AFFILIATION OF AUSTRALIAN WOMEN'S ADVOCACY ALLIANCES

Safety and Quality Guidelines for Privately Practising Midwives
Submission to the Nursing and Midwifery Board of Australia
5 June 2026

PART I. AAWAA'S STANDING IN THIS MATTER

About AAWAA

The Affiliation of Australian Women's Advocacy Alliances (AAWAA) is a national peak body representing women's advocacy organisations, with member groups in all states and territories of Australia. We advocate for the protection, advancement, and human rights of women and girls, particularly where we are vulnerable on the basis of our sex. Our membership includes teachers, academics, health professionals, lawyers, social workers, and others with direct experience of the conditions that affect women's health and wellbeing.

Our standing

AAWAA's engagement with health policy at the national and international levels establishes our standing to contribute to this consultation. AAWAA has contributed to mental health strategy consultations in Tasmania and New South Wales, provided input into the UN OHCHR's report on mental health and human rights, and engaged with Australian parliamentary processes on matters affecting women's sex-based protections and rights. Midwifery regulation is directly relevant to our work: maternity services are among the most sex-specific areas of healthcare, and the regulatory framework governing them must be grounded in biological reality if it is to protect the women who depend on it.

Note on format

This submission is provided as a document rather than via the online feedback form because the issues it raises require a level of analysis, citation, and regulatory argument that cannot be accommodated within the form's fields. AAWAA respectfully requests that the NMBA receive this document as our formal submission. This submission responds to the consultation questions set out in the consultation paper and addresses the proposed amended Safety and Quality Guidelines for Privately Practising Midwives (SQG) as published for consultation.

PART II. PRELIMINARY OBSERVATIONS: THE SCOPE OF THIS REVIEW

The consultation paper identifies the primary purpose of this review as aligning the SQG with the end of the professional indemnity insurance (PII) exemption for homebirth midwives on 31 December 2026. AAWAA does not oppose those changes. We welcome clearer guidance on PII obligations, transition to private practice, the role of second health practitioners,

compliance and regulatory transparency, and the other operational improvements described in the consultation paper.

However, bundled into this ‘limited scope’ review are substantive changes to the definitional and linguistic framework of the SQG, changes that reframe ‘woman’ as a term retained for ‘historical and professional context’ and redefine ‘gender’ as a category that encompasses ‘woman’ as a social and cultural identity. These are not minor or housekeeping amendments. They are substantive definitional changes with regulatory, clinical, and legal consequences. They should not be introduced in a limited-scope review without rigorous analysis of those consequences.

AAWAA’s submission addresses these changes directly. We do so not in opposition to respectful, individualised care for all patients, which we wholeheartedly support, but because we believe the proposed language framework undermines the clinical and data integrity that women’s safety in maternity care depends upon.

PART III. THE CENTRAL CONCERN: ‘WOMAN’ REDEFINED AS GENDER IDENTITY

3.1 The explanatory note

The proposed revised SQG includes the following explanatory note:

> *Midwives provide care to women and people of diverse genders who may require midwifery services. While terms such as ‘woman’, ‘mother’, ‘she’ and ‘maternity’ appear in this document in recognition of historical and professional context, they are intended to be inclusive. We acknowledge that this document cannot fully reflect the diversity of language used in practice and that broader changes may take time. It is explicitly acknowledged in this document midwives are expected to provide respectful, individualised, and safe care to every person, including those who do not identify as women and/or mothers. Where possible, inclusive language has been used in recognition of people of diverse genders who access midwifery care.*

This note frames the words ‘woman’, ‘mother’, ‘she’, and ‘maternity’ as terms that appear only due to “historical and professional context”, as conventions retained for legacy reasons rather than as accurate descriptions of the females who access maternity care. AAWAA objects to this framing.

Those who access midwifery services are biological females. The words ‘woman’, ‘mother’, ‘she’, and ‘maternity’ are not historical artefacts: they are accurate, current, and clinically important descriptors. To characterise them as linguistic conventions retained from the past, in a regulatory document that governs clinical practice from 1 January 2027, is to introduce a factual inaccuracy into the regulatory framework itself.

3.2 The glossary definition of gender

The expanded glossary defines ‘Gender’ as follows (page 56 of the consultation document):

> *Gender is a social and cultural concept. It is about social and cultural differences in identity, expression as a man, woman or non-binary person. Gender includes the following concepts: Gender identity is about who a person feels themselves to be;*

> *Gender expression is the way a person expresses their gender … Gender experience describes a person's alignment with the sex recorded for them at birth …*

Under this definition, 'woman' is classified as a gender identity, that is, a social and cultural category determined by how a person feels themselves to be. There is no corresponding definition of biological sex anywhere in the proposed SQG.

