Women's Health Tasmania

Submission to the Select Committee on reproductive, maternal and paediatric health services in Tasmania

SEPTEMBER 2024

EQUITY
CHOICE
IMPACT

Contents

Acknowledgement

Women's Health Tasmania acknowledges the palawa and pakana people as the traditional and original custodians of lutruwita/Tasmania. We recognise that sovereignty was never ceded and we honour their continuing connection to land, waters and culture. We pay our respect to Elders past, present and future. We acknowledge the strength, resilience and resistance of all First Peoples of Australia in the face of ongoing impacts of colonisation.

Introduction

Based in nipaluna/Hobart, Women's Health Tasmania has been providing evidence-based services and advocacy for better health outcomes for women since 1988. We are run by women for women, with the vision of women being informed and active decision-makers in our own health and wellbeing. Our definition of 'women' is inclusive and our work supports everyone who identifies as a woman.

Women's Health Tasmania regards equitable access to quality healthcare as a fundamental right and recognises that for some women this right is limited by barriers relating to age, gender, disability, sexuality, income, housing, literacy, language, culture, immigration status and legal status. Our work within Tasmanian communities and with government, health and community sectors seeks to respond to these barriers and to identify opportunities for health service improvement and system reform.

Our approach to the inquiry

We have chosen to respond to a selection of the Terms of Reference most relevant to the Women's Health Tasmania remit and our principal areas of research and practice. These are:

a) the adequacy, accessibility and safety of services in relation to:

- *(i) reproductive health*
- *(ii) maternal health*
- *(iii) birth trauma, and*
- *(vi) perinatal mental health.*

These topics are currently attracting significant national attention – evidenced by a number of federal and state inquiries recently completed or underway – and each warrants detailed investigation in the Tasmanian context. In addressing all four topics in a single submission, we have necessarily limited our comments to a summary of key issues and recommendations. We welcome further opportunities to elaborate on our statements.

Our comments on disparities in the availability of services, staffing and outcomes for Tasmanians are included within our discussion of each topic, along with recommendations for state-based actions to ensure these services meet the needs of all people living in Tasmania.

Lived experience is at the heart of our work and we have used direct quotes from Women's Health Tasmania clients and research participants (deidentified and with their consent), to provide real-world context and evidence in support of our comments.

The role of Women's Health Tasmania

Women's Health Tasmania has been a leading voice in the development of better reproductive and maternal health systems and practices in Tasmania for over 30 years.

In addition to our core functions in health promotion, information, counselling and referral, Women's Health Tasmania plays a role in investigating and promoting good practice, based on client experience.

Our recent work in this space includes establishing the Pregnancy Choices website;[1] releasing the *Talking to people about terminations of pregnancy in Tasmania* research report[2] and associated resource *Termination of pregnancy: a good practice guide for Tasmanian care providers;*[3] co-chairing the Sexual and Reproductive Health Collaborative Group; coordinating the Mental Health Professionals Network on perinatal mental health; hosting a Migrant Mother and Baby Playgroup; delivering statewide workshops on menstrual health, menopause, pregnancy choices and reproductive coercion; and preparing new research into Tasmanian experiences of pregnancy, birth and postnatal services titled *Talking about having a baby in Tasmania.*

This combination of frontline service delivery and population peak functions (sector development, research and policy development) is unique in Tasmania. It has earnt us recognition as the state's lead agency on abortion health care policy.

Moreover, our service model offers the kind of 'comprehensive and integrated approach' to reproductive health that was named by contributors to the recent federal inquiry into universal access to reproductive healthcare as key to improving reproductive health service access in regional communities, including the capacity to "identify existing gaps in service provision at the local level."[4]

Supported by a multidisciplinary team that includes health workers and allied health specialists, social workers and a psychologist, we deliver reproductive health service information, coordination, referral, monitoring, counselling and advocacy that is person-centred, responsive and trauma informed. Our use of physical outreach and online modalities cater to Tasmania's largely regional, largely dispersed population and emphasise the creation of safe and welcoming local spaces.

Below are some recent examples of feedback from Women's Health Tasmania service users.

> *Very welcoming private space, affordable – the programs and activities. A rare place that actually is there for all women. Especially those needing support and a place where every women can get referrals, time with other women.*

[1] https://www.pregnancychoicestas.org.au
[2] Women's Health Tasmania (2023). *Summary report: Talking to people about terminations of pregnancy in Tasmania.*
[3] Women's Health Tasmania (2023). *Termination of pregnancy: A good practice guide for Tasmanian care providers.*
[4] Community Affairs Reference Committee (2023). *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia* (Report of the Senate Inquiry into Universal Access to Reproductive Healthcare), p. 32.

Inclusive, non-judgemental information and support offered.

The communication, the vibrancy and the positivity. The consistency of this and the humour has been excellent.

It is a safe place for all women of all ages, backgrounds and circumstances in the way it provides services and information.

At Women's Health Tasmania we hear consistently from women that there is simply nowhere else in Tasmania where reproductive and maternal health support, advice and referrals are freely available and where the response is unequivocally knowledgeable, kind, judgement-free, trauma-informed and inclusive. In the context of Tasmania's overstretched health system and ongoing GP shortage, this model of responsive, person-centred healthcare is the exception.

However, Women's Health Tasmania is confronting a budget shortfall in 2024-2025 that will hamper our ability to provide this breadth and depth of support to individuals and communities, necessitating the loss of skilled staff and significant reductions in service capacity.

Women's Health Tasmania requires a modest but continuing investment to maintain our multidisciplinary reproductive and maternal health service model, for the benefit of women, families and communities across the state.

Recommendation 1: Formal recognition by the Tasmanian Government of Women's Health Tasmania's dual leadership functions as women's health peak body and specialist service provider.

Recommendation 2: An increase in Tasmanian Government funding to allow Women's Health Tasmania to maintain its multidisciplinary, integrated approach to women's health, including reproductive and maternal healthcare.

Section 1. The adequacy, accessibility and safety of services in relation to reproductive health

(i) General comments

Tasmania has a strong track record on reproductive health at the regulatory and policy levels. Termination of pregnancy was decriminalised in Tasmania in 2013, ahead of New South Wales, Queensland, South Australia and the Northern Territory. Financial support to access surgical and medical terminations, including for people not eligible for Medicare, has been available in Tasmania since 2018, and for long-acting reversible contraceptives (LARCs) since 2019. Free public provision of surgical terminations was guaranteed through regional hospitals in 2021.

While on paper these provisions have placed Tasmania ahead of other Australian jurisdictions, in practical terms they have not always translated to the provision of safe and accessible reproductive health services for all. Women continue to report a range of barriers to reproductive healthcare in their communities, including encountering stigma and judgemental attitudes in healthcare settings, a lack of specialist reproductive health knowledge, and the requirement to travel long distances for services.

Issues pertaining to the adequacy and accessibility of reproductive health services are not unique to Tasmania, with the topic attracting significant national attention in recent years. The 2023 release of the Senate Community Affairs References Committee report on universal access to reproductive healthcare[5] – to which Women's Health Tasmania contributed a submission[6] – and the multipartisan support its 36 recommendations received, marked a milestone in this discourse and emphasised a genuine nationwide commitment to reproductive health system reform.

