Submission to the NSW Select Committee Inquiry on Birth Trauma

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About Maternity Choices Australia

Maternity Choices Australia is a company limited by guarantee, originally registered as Maternity Coalition Incorporated in 1999. A volunteer-run organisation, we have become Australia's leading maternity services advocacy body, operating at the local, state and federal levels.

We aim to see all women, no matter their circumstances, have access to a number of maternity care choices that are based on respectful, women-centred care and are modelled on delivering care that is formed on best evidence.

We are grateful for this opportunity for women to speak up about their experience of birth trauma and hope that the current Select Committee Inquiry into Birth Trauma provides the impetus for meaningful change to occur, and all birthing women and their families in NSW can have access to respectful, dignified, evidence-based care.

As such, we would like the opportunity to give evidence at the Inquiry's hearing in September 2023.

A system in crisis

A woman's birth experience will have lasting physical, psychological and emotional impacts on herself, her baby and her family, with many of the individual and societal impacts remaining unrecorded by government and researchers. Giving a woman access to respectful, dignified care during her pregnancy, birth and postpartum is essential to ensuring she will not be disadvantaged in any way by her choice to have children.

With one in three women in Australia experiencing trauma from their birth, one in four suffering from post-natal depression, and up to twenty per cent going on to develop post-traumatic stress disorder (PTSD) (Reed et al., 2017), largely due to how they've been treated, coerced or discriminated against in the maternity system, birthing women in this country are suffering in silence. In fact, 75% of trauma cases are directly related to care providers' need to comply with hospital procedures at all costs, which often involves 'threats, lies, coercion, abuse and violation' (Reed et al., 2017).

Women in Australia have reported experiencing disrespectful, discriminatory and non-consented treatment during pregnancy and childbirth (Keedle et al., 2015; McKinnon, Prosser, & Miller, 2014; Priddis, Keedle, & Dahlen, 2017, cited in Barnett, 2020), being judged, coerced and discriminated against by maternity services staff (McKinnon et al., 2014; Yelland et al., 2012, cited in Barnett, 2020), and being subjected to varying degrees of intimidation and bullying and feeling as though they were 'treated like a piece of meat' (Keedle et al., 2015, cited in Barnett, 2020). The prevalence of postnatal depression in Australia is greater than in other high-income countries (Hahn-Holbrook, Cornwell-Hinrichs, & Anaya, 2018), while the United Nations Special Rapporteur's Report on Obstetric Violence called Australia out as a poor performer (UN, 2019). Not only are women being subjected to a growing number of potentially unnecessary interventions and procedures, but they are being stripped of their sense of agency and choice as they navigate the system.

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For many, despite their best intentions to have a positive birth, they leave the system feeling broken and depleted, like their bodies have let them down, rather than seeing instead that the system has failed them. Women are pathologised with high rates of PND/A rather than professionals and health/social policy recognising women are having a normal reaction to an abnormal situation. Seventy per cent of consumers have low health literacy, and the media plays a large role in pathologising women rather than scrutinising the perverse and complicated dynamics they are confronted with. Just look at who the second largest political donor is for the two major political parties. NSW Health's executive leadership team is almost made up entirely of members of this lobby group, so not only do they have much access to decision-makers but they are the decision-makers.

Respectful maternity care is a human right

How women are being treated and made to feel during their pregnancies and birth points to a broader socio-political disjuncture experienced by women, and particularly mothers, in Australia. The problems stem not just from direct interactions with care providers, whose scope of practice is greatly determined by hospital policies and procedures, but are a reflection of a lack of political will to change the status quo, one that fails to adequately support mothers.

In our experience advocating for dignified maternity care for over 30 years, the current socio-political dynamic that inhibits meaningful change is no more evidenced than in the massive resistance and inertia we encounter from successive governments to even acknowledge, let alone respond to, recommendations.

Despite a growing body of evidence supporting the need for all women to have access to continuity of care, as well as major national and state reviews, including the establishment of the Australian National Maternity Services Plan (Commonwealth of Australia, 2011) and the National Maternity Review (2019), providing resounding support for continuity of care through submissions from practitioners and consumers, the silence from government has been deafening.

This experience has been echoed by other community organisations, such as Human Rights in Childbirth, and in their submission to the Australian Human Rights Commission in 2019, they stated:

> 'Women have been advocating for their right to birth in a safe and respectful environment for over 55 years. Despite the consistency over decades in the composition and content of complaints by women of systemic and procedural forms of abuse and disrespect, successive governments have refused to acknowledge, let alone address, that mistreatment and violence taking place in childbirth facilities. Ignoring women's complaints about their treatment in childbirth has become as normal as the process of abusing and disrespecting women in pregnancy and childbirth. It forms a part of the continuing cycle of abuse in the provision of reproductive and maternity health care' (Human Rights in Childbirth, 2019).

