



Australian Government
Department of Health

REPORT OF THE 2018 ONLINE SURVEY ON THE DRAFT NATIONAL STRATEGIC DIRECTIONS FOR MATERNITY CARE

January 2019

The views and opinions expressed in this document are those of the participants and/or the organisations that they represent and do not necessarily reflect the official policy or position of any agency of the Australian Government.

Creative Commons Licence



This publication is licensed under the Creative Commons Attribution 4.0 International Public License available from <https://creativecommons.org/licenses/by/4.0/legalcode> (“Licence”). You must read and understand the Licence before using any material from this publication.

Restrictions

The Licence may not give you all the permissions necessary for your intended use. For example, other rights (such as publicity, privacy and moral rights) may limit how you use the material found in this publication.

The Licence does not cover, and there is no permission given for, use of any of the following material found in this publication:

- the Commonwealth Coat of Arms. (by way of information, the terms under which the Coat of Arms may be used can be found on the Department of Prime Minister and Cabinet website <http://www.dpmc.gov.au/government/commonwealth-coat-arms>);
- any logos and trademarks;
- any photographs and images;
- any signatures; and
- any material belonging to third parties.

Attribution

Without limiting your obligations under the Licence, the Department of Health requests that you attribute this publication in your work. Any reasonable form of words may be used provided that you:

- include a reference to this publication and where, practicable, the relevant page numbers;
- make it clear that you have permission to use the material under the Creative Commons Attribution 4.0 International Public License;
- make it clear whether or not you have changed the material used from this publication;
- include a copyright notice in relation to the material used. In the case of no change to the material, the words “© Commonwealth of Australia (Department of Health) 2019” may be used. In the case where the material has been changed or adapted, the words: “Based on Commonwealth of Australia (Department of Health) material” may be used; and
- do not suggest that the Department of Health endorses you or your use of the material.

Enquiries

Enquiries regarding any other use of this publication should be addressed to the Branch Manager, Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to copyright@health.gov.au

CONTENTS

Introduction	4
Demographics of respondents	4
General questions about the document.....	4
Comments on the document.....	4
General comments.....	4
Comments on the introduction	9
Comments on the figure.....	9
Comments on the glossary/terminology	10
Comments on the process for developing the document.....	11
Comments on implementation	12
Specific comments on the document.....	16
1 Respect	16
1.1 Respectful, wholistic care.....	16
1.2 Collaboration between health professionals	22
2 Access	28
2.1 Improving access to continuity of care.....	29
2.2 Improving access to maternity care	52
2.3 Improving access to mental health support	64
3 Choice	72
3.1 Providing information about local maternity care services	72
3.2 Supporting informed choice	78
4 Safety	88
4.1 Supporting cultural safety.....	88
4.2 Supporting the maternity care workforce	92
4.3 Supporting safety and quality in maternity care.....	99
5 Aspects of maternity care not covered in the strategic directions	113
5.1 Consumer responses	113
5.2 Health professional responses.....	116
5.3 Organisational responses.....	123

INTRODUCTION

Two periods of consultation were conducted as part of the work on the National Strategic Approach to Maternity Services. This document reports on the second online survey conducted as part of public consultation on the draft strategic directions. The survey opened on 3 September 2018 and closed on 20 November 2018.

Demographics of respondents

Of the 200, responses received, 52 (26%) were from consumers, 131 (65.5%) from health professionals and 17 (8.5%) were submitted on behalf of organisations. There was a number of duplicate responses; these are included once in this report.

Overall, 75 responses were received from Queensland, 43 from Victoria, 31 from New South Wales, 18 from Western Australia, 12 from South Australia, 10 from the Australian Capital Territory, 9 from 'Australia wide', 6 from Tasmania and 4 from the Northern Territory. Note that these numbers do not total to 200 as some respondents chose more than one jurisdiction.

Of the 199 respondents who answered the question on indigenous status, one identified as Aboriginal and the remainder were non-Indigenous.

General questions about the document

Is the document appropriate and easy to follow?

Among respondents overall, 91% felt that the document was appropriate and easy to follow. The document was considered appropriate and easy to follow by 90% of consumers, 90% of health professionals and 100% of organisations.

Are the principles appropriate and comprehensive?

Among respondents overall, 76% felt that the principles were appropriate and comprehensive. The principles were considered appropriate and comprehensive by 65% of consumers, 79% of health professionals and 88% of organisations.

COMMENTS ON THE DOCUMENT

This report includes the comments received through the online survey. These are presented using the structure of the consultation draft. Responses to the question 'Is there anything missing?' are included in Section 5.

General comments

ALL strategic directions are underpinned by "Safety – Respect – Access – Choice"

Although the majority of principles are excellent, there are some contradictory values presented. I think there needs to be greater emphasis on community care models that involve GPs and midwives working together, this is the only way to address all of the 'gaps' identified by the focus groups; inadequate mental health care, continuity of care, postnatal care, wholistic care, and preconception care that begins in high school.

Excellent

High level managers and health service executive need to recognise knowledge deficits in maternity service provision to liaise with appropriately skilled and knowledgeable practitioners when developing hospital wide policies that often are not reflective or do not acknowledge the differences in maternity health care provision and requirements and those required by the general health population. The difference between a wellness model of care and a medical/disease model of care.

I believe the strategic approach to maternity services should be more representative of the majority of Australian women and reflect the values of all. I truly believe that most Australian women would value safety, in the physical sense first and foremost and desire compassionate and respectful care that puts into perspective the reason we get pregnant and have babies.

I strongly support the way this document is built on the Universal Rights of Childbearing Women. I also strongly support the inclusion of consumer expectations/feedback in the rationales. This hasn't been done consistently however, and it would be useful to include consumer sentiment where it has been omitted (e.g. (but not only) 3.2, 4.2, 4.3 Reducing the stillbirth rate)

I think the principles are adequate but the Strategic direction and enablers are not always clear or comprehensive.

I think the principles read well. Putting the woman and her baby at the centre of care is important. They need to be treated as a dyad and what is best for BOTH needs to be considered.

I think this document was pretty lacklustre and not really examining the truth of what happens in the maternity care system. It's all well and good to say "we need longer stays" but if we haven't got the bed space due to funding and staff shortages, you can't change that. Your Principles are good. But the rationale and enablers are very thin and unconvincing.

In all cases the enablers must be stated much more strongly. There are examples of this within the document, e.g. 2.3 where the enabler is "Jurisdictions address the unacceptable morbidity and mortality associated with poor perinatal mental health". Every single enabler should have a clear statement of WHO could do WHAT to work towards that strategic direction. So in 1.1 WHO adopts the RMC Charter? Who develops, collects and reports on PREMs and PROMs in maternity services? And in 1.2 who will implement the NHMRC Guidelines of Collaborative Maternity Care?

It is a complete and well compiled document clarifying the Strategic intent for the Maternity Services provision in the State and Territories of Australia.

It is concerning that there is no mention in these strategic directions of the maternity care system needing to address the needs of the LGBTQI community. Development of services to meet the needs of this vulnerable group is needed to improve birth outcomes and parenting. It is very comprehensive.

It seems that most aspects are covered but do women feel safe accessing these options?

Make Safety the first Priority WHA recommends that the whole section on Safety of Care (currently section 4) becomes the first section of the framework, and that section 4.3 on Supporting safety and quality in maternity care becomes the first sub-section of this part of the framework. Safety is arguable the highest priority for every pregnant woman, as well as for service providers. As the plan acknowledges in the introduction, there is, however, significant room for improvement. There is increasing interventions in labour and birth, a rising rate of

stillbirths, a rising rate of caesarean sections (surgical birth), and demonstrable variation in clinical care between states, between hospitals and even within individual services. The Commission on Safety & Quality in Healthcare has acknowledged a few aspects of this variation in their Atlas. WHA benchmarking data using more than 40 clinical indicators testifies to there being unwarranted variation in care across the national, across all size of services and across all jurisdictions. Be more specific in prescribing the development of national CPGs for labour and birth care.

Once again - it would be great if maternal health care was truly considered from a holistic point of view - that is, including education and support from all angles of life, mind body and spirit. And continuous in terms of being offered services, education and support that covered the full spectrum of considerations in pregnancy, postnatal care, and parenthood transition. Birth is only one moment in time that requires preparation, support and consideration. Parenthood is a lifelong adjustment and role and this receives little support during this period by many maternal health care providers. The Parents Village are doing this, but there should be more options out there.

Overall I think the document is looking far better than draft one. The main comment would be that the document and plan needs to represent and enable real change - real access to readily available models of care that have evidence of improved outcomes for women and babies, and needs to include consideration of better supports for vulnerable women after birth, not just during pregnancy and birth, but into the community. Although workforce is a separate issue (as per discussion at one of the consultations), there are places in this document where additions could be made to improve access and services in rural areas, e.g. bonded scholarships for doctors and midwives.

Remarkably comprehensive.

Respectful maternity care needs to be founded on informed decision making of consumers and active partnership between carers and consumers to develop perinatal care plans. This requires continuity of carer throughout the perinatal continuum and provides the best outcomes for families.

Safety and respect and choices: It is good these principles are made prominent, but the way they are represented indicates they are separate, whereas they are in fact inextricably linked. Safe care cannot be provided without respect for a woman's choices, even if they diverge from the opinions of her carers. By basing maternity care on informed decision making and respect for decisions made, outcomes also need to include a woman's opinion of her care. These insights need to be followed up at least 12 months after birth when a woman has had time to consider and integrate her experience.

Safety is listed as the 4th principle - after choice, access and respect. I believe safety should be first and foremost. All choices are not equal, access to desired models and outcomes is not always possible and respect is often in the eye of the beholder. While all 4 principles are important it seems that safety should be the primary measure.

So much to add in I don't know where to start.

Some 'enablers' do not address the 'strategic direction' and / or 'rationale'.

Thank you for the opportunity to provide feedback on the 'Strategic Directions for Australian maternity services'. Overall the draft was received favourably by midwifery academics at La

Trobe University. We consider the overall document to be clear and easy to follow, and that we support the values and principles of the draft. We also strongly support the strategic directions that women's experiences and outcomes are respected; and used to inform improvements in care; and that we should strengthen interdisciplinary collaboration, culture and communication. A particular strength identified, is the emphasis on values and principles within a framework that also encompasses the universal rights of childbearing women. In terms of the structure of the principles – the term 'enablers' are often measures or outcomes – and perhaps there needs to be separate ways of describing the enablers that are needed for the principles to be achieved and then reasonable measures that can be applied to determine if they have in fact been achieved. Enablers can also mean, policy levers or strategies to facilitate change/improvement, either way – key words and principles used in the document must be clarified (defined), agreed (consistent with other key documents), and understood amongst consumers and carers.

The document has a lack of consumer focus despite being touted as a consumer-focused strategy.

The document is a cohesive document.

The guidelines look like a repeat of what we already have.

The principles in themselves are appropriate, the way in which the ideas are expressed to enable them to be realised come across as somewhat vague in parts.

The RANZCP appreciates the opportunity to contribute to the consultation on the Strategic Directions for Australian Maternity Services and strongly supports the goal to improve maternity services in Australia. The Strategy includes a number of goals, projects and programs which the Commonwealth Department of Health, and other stakeholders, will implement in the coming years, and we look forward to providing further input into these reforms.

The through line that seems to be missing from these strategic directions is feminism. This is applicable to both the strategic directions mentioned above. Historically women's preferences for their health have been ignored and under resourced. The autonomous practice of midwifery has been perpetually challenged and undermined.

There doesn't seem to be much reference to the outcomes for babies. It's all about women, and what women want, but it's as though the outcomes for babies are not important. I believe the majority of Australian women would prioritise their baby's health far above their personal satisfaction with the birth experience.

There is currently overmuch emphasis on the healthcare providers and too little on the actual experience, observations and desires of the actual clients (women and their families).

There needs to be more focus on the woman as central to this review rather than being implied.

There needs to be some effort, graphically and textually, to explore the inter-relatedness of each of the principles, and the values.

This document has all the right words but is lacking in real substance and actions able to be implemented to effect real meaningful change.

This document makes a lot of vague statements without true plans to change anything. I would hope that some stronger comments are made in the next version. Women need choice. They

need evidence provided when they make every decision around maternity care. I would like to see this evidence provided to women.

This is a fantastic draft document.

Throughout the consultation draft there seems to be an overarching focus on maternal satisfaction, choices, cultural safety etc. and limited on the safety of the baby. As a woman who has experienced both - a very satisfying birth experience and a preventable loss of a full term baby in labour I can very confidently say there is no birth experience or cultural safety that would compensate for the preventable death of a wanted baby.

Very basic, very obvious what we need. Needs to be much more in depth.

We believe there should be improved training and education for doctors and midwives, improved access to post-screening counselling, and the development of a public awareness campaign to tackle negative community attitudes and stigma about Down syndrome and intellectual disability.

We think that the principles are comprehensive. For the purpose of clarity, we suggest explicit statements about the interconnection and integration between them. In particular, the references to issues relating to Aboriginal and Torres Strait Islander people and to women from culturally and linguistically diverse backgrounds are located in the section on the value titled 'Safety.' While it is apparent that the other value, Respect, Choice and Access, must also have regard to the diversity of the Australian population, we believe it would be helpful to state this specifically.

WHA strongly supports the commitments to safety, respect, access and choice, as mapped out. Our members particularly value the inclusion of improving access to postnatal support, perinatal mental health services; culturally safe care; continuity of care for women of all risk by a known midwife; to a national mechanism for collecting PROMs and PREMs.

What is the support for organizations?

While I think all these aims are realistic, they will require an enormous amount of work based on my experience as a consumer.

Whilst these documents are an important aspect of review, the wording has remained the same or similar for approx. 20 years. Action on the planned strategic direction without becoming stifled by political and organisational processes is the biggest challenge. Let's embrace it.

Women are not respected in having their birth choices honoured. Standard maternity care is not designed to support or respect women. It pays lip service in the document, but in reality the increasing Caesarean section rate, numbers of induced labours and the incidence of birth trauma - all whilst perinatal and maternal morbidity remains stagnant. This is a health crisis, and this document does nothing to support the necessary changes that are needed to respect women and improve health outcomes.

Women should be absolutely central to the document.

Women should be more central to the document. The focus should be primary health care, not acute health care. Maintenance of the status quo.

Women's needs, wants, health and wellbeing need to be central to the document, not just Figure 1.

Comments on the introduction

When highlighting vulnerable groups of women such as Indigenous women, CALD women etc... This document does not refer or include women with disabilities despite the statistics showing that they have high perinatal mental health disorders (especially anxiety and depression), and high levels of domestic and family violence, and are stigmatised. By not including them at all in this document, the Australian Department of Health continues to stigmatise and create disparities for this group for women becoming mothers. Whenever this Maternity Strategic Plan highlights the need for other vulnerable groups and names these groups, women with disabilities MUST also be included. This section also should include lesbian women who become mothers also.

Need to define- Primary maternity services are provided by Obstetricians, Midwives and GPs. Anaesthetists, Allied Health and other Health Care workers provide specialised services as required.

In the intro of the Strategic Directions document it refers to "significant progress" - really? This statement can't be qualified or quantified. The document refers to Australia as a safe country to birth in, we know this isn't true in relation to trauma and disrespectful maternity care. With 1/3 women experiencing trauma, 1/10 PTSD as a result of birth using safe to define out maternity care totally negates the mental and emotional damage.

There are statements made in the document's Introduction that are not supported by evidence. For example, "Significant progress in improving Australian maternity care services was made under the National Maternity Services Plan (NMSP) 2010-2015" (p 3).

In the introduction, framing maternity care services as part of the life cycle of health services provided to women and their families. Framing in the wellness paradigm. Acknowledging the key role of GPs in providing care to women long before, during and long after their pregnancies but the importance of expertise from midwives, obstetricians, lactation consultants, patient advocates etc. in the perinatal period. Emphasising the value of teamwork and collaboration.

It is not clear how this strategy links to other national strategies currently being developed by the Australian Government Department of Health in particular the National Alcohol Strategy and the Fetal Alcohol Spectrum Disorders National Action Plan 2018-2028.

The introduction should start with the definition of women-centred care (not just described at the end of the document) because this definition is crucial to the whole discussion about maternity care. The introduction statement does not recognise services provided by Privately Practicing Midwives in the community.

Comments on the figure

It is not clear [in the figure] which are the principles, values and strategic directions. The diagram would be enhanced by a key or legend which explains this. There are opportunities within the following principles and the accompanying enablers to more appropriately include the issue of alcohol and other drugs and mental health. This includes the principle of: 'Women's safety and experience of maternity care is supported by respectful communication and collaboration between health professions' and 'Women have access to mental health information, assessment, support and treatment throughout the perinatal period'.

De-segment second circle "Safety – Respect – Access – Choice" as they underpin ALL strategic directions.

Change needed - remove the segmentation lines between the values in Figure 1. The values 'respect, access, choice and safety' should not be segmented as they are in the second circle of the wheel in Figure 1. Those values need to infuse and be integrated with each aspect of the principles and universal rights of childbearing women.

Comments on the glossary/terminology

The point that needs strengthening here is the concept of 'woman centred care' within all options of care - can this be upfront. Please ensure that the language is consistent throughout this section. Currently the document says women, mother, consumers, patients.... Women need to be involved in the development of any evaluation tool that is designed to improve their experiences of care.

Clarity needs to be provided in the language used in the NSAMS document.

Definitions of continuity of care versus carer need to be explained clearly.

Several terms are missing from the Glossary. For example, continuity of care/carers and postnatal support (6 weeks?).

The document should be readily comprehensible to readers of a range of professional and other backgrounds, so the inclusion of the glossary is welcome. A term that should be defined there or in the body of the strategy is "cultural safety" as the apparent breadth of this term in the present context might not be commonly understood. As agencies working with women of refugee backgrounds, we are mindful that their experiences in countries of origin, of temporary sanctuary as well as in Australia are important for the provision of "responsive" care but are not necessarily captured by ordinary understandings of their "culture."

The expansive definition of the term "woman" (and by extension woman-centred care) is extremely problematic. By defining woman as "inclusive of the woman's baby, partner and family" as the glossary does, this document permits an erosion of women's rights. While I appreciate that this definition was drafted with good intentions of being inclusive and simplifying the text, it has unintended consequences, particularly for the way the document's principles can be interpreted. For example, if "women are able to make informed decisions and choices about care for themselves and their babies", actually means that "women, their babies, partners and families are able to make informed decision and choices about care..." it is clear that the woman's role as sole-decision maker about what happens to her body is diminished. Similar issues arise with the principle "women's choices and preferences are respected throughout maternity care". It needs to be very clear in this document when it is the intention is to refer to the woman (as an autonomous individual) and when it is intended to refer to the broader idea of all those with a stake in maternity care. That cannot be done via a glossary.

The term "Woman" needs to include a reference to transgender and non-gender conforming people who are pregnant.

There should be clarity about the differences between continuity of care models and continuity of carer models. Several key concepts/principles not well defined – suggest definitions be included in the glossary (e.g. safety, postnatal care, holistic care)

Wholistic care should read holistic - although wholistic isn't wrong holistic is more widely used and accepted in academic writing.

Woman is used in different ways, sometimes it is just about her, other times it includes her partner /family. When referencing mental health issues it appears to be just about her but partners also experience high rates of postnatal anxiety and depression as well. There is little focus across the board on continuity of care. There is mountains of evidence on midwifery continuity of care reducing obstetric intervention rates including caesarean section, improving breast feeding rates, decreasing anxiety and depression rates, reducing preterm birth rates - please apply this evidence throughout the strategy. There is also anecdotal evidence that continuity of maternity care by GP's improves outcomes and some prefer this model - please address this in the strategy. There is minimal reference to rural and remote patients and particularly on improving their access to care - which is near impossible in remote areas. There is brief reference to Patient Assistance Travel Schemes but the rebates are significantly less than actual costs and are a significant barrier to accessing care for our lowest socioeconomic groups that live in remote communities who also have the highest risks - these women won't leave their communities without a support person or where they have to leave dependent children behind sometimes for months.

Comments on the process for developing the document

I strongly believe that the maternity services should reflect the hopes and desires of mothers and consultation is the most effective means for this to occur. It would be a great shame if the outcome of consultation did not reflect the wishes provided herein.

The design of this survey is a mystery to me. How realistic are all the items? They are certainly IDEAL, but achieving them will be a challenge - so what I wanted to convey was that staff on the whole WANT to provide all of this, but are constrained by limited time, and rigid all powerful management systems. Realistically, all depends on funding for staff. DESIRABILITY may be a better word than REALISTIC?

Despite community organisations' sustained advocacy for equitable implementation of key NMSP commitments by Queensland Hospital and Health Services during the NMSP's term, community representatives observed inequitable implementation of the commitment to increase women's access to publicly provided continuity of midwifery carer services. Community submissions to the Federal Health Minister and Queensland Health Minister in early 2016 were not incorporated, nor referenced in the NMSP's Final Report, despite acknowledgement of submissions' receipt by the Federal Health Minister and the Chair of the Maternity Services Inter-Jurisdictional Committee.

The Commonwealth Health Department ignoring community submissions which were made in early 2016 to the Federal Health Minister and the Chair of the Maternity Services Inter-Jurisdictional Committee and which were excluded from the Final NMSP Report; developing the NSAMS without being informed by an independent evaluation of the NMSP; and excluding representatives for pregnant women and mothers from the NSAMS Project Reference Group.

An independent evaluation of the NMSP was not conducted, despite the COAG Health Council tasking the Australian Health Ministers' Advisory Council to evaluate the NMSP in April 2016. Also, despite community requests to the Commonwealth Health Department and Queensland Health, the NMSP process evaluation report has not been published.

Given that the only places I have seen this consultation process advertised online are midwifery and natural birth groups I wonder if the process has been overly influenced by contributions from consumers and health carers with a strong interest in "natural" birth and a high valuation of maternal choice and satisfaction.

I think these [principles] are realistic but to be honest, I don't feel particularly optimistic about them occurring. These dot points make me reflect that I don't feel like women are authentically listened to in these consultative processes. It seems the only time that we are listened to is when we take to the streets to protest when services are being shut down.

It is great to see that informal focus groups were held in Nowra for Aboriginal and Torres Strait Islander women and in Melbourne for culturally and linguistically diverse women. A focus group for remote women would be very beneficial. This would differ to a rural focus group. A remote group in the Torres Strait at Horn, Thursday or Badu Islands would be much appreciated by the community. Similarly, focus groups in Aurukun or Kowanyama would be helpful. A focus group for women not of Indigenous background would also be very helpful, particularly in areas which become even more remote throughout the seasons such as Daintree and Karumba.

This document and the consultation process surrounding it is vastly better than the farcical process in 2017. Thank you for your efforts to develop a robust and workable plan for the future of Australia's maternity services.

This survey is very difficult to complete. The questions are too broad and the response options of 'not realistic', 'somewhat realistic', 'realistic' and 'very realistic' are hard to determine. How would the average 'citizen' know whether the strategic goals are realistic or not? I am concerned about how the answers to the survey will be analysed and interpreted. I fear that the way the survey is set out that the answers are open to misinterpretation and misuse with the potential for the organisers to use them to support their case for midwifery-led maternity care. Also I have lost my answers 4 times now after reaching question 19. I have had to rewrite my answers each time. This has been very frustrating to say the least.

The Commonwealth Health Department appears not to have learned from past experience with regards to development of the NSAMS. For example, the Queensland Health Minister advised in his response to Question on Notice (No. 1235) that there has not been an investigation into the administration by Queensland Health of the development of the discontinued draft National Framework for Maternity Services (NFMS). An investigation could have been used to guide the Commonwealth's development of the NSAMS.

The Commonwealth Health Department has replicated some of the inappropriate processes that were undertaken to develop the discontinued NFMS. These processes include proceeding with the development of the NSAMS without being informed by an independent evaluation of the NMSP and excluding representatives for pregnant women and mothers from the NSAMS Project Reference Group.

The Queensland Health Minister's response to a Question on Notice (No. 1235) in October 2018 indicated that the jurisdictional representatives who were members of the Maternity Care Policy Working Group (MCPWG, which was chaired by Queensland Health) decided that the NMSP Process Evaluation Report would not be published. The Queensland Health Minister also advised that MCPWG members had decided to exclude models of care and funding mechanisms from the scope of the NMSP process evaluation as "decisions regarding models of care and funding are made locally".

Comments on implementation

Think most are covered; public hospital systems can be more evidence based and subject to evidence based decisions and policy than private practitioners. The challenge of unacceptable and costly practice in private hospitals is not/ cannot be addressed by the public system.

These are issues that hospital administrators / bean counters do not consider to be of any importance. Until they are required KPIs there will always be barriers.

There needs to be staff in the services who are capable and time rich to focus on implementing change to meet these standards. And to be held accountable for meeting these changes.

A monitoring and implementation framework is required. Without this framework, the document is useless.

All of the above-mentioned points are very good, they just need to be carried out. Also, continuity of care can help improve all of those points.

Considerations should be made to allowing private midwifery and doula care to be rebateable under private health funds.

Currently the major barrier to implementing or achieving these strategic goals is funding. Outside of tertiary units there are few documented success stories or research to support continuity of care models. This is resulting in stress for the workforce and a failure to implement maternity models in rural and remote areas in QLD. There is inflexibility to develop models that reflect the needs of the local community with cost cited most often as the reason for not supporting continuity of care and instead reverting to fragmented shared care models.

Funding review leading to funding reform of maternity services in Australia.

Funding: No discussion about accessibility of private midwives to access suitable insurance for homebirth.

How are the principles going to be put into practice?

How are we going to make these changes?

How we are going to do this. The idea is fabulous but it's unlikely any of these things will happen anytime soon.

How will it be funded? It is a primary health care issue. What is the monitoring and implementation framework?

Enhanced details of means of implementation: the enablers are quite broad and lack substance as to how they might be enacted, including the funding arrangements that may need to be incorporated/accessed.

I believe that those strategic directions are achievable, but unlikely in the current climate of medical dominance and control.

I think that we need more measurable outcomes which are somehow linked to funding as this is sometimes the only way that we can evaluate if positive/negative change is occurring.

I think the one aspect that is missing is governance.

I understand that some of my responses are quite negative and all of these directions sound very good in theory but sometimes in practice get lost, for example if we don't have a government/policy to support these ideas then it's not going to happen. This then needs to be followed through with adequate staffing, money etc. As we know the government can promise

whatever it likes but in the end if the staff on the ground can't provide these services for women due to many reasons it's not going to change anything.

In order to achieve the above [strategic directions on safety] you need to decolonise your mindset and the system. It's all very realistic but there is a lot of deadwood that needs to be cleaned out of the system in order to really achieve it.

It is difficult/impossible to determine how realistic any of this document is without the accompanying monitoring and implementation framework. It must contain SMART goals (Specific, Measurable, Achievable, Relevant and Time-based) – otherwise we cannot judge our success.

It is of course necessary to have these things [written] down [and] a plan for them to be changed - but what is going to be [done] to actually change them? There are documents at the moment that state that most of these things should be done, but they are not being put into practice! So what is going to be done to change it?

It's great to aim towards these things and it should be realistic but at this stage in giving feedback I feel like regardless of what women say, there will be either a politician or doctor, or perhaps both somewhere further up the consultation process vetoing our preferences.

It's very easy to change and improve all these things but you have to be brave and put women led care first. It's not unrealistic at all but it does require the funding and the bravery to throw a lot of practices that aren't helpful out and to really listen to women and allied health services who work with the women in the years after childbirth.

Measuring the adoption of the Respectful Maternity Care Charter - it has to be more than just words on a page. What does it look like 'to be free from harm and ill treatment'; 'to be given accurate information, informed consent and refusal and respect for choices and preferences' etc.? Maternity Consumers should be involved in designing these measures.

Monitoring and implementation framework is absent - needs to be added for this document to be functional.

None of this will happen without more budget, more midwife hours per patient or lengthening post-natal care options - more home visits

Significant improvements need to be made to maternity services' governance and accountability frameworks if the sector is to achieve equitable implementation of nationally agreed priorities in the NSAMS.

The approach needs smart goals. Specific, measurable, achievable, relevant, and time-based goals - how are we going to measure the success of this approach without these?

The discussion of funding is missing, particularly primary health funding.

The document doesn't say a lot about how the government will actually make a difference for most women. As the plan stands it will set us backward because the focus is on GP's and obstetricians getting midwives, not on midwifery care as a standalone option.

The document is just a whole set of words unless there is a Nationally Recognised Tool for monitoring and evaluation of the strategic direction. Maternity Consumers need to be involved in the development of this tool.

The implementation and monitoring framework ("carrots and sticks") is absolutely vital, and probably needs to be included in the Strategic Approach. This is because the lack of implementation (rather than the plan itself) was the downfall of the previous National Maternity Services Plan.

The monitoring and implementation framework – this document is meaningless without this.

The strategic directions employing the term 'implement' should reference an evidence-based implementation science approach to implementation that supports individuals and organisations to contextualise the implementation to their own needs, and to identify and resolve system barriers to implementation at the local level. Without some guidance on 'how', it is likely that uptake of the guidance and information/ resources referenced will be low.

There are no implementation framework or monitoring process for the National Strategic Approach, so it is impossible to judge how realistic the strategy will be. It does not address the over-medicalisation of pregnancy and childcare and the high rate of Caesarean sections, induction and interventions.

Unless the Commonwealth strengthens governance and holds jurisdictions accountable for implementation of the NSAMS priorities, there will be little improvement in the safety and quality of maternity services.

What is actually going to be done to put these principles into practice?

What is the implementation plan?

Whilst this is a National document, State Maternity Policies need to reflect the same strategic directions as the National document.

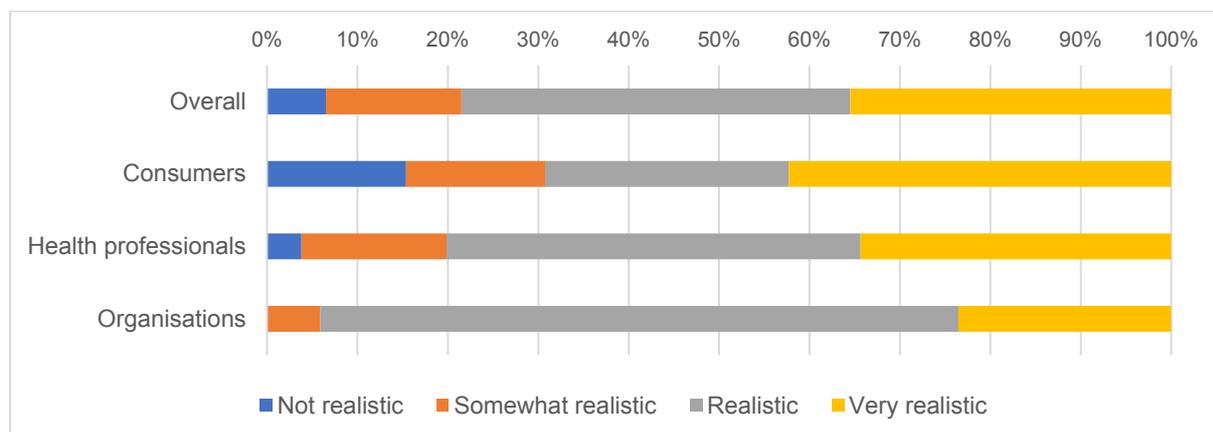
Who is paying for it - there seems to be little imagination to pay for health prevention strategies although it clearly saves money in the longer run.

SPECIFIC COMMENTS ON THE DOCUMENT

1. RESPECT

1.1 Respectful, wholistic care

Figure 1 Responses to strategic direction: Women's experiences and outcomes are respected and used to inform quality improvement in maternity care



1.1.1 Consumer comments

Respect

Respect - love it!

To me it seems the directions relating to respectful maternity care are dominated by the idea that maternity care should be guided by women's experiences and their evaluation of outcome based on satisfaction. Using women's experiences to inform improvement in maternity care is important, but it should not be the only indicator. Surely the outcomes for babies and research evidence are as, if not more, important than satisfaction.

No framework is provided to ensure respectful maternity care

Adoption of the Respectful Maternity Care Charter, an enabler under the Principle of Respect, will need to be supported by the establishment and funding of a national and independent body (like the Australian Human Rights Commission) to educate the health sector and community about women's childbearing rights and investigate complaints regarding the violation of women's childbearing rights Don't bully (I also can't believe I need to add this too) - maternity is not high school.

Further details of the Respectful Maternity Care Charter would be helpful. Specifically, it would be reassuring to know that this charter will include all areas of maternity care including termination of pregnancy, pregnancy and infant loss, and assisted reproductive services.

Maybe need to mention something about listening to women in this section.

Structural disrespect against pregnant women and mothers occurs at multiple levels, including at the national policy and governance level.

The biomedical model of maternity care is inherently abusive and system-wide reform is required in order to genuinely provide respectful maternity care.

The prioritisation of high quality, culturally safe maternity care for Aboriginal and Torres Strait Island women as well as women from culturally and linguistically diverse backgrounds to address inequity needs to be emphasised beginning at this point. This is an opportunity to finally begin the conversation about the impact of systemic racism on women's health which is particularly relevant at such an influential time in their life span. It needs to be named rather than tiptoed around which continues systemic oppression. Birthing on country also needs to be mentioned here.

Reporting of women's outcomes and experiences

Accountability of providers through public available data.

Accountability through publicly available data for all practitioners, all models of care, all birthing facilities, would encourage provision of best practice care rather than care based on profit or opinion.

Exit survey for mothers, please give them a chance to ask questions also catch potential problems such as PTSD or physical problems.

Give women an experience rating. Staff will not provide poor service if they know consumers can complain.

Publicly available data to make providers accountable, in turn steering toward evidence based, woman centred care rather than focus on opinion or profit.

Continuity of care

Continuity of care should be added as an enabler. If a woman sees a different provider with each visit (as is the case at the majority of public hospitals), she will not receive wholistic care. If a woman sees one or two providers throughout her pregnancy, they will be able to more adequately address AND MONITOR her physical, emotional, psychosocial, spiritual, and cultural needs. My experience at a public hospital (with no continuity of care) was that boxes are ticked when information is provided, but no follow-up occurs if issues were noted/discussed.

1.1.2 Health professional comments

Comments on the strategic direction

I'd like to see this strategic direction as holistic, respectful and safe maternity care. I feel that the inclusion of 'safe' will encompass emotional safety that goes hand in hand with feeling respected. Within the rationale it would be appropriate to acknowledge the high rates of birth trauma experienced by Australian women. Australian Birth Trauma Association cite as many as 1:4 women suffer physical and/or emotional birth trauma.

Respectful care

That women will be heard and their choices respected at every step of their care, including choices that oppose policies and procedures that govern our institutions. The needs of the individual come first.

Respect women's rights to care outside clinical guidelines.

Provide a framework to ensure respectful maternity care.

How are healthcare providers going to be made to follow respectful care - in theory it should be done but in practice is it not?

The principle of respectful care is much needed but needs strong detail about how it is achieved with a clear escalation process when disrespectful care is witnessed or raised by women. Need examples of disrespectful care.

Consultation with women

A stronger focus on consultation with women at every level of maternity service provision. Policy that insists on consumer representation on committees and evaluation of services forums

Consumer participation essential.

Consumer representation is not in maternity budgets, how can we engage with women? Too many meetings are driven by medical agendas associated with theatre lists, clinic appointments and availability of doctors.

Reporting of women's outcomes and experiences

Within the data collection, I would suggest adding demographic data to all maternity data collected.

The International Consortium for Health Outcome Measurement (ICHOM) has already developed a standard set of outcome measures for pregnancy and childbirth (I am a co-author), and of the 24 measures in this set, 12 are patient-reported outcome measures. As one of these pertains to 'birth satisfaction', which is arguably a patient-reported experience measure, I would highly recommend using this set as a starting point. However, if adopted nationally, this data would allow for us to nationally and internationally benchmark our outcomes, so this set may also be useful in the longer-term. It is critical that consumer leaders with lived experience and consistent evidence of involvement in the birthing community are employed (i.e. in paid positions) to develop, design and implement patient reporting measures so that the data that is gathered reflects *what matters most*. This would embed the consumer voice and offer a sustainable position at the table for those individuals.

Consumers' experiences and outcomes should not be routinely collected and made publicly available. This would become a name and shame exercise. Even if names were to be withheld it could still be possible to work out the parties involved particularly in small communities. Patients have a tendency to misunderstand the facts and circumstances of certain medical situations and the emotion-charged one-sided venting has the potential to be counterproductive. There needs to be timely meaningful communication not just data collection. GPs need discharge summaries not data and tick boxes.

Have hospital/MGP/Obstetrician statistics available online for public knowledge and to aide in the decision of choice of caregiver/birthplace.

I would be interested to learn more about how the experiences of a woman's maternity care will be explored and by whom?

Facilitate connections between women to enable sharing of their own experiences and knowledge around birthing and motherhood

Similarly the area where the document discusses listening to women. This appears to be after the fact, by measuring birth experience outcomes, but needs to specify listening during

pregnancy and birth also. Otherwise sounds like we aren't interested in hearing about the experience until it's over. Giving information and data to women is education them, not listening to them and perhaps should be put under a different heading.

Acknowledgement of a pervasive lack of respect from health professionals and health facilities towards women (e.g. bullying, coercion, patronising, ignoring) and the need for change. The following statements should be included: *Women's choices must be respected * No woman should be bullied or coerced into accepting interventions Suggested enablers * A consumer representative on public policy decision-making bodies. * Services to be co-designed with women; women decide what is appropriate, safe and desirable for themselves. PREMs and PROMS require development WITH women/consumers - remove the word 'patient' CREMs/CROMs or WREMs/WROMs and would require ongoing funding and management. There is currently no validated tool for measuring women's experiences.

