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## **Response: Public consultation on the Safety and Quality Guidelines for privately practising midwives (SQG)**

*Submission to the Nursing and Midwifery Board of Australia*

*Closing date: 5 June 2026 | Email: [nmbafeedback@ahpra.gov.au](mailto:nmbafeedback@ahpra.gov.au) | Subject line: Public consultation: SQG*

### **Submission type**

- Organisation**
- Individual

### **Your details**

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### **Permission to publish submission**

- Yes - publish my submission with my name and organisation name**
- Yes - publish my submission with my name only
- Yes - publish my submission with my organisation name only
- Yes - publish my submission without both my name and organisation name
- No - do not publish my submission



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## **Introductory statement**

Homebirth Australia is the national peak consumer-and-practitioner body representing women, families, and privately practising midwives (PPMs) who choose, attend, or advocate for homebirth in Australia. Our membership includes women who have planned homebirths, families in every state and territory, and the privately practising midwives (PPMs) who care for them. The positions in this submission have been developed through consultation with our members, including a structured workshop with leaders of Homebirth Australia and Homebirth NSW.

We strongly support the NMBA's stated objectives of safe, evidence-based, woman-centred, culturally safe care that is free from racism. We also acknowledge that this review is described as 'scope limited' to reflect the ending of the professional indemnity insurance (PII) exemption on 31 December 2026 and other minor amendments. Our submission therefore concentrates on the specific clauses within scope of this review - principally the new second health practitioner requirements in Table 1 (Item 2) and the 'private practice midwives as second health practitioners' section - and on related clauses where the consultation paper invites feedback (cultural safety documentation, social media classification, fatigue management, virtual care, mentor relationships, and inclusive language).

Our central concern is that several proposed clauses will, if implemented as drafted, produce the opposite effect to the NMBA's safety objectives: reduced access to safe regulated midwifery care, particularly in rural and regional Australia (an explicit priority population under the proposed SQG), elimination of the mentoring pathway by which the private midwifery workforce reproduces itself, and an increased likelihood that women will be pushed - by lack of access, rather than by genuine informed choice - toward unregulated birth options including freebirth. We also identify a small number of consequential matters that the NMBA should pursue with MIGA and the Department of Health on PII coverage parameters.

Underpinning our submission is a single principle: the SQG must support midwives to be clear on their professional responsibilities and to provide the safest possible care, while ensuring that women's autonomy and decision-making in their care - where they have been adequately informed - is not restricted, and that midwives are not left open to regulatory scrutiny for



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honouring those decisions. A woman's informed and documented decline of recommended care should be paramount in protecting the midwife from regulatory or legal action.

## Questions for feedback

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

- Yes
- No**
- Prefer not to answer

#### Response:

The overall structure is accessible. We identify, however, several specific clauses where the proposed language is unclear, not workable, or has consequences the NMBA may not have intended.

Second health practitioner clause (Attachment A, Table 1, Item 2 Risk management; and 'Private practice midwives as second health practitioners' section). The proposed wording 'the PPM must engage a second health practitioner registered under the National Law who holds appropriate professional indemnity insurance' - read with the related expectation that the second midwife must 'be prepared to assume the role of the primary midwife during a homebirth, if required' - is not workable in the contemporary Australian private midwifery workforce. At a fundamental level, no PII product is currently available in the Australian market that covers a non-endorsed registered midwife acting as second at an intrapartum homebirth. The MIGA product launched on 1 July 2025 covers PPMs providing intrapartum care, but it is one product that makes no distinction between midwives attending as a primary and those attending as a second. There is no specific product for second midwives, and no commercial pathway exists for non-endorsed midwives to obtain the one product available. In the current workforce, it is unusual for other privately practicing endorsed midwives to act as a second for another. The second-midwife pool instead generally consists of casually-attending registered midwives in a back-up arrangement, midwives mentoring under PPMs as a second who are working towards endorsement and their



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own private practice, and even (where they are the only available practitioner) non-midwives such as registered nurses. None of these practitioners has access to a PII product that would satisfy the proposed clause. The clause, as drafted, will dissolve the second-midwife workforce pool and essentially eliminate the apprentice/mentoring pathway into private practice. We address the regulatory options for resolving this in detail at Q2(a).

