

GREAT EXPECTATIONS

HOW GENDERED EXPECTATIONS SHAPE
EARLY MOTHERING EXPERIENCES



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ABSTRACT

Motherhood is commonly viewed in contemporary society as a time of great joy, when 'good mothers' effortlessly bond with their newborns and adapt to their new role with ease. However, for many women and their partners, pregnancy, birth and early parenting do not meet these expectations.

The perinatal period marks an enormous transition and upheaval in women's lives, challenging body image, relationships, intimacy and mental health. Research shows that when a woman's prenatal expectations regarding her pregnancy, delivery, infant, support network, and sense of self as a mother are compromised, she is more likely to experience lower levels of self-esteem and higher levels of depression, anxiety, and stress. The mismatch between expectations of pregnancy and early motherhood and the reality of many women's experiences can act as a barrier to help seeking and compound feelings of stress, failure and isolation.

Mothers need more realistic, holistic and supportive responses from society, health professionals, their families and themselves. Developing and sharing more realistic expectations around early motherhood experiences, and striving to transform gender norms and structures so that women and their partners share the load more equally, can support improved outcomes for mothers and a more gender equal world for their children to grow up in.

ABOUT WOMEN'S HEALTH VICTORIA

Women's Health Victoria (WHV) is a statewide women's health promotion, advocacy and support service. We work collaboratively with women, health professionals, policy makers and community organisations to influence systems, policies and services to be more gender equitable to support better outcomes for women.

As a statewide body, WHV works with the nine regional and two statewide services that make up the Victorian Women's Health Program. WHV is also a member of Gender Equity Victoria (GEN VIC), the Victorian peak body for gender equity, women's health and the prevention of violence against women.

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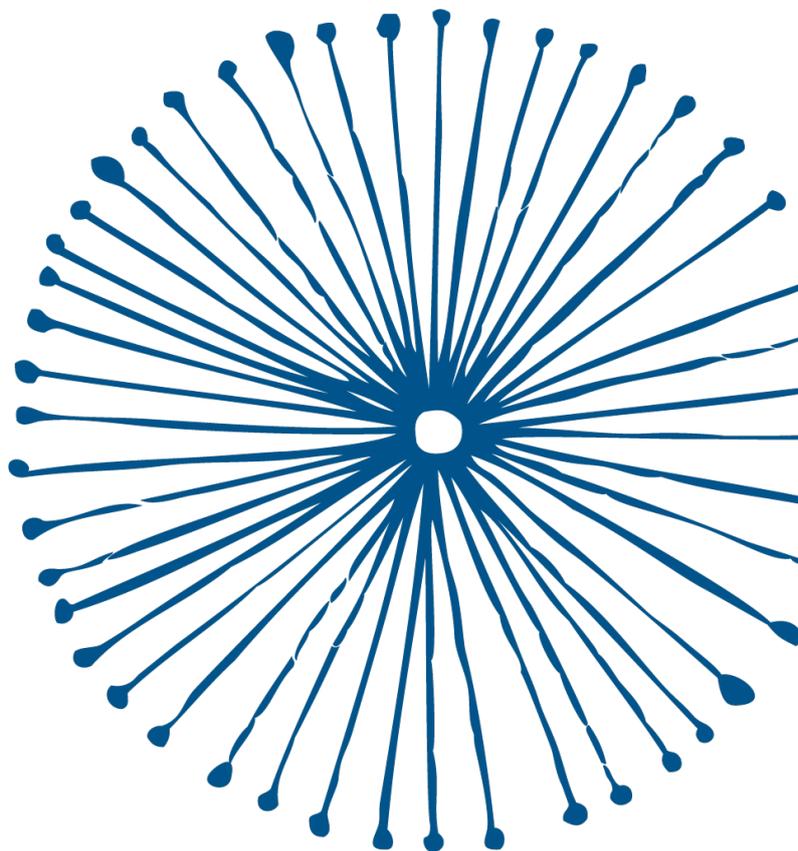
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1. EXECUTIVE SUMMARY

OVERVIEW

Becoming pregnant and having a baby can be a fulfilling and joyous, albeit challenging, experience for many parents. In fact, that is probably what most parents-to-be, and mothers in particular, are taught to expect; that pregnancy is a joyful and beautiful process that prepares women for the natural process of delivering and then nurturing their baby in the context of a loving and supportive family environment.

However, for many women, and their partners, pregnancy, birth and early parenting do not meet these expectations and can instead be a difficult and isolating experience. The pressure on mothers is different from, and generally greater than, the pressure on fathers and non-birth partners, particularly in the context of heterosexual relationships. The impacts on mothers include the direct experience of pregnancy, child birth and recovery; changes to personal identity; primary responsibility for caring; and decreased capacity to work outside the home.

Motherhood is often constructed as innate, natural and effortless. Therefore, women may believe that if they are feeling overwhelmed or not enjoying all aspects of motherhood, then they must not be a 'good mother'.

Research shows that when a woman's prenatal expectations regarding her pregnancy, delivery, infant, support network, and sense of self as a mother are compromised, she is more likely to experience lower levels of self-esteem and higher levels of depression, anxiety, and stress (Lazarus and Rossouw 2015). The mismatch between expectations of pregnancy and early motherhood and the reality of many women's experiences can compound feelings of stress, failure and isolation.

When women are supported they are more confident and feel more capable (McLeish and Redshaw 2017). However, this is not reflected in the supports provided to mothers, which operate on the assumption that mothering skills are innate or natural rather than learned. When motherhood is believed to be instinctive and effortless, it is also seen as not requiring extra support from partners, community or government.

Gendered norms and expectations associated with motherhood are reinforced by gendered structures (laws, policies and allocation of resources). Australian policies relating to parental leave, childcare and sole-parent payments assume women are primary carers of their children, while at the same time participating in paid employment. (Australia. WGEA 2016). Though women's participation in paid employment has increased over the decades, they still perform a disproportionate amount of unpaid domestic work (ABS 2017).

Expectations around early motherhood come from our own families and backgrounds, stories told to us as children, books, TV, news and entertainment, health professionals and from the society around us. Media portrayals of clean houses, well-groomed women, babies that are always settled or sleeping, and loving families can reinforce unrealistic expectations. These expectations cut across all three stages of the paper; pregnancy and birth, the postnatal period and early parenting.

PREGNANCY AND BIRTH

Women are now subjected to new expectations and 'choices' in relation to pregnancy and delivery. However birth 'choices' remain an illusion for many women and informed consent to procedures is not always given (Miller, Thompson, Porter 2011). A positive birth experience can help women enter motherhood feeling strong and capable (Nilsson, Thorsell, Hertfelt Wahn 2013). Though up to 30% of women experience traumatic childbirth and resultant physical and mental impacts, their experiences are still often under-diagnosed, minimised and dismissed by health professionals and those around them (Dietz and Campbell 2016). Fertility and motherhood are central to the construction of womanhood. Therefore, women who experience pregnancy loss or stillbirth may blame themselves and experience misplaced guilt over the loss of a pregnancy.

THE POSTNATAL PERIOD

Prenatal motherhood expectations influence the experience of becoming a mother and parenting. Disparity between these expectations and reality can influence levels of self-esteem, depressive symptoms and stress. Many women experience postnatal depression and research is increasingly recognising the role of social factors and life stressors that contribute to this. During this time women will also navigate issues with breastfeeding, body image, intimacy and their relationships.

It is estimated that 20% of Australian women have experienced postnatal depression, that is, depression in the 12 months after birth (AIHW 2012). Postnatal anxiety is just as common and often, but not always, experienced at the same time as postnatal depression (Austin, Hight and Expert Working Group 2017). While recognition of perinatal depression and anxiety has improved, many women still experience barriers to accessing services and supports, such as financial constraints and stigma (Bilszta, Ericksen, Buist 2010).

Women who do not speak English as their main language face profound barriers to accessing healthcare for pregnancy and birth including: spoken and written language and translator issues, transport difficulties, difficulty navigating the health system, health professionals' lack of knowledge

regarding cultural norms, and service costs (Mengesha, Dune and Perz 2016).

An expectation for women to quickly return to their pre-baby weight is linked to sociocultural pressure to adhere to beauty norms. Body image pressures are often particularly acute both during pregnancy and in the months afterwards. Women's bodies go through rapid physiological changes including stretch marks, weight gain, breast growth and a widening of the hips to prepare for childbirth. This is viewed by some as being incompatible with social expectations of how women should look (Hodgkinson, Smith and Wittkowski 2014).

EARLY PARENTING

The majority of young Australian women aspire to a life that combines paid work and motherhood (Johnstone and Lee 2009). But women are subject to conflicting expectations in relation to how they balance caring for their infants and returning to work. In Australia, motherhood has a marked influence on a woman's paid employment and income. Though they are increasingly participating in paid employment, mothers are still expected to shoulder the lion's share of unpaid domestic and childcare duties.

Structural factors such as the cost of childcare, inadequate income support, unequal pay, and limited access to flexible work arrangements, mean that in practice women's 'choices' about how to balance family and work are constrained (Johnstone and Lee 2016). For women who have always worked previously, not only does motherhood mark a shift in identity and responsibilities, it can also be a time when women become financially dependent on their partners for the first time.

In the media, mothers are blamed for being time-poor, not making home-cooked meals and for working outside the home (Warin, Zivkovic, Moore 2012). Research shows that idealised motherhood expectations can lead to feelings of guilt and shame for needing or desiring to spend time away from the child/ren, which negatively impacts women's wellbeing, particularly their self-efficacy (ability to succeed in situations or accomplish a task), and levels of stress and anxiety (Henderson, Harmon and Newman 2016). The desire to be, and appear to be, a 'good mother' can act as a barrier to help-

How are gendered expectations impacting health outcomes in early motherhood?

- When a woman's **prenatal expectations** regarding her pregnancy, delivery, infant, support network, and **sense of self as a mother are compromised**, she is more likely to experience **lower levels of self-esteem** and **higher levels of depression, anxiety, and stress** (Lazarus and Rossouw 2015).
- Idealised **motherhood expectations can lead to feelings of guilt and shame** for needing or desiring to spend time away from the child/ren, which negatively impacts women's wellbeing, particularly their self-efficacy, stress and anxiety (Henderson, Harmon and Newman 2016).
- **Discourse and practice** around women's **birth preferences can significantly affect birth experience** and adversely affect maternal mental health, particularly when things do not go to plan (Lazarus and Rossouw 2015).
- **Traumatic birth injuries are associated with psychological trauma** from the resulting pain, anxiety, impact on sex life, changes in body image and symptoms of pelvic floor dysfunction. However women **struggle to get a diagnosis**, find support and receive treatment (Skinner and Dietz 2015).
- **Fear of judgement** and a desire to present as a 'good mother' leads to women **concealing depressive symptoms** and not seeking help (Buchanan and Loudon 2015).
- The **pressure to breastfeed can impact the mental health of new mothers**, and make those who cannot breastfeed feel as though they have failed (Woolhouse, James, Gartland 2016).
- Depression may be a contributing factor to breastfeeding difficulties, and **breastfeeding difficulties may contribute to maternal distress** (Woolhouse, James, Gartland 2016).
- **Difficult relationships, partners who are unsupportive**, controlling or critical, and **domestic violence** are all **associated with postnatal depression** (Johnstone, Boyce, Hickey 2001) (Fisher, Feekery and Rowe-Murray 2002) (Rich, Byrne, Curryer 2013).
- **High expectations on women to 'do it all'** (bear the brunt of childcare and housework, participate in paid employment and nurture their sexual relationships) mean that women who experience reduced libido are **vulnerable to feelings of guilt and failure** (Woolhouse, McDonald and Brown 2012).
- Health professionals often tell couples that women can resume penetrative sex 6 weeks after birth, however **many women do not want to resume sex so soon** (Gorman 2017).

- **It remains a taboo for a woman to acknowledge and grieve for the loss of her former life, self, career and relationships** after becoming a parent (Lazarus and Rossouw 2015).
- Women in heterosexual relationships are **expected to manage paid work and family responsibilities** in a way that men are not (Johnstone, Lucke and Lee 2011).
- **One in three Australian mothers has reported feeling time pressure** (feeling stressed or rushed). Depression is associated with time pressure (Roxburgh 2012).
- **One in two mothers has experienced discrimination** related to parental leave and returning to work (AHRC 2014).
- There is a **strong association between poor social support and poor mental health in mothers** (Holden, Dobson, Byles 2013).

ADDRESSING 'GREAT EXPECTATIONS'

Key factors that can support resilience in mothers include a sense of coherence¹, self-esteem, lower stress, family cohesion and social support (Margalit and Kleitman 2006). However, an overemphasis on individual resilience - that is, relying on an individual to overcome adversity - can mean that those experiencing disadvantage or ill health may feel blamed and ignored (Hill, Stafford, Seaman 2007). Any focus on helping new mothers to cope better should be accompanied by attention to social support and structural factors.

Developing and sharing more realistic expectations around early motherhood experiences, and striving to transform gender norms and structures so that women and their partners share the load more equally, can support improved outcomes for mothers and a more gender equitable world for their children to grow up in.

1. Sense of coherence reflects a person's view of life and capacity to respond to stressful situations. A person with a strong sense of coherence views life as structured, manageable and meaningful. It implies that the person has, or is able to identify, resources to use if needed.