Respectful maternity care needs to include respect for the woman's right to access all information related to her care. All policies and procedures. This information to be provided so that a woman has enough time to consider her options carefully.

Respectful maternity care needs to recognise the importance of the value of information given at first point of care. Usually this is the GP. These strategic directions need to promote ready access to information about all models of care available to women - not just the preference or subjective opinion of the consulting GP. For example - a client of mine (I am a Private Practice Midwife) was told by her GP that homebirth is against the law in Australia. (I am aware that this issue is covered further in 3.1).

There is a need for acknowledgement of the innate knowledge and authority of the child-bearing woman.

The experiences of women with disabilities and Lesbian/gay women need to be taken into account and included within representation of Maternity consumer groups. There is limited data or research currently on the experience of women with disabilities in maternity care in Australia, or include within maternity policies or guidelines. The new Pregnancy Care Guidelines (Australian Dept. of health, 2018) do not include women with disabilities as a vulnerable group, despite the research indicating that they experience multiple and many health and social disparities.

Respectful, wholistic care that recognises pregnancy and birth as normal, women as capable and knowledgeable, and that they have choice. Respectful care is care where there is no bullying, coercion, patronising or misleading information. Women's voices need to be heard regarding what they desire. Women's experiences need to guide direction.

Recognition of the rights of all women to debriefing and discussion surrounding their pregnancy, birth and postnatal experience regardless of outcomes whilst also confirming and encouraging a view of pregnancy as a normal physiological event for most women. -Give greater credit to the attitudes and opinions of women/consumers in co-designing appropriate, safe and optimal care for themselves and their families.

1.1.3 Organisation comments

Comments on the strategic direction

Strategic direction should include women's choices (Women's choices, experiences and outcomes).

In the strategic directions section of 1.1 would be good to add in 'choices' - i.e. Women's choices, experiences and outcomes are respected..."

Comments on the principles

In the principle, we suggest that the term "psychosocial" be separated into "social" and "psychological" to strengthen recognition of the significance of "social disadvantage" (e.g. poverty) for perinatal outcomes, access and so forth.

I said 'very realistic for both [principles under respect] because they are essential. Though sadly, I feel the reality is that both are unrealistic in most maternity care systems that exist in this country.

Maternity care givers should be required to display and commit to the Respectful Maternity Care Charter; to ensure women are aware of their rights with respect to Maternity Care. The fact that women reported in the focus groups that they feel 'coerced, bullied, patronised and ignored' is something all maternity care providers should reflect upon and ask ourselves if this phenomena occurs or would even be tolerated in other settings (e.g. cancer care, also a consumer driven healthcare interaction).

What's missing is the acknowledgement of the evidence, and that evidence is strong, that optimal care in childbearing is one to one relationship-based midwifery care with seamless collaboration with medical care as required by any individual woman. Missing is the recognition that there is abundant evidence that there is a deep need for system change in maternity care; change is needed in structure, workforce, models of care and funding. There needs to be a shift from the medically dominated approach to a social health model for maternity care provision. These changes are needed to address access issues and the inequitable and disparate health outcomes at the population health level. These issues are indisputable, ongoing and have not yet addressed by current service models or interventions. In fact, the current structure worsens health outcomes in the vulnerable population groups and even in populations which do not have the same social determinates of health challenges as vulnerable groups. The caesarean section rate continues to rise in private medical care, with all its attendant problems and this problem will not change until women have an understanding of the difference in care models and outcomes and can access the care they need - therefore public reporting is important across the country especially transparent, publicly accessible service and system accountability. Note: New study - Sandall et al 2018 - Short and long-term effects of caesarean section (CS) [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(18\)31930-5.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)31930-5.pdf) "The prevalence of maternal mortality and maternal morbidity is higher after CS than after vaginal birth. CS is associated with an increased risk of uterine rupture, abnormal placentation, ectopic pregnancy, stillbirth, and preterm birth, and these risks increase in a dose-response manner. There is emerging evidence that babies born by CS have different hormonal, physical, bacterial, and medical exposures, and that these exposures can subtly alter neonatal physiology. Short-term risks of CS include altered immune development, an increased likelihood of allergy, atopy, and asthma, and reduced intestinal gut microbiome diversity. The persistence of these risks into later life is less well investigated, although an association between CS use and greater incidence of late childhood obesity and asthma are frequently reported. " Missing is the focus on primary services underpinned by The Lancet Midwifery Series on integrity, with the woman at the centre and community co-design of accessible/acceptable services close to where the woman lives with midwifery caseload care as a core intervention. Missing is the recognition of and strategic plan to overcome the three big influential impediments to system reform - that of money, power and gender and harness the reorientation of these resources to transform services, systems and

outcomes going forward. Missing is the evidence to back any and all of the proposed actions in this document; actions should be backed by evidence to be included. Missing is the evidence of Cochrane and Lancet about the power of continuity of midwifery care to make a positive difference to each woman's experience of maternity care. Missing is the evidence for truly positive maternity service design. Vested interests should not dictate/determine how maternity care is designed and implemented. Missing is the recognition/acknowledgement that midwifery continuity of care a) reduces the rate of caesarean section and the associated morbidity and mortality b) provides choice to women but putting women at the centre of care c) is what women want and do not have universal access to. Missing are targets for Continuity of Midwifery Care across the country. Missing is a strategic change in direction for how to change the status quo and improve high unnecessary intervention rates as evidenced in the divide between public/private (medical) outcomes, or other areas, although lightly touched on, such as perinatal mental health, stillbirth and women's satisfaction. Changes should be explicit about scaling up midwifery continuity of care. The system needs to be wrapped around the woman and the midwife providing her care (and not use the term women when we talk about woman-centred care). A woman should be able to access her carer of choice directly. The other models should be complementing continuity of midwifery carer models and not promoted as a viable alternative when the evidence clearly demonstrates that all women should have the choice of continuity of midwifery care.

Respect

Recognising a woman's intuition and ways of knowing. Lack of respect from health professionals and health facilities towards women (e.g. bullying, coercion, patronising, ignoring).

Women's choices must be respected - It is completely unacceptable to bully or coerce women into accepting care.

Reporting of women's outcomes and experiences

The ACSQHC's work in this space is not currently specific to maternity care. A national PROMs tool would need to be specific to the maternity episode of care if it is to provide any meaningful information to health service managers and clinicians.

There needs to be a much stronger focus on the availability of data in the public forum where outcomes of care are reported and women can use this data to make decisions about the location and model of their care. The value and validity of qualitative data regarding the 'experience' of pregnancy and birth and beyond, should be acknowledged and included alongside any clinical indicators (quantitative measures) that are collected and evaluated. Current patient-reported experience measures or outcomes and reporting is either lacking, not representative, not culturally appropriate, or inconsistently reported – this should be established nationally. There is a need to establish/embed and capitalise on a nationally consistent perinatal minimum dataset. This will encourage a proactive and strategic approach to data collection and information reporting, rather than the short-term, ad hoc and reactive approach as currently appears.

The section on "enablers" rightly identifies the need to "develop, collect and report on patient reported experience measures" (PREMS). We suggest that it is important to explicitly state that the mechanisms must include means to ensure that the voices of women who are commonly excluded (e.g. because their English proficiency is low) are heard. The paper says that the ACSQHC is "currently scoping an appropriate role at national level to support the consistent and routine use of PROMS to drive quality improvement in a way that bring patient' voices and

outcomes to the fore. We suggest that this work should include PREMS and have regard to the need to ensure the inclusion of women who are commonly excluded.

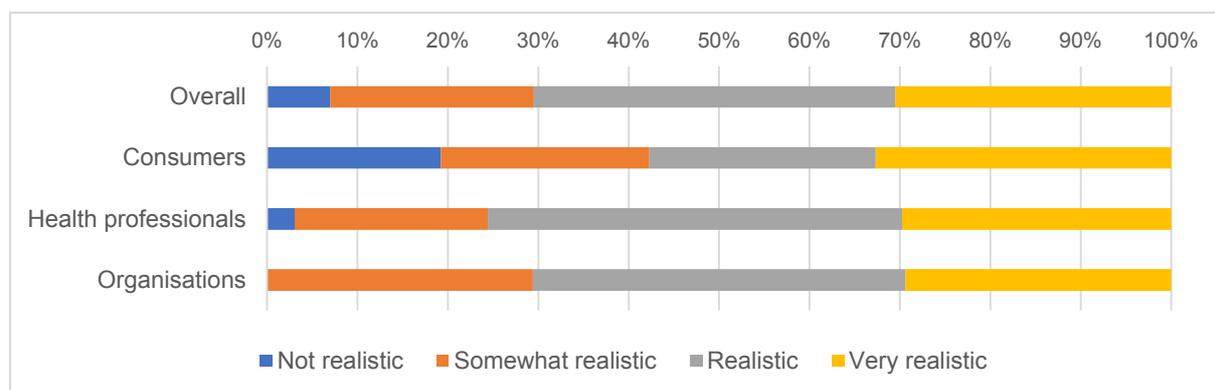
Enablers

In the Rationale section of 1.1 it is not clear what 'special care' means in the sentence context. In the Enablers section of 1.1 would be good to make it explicit that the women's experiences and outcome measures be publicly available. There is no enablers specifically aimed at vulnerable women.

Mandate representation of consumers on public policy decision making-bodies. - Co-design services with women, let them dictate what is appropriate, safe and desirable for themselves. PREMs and PROMS require development WITH women/consumers, and would require ongoing funding and management. There is currently no validated tool for measuring women's experiences.

1.2 Collaboration between health professionals

Figure 2 Responses to strategic direction: Strengthen interdisciplinary collaboration, culture and communication



1.2.1 Consumer comments

Comments on the strategic direction

Would ideally read "Strengthen interdisciplinary and interdisciplinary collaboration, culture and communication". This suggestion is based on the well-researched and reported on culture of bullying that exists in the medical professions (both medicine and nursing/midwifery).

Comments on the rationale

In the rationale of 1.2, I believe it would be appropriate to acknowledge the situations in which progress has already been made towards better collaboration. Mention could be made of the National Midwifery Guidelines for Consultation and Referral (now endorsed by RANZCOG - which was a major milestone!). Likewise, in the enablers, it would be very useful to flag the opportunity for professional organisations to develop a broader range of joint position statement on key issues. There is great momentum to be gained by focussing on what the different professional groups agree on (rather than what they disagree on).

Interprofessional respect

Women want their PPM treated with the respect they deserve, because the entire NSAMS wouldn't be required if every pregnant/birthing woman was treated like a PPM would treat them.

It is also important to note that collaboration should be defined as genuine, voluntary, two-way collaboration, not mandated, one-way collaboration that is not really collaboration at all, and simply gives one profession power over another.

I feel that while the current obstetric culture exists and is enabled by the mainstream medical model, it is impossible to be realistic about improving the current services - especially when it comes to woman's experiences and interdisciplinary collaboration. I feel that focusing on WHO provides the most respectful care should've been covered more.

Interprofessional collaboration

Collaboration - In my experience collaboration is not always possible as private midwives are not able to work at some hospitals (i.e. my private midwife was not allowed to support me at my local hospital). Thus, in this section under "enablers", some way of increasing access for private midwives to provide support in public hospitals need to be added.

How will this joint statement be co-ordinated and actioned? I appreciate the value of the idea and link to consumer preference for respectful collaborative care but this dot point reads vaguely. Also - will Aboriginal Community Controlled Health Organisations (ACCHOs) be part of this statement? Will the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) be a part of this statement? Why aren't they mentioned here?

I also believe it would be appropriate to broaden the understanding of collaboration here to include collaboration with consumers and consumer organisations in the design, planning, governance and evaluation of health services (in line with both the ACSQHC Standard 2 and the NHMRC statement on involving consumers in health research).

1.2.2 Health professional comments

Interprofessional collaboration

NHMRC National Guidance on Collaborative Maternity Care no longer exists on the NHMRC website (see https://nhmrc.gov.au/_files_nhmrc/publications/attachments/CP124.pdf) It was noted to disappear on 5th October by midwifery students at Griffith University trying to reference it. So this as an enabler to Collaborative relationships for Primary Maternity Care is a problem. I realise this document disappeared around the time of publishing, but it still must be rectified.

The previously acknowledged barriers to collaboration, particularly poor relationships, territorialism and mistrust between clinician groups are not likely to be impacted by the wording in the current principle. In my own experience, these types of behaviours are now infrequent as they are no longer tolerated, although I acknowledge that they may remain the default position under times of stress. Unfortunately, the systems that clinicians work in do not support collaboration, particularly at the boundary-points between low and high-risk maternity care. A few examples include: Participation in low/high risk care: Currently, systems encourage midwives to hand over complex obstetric care to medical staff and no longer participate in the collaborative maternity alliance for decisions on care. Inequity between clinician groups for funding of care models: For example, Medicare funding for antenatal care by eligible midwives is appallingly low in comparison to GP or obstetric care, and midwives have to attend a birth for 12 hours to claim intrapartum funding. This financially disadvantages eligible midwives. Power/hierarchy: Medical staff have veto-power of decision-making over all other clinicians Geographic isolation: GPs are often isolated in the provision of maternity care, and may receive little or no communication or opportunities to collaborate with hospital-based maternity care providers I suggest that review of

systems and organisational context to identify barriers to effective collaboration is added to the strategic direction and enablers.

It is common sense for Midwives and Medical practitioners to provide their individual services within the Law, avoid vexatious reporting, avoid the blame game and to maintain their collegiate relationships, wherever they practice their skills.

Medical Officers need to actually collaborate and respect skills of Midwifery workforce.

As a health professional I am very excited by the possibilities for improvement to maternity services in Australia that I am seeing described in the paper. If there is improvement in collaboration between maternity service providers, we should be able to achieve an increase of continuity of care models and an improvement in the perinatal mental health care of Australian women.

Again we need more funding and we need Obstetric staff on board with all of this.

I'm very impressed with these guidelines. I feel they are comprehensive and women-centred. I have my doubts about their implementation, not because they can't be achieved, but because there remains a toxic culture within the maternity system that resists change and discourages innovation. This attitude is not present in the training of midwives and med students but rather starts to fester within the first few years of active practice where new grads and junior RMOs start to take on an us vs them attitude between each other and against the women within their care and her advocates. Dismissive, "I'm the expert, I know best" behaviour is role modelled and replicated everywhere I've worked. As an active midwife, who works across multiple different maternity service platforms in both the public and private system I feel constantly challenged when I try to practice RMC and have been dismissed on countless occasions for spending too much time with women and not meeting the job KPIs. I think this reality needs to be addressed on a national scale also if we are to make true progress.

The enablers are not enough to meet the stated strategic direction. Should be strengthened by being reworded to "Safe and effective interdisciplinary collaboration, culture and communication." Removal of the one-sided collaboration requirements midwives are required to satisfy. True collaboration and partnership cannot be fostered in the current model. Barriers to collaboration are not addressed. Ways to foster collaborative practice between all health care workers not included. Suggested enablers:

- Interprofessional mentoring
- Removal of one-sided collaboration requirements for midwives
- Collaborative clinical governance processes
- Access agreements for privately practising midwives

The woman should dictate who is able to be present at her labour and birth in hospital, including:

- Doulas
- Independent advocates
- Privately practising midwives without admitting rights attending as support.

Collaboration will not occur just because of a joint statement. All health professionals working in maternity care need to foster collaborative practice. This may be enhanced by interprofessional learning and mentoring. Additionally the requirement for collaborative arrangements for midwives should be removed.

Obstetricians require information about collaboration, not just about a midwife asking for 'permission' to practice, midwives requesting a reasonable workable plan for a woman to at least

experience the majority of her options and choices, within a safe collaborative consistent model of care,

Perhaps improvement in collaboration and information sharing between maternity care providers will facilitate the improvements in safety in maternity care.

Strengthen collaboration - but remove need for midwives to have one-way collaborative agreements. Doctors have no such mandate to collaborate with midwives, and this has been used by doctors to stop midwives from practising in an area and/or controlling midwives practices. Its inclusion has limited women's access to midwives as it limits their ability to practice.

Strengthening interdisciplinary collaboration is impossible as long as a substantial part of the obstetric community is focussed on hobbling and even destroying midwifery practice rather than getting behind it to improve the training and effectiveness of midwives. However I have experienced good working relationships with obstetricians and I remain hopeful.

There is excellent collaborative care currently taking place already. I feel the document emphasises too much on improving this when it already works well. The only improvement that could be made in reality is that the medical profession understands the role of expertise of the midwife and that we are not nurses.

There still needs to be a lot of work with the medical profession to work collaboratively with midwives. There appears to be a territorial patch war whereby the appetite to work collaboratively with the women at the centre, is just lip service. Enhanced scope of practice across all professions biggest hurdle in WA is the AMA.

This document is all well and good in theory. However, all these things should already be standard in maternity care as they are in other areas of health. The document does not address the current dominance of medical opinions over the experts in standard birth (midwives). As you'll see, I've marked most aspects as unrealistic. Change needs to happen on the obstetric culture to see any change that actually benefits the women accessing care. There needs to be penalties put in place for obstetricians who are providing substandard care and putting women at risk by continually pushing non-evidence based interventions at every opportunity.

Collaboration between health professionals - what does this mean? How will it be measured? Where does a clinician go if they cannot establish collaboration? Who do they appeal to? My professional experience is that collaboration is very difficult to achieve in this current climate. The strategic direction should be 'creating a culture of interdisciplinary collaboration and communication'. The enablers will be public recognition of all maternity care providers; collaborative clinical governance processes; and access for all maternity providers to interdisciplinary forums.

Need to acknowledge that the system itself needs to be strengthened to support collaboration and communication. I am fully in support of the various professional colleges issuing a joint statement about a commitment to collaboration in caring for women and their families I think there needs to be a specific reference to how this process will be enabled. I would prefer that ACM and RANZCOG as chief stakeholders be the drivers of production of the joint statement. It needs to be acknowledged that there is little precedent for such a collaboration, but that the task should be approached with open-ness and generosity and the well-being of mothers and babies in mind.

Adding in the enablers to 1.2 that IT or other novel communication strategies that fit cleanly into current workflow should be implemented to improve communication. The burden of paperwork and administration is high - streamlining (again likely through technology) to allow collection of data and patient safety but while not adding to or interrupting workflow and time spent with women providing direct patient care (at initial antenatal appointments as a GP, I have to actively warn women that a chunk of time will be printing and filling in various forms).

This does not address barriers to collaboration –or true ways to foster collaborative practice between all health care workers. Suggested enablers: Inter-professional mentoring, Removal of one-sided collaboration requirements for midwives, Collaborative clinical governance processes. The woman should dictate who is able to be present at her labour and birth in hospital, including: Doula's, Independent advocates, Privately practising midwives without admitting rights attending as support.

This should be reworded to include 'collaboration between multiple service providers' as maternity care outcomes do not rely only on health professionals but also many other providers from non-government organisations, and other government non-health departments, particularly for vulnerable women.

Collaboration can be improved through midwifery-led continuity of care models which incorporate interdisciplinary education whereby collegial relationships can flourish with women receiving safe competent care.

Need equitable treatment for all parties, currently collaboration is dependent upon an Obstetrician or organisation (PHO) agreeing to collaborate with a Participating Midwife and not vice versa. Need to delete the need for formal collaborating agreements. All Public Health organisations with an Obstetric service should offer access agreements to Participating Midwives.

The enablers do not meet the strategic suggestion provided. -one-sided collaboration for privately practicing midwives needs to be removed as whilst that is a requirement, collaboration cannot occur. Collaborative practice can be fostered in midwifery led CoC models which fosters collegial relationships and enables interdisciplinary education.

Enhanced recognition and expectation that all women deserve professional, collaborative and respectful care that places them at the centre of any and all decision making and this can only be achieved when open and transparent collaboration is enacted. -Enablers for this may include -- Enhanced mentoring between professions including recognition of each professions complete Scope of Practice and the support of novice practitioners in all disciplines by all disciplines -- Enhanced interprofessional education (as per previous point) and respect -- Collaborative clinical governance processes and procedures.

Include other professional organisations in 1.2 enablers like Australian Physiotherapy Association and Australian Continence Association.

1.2.3 Organisation comments

Interprofessional collaboration

Does not address the structural violence in maternity care - to women and professionals.

GP's have developed strong pathways to their obstetric counterparts but less so with midwives. GP's and midwives could work together to provide some continuity for women that could

translate to the birth environment whether that is at home or within a facility. Shared care with midwives covering antenatal and particularly postnatal, should be adequately funded and available to all women. Increased Post-natal support Access to perinatal mental healthcare workers, lactation consultants and midwives post birth needs to be supported by Medicare in a manner that is commensurate with the professional services being provided and the positive impact this will have on women and their families. This should extend to birth trauma support postnatally which is currently addressed in an ad hoc manner, if at all.

I said 'very realistic for both [principles under respect] because they are essential. Though sadly, I feel the reality is that both are unrealistic in most maternity care systems that exist in this country.

Re interdisciplinary collaboration - every system is perfectly designed to get the results that it gets. Lack of collaboration is particularly the hallmark of private obstetricians and midwives, operating under a framework of professional and financial incentives and disincentives. Public hospitals that employ VMOs to provide obstetric care describe their frustrations about the lack of accountability for non-collaborative behaviour. Some VMOs take little or no interest even in following hospital protocols for care, deferring instead to policies of RANZCOG, their professional body which might be different from those of the health service. These behaviours are understandable given the design of the system. If there is to be any serious improvement in the collaboration among obstetricians and midwives it will require dedicated attention to, analysis of, and redesign of the system issues that are encouraging people to interact in the ways they currently do.

The RANZCP appreciates the dedication of the Strategy to respectful maternity care, especially the focus on productive collaboration between health professionals. However it should be noted that within section 1.2 Collaboration between health professionals there is no mention of a mental health professional body among health professionals called on to issue a joint statement about interdisciplinary collaboration when delivering maternity services. With one in seven women experiencing postnatal depression (Deloitte Access Economics, 2012) the importance of mental health care in maternity services cannot be overstated. In addition, the safe and appropriate management of antenatal care for women with severe mental illness requires the consideration of development of appropriate models of care that can manage the well documented elevated risk of pregnancy complications as well as mental health across pregnancy (Galbally, et al, 2010; Nguyen, et al, 2013). The RANZCP would suggest the addition of a mental health professional body to this group and would be pleased to discuss our role in this field further. Trauma informed care needs to be highlighted as a key aspect of pregnancy care for all women and especially those with a known mental health history. More than one third of women of women in the general population admit to experiencing childhood sexual abuse (Najman, et al, 2005). As women with a trauma history progresses through pregnancy her anxiety about the forthcoming delivery will increase as will the regular vaginal examinations which are part of late pregnancy care. Women are vulnerable to being re-traumatised at this time and clinicians need to be mindful of this in their provision of care (White, 2014). References Deloitte Access Economics (2012) The cost of perinatal depression in Australia: final report. Available at: www.deloitteaccesseconomics.com.au/uploads/File/PANDA%20Exec%20Summ%20pdf.pdf (accessed 10 October 2018). Galbally M, Snellen M, Walker S, Permezel M (2010) Management of antipsychotic and mood stabilizer medication in pregnancy: recommendations for antenatal care. *Australian and New Zealand Journal of Psychiatry*. February 2010, 44(2):99-108. Najman, J.M., Dunne, M.P., Purdie, D.M., Boye, F.M., & Coxeter, P.D (2005) Sexual Abuse in Childhood and Sexual Dysfunction in Adulthood: An Australian Population-Based Study. *Archives of Sexual Behaviour*, October 2005, 34 5: 517-526. Nguyen TN, Faulkner D, Frayne JS,

Allen S, Hauck YL, Rock D, et al. Obstetric and neonatal outcomes of pregnant women with severe mental illness at a specialist antenatal clinic. *Medical Journal of Australia*. 2013; 199(3):26-9 Thornton, C., Schnied, V., Dennis, C., Barnett, B., & Dahlen, HG (2013). Maternal Deaths in NSW (2000-2006) from Nonmedical Causes (Suicide and Trauma) in the First Year following Birth. *BioMedical Research International*, Vol 2013; 1-6.

Collaboration between health professionals needs strengthening; the enablers quoted are too weak for a positive change in practice. True collaboration and partnership is impossible in the current model of maternity care. To have true change, removal of the one-sided collaboration requirements that private midwives have to obtain to practice needs to be removed; barriers to collaboration need to be addressed; ways to foster collaboration need to be included; hospital/healthcare facility access for privately practising midwives needs to be facilitated; collaborative clinical governance processes along with interprofessional mentoring need to be the norm.

The Victorian branch of the Australian College of Midwives is committed to the principle and the plan for preparing and signing a joint statement with relevant professional bodies about working together for the well-being of women and their families. We support ACM and RANZCOG driving this process together and would be interested to know more details about how this would be facilitated.

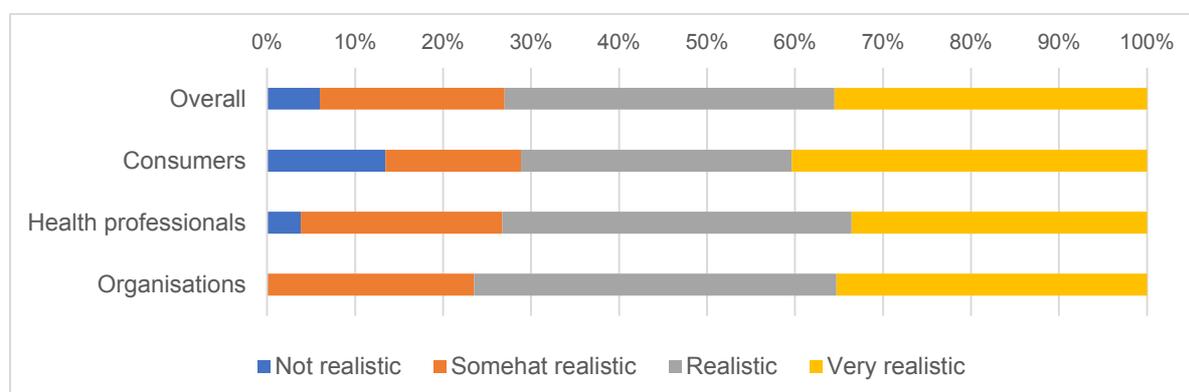
Collaboration between health professionals: This is not a realistic strategic direction, given the enablers. The enablers are not enough to meet the strategic direction. Should be reworded to “Safe and effective interdisciplinary collaboration, culture and communication.” The wording in the draft is not strong enough. Removal of the one-sided collaboration requirements midwives are required to satisfy. True collaboration and partnership cannot be fostered in the current model. This does not address barriers to collaboration –or true ways to foster collaborative practice between all health care workers. Suggested enablers: - Interprofessional mentoring - Removal of one-sided collaboration requirements for midwives - Collaborative clinical governance processes The woman should dictate who is able to be present at her labour and birth in hospital, including: - Doulas - Independent advocates - Privately practising midwives without admitting rights attending as support.

Include commitments to multidisciplinary education of obstetricians and midwives

2 ACCESS

2.1 Improving access to continuity of care

Figure 3 Responses to strategic direction: Expand the availability of models of care that promote continuity for women



2.1.1 Consumer comments

Comments on the principle

Suggestion: "Women have improved access to continuity of care with the care provider and within the care model of their choice."

Continuity of care

Work needs to be done to analyse the real costs and long term cost savings of implementing continuity models in rural and remote areas through lower intervention rates, improved satisfaction, reduced antenatal admissions and postnatal readmissions to hospital and increased breastfeeding rates.

I think striving for greater access to continuity of care is important but should not only be for midwife led care. Some women may wish for continuity of care with a team approach or OB led care.

All women should have access to continuity of carer.

CONTINUITY OF CARE - in this document, there's no solid enablers to creating it in the current maternity climate.

Continuity of care should feature more highly in this document. Studies have proven that this alone will improve birth outcomes for mother and baby, physically, mentally and emotionally.

Midwifery continuity of care

This document holds importance for the future of maternity care in Australia. Until there is a regard held for the quality of MIDWIFERY care within Australia, and until that is reflected in this document, there will continue to be dominance by the medical profession. This dominance chooses NOT to support the plethora of research indicating safe and incredible outcomes for women cared for by Private Practising Midwives and Midwifery Group Practices.

As a consumer who has not finished having babies, I am passionately advocating for the aspects of this document which highlight the positive impact and expansion of models of care which provide continuity of a known MIDWIFERY carer. Such as privately practicing midwives, caseload midwifery, midwifery group practice, publicly funded homebirth programs, midwives in

small teams. And more emphasis and education is needed on why these are valuable - because normal physiological birth is protected and enabled more often by these models. Although the principles are reasonable, the document still leaves an aftertaste of maternity care as something that is 'done' to women by more knowledgeable care providers. I am disappointed at the lack of focus on providing practical solutions 'enablers' for the challenges faced by privately practising midwives who attend women at home. Including the intrapartum indemnity insurance issue, as well as vexatious reporting to AHPRA. This makes accessing privately practicing midwives increasingly difficult and anxiety provoking. This document may benefit from an anti-racism framework provided by an experienced ATSI and CALD consultants.

Collaborative working agreements for all private practice midwives in all public hospitals.

There needs to be more options for rebates or choice for continuity of care. GPs and obstetricians are great but they are not there for your entire labour, midwives are. Continuing care by the same midwife or team of midwives can be invaluable for birthing mothers. Private health funds must be rallied to provide appropriate rebates for this to allow women the CHOICE not be pushed in a direction that finances will dictate. More funding for private midwifery services - this allows women a choice in their provider to find the person that best suits them.

Australia needs to look at New Zealand's model of Midwifery care and implement it here

The plan does not provide any extra ways to help women get midwifery continuity of care. It mentions midwifery but doesn't give any real strategies.

Access - should delete the word "improved" from 2.1 (access to continuity of care models), as research shows that all women would benefit from continuity of care with a known midwife (or very small group of midwives), and therefore we need to aim for all women to have access to this. It's what the majority of women want, and it's clear from research that it leads to better outcomes for both mothers and babies.

Publicly funded midwifery continuity of care models for all women of all risk.

Some recommendations for achieving midwifery continuity of care:- More hospitals to allow midwives visiting access, Higher rebates for all women from Medicare for private midwives care, Higher rebates from private health funds for private midwives care, initiate access for all women to have continuity of care from a known midwife.

Supporting the continuity of care models already in place. More/improved rebates from Medicare for those women who have chosen to employ a private MIDWIFE for their continuity of care, which will improve access to these services. More hospitals granting visiting rights to Midwives to enable ease of access for us as consumers. More research done with Australian statistics about the benefits of continuity of midwife, both within private and public MGP systems, including financial, outcomes and job satisfaction for the midwife.

The exclusion of reference to particular models of care is a step backwards for Australian maternity care, especially given that a stated principle of this document is to ensure women receive care during pregnancy and birth that is based on current evidence. There is now overwhelming evidence, including multiple Australian randomised controlled trials that indicated continuity of midwifery care has significant benefits for women and babies. This document must clearly and resoundingly highlight that it is continuity of midwifery care, in particular, that is the evidence based model of care that all Australian women should be getting better access to.

The government needs to seriously act on introducing and/or expanding continuity of care models of midwifery, specifically midwifery led models where women are provided care throughout their pregnancy, birth and postnatally by a known and trusted midwife.

While the importance of Continuity of Care (COC) is outlined, it does not appear to be sought as the baseline for maternity care. This is despite evidence that it is the 'gold standard' of maternity care. Improving access to COC is not enough if it does not include the option for consumers like myself to choose a privately- or publicly-funded midwife that can attend homebirths and have visiting rights to a hospital of my choice. This would clearly be a workable option as evidenced in many other countries. Without this option of care, the concept of woman-centred care in Australia cannot be taken very seriously. It is an evidence-based care model that embodies human rights, strengthens families and their communities, and promotes better overall health and wellbeing.

A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

A pathway to reduce the barriers to private midwifery care being more widely available across Australia.

A statement in support of Midwifery Continuity of Care has to be forefront. Midwives work within evidence-based guidelines and women and families benefit from their care. It is time for recognition and a change of attitude that has to stem from these strategic plans.

Access to continuity of midwifery care is the clear solution to all of these points. Better outcomes, better satisfaction from the women and families, sustainable and job satisfaction for the Midwives, cost effective, better mental health outcomes, better post-natal care, improved still birth related, informed decision making are all benefits of continuity of care. This is what we want as consumers and what the research says, why isn't the funding following what we have asked for??

Access to more PPM is not mentioned anywhere.

Availability of continuity of care needs to cover antenatal, intrapartum and postnatal care. This needs to be inclusive of all locations, socio-economic groups, risk levels etc. Continuity of care is beneficial for every mother and baby. This needs to include all continuity of care models, including private midwifery care. For example, the current requirement for 2 people skilled in neonatal resuscitation to attend planned homebirths is a major barrier to midwifery continuity of care for women outside of metropolitan areas.

Continuity of midwifery care is a gold standard model for promoting good physical health and mental health outcomes for both infants and their mothers. However, currently access to such a model of care in Australia is quite restricted - there are few publicly-funded models and access to private midwives in the community is largely restricted to women who can pay. The strategic directions should be amended to specifically include suggested strategies for increasing women's access to continuity of midwifery care, including: increased Medicare rebates for women accessing private midwifery care; increased private health insurance rebates for women accessing private midwifery care; consideration of the steps that would be required to increase

the rates of visiting access that private midwives have to hospitals; and putting women in the control of the funding for their own care.

Evidence-based care for women would involve universal continuity of care with a known midwife and access to home birth. This would involve a shift to a system that centres women rather than the medical industry, which is very unlikely to happen.

For example, commitments need to be specifically made to increase women's access to continuity of midwifery carer services.

Improving access to continuity of care – Further information needs to be added in the enabler section regarding HOW the range of continuity of care models will be increased, particularly for private midwifery models of care, which offer very high standards of continuity of care, but are the rarest type of support available to women when compared to obstetric, GP, and public hospital care models.

Inclusion of midwife led care which is proven to provide safe and natural processes (evidence based supported).

Midwifery

Midwifery and the gold standard continuity of care is utterly absent from this document. This is about women having choice - about where they birth, how they birth, and with whom they have supporting them in birth.

More access for private midwives to all hospitals (to ensure midwife and hospital of choice).

More access to midwifery continuity of care to reduce stillbirth rates (see Cochrane Database), improve mental health outcomes and to give them choice, not just to fit the guidelines.

Needs to more clearly and resoundingly endorse improving access to continuity of midwifery models of care as the evidence-based approach to maternity care. One of the enablers here must be that jurisdictions set targets for increasing women's access to continuity of midwifery models of care, and for the establishment/expansion of public homebirth models. Another key enabler is for all health services to develop visiting access agreements with privately practicing midwives.

No improvement on access to a continuity of care model with a known midwife

Not only does WHO recommend midwife-led continuity of care, all of the research to date which has analysed the benefits of continuity of care models has looked at midwifery continuity of care. This section starts by referring to midwifery continuity of care but then seems to lapse into a generic references to continuity of carer of choice. This is incredibly confusing and misleading.

Once again, all of these points will be improved through greater access to continuity of midwifery care.

Once again, continuity of midwifery care and collaboration can improve this point.

PRIVATE PRACTICE MIDWIVES - barely mentioned, who do you think is caring for all these women chewed up by the system for their second and third babies? Or who is debriefing them after horrific experiences of violence in the Maternity System and trying to improve their outcomes? If you don't provide PPM's access to the public and private systems on a larger basis, women are still not getting true choice.

Privately practising midwives - they are still barely funded by Medicare making them incredibly hard to access for most women.

The document repeatedly recommends that women receive continuity of care, recognising the benefits of having a known midwife at birth and through the antenatal and postnatal period. However, the document does not provide any detail on how women will actually increase their access to continuity of midwifery care. There are a number of barriers currently to women accessing such care, and the document does not outline how these will be addressed or how we would know progress has been made. Please refer to responses below.

There was minimal information about midwifery continuity of care.

Will there be increased Medicare rebates for women accessing private midwifery care? Will there be increased access to private midwifery care for women in regional areas? If so, how would this be implemented? Will government work with hospitals to increase the rates of visiting access by private midwives? All these issues are current barriers to Australian women accessing real choice in maternity care.

Women need easier access to privately practising midwives.

The number of private practicing midwives is dwindling because they are being vexatiously targeted and investigated by AHPRA. It must stop.

Put an end to obstetric culture, give each woman her own midwife, and each midwife the ability to practice to her full scope and you will literally solve all of these issues.

Medicare and private fund rebates need to be increased significantly to enable women to access private midwifery models of care. There needs to be greater access for eligible midwives to access hospitals to give women the option to birth in a hospital with their known midwife.

Less red tape for private midwives and hoops to jump through to maintain and obtain eligibility, better access to continuity of Midwifery care for all women of all risk, better Medicare rebates, safe birth environments birthing options e.g. home birth

Less red tape for PPMs. Federal approach to maintaining/increasing rural access

2.1.2 Health professional comments

Comments on the principle

Reword to women have access to a continuity of carer(s) with the care provider(s) of their choice.

The principle should read that women have improved access to continuity of CARER with care provider(s) of their choice.

Reword to: 'Women have access to a continuity of carer(s) with the care provider(s) of their choice'.

Improving access to continuity of care • Reword: Improve access to continuity of carer (not care) regardless of risk/complexity-inclusive of collaborative models of care and enhancing reference to Midwifery lead carer models of care

Principle should be improved access to continuity of CARER and the word carer needs to be inserted in the strategic direction. Health services employing midwives to care for women need to receive reward for remodelling care options to enhance continuity of carer. The current funding models do not promote continuity of carer as stated, they support the fragmented approach to care. All women regardless of geographical location should have access to continuity of midwifery carer.

