communities, and we remain hopeful that this process is matched by a level of political will to see a change in policy and funding frameworks to improve the birthing experience for all women and families.

My role at Zamzam Mums began as a new mum in 2019, where I was a recipient of the care and supportive space the day after I was discharged from hospital. They are days I look back on fondly and I'm glad that I was able to experience it pre-COVID. Our submissions, of course, do talk about the intense level of isolation that many women, including my own sister, faced when they weren't able to access community supports or family visits while they were in the maternity wards in hospital. That really just shines a light on the very role of family support that needs to be part and parcel of the birthing experience.

As a trusted grassroots initiative, Zamzam Mums was able to receive a number of survey responses, but also there was a level of facilitation that was required to support women in sharing their stories. One of the things that became very evident is that to formally share a story requires a lot of emotional energy that many women do not simply have postpartum. Many women are not engaging with the formal mechanisms through the hospital process to share patient surveys. What this really highlights is that there is a need for feedback to be collated throughout the process by really involving patient consumer representatives, and that's a role that I've also played that allowed me to provide support to some of the mums at Zamzam Mums.

According to NSW Health, providing socially and culturally respectful maternity care assists with ensuring physical and wellbeing outcomes for women, her partner and the baby. Each person accessing maternity services must be respected without assumptions, judgement or cultural bias. Sadly, our survey responses don't indicate that such a level of cultural safety is present. There are numerous case studies which I'd like to highlight to the Committee. One of those includes being questioned about domestic violence, a standard protocol—part of interview processes. When a respondent shared that it didn't apply to her, the midwife went on to add that it's quite common in her culture.

Another example is a woman sharing her experience where the nurse was being rude to her because of the way she wrapped her baby culturally. The nurse went on to say, "In your culture I've seen your people do this a lot, but we don't wrap babies like that here", and she was a supervisor. Another story shares a woman's experience who wanted to have a level of spiritual comfort during her labour, and the response that she received by having a statement of the written portrait of Prophet Muhammad in her hand, peace and blessing be upon him, was receiving an eye roll from one of the midwives. That made the woman feel uncomfortable during this vulnerable birthing state.

Another issue that's a very evident part of our survey responses is that, first of all, from the outset birthing is a process where a woman is feeling exposed and this applies to all women regardless of their cultural and religious background, and it's really important to ensure that a woman's dignity is respected throughout this process by all members of the hospital from the staff through to the doctors. For many Muslim women who were surveyed for this inquiry, they expressed that observing modesty was a key element of their cultural practice and a significant portion of them expressed their preferences of interacting with a female healthcare team.

Of course, the degree to which the hospitals accommodate this varies between the respondents. And the Muslim women who observed modesty also expressed that they observe religious practices to varying degrees. For some women, having a female healthcare team is not as important and rules around modesty are much more relaxed in a medical setting. What's important to note is to ensure that a woman and her preferences are at the centre of interactions to establish clear preferences right from the very first interaction and to respect these choices. This is what woman-centric care is all about. Establishing effective communication between a woman and her midwife or other health professionals is essential to determining how culturally safe care can be instituted.

This essentially highlights the need for a level of cultural safety and competency that needs to be discussed throughout the antenatal care process. In addition to this, we need to see stronger workforce capabilities and targeted recruitment of midwives from multicultural backgrounds. To complement the New South Wales blueprint for maternity care, we also recommend that a strategy is put in place for a culturally safe antenatal and maternity care that reflects the Federal department of health pregnancy care guidelines, *Pregnancy care for migrant and refugee women*, which covers a lot of these principles.

Our surveys have highlighted six recommendations, and it goes into some of the details which have been shared by our survey respondents. This includes highlighting issues that have been discussed throughout these hearings, including funding postpartum support and women's health physiotherapy within antenatal maternity care, particularly due to the fact that accessing women's health physiotherapy often is limited to those who have the financial means, through private health insurance. We all know that not having access to these services has long-term impacts for women's wellbeing and their quality of life. Incontinence has a long-term cost. It's got an economic society cost, and it's really important that women are provided the support post-birth to assist them in their recovery. Our submission also highlighted some of the concerns around lack of mental health support, and of course Zamzam Mum has played a really important role in providing women with a space to feel that they are part of a village and to access the support that they require.

Lastly, partners, again, play a very important role as part of the birthing process, and there should be opportunities for them to be involved during the hospital stay. This provides an opportunity to be able to take off the pressure of night midwife staff, and of course we saw the impact of fathers who were not able to be present in the maternity wards during the COVID period and the mental health impact this had on women. Women have a right to a dignified birth, and we believe in the utmost importance of a gentle and compassionate maternity care system with a goal of preserving the dignity and honour of women who bring life to this world and to ensure that their cultural needs are respected. Thank you for listening.

The CHAIR: Thank you so much. Dr El-Assaad, did you have an opening statement?

FATIMA EL-ASSAAD: Yes. Thank you to the select committee for the inquiry into birth trauma and to you, Hon. Emma Hurst, for chairing it. Thank you for selecting the Still Nest submission and for the opportunity to represent culturally and linguistically diverse families impacted by birth trauma. I'd like to begin by acknowledging all women who did not get the level of care that they needed, including my own mother, a migrant woman who birthed six children, with little English, in a new country, with no support, carrying her own mother's birth history of 17 pregnancies and five losses. I also acknowledge all our precious babies and children lost and their bereaved communities. I also acknowledge the diversity across Australia, including our Aboriginal and Torres Strait Islander cultures, their languages and practices, and that it's also vital that healthcare services respectfully manage protocols and provide a culturally positive healthcare experience for all women.

I'm a mother with lived experience of birth trauma, early pregnancy loss and stillbirth. I consult on developing national stillbirth research priorities for Australia through my consumer positions on the NHMRC's centre for research excellence in stillbirth Migrant and Refugee Advisory Group, as well as the stillbirth research priority-setting group. I've engaged with NSW Health to develop a statewide educational resource, Conversations about Perinatal Post-Mortem, and I'm also a policy adviser at the Early Pregnancy Loss Coalition.

I founded The Still Nest to support CALD families who had experienced birth trauma, infertility, pregnancy and child loss. This was borne out of my own lived experience of birthing my daughter Aya on 14 January 2021 still. Although I did experience the best possible clinical care in the worst circumstances, it wasn't until I was being referred on to bereavement support services that my obstetric social worker apologetically said, "I just don't have any cultural ethno-religious resources that I can refer you on to." She was recognising the importance that faith and culture has on our rituals surrounding birth, death and grief. In that moment, admittedly, I did not understand how important this would be in my own journey. We were left to navigate the hospital-to-funeral-to home journey all on our own, and I was unprepared for the physical, emotional and mental postpartum bereavement period.

When a baby dies, it impacts the entire community. The mother is central to this. However, the father, partner, healthcare team, grandparents and wider community are also inadvertently impacted. I've actually captured some of these stories, particularly of culturally diverse Australian Muslim women with lived experience of birth trauma and baby loss and also the healthcare teams who work with them, in the first season of the Still Nest podcast. The second season, which is recorded and yet to be published, actually explores wider communities of diversity, including stories from First Nation midwives; multicultural, multi-faith communities; and stories of fathers.

I believe that through storytelling we can actually raise awareness around the nuanced approach needed to support bereaved families from CALD communities moving towards a culturally inclusive and responsive support system. Many groups of CALD families in Australia are actually at a higher risk of experiencing stillbirths and infant deaths. The rate of stillbirth in women from CALD communities is double the national rate, and this large disparity is not reflected in the number of resources available to women from CALD communities. Unfortunately, the support that is culturally responsive is not available.

After listening to the birth trauma stories of my own community and all the brave individuals in this very hearing, I'm reflecting more deeply about the recommendations that I actually made in my submission, and I can just now envisage a much broader recommendation, which is to bring back the mother to the centre of her own reproductive health. I would like to see a version of the blue book we see for our babies, but for the mother. This could be co-designed by mothers and their healthcare professionals. It could begin way back at preconception. We know that preconception health is so important to the mother's health, as well as the baby's health.

We can include signposts in time to actually understand the cultural and spiritual wishes of the woman. It could have signposts for self-directed antenatal education modules, what to expect during pregnancy, what possible road maps are out there in terms of navigating the system, at what point different clinicians and practitioners could be useful in their journey. It could also be an inclusion of all the resources that have been mentioned in the hearings, in one centralised place, including and not diminishing the importance of postpartum bereavement care in the cases where losses have actually occurred.

This could become the gold standard maternity care or platform or road map for New South Wales. The mother could potentially opt in to share it across both the public and private care and with her allied health professionals when she goes to seek that support. It needs to be available in her preferred language and, obviously, translated back to English for the healthcare professionals to be able to access. It would act as a birthing road map for parents, and it would continue to collate subsequent pregnancies and losses—and, in addition to this, to echo some of the other recommendations, just a bit more core funding for some smaller community groups like ours, who could actually provide those bespoke services needed to support CALD communities, particularly those impacted by birth trauma. Thank you.

The CHAIR: Wonderful. Thank you all so much for those opening statements. We're now going to do some free-flow questions. We'll start with Dr Amanda Cohn.

Dr AMANDA COHN: My question is for STARTTS specifically. We've had discussion, earlier in this inquiry, about the need to identify a history of trauma in people presenting to birthing services, so I'm interested in how you think that process can best be done—noting that, if poorly implemented, it can end up as just another tick-box exercise. Are there validated ways to assess histories of trauma?

DEBORAH GOULD: There would be many validated ways, but they can be done badly too, and it essentially comes down to the clinician, practitioner or community worker being able to engage appropriately and decently with the person involved. Trauma questions can get asked at any time depending on readiness. But because you are asking a technical question, in a way, about when do we go in and ask—usually there would need to be some degree of rapport built with whoever is asking the question, so it could never really be stuck on a piece of paper that a woman ticks off somewhere. Some places do have those private spaces to indicate trauma, where the woman is informed that if she has a trauma history, she can put a red dot on her thing rather than having to articulate it in any other way. So that is one possibility—a non-verbal option.

But in the end, I think it is going to come down to the finesse of the interviewing environment. In some communities we can expect there is a trauma history, like with refugee women. We are not necessarily talking about capital T trauma, where there has been an incident which is traumatic, but the life of a refugee woman is traumatic—the whole trajectory is a traumatic one. The issue with trauma is that it sensitises us to future trauma. That is why we want to know so that (a) we don't repeat it, and (b) we are aware there might be a heightened response already to that.

JASMINA BAJRAKTAREVIC-HAYWARD: It is about knowledge of your local community as a healthcare provider. It is about knowing who lives in your community and which refugee communities are around, and making the assumption. It is better to be safe and say, "Okay, someone is from the Afghan community; there is great likelihood that there was some form of trauma." The other way of identifying trauma, and I know some departments do that, is understanding the visa class system. It is not fail-safe, but if someone has arrived on a refugee visa 200 or they are on a bridging visa, it is very likely that there might be a history of trauma. Then it comes, like Deb said, to a building of trust and relationship, and that then comes with the ability to communicate to the person. The use of bilingual health professionals, creating cultural safety to start with; the use of interpreters and the right interpreters—all of that would allow women to talk about things.

DEBORAH GOULD: In this respect we speak about trauma-informed practice, which doesn't say that we have to know the trauma history of every woman, but we make an assumption that it is possible that any woman has had a trauma history, and then we provide our services always. It is always money well spent to be trauma informed.

Dr AMANDA COHN: We have had a lot of discussion about the continuity of care, and obviously it is the preference of a large number of people to have either one practitioner or a small group of practitioners throughout their pregnancy. I wanted to clarify—it sounds like what you are saying is an additional benefit of continuity would be an improved ability to build the rapport you need to pick up on trauma.

DEBORAH GOULD: Absolutely, yes.

The Hon. NATASHA MACLAREN-JONES: This is a question for all witnesses. One of the recommendations Zamzam Mums and Bubs put in their submission was about building on the blueprint for maternity care and looking at the Federal Government's health pregnancy care guidelines, particularly around migrant and refugee women. The New South Wales Government has a number of health plans. We have multicultural health plans and policy procedures; there is also the NSW Refugee Health Plan. I am interested to know your general views. Is the issue that there are too many plans and that districts are not sure how to implement them properly, or is it that there are systemic issues within the current plans that need to be looked at?

YUSRA METWALLY: I think plans shouldn't be sitting on a shelf collecting dust. It is about how it's implemented. There needs to be reporting on those measures and actionable items, such as numbers of staff who are bicultural and training that is provided to all workers of the hospital. One thing that is really critical is for each local hospital to be very aware of its cultural needs in the local area. There needs to be a level of looking at a plan and actually breathing it into every single process that is undertaken. Those reporting measures need to be done in ways that are practical and that see results for patients and for women.

There also needs to be a way for collecting data around patient experiences in a way that doesn't put the onus on a woman to come back and share her experience. It personally took me 4½ years, just because of this process, to finally write an email to share things that I was unhappy with about my birthing experience. I reflect on my privilege, as someone who is educated, who is a lawyer, who has worked with NSW Health and understands the system, and I know very well that for people who don't have that level of privilege it is very hard to engage with the system to share their experiences. There needs to be systemic change and systemic reform to essentially change the policy, and the gap between policy and practice needs to be a lot smaller.

JASMINA BAJRAKTAREVIC-HAYWARD: I am quite closely acquainted with the Refugee Health Plan and as plans go, it is a decent plan. It is a fairly newish plan at the moment. I think the jury is still out on the implementation. As far as plans go, the Refugee Health Plan is pretty good, but it is about that implementation and practice, and making sure it is monitored—the same as what Yusra said.

The CHAIR: I was just going to ask Dr El-Assaad if she had anything further to add to that question?

FATIMA EL-ASSAAD: Further to what Yusra already mentioned, I think it is the implementation of those plans that is quite important. Further to my own recommendation in my opening speech, if women were actually well versed in those plans, they could supplement what is happening in the healthcare system. It is a collaborative approach to ensure that those plans are actually being enacted. Most of us are so unaware that these plans even exist, and it is only when something goes wrong that we are looking to understand what policies exist and what plans exist.

The Hon. ANTHONY D'ADAM: I am really curious about the process that was established to get Zamzam Mums and Bubs up and running. It seems like an excellent model. I am curious about how replicable it is, and whether it was just a unique set of circumstances that enabled you to set it up with people who have a degree of expertise and capability. Could you tell us a bit about how it got started and what the circumstances are that might enable this model to be replicated elsewhere?

SALTANAT BORA: Sure. It was literally through mothers who were friends, who had an idea. That was the very beginning of it, but the practical steps to bring it to life were that, because we weren't a registered organisation or a not-for-profit ourselves, we allied ourselves with an organisation that already existed, which was the Muslim Women's Association. That was to be able to have access to their insurance and possible funding, although most of our money came from charging women $10 at the door. We raised that money and saved it to basically filter back into the organisation.

Funding is a huge issue. All of our volunteer base were mothers who had young children and who were working part time or full time. The sustainability of it wasn't feasible given that we didn't have that broader support. Somewhere along the line, the bigger organisation that we had partnered with fell apart, so we lost that insurance. But another thing that we did was partner with a particular community council so that we could use their venue spaces, because the biggest practical step to making it happen was having a space in the local area that most women could access—for us, that was in south-west Sydney—that was accessible for getting prams in and was consistent, so that we weren't scrambling every month to ensure that that venue was guaranteed for us.

We had to ensure that there was a volunteer group who could organise the registration of mothers who could come, and we had to organise social media marketing to give alerts about when a session was happening. We made sure that it was essentially the second Tuesday of each month at the same time—10.00 a.m. to 12.00 p.m.—so mothers knew exactly when it would happen, and it didn't diverge from that time either. Other things were trying to organise a childcare worker so that the mothers who brought their babies with them could sit and engage in the conversations. To be honest, that was a problem we could not solve. When you're in a huge community hall, the noise level gets very loud, so you're trying to have conversations with 18-month-olds scrambling over you. So it was important to have an outdoor space that was accessible for the children but where the mothers could also see the children playing. There were a lot of moving pieces. Some of them we solved; some of them we didn't. But we managed to pull it together, and I would say it is entirely replicable by any community who wants to provide that kind of service for their mothers. It didn't take too much for three mothers to put it together, beyond having the practical things like the insurance, the venue and things like that.

Like I said, COVID was a huge hit for us. We lost our space. We could no longer come together physically. We did Zoom sessions, so that was helpful. We tried to up our social media presence to discuss some of those issues online. Then when COVID fizzled out a little bit and we got to meet up again, we did start the sessions again, but ultimately it came down to volunteer burnout and the lack of money. We lost our sponsorship with the community council venue that I was talking about. Trying to find another suitable space was very difficult. But like I said in my opening speech, it made a huge difference for the mothers attending and for myself. I went on my own journey through Zamzam Mums and Bubs to understand birth better and have a more positive birth outcome with my fourth. We saw it in the mothers as well. I think it is something that can be done. We just need more support.