The House of Assembly Select Committee inquiry represents a further, local opportunity to elevate this commitment and to position the experiences of women and families front and centre in relation to the adequacy of reproductive health services in Tasmania.

Recommendation 3: Commit to the Tasmanian implementation of state-based recommendations from the national inquiry into universal access to reproductive healthcare.

(ii) Reproductive health expertise in Tasmanian healthcare settings

Women's Health Tasmania hears regularly from women who have encountered health system gaps and inexperience on reproductive health matters. Stories of doctors failing to give women comprehensive information about reproductive health interventions and their associated risks, and minimising or dismissing their concerns, are common.

Many of the women who talk to us say it takes a considerable length of time to get a meaningful diagnosis or outcome for a reproductive health issue. They tell us about needing to coordinate their own care, self-advocate and seek second opinions, and of the financial cost of this journey.

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[5] Community Affairs Reference Committee (2023). *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia* (Report of the Senate Inquiry into Universal Access to Reproductive Healthcare).

[6] https://www.womenshealthtas.org.au/sites/default/files/resources/inquiry-universal-access-reproductive-healthcare/sub07womens-health-tasmaina.pdf

A woman in her late 40s told us how an appointment for a basic prescription renewal went wrong.

> *I had a new GP refuse to write me a script for the Pill, even though I'd been on it for many years without a problem. She said I was too old and insisted I take a script for an IUD. However, I've got a number of friends who had terrible experiences [with IUDs], so I didn't get it.*

A woman in her thirties had the following experience seeking pregnancy advice.

> *The first GP that I went to when I found out I was pregnant actually said to me that he didn't know anything about pregnancy or babies. [I then saw another GP] that sent me for lots of blood tests that weren't necessary. They told me that my hormone levels were dropping, so I was most likely losing the pregnancy because I was bleeding. [When] I got into the specialist clinic at the Royal they said that by that point in pregnancy, you actually expect that with the hormones. So that was a bit unfortunate because that was quite stressful.*

Another service user encountered a GP with no knowledge of abortion options, risks or referral pathways.

> *It's just absolutely mind boggling that such an essential service is not obvious. If the GPs don't even know what to do, how am I, as a non-medical professional, supposed to know where to go?*

Tasmanian health professionals have told us anecdotally that these experiences reflect low levels of reproductive health literacy in the health workforce, particularly in primary care settings, evidenced by the small percentage of practices offering specialist reproductive services such as medical termination of pregnancy and IUD insertion and removal. The fact that Medicare rebates undervalue the time and complexity involved in delivering reproductive healthcare, and women's healthcare generally, is likely a factor here.[7]

Improving the quality of reproductive health services in Tasmania requires changes both to broader health systems like Medicare and within local healthcare settings. Tasmanians can wait 6-8 weeks for a GP appointment in the current primary care landscape, a context in which health consumers and health professionals rarely have time to adequately explore treatment options. Clients report they are limited to raising two health issues in a GP appointment (any more requires a double appointment) and clients also report being told double appointments are not available.

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[7] Thompson, Kara. *The Gender Medicare Gap is seeing women pay more for ultrasounds and other health services*. Women's Agenda, 11 August 2022.

The Australian Government's new Endometriosis and Pelvic Pain Clinics, delivered in Tasmania by Family Planning Tasmania, are a step in the right direction, however major shifts to health service delivery and culture are required to meaningfully improve reproductive health outcomes for women in Tasmania, especially those living in regional areas.

Recommendation 4: The inclusion of reproductive health training as a core component of Tasmanian healthcare qualifications, including for GPs.

Recommendation 5: Develop shared reproductive health guidelines and resources across Tasmanian health sectors.

(iii) Access to contraception

Women's Health Tasmania has long observed a need for better access to free or lower-cost contraceptive options in Tasmania. Until recently, doctors alone were able to prescribe contraceptives – excluding the 'morning after pill' which is available from pharmacies, emergency departments and Family Planning Tasmania[8] – meaning access to contraception was limited by the cost and accessibility of GP appointments in addition to the item cost itself.

Our staff heard regularly from consumers and services about the impact of this in rural and regional areas of the state, where fewer pharmacies and limited opening hours meant people travelled long distances both for appointments with prescribing GPs and to fill prescriptions. For young Tasmanians and those living on low incomes the combined cost of the appointment, the contraceptive item and travel could be prohibitive.

We welcomed keenly the Tasmanian Government announcement of its new pharmacist prescribing initiative, therefore, allowing approved community pharmacists to provide a resupply of the contraceptive pill for up to 12 months from 1 July 2024.[9] This scheme brings Tasmania into line with other Australian states and territories that are trialling over-the-counter prescribing and dispensing initiatives, and saves consumers the cost, wait time and transport hurdles associated with accessing a GP.

There are some limitations to the new Tasmanian initiative, however, including:

- It provides for resupply of the oral contraceptive pill only, excluding other contraceptives such as long-acting reversible options (LARCs).
- Consumers are required to have been taking the pill continuously for two years to be eligible.
- Pharmacist participation in the scheme is voluntary and while most pharmacists are expected to participate, some may not.
- Consumers are required to attend a pharmacist consultation with a fee.
- Consumers pay private prescription prices for the resupplied medication, without a PBS rebate.

[8] *Emergency Contraception*. Family Planning Tasmania: https://fpt.org.au/advice-and-information/contraception/emergency-contraception/

[9] *Resupply of the oral contraceptive pill*. Tasmanian Government Department of Health: https://www.health.tas.gov.au/health-topics/sexual-and-reproductive-health/reproductive-health/contraception-fertility-control/resupply-oral-contraceptive-pill

With this in mind, Women's Health Tasmania suggests the new prescribing scheme will improve contraceptive access for some Tasmanians, but not at all.

We encourage the Tasmanian Government to monitor the initiative closely in order to understand how well it is working in practice and to identify issues related to equity of access, especially for young people, people on low incomes, and people in regional and rural areas.

Recommendation 6: Close monitoring and evaluation of the new pharmacist prescribing initiative, paying particular attention to equity of access issues, with a view to further expanding low-cost contraceptive pathways for Tasmanians.

(iv) Abortion access and quality of care

Women's Health Tasmania has recently undertaken primary research into abortion experiences in Tasmania, concluding that we and other stakeholders in the local reproductive health landscape must now shift our attention from the establishment of abortion referral pathways to improving equity of access and ensuring best practice clinical and patient care.[10]

To support this goal, we produced the publication *Termination of pregnancy: a good practice guide for Tasmanian care providers* in 2023, using our research learnings as a basis. The Guide is the first Australian resource to combine lived experience with clinical practice recommendations and has been widely acclaimed by clinicians.

Notably, Tasmania does not have routine data collection of GP referrals for abortion services, unlike several other states and territories. Here data is spread across several systems and four Medicare item numbers and is not collated, making the planning, monitoring and forecasting of abortion services in response to community demand difficult.

For a long time, people seeking abortions in Tasmania have found it difficult to get the information they need about where to go for services. Recent initiatives such as the Pregnancy Choices Tasmania website, created and managed by Women's Health Tasmania, have filled an important gap in information provision for patients and clinicians. The website had 4,700 visitors last year and has 200 service providers registered. It has been promoted on television, radio and social media – however, ongoing resourcing is needed to ensure the website is promoted and used.