Footnote 7 of Table 1, Item 2 ('In the event the second health practitioner is unexpectedly unable to attend the homebirth, the PPM must take all reasonable steps to ensure another health practitioner who meets the definition of second health practitioner is present for the birth. This may include engaging a paramedic or consideration to transferring care.') compounds the problem. Where no insured second can be engaged, the only options the SQG contemplates - engaging a paramedic (rarely a practical option in an active labour, and never one a paramedic service will guarantee) or transferring care (i.e. defaulting to hospital) - effectively remove access to planned homebirth wherever the second-midwife supply is thin. This is a direct contradiction with the NMBA's stated objective of improving access to midwifery services, particularly in rural, regional and remote areas (Discussion section, p.14 of the Endorsement consultation paper, recognised as a National Scheme priority).

'Be prepared to assume the role of the primary midwife' expectation. The proposed wording in the 'Private practice midwives as second health practitioners' section - 'second midwives must... be prepared to assume the role of the primary midwife during a homebirth, if required'. This clause anticipates the rare-but-possible scenario in which the primary midwife becomes unable to continue care during a homebirth - typically because she has another woman labouring for whom she is the primary care provider. It is unusual for a primary midwife to leave the birth she is actively attending; in current practice, where another woman in her caseload presents in labour, she would arrange a back-up PPM to attend that second woman, or, where that is not possible or available and the situation is urgent enough to warrant it, advise the second woman to attend hospital. Workshop members of Homebirth Australia and Homebirth NSW - most of whom represented rural and regional PPM practice - reported the scenario contemplated by this clause arising rarely; some reported never having experienced it in practice, and no midwife reported more than three occasions across the last five years. The existing response to the rare case is for the primary to call in another primary-capable midwife from a surrounding area, and where that is not possible, transfer of the woman's care to hospital with her consent. This pathway is well established and works for women, families and midwives. Requiring every second midwife at every birth to be insured to and prepared to act as primary is a



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disproportionate response to a near-non-existent problem; the existing pathway is the appropriate response to the rare scenario the clause anticipates.

Mentor relationship definition (glossary) vs. second-midwife clause. The proposed SQG defines 'mentor relationship in private midwifery practice' as 'a professional, collaborative partnership where an experienced midwife supports another midwife's clinical competence, confidence, and autonomy'. We welcome the explicit recognition of mentoring. In current practice, a mentoring relationship typically involves a registered (non-endorsed) midwife attending births as second with an experienced primary PPM, building clinical competence and confidence in homebirth care, before completing endorsement and progressing into private practice as a primary herself. This apprentice-style pathway is the ideal method for the next generation of private midwifery practitioners to be trained in homebirth care. However, the second-midwife clause in the proposed SQG closes this principal mentoring/apprentice pathway.

Social media classification. The proposed text on page 2 ('Midwives who practise the midwifery profession by providing education or advice to women, people of diverse genders and the public via social media or electronic communications may also be considered a PPM') and Appendix B p.26 ('midwives practising the midwifery profession via online and electronic forums such as podcasts and social media platforms in a private capacity (i.e. not on behalf of a health service) must be mindful that this may constitute private practice') is too ambiguous to be workable. The threshold for what triggers classification as private practice is not stated, creating regulatory risk for midwives engaging in legitimate professional education, reflection and advocacy.

Inclusive language explanatory note (p.16). We support respectful individualised care for all people accessing midwifery services. We are concerned, however, that the proposed move toward additive language as a default ('woman' alongside 'people of diverse genders' as standard SQG terminology) is not supported by the evidence the NMBA itself has cited. We address this in detail at Q2(h).

Cultural safety documentation requirement (Table 1, Item 5 Documentation): 'documenting whether the woman, person of diverse genders and/or either biological parent identifies as Aboriginal and/or Torres Strait Islander'. The wording does not specify whether the midwife is required to ask, how non-disclosure should be recorded, or how this interacts with relationship-based, woman-centred care. We address this in detail at Q2(j) and Q6.



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Fatigue management plan (Table 1, Item 2 - 'A fatigue management plan should also be discussed and agreed'). The clause is silent on how it operates where a woman, having been informed of the midwife's fatigue level and the available management options (for example, substituting another primary midwife where one is available, or transferring to hospital), declines one or more of those options and accepts the residual risk that her midwife may not be at her best professional capacity. This is another rare but possible scenario - more likely to arise where a midwife has had multiple births back-to-back than in a single long or overnight labour - and women commonly prefer continuity with their known midwife to substitution or transfer. The SQG, as drafted, exposes the midwife to regulatory risk in this scenario despite the midwife having met every reasonable obligation in discussing and documenting fatigue with the woman. This needs to be fixed in the body of the SQG; see our recommendation at Q2(k).