The Hon. ANTHONY D'ADAM: Do you think it's something that the local health district should be actively facilitating?

SALTANAT BORA: Yes.

The Hon. ANTHONY D'ADAM: Or would you say that it's critical that it's at arm's length from government?

SALTANAT BORA: No. We spoke about this in the two years that we were running. It would be ideal to partner with local health districts, to partner with local hospitals so that we could reach the mothers who were birthing and who had just given birth and get the midwives to tell them, "There is this community group for you to go to", and to work in conjunction with them to give them—we've been talking about culturally relevant training. Although we're not experts in that area, we come from that demographic and our own experiences inform how we are helping these mothers.

We speak about plans and policies, but the experience of the women on the ground is that they are being treated badly—and that's putting it lightly—in hospitals because of their cultural backgrounds. That is not all women's experiences, obviously. There are some brilliant midwives and birth workers who are very accommodating, but the majority of the experience of the women on the ground is that there is trauma related to their cultural backgrounds. If we were to work closely with hospitals to give them an understanding of how to treat women and what religious rites they may come with to birth—"This is what you can expect. They'll come with their little books and litanies. They may bring a prayer mat with them." Having that open communication between a group that is serving the community on the ground in conjunction with a hospital I think would make a big difference.

YUSRA METWALLY: Could I add one point to what Saltanat said regarding how it would be delivered? One thing that I've observed throughout my motherhood career—

SALTANAT BORA: Yes, it's a career.

YUSRA METWALLY: —is that in Western Sydney there doesn't seem to be a huge take-up of parenting groups. Essentially what Zamzam is doing is about providing that postpartum community of support. I only ever knew to join my local mums' group because I was recommended to, but had I not had a friend suggesting that I do so it would have been up to me to filter through the bags of pamphlets that they give you when you're discharged, and somewhere along the way is ringing the 1800 number. There's such a mental load when you get out of hospital. You have to register your child's birth and learn to breastfeed, and the list goes on. There is such a huge mental load. In my personal experience, I didn't see that it was encouraged or facilitated for women to attend. Most of the women who I speak to in Western Sydney, regardless of their level of education, didn't engage with their mothers' group because they simply didn't know about it. It's one of those things: When the onus is on you to pick up the bag and call the 1800 number, you're not really going to do it. So it needs to be done in a way where it is encouraged for these spaces to be provided.

I also noticed, when I was living between two different LHDs, that some mothers' groups—for example, in the Auburn area—weren't running, and there was quite a significant distance of travelling. I think those groups play a very important role, but we don't see the same level of promotion in encouraging that take-up for women, and they obviously play a very important role in that postpartum care. Throughout the survey responses, there was such a positive impact on women who've had what we call a redeeming second birth. After they've been empowered and gained the information they've gained from the Zamzam Mums space and the different health professionals, they have had an empowering second birth, whether that was going through models of care like midwifery group practice or a homebirth. That has been the core of how our recommendations have been put into place, based on the experiences that we saw. Personally, in trying to help and assist women in making complaints to the hospital, they also gain confidence in addressing their needs in the second birth and building that level of confidence. There's a lot of work to be done to build that trust in the hospital system.

JASMINA BAJRAKTAREVIC-HAYWARD: Can I add to Yusra? There's a model in Victoria—Group Pregnancy Care, in Melbourne—which is a partnership and model that was co-designed by the refugee community and the health system. That model has resulted in the provision of care in language, all by cultural staff collaborating with midwives and those groups, starting very early on in pregnancy, in language, with women from that community. So it is a collaboration between the health system and the community.

YUSRA METWALLY: The partnership approach is very important.

The Hon. ANTHONY D'ADAM: Could you, perhaps on notice, provide us with some information about that particular initiative in Victoria?

JASMINA BAJRAKTAREVIC-HAYWARD: Yes. The program is in our submission, but it's called Group Pregnancy Care, in Melbourne, and it was a partnership. There's a reference in our submission by Riggs et al where they describe the collaborations and the outcomes of the collaborations. It was specifically co-designed with the community in mind and the maternity hospital.

DEBORAH GOULD: Can I add something about process and content stuff? We're talking about information as well as support. We could easily give all of the information and technical stuff, which you have said Zamzam can't really provide. Local health could provide it, but they could completely stuff up the methodology of the teaching of it. When anyone is provided information in an environment that is supportive, calm, familiar et cetera, we learn better. Our frontal lobes don't operate when we're under huge amounts of stress. So there's something about that, whether we call it a sharing circle or learning circle, that facilitates learning of content, not just the support, which I think would be an important crossover.

SALTANAT BORA: One of the most important intentions with Zamzam Mums was that it was not a place for women to receive more facts. We were not going to provide women with a single brochure. It was not going to be a PowerPoint presentation with someone standing at the front. It was a circle, very much like how we are sitting today. Oftentimes, we were sitting on the floor sharing babies between us. The idea was to speak to the mother, not at the mother, and that's a huge difference. It wasn't, like I said, a fact-delivering session. It was building a relationship. It was building a warm environment so that women felt safe. Then when we eventually established the pregnancy "I'm Expecting" sessions, honestly, they were brilliant. They were so brilliant because the very first session we had was not even "what to expect in birth". It was "If you're expecting, come talk about your fears. Just tell us what you've been going through in your pregnancy. Let's just have a session where we get it all out." That was our very first session.

There was no professional expert there. It was just a group of mothers who were speaking in solidarity to validate what we were going through. Then, from there, we went to empower them with knowledge that was culturally sensitive, that was positive, that wasn't framed from risk and dangers. I'm looking at headlines, particular from news outlets, after the inquiry and they are still framing birth in terms of the dangers. The inquiry shows that women do not know the dangers associated with birth. We are still using that type of language around birth. That needs to change because, as a particular doula who came to one of our sessions said, when you frame things from a negative, fear-based perspective, you're setting off the fear-tension cycle, which results in the physical tension of your muscles, which, when you are in birth, actually slows down labour. You need to be relaxed. You need to feel safe and comfortable in your birth for your body to relax and for that labour to progress as easily as possible, and that was our focus.

The Hon. SARAH MITCHELL: You actually just answered my question, which is great. I was going to ask you about "I'm Expecting! Let's Chat ..." Can I also say for the record that I loved when you said that it was three mums who got together and had an idea. I think we could probably change the world if we did that a little bit more often. I have one other question that I want to ask to Dr El-Assaad, changing to a bit more of a serious topic. Firstly, thank you for sharing and thank you for being so open. I'm sorry for the loss that you've experienced yourself as a mother.

You spoke in your opening statement, and you also mentioned it in your written submission, about that health literacy preconception, particularly taboos or secrecy around things like pregnancy loss and stillbirth and what that means in different cultural communities. Obviously you've been working in that space, which is an incredible thing for you to be doing, given your expertise and your lived experience. Is there anything for the

Committee that we could recommend that might perhaps assist in that space? Have things improved, do you think? Is there more information that is becoming available that recognises particularly those from CALD communities who have that experience? Is there something there that the Committee could look to recommend, in your expert opinion?

FATIMA EL-ASSAAD: I think that's an excellent question. I love that you're thinking in that way. I want to borrow from Saltanat's comments earlier, that sometimes in these communities we don't need to be giving them a lot of information; it's just to try to create some safety and lowering the barriers for them to access it and enabling them to feel like they're actually in control of their own journey. I feel like there are a few things to do before we just jam them with a lot of information, and I feel like that is where The Still Nest is trying to lower that threshold by speaking a language that they do understand.

I'm not just talking about a cultural language. It encapsulates a lot more than just that language; it's understanding that intergenerational stuff: the trauma, the taboo, the secrecy. It's about lowering that first, allowing them to feel safe enough and empowered enough to go and access that. Because I work in academia and I have dipped in and out of NSW Health and a few other organisations, I know that when we do get together to create a project and it is multidisciplinary—it is crossing a lot of health professionals—we can produce something that is of an exceptionally high standard. But it's no good just having that if you can't get it down to the community that absolutely needs it.

The CHAIR: I have a question for STARTTS going back to some of the programs. I know in your submission you talk about some amazing services in Brisbane and Melbourne, like refugee midwife group practice. Can you tell us a bit more about those models? Is there anything that's similar that's being trialled in New South Wales or are they quite unique?

JASMINA BAJRAKTAREVIC-HAYWARD: I think they're quite unique.

DEBORAH GOULD: I think they are quite unique. I personally don't have experience of either of them, apart from reading the submission. So I probably can't add to that, apart from to say that one is a group practice model and there's the casework midwife model, which was really well discussed in an earlier submission.

JASMINA BAJRAKTAREVIC-HAYWARD: There are some principles that I think both of them follow: the principles are around culture safety, around being trauma informed, around cooperation with the community, around bilingual staff, around continuity of care. I think those things are quite relevant, looking at the principles of both models. You could be in touch with our sister organisation in Victoria. They're closely involved with the Victorian one and I am sure they would be happy to provide further information about the details of how that unfolded.

I believe in Victoria it was largely focused on a specific refugee community as a pilot. It would be good to look at the findings and extend it to other communities. South-west Sydney would be a great place to have a pilot. To me a pilot would also entail something beyond what was done in Victoria, and that would be partnerships with community groups and refugee-led organisations, which are doing a lot of this work as volunteers, like Zamzam Mums is. There are others as well. If we were to pilot something in south-west Sydney, I think it would include a partnership with groups like theirs—and co-design as well.

DEBORAH GOULD: One of the research authors in our submission, Dube, we've been talking with her. She's the Brisbane person. She would be very open to providing extra information. She's done probably the best explicitly refugee-orientated research in Australia.

The CHAIR: Fantastic. Could we get something like that on notice? If you're able to reach out to them and if they can provide us some further information, that would be helpful.

DEBORAH GOULD: Sure. Yes, okay.

JASMINA BAJRAKTAREVIC-HAYWARD: I could reach out to the Victorian foundation and you could reach out to the research area.

DEBORAH GOULD: Yes. Absolutely.

The CHAIR: Thank you. I've also got a question for Zamzam Mums. You talk in your submission about a lack of funding to be able to continue the programs that you are currently running. What sort of funding is needed to make sure that those programs can continue to run? What numbers of women do those programs reach?

SALTANAT BORA: I wish I was better placed to answer around funding. For example, having a full-time worker who was paid to do all of the admin work would be fantastic. Like we've said with volunteers, they burn out easily. It's admirable to continue volunteering your time, but when that time isn't compensated it's very difficult to continue. Being able to have one or even two full-time paid workers would be fantastic. Covering the money for the venue is very important—that's probably the biggest cost—then being able to pay experts to come into each session to speak to the mothers, because they need money for their time as well. In terms of the funding, those are the things that we would need covered. What was the second part to your question?

The CHAIR: With those sorts of programs, do you have any projections as to how many women that would reach?

SALTANAT BORA: In the two years that we ran, we had something between 15 to 20 women attending each session. That was over two years. That was just the mums and bubs group. For the expecting group, we had similar numbers for each session that we organised.

YUSRA METWALLY: I think it is important for Saltanat and I to emphasise that the group does have a significant online presence, where we're able to reach and share that content with many of the women who are on the social media page.

SALTANAT BORA: If you look at our submission, I think there are about five to six women who attended Zamzam Mums who shared their stories but the rest of them were from our circle of influence in terms of who we could reach out to online. So having a social media manager, for example, would be very important as well.

The CHAIR: Fantastic. If you could also take on notice a bit of a breakdown of what funding you are looking for and a few more specifics as to costs and what that could do, that would be really useful for the Committee as well.

SALTANAT BORA: Yes, sure.

The CHAIR: Is there one more question?

SALTANAT BORA: Is it okay if I say one last thing?

The CHAIR: Please.

SALTANAT BORA: Sorry. Forgive me. I spoke a lot about how Zamzam Mums is able to support and empower mothers by delivering them education through a safe context. What we realised, however, is that Zamzam Mums is an organisation outside of the hospital system and many women who do not have access to this kind of a group do not have access to that kind of information and, therefore, their birth outcomes are vastly different. What this shows us is that a systemic change has to occur and the burden of dealing with the system cannot always fall on people outside of that system, such as community groups. If we want to work with local health districts and hospitals then it needs to be a collaborative effort where they recognise that things need to change at their policy level.

The CHAIR: Thank you all for coming in today, providing your submissions, answering questions and giving your opening statements. Thank you to Dr El-Assaad as well for coming online. Some questions were taken on notice. The secretariat will be in contact about those and any further questions the Committee may have in regard to the evidence given today. Thank you all for all of your amazing work as well.

Applause

(The witnesses withdrew.)

(Luncheon adjournment)

Ms MELANIE BRIGGS, Birthing on Country Manager, Waminda, affirmed and examined

Ms CLEONE WELLINGTON, Executive Manager, Waminda, affirmed and examined

Ms SHANA QUAYLE, Acting Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW, affirmed and examined

The CHAIR: Do any of you have a short opening statement that you would like to make?

SHANA QUAYLE: I would like to start off by saying that whilst there has been increased awareness around the implications of racism, particularly from an institutional lens, there's much work and acknowledgement required. Birth trauma is complex and should not only be limited as being a life-threatening experience and/or medical trauma; rather it is the event that may take place whilst in the care of institutions. The experiences of Aboriginal women are underscored by institutional racism. Broadly, the AH&MRC are taking two approaches by way of providing recommendations. Sorry, there are three recommendations: There needs to be increased investment for ACCHO-based maternal and infant health programs and strengthen partnerships between ACCHOs and local hospitals; the Aboriginal workforce needs to be strengthened to increase funding and retention strategies; and the cultural safety of hospital maternity units and mainstream services needs to be reviewed.

The CHAIR: We now move to free-flowing questions. We will start with Dr Amanda Cohn.

Dr AMANDA COHN: My question is for Ms Briggs and Ms Wellington. Throughout the inquiry we have heard that the New South Wales Government can do better to support culturally safe care for First Nations birthing women. The reputation of Waminda is quite outstanding. We have heard Waminda referred to as the best way to do this. Could you explain to us what you are doing: what your model is, how it works, and how is it different to standard maternity care?

MELANIE BRIGGS: Thank you for your question. I guess—not I guess; I know that our model of care has been developed by the women in community. It's not only maternity care that we provide. We provide wraparound support services in terms of being able to access early maternity care. We live in a regional, rural setting so transport and things like that are really quite complex. Where we live, there's hardly any transport, so making sure that the services that we provide actually go to the women, and also encouraging really professional and personal relationships with the women in our community.

We are from community. Birthing on Country is that continuity of care by your known midwife, also having an Aboriginal health practitioner-led clinic where the women see the health practitioners prior to seeing any midwife in our clinic, or any GPs as well. It's all around Aboriginal leadership and governance, and that's why the women feel safe coming there, because they know that we are Aboriginal and we understand everything that they are going through in community. We have that lived experience and putting that into practice. I feel like that's really important when it comes to implementing a Birthing on Country model, that you need to have people that work in it with lived experience.

We talked about investing in our workforce, having Aboriginal health practitioners studying to be midwives and having more Aboriginal midwives and more Aboriginal child and family health practitioners and doctors. At Waminda we encourage that through the staff wellbeing framework, which is about capacity building for staff. For example, we've got staff that have come through school programs who are now Aboriginal health practitioners and executives of the organisation. Birthing on Country is not just about birthing, it's also about what happens outside of that realm for that woman and that family.

CLEONE WELLINGTON: Can I add to that?

MELANIE BRIGGS: Yes, please.

CLEONE WELLINGTON: Waminda, being an Aboriginal organisation on the South Coast, as Mel has said, we're Aboriginal women led. For us, we have been in operation now for 39 years in our community. That's a long time. Through those 39 years we've fought to keep Waminda open. Being a women's Aboriginal service, it's been really difficult and really hard. I believe that in the last 10 years—I have been at Waminda now for 15. Talking about capacity, when I first came I was a receptionist. Now I'm the executive. Next year the CEO is moving sideways and us four executives will be running the organisation. We have 150 staff. We come from, when I was there, eight to 10 and that was pretty much how big Waminda has ever been. When Mel talks about Birthing on Country, it's so true. Birthing on Country cannot exist without Waminda, because Waminda is about community, it's about truth telling, it's about reclamation, it's about community. Our community own Waminda.

When we talk about the 150 staff, 75 per cent of us are Koori. That's our community that we are working in. When we talk about Birthing on Country and when people talk about that being the answer, the reason why it's the answer is because it's us. It's what we want it to be and what it needs to be. We have the answers for that. For us it's like a no-brainer. Especially being strong, staunch Aboriginal women, it's taken us a long time to find our voice, to find our platform and we're not going to let that go. For us, when talking about making decisions for our people, we have to be involved in that and we need to be the ones who lead that.