While the service system is moving in the right direction, it remains the case that people seeking abortions in Tasmania struggle to get the information they need about where to go for services; that they are not guaranteed person-centred care when they find a service; and that securing an abortion can be especially stressful and uncertain in regional areas of the state and during holiday periods.

These and other barriers to abortion access and quality of care are described below.

- **Cost**

The Women's Health Fund, brokerage funds managed by Women's Health Tasmania, pays for medical terminations and long-acting reversible contraceptives for concession card holders

[10] Women's Health Tasmania (2022), *Talking to people about terminations of pregnancy in Tasmania – Summary Report* available here: wht-talking-people-about-safe-access-terminations-report-summaryfinal.pdf (womenshealthtas.org.au). Full report available from Women's Health Tasmania.

and people in financial crisis. In some cases it pays for surgical terminations where people are referred out of the public hospital for clinical reasons.

While this fund is nation-leading in addressing a healthcare gap, high costs for reproductive healthcare remain for some people and create perverse incentives that reduce choice. People who are not eligible to access the Women's Health Fund for a medical termination face the costs of GP consults, ultrasounds, specialist fees, medication, travel to appointments and aftercare requirements. Participants in our research who had not accessed the Fund reported that the cost of their abortion had caused them financial hardship and that they had relied on a partner, friend or family member to help pay for it.

Expanding the Women's Health Fund to pay the costs of all people accessing medical terminations would increase choice for patients, reduce the stigma stemming from Fund access being linked to financial disadvantage, and potentially reduce demand for surgical terminations of pregnancy.

- **Regional and time-specific scarcity of services**

Women reported difficulty accessing abortion services both in regional areas of Tasmania and at certain times of the year. Pregnancy Choices Tasmania lists 27 practices that have practitioners providing medical terminations of pregnancy, a figure that we estimate to represent around 60% of the providers in Tasmania. The online service directory's map of services demonstrates the large areas of Tasmania where there is no service provision: the entirety of the North East, the East Coast and the Central Highlands, and the North West beyond Wynyard.

One research participant from a regional area shared their experience of needing to access abortion services over the New Year holiday period.

> *New Year's Eve I did a pregnancy test, and it was positive. I just started Googling and spiralling because nothing was open. I couldn't call anyone. When it came to the next business day, still nothing was open. I tried to call [a specialist service]. I was on hold for 40 minutes and I got hung up on and told to leave a message. I just had no control over the situation at all. It was horrible. It took weeks to get an appointment because [the service] was closed. I just panicked. I was pregnant New Year's Eve all the way through till mid-February.*

- **Fragmented processes**

Most people said the process of having an abortion was fragmented, particularly in terms of finding out how to access the procedure and receiving aftercare. GPs without specialist training added to the issue, with several participants commenting, "it was chaos until we went into the private system."

Contributing to fragmentation was the need to visit multiple healthcare settings and practitioners for different stages of the process from the initial appointment, ultrasounds, blood tests, the actual procedure, and then follow up tests and appointments. This was

particularly challenging for people in regional areas where there were often long geographical distances between all these appointments.

- **Aftercare**

Participants said the fragmented process of accessing an abortion in Tasmania contributed to a poor standard of aftercare. Some people reported having no follow up at all after a medical abortion, leading to anxiety about whether the procedure had worked. Most participants felt clinical aftercare alone (the test to ensure the pregnancy is terminated) was insufficient, representing only part of the support they needed.

There were also examples of mistreatment resulting from substandard aftercare. For example, one woman went through four rounds of abortion medication including ultrasounds at each stage because the GP "just didn't seem sure" what was normal and what wasn't. She was later told by a different practitioner that this had been "totally unnecessary overtreatment."

- **Judgemental attitudes**

Our research suggests that people still encounter judgemental attitudes from clinicians across the care pathway. Multiple women described experiences in which they felt criticised, dismissed and disrespected.

> *I felt judged by the GP, to be honest. She was quite condescending, and it made me feel really terrible. She just said, "Oh it's really up to you I guess, but I've got three kids, and you've already got two kids so you know you can do it. Just keep the baby." I remember being really quite angry and feeling even more ostracised.*

People also described receiving patronising and judgemental comments from other healthcare staff throughout the process.

> *I couldn't really believe how many passing comments I got. I feel it should be more neutral. I had a sonographer at one of my ultrasounds who, when I mentioned that I had polycystic ovaries in the past, made a passing comment because she saw the referral and said, "Well with polycystic ovaries you just don't know when you might be able to get pregnant again."*

- **Lack of information**

Most people said finding out how to get an abortion in Tasmania was difficult. For the majority of research participants their first point of contact were GPs, who they described as having a lack of knowledge and information about treatment options, referral pathways, and risks. The lack of health practitioner knowledge had a direct impact on service users' experiences, with most women saying they received inadequate information about what to expect from the abortion process, including pain and duration of the experience, and felt poorly prepared for what they went through.

- **Lack of privacy**

The issue of privacy in regional areas of Tasmania was a recurring one for people seeking abortions. In smaller communities, the feeling that people personally knew the local doctors and healthcare workers added to the fear of judgement and stigma.

> *It was awful because it was meant to be very private. It ended up that I needed to see so many different people in so many different places, so I felt in the end [the abortion] was this very public thing. I wanted it kept private, I was already humiliated.*

- **Lack of inclusivity**

People whose experience is socially and structurally marginalised – including culturally and linguistically diverse people, LGBTQIA+ people and people with a disability – said the existing barriers to abortion access in Tasmania are compounded by a lack of inclusive healthcare systems and practices.

Service users in these cohorts often reported discrimination from the health workers and services they encountered in the course of accessing an abortion. This included targeted comments and microaggressions, as well as a general sense that the services were not designed for them.

Recommendation 7: Implement routine data collection of abortion referrals in Tasmania.

Recommendation 8: Ensure secure abortion care pathways in each Tasmanian region that are equipped to meet service demand, including during holiday periods.

Recommendation 9: Provide clear information about abortion care pathways in each Tasmanian region for both consumers and health workers.

Recommendation 10: Expand the Women's Health Fund to cover the cost of medical abortion for all people living in Tasmania, not just those in financial crisis.

Recommendation 11: Training for medical students, GPs and other relevant health workers in best practice abortion care, including the need for inclusive and trauma informed service delivery.

Recommendation 12: Monitor the quality and consistency of abortion services in Tasmania using standardised evaluation measures – for example, the measures described in the resource Termination of pregnancy: A good practice guide for Tasmanian care providers.

(v) The reproductive health workforce

Tasmania's chronic GP shortage has produced an ongoing scarcity of GP appointments and appointments with female GPs particularly, which many women prefer for reproductive health-related matters. Even in Tasmania's metropolitan centres it is not uncommon to wait more than six weeks for an appointment with a woman GP.

For the large number of Tasmanians who cannot afford the cost of a standard GP appointment the situation is even more dire, with bulk-billing GPs now virtually impossible to find.[11] Unsurprisingly, the GP shortage is worst in rural areas of Tasmania and areas of high disadvantage – the East Coast, North West, Tasman Peninsula and Huon Valley included.[12]

There are a number of reforms underway to address this crisis – including the establishment of urgent care clinics in Hobart, Launceston and Devonport, and the commencement of the GP single-employer model pilot – but the scale of the issue means further measures are required to reduce the current, overwhelming level of unmet need for affordable primary care in Tasmanian communities.

