



Australian College of
Midwives

ACM: For midwives. With women. For the future.

**New South Wales
Select Committee on Birth Trauma**

ACM Submission

Issued August 2023

New South Wales Select Committee on Birth Trauma – ACM Submission

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia and welcomes the opportunity to provide a written submission to the ***New South Wales (NSW) Select Committee on Birth Trauma***. ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice, and is focused on ensuring better health outcomes for women, babies and their families. ACM is committed to growth of the midwifery profession, midwifery leadership and strengthening and enhancing the opportunities for midwives. Better outcomes for women, include the right to access respectful maternity care, quality maternity care, and the care of their choice, close to home.

Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are over **33 000** midwives in Australia, and there are **8 800** practising midwives in New South Wales which form the largest maternity care workforce. The maternity care system, as with other areas of health, faces significant challenges, further exacerbated by the global Covid-19 pandemic¹. The midwifery workforce is declining with data indicating that there are 1,220 less midwives nationally than there were in 2016². There is evidence that work environments are one element impacting midwives leaving the workforce³. Midwives observing or experiencing adversity in the workplace (such as Birth Trauma) are at risk of compassion fatigue, burnout, and stress⁴.

ACM welcomes the select committee on Birth Trauma bringing to the forefront, an inquiry into birth trauma. The recognition that birth trauma exists, is the first step towards prioritising outcomes that will reduce the incidence and impact of birth trauma on women, families, and health care providers. Maternity service reform and actualising objectives cited in the NSW Health Blueprint is required to improve birth outcomes for women and babies in NSW.

Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide evidence at a hearing

ACM is available to present and give evidence at hearing, if called upon.

Terms of Reference

This submission will address the terms of reference identified by the Select Committee.

Definitions/Glossary	
AIHW	Australian Institute of Health and Welfare (AIHW)
Birth Trauma	“the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature” ⁵ or alternatively as “whatever the woman determines it to be” ⁶ .
Continuity of Care	A team of caregivers working within the same philosophy and framework and sharing information however there is an absence of a designated named carer ⁷ .
Continuity of Carer	Defined as ‘relational continuity’ or ‘one-to-one care’ provided by the same named caregiver who is involved throughout the period of care even when other caregivers are required. A defining requirement of ‘continuity of carer’ model is that the care is provided or led over the full length of the episode of care by the same named carer ⁷ .
Obstetric Violence	Pertains to violence against women in that “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” ⁸
MGP	Midwifery Group Practice
Psychological Safety	Psychological safety refers to an employee’s ‘sense of being able to show and employ oneself without fear of negative consequences to self-image, status or career’ ⁹ Team psychological safety is a shared belief that a team is safe for taking interpersonal risks and found strong support for an association between team psychological safety and team learning behaviour, which in turn was related to team performance ¹⁰ .
Trauma informed Care	Trauma Informed Care is when every part of service is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services ^{11, 12}
WHO	World Health Organization

ACM Recommendations

Throughout this submission in each section ACM provides actionable recommendations and findings, however the overarching priority recommendations include;

1. NSW Ministry of Health to commit to fully funding all [ten goals](#)¹³ and associated objectives of the [‘2023 Blueprint for Action](#)¹⁴ – Maternity Care in NSW’ with a completed implementation plan including benchmark targets, actualised within 6-12 months.
2. NSW Ministry of Health to review and/or implement Service Level Agreements with Local Health Districts to ensure the required structural and system level reform in maternity care as per Blueprint objectives is included, funded and actioned.
3. Every woman to have a known midwife and access to full continuity of midwifery models of care, with targets as a matter of priority as per Blueprint objectives 4 and 6.
4. Development of multi-disciplinary trauma informed obstetric emergency and consent training.
5. Priority integration of privately practising midwives into NSW maternity services, including authority to practise within hospital settings and enabling hospital admitting rights NSW-wide for Privately Practising Midwives.
6. Expansion of First Nations’-led midwifery models of care in NSW.

Further recommendations are listed at the end of each question section below.

ACM Response – Background

“People do not start their day planning how they will cause trauma.”

(ACM Survey Aug. 2023, Midwife, 10-20 years, metro NSW).

Birth trauma may result from a single event or range of situations during the perinatal period. Birth trauma is a woman’s experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman’s health and wellbeing¹⁵.

Mistreatment of women during pregnancy, childbirth and the post birth period has been recognised by the World Health Organisation (WHO) as a global issue. In 2014, the WHO issued a statement **‘Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care’**¹⁶ with recommendations to support positive childbirth which include *respectful*

maternity care, effective communication, companionship during labour and birth and continuity of midwifery care.

Australia, and other high-income countries, have been largely absent from global research studies into birth trauma and obstetric and gender-based violence, however that does not diminish that this issue exists⁶. Maternity care in Australia is represented in government policy to have high levels of safety in relation to maternal and neonatal morbidity and mortality – the National Maternity Strategy - Woman Centred Care Strategic directions for Australian maternity services opens with the quote *“Australia is regarded as a safe country in which to have a baby and compares well on a number of accepted measures of safety and quality of care”*¹⁷.

There is, however, a growing body of evidence that birth trauma is increasing in Australia. The largest survey of Australian women’s birth experiences demonstrated 1:10 women reflected they had experienced obstetric violence and 28% of women had experienced birth trauma⁶.

New South Wales Context

NSW Health foreword ‘A Blueprint for Action – Maternity Care in NSW’¹⁴ recognises the fundamental importance of the provision of *‘socially and culturally respectful maternity care assists with ensuring physical and wellbeing outcomes for the woman, her partner and their baby...Each person accessing maternity services must be respected without assumptions, judgement or cultural bias.’*

The ‘NSW Health First 2,000 days Framework’ highlights the following: *‘Service models seek to support continuity of carer where possible and there is smooth transition between those providing care where required’* and furthermore *‘Preparing mothers emotionally for birth, and promoting the mental health of parents and carers in pregnancy, can make a dramatic difference to how parents and carers experience birth, and how they cope in their transition from pregnancy to parenthood’*¹⁸.

ACM Finding: It is evident from this inquiry, and contemporary birth trauma research that this goal is yet to be actualised.

The objectives of the Blueprint for Action¹⁴ strategy fulfill several priority areas ACM recommends through this document. Key objectives include;

4.2 *Every woman has a known GP, and access to a known midwife and/or obstetrician/GP obstetrician with uninterrupted channels of communication between all care providers.*

ACM acknowledges the intent of 4.2, however also asserts that every woman should have a known midwife.

6 Women offered different care options, are actively involved in decision-making about their care and their choices are respected.

6.1 A range of continuity of care models for maternity care, including all risk midwifery models and culturally safe continuity of care models for Aboriginal women, are available.

6.2 Up-to-date information about the full range of local maternity services is publicly available.

6.3 Women are supported to make informed decisions about their care and their choices and preferences are respected.

6.4 Women and health professionals maintain a supportive care partnership when women decline recommended care

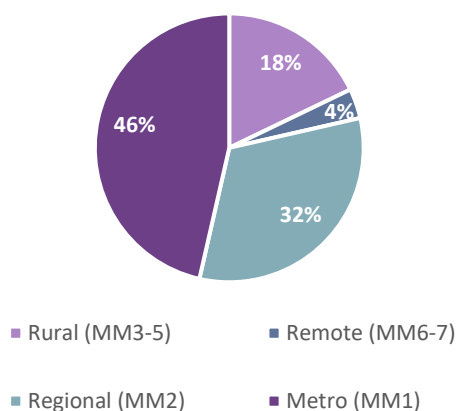
Recommendations:

1. NSW Blueprint document be updated to include; Every woman has a *known midwife*, and a known GP and/or obstetrician/GP obstetrician with uninterrupted channels of communication between all care providers.
2. ACM strongly asserts that an actionable implementation plan for the Blueprint, with timeframes and targets for objectives 6.1-6.4 is required and through this will contribute to improved care for women and their babies and a measurable reduction of birth trauma in NSW. ACM also highlights that there is no references to birth trauma per se in the Blueprint, and this is a gap which requires resolution.

