**Overview**

A newborn baby's health can be a key determinant of their health and wellbeing throughout life. Factors such as physical health, social wellbeing and exposure to harmful behaviours can influence health outcomes for both mothers and babies.

<https://www.aihw.gov.au/reports-data/population-groups/mothers-babies/overview>

**Onset of labour**

Labour can occur spontaneously or may be induced by medical or surgical intervention. If there is no labour, a caesarean section is performed.

Induction of labour is performed for a number of reasons related to both the mother and the baby, such as maternal or baby medical conditions and post-term pregnancy (Coates et al. 2020). Whilst most women who have induced labour – and their babies – do well, induction of labour does increase the risk of emergency caesarean section, infection and bleeding, and a less positive birth experience when compared to spontaneous labour (Coates et al. 2020; Grivell et al. 2012).

In 2021, about 2 in 5 (41%) mothers who gave birth had a spontaneous labour, around 1 in 3 (34%) had induced labour and 1 in 4 had no labour (25%).

<https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care-in-focus/summary>

**Maternity models of care in Australia in 2023**

A maternity model of care describes how a group of women are cared for during pregnancy, birth, and the postnatal period. In 2023:

Around 1,000 models of care were in use across 251 maternity services.

Most of these (81%) fall into 4 categories: public hospital maternity care (41%), shared care (15%), midwifery group practice caseload care (14%), and private obstetrician specialist care (11%).

Over two-thirds of public maternity services (69%) have at least one public hospital maternity care model of care, 60% have a shared care model of care, and 49% a midwifery group practice caseload care model of care.

Around 29% of models have continuity of carer for the whole maternity period; nearly three-quarters (73%) of maternity services have at least one model of care with continuity of carer for the whole maternity period.

Around 35% of models have continuity of carer for part of the maternity period, such as the antenatal period only; a similar proportion (36%) have no continuity of carer.

<https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/what-do-maternity-models-of-care-look-like/other-maternity-care-characteristics>

**Antenatal and postnatal care**

Most maternity models of care (96%) provide antenatal and postnatal care in individual sessions. Some (4.1%) provide this care through a combination of individual and group sessions. These group sessions include both education and clinical care.

Three-quarters (75%) of models of care provide women with access to at least one postnatal visit in a residential setting. All models classified as midwifery group practice caseload care, or team midwifery care, or private midwifery care, offer postnatal visits in a residential setting, compared with 76% of models classified as public hospital maternity care and 41% of models classified as private obstetrician specialist care.

**Labour and birth settings**

A model of care may have one or more planned settings for birth. Nearly all (97%) maternity models of care offer birthing within a hospital birth suite or labour/delivery ward as a planned setting for birth.

Around 65 (6.4%) models of care have a birth centre (either stand alone or in a hospital) as a planned setting for birth. Only a small number of these exist. A birth centre is an alternative setting to the conventional hospital setting for labour and birth. A common feature in a birth centre is a homely space, midwife-led care with a philosophy towards normality and avoidance of interventions. A small number of models (3.2%) have the home as a planned setting for birth.

Around 8% of models of care have routine relocation of women prior to labour for intrapartum care and birth as part of the model. Women cared for in these models require relocation from their communities to another location prior to labour for intrapartum care and birth. Routine relocation usually applies to models where women reside in a rural or remote community with no access to a birth facility and are routinely relocated to a larger town or city some weeks prior to birth. Routine relocation as a characteristic of a model of care is higher in the Northern Territory (25%) and Tasmania (17%).

**PANDA**

If you are experiencing symptoms of perinatal anxiety, depression, obsessive-compulsive disorder or psychosis, some of the thoughts and feelings you may be experiencing can be extremely frightening. Many people may feel afraid to share these thoughts with their partner or family.

Difficult emotions in the perinatal period can trigger a lot of shame, guilt and sadness. The image you may have had of what you’d be like as a parent probably didn’t include feeling low, crying, or wishing you could take a break from parenting. Yet our callers commonly report having those emotions and thoughts. These thoughts and feelings don’t mean you don’t love your baby, and they don’t mean you are a bad person or parent.

In fact, up to 1 in 5 expecting or new mums and up to 1 in 10 expecting or new dads will develop symptoms of perinatal anxiety and/or depression. Perinatal mental health issues are much more common than many people realise. Even if you aren’t experiencing significant changes to your mental health, it’s still common to experience distressing thoughts and emotions, including worry, doubt and sadness.

If you’re struggling with your mental and emotional wellbeing, you might feel confused about whether what you are experiencing is “normal”. You might be unsure of how to start talking about your feelings, or you might feel concerned about what people will think.

It’s okay to talk about what you’re feeling. Starting the conversation with someone you trust, such as your partner or a friend, can be a first step on the road to seeking professional support.

Our culture glorifies pregnancy, parenting and motherhood. Media, social media, movies, TV and advertising tend to portray parenthood as being fun, easy, fulfilling and joyful. While there are moments where being a parent is all these things, being pregnant or caring for a baby can alsobe stressful, tiring and challenging.

Pregnancy and parenthood can be a time of immense struggle, trauma and pain. This time of life can also trigger mental health and wellbeing challenges you didn’t expect.

It can be incredibly upsetting when you confide in someone about how you are feeling, and they’re dismissive or minimise your experience.

This reflects their own thoughts and beliefs and is not a reflection on you. People who call PANDA’s Helpline often tell us that their family, friends and health providers haven’t listened to them, or have responded with unhelpful statements like:

Of course, parenting is tough. You just have to get through it.

It happens to everyone.

You’re just tired. Every parent gets tired – it comes with the territory.

Just have a cup of tea and put your feet up – you’ll feel better.

Sleep will come, just give it time.

Yes, it’s stressful, but it’s also just so rewarding! (it may not be)

You’ll feel better once you get some sleep.

It’s hard for all parents, and you don’t hear everyone complaining, do you?

Oh, lots of mums get by on much less sleep than you’re getting.

If you confide in someone and feel their response minimises your feelings or experiences, or makes you feel ashamed or guilty, it’s important to continue to reach out for help. Every expecting or new parent deserves kindness, respect, and effective perinatal mental health care.

We encourage you to keep reaching out until you feel you’re being heard and supported.