WOMEN'S HEALTH VICTORIA RECOMMENDS:

1. Challenging idealised representations of pregnancy and early motherhood.
2. Promoting gender equitable relationships, parenting and housework.
3. Ensuring that health services, including antenatal classes and maternal and child health visits, are accessible, culturally safe and sensitively screen for and respond to domestic violence.
4. Providing more support for women experiencing perinatal depression or anxiety.
5. Addressing structural contributors to poor health and wellbeing outcomes in early motherhood.
6. Undertaking research on mothering/parenting expectations that specifically impact women from migrant and refugee backgrounds, women with disabilities, Aboriginal and Torres Strait Islander women and LGBTIQ parents. Solutions should be based on consultation with these groups and community-led where possible.

2. INTRODUCTION

Attitudes to women's roles and status in society have progressed markedly since the second wave of feminism in the 1960s and 70s – with the advent of increasing access to contraception, family planning, parental leave and single parenting payments. Despite this, expectations around motherhood are still central to ideas about womanhood and femininity. Motherhood is associated with a range of competing social expectations regarding what a 'good mother' is and how a woman should experience motherhood and embrace her new identity as a mother.

AIM OF THIS PAPER

The aim of this paper is to provide an overview of: gendered expectations about birth and early motherhood; how these expectations impact mothers' health and wellbeing; and the way in which these expectations and experiences both stem from and reinforce gender inequality. These expectations and pressures begin before pregnancy, continue into the early years of parenting, and endure well after children have left home. While these expectations affect women throughout their lives as mothers, we have chosen to focus on expectations surrounding early motherhood and their impacts on women's health and wellbeing.

Research literature often focuses on a single facet of women's experiences during pregnancy and early parenting, such as birth experience, breastfeeding, intimacy, identity or balancing caring and work responsibilities. By bringing these experiences together, this paper shows the magnitude of the pressures facing women during the early motherhood period.

Furthermore, it is clear from the literature that while many motherhood pressures and challenges are collective — that is, they are experienced by all mothers — women are often left to grapple with them individually.

Expectations that mothers will have natural births, bond and breastfeed easily, return to their 'pre-baby bodies', and maintain passionate relationships, as well as carrying on their other care and work responsibilities, are often internalised by mothers, contributing to negative health outcomes over time. However, evidence shows that many of these expectations are simply unrealistic.

VARIED EXPECTATIONS

Motherhood expectations vary depending on women's support networks, access to financial resources and childcare, family of origin and experiences of being parented, family support and cultural beliefs. They intersect with other social expectations and forms of discrimination such as ableism, racism, ageism and homophobia. For example, women with disabilities may face additional scrutiny as mothers or may face additional barriers in becoming pregnant because of pressure to use contraception or not be sexually active.

Aboriginal and Torres Strait Islander mothers may also face unfair scrutiny from health professionals or in the context of accessing health and social services. This experience is intensified by a long history of forced removal of Aboriginal children both in terms of the Stolen Generation, ongoing racism and the over-representation of Aboriginal children in child protection (Denison, Varcoe and Browne 2014).

Age can also determine how a new mother is perceived. Mothers under the age of 25 may experience stigma and judgement for being too young or irresponsible (Butler, Winkworth, McArthur 2010), while women in their mid to late 30s are under pressure to 'start trying' before it's 'too late'. Some women will experience many of these competing and contrary expectations at once.

The transition to parenthood is reported to be more stressful for lesbian, gay and bisexual (LGB) parents than their heterosexual counterparts (Cao, Mills-Koonce, Wood 2016). Heteronormativity (the embedded social and cultural norms that affirm heterosexuality as the norm and homosexuality as abnormal) places emphasis on genetic links between the parent/s and child (i.e. the importance of 'having a father') and can have a negative influence on the health care of lesbian parents (O'Neill, Hamer and Dixon 2013). The emotional energy involved in deciding whether to come out or remain closeted to different health professionals is rarely acknowledged (O'Neill, Hamer and Dixon 2013).

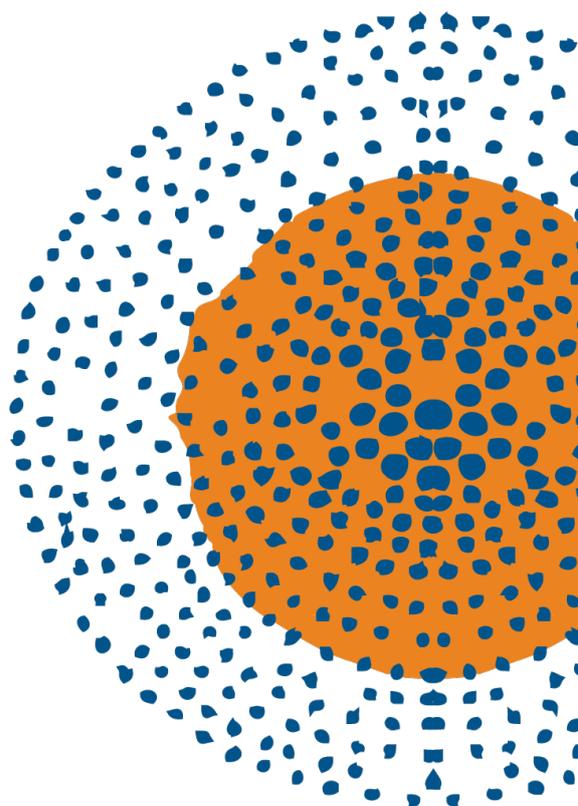
As birth parents and/or primary caregivers, transgender, gender diverse and intersex people will also be impacted by expectations related to motherhood and care giving. While some of the content in this paper may resonate with these groups, they may also be impacted by distinct and unique experiences and expectations, including discrimination and stereotyping. WHV recommends further research into the specific needs and experiences of transgender and gender diverse parents.

This paper argues that instead of (or in addition to) focusing on building mothers' resilience, we should be focusing on transforming the norms, practices and structures that negatively impact women's wellbeing during the perinatal period. This includes promoting equitable parenting responsibilities, improving information and support from health professionals, and changing policy.

FOCUS OF THIS PAPER

The focus of this paper is on women who are able to, and choose to, have a baby, and their experiences of pregnancy, birth and the first months and years of raising their baby. It is important to note that not all women want to or are able to become pregnant or have children and in fact increasing numbers of women in Australia are choosing not to have children and/or are having children later in life (Graham, Hill, Shelley 2013). Different (though related) sets of motherhood expectations impact women who do not become mothers, but these are not explored in detail in this paper.²

Parents who adopt and/or foster children are subject to some of the same pressures explored in the paper, as well as expectations and challenges that are unique to their own circumstances. These experiences are not explored in detail within this paper. However, some of what is covered in this paper may resonate with adoptive and foster parents, particularly particularly in the *Early Parenting* section.



2. Recent Australian research on the experience of women who do not become mothers includes: Graham M, Hill E, Shelley J, Taket A (2013). **Why are childless women childless?: findings from an exploratory study of childless women in Victoria, Australia.** *Journal of Social Inclusion*. 4(1):70-89; Graham M (2015). **Is being childless detrimental to a woman's health and well-being across her life course?.** *Women's Health Issues*. 25(2): 176-184; Rich S, Taket A, Graham M (2011). **'Unnatural', 'unwomanly', 'uncreditable' and 'undervalued': the significance of being a childless woman in Australian society.** *Gender Issues*. 28(4): 226-247.

METHODOLOGY

We have selected, where possible, recent Australian quantitative and qualitative studies that explore women's experiences of motherhood in the postnatal period, as well as studies that looked at the impacts of motherhood on mental health. Many of these studies include an overrepresentation of heterosexual, white, middle-class and university-educated women. Therefore we also searched for literature on the experience of women with disabilities, women in same-sex relationships, Aboriginal women and migrant and refugee women. There is surprisingly little research on the mothering experiences of women in same-sex relationships. There is also limited recent research that does not position having a disability as a barrier to parenting. There is a need for more research that examines mothering with a disability using a strengths-based approach.

Improved and more realistic supports for mothers are needed, as are more honest conversations that transform often unhelpful and unrealistic expectations. Recommendations are made for structural, systemic and social change to transform these expectations and to better support women in their mothering role and everyday lives.

Motherhood statistics:

- The Australian Institute of Health and Welfare (AIHW 2018a) reports that the average age of **first-time mothers in Australia is 30.5 years of age and 25.9 for Aboriginal and Torres Strait Islander mothers.**
- At least **77% of Australian women aged over 15 years are mothers.** (ABS 2018)
- **At least 0.2%** of women who had given birth in 2016 reported being in **same-sex relationships.** (ABS 2018)
- 11.3% of Australian families are headed by single mothers. (Council of Single Mothers and Their Children 2017)
- **31.6% of women who gave birth in Australia in 2013 were born overseas** (MCWH 2017) and **26% were born in a main non-English speaking country.** (AIHW 2018a) Despite this, most perinatal health research and data represent white, Australian-born women who are well-educated and middle-class.
- Women with disabilities, women of lower socioeconomic status, Aboriginal women and immigrant and refugee women remain underrepresented in published research.

3. PREGNANCY & BIRTH

Though the safety of pregnancy and childbirth has significantly improved for most women in Australia over the past century, Aboriginal and Torres Strait Islander women's maternal mortality ratios are double that of non-Aboriginal women (14 per 100,000 compared to 6.6 per 100,00) (AIHW 2017). Increasing numbers of women are attending antenatal care in their first trimester of pregnancy; 68.6% in 2016, up from 62.8% in 2010 (AIHW 2018a). However Aboriginal and Torres Strait Islander women, women from low socioeconomic areas and women from immigrant and refugee backgrounds are less likely to attend antenatal care in the first trimester (AIHW 2018a). The stillbirth rate has decreased to 6.7 deaths per 1,000 births, from a peak of 7.8 per 1000 births in 2009 (AIHW 2018a). Rates of smoking during pregnancy continue to fall.

3.1 BIRTH 'CHOICES' AND INFORMED CONSENT

Women's expectations and 'choices' in relation to pregnancy and delivery (for example, the choice between caesarean and vaginal birth) have also changed. However, birth 'choices' remain an illusion for many women and can be limited by their pregnancy risk status, unplanned emergencies during labour, doctors and hospital processes. Limited service provision in rural and regional areas also impacts women's childbirth options. For some women, not being able to 'achieve' a specific form of delivery can leave them feeling discouraged and distressed.

Respect, informed consent, choice (where possible) and dignity, as well as women's immediate and long-term health and birth preferences must be key considerations

During pregnancy and after childbirth, concern from health professionals and others can focus on the wellbeing or development of the baby in a way that makes the wellbeing of the mother seem secondary. Respect, informed consent, choice (where possible) and dignity, as well as women's immediate and long-term health and birth preferences must be key considerations. For example, framing vaginal delivery as the most desirable and 'normal' mode, to be achieved at any cost, can make women who undergo an emergency caesarean section feel that their body has failed them.

Vaginal and caesarean births

The majority of Australian women wish to give birth vaginally. Non-instrumental vaginal births often mean a faster recovery and shorter hospital stay (AIHW 2018a). At the same time, however, the rate of caesarean sections in Australia is going up. The proportion of babies delivered by caesarean section has increased to 33.8% in 2016, up from 31% in 2006, with caesarean sections more often performed in private hospitals (AIHW 2018a).

The increase in caesarean sections may be due to the changing demographics of women giving birth in Australia. Increased age at first birth, higher body weight, gestational diabetes and previous caesarean section all impact the likelihood of an unassisted vaginal birth. The increase may also be due in part to more women electing caesarean sections, or obstetricians seeking to minimise risk. There is concern that a push to reduce rates of caesarean section may result in more aggressive interventions to achieve vaginal birth (Dietz and Woodrow 2016).

Home births

In 2016, only 0.3% of Australian births occurred in the home. Mothers giving birth at home are usually older and less likely to be first-time mothers (AIHW 2018a). A 2011 UK study found that women who have previously given birth and who opted for homebirth experienced fewer interventions than those who gave birth in an obstetric unit, with no impact on perinatal outcomes. However, homebirths for women who have not previously given birth involved fewer interventions but also poorer perinatal outcomes. The study recommended that healthy women with low risk pregnancies should be offered a choice of birth setting (including homebirth) (Birthplace in England Collaborative Group 2011).

Cultural considerations

Cultural factors, socio-economic status and support networks can influence a woman's interpretation of what a 'good' birth is (Dietz and Campbell 2016). Overseas-born women are less likely to access early antenatal care (before 14 weeks of pregnancy) than their Australian-born counterparts. Barriers include difficulty navigating a complex healthcare system and cost, as free public healthcare is not offered for the first 12 months to immigrant women on temporary visas (Multicultural Centre for Women's Health 2016).

Case study: The importance of bilingual and bicultural workers trained in women's health

Bilingual and bicultural workers who are specifically trained in women's health are critical to improving the health and wellbeing of immigrant and refugee women, particularly during the perinatal period (MCWH Health Education Program 2016). Women should be given the option of interpreters for all consultations.