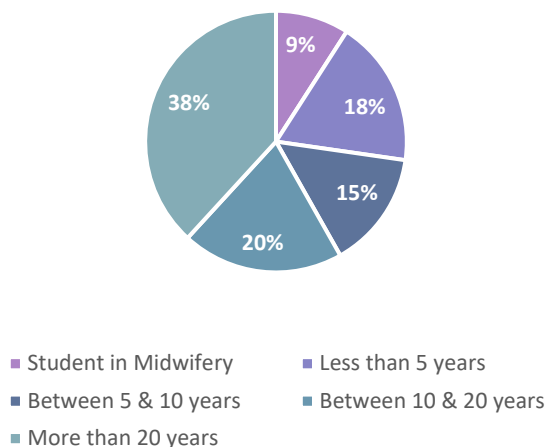
ACM: Midwife survey overview

ACM conducted a National member survey for midwives to gather a background of midwives' experience of birth trauma in Australia and inform the context of this submission. A total of 43% of respondents were from NSW (n=84); 38% of midwives had more than 20 years Midwifery experience; 42% of midwifery student responses were received from NSW. The midwives' experiences are reflected in this submission in the form of select quotations. Midwives are frontline clinical workers in maternity care provision in NSW.

NSW Geographical location



Midwifery experience (years)



Some midwives disclosed within their responses - in confidence - that there were concerns expressed by some managers around midwives providing submissions to this inquiry. ACM considers that this may be indicative of the current maternity care culture and may reflect the patterns of behaviour that are the focus of this inquiry.

ACM's member survey demonstrated the following key themes;

- **Communication**
 - Language - *"Let's do this now before it really becomes an emergency"*
 - Poor provision and sharing of information
- **Consent**
 - Lack of informed consent
 - Coercion in the face of active refusal – Partnering with the woman who declines recommended maternity care
- **Emergency procedures**
 - Post Partum Haemorrhage (PPH) management, shoulder dystocia
- **Medical interventions**
 - Induction of labour, episiotomy
- **Workforce Challenges**
 - Burnout, stress, constraints, trauma

Midwives are leaving the profession citing environmental concerns and workplace issues, which were demonstrated in survey responses. Whilst midwifery education impresses upon midwives the importance of providing respectful, woman-centred continuity of care, the reality is that many midwives feel unable to provide it¹⁹. Workforce shortages compound pressure, contribute to poor communication and time constraints which impact adequate care provision. The Work, Health and Emotional Lives of Midwives (WHELM)²⁰ consists of a range of studies conducted across many countries including Australia. Within this body of work, studies evaluating midwives' responses to birth trauma identify the high level of stress and emotional response midwives experience as a result of their work and workplace²¹.

Student in Midwifery responses (NSW)

*"I witnessed a number of events that may have resulted in birth trauma while on placement in a private hospital. The language I heard used in speaking to labouring and postpartum women was often **degrading, dismissive and belittling**. I saw episiotomy given against a woman's wishes, I saw **racism**, I heard care providers vocally doubting that a mother 'cared whether (your) baby survives"*

*"I am a 3rd year student midwife and have had all university placement at X Hospital. I have been shocked by the number of women who I have witnessed experience births that have been "traumatising" and have looked after women including in continuity of care who have had past experience of birth trauma. My experience in birth suite of witnessing births that require intervention **has outweighed the number of normal vaginal births** in my experience".*

*"Yes. I think most births these days carry an element of trauma for women and birthing people, even if it isn't something us as staff and students would be able to guess. **We do not enable safe care for these people** so by its very nature that means there is reduced protection against birth trauma for them. And yes, I have seen birth trauma and birth distress identifiable in the moment as well".*

*"Yes, I witnessed a forceps birth which was not really communicated well to the woman and what it entails.... The Dr was getting her equipment before getting any consent from woman. There was no emergency for the baby or mum. The Dr stated to the mum 'you might feel tired soon and the baby might feel tired soon too'....The team leader midwife did not advocate for the woman. It was horrifying to witness how quickly the Dr moved and pulled the baby out. **The woman was traumatised and refused to talk for 2 days**".*

Terms of Reference

- a) **The experience and prevalence of birth trauma (including, but not limited to, as a result of inappropriate, disrespectful or abusive treatment before, during and after birth, also referred to as “obstetric violence”)**

“Obstetric violence is frighteningly commonplace. Some days you are saddened by it, some days angry, some days numb to it. We feel powerless to help within the regulations, frameworks, and policies on micro, meso and macro levels” (Student in Midwifery, Metro).

With the recent publication of the BESt study, Australia’s largest survey into birth trauma, the **Birth Experience Study**⁶ examined birth trauma and obstetric violence and found there is a growing recognition of these experiences which are characterised by women feeling dehumanised, violated and powerless. Such feelings are linked with a trauma response, and are not just experienced by birthing women, but an increasing number of birth support people, and healthcare professionals. Witnessing a traumatic birth can result in feelings of helplessness and fear. With more than half of the respondents from ACM’s member survey in NSW reporting that they had witnessed birth trauma whilst working as a midwife or on placement as a student. A considerable number of midwives had personally experienced birth trauma in their own birth experience, suggesting that birth trauma does not discriminate against health literacy.

“Women are not the centre of care, the organisation is. The health professionals, and it is most likely doctors, also want care decisions to be made that make them feel safe. I have seen the most abhorrent disrespect and coercion with language, contemptuous attitude, anger, violation of human rights, bullying, threats, refusing and attempting to withdraw care or the right to enter a public hospital. Birth trauma and violation of human rights and disrespectful maternity care is prevalent and rife and getting worse and health care practitioners are not feeling safe or supported by legislation or regulatory boards or by organisations to support women and their rights to informed choice and respectful maternity care.” (Midwife, 10-20 years’ experience, regional NSW).

*“Yes, in birthing I have seen chaotic events with minimal communication with the woman and poor communication between team. Doctors arguing over women with forceps on a baby’s head. **Not treating the woman as a person**”* (Midwife, 10-15 years’ experience, metro NSW).

“Yes... the first incident I witnessed, and I have never forgotten was as a student midwife... The team just jumped in and started doing things to her... As they were attaching the ventouse to the baby's head and pulling the woman was yelling, 'Stop! Stop! Get out! Get out!'. No one paid her any attention. It reminded me of rape.” (Midwife, more than 20 years' experience, regional NSW).

“too many times - lost count years ago. 1. never obtaining consent then doing an episiotomy 2. pulling on the forceps in between contractions and damaging the pelvic floor (with no fetal distress) 3. Shroud-waving to women to coerce them into agreeing to whatever” (Midwife, more than 20 years' experience, regional NSW).

“This must also include the inappropriate treatment towards midwives and maternity providers whilst providing midwifery cares, by both patients and support persons” (Midwife, NSW).

b) Causes and factors contributing to birth trauma including:

i. Evaluation of current practices in obstetric care

“Lack of midwifery and medical leadership along with a constant culture of blame contributes to poor outcomes and traumatised families - debriefing used as a method of excusing poor practice rather than knowing what woman want to understand” (Midwife, more than 20 years' experience, regional NSW).

Over the last two decades there has been an increased focus on evidence-based policy in maternity care with the intention of improving outcomes for both mother and baby. It is not apparent this goal is being realised - with rates of stillbirth remaining static at 7-8 per 1000 births between 2003 and 2023 whilst interventions such as induction of labour and caesarean sections have risen significantly from 17% in 1996 to 38% in 2021²². The WHO states that at the population-level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates²³.