We need those people beside us to walk that walk. When people talk about Waminda and what we're doing and saying Waminda's the answer, but it's the community. The community's the answer. The community has the answers. For us, we feel very proud and honoured to work in Waminda and the work we're doing and having Birthing on Country and being able to build our own birth centre and going back to our culture and being able to do our cultural practices and have that part of our birthing. That's amazing. For us, that's what the work is about at Waminda.

Like Mel said, it's that holistic wraparound organisation. It's not only working with birthing; it's working with the woman when whatever she brings, whatever she is carrying in her life, in her family. She might be struggling with money, so she needs support with housing. She might need support with her other children at school. There's multiple different issues and challenges that us as Koori people face every single day. When those women come to our service, that's their service. What do they need? We just hold the space. I feel like when people say Waminda's the answer, the answer is the community. Communities know what they need; they just need people to support them to create structures and governance and then they can do the work. That's what I believe Waminda is and does.

Dr AMANDA COHN: Where does Waminda currently get its funding from?

CLEONE WELLINGTON: Both. We get Federal funding. We've got over 60 buckets of funding, of money. Federal, State, regional—we get it from everywhere. For us, the reason why is because we don't work in silos. We don't work in buckets. It's taken a long time for government departments to actually get their head around that as well, to understand that if we are running a DV program, we can't run the DV program without the counselling. We can't run then—we can't have the counselling then without seeing a doctor or an Aboriginal health practitioner. We then can't run that session because if she's going to heal she needs to heal.

What does it mean to heal? Well, it means she needs to connect to her culture so then we have women's gatherings and we have language sessions. Or they go to the gym—we have a gym. For us, our funding comes from all different levels of government. For us, we're getting to a point where it's like—we want to get to a point where we have some sort of self-sustainable income but at the end of the day, we still believe that government has a responsibility to Aboriginal people or First Nations people so for us, we get money from everywhere that we can to run what we need to.

Dr AMANDA COHN: My question is to all three of you. You've spoken about the importance of having Aboriginal staff and Aboriginal health practitioners in a variety of professions, and I know that was in the submission as well from the AH&MRC. What are your recommendations to us about how we can better support the development of that Aboriginal workforce?

MELANIE BRIGGS: I believe there needs to be a three-way partnership. It needs to be a tertiary, an ACCHO and hospital setting because at the moment—and also that pathway into tertiary-level studies. The AH&MRC have an Aboriginal health practitioner course they run. I won't speak on behalf of you, Shana, but they do that. They have a pathway. We need to utilise what's currently there. We have a pathway into university. We have universities that facilitate Bachelor of Midwifery degrees, medical degrees—all degrees. Those universities then need to recognise lifestyle factors of Aboriginal people and also the content they are presenting to the students as to whether it's appropriate—around racism, colonialism and all of those things.

Then there's supporting students to have placements within ACCHOs and also funding to support ACCHOs to facilitate student placements because at the moment universities do place students in ACCHOs but not as much as they should. For Aboriginal students, it's really important because of their cultural safety and their cultural identity. We know that being within a mainstream system can be very debilitating for our people because we are seen as tokenistic. That's not safe for the patient or the staff member—that's just my view—so I think that it needs to be a three-way triangle partnership between those three.

SHANA QUAYLE: The AH&MRC work with a number of Aboriginal medical services across the State, as we are the peak organisation for our member services, and although Waminda have 60 buckets of funds it's not the case for ACCHOs across the State. It's not consistent funding at all. We obviously know that Commonwealth funding, through AIHP funding, is the core funding for these services but this only provides funding for a GP and an Aboriginal health practitioner. There is very limited funding for the places that the services are required to actually operate from and it is the service's responsibility to then generate income to be able to provide further services to their respective communities.

When we're looking at Aboriginal health practitioners and training the local community, we also lose those staff members to local health districts who have further funding to be able to provide to that person, so the pay parity needs to change. We have to look at, you know, the pay scales of ACCHOs, which operate off the Aboriginal Community Controlled Health Services Award—I can send it through later. So there's pay parity and obviously supporting the sector to be able to retain their staff but, again, as Mel was stating around relationships and partnerships with universities, it's so crucial that when they're going through and doing midwifery that there is placement in a culturally safe organisation. That way they're learning Aboriginal people's ways of knowing, being and doing and will be able to support communities in every single way possible, from a holistic approach. There's a number of things that we could be doing to support the retention of staff and increasing maternity services. Sorry, I rambled.

The Hon. SARAH MITCHELL: Thank you all for coming. My question follows on from that. We heard earlier today from some witnesses about the importance in ethnically diverse communities and CALD communities of actually going out and talking to people—whether it's school students—"Have you thought about a career, not just in nursing, but in midwifery specifically?" so you get better representation of different communities working in hospitals, in health systems and in organisations like yours. Do you think that's something else that there could be support for? I think you said that the AH&MRC do some training in specific courses, if you want to tell us a bit more about that, but would it help to raise awareness by saying, "This is a good career. These are some of the ways we could help you. This is how you could look at scholarships"? Is that lacking at the moment? Is there something in that space you see, particularly on behalf of First Nations communities?

SHANA QUAYLE: I think there is an opportunity to provide further scholarships, particularly for Aboriginal health workers and Aboriginal health practitioners. From the AH&MRC's registered training organisation's perspective, we don't really receive any core funding to be able to provide further workforce training opportunities for the sector. At the moment, we are providing the certificate IV in Primary Healthcare Practice which assists in becoming an Aboriginal health practitioner, but from there there's not actually any model around supporting further training and upskilling opportunities for the sector.

MELANIE BRIGGS: Can I just add to that? We actually used to be funded for a program that went into schools and talked about opportunities and healthy relationships with their own bodies and things like that to support the young people in community to really value themselves and have healthy relationships with themselves. That can then become self-determining for them when they do choose to have a baby or do choose to become a family. We used to have funding for that. I'm not sure what it was called but that no longer exists, so obviously there is an opportunity to go into schools and do healthy programs for youth. We also have youth programs at Waminda where we go in and do talks with them about what relationships are and things like that. Around the employment side of things, we just held a massive evening where we invited community on a recruitment drive and we had—how many participants?

CLEONE WELLINGTON: Twenty participants.

MELANIE BRIGGS: We had 20 participants that showed up and every one of them got a position at Waminda, whether it was casual or part time, and they were young people just leaving school. We saw the need in community that people wanted to be employed, so there's definitely an opportunity. I would highly recommend education and body education from ACCHOs or Aboriginal practitioners, and what we are doing for schools in year 10 to year 12 around work experience, placement and things like that.

The Hon. SARAH MITCHELL: And that pathway, presumably?

MELANIE BRIGGS: Yes.

CLEONE WELLINGTON: Yes, very much.

The Hon. EMILY SUVAAL: Thank you to you all for appearing today before the inquiry. I understand some of you have travelled to be here. My question is to Waminda, but I invite you, Ms Quayle, to chip in as well in terms of your perspective around this. I understand, from the NSW Health submission, that Waminda is working with NSW Health to implement the Birthing on Country within the Illawarra Shoalhaven Local Health District. I invite you to comment on what that process has been like for you and also on what additional things we could be doing right now within health services across New South Wales to ensure or enhance culturally safe care?

CLEONE WELLINGTON: That's a big question.

MELANIE BRIGGS: That's a great question.

CLEONE WELLINGTON: I'll let Mel talk to it as well, but, for us, the journey of Birthing on Country—when I talk about Birthing on Country, that's just what I'm talking about. There have been many stories that are similar to this, to other programs that are within our organisation, but it took us seven years of lobbying—seven years of back and forth to this place, to Canberra, meeting with Ministers, meeting with secretaries, meeting with NSW Health, meeting with our local health district. It has been a really rigorous and really complicated journey. Now, it hasn't been complicated for us because we've been like, "We know what we want, and we know what we need; we just need people to get on board." What has been the biggest challenge for us is actually talking about that and trying to convince that we actually have the right to have a birth centre. We've even had comments of, "Well, you're going to have dead babies." Pretty much that's what people have said, directly to us.

For us, it's talking to people who possibly were sitting on the fence and were like, "Well, I don't know about this. I don't know if this is going to succeed." Over those seven years, that's what the conversations have been, back and forth. We created over 1,000 documentations just to prove ourselves—that we can do this, we're more than qualified, we've got the skill and we've got the governance. That was another thing that came up against us. They took on board our past history. When we were quite a bit smaller as an organisation, we went through a lot of challenges, and people still thought that we were back there. They didn't realise how much we've grown and how much we've changed. I feel like it has been a journey but it has been a journey of educating people, bringing people along with us and pushing back.

For us, when we talk about pushback at Waminda, it's a two-way relationship. We're actually teaching people as we go along. When you talk about cultural safety, that is massive for us. Wherever we go, that's number one on the agenda, every time. For us, when we're talking about Birthing on Country and when we're talking about our birth centre, that is actually built from culture. That's the very foundation, as well as what Waminda is. For us, when we talk about NSW Health and you're talking about Aboriginal health practitioners, even for me, I think, "When Aboriginal health practitioners are in the setting of NSW Health, they're not always valued at what they can do and their skill level, in comparison to what they can be in an ACCHO." For us, our Aboriginal health practitioners are doing way more clinical than what our other Koori people are doing in NSW Health.

I believe there's a lot of work to be done within NSW Health. It can be done, though, and I feel like we've started down home. We run something called cultural immersion or decolonisation workshops. It's where we actually go in as an organisation. Our local health district have paid us, and I think we've done about five or six different sessions with their executives, their managers and then all their staff on the ground. We've educated people on impacts of colonisation and what it is to be an Aboriginal person and then talk about white privilege and talk about white fragility. It's not just the hospital; I mean, everyday life for us is unsafe because of colonisation and because of racism. It's in the systems. That's systemic racism. For us, it's really important that as an organisation we keep bringing that to the table and we keep having conversations about that and calling it out.

We know it can change. We see it. We see it before our own eyes. We see people who go through a cultural immersion session, who knew absolutely nothing about Aboriginal and Torres Strait Islander people, let alone know the local history of where they've lived their whole life. They say they're third or fourth generation and it's like, "Well, you can't compare that to 65,000-plus years." But when we sit in that space and we're open and we're honest and we have those conversations, then people walk away and take their lenses off, and they can't see it any other way; they can't ignore it. I feel like that responsibility then is a part of everyone, it is a part of that work, and they've got to work towards cultural safety. Yes, we lead it, and we say what it is, but then it's up to the other people who are non-Koori, non-Aboriginal. They're the ones who have got to make that effort on that cultural safety, because it isn't us; it's everyone else. I believe that's the problem with the system.

MELANIE BRIGGS: Everything that Cleone has just said.

SHANA QUAYLE: I think I could add to that, if that's okay. Generally, the LHD constitutions are required—no, sorry, not a requirement; it's along the lines of, "Where possible, there should be an Aboriginal person that is a representative on the boards of LHDs." I think broadly that needs to change to ensure that there is Aboriginal representation on local health district boards to ensure that it is good governance and that there are Aboriginal people informing policies and processes around health care and accessibility for Aboriginal people in their respective communities. Additionally, there is mandatory training.

Obviously there is Respecting the Difference within local health districts, but a recent mid-term evaluation of the Aboriginal Health Plan showed that there was only—there are two components of that, 86 per cent of which was online training and was completed by NSW Health staff, and only 44 per cent actually attended the face-to-face training, which is obviously problematic in itself. I think you would receive more out of the face-to-face component than you would from the online components. I think the work that Waminda are doing around cultural immersion—sorry if I pronounced that wrong.

CLEONE WELLINGTON: No, you're all right.

SHANA QUAYLE: It needs to be localised to the community members. It can't just be a one-toned training, and it doesn't fit across the whole State. It needs to be worked with by community members and continually updated as well.

MELANIE BRIGGS: Can I add to that? There's no ongoing unlearning within the system; it's continuous. You can go into your training and tick that box, but then you go back into a service where you are a majority. We are really small in terms of that beastly system—so definitely decolonisation, imperfect ally workshops. Back to Birthing on Country, for the last seven years, as Cleone was saying, we have developed over 1,000 documents. We look at other programs that we've brought—nurse-family partnership, for example. These programs have not been developed from the ground up, from community; they have been imported and implemented into community, which haven't been successful in some communities. Birthing on Country is actually an opportunity for Australia to have its own developed community-controlled maternity program and—where was I going with that? I was going somewhere. So seven years is a very long time to be talking to people.

The Hon. EMILY SUVAAL: It is, yes.

MELANIE BRIGGS: We've conducted five risk assessments, risk matrixes. We've developed business cases—multiple business cases—with very minimal feedback. We've got the solutions. We know that Birthing on Country and the model in which it fits within Waminda works. We had a risk assessment with the Ministry of Health. The recommendation to the local health district, the Ministry of Health, would be that they need to facilitate open arms when it comes to implementing Birthing on Country within the system, because at the moment there are too many barriers, too many challenges and too many things that we've actually had to develop along the way to get here. How many risk assessments do you have to do? Who needs to have the risk assessment done on them? Is it the ministry? Is it the local health district? Is it the obstetricians? Is it the midwives? Is it the front desk? It is everything. It's exactly what Cleone said: We are not the problem; it's the system that doesn't allow us to be within it.

The Hon. EMILY SUVAAL: In terms of the system, you've articulated many barriers along the way. Was there any one thing in particular? And I commend you for your work in terms of not relenting and continuing with that conviction around knowing what you want and what is right.

MELANIE BRIGGS: Thank you.

The Hon. EMILY SUVAAL: Obviously, I would hope that you have in some ways paved the way for others to follow and that there are many other local groups out there like Waminda within other LHDs that could indeed continue with that fantastic work. Do you have any suggestions for how that scalability works, or what those significant obstacles were and how to overcome them?

MELANIE BRIGGS: Well, I can name a few, yes. Our administrative policy for—Waminda-employed midwives are seen as privately practising midwives or visiting endorsed midwives, and there have been a couple of barriers with that. One is the policy for privately practising midwives accessing public hospitals. You might have heard of those problems over the last few sessions, so that applies to us as well. In order for us to be able to access—okay, so I'm an endorsed midwife, so I am trying to apply for credentialing to admit women into the hospital. The barrier is that only one hospital that I am aware of in New South Wales does it right now, so that's challenge number one.

The guideline into the policy was the first problem, and now there's only one hospital that does. Now we want to roll it out to all the hospitals, so how do we actually do that? They've changed the policy so that privately practising midwives can now have access agreements with local hospitals, local health districts. Now what needs to happen is those local health districts now need to develop—I think they're calling it VEMs or visiting endorsed midwife policy that outlines how that will work. That is relationships. You've got to have good relationships with the other party to create a really beautiful document that will work for both, for everybody. That's been a challenge, and then you've got the credentialing. To apply for credentialing is massive; it's a huge document. Our team are going through it at the moment, and it's almost like you have to write your life story all over again.

The Hon. EMILY SUVAAL: Is this the credentialing to become an endorsed midwife?

MELANIE BRIGGS: No, that's another. There are many layers. Credentialing is an application to the hospital to say, "I'm endorsed. I want to start providing intrapartum care in your service. Will you please allow me to do that?" That's what we're going through at the moment. That will be done at the end of the month, and that's just one. There's the policy, and then there's the credentialing, and then there are the local policies. You could write a book on this.

There's the policy, and then there's insurance. There's only one insurer for privately practising midwives in the country. You would have heard about this as well, I'm sure, over the last few inquiries about insurance. It's a major problem. Midwives who are employed by the government are insured by the government. Midwives who are not employed by the government are employed by one organisation that provides insurance cover for privately practising midwives, and it's quite expensive.

What we want to do at Waminda is have an organisational insurance policy that covers midwives providing intrapartum care within the public health service, so we've had to then negotiate with our insurer to provide us a package—which is very, very expensive to the government too because we have to get grants from the government to support us to pay for insurance. There are so many layers to this, but we've done it. We obviously have to pay for insurance because this is what the women want. We have to always remember that the reason why we are sitting here today is because it's what the women have been saying. It's what they want, so we have to make sure that we're getting it done. So insurance is definitely happening.

The Hon. ANTHONY D'ADAM: What type of insurance are you talking about?

CLEONE WELLINGTON: Intrapartum care.

SHANA QUAYLE: Professional indemnity.

MELANIE BRIGGS: Intrapartum professional indemnity insurance, yes. Yes, that's a major issue. It's costly. This is not for us but for midwives who are wanting to do homebirths; there's no professional indemnity insurance for those midwives either. A lot of the women who are walking into privately practising midwives' offices or coming into their homes can't provide a full ironclad service because there's no intrapartum homebirth insurance package. It's a major issue for those midwives that want to just work in homebirth. And then—oh, my goodness, there's—

CLEONE WELLINGTON: But on top of that, as well, with the insurance, even for our midwives that we employ, what they've actually came back and told us is that each individual midwife still has to have their own insurance.