The lack of political will to undertake major reform to the maternity system, against mounting evidence, extends maternity dialogues beyond the health policy domain – which, indeed, includes its own gamut of barriers to reform – to that of human rights and social justice. Denying women access to respectful evidence-based care – including to a known midwife – during pregnancy and birth perpetuates the social and economic inequalities and discrimination experienced by women, particularly once they have children (Human Rights in Childbirth, 2019). This discrimination is experienced by women across all socioeconomic levels (Simonovic, 2019) and is so ingrained in our healthcare services that it is often unnoticed, let alone reported on (Simonovic, 2019). Women are told to be happy about having a healthy baby, while their own physical and emotional health is not valued (Simonovic, 2019). All women have the right to birth in a safe and respectful environment, and the NSW maternity system is failing women in upholding this fundamental human right.

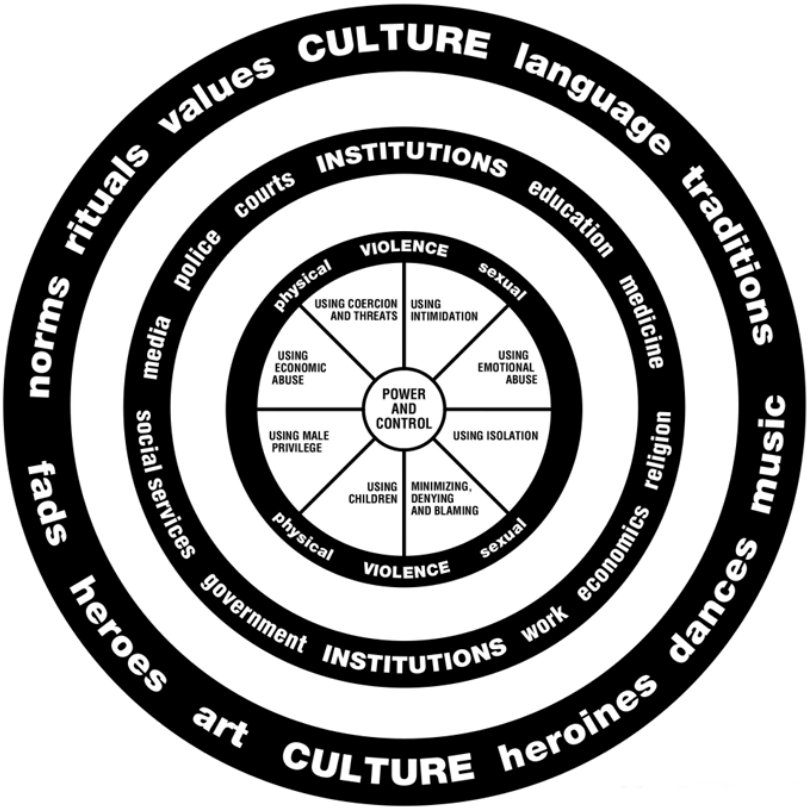

Figure 1. The Duluth Model on Culture provides a framework to understand the different types of sex-based discrimination and abuse women are subjected to in our culture. Strategies used in DV are very similar to what is used in OV.

Recommendation:

1. Ensure NSW as a jurisdiction of Australia upholds its obligations to the Committee on the Elimination of Discrimination against Women (CEDAW), to which Australia is a signatory, by ensuring all women receive dignified, respectful maternity care, in particular, access to Continuity of Midwifery Carer (CoMC) and out-of-hospital birth (close to home), which is considered internationally the highest attainable standard of health care and a human right. The Health and Women's Ministers must issue a directive and include it in all LHD service agreements, while additional funding is allocated for mandatory implementation and independent evaluation.

A fragmented maternity system

Australia and NSW's current maternity system is broken. Only one in 10 women in NSW have access to continuity of midwifery carer (CoMC) maternity models (AIHW, 2020), the rate of which is self-reported by hospitals. Most women in Australia see more than 20 care providers across the continuum of their care (Maternity Choices Australia, 2023). Fragmented care prevents women from building a trusting two-way relationship with their care provider and is known to allow women and their babies to fall through the cracks (Sandall et al., 2016), leading to a greater incidence of low-birth-weight cases, preterm birth, stillbirth and neonatal death (NSW Ministry of Health, 2020).

Decades of reviews and submissions have stated that women want CoMC models, with greater reported satisfaction and better outcomes for mothers, babies and their midwives. Countless studies show that continuity of care is safe for women with varying levels of risk in pregnancy and is particularly beneficial to socially vulnerable women and priority groups (Tracy et al., 2013, WHO, 2017; UN, 2019; NSW Health, 2012). CoMC privileges First Nations peoples' knowledge of pregnancy, childbirth and early parenting, which is contrary to the current biomedical model (Roe et al., 2020). Importantly, CoMC has been shown to improve breastfeeding rates (The First 2000 Days Framework, 2019).

