Women's Health Tasmania

Talking about having a baby in Tasmania

Experiences of pregnancy, birth and postnatal care

ELINOR HEARD

Acknowledgement

Women's Health T asmania acknowledges the palawa and pakana people as the traditional and original custodians of lutruwita/Tasmania. We recognise that sovereignty was never ceded and pay our respects to Elders past, present and future.

We acknowledge the continuing impacts of colonisation on pregnancy, birth and child raising for all First Peoples of Australia and honour their resilience and resistance in the face of these.

Thank you to contributors

Our deepest thanks to the research participants who generously shared their lived experiences with Women's Health Tasmania, making this project possible.

Sincere thanks also to the project's Advisory Group members, whose expertise and guidance has been invaluable: Dimitra Papavassiliou, maternal health consumer representative; Rowena Shakes, endorsed midwife and Secretary of the Australian College of Midwives Tasmania Branch; and Kelly Madden, psychologist with Women's Health Tasmania.

In addition to her Advisory Group role, Kelly Madden conducted the fifteen research conversations on which this report is based. Warmest thanks to Kelly for her sensitive and expert facilitation.

Special thanks also to Women's Health Tasmania CEO, Jo Flanagan, who identified the need for this project and directed it with such care.

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Background

Language

In this report we use the term 'pregnancy care' rather than 'maternity care', acknowledging that people who were assigned female or intersex at birth but who do not identify as women also access pregnancy, birth and postnatal care services. We refer to our research participants by the gender-inclusive term 'women and birthing people'.

About Women's Health Tasmania

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

Recent work in this space includes the ongoing provision of free pregnancy and postnatal counselling; establishing the Pregnancy Choices searchable website of Tasmanian reproductive healthcare providers; coordinating the Hobart Perinatal and Infant Mental Health Professionals Network; hosting a weekly Migrant Mother and Baby Playgroup; releasing the *Talking to people about terminations of pregnancy in Tasmania* research report and associated resource *Termination of pregnancy: a good practice guide for Tasmanian care providers;* and delivering statewide workshops on menstrual health, menopause, pregnancy choices and reproductive coercion.

Supported by a multidisciplinary team that includes health workers, social workers and a psychologist, Women's Health Tasmania provides reproductive and pregnancy care services that are person-centred, responsive and trauma informed. Our use of physical outreach and online modalities cater to Tasmania's highly regional and dispersed population and emphasise the creation of safe and welcoming local spaces.

About the pregnancy, birth and postnatal care system in Tasmania

The Tasmanian Health Service (THS) provides public pregnancy and birth-related services in the state's three regions. In the South, births in the public system take place at the Royal Hobart Hospital; in the North, at Launceston General Hospital; and in the North West, at North West Regional Hospital in Burnie.

Private pregnancy and birth services are also available in Tasmania for those who can afford them. In the South, at Calvary Lenah Valley Hospital or Hobart Private Hospital; in the North, at Launceston Birth Centre or as a private patient at Launceston General Hospital; and in the North West, as a private patient at North West Regional Hospital. Additionally, there are a small number of private practice midwives supporting home births across the state.

During the period from 1 January 2021 to mid-2023 when our research participants had their babies, Tasmania's only mother and baby unit providing inpatient perinatal mental health support was located at St Helen's Private Hospital in Hobart. These services ceased with the closure of St Helen's Private Hospital in June 2023, to significant public consternation.

Since then, the Tasmanian Government has established a mother and baby unit at the Royal Hobart Hospital, with two beds only and reduced services. They have also announced plans for a four-bed 'Mother and Baby Centre' in Launceston, to be delivered in partnership with private provider Tresillian. Additionally, Tresillian has been contracted to deliver a statewide telehealth parenting support service.

Separately, a federal grant has enabled perinatal mental health organisation Gidget Foundation Australia to open a Hobart-based service providing psychological support at no out-of-pocket cost. This service will expand into the north of the state in the near future, co-locating with the new Mother and Baby Centre in Launceston.

About the research

Women's Health Tasmania commenced the *Talking about having a baby in Tasmania* research project in mid-2023 as an addition to our 'talking to' qualitative research series that investigates lived experience perspectives on key health topics for women. The project asked women and birthing people around Tasmania who had given birth after 1 January 2021 about their experiences of pregnancy, birth and postnatal care.

Development and implementation of the project was guided by an expert Advisory Group and overseen by the Women's Health Tasmania CEO, Jo Flanagan, and Board of Directors.

Participants in the project took part in an hour-long research conversation with Women's Health Tasmania psychologist Kelly Madden and were invited to discuss 'what worked well' and 'what could have been better' about their pregnancy, birth and postnatal care. Conversations were non-directive and participants were invited to focus on any aspects of the experience they wished to share.

Participants received a $30 payment or gift voucher for contributing to the research and were invited to complete an online feedback form following their engagement with the project.

Research conversations were conducted by Zoom between July and September 2023. These materials were coded and analysed to produce the research themes and findings discussed in this report.

Who did we talk to?

Fifteen women and birthing people participated in the project. Among the participant group, there were seventeen pregnancies and births during the study period (1 January 2021 to mid-2023).

Of the participants:

- Thirteen were first-time parents
- Eleven lived in regional or rural areas of Tasmania
- Three were younger (aged 18-24)
- Two were Aboriginal
- Five were from culturally and linguistically diverse communities
- Three identified as having a mental health condition
- One identified as non-binary
- One identified as plus-size
- Two had experienced pregnancy loss immediately preceding this pregnancy
- One had undertaken fertility treatment for this pregnancy
- Six had high risk pregnancies
- Two had premature deliveries
- Thirteen births took place in the public system and four in the private system
- All gave birth in Tasmanian hospitals*

* Pregnancy and birth outcomes are not linked to individual hospitals in this research as the sample group is not large enough to produce meaningful conclusions.

How did we reach participants?

A participant recruitment flyer was designed in collaboration with Advisory Group members, with lived experience front of mind. With help from Women's Health Tasmania's networks, we distributed the flyer to playgroups, general practices and health service hubs across Tasmania. We also shared it with community and advocacy groups for key populations such as Aboriginal people, culturally and linguistically diverse people, people with disability, LGBTIQA+ people and young people.

The response to the flyer was strong and we received sixty-eight registrations of interest for fifteen available research places, before closing the registration process. Our first learning was that 'talking about having a baby in Tasmania' was something people wanted to do!

To ensure diversity and impartiality of participation, invitations to take part in the project were extended in the chronological order of registration, within key population groups.

^ The recruitment flyer for the *Talking about having a baby in Tasmania* project

A note about Covid-19

Although we cannot measure the extent to which Covid-19 influenced individual pregnancy, birth and postnatal care experiences for research participants in different regions and at different times, we note that the health system impacts of the pandemic – including health service restrictions and social distancing requirements – were significant in Tasmania during the period in which participants had their babies. Wherever participants have identified Covid-19 or its service impacts as a factor in their experience, we have included this information.

Introduction

The *Talking about having a baby in Tasmania* research conversations produced a wealth of source material that is testament to the extraordinary nature of the pregnancy and birth experience for each individual, even as it reinforces the 'ordinariness' of these events for population-level systems and services.

Despite the diversity of our participant group and the extremes of experiences reported – from care described as "just amazing" and "the best I could have hoped for" to "traumatic" – there was surprising consistency across the aspects of pregnancy, birth and postnatal care that 'worked well' and that 'could have been better' for women and birthing people in Tasmania.

This consistency made it relatively simple to identify a set of research themes. We have named these: I. Pregnancy: it all starts now; II. Birth: the universal unfamiliar; III. Fourth trimester: the postnatal care cliff ; IV. Life with baby: building a village; V. Inclusion: from promise to practice; and VI. Accountability: getting it right when things go wrong.

The body of the report is made up of six discussions reflecting these themes constructed around direct quotes from research participants, our goal being to amplify the voices of lived experience rather than speak for them. Each discussion concludes with a short list of health system recommendations informed by participants' experiences.

Although a relatively small number of participants identified birth trauma as an element of their experience, the theme VI discussion on accountability is largely dedicated to this topic, in recognition of its profound and lasting impact on women and birthing people and their families.

The report concludes with some final 'Words of advice' from participants for other women and birthing people who are having, or contemplating having, a baby in Tasmania.

Of the conclusions we can draw from the *Talking about having a baby in Tasmania* research, perhaps the clearest is that, currently, not all people living in Tasmania have equal access to pregnancy, birth and postnatal care. This finding resonates throughout the report and is explored in detail under the theme V discussion on inclusion.

The project also highlights the gap between the strategic intentions for pregnancy and birth care named in Australian practice guidelines and the lived experience of pregnancy and birth care for women and birthing people in Tasmania, particularly in relation to inclusion and trauma informed practice. A quick survey of the multiple inquiries related to reproductive and pregnancy healthcare either recently completed or underway in Australia tells us Tasmania is not alone in this regard.

Outcomes from the project also offer plenty to be positive about. Many participants reported exceptional care experiences at some if not all stages of their pregnancy journey. These optimal experiences were most often described by participants whose model of pregnancy care facilitated continuity and rapport-building with one or more key caregivers. Invariably, these experiences centred around feelings of safety, empathy and support in care delivery.

Women's Health Tasmania is pleased to share these and other findings from the *Talking about having a baby in Tasmania* project. We hope the report will add usefully to the recognition and understanding of lived experiences of pregnancy, birth and postnatal care in Tasmania.

I. Pregnancy: it all starts now

Information, Choice, Access

For *Talking about having a baby in Tasmania* participants, pregnancy was a life-altering journey that brought with it new emotions, new responsibilities, and a pressing need for information.

With the exception of those who were health workers themselves, participants arrived at pregnancy without pre-existing knowledge about the types of pregnancy care available, eligibility factors, and where to find services. Becoming pregnant was the point at which they engaged with these care pathways for the first time.

For all participants, GPs were an early point of contact in the search for information, and they encountered varying levels of pregnancy care knowledge and competency among practitioners.

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. So he would have to call me back once he found out more about what my options would be. And then he didn't. So then I had to go back and try and find someone else. So it was quite hard getting information about what my options would be.

The GP practice is just down the road, so accessibility is fantastic. But my doctor was a locum. She'd only been here for a few months. So when I was getting those first scans, she wasn't sure where to send me.

