# PUBLIC

**THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON REPRODUCTIVE, MATERNAL AND PAEDIATRIC HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE HOBART ON MONDAY 21 OCTOBER 2024 AT 10 A.M.**

**CHAIR** (Ms Haddad) - Welcome. My name is Ella Haddad. I am the Chair of the committee. I will introduce at the table Jacquie Petrusma, the Deputy Chair for today; Mary, who you know, is our secretary; Kristie Johnston; and Cecily Rosol is a member of the committee and is joining us from Launceston. There are two other members of the committee who are apologies for this morning's session. They are Rob Fairs and Anita Dow.

Thank you for attending today and providing a really informative written submission. I need each of you to state your name and the capacity in which you are appearing before the committee.

**Ms WOOLNOUGH** - I am Chloe Louise Woolnough, Manager of Connected Beginnings, statewide.

**Ms FOSTER** - I am Raylene Foster, one of the senior executive managers at the Tasmania Aboriginal Centre. I am here in the capacity as Director of Connected Beginnings program, lutruwita.

**Ms HARRIS** - I am Dannielle Harris. I am a Registerd Nurse at Kutalayna Health and part of the Connected Beginnings team in Kutalayna in the south.

**Ms THOMPSON** - I am Anissa Thompson. I am a Child Health nurse working with Connected Beginnings across lutruwita/Tasmania.

**CHAIR -** Thank you. Can I confirm that you've each received and read the guide sent to you by the committee secretary?

**WITNESSES** - Yes.

**CHAIR** - It's in the guide that you've received from the secretary, that the hearing is covered by parliamentary privilege, which means that you can speak with freedom and say whatever you want to say without fear of being sued or questioned in court or any other place outside of parliament. The protection is not extended to statements that are made outside of the committee hearing.

The hearing is public and you can see there's some members of the public joining us today and online as well. Should you wish aspects of your evidence that you want to give today to be heard in private, you can ask for that and we can have a short deliberative meeting and then move into what's called an in-camera session. So, if there's anything as you start to begin your statements that make you feel like you'd like to go into a private session, we can do that. It's still transcribed, but it's not a publicly available transcript.

I've introduced the committee. I now need to ask each of you to make the statutory declaration that's in front of you on those cards.

**Ms CHLOE LOUISE WOOLNOUGH** MANAGER, CONNECTED BEGINNINGS, **Ms RAYLENE FOSTER,** COO AND DIRECTOR, **DANNIELLE HARRIS,** REGISTERED NURSE, CONNECTED BEGINNINGS PROGRAM, **Ms ANISSA THOMPSON,** CHILD HEALTH NURSE, TASMANIAN ABORIGINAL CENTRE, MADE THE DECLARATION AND WERE EXAMINED.

**CHAIR** - Thank you. We've also agreed as a committee to provide a sensitive content disclaimer at the beginning of our hearings for anybody here or anybody listening online, so, I'll just quickly go through that now.

We recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The committee encourages anybody impacted by the content matter during the hearing to contact services and support such as Lifeline on 13 11 14, Tresillian Tasmania's Parents helpline on 1300 827 282 or PANDA National helpline on 1300 726 306.

That's all the formalities out of the way. I invite you to provide an opening statement if you would like to do that.

**Ms FOSTER -** I sit here today as a proud Aboriginal woman of lutruwita, a palawa woman, representing the Tasmanian Aboriginal community. I'm here to advocate for a strong and resilient Aboriginal community of lutruwita/Tasmania, particularly concerning the urgent needs to improve reproductive, maternal and paediatric health services for our community.

As we are here today, it's a unique opportunity to consider co-designing a healthier future for our Aboriginal children and families. It's imperative that we confront the significant health disparities faced by Aboriginal people in lutruwita. Our collective goal must be to ensure that every Aboriginal child is born healthy and strong, that every family has the support they need, and that our cultural practices are honoured within a health system that ensures that our new babies are growing elders.

I want to make a statement that when we talk about Aboriginal maternal child health, we talk about non-Aboriginal women carrying our Aboriginal babies and they are as important as the Aboriginal woman itself. I want to make sure that when we talk about that, that's in the context of whoever is birthing our babies on country.

**CHAIR** - Thank you. Would anybody else like to provide an opening statement? Are you happy just to move to committee?

I might start with a question coming from your opening statement and the written submission as well that you provided, just on the inconsistent approaches that you are hearing that Aboriginal women are experiencing in the health system. If you'd like to elaborate on those inconsistencies that have been raised with you as an organisation.

**Ms THOMPSON** - One just came to mind actually as you were talking Raylene, and it was actually when the mother baby unit was still open. I suppose it brings in a little bit of culturally safe places as well as not having constructs or biases in the way that maybe the health system responds to people. That was an Aboriginal mum who needed to come down from Kanamaluka/Launceston to the mother baby unit here. She was really confused because every

time she went out of the mother baby unit, she was searched every time she came back in. She was put in the room closest to the nurse's desk and she noticed that other mums would come and go and they weren't searched. At the time, I was working at Kanamaluka. I came down to visit her a couple of times and each time she just was so confused. She'd say, 'I don't understand why I'm getting searched every time I come back in'.

It really did speak to the constructs and biases that can be held that then have a major impact on young women. She was a teenaged, first time mum, and how she was experiencing what was supposedly support but she actually felt quite unsafe. That was probably one that came to mind for me in those discrepancies between how someone can be cared for and how someone can be judged or given selective care.

**Mrs PETRUSMA** - Was that in St Helen's private hospital?

**Ms THOMPSON** - Yes, that was a number of years ago, but it's something that stood out. I suppose we do hear it day in, day out that there are certain things - we even had, and it's an interesting one, I didn't hear this myself, but we've had feedback from families up in Pataway/Burnie regarding GPs calling and saying, 'Oh, you need to have your Aboriginal needle'. A confusion around the immunisation schedule is such, but nothing's an 'Aboriginal needle'. It's about a schedule and it's about potentially some of those ones that are given at different times for people who are in different categories.

**Mrs PETRUSMA** - It is about that language.

**Ms THOMPSON** - Yes, it's about that way in which people can be left feeling unsupported in a system that is saying they are there to support you.

**Mrs PETRUSMA** - I think it's down to the lack of cultural awareness, that was in your submission, wasn't it, that was culturally appropriate language and actions?

**Ms FOSTER** - Yes, definitely. One of the things that comes to my mind is around when you're asked if your Aboriginal or Torres Strait Islander and you tick the box, you're actually being disadvantaged because you have a lens looking upon you as though you are a stereotype of some notion of not being able to capably look after your children. It is so systemic. I've heard of families and some people quite close to me who have identified in hospital just having had their baby and they're told to watch a couple of videos that you'll need to watch.

We can do bricks and mortar changes, we can put pretty pictures on the walls but unless we're actually really internally changing the systems, the value and the beautiful connection of families having babies. One of the things that also happens is this allowance of time to be with the birthing family where we are community. If I want to come along as aunts or uncles to share that beauty of the baby being born - because that's how we do business - then we should be allowed to do that. But we are excluded: you can come in between 2 p.m. and 4 p.m. and if you're outside those hours then you can't come in, you're not considered family.

It is really difficult in those institutionalised ways of having our babies in institutions, which brings me to the fact that there's some other ways in these worlds where we don't have to be in an institution to have a baby.

**CHAIR** - That leads me to my next question, which you've touched on in the written submission. You talked about co-design in your opening statement and submission and also the need to consider a First Nations' birthing on country program. Are you able to share a bit more information about what both of those things would look like? Co-design in terms of the health system more generally, but also what a birthing on country program might look like for Tasmania?

**Ms FOSTER** - When I say birthing on country, I don't mean going and birthing a baby under a tree, because that's what people immediately think. It's about having the opportunity to say, 'I would like to have my baby at home', or 'I would like to have my baby in this place'; 'I don't want to be in a hospital system because that's where sick people go. I'm not sick. I want to celebrate this birth and I want to celebrate it with the people who are around me'.

I think in relation to that is co-designing, without the four walls of what that should look like in today's society, about what that co-designed approach could be and how we share the opportunities of having babies, where babies are celebrated and everything's as natural as it possibly can be without a whole lot of interventions that often mums don't have choices about: we're watching the clock, we've got to get this baby out. Those are some of the really hard things for our families and that continued trauma that brings around for that family every time they have to go into an institution, the hospital setting.

There's that real ability with the co-design work. NACHO, the National Aboriginal Community Control Health Organisation, national body, has an expert panel which I sit on designing what a maternal and child health program could look like for Aboriginal people. When that's available, I'd love to share that with the committee.

**CHAIR** - That would be really useful. Thank you.

**Ms FOSTER** - It's almost finalised, but I think it's a bit of a blueprint about how to take away just the expectation and start looking more broadly. I've got representation from all over Australia.

**CHAIR** - That would be really helpful. Thank you if you're able to share that with the committee when it's available. Do you know whether many Tasmanian Aboriginal women are accessing homebirths at the moment?

**Ms FOSTER** - No.

**Ms HARRIS** - It's not available in Tasmania at all.

**CHAIR** - Well, not publicly. It is privately.

**Mrs PETRUSMA** - It is privately, yes, Midwife program,

**Ms THOMPSON** - I think I saw in maybe your submission that actually had the statistics around Tasmania being the only state that doesn't fund -

**CHAIR** - With that publicly available, that's right. Yes, but there isn't a great proportion of Tasmanian Aboriginal women accessing private?

**Ms FOSTER** - I would say zero to my knowledge. It's an expensive thing to do as well, but no, it's never been a real option for our community. It's hard enough to get accessible midwifery services for our community who don't have to leave their place of home, like if you live in Launceston/Kanamaluka or Kutalayna at Bridgewater, you have to go out of your suburbs to actually access -

**CHAIR** - Out of community, that's come through in quite a few of the submissions to the commmitte. Regional access, which is one of our terms of reference as well.

**Ms FOSTER** - We work in the Bridgewater Community Health Centre where the child health nurses are and there's such a separation of availability for our families to access many of those services. Of course, mums are not going to their first antenatal visits early because they've got to go out there and do all those things.

**Ms JOHNSTON** - I'm interested in your opening statement. You talked a bit before about the hospital experience, and unfortunately sometimes people have to have that hospital experience, and recognise the importance of celebrating a birth - it's meant to be a happy occasion - and the importance of having people to come in. You talk a bit in your submission about the quick process and its discharge, you are sort of pumped out, out the door again and then your follow-ups, looking at the baby blue book and it's not really that holistic kind of celebrations. What could you suggest in terms of trying to encourage, particularly in those first 24 to 48 hours, how that could be enhanced to provide extra support to the person birthing and the family involvement in that as well?

**Ms FOSTER** - I think it's having that availability for families to support the birthing parents. It's also about not watching the time - okay, this family's next, this one is now, 12 hours in and they can go home. They've had two children before so they're ready to go out the door. Actually, having three children is a big hit, so there's -

**CHAIR** - All the more reason to stay longer.

**Mrs PETRUSMA** - When I had my fourth, I wanted to stay in for 10 days.

**Ms HARRIS** - Every baby is so different when they're born as well. Your first experience is going to be so different from your future ones. It's important for them to realise that just because you've had children in the past doesn't mean that you're not going to need that further help.

**Ms JOHNSTON** - Do you think there's room for acknowledging informal support the family and community provide in that setting? In terms of others who've been through the process and involving them, rather than necessarily healthcare experts, involving family and community members in providing that support to new mothers.

**Ms FOSTER** - Absolutely, and especially with breastfeeding. You might not have had the opportunity to try breastfeeding, or something was not working for you in your first or second, whatever, but this might be the time that you want to try again, and often that ability of lactation consultants in the public system is not there. Everybody is very, very busy and having the ability to bring in peer support for breastfeeding is not just a one-off, come in and help and do this. It is consecutive feeds and all of that.

**Ms JOHNSTON** - Over months, because their babies change.

**Ms FOSTER** - Absolutely, it is really building that. What is it that would make that birthing experience the best for that individual family or that individual parent, whichever it is? How do we actually support that well, rather than having to have a bed available? Or, what are the other options? Is it that you go home with Dannielle as your nurse and she is contactable 24/7? Those things could be the difference about your experience going home with bub. That is beautiful and just the best it can possibly be to waking up at 12 o'clock, baby hasn't fed, you are looking for the next best thing, where is the formula, someone go down to Coles 24-hours and get me that formula or whatever. All of those things that actually -

**CHAIR** - Need support.

**Ms FOSTER** - Need support so that trauma is controlled because it can be very, very traumatic. If you had set destined to breastfeeding and that was all that you wanted to do and that is not something that is working for you right now, that is absolutely devastating.

**Ms HARRIS** - That is why mental health can spiral for new mums.

**Mrs PETRUSMA** - We are talking about lactation consultants and breastfeeding support in communities is lacking, and identified the need for more breastfeeding support from discharge and available close to home, place-based - are there certain locations that are the worst for that?

**Ms FOSTER -** In all the footprints that I have, I do not think I can say there is one place that is wonderful. There was a lady, I do not know where Sue Cox is now, but she was one of the -

**CHAIR** - I remember that name, yes.

**Mrs PETRUSMA** - She is fantastic. Had great videos too.

**Ms FOSTER** - Absolutely. Now, if you have somebody who is as passionate and wants to -

**CHAIR** - Everybody in the room is nodding.

**Ms FOSTER** - And she was amazing. We actually delivered a peer support breastfeeding team at a point in time and that knowledge transfer - and people are nodding in the room - but you have to get those champions in the system who are actually going to support that, wholeheartedly, for all families.

**Ms THOMPSON** - We had that beautiful example at Ningi Pakata, the mum and baby group, that is on Mondays. It is on right now, out at Kutalayna today. There was a mum there who gave the most beautiful breastfeeding support to another new mum. She had come back in with a two-week-old baby. She was expressing and giving expressed breast milk and she was struggling with a pump. Anyway, this mum just stepped in, showed her how to use it. She was like, 'Oh, I think you are are using the wrong flange size'. All this high-level information and skills she was passing on. It was amazing for us to step back and watch and see that

exchange of information. Here is this wealth of information right there in the community, happy to be contacted at any time of the day or night. It is just priceless.

**CHAIR** - It is about knowing about it and making those connections.

**Ms THOMPSON** - Yes, exactly.

**CHAIR** - Coming back to that issue of co-design, I would be really interested in your thoughts on how that can be more practically embedded in system design as well, and also whether the TAC has any regular conduit into communicating - particularly around health - into the Tasmanian Health Service?

**Ms FOSTER** - Yes, there are little bits happening. I suppose, if I talk about our Connected Beginnings program, which is a Commonwealth-funded program to improve school readiness for Aboriginal children aged zero to five. One of the parts of that program is service system change. We have been doing a lot of work on looking at where the gaps are. It is not for us to service deliver those components, but it is saying what is already out there that can be adjusted, changed or not, and what is working well and what is not working so well for families to actually access provisions that support them to be the best versions of themselves, to grow beautiful children.

One of the parts of that is that Chloe has been working closely with service providers and the Department of Health. We can talk about the statewide group that is about five months in.

**Ms WOOLNOUGH** - We have the three collectives around Lutruwita and we acknowledge that not everyone can get to three different meetings, but what we're hearing around the three collectives, there were the synergies -

**Mrs PETRUSMA** - When you say collective, can you explain?

**Ms WOOLNOUGH** - We have the three collectives: Palawa collective; Kanamaluka, which is Ravenswood up through to Georgetown; and Kutalayna, Old Beach through to Brighton. They're the areas in which we work and support community, but also looking at the services in those areas that are there to support families. So, when we had the two new collectives start, we acknowledge that there were things that we were hearing that were synergies. However, there were things that were place-based that the community had the power to work on and control within their space.

So, we brought together a statewide group which has representatives from Health, Education, Housing - it's starting to see the relevance of everyone working collaboratively. For instance, when we talk about housing, it was why are we here? Who lives in your houses? When you're thinking around housing design, are you thinking of those children that will be growing up there? Do they have room to move? Is it a safe space? How do we create communities that support little people. So, it's been really interesting for us as a statewide group to come together and to see how we all flow on and can support one another's work.

What we've been hearing, with health, for instance, is that people are hearing that all these services are in their community, yet they can't tell you who they are. So, we're starting to see our community want to hold services accountable. If you're in this area, I want to know who you are. I don't want to have the expectation that I come through the door constantly to

you and that's where community - when we talk about co-design - they've come up with models that work for them. We hold events called Kipli & Kani. They've been designed by community for community. They invite services to come along to a local park which is out of their building, out of their office, and just engage with them, have the conversations, and from there, when we come together as a statewide group, now we're hearing people say, 'Oh yeah, one of our staff members went along and they were saying that they met such and such' and then they came along and they were comfortable to come into the service.

But, it's also that connection piece for community to come together and have the conversations. As Anissa said, it's bringing community together, and then if someone has an issue, there's always somebody there that can support and we saw that last week in Kanamaluka. We were chatting to one of the mums that has been with our program now for three years and she's just had another baby, and she spoke around the impact of knowing services but also having someone there consistently to support her through that journey, to break down what the jargon is that was being used in the paediatric appointments, but also advocating that she has a voice. She's just had a new baby and she spoke to her and she didn't know what a VBAC was. She'd always wanted to experience childbirth yet she was told 'Third child, you're having a caesarean, it's too dangerous, questions asked, go.'

Then she was able to go along with the support of one of our amazing staff who brought up the question and she was able to express why she wanted to try it and that she was more than willing to have the caesarean, but she wanted to also have the opportunity. They spoke around that and she went into labour and they went up to visit her - she had other young children - to see how she was going. They'd been talking around this for a few months, and her partner actually said, and I remembered, 'I'm going to tell them that we don't go straight for the caesarean. She wants to have one of those VBAC things'. One of those VBAC things, but he had the language there. So, even if she became overwhelmed, he was like 'I know what she wants, and I know that I can advocate for her because that's what she's wanted'.

Then we moved into the journey around breastfeeding, and she said, 'Oh, you know, I was pretty much sent home, you've had two children, you know what to do'. She'd never successfully breastfed for those first two children. I said to her 'Did you share that?' She goes, 'No, no I didn't share because it was like, d-d-d home. There you go. Here's a magnet. Now, if you need anything in between, just call these numbers'. And she's like, 'I was never going to call those numbers, but I was going to call the person I knew from Connected Beginnings who'd helped me through this whole process'. She shared with us, just having her come and sit and have a coffee and then being able to say, 'You know what? I really want to breastfeed, but I'm just so confused. Someone's told me this, someone's told me that. What do I actually do?' We ended up having a little bit of a laugh because in the end the person who was working with her said 'Well, I'm happy to help you and can show you what to do, but I'll connect you with the lactation consultant. Let's try today. Let's make the phone call', but she stepped her through.

So, in the end, she actually breastfed for six weeks, and to see the pride that once she advocated for herself, for the first time during her third birth, she had a go at breastfeeding and her voice was heard. It was just amazing to see, she was empowered. She was like 'I actually had a say in what I wanted and what suited me and my family'. She said 'Now, I don't feel like I've missed out on anything. For the first two births I really felt like I missed out. I wanted to have a natural birth, planned, had to go, ready, set, off. This time I really got to enjoy the experience and know what it was like to be a mum going through the birthing experience. To

be able to not have that power imbalance and to say that it's my body and this is what I want and this is how I want to do it'.

The impact of that, but having the support, was the key thing we constantly heard. Her child's now four months old and we were sitting there and it was like hearing friends talk.

**CHAIR** - It would be transformative.

**Ms WOOLNOUGH** - It really was.

**Mrs PETRUSMA** - With the first two births, do you think it was a lack of health professionals actually asking the right questions or offering information?

**Ms WOOLNOUGH** - She shared that she very much had seen herself as not holding the knowledge. They were the experts. They told her this is what had to happen and that's how she had to have her babies. However, when she learnt that she can push back and advocate on what she also needs as a mother, then she was able to negotiate that with them. Obviously, didn't want it to be unsafe but this is something that as a mum she wanted to experience and to understand. Even though the first two hadn't gone to plan, there's also this opportunity. The fact that she's a third time mum who never even had mentioned to her the opportunity of a VBAC that then was agreed upon by medical professionals that it was doable. Why wasn't that option given in the first place?

