Position Statement

Antenatal Care in Australia

This paper has been developed by the Australasian Birth Trauma Association (ABTA), in conjunction with key professional staff and other members. It was approved by the ABTA Board as a Position Paper on 09 April 2020.

Scope

This position statement outlines ABTA's views on how the provision of antenatal care for birthing families in Australia can be improved in order to reduce the incidence and severity of physical and psychological birth trauma. It is written for those with responsibility for developing policy and making decisions on how these families are supported.

Summary

At the broadest level, ABTA holds the view that birthing women and their families should have access to antenatal care that acknowledges and supports their unique individual physical, psychological and socio-emotional needs. That care will provide accurate information and tools to help them navigate their maternity journey effectively, allowing them to assess their level of risk and make appropriate decisions.\

Current Situation

With 1 in 3 women identifying their birth as traumatic, there is much work to be done in the prevention and treatment of birth trauma in Australia. [1]

Birth-related trauma and stressor-related disorders, including PTSD, is a growing field for perinatal mental health clinicians and includes the effects of other birth issues such as haemorrhage, loss of baby, emergency surgical intervention and inadequate pain relief, among other things. It is now recognised that partners can also experience trauma-related disorders as the result of a traumatic birth however research on the incidence of partner birth-related trauma is limited.

Research suggests that 10-20% of first-time mothers, between 15,000 and 30,000 women in Australia per year, may suffer major irreversible physical birth trauma in the form of pelvic floor muscle and/or anal sphincter tears. [2] We also know that up to 20% of all women who deliver a baby vaginally will end up with surgery for pelvic organ prolapse, anal or urinary incontinence.[3]

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ABTA's view is more should be done in the current system to prepare women (and their partners) for birth, including more accurate physical assessment in preparation for birth, improved quality of information on birthing and procedures that may be involved, better matching of families with a model of care that suits their circumstances, and a move to foster more realistic expectations of the birth process.

Challenges

Below is a summary of the challenges ABTA has identified as impacting the antenatal care of women in respect to birth trauma.[4]

1. *Informed Choice*
   As an Association, we have identified an erosion of objective, unbiased antenatal education being provided to women as hospitals are pressured to meet targets (e.g. to reduce caesarean rates) or cut costs by reducing the availability of antenatal classes. In addition, the proliferation of private businesses offering birth preparation classes has provided increased choice for families. These, however, may be skewed to fit a particular birth ideology and thus may not provide comprehensive, unbiased information on birth.

   The commonly held belief that the traumatic aspects of birth should be withheld from women so as not to 'scare' them, is not supported by the comments from our members. Resoundingly, women report to ABTA they wish they had known of the potential risks and that knowing this information would have likely impacted their decision-making.

2. *Collaborative Care and Continuity of Carer*
   The current maternity care system rarely provides adequate access to continuity of carer nor does it adequately promote collaboration among health care providers. We do not see these two things as mutually exclusive.

   ABTA has identified a collaborative, multidisciplinary approach to care as the key to early recognition of factors that may impact birth. This information can then be used to tailor birth preparation individually for each woman.

   ABTA recognises the benefits to families of forming positive relationships with known carers who will support them through pregnancy, birth and postnatally (continuity of carer), however, we do not feel that one model of care should be given priority over another. What women and their families want is continuity of carer and whether that be midwifery-led care or obstetric-led care is up to the woman/family.

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3. *Birth Ideology*
   The active promotion, within society, of vaginal /'natural' birth being superior creates a stigma for those who birth via caesarean. This can create immense feelings of 'failure' for those who have not been able to birth vaginally and cause them to experience judgment from their peers. It can also contribute to women having unrealistic expectations of birth and prevent them from looking objectively at their particular situation and the possible negative outcomes that may result from a traumatic vaginal delivery.

   Targets set by hospitals to reduce caesarean rates are not considering the individual's' circumstances and may place women at risk of trauma for the sake of achieving hospital targets.

   Birth trauma, whether physical, psychological or both, is not avoided by having one type of birth or one model of care. Birth trauma is very specific to individuals and it can also impact their partners, caregivers and have a long term impact on relationships. This is why ABTA advocates for evidence-based, individualised care, rather than a one-size-fits-all approach to birth.

4. *Models of Care*
   We have observed that most women are not provided with all of their options when they are deciding on a model of care. Certain models of care will suit certain women/families and these considerations need to be taken into account early on in the pregnancy. It is also acknowledged that there can be significant limitations on the models of care available for women outside major metropolitan centres.

   In some situations, the ongoing rivalry between obstetric care and midwifery care has polarised the birthing community and is impacting the quality of care delivered to women when collaboration is required.

   ABTA takes the position that women cannot be provided with informed choice if they are offered only one model of care. We would like to see collaboration on guidelines to help support women achieve both quality information (from a multidisciplinary care approach) and the birthing outcomes they desire.