I found out later that [the GP] 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 having bleeding. But by the time I got into the specialist clinic at the [hospital] they said that at that point in pregnancy, you expect that with the hormones. So that was a bit unfortunate because that was quite stressful.

Some participants sought information about their pregnancy care options from the public health service website, describing it as a useful touchpoint that would benefit from expansion.

I went on the THS website and it's just the tiniest bit of information, like a sentence or two, on each model [of pregnancy care] … I'm sure to someone in the system this makes perfect sense, but for me, it wasn't quite enough. I think if there were maybe more details on the website or a phone line that you could call and say, can you just explain this really quickly?

In total, nine participants reported finding it difficult to get the information they wanted about pregnancy and pregnancy care options.

A further discovery for participants was that access to the full range of pregnancy and birth care models provided by the public system – including popular midwifery-led models of care – was not guaranteed. Ultimately, eight participants said they were able to access their first-choice model of pregnancy care.

The primary factor here was geographical location, with participants from the North and North West experiencing less choice and control over their pregnancy and birth care options than their Southern counterparts.

I was told that Launceston was quite backed up with elective stuff and that all public patients were directed to Burnie. There was no choice, even though I am in the catchment area for both.

You're supposed to be able to choose [between Launceston or Burnie], but I think post-Covid, Launceston has gotten really strict with who they'll accept… We actually got rejected twice to go to Launceston [but] we kept pushing and at my 20-week scan I was diagnosed with a short cervix, and it was only then that they accepted me because I was considered a medical risk.

Beyond regionality, factors influencing the accessibility of pregnancy care models included cost and health insurance status. The cost of private care meant the majority of participants opted to have their babies in the public health system, where popular midwifery-led care programs filled up quickly.

I was quite late being referred to the hospital so I missed out on the Midwifery Group Practice, which I would have liked. But I did still get into the Know Your Midwife program and that ended up being great.

I had quite a few friends that went through Midwifery Group Practice or through Know Your Midwife and really enjoyed that so I put those as my first preferences and had the satellite clinic as my third. And when I finally got allocated to the satellite clinic, I was a bit like, oh. It's not really what I wanted.

For a participant who was living in Tasmania on a temporary visa and unable to access Medicare-subsided public health services, there were no low-cost pregnancy and birth care options. She landed in the private system after being priced out of a home birth.

I'm on a visa so I don't have Medicare. And I wanted to have my baby at home. I imagined that [would be] very simple. Just me, my partner, the midwife. But then I found out that cost like $6,000, and I was like, okay, this is going to be more expensive than having baby at a hospital. So it was better to go with a private hospital. But the doctor fees are around $1,800. And they also charge me, just because I was on a visa, $2,500 extra. And I was like, but I have insurance. I have insurance for two years. Why do I have to pay this?

Pregnancy risk classification was another factor that limited participants' access to specific models of pregnancy and birth care. A participant who identified as plus size reported being told she was ineligible for a birth centre model of care due to risk factors associated with her weight. She described the impact of this on her sense of confidence and agency in pregnancy.

That was quite a blow... that was actually really crushing. And it was a continuing theme throughout my pregnancy, that if you're plus size, you are automatically high risk no matter what your health is. Nobody had confidence in me because I was plus size and high risk.

Her pregnancy risk status meant she was channelled into obstetrician-led care in the public system, an experience she found disjointed and anonymous.

I didn't get a choice. The Midwifery Group Practice was never offered to me or discussed at any point. I didn't have a regular doctor because I was through the public system, [so] every appointment I went to was someone new. I didn't actually even meet any of the midwives until I was, I think, thirty-five or thirty-six weeks, and neither of them were present during the birth. So yeah, it was just all strangers the whole time. Nobody ever got to know me as a person.

This experience speaks to the immense value participants placed on continuity of care in the pregnancy journey and the opportunity to build rapport with care providers prior to birth. Participants who missed out on continuity of care in pregnancy felt the lack acutely and described how it affected their sense of emotional safety and preparedness for birth and beyond.

That would probably be my only criticism... that there isn't continuity of care and you really have to fight to push to get who you want to see. And especially because we had the short cervix and we saw different doctors, they had differing ideas on what the short cervix means and how we treat it and so it was conflicting information and very confusing to us. As far as like their compassion and care, they were great. But yeah, [continuity of care] would be my number one wish for change.

I was just going through different midwives. That was a little bit tricky because everything was recorded that you talked about, but if you did have a little side conversation, the next midwife you saw, they didn't know about it. So there was not a lot of personal care. [Continuity] would have been helpful because it was my first pregnancy as well. It's a bit scary.

Conversely, participants who experienced caregiver continuity through pregnancy reported its benefits in glowing terms, saying it provided an important sense of trust and safety.

It was excellent. Really good. I liked the continued care with just one person, being a bit of an anxious person. It was nice to have those check-ins. [The midwives] were available, you could always call them.

I feel like I've been really lucky with the care, and maybe it shouldn't be that I'm lucky, everyone should get the care that they need – but I feel like I've had a really, really good experience almost from start to finish. I really did feel that continuity all the way through.

I couldn't fault the care that I received. Yeah, fantastic. They just sort of fit me in whenever I needed to be seen and gave me whatever time I needed. They just really listened and they helped.

One participant in the South described how the midwife satellite clinic she was attached to for pregnancy care went out of their way to provide continuity with an individual midwife, even though this is not in-built into their model of care.

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. For me that really felt like it radically altered not only my perception of how I experienced it, but the actual experience itself – was so radically positively altered – because I had that continuity and I felt so supported the whole way through.

A final but significant factor in participants' experiences of pregnancy care is that the interval in which they had their babies – January 2021 to mid-2023 – encompassed Tasmania's peak period of Covid-19 health system restrictions, including the cancellation of public system birth education classes and birth unit tours.

Participants were conscious of these lost opportunities to acquire practical knowledge about birth and birth settings, and we can only speculate that the absence of these key elements of pregnancy care may well have impacted their birth outcomes in material ways.

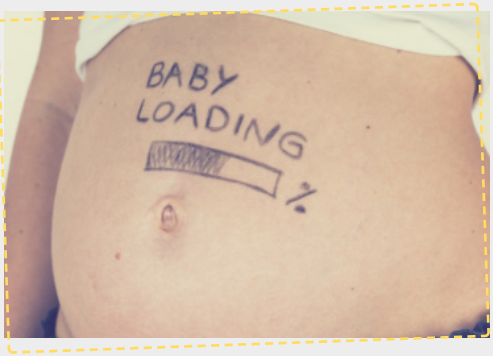
Because it was Covid, you don't visit [the birth unit] beforehand, so you don't know where you're showing up to. And there are also no antenatal classes. I called up and asked and the hospital sent me a piece of paper with a list of resources I could look at and pay for.

I booked in for a [birth unit] tour but it got cancelled because of Covid. Apparently they restarted it before I gave birth but I didn't know until it was too late.

Because it was Covid we didn't have any birth classes except for one physio class. So I went and paid for hypnobirthing classes. So I got that birth education through that. Hypnobirthing is very expensive so if I didn't have that money, it would have been a very different experience.

Recommendations

1. Free pregnancy and birth care for all people living in Tasmania, regardless of visa status.
2. Initiatives to support increased pregnancy care knowledge and competency in the Tasmanian GP workforce.
3. Expansion of the pregnancy and birth care information on the Tasmanian Health Service website to include detailed descriptions of the models of care, including eligibility requirements and regional availability.
4. Development of strategies to improve equity of choice and access for pregnancy care in North and North West Tasmania.
5. Increase the availability of public system continuity of care models of pregnancy and birth care in Tasmania so that more women and birthing people can access them, including expanding the availability of student-midwife supported continuity of care as a pathway, scaffolded by appropriate supports for student midwives.
6. Free and accessible pregnancy and birth education for all Tasmanians, including online engagement options.



II. Birth: the universal unfamiliar

Communication, Trust, Agency

The birth stories shared by *Talking about having a baby in Tasmania* research participants revealed that while no two births are alike, some aspects of the experience are universal.

Virtually all participants described feeling intensely vulnerable during labour and birth. This is unsurprising, given that birth is a transformational life experience that is powerful, primal and exposes aspects of a person that are usually very private. In Australia, birth is also a highly medicalised experience that occurs mostly in hospital settings. For some participants in the project, the unfamiliar clinical setting combined with the unpredictability of birth gave their birth the feeling of a crisis unfolding, rather than a natural life event.

Participants told us that the aspects of birth care that mattered to them most were human elements that spoke to safety and trust. First amongst these was clear and respectful communication from caregivers that reinforced the agency of the woman or birthing person.

The midwife that we had when we 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.

I walked into this whole experience expecting to have to really dig my heels in and have all these really hard, exhausting conversations about what I wanted and why I wanted it. And they were like, you don't need to fight us, that's not what this is about. It really felt like a collaborative and consultative experience and every decision that was put to me was always put to me with the caveat of, it's your choice, it's your body, it's your baby.

For participants arriving to hospital in early labour, a time of heightened emotion and anxiety, the quality of initial communication from caregivers made a significant impact, often setting the tone for the experience of care that followed.

I arrived [at the hospital] and they didn't have a spot free to examine me. And I actually waited for an hour in the corridor. No one was really talking to me – they just said, we don't have a spot for you, just wait there. And there was no communication within that whole hour which was frustrating because I was having contractions and in quite a bit of pain. And then when they finally had a spot free, they told me, we're going to examine you, but just know that we might send you home. That was the third or fourth time they'd said that to me – we might send you home. And I was like, yeah, all right, I get it. And then she examined me and her face fell. She was like, oh, you're six centimetres dilated. And I was like, no kidding, I'm in a lot of pain.

I was really well cared for. The NICU special care nursery is right next to the maternity ward. So they put me in a room right next to the door into the nursery, so I wouldn't have far to go. Then [before my c-section] the NICU nurses came and grabbed me and gave me a tour around. You know, this is what's going to happen when baby comes, they'll go to NICU first, then the special care, and all that stuff. Which is lovely I think, because I hadn't been in that ward before.

We showed up and there were I think four nurses or midwives sitting at the desk. All of them looked up and just looked at us, but none of them thought of saying, hello, how can we help you? That was a little bit weird to me. And I had to say it myself, hello, I called earlier. I mean, it's just a little thing, but when you work in such a sensitive area...