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Fragmented care also leads to higher intervention rates (Sandall et al., 2016). Thirty-seven per cent of babies in Australia are born by caesarean section, and a staggering 46.8 per cent of first-time mothers are induced (AIHW, 2020), many of these unnecessarily. Obstetric procedures, such as episiotomies (now one in four births), often have a negative physical and emotional impact on the woman and her family, and the degree of obstetric intervention experienced during labour has repeatedly been associated with acute trauma symptoms during the postnatal period (Creedy et al., 2013). All the while, increased intervention rates have produced negligible improvements in perinatal mortality (AIHW, 2020). The AIHW has failed to report on physiological birth rates, even though 87 per cent of women want this birth, and less than 2 per cent get it (Dhempsey, 2015).

Recommendations:

2. Provide all women access to CoMC across NSW as a matter of urgency, particularly women from rural and remote areas, disabled (physical and psychological) and women from CALD backgrounds. Trauma-informed care from a known midwife is a primary prevention measure in lowering community and institutional violence. This model of care is a protective factor by affording a woman informed consent, two-way communication and greater confidence. It costs 22 per cent less per birth.
3. Establish midwifery-led level 2 regional and rural birth centres close to home so women in regional and rural areas do not need to travel vast distances to get to a

hospital, creating unnecessary stress and anxiety for the birthing woman and her family. *Research shows care close to home, even without an operating theatre, has better outcomes* (Shah, 2021). This must also include the provision of local employment and retention of First Nations' health care professionals in consulting on and establishing and running these programs.

4. Expand CoC models for First Nations women, such as *Birthing on Country*. Fragmented maternity care increases preterm 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.

Support women's physiology

The current maternity care system in NSW does not support women's physiology. The very fact that the vast majority of births occur in hospitals and are overseen by obstetricians assumes birth is a pathological process that requires medical intervention, rather than regarding it as the normal physiological process it is. The maternity care provided in hospitals largely focuses on the medical aspects of pregnancy and birth and ignores the emotional, psychological, cultural and spiritual facets of this important rite of passage in a woman's life, contributing to the experience of birth trauma. In addition to the way that maternity care is provided, the hospital environment itself is not supportive of physiological birth. Tiling, stainless steel, bright lights, strangers in positions of authority, and being in an unknown environment are all contraindications of normal physiological birth (Foureur et al., 2010).

Recommendation:

5. Design maternity wards and birthing centres, as well as postnatal and NICU wards, with professional consumer reps as co-leads and including local raw consumer voices in line with consumer engagement standard 2 legislation and international best practice to support the physiology of birth and foster and preserve the mother-baby connection in the crucial first hours after birth. Too many times, inappropriate decisions are being made without consideration of women's needs.

Curtail skyrocketing intervention rates

Instead of a system that supports physiological birth, we have a system that is standing in the way. The growing rate of intervention has been linked to increased birth trauma with no improvements in perinatal mortality (Creedy et al., 2013). For many, it begins with induction, and from there, women are at risk of the cascade of interventions (Bell, 2023). First-time mothers have an over 40% chance of induced birth (Bell, 2023). Between 2000 and 2016, induction of labour in Australia (and NSW) tripled. Unnecessary inductions make up at least 15% of cases (Bell, 2023). This is of great concern.

The data in Figure 2 highlights how low rates of homebirth and high rates of caesarean sections in Australia have not correlated with lower infant and maternal mortality rates compared to other OECD nations. This is supported by the World Health Organization that state 'caesarean section rates higher than 10 per cent were not associated with reductions in rates of maternal and newborn mortality' (2021), suggesting that while caesarean sections are necessary for a small percentage of births, for most, they are not. The physical, psychological and emotional risks they present for mother and baby are well-documented, and the impact of an emergency caesarean can be devastating for the mother who has attempted a vaginal birth (See Appendix 1).