Reword: Improve access to continuity of carer (not care) regardless of risk/complexity-inclusive of collaborative models of care.

Continuity of care

The safest care is achieved when a woman is provided evidence-based information in a continuity of carer model (which includes the labour and birth), and her decisions are supported even if they differ with her carer. The Commonwealth needs to find a way to call states to account on why this is only being provided to less than 10% of women.

Offering publicly funded home birth and improved access to birth centres in all states would enhance women centred, safe options and possibly reduce free birthing and associated risks.

Expanding different continuity of care models could enable every birthing woman to have the recommended continuity of quality care in collaboration with medical and multidisciplinary teams in a women centred, respectful and supportive environment.

I cannot emphasise the importance of continuity of carer. I work within a caseload model but find that this could/should be expanded but isn't. All comments in the discussion paper point in this direction and this is vital as we move forward. The outcomes of COC speak for themselves. These models could be changed slightly to incorporate other staff who are not able to commit to on-call work schedules.

Continuity of care for ALL women should be the priority and could address and meet the above strategic directions.

Continuity of care as a model for women centred care is great. I think this comes from a Multidisciplinary team working well together rather than just one person or profession providing 'continuity of carer'.

Continuity of care is proven to enhance safe outcomes for women and babies, therefore is a must.

Unless the government mandates that all states provide continuity of care for all women regardless of risk, then groups of women who are more likely to benefit from continuity of care models are likely to be excluded.

"Expand the availability of models of care that promote continuity for women" - What is it that access is being given to? Access to "Continuity for women" in the sense of *actual* continuity of care (for which the evidence base primarily supports midwives and has done for the last 25 years of study)? Or access to a model of care that superficially meets the definition of "continuity of care"? I am very concerned that a watered down definition of "continuity" is easy to construct and would be used to "tick the box" to accredit providers or pass audits, while real outcomes would be lost - or worse, the "experiment with continuity of care" would be deemed a failure when it was never genuinely implemented in the first place.

Women should have access to not only continuity of care but recognising the importance of continuity of carer(s) and the care provider of their choice.

Women need a better connected service from pre conception to the end of the postnatal period. The care in Australia is generally fragmented and involves too many different practitioners who are not known to the woman. Relational continuity is the best model of maternity care and this can be provided by an obstetrician or a midwife. We need assistance to make this happen for all women.

The terms continuity of care and continuity of carer are two different concepts but I believe have been used interchangeably in this documents, hence reducing the clarity/meaning of the document. For example • Develop funding models to support access to continuity of care models could read • Develop funding models to support access to continuity of carer models. Continuity of care is achieved by comprehensive documentation and handover between clinicians/health care providers.

There has been discussion around the dot point "women have improved access to continuity of care with the care provider(s) of their choice" - I support the removal of the word 'improved' so the statement is stronger and more lasting. I do not support the idea of inserting "midwifery care". While I acknowledge that midwives have a key role to play in maternity services, this should not

be to the exclusion of other carers. This model should remain woman-centred as well as evidence-based and not direct a certain type of care on the woman. Regional differences across the country may affect access to different models of care. We should encourage team care making use of the strengths of each discipline.

Publicly-funded continuity of care models (such as MGPs) need to offer and include greater choice of birthplace options for women (e.g. homebirth and birth centre options). Continuity of care models need to be supported by the wider collaborative team for this to occur (e.g. obstetricians working with midwives and women to support the option of birthing outside of the hospital).

Rates of stillbirth have a lot to do with disengagement from education due to seeing different care providers at each appt in a fragmented system. AGAIN the answer is Continuity of Care. Evidence proves the stillbirth rates are lower than standard care.

Continuity of care is not clearly defined. There is a difference between continuity of 'care' and continuity of 'CARER'.

Care for trauma survivors and sexual assault survivors being that this is 1 in 3 women. These women also need Continuity of Care.

More options and access of continuity of care.

GPs do not just refer to other maternity care providers. GPs can provide antenatal care and do so for at least the first 12 weeks including lifestyle and medication advice, routine testing and discussing and organising early pregnancy screening. GPs often provide antenatal care until the booking in visit at the hospital at 18-20 weeks. I.e. GPs often provide antenatal care for at least the first half of the pregnancy. This needs to be acknowledged and supported.

I am a GP Obstetrician working in rural WA. I care for women before, during and after their pregnancies as well as providing intrapartum care at the local hospital. I love it - being chosen by a woman to care for her is a huge privilege and working in partnership with the midwives, the woman and her family brings me so much joy. One of the problems with our "system" is the fragmentation between federally funded GPs and state funded hospital services. There is little room or vision for developing a truly integrated model of care. It would be great for midwives to be able to provide antenatal care in and from the GP practice. I would love for a small group of midwives to be able to work from my practice location providing most of the antenatal and postnatal care and then being the midwives who are present during labour and delivery. Would it be too much to wish for even more - a social worker, mental health worker, lactation consultant.....all together How awesome would that be!

In the section on enablers, which states the need to develop funding models to support access to continuity of care models, it is important to also include funding models that support women with disability, and in particular women with intellectual disability, given they have different learning needs, and are more likely (up to 60% of this group of women) to have their baby removed from their care into foster care. It is imperative that appropriate models of care be developed to facilitate mothering for this group and meet their needs.

Midwifery continuity of care

There is very little in this document that increases choices for individual women. The previous plan paved the way for Medicare rebates for women who choose their own private midwife. There have been some flaws in this system, but they are not addressed in this document at all.

There is no going forwards here. We have very firm evidence that women have better outcomes when they are cared for by a known midwife. Is not best outcomes what maternity care is all about? It would have been good to see evidence about maternity care have an increased focus in this document. Women's voices are missing from this document also. What do women want? This, combined with best evidence would have been good to have been included in a more definitive way in this document. How are we going to improve women's choices? We are seeing more maternity units closing down, with potential for babies to be born outside maternity units. What is being done to address this stressful and dangerous experience for women and their babies? We seem to have an increase in free birth in this country. There is nothing in this document that addresses providing midwives to women who will not choose to birth in hospital.

Where is the mention of privately practicing midwives as an avenue for expanding access to continuity of care?

The benefits of midwifery care in a relationship based continuity model is clearly absent. Which begs the question why? Midwives, degree based education, scope and philosophy of practice ensures that the women of Australia will receive safe, quality and cost effective model of maternity care, from pre-conception up to an including 6 weeks post-partum. Midwifery care has proven evidenced benefits for women and babies. To ensure that the Australian women of the future get offered not only free choice of provider in line with international standards, midwives must be the first provider of maternity care as they are the experts. As stated at the 2018 FIGO conference & supported by the ICM, let midwives care for all women and collaborate with our obstetric colleagues when necessary, who are educated to deal with complexities. Leave GP's to do the generalist medicine they are educated for. For a well woman to see a specialist obstetrician in pregnancy is simply not appropriate. The ever rising rate of women in Australia, who don't have a normal physiological non-interventionist labour and birth is alarmingly low, 20%. Completely at variance with international standards and as evidence is showing, of huge potential harm not only for and to her physical but mental health. As a consequence it is hardly surprising that there is ongoing hostile communication issues with two professions who both do need to be reminded that the women need to be firmly placed in the centre of all discussions. For this reason midwives, who are autonomous professional should not be 'working' under direction of obstetricians. Their values and belief systems are not the same. As a recent newcomer to Australia from 23 years working in a functional maternity system in New Zealand, I am highly concerned as a professional midwife at the outdated factory style maternity system. I see a maternity system which is outmoded and does not reflect current evidence or adheres to international standards. There are few real options for women except to enter this system as in many areas there is no other choice, where they are met by a paternalistic system, which coerces them and badly meets their human rights. Midwifery practice is so tied up by legislation that you can't even practice as a midwife except in a hospital upon registration is appalling. Do no harm, don't interfere unless you know what you are doing is proven to be better. There is overwhelming research to show not only do unnecessary interventions lead to higher rates of anxiety and depression, higher rates of maternal suicide but impacts physically upon the baby. Australia should be a world leader supporting midwifery, not following the model of obstetric care from the USA, which has high and ever rising rates of maternal death. To do otherwise is alarming and should be of real concern about who is making decisions at high level. The women of Australia can't be true partners in decision making about maternity services as so few of them have experienced a different model. Once they have then their options will be of absolute relevance. There are obvious regional, federal and state barriers to change but if the national maternity system is a world leader sets the scene for change. References need to be updated and reflect international perspective.

Women require choice. Women need to feel safe, informed and respected. This (as backed by vast evidence) is only found in midwifery continuity of care. My own birthing options have been restricted at 28 weeks of pregnancy due to a non-collaborative agreement between my midwife and the hospital I was booked in at. My midwife had a complaint put in against her and the hospital suspended her access effective immediately pending an investigation which could take months. I am aware of the events of the birth of which this occurred and am confident no issues will be found against this midwife. However, women such as myself are now left with limited and non-enticing options within a fragmented system at a very late stage in pregnancy. Complaints such as these can happen for little reason and have detrimental effects on women. Free birthing rates, birth trauma and mental health issues will rise if women are left without choice.

Why isn't there any specific mention of expanding midwifery models of care as an enabler to 'Improving access to Continuity of Care? There is well documented evidence that these midwifery models of care improve outcomes for both mother and baby.

Research shows that midwifery continuity of care reduces premature births and stillbirths, lowers caesarean rates and there is higher maternal satisfaction (Cochrane).

Mentions care in the community – but does not discuss primary sector planning and framework planning. Midwifery continuity-of care models are a long-term, primary health strategy, which delivers health outcomes for generations. - Decreases costs - Increases outcomes - Increases BF rates (which leads to long-term health benefits to woman and baby).

Missing from the document: A clear strategic direction for relationship-based, continuity of midwifery care by a known midwife for each childbearing women with seamless access to medical care if a woman's condition warrants it. The evidence is clear that childbearing women and their prenatals/newborns are safer and women are more satisfied with their experience when they have such continuity of midwifery care. Health care costs are contained as premature birth, stillbirths and surgical birth rates are greatly reduced with continuity of care with a known midwife. The National Strategy for Maternity Services needs to state the evidence clearly so that states and territories have an evidence-based document to follow. It is a moral, ethical and financial responsibility to do so.

There is a Cochrane review into midwifery continuity of carer that should be used as evidence alongside the WHO recommendation. We also know from review after review of maternity services across Australia, that women have a preference for continuity of midwifery carer. Only 8% of women can access continuity of midwifery carer. Demand far outweighs supply. Where is the evidence supporting other models of "continuity"? Bundle payment like NZ per trimester not just for birth.

All evidence supports the benefits of MIDWIFERY continuity of care models (perinatal morbidity and mortality outcomes, costs, maternal satisfaction). There have been no studies exploring the benefits of other 'continuity of care' models, such as obstetric-led. The benefits of midwifery-led continuity of care cannot be generalized to ALL models of continuity of care. Midwifery must not be diluted/removed from proposed solutions. Midwifery led continuity of care is a long-term, primary health strategy which delivers outcomes for generations (Sandall et al. 2016): decreased costs; increased maternity outcomes; increased BF rates – reduces SIDS, increased health benefits including decreased rates of obesity. Midwifery continuity of care to be accessible to all women, regardless of risk or geography or finances. Where risks are identified, midwives collaborate and refer appropriately.

Make the document to reflect midwifery as the prime provider of maternity care, that's the missing element in achieve part of this consultation document and proposal.

Access to MIDWIFERY continuity of care models.

Access to midwifery led care models which women have discussed they want, choice.

All maternity services should provide continuity of midwifery care and ever woman had a known midwife regardless of risk level.

All women of all risk will have a known midwife. There is copious research of gold standard to show this improves maternal & perinatal outcomes and is most cost effective. Yet this document does not explicitly say this. This document should not be open to interpretation for GP/Obs or Private Obstetricians to suggest or to reword to suggest this should be them. Even when seeking care through these alternative avenues all women should still have access to their own known midwife through continuity of care. Additionally all maternity services should offer continuity of midwifery care. Particularly in rural areas where there is resistance to set up these services. Not to do with cost at all. But because there is not enough pressure from the health services and government to do so. As a result not only are women missing out but midwives are leaving the workforce because unless they want to relocate to metropolitan areas they can't work within these models to provide women with the very best care.

Consumer focus informed consent continuity of carer by a known midwife Midwifery led care.

Despite strong consumer voice at round one consultations, the support given by continuity of MIDWIFERY care is being brushed aside and simply represented as continuity of carer. Evidence and consumer voice calls for continuity of midwifery care.

Equitable access to continuity of midwifery care.

Continuity of midwifery led care as the best evidence based model.

I commend the focus on respect for childbearing women though feel that the strategy has not been explicit enough in the promotion and support for midwifery led continuity of care as the most evidence based strategy for improving outcomes and satisfaction for childbearing women. Significant inequities exist and structural reform at all levels is required to promote midwifery autonomy so that women benefit from this evidence based intervention.

Continuity of care in a midwifery led model is evidence based. It improves outcomes for mums and bubs. Less interventions. Improvements in health status. Cost savings for institutions. But most importantly. It is what women want. They told us through the national maternity services plan. And yet we still haven't achieved that. Interventions to improve staffing and support of these models at individual organizations are key to progressing this.

I do not see anything here that will increase women's access to their own midwife. I do not see anything that will increase the ability of midwives to practice privately.

I think the cost benefit analysis of private care versus public care, and then of midwifery care versus obstetrician care will uncover some interesting comparisons.

2.1 I would just comment that the link between workforce planning and models of care/service delivery must be acknowledged and applied. Right now there are significant workforce challenges, in metro, regional and rural services, yet services/governments are not willing/able to look at how they deliver maternity care and how that impacts on workforce recruitment and

retention, capability, availability etc. I saw a quote recently that said "if you build the service, they will come" and I have thought this for many years now, if you want midwives to join a service, stay in a service, provide any level of care, give them the opportunity to do so in an environment that enables them to practice according to the very basis of midwifery, that aligns with their training and their capability. There are so many gaps in maternity care that could be filled by midwives, and yet the majority are quarantined to the hospital system seeing women from 20 weeks gestation - far too late, and their contact with women is cut off on average at day 4 post birth. Women are calling for midwifery-led continuity of care, midwives are calling for it, rural GPOs are so thin on the ground they are burning out from too much on call, metro services are so overbooked they can't fit in the antenatal appointments. All of this could be resolved if midwives were utilised to their full scope of practice and able to practice in the community.

Improve models of midwifery continuity of care.

The only improvement that could be made in reality is that the medical profession understands the role of expertise of the midwife and that we are not nurses. That's not going to come from within this document it will come through Medicare recognition. Opening more opportunities for midwifery practitioners and the government valuing midwives. Understanding we are not nurses.

Midwives should be the lead carer for all women without any risks and obstetric doctors should only provide care for those women and babies with risks or actual complications. Women want continuity of midwifery carer not continuity of care - our system is already supposed to have that.

Not only is it realistic, it is vitally important for women to be heard and their experiences and outcome used to move forward with a maternity model which offers access to continuity of care models of midwifery for EVERY woman. Ideally a midwife is the primary care provider who works in collaboration with other care providers. There also needs to be greater access for women to birth locally (more maternity services, stop closing down maternity services in rural areas).

Once again there needs to be an expansion of midwifery continuity of care services, both public and private, providing choice women. The mental health of women can be monitored closely during the perinatal period by a known and trusted midwife through a continuity of care model, this enables collaboration with necessary health providers. Postnatal care is underrated and poorly delivered with women often leaving hospital with minimal follow-up. There needs to be better services available to women - ideally through a continuity of care model of midwifery.

Respectful maternity care and continuity of midwifery care for every woman are absolutely critical to achieving improvements in every other area listed in this document. Respect is a fundamental human right, and there is overwhelming evidence for the benefits of continuity of midwifery care. So if there is a way to highlight how fundamental these two elements are, and how they would benefit every other strategic direction listed, that would be great. Another enabler of evidence-based care would be to implement a no-fault insurance scheme similar to the one in New Zealand. This would reduce some of the perceived medico-legal risk that contributes to our current harmfully high C-section rate.

The document does not recognise evidence already available in regard to the cost-effectiveness and health benefits of continuity of midwifery-care.

The document needs to address the over-medicalisation of pregnancy and childbirth. It needs to provide all pregnant women access to Midwifery led continuity of carer models, so that women are able to reduce the risk of maternal and infant morbidity and mortality.

The principles do not rely on research that states that women's wellbeing is improved by access to MIDWIFERY continuity of care. The document specifies any continuity. I propose we add MIDWIFERY continuity of care AND other health providers as required.

Increased funding for more continuity midwives and community midwives to increase publicly funded postnatal care up until 6-8 weeks postpartum, as based on current literature, inclusive of the world health organisation.

The cost benefits of continuity of carer model midwifery group practice has already been established through research and is WHO gold standard so I expected embedding this model of care strongly in the document. What other Continuity of carer models available and needing research is not outlined for the reader. Focus groups mentioned a lack of continuity of care – did they mean carer?

We need more midwifery led care, we know that and have for many years. But there isn't any changes. GP/OBS in rural areas continue to monopolise maternity care, and strongly discourage midwife led continuity of care for fear of losing money.

There have been no studies exploring other 'continuity of care' models, such as obstetric-led. Therefore, the benefits of midwifery-led continuity of care cannot be generalized to ALL models of continuity of care. Midwifery should not be diluted/removed from proposed solutions.

There needs to be guidelines for midwives providing continuity of care for all levels of health services.

This document does not provide sufficient enablers around increasing access to midwifery continuity of care. The enablers are well researched, the demand is there. This document fails women on so many points. The true answer - continuity of care, is mostly ignored on all of the below points. Collaboration includes access for private midwives into hospitals around Australia. We know this works (see My Midwives Practices throughout QLD and VIC) well when implemented strongly. You need to find a way to action this if you truly want women to have continuity of care. Access - women easily access obstetric, GP and public hospital care but they cannot access midwifery models of care because of medical buddy systems, kickbacks and unawareness, and in particular private practice models because of the significant barriers that exist (such as cost, location, access to hospitals, birth choices) to uptake and that a strategy to resolve this must be examined. Perinatal mental health - access to midwifery continuity of care for these women should be added as a strategy for reducing mental health issues and costs for women during the perinatal period. Stillbirth - that access to midwifery continuity of care should be added as a strategy to reducing stillbirth, and providing the most appropriate care for women at such a significant time. Aboriginal and Torres Strait Islander health and culturally and linguistically diverse maternity care- access to midwifery continuity of care has been demonstrated to improve outcomes for both these groups YET AGAIN THIS IS NOT MENTIONED.

This plan seems to be ignoring the plethora of research that highlights the benefits and improved outcomes of midwifery continuity of care or the voices of many women who want equitable choice of birth place, including access to home birth, birth centres, and hospitals.

Very concerning that an earlier version of the draft framework, which clearly articulated that expanding midwifery continuity of care services, has been removed from the public consultation draft. All evidence supports the benefits of midwifery continuity of care models (perinatal morbidity and mortality outcomes, costs, maternal satisfaction). There have been no studies

exploring other 'continuity of care' models, such as obstetric-led. Therefore, the benefits of midwifery-led continuity of care cannot be generalized to ALL models of continuity of care. Midwifery should not be diluted/removed from proposed solutions. We know that 1) midwifery continuity of carer must be ACCESSIBLE to all women- Geographically & should be all-risk; 2) Continuity of care models must be accessible from conception up until 6 weeks postnatal and; 3) Midwifery led continuity of care is a long-term, primary health strategy which delivers outcomes for generations. 4) Midwifery led continuity of care model decreases costs, increases maternity outcomes, increases breastfeeding rates – which lead to decreased rates of obesity There have been no studies exploring other 'continuity of care' models, such as obstetric-led. Therefore, the benefits of midwifery-led continuity of care cannot be generalized to ALL models of continuity of care. Midwifery should not be diluted/removed from proposed solutions. Please ensure that the above is re added to the draft.

While I agree wholeheartedly with the central purpose of the new framework being "woman centred care" I am concerned that midwifery care should be acknowledged as the hub of the framework. This does not come from a position of wanting to compare or denigrate other models of care or to play on inter-professional rivalries but rather from the empirical evidence about midwifery-led maternity care. This is actually what frames the WHO recommendations and it is also what the public maternity care system in Australia is effectively doing - but without being named. We have the trained workforce and guiding documents to sustain this model - with incremental change occurring throughout the system already - virtually by stealth - but also out of necessity. Midwifery continuity of care models need to be the default model of care offered to women in the Australian healthcare system. It is gold standard care. It is economically sustainable and efficient. Consultation and referral with medical doctors can occur as required, but the midwife-mother relationship has a purpose beyond medical management and should be sustained in order to improve maternal and infant outcomes.

Without doubt, it is remiss of the Government not to recognise, acknowledge and include Midwifery as a profession in its own Right. Midwifery is not responsible to Nursing or Medicine. Midwives do not take orders from these colleagues. Where and when appropriate and in the event that a different level of skill is required, Midwives are an integral part of the Team. In Law, Midwives are accountable for their actions; responsible for their practice; they have a "duty of care" to each Woman for whom they provide their services. They are expected in Law, to practice as the "reasonable" Midwife would do in the circumstances. The same Law applies to other professionals. Midwives do not go about their practice with "intent to harm". It is a Midwife's "duty of care" to respect and provide every Woman with "reasonable" Midwifery services "in the circumstances" and equally important to acknowledge the Woman's individual rights to making decisions and choices. It's a legal obligation to obtain informed consent from every Woman in relation to her care. The Law of Consent requires she be informed of the benefits, risks and the alternatives and that the information has been documented in detail. One-midwife with one-woman (preferably chosen or known) through the entire journey is statistically significant best care including a reduction of unnecessary interventions. The same Midwife during a Woman's unique transition through her pregnancy, the individual stages of her labour, the birth of her baby, her first breastfeed, the first 72 postpartum hours with her baby and continued postnatal care for up to 6 postnatal weeks is, without doubt, the Right of all Women. Respect for women includes having access to their known or chosen Midwife in the community, as near as possible to their home. That means decentralisation of services, which relieves the formidable pressures current in the centralised hospital systems (public and private). Women may also choose to have Midwife services in their home. Whether at home, in a Community Birthing Centre, or an accessible Community Birthing Home, women are best serviced by Private Midwives or small

Midwifery Group Practices with the inclusion of the woman's chosen General Practitioner if necessary. Healthy Women who make choices for Midwife care do not need to be attached to major institutions. Healthy Women forced to attend illness related institutions is not acceptable. Access to Obstetric expertise is ideal when appropriate if access for the Midwife is welcoming, respectful and absent of obstructive, bullying communication behaviours. The environment of yesteryear is a primary requirement and extinction of the 'blame game' essential. The years of the 70s and 80s were excellent, where the Midwife had unquestionable, easy access to many hospital environments and where hospital employed colleagues participated with undeniable respect for two-way consultation &/or referral. A turn around to an environment whereby collegiate relationships that respectfully include Women as the central focus within an inclusive Team approach, according to the individual requirements at any time of her pregnancy, labour, birth or postpartum transitions. Urgent dissolution of the overdeveloped hierarchical dominance, together with the advancement of vexatious reporting that has continued to increase the phenomenon of anti-collegiate, dominant relationships following the Nicola Roxon, MP, Health Minister era. Urgent requirements for an improved Maternity Service begins with: Healthy Respect for Women and their Midwives is absolute. Eradication of the Tax Payer funding that expects and controls systemisation of Women and Midwives. Commence urgent attention to, and change rampant over-servicing, private and public. Slow the current concentration on rapid institutional input, throughput and output of Women. Return to concentrated care for each Woman according to her individual need. Cease the rapid discharge of Women at the expense of incomplete personal care and the increased readmission. Reduce the increased postnatal mental health issues by providing Women with the same Midwife through her entire journey. Responsibly increase unhurried focus on personalised caring, not organisational dominance. Ensure Professional responsibly, accountability and "duty of care" is achievable and not breached by the unreasonable demands placed on all professionals who provide services within the institutional systems. Please don't forget the MIDWIFE in this Government document and remember the MIDWIFE has been "with" Women for centuries and that personalised MIDWIFE services are more likely to reduce Government and Taxpayer costs while increasing Mother-Baby wellbeing.

Women want midwifery continuity of care. The research is incontrovertible that this model of care is optimal, safe and financially sensible for women, their babies, families and health professionals. Women also want compassionate and humanised care and services. Midwives are best placed to support women through relationship based care. Publically funded home birth services need to be accessible for women throughout the public maternity system too.

Yes [there is something missing], It is omitting the word 'Midwifery' from the context of the document! The majority of the evidence base for continuity of care is explicitly based on Midwifery care, not general continuity of care. "Midwifery" needs to remain in this document. If other professions such as GPs and obstetricians want to claim good outcomes for continuity of care models based in their own professions then they will need to do their own randomised control trials. To illustrate this point, it is only necessary to imagine the outcry if midwives were to utilise clinical trials of doctor-led care to support an extension of their own professional practice into traditionally doctor-led areas. Midwifery-led continuity of care is based on a model that has necessarily long appointment times, less waiting for client appointments and a known person/persons attending *throughout* the client's labour. If obstetricians want to join private midwifery practices and work the same hours alongside midwives for the same pay, I'm sure they will be very welcome, however it is hard to see how an obstetrician's practice can be financially viable if similar continuity of care is provided to what private practice or MGP midwives offer.

Yes [there is something missing], the importance of access to Midwifery Continuity of Carer models is not included yet this has proved to be the most important change to maternity care. Midwifery continuing of carer models have been shown to reduce costs, improve maternal satisfaction, reduced perinatal morbidity and mortality and increase breastfeeding rates. The link between breastfeeding and decreased rates of obesity should be enough of a reason to include Midwifery continuity of care models within this strategic plan.

Yes [there is something missing], the importance of continuity of CARER as opposed to continuity of care should be included. Only Midwifery continuity of care models have been shown to be beneficial in reducing perinatal morbidity and mortality outcomes, costs and maternal satisfaction. Therefore the document should call for Midwifery continuity of carer models to be available to all women regardless of geography or risk. Especially as we know that Midwifery led continuity of care is a long-term, primary health strategy which delivers outcomes for generations. It decreases costs, increases maternity outcomes and leads to increased Breastfeeding rates, which in turn leads to decreased rates of obesity.

Yes [there is something missing], where is midwifery led continuity of care for low risk women as a solution? The evidence based research that is highlighted as a standard to follow is out there so why is it not included in the framework!?

MIDWIFERY! Decision makers can't ignore the evidence any longer, time for change is here, and be a leader.

Midwifery continuity-of care models are a long-term, primary health strategy, which delivers health outcomes for generations. - Decreases costs - Increases outcomes - Increases BF rates (which leads to long-term health benefits to woman and baby) This document does not address the rising issue of the over-medicalisation of pregnancy and childbirth, including the high rate of caesarean section, induction of labour and other interventions. Privately practising midwives are not included in this strategy (in any way) – including barriers to private midwifery and utilising private midwives to address lack of workforce in rural/remote areas. This is certainly in the scope of this document – as there are currently multiple barriers to PPMs, which leads to lack of access for women. It is difficult/impossible to determine how realistic any of this document is without the accompanying monitoring and implementation framework. It must contain SMART goals (Specific, Measurable, Achievable, Relevant and Time-based) – otherwise we cannot judge our success.

"Women have improved access to continuity of care with the care provider(s) of their choice." The rationale includes a reference to continuity of midwifery-led care options. This should remain specifically highlighted throughout the document wherever 'continuity of care' is mentioned. i.e. "Continuity of midwifery-led care models and others." "Conduct research on the cost benefit of models" << This must absolutely reflect what matters most to women. Various 'costs' to women (financial, physical, social, emotional) are often not measured or factored into these sorts of equations. The value-based healthcare model which underpins ICHOM standard sets would provide a suitable definition of 'value' as a starting point.

Enablers - should include 'investigate obstacles to access to continuity of carer - for example lack of PII for homebirth; the requirement for a one sided collaborative agreement for PPM; inability for PPM to gain access agreements'. Another example is that I live in a large metropolitan city where access to services is limited by where I live. I live in Montrose, Victoria which is in the Eastern Health catchment. As a resident within the Eastern Health I do not have access to publically funded homebirth; even if I am prepared to travel neither Western Health or Monash Health will accept my booking - stating that I live outside their area. Further obstacles to

continuity of carer exist because the MGP programs are very limited and have waiting lists. Women report seeking caseload midwifery care only to be told that they have not booked early enough - this clearly shows that these models of care exist but are under resourced.

At a minimum each tertiary site should offer a suite of choices including visiting rights for Participating Midwives, publically funded homebirth, and caseload with a target minimum of 20% in the first year, breech service and NBAC. Less than 10% of women have access to continuity of care models, the government needs to offer incentives to increase caseload and reward good behaviour e.g. increased NWAU for continuity models. Need to remove the barriers to access agreements for participating midwives every woman should have a known midwife

Evidence is irrefutable that midwifery-led continuity of carer models benefit women and midwives. They are cost effective, improve perinatal morbidity and mortality outcomes and improve maternal and midwife satisfaction. No studies have been conducted to show the benefits or improved outcomes for women in obstetric-led models. The benefits of midwifery led care cannot be generalised into ALL models of continuity of care. Midwifery cannot be diluted removed from proposed solutions. Midwifery led continuity of care is a long-term, primary health strategy which delivers outcomes for generations (Sandall et al. 2016). Decreased costs, increased maternity outcomes, increased BF rates – which lead to decreased rates of obesity. The importance of continuity of CARER as opposed to continuity of care. Midwifery continuity of carer must be ACCESSIBLE to all women, regardless of risk or geography or finances. Where risks are identified, midwives collaborate and refer appropriately. “Conduct research on the cost benefit of models” – Which models? MACCS is about outcomes not access – should not be here. No need to develop funding models, simply realign existing funding. Reword strategic direction to “Midwifery continuity of carer models are available for women.”

Women may choose to have midwifery-led continuity of care (CoC) with a known midwife (caseload) and a GP obstetrician. Especially in country areas where women receive care for a GP Obs who declare they provide CoC as they provide AN are present for the birth (usually but don't provide labour care) and will see the women for 2 PN appointments where the woman must travel to them. The evidence about midwifery led care is overwhelming and irrefutable and must be included in this document and made more accessible to ALL women.

Midwifery continuity of carer should be central to improvements.

Continuity of care / carer / known midwife at birth. Currently the only option in my HHS is caseload midwifery. However there are a range of options that could be supported that improve women's access to continuity in a sustainable model, such as team midwifery, open to many more midwives and therefore many more women than just caseload.

Continuity of care access for all women. Homebirth access and availability of midwives.

Continuity of care and education and support opportunities for Midwives is paramount.

Continuity of care for all women should be a basic, minimal standard of care. Evidence substantiates the safety of this care for women and babies, with the best, safest outcomes occurring when women are cared for by a known midwife.

Continuity of care in a relationship based model of midwifery for all women with input when and if need by specialist obstetricians, but not the lead professional to enable and support collaborative ways of working together in partnership with women.

Continuity of care models in Access section should be titled 'midwifery continuity of care models' this is what is evidence based and stated by women as what they would like.

Continuity of care with a known midwife? Seriously - despite the voices of women and supporting international research...we're still beating that drum??? What about an actual framework for respectful maternity care - rather than vague lip service. A tangible framework with measurable features.

Continuity of midwifery care, Home birth, Birth centres (stand-alone)

Do not removal continuity of care with a known midwife. Current best practice literature states continuity of care with a known midwife is the gold standard of maternity care. The proposals continue to focus on the medicalisation of birth, current Australian statistics are poor, and we perform too many inductions and consequently caesarean section births.

Evidence supports that the most improved maternity outcomes are achieved with midwifery-led care continuity models. While other continuity models also offer some evidence of improved outcomes, none achieve the same level of improved outcomes as the midwifery-led models. 2.1 should therefore read: Improving access to midwifery-led continuity of care (as per the WHO recommendation).

Expand availability of models of care that promote continuity for women: This statement is not explicit enough. It should state continuity of "carer" and there should be particular emphasis on midwifery led continuity of care as this is where there is overwhelming support from highest level evidence. Workforce strategy must focus on continuity of midwifery led care (due to the evidence for this model) and include; midwifery education, removal of barriers to private midwifery practice, greater integration across healthcare sector (primary to tertiary) and expanded roles for employed midwives (to enable them to provide midwifery led care rather than supporting an obstetric led model). Birth settings have not been addressed in the strategy. There is good evidence supporting Birth Centres and Home as settings that help avoid unnecessary intervention in childbirth. Improve care in the postnatal period; this should include and state explicitly that postnatal care will be extended to at least 6 weeks postpartum. This is the scope of practice of the midwife.

Face the issue - evidence is CLEAR... all woman should have access to midwifery led care within a caseload model - supported by a multidisciplinary team. This model of care is safer for women, safer for midwives, safer for obstetricians, safer for GPs and safer for organisations. It is all about relationships. Mentions care in the community – but does not discuss primary sector planning and framework planning. Midwifery continuity-of care models are a long-term, primary health strategy, which delivers health outcomes for generations. - Decreases costs - Increases outcomes - Increases BF rates (which leads to long-term health benefits to woman and baby) This document does not address the rising issue of the over-medicalisation of pregnancy and childbirth, including the high rate of caesarean section, induction of labour and other interventions. Privately practising midwives are not included in this strategy (in any way) – including barriers to private midwifery and utilising private midwives to address lack of workforce in rural/remote areas. This is certainly in the scope of this document – as there are currently multiple barriers to PPMs, which leads to lack of access for women.

I feel this encompasses the key focus of expanding continuity of care across the continuum of maternity care. I would also like to see this extend to acknowledge the high risk/identified risk population as this model of care is not only limited by postcode, but is often also limited to low risk populations. Furthermore, with this focus of expanding CoC throughout Australia, will also

address many of the other areas of focus as documented in high level evidence: it will improve satisfaction of women, it will improve mental health support, it will improve PN support and will also improve cultural safety with the ability to form functioning professional relationships. An additional point of focus with the expansion of CoC is a note that research be conducted on the cost benefit of models - I believe that high-level evidence already demonstrates that this is a cost effective model. Furthermore, this shouldn't be a focus, by offering this model of care the wider and more critical benefits will be evidence enough, reducing preterm birth, reducing intervention and increasing satisfaction for women and midwives.

GP shared care

It is disheartening to see that GPs who are expected to provide care from 'cradle to grave' ,in the socially equitable publicly funded health system in Australia, seem to have been excluded from the range of options where 'continuity of care' for antenatal period is being considered. The assumption that GP shared care , as opposed to midwifery led care , offers 'continuity ' is based on the assumption that we have the resources and capacity to provide this utopian ideal system where every woman will have a midwife who will not only care for them during pregnancy but also be present at the time of delivery. Having worked and received care in a medical system which has adopted the quoted recommendations from WHO - and has solely obstetric and midwifery led care- I have seen no evidence to suggest that it addresses the issues brought up in this document.

GP Shared Antenatal Care provides continuity of care and should be promoted not marginalised. Safety is the number one priority.

It is very hard to answer these questions. If by 'expand the availability of models of care that promote continuity for women' you mean GP Shared Care then yes I agree. But if you mean increased midwifery -led care such as Midwifery Group Practice to the exclusion of GP Shared Care then no I do not agree. Quoting WHO regarding midwife-led care without mentioning other models of care including GP Shared Care is unfair and misleading. GPs provide holistic care. GPs want to and need to care for their patients at all stages of life including pregnancy and parenthood. Patients usually attend a GP close to home. General Practice is the ultimate holistic, continuity of care outreach service. Mothers need to be made aware of the importance and the availability of postnatal care. They need to know they do not have to wait until the 6 week check to seek help. Also GPs need to be contacted when the mother and baby leave hospital either by phone or discharge summary (by fax/email) particularly when a risk has been identified. All mental health care needs adequate funding and support.

Enablers

“Conduct research on the cost benefit of models” – Which models?

MACCS is about outcomes not access – should not be here. No need to develop funding models, simply realign existing funding. Improving access to maternity care: Midwife as first port of call for all pregnant women; women will then be fully informed from the beginning of pregnancy about choices, nutrition (also what not to eat), exercise, maintenance of health etc.

MACCS (classification system) - this needs to be mandated i.e. tied to funding. With such poor data collection and difficulties mapping interventions with models of care, and also consumer satisfaction, ensuring the Maternity Care Classification system is implemented and mandatory reporting takes place is essential. This needs to be publicly available.

2.1.3 Organisation comments

Comments on the principle

Women have access to continuity of carer(s) with care provider(s) of their choice.

Principle - suggest change to "continuity of care/carer."

Reword to: 'Women have access to a continuity of carer(s) with the care provider(s) of their choice'.

Women to have access to a continuity of carer(s) with the care provider(s) of their choice with a focus on primary health principles and midwifery model of care.

Continuity of care

Enablers - suggest this should be "Increase availability and access to a range of continuity of care models." And that the second dot point there should end with "...in all areas" - to enable more models across the country.

Midwifery continuity of care

Lack of application of evidence - Continuity of carer in a midwifery model of care. No mention of privately practicing midwives and PII for midwives. Does not acknowledge autonomy of practice for midwives. Does not reflect World Health Guidelines for a positive pregnancy/birth.