All participants in the study gave birth in hospitals and their experiences ranged from births that were no or low-intervention through to births involving induction of labour, augmentation of labour, assisted birth, episiotomy, and caesarean section.

Importantly, the complexity of the birth itself did not seem to be a defining factor for participants in terms of how they perceived their birth experience. Some of the more complicated births reported were also the births described in the most positive terms in relation to care received. The presence or absence of supportive communication and a trustful rapport with caregivers was a more critical factor in participants' perceptions of care.

Several participants described the empathy and encouragement of key caregivers as the lever that helped them to birth their babies, despite the pain and fatigue of birth.

I had the best birthing experience. When I say the best, it was horrible, labour was absolutely horrible and it was not fun at all. But in terms of the care that was provided, the doctor that I had, she was amazing. Like I honestly could not fault her. She kept me calm. She had such a welcoming presence. She was very positive, very knowledgeable, very, very kind. And I never once was worried about the delivery, even though we did have a few complications.

I had a fantastic experience with the anaesthetist. I think because their job is to really kind of connect. 'How are you feeling? Are you nauseous? Are you cold?' They're so connected to everything you're feeling, because it's obviously part of their job. A lot of the other people in that room, they're rushing around and they're doing their checks, doing exactly what they need to be doing. But you can kind of feel very detached from them in that. But that relationship with the anaesthetist is so important because then it feels like, well, not everyone is just sort of treating you like meat on a slab. Somebody's actually connecting with how you're feeling.

The midwives were constantly telling me that [baby] is okay, because I was very concerned about the actual pushing part and all that. I did want an epidural but I didn't actually have time for one. But that ended up being fine, because I got to do the birthing positions that I wanted to and they encouraged me even though I was in a lot of pain, they still encouraged me to get up and go ahead with the positions I wanted to do. They were just very encouraging and supportive.

For some participants, however, this trustful rapport with caregivers never materialised, or if it did, it broke down as labour progressed and intensified. There were commonalities in these more difficult birth experiences too, with communication problems a recurring theme.

She was very invasive. I was waiting for the contraction and I remember her sitting in front of me, waiting for it. I said to her, please, I need my space. I don't need this, I don't want it. But she came back saying it's the protocol of the hospital, that she needs to check the baby's heart [rate] every fifty minutes. Then it was every thirty minutes.

This new pain started after each contraction. It felt like bone breaking pain. I was begging for pain relief and [the midwife] called the midwife in charge in. She didn't touch me, didn't assess me, hands on her hips, said it's my fault that I am in pain because I got the epidural too early when I wasn't even in labour and I'm going to have to do this on just the gas, okay? I was like, was I not supposed to get the epidural? Did I do this wrong? I was crying.

Issues related to consent were another commonality for participants who described adverse experiences during birth. Consent-seeking from caregivers prior to commencing interventions was vitally important to participants and failures to seek consent were experienced as devastating breaches of trust.

The one thing we did find hard about the birth was kind of immediately afterwards. I had the baby and I had a haemorrhage. So sort of immediately, [there were] doctors everywhere, and they were mostly really good. There's only one doctor that touched my vagina without saying he was going to. That was the only time I remember feeling panicked.

The minute he was born, the second he was born, the midwife lifted up my top and popped him straight on my boob. And I guess I don't know if they have to do that, but if someone doesn't want to breastfeed, that's really overwhelming for them. And I mean, in the moment you really don't even know what's going on, but that's quite invasive, after what you've just gone through and what's just happened, to just have a baby chucked on your boob. Yeah, I didn't really like that. That's literally what happened as soon as he came out.

So the doctor said that she would like to try a vacuum delivery. And she started briefly running through some of the risks. And I just knew as soon as she said that word, I was like, absolutely not. I think she mentioned vacuum and forceps. They ended up using forceps and just pulling her out of me. Thinking back to that moment, I'm so angry because nobody should ever have to meet their child like that... Meanwhile, they're immediately trying to get the placenta out. They've jabbed me in the leg without any consent again.

A small number of the participant group described adverse birth care experiences in terms of birth trauma. These experiences and care provider responses are discussed in greater detail later in the report.

What is clear from participants' experiences as a whole is that their perception of the adequacy and safety of care received in birth was complex. While it centred on trust and communication with caregivers during birth, it also reflected their access to continuity of care in pregnancy and extended beyond the experience of 'having a baby' to include participants' pre-existing relationships with healthcare systems and services.

A key learning here is that opportunities to invest in positive birth outcomes for Tasmanian women and birthing people start well before birth and pregnancy.

Recommendations

7. Regular refresher training in healthcare rights and informed consent for all Tasmanian health workers, with a specialised module for pregnancy care providers that includes consumer led content such as 'Better Births With Consent'.
8. Development of protocols in Tasmanian birth units guiding positive early communication and rapport-building for presenting women and birthing people.
9. Education and support for Tasmanian nursing, midwifery and obstetric workforces to develop and expand skills in person-centred care and trauma informed practice.
10. Development and trialling of birth advocate positions within Tasmanian birth units.

III. Fourth trimester: the postnatal care cliff

Recovery, Sleep, Wellbeing

The fourth trimester – a term coined by US paediatrician Harvey Karp to emphasise the dependency of newborns in the twelve weeks following birth – was described by many research participants as the most challenging chapter in the journey of having a baby, encompassing physical and emotional birth recovery, establishment of feeding practices, navigation of sleep and sleep deprivation, and a wholesale adjustment of family dynamics.

Participants' observations on fourth trimester care experiences began with their post-birth hospital care, including their immediate birth aftercare. Some participants said their aftercare reflected the significance of the post-birth moments, while others said their care became less responsive as soon as their baby was born.

They really honoured giving us space after she was born. So you just have that skin-to-skin and try and get [baby] to breastfeed and all of that kind of thing. They really honoured that which surprised me to be honest. We ended up having two or three hours completely uninterrupted, which was so, so special.

I was naked and covered in blood. And I remember saying to this midwife, can I have a shower? She said, oh, if you want to. So my partner had to help me get up and shower. And I couldn't walk or roll myself over in bed. He had to roll me in bed. We both kind of found that – particularly my partner found it – a lot more traumatic than anything that happened in the birth. We were kind of shell shocked and he was really confronted, seeing me like that.

Once he was born, I think I was up, showered and in the ward in about half an hour. I guess that's just due to the fact they need the beds and they probably need you out of there as soon as you can. But I mean, looking back, I remember feeling very rushed and just wishing I could have some time with him. And [baby's father] didn't get any skin-on-skin time after he was born, I wish that was offered.

Several participants observed that the high level of demand in the birth units where they birthed their babies was a factor in their experience of care.

It was a very busy day on the birthing suite. I had to get a few minor stitches and things like that and we were waiting quite a long time to get that done because there just weren't enough doctors to go around.

I had to get some stitches from the doctor. And that was definitely different to the midwives. I mean, she might have just had a bad day. But yeah, I was just there with [baby] on my chest and she was stitching me up and I was trying not to flinch too much. It would have been nicer to have a bit more interaction with the doctor, a bit more human interaction.

I think they did a really good job [caring for me] because they were really busy. There were something like twenty-three births over the weekend that I was there. But they were really kind and responsive whenever you needed stuff.

Postnatal care in hospital

Participants described post-birth hospital stays that ranged in length from a few hours in the public system up to ten days in the private system, for a participant whose baby was born prematurely. Some participants in the public system made efforts to extend their stay, or felt they would have stayed longer, if circumstances allowed it. Others were glad to get home as soon as possible.

I stayed at the hospital two nights and because with the stitches it was very painful, I asked for another night. And the person in administration that night said, probably you can't, because you don't have Medicare. So that was a little bit discriminating. And I asked them why, because [I have] insurance and I don't think it was good to go home. The midwife who was there, she said, okay, I will help you. We are going to say this and this and this, so they don't have an option [but] to keep you at the hospital. So we stayed another night.

He was born at 10:49am and we left by 12pm the next day. Looking back, I definitely should have stayed another night. They were discharging me and I remember just standing there and wanting to bawl my eyes out because it was just so overwhelming and I just wanted to cry and cry – and I just held it in. And I remember thinking I probably should be staying another night because I'm obviously not ready to be going home.

[My baby] was born at about five o'clock and we got moved to the ward at about half-past eleven. We left at one o'clock the next day – so it was a really short stay, which suited me really well.

The majority of participants described their hospital stay in positive terms and felt midwives and nurses offered respectful and supportive care even when wards were crowded. Some participants said the inevitable staffing changes across the duration of their stay interrupted the consistency of support offered.

You know, you're there for so many days and you get so many different midwives and they all have different ways of doing things and you're kind of just trying to follow somebody's advice, and then there's a shift change and somebody else will have some advice. It was a bit difficult that way.

We were there over the weekend so the lactation consultants weren't there. And we were having some real problems getting breastfeeding going. I think that really put us back a bit, because we were getting inconsistent advice about what to do to get things moving. Rather than just having one single lactation consultant that could give you the definitive information.

Going home

When it came to transitioning home from hospital with their new baby, all participants described this as an intensely challenging time of adjustment. Participants who gave birth in the public system received follow-up home visits from their hospital midwifery team and described these as hugely valuable.

Thankfully they did [visit me], because they told me the cut-off driving time for home visits was thirty-five minutes and it was a forty-minute drive [to my house]. My milk was just coming in. And [baby] was having a bit of colic. So it was a hell of a night. I had not slept very much because he was literally crying for hours and nothing would settle him down. So I was really, really exhausted and just tired and completely overwhelmed with life. And this midwife – she was a bit older, she had a lot of experience – she was just so empathetic. And she was saying, yeah, I know it's a lot in the beginning. And her just saying that, I just burst into tears and I started crying, because it was just so good to have someone acknowledge how hard that time is.

The first two visits, [the midwives] came to our house. And again, my student midwife came for the first check-in, which was really lovely. So yeah, that was really good. Having that service was really valuable and took a lot of the pressure off.

During the early weeks at home participants also received visits from Child Health and Parenting Service (CHaPS) nurses and, for those who requested it, lactation consultants providing breastfeeding support. These services were perceived as essential by participants and most described them in positive terms, though some said the multi-worker model of care resulted in disjointed support and advice.