The effect is that the only regulatory definition of 'woman' available to a reader of this document is a subjective, identity-based one. Biological sex – the material reality that determines pregnancy, labour, birth, postnatal physiology, pharmacological dosing, and the epidemiology of maternal mortality – is undefined.

3.3 Internal contradiction

The internal contradictions in the proposed SQG illustrate precisely why the definitional approach is unworkable. The glossary definition of 'Woman-centred care' (page 33) organises the entire model of care around 'woman' as its central concept, referring throughout to 'the woman's baby or babies', 'the woman herself', 'the woman's individual circumstances', and 'the woman's physical, emotional, psychosocial, spiritual and cultural needs'. These usages assume a biological referent. Yet the same definition then appends the following sentence:

> *This model of care also affirms and includes people of diverse genders who experience pregnancy, birth or parenthood, acknowledging that their needs, identities and experiences are fully supported within the principles of woman-centred care.*

The definition thus deploys 'woman' as a biological organising concept in every substantive sentence, then extends the framework to people of diverse genders in its final sentence without resolving what 'woman' means in either context. The same tension runs throughout the document's clinical guidance sections, which continue to use 'woman' as a primary clinical descriptor while the explanatory note characterises that usage as a legacy of 'historical and professional context'.

AAWAA submits that this internal contradiction reflects the unresolved tension between two incompatible frameworks: one grounded in biological sex, which clinical midwifery requires, and one grounded in gender identity, which the explanatory note and glossary seek to introduce. The document attempts to accommodate both simultaneously and succeeds at neither. Resolving that tension in favour of clarity requires retaining the biological definition of 'woman' and distinguishing it from gender identity – not conflating the two, and not treating 'woman' as simultaneously a biological clinical descriptor and a term retained only for historical reasons.

PART IV: THE EVIDENCE

4.1 Clinical safety and health literacy

The consultation paper itself cites Bartick et al. (2025). AAWAA draws the NMBA's attention to the conclusions of this research, which the NMBA has chosen to reference in its own evidence base.

Bartick et al. (2025) find that the substitution of gender-neutral language for sex-specific language in healthcare has a range of documented adverse consequences, including reduced comprehension among women with low health literacy or limited English proficiency, and confusion for women from non-Western cultural backgrounds. Notably, the authors also find that desexed language may cause harm to transgender and gender-diverse people who equally need clear health communications, meaning the proposed approach does not reliably serve the very populations it is intended to benefit. The paper's title itself signals a call for a 'path forward', and AAWAA submits that the logical implication of its findings is a necessary distinction between respectful interpersonal communication with individual patients, where sensitivity to expressed preference is appropriate, and clinical records and public health communications, where biological sex must be clearly identified. The NMBA's proposed SQG does not make this distinction.

The NMBA's proposed SQG does not make this distinction. The explanatory note applies the inclusive language framing to the document as a whole, without differentiating between the interpersonal and the clinical or regulatory register. AAWAA submits that the Bartick et al. (2025) framework – which maintains biological accuracy in clinical records and data, while supporting respectful individual communication – is the approach this document should reflect.

4.2 Sex-based data integrity

Maternity data, including maternal mortality statistics, birth injury rates, rates of postnatal depression, and perinatal outcomes, is collected on the basis of biological sex. This data underpins clinical guidance, public health policy, and the regulatory oversight of midwifery practice in Australia.

When regulatory documents reframe 'woman' as a gender-identity category rather than a biological category, they create pressure on data collection systems to follow suit. AAWAA has documented – in submissions to the Australian Bureau of Statistics, the UN, and the federal and state governments – that the substitution of gender-identity data for biological sex data in public reporting is producing measurable distortions in health and safety statistics. The same risk applies to maternity data.

The proposed SQG should expressly require that biological sex be recorded as a clinical variable in all midwifery records. This requirement does not preclude the separate, respectful recording of a patient's preferred name, pronoun, or gender identity. These are complementary practices; they are not in tension.

4.3 CEDAW and Australia's international obligations

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) defines discrimination against women on the basis of sex – biological sex. CEDAW Article 12 requires that States parties eliminate discrimination against women in the field of healthcare and ensure access to healthcare services on a basis of equality. CEDAW General Recommendation No. 24 makes clear that this obligation extends to maternal healthcare.

The UN Special Rapporteur on violence against women and girls confirmed in her 2024 expert consultation that under CEDAW and international human rights law, 'woman' refers to a biological female and that discrimination is understood as relating to that biological

category. A regulatory framework that redefines ‘woman’ as a gender-identity term is inconsistent with this international legal standard, which Australia has accepted. The NMBA, as a national regulatory body operating under Commonwealth law, should ensure that its regulatory documents are consistent with Australia’s international human rights obligations.