Virtual care (referenced through Appendix B). The SQG defers to AHPRA's 'Information for practitioners who provide virtual care' document. We ask the NMBA to confirm that the SQG does not introduce additional restrictions on virtual care beyond Ahpra's broader guidance, and to clarify that women in remote areas, or who otherwise choose virtual-only models, are not excluded from private midwifery care.

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

- Yes
- No
- Prefer not to answer

### **Response:**

We recommend the following changes. Where we propose amendments to specific clauses we have referenced Attachment A of the consultation paper (the clean version of the proposed SQG).



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(a) Resolve the PII problem for second midwives. The proposed Table 1, Item 2 requirement that the second health practitioner holds 'appropriate professional indemnity insurance' is, as currently drafted, impossible to satisfy unless the second midwife is also endorsed. No PII product is presently available in the Australian market that covers a non-endorsed registered midwife acting as second at a homebirth. The MIGA product launched on 1 July 2025 covers PPMs providing intrapartum care, and requires the midwife to be endorsed in order to access the insurance product. There is no equivalent product for midwives attending out-of-hospital births as a non-endorsed midwife - whether casually-attending registered midwives in a back-up pool, newly-graduated or experienced midwives mentoring under experienced PPMs as a second midwife and working towards endorsement, or non-midwives attending as second where they are the only available practitioner (for example, a registered nurse, as would currently be allowed).

Critically, second midwives have no clinical need to be endorsed in order to fulfil their role. Endorsement confers prescribing authority and Medicare/PBS access - functions that are not exercised by a midwife attending as second. A second midwife attends as professional support to the primary. She does not prescribe medication, order diagnostic imaging, or access MBS/PBS in respect of that birth. Requiring her to hold PII equivalent to that of an endorsed primary midwife - or, alternatively, requiring her to obtain endorsement before she can attend as second - is therefore disproportionate to the scope of the role she actually performs.

The section 284 exemption that ends on 31 December 2026 historically covered both primary and second midwives. The Commonwealth's resolution of the ongoing PII exemption (via the MIGA product) has not been matched by a resolution for second midwives at homebirths. The Commonwealth has also indicated that no further section 284 exemptions will be granted. Imposing a PII requirement that no insurer offers a product to satisfy is regulation by exclusion: it eliminates the second-midwife workforce pool not on safety grounds but because the necessary product does not exist. We recommend the NMBA engage actively with the Commonwealth Department of Health and MIGA before 1 January 2027 to resolve this, pursuing the following solutions in order of preference:

(i) The NMBA clarifies, in the body of the SQG and within its existing powers under section 39 of the National Law, that a registered midwife attending as second in a defined supportive role within a documented mentor or peer arrangement is not 'practising private midwifery' for the purpose of triggering an additional section 129 PII obligation in respect of that birth, on the basis that clinical responsibility rests with the primary. This is our preferred solution. It avoids the



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need for a Commonwealth amendment or a new insurance product, is delivered within the NMBA's existing regulatory powers, and reflects the practical reality that the second's role is to support the primary's clinical decision-making, not to substitute for it. We acknowledge this approach requires legal analysis to confirm consistency with the National Law.

(ii) Extend the primary midwife's MIGA PII policy to cover an attending second midwife in a defined supportive (non-primary) role within a documented mentor or peer arrangement. This is also operationally clean - one policy responds, one premium is paid - and is consistent with the SQG's recognition that the second supports the primary rather than substituting for her.

(iii) MIGA, with Commonwealth support, develops a dedicated, scope-limited PII product appropriate to second-midwife practice. Premiums must be financially accessible to second midwives; our recommendation is that the product be fully Commonwealth-rebated, or otherwise zero-cost to the second midwife. The product should not require the second midwife to hold endorsement, given endorsement is not necessary to perform the second-midwife role.

(iv) Interim relief. Pending implementation of one of (i)-(iii), the SQG should not enforce the second-midwife PII requirement against practitioners for whom no compliant PII product exists. The clause should be redrafted to expressly exempt non-endorsed midwives, midwives attending in a mentor or peer arrangement under the supervision of an insured primary, and non-midwife registered practitioners (such as registered nurses) attending as second, from the PII requirement until a workable PII pathway is in place. Imposing a paper requirement that no insurer offers a product to satisfy removes the second-midwife pool overnight, eliminates the apprentice/mentoring pathway into private practice, and disproportionately affects rural and regional access. This is inconsistent with the NMBA's parallel objective of improving access to midwifery services in rural, regional and remote areas (Discussion section, p.14 of the Endorsement consultation paper).