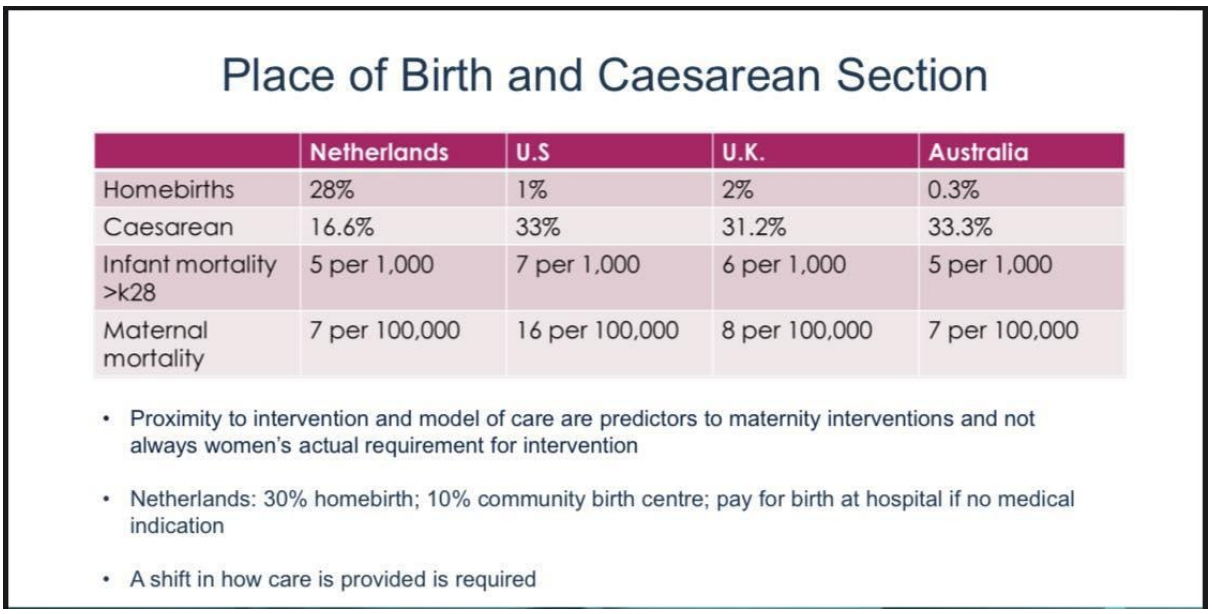

Figure 2. Place of birth and caesarean section rates internationally.

We reiterate here that CoMC is the bare minimum for improving birth outcomes and addressing the skyrocketing intervention rates leading to birth trauma, and not providing women with evidence-based care is a failure of service provision and is harmful. Such models have been found to reduce the chance of stillbirth by between 16 and 25 per cent, and babies are less likely to be born preterm while no reduction is achieved in induced labour or caesarean sections (Homer, 2016).

Initiatives that have acknowledged this worrying trend in Australia and the importance of continuity of care, including *Towards Normal Birth 2010*, the National Maternity Services Plan and National Strategic Directions for Maternity Services, have not received any funding, and very few of the recommendations have been implemented, despite mounting evidence for them.

Recommendation:

6. Expand publicly funded homebirth to the remaining 9 NSW Local Health Districts to give women in NSW the best chance of having a normal physiological birth as only 5 LHDs currently offer this service. This must also include the provision of local employment and retention of First Nations healthcare professionals within these programs. The analysis of 1.25 million births showed that planned homebirths are the

safest place to birth (Homer, 2019). 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 centres or hospitals.

Recognise the '4th trimester'

Birth and postpartum need to be seen for the profound rites of passage they are in a woman's life, encompassing physical, emotional, spiritual and psychological changes. Traumatic birth experiences can cause terrible psychological trauma to women. (Fenech & Thompson, 2015; Shorey & Wong, 2022). The 'ripple effect' of this trauma greatly impacts the postnatal period, with an increased incidence of poor mental health outcomes for mothers themselves including PNA/ PND and PTSD (affecting 5.8% of women in Australia) (Watson et. al., 2020). This expands into the mother-infant relationship both short-term and long-term (Zaides et al., 2021), impacting breastfeeding behaviours, relationships within the family unit and future reproductive decisions.

Women in the postnatal period need to be cared for and supported in making informed decisions that best suit their and their family's needs, not provided with numerous conflicting opinions on feeding, settling, and sleeping arrangements. The lack of empathic support given to women is often signified in the 6-week GP checkup to identify if she has recovered from her birth to healthcare standards and that she is 'caring adequately' for her newborn. Women often tell us about their feelings of worthlessness, anxiety and guilt from these consultations, leading to exacerbation of trauma experienced during labour and birth. Many feel that they are treated by practitioners like a vessel for birthing and feeding a baby (Martin, 2001; David-Floyd, 1994; Neiterman, 2013; Balkagot et al., 2022) and are invisible during the postpartum period, which can create a sense of disconnection from themselves and their baby (Neiterman, 2013).

It is essential that the mother's own intuition is supported and fostered in order to promote the connection with her baby and confidence in her ability as a mother, as the failure to do so can have serious long-term consequences and exacerbate experiences of trauma. This can be achieved through embodied and empathic approaches to antenatal and postnatal care that give primacy to the mother-baby relationship and see the woman as the most valuable producer of knowledge about her body and baby (Clancy et al., 2022). Indeed, embodied approaches to maternity and postnatal care are crucial for women experiencing any kind of trauma, anxiety, isolation or lack of confidence in new motherhood (Engelhard et al., 2021).