4.4 The Australian College of Midwives’ own more cautious position

The consultation paper cites the Australian College of Midwives (ACM) Interim Position Statement 'Gendered language in maternity care' (2023). AAWAA notes that the ACM’s own interim position is more cautious than the approach taken in the proposed SQG. The ACM statement confirms that, while a full position is still being developed, “the use of sexed/gendered terms will continue in ACM publications, with woman meaning anyone accessing maternity care”. In other words, ACM has deliberately chosen to retain 'woman' as the organising term in its own materials while it undertakes further consultation and policy development. If the ACM, whose position the NMBA has chosen to reference, has itself not yet finalised its approach to these questions, it is premature to embed a more far-reaching formulation in a binding regulatory document taking effect from 1 January 2027.

4.5 Disproportionate impact on priority populations

The consultation paper links the revised SQG – including the new explanatory note and expanded glossary – to cultural safety and equity for ‘priority populations’, which explicitly include people from culturally and linguistically diverse backgrounds and acknowledges the need for culturally safe care for Aboriginal and Torres Strait Islander Peoples. AAWAA respectfully submits that the evidence does not support the claim that the particular inclusive language changes proposed (for example, replacing unqualified references to women with ‘people of diverse genders’) will advance equity for these groups.

As Bartick et al. (2025) find, and as AAWAA’s own work confirms, women from non-Western backgrounds are generally more familiar with, and more comforted by, clearly sexed language in healthcare. Western gender-identity frameworks are culturally specific. Imposing them on clinical documentation used to guide care for Aboriginal and Torres Strait Islander women, for whom the meanings of language around birth and country are profound and culturally particular, requires specific consultation with those communities, not a top-down regulatory imposition.

PART V. WHAT AAWAA IS NOT ARGUING

AAWAA wishes to be explicit about the limits of our submission, so that our concerns are not mischaracterised.

- We are not arguing that trans or gender-diverse females should be denied midwifery care. Every person who requires midwifery services should receive respectful, individualised, safe care.
- We are not arguing that midwives cannot use preferred names and pronouns in direct communication with patients. They can, and should, where appropriate.
- We are not arguing against cultural safety or against the inclusion of Aboriginal and Torres Strait Islander content in the SQG.

What we are arguing is this: respectful, individualised care does not require, and is not achieved by, redefining ‘woman’ as a gender-identity category in a regulatory document. The

proposed language framework conflates two genuinely different things: how we communicate with individual patients (where flexibility is appropriate) and how we categorise patients in clinical records and regulatory instruments (where biological accuracy is essential). An additive approach, which maintains biological sex in clinical records while supporting respectful individual communication, achieves all the goals of inclusive care without compromising data integrity, clinical safety, or regulatory clarity.

PART VI. RESPONSES TO CONSULTATION QUESTIONS

Question 1: Is the revised SQG clear and workable for PPMs?

No. The explanatory note and the glossary definition of ‘gender’ create ambiguity about the clinical and regulatory meaning of ‘woman’, a term that appears throughout the SQG’s substantive clinical guidance sections. In the glossary, ‘gender’ is defined as a social and cultural concept, with ‘woman’ listed as one of the identity categories within it, while the clinical sections continue to use ‘woman’ as a biological referent. A document that locates ‘woman’ within a gender-identity category in its definitions but relies on ‘woman’ as a biological descriptor in its clinical guidance is not internally consistent and therefore not fully workable for practitioners.

Question 2: Is there content that should be changed, added, or removed?

Yes. AAWAA recommends the following specific changes:

(a) The explanatory note should be revised to affirm that ‘woman’ in this document refers to a biological female. A form of words such as the following would be appropriate:

> “In this document, terms such as ‘woman’, ‘mother’, ‘she’, and ‘maternity’ refer to biological females. Midwives are also expected to provide respectful, individualised, and safe care to all people who require midwifery services, including biological females with diverse gender identities. Where relevant to individual care, a person’s preferred name, pronoun, or gender identity may be recorded separately from biological sex.”

(b) The glossary definition of ‘Gender’ should be amended to include a clear distinction between gender identity (a social and cultural concept) and biological sex (a biological reality). Biological sex should be added as a separate glossary entry.

(c) The record-keeping section should include an express requirement that biological sex is recorded as a clinical variable in all midwifery records, with gender identity recorded separately where relevant.

(d) The framing of ‘woman’, ‘mother’, ‘she’, and ‘maternity’ as terms retained only due to “historical and professional context” in the explanatory note should be removed.

Question 3: Are there negative or unintended effects for PPMs?

Yes. The proposed language framework creates medico-legal uncertainty for PPMs. Where a regulatory document defines ‘gender’ as a social and cultural identity category that includes ‘woman’, while simultaneously using ‘woman’ as a biological referent throughout its clinical and data-collection sections, a PPM faces uncertainty about which language to use in clinical records, referral letters, and other regulatory documents, and about whether, and

how, biological sex must be recorded. That uncertainty has potential liability implications and could expose PPMs to complaints in either direction. Clarity about the status of biological sex in documentation and data collection serves practitioner safety as well as patient safety.