While the GP shortage is felt desperately by consumers, the toll on overstretched GPs and on other frontline health workers is immense, resulting in a high incidence of burn-out and staff departures. This in turn depletes the workforce further and reduces already scarce pockets of reproductive health expertise and other areas of 'speciality' knowledge.

Women's Health Tasmania supports the widely held view that initiatives allowing nurses, nurse practitioners, midwives and pharmacists to work to their full scope of practice should be explored in Tasmania, for the benefit of consumers and the health workforce alike. To this end, we encourage the Tasmanian Government and other health workforce stakeholders to closely monitor the progress and outcomes of the national Scope of Practice review.[13]

On a more optimistic note, service users in Tasmania also report instances of exceptional care from reproductive health workers and services, and when they do, there is considerable consistency in the features of care that make the experience a better one. These features are described below.

- **Specialist knowledge:** Consumers describe reproductive healthcare delivered by specialist services and practitioners as more coherent, consistent, and free of judgement compared to services that are not specialised or dedicated.
- **Choice:** Consumers report the value of being given clear, unbiased information about their reproductive healthcare options and being supported to make their own choices based on personal circumstances, preferences, and medical history.
- **Judgement-free:** Consumers say good reproductive healthcare is free of bias, moral judgement, assumptions, stigma, coercion and condescending or dismissive comments.
- **Compassionate:** Consumers say reproductive healthcare that is delivered sensitively and compassionately makes all the difference.
- **Privacy:** Consumers emphasise the imperative of client privacy and confidentiality in the delivery of reproductive healthcare, including within inter-service referrals and communication.

[11] Bovill, Monte. *Bulk-billing doctors nowhere to be found, with this Tasmanian mum finding it's cheaper to fly interstate.* ABC News, 21 July 2022.
[12] Davey, Melissa. *Mind the gap: bulk-billing in crisis.* The Guardian, 12 August 2022.
[13] https://www.health.gov.au/our-work/scope-of-practice-review

- **Inclusiveness:** Consumers say reproductive healthcare that values and accommodates diversity (in relation to gender and sexuality, able-bodiedness, culture and language, income, and work status, amongst other things) is vital.
- **Continuity:** Consumers report the benefits of reproductive healthcare services and practices that provide continuity of care, meaning clients are not bounced between services, re-telling their story repeatedly.

In summary, one person said:

> *All procedures, their purposes, risks, complications, and benefits should always be fully explained to patients. When questions are asked, they should never be dismissed... services should ensure all staff are trained in trauma informed care; receiving insensitive care at such a vulnerable time could result in dangerous outcomes.*

Recommendation 13: Continue to identify and respond to issues contributing to the Tasmanian GP workforce shortage as a matter of urgency.

Recommendation 14: Identify opportunities for Tasmanian reproductive healthcare workers to work to their full scope of practice in a clinically safe way, including nurses, nurse practitioners, midwives and pharmacists.

Recommendation 15: Further resourcing of specialist reproductive healthcare services and practitioners within Tasmania's public health system.

Recommendation 16: Training in best practice reproductive healthcare for health professionals and students (including gynaecology and GP trainees, nurses, nurse practitioners, sonographers, midwives, and pharmacists), including a focus on understanding and implementing compassionate, non-judgemental, inclusive and trauma-informed care.

Recommendation 17: Educate and support Tasmanian reproductive health workers to deliver safe and relevant care to underserved groups including Aboriginal people, culturally and linguistically diverse people, LGBTIQA+ people and people with disability.

(vi) Recognising and responding to reproductive coercion

Reproductive coercion and its impact on the accessibility and safety of reproductive health services in Tasmania is an issue of relevance for this inquiry.

The term 'reproductive coercion' refers to any behaviour that interferes with a person's reproductive choice and autonomy. This includes hiding or disposing of a person's contraception, pressuring a person to become pregnant or to terminate a pregnancy, monitoring a person's menstrual cycle, and preventing a person from accessing sexual or reproductive healthcare.

In the experience of our service users, reproductive coercion is common. It often occurs in the context of an intimate partner relationship where it may be accompanied by other controlling

or abusive behaviours, but it can also be carried out by family members or other cultural or religious groups.

Women who have experienced coercion from partners or family regarding their reproductive health say the pressure causes intense doubt and anxiety and can dictate their health decision-making. They also say the coercion usually goes unnoticed by healthcare practitioners, even when occurring in the context of broader domestic violence.

There are also instances of reproductive coercion coming directly from healthcare practitioners, with several women who took part in our abortion research reporting encountering practitioners who tried to influence their decision-making.

Notably, Tasmania's legislation does not require GPs to disclose their position as conscientious objectors, meaning a person seeking a GP referral for an abortion has no way of knowing whether their GP supports reproductive choice or not.

One research participant described the following experience.

> *When I went to the GP, I was 100% clear that I wanted a termination. There was no ambiguity whatsoever. The GP referred me to a specialist, but the specialist had no idea that I was seeking a termination. He did an ultrasound and had the screen open so I could see everything... which was not what I was expecting. I then had to go through asking him for a termination and it wasn't something that he even did. I'm sure the GP referred me there because she didn't believe in terminations. If I'd been on the fence about the termination, or confused or young or alone, it would have been appalling – it could easily have swayed me to make a different decision. I feel really strongly that what happened to me shouldn't be allowed to happen.*

Women's Health Tasmania runs statewide training in reproductive coercion for health workers, however additional resourcing is required to continue this important work (see Recommendation 2).

Recommendation 18: Training for reproductive health workers, including GPs, to recognise the signs of reproductive coercion and practice appropriate referral and intervention approaches.

Recommendation 19: Training for GPs on the legal obligations of conscientious objection.

Section 2. The adequacy, accessibility and safety of services in relation to maternal health services

(i) General comments

In the second half of 2023 Women's Health Tasmania commenced the *Talking about having a baby in Tasmania* research project – an addition to our 'talking to' qualitative research series that amplifies lived experience perspectives on key health topics for women. This project asked women and birthing people in Tasmania who had given birth after 1 January 2021 about their experiences of pregnancy, birth and postnatal care services.[14]

In summary, the experiences of our research participants suggest not all people living in Tasmania enjoy equal access to maternal health service safety, choice and inclusion. While participants reported varying degrees of satisfaction with services across the state's three regions, it was clear that participants living in non-metropolitan areas of the state had less choice and control over the models of antenatal and birth care they received, and the more geographically isolated they were, the more limited their options became.

A woman living in rural north-west Tasmania told us:

> *I thought I could deliver in Mersey Hospital because I'm like, it's a hospital. Why do you have to travel so far away? And apparently you can only deliver in Launceston or Burnie. And then I asked, what happens if I already have to pop [the baby] out and then I still have to drive an hour away? And they were like, well then just call triple zero and ask for the ambulance... it was a bit daunting.*

Beyond regionality, factors influencing the accessibility of maternal health services included cost, health insurance status and pregnancy risk classification. Factors influencing participant experiences of the adequacy and safety of services were more complex and included access to continuity of care across the antenatal, birth and postnatal period; the presence or absence of a trustful rapport with individual care providers; and participants' pre-existing relationships with health systems and services.