“This occurs in the antenatal clinic and labour wards mostly. The baby is front and foremost the most important person in the dyad and the mother is just the vehicle. This comes from health providers being too frightened of consequences when things go wrong if the care provider feels the mother is making choices that might cause harm to the baby”. (Midwife, 10-20yrs experience, regional NSW).

Physical birth trauma includes perineal damage which has been the subject of clinical practice review with the implementation of the perineal care bundle in 2018. An examination of the implementation of this care bundle identified lack of information and consent, the prioritisation of policy over women's autonomy²⁴ and obstetric dominance and midwifery submission²⁵.

"Horrible forceps births with a mother who was hysterical, refused to hold her baby, wasn't given adequate pain relief during suturing despite her begging for more. I was a student witnessing this and it was ages ago, but it still haunts me". (Midwife, more than 20 years' experience, Metro NSW).

Emotional trauma results when a woman feels 'dehumanised', unseen, and unheard. Informed consent, communication, and processes for the women to decline cares outside of recommended guidelines are required in NSW²⁶.

"Yes. Huge problem in understanding of physiological labour and birth process in obstetric and midwifery care. Breakdowns of multi-disciplinary respectful discussions. Cascade of intervention - women really need to be informed of this before the first intervention. We have a huge gap in maternity services in how women are supported after their birth - obstetric teams are debriefing women but this should be midwifery led as well". (Midwife, less than 5 years, metro).

There is a need for greater ability to individualise the care provided to women and families in models of care such as midwifery continuity of care. In NSW currently the Local Health Districts' autonomy does not create a universal focus on continuity of care, and thus there is a continuity of care lottery for entry into this model at a very early gestation depending on where you live.

Midwifery continuity of care is one of the 11 Maternity Care Classification System ([MaCCS](#))²⁷ models of care where women have a primary midwife who provides care from the booking visit in early in pregnancy, through labour and birth and the postnatal period. Continuity of Midwifery Care is the benchmark standard model of care in Australia, yet only 10% of women in Australia²⁸ and only 13% of the models of care in New South Wales are midwifery group practice (MGP) models offering continuity of care²⁷. Midwifery continuity of care has many benefits which positively impact women's outcomes and therefore their experiences of birth.

Maximising midwifery continuity of care models will support opportunities for relational based care thereby reducing the risk of intervention and having access to a known midwifery carer is demonstrated to reduce the risk of birth trauma⁶. Federal Government support for midwifery models of care as the preferred model of care is clearly articulated in the Woman-Centred Care strategy, however the jurisdictions are not required to prioritise continuity of care models with the current funding structures within the National Health Reform Agreement addendum (currently under review)²⁹.

“Lack of continuity of care availability for women must be addressed. Health systems not allowing midwives to work at their full potential- feeling hamstrung by medicalisation of pregnancy and birth care. Increase in Induction of Labour (IOL) for first time mothers (in NSW almost 50% which is a real issue) We have to get the first birth right then subsequent ones will be easier and less trauma to deal with”. (Midwife, more than 20 years’ experience, Metro).

“There is minimal medical governance in rural sites so no one over seeing what is going on or to support midwives” (Midwife, more than 20 years, rural).

“... NSW health policies are poor and severely lacking to support health professionals to support women without fear of blame and litigation. There are absolutely no enablers other than individual strength and courage and integrity and a desire to not make decisions for women” (Midwife, 10-20 years, regional NSW).

“Bullying behaviour from senior staff members. A one size fits all approach. Time pressures to push labour along e.g. attend ARM's, threaten caesareans etc. I have often felt that I was practicing with my foot against the door to prevent unnecessary threat and unnecessary intervention (and I am a very measured midwife). The emotional toll of this was why I eventually left birthing suite after 15 years of practice.” (Midwife, more than 20 years’ experience, regional NSW).

“Length of shifts, adequate breaks during a shift. Perhaps having more on-call staff available in a roster for both medical and midwifery staff to cover during busy shifts. The challenge is finding the extra staff to cover the on-call” (Midwife, more than 20 years’ experience, metro NSW).

Recommendations:

3. That NSW Health develop reduced intervention rate targets in line with WHO recommendations.
4. Implementation of a [partnering with the woman who declines recommended maternity care](#)²⁶ guideline in NSW as per Blueprint 6.4.
5. Increase access to full continuity of midwifery models of care, with targets as a matter of priority (refer to ACT Health [Maternity in Focus](#) Plan)³⁰.

ii. Use of instruments and devices for assisted birth e.g., forceps and ventouse

There is a view that the rising rates of obesity, diabetes, large for gestational age babies and older mothers increase the rate of intervention in birth. However, intervention rates are rising across all demographics²² and are significantly higher in the private sector^{22,6}. It is important that this is considered in the context of birth trauma.

Instrumental birth often results from what is referred to as ‘the cascade of intervention’³¹ and often commences following the use of exogenous oxytocics to initiate (induce) or augment (speed up) labour. This can lead to less tolerable contractions and results in other interventions such as epidural anaesthesia, contributing to a three-fold increase in the rate of instrumental birth in primiparous women (first births)³². The use of instruments and devices for assisted birth is often reflected by women to be highly traumatic⁶. The procedures involve women in vulnerable positions (in stirrups) and are usually conducted due to a perceived problem with the progress of labour or distress of the unborn baby. The use of continuous electronic fetal monitoring severely restricts the mobility of the women, if telemetry is not available. All of these factors alone may contribute to the experience of birth trauma.

Models of care that reduce the rate of intervention should be prioritised. Midwifery continuity of care is associated with a reduction in intervention and offers a protective factor by reducing the rates of epidural anaesthesia, induction of labour and operative birth^{33,34} but also in reducing the likelihood of a woman experiencing birth trauma³⁵.

Recommendations:

6. Actualisation with implementation criteria and targets for NSW Health Blueprint for Action Goal 6: (6.1-6.4) and
7. Inclusion of informed consent information in all NSW Health consumer publications.

iii. The availability of, and systemic barriers to, trauma-informed care being provided during pregnancy, during birth and following birth

Understanding the consumer perspective and consumer involvement in all layers of health care service delivery will ensure experiences such as birth trauma don't go unnoticed. [NSW Health patient reported measures](#)³⁶ will enable transparency in reporting in maternity. Outcomes measures which include patient reported outcome measures (PROM's) and patient reported experience measures (PREM's) are beneficial to the overall maternity care system due to the growing awareness of the short, medium, and long-term impacts of birth trauma which are now being both collected and reported on.

Midwifery continuity of care reduces the risk of stillbirth by 16%, reduces pre-term birth in the general population by 24% and 50% in First Nations' women and results in lower levels of intervention including induction of labour, operative vaginal birth, episiotomy, and it increases women's satisfaction with their birth experience³⁷.

Trauma-informed care requires an understanding by both the maternity care system and the individual health practitioners that each person receiving care may have experienced trauma at some point during their life. Trauma-informed care is based on the understanding that a significant number of people have experienced trauma in their lives, that trauma may be a factor where people are experiencing distress, that the impact of a previous trauma may be lifelong, and that trauma can impact many aspects of a person's life including their emotions and relationships with others³⁸.

There is very limited understanding and access to trauma-informed care in the maternity sector. Models of care where the women and family receive continuity of care are likely to provide a better opportunity for trauma-informed care because the relational model of care provided maximises the relationship with the woman and knowledge of her history including previous trauma. Some areas of health care – including First Nations Health, and health for culturally and linguistically diverse communities within particular

ethnic groups – may have had a better understanding and more education. This may provide an opportunity for trauma-informed care.

Barriers to trauma-informed care include fragmented and standard models of care where there is no ability to develop an understanding of all aspects of the woman's history due to short periods of contact with large numbers of care providers.