**Mrs PETRUSMA** - That's what we want to understand too as a committee.

**Ms THOMPSON** - I wonder if it links in with another really big point that we were talking about before we came in around continuity of care. If it's not relationship based, which is everything you're talking about, Chloe, then somebody doesn't actually have the story of that mum. They don't know what their story's been. They don't know what their hopes are for the next birth or for feeding, that sort of thing. Whereas, if you do have continuity of care and you have a midwife that has been travelling through that journey of antenatal care with a woman, they're going to have a far bigger context of that woman, their home, their family, what they'd love for their birth, all that sort of thing.

I just feel like that continuity of care piece is a massive part of getting better outcomes. We all know that, but it's how you actually get that practically hitting the ground where it is, what most women have the opportunity to be going into a birth with people they know in there with them, and are aware of what their needs are and what their hopes are for that time. As soon as it's someone you're just meeting because they're on shift, how would they know what you want?

**Mrs PETRUSMA** -Would you suggest that the Know Your Midwife program and the Midwifery Group Practice model needs to be increased?

**Ms THOMPSON** - Yes. One of the other things is to make that even more place-based, which we're just such a huge fan of. Whereas, instead of people having to leave community to come in here to Royal Hobart for their appointments, they can have those place-based in their community, that the midwives are running those clinics within community so that that's happening close to home. Other family can come along to those appointments and include more

people within that antenatal and postnatal time. An extension of Know Your Midwife and MGP would be a great start in having more women experiencing that continuity of care.

**Ms FOSTER** - It worked really well when we had a relationship with the Department of Health and we had midwives coming into our service provision to provide services from the Aboriginal Health Service. That was Commonwealth funded. The Commonwealth was funding the state, the state was allowing the midwives to come into our centres and do that delivery. Not delivery of babies - delivery of service provision. When you had a complex care client then they were still able to do that within our health service rather than having, 'Sorry, you've got the complex care tick, we have to see you at the hospital'.

**CHAIR** - Is that no longer a funded service from the Commonwealth?

**Ms FOSTER** - I do not know what the state does with the money anymore but it actually hasn't been happening for a number of years now.

**Mrs PETRUSMA** - You're saying that the state is still taking the money but they're not delivering that service, or you don't know?

**Ms FOSTER** - I'm not sure how it works now but to me it doesn't matter. Often you don't need more money to do better work. If that model worked, then let's look at how that worked and say, 'Let's see if we can actually elevate that to support more families in our service provision'. You've got the cultural competence because they are learning that within our organisation. They are being able to use the multidisciplinary teams that we have in our health services to identify if there are some social things or there's some counselling or there's some other things; that there are these avenues to access that rather than go to a place. Then, all of a sudden, all you're getting attention for is your maternal needs at that point. We all know that there are many other things going on in people's lives and part of our work is doing that comprehensive primary care that encompasses the whole family and what that means to grow.

**Ms HARRIS** - It works so well because it's brought to them in their safe place and it breaks down that power imbalance. When community have to go to the hospital for their appointments, instantly there's that power imbalance of being in that uncomfortable environment. Whereas if we can make things more place based and bring services to places they're comfortable with and familiar with, then there's just going to be much better health outcomes. They're going to attend appointments because they feel comfortable to do so.

**Ms THOMPSON** - Logistics disappear. You don't have to get yourself all the way in to the appointment. You're a lot closer to home.

**Ms JOHNSTON -** With all the children in tow and all those kinds of complex things.

**Ms THOMPSON -** Yes. That is where you're seeing that the DNA's [Did Not Attend] is, because it's just so tricky, whereas if it was in place -

**Mrs PETRUSMA** - How do we increase cultural awareness amongst our health providers?

**Ms FOSTER** - I think the Health department has been doing a fairly good job of trying to do that under the cultural respect framework for the Department of Health. The maternity

ward has put in a lot of artwork and design around trying to be a culturally safe place. But there was always going to be that element of, 'How much time have you got to spend with me?' There's the time -

**CHAIR -** Individual -

**Ms FOSTER -** All that stuff, and they're busy places. I don't know that you can totally do it well in relation to what our needs might be, but acknowledging that, that is very important. It doesn't just happen when you get a job. When you're training, it should be a core component of everything you learn as you transition through your training, whatever that might be. When you are actually in the hospital or whatever setting it is, you're there ready to be able to be culturally responsive to community needs.

**Mrs PETRUSMA** - I know the current nursing students who are at UTAS do a whole semester on cultural awareness and everything. That's why I was interested in how that is translating in practice.

**Ms FOSTER** - It's so systemic. It's really difficult. We do a lot of training for GPs as well - GP registrars. You'll get a cohort who are just - there are 10 out of the 12 who are fully immersed and you only need the two that are not, because that could be the two people that you see. It is so difficult to get it right. But if we are acknowledging that, that's a really important part of the service system that needs developing better, then we're a long way along the track compared to where we were 10 years ago, for example.

**Ms HARRIS** - After going through UTAS doing my nursing, I did that component and I feel like it's still at such a deficit lens. When you work with families, if they tick the box to say, 'Yes, I'm Aboriginal', it shouldn't be, 'Right, they're going to need this, this and this'. It should be to have a discussion with them. What are their circumstances? What things are on offer for them? Is that something that they want? Let them make the decisions for themselves, not just assume that they will need these things.

**Mrs PETRUSMA** - Which is what they should be doing for every patient who comes in the door. They should not allow any unconscious bias. You need to be doing that proper assessment.

**CHAIR** - Is the TAC involved in delivering that in the nursing degree? Who delivers that teaching?

**Ms HARRIS** - It is through Riawunna. They don't have Aboriginal people delivering that.

**CHAIR** - It feels like it should be.

**Ms HARRIS** - Yes.

**Ms JOHNSTON** - I'm really interested in exploring a bit more about the second and third time experiences. From what you said, Chloe, that's a really good example to us of the disparities and the assumptions that are made about mums at second and third time round. I want to know a bit more about how they can be better supported.

As Jacquie said beforehand, that assumption that you know what you're doing, or you tick a box - that kind of thing. Can you explore how those supports might be better provided for second, third and fourth time mums? I know that my birthing experience with my two children were very different. Those supports weren't there the second time round and I had a very different birth. I'm interested to know how you feel they can be better supported.

**Ms THOMPSON** - I think, straight up, that parenting groups, or whatever you want to call those groups postnatally, are essential for everybody, not just a first time mum. You're put through that system and offered that first baby and never offered that again. That is something that every woman giving birth is welcome to come along to those groups.

**CHAIR** - Do they still operate statewide? My kids are teenagers now and I've heard from people with younger kids that it doesn't.

**Ms THOMPSON** - My understanding is COVID changed a lot for those parenting groups that CHaPS ran. They stopped completely. My understanding is they are back up and running, but again, it's offered to first time mums and not consistently, necessarily, depending on staffing.

**CHAIR** - So it's not consistently offered at all?

**Ms WOOLNOUGH** - It's not always ongoing, is what we've heard, or offered.

**Ms THOMPSON** - Usually, if it's still the same as when I was a CHaPS nurse, you run the group for three to four weeks facilitated by a child health nurse. Then the group is welcome to continue that on themselves and meet ongoingly. I know that obviously the north-west is incredibly understaffed CHaPS-wise, so I don't know if things like groups have kicked back in depending on staffing.

That extension to all mums is just - and Ningi Pakata are the mums and babies group that we have on Mondays, and in the other locations too, is a great example of that. The way in which some women - they're having their fourth or even their fifth - what they bring to the group and offer is extraordinary, and the things they're sharing.

Also what you notice around birth debriefing, which a woman's never had, and you see that being an important space where women can actually be debriefing birth one and they're having their fourth baby, but they've still got a lot to - because perhaps someone else has had a very similar experience and they then say, 'Wow, that was exactly the same for my first birth and I never talked about it, but it had a big impact'. The way in which that support can be there and that sharing of knowledge like we saw with the breastfeeding, and the numbers of bags of clothes that have been swapped and given is just extraordinary. Again, it's building up and allowing community to have places to come and meet and to provide that support.

**Ms HARRIS** - The practicality of it also needs to be thought about. So, if they're second or third time mums, they need to think about if they're coming to these groups, they're going to have other children with them, and often that's the barrier, because they need to bring their other children and there's nowhere for those children to play or be supervised properly.

**Ms FOSTER** - We run those in the child and family learning centres and those respective places, so that becomes a support mechanism for them to know that there's another place where they can bring their children to accommodate all of those needs.

**Ms JOHNSTON** - Is that something that you'd like to see as a recommendation of this committee in the future around having that mothers' group, or whatever they call them? Mine was essential for me the first time round and I've got lifelong friends from that, but the second time there wasn't the ability to join and connect. As I say, they were very different experiences. Is that something you'd like to see - that ongoing support provided no matter what number baby you're birthing?

**Ms THOMPSON** - That postnatally you're offered a group to attend?

**Ms JOHNSTON** - Yes, because that was more powerful for me - the other mothers - than anything any health professional could provide me.

**Ms WOOLNOUGH** - It's also about the space where it's hosted, because it's great to say we'll run it for three or four weeks, but then it falls onto a new mother to try and hold it where we've seen - we 've got one mum who has four children and she comes along every week just for her cappuccino that's made and on the table ready for her. She's like, 'It's the one thing each week that's done for me, and I just get to come and enjoy it.'

It's those little things that we're seeing, like having a morning tea, being able to create - and they've turned it into a bit of a craft group now where they're making something, because we acknowledge that it's awkward to walk into a room where you don't know anyone and then you're expected to talk.

**CHAIR** - About really personal stuff as well.

**Ms WOOLNOUGH** - Yes, so having that opportunity to be making something whilst yarning has really opened up the door for connection.

**Ms THOMPSON** - I would say, hands down, it's that connection and conversations between people, like you're saying, that is the most impactful. We'd been waiting for a physio who was going to be available and last week we did have a talk on pelvic floor. That was great; everyone had been asking for that. You can drip in some of that important information that's there and have those health messages coming in, and they're really valued. By far, the most valuable thing is the connections people are making.

**Ms JOHNSTON** - The point you made, Chloe, about having somewhere that you can go to, because I remember the stress about being the mum whose time it was to have it at her house after the fourth week, and my house is a mess - there's washing everywhere, there's nappies and stuff - and that stress. So having that location you can go to where you can get someone else to make you a cup of coffee and that safe space.

**Ms THOMPSON** - I would say that Connected Beginnings has absolutely prioritised that there's enough staffing. Usually, one of the community engagement workers has a whole little corner set up with other toys and things for the other children to come. You prioritise that where you can provide some good interactive things for other children who are coming if it's subsequent births.

**Mrs PETRUSMA -** Under the response to the selection criteria, it says, 'Confusion exists around the role of CHaPS, with nurses often focused primarily on the blue book'. What do you mean by 'focused on the blue book'?

**Ms FOSTER -** It is the check. I need to meet you to do your check.

**Mrs PETRUSMA** - Are you saying that the community does not understand that nurses have to do the blue book or check or - I want to clarify that statement.

**Ms FOSTER -** I think it is the opposite to that - that that's all they're there for. I have always seen child health nurses as much more dynamic than that. Because those blue book checks have decreased over time, there is less interaction, so there is less time. We have been trying to work out how we get into supporting families more regularly, because that is all that is there. You've got to get the blue book check, that's the data - fixed, alright, that goes in the system. Now I can go to my next one, but -

**Ms THOMPSON -** Then you don't pop up on recalls. So if you have had your two-week, four-week and six-week GP check, and your six-month and 12-month blue book, you are not coming up on recalls anywhere in between those checks. There can be big gaps, particularly if there is not enough staffing to do a four-month transition-to-solids discussion. Then you might not be seen from eight weeks until the baby is six months. In the life of a baby, that is a huge amount of time.

**Ms HARRIS -** Even in the first two weeks, if mums are not seen and they cannot breastfeed properly, then their milk will dry out and that's their opportunity gone.

**Ms THOMPSON -** By the time that first home visit at two weeks is being done, they have stopped breastfeeding.

**Ms FOSTER -** Or they haven't slept for two weeks and they are absolutely -

**Ms JOHNSTON -** Beside themselves.

**CHAIR** - And no one has reached out.

**Ms WOOLNOUGH -** If they have had a bad experience on that first one, they won't then do the rest. We have had families who haven't had checks in years. Because they had a bad experience that first time with one CHaPS nurse, then they are like, 'No, not doing it anymore; they just check this, this and this and tick the box'. They do not see the value in the conversation that comes with that and the opportunity to ask questions.

I think that is where we have seen with Ningi Pakata when questions come up, being able to say, 'Okay, I don't know the answer, but I can get that information for you'. That is where that working collaboratively and being able to, as Anissa said, bring in that pelvic floor information; Dannielle's been down to talk about immunisations before because there is a lot of confusion over, 'What am I meant to have; what should I have; will this happen?' Being able to give them the accurate information in a place that they feel safe, where sometimes they don't have to ask the questions because someone else has asked it for them - the power in that.

**Mrs PETRUSMA** - Is that a decline over time, you think? I know - and you can only reflect on your own personal experiences - that when I had my four children, the CHaPS nurses were brilliant.

**Ms FOSTER -** They were gods.

**Mrs PETRUSMA** - And they would spend a lot of time talking to you about -

**CHAIR** - That is my memory as well. I had a visit at home within the first two weeks and then the mum's group ran for six weeks. Like Kristie, I have lifelong friends who I still see from that mum's group when we continued on. When everyone started going back to work, it became a bit patchy. It feels like maybe what is on offer now - my kids are 19 and 16, so it is a long time ago - has maybe decreased in terms of the availability of CHaPS nurses and the scope of their work.

**Mrs PETRUSMA** - Is it time? Is it a quicker appointment or something?

**Ms THOMPSON -** There used to be what they called 'enhanced care', which was outside of the blue book checks. Definitely that, to my understanding, is far less of a thing. If your data is showing that blue book checks are being done, that's good, but that isn't the big picture.

**Ms FOSTER -** It is not holistic.

**CHAIR** - Raylene, you mentioned the child and family centres and that you run something out of them. Is that the Connected Beginnings program statewide?

**Ms FOSTER -** That is the mums and bubs groups - Ningi Pakata.

**CHAIR** - So that is in every child and family centre around the state?

**Ms FOSTER -** It is in the three -

**CHAIR** - Oh, in those three catchment sites. Okay, got it.

**Ms FOSTER -** That is a model.

**CHAIR** - That scope would be working well. I am interested in what you said about bringing in other knowledge, like vaccinations that you have gone and spoken about, and pelvic floor health.

**Ms THOMPSON -** That was great. That was completely pro bono by the pelvic studio here in town. I contacted them and, eventually, there was a physio and she came out. She was great.

**Ms HARRIS -** It was great that we learnt, too, that it is actually offered within the first six months for new mums from the hospital, but people don't get told about it unless it's a complex birth.

**Ms THOMPSON -** The next day, we were on the phone, booking one of the mums in for her physio pelvic floor check, just from that information.

**CHAIR** - I suppose if that hospital stay is really rushed and not necessarily with people who you have had some continuity of care experience with, then you might miss that information. There are a lot of misconceptions for us as women that pelvic floor incontinence is normal after babies. Actually, there is a whole lot that can be done to prevent that.

**Ms FOSTER -** It is even worse when you get older and you realise now what you should have done, but I think that notion of child and family centres is an amazing model.

**CHAIR** - I think it can be expanded upon.

**Ms FOSTER -** I think it's to be nurtured. It's shown with the kids' care clinics across Tasmania being rolled out in the majority of those child and family learning centres. It really shows the importance of bringing education and health together, and how that works together well for families regardless of where they live or what their demographic is - that those things, like your allied health services, can be aligned. Now we've got community health centres around the state, but they don't have that interaction of, 'I'm coming in next - I feel really well, safe, and it's a nice place. The kids feel like it doesn't matter if they're a bit noisy because people understand all that'. Child and family learning centres are set up for those things.

**Ms THOMPSON -** And they're non-clinical. They're social.

**CHAIR** - Is that federally funded for those three catchments, or is that state Department of Health funding?

**Ms FOSTER -** Connected Beginnings is Commonwealth funded.

**CHAIR** - Okay. But the mums and bubs groups?

**Ms THOMPSON -** It's through Connected Beginnings funding.

**CHAIR** - With the right funding, do you think that could be expanded to other child and family centres around the state?

**Ms FOSTER -** Yes. I always think that you don't need more money. It's actually how you realign what you're doing to provide the service. Because from one end, you're going to fill a gap. In economics, you're going to balance the books somehow, because you're going to have more people accessing a part of a service provision, and they're not going to have to have that acute end of whatever it might be for them, or more of something. That's where I think co-design is really throwing up everything in the air and saying, 'Let's see where it all lands'.

**CHAIR** - Like you said, it might not be about more money. It might just be about realigning existing resources to deliver services differently.

**Ms FOSTER -** The kids' care clinics are a really good example of that. Although there was more money to bring in provisions of service delivery, the bricks and mortar weren't recreated. They were used in relation to what was already there, building the capacity of the paediatric registrars to come out into community and actually learn their skills, place based, doing really good place-based work. It eliminates a whole lot of other stuff for families who

are taking their kids along, because it's accessible and they're able to deliver the service for that child, whether they've got ADHD or autism, or just speech, or OT.

**CHAIR** - They could reach out for other services.

**Ms FOSTER -** They're going to access it because it's there.

**Mrs PETRUSMA** - Are you part of an Aboriginal advisory group to the Department of Health at all, or THS?

**Ms FOSTER -** I sit on this cultural respect panel. There's a few, but there's nothing really. I'm hoping the Chief Aboriginal Health Advisor role will start to build a bit more of that capacity network. I suppose we are more aligned to having relationships with Dr Anagha, or wherever that sort of service system sits.

Getting data from the child health section has been absolutely non-existent for so long. Data has been a real issue for us.

**CHAIR** - That's one of the things I know you mentioned in your written -

**Ms FOSTER -** There's definitely scope for more of that stuff to happen.

**CHAIR** - Our time together has really flown. Were there any closing questions from Cecily, Kristie or Jacquie, or any closing statements that any of you would like to make before we finish up?

**Ms FOSTER -** No, but I can forward on any additional information, if that's okay.

**CHAIR** - Yes, please do, either to myself or to Mary. Any one of us will share the information. I'm so grateful that all of you could join us for today's hearing. It's been really insightful and a really important start to the committee. You're the first people to address the committee. It's been really informative. I'm grateful for your time and expertise, and that you've been willing to share it so freely and openly. It has been meaningful for us as members of the committee. Thank you.

**Ms THOMPSON -** One of the things, just quickly, that I've noticed is that when you're outside of that government system, the way in which you can work in a responsive way is massive. The biggest encouragement I'd make is to think outside the box. It doesn't have to look the same way. What's working? Let's do that, or let's ask community what would work.

**Ms WOOLNOUGH -** The highlight of everything we've done has been through community identifying the gap. We haven't come up with the idea of a program. It's what we've heard from the people who need it.

**CHAIR -** That's a really important point. Thank you.

**THE WITNESSES WITHDREW.**

**The committee suspended at 10.50 a.m.**

**The Committee resumed at 10.55 a.m.**

**CHAIR** - Welcome, Charlotte. I know you've been observing but we still need to go through the formalities if that's okay. I'm Ella Haddad, Chair of the committee, Deputy Chair is Jacquie Petrusma; and Kristie Johnston and Cecily Rosol. We might be joined any minute by Anita Dow, who is also a member of the committee but was tied up until about 11 a.m. today. She might come in at some point during your testimony.

Welcome and thank you for attending and thank you for providing a very comprehensive written submission to the committee as well. If you could, please state your name and the capacity in which you are appearing before the committee.

**Ms FIELDING** - My name is Charlotte Fielding, I'm a volunteer breastfeeding counsellor and breastfeeding educator with the Australian Breastfeeding Association. I'm also currently the assistant branch president and was the branch president when we submitted the submission in January.

**CHAIR** - Can I confirm you received and read the guide sent to you by the committee secretary?

**Ms FIELDING** - Yes, I have.

**CHAIR** - This hearing is covered by parliamentary privilege, which allows you to speak with freedom without fear of being sued or questioned in any court or any place outside of parliament. This protection is not accorded to you if the statements that may be defamatory are repeated or referred to you outside of this parliamentary proceeding. The hearing is public and as you can see, we're joined by one member online and there may be members watching from the public gallery and online as well. Should you wish any of your evidence to be heard in private, it's called an in camera session. You can ask for that. We'll have a short deliberative meeting around that and we can move into a private session if there's any information that you'd like to share outside of those parameters. Could I just now ask you to make the statutory declaration that's in front of you there on the card, please?