Calls to Action

1. *Supporting Informed Choice*
   ABTA would like steps to be taken to provide evidence-based, unbiased information on a comprehensive range of birthing practices and potential birth complications along with the development of systems to ensure those options are presented to women in a timely and appropriate way so they can be considered in decision-making.

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2. *Encourage collaboration between healthcare professionals*
   Rather than pushing for one model of care (meaning one-size-fits-all), we would like to see the system moving towards team-based, patient-led care.

   ABTA calls for a multi-disciplinary approach to providing birth preparation information for women and their partners. We would like to see collaboration among health professionals so birthing families are able to access unbiased advice and undertake screening for factors that may impact birth in order to best prepare them for the birth process. Positive and respectful collaboration is essential to the success of a multi-disciplinary approach.

   We would like there to be recognition that each professional group has a range of knowledge, skills and training to enable them to provide evidence-based information to women. There needs to be reconciliation between the need for continuity of carer and the need to receive information from relevant health professionals as required. Positive and respectful collaboration is essential.

3. *Improved Birth Trauma Education for Healthcare Providers*
   ABTA believes that birth trauma training for healthcare providers will not only lead to greater empathy and better health outcomes for the women and families they serve, but also for the healthcare professionals themselves as many practitioners experience burn out and vicarious trauma which impacts their service provision.[5]

4. *Consumer Engagement*
   ABTA advocates for consumers to be involved in the design, implementation and evaluation of all maternity services. Those who have experienced trauma as a result of childbirth are in a unique position to provide valuable feedback on minimising trauma and advising on issues relevant to recovery.

All of the recommendations made in this position statement should be carried out while keeping in mind women for whom financial, geographical, cultural or language barriers may impede access to care.

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References

[1] https://www.ncbi.nlm.nih.gov/pubmed/11251488 accessed 06/05/2020

[2] Breakdown for first time mothers: Perineal trauma - 80%, Anal sphincter trauma - 5% (AIHW) 4000 women a year, Levator injury in first time mums - 10% incidence in normal (52000) – 5200, 10% ventouse birth (16330) – 1630, 35% in those having a forceps (13206) - 4622.1 = 15400 first time mothers per year.

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Shek KL, Dietz HP. Intrapartum risk factors for levator trauma. BJOG: An International Journal of Obstetrics & Gynaecology. 2010 Nov;117(12):1485-92.

Friedman T, Eslick GD, Dietz HP. Delivery mode and the risk of levator muscle avulsion: a meta-analysis. International urogynecology journal. 2019 Jun 1;30(6):901-7.

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AIHW: Australian Institute of Health and Welfare. National Core Maternity Indicators [Internet]. Canberra: Australian Institute of Health and Welfare, 2019 [cited 2020 Mar. 9]. Available from: https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations

Australian Institute of Health and Welfare 2019. Australia's mothers and babies 2017—in brief. Perinatal statistics series no. 35. Cat. no. PER 100. Canberra: AIHW.

This paper also shows the rates of pelvic floor dysfunction to be up to 58% with those women:

MacLennan AH, Taylor AW, Wilson DH, Wilson D. The prevalence of pelvic floor disorders and their relationship to gender, age, parity and mode of delivery. BJOG: An International Journal of Obstetrics & Gynaecology. 2000 Dec;107(12):1460-70.

[3] Smith FJ, Holman CA, Moorin RE, Tsokos N. Lifetime risk of undergoing surgery for pelvic organ prolapse. Obstetrics & Gynecology. 2010 Nov 1;116(5):1096-100.Wu JM, Matthews CA, Conover MM, Pate V, Funk MJ. Lifetime risk of stress incontinence or pelvic organ prolapse surgery. Obstetrics and gynecology. 2014 Jun;123(6):1201.

[4] ABTA Birth Preparation Survey 2019

[5] Women and Birth, Volume 31, Issue 1, February 2018, Pages 38-43, Original Research – Quantitative, The emotional and professional wellbeing of Australian midwives: A comparison between those providing continuity of midwifery care and those not providing continuity, by JenniferFenwick[abc]MarySidebotham[ab]JennyGamble[ab]Debra K.Creedy[a] <https://www.sciencedirect.com/science/article/abs/pii/S1871519217301415?via%3Dihub>, accessed 27/02/2020 & ScienceDirect www.elsevier.com/ Midwifery Australian midwives' experience of delivering a counselling intervention for women reporting a traumatic birth Maree Reed, MPhil, RM, RN (Registered Midwife)[a,b,n], Jennifer Fenwick, PhD, RM (Professor of Midwifery, Clinical Chair Gold Coast Hospital)[c], Yvonne Hauck, PhD, RM (Professor of Midwifery)[a,b], Jenny Gamble, PhD, RM (Professor of Midwifery)[c], Debra K. Creedy, PhD, RN (Professor of Nursing)[c]

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