Recommendations:

8. Education for all health care practitioners and those who manage maternity services with regards to trauma informed care principles is essential to better consider the needs of women and families as per Blueprint¹⁴ Goal 1.2.
9. Actualisation with implementation criteria and targets for NSW Health Blueprint for Action¹⁴ Goal 'Respectful and Inclusive Care' including 1. Women receive maternity care that is socially and culturally respectful and included women with lived experience of trauma.
10. Increased access to midwifery continuity of care with a known carer with targets e.g. ACT Health³⁰ target of 85% by 2032.

c) The physical, emotional, psychological, and economic impacts of birth trauma, including both short- and long-term impacts on patients and their families and health workers.

The 2021 Fuchsia Report³ is a Victorian based state-wide study exploring health wellbeing and sustainability of the midwifery workforce. The Executive Summary notes: 'The provision of safe maternity care that achieves optimal health and wellbeing outcomes for women and babies depends on an adequately staffed, skilled midwifery workforce.' It further acknowledges there is a lack of quality information with regards to the health and wellbeing of the midwifery workforce.

According to the report:

- 20% were unsure about how long they'd stay in the midwifery profession
- Nearly 40% regularly thought about leaving the profession
- >25% were planning to leave midwifery in the next 5 years; due to feeling
- Worn out (73%); experiencing work-related stress (64%) and disillusioned with midwifery (58%)

The report also states: ‘They considered that the lack of midwives, and the fact that a large proportion of the midwifery workforce was exhausted, along with heavy workloads, meant that care provision was less safe than it could be, and that this might impact outcomes for women and babies. The heavy workloads were attributed to inadequate midwife-to-patient ratios, insufficient numbers of staff or experienced staff (both), lack of time with women (due to increased patient acuity and more administration tasks) and less ability to educate women due to the increasingly shorter duration of postnatal care provision, both in hospital and at home after discharge. Respondents also reported that the care they provided was often over-medicalised and not woman-centred due to system-level issues (e.g., policies that do not allow for individualised care, and ongoing staffing deficits). Midwives and managers both reported a lack of support, and frustration about not feeling heard and acknowledged for the work they, do both by their organisations and professional and/or governing bodies.’

As can be seen above systemic staffing and workforce issues are likely to be contributing to birth trauma and this in turn impacts not only women and their families, but significantly also health professionals. There is also a lack of flexible working options in the midwifery workforce which limits the opportunity for flexible return to work options for midwives or reduced working hours or job sharing. The health service should support midwives to work in their preferred model of care and there needs to be targeted strategies for rural and remote areas to support regional continuity of care models.

One survey respondent highlighted the difficulty in accessing perinatal mental health services for women, and the increased demand for allied health referrals, such as women’s health physiotherapy and other services that can support a woman who has experienced birth trauma, however of concern to ACM is the impact this is having on midwives. *“...For us, as birth workers witnessing these disgraceful acts, it has a mental impact on us & we’re more inclined to get sick and suffer mentally. Yet, we need to be strong for our clients, and for future clients.”* (Endorsed Midwife, more than 20 years’ experience, metro NSW).

*“Yes. A woman I was caring for had a suspected amniotic fluid embolism after the Dr did an ARM. She became unresponsive, her oxygen levels dropped to 60-70%. The woman progressed quickly, had a massive PPH and developed DIC. I still remember asking a senior midwife if the woman was going to be ok when she went to the OT. The response from the senior midwife that *she may die* still resonates. The woman and her baby survived, but I was left in pieces as I relived the experience and the idea that she nearly died. I felt a false sense of responsibility for what happened even though rationally I knew the event had nothing to do with my care. I had no support from my workplace as I battled the trauma of the event*

and emotionally, I broke down needing to take time off work. I used my own annual leave and saw a psychologist during this time. My workplace didn't ever acknowledge or offer support. Today I still live with this experience, and I actively need to manage my anxiety related to work.” (Midwife, 10-20 years' experience, regional NSW).

Recommendations

11. implementation of the following Fuchsia Report recommendations in NSW:

- i. Increase access to midwifery continuity models across all services.
- ii. Creation of midwifery leadership roles at all levels to provide strategic leadership specific to the midwifery workforce and the professions unique needs.
- iii. Leadership training for Midwifery Unit Managers with a key goal of improving workplace culture and provide effective leadership; subsidise education programs that build midwifery leadership and expand opportunities for midwives to reach their full scope of practice – ACM also acknowledges the NSW midwifery leader's mentorship program which is in train with very positive responses from midwifery leaders.
- iv. Targeted strategies for regional/rural NSW (e.g., incentives to relocate, bonded scholarships to rural areas for midwifery students, increasing birthing capabilities in services, supporting regional continuity of care models, and fostering partnerships between metropolitan and regional services).
- v. Service Level Agreements with LHD's.
- vi. Increased clinical support staff to support graduate and early career midwives in continuity.

d) Exacerbating factors in delivering and accessing maternity care that impact on birth trauma generally, but also in particular:

i. People in regional, rural and remote New South Wales

Women in regional, rural and remote locations (MM 3-7) have the right to the same equity and access of maternity care as women in metropolitan areas. However, closures of rural and remote maternity services over the last 20 years have created limitations in equity and access for women. Australia wide there are significant workforce shortages in these areas. New South Wales has not been spared from these challenges. Medical workforce shortages mean that more agency or locum obstetricians and/or midwives may be used, which impacts continuity of care provision and services may close or go on bypass as a result.

The additional requirement to travel for birth means that women are unlikely to have continuity of care with a trusted health professional, leave family supports, often having to travel in labour, adding to both the perception and potential of a negative outcome (i.e. birthing on route, complications whilst travelling). Where services exist, there are limitations in options for models of care and staffing. There may be an inability to provide services that are culturally appropriate and there is a significant cost impact on the woman and her family if she must travel in advance of her due date, to be close to a maternity service. All of these factors may contribute to psychological stress and increase the likelihood of birth trauma.

Within NSW, the options for midwives with an endorsement for scheduled medicines to be publicly employed are limited. Only one hospital in NSW (Westmead) has admitting rights for private practice (endorsed) midwives. This minimises the opportunities for full use of this midwifery workforce. Endorsed midwives in other jurisdictions – most notably Queensland, with increasing numbers in Victoria, WA and NT – provide midwifery continuity of care, are able to work in a “hub and spoke” model in rural and regional areas and are integrated with multidisciplinary teams in larger centres. These limitations are despite the National Health Reform Agreement³⁹ which requires the Commonwealth and State Governments to identify: *‘rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes’*.

ii. First Nations people

First Nations people make up 5% of birthing women in NSW²² but according to the BESt study⁶ 37% of First Nations women reported experiencing birth trauma in NSW, significantly higher than the 28% of all women who reported their birth as traumatic. Investment in the First Nations midwifery workforce must be prioritised with First Nations midwives, for First Nations midwives – refer [Genke II](#)⁴⁰ report.

Birthing on Country models have demonstrated the best outcomes for Aboriginal mothers and babies nationally⁴¹. Birthing on Country models include provision of midwifery continuity of care and focus on the RISE framework which looks at redesign, investing in the workforce, strengthening and embedding in community control⁴². Outcomes include reduction in preterm birth by 50%, reduction in low-birth-weight babies, reduction in interventions including caesarean section and increases in breastfeeding rates. The provision of these models of care provides an opportunity to grow the First Nations midwifery workforce in culturally safe models.

Recommendation:

12. Establishing and expanding Birthing on Country models in NSW with State funding, such as Waminda in Nowra NSW to care for First Nations women, in concert with the Federal Government and the ACCHO sector.

iii. People from culturally and linguistically diverse (CALD) backgrounds

Women from culturally and linguistically diverse backgrounds face additional challenges including cultural safety and language barriers impacting informed consent processes. It is critical to consider trauma-informed care particularly for migrant and refugee women. Midwifery models of care with a known carer are the most appropriate relational based care models.

“Vaginal examinations without consent. Episiotomy on woman with no English without a translator.”
(Midwife, 5-10 years’ experience, rural NSW).