The Multicultural Centre for Women's Health emphasises the importance of high quality language services, "because language services are not simply about the presence of an interpreter or the provision of translated material" (MCWH Health Education Program 2016). It is important for bilingual and bicultural workers to be able to accurately translate complex medical information in a way that the patient can understand.



Lack of consent and/or respect for birth preferences

Informed consent and a positive birth experience can help a woman enter motherhood feeling strong and capable (Nilsson, Thorsell, Hertfelt Wahn 2013). Unfortunately, women report that health professionals often do not listen to their birth preferences or seek informed consent, resulting in unwanted birth interventions (use of forceps, episiotomies, epidural, unplanned caesarean). Legally, informed consent is a right that requires unbiased discussion of treatment options and associated risks. However, it is frequently ignored (Dietz and Exton 2016).

Informed decision-making for procedures in childbirth varies among procedures. A 2010 Queensland survey of over 21,000 mothers found that of women who had an unplanned caesarean section, only 20% of women reported making an informed decision to have the procedure (Miller, Thompson, Porter 2011). The same survey reported that only 7.8% of women who had an episiotomy gave informed consent. In contrast, up to 69% of women who had an epidural made an informed decision to have one. (Miller, Thompson, Porter 2011). It is concerning that large numbers of women report not having made informed decisions about these procedures. The study's authors recommend that procedures for patient consent be reviewed to achieve optimal standards of patient information provision.

Women whose first language is not English face language and cultural barriers to accessing healthcare. Language barriers become especially problematic if women need unexpected or emergency procedures during birth (Kang 2014).

Birth-related support

The 2018 Victorian Parliamentary Inquiry into perinatal services found that many women do not get enough support after they are sent home from hospital and struggle with their mental health and breastfeeding (Victoria. Parliament. Family and Community Development Committee 2018). The Inquiry also reported that a shortage of hospital beds sees some women discharged from hospital after a very short admission, often before they are ready, which can compromise the health, safety and wellbeing of mothers and children. Maternal and Child Health (MCH) nurses visit new mothers at their home within about a week after birth to provide support. Additional home visits can be arranged for eligible families. MCH support is discussed in more detail in Chapter 4 of this paper.

Self-determination for Aboriginal and Torres Strait Islander women

Respecting Aboriginal and Torres Strait Islander women's birthing practices and knowledge is crucial for self-determination and wellbeing. Many Aboriginal and Torres Strait Islander women would traditionally have given birth on the lands of their ancestors. However, colonisation, pregnancy complications and limited access to healthcare can mean that this is often no longer possible. Midwives can work with Elders to ensure a spiritual connection to country for the new mother (Marriott 2016).

Informed consent and a positive birth experience can help a woman enter motherhood feeling strong and capable

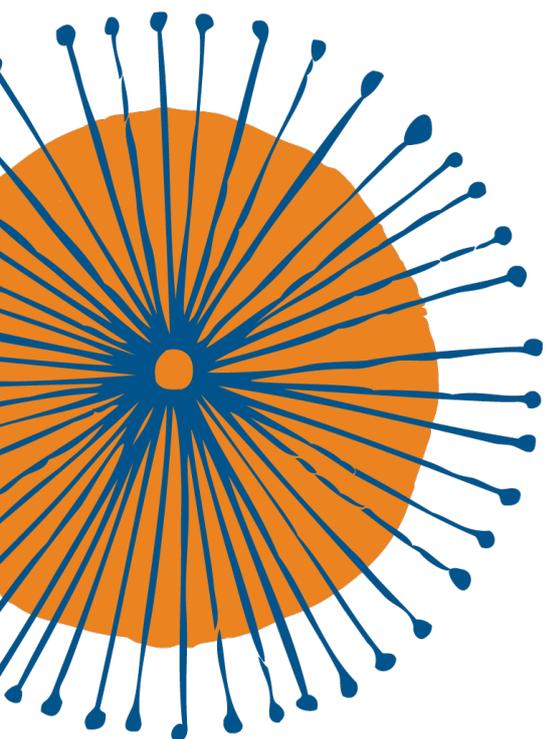
Case study: Birthing on Country

Many factors influence Aboriginal and Torres Strait Islander women's engagement with antenatal care, including the availability and accessibility of culturally appropriate services, and institutional racism (CATSINaM, Australian College of Midwives and CRANA Plus 2016).

Long-advocated for by Aboriginal and Torres Strait Islander women, Birthing on Country facilitates the integral connection between birthing, country and place of belonging (Kildea and Van Wagner 2012), and existed for many thousands of years before white settlement. Maternity services that adopt Birthing on Country models are led, designed and developed with Aboriginal and Torres Strait Islander women and incorporate the following principles. They:

- are community based and governed
- provide for inclusion of traditional practices
- involve connections with land and country
- incorporate a holistic definition of health
- value Aboriginal and/or Torres Strait Islander as well as other ways of knowing and learning
- encompass risk assessment and service delivery and are culturally competent (Kildea, Magick Dennis and Stapleton 2013).

Even though most Aboriginal women live in urban areas, and not necessarily on their ancestral land, Birthing on Country principles can be applied to any setting and allow women and their families to define their own cultural practices to enable connection to culture. Currently, few such models exist in Australia.



Summary

Women should be given information on all the birthing options available to them during their antenatal appointments so that they can choose what will be best for themselves and their baby. Women must have their right to informed consent around birthing options and practices supported by health professionals, including when unexpected circumstances arise. These situations emphasise the critical importance of bilingual and bicultural workers who are specifically trained in women's health and able to relay complex medical information. Aboriginal and Torres Strait Islander women should have the option to practice Birthing on Country principles no matter where they live or give birth.

3.2 BIRTH TRAUMA

Negative impacts of childbirth on a woman's body and mind may be minimised by health professionals (and others) as “manageable, treatable and non life-threatening”, despite seriously impacting women's ongoing quality of life (Hansson 2018). Dismissive attitudes towards women faced with the prospect of living with urinary or anal incontinence, sexual dysfunction and pelvic organ prolapse shows lack of knowledge and understanding of the psychosocial impact of birth injuries.

Traumatic birth experiences can lead to ongoing pain, health complications and psychological trauma for women

Though circumstances can unexpectedly and quickly change during labour, every effort must be made by health professionals to provide women with information so that they are able to make an informed decision. This is particularly important given the significant health problems that can be associated with higher levels of birth intervention. For example, a 2012 UK study found that women who had forceps-assisted vaginal births or unplanned caesarean section births reported poor health and wellbeing at three months post-birth (Rowlands and Redshaw 2012).

Traumatic birth experiences can lead to ongoing pain, health complications and psychological trauma for women. Between 20-30% of women suffer traumatic vaginal birth, that is, major physical damage to pelvic floor structures such as the anal sphincter and the levator ani muscle (Dietz and Campbell 2016). The injuries sustained are associated with psychological trauma from the resulting pain, anxiety, impact on sex life, changes in body image and other symptoms of pelvic floor dysfunction (Skinner and Dietz 2015). The psychosocial consequences of birth trauma are poorly understood and underassessed by health professionals and can lead to postnatal sexual health problems, poor baby bonding, relationship breakdown and reduced quality of life (Skinner and Dietz 2015).

Many women who have experienced a traumatic birth report that they did not receive a postnatal assessment of their injuries and describe health professionals who were dismissive of their injuries and symptoms:

“The midwife said that this was OK... but I knew that it was not normal... The doctors really did not understand the situation... I was in shock – devastated and unable to get any health professional to understand.”

– Woman with major pelvic floor trauma (complete levator avulsion) (Skinner and Dietz 2015)

The result is that women often struggle to get a diagnosis, find support and receive treatment.

3.3 PREGNANCY LOSS AND STILLBIRTH

Pregnancy loss, miscarriage and stillbirth defy the modern expectation of a healthy pregnancy outcome (Human, Green, Groenewald 2014). Women who have experienced prior pregnancy loss are more likely to experience poor mental health including anxiety, depression as well as sadness, low mood and excessive worry during a subsequent pregnancy (Chojenta, Harris, Reilly 2014). However, a recent longitudinal study found that women who had suffered prior pregnancy loss were no more at risk of poor mental health outcomes than those with no history of pregnancy loss in the postpartum period (Chojenta, Harris, Reilly 2014).

Though up to 20% of women who know they are pregnant will have a miscarriage before 20 weeks (Royal Women's Hospital 2018), the experience is often considered private and concealed. The resultant lack of a public way to grieve can make it difficult to overcome the loss (Schwerdtfeger and Shreffler 2009). A US study found that women who experienced both antenatal loss and involuntary childlessness reported higher fertility-related distress compared to women experiencing pregnancy loss who also had children (Schwerdtfeger and Shreffler 2009).

Every day in Australia, six babies will die in the womb and be stillborn. Despite technological and medical advances, the stillbirth rate in Australia over the past 20 years has not decreased significantly, and in 2014 the rate was recorded as 7.1 per 1000 births (AIHW 2018b). The Lancet reports that in high income countries, less than half of parents who experience stillbirth are given follow up support (Flenady, Wojcieszek, Middleton 2016).

Because fertility and motherhood are central to the construction of womanhood, women who experience pregnancy loss or stillbirth may blame themselves and experience misplaced guilt over the loss of a pregnancy. Media and popular discourse that emphasise personal responsibility in maintaining a healthy pregnancy suggests that women who don't carry to term are at fault, or could have prevented their loss. Though fathers and partners also mourn the loss of their child, the pregnant woman may feel a sense of culpability and guilt and may still undergo the physical process of giving birth. Cultural norms paint motherhood as a natural and essential expression of womanhood. These norms can make the experience of pregnancy loss and stillbirth isolating and difficult to talk about for women and their partners.

Hospitals and health professionals should provide adequate bereavement care, information and referral to parents who experience pregnancy loss or stillbirth. Supports should be informed by consultation with women who have had these experiences. Improving public awareness of stillbirth and pregnancy loss may help those who have experienced it to feel comfortable to talk, and help workplaces and the community to offer adequate support and recognition.

3.4 INTIMATE-PARTNER VIOLENCE AND EARLY MOTHERHOOD

Pregnancy and the early years of motherhood are periods of increased risk for experiencing intimate partner violence for the first time, or an increase in the form or intensity of violence (Campo 2015). A 2014

study of Australian first-time mothers found that 29% experienced intimate partner violence before their child turned four (Gartland, Woolhouse, Mensah 2014).

A partner may choose to use violence for the first time or escalate their use of violence if they are jealous of a mother's focus on her baby, or resentful of a mother's reduced availability to her partner and limited ability to perform domestic duties. These circumstances can lead an abusive partner to reassert his control with violence (Campo 2015).

“Sexual violence and reproductive coercion have been identified as features of domestic violence during pregnancy and post-partum as pregnancy may limit a perpetrator's assumed entitlement and free access to his partner's body.”

– (Campo 2015)

Experience of intimate partner violence has significant impacts on women's mental health and is associated with increased risk of depression and suicide. It is also a key risk factor for developing postnatal depression (Yelland, Sutherland and Brown 2010). Mothers who experience domestic violence often blame themselves (and are blamed by others) for 'failing to protect' their children from domestic violence (Moulding, Buchanan and Wendt 2015). Men who use violence often attack mothering skills and the mother-child bond as a tactic to assert power and control over their partner and children (Heward-Belle 2017). This can impact how a woman sees herself as a mother and her relationship with her children (Fish, McKenzie and MacDonald 2009).

There have been some recent improvements in health services' responses to family violence. In 2014 and 2015, the Victorian Government funded the Royal Women's Hospital and Bendigo Health to develop and implement a framework for embedding the practice of identifying and responding to family violence. The *Strengthening Hospital Responses to Family Violence* model recognises that frontline hospital staff are uniquely placed to identify, support and refer victims of family violence, and builds staff capacity to do so. It is now being applied to hospitals across Victoria.

Case study: Health-Justice Partnerships

A health justice partnership between Inner Melbourne Community Legal Service and the Royal Women's Hospital that began in 2013 aims to address family violence by building the capacity and willingness of health professionals to identify signs of family violence and provide legal referrals. The project focuses on reaching patients from low socio-economic, and multicultural backgrounds who are at risk of, or already experiencing, family violence (Hegarty, Humphreys, Forsdike 2014).

Deterrents to accessing legal help in the perinatal period include financial constraints as well as stress and lack of time for yet more appointments. Having a lawyer at the hospital means that women can access legal advice at their antenatal and postnatal check-ups. They are also surrounded by social workers and other health support.

An external evaluation (Hegarty, Humphreys, Forsdike 2014) of the program showed that women found it empowering and helpful to access information and legal advice in the healthcare setting. Most of the women reported that receiving legal advice had a positive impact on their mental and emotional health. The evaluation also found that the health justice partnership training built the capacity, confidence and willingness of over 100 health professionals to identify signs of family violence. There are now 24 health justice partnerships with hospitals across Victoria.

3.5 CONCLUSION

Ensuring that women are able to access appropriate information and support in the antenatal period would support better mental and physical health outcomes for mothers. This includes discussing preferred birth plans, whether vaginal or caesarean, with health professionals prior to delivery where possible. The long-term health and wellbeing of the mother should be a key consideration in how health professionals treat and communicate with women giving birth.