Notably, the experience of participants in key cohorts suggests that in Tasmania, Aboriginal women, women in rural and regional areas, culturally and linguistically diverse women, LGBTIQA+ folk and individuals with mental health conditions are yet to benefit from the kind of targeted maternal health approaches recommended in the Australian Clinical Practice Guidelines for Pregnancy Care (2020).[15] Importantly, these Guidelines are now being updated to include postnatal care.

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[14] 'Birthing people' or the singular 'birth person' is a gender inclusive way to refer to the person who becomes pregnant and gives birth to a child. It does not replace the term women or mother but can be used alongside this term to include people who are giving birth but do not identify as women.

[15] Department of Health (2020). *Clinical Practice Guidelines: Pregnancy Care*. Canberra: Australian Government Department of Health.

When participants reported positive experiences of care from maternal health service providers the service attributes they described were highly consistent, centring on continuity of care, communication, and compassion:

- **Continuity of care:** The antenatal care attribute most valued by participants was continuity – the opportunity to get to know their care providers and build trust.
- **Communication:** Clear and consistent communication from maternal healthcare providers was critical to participants' sense of confidence and agency during pregnancy and birth.
- **Compassionate care:** Participants said compassion and empathy from care providers could mean the difference between birth being experienced as manageable versus unmanageable.

A participant who reported an optimal experience of maternal healthcare told us:

> *That was one of the first things I asked when I met the midwife — am I going to keep seeing you the whole way through? And are you going to be there on the day? And she was wonderful, but she said straight away, look I'm not, I don't work in the hospital... but there are other ways around this. And I ended up getting placed with a student midwife. She was amazing and at every single appointment. I got really fantastic care... because it was this continuity, but it was also the concerted effort to make me feel supported.*

While all participants described adjusting to life with a new baby as challenging, it was clear that participants who felt well supported by maternal health services during pregnancy and birth also felt better equipped for the postnatal period. Correspondingly, participants who described feeling inadequately supported during pregnancy and birth experienced additional challenges postnatally, particularly with regard to their emotional wellbeing.

Participants also said their sense of preparedness for pregnancy, birth and beyond was impacted by access to birth education and antenatal classes, with several participants noting that the advent of the Covid pandemic led to widespread cancellation of antenatal classes and maternity unit tours. Excluding one woman who chose to pay privately for hypnobirthing classes, these participants had no access to practical birth preparation and did not set foot inside the unit where they would give birth until they were in labour.

Overall, participants said the biggest gap in services available from maternal healthcare providers related to their mental health, with a majority of participants saying they needed more psychological support than was offered, especially in the postnatal period.

Participants also felt the focus of care shifted from the mother to the baby too abruptly following birth and said continuity of care for the birthing parent, alongside care for their newborn, would significantly assist postnatal recovery and wellbeing.

It was notable that very few research participants were invited by their maternal healthcare providers to give feedback about their experience of care, and those that were received a generic hospital feedback form rather than evaluation measures specific to maternity care.

Based on the findings of our research, Women's Health Tasmania believes significant attention and resources are required to build the capacity of Tasmania's maternal health services at both policy and practice levels, to ensure equity of access to safe and comprehensive pregnancy, birth and postnatal care for all people living in Tasmania.

Recommendation 20: Commit to delivering Tasmanian maternal health services in line with national guidelines and strategic directions.[16]

Recommendation 21: Consider ways to increase equity of access to maternal health services for all people living in Tasmania, with particular attention to care pathways for regional and rural communities.

Recommendation 22: Ensure all pregnant people in Tasmania have access to birth education, including providing antenatal classes through online modalities should in-person classes be paused or cancelled.

Recommendation 23: Consider opportunities and initiatives to increase the availability of antenatal, birth and postnatal continuity of care, including exploring student midwife schemes.

Recommendation 24: Implement and monitor a best-practice evaluation and continuous improvement framework for all maternal healthcare providers in Tasmania.

(ii) Underserved population groups

While some Tasmanian maternal healthcare providers deliver inclusive services at the individual level, our research suggests equity and inclusion measures are yet to be incorporated into maternal health systems and practices in Tasmania in a consistent and cohesive way – with the consequence that some women and babies experience more comprehensive maternal healthcare than others.

In relation to equity and inclusion for specific groups:

- Aboriginal research participants said there was no recognition of their Aboriginality at any point during their pregnancy care journey. One participant noted that her attempt to bolster her social supports while in hospital through family visits was met with resistance.
- Participants who relied on public health services had less access to birth education and antenatal classes, mental health support, pelvic floor physiotherapy, fewer ultrasounds in pregnancy, and less continuity of care than participants who were able to pay for services privately.
- Culturally and linguistically diverse participants reported finding it difficult to access culturally sensitive and relevant support and advice, particularly in relation to safe co-sleeping.
- A participant who was a migrant and for whom English was a second language said the language barrier was not addressed during pregnancy or birth and that they felt disadvantaged by not having a full understanding of the medical language being used.

[16] See the Australian Government's *Clinical Practice Guidelines: Pregnancy Care*, noting that these are currently being updated to include postnatal care, and the COAG Health Council's *Woman-centred care: Strategic directions for Australian maternity services*.

They said they were not offered access to an interpreter or multicultural social worker at any point in their pregnancy journey.

- Participants living in regional and rural areas had fewer pregnancy care pathways, care models and birth settings available to them, and travelled significantly further to access pregnancy and postnatal care services.
- A nonbinary participant reported being misgendered throughout their pregnancy care journey and said they were advised in hospital that staff 'would struggle' with correct pronoun use.
- Participants with a psychosocial disability said pregnancy care providers had limited awareness of their mental health history and needs despite being provided with clear records. One participant felt her mental health history was used against her following a traumatic birth experience, to minimise what had occurred.
- Participants who were living in Tasmania on short-term visas and were subject to private health insurance requirements said private maternal healthcare providers charged them thousands of dollars of additional fees on top of their standard costs.
- One participant said being plus-size meant her pregnancy was automatically classified 'high risk', which excluded her from her preferred antenatal care pathway and meant she was required to undergo continuous monitoring despite a healthy pregnancy.

Women's Health Tasmania urges the Tasmanian Government to develop and implement maternal healthcare equity of access and inclusion measures for underserved population groups, including Aboriginal women, women on low incomes, culturally and linguistically diverse women, women whose visa status precludes access to public health care, women living in regional and rural areas of Tasmania, LGBTIQA+ women and birthing people, women with a psychosocial disability and those with high-risk pregnancies. Such measures should be supported by appropriate co-design and workforce development strategies.

Recommendation 25: Universal free maternal healthcare for all people in Tasmania, regardless of their health insurance and visa status.

Recommendation 26: Co-design, implement and monitor an equity of access framework for maternal health services in Tasmania that addresses the needs of underserved population groups, including Aboriginal women, women on low incomes, culturally and linguistically diverse women, women living in regional and rural areas of Tasmania, LGBTIQA+ women and birthing people, and women with a psychosocial or other disability.

Recommendation 27: Training in diversity, inclusion and cultural safety for all healthcare workers involved in the delivery of maternal health services in Tasmania.

Section 3. The adequacy, accessibility and safety of services in relation to birth trauma

Please note this discussion contains personal accounts of birth trauma that may be distressing.

i. General comments

The prevalence and impact of birth trauma in the lives of women, birthing parents and families has become the subject of significant concern in Australia, following an outpouring of personal accounts of birth related trauma in specific jurisdictions and nationally.