[The child health nurse] was amazing. She came to my house and then the second appointment was meant to be at the Child and Family Centre. And I talked to her about some of my anxiety around that. So she came twice to my house instead of making me come to the centre which I was so appreciative of. CHaPS has been amazing.

My child health nurse was great. Around all the things to with the baby, she was really non-judgmental and approachable and gave good advice.

[CHaPS] was reasonably helpful with breastfeeding, but again, so many different opinions about how to do it properly. So I ended up going to see a lactation consultant specifically, the same one that I saw in hospital. And that's kind of where I had my source of truth.

Breastfeeding

For participants who struggled to establish breastfeeding, including those who ended up weaning their babies earlier than they had hoped to, there was a significant emotional impact.

My milk didn't come in for a few days and I struggled with the positioning of feeding and getting him latched on. Breastfeeding is a whole new thing, like a whole new topic, a whole new experience, a hard experience that no one really talks about. No one tells you how hard breastfeeding is.

[Baby] had trouble breastfeeding and attaching to me. And every single midwife told me to do something different. And so that was really, really challenging, because I'd [see] one and then I'd struggle to do what they said, and then somebody else would tell me to do something different. I think the inconsistency or the lack of continuity of care there was really the opposite of beneficial. It was detrimental. Yeah, I never ended up being able to breastfeed [and] that made me feel like an absolute failure.

This experience speaks to a more widespread observation amongst the participant group: that following birth, the provision of health system care and support abruptly shifts in focus from the woman or birthing person to the newborn. This comment was made so commonly by participants and in relation to so many aspects of the post-birth experience – physical birth recovery, mental health, feeding, sleep – that it prompted our fourth trimester theme title, 'the postnatal care cliff'. Participants shared a range of feelings about 'the cliff'.

You don't see the Know Your Midwife team again after you give birth. So then I got referred to the extended midwifery services, the midwives that go out to the house for the first week or two. I think it's normally a week unless you've got complications. I was crying a lot so they came for two weeks. Then it just becomes focused on the baby through the child health nurses. So it's quite different postnatally. It would be great if you had something like Know Your Midwife follow you through postpartum, even for the first three months. It feels like the support drops away really quickly after you have a baby.

That was one thing that did stand out a little bit in the postnatal period. Definitely the questions were all around the baby and it didn't feel like, you know – how are you feeling? Are you okay? That shift was quite an adjustment from going to these monthly and then weekly [pregnancy] appointments. It's like, okay, the baby is out, now let's focus on that. You're fine. You're all right.

I think there's a real gap between antenatal and delivery and postnatal. Like, antenatal is one thing. And then we go into delivery, and it's a brand-new thing and a whole new system, and we deal with that little bit. And then postnatal, you're sort of out in the world, and off you go. And there's no consistency throughout, unless you're lucky enough to get your own midwife, or a private obstetrician. For public patients going through the system, it's very disjointed.

Just acknowledging that there is that shift between, okay, the focus has been on you and now it is very much on the baby. You hear everyone talk about that shift between the interest in you [as] a pregnant woman and [as] a mother and how there's a big dip in how the care is structured around that.

There should definitely be more checking up on new mums. Because it really does feel like you're handed your baby, they've done their job, the baby's alive, out you get, you're on your own, you know. Yeah, there definitely needs to be a lot more support for new mums, and well beyond the six-week mark.

Beyond a general desire to see continuity of care for the woman or birthing person extended postnatally, participants identified some specific gaps in the provision of health system supports following birth. These were access to pelvic floor physiotherapy, access to sleep support and access to mental health support.

Tellingly, eleven research participants said they needed more mental health support than was offered during the postnatal period, with eight participants seeking out a private mental health service to assist them through this time.

Mental health-wise, there was no real support. And I did have the baby blues for the first few weeks. I was really worried that was going to turn into something worse but it didn't, thankfully. Like, I did need that support, but it wasn't offered.

No [mental health support], not at all. And I think I did mention that it was a traumatic birth with a few of them, but yeah, I don't remember ever getting referred to see anyone, nothing like that.

They give you the [Edinburgh Postnatal Depression Scale] test. That was very low for me. But that test is so generic. Because even if you don't want to kill yourself, it doesn't mean you are 100% happy. So it was kind of extreme. 'Do you feel that this week you want to kill yourself?' Not that much, but I'm not happy.

The doctor did say that I was at risk of having postnatal depression and she gave me a printout of some [online resource]. I checked it out and it said that you need to have a GP mental health care plan, which she didn't give me. And I was just too exhausted to worry about it but I was also really struggling. For me it would have been better to just give me the mental health care plan and say, look, you can use it or not. Or at least be told how to manage symptoms. Because it was just like, yeah, you have [depression] symptoms. Okay, bye.

[Getting into] the Mother and Baby Unit took months. I went to the child health nurse who referred me to the Parenting Centre. I went to the 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 and Baby Unit. And then I went on a wait list for the Mother and Baby Unit. It was months from really asking for that help and then getting it.

Physiotherapy

A number of participants also identified access to pelvic floor physio and other physical birth recovery supports as missing pieces of the postnatal puzzle. Participants who birthed their babies in the public health system felt physiotherapy services should be available to all women and birthing people, not just those with specific birth injuries.

I feel like public patients need much better access to pelvic floor support and physio support. I had a second-degree tear and I had an unassisted birth. Through the hospital, they don't automatically refer you unless you have instrumental births or third or fourth-degree tears. So we paid [to see a private pelvic floor physio] and that's been really useful. But it has been very expensive.

After I gave birth they told me that I had a moderate diastasis recti, like the splitting of the ab muscles. And no one followed up on that. So I asked at the 6-week [postnatal] GP visit and she said that I could go to a private pelvic floor physio. So I had a look at them and they want $300 per hour and that's just way too much for us. There's so much going on with the muscles in your abdomen and uterus and it can create lifelong issues, so I would have thought that the [public] health system would be on top of that.

I wasn't offered any physio and I mean you can go and get – I could have gone and sourced my own and gone to the doctor myself and done that myself – but as far as being offered the support for it, I wasn't.

For participants who birthed their babies by caesarean section, a major abdominal surgery, there was also a lack of clear advice about the physical recovery process.

No information around post-c-section, nothing. I had to go to the GP because I didn't get any information around changes in sensation at scar site or pain at injection site, or anything like that, exercise after c-section, anything. Like, there was nothing.

I didn't know anything about scar massage. That tightening of your scar, the pain, the lack of elasticity, those sorts of things. I [learnt later] there are these really simple exercises I can do to help with that. And things like compression. Having that earlier on could have really helped. I think any specific caesarean after-care information would be so helpful. I don't know why someone doesn't come around and talk about some of these things. Physios or midwives, anyone.

Sleep

Similarly, participants reported that practical advice around sleep during the newborn phase was a significant gap in fourth trimester care and said better recognition of this issue would contribute to the wellbeing of new parents and families.

From doctors especially, there's not a lot of sympathy for sleep deprivation. I had the doctor say to me, oh yeah, well you don't sleep as parents. And after I left I just burst into tears because I was just at my wits' end. I think [we need] better recognition of just how much sleep deprivation can break you.

As far as support for sleep, I would love some. I just feel like there's no real resources for now. I feel like once you hit a couple of weeks post-partum or your baby turns a few months old, the support and the resources aren't available as much. Because I feel like I do need that help now. I really want him to self-settle and self-soothe but I don't really know where to start or how to start.

Five participants said the provision of culturally sensitive guidance on co-sleeping was a particular gap in health system support, observing that stigma and anxiety about the established risks of co-sleeping was a likely barrier for health professionals.

Everyone here in Australia will tell you that you shouldn't sleep with your baby in the bed. Like, [it's] the worst thing that you can do. So I feel like everyone is too scared about saying that. And I was hiding that part. Because at the beginning my baby was sleeping in the bassinet, and in the morning my husband was putting him into the bed. And [then] that changed to be the whole night. I love it. It works for us. But I was so afraid of telling them.

There's a pretty hard line around, you know, don't co-sleep. Or if you do, there's really strict rules. And I understand why they're there, but there's then not a huge amount of resources around how to do it safely, if you do choose to co-sleep. Or in a way that feels a bit more culturally sensitive. My family in Asia, they sleep in a big pile in the middle of the room. There is no such thing as not co-sleeping.

It would be nice [if] health professionals were a bit more open to educate on how to co-sleep and to say, yeah, it's okay to co-sleep. Because on all the leaflets it says try not to. And that's already making you feel guilty about doing it. So yeah, if a health professional would have told me, you can absolutely co-sleep and it's biologically normal, and that's what babies evolutionarily need, that would have been nice. Because I only got that information weeks afterwards.

You have to kind of get to know people before you bring up co-sleeping because you don't know how people are going to respond. But it would be very useful if the child health nurses could give you some sort of information that would help, like the 'Safe Sleep Seven' – that's really useful. My husband's from Malaysia and co-sleeping is just culturally what they do. That's part of [my baby's] culture as well.

Babies needing special care

The postnatal experience as a whole can look very different for women and birthing people whose babies arrive early or who have complex clinical needs. For a participant in the North whose baby was born prematurely, the early weeks of her baby's life were spent in hospital, first on the maternity ward, then travelling between her regional home and the hospital, and then in the special care nursery, under a boarding arrangement.

She ended up being in [hospital] 37 days, so just over five weeks. Well, she was only in NICU for one day and then she went into special care, which is a step down. They're fantastic. You really get to know the paediatric nurses well.

Despite the anxiety and practical hurdles that come with a premature baby, this participant described her hospital care in the warmest terms and noted that there were some real benefits to remaining connected to care providers beyond pregnancy and birth, into the early fourth trimester.

You've got the lactation consultants coming in every day to see you. They were fantastic, helping me with expressing, establishing breastfeeding, any questions. And the doctor team, they're great. And I had a pelvic floor physio come around to see me twice. The last week or two, they readmitted me [to hospital] as a boarder. They have a couch which pulls out into a single bed, so sleeping next to her in the little cubicle. The other mums in the four-bed room, we became friends and it was really nice, we're still catching up now. They have little events going on in the ward too, just to get you a bit more engaged. They made us all a Mother's Day card with a baby's footprint on it. And they had a little 'kangaroo-athon', where they encourage you to log how many hours you get skin-on-skin [contact] with your baby.