Women must be consulted, respected and given the information they need to make informed decisions. To improve health and wellbeing outcomes for immigrant and refugee women, hospitals and health services require bilingual and bicultural workers who are specifically trained in women's health. These workers must be able to accurately translate complex medical information in a way that the patient can understand (MCWH Health Education Program 2016).

Birth on Country programs in Australia should be supported and further developed to ensure that Aboriginal and Torres Strait Islander women are able to access culturally supportive continuity of care through the antenatal and postnatal period (CATSINaM, Australian College of Midwives and CRANA

Plus 2016). Increasing the Aboriginal and Torres Strait Islander maternal health workforce is also critical.

Cultural safety training for health professionals is integral for the provision of culturally competent health care. Health professionals should also receive training on best practice care for women who have experienced pregnancy loss. Health professionals should avoid minimising women's symptoms, concerns and distress in relation to injuries sustained through traumatic childbirth. Improving public awareness of stillbirth and pregnancy loss may help those who have experienced it feel comfortable to talk, and help the community and workplaces to offer adequate support and recognition.

More broadly, the discourse around pregnancy and birth needs to shift to one which recognises that the health and wellbeing of the mother is as important as, and complementary to, the health and wellbeing of her infant. Respecting and emphasising women's strength and resilience in the face of very real challenges and equipping health professionals, partners and family to understand women's experiences during pregnancy and birth, and the role they can play to provide support, would help to take the pressure off mothers.

4. THE POSTNATAL PERIOD

4.1 POSTNATAL DEPRESSION AND ANXIETY

Though new motherhood is viewed as a time of joy, when mothers effortlessly bond with their children, many women will experience negative mental health in the postnatal period. The 2018 Victorian Inquiry into Perinatal Services found that families today receive less help from relatives, neighbours and the community compared to previous generations. Many submissions described women experiencing isolation in the postnatal period (Victoria. Parliament. Family and Community Development Committee 2018).

Raising awareness and decreasing stigma is important to support early intervention, particularly for women with pre-existing mental health concerns. However, most mothers will feel overwhelmed and in need of support in the postnatal period. Prevention strategies include education for partners and health professionals and increased services and supports for new mothers.

Prevalence

Postnatal depression is depression experienced in the postnatal period (up to 12 months after birth). Symptoms include feeling low or numb, feeling helpless, hopeless and worthless, lack of interest and energy, feeling isolated and disconnected and finding it difficult to get through the day (COPE 2017b).

Postnatal anxiety is just as common and is experienced by many mothers at the same time as depression. Symptoms include persistent feelings of: fear and worry, losing control, restlessness, and recurring thoughts that something terrible will happen. Panic attacks and trouble sleeping may also be experienced (COPE 2017a).

The prevalence of postnatal depression and/or anxiety is debated, and stated rates

often rely on self-reported data. The last comprehensive survey of Australian women on this matter in 2010 found that around 20% of women with children under 24 months old had been diagnosed with depression, with half of this cohort diagnosed during the perinatal period (AIHW 2012). Another Australian study found that up to 40% of women reported experiencing postnatal depression, suggesting that postnatal depression may be under-diagnosed (Lazarus and Rossouw 2015).

Postnatal anxiety is just as common and is experienced by many mothers at the same time as depression

In 2016, maternal suicides and intentional self-harm accounted for almost half of the 17 maternal deaths in Victoria. Three-quarters of these women had pre-existing mental health disorders (Victoria. Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) 2017). This points to the need for better early identification and supports for women with pre-existing mental health concerns in recognition that pregnancy and motherhood places considerable additional pressures and stress on mothers.

Risk factors for postnatal depression and anxiety

While the biggest risk factor for developing a perinatal mental health condition is previous history of a mental health disorder (Austin, Hight and Expert Working Group 2017), research is increasingly recognising that life stressors and social factors place women at increased risk of postnatal depression. These include experiencing a major life-changing event, for example separation and divorce, family violence, serious family conflict, bereavement, losing a job, moving house or homelessness (Yelland, Sutherland and Brown 2010). Isolation and lack of social support also increase the risk of postnatal depression (MCWH 2017), as

does migration experience and challenges associated with the resettlement process for immigrant and refugee women (Hach 2012).

Research is increasingly recognising that life stressors and social factors place women at increased risk of postnatal depression

Experiencing financial difficulties and stress is also associated with postnatal depression (Yelland, Sutherland and Brown 2010). Mothers living in the lowest income households were more likely to experience perinatal depression than those in the highest (14% compared to 7%) (AIHW 2012). Young mothers are at high risk of poor mental health outcomes compared to those who become mothers aged over 25 (Aitken, Hewitt, Keogh 2016). Young motherhood is associated with socio-economic disadvantage, and women who become early mothers are more likely to live in rural areas and experience limited educational and employment opportunities (Holden, Hockey, Ware 2018).

Mothers who are sole parents are at greater risk of developing postnatal depression. They are more likely to experience contributing factors such as stressful life events, including financial strain and limited social support, than their partnered counterparts (Atkins 2010).

Issues related to child ill-health, premature birth (Shaw, Sweester, St. John 2013) and maternal and child sleep problems are also related to depression (Clout and Brown 2015). Premature birth can be traumatic as it is often unplanned, and premature babies are at risk of health complications.

The experience of infertility and undergoing Assisted Reproductive Technology (including in vitro fertilisation, or IVF) may impact women's mental health. Women who have gone through IVF are at increased risk of depression and anxiety, and reduced self-esteem (Barnes, Roiko, Reed 2012). Coming to terms with needing reproductive assistance can be difficult and the often multiple treatment cycles needed can place additional stress on mental health, the body, relationships and finances (COPE 2014).

Each unsuccessful cycle can leave a woman feeling more anxious and stressed, and can be compounded by pressure from family. Women who have undergone assisted conception are more likely to be concerned about miscarriage and the baby's health than those who have conceived naturally (Barnes, Roiko, Reed 2012). Increasing health professionals' knowledge of the impact of assisted conception is important to inform appropriate care and practice (Barnes, Roiko, Reed 2012).

A range of psychosocial risk factors, including poor couple relationship, inadequate social support and poor sleep quality are associated with experiencing postnatal anxiety, as mothers with inadequate support may feel overwhelmed and isolated (Seymour, Giallo, Cooklin 2015). Relationship stress and dissatisfaction are associated with postnatal depression (Rich, Byrne, Curryer 2013). Poor partner support in the transition to motherhood puts women at increased risk of postnatal depression (Najman, Khatun, Mamun 2014).

Prenatal depression is a risk factor for postnatal depression (Pearson, Carnegie, Cree 2018). A recent UK longitudinal study of two generations of young mothers (aged 19-24 years) found that women pregnant in 2012-2016 were 51% more likely to suffer prenatal depression and anxiety than their mothers' generation (pregnant in 1991-1992) (Pearson, Carnegie, Cree 2018). The increases in prenatal depression and anxiety mirror the general increase in depression among young women and may be associated with changes in society and lifestyle (chronic stress, sleep deprivation, eating habits, sedentary lifestyle, pace of modern life) (Hidaka 2012). Difficulties balancing home and paid employment were reflected in women reporting "things are getting too much" (Pearson, Carnegie, Cree 2018).



Barriers to help-seeking

Australian and international research finds that fear of judgement and the desire to present as a 'good mother' leads to women concealing depressive symptoms and not seeking help (Buchanan and Loudon 2015), (Lazarus and Rossouw 2015).

Aboriginal and Torres Strait women are less likely to access maternal health services, less likely to be screened for postnatal depression and more likely to experience 'shame' (Hancock 2006). Shame is a complex concept in regards to Aboriginal women and pregnancy and birthing. Shame is explained as resulting from being forced to act in disharmony with an individual's cultural or social beliefs (Hancock 2006). This can be due to lack of culturally appropriate services, experiences of racism in health services and fear of having their child removed. Aboriginal and Torres Strait Islander women are more likely to become young mothers than non-Aboriginal women, and are often faced with multiple social and emotional pressures (Kildea, Tracey, Sherwood 2016).

Fear of judgement and the desire to present as a 'good mother' leads to women concealing depressive symptoms and not seeking help

Though it is recommended that women be screened for perinatal mental health issues, overseas-born women are less likely to be asked about low mood or relationship problems by health professionals post-partum (MCWH 2017). This is a significant issue as pregnancy and early parenting is a high risk period for the first experience of domestic violence, or an escalation of violence and, compared to Australian-born women, migrant and refugee women have a higher prevalence of postnatal depression (MCWH 2017). This is likely due to isolation, language barriers, fewer social supports and difficulties navigating a complex foreign health system. Migrant and refugee women also report wanting more practical and emotional support (MCWH 2017).

4.2 BREASTFEEDING

Breastfeeding can contribute to the health and wellbeing of mothers and infants. Breastmilk not only promotes sensory and cognitive development in infants, it also protects against infectious diseases. The World Health Organisation recommends exclusive infant breastfeeding for six months (WHO 2011). However, breastfeeding (or breastfeeding for that duration) is not always realistic or possible. The Royal College of Midwives (UK) recently updated their guidelines to advise that women who decide not to breastfeed, or who breast and bottle feed, must have their choices respected and supported (Royal College of Midwives (UK) 2018).

Though most women's bodies after childbirth will have the ability to produce breastmilk, breastfeeding is still a learned behaviour and new mothers need adequate support to establish and sustain the practice. Many women, reinforced by social norms, expect that breastfeeding will be easy and are often ill-prepared for the challenges. Labelling breastfeeding as 'easy' does not do justice to the time, effort to overcome challenges, and sacrifice women make when they breastfeed. (Brown 2016) The pressure to breastfeed can impact the mental health of new mothers and make those who cannot breastfeed feel as though they have failed their children (Woolhouse, James, Gartland 2016). When health professionals, the media and other mothers gloss over the reality that breastfeeding can be challenging and painful, women who experience difficulties may feel disillusioned. (Brown 2016) A lack of partner support and negative comments from family and friends can erode a mother's confidence in her ability to breastfeed.

Though most women's bodies after childbirth will have the ability to produce breastmilk, breastfeeding is still a learned behaviour

There are many reasons why a woman may be unable or unwilling to breastfeed. Mastitis, low milk supply and cracked nipples can make breastfeeding an extremely painful or difficult experience and, rather than bonding with the baby, women may come to fear or resent feeding their child. After giving birth, women report a lack of breastfeeding support and are increasingly sent home from hospital before their milk comes in (Victoria. Parliament. Family and Community Development Committee 2018).

Our culture's aversion to breastfeeding at work or in public spaces, coupled with recommendations from public health bodies to breastfeed exclusively for six months, can limit new mothers' participation in public life and reinforce gender norms that emphasise that a mother's place is at home. Though there is an increasing call for male partners to share childcare responsibilities, the expectation that women should breastfeed exclusively for six months has gendered implications for infant care (Faircloth 2015).

Depression may be a contributing factor to breastfeeding difficulties, and breastfeeding difficulties may contribute to maternal distress (Woolhouse, James, Gartland 2016). On the other hand, better body image is associated with maintaining breastfeeding and lower psychological distress postpartum (Swanson, Keely and Denison 2017). Women in larger bodies report breastfeeding for shorter periods of time than their smaller counterparts due in part to body image concerns (Newby and Davies 2016).

4.3 BODY IMAGE

Pregnancy-related changes have a significant impact on women's body image by transgressing the socially constructed ideals of female beauty, such as thinness, shapely breasts and unmarked skin (Hodgkinson, Smith and Wittkowski 2014).

The pressure to lose 'baby weight' stems from gender norms perpetuated by the broader community and media. A systematic review of the literature found that women protect against this

by distinguishing between 'fatness' and pregnancy. However, the review found that women felt pressure to lose weight in order to 'reclaim' their postpartum bodies (Hodgkinson, Smith and Wittkowski 2014). Striving to reclaim the postpartum body, women viewed the mothering identity conferred by their body as in conflict with other identities (Hodgkinson, Smith and Wittkowski 2014).

"Having the big tummy during pregnancy was fine, I enjoyed that, because it meant I was pregnant and everyone could see that. But now, if I'm not with my baby then people have no idea why I'm bigger."

– (Hodgkinson, Smith and Wittkowski 2014)

While some studies have found that some women feel 'exempt' from body image pressure during pregnancy (Johnson, Burrows and Williamson 2004), (NEDC 2015), 70% of new mothers attempt to lose weight within four months after giving birth (NEDC 2015). A UK report published for the Government Equalities Office stated that women are pressured to lose weight too quickly postpartum: "There is a cultural insinuation that a mother's job is to present herself physically as though nothing as momentously life-changing or body-changing as having a baby has occurred" (Orbach and Rubin 2014).

Pregnancy and post pregnancy is a time of high risk for the development of an eating disorder (EDV 2016). At a time when mothers do not have time to themselves, let alone time to exercise, food intake may be something they feel they can control. A recent Norwegian study found that eating disorders during pregnancy were relatively common (Watson, Torgersen, Zerwas 2014).

"Physically, I didn't feel attractive you know. I was just like "How could you want to have sex with me? I'm like really looking hideously ugly and my boobs are huge and leaking milk everywhere."

– (Woolhouse, McDonald and Brown 2009)

Having a baby can also change a woman's relationship with her body and sexuality. She may struggle to reconcile her sexuality and sexual intimacy with her role mothering an infant.