The Australian Birth Trauma Association defines birth trauma as "a woman's experience of interactions and/or events related to childbirth that cause overwhelming distressing emotions and reactions, leading to short and/or long-term negative impacts on a woman's health and wellbeing".[17]

Stories of birth trauma are plentiful in Tasmania and staff at Women's Health Tasmania see the impact of these experiences as health workers and counsellors, through our participation in a Health Consumers Tasmania birth trauma group, and most recently, as maternal healthcare researchers.

While the scale and qualitative nature of our study precludes drawing causative links between individual maternal health services and traumatic birth outcomes, we can comment on the common factors we observed in the experiences of birth trauma recounted by our research participants.

The women who shared an experience of birth trauma with us reported that their distress – whether physical or psychological or both – arose as a consequence of the conduct, decisions or interventions of a member or members of the healthcare team responsible for their medical care before, during or after birth.

It was notable that for each of these participants there was a dual experience of trauma: the first component arising from the traumatic birth event/s itself, the second component arising from the perceived failure of care providers to adequately acknowledge and respond to what had occurred.

One participant who experienced a traumatic birth told us:

> *Nobody ever came to ask if I was okay. Yeah, no acknowledgement at all. And in terms of follow-up care as well, once we got into the maternity ward, nobody ever followed up. A couple of the midwives saw me struggling to get out of bed and they were like, what's wrong? And I'm like, they have no idea. They don't even know what we just went through.*

[17] Leinweber J, Fontein-Kuipers Y, Thomson G, Karlsdottir SI, Nilsson C, Ekström-Bergström A, Olza I, Hadjigeorgiou E, Stramrood C. *Developing a woman-centered, inclusive definition of traumatic childbirth experiences: A discussion paper*. Birth. 2022 Dec; 49 (4): 687-696.

What is clear is that the experience of birth trauma leaves an acute and often lasting psychological wound that may lead to post-traumatic symptoms such as anxiety, depression, hypervigilance, insomnia, dissociation and suicidality – and that in the current system, maternal healthcare services in Tasmania are not sufficiently informed or equipped to respond to these experiences.

The degree of distress that occurs during a traumatic birth can be difficult to comprehend as an observer. For one participant, the decision by caregivers that no further pain relief could be administered during her birth led to an extreme experience of disassociation.

> *For the next few hours, I asked everybody who came in the room for pain relief. Everyone kept saying, 'This is good pain. This is the right amount of pain.' I started coming to every now and then and begging for help again. They started saying that it wasn't possible, no pain relief possible now. There's none possible. And so, the coming to and blacking out was dissociating. They said that pain relief wasn't possible so I started begging for interventions. I begged for a c-section. I begged for forceps, I begged for vacuum. Then they said, 'No, none of those interventions are possible. You're too far.' So then I started begging for death. And I wasn't even thinking about [the baby] anymore. I just wanted to die. And finally, I stopped. Stopped asking for help and I stopped looking at them. And I stopped pushing. And became non-responsive. It [wasn't] my body anymore.*

Women's Health Tasmania believes strategies to reduce both the prevalence and severity of birth trauma in Tasmania require a two-fold approach: firstly, to address risk factors related to the likelihood of an originating birth trauma occurring; and secondly, to ensure appropriate recognition and responses from maternal healthcare providers when a traumatic birth event occurs.

<u>Recommendation 28:</u> In consultation with women, birthing parents and maternal healthcare providers, develop a strategy to reduce the prevalence and severity of birth trauma in Tasmania that addresses:

1. *Maternal healthcare risk factors linked to originating birth trauma; and*
2. *The provision of appropriate healthcare responses when a traumatic birth occurs.*

ii. Compassion, communication and consent

The experiences of birth trauma shared by participants in our research almost always involved a perceived absence or breakdown of communication and of compassionate care – two of the service attributes identified earlier in this submission as key to positive experiences of maternal healthcare.

Participants described feeling intensely vulnerable during labour and birth and said the value of clear and respectful communication from caregivers could not be overstated. A number of participants said it was the supportive and empathetic interactions with maternity staff,

especially midwives, that enabled them to birth their babies, despite the intense pain and fatigue of birth.

On the value of good communication, one participant said:

> *The midwife that we had when went in was amazing. She really talked us through everything, gave us all the information, sat with us and talked through options as well. And she was really good at saying, you know, there's two different options, here's the pros, here's the cons. So she was just really good at making sure that we were comfortable and informed. It was really nice to feel safe and respected in that way.*

Another theme common to experiences of birth trauma was the absence of consent. Consent-seeking from doctors and midwives prior to touching patients or commencing interventions during birth was vitally important to our research participants and failures to seek consent were experienced as devastating breaches of trust.

> *I can still feel my heart racing thinking about it. She was going through some of the risks. And before I even had a chance to say anything, I had another contraction and it completely overwhelmed me. And so she didn't wait for an answer. They just started the procedure without any consent.*

Notably, on occasions when communication or trust between the participant and care providers broke down during birth, opportunities to interrupt and redirect the rupture were often missed. These experiences reinforce the value of maternal healthcare models that enable continuity of care in pregnancy and birth, allowing women and caregivers to build trust, rapport and a shared understanding of birth care expectations prior to labour.

Post-birth debriefing can also play a role in assisting women and birthing parents to understand events that occurred in the course of the birth, and likewise, gives caregivers an opportunity to learn from the perspective and experience of labouring women. Participants who had an opportunity to debrief with caregivers about their birth said the experience was validating.

> *The day after I gave birth the midwife that helped deliver [my baby] came back and was like, let's debrief, let's chat through exactly what happened. Do you have any questions? That was really appreciated, that she was like, all right, let's unpack this and see how you actually felt about it immediately afterwards.*

Recommendation 29: Education and support for obstetricians, midwives and other maternal health workers in best practice communication and consent-seeking, with an emphasis on person-centred and compassionate care.

Recommendation 30: Education and support for obstetricians, midwives and other maternal health workers to recognise the risk factors and indicators of birth trauma, including strategies to interrupt and redirect potential traumas.

Recommendation 31: Introduce post-birth debriefing and associated training in all Tasmanian maternity units.

iii. Recourse and accountability

As indicated, a significant exacerbating factor in the experiences of birth trauma shared with us by women and birthing parents was the perceived failure of maternal health services to adequately respond when a traumatic birth event occurred.

Of the research participants who had experienced birth trauma, several had initiated formal recourse processes with the Tasmanian hospitals who provided their care, while others said they were unsure how to go about making such a report or who to contact.

None of these individuals had received any follow-up contact from their care providers in relation to their birth experience while in hospital or subsequently, despite reporting that they were visibly distressed during and after their birth.

All individuals had sought mental health support to help process and recover from their experiences, with some saying they were paying significant private fees for this support.

Of the participants who had sought formal recourse with hospitals, all said that the experience of trauma had been further minimised by the senior hospital staff who responded to their complaints and that no recognition or accountability was offered. Participants felt hospitals' fear of legal liability was a factor in this. All reported that the lack of acknowledgement of their birth trauma had significantly compounded their distress.

The below comments were made by participants in relation to the lack of recourse and accountability, following experiences of birth trauma.