We acknowledge that the ACM is engaging with the Commonwealth on this issue. The NMBA should work alongside the ACM, the Department of Health and MIGA to deliver a workable resolution. As drafted, the SQG will, in effect, prohibit planned homebirth across much of Australia from 1 January 2027 unless one of these solutions is implemented.

(b) Amend the 'Private practice midwives as second health practitioners' section. Remove the requirement that the second midwife must 'be prepared to assume the role of the primary midwife during a homebirth, if required'. The scenario this clause anticipates is extremely rare,



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as discussed in answer to Q1. Workshop members of Homebirth Australia and Homebirth NSW report it arising between zero and three times across the last five years of practice. The existing and well-functioning response is for the primary to call in another primary-capable midwife from a surrounding area, and where that is not possible, to transfer the woman's care to hospital with her consent. This is how PPMs currently manage the rare case, and it works for women, families, and midwives across rural, regional and metropolitan settings. The proposed requirement - that every second midwife at every birth be insured and prepared to act as primary - is a disproportionate response to a near-non-existent problem. It eliminates any safe role for non-endorsed registered midwives at homebirth, is incompatible with the mentor relationship the SQG itself now defines, and conflates the role of 'second health practitioner' (present for the birth) with the role of 'primary midwife' (carrying clinical responsibility for the woman's full episode of care). Removing the 'be prepared to assume the role of the primary' expectation preserves the existing transfer pathway as the appropriate safety net for the rare clinical scenario, without imposing the disproportionate PII burden on every second midwife.

(c) Reframe footnote 7 (Table 1, Item 2). Rather than directing that the PPM 'must' engage a paramedic or transfer care where the second health practitioner is unable to attend, the footnote should require the PPM to offer those options to the woman and to document her informed decision. Where the woman, having been informed of the second midwife's unavailability, declines paramedic engagement or transfer and elects to continue with her planned homebirth, the PPM should be protected to document that decision and continue providing care where she feels able and safe to do so. The midwife's regulatory exposure should be defined by the quality of her documented decision-making, not by the outcome of a choice the woman has made.

(d) Cross-reference the mentor relationship definition with the second-midwife clause. Insert wording (in the 'Private practice midwives as second health practitioners' section, and in the 'Transitioning to private practice' section already present in Attachment A) that explicitly recognises mentee participation as a second health practitioner within a documented mentor relationship, with PII expectations scaled to scope of practice. This is consistent with the NMBA's own observation (Attachment C, Item 7) that 'the revised SQG also discusses the value of mentoring, peer group discussion, and professional development activities to prepare themselves for private practice', and with the evidence base in Wissemann et al. (2022) cited by the NMBA.

(e) Clarify the social media / private practice definition. Both the page 2 text ('Midwives who practise the midwifery profession by providing education or advice to women, people of diverse genders and the public via social media or electronic communications may also be considered a PPM') and the Appendix B text ('this may constitute private practice') should be replaced with specific criteria. We suggest the SQG state that a midwife is engaged in private practice when she (i) provides individualised clinical advice or services for a fee to a specific woman or (ii) holds out a fee-for-service midwifery business. Generic educational content, professional reflection, peer commentary, and advocacy should be expressly excluded. Worked examples should be included in the Fact Sheet.

(f) Strengthen Table 1, Item 1 (Informed consent) and Item 5 (Documentation). We strongly support the proposed wording that PPMs must record 'when a woman or person of diverse genders declines recommended care'. We recommend the SQG add an explicit statement that where a woman's informed consent has been comprehensively documented - including her decision to decline recommended care, decline a hospital backup booking, or decline consultation or referral (for women in category B or C of the ACM National Midwifery Guidelines for Consultation and Referral (ACM Guidelines)) - this documentation constitutes evidence of safe, woman-centred practice consistent with the Midwife standards for practice. The documentation must be recognised by the NMBA as protective for the midwife and her registration in the event of an adverse outcome, regardless of the woman's risk profile. The women most likely to seek private midwifery care are often those with risk factors arising from interventions in prior births they do not wish to repeat. Where a midwife can justify her ability to provide care for a woman with risk factors (including, but not limited to, breech or twin births) and the woman declines to be referred on, the midwife should be protected and supported to provide care.

(g) PII coverage parameters across all risk profiles - request that the NMBA work with MIGA, the Department of Health and the Commonwealth to publish explicit, written confirmation that the MIGA intrapartum homebirth PII product covers care for women of ALL risk profiles - including women in category B or C of the ACM Guidelines for Consultation and Referral - where the woman has provided documented informed consent and decline. Without this confirmation, midwives face the practical reality that the Commonwealth-backed PII product may exclude precisely those women most likely to seek private midwifery care - typically women with risk factors arising from prior births they do not wish to repeat. Resolving this is, in our view, the single most important outstanding question raised by the ending of the section 284 exemption.