“One of the things that worries me the most about breastfeeding is your breasts going from being this sexual thing to a feeding practical thing for the baby, so I think that’s one of my worries about our relationship and about breastfeeding...”

– (Faircloth 2015)

However, some women report feeling more positive about their bodies after childbirth:

“I feel like if anything, I had more respect for myself and for the female form. I mean, it’s quite a miraculous thing, and I found that empowering, rather than sort of negative.”

– (Woolhouse, McDonald and Brown 2009)

Focusing on what their bodies can do can help increase body satisfaction in post-partum women (Packham 2017). A UK study found that women who had breastfed their babies viewed their bodies more functionally than women who bottle fed (Fern, Buckley and Grogan 2014).

Perceived support from a woman's partner regarding her postpartum physical appearance has been found to increase body satisfaction (Hodgkinson, Smith and Wittkowski 2014). Though the issue is often minimised due to the normalisation of unhealthy attitudes to food and the body, it is important for health professionals to understand how a woman's body image may affect her wellbeing (Orbach and Rubin 2014). The National Eating Disorder Collaboration recommends increasing research, support and awareness regarding body image during pregnancy and post-partum.

It is important for health professionals to understand how a woman's body image may affect her wellbeing

4.4 INTIMACY AND RELATIONSHIPS

For many couples, relationship satisfaction declines after the birth of a child, with both same-sex and opposite-sex couples experiencing similar changes after birth (Doss and Rhoades 2017). Women who are dissatisfied with their relationship with their partner are four times more likely to report being stressed in the perinatal period (Jonsdottir, Thome, Steingrimsdottir 2016). Compared with Australian-born mothers, immigrant mothers are more likely to report relationship problems and lower emotional satisfaction with their partners (MCWH 2017).

Difficult relationships, partners who are unsupportive, controlling or critical, and domestic violence are all associated with postnatal depression (Rich, Byrne, Curryer 2013). In the transition to parenthood, women in relationships who have poor support from their partners have been found to be at increased risk of postnatal depression compared to single mothers (Bilszta, Tang, Meyer 2008). An Australian longitudinal study found a bi-directional association between poor relationship quality and maternal depression (Najman, Khatun, Mamun 2014).

For coupled women, a supportive partner can help make the transition to motherhood positive. In a 2009 longitudinal study on new mothers in Melbourne, women reported that the following strategies helped them to positively transition to parenthood:

- Talking to their partner about how they would deal with the demands of parenthood;
- Shared responsibility for the emotional and physical aspects of parenting equitably;
- Getting time to themselves;
- Slowly rebuilding a sexual relationship;
- Agreement with their partner that sex is not a priority in the months after childbirth;
- Knowing what to expect after childbirth;
- Having a trusted health professional with whom to talk about sex and relationships (Woolhouse, McDonald and Brown 2009).

Emotional and sexual intimacy

After the birth of a child, women report a considerable drop in both emotional satisfaction and physical pleasure in intimate relationships, with emotional satisfaction continuing to fall up until 4.5 years postpartum (Woolhouse, McDonald and Brown 2013).

On average, parents are only somewhat satisfied with their sex life. Greater parenting stress significantly predicts lower sexual satisfaction for mothers, but not for fathers (Leavitt, McDaniel, Maas 2017).

“I’ve just had an infant kind of attached to me for two hours, I don’t want any more, get away from me, kind of thing.... It kind of feels like “I don’t want any more people kind of feeding off me in that sense, right at that instant.”

– (Woolhouse, McDonald and Brown 2009)

High expectations on women to ‘do it all’ mean that women who experience reduced libido are vulnerable to feelings of guilt and failure (Woolhouse, McDonald and Brown 2012). The pressure for women to have unwanted or ‘maintenance’ sex blurs the line between coercion and consent. Health professionals often suggest that penetrative sex can resume six weeks post childbirth, however many women do not want sex so soon (Gorman 2017).

Experiences of post baby sex can be worse than expected in some cases, especially where a woman has had an episiotomy (Faircloth 2015). Women who have had a caesarean or assisted vaginal delivery have an equivalent or a higher likelihood of experiencing persisting sexual health issues, compared to those who had an unassisted vaginal birth (McDonald, Woolhouse and Brown 2015).

“We tried a few times [to have sex] and just couldn’t do it. Like physically couldn’t do it because of pain, which really turned me off sex for a while.”

– (Woolhouse, McDonald and Brown 2009)

The loss of sex is often more keenly felt by male partners, who may equate such activity

with intimacy or even love or may feel entitled to sex from their partner. Together with the fatigue and sense of responsibility that comes with being a new mother, women’s views on sex and their sexual desire often change after having children and many feel disconnected from their sexuality for a period of time (Montemurro and Siefken 2012).

Nevertheless, the amount of penetrative sex is often used as a barometer for couples assessing the quality of their relationship (Faircloth 2015). This means that some women may feel pressure to acquiesce to their partner’s demands rather than their partner understanding and respecting their needs and boundaries. Using how often couples have sex to measure the health of their relationship is simplistic and reinforces the notion that sex is something to be performed rather than an activity to be enjoyed.

Women report needing more information to prepare them for the changes in sex and relationships after childbirth:

“There’s not enough said about how your sexuality may be affected...if I’d been prepared that things could be different, then perhaps I would have coped better or taken it more in my stride.”

– (Woolhouse, McDonald and Brown 2009)

Women are often reluctant to raise these issues unless asked about them directly. This can be due to short health consultation length, feelings of embarrassment or shame, as well as beliefs that issues will resolve themselves or are untreatable (McDonald, Woolhouse and Brown 2015).

Health professionals should ask their postnatal patients in a supportive and non-judgemental way if they are experiencing any sexual, intimacy or relationship issues. Even though sex and relationships have an enormous impact on health and wellbeing, less than one-quarter of participants in an Australian study reported that their general practitioner had asked directly about sexual health or relationship problems in the first 3 months postpartum (23% and 18% respectively) (Woolhouse, McDonald and Brown 2013).

Case study: Healthy relationships – Baby Makes 3

Baby Makes 3 is a program that aims to support new parents to develop and maintain equal and respectful relationships after the birth of a baby. Delivered by a male and female facilitator, the program helps new parents critically reflect on the level of equality in their relationship and encourages participants to share domestic work and caring more equally.³

Evaluations of Baby Makes 3 have found the program delivered gender-transformative results, with participants developing a greater awareness of how traditional attitudes to gender and parenting roles were shaping their families (Keleher and Hutcheson 2016).

Mothers reported that their partners had changed their behaviours by doing more domestic work, spending more time alone with their children and giving mother's 'guilt-free' time out. Couples reported having a stronger relationship, increased intimacy and a greater appreciation of each other's perspectives and contributions (Carrington Health 2016).

"You get the appreciation of what the mum goes through because I guess I go to work and I come home and my wife might say she's had a tough day..., but you don't fully understand I guess".

- (Father) (Keleher and Hutcheson 2016).

"For me personally I think it was in the first week, it was really nice because at that stage I was still dealing with sort of my own expectations and what I thought society expected. To have it drawn out and to also have the comparison of how much we expect of mothers versus fathers, and talking in the program about what's realistic [helped me]... feel like "Okay, I'm not doing too bad."

- (Mother) (Keleher and Hutcheson 2016).

Case study: Bbkayi (Baby Plus 2)

The resettlement experience, lack of familiarity with the complex Australian health system, and lack of consideration of the health and spiritual beliefs of different cultures can make it difficult for Chinese couples, and for other immigrant and refugee communities, to access health services (Wong 2012).

The Bbkayi report was developed by the Multicultural Centre for Women's Health to find out why Chinese women in the Whitehorse region were not accessing antenatal and perinatal services at the same rate as other women in the region. The report found that family and Chinese cultural practices, such as the 30-day confinement period, play an important part during pregnancy and childrearing and influence how Chinese women access programs and services. Bbkayi is a useful resource for improving the cultural relevance of health services.

3. The initial Baby Makes 3 project (2009-2012) was funded and evaluated by VicHealth. Between 2012 and 2015, Carrington Health was funded by the Department of Justice & Regulation, through their 'Reducing Violence Against Women and Children Grants' to deliver the Baby Makes 3 Program in the Eastern Metropolitan Region (EMR) of Melbourne. The three year project was a partnership between Carrington Health and the seven Local Governments in the EMR.

4.5 CURRENT SUPPORT SERVICES

Maternal and Child Health services

The Victorian State Government funds a free Maternal and Child Health line, which averages 300 calls per day. The phonenumber provides parents with support and guidance from Maternal and Child Health nurses on a range of issues including nutrition, breastfeeding, sleep and settling and childhood illness (Victoria. Minister for Early Childhood Education 2018).

New parents are encouraged to see Maternal and Child Health nurses at 10 key stages of their child's development, beginning with a home visit in the week after birth and concluding when their child is 3.5 years. However it has been queried whether these 10 visits meet the need of families with complex needs or families experiencing adversity (Victoria. Parliament. Family and Community Development Committee 2018):

“Maternal child health services... are set up for middle-class, white people who live in Melbourne to go and get their 10 ages and stages, and often the workforce is really expecting to see those women... So it is almost like there needs to be a specialised workforce that actually works with families with more complex stories really; that are not there just to get their 10 checks, but maybe need a whole lot of different services in a different way”

– Ms Kate Glenie, Loddon Mallee Aboriginal Reference Group Early Years Project Worker, Mallee District Aboriginal Services, Family and Community Development Committee public hearing (Victoria. Parliament. Family and Community Development Committee 2018)

Significant barriers to accessing Maternal and Child Health services exist for refugee women, including lack of access to transport, and lack of confidence speaking English and making bookings. An Australian study found that continuity of nurse and interpreter was important for increasing trust and engagement with the service (Riggs, Davis, Gibbs 2012).

Support for perinatal depression and anxiety

Screening for postnatal depression and anxiety at appointments with Maternal and Child Health nurses aims to identify women who are at risk and refer them for help. However, more information on the success of referral pathways for mental health issues is needed (Austin, Reilly and Sullivan 2012). Screening that is limited to the use of a scale or questionnaire may not identify women who are masking their perinatal depression or other difficulties; consultation, including observation and discussion, is also essential. Some staff who are not trained in mental health report that they fear asking some of the more confronting questions in screening tools, in part because they do not know how to manage a disclosure (Victoria. Parliament. Family and Community Development Committee 2018). Unfortunately, the provision of workforce training for routine perinatal depression screening has been negatively impacted by the loss of Commonwealth funding for the National Perinatal Depression Initiative.

There is demand for postnatal depression support groups, however the resourcing of these groups is difficult where there may be small numbers of women affected in a local area. Women living in rural and regional areas face barriers to accessing health and mental health services due to distance and workforce shortages (Victoria. Parliament. Family and Community Development Committee 2018). The 2018 Victorian Inquiry into Perinatal Services heard that perinatal mental health services were ad-hoc and not integrated with other health services (Victoria. Parliament. Family and Community Development Committee 2018).

There are a range of free state and national phone helplines to help new parents through the perinatal period. Perinatal Anxiety and Depression Australia (PANDA) offers new and expecting parents support as well as fact sheets and resources for new parents. In March 2018, the Gidget Foundation launched a free counselling service for new parents who are experiencing perinatal anxiety and/or depression and are unable to attend face-to-face consultation.

Antenatal classes

Antenatal classes are a useful setting for prospective parents to gain knowledge about the birthing process and life post-birth. However, many hospitals in Melbourne charge a fee to access antenatal classes and programs (Keleher and Hutcheson 2016).

Frankston City Council's *Baby Makes 3 Antenatal Pilot Project* was designed to support the Council's existing (postnatal) Baby Makes 3 program and broaden the reach of key gender equity and respectful relationship messages (Hutcheson 2017). An evaluation of the pilot found that it was effective and thorough and recommended it be included as a core part of antenatal classes. A benefit of the Baby Makes 3 partnership approach with an antenatal provider is that child birth educators and midwives have contact with a wide range of young families, including Aboriginal and Torres Strait Islander families and families from migrant and refugee backgrounds (Hutcheson 2017).

The Royal Women's Hospital runs an antenatal care clinic for women who are pregnant and have a disability. The Women with Individual Needs Clinic provides continuity of antenatal and postnatal care and includes a midwife and a social worker who assess psychosocial needs and provide information about services, support, advocacy, and practical assistance.

Parenting groups

In some areas in Victoria, parents' groups (which are predominantly attended by mothers) are run by the local Maternal and Child Health Nurse for 6 weeks, with women encouraged to meet informally after this and form support networks. The success of these groups varies and depends on individual attendees. Personal connections made at these groups can positively influence wellbeing, providing social support and building friendships in the local area (Strange, Bremner, Fisher 2016). The Victorian Inquiry into Perinatal Services reported that there is a need for more parenting and family support groups in rural and regional areas (Victoria. Parliament. Family and Community Development Committee 2018).

Some mothers' groups can be judgemental of women with postnatal depression and so these women can find these groups difficult. New mothers may feel worse where it appears that the other members are all coping and enjoying motherhood, and they may not feel comfortable divulging their experience to the group. Women who have previously experienced a stillbirth, or who have a child with a disability or a developmental difficulty, have reported reluctance to attend as they worry that the group may not be understanding of their circumstances (Deakin University. School of Health and Social Development 2018), (Barrett, Hanna and Fitzpatrick 2018).