Moreover, almost all women want to breastfeed, and while the NSW health department established a breastfeeding policy to increase breastfeeding support, it was never implemented (Legislative Assembly of NSW, 2018). As a result, there has been 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) (Legislative Assembly of NSW, 2018). For every $1 spent on breastfeeding support, we see a $36 ROI.

Recommendations:

7. Establish a peer-to-peer support network that women can access during pregnancy and postpartum that is coordinated by experienced (and paid) maternity consumer representatives and a network of professionals who can help women navigate the maternity system. This network should be made available, particularly to women identified as vulnerable by the NSW government, including women from rural and remote New South Wales, First Nations women, women from CALD backgrounds as well as women who have previously experienced trauma.
8. Provide all women in NSW access to government-supplied postpartum care in line with leading OECD nations, which includes breastfeeding support from a known midwife or lactation consultant, pelvic floor health examinations, and counselling and bodywork for women suffering from birth trauma in line with best practice.

Legislate 'informed choice'

The purpose of consent is to ensure women are making informed decisions. All obstetric examinations and procedures require consent, but this usually happens in the moment, without deep discussion. This means women are consenting without realising what is actually a decision point (Bell, 2023).

A recent survey of Australian women found nearly 1 in 5 women may not have made an informed decision about the consent given for examinations or procedures they received during their maternity experience (Maternal Health Matters, 2021). The survey found 1 in 3 women who experienced birth with forceps or vacuum extraction, and 1 in 5 having a caesarean did not feel adequately informed.

According to Australian medical law, if consent is not gained prior to a procedure it could lead to an action for 'trespass to the person' (ie., assault and/or battery) (Reed, 2016). Most importantly in the context of maternity care, consent must be voluntary and freely given, which means the woman must not be under any undue influence or coercion, and there must be no misrepresentation as to the nature or necessity of the procedure (Reed, 2016). A healthcare practitioner who fails to provide adequate information to a woman can be sued for negligence (Reed, 2016).

MCA recently approached the Ministry of Health who responded to allegations in our NSW MP Brief (Maternity Choices Australia, 2023) with 'well, we have an informed consent manual which providers must abide by'. However, it is quite clear that providers are not concerned about the possible repercussions as women are often too oppressed to take legal action, which is costly and time-intensive, when they have a baby to care for, not to mention there being no dedicated legal support clinics for obstetric violence (OV).

The United Kingdom has a two-page form, and in two months, women who lodge a complaint about abuse and mistreatment receive compensation. It is disappointing, to say the least, that NSW victims' compensation does not offer OV survivors the compensation they do for sexual assault/domestic violence. Instead, they take evidence from the provider to deem if the mistreatment was medically necessary, which contradicts human rights law and the NSW informed consent manual, where a woman has the right to choose to take a risk, even if the outcome is death.

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Statistically, the leading cause of maternal death is suicide followed by hospital-acquired complications (Modini et al., 2021). And of unexpected stillbirths, a Queensland study found that likely more than half are due to substandard care (Flanady et al., 2021). There is no better example of the institutional discrimination experienced by birthing women than the lack of legal recourse and support they have after experiencing obstetric violence. We receive countless accounts of the stereotyping, abuse and intimidation women are subjected to when they attempt to uphold their bodily autonomy when, in fact, statistically OV and poor care are more likely to cause adverse events (See Appendix 1).

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Beyond bullying and intimidation, there are many routine obstetric procedures taking place where women are not adequately informed of the risks and benefits, such as induction, monitoring, episiotomies, caesarean sections and separation from their babies post-birth. This means providers are routinely failing in their duty of care to women, ethically and legally.

Based on the stories we hear from women every day, their disempowerment during birth in making key decisions about how their labour progresses, as well as the idea commonly perpetuated in the medical profession that decision-making should be shared by the parents and care provider, is a common source of trauma for birthing women (see Appendix 1). In fact, many women are left feeling like their birth has been 'hijacked', and once they give consent for one intervention, consent is assumed for all others, which may not be the case (Bell, 2023). Care providers must also understand that by law their client is the birthing woman and not the baby. However, women are told to be grateful for having a healthy baby with little consideration given to their emotional or physical needs, which particularly shows up in discussions around risks and benefits. No one has a greater interest in the safety of their baby than the mother, and every decision made about her birth is hers alone.

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Recommendations:

9. All maternity care providers in NSW complete funded consumer-led training on women’s reproductive health rights and informed consent, and language around decision-making is reviewed. Care providers must be given more information about risks and benefits for different groups of women so that individualised care can be provided (which is more easily achieved through continuity of carer models).
10. An OV legal clinic in NSW be funded and promoted on all hospital maternity websites, guidelines and waiting rooms that is dedicated to women who have experienced OV.
11. Target obstetric violence by issuing a ministerial directive to shift cultural attitudes to rights regarding maternity services among hospital staff through fines per 360-degree feedback/audit incident and annually published independent evaluations.