Alongside these benefits, there was an exhausting and expensive travel regime associated with visiting her baby daily, before the participant was able to board in the special care nursery.

I guess the only negative, in Launceston, we don't really have any [accommodation] where parents can stay if there's been an issue with the baby or if you have a pregnancy complication and you're waiting to give birth. Launceston doesn't really have that housing option. It would be really hard if, say, you were in the North West, and you had to go into Launceston. There is a [Patient Transport Assistance Scheme] if you're having to get healthcare in an area that's certain distance from your place, where the government will give you some money towards things like accommodation or fuel costs. Unfortunately, where I am, we ran five kilometres short of the criteria. It would have been nice to have that little bit of help.

Clearly, there are important learnings to be gained from the care experiences of women and birthing people whose babies are born early or who have clinical complexities. Further, targeted research within these cohorts would be valuable.

Recommendations

11. Development of protocols in Tasmanian birth units guiding aftercare for women and birthing people.
12. Tasmanian Health Service strategies to support nursing, midwifery and obstetric workforces during periods of high demand and staffing shortages.
13. Consistent messaging on best practice approaches to breastfeeding and newborn care across Tasmanian nursing, midwifery, specialist lactation and child health nurse workforces.
14. Development and trialling of initiatives to establish postnatal continuity of care for Tasmanian women and birthing people, including extending existing continuity of care models into the fourth trimester.
15. Free, short-term community-based postnatal mental health support – for example, subsidised counselling sessions through a service such as Women's Health Tasmania, Gidget Foundation or Tresillian – so that interim support is available to Tasmanian women and birthing people while longer term support needs are identified and referrals made.
16. Expand Medicare mental health treatment plan coverage from 10 to 20 subsidised mental health sessions per year, for the year of pregnancy and the first postnatal year.
17. Free pelvic floor physiotherapy for Tasmanian women and birthing people during pregnancy and the first postnatal year.
18. Shared resources guiding the provision of sleep support, including culturally sensitive safe co-sleeping advice, across Tasmanian nursing, midwifery and child health nurse workforces.
19. Expansion of geographical eligibility for the Patient Transport Assistance Scheme (PTAS) for Tasmanian families with an infant or child in hospital.
20. Establishment of community-based mother and baby units in Tasmania's South and North West that are appropriately resourced for the regions' populations, alongside delivery of the proposed Launceston Mother Baby Centre in the North.

IV. Life with baby: building a village

Education, Connection, Community

Participants in the *Talking about having a baby in Tasmania* project said establishing family life with a new baby could be challenging and isolating, particularly without extended family or other 'in-built' support nearby.

My husband and I have absolutely no support here. We just moved here two years ago – you know, don't have any close friends yet that could help us out. My mum was here for the first six weeks [after baby arrived] and she did the entire household and all the cooking and she was doing some babysitting and nappy changes and then she just left. I was just crying for days. I was just so overwhelmed with everything.

We are without any family here. All the time I was [wishing] to have someone very close to me. To have some support.

I had one really good friend who had just had her second baby so she was definitely my lifeline for a while there, asking all the questions about postpartum recovery and breastfeeding and sleep and everything. [She] was probably the best resource I had.

Following their baby's arrival, participants reported mixed experiences of being linked in to local community-based supports by their postnatal care providers. Some participants received information about local parenting groups, services and activities, while other participants missed out on these early connections.

They told me about some mother groups or baby groups and that was really good, because yeah, we're pretty isolated. So it was nice to know where we could connect a bit.

I wanted to connect with some mums that had babies a similar age. And my GP recommended the migrant mothers group for me. It would have been helpful to know about that a bit earlier on. Because we're all in the same boat, like no one has support at all, and it is hard, especially with your first.

[The child health nurses] have been really good, but they didn't even know about the Child and Family Learning Centre. I eventually found out through a Facebook group. North West Mums Empowerment or something like that. And I joined a group chat with them and then we went and had coffee and they told me about [the Centre]. And because they'd all been, they go regularly, that's when I started going.

I asked [the child health nurse] about mothers groups and she wasn't sure. I think she'd just moved from the mainland so she was a bit unaware of all the facilities down here.

Some participants found alternative groups or networks that worked better for them than those attached to public health services.

I did go to all the groups but didn't really make any friends. But my husband plays soccer and there's so many soccer wives there and they all have babies under the age of one. We all get along pretty well so that's like my personal mothers group. And yeah, I just found it so helpful to have some people to talk to, because the mothers groups, they're good, but it's all pretty superficial.

I've decided to exclusively breastfeed so I've joined the Australian Breastfeeding Association. And they're very good with support if I need support and they have monthly meet-ups. So I've found that really useful.

Participants who had access to a local Child and Family Learning Centre (CFLC) found the services they offer invaluable, providing a mix of formal and informal parenting education, child health supports and social contact. For some participants, their local CFLC became 'the village' that delivered the mix of social connection, resources and practical help they needed with a new baby.

The access to information that they provide is huge. And the support they provide. You know, [material] relief where they can get you clothes and nappies and all that sort of stuff. Those bits in Tassie are absolutely vital.

I got most of my information from [the Child and Family Learning Centre]. Oh my god, it's amazing, yeah.

I did a program through there called Baby and Me. And that was an eight-week program for new mums and babies under six months. I met quite a few people and even now I'm in touch with one of those people every single day, like we've become really close friends. So that was really, really useful. And I used to use the Child and Family Learning Centre almost weekly just as a little drop-in play for [baby].

We've utilised the physio drop-in clinic at [the Child and Family Learning Centre] because I was worried about [baby's] walking and that was really helpful, just for peace of mind. Everything was fine but at least then we didn't have to go through that process of going and getting a referral and waiting and all of that kind of stuff.

Participants' primary recommendation to support the health and wellbeing of women and birthing people and their families during the first year of their baby's life was to expand community-based services such as these. They said extended opportunities to connect with other families were needed and that access to parenting and child activities for working parents and for fathers were specific service gaps.

One of the things that I found really lacking was services available on the weekends. You know, you've got the Child and Family Learning Centre to go to during the week, but there is actually nothing to do on a weekend with kids. And post-birth, weekends can be really isolating and challenging. So I think some more services and supports that we could access on weekends would be really useful.

I would love to see mental health [support] out of the Child and Family Learning Centres, because we go to ours all the time, they're great. Something flexible for people with babies.

It might be worth seeing if there's a market for online [parenting] education sessions for those that live in areas further away. I mean, we do have some healthcare services here, but just not parenting. And I know some other people, they have to drive two hours to get to services, which is ridiculous. So I imagine if there's enough people out there, it might be helpful to have an online group.

Some mums don't have the luxury of having maternity leave. All playgroups that I'm aware of run on a weekday. So [working] mums miss out on having that special connection and watching their babies grow and develop and getting those skills on how to interact with baby. So I think that that's probably a big gap. And like, there's no playgroups for dads. There's no face-to-face services that dads can go to, to connect with other dads. There's literally nothing. So that would be a gap too. I think in terms of looking at it from the perspective of mums as well, if dads had the opportunity to do that on a weekend, it would also give mums a break, a very needed break.

Not all participants who lived in regional and rural areas of Tasmania had easy access to a CFLC, however those that did tended to have greater familiarity and more linkages with CFLC services than participants who lived in urban centres. It was women and birthing people in regional and rural communities that described their CFLC as the hub of their proverbial village.

I think that's such a special thing about being in regional Tassie. As hard as access can be, in terms of community connection, we are so at risk of isolation, but then because of that, there's these centres that are providing that connection and support.

Recommendations

21. Expansion of the Child and Family Learning Centre (CFLC) network to provide access for all Tasmanian communities, including exploration of outreach and mobile service models.

22. Strategies to improve equity of access to new parenting support, education and activities for Tasmanian families, including ensuring all new parents are offered access to a parenting group via CHaPS or the CFLC network.

23. Initiatives to increase access to parenting and child activities for working parents and fathers, including during weekends.

24. Development of information sharing, communication and referral pathways between Tasmanian healthcare providers and new parenting support services to facilitate informed referrals and care coordination.

V. Inclusion: from promise to practice

Equity, Diversity, Cultural safety

Outcomes from the *Talking about having a baby in Tasmania* project suggest that while some Tasmanian pregnancy and birth care providers deliver inclusive services at the individual level, equity and inclusion measures are yet to be incorporated into pregnancy care systems and practices in Tasmania in a consistent and cohesive way.

Participants in the study who were Aboriginal, culturally and linguistically diverse, LGBTIQA+ or living with mental health conditions, did not encounter the kind of targeted inclusion measures recommended in the *Australian Pregnancy Care Guidelines* nor in COAG's *Woman-centred care: Strategic directions for Australian maternity services.*

Other participants impacted by inequitable access to systems and services included those on low incomes, those who lived in rural and regional areas, those whose visa status rendered them ineligible for public healthcare, and those whose pregnancies were classified high risk.

Aboriginal participants

Aboriginal participants who took part in the research said there was no recognition of their Aboriginality from care providers and that they saw no evidence of greater flexibility in care delivery and strategies to minimise family and kinship disruption – measures that are named in the national guidelines for Aboriginal women and birthing people.

They described mixed experiences of care that included some very positive moments and other moments in which they felt less at ease with caregivers. They did not feel that cultural safety was a particular consideration for pregnancy and birth care providers, nor rapport-building.

The doctor said that he wasn't happy taking on clients [from my town] because of the risk involved in the travel. And I tried to explain to him that it's an extra maybe ten minutes [only]. But yeah, you could tell he was not keen on it which was a little bit uncomfortable. It wasn't actually a very nice experience. My partner wasn't allowed in with me on that appointment either.

An Aboriginal participant who gave birth during peak Covid-19 restrictions noted that attempts to bolster her social supports while in hospital were met with resistance.

It was just ridiculous. My husband came in for the delivery but he couldn't come in for the next few days. So I said to [the midwife], I want to change my support person to my friend. And she's like, oh, I don't know if we can do that. And I said, everybody is eligible for a support person. And I had to take it to the NUM [Nurse Unit Manager].

She also noted that the pandemic visitor policies were applied inconsistently within the ward by different hospital staff, to her disadvantage.

