NSW Ministry of Health

46 community organisations support increased access to respectful and evidence-based maternity care models. This includes, choice in location of care and place of birth. Our organisations support safety as defined by the woman: physically, emotionally and culturally.

Continuity of Midwifery Carer

In New South Wales, woman-centred care is essential to optimise maternity care experiences through Midwifery Continuity of Carer models (known as Continuity of Midwifery Carer, CoMC). CoMC means that women and their newborns are supported by a primary and backup midwife during pregnancy, birth, and postpartum [1]. In NSW, we call this Midwifery Group Practice (MGP) or caseload. About 10% of women can access this model and 90% have a stranger at birth. Another way to provide CoMC in public hospitals is through private midwives with universal visiting rights to all sites. Currently, only Westmead Hospital offers this option [2].

Improved Physical Safety

Based on the best quality international research, the CoMC models are safe for all women with varying levels of risk in pregnancy and are particularly beneficial to socially vulnerable women and priority groups [1,3,4,5]. This model also privileges First Nations peoples' knowledge of pregnancy, childbirth, and early parenting, which is contrary to the current biomedical model of maternity services available for Australian women [6]. One study from NSW found that greater effort is needed to expand access to reduce low birthweight, preterm birth, stillbirth, and neonatal mortality [7]. Most women see 20+ care providers across the continuum so having a known midwife also reduces possible Covid contacts.

Increased Breastfeeding Rates

Almost all women want to breastfeed and CoMC improves breastfeeding rates [8]. The department established a breastfeeding policy to increase breastfeeding support. However, it was never implemented [9]. As a result, there is less support for women in NSW to fully breastfeed their newborn babies on discharge from hospital over the last 5 years (75.4% non-Aboriginal and 62.8% Aboriginal) [9]. For every $1 spent on breastfeeding support, we see a $36 ROI.

Improved Mental Health

Traditionally, fragmented maternity services are known for allowing women to fall through the cracks. This prevents women from building a trusting two-way relationship, leading to higher interventions rates [10]. Unnecessary procedures, such as rapidly rising episiotomy rates, have a negative physical and emotional impact on the mother and her family. The WHO states no population should have more than 10-15% c-section rates, but in NSW, the rate is 37%. The degree of obstetric intervention experienced during labour has repeatedly been associated with the development of acute trauma symptoms throughout the postnatal period, which is a cause for significant concern [13]. For example, 33% of women are traumatised, 25% with PND and 10-20% with PTSD from their experience in the maternity system. From these figures 75% are directly related to care providers "threats, lies, coercion, abuse and violation" to comply with procedures [14]. In a Spanish study released this year, 67% of women reported obstetric violence, and 54% reported physical obstetric violence such as coercion and assault. We expect Australian figures to be similar based on the United Nations Special rapporteur's report on Obstetric Violence, where Australia was called out as a poor performer [4].

Demand for Out of Hospital Appointments and Birth

Low-risk women who plan to give birth in a Birth Centre are 20% more likely to have a vaginal birth than those who plan to give birth in a private or public hospital [3, 11]. Unfortunately, Ryde Birth Centre was converted into a vaccination clinic even though the centre was rated the best maternity hospital by the Bureau of Health Information NSW. The analysis of 1.25 million births showed that planned homebirths are the safest place to birth [12]. The ABC

reported a 312% increase in demand for publicly funded homebirth programs during the pandemic to reduce exposure to Covid-19 and unacceptable hospital restrictions. Women unable to access public homebirth services (who have missed out on expensive private midwifery care) have been forced to have an unassisted birth known as freebirth which has less safety data than Homebirth, Birth Centers or Hospital.

Rural Maternity Services

The NSW rural parliamentary inquiry hasn't focused on the unique needs of maternity service users in a wellness model specifically, but research shows care close to home, even without an operating theatre, has better outcomes. Thus regardless of location, continuity of midwifery carer and out of hospital birth (close to home) is considered the highest attainable standard of health care, and a human right according to Committee on the Elimination of Discrimination against Women (CEDAW) to which Australia is a signatory.

First Nations Women

Fewer babies are dying from sudden unexpected death in infancy (SUDI) in NSW, however, the proportion of Aboriginal babies dying from SUDI has increased [8]. Fragmented maternity care increases pre-term birth by a heartbreaking 50% for Indigenous women. There is a clear, ready to go and inexpensive solution to reduce the rate of preterm births, stillbirth, and low birth weight babies in NSW but it is being ignored.

Cost Savings

One NSW dataset shows $1000 per birth savings when compared to all other models of maternity care [1]. Queensland data established a $5208 per birth saving [15]. Maternity is the largest service user group (95,000p.a.) and one of the Department's biggest spends, so universal access to evidence-based care would save the NSW government over $450M annually [16].

Recommendations

1. Expansion of access to publicly funded continuity of midwifery carer services. Including a ministerial directive for service agreements and LHDs strategies to offer 75% of public service users continuity of midwifery carer models and women paying out of pocket for Private Practice Midwife (PPM) to have choice in public birthing hospitals.
2. Provisions to increase resourcing and support for existing Aboriginal Community Controlled Organisations and Birthing on Country programs. As well as the future development of community-led, culturally appropriate patient advocacy supported by djakimirr qualified through a Registered Training Organisation (RTO).
3. Rural women and families are consulted by LHD's with, implementation and independent evaluation committees reporting to NSW Health and consumers; and included in decision-making about where and how local services are designed, re-opened, and expanded to suit specific maternity needs such as local birthing.
4. Expansion of Publicly Funded Home Birth programs (PFHB) to remaining 9 Local Health Districts (LHD's) as only 5 LHD's currently offer this service. As well as the provision of local employment and retention of First Nations health care professionals within these programs.
5. Chief midwifery officer role should be created in the NSW Health Ministry to be qualified to practice in the scope of registered midwife. They should act as a decision-maker with lived experience of maternal health advocacy and can be accountable for the implementation of these recommendations

We hope to receive a written response around your support and request a meeting to discuss further service improvements for vulnerable pregnant women.

Regards,
Azure Rigney
0416638338
Maternity Choices Australia

46 Supporting organisations logos:

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