Allocation of funding exacerbates abuse

A major hurdle to implementing more effective woman-centred systems of care is the current activity-based funding model on which NSW’s public health system is based, which actually works to incentivise treatments and procedures as they attract more funding (IHACPA, 2022). Queensland Health is working on bundled funding for maternity care, and we hope NSW will investigate this also.

Indeed, the growing intervention rates stemming from the lack of ministerial directives lead to more complications, readmissions and longer hospital stays, which makes the current model not only problematic for women but also places greater strain on the healthcare system. While major cost-savings can be achieved through CoMC, the current allocation of funding stands as a major hurdle to its implementation.

One dataset for NSW shows a savings of $1000 per birth in CoMC models compared to all other models of maternity care (Tracey et al., 2013), while Queensland data established a $5208 per birth saving (Callander et al, 2021). Maternity is the largest service user group of health departments, with $7 billion being channelled into maternity care each year (Maternity Consumer Network, 2021). This means universal access to evidence-based care would save the NSW government alone over $450 million annually (Scarf et al., 2021). Furthermore, the ongoing costs of postnatal anxiety and depression arising from birth trauma also run into the billions, most of the costs of which are not tracked (Maternity Consumer Network, 2021).

Recommendation

12. The current funding structures be reviewed and overhauled, moving away from activity-based funding to woman-centred funding where a portion of funding is allocated to each woman during each of the four trimesters. This will incentivise

services to offer facilities and care that women want. Service agreements must incentivise reaching MGP targets and fine LHDs who do not meet their targets set by the NSW Health Minister.

Obstetric oversight inhibits midwives' scope of practice

Midwives are primary care providers, yet the hospital system (and the ACM Guidelines) does not recognise this and keeps the profession of midwifery in a position that is subservient to doctors. This requires them to 'collaborate with' doctors in making decisions, which ultimately translates into midwives having to defer to doctors' opinions and requiring that opinion before they can lawfully support a woman's choices. This effectively puts midwives in the role of obstetric nurses.

This medical view of the role of midwives is perpetuated in industrial relations, unions and hospital structures where midwives are almost always bundled with nursing. Many midwives in hospitals are managed by nurse managers, rather than midwives, upholding the misconception that midwives are just another kind of nurse, and therefore, only able to act under a doctor's orders.

The imbalance in the medical workforce is highlighted in Figure 3, which shows the low proportion of midwives to nurses registered in Australia. Advocating for women on the frontline, we have experienced the barriers to addressing this situation firsthand: An MCA consumer representative sat on a selection panel for two permanent MGP jobs at her local hospital; 30 applications were received, with 14 interviews completed, mostly to an exceptional standard. Midwives want MGP jobs. The power imbalance is made further clear by the refusal to appoint a Chief Midwifery officer in NSW Health who should be responsible for the largest service user group's reform, given that 87 per cent of maternity services are done by midwives.