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We suggest this is either written into the SQGs themselves, or provided as a separate Appendix, Fact Sheet or other published statement.

(h) Removal of collaborative-arrangement requirement, or explicit Record of Understanding (RoU) alternative. The Commonwealth has, in recent years, removed the requirement for a collaborative arrangement with a medical practitioner for endorsed midwives to access the Medicare Benefits Schedule. We ask the NMBA to confirm, in writing with MIGA, that MIGA's PII product does not reintroduce the collaborative-arrangement requirement as a precondition of coverage. Where a woman declines to share her information with a hospital (a reasonable exercise of her right to privacy and informed decision-making), the SQG should explicitly permit a Record of Understanding (RoU) between the PPM and the woman as a substitute mechanism for demonstrating due diligence around collaboration and referral pathways. Without this, MIGA's PII product may be unavailable to precisely the women who most rely on private midwifery to avoid culturally unsafe or traumatising hospital care. Again, we suggest this is either written into the SQGs themselves, or provided as a separate Appendix, Fact Sheet or other published statement.

(i) Protection from deregistration where due diligence is documented. We ask the NMBA to confirm in the SQG an explicit statement of principle: that a midwife who has documented informed consent, comprehensive risk-assessment, declined-care discussions, and referral-pathway compliance in accordance with the SQG and the Midwife standards for practice will be considered to have met her regulatory obligations, even where an adverse outcome occurs. Regulatory action under Part 8 of the National Law must be proportionate to the conduct, not to the outcome. The compliance section's emphasis on 'no further action' as a regulatory outcome (Attachment C, Item 10) is welcome. We ask that this principle be explicitly named in the body of the SQG, not only in the rationale.

(j) Sex-specific language with explicit treatment of additive language. We ask the NMBA to retain sex-specific language ('woman', 'mother', 'breastfeeding', 'she') as primary in clinical sections of the SQG, and to reconsider the proposed default move to additive language (woman/people of diverse genders used together throughout). Pregnancy, birth and lactation are sexed activities. Sex-specific terms are essential for informed consent, accessibility for women with low literacy or English as an additional language, and accurate risk communication. The peer-reviewed evidence cited in the NMBA's own reference list - Bartick et al. (2025) and Gribble et al. (2022) - sets out the documented unintended consequences of additive language: reduced comprehension among women with low literacy or limited English; inaccurate risk

communication; erosion of the sexed reality of pregnancy and birth; and, paradoxically, reduced precision in care for trans and gender-diverse parents. We endorse Bartick et al.'s recommendation that sex-specific language remain the primary terminology in clinical documents, with respectful, individualised pronoun and term choice in direct care of trans and gender-diverse people, rather than additive language as a default. The NMBA also cited Pezaro et al. (2024, Birth) in support of gender-inclusive language; we encourage the NMBA to weight that work against the Bartick et al. (2025) and Gribble et al. (2022) evidence, which documents the harms of additive language to all women's access to clear maternity information.

(k) Clarify fatigue management and protect the midwife where the woman declines the fatigue-management pathway. The proposed clause 'A fatigue management plan should also be discussed and agreed' should be supplemented in the body of the SQG with specific clarifications. First, what is expected of the PPM when no relief midwife is available - the typical situation in solo private practice, particularly in rural and regional settings. Second, an explicit statement that where the midwife has discussed her fatigue level and the available management options with the woman (for example, substituting another primary midwife where available, or transferring to hospital) and the woman has declined one or more of those options and elected to accept the residual risk that her midwife may not be at her best professional capacity, the midwife's documented discussion of fatigue and the woman's documented declining of the fatigue-management options constitutes sufficient evidence of safe, woman-centred practice and is protective of the midwife's registration. Third, that regulatory action arising from a fatigue-related outcome must be proportionate to the midwife's conduct - specifically, whether she discussed fatigue, offered the available options, and documented the woman's choice - and not to outcomes which the midwife had reasonably attempted to mitigate but which the woman had elected to accept. This principle is consistent with the SQG's existing Item 1 (Informed consent) recognition that women may decline recommended care, and with the compliance section's acknowledgement (Attachment C, Item 10) that the NMBA's approach is risk-based and proportionate. A documentation burden that cannot be met within the realistic conditions of solo private practice - or that exposes the midwife to regulatory action despite her having met every reasonable obligation - is not safety-protective; it is performative.

