Response template

Public consultation: Safety and quality guidelines for privately practising midwives (SQG)

The Safety and quality guidelines for privately practising midwives (the SQG) support privately practising midwives (PPMs) to deliver safe, evidence-based and woman-centred care that is free from racism, culturally safe, and meets the unique needs of all people accessing private midwifery services.

The Nursing and Midwifery Board of Australia (NMBA) is undertaking a review of the SQG to reflect the ending professional indemnity insurance (PII) exemption for PPMs providing intrapartum care during a homebirth and to make other minor amendments which provide further clarity and support safe and inclusive practice.

Your feedback is important to us

The NMBA invites you to provide feedback on the proposed changes to the SQG. Please read the public consultation paper before completing the seven questions below.

You can email your response to nmbafeedback@ahpra.gov.au with the subject line **Public consultation: SQG**.

The consultation opens on **Wednesday, 8 April 2026** and closes on **Friday, 5 June 2026**.

Related public consultation

This public consultation is being undertaken concurrently with the public consultation for the review of the Registration standard: Endorsement for scheduled medicines for midwives (Registration standard) and Guidelines: Endorsement for scheduled medicines for midwives. While the Registration standard and the SQG function as separate regulatory instruments, they are closely interlinked in practice.

Publication of submissions

We publish submissions at our discretion. We generally publish submissions on our website to encourage discussion and inform the community and stakeholders.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject to the consultation. Before publication, we will remove personally identifying information from submissions, for example personal contact details. The views expressed in the submissions are those of the individuals or organisations who submit them, and their publication does not imply any acceptance of, or agreement with, these views by the NMBA.

We can also accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information.

Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions designed to protect personal information and information given in confidence.

Please let us know if you do not want your submission published or want all or part of it treated as confidential.

Published submissions will include the names of the individuals and/or the organisations that made the submission unless confidentiality is requested.

Next steps

The NMBA will review and consider all feedback from this consultation. Your feedback will inform the final version of the SQG. More information about your submission may be requested if clarification is needed, however in general, individual stakeholder feedback will not be provided. An advance copy of the revised SQG will be published in the months prior to it coming into effect on 1 January 2027.

Submission type

Are you completing this submission on behalf of an organisation or as an individual?

☒ Organisation

☐ Individual

Your details

- If you prefer to provide only your name or organisation name, please enter N/A in the other field.
- If you prefer to remain anonymous, enter N/A in both fields.

Name:

Organisation: Maternity Choices Australia

Permission to publish submission

Do you give permission for your submission to be published?

☒ Yes - publish my submission **with** my name and organisation name

☐ Yes - publish my submission **with** my name only

☐ Yes - publish my submission **with** my organisation name only

☐ Yes - publish my submission **without** both my name and organisation name

☐ No - **do not** publish my submission

Questions for feedback

1. Is the language and structure of the revised SQG clear, relevant and workable?

☐ Yes
☒ No
☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

We are concerned that several specific clauses in the proposed SQG will reduce access to registered, regulated private midwifery care - both for the women who rely on it, and for the midwives who provide it.

Second-midwife requirement (Table 1, Item 2 Risk management). The proposed text requires the second midwife at a homebirth to 'hold appropriate professional indemnity insurance'. In practice, second midwives are often newer midwives learning alongside experienced ones, or experienced midwives who attend as second only occasionally. These midwives will not pay for the same insurance product as the primary midwife for occasional work. This clause will eliminate the second-midwife pool and, with it, the ability of women to access a private midwife at all.

Footnote 7 (Table 1, Item 2). The proposed footnote says that if the second midwife cannot attend, the primary midwife must engage a paramedic or transfer care to hospital. This means that in the moment of labour - without warning - a homebirth could be cancelled because of a workforce supply problem the NMBA has created. This is the opposite of woman-centred care.