> *I think the hospital system that I have complained to, they know that it's very difficult to recount [an experience of birth trauma], and I think they lean on that to cover complaints.*

> *They just keep holding, closing ranks. [A senior hospital staff member] told me I was lying, none of it happened. He insisted that I was lying.*

> *In the meeting was one of the directors of the hospital, a midwife manager and the obstetric manager as well. The midwife manager was really open, she understood all of my concerns – but the doctor was like, I don't care. I said the word 'mistake' and everyone jumped to the table and said, "there is no mistake!" They were worried just to protect their interests.*

> *If they are going to go around traumatising people and discarding them, then they could at least clean up their mess. At the very least, acknowledge it, you know... It's not fair for me to have to do all this work and pick up the pieces.*

Women's Health Tasmania believes Tasmanian maternal health services should prioritise the development of procedures and practices to ensure women and birthing parents who experience birth trauma receive adequate acknowledgement, support and accountability (resources available from the Australasian Birth Trauma Association website provide a good starting point).[18] Where this undertaking is complicated by issues of medical liability, we suggest pathways for birth trauma recognition and support be developed separately from avenues for legal recourse.

Recommendation 32: Develop procedures and practices guiding best practice birth trauma responses for implementation in all Tasmanian maternity units, with an emphasis on the provision of recognition, support and accountability.

[18] Australasian Birth Trauma Association: https://birthtrauma.org.au/

Section 4. The adequacy, accessibility and safety of services in relation to perinatal mental health

i. General comments

In Section 2 of this submission we noted that participants in the *Talking about having a baby in Tasmania* research project identified mental health support as the most significant gap in the Tasmanian maternal health service system.

The majority of participants who took part in our study said they needed more mental health support than was offered by their maternal healthcare provider, with more than half of the participant group seeking out their own professional mental health support to assist them through pregnancy, postnatally, or both.

Of the participants who ended up paying privately to see a psychologist, a number had sought assistance through the public health system or via publicly available helplines first, with limited success.

One participant was eventually admitted to the inpatient perinatal mental health unit, which at the time was located at St Helen's Private Hospital in Hobart. She described the hoops she had to jump through to access this support.

> *I went to the child health nurse who referred me to the parenting centre. I went to parenting centre who told me to go to my GP. I went to the GP and got the referral to the perinatal mental health service so that they could refer me to the Mother Baby Unit. And then I went on a wait list for the Unit. It was months from really asking for that help and then getting it.*

St Helen's Private Hospital has since closed, taking with it Tasmania's eight-bed Mother Baby Unit and the state's only inpatient perinatal mental health service. The hospital's mid-2023 closure prompted an outcry from women, families and maternal healthcare providers across Tasmania and illustrated the risk of allowing a private hospital to carry an essential statewide public mental health service.

The Tasmanian Government has now opened an 'interim' two-bed Mother Baby Unit at the Royal Hobart Hospital that is, notably, unable to accommodate women experiencing acute mental ill-health due to a lack of safety features. The Government states that it "continues to work with stakeholders – including private providers and primary care services – to establish a comprehensive model of care for mothers and babies."[19]

Another participant who had experienced a traumatic birth was referred several times to the Perinatal Infant and Mental Health Service (PIMHS), but had her referral rejected. She said the reason she was given was that the service was intended for women with postnatal anxiety and depression, not experiences of birth trauma.

[19] https://www.premier.tas.gov.au/site_resources_2015/additional_releases/new-public-mother-and-baby-unit-opens-at-the-rhh

Based on this combined feedback, it seems clear that mental health support during the life-changing experiences of pregnancy, birth and early parenting is a universal requirement, rather than an occasional or exceptional need.

Recognising that both private and public psychological support services in Tasmania are facing overwhelming demand, and that statewide capacity for inpatient support has shrunk significantly, Women's Health Tasmania urges the Government to consider adopting a community-based, psychosocial model of perinatal mental health and wellbeing support.

Recent state and federal funding has generated some new capacity in this regard, with both Tresillian and Gidget Foundation establishing service models in Tasmania, however these services must be expanded and carefully coordinated if women and birthing people throughout the state are to have equitable access to support when they need it.

Recommendation 33: Adopt a community-based, psychosocial model of perinatal mental health and wellbeing support that is accessible to all women and birthing people in Tasmania.

ii. The experience of women with pre-existing mental health conditions

A concerning finding arising from the *Talking about having a baby* study was that Tasmanian women and birthing parents with pre-existing mental health conditions and/or psychosocial disability did not feel that their mental health support needs were adequately met by maternal health services during pregnancy and postnatally.

Several participants in this cohort reported that critical information relating to their mental health histories and support requirements was either missing from their maternal healthcare records, ignored during antenatal check-ups, or led to a range of misunderstandings and mis-referrals.

One participant spoke about the confusion that resulted from attending what she believed to be a routine antenatal check-up.

> *I thought I was going in for, you know, fundal height check. That was not the case. It was a mental health history interview. And one of the questions is about suicidal history. And it's not good enough to say 'yes' or 'no'. They want to know how you did it. So I was crying during this appointment. And this midwife was so lovely. She was like, "Oh, I've upset you, I'm sorry." And I think she maybe thought I was having a bad pregnancy and I was like, no, no, I'm very happy in my life now. We've just talked about the darkest time of my life. And I didn't see this coming. She said she was going to put in some kind of referral and I was like, all right, yes, thank you. I will take any support you would like to offer. Later that week on a Saturday evening, I got a call from a triage person. And she thought that I had already had my baby and that I was in crisis. And we were both very confused. Had a little chuckle about it. And she determined that I was not in need and closed that referral. I don't even know what service that was. That began the pattern of referrals being really miswritten and incomplete.*

Another participant described alerting their antenatal care provider to past perinatal mental health experiences in the hope of receiving preventative support early in their new pregnancy and being disappointed by the lack of follow-up.

> *I was diagnosed [after my last pregnancy] with postnatal anxiety and OCD. So this time I flagged that early as well, that it would be nice to touch base with someone early on. And they said yes. But then I didn't hear from anyone. And because I was okay, I didn't follow up. But 'okay' is one of those very loose words that has a lot of different levels. So comparatively, I'm better, I know what intrusive thoughts are, I know how to look out for them. [But] it's a shame that I didn't have access to [a psychologist] this time. I would have liked to have built that relationship, even if I saw someone twice through pregnancy, just to kind of build that little bit of connection so that now, I could reach out to someone and have, maybe someone checking in.*

A participant with an ongoing complex mental health condition said they initiated their own referral to PIMHS during pregnancy and had a positive experience with the service but were discharged too early.

> *I had to go and seek my own referral to Perinatal [Mental Health Service]. And when I was there, that was really good. And then I think day two post-delivery, I was discharged. It was just sort of, symptom management right through [the pregnancy] and then you got to the end, and then it's done and dusted, and you've got no other management at all. And cause, you know, I was really concerned about postnatal depression or psychosis, and there was no checks on that. I think that they need to have psychiatry and psychology services attached [to the maternity care unit]. And it needs to follow through at least to six weeks post-delivery, because that's when the biggest stuff sort of happens, your milk, the attachment [with baby], all that sort of stuff. Or until they've got a clear referral pathway for long-term supports.*

It is worth noting that the national guidelines for pregnancy care make a number of specific recommendations in relation to the provision of maternal healthcare for women with pre-existing mental health conditions, including that "a multidisciplinary team approach to care in the antenatal period is essential, with clear communication, advance care planning, a written plan, and continuity of care across different clinical settings."[20]

Recommendation 34: Implement training and protocols to support the delivery of best practice maternal healthcare for Tasmanian women and birthing parents with mental health conditions and/or psychosocial disability, in line with national guidelines for pregnancy care.