A recent Australian study found that parenting groups can perpetuate gender stereotypes and are not inclusive of fathers. Though the name 'mothers' groups' had been changed to 'first-time parents' groups', fathers were still underrepresented in attendance. The study identified barriers including the fact that these groups are framed as a female space, sessions being scheduled during business hours and the perception that childcare is a female activity (Deakin University. School of Health and Social Development 2018). There is clearly a tension between recognising that women are still overwhelmingly the primary carers for the first 12 weeks and seeking to move to a gender transformative approach, which aims to shift gender norms about who is responsible for childcare and be more inclusive of dads/male partners.



4.6 CONCLUSION

The postnatal period marks a major transition in life, particularly for first time birthing mothers. Physical and emotional recovery from pregnancy, lack of sleep, breastfeeding, and changes to relationships and identity are challenging for any mother. However, for women who have fewer social supports, younger women, women from migrant backgrounds and women with pre-existing mental health conditions, the postnatal period can be particularly difficult in terms of mental health due to a lack of appropriate supports.

Universal mental health screening for women during the perinatal period, universal screening for family violence, and ensuring health professionals have clear integrated referral pathways would improve the access to and availability of perinatal mental health care

There is a need for more accessible and high-quality maternal and mental health services, particularly in rural and regional areas (Seymour, Giallo, Cooklin 2015) and improved screening. Universal mental health screening for women during the perinatal period, universal screening for family violence, and ensuring health professionals have clear integrated referral pathways would improve the access to and availability of perinatal mental health care (Victoria. Parliament. Family and Community Development Committee 2018).

Breastfeeding policies should provide appropriate and compassionate support to groups with low rates of breastfeeding, including women at risk of mental health problems. This may help to reduce maternal distress (Woolhouse, James, Gartland 2016).

Greater awareness is needed among health professionals around the correlation between maternal depression and difficulty breastfeeding (Woolhouse, James, Gartland 2016). More research and training is required so that health professionals are more aware of the complex interplay between breastfeeding, self-esteem and body image for some women. Understanding how a woman's body image may be affecting her wellbeing and functioning is important for the health professionals caring for women postpartum (Orbach and Rubin 2014).

Adequate support from partners is essential to a new mother's wellbeing

Adequate support from partners is essential to a new mother's wellbeing. In fact, in heterosexual couples, emotional support from fathers creates the greatest reduction in a mother's stress (Sampson, Villarreal and Padilla 2015). Encouraging and facilitating partners to share emotional and physical responsibility for their baby is important for women's wellbeing postpartum. It is also important that the new mother is encouraged and enabled to take time for herself.



5. EARLY PARENTING

5.1 BEING A 'GOOD MOTHER'

Contemporary child-rearing norms, focused on 'intensive mothering', are characterised by intense risk aversion and putting the child at the centre of everything a mother does. 'Intensive mothering' holds mothers accountable for their child's behaviour, even into adulthood, and expects them to be emotionally absorbed and personally fulfilled by their caring role (Hays 1996). Dominant ideas of good parenting/mothering stem from middle-class perspectives, and are now the benchmark against which all mothers are assessed, including working-class mothers (Dermott and Pomati 2015). Intensive mothering ideals assume that families have good access to resources and that the mother is not the primary breadwinner. This has implications for who is considered by service providers and our wider society to be a 'good mother'. Further, intensive mothering is framed as both the 'solution' to and the 'cause' of a host of social and health problems, placing women in an impossible situation (Faircloth 2015).

Women with disabilities who have children have historically been stigmatised. They face negative attitudes and assumptions that they can't take care of their children. This means parenting with a disability is often seen by others as a negative experience rather than a positive one (Storr 2007). Many women with disabilities feel that to pass as a socially acceptable mother, they must achieve a better-than-ideal performance of motherhood (Frohman 2009). This pressure means they are less likely to ask for assistance, as to do so would conflict with being a 'good mother' who is competent and therefore needs no help (Frohman 2009). Support services that assist adults, and those that assist children, often have inflexible boundaries, which can be a significant barrier for mothers with a disability who require service support (Frohman 2009).

Support from others, including from services, family and the community, provide a 'buffer zone' to help women raise their children (Storr 2007). There is limited recent research examining the mothering experiences of women with disabilities from a strengths-based perspective, and identifying the particular structural or attitudinal barriers they face and how these can be addressed.

Mothers, particularly working-class mothers in paid employment, who don't 'live up to' middle-class expectations about intensive mothering, risk being labelled inadequate mothers (Braun, Vincent and Ball 2008). Same-sex couples are more likely than their heterosexual counterparts to encounter stressors associated with identity and the transition to parenthood (Cao, Mills-Koonce, Wood 2016). Lesbian couples often encounter doubts and concerns about their parenting and the legitimacy of their family from other people, as they challenge the dominant heteronormative model of parenting (Cao, Mills-Koonce, Wood 2016). This adds pressure for them to enact and confirm identities as 'good parents', which can be a barrier to help-seeking (Cao, Mills-Koonce, Wood 2016).

As the birth parent, women are expected by health professionals, family and the wider community to be models of good health in terms of diet and to abstain from alcohol, cigarettes and drugs (as a minimum). Male partners and non-birth parents do not face the same scrutiny of their diet, appearance and lifestyle. Few services exist to support women to transition from drug or alcohol use during their pregnancy and stigma remains a key barrier to seeking help (Breen 2015).

5.2 IDENTITY

Pregnancy and early parenting is a time of significant change and often marks a major transition in women's lives. Yet because motherhood is seen as natural and universal, women may feel they should adjust seamlessly to their new identity, defined by their role as mothers. Often, women will experience changes to their identity, their body, their responsibilities, and – if they have a partner – changes to their relationship. For some, these changes can be positive. For others, these changes can take a toll on mental and physical health, particularly in the absence of adequate social support.

Gendered norms, practices and structures position motherhood as a key feature of female identity (Nicolson 1999) and motherhood is typically viewed as an experience of fulfilment and happiness (Buultjens and Liamputtong 2007). Prenatal motherhood expectations influence the experience of becoming a mother and a disparity between these expectations and the postnatal reality can significantly affect levels of self-esteem, depressive symptoms and stress (Lazarus and Rossouw 2015).

Failing to live up to idealised motherhood expectations can leave women feeling guilty and ashamed (Clarke 2015), as many new mothers think that they should be able to cope with a new baby on their own (Woolhouse and Brown 2015). Mothers may fear judgment from others and adopt two selves – the ideal self as mother and the 'real' self (Henderson, Harmon and Newman 2016).

Gendered norms, practices and structures position motherhood as a key feature of female identity

As a major life event, motherhood is a time of gains and losses. However, the dominant cultural narrative around motherhood only allows mothers to celebrate what they have gained (the baby, and their status as mother). It remains taboo for a woman to acknowledge and grieve the loss of her former life, self, career and relationships after becoming a parent (Lazarus and Rossouw 2015).

The transition to motherhood, including changes to body shape, is viewed by some women as being incompatible with societal expectations of how women should look, as well as with their other roles, including being sexually attractive or being a working woman (Hodgkinson, Smith and Wittkowski 2014). Not only does motherhood mark a shift in identity in terms of responsibilities, it can also be a time when a woman becomes financially dependent on her partner.

It remains taboo for a woman to acknowledge and grieve the loss of her former life, self, career and relationships after becoming a parent

5.3 MOTHERHOOD AND PAID EMPLOYMENT

The majority of young Australian women aspire to a life that combines paid work and motherhood (Johnstone and Lee 2009). Participation in work or activities outside the home has been shown to be important for mothers' mental health (Haslam, Patrick and Kirby 2015). For example, maintenance of social group memberships through the transition to motherhood is beneficial to mental health (Seymour-Smith, Cruwys, Haslam 2017).

“Work's played a really big role in ... helping me feel like a person rather than just a mother. I can go out and get all the affirmation of being in the adult world and that helps me feel good about myself, which helps me feel that I've still got something interesting to bring to the relationship.”

– (Woolhouse, McDonald and Brown 2009)

Participation in work or activities outside the home has been shown to be important for mothers' mental health

However, women in heterosexual relationships are expected to manage paid work and family responsibilities in a way that men are not (Johnstone, Lucke and Lee 2011). Though women's participation in paid employment has increased over the decades, they still perform a disproportionate amount of unpaid domestic work (ABS 2017).

Unequal responsibility between women and men for paid and unpaid labour has long-term health implications for women. It results in lower lifetime earnings, limited career progression, less job security and lower superannuation for women, which has been shown to erode their mental health (Platt, Prins, Bates 2015).

Current policy settings disincentivise mothers from working longer hours or full-time in paid employment. Income-tested financial supports, such as childcare subsidies and family tax benefits, favour women as secondary earners in the family and encourage one parent (usually the mother) to stay at home, discouraging them from re-entering paid employment, reinforcing gender norms and contributing to the gender pay gap (Johnstone and Lee 2016). These policies may explain why Australia continues to have a higher rate of part-time employment among women than many other countries. Australia ranks 27th out of 41 OECD countries for employment rates of women with children under 12 years of age. 45% of partnered working mothers (aged 25-45 years) work part-time in Australia, with 80% of these mothers citing family reasons (OECD 2017). For women caring for a child under five, the rate of part-time work increases to 61%, compared to only 8.4% of men (ABS 2018b).

Time pressure

An Australian study found that 33% of women with children reported feeling rushed, pressured and busy every day, compared to 20% of women with no children, and the majority of mothers reported feeling time pressure multiple times per week (Otterbach, Tavener, Forder 2016). This study also found that time pressure (rushing and feeling too busy)

increased by 10% for women with children between 1996 and 2012.

Women in heterosexual relationships are expected to manage paid work and family responsibilities in a way that men are not

Women with younger children experience greater time pressure (Otterbach, Tavener, Forder 2016). Time pressure is also associated with being employed, and increases with number of children and work hours, as well as economic insecurity (i.e. job instability and financial hardship) (Otterbach, Tavener, Forder 2016).

The intensification of work and longer work hours can undermine the time and energy available for private family and social life (Tali 2018). Depression is associated with time pressure (Roxburgh 2012). Perceived amount of time available also influences diet, eating habits and exercise, with significant public health impacts (Otterbach, Tavener, Forder 2016). Chronic stress impacts physical health and has been linked to chronic health conditions such as diabetes and cardiovascular disease (Mariotti 2015).

“Rarely is it acknowledged that being a mother is a difficult and demanding job and that, like any job, at times there can be a sense of uncertainty, disappointment, and regret about the job they are doing. Compared to other positions of responsibility, society regards motherhood very differently, and this differentiation between career-driven responsibility and motherhood responsibility can result in new mothers experiencing disenfranchised grief.”

– (Lazarus and Rossouw 2015)

Discourse around time pressure is often framed in individualised or neoliberal terms such as ‘work-life balance’ (Warner-Smith, Brown and Fray 2007). It assumes that people can simply choose whether or not to participate in paid employment, how well the work is remunerated, and number of hours worked. However, women's participation in the paid labour force and family ‘choices’ are affected by economic and social pressures and other constraints including gender norms.

Paid parental leave

Traditional gender norms, practices and structures remain deeply entrenched in both workplace cultures and intimate heterosexual relationships (Wirz 2014). Policies such as paid parental leave (PPL) and the accessibility of paid childcare are not based on shared parenting models, and reinforce women's role as primary caregivers. Currently, in Australia, policies and debates regarding paid parental leave tend to target mothers, excluding fathers or partners.

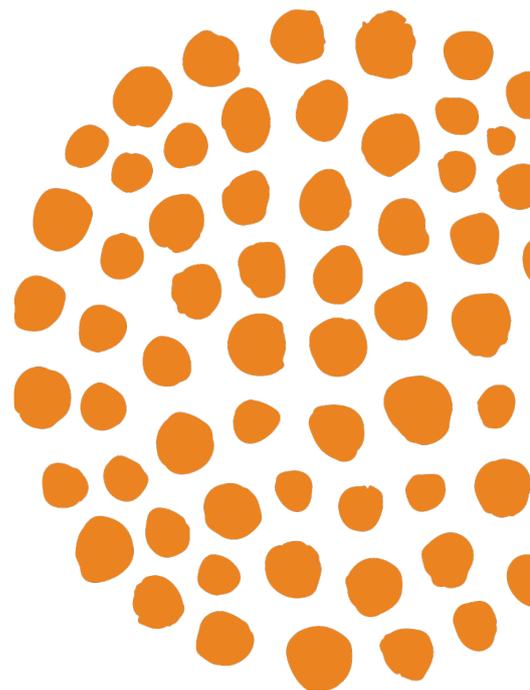
Under the Commonwealth PPL scheme, the primary carer of a child (usually the birth mother) is entitled to 18 weeks' leave at minimum wage, while the father or partner is entitled to two weeks' Dad and Partner Pay (DAPP). Set at minimum wage, Australian fathers have stated that the main reason they don't take DAPP is because they can't afford to (Martin, Baird, Brady 2014). This is in turn related to the gender pay gap and the fact that the father is likely to be in a higher paying job than the mother (ABS 2018c), making it more financially viable for the mother to take leave. This demonstrates how current policy settings, combined with existing inequalities, reinforce gender norms and practices that hold women responsible for child care and unpaid household labour.