“The practice of inducing labour in women of South Asian Origin before or at term based on anecdotal evidence of an ‘increased risk’ of stillbirth for these women if not induced.” (Midwife > 20 years, metro).

“Birth trauma is significantly more likely for women who don’t have English as their first language. Trauma is more likely to be caused by maternity care providers that are not up to date in their practices”. (Midwife, 5-10 years, rural).

Recommendations:

13. Actualisation with implementation criteria and targets for NSW Health Blueprint for Action Goal ‘Respectful and Inclusive Care’ including 1. Women receive maternity care that is socially and culturally respectful and included women with lived experience of trauma.
14. Increased access to midwifery continuity of care with a known carer.

iv. LGBTQIA+ people

The experiences of LGBTQIA+ people are reflected in the Senate Inquiry into Universal Access to Reproductive Healthcare and reflect those of other marginalised groups. International evidence demonstrates the LGBTQIA+ community experience worse outcomes, particularly when considering psychological well-being during the perinatal period⁴³. There is evidence that fragmented models of care are not well equipped to support the individual needs of LGBTQIA+ people in childbirth.

Recommendations:

15. for d) i-iv

- Actualisation with implementation criteria and targets for NSW Health Blueprint for Action Goal 'Respectful and Inclusive Care' including
1.2 Culturally and psychologically safe evidence-based models of care are developed and supported in partnership with:
 - women with lived experience of trauma
 - Aboriginal women and communities
 - women from culturally and linguistically diverse backgrounds and their communities, including refugee communities
 - women with disability
 - Lesbian, gay, bisexual, trans and gender diverse, queer, intersex and asexual + (LGBTQIA+)

v. Young parents

The BESt survey revealed that 41% or 1 in 6 young women having maternity care had significantly higher rates of birth trauma⁶. The reasons for this are not demonstrated in evidence but could include the perceptions of care providers, lack of appropriate antenatal education that is available and inability to access choice in models of care.

Recommendations:

16. Implement a maternity and early childhood strategy for young parents
17. Expand and prioritise access to continuity of care places for young mothers.

e) The role and importance of “informed choice” in maternity care

“You do not have informed choice if you're told there is no choice - which women are told all the time, about a huge variety of things.” (Midwifery student, metro NSW)

Informed choice informing shared decision making that is woman centred is fundamental in maternity care. It is defined as the process of choosing from a set of options based on accurate information which align with an individual set of values⁴⁴. A lack of informed choice is a significant contributing factor for women experiencing birth trauma.

Health professionals are provided undergraduate education on the informed consent processes however the application of the principles of informed choice in practice are inconsistent. It is critical that the health care professionals informing women take the time to explore in detail the options available and provide sufficient accurate unbiased information to enable informed choice. Staffing and workforce issues impact time available for education and consent. Midwives reflect that this alone is a serious issue for them in meeting their own expectations about the care they provide²¹.

There are often limited opportunities for care providers to reflect on their own assumptions and bias about the nature of choice and what constitutes informed choice. Informed choice requires women to be offered the ability to accept and decline treatment and options. Right of refusal is an issue health care providers may find difficult to reconcile in certain situations. The law is clear that women have the right to bodily autonomy and that until born, a baby does not have the same rights in law however elements of this prove controversial at times. Partnering with women who decline recommendations in care is well developed in some jurisdictions including Queensland²⁶ and ACM includes within our National [Midwifery Guidelines](#) for Consultation and Referral an appendix for documenting refusal of aspects of care⁴⁵.

Less than half the NSW women within the BEST study experienced high level of autonomy in decision making during their maternity care⁶. This is a significant factor in birth trauma and also for workforce environmental issues where healthcare providers, including midwives feel unable to spend sufficient time with women in education and also feel that women's choices are not respected²⁸. In certain situations where midwives are working in the community, in MGP's or in private practice, the informed choices that women make may place the midwife under scrutiny and potentially in breach of regulatory requirements. This is a growing area of concern where women are seeking, for example, home birth in areas where it is not available in the public system.

Women are also often excluded from specific options in care due to varying site policy documents. These include women not being offered home birth, water birth and midwifery continuity of care due to risk factors. These policies, whilst designed to minimise risk of harm, do not fundamentally provide an opportunity for informed choice as there may be alternatives in other maternity care settings that are not available to all women, depending on the policy itself and their location. There are rising rates of avoidance of the hospital system from women seeking home birth, water birth and midwifery continuity of care. Where women fall outside the guidelines and are unable to find care from a Midwife they are, in growing numbers, birthing without a regulated health professional in attendance. There is currently no

data collected or reported within NSW or Nationally on the numbers of women who are choosing to birth at home without midwifery care; leaving gaps in understanding of these trends.

"I've seen a woman's knees be forced open to access her perineum for suturing. I've seen a baby removed from their mother (with preexisting trauma due to separation from previous baby), purely due to cultural norm and staffing choices in unit. I've seen women berated like children and told they will kill their baby if they don't do what they're told. I've seen gross omissions of information resulting in a failure to obtain true consent". (Midwife, less than 5 years' experience, regional NSW).

"Staff don't understand this effectively and all too often fall on the side of their employer / superiors / colleagues instead of supporting what the individual patient wants and needs, because they are scared to support her effectively, thinking they could lose their registration for not adhering to NSW Health policy." (Midwife, 5-10 years, rural NSW).

Recommendations:

18. Actualisation with implementation criteria and targets for education for health care providers with regards to informed consent to ensure NSW Health Blueprint for Action Goal is actioned: 6.3: Women are supported to make informed decisions about their care and their choices are preferences are respected.
 - a. Ensure that comprehensive care planning explores the woman's preferences, and her choices and decisions are respected, communicated and documented. This includes obtaining valid consent when required.
19. Actualisation with implementation criteria and time-bound urgency to ensure NSW Health Blueprint for Action Goal is actioned: 6.4: Women and health professionals maintain a supportive care partnership when women decline recommended care
 - a. Develop and make available guidance for health professionals for when women decline recommended care – within the next 6-12 months.
20. Supplementary recommendation: Review and implement a similar model to the Queensland Health process for partnering with women who are declining recommendations in care. Provide education around this process and ensure that there is recognition of women's right to choose alternatives that are outside of maternity service policies.
21. Implement data collection methods to inform women choosing care outside of the system.

f) Barriers to the provision of “continuity of care” in maternity care

The NSW Health First 2000 days Framework asserts that ‘Families will be supported by continuity of care in antenatal to school and beyond’ and that ‘Service models seek to support continuity of carer where possible and there is smooth transition between those providing care where required’¹⁸. However despite these assertions, many women in NSW are unable to access or experience continuity of care by a known care provider.

The barriers to provision of midwifery continuity of care are complex.

They include;

- a focus on activity rather than outcomes in both Commonwealth and State and Territory **maternity funding** models,
- a lack of investment in **midwifery leadership**
- **Disparity of remuneration compared to other jurisdictions**
- **Unfounded perceived risk of all risk models of care**
- workforce issues, including
 - **education and pathways to practice, and**
 - **endorsed midwives**

Barriers also occur for priority populations and higher risk women due to a lack of understanding of midwifery scope of practice and consultation and referral pathways where midwives provide care to higher risk women. Locational factors and a lack of awareness of options for maternity care impact access to midwifery continuity of care, and importantly midwifery continuity of care requires investment and sustained development. As a strategic imperative it will, if employed effectively, contribute significantly to the reduction in birth trauma⁶.