Access needs to be addressed specifically to MIDWIFERY continuity models – which is where the empirical evidence for continuity of care lies. We applaud the reference to the WHO recommendations for midwifery antenatal care provisions in improving maternal and child outcomes. It should also be stated that there are significant benefits for this model for birth and postnatal care. While the “range” of these services is remarked on, access to continuity models includes the need for supply of enough services to meet demand. In many contexts demand for midwifery continuity models outstrips supply to the point that women are placed on waiting lists rather than having a choice about their maternity care. In this way, the inverse care law is enacted and women with the least social capital and at most risk of poor health outcomes are also the least likely to access these models of care and therefore able to benefit from the advantages these models confer. Attempting to address these inequities of access requires examining the process of referral to antenatal care providers and evaluating the available information regarding the range of care models. A commitment is required to giving women the models of care they are telling us they want and need AND that is evidence-based. It is noted that cost benefit analysis around midwife continuity models has been thoroughly researched in a number of contexts, which suggests that further study of this issue should not be a priority. Funding models to support continuity models of care would indeed be welcomed however. Women don't just “want” to be able to access a range of models of care – it needs to be recognised as a right that women have access to evidence-based care models that support optimal outcomes for their pregnancy and birth.

WHA supports data being reported by all maternity care providers using the national MaCCs classification. The MaCCs acronym should be spelt out given this is a public document. The missing element here is timeliness. At present national reporting of data is often 3 years behind the period it relates to. This hinders its usefulness for consumers as well as for service manager. Data is also typically reported in such an aggregated format that it is not possible for consumers to assess the relative performance of different maternity service providers in their local area.

Timeliness and accountability should be core commitments in this section of the plan. The "All maternity service providers" also needs to stipulate, both public and private. There is currently no public accountability for outcomes of care by private obstetricians and midwives.

Access to midwifery continuity of care for all women will address these issues. Midwifery led continuity of care models have been shown consistently to improve outcomes for women and babies. They are economically sound, have shown increased job satisfaction and less burn out in the workforce. This model should be standard for all women with consultation with the obstetric team only when required. The woman can maintain her relationship with her midwife whilst receiving obstetric care for the pregnancy complication. Midwifery led continuity models are wholistic woman centred care in a nutshell.

All evidence supports the benefits of midwifery continuity of care models (perinatal morbidity and mortality outcomes, costs, maternal satisfaction). There have been no studies exploring the benefits of other 'continuity of care' models, such as obstetric-led. Midwifery-led continuity of care is a long-term, primary health strategy which delivers improved outcomes (decreased costs, increased breastfeeding rates - which leads to decreased obesity, lower rate of caesarean sections etc.) for generations (Sandall et al. 2016) Realign existing funding, no need to develop funding models. Midwifery continuity of care decreases costs. Note the importance of continuity of known carer, not just continuity of care. The evidence is strong that better outcomes are associated with relationship-based midwifery continuity of care with a known midwife; this care must be accessible to all women, regardless of risk or geography or finances. Where risks are identified, midwives collaborate and refer appropriately. Other areas for access which need to be included are: home birthing services, including publically funded models maternity services in women's communities - including birthing services Antenatal education for women and families - including mental health An app for the pregnancy and birth helpline - many women have phones and would access online information; there is evidence that phone access to information is effective with vulnerable groups time and freedom for women to progress naturally in labour; VBAC and water birth facilities longer antenatal visits - a feature of midwifery models of care - midwives must be able to work to each individual woman's needs preconception education for women and partners Postnatal care needs can be addressed with midwifery continuity of relationship-based care; research needed into what is the optimal length of time to stay in hospital post birth. Women need to be consulted and services need to be co-designed with women Need for free, non-admitted postnatal care up to 6 weeks postpartum by midwives (ideally in the home) – and more emphasis on postnatal care, including postnatal debriefing, postnatal survey and mental health assessments, access to postnatal services (child and family health nurses, physiotherapy and lactation consultants) Access to Medicare rebates for lactation consultants required. Mental health support access will be improved by the following strategies: Increased training for mental health practitioners in mental health to support the mother and father from preconception through to extended postnatal period. Need for perinatal mental health beds where babies can stay with mothers. Pathways for midwives to specialize in mental health – this is already in practice in the UK Increase in mental health services for women. Establishment of specific and targeted mental health services in maternity settings. Access to free DV training for health professionals. Recognition and follow-up of birth-related trauma. PN guideline standard must be evidence-informed Funding review required leading to funding reform of maternity services in Australia Increased Medicare rebates for services provided by privately practising midwives – as well as Medicare rebates for homebirth with a PPM.

All evidence supports the benefits of MIDWIFERY continuity of care models (perinatal morbidity and mortality outcomes, costs, maternal satisfaction). There have been no studies exploring the benefits of other 'continuity of care' models, such as obstetric-led. The benefits of midwifery-led

continuity of care cannot be generalised to ALL models of continuity of care. Midwifery must not be diluted/removed from proposed solutions. Midwifery led continuity of care is a long-term, primary health strategy which delivers outcomes for generations (Sandall et al. 2016): - Decreased costs - Increased maternity outcomes - Increased BF rates – which lead to decreased rates of obesity The importance of continuity of CARER as opposed to continuity of care. Midwifery continuity of carer must be ACCESSIBLE to all women, regardless of risk or geography or finances. Where risks are identified, midwives collaborate and refer appropriately. “Conduct research on the cost benefit of models” – Which models? MACCS is about outcomes not access – should not be here. No need to develop funding models, simply realign existing funding. Reword strategic direction to “Midwifery continuity of carer models are available for women.”

Birthing parents and babies are more likely to survive the perinatal period when they receive continuity of midwifery care. One reason for this is the woman has the opportunity to discuss the risks and benefits of certain treatments in depth and come to her own informed decision. This cannot be achieved in fragmented care models. The Commonwealth can ask the states: * to prioritise these models * why they are not being implemented. * What they are doing to encourage the implementation of Standard 2 in their local health districts (e.g., by encouraging consumers to co-design their services.

Mentions care in the community – but does not discuss primary sector planning and framework planning. Midwifery relationship-based, continuity-of-care models are a long-term, primary health strategy, which delivers health outcomes for generations. - Decreases costs - Increases outcomes - Increases BF rates (which leads to long-term health benefits to woman and baby)

Real strategies for improving access to continuity of care from a known midwife. Access to choice in birth place (conventional, birth Centre, Homebirth).

Reword strategic direction to “Midwifery continuity of carer models are available for women.”

The enablers under improving access don't quite hit the point. Access to continuity of care by obstetricians or GPs is already fairly robust across Australia. Where the access is poorer is to midwifery continuity of carer models. In the effort to placate the voices of a few private provider organisations, this point has been lost in the updated draft Framework. For example, there is currently good access for women to high risk care services. If a woman is identified, for example, as needing maternal fetal medicine expertise for herself or her baby, public maternity services refer them to hospitals that offer such care. What is lacking in most such services is access for such women with complex care needs to continuity of midwifery care in partnership with their MFM specialist. The Royal Hospital for Women in Sydney is a notable exception and has been achieving excellent results for these women by having a known midwife provide care in partnership with the MFM specialists. Access is obviously at different levels of the system and in different locations. WHA supports increasing outreach and telehealth services, better use of the Australian Rural Birthing Index and women who have complex needs accessing higher risk services. Use of interpreter services is a missing element here, and is key to improving access to care for women from CALD backgrounds, especially refugees. Public maternity services struggle to access enough interpreter services and cannot claim funding to defray the costs under Activity Based Funding. WHA strongly endorses the provisions around improving access to postnatal support. National evidence based guidelines will be a key step, and will enable IHPA to provide postnatal care appropriately. Currently more than 14% of women attend Emergency departments within the first week of being discharged from a maternity service for want of any other support in the middle of the night. Breastfeeding rates at 6 weeks and 6

months are a national disgrace for a developed nation. Access to Maternal & Child health services are very variable and only 2 in 3 women receive any postnatal visit at all from their maternity service provider after being discharged, and those that do receive on average only 2 visits. The system is failing to support especially new mothers to successfully transition to parenthood and help their baby to thrive. Re access to mental health support - there is an urgent need not just to have current guidelines and policies but to fund tangible mental health services on the ground for women and newborn babies and infants. There is a shocking lack of access to Mother/Baby units across Australia. The College of Psychiatrists has recently documented this. Funding is inadequate. There is insufficient workforce.

The importance of continuity of CARER as opposed to continuity of care. Midwifery care is associated with longer prenatal visits, more education on pregnancy and breastfeeding; prenatal counselling, fewer hospital admissions and a more positive birthing experiences for women, easing a woman's transitioning to parenting and in meeting the demands of a new baby. (Leslie & Storton, 2007). A Cochrane Systematic Review based on a systematic review of 13 trials involving 16,242 women, concluded that most women, unless they have significant risk factors, should have the option of midwife-led continuity of care. Midwife-led continuity of care – in which a pregnant woman sees the same midwife during pregnancy and labour – is associated with a higher level of spontaneous vaginal birth; the women were less likely to experience interventions such as episiotomies or use of forceps; more likely to be satisfied with their care; had a lower risk of foetal loss before 24 weeks' gestation and at least comparable adverse outcomes for women or their infants than women who received other models of care. Midwifery care has also been found to result in fewer women suffering from debilitating post-natal problems such as illness or injury associated with some interventions (particularly operative deliveries) and postnatal depression, (Sandall et al, 2016). Midwifery continuity of carer must be ACCESSIBLE to all women, regardless of risk or geography or finances. The strategic direction must be Midwifery continuity of carer models are available for women. No need to develop funding models, simply realign existing funding. Cost benefit analysis will show that midwifery models of care are cost effective. We only need to look to the home birth outcomes.

The inclusion of privately practicing midwives is required. Addressing and including professional indemnity insurance for homebirth, one-sided collaborative agreements, admitting rights, unwarranted and vexatious reporting and bullying by health professionals and health services against midwives. Women need to be central to the document. Woman centred care is fundamental.

We fully support the aim of expanding models of care that promote continuity. There is very strong evidence of the benefit of continuity of care and carer (see Cochrane review by Sandall et al). We also support the aim of improving postnatal care and that there should also be a focus on perinatal mental health. We would like however increased emphasis and policy direction to support rural/regional women with access to models of care that provide continuity of care (carer if possible, who may be able to support them in labour) and that support them staying as close to home as possible for as long as possible. We need to address the inequity in access to different models of care based on location (be they metro, rural, or regional). Enablers to improved access, may include high risk obstetric outreach models that visit rural communities as rural women are currently highly disadvantaged by distance and cost when they are considered high risk.

2.2 Improving access to maternity care

Figure 4 Responses to strategic direction: Re-design services around the needs of women and communities

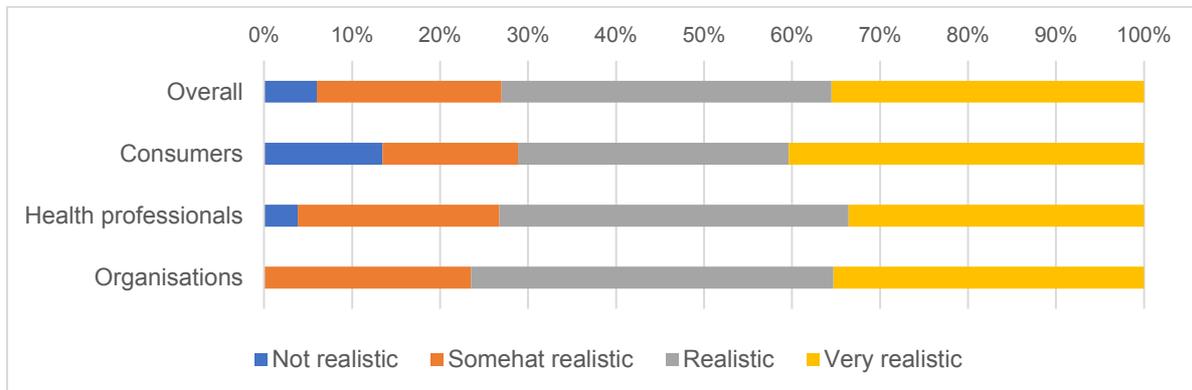
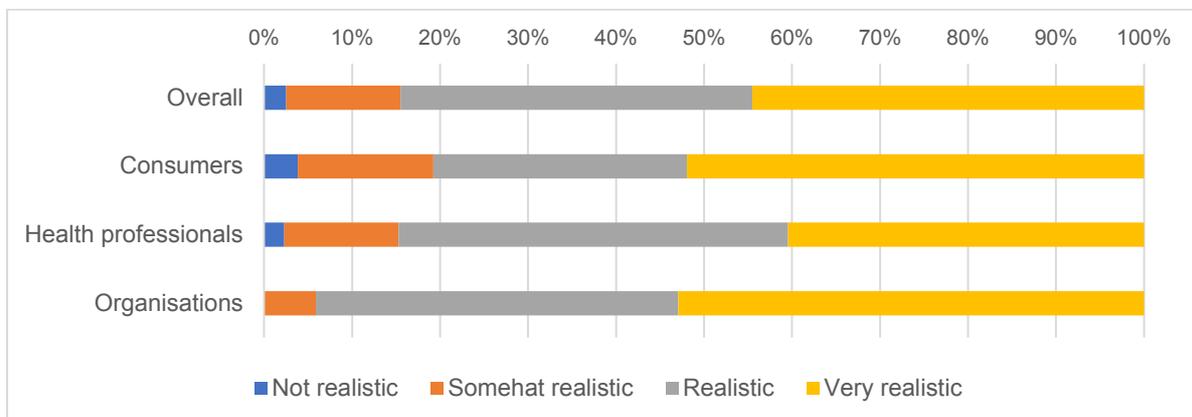


Figure 5 Responses to strategic direction: Improve care in the postnatal period



2.2.1 Consumer comments

Maternity services

Birth centres should not be exclusive to women who are going home straight away. If there is a risk based reason they need to stay that doesn't affect how they will labour and birth, then they should be able to birth within their chosen environment. If a woman prefers to birth at home, and it is deemed safe for her to do so, then the MGP service should be set up to provide midwives to meet that request.

Choice for women in maternity models of care options.

Choices to use a Midwife service

Access to a third trimester ultrasound for those that would like one - maybe partially funded for those with risk factors/healthcare card holders.

Access to high risk care, extra vigilance, maternal request C-section.

If women prefer GP shared care, then there should be a list provided of capable GPs who are trained in obstetrics.

Increasing access to the models already currently available by removing barriers to them needs to be mentioned here.

The rationale for improving access to maternity care makes a good point about disruptions to family life. However, a more important rationale is safety for mother and baby. Lack of access to maternity services due to geographical challenges present a major safety issue when mothers travel in unsafe conditions, and travel long distances. Women who feel they have no access to their preferred choice of care also tend to employ unqualified care providers or free birth when they would in fact choose an alternative model given the chance. Unfortunately, this is such a longstanding issue in certain areas of Australia that the women who reside there have been unfairly labelled as alternative or 'hippie' by care providers and the wider community. In fact, the inability to access maternity care has become standard for many women and their choices reflect this. Furthermore, this group of women may also not attend antenatal and post-natal appointments or decline recommended tests or treatment due to their lack of access to services. This certainly disrupts family and work life, but more importantly increases the chance of women not accessing maternity care at all.

Prioritising access for Aboriginal and Torres Strait Islander (ATSI) women needs specific mention here.

Yes please give every women an exit survey before they leave hospital. Are they ok. ? Do they feel traumatised? Are they satisfied with the staff actions during and after birth or after birth? Where I their problems. Do they need a meeting to discuss the birth? A debriefing? Do they need to talk to someone about options for next time? I had my first and only child at Katoomba hospital 16 years ago. I never had another child I was so traumatised. I was induced then doctor left for the weekend. They had no doctor or anaesthetist. I begged for an epidural and a doctor the whole 8 hours. The midwife wouldn't call one in. 30 minutes after birth I was left by a nurse to have my first shower alone (husband went home). No one bothered to check if my uterus was contracting. I haemorrhaged in the shower. Lost consciousness and eyesight. Came to and made it to the room. Almost tipped my baby out of the crib as I grabbed for something. Woke up to huge amount of doctors in room and the crash cart (was out for a while). Was treated for a haemorrhage on drip with catheter. Was partially unconscious sleeping for the rest of the day. No explanation, they told my husband I had a turn. Could not get anyone to tell me what happened. Finally got a nurse who denied I had a haemorrhage saying they thought I only lost 500ml of blood. Told me it was probably due to hot water I fainted. I was bleeding massively before I got into the shower. The doctor that saw me during pregnancy came to check on me. He stood at the door couldn't even be bothered to come in. I told a nurse I thought I was going to die. No comment. I was absolutely avoided after the birth and two months later they closed the maternity ward down due to being too dangerous when no staff. Due to sloppy practice I was so traumatised I believed I would lose my life if I had another child. I am 43 now and grieve this deeply. I would avoid the public system. I would have also taken legal action. I didn't even write a complaint letter at the time as I knew my complaint would not be heard. Everyone trying to cover themselves for a job terribly done. I have complained this year and Katoomba said sorry. Nothing can make up for my experience.

In line with my earlier comments about more strongly worded enablers, there should be an enabler here that "Jurisdictions set targets for the return of maternity services to rural and remote areas" - these targets could be in terms of the proportion of women able to birth within their community, for example. In addition to that, it needs to be clear in this document that where services are restored, opened or re-opened, that they need to be built on a functional primary maternity service. While a facility may also offer higher level service, these are always

dependent on the availability of local obstetric and anaesthetic support. Embedded within these high level services, there must be a functional primary maternity service so that when that obstetric or anaesthetic support is (temporarily or permanently) unavailable, women of normal risk are still able to access local birth services (rather than services closing entirely and/or going on bypass frequently).

More people need to be attracted to the field

Currently, for me to access private midwifery services this means having to access a hospital which is not as close as possible to my home, as the closest hospital does not allow private midwives to support women at their hospital. Thus, in the enablers, a point on improving access for private midwifery continuity of care models at more hospitals needs to be added.

More options in care for women in their own areas - near home

Rationale - care closer to home = better outcomes for mother & baby, families and sustainability of communities, not just less disruption to family & work life!

It is not only women's "needs" that women need services designed around, but also their wants. For example, many women would like the option of immersion in water during labour and birth (primarily for pain relief), conditions that support the hormonal physiology of childbirth (dimmed lights, privacy etc.), to have delayed cord clamping and immediate skin-to-skin for the first hour (in the absence of a medical emergency). These types of desires could easily be dismissed as not being a "need", despite the evidence that they are beneficial to mothers and babies.

Rural and remote areas

Perhaps more emphasis on inequity between rural and remote living women and Aboriginal women's access to care and poorer outcomes to help influence location of appropriate services; lack of evidence for regionalisation of services for normal healthy women and outcomes and 'costs' of this regionalisation to families

A way to have services available in Remote Areas is required.

I think the document is not realistic in its approach to accessing care / services. It does not address the known workforce issues in remote areas. It seems to say all models should be available in all areas but we know there is not the required work force to do this.

Insufficient focus on remotes area services

Need to focus on building maternity services in country and rural communities, not simply serving them via telehealth. This includes the ability to birth in their own communities.

Safety in rural areas with constant education and feedback for the isolated care providers here. Consider a system where these Drs can choose to 'upskill' for 6-12 months in a metro hospital every few yrs., possibly extending their skills to do Ed and paediatric terms also. We need metro hospitals to support GPs obstetricians and rural midwives.

The enabler about investigating inconsistent uptake of the ARBI is laudable, and should be expanded to indicate that jurisdictions commit to assessing every service closure decision against the ARBI, prior to closure. This document should also flag the need to investigate service closures and the reasons for them, to inform strategies to prevent further decline in rural and remote areas.

Rural birthing services are a national emergency. The trauma and social cost to women and their families of seeking care outside of their home town, sometimes travelling hundreds of kilometres can have devastating consequences. Rural women are not second class citizens.

Postnatal care

Improve care in the postnatal period - this is ill defined, but hopefully the evidence based guidelines flesh out what high quality postnatal care looks like. Part of the rationale for this must include that we need world-leading maternity and paternity leave, that breastfeeding rates are currently much lower than ideal, and that postnatal depression and anxiety rates are at historic highs.

Postnatal care needs to be holistic and talked about in the antenatal period.

A lot of focus on the maternity and the postnatal as being separate things. It would be good to see these all-inclusive in a holistic way.

Aftercare is so important. For 10 months women are seen regularly then: “bye good luck see ya hope your vagina is ok oh it’s not? Well bye not our problem.”

2.2.2 Health professional comments

Comments on the principle

Principle - unsure why it is necessary to say 'including postnatal support' as all services are equally important.

Women have access to pregnancy, birth and postnatal support as close to, and where appropriate, in their home.

Maternity services

Enablers: increase publicly funded homebirth models for low risk women.

There is a significant problem with private obstetrics in Australia. It is of great concern that women in this model of care are not receiving evidence-based care - with increased rates of intervention in pregnancy and during labour/birth, and no provision of postnatal care by medical staff. Women do not receive ongoing postnatal care once discharged from hospital and breastfeeding supports are varied and lack consistency. Evaluation of this model of care is urgently required to ensure the safety and well-being of the women receiving it.

The access section does not mention other important specialist support such as lactation consultants, diabetes educators and physiotherapists Women cannot be cared for by effectively staff that are burnt out. Issues of retention, mentorship, education as well as meaningful dialogue about reasonable staffing levels and demand management are critical for a woman centred approach.

What is concerning me - especially in regional-rural-remote areas - is that models of care within the public health system are going to be under the leadership of those who are dissonant to the needs of midwives and women. The leadership is generally lacking the vision - dare I say the passion - required to support and expand services so that women remain central and midwives are supported. Current leadership, at local and regional levels, are so used to placing the needs of the organisation as central to care, historically supporting medicalised birth to achieve this

end. This document seems to achieve this. Change management needs to focus on the views of local and regional maternity care leadership.

Protection of services from political agendas.

Women and their families need to be central in the maternity care strategy. They need to have access to more options to promote safe care that suits their needs. Women will not conform to the systems we have in place, if they are not suitable; they will birth outside the system, putting them at risk. Families need access to professional maternity support which requires enabling these professionals to be able to legally practice in models which are acceptable to the population. This plan does not address this and is a massive step in the wrong direction!

Women being able to choose the care they want in the locality they need.

Assisted reproduction and availability of neonatal care services - which will impact postnatal care delivery and quality.

Availability of maternity services in women's communities (including birthing).

Consult with women, co-design services WITH women.

Increase length of stay/and or community care.

It is common sense to provide the best possible services for and with women close to where they live or in their own home.

Longer antenatal visits.

Access for all women to all current care regardless of location.

Access to choice of birth place

Access to include access to all policies and procedures of all maternity settings in Australia including private hospitals. Open access. How else can a woman make an informed choice??

Better access to equipment that supports women's choices while safely monitoring mother and baby.

Choice of birth place and publicly funded home birth

Funding to provide additional staff and programs to provide these services. Not give the head of obstetrics in the hospital the largest 'say' about services provided, for example; whether an MGP program is all-risk, or whether a home birth program is offered

I do not see anything that ensures GPs providing maternity care are upskilled and kept up to date with latest evidence, or any onus for them to do so. They have no requirement to do CPD on maternity care in order to provide maternity care to women. I think this need to be addressed if women and their babies are going to have best care.

Improve care in the antenatal period

Misses the point that most women do not want to reveal their pregnancy status until at least 12 weeks but attending a midwife either privately or in a public clinic before 12 weeks automatically declares her pregnancy to all observing her to be there. Attending a GP could be for any myriad of reasons so her 'secret is safe' from prying eyes in the waiting room or the community at large.

More acknowledgement in regards to supported homebirth needs to be acknowledged.

Of even more concern is the document does not acknowledge the role of the GP in maternity care. The GP provides preconception counselling and screening, is usually the first point of contact in antenatal care and organises routine tests and screening tests and essentially manages the first 18-20 weeks of pregnancy until by necessity (due to indemnity requirements) refers the woman to an Obstetrician-led maternity team, can offer GP Shared Care (but often excluded from the third trimester care apart from providing vaccinations due to lure of free public funded (tax payer funded)maternity care in public hospitals or Midwifery Group Practice in the community.

The lack of safety of being born on the road or being born at home without maternity care, due to a lack of access to it, have not been addressed.

Access to home birthing services (including publicly funded models).

Availability of maternity services in women's communities (including birthing).

Improving access to maternity care: include home birth, rural birthing facilities, birthing 'on country', access to birth methods of choice, more funding for perinatal education, more CALD resources.

Maternity services for Aboriginal and/or Torres Strait Islander women need to be designed by them.

A review of access to publicly funded home birthing, VBAC, water immersion, vaginal breech models of care: attention to sufficient time in antenatal consults to address the woman's needs

Rural and remote areas

Specific attention to access to rural and remote birthing services including for Indigenous populations

Access to VBAC, water birth, time and freedom to allow labour to progress naturally. Longer antenatal visits. Access to pre-conception education for women

Access to maternity care in rural communities, including rural birthing services.

Between 1995 and 2005, over 130 rural maternity units have closed across Australia and 36 out of 84 unit have closed throughout Queensland. Many of these closures have been hospitals that have less than 100 births per year, such as Theodore (S. Kildea, Kruske, Barclay, & Tracy, 2010). These closures raise serious concerns about equity of access to and quality of maternity care for rural residents. These closures have had many significant and negative effects on women, families and on rural communities. These issues are numerous and now with the closure of Theodore, effects our community. One of the reasons our maternity service has closed is the belief that the provision of maternity services in rural Australia is that units must have 24 hour on-site surgical and anaesthetic capability to be considered safe (Sue Kildea, 2006; Monk, Tracy, Foureur, & Barclay, 2013). However, research into Level 2 units, state that a maternity service can be safely offered in rural areas and should be made available in line with state and national policy and international evidence (Kruske, Schultz, Eales, & Kildea, 2015). Theodore, prior to closure in 2011 was a Level 2 birthing facility under the CSCF.v3.2 which aims to achieve the safe provision of maternity care for mother and baby, as close as possible to home (QH). Research demonstrates that births for low-risk women in small rural and remote units are safe,

with some showing more favourable outcomes than births in larger, often metropolitan hospital settings (Cameron & Cameron, 2001; Tracy et al., 2007; Tracy et al., 2006; Wagner, Epoo, Nastapoka, & Harney, 2007). This is partly because Theodore midwives provide continuity of care and carer with a known midwife, which has been internationally accepted to have significant positive outcomes for women and babies (Dahlen, 2016). Perceptions of clinical risk are often privileged amongst health providers and policy makers in the planning of rural maternity services. However, these perceptions do not often correspond with evidence about actual risk and how it relates to poor clinical outcomes (Barclay et al., 2016). Closing our birthing facility increases the odds of non-favourable clinical outcomes including increased perinatal mortality and an increased incidence of babies born before arrival. With an increase of 47% of unassisted roadside births, or born before arrival (BBA's), since 1995, coinciding with the closure of Queensland's rural maternity services and are understandably associated with poorer outcomes (Sue Kildea, McGhie, Gao, Rumbold, & Rolfe, 2015). To withdraw our local maternity services means that mothers will need to not only travel long distances at significant personal cost, but will need to be separated from their families and support groups for extended periods of time (Australia. Department of Health and, 2009; Brown & Dietsch, 2012; Hoang, Le, & Kilpatrick, 2012). This is most challenging for those socioeconomically vulnerable women and families who are more likely to make a calculated decision to stay at home until very close to their due date or early labour, based on economic reasons and for the sake of family relationships. The increased financial burden on family, negative psychosocial consequences including increased stress, feelings of isolation and loneliness and well as decreased bonding time with family members is not acceptable to the community of Theodore. Furthermore, the risk of driving in labour along often inherently dangerous roads (dirt roads, rough roads, at night, sun in the eyes, risks of kangaroos and other wildlife, livestock, driving tired etc.), because the mothers right to choose her place of birth has been removed, is unacceptable. Rural communities such as ours relies heavily on farming and mining (long hours and/or shift work), whereby families need reliability for support for other children and childcare, which often falls to the mother. If she needs to relocate to birth, up to 270km away, or further if she is from out of town or a neighbouring town, is unacceptable to the community of Theodore. There have also been documented accounts of women who have been reported to child safety for not leaving at the required 36 or 37 weeks' gestation and we the community of Theodore, do not support this threatening behaviour or coercion (Barclay et al., 2016). Furthermore, the literature demonstrates there is significant adverse health implications for both women and babies, who do not have local maternity services (Ravelli, Eskes, Jager, & Mol, 2011). For those women needing to travel more than one hour to access maternity services, evidence examining the psychological experience of pregnancy in rural communities has a documented 7 times greater likelihood of increased stress for women (Kornelsen, Stoll, & Grzybowski, 2011). Stress in pregnancy can have a detrimental impact on mothers and babies including preterm labour and birth and spontaneous abortion (Grzybowski, Stoll, & Kornelsen, 2011; Hoang, Le, & Terry, 2013). Furthermore, it has been demonstrated that poor accessibility and long-distance travel to maternity units is associated with increased neonatal mortality and morbidity (Grzybowski et al., 2011; Nesbitt, Larson, Rosenblatt, & Hart, 1997; Ravelli et al., 2011). Most significantly, suicide is a leading cause of maternal death, according to the (AIHW, 29th May, 2018), which emphasises the point that local maternity care with a known midwife, is so critical to the health and well-being of our mothers not just for antenatal care, labour and birth but in the postnatal period also. Our birthing facilities have been closed since the 2010/2011 Queensland floods and the initial and ongoing stress from this is felt by the entire community (Sue Kildea et al., 2018). These social risks, rather than influencing only women and families, actually increase health service and clinical risk and therefore contribute to overall risk (Barclay et al., 2016). With an increasing recognition that postnatal mental health is a major public health issue in combination with the vulnerability rural communities we urge QH and

CQHHS to decrease the burden on our families, not increase these afore mentioned major life stressors (Alliance, 2017). Whilst Australia is recognised for having a high-quality health care system, evidence demonstrates that maternity services are not being adequately met for those residing in rural Australia with the closure of our rural maternity hospitals. Babies born to women who live in remote and very remote Australia were 65% more likely to die in the perinatal period (perinatal mortality rate 15.2 per 1,000 births) than those born to women who lived in major cities and 4 inner regional areas (AIHW, 29th May, 2018). Perhaps this is due to the closure of rural maternity units and the increase risk to mothers who therefore have to leave their hometowns and travel to birth? We reject your claim in your statement that one in four births require obstetric support during labour and/or an emergency. These figures are based on hospitals providing care to ALL risk women, Theodore will only continue to plan to birth with low obstetric women. We believe that you are fear mongering the community with statistics that are not reflective of our population. With pressure to return home to their families, mothers are at greater risk of the cascade of obstetric intervention. Induction of labour is commonplace for many women who are forced to birth away from their home town as a convenience and/or to save mothers the risk of travelling long distances in labour. This often starts with a social induction of labour which often results in deteriorating health in mother and or baby which often requires an emergency caesarean birth or instrumental delivery. It is also common for mothers to opt for a social prelabour caesarean section so that they can plan the baby's arrival around family commitments. If the opportunity to birth locally was an option, the mother would have a greater likeness of having a spontaneous vaginal birth supported with a known midwife in a familiar environment, with backup from a known GP/Ob (Elaine Dietsch, 2008). We the community of Theodore, object to our mothers and our families being coerced to make such horrendous 'choices', when we have a maternity unit here that can be made fully operational. Furthermore, the models of care that you are now offering women are fragmented and do not support best evidence. Women will now see many, many care providers during their care at Theodore, Biloela or wherever they must go to give birth. In addition to the closure of our maternity hospital effects our mothers it will also have a huge detrimental effect on our health care workers, in particular the midwives and GP/Ob. Research into the impact of rural maternity closures also highlights the subsequent loss of maternity care providers training opportunities, especially local opportunities resulting in the deskilling of health professionals (Sue Kildea et al., 2015). Not to mention the years they have spent both studying and working in their fields of expertise to provide maternity care in the town they reside. Taking away maternity services, fundamentally takes away our health professionals' careers.

Whilst there is material regarding rural services there is little regarding remote services, and nothing about emergency retrieval services. This is a gap that needs consideration.

Timely Access to higher levels of care in rural areas.

The importance of recognising the difference between cities and rural/regional areas for the delivery of maternity services and being flexible in this delivery. Etc. looking outside the box for rural areas to ensure that women have a choice. Also in the first section where it is mentioned about the usually the first point of contact for your pregnancy is usually your GP, it's important that GP's know the options for pregnancy care in our area and that women know about these.

Plans to keep open rural services.

No mention of initiatives and strategy to improve access to rural and remote communities

Greater emphasis and detail on: rural birth services to re-open with appropriate support and in models supported by evidence. Detail how to safeguard availability of services from government agendas.

Considering rural, regional and remote women have limited choice in maternity care, there needs to be more collaboration between services especially between NSW Health and NGO, GP providing not only maternity care but longitudinal family care, including extended family.

Better support systems for women who must seek more specialised care at a greater distance from their local centre. Travel assistance and accommodation. Child Care.

Access to continuity of midwifery carer and complicated care in the rural settings is very challenging. For example, if a woman lives remotely and has a high BMI, she may be excluded from the local maternity care. There needs to be active partnership with rural and higher levels of care using telemedicine which may enable the woman to be cared for in her local community. More resources need to be provided to achieve improved access and care. The current funding model prohibits many needed initiatives, including improved postnatal care.

Access to maternity care in rural communities, including rural birthing services.

Rural birthing services. There should be formalised MOU's with referral hospitals. The defined levels of care can prove problematic on a day by day basis. A level 2 birthing service may have times when OBGYN / GP or Anaesthetics is not available for a short period of time. A woman who may normally meet the criteria to birth at a level 2 service may need to be transferred to a referral service related to capacity. The receiving service must respect the decision to transfer a normal birthing woman. Capability frameworks do not always reflect day to day capacity of small services. Models of care should be formalised between services so a midwife from a rural service may accompany the birthing woman to another service for the birth. Large projects to develop collaborative models are still largely managed through large regional or tertiary centres. There is opinion that small rural services are unsafe to birth if numbers are low.

Rural hospitals that would have been designated a Level 2 birthing facility, but have been closed need to be given the funding to open and staff accordingly. We need scholarships for midwifery, to help staff the rural workforce.

For women being transported away from family to birth, there needs to be increased provision for other family members to relocate.

Increasing the rural workforce to support pregnant women seeking services. Due to funding, interns are no longer placed in rural hospitals. Registrars work in country hospitals and then leave, some with obstetric skills, some without. There does not seem to be a back-up plan for our aging workforce in the country, especially obstetric GPs. Options for women in rural communities are under threat due to a service that has no forward planning, due to funding issues and a lack of initiative/incentives to attract skilled labour to country areas.

Postnatal care

Need for free, non-admitted postnatal care up to 6 weeks postpartum by midwives (ideally in the home) – and more emphasis on postnatal care, including postnatal debriefing, postnatal survey and mental health assessments, access to postnatal services (child and family health nurses, physiotherapy and lactation consultants).

Research is needed into optimal postnatal stay following birth. Can likely be addressed with midwifery continuity of care which commences in pregnancy and extends into the postnatal period. PN guideline standard must be evidence-informed BFHI strategy as mandatory for hospitals and community services (and audited to ensure compliance).

Improved funding for postnatal care in the woman's home, currently our services provide one or two visits, where as the best maternity services in the world provide care up to 28 days.

Postnatal care is lacking in the current draft, as previously described

There is a lack of focus on the postnatal period in general. As women report the highest dissatisfaction with postnatal care in their maternity experiences, this is a vital stage of care to get right. Women are the most vulnerable as they transition from hospital to community based care so it would be good to have some direction to improve the gap between these services.

There is an indication that the postnatal period extends for 6 weeks, but who is responsible for that care is not clear. Nor is it clear when the maternity responsibility and accountability should end and ongoing care divested to Child health / GPs etc. It would be easier to argue for extended postnatal care if there was a guide.

Not enough planning for more availability of breast feeding support services for all women. - Better and easier access/use of Medicare rebates for women who wish to access Independent Lactation Consultants and Independent Midwives during their pregnancy and postnatal period. Not enough mention of this in the document. –

Enablers - should include information about Medicare rebateable postnatal care provided by endorsed midwives up to six weeks post birth. This service already exists but is not readily recognised.

Improve care in the postnatal period. I feel the with respect to breastfeeding and its value to society, the role and underutilisation of IBCLCs within the maternity services is such an economic and social injustice. We are underutilizing and underfunding an internationally recognised profession that provides statistically significant improvements in breastfeeding rates which equates to improved infant to adult health and maternal and family health. If we are looking at the strategic direction of maternity services how can we not get more specific with specifically naming an underutilised overlooked profession that can offer significant improvements in breastfeeding retainments rates. This is an area that would benefit from further research and economic projection forecasting to highlight the impact that lactation services have on our population health. Let's consider the impact that IBCLC can have on maternity services and if we can name the profession within the document then we will be able to pressure for inclusion into Medicare rebates and more women will have access then to high level postnatal care and high level infant outcomes.

Postnatal care in CoC model women would receive in home care for up to 6 weeks. Privately practicing midwives currently proved care for up to 6 weeks for women accessing those services. Lactation consultants need access to Medicare rebates to increase availability of specialised breastfeeding support for all women regardless of financial position. Funding. Funding review leading to funding reform of maternity services in Australia. Unique Patient identifiers, implanted by all states and territories to allow bundled payments to progress at a hospital level. Increased Medicare rebates for services provided by privately practising midwives – as well as Medicare rebates for homebirth with a PPM o Resolution of funding issues that reduce access, bundled payments, Medicare payments for lactation consultants.

Access to maternity care - care in the postnatal period Additional enabler: routine postnatal Pelvic Health Physiotherapy (at 6 weeks) for all women.