(l) Cultural safety documentation as a basis for relationship rather than compliance. The proposed Table 1, Item 5 requirement to document 'whether the woman, person of diverse genders and/or either biological parent identifies as Aboriginal and/or Torres Strait Islander' should be implemented as a basis for offering culturally appropriate care - at the woman's



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invitation, with non-disclosure respected, and documentation that supports rather than gates culturally safe care. The SQG should make this explicit, consistent with the National Scheme Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy.

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

- Yes
- No
- Prefer not to answer

#### **Response:**

Yes. The negative and unintended effects are significant and, in our considered view, threaten the viability of private midwifery in Australia.

Workforce destruction. The combination of Table 1, Item 2 (Risk management - 'a second health practitioner... who holds appropriate professional indemnity insurance') and the related 'be prepared to assume the role of the primary midwife' clause will: eliminate the existing pool of non-endorsed registered midwives who provide second-midwife services on a casual basis; eliminate the apprentice/mentoring pathway into private practice (the principal mechanism by which the private midwifery workforce most safely reproduces itself, and a mechanism the NMBA itself supports per Attachment C Item 7); make private practice economically unviable in rural and regional areas where birth volumes do not support a second endorsed and insured midwife; and force experienced midwives to refuse intrapartum care, or exit private practice. None of these outcomes is consistent with the SQG's safety objectives, and several are inconsistent with the National Scheme priority on workforce sustainability.

Risk of vexatious reporting, deregistration, or other regulatory action. PPMs are not infrequently the subject of vexatious reports, whether or not there has been an adverse outcome. Without explicit protection (Q2(i)) of midwives who have documented informed consent, informed decline, and due diligence, midwives will rationally decline to attend women with risk factors.



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The consequence is that women - who have valid clinical and personal reasons for choosing homebirth and would have made an informed choice for it - will be pushed out of regulated care into freebirth not as an empowered, fully informed choice but as the default where no regulated option remains. Freebirth, made as an informed and empowered choice, is the woman's right and not something the NMBA can or should prevent. The harm we identify is women who are pushed to freebirth because the regulated care they would have chosen has been made unavailable. This is the safety harm the SQG should be preventing - though we acknowledge it is not, strictly, an effect on PPMs as the question asks; rather it is a downstream consequence the SQG should be concerned with.

Social media silence. The ambiguity in the social media / private practice classification will produce a deterrent effect on midwife public engagement. PPMs will retreat from public education and advocacy to avoid regulatory exposure, reducing the public visibility of homebirth options and the consumer information available to women considering them.

Tick-box compliance crowding out relationship-based care. Documentation requirements for cultural safety identification (Table 1, Item 5), if implemented without the relationship-based framing we recommend at Q2(l), will reduce relationship-based care - the defining feature of private midwifery - to compliance exercises.

Performative fatigue management. As discussed at Q2(k), a documentation burden that cannot be met within realistic solo practice conditions is not safety-protective.

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

- Yes
- No
- Prefer not to answer

**Response:**



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Yes. The following sections require additional explanatory material, with worked examples drawn from real homebirth practice scenarios.

Second health practitioner and mentor arrangements (Table 1 Item 2; 'Private practice midwives as second health practitioners' section). Once the PII problem for second midwives is resolved (per our Q2(a) recommendations), explanatory material should include: worked examples of compliant mentor or peer arrangements; how mentee participation is to be documented; and what arrangements satisfy the requirement in the absence of an available second.

MIGA coverage parameters. Required explanatory material: (i) confirmation that the MIGA product covers care for women of all risk profiles where informed consent is documented; (ii) confirmation that MIGA does not require a collaborative arrangement with a medical practitioner; (iii) what counts as 'due diligence' for the purposes of PII coverage; (iv) the interaction between MIGA coverage and a woman's documented decision to decline a hospital backup booking or to decline transfer in labour; (v) the role of a Record of Understanding (RoU) where a woman declines recommended care. The NMBA should publish this jointly with MIGA and the Department of Health.

Informed consent, informed decline, and protection of registration (Table 1 Item 1; compliance section). Required explanatory material: worked examples of comprehensive informed consent and informed decline documentation, and an explicit statement that a midwife with documented due diligence will be considered to have met her regulatory obligations - including in the absence of an adverse outcome where a vexatious report has been made.

Social media / private practice classification. Required explanatory material: worked examples of activities that do and do not constitute private practice, including: generic education (does not); professional reflection (does not); free individualised advice (does); fee-for-service consultations (does); paid advertising of a midwifery business (does)..