MELANIE BRIGGS: On top of that.

CLEONE WELLINGTON: On top of that. They expect us to take out this massive policy of insurance as an organisation, and then also they expect the women we employ under our insurance to actually have their own insurance as their own practising midwife on top of that. That's a major, major cost. I know if I was a midwife, I wouldn't want to pay my own policy of insurance. I should be covered by my organisation who I'm employed by. That's a major concern.

MELANIE BRIGGS: Yes, that's what government employee midwives get. They get insured and they get a wage.

CLEONE WELLINGTON: And that's because they're private practising midwives.

MELANIE BRIGGS: Midwifery continuity of care—we don't have an MGP on the South Coast. The closest MGP that we have is Wollongong Hospital that's publicly funded, so we will be the only MGP service in Shoalhaven come February—well, now, but February. The women will have their own known midwife providing that whole care from pregnancy confirmation all the way up to six weeks postpartum, including intrapartum. Waminda will be the first ACCHO in this country that will employ their midwives, have intrapartum insurance cover and be able to admit women into the hospital for their births. We will be the first, which is great.

The Hon. EMILY SUVAAL: It is. Again, thank you. I commend the work that you've done so far. It doesn't sound like it's been at all simple or straightforward, but it's wonderful. What a great initiative.

The CHAIR: Melanie, I think I read—and correct me if this is wrong—that you're the first endorsed Aboriginal midwife in New South Wales.

MELANIE BRIGGS: In New South Wales.

The CHAIR: And that was in 2020.

MELANIE BRIGGS: Yes, I think so.

The CHAIR: And you're the second in Australia.

MELANIE BRIGGS: At that time I might have been. Yes, I think so.

The CHAIR: It sounds like there's a desperate need to get more Aboriginal people as endorsed midwives. How do we encourage that so that we have more diversity in midwifery care?

MELANIE BRIGGS: I think it relates back to capacity building from the ground up, so going into high schools, encouraging work experience placed in with our programs. It's also going out to high schools—exactly that—and explaining what we do, talking about it. I know that when I did do it back in—so many years ago, maybe like five years ago or something—the girls would come up and say, "How do I become a midwife? I want to be a midwife." I would support that link between how to, say, at any university and just encourage them to go to a university. But the steps to that would be—obviously, schools have career expos, so facilitating going to those and encouraging young people to become midwives in that space.

And then what do we do with the young people that don't get an ATAR of 99-something? What is the pathway then? It's obviously programs like what the AH&MRC have pathways into. You can then have an Aboriginal practitioner with a maternal and infant component, which is what they do in South Australia, where then they work in that space and then they can have RPL—recycled prior learning—when they go to university, say. They may not get a lesser time to complete their studies but they'll have worked and lived experience in it. We also have to think about the impacts of colonisation on our people in education systems and why our people don't retain all the way up until year 12, so thinking about that when we are actually asking our people to go into university and study midwifery—"What lived experience do you have?"

I know we said we wouldn't put names and stuff out there, but Jumbunna at UTS, the Aboriginal pathway program there—I was supported through that as a mature-age student for my studies. It's also about that. Also, mums that are returning to work—there are opportunities there, pathways. What are universities doing to support that? Talking about that, mature-aged women go off and have babies sometimes and they have a responsibility to look after their families. Then they want to come back into the workforce. What are we doing to support those women financially? What grants are we providing to those women who want to come back into the workforce? There's a lot to think about, but we can't do it all in one day.

The CHAIR: In regards to the Birthing on Country model that's implemented in the Shoalhaven, obviously this is the sort of program that we need to expand to other areas around New South Wales. What are the barriers to actually expanding that program and making sure that it's statewide?

MELANIE BRIGGS: I'll just do a disclaimer: Not all communities will want Birthing on Country. We need to be very mindful about—we're not one-size-fits-all peoples. We're all different and we all have different needs. What works at Waminda is what we do, right? I think it's important to use frameworks that have been developed, such as the RISE framework by Kildea and Roe, where it sets out how to implement a Birthing on Country model in your community, because what we need in that RISE framework is absolutely different to what's needed down the road. You know, like, it's individualised.

The CHAIR: They're all unique.

MELANIE BRIGGS: Yes. And Birthing on Country is every single component, but the gold standard is what we're developing, what we are doing. There's all that. You want to get to that. Each community might only want to have midwifery, they might only want to have a sexual health worker. There are just components that they might only want for now. I don't know, but that's my take on that question.

CLEONE WELLINGTON: I think it's important to take that into consideration, though. Like you said, it's not one size fits all. I feel like that happens a lot in government: You roll out programs and you do pilots and then think, "Yeah, we can take that and we can put that there." It's like, "No, you can't." You can take components of it and you can take it to other community members and say, "What do you think about this? How does this look? How would this look for you?" For example, we work with the wonderful women from Galiwin'ku, which is up the top end of Northern Territory. They're part of this BOOSt project as well. For them, they look at Waminda and they're like, "We need our own women's service. That's what we want." But also they want birthing as well, but then it's like first steps. What's the first step? What is it that you want to establish? What are you already doing?

When we spoke to those women, there's a lot they were already doing. They just need someone to give them resources, to give them flexibility within policy in the NT, because there are some things that they've—there's definitely barriers for them, too. I can't speak on behalf of them, but they've shared that with us. Every community is going to have different things that they need, but we need government to be flexible with that and work with the communities with that. But definitely you can look at what we're doing with BOC and then take that to another community and say, "What do you think about this? What are the things you like? What are the things you don't like? How would it differ in your community?" I think that needs to be a reminder.

SHANA QUAYLE: I believe that there is also another program as well, Aboriginal Maternal Infant Health Service, that we have been trying to push for through the Close the Gap national agreement, through the budget bid process in partnership with NSW Health. We would have liked to have seen an expansion. It has been stuck in limbo for the last two years around a scoping project to have a look at what services are available for maternal infant health and antenatal care. Just the expansion of these particular services that already exist is so crucial.

There's evidence there that these services work and there's a need for them. It's just investing in the community controlled health sector to be able to deliver these serves to our people.

The Hon. EMILY SUVAAL: Ms Quayle, sorry to interrupt: Is that mentioned in your submission anywhere?

SHANA QUAYLE: I don't believe we've referred to AMIHS.

The CHAIR: Ms Quayle, I also wanted to have a look at some of the recommendations that you've made in your submission and also in your opening statement. I was just hoping we could talk through those a little bit. I'd be quite keen to get some thoughts from Ms Briggs and Ms Wellington, too, in regards to what you would like to see as recommendations to the Government as part of this inquiry, coming particularly from this hearing.

MELANIE BRIGGS: Well, we want Birthing on Country, would be number one. We want to be able to have cultural safety ongoing for all people working in mainstream services, especially in terms of maternity. We want to be included in decisions when it comes to making policy about our birthing women—and also around Department of Communities and Justice removing our children. It's really important that we're involved in those discussions and those policies, because we know that women, when they're going into birth, they're thinking about these things—"Is my baby going to be taken?"—because the system does that. That's another thing. Like a national—not national but New South Wales, sorry; I keep saying national—a framework to support that triangle sort of partnership approach from ACCHO, university and hospital sort of relationship, you know? What is that? Like, we need to actually formalise something like that. More Aboriginal midwives, more Aboriginal doctors and more Aboriginal people working in services in mainstream.

SHANA QUAYLE: I think, broadly, just implementing the priority reforms under the national agreement. Obviously, the Productivity Commission did a review on CTG and how governments are implementing those priority reform areas, but we're yet to see any improvement around how they're implementing things. Invest in the ACCHO sector, that's all we ask: investment through funding of resources, human resources. There's evidence there that the Birthing on Country model works, through the systematic review that was done. Invest.

CLEONE WELLINGTON: Yes, and it always goes back to—we've got to stop comparing Aboriginal and Torres Strait Islander people to everyone else. We have got to stop that. We are who we are. We have the challenges that we have and—let's be real—the challenges come from colonisation. So that needs to be at the forefront of everything that happens and comes from this inquiry. And when we are talking about our Aboriginal women and Torres Strait Islander women, let's talk about intergenerational trauma. Let's talk about transgenerational trauma.

When we're sitting here and it says "birthing trauma", and I was actually in—I'm going to say it. I was talking to Mel earlier, and I remember being on a panel online, and Mel and I talked about what it is to be an Aboriginal woman and the traumas that we have, and then another woman—a non-Koori woman—turned around and said, "All women have trauma," basically. And it really infuriated me, because you can't compare the trauma of an Aboriginal woman to every other woman. And I'm not dismissing every other woman's birthing experience. Of course, it's significant, and it's valued, and it needs to be heard. But we need to be heard, as First Nations people. This is our country, and what we go through, every single day of our lives, needs to stop.

And that, for me, is the biggest thing that comes from any inquiry. Today we are talking about birthing. Birthing is connected to the justice system. Birthing is connected to the education system. It all connects. So when we sit here and we're talking about deaths in custody and we're talking about our children being removed, they all connect. And, for me, that's another thing that should come from this inquiry. Yes, this is about birthing, but look outside of the birthing. What else impacts the birthing trauma of Aboriginal women? What's their birthing trauma? Because their trauma is multilayered and multifaceted. There is so much more. So I just want this inquiry to remember that. When putting out recommendations and outcomes and whatever the findings are, you remember that.

The CHAIR: Thank you for sharing that.

The Hon. SARAH MITCHELL: This follows on from the intergenerational trauma you just touched on. "Is my baby going to be taken away?" These are very real feelings that Aboriginal mothers giving birth in hospitals will be having right now. It is not, in that sense, historical. I think that's really useful evidence for the Committee, because we talked before about making sure the medical workforce is aware of past trauma. We were talking about it in the sense of birth trauma but, to your point, Ms Wellington, it's so much broader than that for Aboriginal women. I think that's something the Committee really need to be cognisant of. It is not just a matter of previous birthing experiences that did not go to plan; it is much deeper than that, and we need to be cognisant of that with our recommendations. So thank you. That was more of a comment than a question.

The Hon. EMILY SUVAAL: I have a question around the current training. Ms Quayle, you mentioned statistics around NSW Health training. You made some suggestions about having a requirement for someone of an Indigenous background on the board. I wonder whether there are any other practical suggestions you might have that could form recommendations from the Committee. I know, Waminda, you talked about the training that you have done with Illawarra Shoalhaven Local Health District. That is an example of one LHD that has started that work. Would that be useful? I just invite your comments on how we can practically make sure that this education and information is better disseminated within the workforce.

CLEONE WELLINGTON: I was just going to say, yes, it is true. There is Respecting the Difference training, but I feel like—exactly what you said—it is not localised enough. What happens is, in that training, you can be online or you can be in person. I've actually spoken to an Aboriginal woman who used to run them, many years ago, in our health district. She talked about how unsafe it was for her to run them because it was just her in front of all these non-Aboriginal people, and you got really racist comments coming from her staff talking to her. And it was really sad to hear that. When we met with her, she talked to us about how she then had to go back to her non-Koori manager to then try and explain what that felt like. Again, she was culturally unsafe. So, for me, if you're going to do training, what works best is if it's external—if people are coming in. For us, as Waminda, as an Aboriginal women's service, that's what we're coming in as. We are coming in as community members and we're training and we're teaching people and we're educating people from our community who are working with our community. You can't get better than that, because it's the truth and it's raw.

I feel like Respecting the Difference is just one layer. For me, if I speak openly, that's surface layer. It needs to go deeper than that. I'm not saying get rid of it, but that's the start—but then what's the continuation? Like Melanie talked about earlier—tick-a-box stuff, or people do it once and then it's done. There needs to be continuous training, because when we talk about Aboriginal history and when we talk about the truth of this country, it isn't taught in our schools. We were just talking to one of our staff members at work before we came up here, and she talked about how her child is doing this assessment where they have to choose either a settler or all these different people who were the discoverers and then do an assessment on that. It's still being taught in our schools that this country has been discovered. When I think about the truth and when I think about history, it's not taught in our systems, and it's not taught in the institutions. So, for me, we're doing it backwards. There needs to be the training. It needs to be mandatory. It shouldn't be a choice. You should have to go and you should have to sit there and listen.

The Hon. EMILY SUVAAL: Is this the face-to-face component?

CLEONE WELLINGTON: That's right—the face-to-face. You can't get better than face-to-face. Online isn't good enough. It just doesn't hit home in the way it's meant to and, definitely, you need that localised voice and you need the local people to talk to that and what that means. For instance, down home, we've got the Bomaderry homes. The Bomaderry homes is the birthplace of the Stolen Generation. All the babies that were stolen, that were taken in New South Wales—even Queensland and Victoria—were all brought to the Bomaderry homes, which is in our town, and people don't even know that, who have lived there their whole lives. It's not good enough. So, for me, you have to have that localised view because those health workers are working with community. That community is walking in. That's who they're supporting and that's who they're meant to be giving care to. So for them to give the best possible care that is culturally safe, they have to learn from the community and from the Aboriginal community that's there. So, for me, it has to be not just a tick-a-box. It has to be continuous, and it should be mandatory—all that training.

MELANIE BRIGGS: And paid for.

CLEONE WELLINGTON: And paid for, yes, for people to come in.

MELANIE BRIGGS: Because we know exactly that. It's 100 per cent that. But, you know, it has to be paid for. It's knowledge. It's intellectual property and it's our people's lives. We've always been asked to come in as a last-minute thing and just expected to do it on behalf of the organisation, but it needs to be a paid workshop. Also, there needs to be a position or a role within the local health districts and in each hospital where there is a cultural mentor and there's a person there for the Aboriginal staff to actually—it needs to be a paid position. At the moment we have Aboriginal liaison officers, but they don't have support services around them. They sit within social work departments and with other non-Koori staff. It's a very siloed position and a very unsafe position. There needs to be continuous, mandatory unlearning—and paid for.

CLEONE WELLINGTON: And then, when you talk about the liaison officers, they're one person in a hospital. That's not enough either.

MELANIE BRIGGS: It's not enough.

CLEONE WELLINGTON: I think one part of the cultural emergence and the outcomes that we did with our local health district is we talked about employing Aboriginal health practitioners in the ED. They're your go-to person. They go and meet with the Aboriginal patients that come through. And then have more than one person employed. So, if you're going to have a traineeship, have two or three. But then, after the traineeship, have an actual position available. Don't just have a traineeship for 12 months and then have no employment at the end of it. And then, like you said, you've got to have more than one person. I mean, we expect one liaison officer to see all of our unwell community members. That's not fair. It doesn't work.

The CHAIR: Thank you all for coming in today. Your evidence has been extremely useful. If any questions were taken on notice or if we come up with any questions afterwards, the secretariat will be in contact.

(The witnesses withdrew.)

Mr STEVEN KENNEDY, Founder and Executive Director, Prepare Foundation, affirmed and examined

Dr ALKA KOTHARI, Associate Professor Obstetrics and Gynaecology, University of Queensland, and Prepare Foundation Board Member, before the Committee via videoconference, affirmed and examined

The CHAIR: I now welcome our next witnesses. Before we begin this session, I remind witnesses to avoid referring to specific names, hospitals or medical facilities in their evidence and to speak generally about the issues raised in the terms of reference. Do either of you have an opening statement that you would like to make?

STEVEN KENNEDY: Yes, thank you, Chair. Thank you for the opportunity to share my story and advocate for greater inclusion of fathers in maternity care. In 2017 my son was born with an Apgar of 1 after an emergency caesarean section. I vividly recall seeing his lifeless body as he was handed to an emergency team. After 4½ minutes, he was resuscitated. I watched over the shoulders of the incredible humans saving his life, returning several times to the operating table to reassure my wife with words of comfort that I did not feel. In the lift on the way to special care, he needed resuscitation again. We shared skin to skin via my little finger and his clutched left hand through the humidicrib.

When he was six hours old, the head of paediatrics informed me that he had stabilised well. Her positive demeanour brought immense relief. Overwhelmed by emotion, I broke down. It was at this point I heard her say, "Dad's lost it. Get him a cup of tea." I was fortunate to stay overnight in the hospital, sleeping on a narrow bench. This opportunity isn't always afforded to many fathers in similar situations. Seeking support, I requested a visit from a social worker. We were told we would have to say it was for my wife, which we did. My initial experience of fatherhood was marked by post-traumatic stress and depression, a challenging time of extreme irritability, alcohol use and strained relationships. Today my son is a healthy six-year-old, albeit with behavioural concerns that have prompted visits to a paediatrician, an occupational therapist and a child psychologist. His assessment is ongoing. I can't help but wonder if his traumatic birth or my mental health struggles affected his development. I should point out that my son was born in a metropolitan hospital in Victoria, not in New South Wales.