Postnatal care needs a complete overhaul. We need to be thinking and asking what women/families really need and want at this time. There is minimal specific postnatal research - this needs to be funded alongside the development of evidence based guidelines. What indicators would be used to demonstrate an improvement in the care? - Better postnatal mental health and exclusive breastfeeding duration would be two to start with - we need better data. Better links with ongoing services need to be created - midwife to maternal child health person. Single registrant midwives need to be eligible across Australia to enter education programs for Maternal and Child Health and be able to secure employment in this area. The funding for maternity services and ongoing family health needs to be reviewed - this fragmented system creates a poor service for women and their families. We need to look to the UK where health visitors provide ongoing care to families following handover from the midwife between day 10 and day 28. Breastfeeding rates need to be improved. We need to look to the World breastfeeding trends initiative to measure our success. Women need more support to successfully breastfeed and this should be the major focus of postnatal care. We also need to focus on the long-term outcomes for women's health following childbirth.

Women due to geographic location are denied services such as homebirth, vaginal breech birth, private care (midwifery or obstetric), water immersion for labour and birth, vaginal birth after caesarean section etc...And this is not just about metropolitan versus rural.

Re-design services around the needs of women and communities as above, groups of women who would benefit from continuity of care are often excluded. They may also be excluded from the benefits of postnatal home visiting services, when there is concern around potential domestic violence. Re-designing of service provision is important to meet the needs of these women whilst maintaining staff safety.

Access to lactation support, postnatal home visiting care and support, regardless of geographic location.

Consideration of the needs/opportunities for women to be key decision maker in determining length of stay within maternity units post birth: enhanced woman-centred care in terms of this consideration; working in partnership with the woman to best address her needs whilst also considering the realities of provision of services. Enhanced postnatal services within the community to support this change.

Improve postnatal care duration, support BFHI, Medicare rebate for lactation consultants, support for more access to postnatal services that women want.

2.2.3 Organisation comments

Maternity services

Services need to be available "as close as possible" or IN women's homes. As close as possible is most likely to be interpreted by health services by their own criteria, which is often different to a woman's criteria.

Ensure all women see a midwife in the first trimester. Access to publically funded home birthing services.

Women have the right to choose their maternity care however, in my experience if this does not equal the local health district it means that the woman and her care provider are both disadvantaged.

Equity and Access to affordable care for the lowest socioeconomic groups with the highest clinical risks.

Maternity services in rural and remote areas

Enablers - suggest there be a mention or target that the continued closure of small units is unsustainable if women are to really have access to a range of models and actual care near their home. Some form of commitment to this approach would be beneficial.

Equity and Access to care for rural and remote

Availability of maternity services in women's communities including rural birthing services with retrieval service similar to NETS.

Providing rural and remote women with appropriately funded travel (including travel method for long distances) and accommodations including for their support person and dependent children

Too light on for rural and remote women, particularly across large distances

Postnatal care

Research is needed into optimal postnatal stay following birth. Can likely be addressed with midwifery continuity of care which commences in pregnancy and extends into the postnatal period. PN guideline standard must be evidence-informed BFHI strategy as mandatory for hospitals and community services. Consult with women, co-design services WITH women. Need for free, non-admitted postnatal care up to 6 weeks postpartum by midwives (ideally in the home) – and more emphasis on postnatal care, including postnatal debriefing, postnatal survey and mental health assessments, access to postnatal services (child and family health nurses, physiotherapy and lactation consultants) Access to Medicare rebates for lactation consultants.

It is pleasing that this document includes a mention of postnatal care, which has so far been a neglected aspect of maternity care. We support the goal of working to produce evidence-based National Postnatal Practice Guidelines. We envisage that this process has the potential to do some important, but as yet neglected tasks defining postnatal care - what it is, where it is provided and who provides it. As an acknowledgement of its importance as a key component of postnatal care, we would also support a focus on the protection, promotion and support of breastfeeding in these guidelines.

The RANZCP would also like to clarify that, within Australia, there is some contention and discussion around the length of time allotted to the postnatal period of care (AIHW, 2014). To minimise confusion and ensure continuity of care, the definition of 'postnatal' should be added to the Strategy.

The policy is very light on postnatal services. This is an ideal opportunity and timeframe for great primary health care measures. Breastfeeding is healthy for mums and babies. There's nothing that can compare to giving a baby a healthy start in life with breastmilk. Yet postnatal support is scarce. Women are not supported in the practical aspects of breastfeeding. They often have no choice but to transition to formula because they don't know where to go to. We need to talk very honestly about the risks of not breastfeeding. Increases in diabetes, childhood cancers, obesity,

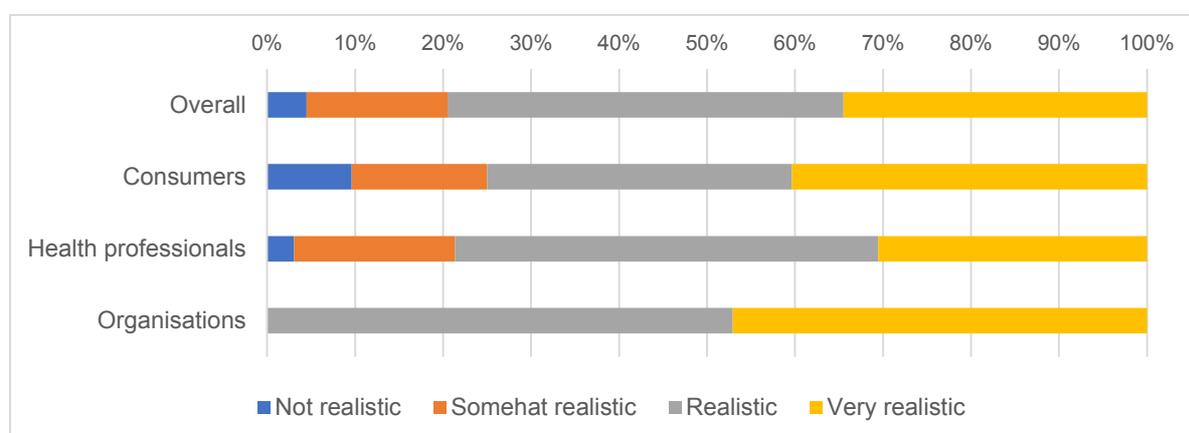
allergies. We need GPs who can support breastfeeding. Not just prescribe formula when things are going to plan. We need better integration from maternity to maternal and child health Australia wide. The ACT model is quite good. Much better than QLD for e.g. it could of course be better, but as someone who has worked in both states, I feel the women of QLD (Brisbane) are not getting the highest quality PN care And I'm sure this is happening other places also.

Postnatal care is neglected in the document. Breastfeeding, earlier intervention and transition to parenting support postnatal has significant impact on the health of the mother and her child. A midwifery primary health approach is recommend by WHO. When will we acknowledge that poor mental health is often a result of iatrogenic harm? One of the smartest investments a society can make is to foster the health of its mothers. Healthy mothers raise healthier children, which boosts the productivity and stability of communities and economies. We need to embrace the continuum of mother and child health to provide more effective care and use of resources so as to achieve health benefits to mothers, children and their families across their lifetimes. Poor pregnancy and birth outcomes have a profound impact on parents. Many suffer from ongoing depression and anxiety exacerbated by having to manage chronic pain, have ongoing health care needs as a consequence of iatrogenic injury to the mother and child, the effects often lasting long periods of time. There is a heightened risk of stress and anxiety in subsequent pregnancies. Poor birth outcomes put considerable strain on marital or partner relationships which has flow-on effects for the other children, as poor early relationships in child hood lead to great vulnerability in life, (Fisher & Rowe, 2013). Increased Medicare rebates for services provided by privately practicing midwives – as well as Medicare rebates for homebirth. Resolution of funding issues that reduce access, bundled payments. Handover of care creates risk for clients. All midwives must be competent in lactation support.

An enabler should be included about access to postnatal care - both in hospital and out of hospital, and there should specifically be an enabler to facilitate support for breastfeeding - this is a very large area of deficit across the country yet there is little explicit strategic support for breastfeeding/lactation services, but home based and hospital/clinic based. Increasing breastfeeding rates greatly improves children's health.

2.3 Improving access to mental health support

Figure 6 Responses to strategic direction: Jurisdictions address the unacceptable morbidity and mortality associated with poor perinatal mental health



2.3.1 Consumer comments

Midwifery continuity of care

Providing greater access to midwifery continuity of care should be added as an enabler to reduce mental health issues for women during the perinatal period. Providing women with continuity of care allows for their mental health to be screened AND MONITORED – a job completed much more successful through continuity of care (can you imagine discussing your low mood with a psychologist, and then seeing a different psychologist every time to monitor your mood... that's what is like discussing perinatal mood with providers at services who don't offer continuity of care).

Midwives need to have a better understanding of mental health and its impact on woman and the growth and development of their babies. Different area health have different services like Perinatal Mental Health and this is depended of if the CE thinks it is important.

More access to midwifery continuity of care to reduce mental health problems for women.

Access to maternity services

A commitment to improve maternity services/reopen maternity services in more rural environments. This would improve mental health outcomes for our more rural women.

Preventing and treating poor perinatal mental health

Poor perinatal mental health is complicated. Some of it is related to pre-existing mental health issues, and some of it only arises during the perinatal period. There is a causal link between disrespectful maternity care and perinatal mental health issues, meaning that some of these issues could be prevented by adherence to the values, principles and universal rights described earlier in this document. This presents an exciting opportunity to prevent the preventable perinatal mental health issues. Then the remainder can be assessed, supported and treated appropriately.

There seems to be a perception that morbidity and mortality due to mental health in the perinatal period is directly related to birth "experience". I do not believe this is clear from the available data. Therefore attempts to address this issue from the angle of "women need to have more home births or natural births" is not likely to help. It would be more helpful to better fund existing mental health services to be sure women with already existing mental health conditions do not fall through the cracks after having a baby. Extra home visits with specially trained midwives, FREE easy to access (possibly at home) counselling and psychiatry services. Psychiatry services are very expensive and very difficult to access with a small baby, particularly for women with no private transport or support. Women may reach out for help only to be told they can't get an appointment for 3weeks. To view suicide in the perinatal period as a result of not having an "empowering" birth is to misrepresent the reality and diverts attention from where it is most deserved.

Mother-baby units

We need dedicated long-stay mother/baby mental health units.

Funding

Does not mention the budget required to support the rationale etc.

2.3.2 Health professional comments

Antenatal mental health is not mentioned other than for known suicide risk or severe mental health even though there is growing evidence about anxiety and depression particularly in the antenatal period, including the need to address issues of birth trauma from previous births.

The RANZCP would like to reiterate the importance of mental health in the maternity experience. Having a child is a time of upheaval and change not only physically but also emotionally.

Continuity of care

Perinatal mental health is improved by continuity of care provision so the woman gets to know the midwife, which in turn leads to increased trust. When women are more likely to trust their service provider, they are more likely to disclose perinatal concerns.

Health professional mental health training

Enhanced and facilitated education for all midwives in addressing mental health concerns throughout the pregnancy and birth continuum.

Enhanced pathways for midwives to specialise in mental health as Mental Health specialist midwives

The suggestion to educate the workforce, in particular midwives regarding perinatal mental health. Education is not just the issue - the midwives do not have the time in 20 minute antenatal appointments to adequately explore the mental health of women. There should be funding models that allow support for high risk women, from midwives or whoever else, within the antenatal period to explore mental health risks and solutions.

All health providers in maternity care should undergo mandatory training in supporting parents with mental health issues and domestic violence. There should be a stronger emphasis on ensuring that any trauma experienced in birth is acknowledged and treated by an appropriately trained health practitioner. Multidisciplinary training would be good here - at times if we don't follow up with women in our fragmented system we have no idea of how she has found her care experience.

Include Centre for Perinatal Excellence (COPE) Standards for Perinatal Mental Health Training. <http://cope.org.au/> Increased training for mental health practitioners in mental health to support the mother and father from preconception through to extended postnatal period.

Pathways for midwives to specialize in mental health – this is already in practice in the UK Increase in mental health services for women. Establishment of specific and targeted mental health services in maternity settings. Access to free DV training for health professionals. Recognition and follow-up of birth-related trauma.

Pathways for midwives to specialise in mental health. Access to free FDV training for health professionals.

I think there may be an assumption that perinatal mental health is well understood by maternity providers.

Access to mental health services

Include collaboration with Mental Health as normal, not because you need it.

Increase in mental health services for women.

Establishment of specific and targeted mental health services in maternity settings.

There are also significant gaps in service and resources for many jurisdictions.

Increased access for mental health workers dedicated to maternity.

PEHP [Perinatal Emotional Health Program] (Victoria) now eroded. I believe only SW Vic and Wangaratta have PEHP midwives still in practice.

Debriefing

Recognition and follow-up of birth-related trauma.

There are a significant number of women in the community who suffer grief and loss following birth experiences that have been disappointing, negative and/or traumatic. Many of these women are otherwise functional and will 'pass' standard depression tests, even though they continue to be adversely affected by the events of their birth/s for many years. This means that we currently underestimate the number of women who have been harmed emotionally and psychologically by the way their births have been managed. There are many reasons why women are not likely to 'complain' or speak up about their hurt, some of which include feeling shame, and being afraid to speak out lest it affect their care if/when they return to the maternity service. We need to broaden post-birth conversations with consumers so that these discussions are not simply clinically- or system-focused 'agenda items' which line up with depression scales and hospital satisfaction surveys (though, these things are important). It is the stories women tell each other at the playground, the school gate and in other 'safe' settings where we will find the truths the system needs to hear. To this end, a community-based workforce of trained professionals who can not only debrief women's experiences of birth in a more human way, but also capture their stories as qualitative data to inform the development of PREM sets and the future reform of maternity care.

Domestic violence

I know NSW is doing a lot of work around Domestic violence but from what I am seeing the clinicians are still afraid to ask the questions and when they do they don't know what to do with the response. Referral to services can be difficult depending on where you live.

Mother-baby units

Need for perinatal mental health beds where babies can stay with mothers.

Not enough mention of the importance of access to specific perinatal mental health services. It is mentioned, but there are no solid plans to increase mother baby units or encourage specific perinatal mental health services in hospitals.

It is an imperative that we have perinatal mental health services that keep mothers and babies together in publically funded beds. There need to be incentives to the states to improve access to perinatal mental health care e.g. mother baby units, linked outpatient services to women in the community and a known referral pathway/services and care providers.

Urgent review and priority funding supplied for perinatal mental health beds with the capacity to support mother and baby staying together.

2.3.3 Organisation comments

It is concerning that mental health support is referred to here in regard to birthing experiences only, when there is evidence that mental health support is important throughout the perinatal period.

Comments on the principle

Should be broadened and moved to the principle of safety. It is critical that women's mental health is not compromised through pregnancy, birth or in the postnatal period. It is important that this is recognised as being a principle contributing to safety. Another option it to retain the current principle within 'Access' to focus on improving access to mental health support and including an additional principle within 'Safety' that focuses on maintaining a women's mental health throughout preconception, pregnancy and postnatal period.

Health professional mental health training

Include Centre for Perinatal Excellence (COPE) Standards for Perinatal Mental Health Training. <http://cope.org.au/> Increased training for mental health practitioners in mental health to support the mother and father from preconception through to extended postnatal period.

Need for perinatal mental health beds where babies can stay with mothers.

Pathways for midwives to specialize in mental health – this is already in practice in the UK
Increase in mental health services for women.

Establishment of specific and targeted mental health services in maternity settings.

Access to free DV training for health professionals. Recognition and follow-up of birth-related trauma.

The enablers within principle 2.3 should also include information about the comorbidity of alcohol and substance use with mental health issues. Additionally there could be an enabler on the social determinants of health added to this principle that acknowledges the other aspects in women's lives that can interact and potentially impact on or confound a woman's mental health including being subject to family violence, experiencing homelessness or unemployment, those with alcohol and other drug issues for example.

Perinatal Mental Health Plan

We support the development of a Perinatal Mental Health Plan, with particular attention paid to the specific needs of Aboriginal and Torres Strait Islander people and also consideration of the particular needs of asylum seekers and refugees.

Mother-baby units

Perinatal mental health is a large and growing area. There is not enough inpatient facilities for women with serious mental health issues in the perinatal period. I cannot see evidence of this being addressed in the strategic document.

It would be helpful for a policy commitment to be made to keeping mothers together with their babies during psychiatric inpatient admissions in the postnatal period, as this would guide appropriate models of mental health care for women and babies. See the position statement of

the RANZCP regarding this: <https://www.ranzcp.org/News-policy/Policy-submissions-reports/Document-library/Mothers-babies-and-psychiatric-inpatient-treatment>

Collaborative care

There could be more emphasis and mention of collaborative care models - midwives and doctors working together for the best outcomes. There could also be more emphasis on governance frameworks, and enablers to ensure staff know when and how to escalate if there are issues not solvable with their immediate line managers and senior colleagues.

Centre of Perinatal Excellence

Reference to COPE.

I think reference to the Centre of Perinatal Excellence (COPE) should be able to be visible in the document and not buried in another link to another document. As this document is about women, consumers need to see the COPE resources- they will not know about this if this is within a link to another document.

Domestic violence

Also I think more reference needs to be made to the available resources for women experiencing domestic violence in each state and territory.

Royal Australian and New Zealand College of Psychiatrists response

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) believes that the National Strategic Approach to Maternity Services (the Strategy or NSAMS) is an important expression of the principles on which maternity service reform should be based. While this is a valuable and largely comprehensive starting point for maternity reform, the RANZCP would encourage greater focus in the Strategy on the following issues:

- Increasing public funded mother-baby unit beds available in all Australian states and territories
- Clarifying and supporting pathways towards perinatal careers (including specialist training in perinatal psychiatry who provide clinical leadership and governance for specialist perinatal mental health services)
- Recognition of the impact of mental health when untreated or undertreated on pregnancy complications and outcomes
- The complexity of antenatal management of severe mental illnesses such as Schizophrenia, Anorexia Nervosa, Bipolar Disorder in pregnancy and consideration of this within the models of care for maternity care in the same way as significant physical illness co-morbidity is considered within maternity care. This is to ensure women are able to access safe care that has the appropriate expertise in managing both the obstetric and mental health complications associated with severe mental illness in perinatal period.
- Inclusion of mental health professionals in workforce collaboration actions and recognition of other relevant healthcare professionals in supporting decision making for women

In the Round 1 consultation on the NSAMS, the RANZCP noted that pathways to public specialist perinatal mental health care are limited within maternity services. The RANZCP also highlighted the current inadequate number of publically funded mother-baby beds providing care seven days a week for managing women with a severe postnatal mental disorder requiring inpatient treatment. These issues around access to mental health support and variability of

services are somewhat represented in the strategic directions, however the RANZCP would encourage the inclusion of an 'Enabler' under 2.3 Improving access to mental health support which specifically related to increasing mother-baby beds available in all Australian States and Territories. This should also be a significant focus in the development of a Perinatal Mental Health Plan.

The RANZCP fully supports safety as a value for Australian maternity services and recognises Australia's ongoing emphasis on mother and child safety. However the RANZCP is concerned that emotional and mental health safety is not mentioned under this value. Mental and emotional safety of mothers, carers/families and health professionals is an important part of service delivery. In addition, the RANZCP would like to highlight ongoing issues around recognition of the importance of mental health support as an integral part of maternity services. Between 2012 and 2014, there were 5 maternal deaths attributed to suicide. Prior to this, from 2008 to 2012, there were 16 maternal deaths related to psychosocial causes, 12 of which were from suicide (AIHW, 2017). As such it is imperative that mental health support is recognised as a key and core aspect of maternity services. Improved multi-disciplinary co-ordination to manage complex care within maternity services including mental health, family and domestic violence, substance abuse and other psychosocial complexity is also necessary in delivering safe, high quality maternity care. Screening for psychosocial complexities could also be a useful strategy in multi-disciplinary coordination planning. References Australian Institute of Health and Welfare (2017) Maternal deaths in Australia 2012-2014. Maternal deaths series. Cat. no. PER 92. Canberra, Australia: AIHW.

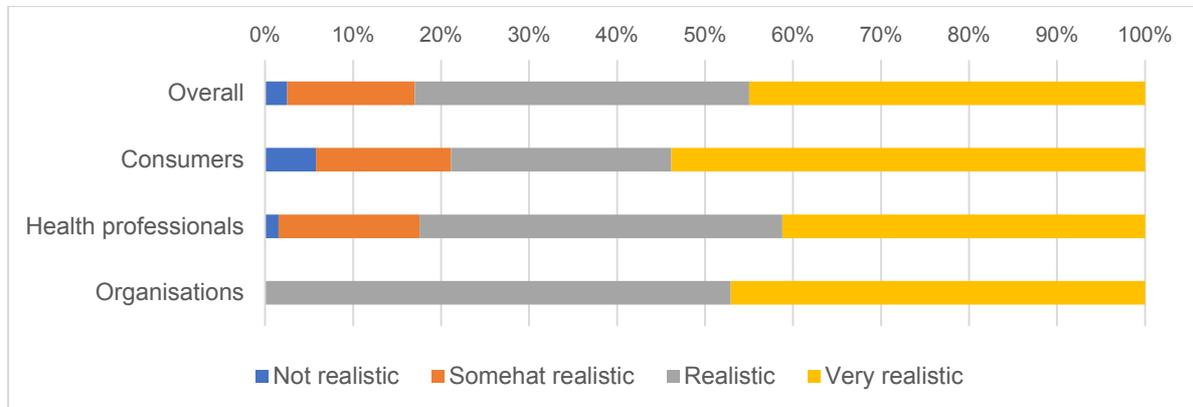
While the RANZCP welcomes the focus on mental health in some sections of the draft Strategy, we believe that mental health should be more prominently featured throughout all values, reflecting the role that good mental health plays throughout the maternity care experience. There are a number of concerns regarding maternal mental health in Australia. An Australian Institute of Health and Welfare (AIHW) survey of nearly 29,000 women in Australia who had a child aged 24 months or less, asked if they had ever been diagnosed with depression. Almost 20 per cent reported being diagnosed with depression, those who reported being diagnosed reported being diagnosed before falling pregnant, while pregnant and in the first year of the child's birth as 73.4, 3.7 and 18.8 per cent respectively (AIHW, 2012). Rates and reporting of maternal suicide are also concerning, particularly considering maternal mortality due to suicide is believed to be underreported (Thornton et al., 2013) and has been one of the leading indirect causes of maternal mortality in Australia (AIHW, 2017). Maternal Mortality Rate due to suicide has been increasing while medical causes for maternal death are all decreasing (Humphrey, 2016). The RANZCP believes there needs to be greater acknowledgement and understanding of the mental health challenges women may face throughout the antenatal period, and we believe mental health should be firmly integrated through all aspects of the Strategic Directions for Australian Maternity Services. Maternity care providers need to be given additional support in caring for women presenting with emotional dysregulation or borderline traits whose personality vulnerabilities will often exacerbate at this time and be challenging to manage for these staff (Austin, et al, 2017). References Austin M-P, Highet N & the Expert Working Group (2017) Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Melbourne: Centre for Perinatal Excellence. Australian Institute of Health and Welfare (AIHW) (2012) Perinatal depression: Data from the 2010 Australian National Infant Feeding Survey. Information Paper. Cat. no. PHE 161. Canberra, Australia: AIHW. Australian Institute of Health and Welfare (2017) Maternal deaths in Australia 2012-2014. Maternal deaths series. Cat. no. PER 92. Canberra, Australia: AIHW. Humphrey, M.D (2016) Maternity mortality trends in Australia. Medical Journal of Australia, 17 October 2016, 8 350-351. Thornton, C., Schmied, V., Dennis,

CL., Barnett, B., & Dahlen HG (2013) Maternal Deaths in NSW (2000-2006) from Nonmedical Causes (Suicide and Trauma) in the First Year following Birth. Biomedical Research International, 2013:1-6

3 CHOICE

3.1 Providing information about local maternity care services

Figure 7 Responses to strategic direction: Improve availability of quality information for women



3.1.1 Consumer comments

Comments on the principle

Change to "Women are provided with information about all locally available maternity services." This clarifies that care providers have a responsibility to provide complete information (including options such as private midwives), and that this principle encompasses other maternity services (beyond antenatal care and birthing options), such as breastfeeding support/lactation consultants, maternal and child health nurses etc.

I would re-write this to say "All GPs and maternity services care providers provide all women with unbiased information about local maternity services, including publicly reported KPIs, PREMs and PROMs at a facility level"

Information provided to women

Personally I was advised by a local GP for my pregnancy #4 that the home birth with two qualified midwives was illegal. I was astonished and appalled at the amount of misinformation from this GP who claimed was a specialist in Women's Healthcare and in fact has a contract to share care with public hospitals. This GP refused to provide a referral for my midwife at which point I had to seek help from other OBs who had ethical and moral compass to help me make this informed decision. All doctors should support woman's right to an informed decision and autonomous choice when it comes to birthing care.

According to recent studies, GPs are the 'gate-keepers' and women access them 98% of the time in order to receive information about maternity options. It is unfortunate that most GPs do not support midwifery models of care; are reticent to refer women to PPMs; and many are not aware of any other options other than Obstetrical-led public or private services. They need educating and regulating so that they give women the information required - otherwise, they are negligent in their professional duty and are guilty of withholding information as required by law.

Current policy is not supporting a non-biased view for any information given out to woman. How can that be enabling women to even begin to make informed decisions about their pregnancies and birth.

GPs refusing to write referrals to privately practising midwives needs to be addressed.

Integrity of GP information that is being provided to consumers. There should be a reporting tool for consumers to advise the government of any GP who are not honest in providing entire information on available maternity care (pre and post-natal included).

My GP stated that home birth is ILLEGAL in Australia.

Information availability through primary care providers to be ethically and honestly given to women under care so they can have a truly informed consent and options.

Women are often not aware that their choice of care provider is also a choice of model of care. It would not hurt to use this principle to make this distinction.

Acknowledgement needs to be made within the NSAMS document that some General Practitioners experience a conflict of interest when advising women regarding their maternity model of care options. Therefore, independent organisations should be funded to provide evidence-based information to women regarding maternity models of care.

Pregnancy Birth and Baby website

Website would be good with different options.

The information provided on the Department of Health. Pregnancy, Birth and Baby 2018 website regarding homebirth is not constructive and fear mongering. Where is the plethora of positives about giving birth at home? The information is biased and unacceptable.

The website constantly mentions going home after birth as a positive. Wouldn't you say that not needing to travel at all during labour or post labour is a huge advantage? This is just one of many advantages to giving birth at home.

3.1.2 Health professional comments

Comments on the principle

Maybe it isn't just the availability of information that is important but the ease of access to the information that is equally important. Just because the information is available doesn't mean that every woman has equal access to it. There could be language or cultural barriers to such information, for example. Or lack of education could be a barrier to accessing information.

in the section on 'Choice' - 'women can readily access information about locally available antenatal care and birthing options' to also include 'provided in formats readable by all groups of consumers' - This would cover the idea of information being provided in 'easy read' formats.

Principle Women can readily access information about locally available antenatal care and birthing options

Information provided to women

Information should include the statistics related to models of care.

For women new to maternity services it can be difficult to find out information and navigate services. GP's are not fully aware of services and some GPs choose not to disclose all the available options.

Once again GP's are responsible for providing referrals when women ask for Private Practising Midwives. If women do not receive a referral, this is NOT supporting women's choice. This has been a common theme for Private Practising Midwives.

GPs are the 'gate-keepers' and women receive information about maternity options through them. Most GPs do not support midwifery models of care; are reticent to refer women to PPMs; and many are not aware of any other options other than Obstetrical-led public or private services. They need educating and regulating so that they provide women with the correct information.

GPs are the 'gate keepers' and rarely know or discuss all models of care and inform women of the benefits and risks. 95% of women didn't know about the website (pregnancy and birth) to inform them of options (from MCN survey)

As GPs are often the first point of care for pregnant women, their responsibility to inform women of the available options should be highlighted. Research evidence in Australia shows that few women do receive adequate information from their GP. It is important to develop other information sources so that women are not reliant on GPs.

Enabler - PHN or others tasked with ensuring up to date guidelines are readily available to GPs, regular education about best practice care and options available locally. (Health pathways are good resource and I think mentioned in this document).

GPs to offer women choices which are not dependent on whether they have private health care insurance. Women to have access to a midwife (within a GP surgery/ health care facility) at first visit on discovering they are pregnancy. Removal of collaboration agreement; midwives are educated to be autonomous practitioners.

If a particular healthcare provider (e.g. GP) is to be the provider of information regarding birth and care choices at the beginning of pregnancy, how will it be ensured that all options are covered without individual bias playing a role?

In the public system I find many women present to birth unit having no knowledge of care choices available to them. Being able to attend an initial booking in visit with their preferred location of birth without referral would assist this. Women could then be encouraged to return to their GP with the choice they have made and the referral requested. Many GPs in my observation hold onto women until past 20 weeks which limits the woman in choice as many options do not remain available that far into her pregnancy. I don't know if encouragement for GPs to share models of care is enough when the two services GP and public do not communicate well between one another.

Midwives could be employed in General Practice to ensure that women find out about all options for maternity care. The midwife could be seeing women for preconception advice and then for information about models of care and extend into postnatal care in the first six weeks - this would increase the referrals to privately practicing midwives and midwifery models of continuity of care within public hospitals. Women need to be given access to data to assist them to make decisions about their care.

Prior knowledge is often not considered and should be. Age group varies and the increasing age of first time mothers limits there previous knowledge and increases their expectations

Private midwives often have difficulty getting GPs to refer women to them so that the woman can choose her own midwife and receive a Medicare rebate. There needs to be something put in place so the woman does actually have a choice in this situation. There needs to be

comprehensive information available to all women so they know all the choices available in their area. Private hospitals and doctors need to publish their statistics so women have full information when they make a choice about maternity care. They may choose a private hospital still, but it is an informed choice at that point.

Provide incentives for GPs to refer women to midwifery continuity of care models where available

Providing information is not the key issue with deciding women's choices. Women decide about services and their appropriateness based on a host of factors including the accommodation of the practical needs of their families, cost, their hopes and fears for the experience of giving birth, and their perceptions about the kind of care they are implicitly or explicitly promised (whether or not they actually receive what they were promised). Therefore support for decision making needs to have realistic and truthful assessments of the likelihood (including consumer-friendly statistics) of their receiving the care they desire. The Queensland document on decision making in health care is an excellent document that could be used as a resource.

Providing quality information is most valuable when a health professional is available at some to go through resources with the woman. Standalone printed/ online resources have more impact when health professionals can guide woman about how to best use information and how locally applicable it is.

Providing women information relating to maternity services which is unbiased and meets the expectations of women's needs. Informed choice Encourage information that is current, evidence based and informs women of their choices Public awareness of the models of care, accessible of care and choices for care needs to be greater.

Support GPs to provide information to women about midwifery models of care. Ensure there is a midwife in each GP surgery so that the midwife can be the first port of call. This will ensure that women will be able to make an informed choice about model of care and care provider.

Supporting Informed Choice Need to reword the first enabler "As part of antenatal care, provide women with evidence-based information about potential outcomes of different models of care". Informed choice is not simply about birth outcomes, it is also about maternal satisfaction, breastfeeding rates, rates of episiotomy and rates of intervention. Women need clear information about a care providers outcomes. Women must have full access to information regarding choice of care provider.

The strategic directions do not offer solutions as to how women can access information about services within their area and which ones are most suited to their own requirements. Choice of care provider is the first decision women need to make, and unfortunately they enter our Maternity services with no knowledge that there IS a choice until they are unhappy with their first experience of care (and then other choices are sought). GP's do not provide women with appropriate information given research available. GP's do not support Private Practising Midwives or midwifery care for primiparas. Information needs to be dispersed to GP's outlining RESEARCH that states that MIDWIFERY CONTINUITY OF CARE is a safe option for well and healthy women. To simply say "GP's will be supported" does not render a solution.

Option should be available for women to refer to a midwife as first point of contact. The rationale identifies the GP as key source of information. While many antenatal services work closely with GPs it is evident that there are pockets of the profession clearly anti midwife models with some GPs declining to provide a referral to a Private Midwife.

Support GPs to provide information to women about midwifery models of care. Provide a publicly available, evidence-based decision aid to assist women in choosing a model of care and care provider. Have it available online and in GPs rooms. This removes potential bias when referring pregnant women to a care provider. Expand The Pregnancy, Birth and Baby website to include information about midwives and private midwives.

Provide publicly available non-biased, factual information based on care provider with an increase in the information provided on privately practising midwives and midwives as continuity of carer.

Supporting women in decision-making needs to recognise the importance of the value of information given at first point of care. Usually this is the GP. These strategic directions need to promote ready access to information about all models of care available to women - not just the preference or subjective opinion of the consulting GP. For example - a client of mine (I am a Private Practice Midwife) was told by her GP that homebirth is against the law in Australia.

Improve availability of quality information for women.

Pregnancy Birth and Baby website/app

Expand The Pregnancy, Birth and Baby website to include information about midwives and private midwives.

Developing an app with two-way functionality so that users can communicate with the system, book appointments and seek guidance regarding their care. Liverpool Hospital has a 'Maternity Assist' app which has been successful and could be replicated here.

The website Pregnancy, Birth and Baby website does not provide information on services and models of care available for women rather an overview of models of care available generally within Australia. It would be useful for women to be able to click on their location and have the available models of care come up with contact numbers.

I looked at the Pregnancy, Birth and Baby website thinking that it would give me local information (based on the directions) but found it unhelpful when looking for pregnancy care options. Maybe it is there but as a first time user of the site I could not find it.

APP development a great idea, consistent information based on current evidence.

Offer evidence based information or where to find it, not just the basic hospital often biased information, incorporate safe alternative therapies within this as options to explore without bias, which often women look for as drug free, intervention options

National app with evidence based consumer pregnancy, birth and newborn care advice, pregnancy and immunisation care reminders and advice on locally available services and helplines etc.

Conversion of pregnancy and baby helpline into an app.

3.1.3 Organisation comments

Comments on the principle

This principle needs to be framed in women's rights language: "women have a right to readily access locally available, evidence-based antenatal care and birthing options".

Information provided to women

Focus in this section needs to move towards “Models of Care” rather than “different ways of giving birth”. There needs to be recognition that as the first health professionals to see pregnant women, GP’s hold the key to offering up-to-date and accurate information about options for maternity care. There is certainly a need for development of resources that explain the available care options available to women. These would need to be locally accurate, given the differences in options available according to location. These resources should also commit to providing evidence –based information on models of care – including intervention rates, women’s satisfaction, and likely costs. If the maternity care system is centred on midwifery models of care as per current evidence then models of care information should reflect this.

Informed choice is not simply about birth outcomes, it is also about maternal satisfaction, breastfeeding rates, rates of episiotomy and rates of intervention. Women need clear information about each care provider’s statistics, as well as that care providers preferences (and at times need) for women to undertake certain screenings and interventions in pregnancy/birth. Does the care provider routinely induce at 39 weeks? Care providers must share their statistics on the first visit, to ensure women can make an informed choice.

More emphasis throughout could be put on assisting women with decision making by the provision of health service based and national outcome data. They should also be given evidence based data on the benefits of continuity of midwifery continuity models and the poor long term health outcomes of caesarean birth. Balanced and available data should be readily accessible in plain language formats.

Families also need clear evidence based information about the choices available to them in their region. Information that helps families decide which option to choose includes publicly available data from health providers about their outcomes.

The RANZCP supports the focus of the strategy on supporting women in decision-making in maternity care. Section 3 Choice provides a valuable broad overview of enabling support decision making for women with regard to maternity care. However, the RANZCP notes that supporting decision-making needs to be underpinned by increased availability of services and an appropriately trained workforce. The only mention of the role of workforce in supporting informed decision making is the ‘enabler’ relating to general practitioners. This ‘enabler’ should be expanded to include all relevant health professionals, including allied health professionals, psychiatrists, and other specialists.

It says it in the plan - GP's need educating. They are the gate keepers so to speak and rarely give women information about all of their maternity care options.

Private midwives are primary carers, like GPs, but few women know about their local private midwifery services. Unfortunately GPs tend not to either, or they withhold this information. Health services and GPs need a simple way to direct women to explore this choice if it appeal to them, but they won't know unless they are told about it. Local hospitals also need to be willing to adopt their state's policies on collaborating with private midwives, which allows women to transfer to hospital from home if that is their choice, and remain under the primary carer of her chosen (private) midwife. This ensures continuity of care, which is the safest option for her and her baby.

This should include higher quality data being made available to women – reporting outcomes etc. – not just information on services and models of care.

Provide a publicly available, evidence-based decision aid to assist women in choosing a model of care and care provider; have it available online and in GPs rooms. This removes potential bias when referring pregnant women to a care provider.

Support GPs to provide information to women about midwifery models of care. Provide a publicly available, evidence-based decision aid to assist women in choosing a model of care and care provider. Have it available online and in GPs rooms. This removes potential bias when referring pregnant women to a care provider.

Pregnancy Birth and Baby website/app

It is doubtful that the federal health department's Pregnancy, Birth and Baby website has been evaluated properly and [we] would oppose any further funding being dedicated to this before steps to evaluate its effectiveness have been taken.