Question 4: Are there sections requiring additional explanatory material?
The record-keeping section would benefit from explicit guidance that biological sex is a primary clinical variable to be recorded in midwifery records, that gender identity may be recorded separately where relevant, and that these are complementary rather than competing practices. This guidance would resolve the ambiguity identified above, particularly in relation to perinatal data collection requirements for 'women and people of diverse genders', and support consistent, safe documentation practice.

Question 5: Are there positive or negative effects for priority populations?
There are potential negative effects for women from culturally and linguistically diverse backgrounds, including migrant women, refugee women, and women with low English literacy, for whom clearly sexed language is more familiar and more comprehensible. The Bartick et al. (2025) evidence on health literacy supports this concern. AAWAA recommends that the NMBA seek specific evidence of the impact of the proposed language framework on these populations before finalising the SQG.

Question 6: Are there positive or negative effects for Aboriginal and Torres Strait Islander Peoples?
A regulatory framework that locates 'woman' within a gender-identity category in its definition of gender, rather than clearly affirming 'woman' as a biological and cultural category, should be subject to specific, structured consultation with Aboriginal and Torres Strait Islander women and communities before being applied to Birthing on Country contexts.

Question 7: Are there suggestions for the accompanying Fact Sheet?
Yes. The Fact Sheet should include clear guidance that:
- biological sex remains the primary clinical variable for midwifery records;
- gender identity may be recorded separately as part of respectful, person-centred care;
- using a patient's preferred name and pronouns is an interpersonal practice that does not alter the clinical record's biological sex category; and
- PPMs who have questions about recording practices in specific circumstances may seek guidance from the NMBA.

PART VII. RECOMMENDATIONS

AAWAA makes the following recommendations to the NMBA:
- Recommendation 1: Revise the explanatory note to affirm that 'woman' in the SQG refers to a biological female, while separately affirming that respectful, individualised care is required for all people who access midwifery services.
- Recommendation 2: Add a definition of 'biological sex' to the glossary as a distinct category from gender identity.
- Recommendation 3: Amend the record-keeping section to require that biological sex be recorded as a clinical variable in all midwifery records.
- Recommendation 4: Remove the framing of 'woman', 'mother', 'she', and 'maternity' as terms retained only due to 'historical and professional context'.

- Recommendation 5: Ensure the Fact Sheet clearly explains the distinction between biological sex (for clinical records and data) and gender identity (for respectful person-centred communication).
- Recommendation 6: Prior to the full-scope SQG review being considered for 2027, undertake structured consultation with sex-based women's organisations, including AAWAA and its member organisations, on the proposed language and definitional framework.
- Recommendation 7: Prior to the full-scope review, undertake specific consultation with Aboriginal and Torres Strait Islander women and communities on any proposed changes to the language framework as it applies to Birthing on Country services.
- Recommendation 8: Prior to the full-scope review, undertake specific consultation with medical services/clinics that service women and communities from non English speaking backgrounds.

PART VIII. CONCLUSION

AAWAA thanks the Nursing and Midwifery Board of Australia for the opportunity to comment on the proposed revisions to the *Safety and quality guidelines for privately practising midwives* and for the Board's broader commitment to transparent public consultation and stakeholder engagement. We appreciate the Board's stated intention to continue liaising with key external stakeholders and to consider a full-scope review of the SQG in the next regulatory planning cycle.

Given our focus on women's health, sex-based protections and rights, and regulatory clarity in maternity care, AAWAA would welcome the opportunity to participate in any future stakeholder engagement, including workshops, advisory groups or roundtables associated with the SQG, the related professional indemnity insurance and endorsement registration standards, and the full-scope review being considered for 2027. See the Annex for some of our recent, relevant engagements. We would be pleased to provide further information or meet with the NMBA to discuss the issues raised in this submission.

ANNEX. AAWAA'S SELECTED RECENT RELEVANT ENGAGEMENTS

- UN Special Rapporteur on Violence Against Women and Girls, Expert online consultation on violence against older women, May 2026
- Tasmania Department of Health, Towards Tasmania's Next Mental Health Strategy: Rethink and Beyond, five submissions across our organisation, May 2026
- NSW Government, Mental health and wellbeing strategy consultation, submission, August 2025 (NSWWAA)
- NSW Parliamentary Select Committee on Fertility Support and Assisted Reproductive Treatment, evidence provided at hearing, April 2026
- UN OHCHR, Comprehensive report on mental health and human rights, submission, October 2024
- Australian National Audit Office, Age pension administration, evidence, January 2025
- Senate and parliamentary committee submissions on the Sex Discrimination Act, elder abuse, surrogacy, aged care, and domestic violence (ongoing)