**Ms CHARLOTTE FIELDING,** BREAST FEEDING COUNSELLOR AND BREASTFEEDING EDUCATOR AND ASSISTANT BRANCH PRESIDENT, AUSTRALIAN BREASTFEEDING ASSOCIATION, TASMANIAN BRANCH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIR** - I will also start with the sensitive content warning, just in case there's members of the public joining online who weren't here for the last session. As a committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings and the Committee encourages anybody impacted by the content matter during this hearing to contact services and supports, including Life Line's Helpline on 13 11 14. Tresillian's Parenting Helpline on 1300 827 282 or PANDA's National Helpline on 1300 726 306.

With those formalities completed, would you like to make an opening statement to the Committee?

**Ms FIELDING** - I'd like to start by acknowledging the traditional owners of lutruwita/ Tasmania and pay my respects to elders past and present, and acknowledge that Aboriginal women have breastfed their babies on country for more than 60,000 years with the support of their families in the country. It was fantastic to be able to hear the previous session.

The focus of our submission is on breastfeeding and the difficulties mothers in Tasmania tell us they face accessing support to successfully breastfeed. The recommendation of the Tasmanian and Australian governments and the World Health Organization is that a baby is exclusively breastfed until about six months of age. This means no other food or drinks are given unless medically indicated. At the moment, mothers in Tasmania find it very difficult to access the right support to enable them to achieve this. ABA volunteers frequently hear this from mothers around the state. We have included one case history from a mother in one location, but we hear similar scenarios from mothers across the state.

Parents in Tasmania understand the importance of breastfeeding. They understand the importance of breastfeeding to their baby's health and to the mother's health. Most mothers initiate breastfeeding at birth. We know that most want to breastfeed but many are unable to access the support they need to overcome challenges they may face to continue breastfeeding. The enablers for successful breastfeeding in Australia are all set out in the Australian National Breastfeeding Strategy 2019 and beyond. This was published on the 1 August 2019, following an exhaustive consultation process, including here in Tasmania, all state and territory Health ministers at the time agreed to it. The Australian Breastfeeding Association Tasmania Branch is calling for it to be fully implemented here.

Improving health professional education is a key part of the Australian National Breastfeeding Strategy. Mothers who are being supported by ABA volunteers in Tasmania often tell us the information that they've been given by their healthcare providers is out of date and inaccurate. They often receive little or no breastfeeding education during their health professional training. The Australian Breastfeeding Association offers health professional education online and face to face, and we can facilitate that here if funded to do so.

Peer support is another key element of the Australian Breastfeeding Strategy and there is strong evidence that having access to trained peer support, such as that provided by the qualified volunteers of the Australian Breastfeeding Association has a positive impact on breastfeeding outcomes. Anissa [Thompson, Tasmnian Aboriginal Centre] gave some examples of that. In Tasmania, ABA offers free local groups and locations across the state, facilitated by Certificate IV trained breastfeeding counsellors and educators. Mothers are able to come along and discuss any challenges they may be having. They're also able to chat with other mothers who may be further along in their parenting and who may have experienced similar challenges. Mothers report feeling encouraged and more confident after attending ABA events and/or speaking with an ABA trained educator or counsellor.

Peer support such as this is an evidence-based strategy highly recommended by the World Health Organization. Despite all the advances in technology, mothers still tell us they value real life face-to-face support. They tell us they get emotional support as well as information they could not find elsewhere. They learn and grow together and gain confidence in their parenting as well as breastfeeding. Again, this was discussed in the previous session.

ABA breastfeeding counsellors and educators all have a Certificate IV in breastfeeding education. They are highly trained and are the only peer supporters working across the entire

community in Tasmania. The support they provide is not the same as that offered in a Facebook group where members may only have their own experience to go on. ABA volunteers offer mothers a range of suggestions, not advice, which are all evidence-based and reflect the latest research. We are all required to complete regular professional development to keep up to date. We are highly trained both in the knowledge provided and in the way we talk with mothers. All breastfeeding counsellors have breastfed at least one baby, which combined with their training, places them in a unique position to offer breastfeeding information and support.

This network of trained ABA volunteers is already in place in the community working at grassroots level and it needs government support. In the May 2023 Budget, funding of $110,000 over two years was allocated to ABA in Tasmania. This was the first time we had asked the government for support in Tasmania. It has allowed us to employ one part-time worker. We are now calling on the government to extend this funding to allow us to continue our work in Tasmania. Most mothers in Tasmania want to breastfeed, but they need to be supported to do so. We do mothers a disservice if we're giving them glib messages such as breast is best, but we're not giving them the resources and support to achieve their breastfeeding goals.

**CHAIR** - Thank you very much for that opening statement. I'd like to start with the groups that you run around the state. Whereabouts are they held and how do people find out about them?

**Ms FIELDING** - There's one happening right now in South Hobart. They happen at the moment in South Hobart, in Ulverston, Penguin and in Burnie and Wynyard.

**Mrs PETRUSMA** - So mainly in north west coast then?

**Ms FIELDING** - At the moment, yes. We're limited by our volunteer capacity. Our local mothers groups are run by our trained volunteers.

**Mrs PETRUSMA** - How many volunteers in the state?

**Ms FIELDING** - We have about 29 volunteers, about 19 of them are trained breastfeeding counsellors and about five are breastfeeding educators. I think in our submission it says we have 16 breastfeeding counsellors but we've recently had three newly qualified. Now we've got 19 breastfeeding counsellors, which is great.

**CHAIR** - Do people register interest and then do their training through the ABA in terms of that Certificate IV qualification or how does that process work?

**Ms FIELDING** - Anybody can do the training. They can go online and have a look. The one criterion for being a breastfeeding counsellor is having breastfed a baby for at least six months. To be a breastfeeding educator, you do not have to have breastfed a baby. That includes a whole range of other people who can do the training. The training is delivered mainly online, but we are fortunate here in Tasmania to have two trainers who really enjoy doing the face-to-face training as well. It's very family friendly. The trainees can bring along their children to the training if they want to do that. It's kind of a traineeship format. It's focused on actually working in the workplace, which is your ABA local group.

**CHAIR** - Yes. I'd like to ask you a question that came partly from what you've provided, but also from that previous session that you listened to as well, and that is around people not necessarily having the confidence to breastfeed a second or subsequent child if they've had a negative experience with their first experience or their first attempt to breastfeed. Is that something that's a focus for the ABA? Do you find many second, third, or fourth subsequent time mums reaching out for that breastfeeding support?

**Ms FIELDING** - We treat every mother individually in that conversation. It would depend on what she is telling us about her experience. For some mothers say, failure to breastfeed or however they would describe it, the first or second time can be a real driver to get different information and that sort of thing. It all comes down to education and support. As breastfeeding counsellors, we're trained to provide that on a very individual basis.

Some women may try breastfeeding a first and second time and decide that it's not what they want the third time. That's completely their decision, but getting the right information across is really important. Some of the things we talked about in the submission is some of the ways in which breastfeeding, for example, protects the baby's health and protects the mother's health. Some of those things are quite scary for mother to hear when she's struggling to breastfeed, so she needs that information antenatally. Things like breastfeeding potentially providing protection against some forms of breast cancer, some forms of ovarian cancer, some forms of diabetes, and that sort of thing, and for the baby, offering some protection against things like leukaemia, respiratory illnesses, SIDS and those sort of things. That's really difficult for a mother to hear that when she's struggling there and then. Mothers need the breastfeeding-specific education antenatally.

**CHAIR** - I will ask one more question and it's about how best to provide that. Do you have access, first of all, to people antenatally during pregnancy to start that conversation? Secondly, do you have access to mums in Tasmanian public hospitals or private hospitals after their babies are born to be able to start those breastfeeding conversations? Or are there ways to provide that access to ABA councillors and educators?

**Ms FIELDING** - It all comes down to resources. We don't really have a direct kind of pipeline. A lot depends on the actual hospital and that sort of thing, and the communications that we have with that hospital. With our paid worker who we've had due to this funding that we received in December last year, that allows us to improve those connections, but it's only a part-time worker so we need more money in order to extend her hours. That funding finishes at the end of June next year. We have written to the previous minister asking for a meeting to discuss.

**Mrs PETRUSMA** - He's still the current one.

**Ms FIELDING** - Is he? Okay, well, we'll ask him to forward the letter on to you, Jacquie. We do our best, we really do.

**CHAIR** - It really comes down to resourcing issues.

**Ms FIELDING** - Yes. Also it's very much up to the mothers to contact us. We don't go running around asking who's breastfeeding their baby. That's none of our business. They have to reach out to us and they have to be able to receive the information.

**CHAIR** - Do they, at the moment, receive that information through the hospital, through CHaPS or elsewhere?

**Ms FIELDING** - Antenatally, they would receive it through the hospitals. We have information on our online breastfeeding preparation sessions which run every Wednesday evening and Saturday afternoon, and they have access to that through most of the hospitals. It depends on how they go getting through their resources in terms of distribution and that kind of thing, and then the support from CHaPS would come postnatally.

Then there is also that gap that we talked about between leaving hospital and the first appointment with CHaPS potentially being two weeks, which, as Anissa [Thompson, Tasmanian Aboriginal Centre] said, it a very long time.

**Mrs PETRUSMA** - Do some people have Zoom calls for those meetings you said you have on Wednesdays and Saturdays. Can they Zoom into those if they can't actually get there?

**Ms FIELDING** - That's an online session. The Wednesday evening ones, yes. They're part of our suite of resources, which is part of the Newborn Virtual Village, and that's online every Wednesday evening and Saturday afternoons. The other good thing about that is that in Tasmania, that cost is $20, and in Tasmania, our generous local groups refund that cost. For a member of the virtual village, that is free once you're part of the virtual village, which is a fee-based service.

**Mrs PETRUSMA** - The mother can attend the sessions as many times as she wants to?

**Ms FIELDING -** The breastfeeding preparation session, that's the one-off antenatal, yes. The breastfeeding helpline, which is one of the core roles our breastfeeding counsellors do, that's a federally funded service. The Breastfeeding Helpline is available 24/7 and the number is 1800 686 268. That's available 24/7 for anybody to phone. They can phone that as often as they like. All the breastfeeding counsellors in Tasmania volunteer on the helpline and the calls come through to us at home. We do a monthly or a weekly shift, or whatever it is, to answer those calls.

The other thing about the online breastfeeding antenatal sessions is that for a FIFO family, your partner can attend from a different location. If one partner is here in Tasmania they can register, and the other partner, wherever they are in Australia or even overseas, can attend the same class at the same time.

**Mrs PETRUSMA** - That's brilliant.

**Ms FIELDING -** Yes. It requires a bit of organising, that particular scenario, but it is doable.

**Mrs PETRUSMA** - That's wonderful. You've mentioned in your opening about the Australian National Breastfeeding Strategy. Has any of it been implemented yet?

**Ms FIELDING -** I will need to get back to you on that, Jacquie. I'm not totally certain. Most of it has not been implemented here.

**Mrs PETRUSMA** - It would be good to understand what has been implemented and where the biggest gaps that you see are. That would be very helpful for us as a committee.

**Ms FIELDING -** I will get back to you on that.

**Mrs PETRUSMA** - I noticed on page 4, where you discuss the inconsistencies most prominent in regards to breastfeeding experiences on the hospital ward, suggesting that women struggle to comprehend the advice provided to them. Why do you think that is so? Is it lack of time with midwives, or not explaining in simple enough terms, or not spending enough time with the mother? Why do you think that is happening?

**Ms FIELDING -** I would say it's all of those, Jacquie. The best time to learn about breastfeeding is before you have your baby. Research shows the best time to absorb information about breastfeeding is in the middle trimester. In the first trimester, you are feeling really sick and not really good about anything, then in the last trimester, you are focused on the labour and the birth. The middle trimester is when, the evidence shows, is best for mothers, for parents, to take in that information.

In terms of being on the ward, just after you've had a baby is a really difficult time to learn about anything - and you have so much to learn about at that stage, not just breastfeeding. You have to learn how to look after this baby, you have to learn about everything. You have to learn how to cope with your other children, if you have other children, as well. Of course, in getting information across, different people accept information in different ways. That is another element of it too, possibly. Also, the mothers consistently tell us that, in hospital, they felt there was not enough time, and the midwives did not have enough time to spend with them.

**Ms JOHNSTON** - That issue of time is something we hear repeatedly, and I notice in your case study that you provided there, it spoke a lot about that time in the initial stages and how important that is. Do you have any recommendations in terms of the best time period to allow for mothers to spend with their babies, particularly newborn babies, to facilitate that connection and that ability to take in all that information they're bombarded with at the time?

One of our previous witnesses talked about the push to get mothers out the door and discharge them quickly. Do you have thoughts around how important that time is in hospital, with those services and supports around them - if that's where they choose to give birth - and how that can enhance breastfeeding?

**Ms FIEDLING -** Again, I will say antenatally is a really key time. Postnatally, it can often take mums six, seven, eight weeks before they feel really confident and like they know what they're doing. Really, the intensive care needs to be available, if they need it. For some people, they wouldn't need it, but it needs to be available for at least six weeks and it needs to be accessible.

There's no good in phoning up somebody and you get an appointment in 10 days' time. You need that help now. That's where the Breastfeeding Helpline comes in, which our volunteers contribute to, and they do a really good job in terms of the number of shifts our Tasmanian counsellors take. The Breastfeeding Helpline comes in there. However, that's volunteers being available. It actually needs to be within the systems, it really does - extending the timeframe, or being clearer about what the timeframe is for intensive support available after you leave hospital. Mothers tell us all the time that they don't know how long they can access

the hospital support for after they leave hospital. They just don't know. There's no clarity about the support they can get and for how long.

The other thing, too, the mother whose story we've included - and I want to say that was a really big job for her to write that - it took her a really long time -

**CHAIR** - Please pass on the committee's thanks to her for sharing such a personal story, and so eloquently. It was very meaningful to read it, very impactful.

**Ms FIELDING -** I will do. For her, as she said, she was just outside the radius of support. Successful breastfeeding shouldn't rely on your location - a couple of kilometres in or out of whatever. If mothers are breastfeeding successfully, that's great. If they are facing challenges, some of those challenges can be supported by talking to a breastfeeding counsellor, a volunteer. The more intensive challenges will need support from an International, Board Certified Lactation Consultant (IBCLC). There are private practice ones available but, again, not all over the state. Up in Wynyard it's very hard to get into an IBCLC. A key recommendation would be to increase the number of IBCLCs, who are working within the Child Health and Parenting Service (CHaPS), because if they're working within CHaPS, then they're free. At the moment, that's not the case.

**Ms JOHNSTON -** I'm also interested in the story that was shared with us - and thank you to her for sharing such a deeply personal story - in that frustration about the time and the rush to tick the boxes. Certainly, those first three hours she'd expressed a really strong desire to be able to have skin-on-skin contact. How does that rush to tick the boxes - to do all the checks and the weighing and things like that - impact on that connection that's so important to breastfeeding? Do you have any thoughts on how that can be improved, in terms of policies or practices within hospitals, to recognise the importance of that time?

**Ms FIELDING -** It comes down to resources - more beds, more staff, and staff who are better trained in breastfeeding support. Not just trained as nurses but trained in terms of breastfeeding support. Also, in terms of doctors, they need to have the health professional education in breastfeeding. We do know that most doctors receive very little education in breastfeeding during their training.

**Ms JOHNSTON** - The Certificate IV you talk about your volunteers doing, is that something that can be available to nurses?

**Ms FIELDING -** Yes, they can do it if they want to. When a volunteer does the Certificate IV, it's family-friendly. You can do it, more or less, in your own time. It takes maybe 18 months, something like that. Anybody can do the breastfeeding educator stream, where you don't have to have breastfed a baby. That's part of the traineeship.

We are training volunteers to staff our core services, which are the Breastfeeding Helpline and our live chat service, which is a text-to-text service in the same way as if you're booking an air ticket or phoning your telco. It's an information service that you do online, via text. That's an information service, whereas the helpline is a counselling service, and the mothers receive much deeper and greater individual support. A mother will end up with an individual plan for the next steps. Like I said, we give suggestions, not advice, as counsellors.

When someone is training, because we provide that training to them for free, part of the agreement is that they will then volunteer with us for two years. Most people stick around for a lot longer than that, particularly in Tasmania. They are required to volunteer actively with us either on helpline or live chat, or in our local groups, for two years.

**CHAIR** - I'd like to drill down a little bit more on training. It's something that you've mentioned in your written submission: the need for training more broadly for health practitioners, midwives, nurses, pharmacists, dieticians, and you've mentioned doctors now. Do you have much information about what's currently provided and how that training could be better provided in the courses that those health professionals do at uni or their continual professional education opportunities?

**Ms FIELDING** - I'm not totally across what's included in the UTAS medical students' curriculum at the moment, except I do know at the rural clinical school in Burnie, one of our newly qualified breastfeeding councillors is also a GP and teacher. She teaches the rural clinical school. She does provide breastfeeding education to those students there. That's purely because it's just the way it's worked out in terms of her being there.

**CHAIR** - Her personal passions?

**Ms FIELDING** - Yes and her knowledge. We can provide online education to health professionals. There is face-to-face education also available. We haven't offered that in Tasmania for a few years just because of our limited resources here. There is a very great need for that. I would say also funding the Child Health and Parenting Service nurses and funding the midwives to actually attend the breastfeeding education, so they aren't expected to go and do it maybe on a Saturday morning but it's actually part of their employment, their paid time. They shouldn't have to do it in their spare time.

**CHAIR** - I will come to you, Cecily, if you had any questions from up north?

**Ms ROSOL** - Yes, I do. I noticed the groups you run around the state, there are none available in the north at the moment, which I understand is because there must be no volunteers available here. I think it's the helpline and the texting, but what are the supports available for women in the north at the moment if they have breastfeeding problems they need to get in touch about?

**Ms FIELDING** - From the ABA's point of view, it would be the helpline and the live chat service. Anybody can phone them. Yes, we are of course very eager to get some events happening in Launceston. It comes down to the lack of volunteer capacity there at the moment. We are trying very hard and one of the things our paid worker is doing. She's based in Hobart, but she covers the entire state. She's trying very hard to get some trainees and events happening in Launceston.

**Ms ROSOL** - Are you able to give some indication of volunteers with the Australian Breastfeeding Association in Tasmania, an average of the number of the hours they're putting into their volunteer roles, say across a month?

**Ms FIELDING** - We've actually just completed our annual volunteer survey and the data from that will be out in the next couple of weeks. I might get back to you about that. I can tell you that the volunteers in Tasmania contribute a lot. A lot.

**CHAIR** - Data is something you've talked about as well in your written submission and you said the data we have is from 2010 and revealed that only 15 per cent of Australian babies were exclusively breast fed by six months of age. How could we better capture that data and more up-to-date data for Tasmania?

**Ms FIELDING** - Data is being collected in the hospitals and data is available on discharge. After that, the data is being collected, I believe via CHaPS but that's not publicly available.

**Mrs PETRUSMA** - On page 5, I was interested when you said mothers received timely and accurate advice about medications and contraceptives that are compatible with breastfeeding. Because that is a role the GP should understand, what category the medication is. Whether if it's category D for example. There are certain categories you can't prescribe that sort of medication to a woman who is breastfeeding. Is that information not being passed on to the mother, or is the pharmacist not even checking it? Because it's also the pharmacist's role in dispensing the medication for them to check these things. I'm querying about mothers not receiving accurate advice, but also from GPs and physicians and pharmacists not actually checking this information.

**Ms FIELDING** - We have examples of mothers being told they can't take a certain medication because they're breastfeeding, but sometimes the timing of that medication means they can take it safely.

**Mrs PETRUSMA** - That's what I mean. It seems like -

**Ms FIELDING** - There are gaps in the information, yes. Also, what's relevant for a baby of five days is different for a baby of five months or a toddler of two years old. It is not necessarily a blanket recommendation for all medication. We always encourage the mother to talk in detail with her pharmacist, with the GP too, if that's possible. Sometimes you don't think of these things until you leave the GPs room and you can't just quickly phone up the GP, whereas you can spend time with the pharmacist and they can check in a bit more detail. These are the examples that mothers give us, so there's gaps in the information.

**Mrs PETRUSMA** - That is good to know.

**CHAIR** - It came up a little bit in that last session with the TAC, but you've mentioned in the written submission the value of a mix of professional and peer support. Have you examples or insights you can share with us, either from your volunteers here in Tasmania or nationally on where that mix of adding in peer support is working really well that we could learn from as a committee.