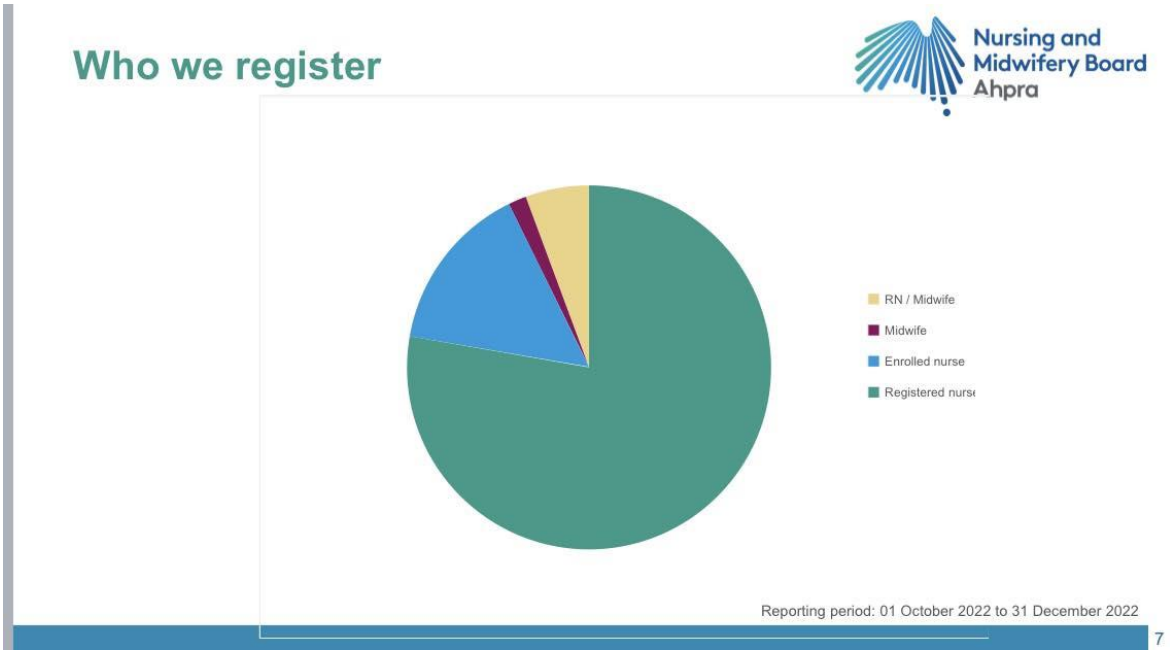

Figure 3. Registrations by Ahpra highlight the low proportion of midwives to nurses in Australia (Ahpra, 2022).

Midwives are experts in normal physiological birth and should be able to practise autonomously in this capacity. They are trained to be with the woman in all senses, physically, emotionally and even spiritually for the benefit of the mother and baby. The WHO's extensive studies across the developed and developing world (WHO, 2017) found that 85% of women can give birth normally, without medical assistance (See Figure 4). Any more than that means women are being overserviced by their health system.

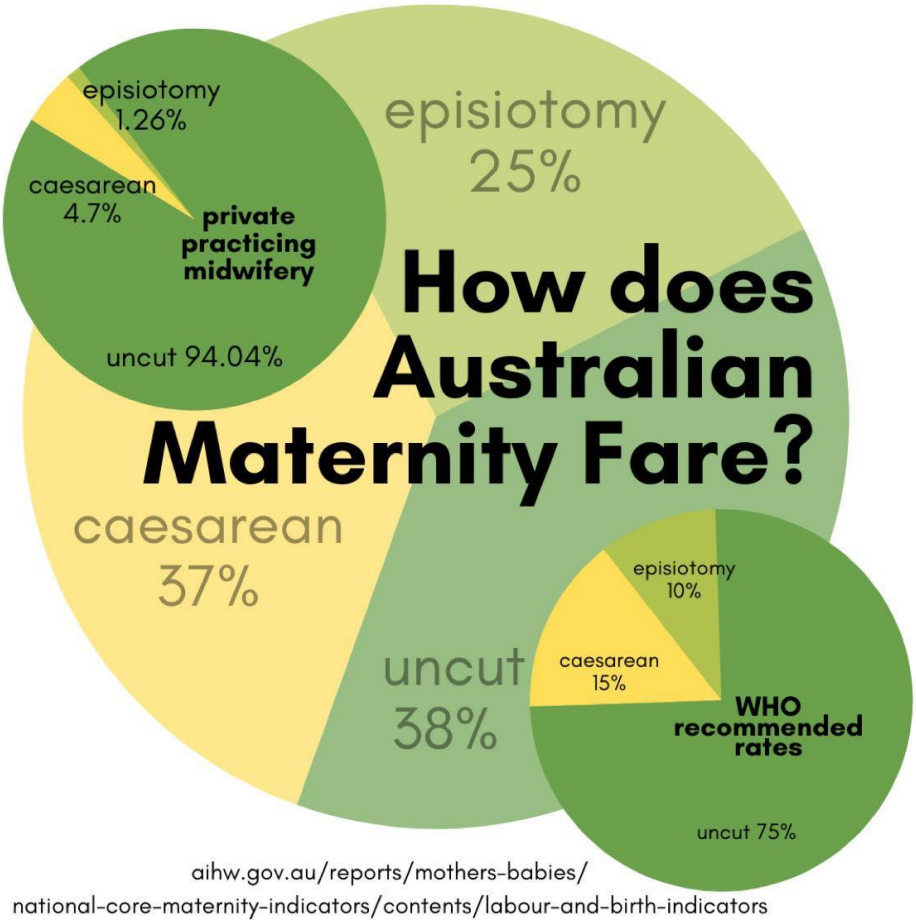

Figure 4. WHO's recommended rates of caesarean versus Australia's maternity system (AIHW, 2023).

When midwives are able to provide continuous care to a woman, they develop an intimate knowledge of the woman and her pregnancy and can make individualised assessments and practise autonomously to the benefit of all. This is critical at a time when the profession is being significantly challenged by workforce shortages – marked by burnout, high attrition rates, and an ageing workforce with insufficient numbers joining the profession due to restricted student placements. This is supported by research by Fenwick et al. (2018) finding that midwives working in CoMC models experience less psychological distress and are able to work more autonomously than those working in standard models. It does not need to be said that workforce shortages are a major problem the NSW health system is grappling with.