'Be prepared to assume the role of the primary midwife' clause. The proposed SQG says that second midwives must 'be prepared to assume the role of the primary midwife during a homebirth, if required'. This is the clause that requires the second to hold the same insurance as the primary. It anticipates the rare situation where the primary midwife becomes unavailable mid-labour - usually because she has been called to another woman in her caseload. Midwives in our community report this happening only zero to three times across five years of practice. There is already a working pathway for this rare situation: another primary-capable midwife is called in from a surrounding area, or, if that is not possible, care is transferred to hospital with consent. This pathway works for women, families, and midwives across rural, regional and metropolitan Australia, and is rarely if ever needed. Requiring every second midwife to be insured to and prepared to act as primary at every birth is a disproportionate response to a near-non-existent problem.

Social media wording. The proposed text says that midwives providing 'education or advice... via social media or electronic communications may also be considered a PPM'. This is too vague. Many women find a midwife through social media. If midwives have to retreat from sharing public education about homebirth to avoid regulatory risk, women will have less information available to them when making the most important decisions of their lives.

Documentation of Aboriginal and/or Torres Strait Islander identification (Table 1, Item 5). The proposed requirement should make explicit that identification is at the woman's invitation, and that women have the right not to disclose without it affecting their care, or affecting the midwife from a regulatory perspective.

2. Is there any content that needs to be changed, added, or removed in the revised SQG?

☒ Yes
☐ No

☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

We ask the NMBA to make the following changes:

(a) Resolve the PII problem for second midwives. The proposed SQG (Table 1, Item 2) requires the second midwife at a homebirth to hold 'appropriate professional indemnity insurance'. The problem is that no such product exists in Australia, unless the second midwife is also endorsed. The MIGA product launched in July 2025 covers the primary endorsed midwife only. There is no equivalent product for the people who actually attend homebirths as second - casually-attending registered midwives in a back-up arrangement, newly-graduated or experienced midwives mentoring under a PPM and working towards endorsement, or (where they are the only available practitioner) non-midwives such as registered nurses. Critically, second midwives have no clinical need to be endorsed to fulfil their role - they attend as professional support and do not prescribe medication or order diagnostic imaging. The Commonwealth has said it will not grant any more exemptions. So as drafted, the SQG requires something it is impossible to obtain, and on 1 January 2027 the second-midwife workforce will disappear overnight. We ask the NMBA to work with the Commonwealth Department of Health and MIGA before then to deliver one of the following, in order of preference: (i) clarify in the SQG (using the NMBA's section 39 powers) that a registered midwife attending as second in a supportive role under a mentor/peer arrangement is not 'practising private midwifery' for the purposes of triggering a separate PII obligation, because clinical responsibility rests with the primary; (ii) extend the primary midwife's MIGA insurance to cover the second within a documented mentor or peer arrangement; or (iii) support MIGA to develop a dedicated, scope-limited PII product for second midwives, fully Commonwealth-rebated or otherwise zero-cost to the second midwife and not requiring her to hold endorsement. Without one of these solutions, access to private midwifery - and the ability of newer midwives to learn the profession in an apprentice-style model - ends on 1 January 2027. (b) Remove the requirement that the second midwife be able to act as primary. The rare scenario this clause anticipates - the primary midwife becoming unable to continue care during my homebirth - already has a working response: another primary-capable midwife is called in from a surrounding area, and where that is not possible, care is transferred to hospital with consent. This pathway is in current use across rural, regional and metropolitan Australia, and midwives in our community report it being needed only zero to three times across five years of practice. Removing the 'be prepared to act as primary' expectation preserves this existing pathway as the appropriate response to the rare case, without imposing the disproportionate requirement that every second midwife at every birth be insured to act as primary. The current wording will prevent newer midwives from learning alongside experienced ones - which is the best way the next generation of homebirth midwives is trained - and will mean there are simply fewer private midwives in the future for women like me. (c) Remove or amend footnote 7. As a woman planning a homebirth, I do not want my homebirth automatically cancelled because the second midwife cannot attend. Where my informed consent is documented, I should be allowed to choose how to proceed in the moment, with my midwife. (d) Include the mentoring pathway explicitly. The SQG should recognise mentor relationships (defined in the glossary) as a way for newer midwives to attend as second within an apprentice-style learning arrangement. (e) Make the social media wording specific. The phrase 'may constitute private practice' should be replaced with clear examples. Generic education and advocacy should not be classified as private practice.(f) Recognise my informed consent and protect my midwife's registration. Where I, as a birthing woman, decline a recommendation - such as declining a hospital backup booking, a recommended intervention, or transfer to hospital - the SQG should make clear that my informed, documented decision is respected, and that my midwife will not have her registration removed for respecting it. Without this, midwives will be too scared to support women like me at home, and we are left with the decision to choose between either freebirth or birthing within the system, where neither may feel like a safe option. (g) Confirm PII coverage for women of ANY risk profile. I ask the NMBA to confirm, in writing with MIGA and the Department of Health, that MIGA's intrapartum homebirth insurance product covers care for women of all risk profiles where informed consent is documented. Without this confirmation, the women most likely to want a private midwife will be excluded from access. (h) Remove the collaborative-arrangement requirement (or allow a Record of Understanding). The Commonwealth has removed the requirement for endorsed midwives to have a collaborative arrangement to access Medicare. If MIGA's PII product re-introduces a collaborative-arrangement requirement, women who want to keep their pregnancy private from a hospital will be unable to access private midwifery. I ask the NMBA to confirm MIGA does not require this, OR to allow a Record of Understanding (RoU) between the woman and the midwife as an alternative where women decline to share their information with a hospital. This is particularly important for women with prior trauma, for Aboriginal and Torres Strait Islander women, and for women whose values do not align with mainstream hospital care. (i) Protect my midwife from deregistration where due diligence is done. I ask the NMBA to state explicitly that where a midwife has documented informed consent, comprehensive risk discussion, and referral-pathway compliance, she will be considered to have met her regulatory obligations even if an adverse outcome occurs. Regulatory action should be proportionate to the midwife's conduct, not to *outcomes that no midwife can guarantee. (j) Use sex-based language with respectful individual care. Pregnancy, birth and breastfeeding are sexed activities. As a woman accessing maternity care, I want my experience and my body to be named clearly. Adding 'people of diverse genders' alongside 'woman' as the default everywhere in the SQG creates problems documented in research the NMBA itself cites: Bartick, Dahlen, Gamble, Walker, Mathisen and Gribble (2025) - 'Reconsidering inclusive language' (Sexual & Reproductive HealthCare 44:101088) - found that additive language reduces comprehension for women with low literacy and English as an additional language, undermines accurate risk communication, and erodes the sexed reality of pregnancy and birth. Where individual women request*