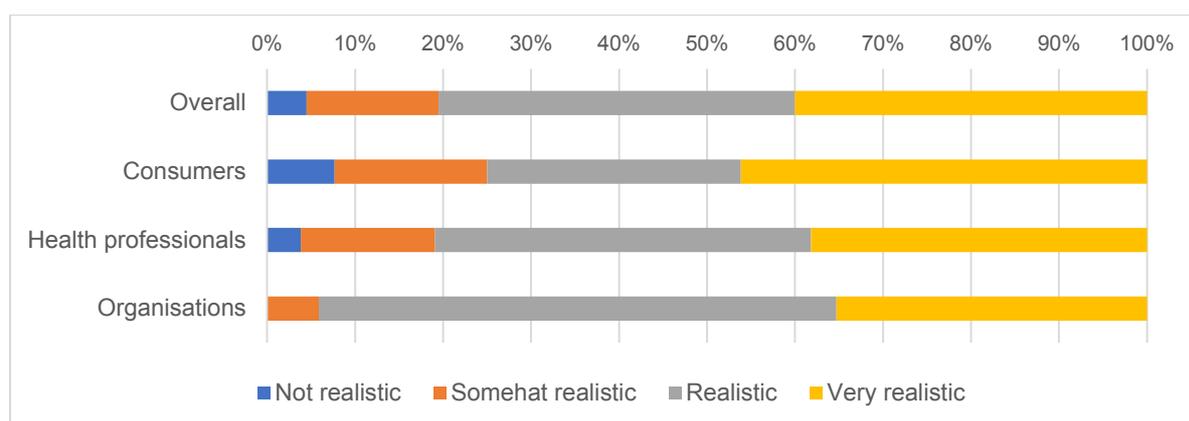
Expand The Pregnancy, Birth and Baby website to include information about midwives and private midwives; informed choice, choosing a health professional and incorporate principles for developing and implementing a birth plan/map to inform consent in maternity care so as to minimise systemic abuse and disrespect in childbirth.

According to a Maternity Choices Network survey, only 5% of women knew about the 'Pregnancy, Birth and Baby' website.

The NSAMS also indicates improvements will be made to the Pregnancy, Birth and Baby website (within Section 3.1). It is important to note that improvements to this resource will need to be evidence-based, with clear links to mental health services and information.

3.2 Supporting informed choice

Figure 8 Responses to strategic direction: Enable women's decision-making through the provision of evidence-based information about outcomes associated with different ways of giving birth



3.2.1 Consumer comments

Comments on the strategic direction

Edit end of this strategic direction so it reads "Enable women's decision-making.....information about all the risks and benefits of all alternatives, including expectant management". My reason for this is that there are many decisions that must be made during the antenatal, intrapartum and postnatal period, many of which are independent of "ways of giving birth". This strategic

directions needs to encompass all the decisions and choices that women are provided with, from having the nuchal translucency test all the way through to hep B vaccinations soon after birth and whether to supplement maternal breastfeeding with donor breastmilk or formula. It is also important to note that women should not be denied care due to the choices they make, as this would be inconsistent with all 4 values.

Comments on the principles

Change to "Women are supported to make informed decisions.....their babies, free from coercion". Again, this clarifies that care providers have a responsibility to explicitly tell women that the choices are theirs to make, and provide information is as unbiased a form as possible, without unduly pressuring a woman who has made a decision to change her mind. This is a necessary change in the context of Australian maternity care, as women are already legally and ethically "able" to make informed decisions, but in practice are not always told that they have this right, supported to exercise it, or given unbiased information with no coercion as they make their decisions.

Similarly, the second principle in 3.2 needs to read "Women's choices and preferences are sought and respected throughout maternity care". Again, it clarifies the responsibility of care providers to ask women what their choices and preferences are. If they don't know what they are, it's impossible to respect them.

"Women are able to make informed decisions and choices about their care for themselves and their baby. Women's choices and preferences are respected throughout maternity care."

Suggestion: "Informed choice is supported when women have access to balanced information, are active participants in discussions relating to their care/the care of their baby, and decision-making processes are explicit and de-mystified."

Informed decision-making

In the enablers of 3.2, there is a pressing need to protect women's direct access (without referral from a GP) to Privately Practicing Midwives.

It also needs to state that consent to all aspects of treatment is required, if there is a change in treatment plan consent must be obtained. Doctors or Nurses should not touch a woman's private parts without obtaining informed consent.

It is not always easy for lay people to determine what actually quality information is and what evidence based actually means. I have often seen or heard the term "evidence based" to describe practices that are not evidence based like eating placentas or vaginal breech birth at home. A layperson may not understand that links to blogs or websites do not necessarily constitute good quality information. There needs to be a clearer definition of what "evidence based" means.

It was touched on about have uniform guidelines based on evidence however who decides what evidence to follow. There is so much out there and more coming out every day. Birth is a natural process that is governed by women, her baby, and her body. I am unsure how evidence will assist in ensuring her process is undisturbed as procedures are about intervention. Often intervention which is not often needed but is done anyway due to risk. Consumers need to be aware that unless it is a true life or death situation and not just a potential one that ANY intervention is taken as a precaution and may not even be needed.

I made my decision and the doctors changed my treatment plan when I said no to the change in treatment plan. I had procedures done to me without even being asked for any type of consent and also had procedures done against my consent (actively said no) so I don't know how effective supporting woman's decisions actually is. It should be very simple... provide accurate information about risks and benefits, provide options and respect her decision.

Allowing women to make truly informed consent, safe birthing spaces allowing for physiological birth.

Consumers would benefit from the consistent provision of information and especially education about what defines midwifery care and the research which illustrates the benefits of continuity of care with a known midwife. Consumers may also benefit from having the International Confederation of Midwives (ICM) definition of a midwife and their scope available.

Transparency in information from GP/OBs that home birth is a safe option under guidance of a midwife.

Not making the women to fit the guidelines but making the guidelines support women in safe, informed decision making

Women need to be able to identify opportunities where a choice can be/is made, how to quickly appraise the evidence available to them (the BRAIN decision making tool is often the quickest), and how to advocate their choices. Without this support, 'informed choice' loses meaning.

Women need to learn how to be powerful and effective decision-makers before they will be able to accept responsibility for their choices. Making information available is simply leading the horses to water - it is not teaching them how to drink it, nor is it teaching them how to appraise whether or not they want to drink it (or whether there is a suitable alternative elsewhere).

Care provider preference and hospital policy are missing, and both play a massive part to women being supported to make truly informed decisions. Rather than being told only what that professional or hospital will allow them to do. It's been my experience that the health professional's preference or recommendation is seen as the final say, when a health professional shouldn't be having a preference, they should be presenting all of the information to the woman in a non-biased and non-coercive way and allowing her to make her decision. This is absolutely not how it currently happens and building another document informing her of her choices won't matter at all if you have professionals who prefer her not to make those decisions in the first place.

I would like to see 'knowledge' foregrounded in the Strategy, rather than embedded within choice. I think knowledge about the birthing process and the procedures and instruments that may be used is fundamentally lacking in the present maternity services. Underlining knowledge as essential to maternity services would begin to reorient the current culture that fails to educate women regarding the risks and their rights as consumers.

Part of supporting women's decision making is giving them access to up-to-date and accurate facility level safety and quality data. A key enabler here would therefore be to the expansion of the relevant website (be that Pregnancy Birth and Baby or elsewhere) to include facility level (and model of care level) data, including PREMs and PROMs data also.

Obstetricians need to be educated in explaining actual risk/benefit analyses rather than providing coercive counselling.

Providing women with details of how to make informed decisions is imperative.

Real advice. Real options. No sugar coating. And really listen to what is important to a woman.

Real choices for women and the level of care, the private midwife and the hospital they choose.

There needs to be a huge review about the importance of informed consent. Hospital staff telling a woman they are going to perform a procedure and throwing her a form to sign is not informed consent. It seems like in many hospitals its policy over the person. Choices seem very limited to what the individual staff member considers appropriate or routine. Women are currently being bullied in the current model. There needs to be serious reform, perhaps a type of consumer review provided to women after their births would shed some light on how poorly women and their families are being treated.

There needs to something about change in treatment plan consent.

There's no mention of homebirth, private midwives and very little information on natural pain relief or methods of induction in current models of care. Again plenty of information on the drugs and interventions that will be 'necessary' or offered throughout labour. Without doing your own research it's an incredibly biased view of what's possible.

Women's rights as a patient should be made clearer, decisions cannot be made without consent.

Written materials provided by any registered health professionals should reflect the most up to date as possible evidence based information and include easy to understand explanations and statistics. A strong stance should be taken against health professionals that promote dangerous misinformation - for example, anti-vaccination propaganda, anti-vitamin K, nuchal cords are "necklaces", homeopathy.

You need to start allowing for evidence based information that comes from non-western perspectives that was around before western 'evidence based' medicine came into being.

Change in treatment consent.

Evidence can be viewed in many ways too. For example, evidence that shows a certain choice results in greater maternal satisfaction may contribute to a woman choosing that option, but not understanding that evidence also exists that shows that option has a higher rate of another adverse outcome. It has been my personal experience and witnessed among others that women may form a belief about a certain intervention or way of giving birth that is based on a lower risk cohort, or a result that may be influenced by other factors. A good example of this would be a woman that decides to give birth at home because she has been told VBAC is safer than C-section and shown a study that shows VBAC is more likely to be successful at home. She has however, not been informed that VBAC at home carries a far greater risk of perinatal death, and or has been given information and statistics on homebirth based on a low risk model, that excludes VBAC.

Explain the risks of vaginal births to women. Explain the risks of interventions to women. Explain the risks of induction to women, and offer the - a caesarean. Let her choose.

Explaining that consent can be withdrawn at any time and that women can change their mind at any time.

Explaining the importance of choices and decisions in maternity care.

Explaining what consent is and providing visual models that can be easily referred to.

How do we stop the inaccurate messages that women get from their care providers?

I am also concerned with the focus on women's decision making as a decision making process about something as important as the birth of a wanted baby needs considerable input from a trained medical professional. There should be some reference to the responsibility and contribution of the health professional to the decision making process and perhaps if women want to choose something that is outside of the recommended course of action a documentation process to ensure that the woman has been adequately and correctly informed and that this exchange has been witnessed by at least two non-vested interests and therefore the medical professionals are indemnified if the choice results in a poor outcome that would have likely been prevented had the recommended advice been taken.

I believe an important part of respectful maternity care is making sure a woman is appropriately informed by the medical and scientific evidence, even if this goes against her personal beliefs and this can be done in a respectful and kind, but firm manner. No-one wants to find out after making a decision, or after having a tragic outcome, that the things she believed to be true were not, and no-one felt compelled to be honest, for fear of hurting her feelings or upsetting her.

I think the sub themes under choice are superficial. I don't really know how to change them but they need more substance. Something to counter the lack of choice consumers actually have in most places

Impact of intervention.

Women who decline recommended care

It needs to be clear that when a woman says no to certain treatment methods that no means no, it doesn't mean doctors can ignore her choice and perform procedures against her will.

A respectful way to treat consumers who do not wish to follow medical advice.

Respecting a woman's choice to decline the advice given

In Queensland, a state-wide guideline for partnering with women who decline recommended maternity care is currently in draft and will be piloted in early 2019. This work is ground-breaking and should be mentioned here to recognise that part of supporting informed choice is knowing that women won't always choose what is recommended to them. When such situations arise, clinicians and health services often feel medico-legally and professionally vulnerable, and the Guideline in Queensland is intended to provide additional support to address that. Without such support, recourse to coercive efforts to get women to comply are common and in some cases this leads women to disengage from mainstream maternity services. An enabler in this document could therefore be "jurisdictions develop processes and communication pathways to support clinicians and women to maintain a care partnership when women decline recommended care".

3.2.2 Health professional comments

Comments on the principles

"Women are able to make informed decisions and choices about their care for themselves and their baby... Women's choices and preferences are respected throughout maternity care."

Informed decision-making

I have suggested the use of a shared decision-making approach, which has a framework clear standards for the type, presentation and quality of information used for information-sharing, and metrics to evaluate the quality of the decision-making experience.

Public campaign on avoidable risks to allow women to make informed decisions around birth to reduce risks and costs to system of overuse of C/S birth- particularly in privately insured women

Respect for women's autonomy and informed decision making.

Reference to respecting maternal choice should include support for clinical teams to recognise scope of practice and necessity for safe practice to include referral to more well equipped clinical settings when maternal preferences carry high risks of serious adverse maternal and/or neonatal outcomes. The latter may include the necessity to arrange for emergency transfer to an appropriate care sight when women present at an inappropriate care site. Poor outcomes resulting from unquestioning support and respect for maternal choice can have traumatic and adverse professional effects on care team members as well as families. It can lead to the loss of clinicians from the maternity care workforce.

There needs to be a formal commitment to women participating fully in decision-making in their maternity care. This could be considered another hallmark or requirement of all models of care offered to women and is an important reflection of the principle of woman-centred care.

They are covered, and I'm hoping hard evidence is cited to women (in terms of easily) accessible facts and figures to assist women with making fully informed decisions regarding their health care. Health care providers need to be able to demonstrate that information provided to women help them to make fully informed decisions and if intervention rates or injury rates are high in various models of care, then they should be financially and professionally accountable for these issues.

Reference to (and metrics for) shared decision making. Use of a shared decision making approach is recommended by ACSQHC, and is now incorporated in the Nursing and Midwifery Professional Code of Conduct and Competency Framework. As discussed in the Melbourne forum, shared decision making is poorly understood by clinicians currently, but is a process and framework for practice that operationalises 'partnering with consumers', 'information sharing' and 'informed consent'. Including, defining, and contextualising shared decision making within the National Framework provides the missing link for clinicians to bridge collaborative maternity practice between clinicians and woman-centred care. Under the value Respect: Reference to the importance of systems to support clinicians to collaborate effectively. The wording focuses upon clinicians communicating and collaborating respectfully, but misses the fact that 'systems' may impede clinicians from collaborating effectively, and negative impact upon safety. As such, the enablers currently identified in the document are unlikely to impact upon multi-professional collaboration from current state. In the Strategic National Approach to Maternity Services, organisations (from individual providers through to Federal Government) should be compelled to review organisational systems and context to identify barriers to effective collaboration (for example, funding models, hierarchy, communication systems, co-location of services).

The way that this section is written implies that the woman is a passive recipient of maternity care, particularly in the collaborative process. The outcome of any collaboration should be an action or decision, and as such, under the Australian Charter of Healthcare Rights (Participation) women's rights to be included in decisions and choices about care should be respected. The

best way to facilitate this (using current knowledge) is for adoption of a shared decision-making (SDM) approach- explained by Tammy C Hoffmann, France Légaré, Magenta B Simmons, Kevin McNamara, Kirsten McCaffery, Lyndal J Trevena, Ben Hudson, Paul P Glasziou and Christopher B Del Mar Med J Aust 2014; 201 (1): 35-39 as: 'Shared decision making is a consultation process where a clinician and patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances. Shared decision making is not a single step to be added into a consultation, but can provide a framework for communicating with patients about health care choices to help improve conversation quality. It is a process that can be used to guide decisions about screening, tests and treatments. It can also be thought of as a mechanism for applying evidence with an individual patient through personalising the clinical decision.' An enabler of SDM would be to promote the use of 'decision aids' (review link for more information: <https://decisionaid.ohri.ca/azlist.html>). An easy-to-use metric to measure the effectiveness of shared decision making is the SURE test (https://decisionaid.ohri.ca/docs/develop/tools/dcs_sure_english.pdf)

It discusses women making informed choice and choices being respected. What is missing is women being offered choice; options; to make informed choices. The way information is presented to women is too commonly "you need to have an induction at 39 weeks for this risk factor." And most women hold onto that their entire pregnancy. But they have not been counselled about what induction involves. What the risks are. What the other options are.

It is articulated that women's choice and ways of knowing are to be respected. What is the process for ensuring this happens? It risks being words without substance.

It's not just about disrespect and abuse - it's also about empowering the workforce to feel safe to counsel and allow women to make their own choices. The words 'non-compliant', 'refused treatment', 'difficult woman' need to be removed from Maternity speak. Junior doctors and midwives don't know the actual risks of women declining treatment e.g. Vitamin K or antibiotics for GBS and so women are not appropriately counselled.

'Woman centred care' should change to 'woman centred care in partnership' to reflect informed joint decision making.

A women's right to make evidence informed decisions regarding choices available to her throughout the pregnancy and mother/child-bearing continuum is respected. This includes respect toward her choice of birth place, respect towards her declining medical intervention, and respect toward her if she may need to transfer into a hospital setting.

Decision-making is a lot more than just giving birth. Every decision a woman makes needs to be respected, from declining routine procedures to mode of birth.

Detailed plans for decision support when standard care is not chosen.

Health care professionals accept the woman's right to informed decision making. What happens now in practice is woman are coerced because it isn't accepted one health professional can have that conversation with her to make that decision. If she chooses care outside usual care then the woman has to be subjected to medical interrogation.

I would say 80% of supporting women in decision making is time and skill: time in antenatal clinic: there's only so much you can do (and do well) in 15 minutes. If the staff don't have the skills, experience and further education in delivering unbiased evidence based information, then

the objective is highly compromised. Underlying issues: I repeat: Time, Skill and Experience of staff.

Ideally all decision making in maternity care should follow the same pro format; - we recommend intervention a - your other options are b, c and d - the strengths and weaknesses of the evidence for intervention a are: - taking into account the individual characteristics of you and your baby are.... Respectful relationships between care providers is a can of worms. Education on this complex topic needs to begin in medical/ nursing/ physio/ pharmacy school.

Improve education of all maternity caregivers on all aspects of informed consent

Support informed choice but not when those with the medical/obstetric knowledge and expertise deem the mother's choice to be unsafe for mother and/or baby. Safety must always come first.

Where the document discusses consumers' choice and the need for them to be heard: how does the document support the women if they choose to go with care options advised against by healthcare providers? Needs to be clearer that there should be no bullying or coercion of these women. Once they have been given the evidence their choices need to be protected. Also what about the healthcare provider's protection? If they provide care to a women who has opted to choose against advice? Too many midwives especially are being taken before AHPRA. This makes it difficult if not impossible for care to be provided to women making their own choices. Needs to be clear or will just be lip service.

Ensure women are at the centre of all choices and are not bullied or coerced into interventions using fear based tactics by clinicians with unfounded personal fear of litigation. Interventions are driven by clinician preference and clinician workload or on call load and are not in the best interests of the woman or child or aligned to evidence. Privately practising midwives should be able to admit public patients it is anti-competitive that doctors can admit public pairings but midwives can't, it is discriminatory against midwives and discriminatory against women who can't afford private health insurance - those who can't afford private care are the ones who benefit most from continuity of midwifery carer.

Not having a system where women are continuously brought back each week for unnecessary appointments with DRs until they agree to what is being recommended; stop coercing women and instead provide information and empower them to make a choice and then respect that choice.

Place of birth not specifically mentioned in relation to choice, regarding homebirth as a safe option for low risk women, in collaboration with midwives and Obstetricians.

Women's choice needs to be upheld; and this concept normalised as ethical care and a human right.

Women's CHOICES must be respected regardless of whether these align with the health professional's position.

For women with learning or intellectual disabilities, there is little information that is available in 'easy read' format to assist this group of women make choices. Given that women with intellectual disability will likely acquiesce and agree despite not understanding the information, consent is likely to be informed compliance rather than informed consent. 'Easy read' versions of all maternity documents should be available for this group of women and others with low literacy.

Consumer-led, peer support groups already exist within the birth community ecosystem. We need to identify the 'good pockets' and better connect consumers to these resources as a way to complement antenatal care.

As stated previously, decision-making can only occur when women and their significant others fully understand the information and choices being offered to them. For women with intellectual disability and women with low literacy, most maternity related documents are not easily understandable, and health professionals have often limited time available to provide the information at the level the woman requires in order to understand and make an informed choice. In order for this strategic direction to be realistic two enablers are required - firstly by providing information in 'easy read' format, and secondly, by training staff to be able to provide it in the appropriate manner i.e. checking of understanding, chunking of information, etc...

Need to heighten the awareness of what care and service a midwife and a doctor provide to women

Need to reword the first enabler "As part of antenatal care, provide women with evidence-based information about potential outcomes of different models of care". Informed choice is not simply about birth outcomes, it is also about maternal satisfaction, breastfeeding rates, rates of episiotomy and rates of intervention. Women need clear information about a care provider's statistics, as well as that care providers preferences (and at times need) for women to undertake certain screenings and interventions in pregnancy/birth. Does the care provider routinely induce at 39 weeks? Care providers must share their statistics at the first visit, to ensure women can make an informed choice. Women need clear information about what will happen if they decline a care provider's routine care (e.g. decline GBS swab, decline OGTT).

To support their informed choice women need access to care provider statistics e.g. if I am hoping for a VBAC I would not make an informed choice to visit a clinician who does not facilitate VBACs. Access to care provider statistics is essential for a woman to make an informed choice regarding her care provider.

Informed choice is addressed across the pregnancy continuum, not just birth and is addressed actively at all stages: time is allowed where possible for women and their families to consider all options without coercion or undue haste.

Provide women with evidence based information regarding outcomes of different models of care. Care providers statistics need to be made readily available. Women need more support in making informed choice based on evidence based data presented in easily accessible formats and early in pregnancy.

3.2.3 Organisation comments

Comments on the strategic direction

Section 3.2 should also include more specificity around types of outcomes beyond different ways of giving birth. This may include emotional and psychological outcomes, rather than just a focus on physical outcomes.

Informed decision-making

Information about Standard 2: Partnering with Consumers is needed, as it is still not widely understood - by consumers or their providers. Specific reference to Standard 2: Partnering with Consumers needs to underpin this document. This will prioritise informed decision making by

consumers, and the provision of evidence based information by providers. Providers and consumers need to be informed that the best outcomes in healthcare are delivered through the active engagement of consumers in their decision making and practitioners partnering with their consumers to develop the best plan for their care. This also requires an acknowledgement that this is a change from the past and that health services will need to be proactive in informing their populations of available birth choices and how to make informed decisions.

We also support the aims of improving the availability of quality information for women and of enabling women's decision-making through the provision of evidence-based information about outcomes associated with different ways of giving birth.

There is large variability in the level of women's informed decision-making and consent to a range of hospital procedures (Prosser et al., 2013). For example, 26% of women experiencing an episiotomy reported that they were neither informed nor consulted about the procedure, while 13% of women receiving vaginal examinations were neither informed nor consulted, indicating concerning levels of non-consented care (Thompson & Miller, 2014). As Freedman and Kruk (2014) observe "health systems often reflect the deeper dynamics of power and inequity that shape the broader societies in which they are embedded". Women need clear information about a care provider's statistics, as well as that care providers preferences. Clinical audit is about measuring the quality of care provided against relevant standards. Clinical Audit identifies variances in practice and outcomes, helping to understand the factors that are contributing to the outcomes so priorities can be set and improvements made. Audit is required to identify the disparities in practice between different parts of the system and between individual institutions. Audit data relating to the number of services performed by particular services and services providers (public as well as private) is generally not publicly available, and so variations in the rates at which services are performed is not available. This is unacceptable given that the public purse funds 70 per cent of total health spending in 2011-12. How will the Australian public know they are getting value for money, without the publication of clinical audit data? Care providers data must be available on an independent website and displayed in clinicians rooms, to ensure women can make an informed choice.

Need to reword the first enabler "As part of antenatal care, provide women with evidence-based information about potential outcomes of different models of care".

4 SAFETY

4.1 Supporting cultural safety

Figure 9 Responses to strategic direction: Support implementation of culturally safe, evidence-based comprehensive models of care that have been developed and implemented in partnership with Aboriginal and Torres Strait Islander people and organisations

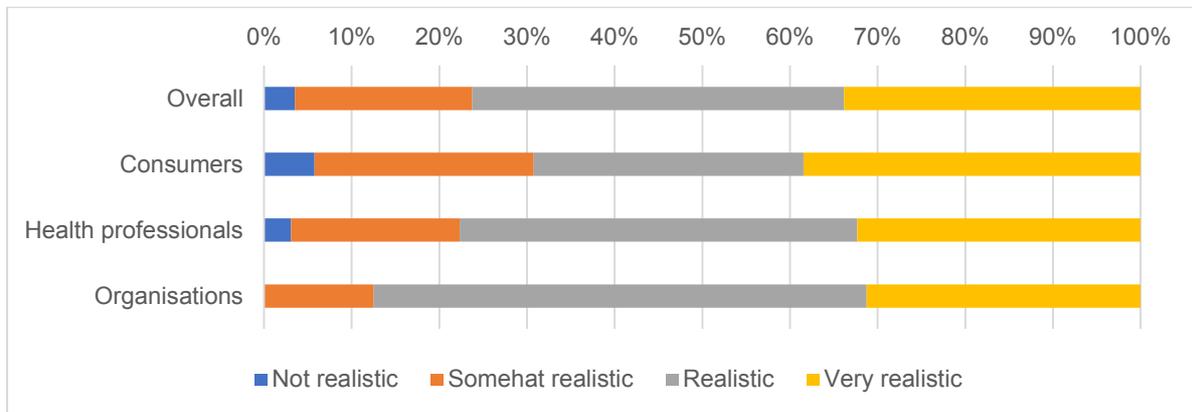
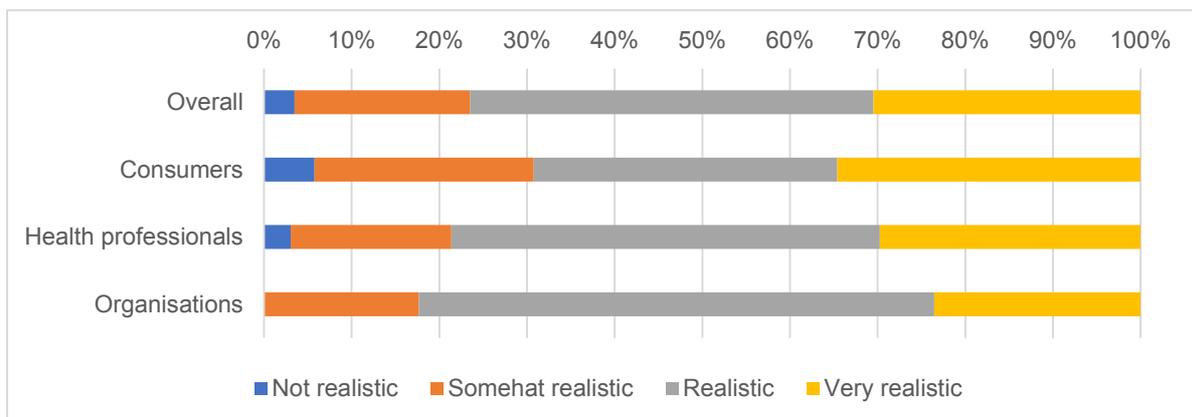


Figure 10 Responses to strategic direction: Support implementation of culturally safe, evidence-based comprehensive models of care that have been developed and implemented in partnership with women from culturally and linguistically diverse backgrounds and their communities



4.1.1 Consumer comments

Cultural safety

ALL women come into the experience of birth and parenting with culturally specific attributes, not only those who identify as ATSI or come from an ESL background. ALL WOMEN ARE CULTURALLY DIVERSE. That is why individualised maternity care is so important. That is why women need to be cared for holistically so that her emotional, spiritual, cultural, social as well as her physical needs are met.

I think with regards to cultural safety we need to be sure that cultural safety does not come at the expense of physical safety unless the woman and her family has truly understood that cultural practices may not be in line with evidence based medical practice and could harm them or their baby. An example of this would be bed-sharing, which is common in many cultures - but is shown to increase the risk of SIDS and sleep accidents. In my opinion it is possible to be

culturally sensitive and respectful, while at the same time fulfilling the responsibility of maternity services to ensure truly informed choice.

4.1 and 4.2 look good

These are fantastically ambitious. But there seems to be an expectation that changes can be made to provide more equitable care without first engaging in any conversation around how ATSI and CALD people have come to experience such poor current care - essentially systemic oppression and racism, predominantly from unaddressed unconscious biases. It isn't random. A solution can't be gained while pretending a problem doesn't exist in this case, so I don't see this strategic direction progressing at all without some radical education from ATSI and CALD consultants around how the maternity system can start to unpack the embedded systemic racism.

Aboriginal and Torres Strait Islander women

Prioritisation of ATSI women's maternity care nationally.

Existing birthing on country models seem to appropriate the term 'birthing on country'. Models in which women still have to travel to major centres to birth are not 'birthing on country'. Culturally safe programs are sorely needed but labelling them 'birthing on country' when women are still required to leave country is disingenuous. Aboriginal women should be supported to return to traditional birthing practices if they wish to do so. All programs for Aboriginal women focus of forcing conformity with Western systems, but Aboriginal women have 60,000 years of traditional birthing practices behind them. Aboriginal women should be offered midwifery care in their own communities and supported to birth on their ancestral lands.

Again, the enablers here need to be stronger - for example, for jurisdictions to set targets for the establishment of birth on country services in each state.

Women from culturally and linguistically diverse backgrounds

Prioritisation of Culturally and linguistically diverse women's maternity care nationally.

Related to my earlier comments about access to information and antenatal education, enablers in this strategic direction need to emphasise the need for information and antenatal education to meet the needs of culturally and linguistically diverse women.

Does not address transport and cost of services as mentioned in the rationale

4.1.2 Health professional comments

Cultural safety

Compulsory cultural safety training for all providers of maternity care which is developed by a multicultural working party. Peer support for midwives to assist them in career development. This may be via a formalised model of support funded by health services.

Implement cultural capability education throughout the health care services.

I provide care for - Aboriginal women - Afghani women - Karen women to have culturally appropriate information that is keep up to date and that is available in the appropriate language would be ideal. There is very little available information for any of these groups really and certainly nothing comprehensive. Frustrating.

Compulsory cultural training for midwives, GPs and obstetricians working in all areas, but especially in rural and remote areas.

This section should also spell out the importance of cultural safety for women with disabilities.

Whilst cultural safety most often refers to Indigenous populations, and other groups from other language groups, this section should also refer to women with disability as a distinct cultural group with specific needs. Women with disabilities need health staff to care for them who have disability awareness. When staff do not have disability cultural awareness, they are not able to provide safe care for women with disabilities. In the section on consumer focus groups, why weren't women with disability included in a specific focus group to find out what their particular needs in maternity care are.

Whilst I think the strategic directions for 4.1 are achievable, I think this section needs to include both women with disability and lesbian/gay women as also distinct cultural groups who have specific needs to feel culturally safe within maternity care.

Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women are able to assess specialised continuity of midwifery care services. Currently they are not able to access in NSW the benefits of continuity of midwifery care throughout because the state AMIHS program is not funded adequately or set up to provide caseload midwifery care. As a result these women are unfairly disadvantaged because there has been no additional funding into AMIHS services since its implementation in 2009.

Compulsory cultural training for all midwives, GPs obstetricians working with Aboriginal and Torres Strait Islander women and their families.

Conduct a full review of the proposed Birthing on Country model – ensure that it is co-developed with Aboriginal and Torres Strait Islander women. This could be similar to the model used by ACM in the Birthing on Country Project <https://www.midwives.org.au/birthing-country-project> Inclusion of traditional practices, valuing Aboriginal and/or Torres Strait Islander ways of learning and knowing. Acknowledgement of cultural birthing practices.

Funding for midwifery continuity of care for all Aboriginal and Torres Strait Islander women.

If you were serious about Aboriginal & Torres Strait people's health care, you would allow birthing on country without obstetric services. It's culturally safer, and this is what is so crucial to this population.

Improved options for indigenous and Torres Strait islander women to birth on country.

Support implementation of strategies in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016 - 2023.

Supporting Cultural Safety Addition in “Enablers” Under the mention of Birthing on Country:
*Implementation of legitimate opportunities for Registered Aboriginal and Torres Strait Islander Midwives (or dual) into the workforce with a specific Graduate program for preparation for Birthing in Country service model.

The distrust between Aboriginal and Torres St Islander people and the health care system needs to be discussed and addressed with the interventions already proving better outcomes in some areas of Australia.

Will the evidence base include actual experience with Aboriginal and Torres Strait Islander people? Or will be it drawn from elsewhere in the world and be applied inappropriately? And the same can be said for other cultural groups.

Women need support to birth on country incorporating cultural birthing practices. Mandatory training for all maternity care providers on traditional practices, valuing Aboriginal and/or Torres Strait Islander ways of learning and knowing

This needs to involve Aboriginal and Torres Strait Islander women to develop and implement a model which suits their needs and provides culturally safe and appropriate care. Acknowledging traditional cultural birthing practices.

Women from culturally and linguistically diverse backgrounds

Women are represented in the numbers -->improved data collection on issue affecting specific groups of women who commonly get overlooked or who are pulled into a broader thematic group. For example, migrant and refugee women have a diverse range of access barriers and enablers. When we lump them all into one group we reduce the chance of offering equitable care.

Enabler - foreign language materials and antenatal education

Need mandatory training for all maternity care providers on issues facing CALD population, cultural birthing practices, translated information, support for maternity liaison officers working with CALD populations and women's chosen care provider.

The enablers do not match the strategic direction. Suggested enablers:

- Co-design services with CALD women.
- Maternity liaison officers working between hospitals and communities for culturally and linguistically diverse women.
- Incorporate framework: Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds

4.1.3 Organisation comments

Cultural safety

It is unclear as to whether this section adequately differentiates cultural awareness from cultural safety.

We fully support all of the strategic directions in terms of the safety of maternity care; specifically – the aims of culturally safe maternity care developed and implemented in partnership with Aboriginal and Torres Strait Islander people and organisations and in partnership with women from culturally and linguistically diverse backgrounds and their communities and that there is careful workforce planning.

Aboriginal and Torres Strait Islander women

The utilization of Birthing on Country principles to guide the development of models of care would optimize cultural safety for ATSI women. Consultation and collaboration with ATSI consumers should be encouraged in developing these services further.

There should be something in there about prioritising Continuity models for Aboriginal women

WHA strongly supports the implementation of the Birthing on Country Service Model and Evaluation framework, as an evidence based strategy to improve experience and outcomes of care for Aboriginal and Torres Strait Islander women wishing to exercise this choice.

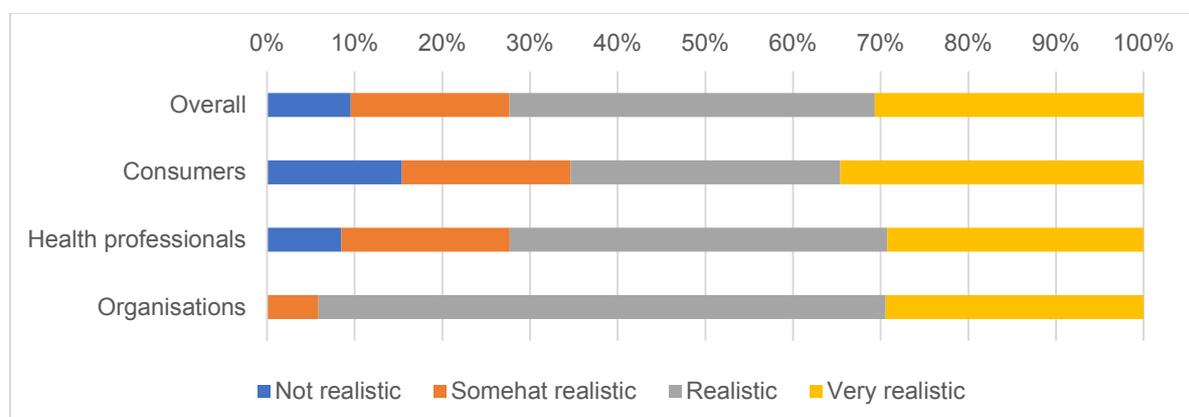
Women from culturally and linguistically diverse backgrounds

Negotiating the maternity care system is indeed particularly difficult for women from CALD communities and initiatives that improve access to and engagement with optimal maternity care would be welcomed. Women from these communities need more than language-based resources to ensure that maternity care is accessible and appropriate to their needs. Recommendations that encourage concerted efforts to recruit and train health professionals from these CALD groups as well as funding for research that examines both CALD women’s lived experiences and measured outcomes of their care in the Australian maternity care system are needed. This research would support the stated strategic direction referring to collaboration between CALD consumers of maternity care in building new models of care.

The rationale seems to be focussed purely on language. Many of the rationale statements from the section on Aboriginal women apply here also.

Re interpreters, the improved access needs to be both for consumers and for service providers. Many maternity services are faced with ethically challenging situations of providing personal clinical information to women through a relative who is untrained in clinical terms, and where it may not be culturally appropriate for want of any other means to support women to understand their care options and to communicate with care givers. Supporting the maternity care workforce

Figure 11 Responses to strategic direction: Workforce planning enables the delivery of sustainable maternity services



4.1.4 Consumer comments

Sustainability

There needs to be a complete overhaul of the system and the training Drs, midwives and nurses receive in how they care for people.

Workforce sustainability - where culture doesn’t enable or support this then efforts to make it sustainable are futile.

Midwifery

Addressing vexatious reporting of privately practising midwives to AHPRA, an appropriate intrapartum insurance solution to be put in place for PPMs by December 2019, student midwives enabled to attend both public and private midwifery model births at home for succession planning and to increase the PPM workforce.

The principles do not address the private midwifery workforce.

It is alarming to me that enablers for 4.2, makes mention of models that involve midwives working with GPs and obstetric practices, but nowhere in this document is any attention given to midwives working in community based practices as autonomous professionals. That needs to be rectified, as they provide an evidence-based model of care!

Supporting maternity care workforce - doesn't mention reducing red tape for ppm/ increasing mgp/ppm funding to allow midwives to use their full scope & work in models of care that they were trained for

4.1.5 Health professional comments

Sustainability

Primary health care as opposed to tertiary funding is not discussed

Sustainable maternity services - what metrics will be used to assess this word "sustainable" which has so many meanings as to be virtually meaningless? A clear and detailed definition of "sustainable" - what it is, and what it is not - is needed. If financial sustainability is considered, consider the financial support offered for caesarean (>90% in some hospitals) vs a natural birth which makes the latter "less sustainable" financially though surely more sustainable in all other ways?