Maternity Funding

Maternity care is funded by both the Commonwealth and the States and Territories. There is no funding model which currently offers an opportunity to preference continuity of care. The current funding supports models based on fee for service and acute episodes of care. This perversely incentivises activity rather than outcome. Activity in maternity care tends to be linked with actions, potentially interventions. However, the maternity care pathway is also fairly fixed in length and almost universally leads to a hospital

admission for birth. This makes it possible to plan and predict costs, particularly if costs were grouped or bundled into antenatal, intrapartum and postpartum period as per the [2017 IHACPA review](#)⁴⁶. The decentralisation of responsibility and autonomy of each Local Health District (LHD) in NSW also compounds this and further fragments the way maternity care is funded and care is provided. The Commonwealth has developed the Woman Centred Care Strategy, however without an implementation plan or funded action plan associated with it to require the implementation of continuity of care models.

Midwifery Leadership

Barriers to continuity of care include a lack of midwifery leadership in NSW Health at all levels of workforce. Transforming provision of care to a midwifery continuity of care model and sustaining that model requires an understanding of the principles that underpin the way that midwifery models of care work. There is a significant shift in management principles to support midwives working in caseload models as they work more autonomously, are on call and manage their own time. This is quite distinct from a traditional shift work pattern and does not align well with nursing models which makes it difficult for nursing leadership, as opposed to midwifery leaders, to understand, implement and sustain midwifery models of care⁴⁸.

Annualised Salary for midwives working in caseload / midwifery group practice

The midwifery group practice localised industrial agreements for annualised salary in NSW does not align with annualised salary loading payments for midwives working in comparative continuity of care caseload models across various states and territories in Australia and therefore disincentivises midwives wanting to work in these models and contributes to further pressures on the workforce with midwives relocating out of New South Wales for work.

Perceived Risk

Developing and sustaining midwifery continuity of care requires services to have a fundamental understanding and education in the premise of an all-risk continuity of care model. Women may be restricted entry to models based on risk i.e. the models may only cater to low-risk women, despite the assertion in the NSW Blueprint¹⁴ that all risk models should be available. Midwifery continuity of care is safe at all levels of risk when there is appropriate consultation and referral pathways established³⁵. The ACM National Midwifery Guidelines for Consultation and Referral⁴⁵ is a guideline agreed by ACM and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) outlining

provision of midwifery care for women at all levels of risk including within midwifery continuity of care models. It is critical that women are not excluded from a particular model of care due to risks as research demonstrates that those of highest risk may experience the most benefit from this model⁴⁹.

Education and pathways to practice

Midwives graduate ready to provide midwifery continuity of care. Many graduates are leaving the profession shortly thereafter due to an inability to work in practice settings that aligns with their philosophy of care i.e. midwifery continuity of care⁵⁰. Additionally, the pathway into an endorsement for scheduled medicine requires 5000 hours (3 years) of clinical practice in order to meet AHPRA requirements⁵¹. This is another barrier for midwives seeking to work to full scope of practice and a reduction in hours should be considered. Graduate midwives should be mentored into midwifery continuity of care models on graduation.

Endorsed (or privately practising) midwifery and admitting rights to hospital

The BEST study indicates that the privately practising midwifery model is associated with the lowest levels of birth trauma⁶. Privately Practising midwives have an endorsement for scheduled medicines from AHPRA, a Medicare provider number and the ability to admit women to hospital. The pathway for this is achievable and seeks to sustain the midwifery workforce long term. Once a midwife is registered, completes 5000 hours of clinical care, and a postgraduate qualification in prescribing, they are eligible to become 'endorsed' by AHPRA. An endorsed midwife can apply to Services Australia for an MBS provider number and purchase insurance from the Medical Indemnity Group of Australia (MIGA)⁵² under a government supported professional indemnity insurance product.

Privately practising midwives offer continuity of care throughout antenatal, intrapartum and postpartum care. This model has not been widely adopted in NSW and represents a missed opportunity for expanding continuity of care models, particularly in rural and remote areas and in the Aboriginal Community Controlled Health Services (ACCHO) setting. NSW Health has a policy directive [Private Midwifery Practice](#)⁵³ which outlines this model and its implementation in NSW. Currently only one hospital – Westmead – offers this option for NSW women. ACCHOs are developing a Birthing on Country model which requires admitting rights to hospital, utilising endorsed midwives to offer continuity of care, but this process has met with significant barriers to implementation⁴⁹.

The low level of birth trauma associated with privately practising midwifery, demonstrates that not only should midwifery continuity of care be maximised, but additionally that private practice models using endorsed midwives should also be optimised.

“MGP is the only means for this type of care and the list of women seeking MGP outweighs service capacity. Women who experience MGP have better outcomes and tend to return to this model of care. Many midwives would like to work in this model but lack of opportunity and the inflexibility with “on call” interferes with family life.” (Midwifery student, regional NSW).

“Pursuit of private midwifery by public hospital staff: constant reporting to AHPRA for minor incidents. Lack of integration of private midwifery into hospital system so transfer and consultation is difficult and/or not supported.” (Endorsed Midwife, 5-10 years’ experience, regional NSW).

“Poor executive / government support. Low pay fails to encourage midwives to enter this demanding model of care. Critical level staff shortages.” (Midwife, 5-10 years’ experience, rural NSW).

“Burn out of midwives, health systems not valuing excellence in midwifery continuity of care programs, midwives not wanting to work in ways which will impact their home lives, midwives working in these programs being undermined by medical decision making” (Midwife, more than 20 years’ experience, metro NSW).

Recommendations:

22. There are significant opportunities to reform maternity care funding to maximise the ability to provide continuity of care and carer. NHRA²⁹ addendum mid-term review could be used to aid significant funding reform via the following mechanisms e.g. [19.2 Exemption](#)⁵⁴ universally applied to all midwifery models of care
23. Midwifery leadership at all levels of service provision
24. Pathways for mentoring graduates in the first year of practice in midwifery continuity of care models to be expanded and universally applied across NSW.
25. NSW Govt support for changes to reduce the 5000 hours requirement leading to endorsement when the Endorsed Midwife Standard is reviewed late in 2023.

g) The information available to patients regarding maternity care options prior to and during their care

The BEST study identifies that the top sources of childbirth and pregnancy information are;

1. Maternity care provider,
2. Website,
3. Friends and Family,
4. Childbirth education classes and
5. apps⁶.

NSW Health has webpages dedicated to pregnancy and the first five years⁵⁵. Prior to care, the advice on this page is as follows: *'Ideally, about three to six months before trying to get pregnant, you should visit your doctor and consider making some health changes.'*

Health literacy with regards to pregnancy is therefore reliant on the prospective parents' GP providing them with all models and availability of care options. It is also reliant on the woman being sufficiently educated and empowered to ask the 'right' questions independently of the health literacy information.

Evidence shows that continuity of care with a known midwife provides both the best health outcomes, and higher rates of vaginal birth in NSW versus other models of care⁶ which aligns with international evidence³⁷. However, with the current health literacy models, the prospective parents may not always be apprised of midwifery continuity of care models, such as privately practising midwife models of care, or MGP and thus may not have the opportunity to have access to the gold standard of maternity care, even if available to them in their area.

NSW Health offers a comprehensive 160 page online book with regards to '[Having a Baby](#)' including a chapter on maternity care options '[choices for care](#)' and [labour and birth](#)⁵⁵. This is an excellent resource, (translated also into a number of languages) however it does not reference in detail the premise of informed consent. This therefore creates a lack of clarity which disempowers the woman during her labour and birth, and is a major driver for birth trauma⁶.

The lack of transparency with regards to maternity models of care options may require women to educate themselves, or via crowd sourced information such as social media and consumer groups, to identify what options are out there for them. For priority populations this is exacerbated.

Furthermore, the National Health Reform Agreement²⁹ requires the following with reference to empowering people through health literacy via the Commonwealth and Jurisdictions:

- a. improve population health outcomes;
- b. make the health system and organisations more health literacy-friendly, so it is easier for people to get appropriate health information, support and services;
- c. empower people to become informed and active participants in their own health care;
- d. increase the uptake of health promoting behaviours, particularly among population groups at high risk of ill health;
- e. develop providers' capacity to engage consumers in co-designing health services around patients' needs; and
- f. improve the efficiency, effectiveness, and equity of health service delivery.