3. Would the proposed changes to the SQG result in any potential negative or unintended effects for PPMs?

☒ Yes
☐ No
☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

Anything that makes private midwifery more difficult, more expensive, or more legally risky for midwives directly affects my access to that care. The second-midwife insurance requirement will push midwives out of private practice, especially in rural and regional Australia. Footnote 7 turns the second-midwife problem into my problem - my homebirth can be cancelled in labour because of a workforce supply issue. Without explicit protection of midwives' registration where due diligence and informed consent are documented, midwives will rationally refuse to attend women with any complexity in their history. Social media ambiguity will mean less public information for women trying to find a midwife. Documentation and fatigue requirements that are not workable in real practice will erode the trust between midwives and women.

4. Are there any sections in the revised SQG that need additional explanatory material to help PPMs to understand their obligations?

☒ Yes
☐ No
☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

We ask the NMBA to provide additional explanatory material on: What second-midwife arrangements will be allowed, including for mentor relationships with newer midwives. What footnote 7 actually means in practice - in particular, what 'all reasonable steps' looks like before a homebirth is cancelled in labour. What 'private practice' means for social media, so midwives can continue to provide public education about homebirth. MIGA coverage parameters: confirming coverage for women of all risk profiles where informed consent is documented; confirming MIGA does not require a collaborative arrangement; explaining how a Record of Understanding works where a woman declines hospital information-sharing. How my documented informed consent (including any decision to decline recommended care) interacts with my midwife's regulatory obligations - in particular, explicit confirmation that my midwife is protected from deregistration where due diligence is done. Whether virtual care is allowed when I, the woman, explicitly choose it - particularly important for rural and remote women.

5. Would the proposed changes to the SQG result in any potential negative or unintended effects for people from priority populations[1] in the community?