**Ms FIELDING** - I'd say it's working really well at the ABA local groups, because usually at a local ABA group there is a trained breastfeeding counsellor. As Anissa [Thompson, Tasmanian Aboriginal Centre] said, when you come along to the mother's groups, it's not just you and your baby, you have older children too. You can sit down next to a mother who's got older children and it's almost like by osmosis the mother seemed to pick up that information about parenting. It is not just breastfeeding information; they learn about parenting too and one example in terms of peer support.

Your question was also about the multi-layered support and obviously, they need support in their family also, partners need to be well informed about breastfeeding. Partners can have quite strong views on breastfeeding and they need to have accurate information. Often, the accurate information is not around, particularly if people have gone straight online because once you start searching for information online, you get bombarded by information that has a commercial bias and it won't necessarily be the most accurate and up-to-date information.

They need information. They need support from the various arms of the medical and nursing systems. They need support from their workplace to allow them to continue to breastfeed once they return to work because, as we've said in the submission, if a mother is supported to continue breastfeeding once she goes back to work, she's a lot less likely to have to take time off work to look after a sick baby, because her baby is less likely to get sick.

**CHAIR** - I noticed in your written submission of the need for breastfeeding friendly workplaces. Do you have some examples of how well that can work or are there resources available to your knowledge for workplaces and for employers to do that better?

**Ms FIELDING** - That's a program that ABA runs, the breastfeeding friendly workplaces. I think UTAS is a breastfeeding friendly accredited workplace. Certainly, the Breastfeeding Coalition of Tasmania was trying to get all the government departments to be breastfeeding friendly as a workplace. It's an accredited program so, there are some costs involved in that and there are various steps that a workplace would go through to ensure they comply.

**CHAIR** - Is there reasonable uptake of the program and of the accreditation?

**Ms FIELDING** - I couldn't tell you how many workplaces there are, I can get back to you.

**CHAIR** - I imagine it would also come down to - thinking as a former public servant - even if there was a department-wide acceptance of a policy or accreditation, it would also sometimes come down to your line manager and that cultural change and cultural knowledge within the workplaces on what it means to be a breastfeeding friendly workplace. The knowledge from employees to ask for those allowances if they're available because sometimes people might not actually even know that's an option for them.

**Ms FIELDING** - Yes. Education and support at all those levels. Very often people just don't know why breastfeeding is important to health and they might make all sorts of assumptions. It's really important to get the information out there.

**CHAIR** - At all levels.

**Ms FIELDING** - Yes.

**Mrs PETRUSMA** - Do you think on that because our kids are adults or who are getting a lot older because when I had my children it was explained very well the importance of breastfeeding. Do you think it's sort of waxed and waned that information or where people just don't see it?

**Ms FIELDING** - I do think that, Jacquie, yes, a lot has changed since 2010 when that National Infant Feeding Survey happened. I think when we do get new data nationally,

whenever that is, hopefully soon, the picture is going to be very different. At the moment we just don't know because there's no data. I think things have changed a lot since 2010.

**Mrs PETRUSMA** - Do you think it has gone down further or gone up?

**Ms FIELDING** - That would be my guess -

**Mrs PETRUSMA** - Which way?

**Ms FIELDING** - Down. This is my sort of guess informally as it were, because 2010 sort of coincides with social media, and we do know that the formula companies are using very exploitative methods to get their information across. We do know they are looking at what mothers are posting on social media and targeting their adverts to what her experiences are. If a mother talks on social media, regardless of whether it's public or private, if a mother puts on social media her baby, for example, is crying a lot and won't sleep, then we know the formula companies are able to target their advertising and they may, for example, target a product which they are marketing as being better for her particular situation. Their information is not unbiased; that's commercial information.

**Mrs PETRUSMA** - That is getting back to what they were doing in the African countries when there was a big court case over that sort of issue. I studied in ethics at university.

**Ms FIELDING** - I was aware of that.

**Mrs PETRUSMA** - Do you know the number of midwives in Tasmania who are International Board-Certified Lactation Consultants at all?

**Ms FIELDING** - No, I wouldn't know that. To be an IBCLC, you don't have to be a midwife.

**Mrs PETRUSMA** - It was one of the recommendations, to increase the number of midwives. Increase the number of midwives which is separate to the International Board of Certified -

**Ms FIELDING** - Yes.

**Mrs PETRUSMA** - Okay, two different things.

**Ms FIELDING** - At the moment there are IBCLCs is working privately and obviously IBCLCs working in the public system and some doing both. There is a really urgent need for more IBCLCs in the public system and to have them more accessible.

**Mrs PETRUSMA** - The idea would be to have like at least one or two in the North West Regional Hospital, Launceston General Hospital, Royal Hobart Hospital and would that be enough or more? What would you see?

**Ms FIELDING** - A lot more, I can't give you a specific number, Jacquie.

**Mrs PETRUSMA** - That way, the midwife, I suppose, is busy delivering babies or doing post-natal care and they don't have time to focus and sit there for an hour, then the IBCLC could then sit there with the mother and assist.

**Ms FIELDING** - Yes, that would be helpful.

**Ms JOHNSTON** - Regarding providing Breastfeeding Friendly Workplaces, what about educational settings and things like that? We talked about the university, but I'm sure that was in regards to it being a workplace rather than educational setting. Obviously, there are mums who want to engage in education. Have you done any work with education settings for providing breastfeeding places that are suitable, and trying to encourage mums to be able to continue to engage in education, if that's what they want while they're breastfeeding?

**Ms FIELDING** - Certainly the breastfeeding workplace accreditation program is open to any workplace. I can't say we've done any of that work in Tasmania. Our volunteers are working very hard on facilitating our local groups, being on helpline and doing live chat. I can't say we have put much into that in recent years.

**Ms JOHNSTON** - That is interesting because with my second child, I was a university student and there was no place to go and breastfeed at the time. I had to hide in toilets and do it.

**Ms FIELDING** - That's horrible.

**CHAIR** - Incidentally, Standing Orders of the parliament were changed when Rebecca was having Mia, her first child, to allow the baby to be on the Floor of the -

**Mrs PETRUSMA** - Also maternity leave, to have six weeks maternity leave and to have breastfeeding because, apparently, you did not need to have time off to have a baby.

**CHAIR** - Charlotte, if you had one or maybe two magic wand key recommendations you would want this committee to be able to make to government, what would they be?

**Ms FIELDING** - I would ask for the funding that was allocated to the Australian Breastfeeding Association in Tasmania, which was $110,000 over two years, I would really emphatically ask for that to be extended after June 2025 and to be increased. Yes, because our volunteers work very hard, but by having a paid worker, we can do the outreach we talked about before. Our paid worker can support those volunteers by doing the nitty gritty, doing the photocopying, finding a venue that works in Hobart and doing outreach, say, in Launceston and supporting our volunteers who do the Agfest feed and change tent, that kind of thing, yes, and health professional education.

Yes, that is what we hear most from mums, is that the information they are getting from from all levels of the health service is that they give us examples of inaccurate and out of date information, yes.

**Mrs PETRUSMA** - Did you make a submission to the last community budget process?

**Ms FIELDING -** Not this budget, no we did not.

**Mrs PETRUSMA** - They should open up community budget submissions again soon because the next budget is going to be in May. I encourage you to make a submission to that.

**Ms FIELDING -** We would like it to be not a requirement to have to come begging for funding. Like $55 000 a year for something that is very evidence-based, it really should not be us having to ask every year, or every two years for that. We actually asked for money for three years, for that worker, and we were given money for two, yes.

We should not have to be putting money into the budget. When we met with Jeremy Rockliff, he said it was a foot in the door for us. That is what he said, his words. He said that we should not have to be applying for grants all the time. That takes our volunteers away from the work of supporting mothers. I would much rather be supporting a mother in the context that Anissa [Thompson, Tasmanian Aboriginal Centre] and Chloe [Woolnough, Tasmanian Aboriginal Centre] described and the Kipli & Kani that Chloe talked about. I have been invited to go to that this week in Burnie. I do go to the Kipli & Kani events at the Child and Family Centre in Burnie, so yes.

The other thing, too, is in terms of the formula companies. I mentioned the exploitative tactics the formula companies use. To put it in context, the marketing budget for the formula companies around the world is greater than the entire budget for the World Health Organization. Now, that is quite staggering. They are out there, making all these claims, which can be unsubstantiated, and it undermines a mother's confidence in her ability to breastfeed.

**CHAIR** - Thank you, Charlotte. I ask if you had any other closing statements you would like to make to the committee before we finish our time?

**Ms FIELDING -** I think I have covered everything I wanted to bring to your attention, yes. It is really important the recommendations of this committee are acted upon. All this information is not new. These are clear examples of what mothers tell us and the step-by-step guide for improving breastfeeding rates- which is the government's job, not the job of ABA volunteers in Tasmania- is all in the national strategy and was signed off in 2019 by the then minister for health.

**CHAIR** - From the sounds of what you have shared with us today, not much of it has been implemented locally.

**Ms FIELDING -** That is right, Ella, yes.

**Ms JOHNSTON** - Might be a question to ask the health minister when they come.

**CHAIR** - Great. Thank you very much.

**Ms FIELDING -** Thank you all. Thank you.

**THE WITNESS WITHDREW.**

**The committee suspended at 11.39 a.m.**

**The committee resumed at 11.59 a.m.**

**CHAIR** - There's just a few formalities that we need to do before we get going into our free-flowing conversation. Welcome, both formally to the hearing and thank you both for joining us. I will introduce the committee members. My name is Ella Haddad, I'm the Chair of the committee; Jacquie Petrusma is the Deputy Chair; Kristie Johnston is joining us here at the table; Anita Dow is joining us at the table; Cecily Rosol is also joining us online along with Kristyn.

We do have one more committee member who's an apology today, but Rob Fairs will form part of the committee in the report writing stage.

Could I ask each of you to just formally state your name and the capacity in which you are appearing before the committee? Perhaps start with you, Anna.

**Ms FOLKERTS -** My name is Anna Folkerts and I'm here to represent endorsed midwives in Tasmania and the women and families that they serve.

**Ms BEGNELL -** My name is Kristyn Begnell. I am the coordinator of Homebirth Australia.

**CHAIR** - Can I confirm that you have both received and read the guide sent to you by the committee secretary, Mary?

**Ms FOLKERTS -** I have.

**Ms BEGNELL -** Yes.

**CHAIR** - I can explain to you both that the hearing is covered by parliamentary privilege. That allows you to speak freely and without any fear of being sued or questioned in any court or place outside of parliament. The protection is not accorded to you if statements that you make could be defamatory are repeated or referred to by you outside of these public proceedings. That all sounds very formal, but it's basically the same protection that it applies inside the parliaments, called parliamentary privilege. This is a public hearing and we do have some members of the public attending here in the public gallery as well as online potentially, but if there is evidence that you would like to be able to provide to the committee in private, you can request that during today's session. We'll have a short deliberative meeting as a committee, and then we're able to hear information in private if there's anything that comes up during your evidence that you would like us to hear in that way. It will be transcribed by our Hansard staff, but it's not then a publicly available transcript for that portion of the hearing.

For Anna, I need to formally swear you in, so if I could ask you to make the statutory declaration that's on the card in front of you.

**Ms ANNA FOLKERTS**, RETIRED ENDORSED MIDWIFE, HOMEBIRTH AUSTRALIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**Ms KRISTYN BEGNELL**,VIA WEBEX CORDINATOR, HOMEBIRTH AUSTRALIA, WAS CALLED AND WAS EXAMINED.

**CHAIR** - I don't need to repeat that for you, Kristyn, because you're in a different state. However, the parliamentary privilege parts that I just explained to you still apply to any evidence that you give today. You're protected by that.

There's one more formality. We agreed as a committee to provide a sensitive content warning at the beginning of each session recognising that there might be people who weren't watching online or reading transcripts for the previous session. I'll just quickly read that formal statement too.

As a committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. I'd encourage anybody impacted by the content matter during this hearing to contact services and support such as Lifeline 13 11 14. Tresillian's Parent Helpline 1300 827 282 or PANDAS National Helpline 1300 726 306.

I'll start by inviting each of you to make an opening statement if you would like to do that.

**Ms BEGNELL -** Thank you to the select committee for the opportunity to present at today's hearing. Thank you to all the brave women who've shared their very personal experiences with this inquiry and who will testify at future hearings.

I acknowledge the traditional custodians of the land on which the hearing is held today, the muwinina and palawa peoples, and also pay respects to the custodians of the land that I live and work on, the Darak and Gundagara peoples.

Homebirth Australia is the national advocacy body for homebirth in Australia with a 45-year history. We receive no government funding and we have about 300 members. We represent women and families who choose to birth at home as well as the privately practising midwives or PPM's who provide their care.

Birth is not an illness or an injury, but it's been pathologised and monetised by our health system. When a woman feels safe, supported and unobserved, she's perfectly capable of giving birth to her baby without medical intervention the majority of the time. The safety of homebirth is continually brought into question by the media, despite the evidence being clear that homebirth is as physically safe for low risk women and babies as hospital birth. As stated in the Human Rights and Childbirth submission to the recent New South Wales Inquiry into Birth Trauma, attacks on homebirth or other models of care are a convenient distraction from the real issue: the obstetric violence that women face in facility-based care.

Our health system does not fully trust midwives or women. Midwives are unable to practice to their full scope due to the restrictions placed on them by hospital policy and a medicalised approach to birth. According to the latest Australia's Mothers and Babies Report, 1.1 per cent of all births in Tasmania in 2022 were planned homebirths, one of the highest rates of homebirth in the country. This is a 0.2 per cent increase on homebirths in 2021 and it correlates with the information we received from PPMs in Tasmania. That demand for homebirth services has increased significantly and there is not enough supply to meet the demand. This is partly due to the many barriers that midwives face in entering private practice.

Homebirth with a PPM is a luxury in Australia reserved for the least disadvantaged women in predominantly metropolitan areas. Again, this can be linked to the barriers in the PPM space but it's also due to the lack of education provided to women about their birth choices and prohibitive cost of homebirth. Despite these barriers, we continue to see an increase in women choosing to birth at home each year and this correlates with the increase in birth trauma that women experience in the fragmented hospital system. Women are becoming more educated about their options and taking their birth choices back in an effort to avoid birth trauma. Women in Tasmania deserve to have access to their preferred model of care regardless of their financial situation or where they live.

Publicly funded homebirth programs have existed in Australia for over 20 years and are provided by every state and territory except Tasmania. Australia has currently 19 functioning programs which are provided and funded by public hospitals. Eligible women are assigned a primary midwife who cares for them throughout pregnancy, birth and postpartum and are supported to plan a homebirth. These programs are usually available to women who are at low risk of medical or obstetric complications. For context, it's only about 25 per cent of women who choose a homebirth that fit into this neat description of low risk. True, undisturbed physiological birth is becoming a rarity in Australia. Many midwives working in the hospital system have never seen a physiological birth. Midwives working in private practice and attending homebirths are the most skilled and knowledgeable clinicians to facilitate a physiological birth.

Research suggests that exposure to homebirth has positive impacts on midwives. A 2020 study of hospital-based midwives experiences of providing publicly funded homebirth in Australia showed that witnessing undisturbed birth in the homesteading transformed midwives attitudes towards birth. Following exposure to homebirth, many midwives felt they were seeing undisturbed birth for the first time. This led them to question their current understanding of physiological birth and develop a new awareness of the powerful influence that the environment has on labour and women. This new understanding resulted in changes to their practice.

Tasmanian women and midwives are unfairly disadvantaged with the lack of publicly funded homebirth programs. Women who choose homebirth also deserve access to safe and respectful hospital care if it's wanted or needed. PPMs provide gold standard continuity of care to women and their babies. Admitting rights with public hospitals enable them to continue providing care within a hospital setting should the woman require a transfer during pregnancy, birth, or shortly after.

In 2022, NSW Health issued a policy directive supporting public hospitals to enable admitting and practising rights for PPMs. The groundwork for this has already been laid in Tasmania and we believe that this is an essential component to increasing choice for Tasmanian women and reducing rates of birth trauma.

Homebirth midwives and women deserve the same protections provided to those in the hospital system. Our organisation, in collaboration with other consumer groups in midwifery academics, recently conducted a national survey addressing the federal government's proposed changes to professional indemnity insurance or PPMs, attending low risk homebirth. We received almost 6,000 responses to our survey and have had more than 1,200 people send letters to their federal MPs supporting our position on this issue. The results from our survey show

that 56 per cent of women planning a future homebirth would freebirth if they could not legally access care with a PPM to birth at home due to insurance limitations.

PPMs and families who choose homebirth deserve access to an insurance product regardless of their perceived risk factors. The government's proposed definition of low risk only considers a medicalised view of physical risk and does not consider the emotional, psychological and cultural risks. We welcome the extension to the current exemption, but maintain that for any insurance product to be fit-for-purpose, it cannot restrict PPMs from providing care to women at home. PPMs are already providing care to women with various conditions that fall outside the government's definition of low risk, and they're doing it safely.

Changing in this process will only result in midwives leaving private practice and more women free birthing when it is not their first choice to do so. This is a dangerous prospect that state and federal governments should be aware of when making decisions about who can access an insurance product. Thank you.

**CHAIR** - Thank you very much, Kristyn. Anna, did you want to start with an opening statement too, or would you like us to move to questions?

**Ms FOLKERTS** - I'm happy, what's the best way for it to go?

**CHAIR** - If you have something prepared, it would be great to hear it. I don't want to miss any information that you've prepared.

**Ms FOLKERTS** - I've recently retired as an endorsed midwife. I have five children myself and the last two were born at home. Of my 16 grandchildren, eight were born at home under my midwifery care. My personal experience of having had continuity of midwifery care in my own pregnancies inspired me years later to become a midwife. It inspired my daughters to choose homebirth and it started a determination in me to see more women have the option of continuity of maternity care.

I worked for three decades as a registered nurse across a variety of specialties before studying midwifery when I was 50. As a registered midwife, I became involved with homebirth from the outset. I was mentored into becoming a homebirth midwife by a great pioneer and started to attend homebirth soon after graduating alongside working in the hospital. I became the first Tasmanian midwife to obtain a Medicare Provider number in 2010 and, soon after, prescribing rights. I was the person to write the letter that resulted in the establishment of the MGP, the Midwifery Group Practice at the Royal in July 2012. That's when it began. I'm reading the letter two years prior.

This MGP was the first publicly funded continuity of care model in Southern Tasmania. I worked in the MGP for six years before leaving Royal Hobart Hospital (RHH) and to work solely as a privately practising midwife offering homebirth services from 2018 until my retirement 10 months ago. During my last six years in private practice, I spent countless hours as a volunteer on a committee at RHH to establish admitting rights for private midwives. That body of work was concluded in 2018 with a robust agreement from private midwives, the Royal Hobart Hospital's midwifery and obstetrics staff, the whole thing was agreed upon. It proceeded to Crown Law in December 2018 but has not yet come to pass.

Also at that time, 2012 to 2020, the MGP manager prepared a solid case for a publicly funded homebirths program to arise from within the MGP model, similar to what has been successful interstate. That is another body of work that has ended up remaining on a silicon chip in a THS computer. I have written several letters to the Health Department over the last 13 years requesting that Tasmania's restricted prescribing formulary for endorsed midwives be removed and that the midwives can be permitted to prescribe across their scope of practice, as is the case now in all other states and territories. This matter also remains in abeyance.

Over the 23 years I practiced as a midwife, I attended over 500 births, most of them at the Royal Hobart Hospital and provided countless hours providing antenatal and postnatal care. Homebirth is the only model of care offering six weeks postnatal care in the home. I would have to say our breastfeeding statistics were probably 98 per cent at six months.

In my private practice, I was the primary midwife for 75 pregnancies and births at home, and attended another 27 homebirths as a second midwife. Of my 75 primary client's episodes of pregnancy and birth care, 86 per cent experienced a normal birth, eight women had a caesarean birth, one ventouse and a forceps. So that caesarean rate of mine was just over 10 per cent, which is about what the World Health Organization considers an acceptable caesarean rate, 10 per cent to 15 per cent.

These personal stats of mine are representative of most homebirth practices. My clients were not all low-risk women. Four had gestational diabetes and one of those was on insulin. Six women had previous caesareans, several had previous postpartum haemorrhages, and one woman who had had a previous caesarean had had surgery as an infant for a pelvic floor abnormality. The reason she was only offered a caesarean for her first birth was because the doctors said that it wouldn't be a good idea for her to birth normally. They didn't do any investigations. When she came to me, she asked me would it be possible. With consultations with obstetricians and other surgeons, she was given a lot of information that enabled her to make a decision to attempt a normal birth at home, which she did.