Virtual care. Confirmation that the SQG does not introduce restrictions on virtual care beyond Ahpra's broader guidance; explicit recognition that women in remote areas, or women who choose virtual-only models, are not excluded from private midwifery care.

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



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- Yes
- No
- Prefer not to answer

**Response:**

Yes. The NMBA's own definition of priority populations (Glossary, p.32) includes 'people from culturally and linguistically diverse backgrounds, victim-survivors of family and domestic violence, LGBTQIA+ communities, people living in rural, regional and remote areas, people living with disability, people with mental ill health and people living without stable housing'. The proposed changes will disproportionately affect several of these groups.

Rural, regional and remote women - an explicit priority population. Private midwifery is already difficult to access in many rural and regional areas. The second-midwife PII requirement (Table 1, Item 2) will reduce the number of viable private midwifery practices in these areas, increase costs to consumers where any private midwife remains available, and make planned homebirth unavailable wherever the second-midwife supply is thin. The NMBA itself notes in the concurrent Endorsement consultation paper (Discussion section, p.14): 'Rural, remote, and regional communities continue to face challenges in accessing healthcare including midwifery services.' The proposed second-midwife clause will exacerbate this.

Women unable to access regulated private midwifery. The harm extends beyond reduced choice. Australian research (Rigg, Schmied, Peters & Dahlen, 2017, BMC Pregnancy and Childbirth, 17:99; Rigg et al., 2020, Women and Birth, 33(1); Dahlen, Jackson & Stevens, 2011, Women and Birth, 24(1)) documents that an inability to access registered private midwives is a driver of women's decisions to use unregulated birth workers or to birth unassisted (freebirth). The SQG should be reducing this risk, not amplifying it.

Victim-survivors of family and domestic violence; women with prior birth trauma; women with mental ill health. These women are disproportionately represented among those who choose private midwifery care precisely because mainstream hospital-based care has not met their needs. They are also disproportionately likely to have a risk profile (e.g. trauma-influenced declining of interventions or hospital booking) that may exclude them from a



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narrowly-interpreted MIGA PII product. The combination of the second-midwife requirement and uncertainty about MIGA coverage parameters (Q2(g), (h), (i)) has the potential to push these women out of regulated care.

Women from culturally and linguistically diverse backgrounds. Women with low literacy or for whom English is an additional language may be disadvantaged by additive or sex-neutral language about pregnancy and birth (Bartick et al., 2025).

LGBTQIA+ women and gender-diverse parents. Sex-specific language with respectful individualised pronoun and term choice in direct care (Q2(j)) is, in our view, the most accessible and accurate approach across all priority populations - including for LGBTQIA+ women and gender-diverse parents - and is supported by the evidence base.

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

- Yes
- No
- Prefer not to answer

### **Response:**

Yes. Aboriginal and Torres Strait Islander women have particular and long-standing reasons to seek private midwifery and homebirth, including Birthing on Country, continuity of carer, and concerns about culturally inappropriate hospital experiences.

Reduced access. The second-midwife PII requirement (Table 1, Item 2) will reduce the supply of private midwives, particularly in rural and regional areas where many Aboriginal and Torres Strait Islander communities are located. This will disproportionately exclude Aboriginal and Torres Strait Islander women from access to private midwifery care.

Documentation framing (Table 1, Item 5). The proposed wording 'documenting whether the woman, person of diverse genders and/or either biological parent identifies as Aboriginal and/or



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Torres Strait Islander' should be implemented as a basis for offering culturally appropriate care, not as a tick-box assurance exercise. The SQG should make explicit that identification is offered at the woman's invitation, that non-disclosure is respected, and that the documentation supports (rather than gates) culturally safe care. This is consistent with the National Scheme Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy and with the National Scheme definition of cultural safety as 'determined by Aboriginal and Torres Strait Islander individuals, families and communities'.

Workforce equity. Aboriginal and Torres Strait Islander midwives remain significantly under-represented in the Australian midwifery workforce. We acknowledge CATSINaM's ongoing engagement with the National Scheme on cultural safety, and the development of the National Scheme Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. We recommend the NMBA undertake a specific equity assessment of the proposed second-midwife clause against this workforce, and continue engagement with CATSINaM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) on implementation. This is particularly important for Birthing on Country models, which the SQG explicitly recognises but which depend on a workforce that the second-midwife clause will further constrain.

MIGA coverage parameters for Aboriginal and Torres Strait Islander women. We ask the NMBA to ensure that MIGA's PII product explicitly covers care for Aboriginal and Torres Strait Islander women who, in exercising their right to culturally safe care, may decline a hospital backup booking, decline transfer recommendations, or choose to keep their pregnancy information outside the mainstream hospital system. The Record of Understanding mechanism proposed at Q2(h) is particularly important for this population.