My childbirth experience inspired me to become a subject matter expert in the topic of men at birth. In August 2020 I founded the social enterprise Birthing Dads. In November of the same year I established a registered charity—the Perinatal Relationship Education and Paternal Advocacy, Research and Engagement, or the Prepare Foundation. Both organisations support expectant and new fathers, providing vital information and resources to define the role of fathers in the perinatal period. Our work in no way detracts from the focus on mothers and babies. Instead, it enhances women-centred care. We aim to empower fathers to contribute effectively to this care as an essential aspect of overall family wellbeing. I have appointed an eminent board made up of distinguished leaders from the midwifery, obstetrics, parenting and psychiatry fields.

Over the last three years the Prepare Foundation has developed a transition to fatherhood package, a globally unique suite of online resources for expectant fathers. We have heard of staff shortages across maternity care in New South Wales, and fathers are an extra pair of hands that are currently not being utilised. If provided with targeted information, they may in time reduce the burden on our strained system. If continuity of care from a known midwife is the gold standard in maternity care, then continuity of midwifery care in addition to an informed and involved father is the platinum standard of maternity care.

I believe that no individual is to blame for the widespread issues we are discussing in this inquiry, or for the lack of care and sensitivity that I myself experienced. I extend my gratitude to everyone working in maternity care. Your efforts within a flawed system are commendable. Our society values emotional awareness in our men yet our maternity care system consistently undervalues, excludes and underestimates fathers, expecting them to resume normalcy after traumatic experiences. This stark contradiction highlights a fundamental flaw in our societal expectations. Lastly, my heart goes out to fathers navigating the perinatal period without the tools and the information to provide the support that we inappropriately expect of them. I hope for a future where dads are acknowledged as a valuable asset to women-centred care and society recognises that the birth of a child is a monumental moment for fathers as well.

The CHAIR: Thank you for coming today and providing that statement. I know obviously it has been very difficult for you but we really appreciate you being here and we were really glad that you accepted the invite to be here today. I know that there was strong support from the whole Committee to hear from dads as well so we are really glad that you were able to come today. We really appreciate that.

STEVEN KENNEDY: It's a pleasure. It is actually great that the Committee has actually invited a representative from the other half of this equation, so thank you all for that. I really appreciate that, and I think it is wonderful.

ALKA KOTHARI: Thank you for the opportunity to speak today. Steven is part of the reason that I am here today—Steven and other dads like him that I see in my practice. I sincerely applaud this initiative of the New South Wales Government, inquiring into this complex and distressing issue, which is obviously extremely important to the wellbeing of women and their families, including their partners. I am an obstetrician and gynaecologist and a clinician researcher, a current board member of the Prepare Foundation, and I am also on the governance committee of SMS4dads—the clinical advisory committee for dads group—and I have been on the board for the ABTA, the Australasian Birth Trauma Association, and their clinical advisory committee. Today I want to speak to the terms of reference 1 (c) "the physical, emotional, psychological, and economic impacts of birth trauma … on patients and their families and health workers" and also (i) "any legislative, policy or other reforms likely to prevent birth trauma."

As an obstetrician practising in various Australian healthcare settings for more than 25 years, I often witness the isolation of men, even today. I observe fathers being barred from the operating theatre in the case of a severe complication or when a general anaesthetic is administered to the mother. I have witnessed fathers standing in the corridors alone, wondering whether their partner and baby will survive. I have seen mothers and fathers share the burden of complex decision-making when faced with a fetal anomaly and grief after a fetal loss or stillbirth.

I have just completed my PhD on forgotten fathers in pregnancy and childbirth, which is a passionate journey from the heart and was born from these heart-wrenching experiences and a desire for change. My work is based on the experiences of cisgender heterosexual men partnered with women, and therefore I will use the term "fathers". My work has now expanded to include gender diverse partners, non-biological fathers and other family structures. I have also commenced on a four-year postdoctoral fellowship where I am developing consumer co-design educational strategies for healthcare providers to better support fathers and their families exposed to birth trauma and build and develop consensus statements and national guidelines in this space.

My work and this presentation are not intended to discount in any way the importance and experience of birth trauma for women. I work with them every day. I feel it enhances our knowledge and capacity to respond if we widen our lens to understand the impact of trauma on the whole family system. I would like to remind the Committee of the *WHO recommendations on health promotion interventions for maternal and newborn health 2015*, which highlight that men are essential gatekeepers and decision-makers. The WHO advises harnessing men's support and active involvement for improved maternal and neonatal health outcomes. Fathers also form an important untapped resource and support for women who have experienced birth trauma.

Currently, we have no systems in place for routine pre-conception care and screening for men's physical and mental health conditions. There is poor health literacy among men, and even the healthcare providers are not aware of the contribution of men to pregnancy outcomes. Poor sperm quality due to lifestyle behaviours, genetic factors, environmental exposures, advanced paternal age more than 45 years and paternal obesity all contribute to adverse pregnancy outcomes. We know nothing about the men who walk in the doors of antenatal clinics and our labour wards because we do not screen them for mental health conditions. We do not even acknowledge them properly.

In my PhD work, 99 per cent of fathers indicate an intention to attend the birth. With one in five people born overseas in our catchment area, with some of the families being First Nations, CALD and other gender diverse groups, they may have poor language skills, they may be financially struggling, they may have unique needs, and I think we need to really cater for them better. Obstetrics, as you know, is a very volatile environment and complications occur in approximately one-third of pregnancies. To give you an example, postpartum haemorrhage occurs in 16 per cent of deliveries, and unexpected resuscitation of a newborn, like how Steve was describing, can happen in 15 per cent of cases. This may result in inadvertent exposure to traumatic circumstances for families, with potentially significant long-term psychosocial consequences.

I also know that less than half of the partners may attend antenatal clinics and they may have poor knowledge of what to expect and how to support the mum in an emergency. I see underprepared fathers every day, and some of them may have never even held a baby before in their lifetime. They are fearful, they are confused, and they do not understand what is expected of them—what is their role in this whole childbirth. My research highlights that traumatic events considerably impact fathers' physical and mental wellbeing, resulting in grief, guilt, self-blame, fear, shame, stigma, anxiety, depression, post-traumatic stress symptoms and thoughts of self-harm. I know this because I've researched the fathers for the last 10 years. Most fathers struggle with healthcare communication, discussions with healthcare providers, complex decision-making—an example would be to make a decision regarding a termination—and relationship strains. Even three to four months after a traumatic event, a substantial proportion of fathers self-report ongoing distress, concerning high rates of crying and thoughts of self-harm.

Another worrying aspect is that the fathers most in need of support and counselling after a traumatic event, in my studies, were reluctant to engage with health services. Obviously, this raises essential societal implications because fathers struggling with significant mental health concerns may have ongoing responsibilities for caring for a vulnerable mother and newborn and other children, in addition to trying to put food on the table. Unsupported and struggling fathers may not be able to support traumatised mothers. Additionally, we know that children of fathers with mental health conditions and psychiatric illnesses have a significantly increased risk of behavioural and psychiatric illness, homicide and adolescent suicide. After exposure to traumatic circumstances, ongoing mental health support must be made available to both partners. There are also significant health service implications, because fathers are patients who need access, including mental health support. Unfortunately, we know that fathers are only treated as the next of kin of pregnant women, with no support systems built into healthcare services.

A stark example I will give you: as an obstetrician, if I have a family who loses a baby, I can't write a prescription for the father because he doesn't have a UR number—he is not my patient. What we need are specifically tailored, targeted, flexible and father- and partner-inclusive programs, improving engagement in the antenatal period and contributing to better preparedness for both partners for the birth. What this may look like is pre-conception screening and education of both partners. We know that pregnancy is a risk factor for domestic violence. We also need to screen for adverse childhood experiences. In one of our group's papers, meta-analysis has indicated that exposure to adverse childhood circumstances increases the risk of pregnancy complication by a third. We also know that complicated pregnancy is a recipe for birth trauma. Routine paternal mental health screening—and I cannot stress this enough. We need targeted, father-inclusive antenatal education and specialised information, including pregnancy, birth and postpartum complications.

I think it is really important to have a think about how we can deliver this information. I know that in my hospital less than half of the fathers would attend antenatal classes because the format, the timing and the way it is delivered is not conducive to them being able to attend. We must have individualised discussions about the father's health role and expectations in pregnancy, childbirth and postpartum, and individualised communication with healthcare providers because one size does not fit all. We need whole-of-family preparation for birth, and fathers need targeted information.

Obstetrics is the only specialist area of medicine where people like me perform procedures in front of family members. The experience of this can be quite distressing and traumatising. Imagine at two o'clock when you are shooed away out of the theatre where your wife is bleeding, and you don't know what is going to happen. The degree to which a coping style is adaptive or dysfunctional is individual, and it is influenced by background vulnerabilities and strengths. Often a gap between expectation and reality can exacerbate trauma.

As one of the fathers in my work said, "You expect this pregnancy to be a magical time where everything is perfect, and we don't have it." And we also know that trauma does not differentiate. It also results in significant collateral damage. As an obstetrician, I can certainly recall difficult experiences from my own career, including giving parents the devastating news of fetal demise when I have scanned somebody, delivering a dead baby at caesarean section, and performing a perimortem caesarean section. We need culturally sensitive and trauma-informed care to support control, choice and autonomy without compromising outcomes.

A decision to become pregnant, go through labour and delivery, and raise a family, is a partnership. Patients and their partners are also in partnership with healthcare providers. To improve outcomes, we also need to take a partnership approach. Based on health equity and social justice principles, we need inbuilt support systems to respond to the care and support needs of families. Obstetric services need a shift towards a community-academic partnership consumer-designed model design of care. There is no point having a service if the patients don't think that it is useful. These partnerships are essential to listen, acknowledge and learn from consumers' lived experiences to ensure their needs are appropriately identified and assessed. Furthermore, health services must develop, test, implement and evaluate solutions to address health inequities in partnership with consumers. In 2023, childbirth is fathers' and partners' business too. Let us recognise and support them as an essential part of the team. Thank you.

The CHAIR: Thank you so much. That was a really useful opening statement.

The Hon. SARAH MITCHELL: Thank you both for your evidence so far. Mr Kennedy, thank you, particularly, for being so open about something which is probably hard for you to talk about. We certainly appreciate you being here. I can tell by the way you talk about your son that you are a great dad. I am sure when he's old enough to understand what it meant for his dad to come to Parliament he will be very proud of you. Thank you for doing this. I am happy for either or both of you to answer. I wanted to ask more specifically about your recommendations. Dr Kothari, I think you said you are also involved with the Australasian Birth Trauma Association, who gave evidence on the first day of the hearing. I am interested to hear you talk more about the association, your foundation and NSW Health potentially working together to prepare some better resources to go out to families.

You talk about online support groups for fathers. Could you expand a little bit more on how you think that would work, what that would look like and if you have done some work already? Two points I got from your submission were how fathers can better support women going through pregnancy if they are informed, and that we cannot dismiss that birth trauma is also a traumatic experience for the father. Dr Kothari mentioned men watching their partner being taken away for surgery, not knowing what was happening, and there is your own experience with your son in the humidicrib. It is a tough thing for dads to go through as well and I don't think we should dismiss that as a committee—nor would we. Have you given much thought as to what those resources might look like? Has anything happened in that space yet?

STEVEN KENNEDY: Absolutely. Thanks for the question. I worked with the Australasian Birth Trauma Association to develop an A4-size bit of guidance around that. I have spoken to Amy Dawes, the CEO, about creating an online—what I am calling the—Dad Stress Initiative. That would be just a monthly type of men's group, facilitated by a psychologist—kind of a men's work expert. I have applied for four grants for that and none of them are successful so far, because I don't think anyone necessarily sees that as a big issue. I have spoken to the CEO of Bears of Hope, as well. That is a loss charity. It would essentially be a facilitated monthly catch-up where you can drop in and out. You can come in, you can tell your story and get support from other guys. Then there would be a WhatsApp group, so that they could be contactable outside of those times. So if a guy is going through a particular concern at some time, maybe he can post to that group—and with social media I am sure we could probably do it on other platforms as well.

But I do think that there are resources, in a sense, where it's kind of—and I have done this myself. I have created A4s and stuff like that. But I think men, particularly when there are sensitivities around it, if given the opportunity, they do share, they do actually open up in a safe environment. And so I think just giving them an opportunity in a safe environment, that's facilitated—just a monthly catch-up would be good. I am also working with a charity in the UK called 4Louis, and we are going forward with this, we are trying to fund it ourselves, a monthly catch-up for men who have experienced loss, because that is a real gap at the moment. So that will be a kind of international effort to get men from the UK and potentially elsewhere to come to these online sharing groups. Again, that's an informal kind of way that they—it would probably be driven by them. I don't know what it looks like yet because we haven't really tried it out, but I think it would be driven by them, and over time we might get a better idea of what the needs are of these men.

The Hon. SARAH MITCHELL: Did you want to add anything, Dr Kothari?

ALKA KOTHARI: Yes. In the research space, I've got a $10,000 grant to develop some online health messages to support the mental health of fathers, especially after traumatic events. And with SMS4dads we are doing some work where we are crafting messages for fathers who have been exposed to trauma. They have been received quite well. An example would be, "I hear that your baby has passed away. What supports can we provide you? Here is a link to PANDA, or here is a link to Red Nose. You may find these resources helpful"—simple things like that. Also, preventative messages, I think, are really important in this space. With the Safer Baby Bundle—you might be aware of it—we advise the mothers do not smoke, do not drink, sleep on the side, keep an eye on the baby's movements. SMS4Dads is providing messages to dads to say, "Hey, keep an eye on me. Make sure that I move, and don't steal Mum's pillow, so she can sleep on her side"—things like that. I think anything and everything that we can do in this space is really important, because if men are not supported there is no way they can support the women.

The Hon. SARAH MITCHELL: Can I ask one more question? It is a little bit different. One of the things we have heard, particularly from the women who have given evidence who have had traumatic birth experiences, has been about informed consent. Sometimes women in labour find themselves in a position where they suddenly need to have a medical intervention in the birth or a caesarean section. They may have been in labour for hours, and they are not understanding. Some have said that they found that process quite overwhelming and if they had had more information prior to giving birth they might have made different decisions.

We have talked with other witnesses about the role that fathers can play in the birthing suite by understanding what is happening, because they are not physically giving birth. Is that something that you think we could also look to improve, in terms of this information? I know you mentioned the antenatal classes and fathers attending. But also, if the woman is in labour—and your head is elsewhere when you are having your baby—what role can dads and partners play in terms of helping to make that informed decision as a couple, or as a family unit, rather than it being a less than ideal process?

STEVEN KENNEDY: The first thing we would need to do is actually increase the birth literacy of men and understand that they were involved throughout the process, so they actually know what her intentions are, so that he might be able to say something in that process of gaining consent and all she needs to do is say yes, instead of actually having to listen to it and be brought out of her process. So I would say that, yes, it's about increasing the literacy of dads. I don't like the idea of dads providing that consent. That's not—

The Hon. SARAH MITCHELL: Yes, but just doing it as a partnership sometimes or having that information—does that make sense?

STEVEN KENNEDY: Yes. Being involved in those conversations and being confident to be able to communicate to health professionals is really important because that is where dads feel the most helpless, because they might be talking about a forceps delivery and he is like, "What's that?" He has never really come across that before. He's seeing those instruments for the first time. And then, as Alka said, it's the only profession where you perform these procedures in front of the family member, so the dads can see, perhaps, that unfolding. He needs to understand those kinds of aspects—that that is birth. That is part of childbirth and it's a potential outcome. Alka, would you like to add anything?

ALKA KOTHARI: Yes, I'd like to add a couple things. Certainly, when I ran the antenatal classes, I would take a pair of forceps and a vacuum with me and I would leave it on the table and I would say to dads, "Sometimes this is what we have to use in the middle of the night when your baby is struggling. You're welcome to touch it, feel it, ask questions, feel comfortable about it so that it doesn't come so much as a surprise and it's not as frightening, and we do have to do things but forewarned is forearmed. If you know about it at least you're a little bit prepared."

The other thing that I need to make a point about is consent is dynamic. What you may have consented to before may not apply five minutes later or 10 minutes later, and the woman is allowed to change her mind. An example was last week—for example, I was doing a caesarean section for a breach presentation and, as the epidural went in, the baby flipped around, became cephalic, and I reconsented the couple. I reconsented the patient and I sought consent from the dad as well because the situation had dramatically changed. The indication for a caesarean section no longer existed. So I really want to make this point very strongly that consent is dynamic and it has to be sought at multiple times as your situation changes.

The Hon. EMILY SUVAAL: Thank you, Mr Kennedy and Alka, for appearing today at our inquiry. The evidence and your opening statement—I really want to commend you for that and thank you for the input. It's an important part of the recommendations that we'll form. I wanted to ask you a little bit more about the antenatal education and screening that you've obviously talked about earlier, and seek your views as to your suggestions for our inquiry in terms of the recommendations we have to make about this antenatal education. I know, Dr Kothari, you mentioned making it individualised. How would that work in practicality? You've also mentioned examples of bringing forceps and a ventouse into education, which I think is commendable. How would we ensure that that was delivered in such a way as to strike a balance between providing enough information about the potential risks and things but also not alarming at the same time?

