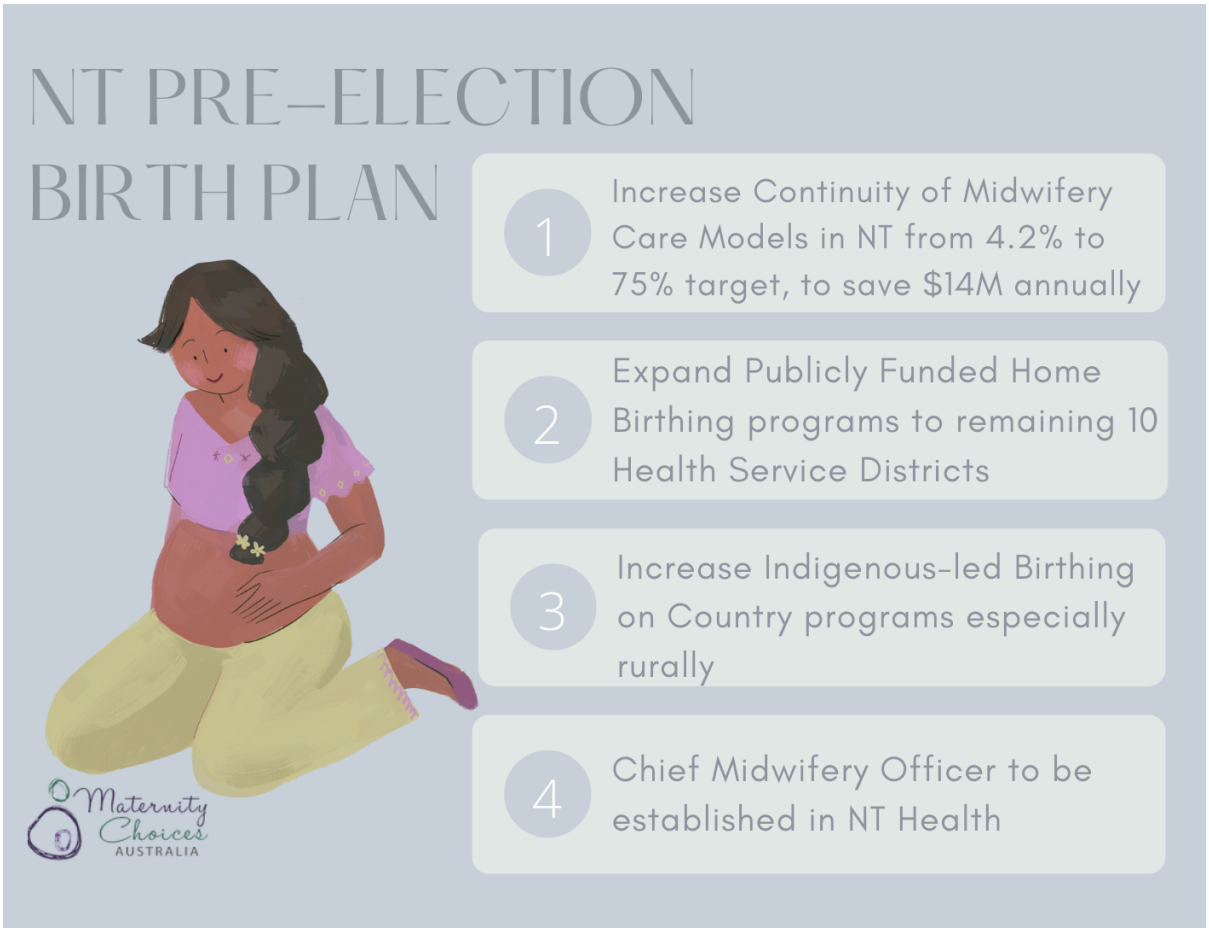

Endorsing Organisations:

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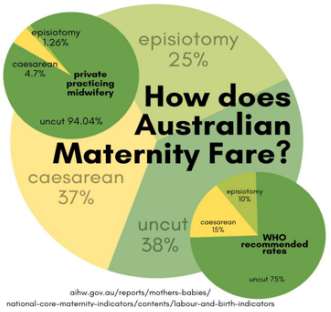
NT Maternal Health Brief: For MPs, Candidates and Senators

The purpose of this brief is to inform MPs, Candidates and Senators about the current state of public maternity services and make recommendations for change. Before the 2024 State election, we plan to provide 3,728[1] Northern Territory maternity service users annually, with a 'scorecard' of pre-election commitments for each political party.



