Public Health Association of Australia submission to the NSW Legislative Council Select Committee on Birth Trauma

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15 August 2023

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Public Health Association
AUSTRALIA

The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction

PHAA welcomes the opportunity to provide input to the Legislative Council's Select Committee on Birth Trauma.

PHAA supports the rights of all people to maternity care, free from any form of mistreatment or violence to prevent birth trauma. We support the right to access affordable, high-quality, evidence-based and respectful care, and the right to make informed choices and provide informed consent regarding maternity care.

Obstetric violence (OV), mistreatment of women, and the resulting birth trauma, has long-term consequences for women's and babies' physical, psychological, spiritual, sexual and reproductive health. PHAA recognises OV, and mistreatment of women is a human rights issue, inherently linked to underlying organisational structures, and is a key barrier to accessing high-quality woman-centred maternity care in Australia.

PHAA recognises that marginalised women may be especially vulnerable to gender-based violence, including women who are Indigenous, women of colour, refugees and migrants, women who are disadvantaged socially, economically, educationally, geographically, and women who are younger (<24 years of age), incarcerated, or living with a disability or mental health condition. These women, who may have already experienced significant gender-based violence, may experience compounding trauma from their experience of maternity care in Australia. Currently these women face a multitude of barriers, with communication issues being highlighted across the literature, including interpreter services and lack of culturally appropriate and continuity of care programs. The current dominant fragmented models of care are not meeting their needs.

We urge the Committee to take into account the following issues:

1. The need for recognition of what constitutes OV, and the structural factors in Australian maternity care that contribute to OV, birth trauma and related outcomes.
2. The need to recognise that respectful maternity care is a human right, and that best practice guidelines include the implementation of evidence-based practices to prevent OV and mistreatment.
3. The need to recognise that respectful maternity care is a woman-centred partnership with health professionals, which maintains women's dignity by respecting privacy, culture, values and belief systems, and recognises individual needs, circumstances and expectations without discrimination.
4. The need to recognise that respectful maternity care is an organisational and structural responsibility and is a fundamental human right. Therefore, there is a need for continued organisational awareness regarding the provision of respectful and dignified maternity care for all women in all settings. These includes public and private health care services and models of care, GP practices, public and private consultation spaces, birth centres, home birth programs, hospital in the home, postnatal and early childhood services.
5. The need for specialised services for women who are marginalised, and who may be especially vulnerable to obstetric violence and mistreatment, including collaborative and co-created programs in language for Indigenous, refugee and migrant women, women who are disadvantaged, young, or living with a disability or mental health condition.

Obstetric violence and birth trauma

The present situation

1. Obstetric violence as a manifestation of gender-based violence. OV has been described in both low and high resource countries [1], with previous research estimating prevalence of between 15-91% depending on the country and measure [2]. OV has been estimated to affect around 11% of women in Australia according to a 2022 national survey. [3]

2. Seven categories of disrespect and abuse in childbirth have been proposed, which include physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. [4]

3. OV takes place as a consequence of structural violence in maternity care [5], and in such cases includes any form of abusive and disrespectful attitudes or practices toward women and people during childbirth [6]. OV is deeply embedded in unequal relationships of class, gender, race, and medical power, and constitutes a major barrier to women accessing appropriate services and care [2, 7, 8]

4. According to the World Health Organisation, women may experience OV as disrespectful, abusive or neglectful treatment throughout pregnancy, but are especially vulnerable to OV during childbirth. The WHO recognises that these practices have long term adverse effects on the mother and the baby, [6, 9] that may be dismissed as trivial or non-violent, such as dehumanisation, loss of autonomy and coercive verbal forms of violence. [8]

5. OV advocacy and research takes a human rights approach, driving international advocacy for humanised and respectful maternity care [6, 8, 10-12]. OV has been included in legislation in South America [2], and highlights the need for structural drivers for prevention [2, 5, 7, 9, 11, 13].

6. A growing body of literature on OV addresses practices such as:

    a. high rates of medical interventions, with a focus on birth as pathological rather than physiological event

    b. excessive or unnecessary use of drugs or medical procedures

    c. harsh, rough or disrespectful treatment or communication

    d. coercive or unconsented care, procedures or medical interventions

    e. disrespect and other abusive practices. [3, 5, 8, 13-15].

7. OV also includes cases where women are made to feel infantilised, being forced to give birth in a certain position, unnecessary acceleration of labour, unnecessarily applied fundal pressure, given excessive medication or made to feel guilty or foolish for not wanting to give birth in a standardised way [6, 9, 16].

8. In Australia, normalised and institutionalised mistreatment and violence against women in facility based maternity care is reported [3, 12, 17], and the importance of advocacy in this area is emphasised [17]. The areas where violence and mistreatment are identified in Australian research range from inadequate information for informed consent, excessive medical interventions, including induction of labour, electronic fetal monitoring and caesarean section, bullying and coercion or unconsented procedures such as episiotomy, induction and augmentation of labour, vaginal exams and rupturing of membranes [3, 17].