STEVEN KENNEDY: I think antenatal education as it currently stands doesn't meet the needs of modern fathers. It doesn't really explain birth support. It doesn't really kind of go into details of how he can be helpful. Even when it's actually targeted at men, they talk about fatherhood more than actual pregnancy and birth support. For example, down in Royal Randwick they run a session down there, and I went along one time and it's run by an ex-Wallabies and he's a big fella who just kind of says a lot of jokes and a lot of clichés and stuff, and that's their antenatal education. If you really want to provide antenatal education, it's very difficult to get men to engage in a hospital setting, I believe—like targeted for them. Because they've got all other kinds of things and there's actually a lot of culture that we have to change before they come out of the house to talk about childbirth or to listen to childbirth. That's why I've developed everything online, so that they can do it in the comfort of their own home at their own pace. Of course, I'd recommend that you encourage fathers to do my program, but I'll pass over to Alka now.

ALKA KOTHARI: I think that one size will not fit all. We know—and I know this from my own research—that younger, educated fathers have very high information needs because that helps them to feel more in control to plan their life and do what they need to do. So the format of antenatal classes has to be consumer co-designed. You have to ask fathers what they would like, how they want their information to be delivered, how much information do they want, because, like you said, we really need to strike that delicate balance between too much and too little information.

We also perhaps need to invite people like Steven and other men who may have had good births to share their lived-in experience to talk about it. I think some of the work being done by other organisations is really helpful in this regard, because you have this man come in—they come and bring their baby in the pram and they talk about what it meant to be going through antenatal classes, how it really empowered them because they felt they were more in control, they knew what to expect, they were not fearful. It didn't come too much as a surprise even when their partner had an emergency caesarean section because they sort of knew what to expect. And they also had the opportunity to ask questions.

I think you have to lead by example. The more we normalise this, the more we say, "This is here. This is available at a time in a format the way you want it, the way it suits you. Take advantage of it", I think more uptake will follow. Because in my practice I see that dads turn up at the first doctor's appointment because they want to know how this is going to run. Then they turn up at about the 36-week mark, when we're making decisions about the mode of delivery and what to expect and if you're making any decisions like induction of labour or elective caesarean section. That's when they turn up. So I think the better engagement we have in the—perhaps even take a step back in the preconception space because most men do not see their GPs. You know, we talk about, if you're thinking about having a baby, go see your GP, get your blood test, get your screening done. Let's start talking about what it means to have a family.

STEVEN KENNEDY: I'd also like to add to that. Trying to roll something like that out would be a bit of a problem because I think it's really important that it comes from a male if it's targeted at males. Just like if it was targeted at same-sex couples, you would kind of expect a same-sex person to be the person facilitating. So the staffing of that would be difficult. I've developed face-to-face programs and we went through a process with a local LHD and got to middle management. It was all going well. We budgeted it. I was going to provide that for free as a pilot for six months and then it got to the executive and got knocked on the head. Yes, the problems would be actually trying to staff it with men across the State. Because I've thought about how we might do that.

The Hon. EMILY SUVAAL: And do you have any suggestions? We've heard a lot today about the importance of culturally sensitive care, trauma-informed care and tailoring care specifically with those sorts of things in mind. Have you any suggestions as how to then overlay these other types of education with those things in mind specifically?

ALKA KOTHARI: I might actually take this question on notice because I would like to provide you a detailed written response to this question with the learnings from my PhD, the rest of the literature and what I learned from the fathers when I do focus groups with them. I think it is really important that we use a consumer co-design approach. Because I feel instinctively that the uptake would be much better. Some dads may utilise resources that are available offline any time whenever they want to—things like what Steven has prepared for the Prepare Foundation. Other dads might want to be there in person because they feel more comfortable speaking to people. Some dads may want to speak to a male and it's a great idea to have male peer educators, but we know that they are thin on the ground. Perhaps we could do a targeted recruitment drive to see if men might—midwives might be interested in performing such a role. I think we really need to have a multi-pronged approach if we're going to win this.

The Hon. EMILY SUVAAL: Dr Kothari, would it be fair to say that we could not provide a standardised one-size-fits-all education package?

ALKA KOTHARI: No. Well, you could start with that but remember this: It will not apply to everyone. So you need to have systems in place where you also are able to reach those subgroups that don't fit the big group.

The Hon. EMILY SUVAAL: I suppose that they then have to know that it doesn't apply to them, because we're also talking with the complexity around—this may be the first time someone has had to encounter or even been in a hospital, for example, so that additional layer. Sorry, I think you might have had something to say, Mr Kennedy.

STEVEN KENNEDY: I tend to think you would have to start with a standardised version and then over time—this is a long-term endeavour. Over time you would develop some kind of feedback mechanism to develop it in more detail for other communities, other cohorts. But I will also say, just back-pedalling a little, I think it's important that men do understand the different interventions that might be possible, because I feel like if you don't provide them with that then it's a gap. They might feel somewhat ripped off—for want of a better term—if you take them through a whole process and then you don't actually mention inductions, ventouse, all the other things that might go on.

Dr AMANDA COHN: We've talked a lot already about the specific needs of partners during the pregnancy and birth, which has been really valuable, but I was hoping to ask you how important it is for partners and fathers to also have their own independent support, noting statistics saying that men are far less likely to have their own regular GP, for example—let alone choose to go to see them when they're considering starting a family.

STEVEN KENNEDY: You mean after birth or throughout the process?

Dr AMANDA COHN: I suppose in general. We're talking about these really specific targeted programs for expectant fathers or recent fathers. I'm interested in a discussion of the role of having regular practitioners—

whether it's a GP, a psychologist—separate to your partner's. We've talked about bringing dads into antenatal care. Dr Kothari, you gave the example of not being able to prescribe antidepressants to a partner. What is the role of a partner's—or a father's—own independent practitioner?

STEVEN KENNEDY: Do you want to answer that first, Alka?

ALKA KOTHARI: Yes. One of my big concerns is that fathers don't have any dedicated personnel looking after them. The pregnant mum has got the midwife. We are focused on the mum and the baby, and everyone else is. This is a systems issue. You need to have a look at how can we provide support to dads, just during normal circumstances? Because we know from the research that even normal birth, where everything's gone absolutely fine, can be perceived as traumatic for dads. So I think if you had a designated person, say, for example, supporting them or a designated system put in place where they could link in—at the moment, they come in as a plus one.

When mums have social work appointments, we say on purpose, "Can you please bring your partner. Can you please bring Dad." Sometimes they can make it; sometimes they can't. But if there was a dedicated system put in place where fathers would link in during pregnancy and certainly after birth, when things haven't gone as well as they hoped, then perhaps you might get some engagement. Because my qualitative work has very clearly shown that they want to be engaged. They want someone to look after them. They're asking for help. Even the society doesn't actually encourage them to seek help, because they're men. They're meant to be strong. They're meant to be the breadwinners of the family.

I think we need to make it easy. We need to normalise it to say, "It's okay to say you're not okay. It's okay to seek help. We have the systems put in place where it's very easy for you to link in." Whether it's a multidisciplinary clinic where you have a social worker, a perinatal mental health person, a GP, someone that they can go to when they leave the hospital, this is really, really important. Because especially when a baby dies, I think, we lose those families after a few days. They might come for a couple of appointments and then we don't know what happens to them. I think that period is really important.

STEVEN KENNEDY: I'll just add to that. I think that there's a step before actually trying to implement some program and then finding out that dads don't turn up, because that's what we've continuously done in this field for quite a while. There's a culture change kind of process that needs to be undertaken first, and that is dads seeing themselves as having a role during pregnancy. One of the things I hear a lot is, "My job doesn't start until the baby's in my arms. Isn't that right, Steve?" And I say, "No. You're a father from conception." They don't seem to get that. So we need to inspire men to be more connected to the fetus during pregnancy and fundamentally involved, knowing that they're important during birth as well but then actually following that through and proving to them that they're important during birth.

I think the only time we're actually going to see significant change in this space is when men start to share with each other their birth wisdom—and that's a few decades or more—so that the next generation comes through and they understand that they've got a role. That's why I developed something like this, which is just a little flyer that I developed with the Sutherland family interagency. It's just trying to say, "Guys, you've actually got a role, and this is what it is." Because men as fathers have taken up the mantle. They've said, "Okay. I know how to be a dad." They might have a role model from their own dad. They can rely on their peers. There's actually quite a lot of information for men when they become fathers.

It's still a gap there during pregnancy and birth and a little bit afterwards—newborn care—which is why we brought this in from the UK, which is the DadPad. This is across the NHS in the UK. This is a newborn healthcare manual. We adapted it to Australian circumstances. That's actually saying to dads, "You've got a role in newborn care, and this is what it is." As parents in the room, you'd say, "This is all really basic information," but it's wonderful because it says to dads, "You can be doing all of these things as well," and it takes the pressure off new mums. Because he's picking this up, and he might even be teaching her a thing or two—you never know. I think dads need to see themselves in this space before they're going to come. They don't expect anything, as well. They want the focus to be on their partner, their wife. We need to shift that kind of cultural expectation.

The CHAIR: I've just got one quick question for Dr Kothari in regards to some of these resources that we've just been provided. Could you just take us through some of the main aspects of the research that you've done and the findings? I know it's quite a big question when we're at the end of our time, but just to give us a bit of a heads-up on some of this paperwork that we're looking at.

ALKA KOTHARI: Sure. In a nutshell, preconception care for men is non-existent. That needs to be fixed because they have a huge role to play in terms of their contributions to their offspring's health and future outcomes. I did the first study where 99 per cent of the fathers attending my hospital antenatal clinics indicated that they will attend the birth. Most fathers don't feel prepared for it. A significant number said they would like mental health support. Remember, in our antenatal clinics we're not actually providing them any mental health support. The small proportion that said they received it may be those fathers where things were not going very well and we have spoken to both partners, or maybe there's a fetal anomaly or there's a concern on the ultrasound scan. Fathers are significantly affected when they're exposed to traumatic circumstances, which are, unfortunately, quite common and can happen in one-third of births. There's significant mental health complications. I sent you a little thematic map from the qualitative study, where you look at the fathers.

If you read that paper, you will know that they're affected right from their physiological being. They're not able to sleep. They're not able to drink. They can't think. They can't go to work. One of the examples I will give you is where a dad, after losing his baby, went to work and said, "I was ready to punch someone who said to me, 'How was your holiday, mate?'" Because he never told them that his baby died. They don't feel empowered. They don't feel supported. We have no systems in place in maternity services. In fact, we call our departments "women's and newborn services". Where is the dad in the equation? There's significant health inequity. They're also ticking time bombs because, after something terrible happens in the pregnancy, they go out in the society, they are still struggling, they're still crying, they're having thoughts of self-harm, and they have to go to work. They are completely unsupported. Imagine going home to a mother who's struggling already after having a traumatic birth and having to then support her without any consideration of your own feelings.

I think we need to do a lot more for fathers, and it has to start right from the very beginning. We have to start normalising mental health support, seeking help right from when they are young boys. This is a holistic view I've taken because we need to normalise health-seeking behaviour. Because these young boys who grow up in families where the fathers have perhaps a mental health issue and they don't have a very good childhood—they have adverse childhood experiences—they grow up and they become fathers themselves. There's an increased risk of substance abuse. It's a recipe for domestic violence and so on and so forth. My PhD work has shown that we need preconception care. Most fathers intend to attend the birth, they're significantly affected after traumatic circumstances—after birth trauma—and they need urgent support if we're going to support our mums and our babies and the next generations.

The CHAIR: Wonderful. Thank you both so much for coming today. I think there was a question that was taken on notice, so the secretariat will be in contact in regards to that. If there's any further questions that the Committee has, the secretariat will be in contact in regards to that as well. Thank you both for all that amazing work that you're doing. Thank you for coming today.

STEVEN KENNEDY: Thank you.

ALKA KOTHARI: Thank you for the opportunity.

(The witnesses withdrew.)

(Short adjournment)

Dr KATHRYN AUSTIN, Vice-President, Australian Medical Association (NSW), and Obstetrician, Gynaecologist and Maternal Fetal Medicine Subspecialist, affirmed and examined

Ms FIONA DAVIES, Chief Executive Officer, Australian Medical Association (NSW), affirmed and examined

The CHAIR: I now welcome our next witnesses. Would you like to give an opening statement?

KATHRYN AUSTIN: Thank you very much. I would like to give an opening statement. The Australian Medical Association (NSW) would like to thank the select committee for the opportunity to provide a submission to this inquiry and for the chance to appear before you all today. I would like to acknowledge the traditional owners of the land on which we meet. My name is Dr Kathryn Austin. I am the vice-president of the Australian Medical Association (NSW), as well as a practicing obstetrician and maternal fetal medical specialist. I work in both the private and the public hospital system, where I practice general obstetrics as well as the highest risk obstetrics through maternal fetal medicine. I have undertaken additional subspecialist training to also hold this maternal fetal medicine qualification, allowing me to work in the highest risk and most complex pregnancies for families across New South Wales.

I work with an extraordinary group of talented doctors, midwives, nurses and allied health workers, all of whom share the same passion and commitment for maternity services that I bring today. The AMA acknowledges the experience of birth trauma felt by large numbers of women over many decades. Those of us working in health believe that it is crucial that the system we work in should be seen to be, felt to be and fundamentally be safe, because it is through that prism of safety that trauma can be minimised. We believe it is important to recognise that a safe system needs to involve the physical safety as well as the psychological safety of those working within it.

It should be acknowledged that Australia has among the world's lowest rate of infant and maternal mortality. This is thanks largely to a strong health system, but also to the multiple forms of intervention available to medical and midwifery professionals to address the multitude of birth impacts. These figures are obviously welcome, but we also need to ensure that our strong physical outcomes are matched by similar outcomes of psychological safety. We acknowledge the NSW Health Blueprint for Action in maternity care. The blueprint has a sound evidence base. It has been well informed by feedback from mothers and families and from those working in the health system. Unlike the previous NSW Health policy, Towards Normal Birth, the updated blueprint document seeks to provide options for women rather than creating the expectation of one particular maternity pathway being normal. We believe there is no such thing as a normal birth.

While many births in this State and across the nation occur without complications, every birth every day has the potential for risk. We believe that a lack of understanding of the scope and frequency of these birth impacts has contributed to the levels of trauma that have been experienced and demonstrated through this inquiry. We note that many of the submissions of those with lived experience express how a lack of information and understanding has exacerbated their feelings of trauma. What is often not well understood is the prevalence of the many possible physical and emotional impacts of birth that can occur. The Australian Institute of Health and Welfare reports that in 2019, of all the women in Australia who gave birth vaginally, 85 per cent suffered some degree of perineal trauma. Around one in five or 20 per cent of women will require some form of instrumental intervention during their delivery in their first pregnancy.

The statistic has been largely unchanged overtime. As I remind my patients, we generally do not know which one will be that one in five. Contrary to social and mainstream media suggestions, and well-meaning non-medical advice, it is nature, not the patient, who determines who may require this assistance. We know pre-term delivery occurs in approximately 7 to 8 per cent of pregnancies across this country. Preeclampsia can affect somewhere between 3 to 10 per cent of pregnancies, depending on severity. Gestational diabetes can now be diagnosed in up to 15 per cent of pregnancies. Rates of all of these known pregnancy risks are significantly higher in multiple pregnancies. Increasing maternal age and elevated body mass index will add complexity to a pregnancy. These are simply some of the many figures that demonstrate that pregnancy carries innate risks that are often unbeknownst to people prior to conception and that can in many cases endanger their life or the life of their baby.

In many or maybe most aspects of our life, we are used to having some and usually a large degree of control. What cannot be prepared for is when things suddenly and unexpectedly, and quite dramatically, go off plan. We believe that women are not given enough preparation for the significant, overwhelming and often terrifying loss of control that can occur during a pregnancy or during a delivery, and this can happen to any woman at any time. Birth by nature can be painful and unpredictable, but it doesn't mean it will necessarily result in trauma. We believe the best ways to reduce trauma are by a number of factors: building the confidence of women and their families by providing better antenatal and postnatal education; informing women of the spectrum of procedures that can be associated with birth; involving women in decision-making as much as possible; and discussing birth outcomes in that postnatal period. Essentially, we need to have better education at every stage of the birth journey for a better-informed birth experience.

These discussions should involve medical and midwifery input so that women understand and are made aware that, whatever their hopes or plans, they may in fact require medical intervention. The possibility of requiring medical intervention should be seen as a part of the normal birthing process, not an unexpected or traumatic outcome. Many of the submissions in the inquiry refer to the frustrations felt by expectant parents at the lack of continuity of care within the public system. This is a frustration that we share as doctors and healthcare providers. Lack of continuity is an unfortunate consequence of the workforce pressures that we face.