Recommendations:

13. Provide $25/hr for all student midwife placements to reduce attrition rates at universities and offer all graduates an MGP graduate role. All students should be given the opportunity to witness a public or private out-of-hospital birth under NSW health insurance.
14. Give all NSW midwives access to affordable intrapartum insurance through a grants program funded by NSW Health, similar to what we saw with subsidised IVF grants.
15. Issue a directive to LHD CEOs to incentivise the restructuring of hospital hierarchies to allow midwives to practise as primary carers, not needing medical oversight within

their scope and not having nurses as EDNM when they have no experience with managing an MGP maternity service.

Summary of recommendations:

1. Ensure NSW as a jurisdiction of Australia upholds its obligations to the Committee on the Elimination of Discrimination against Women (CEDAW), to which Australia is a signatory, by ensuring all women receive dignified, respectful maternity care, in particular, access to Continuity of Midwifery Carer (CoMC) and out-of-hospital birth (close to home), which is considered internationally the highest attainable standard of health care and a human right. The Health and Women's Ministers must issue a directive and include it in all LHD service agreements, while additional funding is allocated for mandatory implementation and independent evaluation.
2. Provide all women access to CoMC across NSW as a matter of urgency, particularly women from rural and remote areas, disabled (physical and psychological) and women from CALD backgrounds. Trauma-informed care from a known midwife is a primary prevention measure in lowering community and institutional violence. This model of care is a protective factor by affording a woman informed consent, two-way communication and greater confidence. It costs 22 per cent less per birth.
3. Establish midwifery-led level 2 regional and rural birth centres close to home so women in regional and rural areas do not need to travel vast distances to get to a hospital, creating unnecessary stress and anxiety for the birthing woman and her family. *Research shows care close to home, even without an operating theatre, has better outcomes* (Shah, 2021). This must also include the provision of local employment and retention of First Nations' health care professionals in consulting on and establishing and running these programs.
4. Expand CoC models for First Nations women, such as *Birthing on Country*. Fragmented maternity care increases preterm 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.
5. Design maternity wards and birthing centres, as well as postnatal and NICU wards, with professional consumer reps as co-leads and including local raw consumer voices in line with consumer engagement standard 2 legislation and international best practice to support the physiology of birth and foster and preserve the mother-baby connection in the crucial first hours after birth. Too many times, inappropriate decisions are being made without consideration of women's needs.
6. Expand publicly funded homebirth to the remaining 9 NSW Local Health Districts to give women in NSW the best chance of having a normal physiological birth as only 5 LHDs currently offer this service. This must also include the provision of local employment and retention of First Nations healthcare professionals within these programs. The analysis of 1.25 million births showed that planned homebirths are the safest place to birth (Homer, 2019).
7. Establish a peer-to-peer support network that women can access during pregnancy and postpartum that is coordinated by experienced (and paid) maternity consumer representatives and a network of professionals who can help women navigate the maternity system. This network should be made available, particularly to women identified as vulnerable by the NSW government, including women from rural and

remote New South Wales, First Nations women, women from CALD backgrounds as well as women who have previously experienced trauma.

8. Provide all women in NSW access to government-supplied postpartum care in line with leading OECD nations, which includes breastfeeding support from a known midwife or lactation consultant, pelvic floor health examinations, and counselling and bodywork for women suffering from birth trauma in line with best practice.
9. All maternity care providers in NSW complete funded consumer-led training on women's reproductive health rights and informed consent, and language around decision-making is reviewed. Care providers must be given more information about risks and benefits for different groups of women so that individualised care can be provided (which is more easily achieved through continuity of carer models).
10. An OV legal clinic in NSW be funded and promoted on all hospital maternity websites, guidelines and waiting rooms that is dedicated to women who have experienced OV.
11. Target obstetric violence by issuing a ministerial directive to shift cultural attitudes to rights regarding maternity services among hospital staff through fines per 360-degree feedback/audit incident and annually published independent evaluations.
12. Review and overhaul current funding structures, moving away from activity-based funding to woman-centred funding where a portion of funding is allocated to each woman during each of the four trimesters. This will incentivise services to offer facilities and care that women want. Service agreements must incentivise reaching MGP targets and fine LHDs. who do not meet their targets set by the NSW Health Minister.
13. Provide $25/hr for all student midwife placements to reduce attrition rates at universities and offer all graduates an MGP graduate role. All students should be given the opportunity to witness a public or private out-of-hospital birth under NSW health insurance.
14. Give all NSW midwives access to affordable intrapartum insurance through a grants program funded by NSW Health, similar to what we saw with subsidised IVF grants.
15. Issue a directive to LHD CEOs to incentivise the restructuring of hospital hierarchies to allow midwives to practise as primary carers, not needing medical oversight within their scope and not having nurses as EDNM when they have no experience with managing an MGP maternity service.

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Appendix 1

Reviews from MCA's Best Birth Finder (www.bestbirthfinder.org.au).