Implementing previous workforce plans.

Workforce to include credentialed clinical medical practitioners, consultation and referral pathways.

Working in the Health system it's more about funding - yes we want respectful care but on a budget

Australia has a world class health service that has the ability to provide optimal care for all. Despite this, our rates of intervention are too high, we face a shortage of qualified and competent midwives who work in often stressful environments and may endure collaborative relationships with medical and allied health colleagues that do not put the woman at the centre of her own care and are challenging for the individual as well. Commitment to change and improvement in our maternity services is an urgent priority that can provide better health outcomes for not only the women we care for but future generations and so deserves active and comprehensive attention as well as appropriate funding that recognises the importance of this.

Education and mentorship of the maternity health workforce.

Implement wellness courses for health professionals such as MBSR courses - evidence based courses and practices for sustainability for health professionals. (See Jon Kabat-Zin's work on Mindfulness Based Stress Reduction courses).

Services and staff are constrained by workloads. Accountability of health services to provide stable jobs and family friendly rosters: strongly impacts the provision of quality services. Particular focus on rural areas - significant difficulty attracting educated experienced professionals due to harsh working conditions and bad reputations. Results in large numbers junior staff - and predictable falling standards of care - they simply don't have the experience in basic communication for informed consent and unbiased presentation of information.

The document also fails to take into consideration the wellbeing of medical practitioners including Obstetricians and neonatologists who are called in when things go 'pear shaped' and have to deal with adverse outcomes that could have been avoided if safety was considered above the woman's choice.

The workforce constraints need to be more considered in the context of providing improved woman centred care. There has been a significant increase in the requirement for midwives and others caring for women to provide data to several sources as well as their traditional documentation, which is often duplicated on paper and electronically. It is time consuming and often means that caring professionals cannot spend time with women and their families due to having computers or other devices, often outdated, fixed in a specific area of the room. Whilst data collection is a vital component of planning and recording, policy makers and data managers need to be included in an all-encompassing framework to ensure data sets interact effectively with each other rather than simply duplicating or fragmenting the manner in which practitioners record information.

We are all working at capacity now and doing our best to reduce stillbirth rates. Our aging workforce is constantly under pressure - they need support not to be pushed out of the profession by adding more workload.

Does not recognise the state of the current workforce and its fragility. The system for the most part is fragmented and staff are chronically over worked, understaffed, lack resources to provide basic fundamentals of care, working in very busy chaotic workplaces where women are not receiving the care midwives want to. The models in which midwives work and the funding they receive needs to be addressed, including newborns being included as patients. They are provided with care however as they are "unqualified newborns" receive no hours of care but do significantly contribute to a midwives workload in the postnatal setting.

Midwifery

Workforce planning enables the delivery of sustainable maternity services; remove barriers to privately practicing midwives, expand role of employed midwives within public maternity services, strengthen midwifery education (enabling midwifery graduates to prescribe, and be work ready to provide continuity of care for example), facilitate integration of midwifery workforce from primary setting to tertiary (facilitate hospital accreditation/credentialing for private practice midwives for example), strengthen ability of midwives to provide midwifery led (not obstetric led) care in all settings, promote birth centres and homebirth. Promote midwifery autonomy (an evidence based strategy); rather than positioning midwives as employees (or handmaidens) to GPs or obstetricians, promote their equality. If midwifery private practice is enable for instance then midwives may well work in partnership with GPs or obstetricians (on an equal footing) to deliver a comprehensive service to childbearing women (4.2: consider modes that involve midwives working with GPs and obstetric practitioners).

Multiple barriers to access by privately practising midwives should be addressed.

Retaining the midwifery workforce by improving working conditions is an issue.

There is no real recognition of the role of Privately Practicing Midwives as a viable option of care for women: this should be clearly delineated and incorporated throughout the body of the document where appropriate.

These principles do not mention Privately Practicing Midwives (PPM). They are an important part of Maternity services and such they should have barriers reduced to enable them to be more available for women that want them. They should have more rights to access local health services and insurance should be provided so that they can provide women with a home birth choice. Midwives should also be able to work to their full scope and should be able to specialise and become mental health midwives and Community postnatal midwives. There also needs to be a section on issues addressing rural/country areas including growing their own midwives, obstetricians and PPMs.

Privately practising midwives are not included in this strategy (in any way) – including barriers to private midwifery and utilising private midwives to address lack of workforce in rural/remote areas. This is certainly in the scope of this document – as there are currently multiple barriers to PPMs, which leads to lack of access for women.

Privately practising midwives should be included. There should be specific plans for monitoring the progress towards achieving goals.

Privately practising midwives and the multiple barriers for childbearing women to access their care needs to be included in document; the issue of insurance needs to be resolved; the requirement for a one-sided collaborative agreement needs to be removed; admitting rights for privately practising midwives needs to be added and vexatious reporting and bullying by health services and other health professionals need to be addressed.

Many midwifery graduates fail to obtain a position in a midwife graduate program. We need to improve our capacity to include new graduates and expand their clinical experiences to build the midwifery profession for the future. Whilst we have an 'aging midwifery workforce', many young and new midwives can't get jobs as a midwife. There are evidence gaps that prohibit the design and delivery of improved services - for example, data on staff qualification, number and skill mix, and the quality of collaboration in the team, would assist in designing improved care.

Midwives being able to work in their full scope, including expanded career pathways and private midwives. Pathways for midwives to refer and develop careers in perinatal mental health, child and family health, women's health, sexual and reproductive health, neonatal care to expand scope. Increase midwifery graduate opportunities (ability to work in caseload models in grad year). Privately practising midwives. Collaborative agreements. Lack of PII for intrapartum care at home. Inability to access health services (e.g. admitting rights except Queensland). Need to work 3 years prior to endorsement. Inability to access health services in most states/territories (e.g. admitting rights). Vexatious reporting and bullying by health services and other health professionals.

Midwives being able to work in their full scope, including expanded career pathways and private midwives.

Enabler: Support the expansion of the private midwifery model. This model is on the brink of extinction in South Australia, and under threat in other states. For mothers who are able to self-

fund continuity of care with a midwife, this should be an option which alleviates the public system.

Recognition of the importance of student midwife support in supporting workforce and ensuring ongoing provision of services: addressing the need for enhanced relationships between education providers and clinical partners to ensure supportive and optimum educational experiences, both theoretical and clinical. • Expanded career pathways that address need such as Mental health and Community services • Review of services within Maternity care models that encourage and support midwives working to full scope of practice and the provision of Maternity led care.

Midwives being able to work in their full scope, including expanded career pathways and private midwives. Pathways for midwives to refer and develop careers in perinatal mental health, child and family health, women's health, sexual and reproductive health, neonatal care to expand scope. Increase midwifery graduate opportunities (ability to work in caseload models in grad year) privately practising midwives

- Collaborative agreements
- Lack of PII for intrapartum care at home
- Inability to access health services (e.g. admitting rights except Queensland)
- Need to work 3 years prior to endorsement
- Inability to access health services in most states/territories (e.g. admitting rights)
- Vexatious reporting and bullying by health services and other health professionals

Ensure that new graduates are exposed to continuity of care models, and remove the barriers to midwives becoming participating midwives.

Enablers of Delivery of sustainable maternity service should include fostering a culture of 'creating a culture of interdisciplinary collaboration and communication' see 1.2 recognising the value of the midwifery workforce. I am a midwife, with over 25 years of full-time midwifery experience in public and private sectors and in different models of care, who now in private practice as an Endorsed Midwife providing homebirth is treated as a second class citizen - this is just not right, just or equitable. I and my colleagues have nowhere to go practicing in an environment of vexatious reporting and distain. I received notation as an eligible midwife 1/11/10 and in spite of many approaches still do not have access to any public hospital in Melbourne.

The workload of midwives needs to improve to prevent attrition. Value and respect midwives and they will stay with the profession.

The high rates of maternity leave amongst Midwifery staff make maintenance of a quality and sustainable workforce a challenge.

Midwifery workforce retention and the aging workforce in general.

Midwives are experiencing burnout at disastrous rates due to the obstetric violence and coercion towards women that they see every day. You can't workforce plan if you do not fix those problems.

Graduate midwives must be given access to working in midwifery continuity models of care. There is ample evidence that this is a better way for them to learn (See the work from Allison Cummins) and provides the workforce to work in this way for the future. There are opportunities

are not available in metro Adelaide but are increasing in other forward thinking health facilities. Midwives need to have professional indemnity insurance and this problem needs to be solved. Midwives working in Midwifery Group Practices in the health system need to be supported and valued by their health facilities. Unfortunately currently this is rarely the case with many midwives bullied and disrespected by colleagues including midwifery, medical and nursing. They need to have midwives with contemporary experience of midwifery practice in management positions to forge the way and assist in providing the high quality care they do. These models of care are not new. There have been MGPs in Australia for nearly 20 years and yet most are tolerated at best in health facilities with a lack of understanding by the mainly nursing managers of midwifery care and little exposure of newly graduated midwives to these great models of care.

Something that has been touched on is the recommendation for access to midwives within GP and obstetric care. I think this should be enforced, with a particular focus within the private maternity care system. Midwifery care is widely acknowledged be the most efficient maternity care for all childbearing women as well as being good value for money (WHO 2018). Furthermore with a focus to improve postnatal care, improve mental health support and increase satisfaction and wholistic wellbeing for childbearing women and their families, midwifery care is paramount with effective collaborative relationships with a multidisciplinary team. Access to midwifery care throughout the continuum of care regardless of risk and private/public system should be paramount to promote the optimal outcomes for all women and their families.

A lot more midwives and funding required to implement these changes, and ratios of midwives to Mum and baby to be considered. Offer more visa sponsored jobs for experienced overseas midwives if locally cannot be employed, make the process for hospitals to employ midwives smoother, and increase support as per AHPRA conditions to enable quality practitioners to be employed.

Staffing ratios

Staff shortages and no staff ratios assured.

Ratio's has not been covered or mentioned to be investigated.

Neonates need to be included in staffing ratios as does the acuity of women. One to one midwifery care during birth should be mandatory.

Ratio's with baby/babies

Recognition of workload for unqualified neonates, particularly those not admitted to NICU but requiring extra care e.g. late preterm on ward with mother

4.1.6 Organisation comments

Sustainability

The provision related to workforce must include reference to collaboration among care providers - e.g. Women receive care from a maternity care workforce that is responsive, skilled, competent, resources, collaborative, and reflects cultural diversity. The enablers should then extend to multi-disciplinary undergraduate education for trainee obstetricians and midwives, so they have an improved understanding of one another's expertise & training.

National CPFs in maternity - beyond the antenatal care guideline - is a priority. However there also needs to be greater thought given to how to support maternity services to implement the

necessary changes to achieve reliability in meeting evidence based guidelines. There is currently a significant lack of accountability for private obstetricians and midwives working within public hospitals, and there is also unwarranted variation among salaried staff. There is a rich body of scientific evidence on methods to improve the reliability of care for consumers, in the international literature. Australia needs to embrace these proven strategies and better support services to employ them. The NSW Clinical Excellence Commission, the CED in Qld Health and Safer Care Victoria are moving in this direction but progress is patchy and there is very limited expertise within health services to facilitate evidence based improvement work. This is a yawning gap. Outcomes for women and babies will not measurably improve until this gap in expertise and support is addressed.

While the strategic directions do acknowledge that more support is needed to build a sustainable and appropriate workforce, section 4.2 supporting the maternity care workforce could include more focus on increasing pathways towards perinatal mental health and psychiatry careers. In order to encourage a robust and effective maternity workforce, the RANZCP would support acknowledgement of the fact that workforce training is limited with no recognised pathways within psychiatry for specialist training in perinatal psychiatry.

Discussion around the benefits of “generalists” in medical workforces needs further consideration in order to avoid confusion with the benefits of primary health care workers in rural and regional settings. There is a recognised place for expert primary healthcare workers such as registered midwives to form the backbone of maternity care services in a number of different contexts. These midwives are not generalists, but experts in their recognised discipline.

Staffing ratios

The provision for 'consider the impact of 'unqualified neonates' on cost and workload is a welcome flag of an important issue but an insufficient commitment. The impact on cost and workload is already well understood. There is a need to urgently update the Commonwealth's regulations defining qualification of the neonate to facilitate newborn babies being kept with their mothers wherever possible, and provided clinically indicated care alongside the mother instead of only in a separated nursery cot.

Midwifery

Midwives being able to work in their full scope, including expanded career pathways and private midwives. Pathways for midwives to refer and develop careers in perinatal mental health, child and family health, women's health, sexual and reproductive health, neonatal care to expand scope. Increase midwifery graduate opportunities (ability to work in caseload models in grad year) Privately practising midwives -Collaborative agreements -Lack of PII for intrapartum care at home -Inability to access health services (e.g. admitting rights except for Queensland) -Need to work 3 years prior to endorsement - Inability to access health services in most states/territories (e.g. admitting rights) -Vexatious reporting and bullying by health services and other health professionals

4.2 Supporting safety and quality in maternity care

Figure 12 Responses to strategic direction: Evidence is used to develop, design and deliver services and for continuous quality improvement

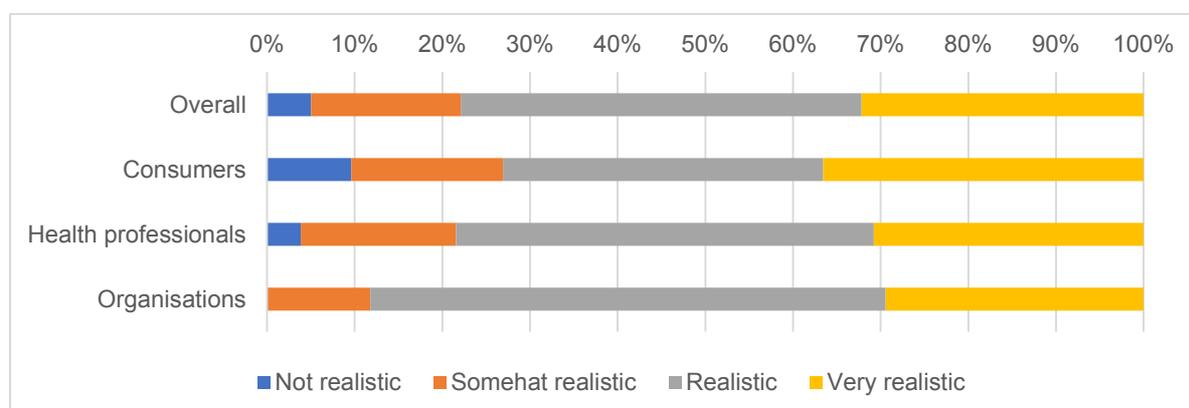
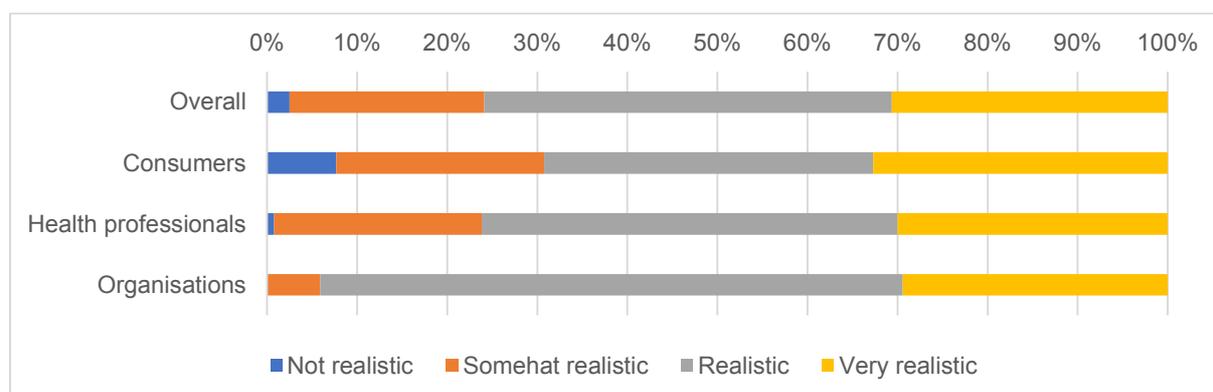


Figure 13 Responses to strategic direction: Service providers implement measures to reduce the rates of stillbirth



4.2.1 Consumer comments

Informed decision-making by women

Should read "Women receive information during pregnancy that is complete and based on current evidence" Again, the role of care providers is not to paternalistically decide what they will do and provide that care, no matter how evidence-based their decisions are. It is to provide the information to the woman that she needs to make her own informed decisions.

We need more honesty about childbirth.

Unfortunately during labour and prior to labour many women are not provided with actual informed risks of procedures, the most common thing we hear is "why didn't they tell me this could happen? I would have chosen another option" women are also not allowed options, if forceps can be used is there another option? Doctors need to allow women a choice and respect it and they should not perform any procedures against consent or without obtaining consent. Telling woman in labour that a procedure is safe when it actually carries significant risks to both mother and baby is happening all the time in our hospitals and it's not right.

Ensure women are supported in their rights to decline routine screenings, such as GBS and GDM.

Women should not need to beg for a caesarean if she chooses. Even in the public system.

I wonder if evidence and accountability should be included in the key principles. A woman should be able to trust that any and all maternity care by a registered health professional is guided by the accepted medical evidence and a shared responsibility for outcome.

Recognition throughout the document that (consistent with the values of "Choice" and "Respect"), it is the role of health professionals to provide information and recommendations on all risks and benefits of all alternative courses of action (including expectant management), not to make decisions or choices for women capable of making decisions. Women retain the right to provide informed consent or informed refusal, have this respected, and not be abused, bullied, coerced or abandoned as a result of exercising this right.

Basically the 'dead baby card' is thrown around too much to get women to do what the staff want them to do or what the guidelines tell them, or their superiors but in reality, death is always a possibility no matter what you do and many interventions are an attempt at reducing the risk. Not saving a life. Unless it is a true life or death situation.

Labour and birth

There is more to birth than safety. Women need more choices that are appropriate to their specific needs. This one size fits all approach is complete rubbish.

I feel like ultimately having a baby is about having a baby - not having a birth. Birth is one day - the outcome is forever. It may be my personal experiences that biases me but I feel like the consultation is overly focused on maternal satisfaction as the key outcome. While it's very important, and the ideal should be both a great outcome and a happy Mother and family - it should not be the only measure of successful maternity services.

The challenge is more around the decision makers in hospital facilities are often not Midwives nor do they care about midwifery. So trying to implement models of care it isn't a priority as they are too busy trying to sort out emergency department.

Best evidence - Hospital or health service policy need to reflect best current evidence, which also needs support from the current clinical staff AND higher management staff. It's great to have best evidence, but if upper management don't agree, then it's impossible to implement.

Review of induction rates occurring in hospitals - more research and again better education for women about the risks as well as benefits.

Birth is seen as a medical procedure rather than a physiological process. Yes there is risks but these shouldn't be assumed.

Does not address reducing the rate of intervention in pregnancy and birth

Don't make pain relief seem out of reach.

Don't make women beg for pain relief

Be respectful to the woman in front of you in the birth suite (I can't believe I need to add this point)

Under evidenced based care there is nothing nuanced about stopping non evidenced based practices.

Enforce a birth plan where women can refuse forceps in favour of a C-section, or vice versa

More support and options for women seeking a VBAC. More education about the benefits of VBAC as well as risks associated with repeat c-sec. Plenty of information of risks associated with VBAC - information is completely one sided (this is not informed consent)

Please stop having an emphasis on natural birth at all costs. I felt if I became pregnant again (no private health insurance). I would not have an option for a c section. This belief of the system influenced my poor decision not to have another baby. I needed someone at the hospital to sit down and talk. Let me ask questions like, if I had another baby can I have a c section. I am scared I am going to die next time. Women need caring, information and options.

Protect a woman's pelvic floor and function - make this a priority

Public OBs and midwives should be responsible for the damage they do. Part of the problem is they're not seeing the aftermath of women because once you've had the baby you're out - usually into the private sector to be repaired.

As a part of the Stillbirth community I see a very different set of values regarding birth and maternity services. In the Stillbirth and loss community women have a very strong focus on a healthy baby as the most important outcome of a birth. I'm also part of the Australasian Birth Trauma Association which is made up of women and professionals that have experienced or work with women that have had physical or psychological trauma or both as a result of giving birth. In this group many women are dealing with severe life limiting injuries and feel that they weren't given adequate information about the risks of giving birth vaginally. Not all, but many women in this group feel that ideology prioritising method of birth over outcome influenced their care for the worse. I would suggest that women that have had experiences that may act as a balance may be unable to speak out in a public consultation out of fear and embarrassment. Input from a diverse range of Australian women should be sought, even if this is done individually or privately. Personally I would not feel comfortable attending a public consultation as I have been treated very cruelly by some of the interest groups I know would be in attendance.

Ban forceps.

It should be noted that there is not always high quality scientific evidence available for every aspect of the design and delivery of services. For example, the only 9-12% of the UK RCOG guidelines were based on Grade A evidence (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4245184/>). Therefore, it is vital that this strategic direction is closely integrated and linked with the principles under the value of 3. Choice, especially the need for women's choices to be respected.

Reducing caesarean section rate

Reducing unnecessary screenings/tests

Intervention vs risk vs no action

I think there should be something stating that safety in terms of healthy, live, Mothers and babies should always be at the forefront of maternity services.

Make OBs accountable every time they do an episiotomy. Have them specify why it was needed.

Stillbirth

More focus on the needs during the birth of women who experience a stillbirth or a birth where a death of the baby is expected.

Measures to reduce the rates of stillbirth. I agree that this is an important area of focus. However, recent evidence highlights that if there is a narrow focus on reducing stillbirth only, without giving due regard to all maternal and foetal morbidity and mortality, the results of that focus can unintentionally cause harm ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31720-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31720-3/fulltext)). Ideally I would like to see a more balanced and wholistic strategic direction here, that would include reducing preventable stillbirths (we all want that), but not exclude reductions in other forms of maternal and neonatal morbidity and mortality. This could be accomplished by either editing the current strategic direction to replace the word "stillbirth" with "maternal and neonatal morbidity and mortality". Or by writing a separate strategic direction 4.3(c) Service providers implement measures to reduce the rates of maternal and neonatal morbidity and mortality. It is very important that this includes not only traditional measures of physical morbidity (maternal Grade 3/4 perineal tears, haemorrhage, infections etc., neonatal APGAR scores, respiratory issues, admissions to special care etc.) but also psychological morbidity, such as postnatal mental health symptoms (including depression, anxiety and trauma symptoms).

In the enablers around reducing the stillbirth rate, I think a more tempered approach is needed given the emerging nature of the evidence base in this area. Evidence is emerging that monitoring fetal movements may actually cause harm (see recent Lancet publication, DOI: 10.1016/S0140-6736(18)31720-3).

I didn't see any strategies that realistically alter stillbirth rates, without the obstetric reaction of increasing intervention.

I don't think reducing the rate of stillbirths is needed equally everywhere so no need to mention it specifically. Some places have reached the lowest numbers already

I think there is a lot of motivation around decreasing the rate of stillbirth, as there should be so perhaps this has the best opportunity for making some ground. However, the prospect of this search for a way to reduce stillbirth being about further intervening in the birth process is concerning.

To make clear what specific strategies are for reduction of still birth rates. For example, the routine induction of all women at 39 weeks would not be woman centred, could increase neonatal complications and would not necessarily reduce still birth rates as rates peak from 38 weeks. However midwifery continuity of care would likely improve still birth rates due to increased quality of antenatal care and increased communication and relationship between care provider and woman.

Care after the birth

Debrief about the birth so a woman can try to understand what has happened if it was traumatic.

Under the 'Safety' heading, more consideration needs to be given to women in the immediate postnatal period. Traumatic labours and birth injuries are often over looked or not considered in postnatal care.

4.2.2 Health professional comments

Comments on the principle

Need to add postnatal care in principle and enablers dot point 3 need to develop national policy/standards for continuum of pregnancy birth and PN

Comments on the strategic direction

Evidence is used to develop, design and deliver services and for continuous quality improvement

"Evidence is used to develop..." Will such evidence be trustworthy? Will it be based at least partly on the frontline experience of practitioners and not on indirect and spurious statistics?

Service providers implement measures to improve mental and physical health (morbidity (mood disorders and pelvic dysfunction; back pain) and mortality (suicide).

This strategic direction to be effective must include some targets that the strategy is measured against. How will this strategic direction address the over-medicalisation of pregnancy and birth and its long lasting effects?

Safety

In terms of Clinical safety.... Australian Commission on Safety and Quality in Health care published 16 of the top hospital acquired complications (2018). Of the 16 complications several relate to the maternity cohort. We have a lens on perinatal mental health (and rightly so, do we give enough attention to other complications? Health Care associated Infections, Surgical Complications requiring unplanned return to theatre, Venous Thromboembolism, Medication Complications, Persistent Incontinence, third and fourth degree perineal laceration during delivery, Neonatal birth trauma.

The document also misses the point that the health professional providing maternity care needs to also be the advocate for the health and wellbeing of the unborn baby so at all times safety of the mother and unborn child needs to take priority over the woman's choice.

Safety in Maternity care is vastly improved when the fear of litigation is removed from Maternity Care providers. Choices made by care providers change, and as a result women and therefore their babies enjoy better outcomes. Research again proves this. I believe this is the key to safety for Maternity services in Australia, and the key to improving our rates of caesarean section and morbidity and mortality rates.

Safety being an individually assessed matter. Medically/biologically safe may not be mentally or wholistically safe. Women need more space to determine what they find and to be their safest choice.

Safety must always be the number one priority and at time must override the woman's choice. Depends what type of evidence you plan to use to develop, design and deliver services. Premature labour is a risk for stillbirth. Consider including 'The whole nine months' in the Strategy. This program aims for babies to not be delivered prior to 38+1/2 weeks (unless there are medical indications).

Preconception care

Under this principle preconception care is mentioned but no real way forward to progress preconception care as a gold standard. If Australia wants to turn health outcomes around for women and babies this is the place to start.

Informed decision-making

If a woman makes a choice that isn't what the Obs wants, she often experiences resistance and 'bullying' tactics, without full explanation to follow expected routes.

Review of 'standard' testing and investigative processes with enhance information to women for improved decision making regarding accepting/declining testing.

Evidence is skewed to support hospital practice. Stillbirth measures are policed like bullying tactics, collaboration is one sided, Obs way or no way

Re Question four, and strategy (Lack of transparency — this also contributed to women not being sufficiently informed to be able to provide informed consent and failure to respect women and their wishes. Women should have access to data on health provider performance (including rates of interventions and woman satisfaction). Health professionals should use woman-friendly language when talking to women in labour and not be bullying or coercive). It's great that this is included: however "Health professionals should use....." in itself needs a strategy and be highly focused on how results will be obtained. Medical professionals simply do not receive education on how to present UNBIASED information including a view that is outside MEDICAL MODEL. This issue is HUGE. How can it be made a priority? Mandatory training in language for medical professionals?

Women can make decisions, but the reality is that bed blockage causes a lot of instrumental/C-Section births. If women had continuity and policies in hospitals were actually adhered to by Obstetric Staff, then we wouldn't have so much fear around birth. Women can make decisions, but they are constantly coerced, misinformed, physically assaulted and told "I am the doctor" as the reasoning. I don't think OBSTETRIC or MATERNITY CARE VIOLENCE has been addressed at all in these strategic directions, and so therefore it's very half-hearted saying that women will have evidence based decision making. Women should be the only ones making decisions in the birth room - but I only ever see that actually occur with Private Practice Midwives.

Women being cared for by Midwives providing continuity of care, who make decisions based on information provided to them by their care provider, do not then need doctors to interfere with the woman's labour environment to repeat these discussions. Respect each other as capable care providers and respect the choices made by women.

Fear mongering and extreme 'possibilities' are to be reportable crimes against women. These comments are not based on evidence but on subjective opinions of the so-called birth 'expert' and are harmful to the wellbeing of women and their unborn children (this has been shown through research).

Women are influenced by social media, their friends and others, the TV, more than evidenced based information. Coercive language about "risk" is more commonly used and we all use heuristic decision making tools not evidence based. The word Risk is heavily loaded and ensures compliance to one system of beliefs that women can't make their own choices about care provider, they can't make choices if there are in reality no choice.

Usage of decision making aids. More national resources around intervention. Currently our hospital develops consumer handouts or more often uses RANZCOG supplied handouts. We can do better. We can have better collaboration on information provision. Australia is a multi-cultural country. We need better resources for CALD women.

To provide women with evidenced-based choices there first needs to be agreement amongst care providers about what this looks like.

When women and their wishes are placed at the centre of the care plan and time is taken to explain rather than just thrust into their care good things will happen. Women need to feel support and cared for at every stage.

Absence of publicly known/publicised risks of elective operative birth that make it harder for women to opt for normal birth and influence the inordinate rate of C/S in private hospitals. Informed decision making is not occurring in these groups of educated and affluent women

Fear has no place in maternity service planning, provision or evaluation.

I feel strongly that women need to be informed of the risks of all types of delivery, not just surgical. We have good research that notes the risks for maternal pelvic health associated with forceps deliveries, yet it is being ignored. Women find out afterwards that there are significant risks to them with this particular mode of delivery and they are angry that they have not been informed and been able to make an informed decision during their birthing process. Each week I have another lady coming in for assessment, frustrated that they did not know enough about giving birth and their options and the associated risks before delivering their baby only to sustain a birth injury that has lifelong consequences. Some of these injuries can be prevented. They all should be treated to optimise the outcome.

Labour and birth

Listen to consumers. The model of care based needs to be based on salutogenic and primary health care principles promoting factors that support human health and well-being, rather than on factors that cause disease. The current strategy does not reflect the World Health Organisation's framework for quality of care for pregnant women and newborns published in May 2015. The framework breaks quality of care into two equal parts that influence each other:

- the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and
- the patient's experience of care (effective communication, respect and dignity, and emotional support), (WHO, 2015).

The current strategy does not honour the National Safety and Quality Health Care Standards that require respect for patient rights and engagement in their care, <https://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/>. Reducing unnecessary screenings/diagnostics, as well as protecting women's right to decline such interventions without penalty. The World Health Organisation (WHO) states - In normal birth there should be a valid reason to interfere with the natural process; 85% of births do not require interventions. As caesarean section rates rise towards 10% across a population, the number of maternal and newborn deaths decreases. When the rate goes above 10%, there is no evidence that mortality rates improve, (WHO, 2015). Therefore we need to work toward a target of 85% of births not requiring interventions and work toward a 15% total intervention rate for birth. Aim for spontaneous labour rate of 85%. Reducing rate of caesarean section, unnecessary

interventions, instrumental deliveries and birth injuries for mother and child. Adopt performance targets for care by a known midwife. National evidence-based guidelines for maternity care that identify preferred service provider. Develop a national standard for continuity of care. When a woman engages an obstetrician for their maternity care, they see the obstetrician often in their private rooms. Antenatally, the obstetrician monitors the progress of the pregnancy. The woman independently has to seek education on labour, birth, breastfeeding and parenting. When the woman presents to the hospital in labour, the midwife employed by the hospital provides care to the woman. If the labour progresses without complications, the obstetrician only appears when the baby is about to be born and the midwife steps aside. If the birth is without complications, the obstetrician departs and the midwife provides the post-delivery care and supports the woman to commence breastfeeding. Where is the continuity of care? Why are women deprived of comprehensive continuity of care? How is this value for money? Why does the healthcare system pay twice? Regrettably most women in Australia continue not to receive continuity of care. There has been an increase in access to continuity of midwifery care for women using public health services though it is relatively modest, increasing from approximately 2-5% in 2010 to approximately 8% in 2015 (Butt, 2015). Include Transition to Parenting Education in pre-birth and post birth education. Include a strategy to get the first birth right. One option is to promote the First Baby Campaign to enhance a woman's understanding of childbirth. Outcome data options

- Report breastfeeding rates at six weeks postpartum by clinician.
- Collect and report longitudinal data on the impact of preventable chronic disease for the woman and her child.
- Collect and report longitudinal data on the impact of shorter hospital stays for the woman and her child.
- Collect and report longitudinal data on the impact of shorter hospital stays on breastfeeding.
- Provide a mechanism to train and ensure competence all health professionals in the normal transition of pregnancy and natural normal birth.
- As part of the registration process incorporate a process for annual declaration of competency for normal transition of pregnancy and natural normal birth for all doctors and midwives.

This document does not address the rising issue of the over-medicalisation of pregnancy and childbirth, including the high rate of caesarean section, induction of labour and other interventions.

The ballooning induction of labour rates needs more emphasis.

Reducing rate of caesarean section and unnecessary intervention in antenatal, intrapartum and postnatal periods. Increase women's voice as central to policy development.

Urgent review of rising rates of intervention and caesarean section rates: review of health services/practitioners with rates above the WHO target of 15% intervention rate with the aim of implementing supportive strategies for reduction where appropriate and based on best practice and latest evidence.

Change has to happen before the current system is seen for what it currently, gender biased and paternalistic driven by cash rewards and outdated values and beliefs. If this does not happen quickly women will chose to free birth at home and place themselves in potential danger with untrained doula in attendance. Stop blaming women for the interventionalist style current

system, this is not risk adverse behaviours but based in outdated belief systems, not evidence based or informed. Women in 2018 should not be birthing their baby's in the lithotomy stirrups, flat on their backs resulting in a trauma, physical and mental. This is the current reality of birth for many and often the most vulnerable women.

The glaring omission is the service gap concerning women who experience acute complications associated with pregnancy. For example, women who experience severe preeclampsia or massive postpartum haemorrhage are often separated from their baby, cared for by non-midwives, receive fragmented care and receive no supported follow-up about their complication and experience. The childbearing population has more co-morbidities than in the past and consequently has more complex health service needs. Women should have access to continuity of a midwife even if she has a high-risk clinical condition and is under the primary care of a specialist obstetrician. For example, a woman with severe congenital heart disease who becomes pregnant, should still have access to a consistent midwifery carer throughout her antenatal period, labour and birth, and postnatal care.

This document does not address the rising issue of the over-medicalisation of pregnancy and childbirth, including the high rate of caesarean section, induction of labour and other interventions.

There are still issues where things like water birth must be supported by all care providers, however it seems the providers support it under duress and absolutely do not promote it as an equally safe method of birth despite research and literature supporting this. In addition women are often held ransom by service policy and procedure. An increasingly apparent problem, for example is a women not wanting to have an active management of the 3rd stage having to sign a non-standard management plan, which should really be an opt in and consent process rather than an informed refusal and negotiate out of process.

Hold practitioners and the system accountable to ensure women are offered VBAC and breech birth to reduce the impacts of high C/S rate. More detail around PII for home birth midwives and access and provision of publicly funded home birth models for all women geographically and across socio-economic spectrum.

Hospital births carry risks, such as increased risk of infection and higher rates of “unnecessary” medical interventions. Women need to have access to professional support both in their homes and in birth centres that are not attached to hospitals.

For real reform - listen to the 1 in 10 women walking out of their birth experiences traumatised by the current policy driven care model. People before profits please!

I am answering this survey as a consumer - however I am also a registered nurse currently working in the public system. My labour and delivery was the worst experience of my life. I was physically and emotionally traumatized. The staff were under resourced and poorly educated on the adverse outcomes I experienced as part of my labour and delivery. I believe that it is a midwifery cultural issue as well as a systems failure. I did not feel like I was advocated for at any stage in my delivery and post-partum period. There is a lot of focus on a healthy baby but barely any on a healthy mother. I have never treated any of my patients as a registered nurse in the way I was treated by both the medical and maternity staff. I hope for future mothers there are some major changes made.

Controlling excessive rates of C/S in private hospitals.

Education of all maternity workforce on the necessity for privacy during labour and birth. Restricting the number of caregivers to appropriate minimum during labour and birth.

Care of complex women in hospitals within a birthing context. Many women feel disempowered due to complexities in their birth that require invasive and continuous monitoring. This eliminates many birth choices that women value such as access to water immersion in labour and simple mobility. We need to develop and support services to provide options for continuous monitoring that may affect financial outcomes but will yield enormous patient experience outcomes.

It is common sense to avoid unnecessary interventions currently unchallenged in the institutional systems. It is common sense to reduce stillbirth whenever possible, however, it is equally important to realise that there is no guarantee that there will always be a perfect outcome.

It is contradictory to focus on both choice and autonomy AND reducing intervention rates, as many women request (and evidence supports) term induction or primary c section. Choice, auto only, women's rights and experience outcomes should be our performance indicators, C-section and induction rates are far less relevant.

Including the WHO target of 15% procedural intervention as a goal is an unrealistic aim in the Australian health care setting **[NB this refers to a comment from the first round of consultation]**. The target refers to the minimum intervention rates supported by health care resources to minimise severe adverse maternal and neonatal outcomes. It does not refer to optimal intervention rates which vary according to community expectations and demographic profiles. Optimal intervention rates remain controversial based on available evidence. E.g. current research increasingly suggests optimal labour induction rates before 41 weeks with respect to neonatal outcome in developed country settings are higher than that suggested by WHO. Optimal intervention rates will change over time as population profiles change. E.g. as pregnant women cohorts become older and women become more obese on average, it is likely that optimal caesarean section rates will be higher than where there are younger, slimmer women with larger family size aspirations.