Set at minimum wage, Australian fathers have stated that the main reason they don't take DAPP is because they can't afford to

Australian research shows that paid maternity leave positively impacts the mental health and wellbeing of mothers, particularly mothers who were on casual or insecure contracts before the birth of their child (Hewitt, Strazdins and Martin 2017). A European study found that maternity leave has significant positive mental health benefits in that it prevents the stressful weeks around childbirth from resulting in long-term mental health consequences (Avendano, Berkman, Brugiavini 2015).

Low uptake of DAPP and flexible working arrangements for partners may also suggest that fathers and partners who seek flexible work in order to care for their children encounter stigma. This denies fathers and partners the opportunity to care directly for their child and support their partners in the child's early days, and reinforces the expectation that childcare is a mother's responsibility. In fact, the Australian Human Rights Commission found that 27% of fathers and partners reported experiencing discrimination related to parental leave, despite the very short periods taken (AHRC 2014).

An evaluation of the Australian DAPP scheme found no change in the distribution of household chores or any other evidence of an increase in gender equity (Martin, Baird, Brady 2014). By contrast, the parental benefit scheme in Norway, which requires fathers and partners to take up to 3 months parental leave and is better remunerated and more flexible than DAPP (see Case Study), has led to fathers taking on more responsibility for child care and domestic work, and this has continued after the paid leave period had ended.



Case study: Paid Parental Leave in Norway and Sweden

Paid parental leave schemes have the potential to promote a more equal distribution of household and caring responsibilities.

Norway and Sweden are among some OECD countries that have introduced gender-transformative measures into their PPL schemes in order to encourage fathers to take a more active role in child care and domestic labour (Swedish Institute 2015), (Norwegian Labour and Welfare Administration 2018).

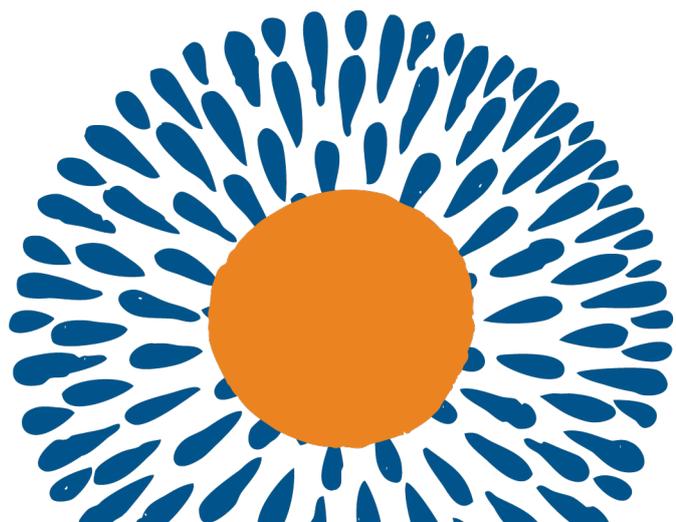
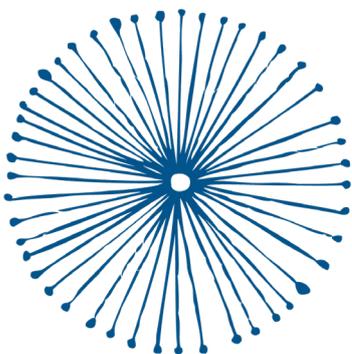
Norway's PPL scheme has a high rate of income replacement (80-100%). Total parental leave is up to 59 weeks, 10 of which must be taken by the father/non-birth parent or it will be lost (a single parent is entitled to use the entire amount) (Norwegian Labour and Welfare Administration 2018).

In Sweden, the proportion of fathers taking parental leave increased dramatically from 7% in 1987 up to 90% in 2008, following the introduction of a mandatory 'daddy quota' in the 1990s. By contrast, in 2014, only 36% of Australian eligible fathers took 2 weeks' parental leave (Martin, Baird, Brady 2014).

Studies have shown that the 'daddy quota' in PPL schemes has a gender-transformative effect by increasing the distribution of household chores and childcare more evenly, even after the leave entitlements have been used up (Kotsadam and Henning 2011), (Duvander and Johansson 2015).

By promoting fathers' engagement with childcare and housework, these schemes allow mothers greater employment opportunities and allow fathers an equal chance to develop close relationships with their children (Chronholm 2007).

The experience of Norway and Sweden shows that, to be effective, a gender transformative PPL scheme must be well remunerated and flexible enough to be used at various intervals over the first few years of their child's life (Rush 2013).



Childcare

A US study of 1000 children up to 4 and a half years old found that children who attend child care have the same outcomes as children who are cared for at home (Kennedy-Shriver 2006). The structure of early childhood education and care in Australia is complex and many parents find it challenging to understand and navigate (Pascoe and Brennan 2017). The expectation that mothers should provide care to small children can also lead to feelings of guilt for using childcare services (Rose 2017).

Federal government childcare policies adversely impact many women's ability to return to work. Nearly 80% of parents report experiencing substantial problems when it comes to the accessibility, quality and cost of childcare (Wilkins 2017). High effective marginal tax rates arise when the income of the secondary earner (usually a woman working part-time) is added to the primary earner's income, so that their combined income makes them ineligible for childcare subsidies and other benefits as the secondary earner moves closer to full-time employment. Effective marginal tax rates for low income women can be as high as 95% (Ingles and Plunkett 2016). By increasing the cost of childcare, high effective marginal tax rates mean that families end up relying on grandparents or other family to look after children.

The expectation that mothers should provide care to small children can also lead to feelings of guilt for using childcare services

Changes to the Australian federal childcare subsidy policy in July 2018 require the parent who is the secondary earner to submit 'proof of activity' in order to qualify for the subsidy. More proof of activity (paid work hours, voluntary work, time spent looking for work, studying, training, unpaid work in a family business) means entitlement to more hours of subsidised childcare. These changes do not address concerns about accessibility or affordability of childcare, and administrative hurdles and prescriptive requirements may serve to reduce families' access to the childcare subsidy (NFAW

2018). While families on incomes under \$66,000 automatically qualify for childcare subsidised at 12 hours per week, this is half the previous entitlement.

5.4 MATERNITY DISCRIMINATION AND RETURNING TO WORK

Though pregnancy discrimination is illegal under the *Sex Discrimination Act 1984* (Cth), the *Fair Work Act 2009* (Cth) and the *Equal Opportunity Act 2010* (Vic), the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) reports that it still receives many complaints regarding pregnancy, breastfeeding and parental status discrimination (VEOHRC 2017). The Australian Human Rights Commission reported in 2014 that 49% of mothers had experienced discrimination related to parental leave and returning to work compared to 27% of fathers and partners (AHRC 2014).

There are still negative stereotypes about employing pregnant women and new mothers, for example, that they will be a burden and unreliable. Discrimination can be direct, for example, when an employer makes unfair assumptions about what work a woman is capable of due to pregnancy or caring responsibilities, which could result in a demotion. Discrimination can also occur indirectly when an employer imposes a practice that will unfairly impact a pregnant woman, for example, only being able to take a limited number of toilet breaks. Breastfeeding women may find that there is no private space to express milk.

Victorian employers have a positive duty to eliminate discrimination 'as far as possible' in the workplace under the *Equal Opportunity Act 2010* (Vic). Employers can do this by having policies aimed at preventing discrimination against pregnant women and parents as well as good complaints handling procedures, and ensuring all staff are aware of their rights and obligations (VEOHRC 2017).

5.5 CHILDCARE AND HOUSEWORK

Gendered structures (such as laws, policies and physical infrastructure) can reinforce gendered norms about who is responsible for paid work, and who is responsible for housework and childcare both at home and in public spaces.

Mothers, whether they have partners or not, usually shoulder the primary responsibility for childcare. The 2018 Household, Income and Labour Dynamics in Australia report found that although attitudes towards gender roles, parenting and paid work have become less traditional, these attitudes are not reflected in the division of paid and unpaid household labour, including childcare (Wilkins and Lass 2018). There are also significant discrepancies between men and women's perceptions of a fair share of work. Women feel overburdened with housework, while men feel that they do their fair share. The gendered division of household labour and employment continues even after children have left school (Wilkins and Lass 2018). If a relationship breaks down, a woman who has spent significant time out of the workforce or in part-time work in order to care for children, may find herself at a significant financial disadvantage.

The design of public spaces reinforces gendered norms about childcare. For example, when baby changing equipment is only installed in women's bathrooms, it reinforces the expectation that childcare is women's responsibility. Media depictions of motherhood and family life also reinforce this expectation.

'Mental load' refers to the additional time a woman spends organising and managing daily domestic duties and childcare responsibilities, including delegating tasks to her partner (Ruppanner 2017). It is an emerging concept that has been popularly embraced and requires further research. Parenting often generates a different mental load for women and men, typified by 'mother-blame'. This is where women are held responsible not just for their own behaviour, health and wellbeing, but also for their (sometimes adult) children's. In the media, women are blamed for being time-

poor, not making home-cooked meals and for working outside the home (Warin, Zivkovic, Moore 2012). Significantly, the focus on individual mothers avoids a discussion about the broader social determinants of health.

Research has found that non-birthing mothers in same-sex couples are motivated to take on equal amounts of parenting work as their partners, in order to assume an equal parent role and affirm their maternal identity (Cao, Mills-Koonce, Wood 2016). It is also suggested that lesbian couples engage in a more equal distribution of household labour than heterosexual couples (Brewster 2017), and assign housework by ability (Goldberg 2013).

5.6 SINGLE MOTHERS

Mothering can be particularly demanding for single women who are both the primary caregiver and the primary earner for their families (Taylor and Conger 2017). 11.3% of Australian Families are headed by single mothers (Council of Single Mothers and Their Children 2017). The expectations placed on single mothers to carry out both of these roles, sometimes on welfare payments below the poverty line, to put their children first and be a 'good mother' while also prioritising meeting onerous welfare requirements with no childcare support are unrealistic and unfair. A European longitudinal study found that single motherhood was associated with poorer health later in life (Berkman, Zheng, Glymour 2015). In Australia, single mothers are more likely to experience poverty and housing insecurity (ACOSS 2016).

“Mothers are still regarded as primary caregivers and are responsible for preparing meals, organising schedules, taking responsibility for overseeing education, taking children to community and sporting events, reading stories before bed, organising bath times, and generally being on call 24 hours a day. The list of daily and weekly responsibilities that takes up a great deal of energy and effort is unending. Added to this, women are the ones expected to take time off from work to care for sick children.”
– (Council of Single Mothers and their Children 2016)

Single mothers are trapped within a policy construct that cycles between incentivising them to stay at home to raise children and using punitive welfare policies to force them to work. This structural inequality is compounded by norms and practices that perpetuate stigma and discrimination against single mothers. Contradictory norms dictate that 'good mothers' should be at home putting their children first, but 'stay at home single mums' set a bad example for their children and contribute to intergenerational poverty.

Single mothers are trapped within a policy construct that cycles between incentivising them to stay at home to raise children and using punitive welfare policies to force them to work

An example of this is that Parenting Payment Single payments are automatically switched to the lower-paying Newstart Allowance payment when the parent's youngest child turns 8 years old (Council of Single Mothers and Their Children 2018). This significantly reduces the parent's (usually the mother's) income, without addressing barriers to employment such as access to childcare, and despite the fact that the costs of caring for their child/ren may remain the same, or even increase, as the child/ren get older.

Welfare compliance requirements (welfare conditionality) also mean that single parents must juggle household tasks, childcare and welfare compliance tasks. Inadequate welfare policies devalue the work of caring for children, while at the same time entrenching poverty, and can make returning to work extremely difficult. This difficulty can be compounded by a lack of workplace flexibility for single parents.

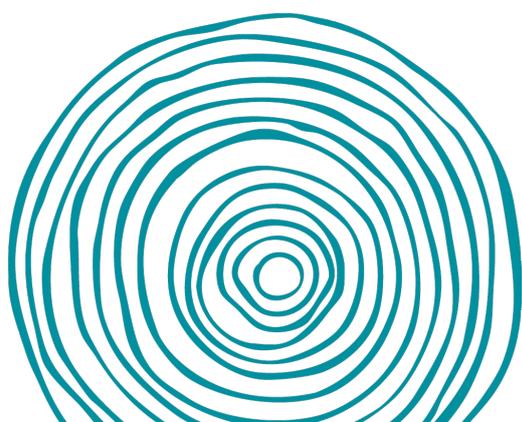
5.7 SOCIAL SUPPORT

There is a strong association between poor social support and poor mental health in mothers (Holden, Dobson, Byles 2013). Women's emotional wellbeing is more at risk if they have little social support, a low income, are single parents or have a poor relationship with their partner. Overall parenting stress also predicts later depressive symptoms (Thomason, Volling, Flynn 2014). Migrant mothers from non-English speaking countries are more likely to report having no 'time-out' from baby care and are more likely to want more practical and emotional support (MCWH 2017). Research shows that mothers experiencing poverty may cope better if they have close relationships outside the household that they can rely on for information and practical and emotional support (Hill, Stafford, Seaman 2007).