I refer you to the Ockenden review of maternity services conducted in the UK and released in 2022, which we will table. It calls for an appropriately funded model of care which allows birthing units to be properly staffed and to be funded in a way that all forms of care can be delivered in concert. It recognises that safe staffing levels must be addressed, including backfill to ensure staff are able to provide and attend training, as well as calling for measures to address and record rates of attrition as maternity staff burn out and move on. The review calls for regular emergency drills and better training at all levels for antenatal cardiotocography, or CTGs, for the monitoring of babies' heart rates, as well as for the creation of better systems of training and compassionate care, particularly for families who have suffered bereavement.

The AMA believes that the best outcomes are achieved by a collaborative, multidisciplinary team-based model of care, with each profession supporting and respecting the opinion and the approach of others. When doctors, midwives and other allied health workers act in concert, early recognition of risk factors that may cause pregnancy or birth complications are better identified, birth outcomes are improved, and postnatal complications are reduced. An example of exceptional collaboration is that between medical professionals and physiotherapists. There are many, but this collaborative model of care from the beginning of pregnancy could provide significant safeguards to prevent birthing impacts, including trauma. We believe physiotherapy services should be provided extensively both before and after birth.

We do, however, suggest that measures be put in place to ensure that information provided by non-medical advisers does not contradict evidence-based care. We believe expectant parents should receive education in relation to the difference between medical and non-medical advice—for example, being told that a so-called natural birth with no form of intervention is best for your baby, and that all forms of intervention, including pain relief, forceps, vacuums and emergency caesareans, should be avoided at all costs. A natural birth in which a baby is breach, has a cord around their neck or a shoulder stuck in the birth canal, or involves many of the other potentially life-threatening or serious complications that can occur, may lead to lifelong implications, or, rarely and most catastrophically, death. These more rare but serious conditions like a uterine rupture, in which the uterus may break open and a baby's heart rate drops to zero, if left to nature, would most certainly lead to death for a mother and a baby.

Doctors want what expectant parents want. We are on the same team. We want a birth that is medically and psychologically safe for a mother and her child. The AMA believes there needs to be realistic pathways to adequately address antenatal education to provide this. Just as important is the scope for postnatal education. Studies have showed repeatedly that when explanations are provided for what happened, why things did not go according to plan, and, where necessary, what intervention was required, the level of trauma that is felt is vastly reduced.

Education for expectant parents is not the only answer. Among the solutions should be better training and resources for those providing the services for them. We believe there should be greater screening for those who may be predisposed to or at greater risk of birth trauma so that trauma-informed care can be tailored individually to address further needs. There must also be robust mechanisms in place to identify psychological distress and clear pathways to access emotional support and specialist support where needed as soon as possible. All of these require significant resourcing and workforce, and simply adding these additions to an already overburdened staff simply cannot be the answer.

Working in maternity services is an incredible privilege. We live through every mother's story, every baby, every joy and every loss. We accept that the tragic outcomes are sadly part of our job, but we feel that the experience of vicarious trauma among maternity health workers should also be acknowledged and addressed. High-quality maternity services rely on a stable medical, midwifery and allied health workforce. There is a concerning risk that the result of this inquiry could lead to a loss of workforce, inadvertently undermining the most important objectives of increasing the medical and psychological safety that is afforded to our patients. If the inquiry results in recommendations that are not safe for those working within the system, this could lead to the catastrophic failure to attract and retain a workforce we so desperately need to provide this informed care across the State. It is our hope to work with this inquiry to create a safe maternity service, both medically and psychologically, for all patients and for all those working in the system. I am happy to take your questions. Thank you.

The Hon. SARAH MITCHELL: I would like to ask just one question. One of the parts of your submission, Dr Austin—and you touched on it a little bit then—is that sometimes doctors are forced to make split-second decisions. Every birth will be different. You can't always foreshadow what will happen. That's obviously done to save the mother and the baby as well. Earlier today we heard from one witness who, in their submission, was talking about criminalising obstetric violence. I wanted to get the view of the AMA on that. You've also spoken about workforce pressures. The insurance requirements are something that has come up throughout today as well. What would be your view on any move to criminalise obstetric violence? Do you think that's even possible considering the various circumstances that might arise? And what would the impact be, particularly on the workforce, if that was something to that was to come in?

KATHRYN AUSTIN: I think it's an incredibly important aspect. Drawing back, the fact that split-second decisions are made is an incredibly challenging part of obstetrics. Flashing through my mind are a number of challenging circumstances where we have, in fact, made split-second decisions which have hopefully saved, and in many cases have saved, the life of the mother and baby. Obviously knowing that with that comes the importance of discussing post that event what might have led to that decision-making and hopefully providing that informed care about what led to it. But in circumstances of criminalising those split-second decisions is incredibly damaging to our workforce. Whilst we don't take away from the trauma that may have been encountered in some of those split-second cases, as has been evidenced by the number of cases we have presented in this inquiry, I think criminalising these sorts of obstetric interventions, where they are in the purposes of life-saving procedures, would in fact decimate the workforce in which we have. I think it would be impossible to practise in a public setting should that be a criminal result, and I think it would be nigh impossible to practise in a private setting.

One of the challenges to that is that in a private setting, we have the ability to get to know a woman over time and talk to her about the role for things like emergent deliveries with a vacuum or forceps, an emergency caesarean section or episiotomy that might have to be performed. Criminalising those, which are known obstetric interventions and happen so commonly—as we said, 20 per cent of our first-time mothers require, for example, an instrumental birth—would mean that, should there be a case where that may not have been performed to the standards or along those lines and where there was an event of trauma occurring, we do worry that a criminal process around something that is simply a part of obstetrics would render that there would be no workforce to undertake maternity care services. Midwives and obstetricians alike would find it impossible to work under those circumstances.

Dr AMANDA COHN: I first want to put on the record my conflict of interest that I am a member of the AMA but that I was not involved in the preparation of the AMA's submission to the inquiry. You mentioned in your response to the last question the value of continuity of care that you've had as an obstetrician with your private patients. I'm interested, as the AMA also represents GPs, in the role that GPs can have, either in shared care or GP obstetricians in the country.

KATHRYN AUSTIN: The continuity of care is obviously an exceptionally important part of how we can look at ways to hopefully improve outcomes. I'd like to think that is what does come from this inquiry is improving those outcomes for the women coming behind those who've put their submissions in, to try to establish an incredibly psychologically safe system in which we all work. The answer comes in multiple ways. Continuity of care can be done through many ways. We know that in the public hospital system, and particularly in the high-risk clinics in which I work, there is an incredibly good degree of continuity of care. Women meet with myself as the maternal fetal medicine specialist. They often meet with a general obstetrician. They meet with midwives. They meet with allied health social work along the way and the neonatal teams and anaesthetic teams caring for them. The challenge is that when that's done in a high-risk setting, it's obviously even with all of those challenges, it's incredibly under-resourced. That is one of the challenges we face in the public system.

One of the roles of looking at how we can provide more continuity of care was to look at the role of GP Shared Care. That is something that a number of the New South Wales health districts already have up and running, but that requires a significant investment to ensure that women have access to that continuity of care, education around that being an appropriate model for them. One of the other challenges, as you well know as a practising GP, is that good care takes time, and unfortunately any of the MBS funding that goes around GP Shared Care is for very short periods of time, which doesn't always allow general practitioners to be appropriately funded or resourced for providing the care that those women may need.

That said, the GP is often the centre of many women's and their family's lives and is an essential part of how we can provide one aspect of continuity of care through this review. I think it's certainly something that can be expanded upon, and we can look at additional ways for resourcing and staffing that can roll out further GP Shared Care programs. It is one of the many ways that we can look at that. Certainly for women who may fall in a slightly higher risk than a standard, low-risk midwifery program, but not necessarily require the resources of staff specialist obstetricians or VMOs within a hospital system, GP Shared Care and continuity of care can be incredibly value throughout that.

Dr AMANDA COHN: The terms of reference of the inquiry were to look at the impacts of birth trauma on patients and their families and also on health workers. You mentioned in your opening statement vicarious trauma. I was hoping you could expand on the impact those traumatic births have on practitioners.

KATHRYN AUSTIN: We take every single birth with us every time. I probably could not detail all of them. There have been many hundreds, if not thousands, over the many years that I have worked. But every birth that we do leaves a little piece with you. The trauma when things don't necessarily go according to a plan or in fact where there are interventions required do take a little bit of us along the way. I think the challenge at its most severe is burnout and loss of enjoyment of one's profession, and unfortunately with that often comes loss of empathy and loss of ability to walk in a patient's shoes and be able to deliver that joyous and informed care along the way. That's the very worst situation.

Equally, healthcare workers leaving the profession because they simply can't tolerate that any more. That's an incredible shame. We know that the obstetricians and the GPs in this country who are skilled and able to provide that care are limited in number. It is a very precious resource for which we hold. There is, unfortunately, very limited support that goes to the medical professionals providing this support. Certainly speaking on behalf of midwifery colleagues, not in a formal capacity but those who spoke to me prior to this, obviously there is the trauma that goes along with them as well when they can't provide safe staffing ratios or the care that they would like to give, not only in the antenatal space but during the birthing process and equally important in that postnatal setting where women may require additional time to be spent with breastfeeding services or to talk about what might have occurred during a birth, how they will integrate that with other children at home, with domestic violence that may occur in the family, with living in geographic isolation—so many of the different factors we send women home to in their environments.

But I think that vicarious trauma is incredibly powerful. I think it's an incredible risk to come out of an inquiry like this is that where we perceive there hasn't necessarily been an understanding for what the impact is on the healthcare workers, I think it's something that we really need to look at and provide those appropriate supports, certainly for our patients but also for those doctors and midwives who are providing care for the patients going forward so that they can continue to deliver exceptionally safe physical care but also be able to be in a place to deliver that psychological care.

The CHAIR: I will jump in with a few questions as well. You mention in your submission that one of the biggest barriers to continuity of care is the staffing levels and that this needs to be come as a priority before we can start to look at increasing those continuity of care models. Can you talk a little bit more about that and what needs to be implemented immediately to ensure retention of healthcare workers, the right amount of recruitment and making sure that there are proper staffing levels?

KATHRYN AUSTIN: There are incredible barriers to maintaining good staff within our healthcare systems across both the public and private space. Part of that is obviously around the support not only for the exemptional skill set that the doctors and midwives have in this setting—for example, senior doctors and senior midwives, without whom birth units are incredibly hard to run very well. Experience is something in obstetrics that is incredibly valuable and often not necessarily recognised in staffing ratios or in how we staff public or private hospitals and yet it is incredibly valuable, so certainly recognition of that experience.

Equally, looking at how can we provide 24-hour care across a spectrum of geographical but also across the increased needs that women of this generation will require? They are older and they have exceptionally good access to social media and other information sources. So good medicine takes time. One of those challenges is setting up systems so that we can give the patients the time they need to have that, but recognising that health is a precious resource, that healthcare workers are precious, and we obviously do have significant resourcing and funding requirements to do that but across all of that public and private mix, we need that recognition. That may be beyond the scope. We always know that health has a limited dollar, but spending that money sensibly and looking at the resourcing and staffing that is required would be exceptionally important as far as delivering better and ongoing psychologically safe healthcare services.

The CHAIR: Following on from that, you mention in your submission some of the reimbursement amounts for different appointments. They seem quite low numbers, in regard to those reimbursements. I know you have made a recommendation that that whole space is reviewed. What would you ideally like to see come out of such a review?

KATHRYN AUSTIN: It's lovely to hear that you agree that they are low. For the incredible value of bringing life into the world, and obviously the complexity that that takes with it, it is under-resourced and undervalued. It would be hard to give you an exact number today. I am sure we would be very happy to come back to you with figures that have been appropriately worked up over time. But we need to look at the complexity of what is required, not only for a physical examination but also for psychological examinations and the psychological input that is required into ongoing birthing care services—certainly for midwives but also certainly for the doctors—and how that is done across those different reimbursement items and how different numbers of visits may be required for different patients, and that they carry with them different and appropriate funding sources going forward.

The CHAIR: If you could take on notice some of those more specific figures, that would be really useful to get.

KATHRYN AUSTIN: Yes. To add to that, one of the other things we have put in our submission is looking at the additional services for women, such as physiotherapy and midwifery services, that do have and carry rebates for women of this State and of this country, so that doctors don't work in a vacuum. We work best when we work in multidisciplinary care teams. Obviously, part of that is the appropriate education so that women are given accurate advice around what is available to them. I think that is incredibly important, to look not only at the medical space but also across those additional healthcare spaces so that everyone in the team is well supported to provide that care.

The CHAIR: Absolutely. You mention in your submission as well care provided by other medical staff, such as physiotherapists. We had a submission this morning that physiotherapy after birth, despite how needed it is, is often not available to most women. Is that something you think should also be part of the review of the MBS item codes or some other review in regard to what care is provided to women?

KATHRYN AUSTIN: We know physiotherapy services can be incredibly valuable in that education space, also for physical birth preparation and then obviously for postnatal recovery. In my private practice I have a number of midwives which work very closely with us And I encourage most, if not all of my patients to see physiotherapy support, not only for birth preparation if it's a vaginal birth that they're aiming for but also for caesareans. We know that whilst the literature is somewhat mixed—and I am happy to provide more information about that in time on notice—we know that women who see physiotherapists and women's health-trained physiotherapy, that is obviously a small subset of the physiotherapy training. In the nicest way, the physio who sees the guys for the hips and ankles of the rugby league players is probably not the ideal person to perform a vaginal examination and assess a pelvic form. We know that women's health specialty is developing and growing over time, and it is something that we should be able to grow and develop in this country to provide women those services.

One caveat I will say to that is that that obviously needs to work in conjunction with a concert of practice. We have, unfortunately, anecdotal stories of physiotherapists telling women that they should tell the doctors not to do a forceps on them because it will ruin their pelvic floor. Obviously that can be incredibly damaging when, for example, a woman is fully dilated and her baby's head is very low that it would cause an incredibly dangerous caesarean section and may not, in fact, be appropriate for a vacuum delivery. Obviously the nuances of performing a vacuum, a forceps or an emergency caesarean take many years of training and expertise to find those nuances. But working as a part of that team to know that whatever that situation may be, talking about that in the antenatal space, ensuring that women feel appropriately educated going into the birth, knowing that there are a number of situations that can occur and then having that postnatal rehabilitation can be incredibly value and an incredibly important part of that healthcare team.

The CHAIR: I notice in your submission you talk about unrealistic expectations of control that women have. A lot of the submissions that have come through from individual women—and this isn't every submission, but a lot of the submissions—seem to talk about feeling a lack of control because there was no information. I note that in your submission you highly support this desperate need for information and education at all stages. Do you feel that if we commit to that idea of informed consent and making sure that all that education and information is provided, that helps to overcome this feeling of lack of control that a lot of women have come to this inquiry expressing? Is that part of the solution? Obviously there are going to be those split-second decisions and those emergency situations that happen, but what we have heard so far from most people who have come forward is that if they had been informed during or asked questions, or even just warned that things could happen where they had absolutely no idea, they wouldn't have felt that loss of control. I want to get your feelings around that.

FIONA DAVIES: If I could take this to start, and I say from the outset that I am not legally trained, nor am I a doctor, so I am going to give very general comments about this. If we are talking about informed consent in a formal sense, in the medico-legal environment, then that is an area we need to be incredibly careful about.

That is because informed consent is part of a legal framework and that legal framework is very well developed and is part of the system by which we regulate healthcare practitioners. There's a very significant distinction, and I'd actually encourage this Committee to consider getting formal advice on the potential implications around making recommendations that may change the legal frameworks of informed consent, as opposed to the need to provide better information for people.

What doctors are obligated to do, midwives and other health practitioners, in terms of their practice about consent, is that they are required to follow—this is a dramatic simplification of a very complex system—what would a reasonable peer do in the circumstance? Again, dramatic simplification, so please bear with me on that. That is a test that you can, as a doctor, know and understand what that is and how to ensure that you are complying with it, or a midwife or healthcare—and this is a very regulated space. All healthcare workers are subject to the Health Care Complaints Commission, the guide to good medical practice and a range of regulated spaces. If you were to seek to change the legal framework of informed consent, you would really need to consider what that was going to mean for healthcare workers and how they discharge that obligation.

We just want to be very clear on the need for this Committee to separate the provision of information from potential changes to informed and well developed models of the obligations of consent. Because once you move to—or what appears to be potentially contemplated here is a test where it would be very difficult to guide the doctor or midwife on what would be required to disclose that discharge, that obligation. Again, we just want to be really clear that there is a difference between changing legal models of informed consent and the provision of good information. They are just two different processes.