Our Organisation

For the past 35 years Maternity Choices Australia (MCA), an unfunded, non-profit organisation, has worked as the peak advocacy body for women's birthrights. We are concerned about limited birthing choices, increased coercion, procedures without consent and unnecessary interventions pregnant women are routinely subjected to in public hospitals. The Safety Commission's (ACSQHC) 3rd Atlas reports a 12-fold variance in C-section rates across Australian hospitals.[2]

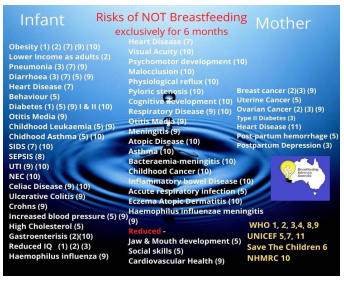
International Picture

In response to high levels of "abuse and mistreatment" in maternity care, especially in high-income countries like Australia,[3] WHO launched a campaign in 2021 focused on 'Safe and Respectful Maternity Care'. During covid, hospitals in LA launched 'pop up' birth centres in hotels to reduce virus transmission, protect the workforce, reduce costs, and improve outcomes. The British government has created a Chief Midwife position whose job has been to implement a known midwife to 75% of women and 100% access for Black and Minority Ethnicities.[4] If a UK public hospital cannot facilitate homebirth, the government pays the cost of a private midwife. In Australia, it would be $4,000-$6,000 in out of pocket costs for 20x60 min pre and postnatal appointments and the two midwives to attend the birth, compared to the public hospital average of $25,000. In comparison, almost all pregnant women in New Zealand have access to all models of care and all places of birth[5], 94% choose a known midwife and 40% choose to birth in birth centres or at home. In 2019, the UN Special Rapporteur coined the term Obstetric Violence and called Australia out as a particularly poor performer.[6]

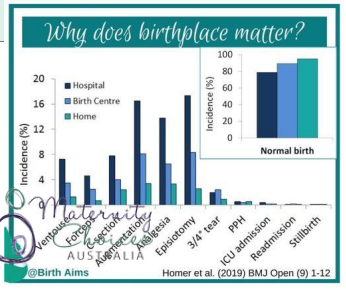
Recommendations for Change:

1. Expand access to Continuity of Midwifery Carer models (MGP) from 4.2%[7] to 75% in NT

Continuity of Midwifery Care models such as Midwife Group practice (MGP) or caseload midwifery, supports women by having a primary and backup midwife through all stages of pregnancy, birth and postpartum. MGP models of care cost 22% less ($5208/birth) than other models of care.[8] **Universal access to MGP in NT would save $18M/year.**[7] Currently, MGP is only available to women birthing in Darwin or Alice Springs; significantly limiting remote areas. Remote women are forced to relocate at 36-38 weeks to the cities for the remainder of their pregnancy regardless of risk status to birth, usually away from family and support networks. The pressure and cost of waiting up to 7 weeks to birth is excessive and women often feel pressure to induce causing the cascade of interventions to follow. MGP is the physically and emotionally safest and most cost-effective care model for women and thus, should be made readily available to all expecting mothers.[9] **Universal access to MGP reduces perinatal deaths by 16% and preterm birth by 24%**.[10] Hospitals regularly neglect to adhere to legislative requirements to make reasonable adjustments for pregnant women with a disability (16.4% national[11]). MGP is a model better suited to adapt to the mother's specific needs and modify care. Additionally, MGP increases the likelihood of breastfeeding, despite WHO's universal recommendation for exclusive breastfeeding until 6 months and continuing breastfeeding to 2 years old, only 29% of babies are exclusively breastfed by 6 months of age and 5% till 2 years.[12] Breastfeeding reduces the likelihood of death, illnesses, and chronic diseases such as allergies, obesity, diabetes and cancer for BOTH mother and baby.[13] For every $1 spent on breastfeeding promotion generates a $35 future economic return on investment.[14]



2. Increase Publicly Funded Home Birth (PFHB) programs, to save $6,000/birth and reduce rising unassisted (freebirth) birth rates.