I lost my train of thought. I had eight of my women who had a small postpartum haemorrhage - no serious ones. They were all managed at home with midwifery skills, IV fluids and drugs. None of my women had a serious perineal tear and I sutured minor tears myself at home. If obstetricians are the experts in abnormal birth and midwives are the experts in normal birth and 85 per cent of women can be expected to birth normally, then why in Australia are 99 per cent of women having their maternity care overseen by obstetricians?

Tasmania, as previously stated, has a 1.1 per cent of women birthing at home. As far as I am aware, the caesarean rate at the Royal Hobart Hospital is now around 40 per cent and more than half the women are having their labour induced. It is my opinion that not all maternity care in the hospital is evidence-based, but an awful lot of it is fear-based and an increasing number of women are experiencing birth trauma.

Regarding the increase in birth trauma, now standing at 29 per cent in Tasmania, I note that the submissions from the GPs and obstetricians to this inquiry affirm this increase and recommend increasing the availability of perinatal mental health services to treat it. What about prevention? As an endorsed midwife since 2010, I've enjoyed a mutually respectful working relationship with the midwifery and obstetric staff at the Royal Hobart Hospital. I've always consulted with obstetric staff when appropriate. Despite that, I have seen my women experience coercive control and denial of choices by obstetric staff when I've transferred them to the Royal

Hobart Hospital. These situations were exacerbated by my not having admitting rights at the Royal. If a midwife has admitting rights, she can provide primary care to her clients if they desire or need to be in hospital for the birth or are transferred to the hospital during labour or after.

Currently, with no admitting rights, the private midwife gives a handover to hospital staff and then is required to step back into the position of a support person, not being permitted to advocate for her client or give any midwifery care. In this situation, the birthing woman can feel abandoned. Women reflect later that they lost their agency in a system that seeks actively to manage all labours and births. It is often language that showcases this. A woman being offered an induction of labour may be told by the doctor, 'We just want your baby to be born in good condition', 'We think your baby is too big or too small'.

I will quote from RANZCOG's update to this inquiry published a few days ago. This is the direct quote.

> Consideration should be given to devising strategies to manage the population of obstetric patients who decline components of care occasioning short- or long-term adverse outcomes for themselves, their children and the health professionals and services assisting them.

Does this sound like woman centred care to you? Here you see a tableau of women trying to make informed choices about their maternity care while the doctors are devising strategies to prevent them.

I support all the recommendations of the Australian College of Midwives, especially the establishment of admitting rights to the Tasmanian hospitals for private midwives, given that the work has been sitting there on a desk for six years. The removal of the restrictive prescribing formulae from the *Poisons Act* in Tasmania, the establishment of continuity models of care, including publicly funded homebirth and reopening rural centres, the professional indemnity insurance matter is now on hold yet again as the federal government's proposal is not workable and so they have extended the exemption for private midwives to have insurance for the birth for another two years. That's been going on for 16 years. Any professional indemnity insurance policy for private midwives needs to be affordable for the midwife and needs to cover midwives to continue to work in the same manner as they do currently in an all-risk model so that our women retain choice with us consulting with obstetricians as per accepted guidelines, but maintaining the primary care.

Homebirths should not be a boutique service for the financially abled but should be socially just, acceptable to all either through publicly funded models or by Medicare supported private care. If you wish I can give you some examples from my private practice which would illustrate the interface between private midwives and the hospital with clients and illustrate the need for admitting rights.

**CHAIR** - Thank you, Anna, and thank you, Kristyn, for those very comprehensive opening statements. I know we all have lots of burning questions.

I want to start where you both finished, which is the insurance issue. Please treat me very much as a layperson. I've just followed a little bit in the national news on what's happened with that. I understand there's been a two-year extension of the exemption. Obviously, we're a state

parliamentary committee, not a federal one, but it would be very helpful for the committee to hear about the complexity on that insurance issue particularly, when it comes to the definition of low risk. My understanding is that a woman's status as low- or high-risk might change throughout pregnancy and during labour.

What risks those present to your profession, but also how best an insurance product could be tailored to make sure the work you do is not hampered, put in danger or jeopardy because of a wrong insurance product? You both explained the proposal wasn't suitable and that's why they've put it on hold. It may be useful for our committee to be able to hear some of those complexities so we can make recommendations that we could then share with the federal government on a Tasmanian perspective on how to handle those complex issues.

**Ms BEGNELL** - Our understanding is the federal government did a consultation process in August and is still going through all the submissions from that process. The insurer they are working with, we've been told there will be a product coming out and they'll be making an announcement in the next couple of weeks. This extension is to allow families who are - or women who are pregnant now to make appropriate plans for their birth because women who are pregnant now will be due in June/July next year, which is when the previous exemption was meant to expire.

The way things work now that Anna alluded to in her introduction is that the Australian College of Midwives has guidelines for referral and consultation, which lists numerous risk factors a woman can develop in pregnancy, during birth or immediately after birth. They are labelled as category A, B or C depending on the severity of the condition. These guidelines are used by homebirth midwives currently as a guide to collaborate with other health professionals, as Anna mentioned as well. If a woman does have a complication, the midwife will offer a referral to the woman and she has the right to decline that consultation. Then they document that in a record of understanding which protects the midwife should anything happen to the woman as a result of this complication she chose not to seek third party referral for.

What this new proposal for insurance by the federal government leaves out is that whole process. They have stated that women with category A conditions will be considered low risk. Some category B, but as I said before, that's really only 25 per cent of the women who currently seek a homebirth. Anna mentioned many of her previous clients have what are considered category B or C conditions. Most midwives we surveyed said that the majority of their client base were considered category B or C. They are already facilitating care for these women safely in the home and, if a transfer to hospital is required, they have pathways to do that.

If third-party advice is required during the pregnancy, they have pathways but the woman has choice - always - to decline or accept these referrals. That is the one thing really left out in this federal government proposal, because they have explicitly said that category C women will be encouraged to birth in hospital and category B women will have to have a referral with a third-party, there is no choice in there anymore.

**CHAIR** - Thank you for describing that scenario. So that I understand it fully, if the current proposal went ahead and a category B woman or a category A woman whose risk status might change during her pregnancy or labour did not take up that referral, what would that then mean for her rights to birth at home and what would it mean for the PPM and their insurance status or their safety as a worker?

**Ms BEGNELL -** This is one of the questions we have put to the federal government and do not yet have an answer for. However, with the information we have currently, that midwife would not legally be allowed to provide woman care in the home which, of course, makes all sorts of problems from that point on because complications can arise during labour. An example would be if a woman declines ultrasounds throughout her pregnancy - as some do - and then the midwife finds out during labour, this woman's baby is breech. That is a category C condition that she would not be covered for to buy insurance, to provide care to that woman in the home. What would happen in that scenario? This is one of the things we have asked the government. These things do come up more commonly during pregnancy. Again, we would hate to see a situation where midwives are put in a position where they need to drop a client at 38 weeks because their baby has turned breech when that could be safely managed at home as they do now and many other examples.

Yes, we do not have a firm answer for that, but that is one of our main concerns we have put to the government.

**CHAIR** - Thank you. I will ask one last question on this before I open it up to the rest of the committee. For the states and territories that provide publicly available homebirth, are those health professionals covered through insurance provided by their regular work in the state health system?

**Ms FOLKERTS -** It is the hospital insurance.

**CHAIR** - Okay, great. Thank you. I will open it up to the committee. Jacquie?

**Mrs PETRUSMA** - Have you ever been told why the admitting rights you submitted in 2018 is still with Crown Law?

**Ms FOLKERTS -** It may have passed through Crown Law, it might be back in the Royal. One of our colleagues is communicating with somebody at the Royal about it. I spoke to her the other day and she just says she keeps being told it is close, but it was close six years ago.

**Mrs PETRUSMA** - Yes, that is what I am trying to understand.

**Ms FOLKERTS -** There was a woman who did the project. She put in an enormous amount of work on it and it was a really robust agreement. We all got together. We had obstetricians, midwives and private midwives around a table, agreeing. It was very special and it has been sitting there.

**Mrs PETRUSMA** - One to look into. Also, the restricted formulary, what has been the barrier there to opening it up more?

**Ms FOLKERTS -** I do not know. Victoria and Tasmania, until recently - Victoria has just gotten rid of theirs - but the other states quite some time ago said their midwives would be able to prescribe along their scope of practice. They would not be prescribing Pethidine to their son-in-law. They would be prescribing Oxytocic to their pregnant woman post-birth, appropriate prescribing rights. But the formularies we have had here, I remember it having 27 drugs named on it and it did not even have anti-D. There were some drugs we do use quite frequently that were not on it. It is completely silly and -

**Mrs PETRUSMA** - Can you give vitamin K?

**Ms FOLKERTS** - Yes, we could, vitamin K was on it. Yes, we were able to prescribe some things and antibiotics and IV fluids and the Syntocinon and Syntometrine drugs, but it wasn't adequate. Midwives in private practice should be putting in Implanon contraception and there was one contraceptive we could prescribe, but an inadequate number.

**CHAIR** - Is that state by state?

**Ms FOLKERTS** - Yes, it's a state *Poisons Act* in Tasmania.

**CHAIR** - It is under review at the moment, by the way.

**Ms FOLKERTS** - Yes, I was told it was under review about five years ago here.

**CHAIR** - I have it under good authority that it is under current review.

**Ms FOLKERTS** - Yes, it just needs to be removed. I mean, you don't have to invent it, you just have to remove it and trust the midwives that they are only going to prescribe appropriately. You're trained to do it. You've gone to university to do the prescribing course.

**Mrs PETRUSMA** - Also, just on page 4 of the submission, under Public Funded HomeBirth, I was interested in the last line in the first paragraph which says:

> Publicly funded homebirth is more accessible to migrant women, women from low socio-economic demographics, and those who are unable to secure a PPM due to the high demand of their services.

Why is a publicly funded homebirth more accessible to migrant women and women from lower socio-economic demographics?

**Ms BEGNELL** - Well, largely because of the cost.

**Mrs PETRUSMA** - Isn't it about $6,000 for the cost?

**Ms FOLKERTS** - Only with a private midwife; publicly funded it's free.

**Mrs PETRUSMA** - A publicly funded homebirth - are you saying it's not in the home?

**Ms FOLKERTS** - A publicly funded homebirth is like having the Midwifery Group Practice currently at the Royal offering women to birth in the hospital or to birth at home. The midwives would be covered by the hospital's insurance and the woman gets to choose the venue for her birth, providing she meets certain criteria. That would be free to the woman. Whereas, if you engage a private midwife like me, then you would be paying thousands of dollars, some of which you would get back on Medicare rebates.

**Mrs PETRUSMA** - Have you asked to see if a publicly funded homebirth could happen at the Royal Hobart Hospital?

**Ms FOLKERTS** - As I said previously, there was a project underway by the midwifery group practice manager years ago.

**Mrs PETRUSMA** - And that didn't go any further.

**Ms FOLKERTS** - No, it didn't.

**Ms JOHNSTON** - Do you have statistics on those women in other jurisdictions who do access publicly funded homebirths where they're available? Do you know how many do it through private means, or how many do publicly funded?

**Ms BEGNELL** - Off the top of my head, I don't know how many women birth through publicly funded homebirth programs in the country. I could try to get you that information on notice. Currently, birthing with privately practising midwives, the national rate is 0.6 per cent of all births, so I think that's around 300,000 births, slightly less in 2022. In Tasmania, it's 1.1. I'll have to have a look to see what the exact number was. I'll let you know.

**Ms JOHNSTON** - Thank you. I'm really curious. Obviously, we don't have publicly funded homebirth in Tasmania. I know we are the only jurisdiction not too. How do women find out about the choice to privately homebirth? I'm certainly aware that when I had my babies there was no option given to me. It was never mentioned that there was a homebirthing option in Tasmania. I went for my first birth through the Royal; my second birth was through Hobart Private. The Royal was my only option or it was Hobart Private. I was never told about homebirthing services. How do people find out?

**Ms FOLKERTS** - It's a grassroots thing, Kristie. It's a word of mouth thing and now there's social media of course, but I don't know of any. I have quite a few GP friends but I don't know of any GP who will say to a pregnant woman, 'Would you like to see an obstetrician, would you like to go to the Royal, or would you like a private midwife?'. It doesn't happen and that's really quite sad that there's still that tension there, a sense of disapproval, despite the very good statistics on homebirth for low-risk women across the world.

It is by word of mouth. People don't usually advertise. The younger ones, not me, might have a web page that flags homebirth where women might look it up. The first-time mums don't know. It's only after they've had their first baby - they're amongst the big mother's club - then they find out their options.

**Ms JOHNSTON** - So, is there some work that could be done with GPs in terms of when they could provide that referral - referrals to an obstetrician - but to give mums the opportunity to have that choice?

**Ms FOLKERTS -** Information, yes, there is a lot of room for that. I had thought that I might offer to go around GP surgeries and talk to the GPs on some of their in-service things, suggesting that could be spoken of and women given a little bit of information about choice, but I haven't done it.

**Ms JOHNSTON** - It would seem to me to be particularly important where perhaps the first time was quite traumatic and there needs to be that different approach the second time around. That would be particularly important, I think, for GPs to have that information.

**Ms BEGNELL** - Could I just add to that? Homebirth Australia has created flyers of information with all the research on homebirth safety. At previous conferences we have invited GPs to attend information sessions on homebirth for free. We find it really difficult to get any traction there. There is a real medicalised view that birthing in hospital is safest and a lot of GPs, not all of them, there are some who are a bit more open minded and up-to-date with the research, but it's a real barrier. Even working with professional colleges we found it quite difficult to get a foot in the door there.

**CHAIR** - It's interesting what you shared, Kristyn, in your opening statement around the experience of midwives who might have been practising a long time in a hospital setting and their changed views when they do observe a homebirth. I imagine that would probably be the same for other health professionals if they were open to hearing that information more willingly. That was going to be my next question about working with those professional colleges. It sounds like that's work you've attempted and not had a warm reception to. Would that be the right way to describe it?

**Ms BEGNELL** - Yes, it would. As Anna pointed out in her opening statement, obstetricians are the experts in complications that arise during birth and pregnancy. Midwives - and I know the Australian College of Midwives has done a lot of work in this regard to elevating the profile of midwives - they're sometimes seen in our birth culture as assistants to the obstetrician, when they are in fact the experts of normal physiological birth. In a public hospital setting they do the majority of the care.

It is a challenge because in some ways we have to change the culture around birth, not just within the medical sphere but with the general public as well. There's a lot of misinformation. As I mentioned, the media is very quick to jump on homebirth and label it as something completely irresponsible when that's just not the case.

**Ms DOW** - Thank you both very much for your comprehensive submission and your presentation to our committee. I'm a regional MP and I know that in your opening statement, Anna, you spoke about regional models of care. Can you provide me with a breakdown of how many private homebirths are done across regional Tasmania at the moment?

**Ms FOLKERTS** - I don't know. I was doing 14 per year amongst a group of midwives, probably all doing much the same. That would be about 45 per year in southern Tasmania. The Launceston Birth Centre has been going through a slump recently with not enough midwives, but they were doing 50 or 60 per year for a long time. I think there's another midwife coming to join the Launceston Birth Centre in that group up there. A couple of midwives in the north-west coast handle some homebirths. We are talking about small numbers.

A lot of the women in northern Tasmania utilised the Launceston Birth Centre - by 'utilised', I mean they actually had their homebirth in the Launceston Birth Centre. That's a rented, normal house really - because they lived in the country and the Launceston Birth Centre is situated so close to LGH, so, in the case of a need for transfer it was not very far.

I've attended homebirths on the Tasman Peninsula, Ellendale, and Garden Island Creek. We do some regional work. That extra distance carries another added layer of risk for the family, when they consider that if you need to transfer, you have a distance.

**Ms DOW** - This is probably more a statement rather than a question, but I think some of that misunderstanding across the media and stories that you hear about homebirth - that, in fact, it is just in a home setting, not with people being admitted to hospital. That's a really important thing that's on the record as part of this, is that you do have the opportunity to homebirth in a hospital. Obviously, admission rights would make that a much smoother process, an autonomous process, not only for yourself as a homebirth midwife, but also for the patient. I thank you for having that clarifying statement here today, because that helps dispel some of the myths.

**Ms FOLKERTS** - I've had several midwives on my case load, and a doctor - people who vote with their feet away from the hospital system. One of the midwives I had, she'd been graduated about four or five years, and she had one child in the hospital. I don't think she said it was a traumatic birth, but after she birthed her second child at home, she was still in the birth pool in that lovely, dreamy state with a baby in her arms and she said, 'You know, Anna, that's the first time I've ever seen a normal birth.' I mean really, really normal; physiological. I was really touched by that. It's such a shame that these lovely young midwives are not. We've had students with us in homebirth coming along side us and say, 'This is the only place where I get to see a normal birth'.

**CHAIR** - Are homebirths more common for second and subsequent pregnancies than for first pregnancies generally, would you say, in your experience?

**Ms FOLKERTS** - I don't know. I've had a lot of women come with their first baby. I can't give you a straight answer on that. It's a mix. Certainly those who come for a subsequent birth, usually are wanting a different experience to what they had. I don't want to bag the hospital experience in particular, but they want something that's more intimate, that is family based. When I had my homebirths, my older children sat by and watched their little sisters being born. It just seemed very natural. When they came to have their babies, they thought, 'I'm going to have a homebirth like Mum.' It becomes part of our family culture, and we've seen that. Some of the midwives who've been practising midwifery in the home longer than me are looking after young adult couples whom they home-birthed years ago.

**CHAIR** - That's pretty special.

**Ms FOLKERTS** - I guess that's the strength of the word-of-mouth thing, which is very much the case in Tasmania, isn't it? We hear about these things.

**CHAIR** - Cecily, I don't want you to miss out. Did you have any questions?

**Ms ROSOL** - I'm just trying to get my head around freebirthing, because that seems to me where the greatest risk is. Do you have any examples or anecdotes around that? Is there any data collected on that? How do they then access care afterwards if they've freebirthed? I guess it's outside of what you do because they, for whatever reason, have had to choose freebirth or have chosen that, but do you have any further information about that?

**Ms FOLKERTS** - I don't know who's collecting statistics, but usually those who freebirth will educate themselves extensively about how to manage possible complications that would arise without the help of a midwife. I've had women call me after a freebirth, if you like, to ask me to give them the documents for the birth certificate, but they can just as easily sign a

stat dec and do it. They're probably connected within their communities and their family systems, where they have what they must consider adequate support.

A birth, in hindsight, it's fine. It went very well. Yes, the baby didn't die and I'm well, but what might happen and what can happen? Our midwifery skills - I could give you many examples of where a mother or baby might not have survived had I not been there. That would be so for all the private midwives - that we are sometimes called upon to resuscitate a baby or manage a postpartum haemorrhage, or deal with a baby whose head comes out and the shoulders won't. Those things are very much at risk in a freebirth situation.

**Ms BEGNELL** - I can speak to the statistics a little. The Australia's mothers and babies report - it doesn't report specifically on freebirth, but it has a category called 'other', which includes those babies that are born before arrival to hospital or born at home but weren't a planned homebirth, or they were born at home without a midwife in attendance. Those would be considered freebirths. It's a woman's choice to birth wherever she likes. The risk comes into it when that choice is not her first choice.

As Anna said, those who choose freebirth do a lot of research and train themselves in first aid and CPR and all those things, in preparation for that. In the instance where a woman is at 37-38 weeks and has been kicked out of the MGP program because of her risk factors - or sometimes that happens with publicly funded homebirth programs - then she has an impossible choice in front of her. Many women choose homebirth because of previous hospital trauma, so re-entering the hospital system is the last thing many of them want to do. In that instance, that woman might choose to freebirth, and because she hasn't had the preparation time for that, that is where it becomes a bit risky.

**Ms JOHNSTON** - I'm hearing strongly that the continuity of care is critically important. Thank you for your submission, where you talk about the importance and recommendation for us to listen to the voices of women - in particular, recognising significant trauma that some women go through. How important is the admitting rights, regarding providing continuity of care, particularly when perhaps the first time has been a traumatic experience in a hospital and there's that reluctance to go there again? In your experience, how has it impacted the birthing process when you've had to go into hospital, you don't have the admitting rights and the care is transferred to someone this woman has probably never met, never had a conversation with, and things are very tense? How does that impact on the experience of women?