## **7. Feedback on the updated Fact Sheet.**

- Yes
- No
- Prefer not to answer

**Response:**



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We have reviewed the current Fact Sheet (Safety and quality guidelines for privately practising midwives, July 2023, v2.1). Our suggestions for the revised Fact Sheet follow the current structure.

**Background section.** The current Fact Sheet's Background section explains the section 284 PII exemption and how the SQG enables it. This entire section requires rewriting given the ending of the exemption on 31 December 2026. The revised section should set out: (i) the ending of the section 284 exemption; (ii) the MIGA intrapartum homebirth PII product launched on 1 July 2025 and that it requires the primary midwife to hold endorsement; (iii) the unresolved position for second midwives at homebirths (no available product) and the NMBA's intended approach (per the resolution of our Q2(a) recommendations); and (iv) how the SQG continues to support PPMs in safe practice from 1 January 2027 onwards.

**Key features section.** Should foreground the changes most relevant to practitioners and consumers: ending of the PII exemption; the new informed consent documentation requirements in Table 1 Item 1 and Item 5; the new cultural safety and priority populations content; the new mentor relationship definition; and any resolution of the second-midwife PII problem.

**What's different section.** Replace the current bullet-list comparison to the 2016 version with a comparison to the 2023 version, structured around: ending of section 284 PII exemption (most significant change); new informed consent and documentation requirements; new content on cultural safety, priority populations and Birthing on Country; new content on AI, virtual care, social media; new mentor relationship definition; new fatigue management plan requirement.

**What does this mean for me section.** Update with explicit guidance on: (i) what PII a primary midwife must hold from 1 January 2027 (MIGA product) and how to obtain it; (ii) what arrangements satisfy the second-midwife requirement (this depends on the resolution of our Q2(a) recommendations); (iii) what documentation of informed consent and informed decline looks like and is sufficient; (iv) what circumstances may attract regulatory scrutiny, including in the absence of an adverse outcome where a vexatious report has been made.

**Frequently asked questions - update existing FAQs.** The current FAQ on 'I practise as a second health practitioner for homebirths' requires a complete rewrite. The current answer references compliance for eligibility under the PII exemption - which ends 31 December 2026. The revised answer must reflect the NMBA's chosen approach to the second-midwife PII problem (per our



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Q2(a) recommendations). The current FAQ on 'I have a social media and/or a digital health platform...' should be expanded with worked examples of activities that do and do not constitute private practice, including: generic education (does not); professional reflection (does not); free individualised advice (does); fee-for-service consultations (does); paid advertising of a midwifery business (does).

Frequently asked questions - new FAQs we recommend adding:

- 'What does MIGA's PII product cover?' - including confirmation that the product covers care for women of all risk profiles where informed consent and decline is documented (per our Q2(g)).
- 'Does the MIGA product require a collaborative arrangement with a medical practitioner?' - including the Record of Understanding alternative where a woman declines to share information with a hospital (per our Q2(h)).
- 'What if a woman in my care declines a hospital backup booking, declines transfer, or otherwise declines recommended care?' - with explicit confirmation that documented informed consent and decline is protective for the midwife's registration (per our Q2(f) and Q2(i)).
- 'What if no second midwife is available at the start of labour?' - with a clear answer that does not default to paramedic engagement or cancellation of homebirth.
- 'What happens if the primary midwife becomes unable to continue care during a homebirth?' - explaining the existing pathway (calling in another primary-capable midwife, with transfer to hospital as the safety net with the woman's consent).
- 'What support is available for newly graduated and newly endorsed midwives transitioning into private practice?' - explaining the mentor relationship pathway and how it interacts with the second-midwife requirements.
- 'What if I receive a vexatious notification?' - explaining the NMBA's risk-based, proportionate approach and confirming that documented informed consent and decline, and due diligence, are protective.

For more information section. Update to include: the MIGA PII product information page; the Commonwealth Department of Health information on the ending section 284 exemption; ACM resources; consumer advocacy resources including Homebirth Australia.



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Consumer-facing material. The current Fact Sheet is explicitly practitioner-facing. A short companion Fact Sheet or consumer-facing section is needed to explain the changes to women and families - particularly the effects on access to private midwifery and homebirth in rural and regional areas, for Aboriginal and Torres Strait Islander women, and for women with risk factors who already face barriers in accessing private midwifery care.



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