KATHRYN AUSTIN: Thanks very much, Fiona. I think, certainly, in that setting it is incredibly challenging to know the full spectrum of information for which to give a patient. Obviously, it's essential to give open disclosure about the situations that can occur, but at which point do we find that that is what a reasonable person would give you? I think that's incredibly important about that antenatal information provision and being very open about what birth entails and what is required, or may be required in certain circumstances, through to then, obviously, what the legal frameworks may be around that.

The CHAIR: Can you explain to me a little bit, as a lay person, what you mean by what information would be given by a reasonable person? I am not sure if you are aware of a lot of the evidence that we have heard. A lot of women feel that they have not had a significant amount of information that could have been provided beforehand. Can you explain that terminology that you used in a little more detail?

KATHRYN AUSTIN: Sure. Part of the antenatal piece for which we call is education around the things that often are not spoken about, things like forceps, vacuums, emergency caesarean sections, need for episiotomies—some of what would potentially be considered birth intervention, but we know in fact occurs in such a significant number of patients. One of the challenges is the system isn't always set up to provide that. Women who maybe go through low-risk models of care may be perceived to be low risk and therefore this couldn't happen to them. One of the most challenging things is birth is often low risk until it's not any more. Therefore, provision of that information is obviously essential to every pregnant woman going forward.

The degree of that information obviously is open for testing and challenging as time continues and for every person they will need a differing degree of that. Part of that is the nuance of developing rapport with a patient through whatever provision of model of care that may be. That may be through a general practice model of care, a midwife. But obviously, every part of that healthcare team is providing that information regardless of someone's model of care. I think it is incredibly challenging for doctors when we may meet that person for the very first time and they've not been given any information about this, yet we are at a point where then we're expected to perform a potentially life-saving procedure for mother or baby, with very limited time and with limited antenatal education surrounding that.

The Hon. EMILY SUVAAL: I have some questions following this line of consent. Thanks very much to you both for appearing today. We have heard about consent in previous hearings, including our first hearing, where we heard from Dr Bashi Kumar-Hazard, the chair of Human Rights in Childbirth, who described how consent should occur for a woman who was required to have an unplanned forceps birth. She stated that:

> … someone to come in 10 or 15 minutes beforehand and say, 'This is something that we need to do or the alternative is that we would recommend that you have a C-section.' Then you step out and giver her the five minutes to think about it and talk with her partner about what she would prefer.

Could you explain if this is an appropriate and realistic method of giving consent?

KATHRYN AUSTIN: I think in some circumstances it can be. But one of the challenges that we've all talked about today is sometimes the time challenges for which we are faced in obstetrics. The other challenge is those very significant nuances around what is decision-making in obstetrics. Again, I believe that does require significant years of training and education, for which our specialists in this country are obviously educated and trained for and undertake rigorous examination to be considered a recognised specialist obstetrician. One of the challenges is that whilst in some cases we may have appropriate recognition that a labour may not be progressing as we had hoped, or that in fact intervention may be needed in time—in which case, certainly, time is often given to patients. I have been in a number of situations where myself or my juniors have given women that information, suggesting that as time progresses they have a little bit of time to consider those nuanced discussions around what we talk about.

One of the challenges is to provide all of that information in what is often a very stressful situation. A woman may be in pain; a woman may be sleep deprived after a number of hours of being in labour. For them to take on that information in that setting can be incredibly challenging. Part of that information obviously does need to then be provided in that antenatal setting so that women, if they may then find themselves in this situation, feel they had more understanding about what that might be. One of the other challenges is saying how do we provide that information appropriately so that time can be given, respectful practice can occur so that women can take the time they need, notwithstanding the physical safety that may occur if in fact decisions are needed to be made in a split second. That is obviously not all the time but is something that's incredibly challenging to work with and is inherent in the nature of obstetrics.

The Hon. EMILY SUVAAL: How should consent occur for a forceps birth? Do processes need to change in these time-critical emergencies? Earlier on you spoke about an instance where a baby was low but not quite low enough, but then there is no such thing. Could you talk us through, as lay people, the process of developing that expertise and that nuance and understanding, but then also the risk of not getting that baby out? What happens?

KATHRYN AUSTIN: Unfortunately, there is no risk-free way to have a birth. When it goes well, that is fantastic. As we talked about those very challenging situations of, for example, caesareans at full dilatation, where the cervix is fully open—a baby would otherwise hopefully be born, but for whatever reasons the baby is not coming through the birth canal. That may be that a woman has been pushing for a period of time, and in fact we can give her more time to hopefully allow that baby's head to descend and she has a normal birth; or that the head becomes low enough that it would be safe to do a vacuum delivery, for example; or that in certain circumstances a baby's heartbeat may drop dramatically at that point in time, in which case, for those doctors trained in using forceps, that can be a very safe and appropriate tool. Forceps often get a very bad reputation. We know that they do have concerns around longer term pelvic floor function. However, a lot of this information comes where women haven't had appropriate pelvic floor rehabilitation.

Forceps were actually designed to protect a baby's head and a forceps, in an appropriate setting, can actually help expedite birth, meaning baby could be delivered over a short interval of time—one or two contractions—rather than waiting for 20 or 30 minutes, where a baby's oxygenation drops very rapidly in that second stage, meaning we have put not only a baby at risk but also a mother at risk for performing a very complicated caesarean section. When a baby's head is very low in the pelvis and may be deliverable vaginally with forceps, there is a risk of things like tearing very badly into the large blood vessels that supply the uterus. There's a risk of damage to not only the uterus but the bowel, the bladder and other organs that can be in that area. Most importantly, there is a significant risk of bleeding.

The other major consideration is there is also a risk for future pregnancies for caesareans performed at full dilation—a risk for pre-term delivery, a risk of the scar causing complications and a risk of plastination issues. Obviously in this setting it feels like there is no good way out and I think that's where there is that very subtle discussion and nuanced approach to my specialty where we decide what is the safest way to deliver that, in consultation with the patient, but explaining those nuances of why these are challenging things to do.

It's probably taken me about three or four minutes to even go through that in a very calm and non-distressed setting. Obviously that's why there are challenges to doing this in an obviously emerging situation. Obviously respectful practice has to be the cornerstone of that, and I would like to think that, in every situation, we can still do these nuances discussions very appropriately. That's part of being able to develop rapport with a patient very quickly, which is what my specialty of doctors and midwives do, particularly when we all work on the same team. The midwife, who's been caring for a patient for that six or eight hours in labour, can say, "This is true. This is a situation that really needs the doctors. These are part of my team. We all work together do to that." When obstetrics works best, in fact they are often not the births that may have those significant traumas. It's often those where that piece of education and information is missing. But then also that postnatal debriefing has obviously not necessarily discussed those nuances. That leaves a woman potentially scared or frightened about what occurred, but also what may occur into the future.

The Hon. EMILY SUVAAL: Would it be fair to say that it may or may not appropriate to offer a woman an emergency caesarean section as an alternative to a forceps birth?

KATHRYN AUSTIN: That's correct. Sometimes that may be a significantly higher risk operation to offer. I can't speak for individual circumstances but it may account for why sometimes a forceps delivery was performed rather than an emergency caesarean section.

The Hon. EMILY SUVAAL: You talk about the second stage of labour—which is something we haven't really heard much about in this inquiry as yet—and the baby's oxygen level dropping and having that marked drop in heart rate. Could you explain more for committee members what is happening there and what are the risks?

KATHRYN AUSTIN: We know that babies are designed to tolerate the second stage of labour very well, which is why our population continues to grow but obviously, in some circumstances, babies can become distressed during that second stage for reasons that sometimes aren't even clear to us, even with the best medical technology that's available. Obviously the role for monitoring can detect that a baby's heart rate is dropping. That may go from intermittent heart rate osculation, which is performed in a low-risk situation, to then needing to apply a cardiotocograph, or CTG, monitor. That can give us a detection of what baby's heart rate is showing us during labour. CTGs are very good at predicting when babies are healthy; they are less good predicting when babies are undertaking distress but do have very significant signs of certain circumstances where that can lead the medical and the midwifery teams to have to recommend action.

I think it's important to recognise it is not a trial of the baby—obviously all mums and all babies would like to be delivered in good condition. Part of seeing that recognition of a baby's heart rate dropping may mean that birth needs to be expedited. Rather than giving women time for that baby's head to descend and rather than letting the second stage, the pushing stage, happen more naturally, sometimes that baby's delivery may need to be expedited. That's where we have the consideration of those roles of instrumental births. For example, sometimes an episiotomy, and occasionally a caesarean section, will still need to be performed at that time.

The Hon. NATASHA MACLAREN-JONES: You mentioned a couple of times about being trained in forceps delivery. Is that a requirement, or is it a skill that people should have?

KATHRYN AUSTIN: It is part of obstetric training, the role of instrumental births.. Varying places around the world will have differing levels of expertise with forceps, but it is something that here in Australia the vast majority of obstetricians are trained in how to use forceps - that depends a little bit on the centre for which they practice. Different locations will have different expertise. Medicine is obviously still, in many ways, an apprentice model, where you learn from the seniors teaching you. but obviously also different demographics of population will mean that sometimes instrumentals can be subtly chosen for the idiosyncrasies that are required for certain demographics. For example, we know that in areas with a high Asian population, they do, unfortunately, have higher rates endemically of perineal trauma. Forceps may exaggerate that, in which case a vacuum may be a more suitable instrument. These are all the subtle features that we work towards. It's something that I believe we should continue to utilise but utilise in an appropriate and informed way, and obviously with that rehabilitation that goes along with any delivery.

The Hon. NATASHA MACLAREN-JONES: My other question is around multicultural health plans. You referred to the blueprint that was released earlier this year. Some of the feedback we have received is partly that these plans aren't necessarily filtering down, but also that more work needs to be done. I am interested to hear, from both of you, your views in relation to the plans that the Government already has in place and how that is actually being delivered in the districts.

KATHRYN AUSTIN: Part of that I would probably refer you back to NSW Health, in that it's the delivery of their blueprint. Certainly in NSW Health maternity services, one of the biggest challenges is around staffing and workload, and I draw your attention back to the fact that this is the high-level advice of what we would all aim to have maternity services to be. The practicalities of shifts that are not staffed by enough midwives, and where there are vacancy rates across VMOs and staff specialists of their obstetric workforce, make it incredibly challenging to deliver these services as a whole, but I think it's certainly something that we continue to strive towards. With appropriate reforms in place we could look at delivering those services, particularly to those women who need, from culturally and linguistically diverse backgrounds and our Indigenous population of Australia to really provide those specific areas of care that are outlined in that blueprint.

FIONA DAVIES: We do recognise and acknowledge the newness of the blueprint. We are very supportive of it and we are really keen that it's given the chance, given the work that has gone in. The AMA does not say that lightly. We do not endorse all NSW Health policies but we actually recognise the work that's gone into the development of the blueprint and the opportunities it presents.

The Hon. EMILY SUVAAL: I have another question around midwifery and continuity of care. It is something we have heard about a bit today and along the course of the inquiry, including that midwifery continuity of care should be provided to all women. Women with some risk factors should obviously be also seen by an obstetrician. Can you advise the best way this collaborative care could be achieved to ensure best outcomes for both the women and their babies?

KATHRYN AUSTIN: I think one of the things that we do know is that from probably an early visit and linking and engaging early with maternity services can in fact streamline women into appropriate care models. Women who are low risk or have had uncomplicated pregnancies before can then be linked with lower risk models of care. That may be midwifery continuity of care services. For those women who may fall into a higher risk model, obviously there are still a number of continuity of care services, such private obstetrics, general practice and shared care that we have talked about, that provide a bit more of that medical element to that.

One of the most important things, though, is continuing to expand and develop those services within the workforce constraints. I think one of the biggest challenges around all of this is that workforce and resourcing is obviously incredibly vital to ensure that that continuity of service can be continued to be developed so that women have a lead clinician as a part of that, but we recognise that the NSW Health budget simply does not, and cannot, account for a single obstetrician to care for you in a public hospital throughout your birth. There is no question that aiming towards that continuity of care to provide those education services—be that through those different models that we have discussed—is obviously something to aim for, but recognising the practical implications of what that might mean for our health service and how we can deliver that.

The Hon. EMILY SUVAAL: In terms of the care that women receive more generally, we have also heard about women wanting to receive more respectful care, care that is trauma-informed, so that they can make informed decisions and provide valid consent, indeed. Can you describe some key actions and ways that we could also achieve this also?

KATHRYN AUSTIN: I think one of the biggest challenges—and I keep coming back to this—for the purposes of the Committee is really around that resourcing and looking at workforce development. We know that respectful care occurs beautifully where there is appropriate staffing levels, where women feel they have the appropriate teams around them to care for them for all of those not only physical aspects of birth— with the medical components I have spoken about today—but also the psychological aspects, looking at their emotional wellbeing, looking at physical recovery, looking at things like breastfeeding and midwifery support rates in the postnatal setting. All of those obviously come back to appropriate resourcing and infrastructure to ensure that we have the ability to care for women through that way.

Dr AMANDA COHN: We have had some mention in submissions, particularly from consumer representative groups, about some of the changes that have taken place in Queensland. Some of that was to do with their informed consent model; some of it was to do with endorsed midwives. I'm interested in the perspective of the medical profession on those changes in Queensland and how they've been received.

FIONA DAVIES: We were really interested to note the evidence given around the Queensland roundtables because there has been very significant concern across the country about the state of maternity services in Queensland. It's not melodramatic to suggest that actually in large parts of Queensland maternity services are on the brink of collapse. In fact, the roundtables have been called by the Queensland Government in response to the crisis in the delivery of maternity services. There are large centres now currently struggling to attract doctors to work in those areas, so that has driven the crisis in roundtable response. We should learn from all jurisdictions about places where there are good models, but I think we need to be incredibly careful about the situation in Queensland because it's being watched around the country as a place where people in large centres are not able to access or are running the risk of not being able to access maternity services.

We need to be really clear that the role of doctors and the role of midwives are critical to the provision of maternity services, particularly in large regional centres. I think it's really important for the Committee to just review the context of what's happening in Queensland. Our understanding of the issues is that they are working through them with roundtables, but it is a very significant matter. There is a national shortage—in fact, an international shortage—of skilled workforce. In New South Wales we certainly wouldn't want to see any further reductions to the access to—well, we can comment on medical specialists, but it's a matter that people should be very concerned about.

KATHRYN AUSTIN: Following from that, even in tertiary centres in Sydney there are a number of vacancies across obstetric medical positions. That challenge only becomes greater as we step further away from metropolitan areas. That's a significant challenge to provision of obstetric services and all of those ambitions we have to provide excellent care to women.

The Hon. EMILY SUVAAL: You mentioned your endorsement of the blueprint, which comes as great news and something that's not given away lightly. This inquiry will obviously make recommendations to the Government. If you could suggest anything as a recommendation, what would that be?

FIONA DAVIES: I think our submission actually sets out very much the requirements. I think, firstly, we would really strongly urge a caution about the potential to do harm—so not making recommendations that may seem well intentioned but actually could be catastrophic to the delivery of services. If there was one most critical recommendation, that would be the main one we would make. We don't want to actually inadvertently make this system less safe and harder to work in. That's probably our number one recommendation and, yes, number two is resourcing and workforce.

KATHRYN AUSTIN: Absolutely. That challenge from today of concerns around what that might mean for obstetric practice being held to different account is obviously incredibly concerning for obstetric practice, not only for obstetricians but for midwives on the ground in our birth units in this State, as we speak. Obviously anything that would harm that provision of safe care is incredibly challenging and would be something that genuinely has the capacity to decimate our services. Notwithstanding the importance of psychologically-informed care and the emotional wellbeing that goes with appropriate care for women, I think part of that really is addressed through that appropriate workforce and resourcing that comes behind giving that very best in obstetric care.

The Hon. EMILY SUVAAL: Given the challenges facing, indeed, the world—you mentioned the shortage internationally of certain skills—have you got any suggestions for us as a committee on recommendations that we could make around that, acknowledging as well that obstetrics is certainly a very honed area of medicine and takes many years—in fact, decades—to really refine your craft? How can we work so as to make these positions attractive but also keep people in them?

KATHRYN AUSTIN: I'm not an HR expert; I am an obstetrician. But I think, working in that, obviously recruitment and retention strategies need to be first and foremost. If you have a happy, healthy, safe workforce, all of those things can and should flow down to providing that excellent and empathetic care that we all want to be able to give our patients. Looking very specifically at the appropriate resourcing for positions, recruitment, retention, appropriate funding and salary models for both midwives and obstetricians in the public and the private sector and how those are supported appropriately would be incredibly valuable.

The CHAIR: Thank you both for coming in today. I note that you did take some questions on notice, and there may also be some follow-up questions from committee members, which will be sent through as well via the secretariat; they will be in contact about those. Thank you again for your time.

(The witnesses withdrew.)

The Committee adjourned at 17:30.