**Ms FOLKERTS** - For the woman?

**Ms JOHNSTON** - Yes.

**Ms FOLKERTS** - They tell us afterwards. I had a woman I transferred in a labour that wasn't going very well because of the baby's position, but the baby was okay. I transferred mainly for pain relief. She had an epidural, and once I'd handed over, I'm just sitting there like I'm her mum or something - can't do very much. There came a decision point, they accelerated the labour with drugs and the baby had a higher heart rate. They wanted to do a caesarean, and the woman wanted to wait. She said, 'Couldn't you just turn those drugs off and we'll wait and just let my baby recover, and then we'll keep going.' The doctor said no. Now, had I had admitting rights, I would have remained the primary carer and been actively involved in that decision. I would have said, 'It's probably safe to turn those drugs off. You have a sleep with

the epidural. We'll watch over you and we'll just reconsider this in a couple of hours.' That woman lost that choice, had the caesarean.

She came back a second time a few years later to have another baby with me and wanted to try for a VBAC (vaginal birth after caesarean). She ended up with another caesarean, which was unfortunate. She had a similar labour, the same sort of story. When we transferred to hospital for pain relief and for review, the doctor was really lovely, a very gentle woman. The woman asked for an epidural and the doctor said, 'Look, we've examined you. This all happened before. We just want to do a caesarean. We won't do the epidural. We'll wait till you go to theatre and give you a spinal.' I think it was two hours she had to wait, in pain, that she'd transferred for an epidural. She was in pain for two hours, and she didn't have that chance of good pain relief to allow her body to settle down. Perhaps she could've had her VBAC then. The doctor made that decision; I had no power. She said to me very sadly afterwards, the language has changed but the message is the same, about no choice.

In both those instances there's nothing critical happening and she just was robbed. Now I don't know how she feels about herself as a woman and her sexuality, but these are the cultural things that surround decisions and women's choice about coercive control. I can give you other examples of that. She just said that very sadly: 'The message is the same'.

**Ms JOHNSTON** - Clearly, in that example, the woman's engaged you for that continuity of care, that wraparound service that you provide. That control and that ability to choose has been removed from her simply because you don't have admitting rights in the hospital to be able to continue that model of care - which she needs for a better outcome for her wellbeing and the baby's wellbeing too.

**Ms FOLKERTS** - On the other hand, I can't remember those times I possibly had done 15 hours in the home, I might not have been able to continue to care for her but one of my colleagues might've been able to take over at that point.

**Ms BEGNELL** - I just wanted to say we did survey women about their homebirth transfer experiences early this year and some of those are included in our submission, some of those quotes.

**Ms DOW** - I was going to ask, what is the reason you've been given as to why we don't have publicly funded homebirths in Tasmania?

**Ms FOLKERTS** - I haven't particularly asked that question in recent years. I don't know.

**CHAIR** - Our time together has flown by. I could easily speak to both of you for hours. I'm sure the rest of the committee feels the same. Did either of you have any other things that you wanted to raise with the committee before we close proceedings? Anything that's come up during the hearing?

**WITNESSES** - No.

**CHAIR** - Thank you both very much for being so free and open and generous with your advice to the committee. It's been a very important conversation. If other things do arise after today that you want the committee to be aware of, please feel free to write to us again, either to me or to Mary or to any of the committee members. We'll share that information freely as

we form our report and recommendations. For now, thank you very much, both of you, for attending

**THE WITNESSES WITHDREW.**

**The committee suspended at 12.51 p.m.**

**The Committee resumed at 2.02 p.m.**

**CHAIR** - Thank you and welcome. There are a few formalities that we need to do at the beginning of a session like this. I will start by introducing the committee. My name is Ella Haddad, I am the Chair of the committee, Jacquie Petrusma is Deputy Chair, Kristie Johnston is a member of the committee, and Cecily Rosol is joining us online, who is a member of the committee, based in Launceston. Anita Dow is also a member of the committee, she is running a few minutes late, so she will join us and sit at the end of the table there when she is finished with her other meeting. Apologies that she is not here at the table right now.

First of all, thank you for attending and for providing the written submission that you have provided, the information to the committee that has been very informative. Could you please each state your name and the capacity in which you are appearing before the committee?

**Ms MacDONALD -** I'm Ellen MacDonald, and I'm here today as the CEO of Health Consumers Tasmania.

**Ms FIELDER -** I'm Hannah Fielder, and I'm here today as the advocacy and impact lead from Health Consumers Tasmania.

**CHAIR** - Can I confirm that you have each received and read the guide sent to you by the committee secretary?

**Ms MacDONALD -** Yes.

**Ms FIELDER -** Yes.

**CHAIR** - Great, thank you. To explain the proceedings, this hearing is technically a parliamentary hearing. You are covered by what is called parliamentary privilege. What that means is that you can speak freely, you can say whatever you want to, and you are protected from any legal proceedings or having to be sued or questioned in any court or place outside of parliament.

The protection isn't accorded to you if you make statements that could be defamatory and you repeat them or refer to them outside of these parliamentary sittings. That said, it is a public hearing, so we have got members of the public attending today in person and potentially watching online as well. If you do, throughout giving information to us as a committee today, feel that there is something that you would like to provide in private, that is possible. Ask us if you would like to do that and we then have a short deliberative meeting, we move into what is called an in camera session, and the broadcast stops. It is still transcribed, but the *Hansard* transcript doesn't become public. That is an opportunity if you would like that to happen.

I need to swear both of you in, so one by one, if you could read the statutory declaration that's in front of you.

**Ms ELLEN MacDONALD**, CEO, HEALTH CONSUMERS TASMANIA, AND **Ms HANNAH FIELDER**, ADVOCACY AND IMPACT LEAD, HEALTH CONSUMERS TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** - As a committee as well, we've agreed to provide a short sensitive content warning at the beginning of each hearing for those of us who are here, as well as anyone watching online or reading transcripts later. I'll share that now; as a committee, we recognise that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals listening to or participating in these proceedings. The committee encourages anyone impacted by the content matter during this hearing to contact services and supports including Lifeline on 131 114, Tresillian's Parent Help Line on 1300 827 282 and PANDA's National Helpline on 1300 726 306.

That's all of the formalities done. The rest of our conversation can be very free-flowing and as frank as you would like it to be. I start by inviting one or both of you to provide an opening statement if you'd like to do that.

**Ms MacDONALD -** Sure, I think we both have some talking points. First, I wanted to say thank you for that statement and providing that information. There have been concerns raised with consumers with us in the past around these sorts of proceedings and the safety for consumers to give evidence in these spaces. Change there is good.

For anyone who does not know, Health Consumers Tasmania is funded partly by the federal and state governments as a systemic advocacy organisation and the peak for consumer, for anyone who would like to access their health service in Tasmania.

A bit of background, I guess. What's also informed our work, we have engaged with 836 Tasmanians through formal consultation processes in the last three years, and worked with 359 Tasmanians through co-designed processes to bring about meaningful change for health and wellbeing in collaboration with health services. We have also trained 647 service providers and consumers in how to meaningfully engage with each other. We see this as an important part to create that change that is necessary and also around healthcare rights and complaints processes too.

I wanted to firstly say it's incredible the number of submissions that there has been, which is fabulous with people with lived experience, services, so much data. It's great to see all of that coming out and also to provide some of that ourselves. We'll touch on a bit of that. For us as well, it's also around that culture of 'What's next?' and how we're involving people in creating the change. Did you have a summary that you wanted to give?

**Ms FIELDER -** Just based on our submission, yes. The written submission that we provided earlier was based on some of the consultations that Ellen has mentioned already. Especially in rural and regional areas, there was quite a large number of kitchen table conversations that we facilitated. The host would be a member of the community and they invited friends or acquaintances to come along and talk about health issues. These weren't specifically around the topics that we're talking about today, but a lot of that stuff came up as well. That's what we've drawn on to inform a lot of our submission.

Some of the key points that came out of that data, that community input, were better access to services especially in rural Tasmania. A lot of the consultations we have done have been in rural Tasmania. A lot of things we'll talk about today are probably exacerbated in those areas as well. That's a bit of a focus of what I'll be talking about especially. Continuity of care, as well, more affordable access to care, and to be to be listened to, to have your concerns heard,

to exercise patient's right to autonomy and be an active partner in decision-making; and more and better choices for models of care and service providers that relate to specific needs.

I'll mainly talk about the first three and then Ellen's going to talk about the other ones a bit more afterwards.

In addition to a lot of the submissions coming from rural areas, my own lived experiences, I live in Nubeena on the Tasman Peninsula. I have four children so I access child health services and have accessed maternity services as well. There's a little bit of a mix in there of what I would like to talk about today.

I wanted to make a brief comment about the scope of this inquiry. This inquiry is quite broad. There's a bit that focuses more on birthing care and the antenatal stuff, but we did also hear quite a lot about the child services as well. I'll try and touch on a little bit of each there.

First off, the access to services. Obviously, people have described across the different types of services that you would expect, reproductive, maternity, antenatal and child health - Tasmania has a big service access issue in terms of primary care and in terms of specialists as well. Some of the other services are especially hard to access in rural areas. For example, we've heard from people on the East Coast and also Tasman Peninsula, the CHaPS service is quite difficult to access on the East Coast, especially the Coles Bay area. People were saying, 'They used to come here but they don't anymore'. I know from my own personal experience, they come once a fortnight for about five hours in the middle of the day on a Tuesday. If you work on a Tuesday then that's it, too bad.

You can access some of that through a GP, and we're lucky to have a great GP there, but if you didn't then - there's a few gaps in terms of all the different types of services that you might need ranging from antenatal through birthing. I'll talk about that in a minute, and then through to child health services as well.

Paediatricians especially, we hear a lot that people have huge waiting lists through the public system. Even private ones can be really hard to get into. That's something that we hear about a lot, especially in those early years, and in the not so early years as well, but it's sort of separate, I suppose. I guess for people who live rurally, access to midwifery and maternity care is pretty difficult. It's only really available in the urban centres. That's changed quite a lot over historically, I suppose a lot of the regional hospitals used to provide services like that. Also for after hours as well, and so that's an issue for people. It's a long way to go in terms of travel and especially for services, like anything that involves families and children, travelling a long way is pretty hard. With the antenatal stuff, I'm thinking about having to come into the Royal for appointments with my second child. You have more children in tow and it takes the whole day out of work or whatever, plus the cost of the travel and everything, so it's a big deal. I guess it's the same for lots of different things.

The other thing that we noticed was that with after-hours care, a lot of the need for after-hours is for children and especially the young children so that exacerbates for that group. Even when we were talking about after hours care more generally, a lot of what people were saying was, 'I want to access it for my kids, I don't care so much about myself, but it's the kids I really want to make sure that -'.

**CHAIR** - That has come through in your written submission too.

**Ms FIELDER** - That's something that's changed over time in terms of being able to access that in the rural area through the regional hospitals or whatever that scale back. I think in terms of financial accessibility it's the same kind of thing: the travel costs a lot and having to take time off work and also the continuity of care. I guess being able to access continuity of care both for maternity services but also for primary health care is a big issue. A lot of the GP practices rely on locums; that's probably the same state-wide. I don't think there's a real rural and non-rural sort of divide in that from what I've heard but there are programs that you can access for continuity of care to some extent if you're close to the major hospitals like the MGP and the Know Your Midwife program.

When I was pregnant, I wasn't eligible for those because I wasn't close enough because of the distance.

**CHAIR** - They're all so different, so that's regionally -

**Ms FIELDER** - When I had a baby through the Royal, I was not able to access any of the continuity of care midwife supported programs.

**CHAIR** - I didn't realise that was regionally limited even if you were obviously giving birth in the Royal, but you weren't eligible for that, you couldn't still become a part of that.

**Ms FIELDER** - No, I wasn't. I couldn't become a part of the Midwifery Group Practice or the Know Your Midwife program, so I ended up doing shared care with my GP rather than having to come in.

**Mrs PETRUSMA** - Was that because they were fully booked out and they didn't have space for you?

**Ms FIELDER** - I was told it was because of where I lived, yes.

**Mrs PETRUSMA** - Okay, I didn't realise that.

**Ms FIELDER** - This was in 2017. I think I did that one and I guess in terms of choice, this is an issue all across Tasmania. In the end, for my second two, I ended up going with a private midwife and had a homebirth, But that's only possible for me because I had the financial means at the time. That's a pretty big expense that I end up taking because there's really no opportunities to have that sort of birthing experience in Tasmania funded by the state.

**Ms MacDONALD** - I wanted to reflect some of the sentiments, the gratitude that we have for all the people who have been involved in our consultations and the birth trauma peer group that we've had with Health Consumers Tasmania that helped inform the submission and what they've put into this. Those partnerships with consumers is where a bit of my focus is because we know that people have put a lot into sharing. Some of them also through their gender bias in healthcare inquiry sharing particularly stories about birth trauma through those spaces and they're wondering what's happening with this and what's next. I think that what we're finding is this - you know, we've seen with the commission of inquiry that happened. There's a need for people to know about what their rights are in accessing health services and for health staff to be well-informed about consumer healthcare rights and around those complaints processes as well.

In regards to this inquiry, what I guess is happening with a lot of reviews and inquiries that are occurring at the moment have incurred recently, is asking, 'Where is the meaningful consumer engagement happening in developing the solutions?' We're asking people a lot to tell their stories and to share information and sometimes people are engaged in processes as consumer representatives or whatever it might be but it's very difficult to see places where people are meaningfully engaged potentially in co-design processes to determine the solutions.

We see that there's opportunity in changing the culture around complaints and giving feedback for those to be mechanisms to enable quality improvement and involve people where it's safe to do so for who've made a complaint or who have had a negative experience in those change processes. Sometimes that isn't possible. It's not the right thing to do, but sometimes it is and sometimes it's an opportunity to close the loop with people. We see a lot of opportunity there and I guess the concerns that we have around the diversity, particularly around identity with in the consumer representation spaces. The people who are informing what's happening and how the solutions look need to represent the diversity of the community and also the lived experience because if we need to make change because there's access and inequity in health services for rural people or people from the LGBTQA+ community or any community, then we need to make sure that those people are meaningfully engaged in processes to make the changes that need to happen. Otherwise, we're not going to know what's actually needed. That was all I had to share for now.

**CHAIR** - I might open with a question, starting where you finished off. I agree that the consumer voice is very important in co-designing any service system and often solutions to tricky problems are often held by members of the community who are accessing services, be there health services or other systems of government. I also believe that complaint handling can be seen by services as an opportunity for service improvement rather than only as a negative thing. There are jurisdictions in the community services space that run complaint handling systems that are actually quite collaborative in getting data and information about people's experiences and building that into service improvements. I know you've made that recommendation in recommendation 5, around developing more robust mechanisms to check and review consumer complaints. I wondered if you could provide a bit more information about that, or perhaps share some examples of other places that do that complaint handling differently that we could benefit from or learn from?

**Ms MacDONALD** - That's a really good question.

**CHAIR** - More information about how people's experience is now - that would also be useful for the Committee.

**Ms MacDONALD** - People give feedback in lots of different ways. We've heard from people who have given feedback through the usual survey feedback mechanism to the health services that have included information that I would probably follow up on that that hasn't been followed up on. I guess because they sort of used that data in different ways. I'm not exactly sure what happens there for that to get missed. I know that there are people who are really trying to make change in terms of complaints processes, informing quality improvement, changes that are occurring. It takes time though, I guess. I think that the issue that a lot of people experience is that they are really dissatisfied with outcomes of complaints processes. Some people have talked to us about how it has been a traumatic experience to go through a complaints process.

**CHAIR** - They have to re-live issues.

**Ms FIELDER** - Being questioned as well. Their reality being questioned and really scrutinised and that's quite a difficult thing to have to do.

**Ms MacDONALD** - That's relevant on multiple levels. That's not just on the service level, but it's also through other mechanisms like the regulator and others. There are all the systems and process, which isn't necessarily a very empowering or comforting process for people. Often the language used isn't plain English or understandable. It's difficult to understand where to go and what to do. If we're looking at the Tasmanian context, a lot of people don't know that they have rights. A lot of people are restricted in complaints processes by being worried if they make a complaint about a certain practitioner that there's not another specialist where they live. Will they have to go to Melbourne? It is really difficult.

People often don't know how to have conversations with health practitioners, how to bring something up. We do sessions where we can, about healthcare rights and complaints to help inform people about what AHPRA does. What does the Health Complaints Commission do? What you can do before you get to that point, that where it's safe to do so, you can have conversations with health practitioners.

That also relies on health practitioners and health services being able to see complaints as an opportunity. We know that health practitioners can't know everybody's lived experience. They can't know everything. When someone comes to them and says - and I give a good example of it when I do the healthcare right sessions about a report that was written about me that I felt did not reflect me at all. I went back very nervously to a specialist to talk about that. They took that very well and were very apologetic and went through all the steps. It was a really fabulous experience. That's not going to be everyone's experience but where there are services that are able to see what the opportunity is in understanding the diversity of the people that we're working with, that is a really good thing.

Generally, when we're looking at people's complaints processes and how people can be involved, I would like to see more people with lived experience or complaints potentially being involved in looking at where there's actions that are taken, how people are understanding what the situation is and how services and practitioners are understanding what they need to know and how to get there. Sometimes there is a gap between the understanding of that person's lived experience and what their lived experience is. It is particularly relevant around birth trauma because I think it's not very well understood.

I guess that what we were talking earlier about is fascinating. I have the lived experience of birth trauma. Not in Tasmania though, but it has been fascinating to talk to other people with lived experience of birth trauma, but it's been for the opposite reasons in some ways as I saw it as less intervention some people were seeking intervention that they felt like they needed. It all sits in a lack of agency at the end of the day. Being listened to and feeling like we have a choice at the end of it. When we feel like we don't have autonomy, that's what the point of trauma really, where your rights are stripped away, I guess to some degree, when you listen to it's sort of a different situation.

**CHAIR** - Thank you. I'll open it up to the committee.

**Mrs PETRUSMA** - It's interesting, especially you were just saying about agency and choice and the birth trauma. How do you see that? I had my last child 18 years ago. It seems that things have quite slipped or standards seem to have decreased. I don't know if it's due to not having enough staff or things are rushed. Each of my four births have been quite different but I felt strong enough to be able to argue and advocate. Do you think it's just that women don't feel that empowerment or if they are empowered, they feel that staff aren't listening to them? It seems to be some sort of disconnect. What we've seen through everything that's been provided to us is so many stories of birth trauma where they didn't have agency, they didn't have the control, they didn't have choice. I'm trying to work out what is the problem? Why has it become so bad?

**Ms MacDONALD** - There's probably multiple reasons for that. I'd be interested to ask Hannah. I haven't experienced maternity services in Tasmania. I honestly feel like a lot of it was something that happened in secret, probably. I had my older children, 20 and 18 years ago and it wasn't talked about as much. I'm sure still there is an expectation that you should just have to be grateful that you've got a baby.

**Mrs PETRUSMA** - Or that doctor knows best or what.

**Ms MacDONALD** - It's more talked about now. I also think that there has potentially been a bit of a shift in the way that that systems work. I don't know if you have thoughts.

**Ms FIELDER** - I don't know what it was like 20 years ago maybe, but the issue that comes to me is when often I think in a hospital system when you have protocols that are best practice or that hospitals put in place, it can be hard as a consumer to understand that those are moments of choice and you have to consent to them. They're not just the way things are going to be and they're not always presented as a choice. They tend to be presented as, 'Well, if this happens then we're going to have to do this', not like, 'Then this would be what we'd recommend but there are also other options'.

Thinking back to my birth, I was pretty happy to go along with what the midwife was saying because you don't really feel like arguing a point. I didn't have any traumatic births. I had great births. Comparing my first and my second one was at a midwife-led clinic in the UK and the second was at the Royal. I had no interventions at all in the first but the second I did and it was only a small one, but I didn't think, 'Oh yes, I'm going to have that intervention because it'll be safer'. It's just happened because they said, 'Oh, well, I'm going give you this injection for the third stage now'. I was like, 'Oh, do I have to?' And they said, 'We recommend it, so let's do it'. That's when I said, 'Whatever, I don't care'. It wasn't presented as a choice. I think I was quite lucky as it was only a small thing. I didn't care that much either way. I wasn't dead set on not having any oxytocin, whereas that was a different experience to my first and then also when I had my private midwife and births at home. That was very much every single thing, although I went through all the normal stuff, had all the scans. I didn't go particularly off the best practice recommendations in terms of antenatal care, but all of those things were discussion and a choice.