For maternity care, this national health lever for improved care has not been actualised. The limited transparent data, and thus lack of health literacy with regards to maternity care options may exacerbate birth trauma as women may not be aware or made aware of continuity of care models available in their area and may 'miss out' on the opportunity to have MGP, as places may have often filled up before they have even been to see a GP. The limitation on MGP places is an issue throughout NSW, both in metropolitan as well as rural and regional areas. The lack of access to easy-to-understand information relating to models of care means that women remain uninformed and uneducated about their future birth experience. In turn this means that women lose agency and control, which can further contributor to birth trauma.

"It all depends on the clinician giving the information. Often women don't get the full scope of available options of care." (Midwife, less than 5 years' experience, metro NSW).

"GPs are often not aware of options, and these are usually point of referral for maternity consumers" (Consumer rep, metro NSW).

Recommendations:

26. NSW Health, in conjunction with the Commonwealth implement C31 of the National Health Reform Agreement, and in particular NSW Government requires NSW Health to develop accessible health literacy information pertaining to maternity models of care options.
27. That NSW Government considers models of care locational availability mapping and telephone service.
28. Resource universal access to midwifery provided pre-conception care.

h) Whether current legal and regulatory settings are sufficient to protect women from experiencing birth trauma

The best solution is to ensure the maternity system is structurally reviewed and reformed to maximise a woman's autonomy and decision-making. This can only occur with significant shift in models of care and in women's access to services that meet their needs.

Women are not protected from experiencing birth trauma. Regulatory and legal frameworks are available to women, yet most women are not utilising them⁶ for potentially many reasons including the pathways for reporting and the fear of having to relive the events. It is also difficult for care providers who witness disrespectful or trauma producing care, and who may feel complicit in the provision of poor care, may also feel and be unsupported in their workplaces⁵⁶. The wide spectrum of trauma causing events – from obstetric violence and procedures performed without consent to situations where trauma may be unable to be prevented in the case of an intrauterine fetal death prior to the onset of labour of unknown origin mean that it is difficult to provide legal and regulatory solutions that are sufficient to protect all women from all trauma.

"If health professionals were protected and supported by regulatory bodies and legislation / law then I believe we would start to see a decline in trauma and abuse of human rights" (Midwife, 10-20 years, regional NSW).

"I cared for a woman in labour whose husband was a police officer and he said to me 'I would call what that man 'doctor' did to my wife as sexual assault'" (Midwife, less than 5 years, metro NSW).

i) Any legislative, policy or other reforms likely to prevent birth trauma

See recommendations in this document, and in particular key recommendation 1:

1. NSW Ministry of Health to commit to fully funding all [ten goals](#)¹³ and associated objectives of the [‘2023 Blueprint for Action](#)¹⁴ – Maternity Care in NSW’ with a completed implementation plan including benchmark targets, actualised within 6-12 months.

j) Any other related matter n/a

Conclusion

ACM would like to thank all of the midwife members who participated in this survey and acknowledge the incredible contribution of midwives in NSW and across Australia, every day. ACM also acknowledges the lived experience of those women and families who have been impacted by birth trauma. It is the hope of ACM that raising awareness of birth trauma and obstetric violence through this NSW select birth committee will enable a proactive approach to structural reform in maternity in NSW to improve the quality of equity and access to maternity care in NSW, and across Australia.



Helen White
Chief Executive Officer

E: Helen.white@midwives.org.au

W: <https://www.midwives.org.au>



Alison Weatherstone
Chief Midwife

E: Alison.Weatherstone@midwives.org.au

References

1. Bradfield Z, Hauck Y, Homer CSE, Sweet L, Wilson AN, Szabo RA, Wynter K, Vasilevski V, Kuliukas L. Midwives' experiences of providing maternity care during the COVID-19 pandemic in Australia. *Women Birth*. 2022 May;35(3):262-271. doi: 10.1016/j.wombi.2021.02.007. Epub 2021 Mar 15. PMID: 33752996; PMCID: PMC9051255.
2. Department of Health and Aged Care. (2023). National Health Workforce Dataset. Retrieved August 12, 2023, from <https://hwd.health.gov.au/nrmw-dashboards/index.html>
3. Matthews, Robyn; Forster, Della; Hyde, Rebecca; McLachlan, Helen; Newton, Michelle; Mumford, Sharon; et al. (2023). FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross-sectional study exploring health, well-being and sustainability. La Trobe. Report. <https://doi.org/10.26181/21729068.v1>
4. Mayra et al, 2023. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10332579/pdf/pgph.0002034.pdf>
5. Greenfield M, Jomeen J, Glover L. "It Can't Be Like Last Time" - Choices Made in Early Pregnancy by Women Who Have Previously Experienced a Traumatic Birth. *Front Psychol*. 2019 Jan 25;10:56. doi: 10.3389/fpsyg.2019.00056. PMID: 30740076; PMCID: PMC6355667.
6. Keedle, H., Keedle, W., & Dahlen, H. (2022). Dehumanized, Violated, and Powerless: An Australian Survey of Women's Experiences of Obstetric Violence in the Past 5 Years. *Violence Against Women*. doi:<https://doi.org/10.1177/10778012221140138>
7. Toohill J, Chadha Y, Nowlan S. An interactive decision-making framework (i-DMF) to scale up maternity continuity of carer models. *J Res Nurs*. 2020 Sep;25(6-7):561-576. doi: 10.1177/1744987119887424. Epub 2020 Jan 17. PMID: 34394674; PMCID: PMC7932297.
8. United Nations. (1994). Declaration on the Elimination of Violence against Women: resolution / adopted by the General Assembly. Retrieved <https://digitallibrary.un.org/record/179739?ln=en>
9. Kahn, W. A. (1990). Psychological Conditions of Personal Engagement and Disengagement at Work. *The Academy of Management Journal*, 33(4), 692–724. <https://doi.org/10.2307/256287>
10. Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), 350–383. <https://doi.org/10.2307/2666999>
11. National Trauma Centre for Trauma-Informed Care. What is Trauma informed Care? Retrieved from <https://www.traumainformedcare.chcs.org/resource/samhsas-national-center-for-trauma-informed-care/>
12. NSW Health. What is trauma-informed care? Retrieved from <https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/trauma-informed.aspx>
13. NSW Health. (2023). Maternity Care in NSW. Retrieved from <https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/professionals/Publications/maternity-care-in-nsw.pdf>
14. NSW Health. (2023). NSW Health. Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW Retrieved from <https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/professionals/Publications/maternity-care-in-nsw.pdf>
15. Leinweber, J., Fontein-Kuipers, Y., & Thomson, G. (2022). Developing a woman-centred, inclusive definition of traumatic childbirth experiences: A discussion paper. <https://doi.org/10.1111/birt.12634>
16. World Health Organization. (2014). The prevention and elimination of disrespect and abuse during facility-based childbirth. Retrieved from <https://www.who.int/publications/i/item/WHO-RHR-14.23>
17. COAG Health Council. (2019). Woman centred care: Strategic Directions for Australian Maternity Services. Canberra. Retrieved from <https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf>
18. NSW Health. (2019). NSW Health. Retrieved from First 2000 Days Framework: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_008.pdf