Moderated online mums' forums, social media, blogs and chats can be an easy way for mothers to connect with other mothers and find support, and can be a space where new mothers can test or legitimise their new identity as a mother (Johnson 2015). On the other hand (as noted in Part 2), they can also reflect and reinforce gendered norms and practices related to mothering identities (Schoppe-Sullivan, Yavorsky, Bartholomew 2017). Divisive issues include breastfeeding, sleep and birth 'choices' (shame around non-vaginal birth).

One-to-one peer support during pregnancy and after birth can have a number of interrelated positive impacts on the emotional wellbeing of mothers, contributing to overcoming feelings of isolation (thereby reducing low mood and anxiety), a reduction in stress, and increased self-esteem and feelings of competence as a parent (McLeish and Redshaw 2017).

Taking time for themselves reduces the chance of postnatal depression for new mothers (Woolhouse and Brown 2015). Though this sounds simple, taking time-out relies on strong support from others (partner, family, friends and communities).



6. CONCLUSION

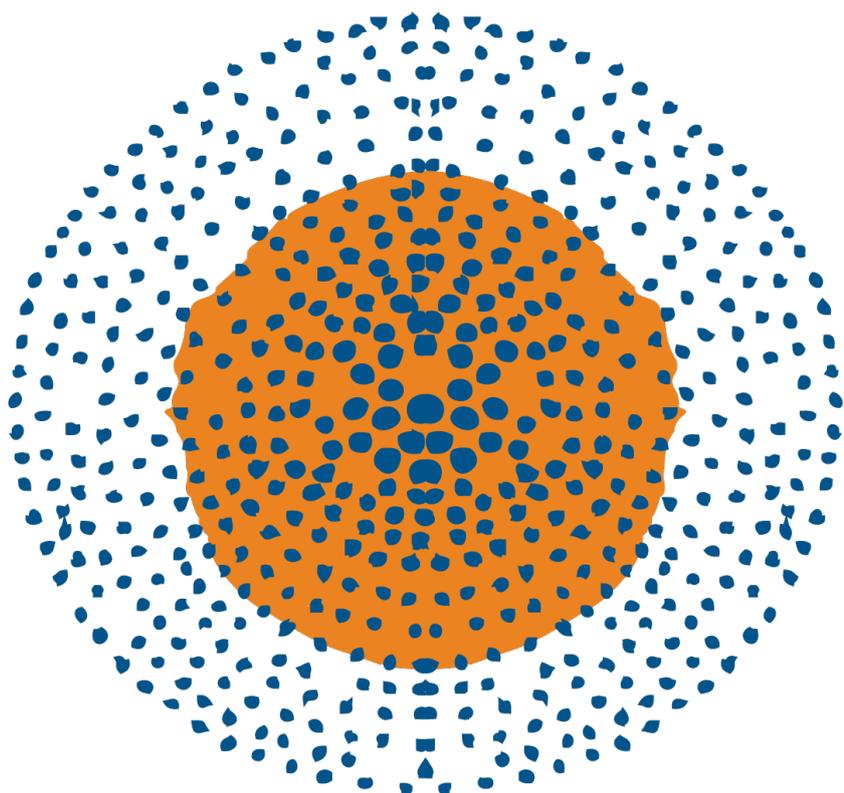
The expectations around pregnancy, birth and early motherhood are unrealistic, often contradictory and lead to many women feeling overwhelmed and unsupported.

Women are often expected to give birth 'naturally', stay silent about any negative and traumatic experiences of childbirth, and resume penetrative sex quickly. They are expected to exclusively breastfeed for six months in a society that frowns upon public breastfeeding. Contradictions exist in the expectation that a mother should happily put all her time and resources into parenting, but must also regain her 'pre-baby body'.

Women are expected to take on the bulk of childcare and domestic duties, while at the same time participating in the workforce to self-fund their retirements. Child care and income support policies mean that mothers who do seek help with childcare are limited in their ability to financially support themselves and their children.

The notion that early motherhood is a time of only joy, fulfillment and reward makes it difficult for women who struggle to seek help or make sense of their own distress. In short, women are encouraged to be selfless and adapt naturally to the many demands having a baby puts on them physically, emotionally, financially and psychologically. The pre and postnatal period marks an enormous transition and upheaval in women's lives, challenging body image, relationships, intimacy and mental health.

More focus needs to be directed towards generating and depicting realistic expectations to prevent poor health in the early stages of motherhood. Mothers also need more realistic, holistic and supportive responses from society, health professionals, their families and themselves.



7. RECOMMENDATIONS

1. Challenge idealised representations of pregnancy and early motherhood

- ▶ Inform and empower women in relation to birth options and potential risks. The long-term health and wellbeing of the mother should be a key consideration in how health professionals treat and communicate with women giving birth.
- ▶ Provide holistic support and follow up to women who have experienced traumatic births including access to counselling, physiotherapy, etc.
- ▶ Ensure that adequate bereavement care, information and support is provided to parents who experience stillbirth/pregnancy loss.
- ▶ Ensure that antenatal appointments and classes provide women and their partners with realistic information and practical supports in relation to birth trauma and postnatal depression.
- ▶ Develop strategies to increase engagement with antenatal appointments and classes, particularly for Aboriginal and Torres Strait Islander women and immigrant and refugee women.
- ▶ Ensure that messaging in relation to breastfeeding is balanced and supportive. Women should be supported and enabled to breastfeed in public and compassionate support, information and alternatives should be provided to women who find it difficult to breastfeed. Greater awareness is needed among health professionals around the complex interrelation of body image, breastfeeding and maternal distress.
- ▶ Increase research, support and awareness regarding body image during pregnancy and post-partum. Understanding how a woman's body image may be affecting her wellbeing and functioning is important for the health professionals caring for women postpartum (Orbach and Rubin 2014).
- ▶ Provide women and their partners with more information about potential sexual and relationship changes after birth in ante and postnatal appointments.

2. Promote gender equitable relationships, parenting and housework

- ▶ Provide women and their partners with information in the pre-natal period to support positive, equal and respectful relationships after the baby is born. This includes fostering realistic shared expectations around how parenting and domestic duties will be shared, as well as body image, sex and intimacy.

- ▶ Ensure that partners are aware of the importance of a new mother's mental health, how best to provide support, and how to seek help. Adequate support from partners is essential to a new mother's wellbeing.
- ▶ Challenge normative expectations that women are responsible for domestic and parenting work to enable a more equitable division of labour.

3. Ensure that health services, including antenatal classes and maternal and child health visits, are accessible, culturally safe and sensitively screen for and respond to family violence.

- ▶ Ensure that bilingual and bicultural workers with expertise in women's health operate in all hospitals, particularly those that provide maternity services. A qualified interpreter must be used wherever possible and the gender of the interpreter should be considered.
- ▶ Foster collaboration between mainstream health providers and women's ethno-specific/multicultural health and welfare agencies to promote and refer appropriate services among immigrant and refugee women.
- ▶ Allocate additional time and resources to enable immigrant and refugee women and women with disabilities to access longer and multiple appointments with health services.
- ▶ Provide more accessible and high-quality maternal and mental health services in rural and regional areas and ensure there is an adequate supply of skilled workers.
- ▶ Ensure that health professionals routinely assess for family violence and are able to respond, assess risk and refer appropriately.
- ▶ Support and expand Birthing on Country programs.
- ▶ Improve services and supports to enable women with disabilities who want to become parents to do so.

4. Provide more support for women experiencing perinatal depression and anxiety

- ▶ Improve access to health information on perinatal depression and anxiety (PND & A) by making it available in all community languages.
- ▶ Encourage parents to seek timely, non-judgemental support.
- ▶ Improve early identification and supports for women with pre-existing mental health concerns in recognition that pregnancy and motherhood place considerable additional pressures and stress on mothers.
- ▶ Improve referral and treatment pathways for women screened for postnatal depression.
- ▶ Improve treatment for perinatal depression and anxiety by addressing unrealistic expectations, social issues and lack of support.

5. Address structural contributors to poor health and wellbeing outcomes in early motherhood

- ▶ Urgently prioritise closing the maternal mortality gap between Aboriginal and Torres Strait Islander women and non-Aboriginal women.
- ▶ Improve income support for single mothers and decrease welfare conditionality.
- ▶ Extend best practice Paid Parental Leave and Dad and Partner Pay to encourage shared childcare and employment responsibilities.
- ▶ Ensure access to high quality, universally accessible and affordable childcare. Childcare workers must also be adequately remunerated.
- ▶ Increase uptake of flexible work arrangements by mothers and partners to support the sharing of parenting responsibilities, as well as for single mothers who must also manage unpaid domestic work and childcare requirements.

6. Undertake research on the mothering/parenting expectations that specifically impact women from migrant and refugee backgrounds, women with disabilities, Aboriginal and Torres Strait Islander women and LGBTIQ parents. Solutions should be based on consultation with these groups and community-led where possible.



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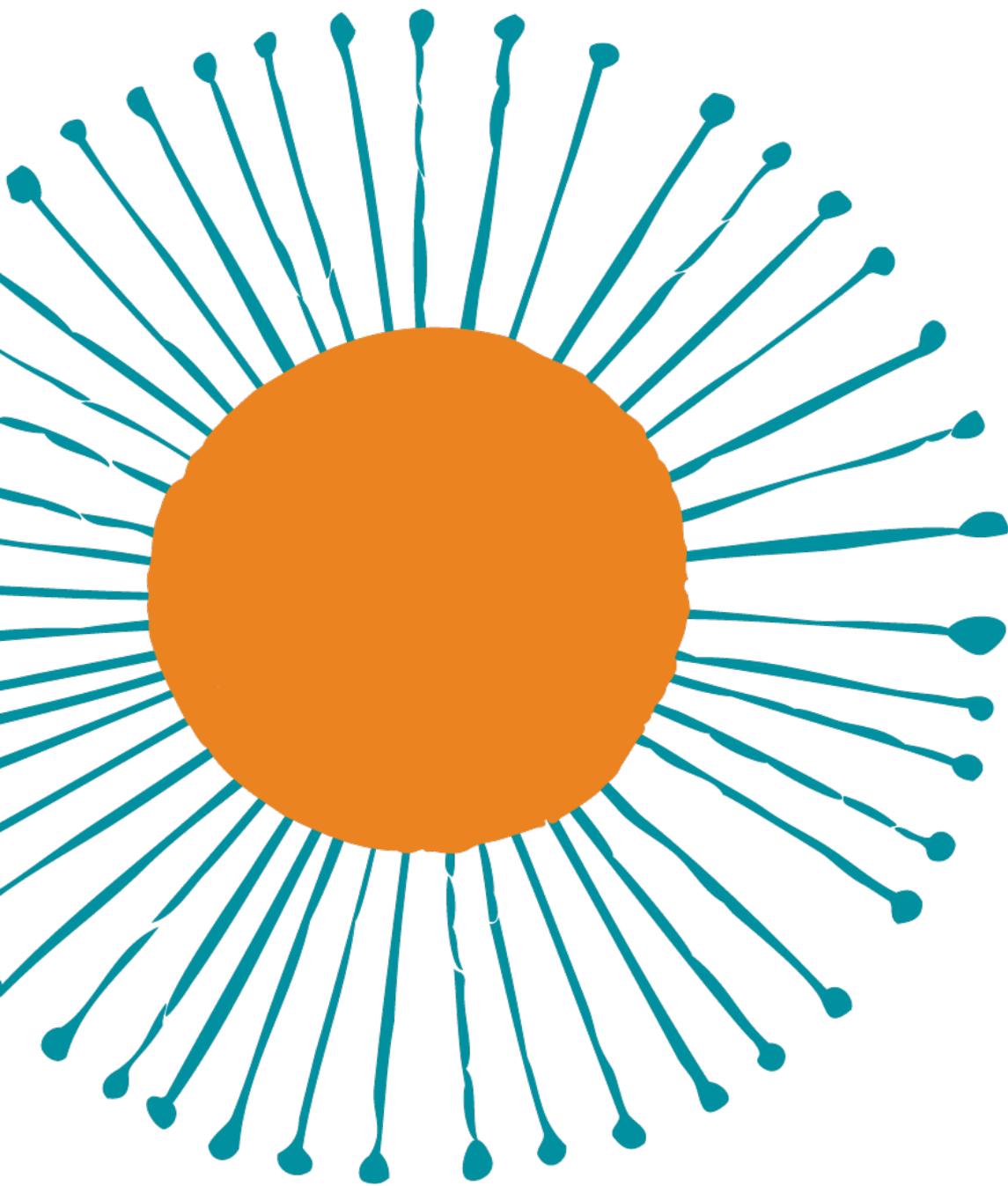
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GREAT EXPECTATIONS: HOW GENDERED EXPECTATIONS SHAPE EARLY MOTHERING EXPERIENCES

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Women's Health Victoria acknowledges and pays our respects to the traditional custodians of the land, the peoples of the Kulin Nation. As a statewide organisation, we also acknowledge the traditional custodians of the lands and waters across Victoria. We pay our respects to them, their cultures and their Elders past, present and emerging.

We recognise that sovereignty was never ceded and that we are beneficiaries of stolen land and dispossession, which began over 200 years ago and continues today.