My son came in on the second day to meet his new baby brother, my nine-year-old, and they wouldn't let him on the ward, just to meet his little brother. And the woman who said 'no' came in try to have a conversation with me. And I said, well, there's a family sitting out in the waiting room with their baby in a crib and there's about twenty people visiting them. So my son coming in for ten minutes to meet his baby brother before he goes to school, versus them sitting out there – it's very hit and miss.

While we can't assume these experiences are representative of the broader experience of Aboriginal Tasmanians, in isolation, they suggest a lack of responsiveness to the holistic needs of individual Aboriginal women and birthing people.

Participants on low incomes

Participants on low incomes said healthcare costs limited their access to a range of services and support during their pregnancy journey. One participant described how cost impacted their access to GP care while pregnant and following birth.

I've got a healthcare card but they don't bulk bill at all anymore for anyone. You don't want a long appointment because you've got to pay for it. I think it was $90 [for a short appointment]. And then obviously I get some of that back from Medicare. But it's still $90 out of my bank account until I get that rebate. It's not nothing, you know, when you're not working and with the cost of living and everything else. For my kids I wouldn't hesitate. But for yourself, you do.

Other participants also described going without certain health supports during pregnancy and postnatally due to expense, or until they were able to find a lower cost access point.

She referred me to a good physio, but financially, you know, we're new parents, it just wasn't financially doable for us.

I was feeling not happy for a very long time. And then [my workplace] were offering psychologist consultations with an external company and they were paying for it. So I took that up because it was free.

As a whole, participants in the study on lower incomes who relied on public health services had less access to birth education, mental health support, pelvic floor physiotherapy, fewer ultrasounds in pregnancy, and less continuity of care overall, than participants who were able to pay for services privately.

Culturally and linguistically diverse participants and participants on temporary visas

In the discussion of fourth trimester care experiences we noted that culturally and linguistically diverse participants at times received health advice that lacked cultural awareness, especially in relation to safe sleeping practices.

Participants also said care providers tended to assume they were familiar with local healthcare systems and did not offer detailed information about referral pathways and options, which limited their decision-making.

I didn't have an idea that there was like three or four or five different types [of care] that you could go through with your pregnancy – like with midwife, with obstetrician, with GP, with the hospital, without the hospital, in private – a friend explained that to me after I took my decision.

One participant for whom English was an additional language said the language barrier was not addressed during pregnancy or birth and that she felt disadvantaged by not having a full understanding of the medical language being used. She said she was not offered access to an interpreter or multicultural social worker at any point, despite later reading that these services were available in Tasmanian hospitals.

They never asked me if I understand. And they never told me that they didn't understand me. But I always felt that the communication wasn't good, because my English, in the specific work of medicine, is not the best. So I always ask, two or three times, what are you doing now? I need another transfusion? Why – what happened? What is the level of haemoglobin, and what do I need? I did all the questions, but they don't take enough time to explain. So I was asking my aunt in [my home country], who is a doctor. She was guiding me.

Access to pregnancy care was further complicated for culturally and linguistically diverse participants on temporary visas who were not eligible for Medicare-subsidised public health services. Despite being required to have private health insurance as a condition of their visa arrangements, private pregnancy and birth care providers charged them thousands of dollars in out-of-pocket costs. One participant said it was impossible to get an accurate sense of how much she would be charged following birth.

I wanted to know how much that could be but no one could give me an answer of how much they charge. I mean, I understand because you can have like a normal and easy birth, otherwise a c-section, so they never know. But it was like, how come you don't have a rough idea? My insurance doesn't know how much it will cover. So I could jump from $6,000 paying to maybe $20,000. We don't know. I call the insurance and the hospital so many times.

Participants living in rural and regional areas

Participants living in rural and regional areas had fewer models of pregnancy care and birth settings available to them and travelled significantly further to access pregnancy and postnatal services. Service scarcity was most acute in the North and North West.

In the first pregnancy I was actually surprised. 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.

Several participants living in North West Tasmania said they were surprised to find that in practice there was only one model of pregnancy and birth care available to them, despite the THS promoting a range of options.

I was a public patient and there was, yeah, no choice really... At the time it didn't bother me, but [a choice of care] wasn't offered. It wasn't offered at all.

Another regional participant in the South described how their location impacted their access to pain-relief after a caesarean birth.

They sent me home with ten [pain-relief tablets]. They didn't really wean me off them in the hospital. And I would have been taking eight of them a day in hospital. So that wasn't enough. I was breaking them in half, stretching them out. So I called the [hospital]. I'm about to run out of pain relief, can you please get a new script sent out to my local chemist? And they said, no, we can't do that. You go to your GP. And I said, it's a Thursday, my GP is closed tomorrow. It's usually two weeks to get an appointment. And they said, go to the after-hours. But I can't drive because I'm five days post-caesarean and the after-hours is an hour away from my house. I don't have enough pain medication to sit in a car with three children.

Unsurprisingly, service access issues across regional Tasmania had a bearing on participants' mental health and on access to health support and interventions for their new babies too.

You can ring up the hospital to try to see a lactation consultant in Burnie or Latrobe, but there's only one or two that way, so you'd be really hard pressed to get in to see them. And there's only one or two speech pathologists that way. And you know, it can be a big sticking point for anxiety or depression, if you have trouble, if you're really set on breastfeeding or a certain feeding journey and you're not able to achieve it.

LGBTIQA+ participants

While the small sample size in this study prevents us drawing broad conclusions about pregnancy care for LGBTIQA+ Tasmanians, the experiences shared by a non-binary participant offer valuable insight into what it means to access pregnancy and birth care in Tasmania as a gender diverse person.

This participant explained how the language of pregnancy care was incongruous to them from the outset.

A really big standout for me, as a non-binary person, is the disassociation between my identity and the language use. That's been huge. There's a lot of that real feminised language. Real kind of sweeping generalisations about women. Speaking to a medical practitioner and having them constantly referring to 'pregnant women'. There's a detachment there. Like you could be saying 'men in their fifties'. And I know I have female body parts. I know that is relevant to me. But I feel a real detachment any time someone starts talking about it. Like, 'women', 'ladies'. 'Hi ladies, how are we all today?' I just feel very excluded from that kind of language.

This participant had a high risk pregnancy which meant they were required to interact with a wide range of clinicians, midwives and other health workers. They said appointments were accompanied by anxiety about how they might be received by caregivers.

There's that fear. What are these peoples' opinions, preconceptions, you know, their ideas? Are they going to treat me differently? Am I going to get the same level of care? Is there going to be any prejudice? Do I hide my identity to be treated equally? That kind of thing.

Although they did the work of explaining their identity to a stream of different caregivers during pregnancy, they still found they were misgendered during their caesarean birth.

You know, they're putting cannulas in and uncomfortable things and there was quite a few instances of 'good girl, good girl'. Which, it's misgendering, but even if I identified as female, I would have felt, this is quite condescending – like infantilising that person. Language use is a big thing. I'm literally having a baby right now. I'm an adult

The experience of being misgendered continued for the participant after their baby was born.

You know, I'm recovering. I'm tired. I'm not advocating for myself. I'm not correcting people because I need to just focus on this new life. And a caesarean is a huge physical thing. You know, they write up all your details on the wall. And I put, they/them. And they were really terrible at using it. And then I wonder what the point of that whole thing on the wall is. At some point I said to one of the younger staff, it's they/them. And she said, 'yeah, look, everyone here's going to try their best, but I'm just going to tell you right now, some of the older staff are going to struggle with that'. When you're vulnerable, it adds to it. It's just another thing.

Participants with mental health conditions

The *Australian Pregnancy Care Guidelines* emphasise the need for tailored pregnancy care approaches for women and birthing people with pre-existing mental health conditions, including multidisciplinary care planning and continuity of care across clinical settings.

Participants in the *Talking about having a baby in Tasmania* project who had mental health conditions said they did not encounter this type of coordinated care. In fact, they said their mental health histories and support needs often weren't included on their pregnancy records or were ignored in pregnancy care appointments.

With the mental health stuff, I got them to put clear notes in the DMR [digital medical record] system and then clear notes in the obstetric system. They still didn't go together, you know. I had to point to them and say, you need to read these. And like, there was even an alert put on there. The midwife was like, I will put in an actual birthing plan for you on the system. Nobody read it.

The above participant said caregivers did not consider her mental health needs alongside clinical aspects of pregnancy care and assumed this was because they had not read her records. She reported that when she asked an obstetrician for help managing symptoms associated with medication titration, he failed to follow up. She was eventually connected to Perinatal Mental Health Services through her own efforts.

I was on a drop down of medication during pregnancy and I got to a point where I couldn't drop any further and so the GP did an urgent referral to obstetrics. When I got to that appointment [the obstetrician] said to me, I don't know anything about that because I only specialise in the people that are in your belly. And he attempted to ring a psych while I was there and didn't get an answer and he was like, someone will follow you up. And nobody followed me up. I had to go and seek my own referral to Perinatal [Mental Health Services]. And when I was there, that was really good. And then day two post-delivery, I was discharged. And I'd said, you know, I was really concerned about postnatal depression or psychosis, and there was no checks on that.

Another participant said they alerted their pregnancy care provider to a previous mental health episode in an earlier pregnancy in the hope of receiving preventative support early in their new pregnancy, but there was no 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 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.

A third participant spoke about the confusion that resulted from attending what she believed to be a routine pregnancy check-up but was in fact a mental health consultation.