☒ Yes
☐ No

[1] For the purpose of this consultation and in a midwifery context, priority populations include, but may not be limited to people from culturally and linguistically diverse backgrounds, victim-survivors of family and domestic violence, LGBTQIA+ communities, people living in rural, regional and remote areas, people living with disability, people with mental ill health, and people living without stable housing.

☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

The NMBA's own definition of priority populations (Glossary, p.32 of the SQG consultation paper) explicitly includes 'people living in rural, regional and remote areas', 'victim-survivors of family and domestic violence', 'LGBTQIA+ communities', 'people living with disability', 'people with mental ill health' and 'people from culturally and linguistically diverse backgrounds'. The proposed changes will hit these groups hardest.

Rural and regional women. Private midwifery is already hard to access in many rural areas. The second-midwife insurance requirement will reduce the number of midwives available, increase costs substantially, and via footnote 7 make planned homebirth structurally unavailable in many places. Women who cannot access private midwifery may turn to freebirth (unassisted birth) where it is not their first choice to do so. Australian research (Rigg et al., 2017 and 2020) has documented that the inability to access registered private midwives is a driver of freebirth. Women should be supported to the informed and empowered decision to freebirth where that is her choice, but they should also never be forced onto that pathway because of a lack of other safe options for them, i.e. homebirth with a private midwife. Women being pushed to freebirth where hospital is not safe for them is the opposite of what safety guidelines should produce. Women with prior birth trauma, women with mental ill health, and women whose values do not align with mainstream hospital care will be disproportionately affected - they have fewer alternatives that meet their needs, and they are more likely to have a risk profile (e.g. declining a hospital booking) that may exclude them from a narrowly-interpreted MIGA product. The collaborative-arrangement / Record of Understanding question is critical for this group. Women with low literacy or English as an additional language may struggle with sex-neutral or additive language about pregnancy and birth, undermining informed consent (Bartick et al., 2025).

6. Would the proposed changes to the SQG result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples?

☒ Yes
☐ No
☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

Aboriginal and Torres Strait Islander women have long-standing reasons to seek private midwifery and homebirth, including Birthing on Country, continuity of carer, and avoidance of culturally unsafe hospital environments. The proposed changes will reduce the supply of private midwives in the rural and regional areas where many Aboriginal and Torres Strait Islander communities are located. Footnote 7 will disproportionately exclude Aboriginal and Torres Strait Islander women from planned homebirth. The proposed documentation requirement (Table 1, Item 5) for 'documenting whether the woman, person of diverse genders and/or either biological parent identifies as Aboriginal and/or Torres Strait Islander' should be implemented at the woman's invitation, with non-disclosure respected. It should be a basis for offering culturally appropriate care, not a tick-box. MIGA coverage and the collaborative-arrangement / Record of Understanding question is particularly important for Aboriginal and Torres Strait Islander women, who may choose to keep their pregnancy information outside the mainstream hospital system in the exercise of their right to culturally safe care.

7. The NMBA will revise the Fact Sheet for the SQG to reflect the updates arising from this review. You are invited to provide any feedback or suggestions for content to be included in the updated Fact Sheet.

☒ Yes
☐ No
☐ Prefer not to answer

Would you like to provide information about your response? Please enter N/A if you prefer not to provide details.

The Fact Sheet should include: A clear consumer-facing explanation of what the changes mean for women's access to private midwifery and homebirth. An explanation of what the second-midwife clause and footnote 7 mean for women in rural and regional areas. MIGA coverage parameters in plain English, co-published with MIGA, including: (i) coverage for women of all risk profiles; (ii) whether a collaborative arrangement is required; (iii) whether a Record of Understanding is available where the woman declines to share her information with a hospital. How women's informed consent and decisions to decline recommended care are documented and respected, and explicit confirmation that midwives are not at risk of deregistration for honouring those decisions. How women can continue to find a private midwife if midwives are restricted in what they can post publicly.

References

Bartick, M., Dahlen, H., Gamble, J., Walker, S., Mathisen, R., & Gribble, K. (2025). Reconsidering 'inclusive language': Consequences for healthcare and equitableness of a growing linguistic movement to address gender identity with a path forward. Sexual & Reproductive HealthCare, 44, 101088.

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