Australasian birthtrauma Association

Position Statement

Postnatal Care in Australia

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

Scope

This position statement outlines ABTA's views on how birth trauma can be better diagnosed and treated for women and their families during the postnatal period in Australia. It is written for those with responsibility for developing policy and making decisions on how these families are supported.

Summary

At the broadest level, ABTA holds the view that women and their families who have experienced trauma as a result of childbirth, should have timely access to a co-ordinated care pathway that supports their unique physical, psychological and emotional needs and provides the relevant information, support and services to help them navigate their recovery.

Current Situation

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

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

Apart from the physical damage and other complications (such as haemorrhage, infections, embolism, pre-eclampsia) that may be experienced, and result in psycho-social stress and trauma, non-physical aspects may also prove psychologically damaging. These might include:

- emergency c-section;
- inadequate pain relief;
- illness; or
- loss of the infant.

ABTA holds the view that the timely diagnosis, treatment and support of women and their partners after experiencing physical and/or psychological trauma after childbirth is crucial to the health and well-being of the mother as well as vital to fostering strong, healthy, partnerships and families.

It is important to recognise that support provided by a birthing woman's partner is vital to her well-being, however the partner may not be in a position to provide this support if she or he is also traumatised. Maternity policy does not adequately acknowledge the far-reaching societal impacts that birth trauma has, and considerable barriers remain in place that prevent people from receiving timely and effective care.

Challenges

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

1. *Stigma and judgment around birth trauma*
   Feelings of failure when a birth has not gone to plan, along with judgment from society and health professionals is creating stigma around birth trauma that further compounds the problem and may reduce the likelihood of sufferers seeking support. Women also report being reluctant to seek help due to the very personal nature of physical birth injuries.

2. *Diagnosis*
   Delays in diagnosis and inaccurate diagnoses lead to prolonged suffering and the compounding of health implications for affected women, their partners and families.

3. *Lack of care pathways*
   Many women report receiving a diagnosis without being given an adequate explanation of the condition or a care pathway to services that can assist. Having access to relevant trauma specialists (physical and/or psychological), is an important part of the healing journey. Access is especially difficult for those in remote and rural areas and those from culturally diverse backgrounds. A lack of care pathways for fathers and partners is also a significant challenge for our members as these pathways often simply don't exist.

4. *Cost of Treatment*
   Our members report spending thousands of dollars on out-of-pocket expenses for treatment of physical and psychological injuries that impact their daily lives. For many women, however, funding their recovery is simply not possible and they live with chronic conditions for the rest of their lives with adverse impacts on relationships, health and the ability to generate an income.

5. *Fear of Liability*
   A key contributor to how women and their families feel about their trauma and whether they receive timely support is the culture of the hospital or care provider. The unwillingness of some hospitals or professionals to discuss the birth experience compounds the trauma

   for the woman and her partner and can further delay their access to accurate diagnosis and treatment.

Calls to Action

1. *Improved diagnosis and pathways to care*
   ABTA would like to see funding put toward postnatal services that are able to diagnose maternal trauma in an accurate and timely manner and provide pathways to care.

   It is envisaged that these postnatal services would assess birth trauma in the early postnatal setting (as opposed to months or years later) and would include the following:

   - Allow for clinical audit, improve health outcomes for affected women and their partners, and facilitate staff teaching, training and support. Removing the fear of liability is crucial to the success of this.
   - Providing women and their partners with an opportunity to receive an appropriately respectful and empathic hospital debrief and potential referral for those women and/or partners that are affected by psychological morbidity to access mental health services.
   - Providing access to specialist pelvic physiotherapy, in particular for women who are most at risk of future health problems such as urinary and faecal incontinence and/or pelvic organ prolapse would reduce such morbidity.
   - Providing women with access to imaging services capable of diagnosing somatic birth trauma, that is, anal sphincter tears (3^{rd} or 4^{th} degree tears) and pelvic floor muscle tears ('avulsion'), with a referral pathway to tertiary urogynaecological and/or colorectal services.
   - Allow prompt referral for those women and their partners affected by psychological morbidity so they can access mental health services. Early diagnosis and intervention allows for more effective treatment and faster recovery.

2. *Removal of financial and geographical barriers to care*
   ABTA calls for increased funding for the treatment of birth-related physical and psychological trauma to reduce the significant out-of-pocket costs to families and provide funding for those unable to afford care.

3. *Improved birth trauma training for healthcare providers*
   ABTA would like to see all health care service providers involved in the postnatal care of birthing families receive more comprehensive training on both physical and psychological birth trauma, how it impacts people's lives and how they can play a role in limiting the severity of this trauma, with a view to improving empathy and clinical diagnosis and treatment. This requires provision of on-going support and training in self-care for all staff involved. [5]

4. *Consumer Engagement*
   ABTA advocates for consumers to be involved in the design, implementation and evaluation of all maternity services. Those who have experienced trauma as a result of childbirth are

   in a unique position to provide valuable feedback on minimising trauma and advising on issues relevant to recovery.

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

References

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

[2] Breakdown for first time mothers: Perineal trauma - 80%, Anal sphincter trauma - 5% (AIHW) 4000 women a year, Levator injury in first time mums - 10% incidence in normal (52000) – 5200, 10% ventouse birth (16330) – 1630, 35% in those having a forceps (13206) - 4622.1 = 15400 first time mothers per year.
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AIHW: Australian Institute of Health and Welfare. National Core Maternity Indicators [Internet]. Canberra: Australian Institute of Health and Welfare, 2019 [cited 2020 Mar. 9]. Available from: https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations
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This paper also shows the rates of pelvic floor dysfunction to be up to 58% with those women:
MacLennan AH, Taylor AW, Wilson DH, Wilson D. The prevalence of pelvic floor disorders and their relationship to gender, age, parity and mode of delivery. BJOG: An International Journal of Obstetrics & Gynaecology. 2000 Dec;107(12):1460-70.

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

[4] ABTA Birth Preparation Survey 2019.

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

Contact

Amy Dawes
E: amy@birthtrauma.org.au
P: PO Box 3250, Norman Park QLD 4170
ABN: 14 614 751 343

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