19. Harvie, K., Sidebotham, M., & Fenwick, J. (2019). Australian midwives' intentions to leave the profession and the reasons why. *Women and Birth*, 32(6), e584-593.
20. Transforming Maternity Care Collaborative. (2023). Our Workforce. Retrieved August 13, 2023, from <https://www.transformingmaternity.org.au/work-health-and-emotional-lives-of-midwives-whelm/>
21. Leinweber, J., Creedy, D. K., Rowe, H., & Gamble, J. (2017). Responses to birth trauma and prevalence of posttraumatic stress among Australian midwives. *Women and Birth*, 30(1), 40-45.
22. AIHW. (2023). Australian Core Maternity Indicators 2021. Retrieved from <https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators-1/contents/labour-and-birth-indicators/caesarean-section>
23. World Health Organization. (2015). WHO statement on caesarean section rates. Retrieved from <https://www.who.int/publications/i/item/WHO-RHR-15.02>
24. Barnett, B., Jenkinson, B., & Lee, N. (2023, May). The impact of a perineal care bundle on women's birth experiences in Queensland, Australia: A qualitative thematic analysis. *Women and Birth*, 271-280. doi:doi.org/10.1016/j.wombi.2022.09.002.
25. Allen J, Small K, Lee N. How a perineal care bundle impacts midwifery practice in Australian maternity hospitals: A critical, reflexive thematic analysis. *Women Birth*. 2022 Feb;35(1):e1-e9. doi: 10.1016/j.wombi.2021.01.012. Epub 2021 Jan 21. PMID: 33485817.
26. Queensland Government. (2022). Partnering with the woman who declines recommended maternity care. Retrieved from <https://www.health.qld.gov.au/consent/clinician-resources/pwdrmc>
27. AIHW. (2022). Maternity Models of Care In Australia 2022. Retrieved August 13, 2023, from <https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/how-many-models-of-care-are-there>
28. Cummins, A., Coddington, R., Fox, D., & Symons, A. (2020). Exploring the qualities of midwifery-led continuity of care in Australia (MiLCCA) using the quality maternal and newborn care framework. *Woman Birth*, 33(2), 125-130. doi:DOI: 10.1016/j.wombi.2019.03.013
29. National Health Reform Addendum (2020). Retrieved from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf
30. ACT Health. (2022). Maternity Health Plan. Maternity in Focus: The ACT Public Maternity System Plan 2022-2032. Retrieved from <https://www.health.act.gov.au/sites/default/files/2022-06/Maternity%20in%20Focus%20-%20ACT%20System%20Plan%202022-2032.pdf>
31. Fox, H., Topp, S., Lindsay, D., & Callander, E. (2021). A cascade of interventions: A classification tree analysis of the determinants of primary cesareans in Australian public hospitals. *Birth*. doi: <https://doi.org/10.1111/birt.12530>
32. Antonakou A, Papoutsis D. The Effect of Epidural Analgesia on the Delivery Outcome of Induced Labour: A Retrospective Case Series. *Obstet Gynecol Int*. 2016;2016:5740534. Doi: 10.1155/2016/5740534. Epub 2016 Nov 20. PMID: 27990163; PMCID: PMC5136389
33. Forster, D., Forster, D., McLachlan, H. L., Davey, M.-A., Biro, M. A., Farrell, T., . . . Waldenström, U. (2016). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with antenatal, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy and Childbirth*, 16(1), 28-28. Retrieved 6 21, 2020, from <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0798-y>
34. McLachlan, H. L., Forster, D., Davey, M.-A., Farrell, T., Gold, L., Biro, M. A., . . . Waldenström, U. (2012). Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: The COSMOS randomised controlled trial. *British Journal of Obstetrics and Gynaecology*, 119(12), 1483-1492. Retrieved 5 9, 2021, from <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/j.1471-0528.2012.03446.x>
35. Tracy, S. K., Tracy, S. K., Hartz, D., Hall, B., Allen, J., Forti, A., . . . Kildea, S. (2011). A randomised controlled trial of caseload midwifery care: M@NGO (Midwives @ New Group practice Options). *BMC Pregnancy and*

- Childbirth, 11(1), 82-82. Retrieved 5 9, 2021, from <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-11-82>
36. NSW Health (2023). PROMS and PREMS. Retrieved from <https://www.health.nsw.gov.au/Value/Pages/patient-reported-measures.aspx>
 37. Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews. doi:DOI: 10.1002/14651858.CD004667.pub5
 38. NSW Government. (n.d.). NSW Health. Retrieved from Trauma Informed Care: <https://www.health.nsw.gov.au/patients/trauma/Pages/default.aspx>
 39. Australian Government (2020). National Strategic Framework for Rural and Remote Health. Retrieved from <https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf>
 40. Congress of Aboriginal and Torres Strait Islander Nurses & Midwives. (2023). Gettin em n keepin em n growin em'.(GENKE II). Retrieved from https://issuu.com/catsinam1/docs/catsinam_education_plan_2022_v18.0_final
 41. Waminda (2023). Birthing on Country. Retrieved from <https://waminda.org.au/maternity/birthing-on-country/>
 42. Charles Darwin University Australia. (2023). Molly Wardaguga Research Centre. RISE framework. Retrieved from <https://www.cdu.edu.au/mwrc/rise-framework>
 43. Croll, J., Sanapo, L., & Bourjeily, G. (2022). LGBTQ+ individuals and pregnancy outcomes: A commentary. BJOG, 129(10), 1625-1629. doi:doi: 10.1111/1471-0528.17131
 44. Yuill, C., McCourt, C., Cheyne, H. et al. Women's experiences of decision-making and informed choice about pregnancy and birth care: a systematic review and meta-synthesis of qualitative research. BMC Pregnancy Childbirth 20, 343 (2020). <https://doi.org/10.1186/s12884-020-03023-6>
 45. Australian College of Midwives. (2021). National Midwifery Guidelines for Consultation and Referral. 4th Edition. Retrieved from [https://midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/National-Midwifery-Guidelines-for-Consultation-and-Referral-4th-Edition-\(2021\).pdf](https://midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/National-Midwifery-Guidelines-for-Consultation-and-Referral-4th-Edition-(2021).pdf)
 46. Independent Hospital Pricing Authority. (2017). Bundled pricing for maternity care. Retrieved from <https://www.ihacpa.gov.au/sites/default/files/2022-02/Bundled%20pricing%20for%20maternity%20care%20-%20Final%20report.pdf>
 47. Joy E. Adcock, Mary Sidebotham, Jenny Gamble,
 48. What do midwifery leaders need in order to be effective in contributing to the reform of maternity services?, Women and Birth, Volume 35, Issue 2, 2022, Pages e142-e152, ISSN 1871-5192, <https://doi.org/10.1016/j.wombi.2021.04.008>.
 49. Haora, P., Roe, Y., Hickey, S. et al. Developing and evaluating Birthing on Country services for First Nations Australians: the Building On Our Strengths (BOOSt) prospective mixed methods birth cohort study protocol. BMC Pregnancy Childbirth 23, 77 (2023). <https://doi.org/10.1186/s12884-022-05277-8>
 50. Bacchus A and Firth A (2017) What factors affect the emotional well-being of newly qualified midwives in their first year of practice? MIDIRS Midwifery Digest. 27(4): 444-450.
 51. Australian Health Practitioner Regulation Authority (AHPRA). (n.d.). <https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines-for-midwives.aspx>.
 52. MIGA. (2021). Insurance for Eligible Midwives in Private Practice. Retrieved from <https://www.miga.com.au/MIGA/media/MIGA/Policy%20Documents/2021-midwives-fsg-pds.pdf>
 53. NSW Health. (2022). Private Midwifery Practice. Policy Directive. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_018.pdf
 54. Australian Government. (2023). COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas. Retrieved from <https://www.health.gov.au/our-work/coag-section-19-2-exemptions-initiative>

55. NSW (n.d.) Pregnancy and the first five years. Retrieved from <https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/thinking-of-having-a-baby.aspx>
56. Toohill J, Fenwick J, Sidebotham M, Gamble J, Creedy DK. Trauma and fear in Australian midwives. *Women Birth*. 2019 Feb;32(1):64-71. doi: 10.1016/j.wombi.2018.04.003. Epub 2018 May 16. PMID: 29759933.