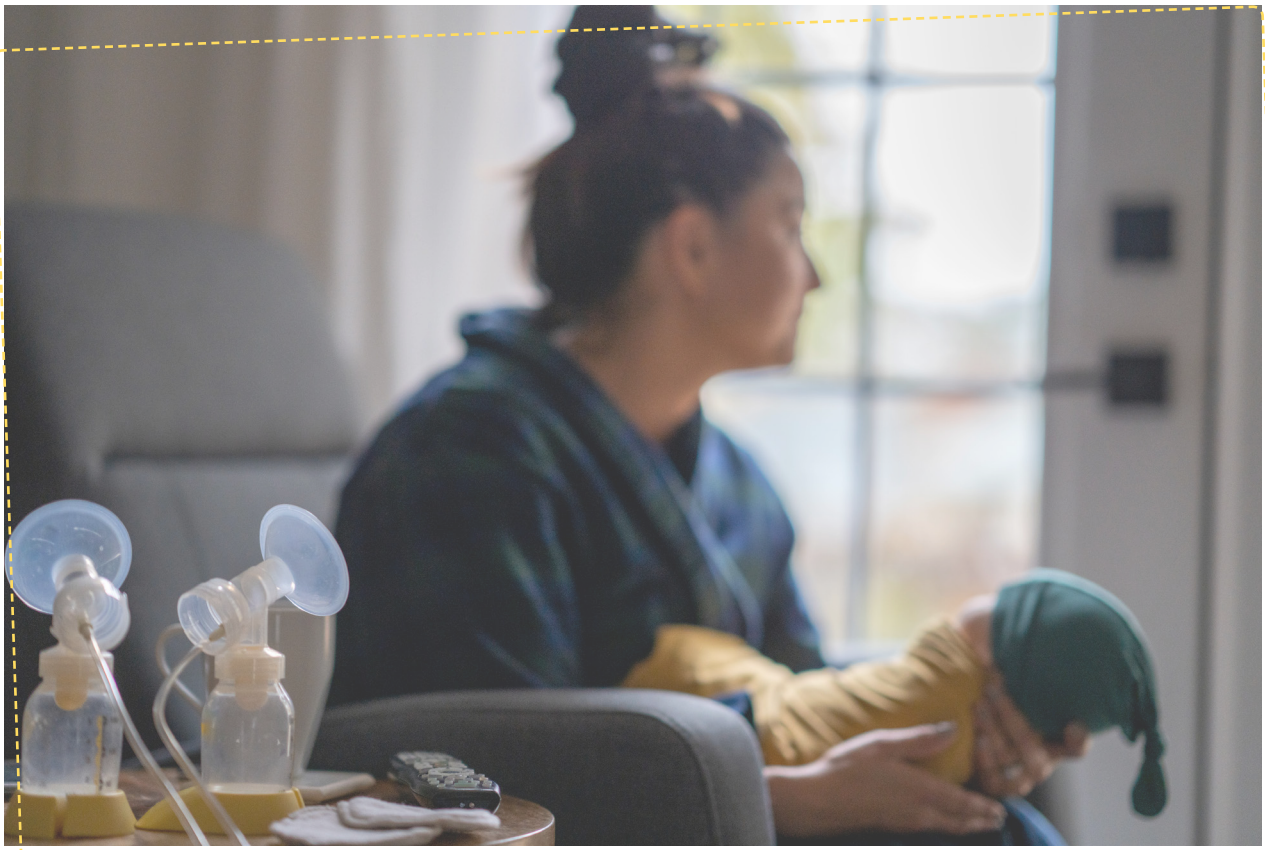
I thought I was going in for, you know, fundal height check, blood pressure. It was a mental health history interview. And the purposes of it I'm assuming were to enact some preventative support if needed. But what happened was, they go through a mental health history questionnaire. And one of the questions 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.

This participant went on to experience a traumatic birth and said she was later told by a doctor that her mental health history ought to be an advantage, the implication being that she was already linked to a well-coordinated mental health service system.

When I had the six-week debrief with the obstetrician, she said, well you are the perfect person for this [birth trauma] to happen to. You're already connected with mental health services. You know how to navigate that. And that is such a fundamental misunderstanding of our services in the region.

Aligning with the broader call for postnatal continuity of care, a participant made the following recommendation for how the Tasmanian health system could better support women and birthing people with mental health conditions.

I think that they need to have psychiatry, psychology services attached [to pregnancy care services]. And it needs to follow through at least to, at minimum, 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 support pathway for long-term supports.



Participants with high risk pregnancies

Six participants in the research had pregnancies that were classified high risk. For participants who had their babies in the public system, this classification meant they were channelled into a medical model of care. Under this model, pregnancy, birth and postnatal care is provided by many different obstetricians and midwives.

This model of care came with its disadvantages, including the requirement to travel to hospital for appointments and a rotating team of caregivers that meant continuity of care was not achievable. Participants described mixed experiences with medical clinic staff.

Some [of the doctors] were really great. Some were a bit iffy. Just depending, because it was all clinical doctors, so you didn't get to choose your own. There was some that, like, really listened to what was going on, and were really supportive and listened to what I needed. And then there was a couple that were just sort of like, speak at you, and you will follow my advice, and we're done.

For participants that placed a high value on continuity of care, the reality of receiving pregnancy care within a model that did not allow for that consistency was a significant loss.

Because of the gestational diabetes I was high risk, so everything has to go through the hospital. From then, every time, I'm getting a different midwife or a different RN or whoever. So then [everything] was a repeated conversation.

One participant discovered that being plus-size meant her pregnancy was automatically classified high risk, excluding her from her preferred models of pregnancy and birth care. Because she received care through a medical clinic, she was required to undergo continuous tests and monitoring, despite a healthy pregnancy.

I really just felt like a number. And I never felt like I got any type of individualised care. They didn't understand me or the type of birth I envisioned. And I mean, clearly the fact that I wanted to originally have a home birth, I was already more of an alternative person than they're used to. So I think, you know, their model of care and me were not jelling at all.

In concluding our observations on inclusion, we should note that participants in the study – like members of the broader community – often fit within several of the above population groups. Therefore, the barriers they encountered in accessing pregnancy and birth care were not limited to one life domain but were multidimensional and intersecting. For this reason, system responses aimed at increasing equity of access to pregnancy and birth care in Tasmania should also be intersectional, able to respond flexibly to overlapping social identities and forms of disadvantage.

Recommendations

25. Commit to delivering pregnancy, birth and postnatal care in Tasmania that considers the individual cultural, social and emotional needs of each woman and birthing person, in line with person-centred standards described by the *Australian Pregnancy Care Guidelines*.

26. Identify and promote the role of pharmacists as key health providers supporting the care continuum alongside GPs and hospitals, for women and birthing people in rural and regional areas of Tasmania.

27. With lived experience representatives, co-design an equity of access and inclusion framework for pregnancy, birth and postnatal care services in Tasmania that responds to the specific needs of underserved population groups, including:

    a) Recognition of and holistic care planning for Aboriginal women and birthing people;

    b) Strategies to increase equity of access to continuity of care throughout the pregnancy journey and to critical postnatal services such as mental health support and physiotherapy for women and birthing people on low incomes;

    c) Education and support for Tasmanian pregnancy, birth and postnatal care workforces to provide culturally safe and responsive care to culturally and linguistically diverse women and birthing people;

    d) Initiatives to increase pregnancy and birth care choice, control and equity of access for women and birthing people living in regional and rural areas of Tasmania;

    e) Education and support for Tasmanian pregnancy, birth and postnatal care workforces to provide person-centred and inclusive care to LGBTIQA+ birthing people;

    f) Shared communication and care coordination protocols across pregnancy, birth and postnatal care providers for women and birthing people with pre-existing mental health conditions;

    g) Initiatives to increase pregnancy and birth care choice, control and equity of access for women and birthing people whose pregnancies are classified high risk.

VI. Accountability: getting it right when things go wrong

Feedback, Reflection, Recourse

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

The reality of what is at stake during pregnancy and birth – the physical and emotional safety of the woman or birthing person and their baby – means that when something goes wrong, it can be shattering.

While most participants in the *Talking about having a baby in Tasmania* project reported some moments of adversity in pregnancy or birth, three participants reported significant adverse experiences that resulted in trauma.

The Australasian Birth Trauma Association defines birth trauma as an "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".

Just as there were commonalities across participants' positive birth experiences, there were factors common to the experiences of birth trauma recounted by participants. Notably, all participants felt the trauma they experienced arose as a consequence of the actions or decisions of one or more caregivers during or after birth.

The degree of distress that occurs during a traumatic birth can be difficult to comprehend as an observer. Participants said the opportunity to articulate these experiences in their own words in a context where lived experiences were not minimised was meaningful.

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 asking 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.

Another participant described an experience of trauma associated with unmanaged post-birth haemorrhaging. Her caregivers chose not to intervene surgically and she experienced multiple further haemorrhages and hospitalisations.

That afternoon we'd come back home. Around 9 pm when I was putting [baby] to sleep, I start bleeding, really badly, all over the floor. I felt that I was losing something. I said to [my partner], give me a container, because something is coming. I called [the hospital], they say you have to come, you need to call an ambulance. I remember all my shoes with blood. They start giving me antibiotics, because they realise that probably I have placenta in my uterus, after almost fourteen days from birth. So, next day in the morning the doctor came to my room with all the staff, very dramatic. He say, we need to bring you to the theatre because we need to make sure that you don't have anything in your uterus. So, they did a D&C. And after the D&C I have another haemorrhage in the recovery room. After that, I have to receive three blood transfusions in six days. After that six days I came home. And a few days later, I lose another clot. A big one. So we come back to the hospital. And I was crying like, I don't want to come back here anymore. I want to stay home with my baby. Everything was really traumatic. When I went to the GP for my six-week appointment, she said this looks like negligence.

A third participant recounted an experience of trauma that unfolded during an assisted birth involving procedures that were undertaken without consent. She described her shock when, unable to speak during a contraction, caregivers commenced the unwanted intervention without her agreement. She said her distress was compounded when she screamed for them to stop and caregivers ignored her.

I want to make it clear that what happened to me was rape. That word needs to be used because that's what it was. I can still feel my heart racing thinking about it. It was so painful. It was horrible. It was not something that I ever would have thought could happen to me or to anyone else.

Recounting these experiences was observably difficult for participants and they reported that their distress was increased because it was ignored or diminished in the hospital settings where they gave birth.

Ultimately, there was a dual experience of trauma: the first component arising from the traumatic event/s itself, the second component arising from the perception that care providers failed to acknowledge and respond to what had occurred.

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.

The experiences of birth trauma described by participants all involved a perceived absence or breakdown of communication and trust – attributes identified earlier in this report as key to positive experiences of pregnancy and birth care.

Further, on occasions when communication or trust between the participant and caregivers broke down, opportunities to repair these ruptures were missed. This may reflect the fact that the progression of a medically 'normal' birth felt far from normal to the participant, resulting in dissonance between their understanding and caregiver understandings of the birth and its outcomes.

Clearly, this reinforces the value of pregnancy and birth care models that enable continuity of care, supporting women and birthing people to build trust, rapport and a shared understanding of birth care expectations with caregivers prior to birth.