[20] Department of Health (2020). *Clinical Practice Guidelines: Pregnancy Care*. Canberra: Australian Government Department of Health.

Conclusion

Evidently, addressing the adequacy, accessibility and safety of reproductive and maternal health services in Tasmania is a significant task that requires the commitment and collaboration of State Government, policymakers, health service planners, health administrators and executives, and frontline health workers. It will require changes to healthcare funding arrangements, healthcare training curricula, healthcare practices and healthcare cultures.

While some of these changes require a major investment of time and resources, findings from our primary research and ongoing work with Tasmanian communities demonstrate there are opportunities for immediate, local and low-cost service improvements and solutions as well. Importantly, each one starts with Government and key stakeholders listening to and learning from the experiences of Tasmanian women, families and communities.

As leaders of reproductive and maternal health policy and practice, Women's Health Tasmania looks forward to supporting these opportunities and solutions, for the benefit of all people living in Tasmania.

Summary of recommendations

RECOMMENDATION 1	Formal recognition by the Tasmanian Government of Women's Health Tasmania's dual leadership functions as women's health peak body and specialist service provider.
RECOMMENDATION 2	An increase in Tasmanian Government funding to allow Women's Health Tasmania to maintain its multidisciplinary, integrated approach to women's health, including reproductive and maternal healthcare.
RECOMMENDATION 3	Commit to the Tasmanian implementation of state-based recommendations from the national inquiry into universal access to reproductive healthcare.
RECOMMENDATION 4	The inclusion of reproductive health training as a core component of Tasmanian healthcare qualifications, including for GPs.
RECOMMENDATION 5	Develop shared reproductive health guidelines and resources across Tasmanian health sectors.
RECOMMENDATION 6	Close monitoring and evaluation of the new pharmacist prescribing initiative, paying particular attention to equity of access issues, with a view to further expanding low-cost contraceptive pathways for Tasmanians.
RECOMMENDATION 7	Implement routine data collection of abortion referrals in Tasmania.
RECOMMENDATION 8	Ensure secure abortion care pathways in each Tasmanian region that are equipped to meet service demand, including during holiday periods.
RECOMMENDATION 9	Provide clear information about abortion care pathways in each Tasmanian region for both consumers and health workers.
RECOMMENDATION 10	Expand the Women's Health Fund to cover the cost of medical abortion for all people living in Tasmania, not just those in financial crisis.
RECOMMENDATION 11	Training for medical students, GPs and other relevant health workers in best practice abortion care, including the need for inclusive and trauma informed service delivery.
RECOMMENDATION 12	Monitor the quality and consistency of abortion services in Tasmania using standardised evaluation measures – for example, the measures described in *Termination of pregnancy: A good practice guide for Tasmanian care providers.*
RECOMMENDATION 13	Continue to identify and respond to issues contributing to the Tasmanian GP workforce shortage as a matter of urgency.

Summary of recommendations (continued)

RECOMMENDATION 14	Identify opportunities for Tasmanian reproductive healthcare workers to work to their full scope of practice in a clinically safe way, including nurses, nurse practitioners, midwives and pharmacists.
RECOMMENDATION 15	Further resourcing of specialist reproductive healthcare services and practitioners within Tasmania's public health system.
RECOMMENDATION 16	Training in best practice reproductive healthcare for health professionals and students (including gynaecology and GP trainees, nurses, nurse practitioners, sonographers, midwives, and pharmacists), including a focus on understanding and implementing compassionate, non-judgemental, inclusive and trauma-informed care.
RECOMMENDATION 17	Educate and support Tasmanian reproductive health workers to deliver safe and relevant care to underserved groups including Aboriginal people, culturally and linguistically diverse people, LGBTIQA+ people and people with disability.
RECOMMENDATION 18	Training for reproductive health workers, including GPs, to recognise the signs of reproductive coercion and practice appropriate referral and intervention approaches.
RECOMMENDATION 19	Training for GPs on the legal obligations of conscientious objection.
RECOMMENDATION 20	Commit to delivering Tasmanian maternal health services in line with national guidelines and strategic directions.[21]
RECOMMENDATION 21	Consider ways to increase equity of access to maternal health services for all people living in Tasmania, with particular attention to care pathways for regional and rural communities.
RECOMMENDATION 22	Ensure all pregnant people in Tasmania have access to birth education, including providing antenatal classes through online modalities should in-person classes be paused or cancelled.
RECOMMENDATION 23	Consider opportunities and initiatives to increase the availability of antenatal, birth and postnatal continuity of care, including exploring student midwife schemes.
RECOMMENDATION 24	Implement and monitor a best-practice evaluation and continuous improvement framework for all maternal healthcare providers in Tasmania.

[21] See the Australian Government's *Clinical Practice Guidelines: Pregnancy Care*, noting that these are currently being updated to include postnatal care, and the COAG Health Council's *Woman-centred care: Strategic directions for Australian maternity services*.

Summary of recommendations (continued)

RECOMMENDATION 25	Universal free maternal healthcare for all people in Tasmania, regardless of their health insurance and visa status.
RECOMMENDATION 26	Co-design, implement and monitor an equity of access framework for maternal health services in Tasmania that addresses the needs of underserved population groups, including Aboriginal women, women on low incomes, culturally and linguistically diverse women, women living in regional and rural areas of Tasmania, LGBTIQA+ women and birthing people, and women with a psychosocial or other disability.
RECOMMENDATION 27	Training in diversity, inclusion and cultural safety for all healthcare workers involved in the delivery of maternal health services in Tasmania.
RECOMMENDATION 28	In consultation with women, birthing parents and maternal healthcare providers, develop a strategy to reduce the prevalence and severity of birth trauma in Tasmania that addresses: 1. Maternal healthcare risk factors linked to originating birth trauma; and 2. The provision of appropriate healthcare responses when a traumatic birth occurs.
RECOMMENDATION 29	Education and support for obstetricians, midwives and other maternal health workers in best practice communication and consent-seeking, with an emphasis on person-centred and compassionate care.
RECOMMENDATION 30	Education and support for obstetricians, midwives and other maternal health workers to recognise the risk factors and indicators of birth trauma, including strategies to interrupt and redirect potential traumas.
RECOMMENDATION 31	Introduce post-birth debriefing and associated training in all Tasmanian maternity units.
RECOMMENDATION 32	Develop procedures and practices guiding best practice birth trauma responses for implementation in all Tasmanian maternity units, with an emphasis on the provision of recognition, support and accountability.
RECOMMENDATION 33	Adopt a community-based, psychosocial model of perinatal mental health and wellbeing support that is accessible to all women and birthing people in Tasmania.
RECOMMENDATION 34	Implement training and protocols to support the delivery of best practice maternal healthcare for Tasmanian women and birthing parents with mental health conditions and/or psychosocial disability, in line with national guidelines for pregnancy care.

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