9. A 2022 national survey of Australian women reporting OV perpetrated by healthcare professionals, included reports of bullying, coercion, non-empathic care, and physical and sexual assault, contributing to high rates of birth trauma, and ongoing trauma. Commonly reported types of OV in Australian maternity care were disrespect and abuse, and non-consented vaginal examinations. Systemic issues identified as drivers for OV include healthcare provider education, staffing ratios, and a lack of access to continuity of care models. [3]

10. Women who are marginalised have been identified as being especially vulnerable to OV, including women who are migrants, refugees, Indigenous, have a history of domestic violence, are non-gender conforming, young, disadvantaged socially or economically, geographically isolated, or who are living with a disability or mental health condition [2, 5, 6, 9, 10, 16, 18, 19]. However, there is insufficient Australian data to draw conclusions about the magnitude of its impact. Barriers to access to maternity care in Australia include being Indigenous [20], migrant or refugee, or lacking access to universal health coverage [15, 21], lack of access to continuity of care programs, or being socially or geographically disadvantaged [22-24]. Australian research has identified a lack of culturally appropriate services, including interpreter services, with communication issues as the key barrier for refugee or migrant women in Australia. [21, 25]

11. In Australia, investigation of the use of electronic fetal monitoring (EFM) also highlights the excessive and unnecessary confinement of women due to medical interventions such as EFM where women are tethered to machines using straps and cords, resulting in reduced freedom of movement, excessive discomfort and increased intervention rates. [26-28]. The use of EFM remains controversial with a lack of evidence of benefit [28-31]. Women also report being forced to submit to uncomfortable and distressing positions to facilitate clinician examination or to accommodate monitoring [26, 27]. EFM is often an undisclosed component of induction or augmentation of labour [WOMB study, First baby study], and has been identified by women as a cause of birth trauma [first baby study].[32, 33]

12. Evidence-based, woman-centred, supportive practices for physiological approaches to labour, including non-pharmacological approaches to intrapartum care [34], having a support person or doula [22], birth facility design [35], evidence-based complementary therapy techniques [36-38], and comprehensive childbirth education programs [14, 39-41] are promising, but remain largely unintegrated due to organisation and systemic barriers [42], despite rapidly increasing rates of medical interventions [43, 44].

Recommended actions

13. Further research is required to more accurately establish the scope and prevalence of obstetric violence, birth trauma and related outcomes in a diverse population of Australian women. This includes the experiences and specialised needs of Indigenous women, migrant and refugee women, people who are gender diverse, disadvantaged, or where there is intersection of these.

14. Australia-wide policy development that takes a human-rights based approach to identify, target and prevent practices that contribute to obstetric violence and mistreatment of women during birth, and the identification and implementation of practices that support access to respectful, dignified, equitable maternity care for all women in Australia. This acknowledges that working conditions in health care institutions can be difficult with staff shortages, resource limitations and excessive workloads that can have an impact on the way women are treated. However, all forms of violence against women, including OV, should be acknowledged and prevented, understanding the human rights implications, in particular in the health care context.

15. The concept of obstetric violence, used in some South American childbirth activism and legal documents, can be applied to address structural violence in maternity care to prevent high intervention rates, non-consented care, disrespect and other abusive practices [45].

16. Translation and integration of evidence-based practices that are supportive of physiological birth into intrapartum care practices to reduce the rising rates of medical interventions in labour and birth. These include continuity models of maternity care, having support people or doulas accompany every woman, comprehensive childbirth education programs, non-pharmacological techniques, supportive clinical care practices, and evidence-informed information and consent procedures regarding common medical interventions including induction of labour, augmentation of labour, rupture of membranes, routine EFM, episiotomy and caesarean section.

17. Australian women, clinicians and healthcare providers need to be empowered with knowledge, education and information regarding the physiological, psychological and social impacts of obstetric violence and birth trauma, so they can proactively design women-centred models of care, supportive care practices, and promote communication and informed decision making. Some notable Australian and international research has described pathways to implementation of respectful evidence-based care. [46-48]

18. More accessible and culturally sensitive health information, education and resources on OV are needed for women from Indigenous, refugee, migrant or diverse backgrounds, those with low health literacy or are disadvantaged physically, socially, psychologically, geographically or financially

19. Currently, there are significant gaps in health professional training and understanding of OV, which does not adequately acknowledge the complexities associated with OV, mistreatment and birth trauma. Health care professionals should be adequately trained in OV and offer non-discriminative, confidential, and culturally appropriate care to improve the quality of life for women. There should be an emphasis on whole-person or person-centred care focusing on the individual needs of women and high-quality contextualised care plans.

20. Working together to implement collaborative continuity of care models, and training for the healthcare professions to ensure that women are knowledgeable and have autonomy over their bodies. Listening to women and respecting their human rights, women should be equitably involved in their childbirth experience, free from violence and discrimination. This requires political commitment to change.

Conclusion

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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15 August 2023

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