All participants who described experiences of birth trauma said that they had not 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 at the time.

All three had sought mental health support to help process and recover from their experiences. Two had initiated complaint processes with the hospitals that provided their care, and a third said she was considering reporting her experience but was unsure how to go about it. The participants that pursued formal recourse said they felt their experiences were further minimised by the hospital executives who responded to their complaints. They believed fear of legal liability was a factor in this and said the lack of institutional recognition compounded their distress.

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. When I had my open disclosure meeting and she told me to supply questions in writing, one of them was: What could I have said or done different to get me the help I needed when I was begging for pain relief and expressing suicidality. [In the meeting] she said, essentially nothing – women in that stage of labour say all sorts of things and midwives have to interpret what they think is really going on. There's nothing you could have said different.

I opened an investigation. It took two months for them to reply with a letter. Just an apology without any answers. So the next step was to have a meeting with the staff from the hospital. I went to the meeting with a social worker, my partner, baby and an interpreter. The meeting was really hard. It was in the hospital in a room just close to the maternity area. 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, she 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.

These experiences suggest strategies to reduce 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 care providers when a traumatic birth event occurs.

If this undertaking is complicated by issues of medical liability, care providers should consider developing pathways for birth trauma recognition and support that are managed separately from avenues for legal recourse. For example, when a complaint is received, offering the woman or birthing person referral to an independent birth trauma counselling service, free of cost.

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

Learnings from the *Talking about having a baby project* also indicate there may be simple ways to improve how women and birthing people feel about their birth experiences, whether or not trauma is present. Two participants in the study reported being offered an opportunity to debrief about their birth with caregivers while in hospital and both said this was useful and 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.

Just after birth, they asked me if I wanted to meet with the midwives and doctors. So if there was anything that I found confusing during labour that I wanted to follow up on, I had the chance. I found that really, really good. My birth was really smooth but I imagine if someone struggled or had complications, it is nice to know that you can ask questions and that you can have a formal discussion about what went on.

Participants said other opportunities to communicate or share feedback with care providers were limited. In total, four participants reported being asked to provide feedback on their experience of hospital care. Of these, three participants said they were sent a link to a hospital feedback form that was not specific to pregnancy and birth care, and one participant said she was invited to give feedback on how 'breastfeeding friendly' the hospital was.

A participant shared these thoughts on the subject of feedback.

I don't think they've got the time or the capacity to do it. I mean, I know that they are short staffed – I mean, everywhere is short staffed in every industry at the moment. Yeah, I just don't think that they've got the capacity to do that, they're too busy trying to do those core roles

In terms of the adequacy and safety of Tasmanian pregnancy and birth care systems, this comment speaks to the heart of the matter. In a healthcare system under strain, it is surely the responsibility of health system leaders – government planning and funding bodies, health service executives and workforce managers – to establish cultures of self-reflection and accountability within their own spheres of influence, across Tasmanian healthcare settings.

Recommendations

28. In consultation with women and birthing people and birth care providers, develop a strategy to reduce the prevalence and severity of birth trauma in Tasmania that addresses:

    h) Systemic risk factors linked to originating birth trauma; and

    i) The provision of appropriate care provider responses when a traumatic birth occurs.

29. Further to Recommendation 9, mandatory training in trauma informed care for Tasmanian pregnancy, birth and postnatal care workforces.

30. Introduce post-birth debriefing in Tasmanian hospitals, supported by appropriate training and protocols.

31. Introduce a model for continuous improvement in Tasmanian birth units that incorporates consumer feedback mechanisms specific to pregnancy, birth and postnatal care.

Conclusion

The *Talking about having a baby in Tasmania* project revealed much that is working well in the delivery of pregnancy, birth and postnatal care in Tasmania, as well as significant areas for system development and reform.

While some of these changes require a major investment of time and resources, 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 and birthing people, their families and communities.

Women's Health Tasmania will continue to amplify the voices of lived experience, and continue working towards these opportunities and solutions, for the benefit of all people who are having – now or in the future – a baby in Tasmania.

Words of advice

Participants in the *Talking about having a baby in Tasmania* project shared the following words of advice for other people who are having a baby in Tasmania.

Learn how to push. That's the only thing that I would say to everyone. That's my main advice. And rest.

Try and find all the resources you can. Try and connect with people that are pregnant around a similar time that you are. Because the medical resources are great, but I think the mental health and social resources are more important.

I'd definitely tell them to go to their Child and Family Learning Centre because it's so good.

I would recommend agreeing on a non-verbal sign if you want more pain relief or just any other request that you might have, during labour. Because you might not be able to communicate normally anymore.

Take the advice of your midwife and your health professionals, but also, find more resources and really arm yourself with knowledge, so that you can go into it and make the decisions, feeling like you're making them to the best of your ability.

Find a healthcare professional that you trust their judgement. I think that's probably the most important thing. Find the best option for you where you really, truly, trust the people around you.

Stand up for what you believe in and if you don't want to do something, you don't have to. Trust your body and yourself.

Summary of recommendations

Recommendation	
1	Free pregnancy and birth care for all people living in Tasmania, regardless of visa status.
2	Initiatives to support increased pregnancy care knowledge and competency in the Tasmanian GP workforce.
3	Expansion of the pregnancy and birth care information on the Tasmanian Health Service website to include detailed descriptions of the models of care, including eligibility requirements and regional availability.
4	Development of strategies to improve equity of choice and access for pregnancy care in North and North West Tasmania.
5	Increase the availability of public system continuity of care models of pregnancy and birth care in Tasmania so that more women and birthing people can access them, including expanding the availability of student-midwife supported continuity of care as a pathway, scaffolded by appropriate supports for student midwives.
6	Free and accessible pregnancy and birth education for all Tasmanians, including online engagement options.
7	Regular refresher training in healthcare rights and informed consent for all Tasmanian health workers, with a specialised module for pregnancy care providers that includes consumer led content such as 'Better Births With Consent'.
8	Development of protocols in Tasmanian birth units guiding positive early communication and rapport-building for presenting women and birthing people.
9	Education and support for Tasmanian pregnancy, birth and postnatal care workforces to develop and expand skills in person-centred care and trauma informed practice.
10	Development and trialling of birth advocate positions within Tasmanian birth units.
11	Development of protocols in Tasmanian birth units guiding aftercare for women and birthing people.
12	Tasmanian Health Service strategies to support nursing, midwifery and obstetric workforces during periods of high demand and staffing shortages.
13	Consistent messaging on best practice approaches to breastfeeding and newborn care across Tasmanian nursing, midwifery, specialist lactation and child health nurse workforces.
14	Development and trialling of initiatives to establish postnatal continuity of care for Tasmanian women and birthing people, including extending existing continuity of care models into the fourth trimester.
15	Free, short-term community-based postnatal mental health support – for example, subsidised counselling sessions through a service such as Women's Health Tasmania, Gidget Foundation or Tresillian – so that interim support is available to Tasmanian women and birthing people while longer term support needs are identified and referrals made.
16	Expand Medicare mental health treatment plan coverage from 10 to 20 subsidised mental health sessions per year, for the year of pregnancy and the first postnatal year.
17	Free pelvic floor physiotherapy for Tasmanian women and birthing people during pregnancy and the first postnatal year.
18	Shared resources guiding the provision of sleep support, including culturally sensitive safe co-sleeping advice, across Tasmanian nursing, midwifery and child health nurse workforces.
19	Expansion of geographical eligibility for the Patient Transport Assistance Scheme (PTAS) for Tasmanian families with an infant or child in hospital.

20 Establishment of community-based mother and baby units in Tasmania's South and North West that are appropriately resourced for the regions' populations, alongside delivery of the proposed Launceston Mother Baby Centre in the North.

21 Expansion of the Child and Family Learning Centre (CFLC) network to provide access for all Tasmanian communities, including exploration of outreach and mobile service models.

22 Strategies to improve equity of access to new parenting support, education and activities for Tasmanian families, including ensuring all new parents are offered access to a parenting group via CHaPS or the CFLC network.

23 Initiatives to increase access to parenting and child activities for working parents and fathers, including during weekends.

24 Development of information sharing, communication and referral pathways between Tasmanian healthcare providers and new parenting support services to facilitate informed referrals and care coordination.

25 Commit to delivering pregnancy, birth and postnatal care in Tasmania that considers the individual cultural, social and emotional needs of each woman and birthing person, in line with person-centred standards described by the Australian Pregnancy Care Guidelines.

26 Identify and promote the role of pharmacists as key health providers supporting the care continuum alongside GPs and hospitals, for women and birthing people in rural and regional areas of Tasmania.

27 With lived experience representatives, co-design an equity of access and inclusion framework for pregnancy, birth and postnatal care services in Tasmania that responds to the specific needs of underserved population groups, including:

a) Recognition of and holistic care planning for Aboriginal women and birthing people;

b) Strategies to increase equity of access to continuity of care throughout the pregnancy journey and to critical postnatal services such as mental health support and physiotherapy for women and birthing people on low incomes;

c) Education and support for Tasmanian pregnancy, birth and postnatal care workforces to provide culturally safe and responsive care to culturally and linguistically diverse women and birthing people;

d) Initiatives to increase pregnancy and birth care choice, control and equity of access for women and birthing people living in regional and rural areas of Tasmania;

e) Education and support for Tasmanian pregnancy, birth and postnatal care workforces to provide person-centred and inclusive care to LGBTIQA+ birthing people;

f) Shared communication and care coordination protocols across pregnancy, birth and postnatal care providers for women and birthing people with pre-existing mental health conditions;

g) Initiatives to increase pregnancy and birth care choice, control and equity of access for women and birthing people whose pregnancies are classified high risk.

28 In consultation with women and birthing people and birth care providers, develop a strategy to reduce the prevalence and severity of birth trauma in Tasmania that addresses:

a) Systemic risk factors linked to originating birth trauma; and

b) The provision of appropriate care provider responses when a traumatic birth occurs.

29 Further to Recommendation 9, mandatory training in trauma informed care for Tasmanian pregnancy, birth and postnatal care workforces.

30 Introduce post-birth debriefing in Tasmanian hospitals, supported by appropriate training and protocols.

31 Introduce a model for continuous improvement in Tasmanian birth units that incorporates consumer feedback mechanisms specific to pregnancy, birth and postnatal care.

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