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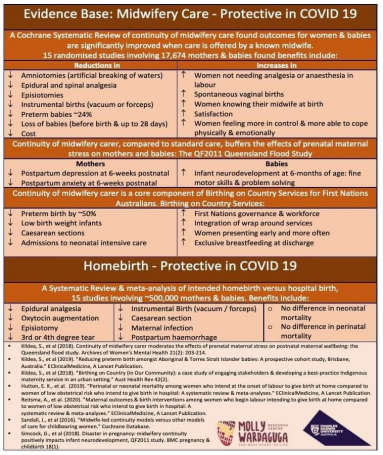
Planned home birth with registered midwives is the safest way for women to give birth.[15] For low-risk mothers, planned hospital birth significantly increases the risks of physical and emotional poor outcomes for themselves and their babies. Homebirth is a genuine harm reduction technique. PFHB would have significant benefits for women living in remote areas of NT. Only Darwin and Alice Springs offer PFHB through Alice Springs Memorial Hospital, which does not reflect the demand. Out of hospital births (inc. freebirths; planned or unplanned, unassisted births) are increasing significantly with NT rates being nearly 7-fold higher than the national average (2%:0.3%).[1] This is due to non-evidence-based care, abuse and mistreatment experienced in public hospitals, lack of birth choice in remote areas, and, expensive out of pocket costs to hire a private midwife (freebirth).[16] Harvard research showed that birthing adjacent to an operating theatre significantly increases your risk of an unnecessary C-section and there is no difference in perinatal and maternal mortality rates between hospital birth and assisted homebirth.[17] Consequently, greater access to remote birth centres and PFHB, saves the NT government money with reduced interventions and travel expenses of relocating rural women to birth.

3. Increase Birthing on Country programs for First Nations women and Indigenous-led midwifery care services rurally.



First Nations Mothers (32% NT) are 5 times more likely to have insufficient antenatal care (<5 antenatal visits) in NT and 2-3 times more likely to have adverse maternal and perinatal outcomes than non-Indigenous.[1, 18] NT recorded an overall perinatal mortality rate of 2.83% compared to 1.2% for non-Indigenous births.[1] The rate of preterm birth for Indigenous in NT is over double that of non-Indigenous babies (17.5% and 7.8% respectively).[1] **The annual cost of preterm birth to the NT government is $22.1M ($11.2M Indigenous: $10.9M non-Indigenous).[1]** Precedent from QLD's Birthing on Country Program (Birthing in our Community), has reduced perinatal deaths and preterm rates by half; an 80% increase in antenatal care attendance and a 40% increase in breastfeeding after discharge, proving its success to reduce inequalities of maternal outcomes for First Nations mothers.[19,20,21] Considering NT has the highest proportion of First Nations mothers in Australia, there is limited access to Indigenous-led birthing care and support programs that work alongside public hospitals. Midwife-led birth units in rural areas across Australia reduce the need for birthing mothers to relocate, and with appropriate transfer pathways, show exceptional outcomes. The current First Nations birthing support worker program 'Strong Women, Strong Babies, Strong Culture' in Canteen Creek, Utopia or Yuendumu regions, provide culturally appropriate pregnancy education to support First Nations women during their pregnancy.[22] However, more hands-on Birthing on Country programs need to be established.

4. Chief Midwifery Officer (CMO) role to be established in NT Health

A CMO role is warranted to focus on implementing these recommendations and reporting directly to the Deputy Chief Executive. There is currently no midwifery leadership role in NT health and given that 87% of maternity tasks are performed by midwives, a CMO is necessary.[23] Australia specifies midwifery as a distinct and separate profession in health, yet, this has not been operationalised as midwifery is constantly overshadowed and interfered with by medicine and nursing, creating dissonance between best practice and professional autonomy. Maternity is the largest service user group, the biggest spender for the health department, has the most consumer complaints, the largest proportion of insurance claims, the least evidence-based guidelines, and unwarranted variances compared to any other area of health. A CMO with lived experience as a midwife would ensure midwives have a voice; and are supported professionally in their education, regulation and practice.

More information on this topic can be found in the documentary called 'Birth Time'.[24] I welcome you to watch this documentary and consider sponsoring a parliamentary screening. We hope to receive your written support for these recommendations and request a meeting to discuss further commitments for pregnant women.

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