That's the way that this midwife practised and that ethos, I suppose, of that sort of care. That's the distinction. A lot of the time I'm not sure whether people are either not being able to stand up for themselves. I'm not sure exactly what the solution is, I suppose, but part of that communication around that. This is the way it will be, and it becomes like it's a big effort to be able to go around that.

**Ms MacDONALD** - As well, when we've talked to some people who experienced birth trauma, it's when there's been a less intervention push put on them when it's not where they want to go in terms of pain relief and that sort of thing. It's that bit about being listened to and respected, at the end of the day.

**Mrs PETRUSMA** - I suppose that it didn't because pain relief - that one. But, say if it was getting to the point where the obstetrician is thinking the child's life is at risk and the mother's life could be at risk too if we keep on proceeding with their vaginal birth because the baby's head is too big and it is going to get stuck in the birth canal and everything else, but the mother is insisting vaginal birth and could put herself and the child at risk. Do you think that it comes down to better explanation from the staff concerned? The mother still has her choice, but where do you balance it up where her own physical safety or the child's safety could be at risk?

**Ms MacDONALD -** That would be an unusual circumstance, and I guess I trust that mothers know -

**Mrs PETRUSMA** - When that point is reached.

**Ms MacDONALD -** Yes, and will always make the right decision for them at the end of the day.

**Ms FIELDER -** I also think that it comes back to continuity of care. If you know and trust whoever is doing your care, then you have that partnership, in terms of doing the best thing. I would never have second guessed my midwife if she said, 'Something's wrong; let's go'.

**Mrs PETRUSMA** - So it could be a trust issue, then?

**Ms FIELDER -** I think so, yes.

**Mrs PETRUSMA -** So if you have continuity of care, you are more likely to build up a level of trust and you know that they are there to fight for your birth plan, what the best interests are of you and your baby. So, if they say to you, 'This is what we are recommending', and you have that relationship, then -

**Ms FIELDER -** I think so, yes.

**CHAIR** - It is less daunting, I suppose, if it is coming from someone you have built that relationship with.

**Ms FIELDER -** You know that they know your values a bit more, and they know what you want with the birth plan. I don't have any lived experience of anything high risk or anything like that. It might be a little bit different if you have lots of different medical practitioners involved. It does get a bit more complicated when there are lots of people in the room, some of whom might have different ideas about what is the best thing to do. Some of the stuff we have heard becomes really overwhelming; you don't know what to believe and all that sort of stuff.

**Ms MacDONALD -** Yes. This is an example from me about trusting practitioners - in Queensland though, not here. When my son was born, he was this much over four kilos, so they said, 'We have to do this test'. I had a midwife who said, 'At the hospital down the road, that is not their protocol, so you have a choice about it'. But I had a paediatrician sort of standing over me saying, 'Your baby might die', and being really quite full on.

When you don't have a trusted relationship with that health practitioner and understand each other's values, it is quite daunting. That's the thing more broadly in terms of going into hospital and having these experiences. It is every day for people who work in hospitals, but it is so foreign for the rest of us in how things work, even though it is running business as usual, but for everyone else it is such a strange environment to be thrust into.

**Mrs PETRUSMA** - There also seemed to be, in that case, conflicting advice, too, where you had one health practitioner saying one thing and another health practitioner saying another, so that is leading to confusion and lack of trust.

**CHAIR -** That is a very vulnerable point.

**Ms MacDONALD -** Yes, that's right, but I had the trusted relationship with the midwife and I did take her advice and everything was great. It's interesting how strong people can come on with what the rules are and what the impacts can be when there are different rules down the street, and the lack of consistency in that regard is also quite difficult.

**Ms JOHNSTON** - Further on that trust and that continuity of care, how important is it for not only the the healthcare provider to understand the medical issues of what is happening to that person, but also understand their previous experiences with health services - whether it be birth services or any other kind of health services - and understand what that person might experience in a very stressful moment, which birthing can be? How important is it for the health provider to understand the complete person rather than just the medical issue that they are being presented with?

**Ms MacDONALD -** It is incredibly important, particularly in the maternity and early childhood space. I think - the thought's left my brain briefly.

**Ms JOHNSTON** - Have you got any examples of where that's been done particularly well? I can imagine it being important during maternal services, but also if you have a mother who has experienced a particularly traumatic birth, accessing paediatric services after that and trusting the medical profession after you've had a horrific experience is very difficult - so trying to ensure the health providers understand the delayed effect of that.

**Ms MacDONALD -** Even when we're looking at people who have experienced birth trauma, and we can see where people have an identified mental health concern beforehand, they can sometimes be put into a bit of a box and listened to less. Where for me, it should be the flag to say they need greater choice and autonomy, and to have greater agency, because they're more at risk of experiencing birth trauma. That should be the point rather than those people potentially having a more dismissive experience or engagement with a health practitioner. It's incredibly important to understand that person and what their experience has been, and where they've come from.

**Ms FIELDER -** The only thing that's brought that to my mind is that, because you go through a lot of different services - especially if you're including early childhood and everything like that as well - one of the problems that consumers face is, when they move from service to another, they don't have their information. They're going through everything all over again and they may not ask them about their mental health background. That would be something that the consumer would have to volunteer up, or they might not even know that the specialist they're now seeing doesn't actually have that information. Information sharing, basically - health records and stuff like that - comes into that as well between primary care specialists, child health services and all that sort of thing.

**Ms MacDONALD -** The smallness of Tasmania can sometimes be a bit difficult when you have had a certain traumatic experience and you are potentially reliant on going back there for paediatric services, or having to engage with them for mental health support, or whatever it might be. It's tricky.

**Ms FIELDER -** We do hear a lot from people who've had, not necessarily this topic specifically, but they just won't go back to hospital. They say, 'Unless I'm dying - I'm not going unless I'm going in an ambulance'. That's the impact of having those really terrible experiences.

**Ms DOW** - Apologies for being late to this hearing. Thank you very much for your submission and for presenting to us today. You've provided a lot of really good, summarised lived experience from people. I wondered if you had a survey or where you got that from, and whether you'd be willing to share that with the committee. It would be useful for our report. We can refer to parts of it through the body of what you've provided to us, but you obviously do a lot of really good work bleeding information and feedback from communities. To my mind, if we're going to listen to people on the ground as part of this inquiry's findings, we need to be well informed about people's experiences. Is there any more information that you can provide to us?

**Ms MacDONALD -** We haven't done a targeted consultation around the topic. It's come through our general consultations. So far there have been 836 people who have engaged with our formalised consultations through kitchen table conversations and focus groups. They've been either regionally place based, particularly in rural communities, or come through other consultations that we've done about virtual care or after-hours access. It's a topic that comes up everywhere. There's not a particular survey that this has come through, but we have had a birth trauma peer group, which we've unfortunately not been able to sustain, but we would like to. They've also informed a lot of our knowledge around experiences of birth trauma and things like that. We don't really have a particular survey that we could share, unfortunately.

**CHAIR** - That's really interesting, though, to know that these stories have come out organically through your other work, rather than specific to a maternal health inquiry like this one.

**Ms FIELDER -** The questions were things like, 'What matters to you around your health? What services would you like to see?' They were really general questions. That's where this data's come from; it has been drawn out of that.

**Ms MacDONALD** - The opportunity to undertake consultations and then draw into a co-design process is our ideal. That has been a large part of the consultation that we've done - led into place-based co-design processes with communities. We have a lot of data that we've

collected over the last couple of years, which is great to be able to draw on and share these perspectives.

**Ms ROSOL** - Following up on your comment on the birth trauma group and not being able to run those anymore, what's the reason that those have had to stop?

**Ms MacDONALD** - Our funding is probably the issue at the end of the day. We've had the same core funding that has not been indexed since we started as an organisation. We would love to be able to to pick that up again, particularly in the advocacy space. There are some really engaged people who are keen to continue to have a say and make meaningful change. A lot of the people who we talked to have said, 'We've talked and talked and talked, and really want to get involved in being a part of the next steps'. They're the people who can inform how this can happen well. I think that's where our focus is in particular.

**CHAIR** - I was going to ask something of you both, but it might not be easy to do because of what you've just revealed - that these stories have come out through your general work. However, if there is a way to pass on the thanks of the committee to the people who have shared those stories, a lot of it is deeply personal information and it is very powerful for a committee like this to hear those stories. The result of that is that the report that we end up writing and the recommendations that we'll be making to government will be informed by those consumer stories. If there is a way to formally pass on our thanks to those people who have contributed to the work that has made its way to your written submission, we'd be grateful.

**Ms MacDONALD** - Absolutely, and if there's any opportunity for consumer involvement in the recommendations, in looking at drafts or even just to have a chat about it, we'd be more than happy to help facilitate something like that. If there's a possibility for that, that would be great.

**CHAIR** - That is a really generous offer. I haven't seen that happen with a committee before, but let's have a think about that. That would be interesting. Are there any final comments that either of you wanted to make that haven't come up in our conversation?

**Ms MacDONALD** - I don't think so. I think we've probably covered it.

**CHAIR** - Thank you so much for giving us your time, and for the time put into the written submission. If any other things do come up for you in the next few days or weeks after today's conversation, please feel free to get in touch with anyone of us or with Mary directly through the Secretariat. We'd be happy to hear from you again.

**THE WITNESSES WITHDREW.**

**The committee suspended at 2.45 p.m.**

**The committee resumed at 3.17 p.m.**

**Ms ELLEN O'KEEFFE,** VIA WEBEX, PRESIDENT, MATERNAL HEALTH MATTERS, WAS CALLED AND EXAMINED.

**CHAIR** - Hello, Ellen. Nice to meet you. My name is Ella Haddad, welcome. I'm the Chair of the committee. Welcome to the Tasmanian parliament and thank you very much for providing a really comprehensive written submission to our committee. You've met Mary, the secretary of the committee. I'll just introduce the rest of my fellow committee members: Jacquie Petrusma, the Deputy Chair; Anita Dow is nearest to you here, Kristie Johnston is across the table and Cecily Rosol is joining us online. There is one other member of the committee who's an apology today, Rob Fairs, he's away.

A few formalities before we can move into a more informal discussion and hear from you. First of all, can I ask you to state your name and the capacity in which you are appearing before the committee?

**Ms O'KEEFFE** - I'm Ellen O'Keeffe and my current capacity is president of a national organisation and charity called Maternal Health Matters Incorporated.

**CHAIR** - Thank you very much. Can I confirm you have received and read the guide sent to you by the committee secretary?

**Ms O'KEEFFE** - I have, yes.

**CHAIR** - Thank you. The hearing is covered by parliamentary privilege and technically this is a hearing of the Tasmanian parliament. What that means is it allows you to speak with freedom and without fear of being sued or questioned in any court or any place outside of parliament regarding anything you share with us today. However, the protection doesn't extend to any statements that could be considered defamatory if you repeat them or refer to them outside of this parliamentary hearing.

If there is information you would like to provide to us in private, you can ask for that during the hearing. We have a short deliberative meeting to agree to do what's called going in camera, I'm sure you're familiar with that term. After that, we are able to hear information in private. The information will still be transcribed, but the public broadcast would stop and that the transcript wouldn't become a public transcript. If throughout our conversation, when it gets underway, you feel there is information you would like to share in that way, then please let us know and we can consider that request.

That leads to, obviously implicit is the other parts of today's hearing are a public hearing. We do have some members of the public attending in person and watching online.

We've also agreed as a committee to provide a sensitive content warning at the beginning of each hearing, recognising the sensitivity of lots of what's being discussed in this committee. I will share that now as well for any members of the public or for all of us here attending the committee.

We recognise as a committee that during these hearings we may discuss highly sensitive matters that have deeply impacted the lives of Tasmanians. This may be a trigger for individuals

listening to or participating in these proceedings. The committee encourages anyone impacted by the content matter during this hearing to contact services and supports such as Lifeline on 13 11 14, Tresillian's Parent Helpline on 1300 827 282 and Pandas National Perinatal Mental Health Helpline on 1300 726 306.

With those formalities dealt with, I'd like to formally welcome you to the committee and invite you if you'd like to make an opening statement.

**Ms O'KEEFFE** - Thank you very much for being brave and holding this inquiry. Also thank you for the opportunity to comment on the impact of maternity care and birth trauma on women in Tasmania and in Australia. It's just not unique to Tasmania.

About us, Maternal Health Matters is a not-for-profit incorporated organisation. It is a registered charity working to improve maternal health by promoting and advocating for respectful maternity care for all women during the pregnancy, childbirth and the time after birth. It's a vulnerable time for women and it's also an important time for women. When women are vulnerable, it doesn't mean they're weak. When they're vulnerable, it's because they're experiencing a life experience they've not had before and they need support in that. They're entitled to respectful care, it's a fundamental right to dignity, autonomy, privacy, equity, to be free from harm, to be free from abuse and disrespect.

We need maternity care to be women centred, be efficient, cost effective and the aim should be to deliver appropriate care at the right place, the right time, with the right health professional and at all times being mindful of the woman's needs. We talk about evidence-informed care. There's lots of evidence out there. It's very valuable evidence, but it must always be applied in the situation a woman finds herself in. It's not one-size-fits-all just because it's evidence. The woman's right to respect is about due regard for her feelings and her wishes.

I want to say that disrespectful maternity care represents a dimension of violence against women and remains a significant public health issue with an ever-increasing number of women emerging from birth and pregnancy feeling traumatised as a consequence of disrespect, abuse and the violence they encounter. This abuse can vary from verbal insults to refusal of information, authoritarian behaviour such as forced immobilisation, forced monitoring, unwanted vaginal examinations, refusal of pain relief, and a lack of opportunity to have the place of birth they want. It's any act that forces the pregnant woman to undergo something against her will, or strips her of her dignity, including the problem of obstetric violence that arises in the context of over-medicalisation and coercive control.

Coercive control is language that's being used very often in here. Coercive control is actually grooming behaviour. As you can imagine, when women are vulnerable to the suggestion that their babies wellbeing depends on medical interventions, it's not unknown for care providers to take advantage of that ability and push what they want by telling you what you should do. This may frighten a woman into agreement to care that she doesn't really need. That comes back to that balance of power within maternity care where there are significant asymmetries in power. There can be abuses of power where people want what they want without considering the person that they're taking care of.

I think we have this problem arising all the time because we do not provide women with factual, unbiased information that they can apply to their situation. I'll draw on a classic

example where we know where certain things need to happen in pregnancy as the evidence tells us. When it doesn't happen at the time that's expected, we suddenly mark a pregnancy as at risk. However, in reality, it may not be at risk. I will use an example of an experience a woman had recently, where she was advised at 36 weeks in her first pregnancy to have a caesarean section because her baby's head was high. We expect babies' heads to be engaged in a first pregnancy at 36 weeks, but not all heads are engaged at 36 weeks because there's a bell curve. In that bell curve, some people will fall outside of it [the average]. That doesn't mean a woman needs a caesarean section just because of that. It's not unreasonable for her to ask to wait another week or two. If the head doesn't engage in labour, that's a completely different situation. They're the sort of coercions that I'm talking about. They're subtle, they're simple, but they have huge impacts.

I will make myself open to you for questioning or matters that you'd like to draw to my attention to discuss.

**CHAIR** - Thank you very much. I wanted to start with a question before I open it up to the whole of the committee for us to have a conversation. On page 7 of your written submission, I was interested in what you had to say around the fact that the role and scope of midwives is clearly defined, but the role and scope of obstetricians' practice is not clearly defined. I wondered if you could elaborate on that a little bit and around what that means for patient care?

**Ms O'KEEFFE** - If you look at the International College of Midwives, they absolutely defined the scope of practice for midwife. When you go on to any of the literature around obstetricians, there is no defined scope of practice for obstetricians. They say their role is to care for pregnant women. That's actually correct. It is their role is to care for pregnant women as is midwives. The difference is midwives are very much trained in the normal and how to identify the abnormal. Their role is to work within the normal. Whereas obstetricians' training is always focused on risk of things that can go wrong without acknowledging that there is also a normal pathway.

The whole focus of training is risk. It's about preventing poor outcomes. Every time something is identified as a slight risk - like the example I said of a baby's head not engaged in 36 weeks, it becomes a problem. Then they provide interventions and insist on interventions for good outcomes. Whereas, in the midwife's role, they follow the normal and understand the deviances of within the normal, but they refer on when they identify something that is truly abnormal. It's that ethos that is very different. Unfortunately, we've got the role of the midwife who will never go into the high-risk area, but we've got the role of the obstetrician who will go into the normal when they're not experts in that role.

That's where we have issues in practice. When you treat something in a wellness model that's going to happen according to normal physiology, you have a slightly different approach. Whereas, if you have a risk approach - they start from the premise that pregnancy and birth are dangerous, and they say their job is monitoring and intervening pre-emptively, when in reality, what is abnormal? That's a very subjective argument and it is reasonable to continue with the normal.

I'll use an example of a young woman who was very traumatised during her pregnancy. She was deemed at high risk for a couple of reasons. She was having regular ultrasounds. One week she went along at 34 weeks and she had a new ultrasonographer using a new machine.

Her trajectory of the monitoring changed so that she had a variant. When she saw her obstetricians after that process, that obstetrician said, 'I want you to go for an immediate caesar'. She was absolutely distraught with that and she said, 'One variance doesn't make a trend'. He said, 'Yes, it does. I'm recommending a caesar,' and documented in her notes that she refused a caesar. Next week, she went along to the ultrasonographer and she asked for the test to be repeated. She was told no, it wouldn't be repeated, because it wasn't part of the protocol. She said, 'I'd like it repeated. Last week it was abnormal. I've got my regular sonographer back and I think that it should be repeated because when I go into the obstetrician this afternoon he'll insist again on a caesarean section or an induction which I don't want'. The ultrasonographer did the test, and guess what, it trajected back to normal. That over-responsiveness around risk when it's not warranted - that's when that mother educated me very well when she said, 'I asked them where I fell on the bell curve', and she was told by the obstetrician that it didn't matter. He thought it was a risk.

That's what I'm talking about being respectful care. We can jump at every risk, but we shouldn't, because if that baby had been born at 34 weeks, it would have gone to [a special care] nursery. It would have had some disadvantage. We know for every week of prematurity a child gets a disadvantage. We know that every week counts and that 39 weeks, later, is a preferable time for delivery.

This is the sort of thing I'm talking about, working with the woman, working with her knowledge, understanding her needs and not just assuming because we have one variant at one moment in time that there's going to be a problem. That points to continuity of care. If this same sonographer had done that test all the way through, she might never have got that variant. Because she had a variant because of a different sonographer, she was suddenly in a higher class of risk.

**CHAIR** - That's a really compelling story. Thank you for sharing it. We will open it up to the committee for questions.

**Mrs PETRUSMA** - I want to thank you for the submission. I found it really good and really informative, especially how you talk about the WHO data in 2.2, and then in your measurement and reporting as well in section 4.1.

I was interested where you spoke about in section 2.3 down the bottom, where you said in developed countries obstetrician involvement and interventions have become routine in normal childbirth without evidence or effectiveness. Then there is the quote that care providers who rely on what people would say is 21st century technology and advances and are plotting courses that emphasise risk - they are more likely to exert their control and feel strong through minimising women's power and control and ultimately their integrity. Then, as a consequence, medical preference and expediency appears to be taking a priority over best outcomes, with obstetricians often operating according to their own timetable rather than less predictable schedule of mothers and babies.

Are you going to talk a bit more to that? Most of us here have had our children quite a few years ago. Based on all the reports that we've had - I noticed in your report it talks about 20 years ago. It seems to be a lot better service than what we are today. Are you able to outline a few more thoughts in regards towards all that?

**Ms O'KEEFFE -** I'll actually go back 60 years and go back to 1964. In 1964, it was the first time maternal mortality fell below seven in Australia. It has stayed below seven since then, the majority of times. There have been times when it has picked up. In 1964, we also had the high-risk Aboriginal and Torres Strait Islander people in that, who had really poor outcomes. They're getting better outcomes now. What we've had since 1964 is an increasing amount of technology with actually no improvement in outcomes for morbidity. But for mortality, our outcomes are terrible.

Our caesarean section rates are anything up to 80 per cent, but when they average out, we say it's about 32 per cent. We have country rural doctors saying they'll only perform caesarean sections in their town because they think they're safer and they lack back-up. We also see postnatal depression rates going up. Part of that could be the climate in which women have children today. Women had more nuclear families and all those things. But when postnatal depression goes up and it's related to birth trauma, one in three women who have postnatal depression also report birth trauma. That's not helpful at all. Ten per cent of women go on to get post-traumatic stress disorder.

We've got to look at the humanisation of birth. We've evolved a way of birthing that means women no longer birth by themselves. Traditionally, they birth with family and what were called wise women. Wise women in some literature gets translated as witches, but actually they were wise women; they were very skilled at observing and understanding. Now we've got it all dominated by what we call technology and surgery, and we're not allowing women to follow normal physiological pathways.

As a consequence of that, we also have women now birthing in hospitals. That's an illness model; it's not a wellness model. We expect to intervene when people are ill, whereas when people are well, we expect normal processes to take a path. I'm losing my train of thought a little bit here, but I think what's happening is that we've medicalised birth. We've made it a medical event when it's not a medical event. It's not an illness to have a baby. It's a normal physiological process. There should only be interventions in that process when it's valid.

The medicalisation of pregnancy these days, especially of a normal healthy woman, ignores reliable evidence that pregnancy and childbirth are normal processes. I point you to the homebirth data. We ignore it. We ignore it at our peril. Homebirth can achieve a 97 per cent normal birth rate and a 95 per cent breastfeeding rate. Hospitals don't retrieve a 95 per cent normal birth rate. We're lucky if we get a 50 per cent normal birth rate, and we certainly have appalling breastfeeding rates in Australia. That shows medicalisation is not necessarily working.

Having said that, technological advantages and surgical skills used appropriately can save life, but when used without valid indications, routine interventions transfer childbirth from a normal biological process into a potentially harmful medical procedure. When the medical model is applied to women and their infants who need intervention, it is medicine at its best. It is beautiful medicine. It transforms lives; it saves lives. When applied to all women, however, it has the potential to cause harm and violates the underpinning principle of medicine of above all, do no harm.

I think the changes that we've seen happen is because our society has changed. There's much more fear in our society. There's fear of litigation, fear of loss of reputation, and there's also a health system now that's hospitalised so it's like a factory. Birth isn't like a factory; it

doesn't follow one path. When the hospitals are trying to be super efficient, and when health professionals want to work regular hours and don't want to be called out at 2 o'clock in the morning, then the system lets women down.

**Mrs PETRUSMA** - We've had a lot of individual submissions, and like what you were saying on page 9, it seemed to me that the women who had early intervention or inductions are the ones who then had unintended negative consequences of the birth being traumatic, where they feared for their life or their baby's life, and then they went on to have PTSD and a caesarean. It seems to be a similar story that's retold in our submissions, and it backs what you've said there. Its a very consistent theme throughout a lot of the submissions.

**Ms O'KEEFFE** - Correct. We did our first dignity survey in 2016 and our second one in 2020. In 2022-23, we had the University of Western Sydney BESt [Birth Experience Study], which incorporated a lot of the stuff we had in our dignity survey. I refer you to the Western Sydney one because it is a proper research project, as opposed to ours, which is just observational and a survey of community. The stories are the same. They are repeated the world over; they have been repeated in the United Kingdom with their birth trauma surveys - the birth rights movement in the United Kingdom.

You just have to look at the King Edward Memorial Inquiry in Australia or the Bacchus Marsh one in Victoria, or more recently the birth trauma inquiry in New South Wales to know the stories are there. They are absolutely there. The problem is that our culture doesn't respect those stories, and that there are unequal power balances in maternity care, which lead to disrespect and abuse. There are significant asymmetries in power and that leads to abuses in power.

The consumer, when they go into a hospital, doesn't really have much power because the hospital follows what I call 'recipe medicine' - policies and procedures. Whereas, when a woman actually labours in her home, she is in her environment and she is in charge, and she is respected in that environment as having a voice.

I am not saying that we should go to homebirth. What I am saying is that hospitals need to learn from the homebirth movement and implement those practices. We know that there are birth centre movements in hospital, but that doesn't work because they are still attached to a hospital. Literature actually points out that the best place to birth is in a birthing centre not attached to a hospital. You could have professionals on tap, but not on top. That is a really important thing to think about.

**CHAIR** - I like that, 'on tap, not on top'. That is interesting.

**Ms O'KEEFFE** - A colleague of mine uses it all the time. We need every professional on tap, but they should not be on top dictating and controlling the power in the room. It is the woman who has the autonomy in the room. Don't use the excuse that professionals know what's best, because a woman knows what is in her own best interest to have the best outcome for pregnancy in birth, because she will wear the burden of anything that goes wrong. When professionals are on top, the burden is given to the woman to wear, they walk away from it and don't ever have to worry about it again. It's a very important message that the mother-baby dyad is so important.

**Ms DOW** - Thank you very much for your submission; it is incredibly comprehensive. You talk about evidence-based models of care that are based on compassion, empathy, sensitivity, non-judgement, tolerance, kindness and caring, as well as excellence in clinical practice. Are there models that are in situ at the moment across the country that you could provide examples of to this committee?

**Ms O'KEEFFE** - There are not a lot of models across the country. If anywhere, America is probably doing it better than us at the moment, which is unusual because America has terrible outcomes for health care. Because they are so bad, I think they are being given to change it. There is a model in France where one of the obstetricians is using this model of care, and it's working very well.

There is also the Robert Youngson movement, where he is trying to put 'compassionate' back into health care. He was doing it in obstetrics originally in New Zealand, but he is now doing it around cancer care and, more generally, care in hospitals. He is saying a caring professional is not controlling. A caring professional meets the physical, psychological and emotional needs of the person, and they do not worry about losing their reputation or having legal cases against them because they know that they're doing the right thing. Those models of care - it is going to take a lot of work to change it, but until we start talking about these stories and start working towards it, we will not have change.

I think that you'll look at the Scandinavian systems and you'll look at their model of the first 1000 days, which is focused on the baby, but in reality they have incorporated the woman into that very well. They actually state that the woman who emerges well from pregnancy will be able to care for her baby. This is groundbreaking stuff, putting humanity back into health care. It needs to happen for women to stop being traumatised.

**Ms DOW** - Thank you. The only other question I have is around your recommendations around education in schools, around breastfeeding, childbirth and being more open and upfront about the experiences of women across our community and families. Can you provide examples of where that's done well, or do you have anything further that you'd like to leave with the committee about those educational programs?

**Ms O'KEEFFE** - There's growing awareness in our society that we educate children, women, and girls and boys about sex and birth control because we don't want teenage pregnancies. Of course we don't want teenage pregnancies, but actually we really need to educate boys and girls about sexuality, and pregnancy is part of sexuality.

Until recently, in Australia, we had a sexual health policy that didn't include maternity. Now there's push to get maternity into sexual health. What we're seeing is sexuality and preventing babies means that women no longer know about menstrual cycles. There is an increasing body of evidence that women don't even realise that ovulation is how they get pregnant. That sounds naive to us, but it is actually true. In the infertility literature, some of them, there are two obstetricians in particular who have said that all they've taught women is about ovulation and they get pregnant.

Women need to know that it's not just about sex, it's not just about birth control. It is actually about the opportunity later in life to reproduce children and to put that into context and we need to educate young girls, in particular, that there's no need to be scared of being pregnant or birthing. Yes, it's not the most comfortable procedure we'll ever go through, but your body

is designed to do it. So, they have confidence and are not undermined when they do become pregnant and end up in a medicalised system that treats birth and pregnancy as an illness.

We know from the Calm Birth literature, the hypnobirth literature, and the relaxing into parenting literature, the research evidence around is that the better informed girls and women are about pregnancy and how to cope with pregnancy, the better the outcomes. At the moment we have antenatal education in hospitals, but it's about the hospital's procedures and policies. It's not about the woman's body and there are now recommendations that any childbirth education should take place outside of the hospital setting and it should be more in a social context so that women and their partners form community groups that can provide support because they're going through a similar journey and they start their community - it's a community development approach - before the baby is born. Once the baby is born, it's really hard to reach out and get help and you usually end up in the medical model. Whereas, if you can get it up in a community development model, it's better.

Also, regarding education, if a young girl does happen to get pregnant, if you do it in schools, they know what's available to them so that they can work their way through it rather than keep it quiet until it's too late to get the care they need. It's about empowering women with knowledge about their bodies and having respect for their bodies. That's a really important message, and also helping them to seek help early in their pregnancy about their processes and their choices, place of birth, health professional help provide care for them. I think that preparation works very well and again, we see communities where they do really good sex education in school and it includes maternity.

**Ms JOHNSTON** - Thank you very much for a really comprehensive submission. I'm interested that you talked beforehand about your research you did, I think you called it a dignity report, which speaks volumes to me because that's how I describe my first child birth as lacking complete dignity at all. That speaks to the trauma and the power imbalance that many women feel when they're going through a birth experience.

You've made a couple of recommendations in your submission around trying to shift that power imbalance that women experience. Can I get you to elaborate on whether there are any examples that you've seen where there's been that shift in the service delivery being done well or any examples you can give us of how that might be practically implemented?

**Ms O'KEEFFE** - I'll actually cite one individual. I'm not sure whether it's appropriate to name that individual in this situation, but there is an obstetrician who works out of Prince of Wales who has a very high normal birth rate and a very low caesarean section rate and that flies in the face of what we're seeing elsewhere. His attitude is that birth is a normal, physiological process and most women are capable of delivering a baby. World Health says 15 per cent of them aren't. So, let's use the 15 per cent figure and World Health goes further, it actually says if the caesarean section rate goes above 10 per cent in any economy that we do harm.

That's one figure,even just to work at within organisations to see which organisations are achieving that and look at what they're doing well and how they're achieving it. As I said, I use the example of homebirth; I'd use the example of this obstetrician's practice. We look at other countries. We've got countries that don't have caesarean section rates as high as Australia. They are as developed as us: the Scandinavian experience. In Iceland, they had a caesarean section right approaching 30, they've now reduced it to 18 per cent.

You know, it can be done, it's just about looking at the way we provide care. World Health has said the current way we monitor labour is not helpful. They've introduced a new model for monitoring labour. It had some Australians doing that. I don't know of any hospital in Australia that has introduced that new model. Is it because we're resistant to change, or is it because we don't want to go down that path because we're too scared? It's a significant model of care and it actually incorporates the woman in the process. It's a no-brainer not to introduce; it just hasn't been introduced.

**Ms JOHNSTON** - I was going to say, is it one of the features then of perhaps an obstetrician who's got those incredible rates in other countries? Is it a feature of allowing time to take place so that women can be informed and feel part of the process, that continuity of care and that building of trust between the woman and the healthcare provider? Is that the common feature amongst all those kinds of examples?

**Ms O'KEEFFE -** Yes, absolutely. It's a philosophy that a woman can do this, it's our role to be patient, if the labour is progressing maybe slowly but still going well and there's no stress or anything to allow it to continue. Whereas many hospital policies say that the woman's got to dilate a centimetre an hour and if she hasn't dilated by 10 hours then she needs a caesarean.

That's the other thing about this whole process that's actually scary. The number of women who are told that they require a caesarean section because their labour is not progressing, and then they wait four or five hours to have that caesarean section. That is cruelty. You've been told you need a caesarean because you're not progressing and your baby is at risk and yet you wait hours for it. There's no reason in that. I think you're right. It's about having a positive outcome, a positive perspective on what a woman can achieve, but absolutely being available if it doesn't work out the way it's meant to be and to intervene appropriately.

**Mrs PETRUSMA** - Thank you. I also quite like section 3.3 where you talk about the way we're running maternity services is just not sustainable and, even though maternity care is one of the top uses of the healthcare budget, this doesn't need to be the case because if it was a primary health service then the cost would be a lot lower. As you said, the main driver of maternity health expenditure increasing is that health professionals are doing a lot of things differently, including - like you have here - continuous electronic foetal heart monitoring, which you're now saying there are different recommendations in regards to monitoring that we're not following up on. We're giving a lot more ultrasounds and also induction or augmentation of labour without medical indication.

I am also very interested if you could share a bit more about where you talk about 'too much, too soon' and 'too little, too late', about the healthier and wealthier you are, the more likely you are to access expensive specialist care resulting in higher levels of intervention with resultant high levels of morbidity and trauma for both mother and baby. People would be really surprised about that.

**Ms O'KEEFFE** - Yes, so 'too much, too soon, too little, too late' is a model identified by the *Lancet* in their midwifery series. That series was written by obstetricians, health professionals, health services, and midwives and it had some Australian experts on that literature. There is an identification that because of the fear in our society - and you have to be fearful if you're practising health professional because we've got an insurance system, a litigation system, a media system that thrives on what goes wrong and doesn't tell you what

could be good. I use, again, homebirth as an example. Every time something goes wrong in a homebirth it is publicised in the media and it is considered negligent. Whereas, if something goes wrong with hospital it never hits the media and, more importantly, if it is in hospital it is considered inevitable, it could not have been prevented.

That is not true. 'Too little, too late' [too much too soon] is where because of the fear in our society, the fear of litigation, the fear of things going wrong, the fear of loss of reputation, we do everything possible that is available from a technology, a surgical or a medical point of view and applying that to the whole population does harm. Whereas, if you only apply to the people who truly need it, it might ameliorate the problem they have and do good. It is 'too little, too late' [too much too soon] and it is best-evidenced in countries that have private health insurance, where lots of work is done in the private health insurance system in a private hospital.

However, the flow on effects actually are public hospital because it is not a very known fact, but do you know that 65 per cent of presentations to emergency departments in the six weeks following birth come from women who birthed in the private hospital system, not the public hospital system? Private hospital systems have a much higher rate of intervention than the public hospital system.

That is the 'too much, too soon' that we are talking about, [rather] than 'too little too late.' I use the example of the ultrasound at 34 weeks earlier. That would have been too much too soon for that woman but we only realised it was too much too soon because at 35 weeks everything was back on track. It is having the expertise and the knowledge and the confidence to talk through the scenario with the woman and let her make a decision.

Another person who was in the 34-week scenario of an ultrasound would have said, 'I will have the caesar.' That was their need; but this other woman who had a need not to have a caesar wasn't respected for that choice. Again, it is too much too soon and to be honest, if we follow the clinical practice guidelines and stop the over-servicing, the amount of money that we will save would be incredible.

Not just because we are not using excessive hospital services; just look at the environmental waste. The environmental waste from birth that requires no interventions and progresses as expected is one garbage bag. The clinical waste from a hospital birth and a labour ward is up to five or six garbage bags. The cost associated with that is just amazing for no extra benefit. The 'too much too soon' causes harm and then we get 'too little too late'.

Let's go to the rural and remote women and the Aboriginal and Torres Strait Islander women in Australia. If we had maternity care in community with appropriate qualified midwives who could identify something going wrong and referring on, women wouldn't have to travel to cities. They wouldn't get isolated in cities and they wouldn't get poor care. I use an example of a young woman who was in Bourke. She was having her first baby and she was told she had to go to Dubbo and stay there for four weeks before her baby was born because there are no birthing services in Bourke. She ends up in Dubbo and she finds herself getting low mood, being lonely, being stressed. She moves from Dubbo to Young and she has her baby in Young.

This happens to your people who were in Strahan, Derby and places like that or who are in the more remote islands. She ends up going to Young because her Mum is in Young and she

decides she'd be safer there. She goes to Young and the pregnancy progresses well. She goes into labour in Young and goes to the hospital to find out that there is no midwife; no obstetrician on duty, even though it provides a maternity service and is transferred to Cowra. She is transferred to Cowra in a private car with a partner who's petrified of taking a labouring woman. She arrives in Cowra fortunately in time to have her baby. That is really bad care.

If the woman lives in Derby and she goes to the local hospital, which would be Launceston; she is isolated from her community in Derby. Launceston won't have that problem because it is big enough but is the sort of thing I am talking about. That, they get too little care too late because they are isolated from their homes and their families and, to get the care they need, they have to be separated, which psychologically is not helpful.

More recently I was talking to a young woman who had a baby in Tennant Creek. She was pregnant and she was told she had to go to Alice Springs, four hours away, to have her baby. Okay, that is fine, she was actually happy to do it. When she gets to Alice Springs she says, 'Oh I cannot wait to have this baby. I am really excited about it and I really want to be a mum'. She is 37 weeks. The person who admitted her happened to be a medical doctor and he said, 'Well, if you would like your baby, you could have it today and induced her at 37 weeks'. She was excited -

**CHAIR** - Without explaining the risks?

**Ms O'KEEFFE** - Yes, without explaining the risks, any consequences or anything like that. For her, it was like, 'I can meet my baby today and I can go home in a couple of days' time'. It's not good care and that happens to rural remote women all the time. They have this need to be with their family and supportive of people they care about and not feel isolated, but the services they need are elsewhere.

We do NETS [Newborn & Peadiatric Emergacny Transport Service] retrieval services: we retrieve a baby when it's unwell, but what about a Flying Squad for women in rural and remote. That would be really good service. You can if you can get an ambulance to a woman within an hour with the right skill set of people on it, that's much better than having them spending three weeks in the city and having an early baby. Yes, so too little too late is very modern phenomena, and there's a perception that everything we do will make good outcomes. Actually, that's not true. We need to only do the interventions that the woman needs, not one-size-fits-all for everyone.

**Mrs PETRUSMA** - No, it's very good.

**CHAIR** - Any other questions around the table or any other issues, Ellen, that didn't come up in our conversation that you would like us to hear about or like to share?

**Ms O'KEEFFE -** I actually think we can make this change really easily if we identify that the women do best in continuity of care that is in relationship. It's not a physical process of just doing monthly checks. It's about developing a relationship so the woman and her carer understand each other. The evidence absolutely says that that is midwifery models of care. We need to stop the coercion that is happening for women by designing health services that provide what they need.

It's coercive to send a woman to a city when she doesn't want to be in a city. It's coercive only to provide a birth centre attached to a hospital when the woman prefers not to birth in a hospital. We need to look at consent and the gold standard is informed consent. But guess what? Informed consent is only valid when a woman that makes an informed decision based on the facts, the unbiased facts. Where a woman makes a decision based on facts that are biased, it's not informed and so that's really important.

**CHAIR** - For the example you just gave, the women being told that it's exciting to have your baby now, you can be induced at 37 weeks, no doubt she felt she provided consent for that procedure but wasn't provided the information about the risks of induction.

**Ms O'KEEFFE -** Exactly, absolutely. The other thing is that we need compassion in our healthcare. We actually need to understand that we're not going through this post process with pregnancy. It's the person who is pregnant going through the process and we have to have compassion for the wants, desires, autonomies and we need to respect those. More importantly, we need health services designed by consumer voice, and this is a really hard thing to achieve. I've been in lots of forums where I've raised things and I've been asked, 'But what about the baby? What about the father? What about the health service?'. They are all important, but the woman is the start of it and unless that voice is heard and the services are designed around her, we will not provide good services. The consumer voice is a continuum. There will be the woman at one end who will freebirth and there will be woman at the other end who will want absolutely every service. We have to design a service to meet those needs. But we shouldn't groom the women for our needs. We should absolutely raise the woman up to be informed.

**CHAIR** - That sounds like a lovely spot to finish. Thank you very much, Ellen, for joining us and giving us your time today. We're grateful as a committee to be able to draw on your experience and your insight both in person and through your very informative written submission. Thank you. If over the next few days or weeks you think of other things that you wish you had raised, please do feel free to write to us again to get in touch either with Mary, who you know in our secretariat or anyone of us will share that information across the committee. We welcome anything further that you would like to share with us as well.

**Ms O'KEEFFE -** Thank you and the same goes for you. If you think of something you'd like some evidence on, some information on, please just put your hand up and ask for it because we can do it. Even though I've written that submission, things have moved since then.

**CHAIR** - Thank you.

**Mrs PETRUSMA** - Is there important information? You just said things have moved on since then. Are there any thoughts? Is that important information you feel that we should be sent now or?

**Ms O'KEEFFE -** I think, well, if I've got the reference to *Lancet* series, I think the World Health literature on a positive birth experience is excellent and it's been evolving over the last three or four years. Oh, no, actually, probably more like six or seven years. They're really focused on that. The State of the World's Midwifery Report is a really good read and there was a new one released late last year. I'm just trying to think what else.

**CHAIR** - The *Lancet* series you said was called 'Midwifery Series', is that right?

**Ms O'KEEFFE** - There's the *Lancet* Midwifery Series - I can send you the links for these - and they just released a new one called the 'Post Natal Series'. Some of it is harrowing reading, but there's really good solutions in it.

**CHAIR** - Great. That would be really helpful, thank you.

**Ms O'KEEFFE** - They are worth doing and as I said I'll send you a list of what I think are relevant current recommendations and literature.

**CHAIR** - Thank you, Ellen.

**THE WITNESS WITHDREW.**

**The Committee adjourned at 4.03 p.m.**