'Facilities to labour in water are available in hospitals' on page 19 **[NB this refers to a comment from the first round of consultation]**. I work in a country hospital. For a long time, we have only been able to let women labour in the bath, and get out of the bath for 2nd stage, as per Country Health SA guidelines/policy. Now, it seems, we are being told that women are no longer allowed to use the bath in labour and the bath is to be removed from our hospital!!! This is not an evidence based decision, and will affect women's choices in labour, making them drive further to find a service that will allow them to labour in water. This kind of decision making has to stop.

Ban forceps. How has this not happened in 2018?

Acknowledging the importance of care that is 'safe' for the woman in reducing birth trauma

I would like to see a clinical care guideline on Delayed Cord Clamping with corresponding mandatory educational package.

Improve women's ability to birth outside hospitals (i.e. home and standalone birth centres)

Research needs to be undertaken around whether maternity care models and staff working within those models have an understanding of how to make reasonable adjustment to meet the needs of women with various disabilities. Audits of maternity services needs to occur to ensure the physical environment, the policies, staff training and disability cultural awareness are consistent and meet the needs of this group of women.

Stillbirth

"...reduce the rates of stillbirth" At least rates of stillbirth are easily measurable! What will be harder to show is what link there actually is between the measures implemented and any improvement that may be noted.

Implementing measures to reduce still birth rates will inevitably increase intervention rates, as discussed earlier, the intervention rate is the least important measure, neonatal outcomes, maternal trauma and satisfactions scores are paramount.

While stillbirth rates have not decreased over the last decade, the poor autopsy rate and poor placental histology rate must be addressed before we can understand the high rate of stillbirth of undetermined cause in Australia.

Continuity of care models reducing the stillbirth rate, need to invest in and promote these models.

Care after the birth

Reduced workload on postnatal wards to allow full breastfeeding help and postnatal recovery. Currently midwives do not have enough time to provide adequate care due to allocation of women to midwife. Staff providing antenatal, labour and postnatal care should be midwives, not nurses or HCAs or Maternity Assistants; only midwives have the full education to provide midwifery care.

BFHI should be mandatory in all hospitals.

Staffing ratios

Safety Principle should have an extra principle such as: Principle: Safe ratios of Midwife to Woman and baby/babies with particular complex needs i.e. mental health, comorbidity, after childbirth life-threatening complications, management of postpartum sepsis etc. Strategic direction: Jurisdiction address the ratio's to receive safer and higher quality care for both mother with qualified and unqualified babies. Rationale: Mother and baby are treated as one individual and are receive to safe and high quality of care in postpartum. Enablers: An independent assessment of the laws to meet the changing postpartum needs and complexities to deliver safer and quality care is in demand throughout Australia's Maternity. Improve ratios to ensure Midwives can devote more time with medication regimes, observations for medical reviews and perform tests/preventive measures requested by Obstetrics.

Governance of maternity settings often compromises maternity care. Hospital Boards need to be held accountable for staffing ratios, unacceptable birth interventions, not retaining the midwifery workforce and consumer feedback after the postnatal period. How payment for maternity services is determined also needs to be considered for safety. Over servicing to generate income is not safe.

Evidence-based care

National evidence based, current and reliable guidelines for care: pregnancy, birth and postnatal for consistency of care for all women regardless of location, health provider and health service.

Data collection

"Continue reporting on National Core Maternity Indicators to support continual improvement in the quality of maternity services." Enabler: Look to international counterparts and implement sets such as the ICHOM standard set to allow for international benchmarking, as well as national.

National clinical guidelines for antenatal, intrapartum and postnatal care

4.2.3 Organisation comments

Preconception care

The enabler to 'Promote preconception health and convey risks of smoking, alcohol and substance use in pregnancy and the risks associated with obesity, diabetes for pregnant women and babies' should be broken into a few components. It is not clear if this enabler only refers to preconception health and conveying the risks during that time period.' It is important that the risks of smoking, alcohol and substance use are conveyed to women during preconception, during pregnancy and during the postnatal period, including women who are breastfeeding and may consider drinking. More detail is needed within this enabler to ensure that maternity care providers are trained on the risks of smoking, alcohol and substance use in pregnancy. Additionally all women need to be routinely screening for these risk factors, that this data is recorded with the woman's and child's health record and that appropriate, evidence-based advice is provided to women about the risks of these actions.

Labour and birth

Does not address over servicing by medical staff.

Reducing rate of caesarean section and unnecessary interventions. Reducing unnecessary screenings/diagnostics, as well as protecting women's right to decline such interventions without penalty. -Adopt and work toward the WHO target of 85% of births not requiring interventions and work toward a 15% total intervention rate for birth. -Aim for spontaneous labour rate of 85%. Reduce caesarean rate, instrumental deliveries and birth injuries. -Adopt performance targets for care by a known midwife. -National evidence-based postnatal care guidelines. -National standards for antenatal education. -National Pregnancy Care Guidelines need expanding and reviewing (e.g. bleeding in pregnancy) -Involve women in this, where is the consumer voice in this section? -Develop a national Handheld Pregnancy record -What is better monitoring in labour for stillbirth? CTG does not reduce intrapartum fetal death and increases rates of caesarean section. -Need for support services for staff who care for bereaved mothers and families. For reduction of stillbirth rates -Midwifery continuity of care models -Addressing increased rate of SB amongst Aboriginal and Torres Strait Islander women, CALD women, vulnerable women, women experiencing domestic violence -Public health around smoking - Alcohol in pregnancy.

Stillbirth

It is important that the enablers within the strategic direction on stillbirth 'Service providers implement measures to reduce the rates of stillbirth' recognise the links between stillbirth and alcohol use antenatally. An enabler could be that "service providers give evidence-based advice to pregnant women about the various modifiable risk factors such alcohol and other substance use that can increase the risk of stillbirth and the actions that pregnant women can take to mitigate and ameliorate these risk factors.

Reducing Australia's rate of stillbirth is a laudable and important aim. However care needs to be taken in how this is done. With misinformation currently rife in social media, there is a risk that many more tens of thousands of women will receive significant obstetric interventions in their pregnancies - which themselves carry risks - without successfully reducing the rate of stillbirths. Hasten slowly in this space.

Reduction of stillbirth rates is an important public health issue. The evidence around prevention of stillbirth through midwifery Continuity of Care models should be acknowledged, as should the need to facilitate appropriate bereavement care for women and families. There is a danger that close attention to reduction of stillbirth generates a response based on increased medical intervention alone, without due consideration of the complexity of the aetiology of pregnancy loss.

There needs to be a balance on the focus on stillbirth. Some stillbirths are preventable, some are not. The associated economic and social impact of birth in Australia are poorly documented, resulting in an under-estimation of the impact of birth and its impact on future health costs and productivity. There is a need to develop a template for and undertake a study to identify the whole of life costs and the loss to productivity associated with birth outcomes so as to better understand the economic and societal burden of birth outcomes; through estimating the economic impact of birth by quantifying the direct and indirect costs and describing the intangible costs of birth.

Incorporate the latest evidence on impact of measures aimed at reducing stillbirth - no difference in outcomes and increased neonatal deaths in treatment arm. Incorporate Aboriginal Maternity health Worker models of care for rural and remote in partnership with telehealth and outreach clinical by Obstetric doctors and midwives. Expand 19(2) exemption sites to include those where no obstetric doctors to allow midwifery support care. Create a legislated pathway to allow Endorsed Midwives to admit uninsured low risk women to public hospitals without need for collaboration with Obstetric doctor unless conditions requiring referral to obstetric care develop. The current model which only allows Endorsed Midwife to admit privately insured patients is discriminatory against the lowest socio-economic women who have the highest need to access care and anti-competitive. National electronic maternity record accessible by consumer, all care providers - public, private, hospital, community, diagnostics and imaging.

Guidelines on labour and birth

While a commitment to evidence-based care is frequently touted in healthcare circles as a driver for improvement, the development of an evidence-based National Guideline for Labour and Birth has the potential to create a consistent standard of care for the national maternity care system.

Developing nationally consistent, evidence based guidelines for labour and birth is essential, and the provision should stipulate a minimum list of conditions that will be covered and who would be responsible for developing them. At a minimum WHA recommends such guidelines cover: - Induction of labour: Why, who, when and how - Keeping birth normal - Intrapartum Care for Healthy Women & Babies - Preterm Labour and Birth - Caesarean Section - Supporting women in their next birth after caesarean section (NBAC).

National clinical guidelines (as per NICE) - also available via an app National evidence based consumer information - also available via an app National register of locally available maternity care (all local options), newborn services and related support services. - Available via an app

There should be a focus on the development of intrapartum care guidelines that are aimed at reducing unnecessary interventions in birth.

Family violence

The enablers within 4.3 should including preventing and supporting women affected by family violence.

Social disadvantage

Social disadvantage should also be specifically cited in section 4.3 "Supporting safety and quality in maternity care."

5 ASPECTS OF MATERNITY CARE NOT COVERED IN THE STRATEGIC DIRECTIONS

5.1 Consumer responses

5.1.1 *Specific population groups*

The social gradient in health is well established. Therefore recognition and specific attention also needs to be made to meeting the needs of socioeconomically disadvantaged women.

5.1.2 *Birth as a normal event*

Consenting for a physiological process is ridiculous.

Would be good to explicitly state that pregnancy and birth is a normal physiological process, not an illness.

I think we have to start by realising women as responsible experts of their own birth. For so long, we have taken the responsibility away from women and are now at a point where women no longer feel they have any control over the care they receive - but are told what they 'have' to do, what they are 'allowed' to do. Fear mongering and extreme 'possibilities' are regularly brought to the antenatal consultations and often, these comments are not based on evidence but on subjective opinions of the so-called birth 'expert'.

5.1.3 *Prenatal screening*

There is not enough up to date info for prenatal screening

5.1.4 *Antenatal education*

The maternity service sector is the perfect space for targeted consumer education programs because it contains a high volume of patients with similar needs, regardless of birth setting or model of care.

Support must be given in this document for expanding women's access to high quality, evidence-based antenatal education. These services should not be provided (or not only provided) by maternity services directly, because doing so risks their content being skewed towards preparing women for compliance with hospital policies ('expectation management'). The focus of antenatal education should be on informed decision making, and should provide women with a seamless transition to social support in the postnatal period.

5.1.5 *Homebirth*

Encourage low risk women to have a homebirth and unconditionally support midwives who provide this service.

Home birth and support for the private midwifery workforce is not addressed. Women do not have adequate access to birth at home, and this is largely because private midwifery care is under-insured, underfunded and under-supported by the medical model. Midwives are being inappropriately reported to AHPRA by hospital staff when acting within their scope. Many cannot take the risk of providing intrapartum services as there is no professional indemnity insurance product which covers these services. Public hospital home birth programs still require that women engage with an obstetric model of care, as most (all?) require 'approval' by an

obstetrician before the home birth can go ahead. This is coercive nonsense, not actual choice. Obstetric care provides poor maternal outcomes and system reforms need to remove obstetric input from the care of low-risk women entirely. Women of higher risk levels should be offered medical care but should not be forced to engage with it. Birth is not a medical event. Obstetricians do not have a place in normal birth; the US has >90% obstetric care and some of the worst maternal morbidity and mortality rates in the developed world. Australia's comparatively positive outcomes are not because of obstetric care, but in spite of it.

Home birth funded publicly and privately and if this will be promoted as an option without fear based opinions.

Home birth. Support for private midwifery practice. Actual birthing on country programs that do not require Aboriginal women to travel.

Homebirth is consistently shown to be at least as safe as low risks births that occur in hospitals. Why aren't more hospitals introducing homebirth programs? Women need more choices for natural birth if that is what they want.

Homebirth with a privately practising midwife needs to be specifically listed here- a solution to the intrapartum insurance conundrum. Increasing the PPM workforce - creating more opportunity for midwifery students to experience birth at home through both public and private models so that they can gain insight and consider whether they would prefer to attend women at home in their career pathway.

More direct information relating to homebirth

More support for home birthing and the inclusion of private doulas and midwives

Where are the strategies relating to homebirth, which are so prominently featured in the prior consultation feedback, in the draft?

Women want easy access to homebirth.

Women want more privately practising midwives (PPM).

Women want publicly funded homebirths.

Women want to be able to access homebirths through hospitals without the fear of being rejected very late in pregnancy

5.1.6 Funding/insurance

The document does not mention place of birth as an important element of maternity care. Maternity care is a primary care intervention that is often delivered in an acute care setting; not surprising then that we medicalise women's experiences and have tertiary type outcomes. There is a structural divide between primary (e.g. MBS; commonwealth) and tertiary (Hospital; State based) services which needs to be addressed to better integrate care provision to childbearing women.

There needs to be a federal reform with a woman in charge of her own Medicare funded care and less rubbish for private practicing midwives to go through to enable more equitable choice for more women.

I think the principles are great, however my concern is that the current lack of resources in the health system won't allow for these changes to take place, when they are so desperately needed.

We need to support a 'no-blame' model of care like NZ and start seeking advice from women rather than insurance companies when it comes to childbearing. So many medical/obstetrical providers are locked into litigation cycles and as a result, they provide fear-based treatment, screening, assessment and risk allocation rather than care. They are scaring women into submission - or even worse, scaring women so that they are left unable to birth without interventions.

Liability of Hospitals, Staff and Consultants needs to be limited both in time and competence. The current high level risk for future Professional Competence Action needs to be addressed and time constraints tightened and professional competence reviewed and accepted by a team of professional consultants prior to a claim being able to proceed. This would encourage more people to pursue careers in the field.

5.1.7 Other topics

Let a woman choose her birth, ensure staff are made aware when shift changes occur.

More focus on improving access to primary maternity care given for all women, this is evidence based best available care for women of all risk. Women also need to be allowed to make decisions about their own care.

Offer care beyond having the baby. Aftercare for mothers in this country is dismal.

The advantages listed under the 'midwifery units or birth centres' are far more applicable to homebirth as well as many others.

Transparency in community consultation for all of the above.

Transparency of key stakeholders.

Transparency of ownership.

Women in control of the funding for their maternity care.

Women to be able to have real choice in care - not to just fit into guidelines.

It's not that they're not covered, it's just that although maternity providers may have great intentions, their aims seem to quickly shift from being woman centred to being maternity provider centred.

I think improving access to care in early pregnancy should be considered.

Honesty and transparency in available care.

I think safe care / safe services needs to be more realistically addressed in the document.

Furthermore, providing women with the choice to have a chaperone or advocate present at times throughout their maternity care would be beneficial. Many women are able to make informed decisions but have trouble communicating this to their care provider for various reasons. Currently there are hospitals in Australia who have Maternity Choices Australia staff at hand. Ideally, this should be available to all women.

Miscarriage care - access to maternity ward, rather than being left in emergency or having to wait hours and hours to get a scan or see a midwife or OB.

I think that the maternal health books we receive after having a baby should have packs that can be added if you have a baby born with a disability. The packs should contain correct growth charts for each diagnosis, contact info for support groups and organisations, etc. This would take the pressure off trying to source the information yourself.

I would suggest as a part of all care for women the ready access to a community service workers that work with and alongside OBs, Midwives and other maternal health staff to function as an advocates/supporters for consumers through all stages including during bereavement birth and neonates who are admitted into the SCN and NICUs. A dedicated community maternal service worker group whom consumers will have contact with throughout their antenatal period and then the postnatal period or when consumers are admitted to hospital. This would work to elevate some pressure from midwives while they continue to provide amazing medical care knowing that the women they support are also supported by others also. I feel this group could also facilitate feedback and assist in ensuring the stated measures are adhered to.

Antenatal care including physiotherapy, chiropractic care, mental health and gynaecological care.

Women should not be bullied into breastfeeding if they cannot. "Breast is best" is old news and contributes to PND. Fed is best. Support women, don't bully them.

Concept in Victoria where they have Maternal Child and Family health workers is a far more workable and woman centred model, and it is seen as a profession. In NSW CFHN are seen as just weighing babies even after all these years and staff that work in the nursery are just seen as they only feed the babies so when there is a roster deficit in the Hospital it can be filled by one of these staff members.

Cost of ultrasound scans is prohibitive for some. I have seen women commenting online that they plan to skip the morphology scan due to the cost.

Decolonise the system and create a system that is women led that is inclusive of non-western based medical practices with much more focus on the postnatal/postpartum period and we'll be onto something special but doing the same thing we've been doing and you have to wonder why there are so many wider community issues as a whole.

Easy access to physiotherapy and actually explain to woman what prolapses are and how they occur. (Most woman have no idea about this until they are unfortunately living with it).

Explanation and transparency of funding models and values.

5.2 Health professional responses

5.2.1 *Birth as a normal event*

Women as responsible experts of their own birth.

Recognising the wellness model of pregnancy, labour and birth and the postpartum period as being normal aspects of childbirth but also a significant physiological event for women. Respecting women's choices and the importance of informed consent Collaboration with all care providers for women ensuring communication and respect between care providers is maintained.

Childbearing is a normal, significant physiological, psychological, emotional and spiritual event for a woman. The importance of respecting a woman's intuition and ways of knowing.

Recognising pregnancy and childbirth as a normal, significant physiological event for women. Recognising a woman's intuition and ways of knowing. Lack of respect from health professionals and health facilities towards women (e.g. bullying, coercion, patronising, ignoring). Women's choices must be respected. It is completely unacceptable to bully or coerce women into accepting care. Suggested enablers. Mandate representation of consumers on public policy decision making-bodies. Co-design services with women, let them dictate what is appropriate, safe and desirable for themselves. PREMs and PROMS require development WITH women/consumers, and would require ongoing funding and management. There is currently no validated tool for measuring women's experiences. Why not adopt the Universal Rights of the Childbearing Woman?

Pregnancy and childbirth need to be recognised as normal, significant physiological events for women. Women at times are bullied and coerced, being patronised and ignored. - their choices need to be respected and under no circumstance should they be coerced by any health practitioner Suggested enablers: - consumer representation on public policy decisions -women as consumers of services co-design and decide what they deem is appropriate, desirable and safe.

5.2.2 Specific population groups

The specific needs of people from the LGBTQI community need to be recognised by the Australian maternity care framework. Consideration needs to be given to the most vulnerable members of our community having access to midwife continuity models.

I know these strategic directions cover ATSI and CALD women, I'm just wondering if women outside of these groups also need some strategic direction-socially, educationally and economically challenged women, women from a DV background, teenage pregnancies, recreational drugs and alcohol abuse. I know there is a lot of support for these women once they are assessed, but does there need to be a strategic plan to address these issues which may improve outcomes overall?

5.2.3 Preconception care

The acknowledgement of pre conceptual care is very encouraging. It is difficult to argue for the development of services such as these when resources are stretched to support existing services. Good forward planning and proactive care will reduce the burden on antenatal, intra partum and post-partum care.

Access to pre-conception education for women.

Pre-conception care information. Most women make the choice once they find out they're pregnant and speak to a GP. Having that information accessible and being aware it exists improves the chances a woman makes an informed choice.

Pre-conception care is not acknowledged. Affording women a true choice of maternity care providers means they need to know what their options are independent of what a GP suggests. Family Planning education, in particular education on birth spacing and contraceptive choices between children is part of the midwife scope of practice that is afford minimal training and is under-utilised in practice.

Preconception is such a potential area of improvement. Yes, school age children, education re conception, pregnancy and birth, to assist with normalising childbirth. Not secret business.

5.2.4 Genetic health care

In addition to the current content it may be timely to consider incorporating genetic health care into the Strategic Directions. There are several areas where better integration of genetic health care with Australian Maternity Services can improve the health of women and children, especially but not limited to: respectful and holistic care, stillbirth, congenital anomalies, mental health, supporting cultural safety for Aboriginal and Torres Strait Islander health care; supporting informed choice and improving collaboration between health professionals. Clinical genetic health care traverses the lifespan and has particular importance to improving maternity services across the pre-pregnancy period, pregnancy, childbirth and the postnatal period. This importance continues to expand with the advent of new technologies, and in particular, and with the immediate clinical relevance to maternity care, with their increasing clinical implementation as part of health care pathways. This is relevant to patients and families and therefore also to the maternity services workforce and its training. Current and expanding applications include: the diagnosis of the causes of stillbirth and congenital anomalies, either alone or in isolation; screening in the forms of aspects of newborn screening, non-invasive prenatal screening and preconception carrier screening; pharmacogenomics with applications to for instance prescribing of anticoagulant therapies and treatments for mental health. Each of these applications, and the manner in which they are delivered, have the ability to significantly reduce mental health burden, or to create it. That is each of these approaches requires skilled counselling, through an educated and empowered workforce for informed choice and improved care. This includes for quaternary prevention that is avoiding over medicalisation of women, their partners, their pregnancies and their children. In recent years in clinical service in the public health system, of at least one jurisdiction, we have seen a tripling, and then further increase, of the ability to identify the underlying genetic cause of congenital anomalies. This is particularly when they occur in combination - as either a group of congenital anomalies, or congenital anomalies associated with other attributes such as intellectual disability or dysmorphism. The improvements in these domains are consistent with the knowledge that congenital anomalies are a large class of mainly rare diseases. Most rare diseases have a genetic cause, and with increasing clinical implementation of new genetic technologies, we are increasingly confirming that rare genetic diseases cause many congenital anomalies and stillbirths. A definitive diagnosis of the cause of congenital anomaly and stillbirth provides for clear clinical pathways for mothers, their partners and in the case of those live born with congenital anomalies, themselves. Confirming a definitive diagnosis also significantly reduces the mental health burden on women, and their partners, through reduced uncertainty and the opportunity to reduce isolation through connection with others in similar circumstances. The clarity through an accurate definitive diagnosis also supports improved transition of care in the postnatal period, including to regional and remote areas. Similarly, the accurate diagnosis of the cause of congenital anomaly during the pregnancy can reduce uncertainty during the pregnancy, with all the benefits that brings. Experience of clinical genetic testing in congenital anomaly and stillbirth shows that in the majority of instances in which a genetic cause is found, the recurrence risk in another pregnancy is confirmed to be low, reducing mental anguish. In the settings in which the recurrence risk is higher a genetic diagnosis offers the possibility of otherwise unavailable options, such as pre-implantation and prenatal genetic diagnosis, should a couple wish to pursue these in further pregnancies. The approach to genetic diagnosis and health care provision requires a multi-disciplinary approach that breaks down siloes, especially in maternity services. Because of the importance of genetic health care for Aboriginal and Torres Strait Islander (ATSI) people, state services and national

bodies are also investing in improving genetic health care delivery for ATSI peoples. Of particular relevance, to accuracy of healthcare data and the maternity health care provision planning dependent on that data, is the importance of congenital anomaly registers, which in turn can inform national perinatal data collections and empower data linkage. For instance, the data from these registers has delivered interventions (mandatory folic acid supplementation) that have reduced neural tube defects by 75% in aboriginal women and 50 % in teenage mothers, as well as approximately 20% across all women. Enhancing linkages of maternity care with such registers provides a critical foundation to support improved maternity care service planning. We are now also seeing further insights into the genetic causation of disorders that historically were thought to be largely attributable to obstetric complications or non-genetic causes. For instance, recent studies are indicating that rare genetic disorders may account for approximately 30% of cerebral palsy, or at least some categories of cerebral palsy. Rare diseases are cumulatively common, affecting 6-8% of the population and are associated with a high burden on women, their families and health system. For instance, just looking at a subset of less than 500, of the estimated 7000, rare diseases in Western Australia showed that more than 10% of hospital inpatient expenditure was attributable all to these diseases. In WA alone, that accounted for approximately \$400 million per annum. Of note, the largest single class of rare diseases in these studies was developmental anomalies, which in Western Australia includes congenital anomalies affecting live and stillborns. Congenital anomalies also account for approximately 30% of hospital inpatient expenditure in the 1st year of life. There are clear opportunities to improve patient journeys, family experiences and to provide for health system savings, through improved diagnosis and care of rare genetic conditions and their impacts on stillbirth and congenital anomalies. Also of particular relevance to health care data for care provision and planning is accurate disease coding. The current health coding in Australia uses the ICD 10-AM system. This only has a specific code for 3.5% of rare diseases, meaning 97.5% are coded as "other" which prohibits best care provision and health system planning. This is particularly relevant to maternity services as many women using these services have rare diseases and many rare genetic diseases (and some rare non-genetic) are causes of stillbirth and congenital anomaly. It is therefore critical that rare diseases are coded more comprehensively in maternity services. To address this, at least one Australian jurisdiction is incorporating rare diseases coding (Orphacodes) into health data sets, however a national approach is required so that Women in all jurisdictions equitably benefit. In summary, there are multiple and deep opportunities for genetic health care to improve maternity services, if genetic health care is not included within the Strategic Directions then maternity services run the risk of being less able to capitalise on these opportunities when compared to other health care domains such as paediatrics and adult medicine.

5.2.5 Antenatal education

Noted that no mention is made of parent craft education which has traditionally been used to deliver information to women around decision making.

There is mention of the need for both holistic and continuous maternity health care, however there is no mention/consideration of the need to properly prepare and educate expectant mothers (and fathers) on all that comes with birth AND, postnatal recovery AND parenthood. If there were more of a well-rounded holistic approach to perinatal care, providers would take into account the need for prevention rather than cure (re: mental health issues). In other words if expectant couples are properly educated and upskilled for their labour and their transition to early parenthood there would be much less of a shock to the system for so many parents. This would facilitate improved parent-infant bonding, improved relationship satisfaction and improved mental health and overall adjustment to parenthood. This is an area that The Parents Village in

Sydney are passionate about shifting, and was the driver for our creation of the Birthing the Parent prenatal program which prepares and upskills for parenthood.

Improving the knowledge and awareness of the population as a whole to become informed of pregnancy, childbirth and the transition to parenthood. By this I mean public awareness campaigns, structured education for children and teenagers (as age appropriate), normalisation of maternity issues (healthy pregnancy, normal birth, breastfeeding, newborn behaviour). It is too difficult to re-educate women and their families about these issues when they are already pregnant.

Antenatal education for women – including mental health.

Antenatal education is undervalued and has significant potential. There could be generous Medicare rebates for group education and telehealth education. There could be funding for training of educators and for research, particularly around active birth.

Antenatal education of a high standard is an achievable strategy that would support women.

Improved antenatal education opportunities.

The other aspect not mentioned clearly is antenatal education. This is a current gap filled to various extents by state run services, private companies etc. Sourcing antenatal education is often quite self-directed from women. There is little feedback to GPs as to what education and resources have been provided to women in hospitals.

5.2.6 Midwifery and home birth

Restore references to Midwifery Group Practice in the public hospital system as a model for delivering continuity of midwifery care to women with proven benefits. While it is good to acknowledge women's right to choose continuity of care from a GP or private Obstetrician, it is access to the choice of continuity of care by a known midwife that is the gap in the current system. Nearly all MGP services in public hospitals across Australia have more women wanting to access the service than they have places available. There is also non-evidence based restrictions placed on women's access in some services - e.g. only low risk uncomplicated pregnancies. Women with medical or obstetric risk factors have been shown to benefit even more than healthy low risk women from the relationship built with a midwife over the maternity care episode, especially when this relationship is supported by consultant obstetricians and/or Maternal Fetal Medicine Specialists, as the needs of the woman and/or her baby dictate. A general commitment to women having "improved access to continuity of care with the care provider of their choice" does not adequately target the focus to where the gap lies.

Some models of care provide very limited post-natal follow up combined with early discharge. Team, caseload and independent midwifery care usually provide a much longer follow up and are able to refer to further care as required. There is often a delay in getting help around mental health issues, an area frequently under resourced.

The Role of the Midwife according to the International Definition of a Midwife is absent. Where is the Midwife? Why is the Midwife assumed to be under the control of Medicine and Nursing? Midwifery is a Profession in its own Right; recognition of this is essential.

The conservation of and acknowledgement of the importance of Midwives and midwifery work with woman.

More options for birthing women outside of the public birthing units, more home birthing options.

Women should be provided with access to a midwife if accessing private obstetric care. Women should not be referred to an obstetrician for care as a first option in the absence of any deviations from normal.

Needs more support and planning for Homebirth. There is great evidence to support the safety of Homebirth. It's good for outcomes. It meets many women's needs. It's cost saving. But it has been slandered by the medical profession invoking fear. There needs to be better discussion around Homebirth. There needs to be retribution for professionals that make non evidence based, untrue, malicious statements in the media that incite fear in the birthing population.

Maternity care is heavily regulated by doctors and a medicalised view of pregnancy and birth. Respectful maternity care will spring from doctors and women valuing midwives as gatekeepers of normal birth. Doctors need to step away from controlling birth to managing high risk birth and leaving normal birth to women and midwives. This is respectful maternity care, recognising where clinical strength and resources need to be situated. Women need to realise the art of childbirth is innate and carriage of this knowledge is central to women retaining control of their bodies. Midwives must continue to hold space for women in hospitals throughout Australia.

Public funded home-birth should be explored as a priority. Following the evidence for same and in line with other states and countries providing this safe option for birth for appropriately screened low risk women.

Increased Medicare rebates for services provided by privately practising midwives – as well as Medicare rebates for homebirth with a PPM.

Access to home birthing services (including publicly funded models).

Furthermore, homebirth needs to be more widely acknowledged within this agenda as an outcomes/choice many women would explore, but are currently restricted. Furthermore, to facilitate true interdisciplinary collaboration, this needs to be addressed within education as well as a local level. This is a wider picture, it occurs very well at times and also poorly at others.

Homebirth access and continuity of care as a basic right if care for all women.

We need access to homebirth with a known midwife. These midwives need access to insurance and hospital visiting rights. Please finally take this seriously as we see the rise of 'freebirths' and the vilification of private midwives.

Homebirths need to be recognised and supported as a viable and safe option for women, therefore a midwife needs to be able to provide collaborative care to women if this is their choose of birth. Midwives need to be able to provide this care without all the red tape.

There is no mention of doulas as an important support and knowledge base for women or about standardising their education and knowledge.

5.2.7 Breastfeeding

Rebate costs for Lactation Consultants through Medicare.

Access to Medicare rebates for lactation consultants. Improving access to mental health support.

Medicare payments for lactation consultants.

Please recognise breastfeeding as a public health issue and provide more lactation specific hours in every hospital. What we spend now we will get back a hundredfold in the future!

There does not appear to be anywhere that increased breastfeeding support can be provided to women. We have good evidence about the advantages of long term breastfeeding, so breastfeeding needs to be addressed in any maternity care reform.

Focus on improving and increasing breastfeeding rates.

I would also hope to see a focus on strengthening community based measures to support breastfeeding and the transition to parenting, ideally including the introduction of legal and financial sanctions for the international code of marketing breast milk substitutes.

Breastfeeding is only mentioned once. As a vital health promotion initiative it should be given more detail and presence.

5.2.8 Women with pre-existing conditions

The principles are appropriate but not comprehensive enough. There is no mention of women with major pre-existing medical conditions or of women who experience severe complications associated with pregnancy. Severe maternal morbidity is relatively common and the rate is increasing in Australia. Whilst the document quick rightly recognises Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, and women with mental health conditions as groups of women with specific and potentially additional needs, there is no recognition of the needs of women with pre-existing illness or those who develop potentially life-threatening illness associated with pregnancy. These women frequently experience fragmented care, separation from their baby, care by nurses (and may have no access to midwifery care), and receive no supported follow-up after the birth. The maternity care workforce needs to be up-skilled to be able to continue the care of women with complex needs and the health system needs to create improved models of care for women with complex medical needs.

5.2.9 Funding and insurance

Unique Patient identifiers, implanted by all states and territories to allow bundled payments to progress at a hospital level.

Resolution of funding issues that reduce access, bundled payments.

Funding is not discussed. There needs to be a framework of funding for a primary health care approach to maternity care instead of a tertiary funding model.

A 'no-blame' model of care needs to be brought into play via the appropriate avenues of national law. Medical/obstetrical providers are locked into litigation cycles providing care that revolves more on risk-management that focuses on screening, assessment and risk allocation rather than care.

Pelvic health.

Routine pelvic health physiotherapy for all women at 6 weeks post birth.

In the section "right to equitable healthcare and the highest attainable level of health" you address mental health care and maternity continuity and post-natal care in the context of breastfeeding, GP and maternal/child health care, but there is no mention of the physical post-natal care of the mother. Specifically I am addressing pelvic health in women. We know from

multiple research papers that the risks for women suffering from prolapse, incontinence and other pelvic floor disorders post-childbirth are high and can have lifelong sequelae, yet this aspect of maternal care has been by-passed forever within our health care system. As Pelvic Health Physiotherapists we feel very passionately that the physical pelvic health of the mother should be addressed, as standard, in the same way that women have their 6 week medical check-up, to provide them with the highest attainable level of health that you are striving for in your title. By this I mean, all women should be assessed by a Pelvic Health Physiotherapist, ideally pre-natally at 20/40 and 34/40 to assess status of pelvic floor muscles and have time to deal with any weakness/tightness etc. to optimise her chance of a normal delivery and then be assessed at 6 weeks post-natally to assess for any dysfunction of the pelvic floor muscles, prolapse, tightness, pain, symptoms, abdominal wall status. We don't have research yet to say that this will improve the lifelong statistics for women but common sense would tell you that treating an injury at a time when the body is naturally healing and empowering women about their pelvic health and how to manage it, will improve outcomes. Pregnancy, labour and birth are physically demanding times and can lead to physical injury. Traditionally this has not been addressed, women have put up with symptoms for years and years. I treat women in their 80's and 90's who relate their issues starting after the birth of one of their children. How transformative would it be if the opportunity to address these issues early on, resolve them or provide the tools to manage them, was given to women as part of their peri-natal care? It could be argued that GP's and Obstetricians check the pelvic floor and ask questions regarding incontinence and prolapse, and some do, but the vast majority don't. If they do ask it's usually a cursory question without any directed response unless it's very severe and other Medical Specialists need to be involved. In my local area, we are working hard to change this and are seeing a gradual shift of awareness. Women are actively seeking out post-natal pelvic health assessments and GP's and Specialists are referring more and more consistently. This empowers women to be involved in their healthcare, rather than waiting until symptoms get too bad they're offered surgery.

5.2.10 Drug and alcohol services

Once again the enablers within the document, particularly within 4.3 include information and training for maternity services to work with and link to alcohol and drug treatment services to ensure that women are appropriately referred and that maternity professionals are aware of local pathways and referral options.

5.2.11 International visitors

International visitors and cost of having a baby for them.

5.3 Organisational responses

5.3.1 Recognition of birth as a normal process

There is no recognition or mention of childbearing being a normal, physiological, psychological, emotional, spiritual, social and cultural event for a woman or the importance of respecting a woman's intuition and/or knowing. There is no acknowledgement of the need to address the issues around racism, coercion, patronising, ignoring and bullying of women in the health care system. Statements addressing these topics need to be included. Suggestions for enablers include: Ensuring consumer representation in public policy decision-making bodies Maternity services to be co-designed with women with women to decide what is safe, appropriate and desirable for themselves. Development of benchmark tools with women/consumers. There is currently no validated tool for measuring women's experiences.

Pregnancy and birth is a normal physiological life event – not an illness. Birth is not just a physical act, it is an emotional, social and psychological act. Birth is uncertain but not dangerous for the majority of women. The concept of safe motherhood is usually restricted to physical safety at birth. Cultural, emotional, social, psychological and spiritual safety does not appear in the document. Not only do these factors dominate women's thinking, research indicates ignoring its importance is potentially deadly. The productivity commissions report on Report on Government Services – Health – 2018 at page 48, states, The international and Australian experiences with integrated care indicates that, if properly implemented, it leads to gains in health outcomes for patients, improvements in the patient experience of care, reductions in costs, and improved job satisfaction for clinicians (SP 5). Since hospitalisation is the single most costly and distressing part of the health system, effective management of people's conditions in the primary care system is a key element of integration. While Australia has been searching for a more coordinated system for nearly two decades, realising the goal has been elusive. This reflects systemic deficiencies in the structure of the health care system — it's funding, governance, linkages, attitudes — that inevitably act as stumbling blocks. This draft document fails to address a primary care system in a wellness model. The essential elements of integrated care must be reflected in the strategy. Issues of gender equity and gender violence are at the core of maternity care. The truth is, while everyone thinks they have a right to dictate a woman's choices in birth, no one considers it their responsibility to pick up the pieces afterwards, particularly when, even with the best of intentions, things go wrong. Does not address the grooming of women by some health professionals. When a woman engages a maternity care provider, she wants that person to be skilled and to use that skill when clinical indicated, not for their own convenience. No acknowledgement that Practitioners need a faith in the ability of the women to achieve a good outcome. When Practitioners support and validate our clients, their innate strength is enhanced. Care providers who rely on surveillance, interventions, and plotting courses that emphasized risk were more likely to exert their control and feel strong through minimizing women's power and control. Does not address that there has been no major improvement in maternal mortality over the past 20 years - despite the ever increasing interventions. When are we going to call health professionals to account? Jurisdictions must address the unacceptable morbidity and mortality associated with poor perinatal physical and mental health.

5.3.2 Preconception care

Access to pre-conception education for women

5.3.3 Genetic health care

The document does not contemplate prenatal screening and diagnosis which is an important part of a woman's journey through pregnancy. Down Syndrome Queensland understands that access to prenatal screening and diagnosis is important for many families. We respect the right of women to undertake prenatal testing if they choose to do so and to make decisions about whether or not to continue a pregnancy based on their own circumstances and beliefs. Research suggests that currently many families may not be making fully informed choices about prenatal testing. We are concerned that some families may be making decisions that are based on negative community attitudes and inaccurate, outdated information about Down syndrome. Down Syndrome Queensland recommends that the that all women who are contemplating a test during pregnancy have access to accurate and balanced information about Down syndrome including opportunities to connect with families. This should include improved training and education for doctors and midwives, improved access to post-screening counselling, and the

development of a public awareness campaign to tackle negative community attitudes and stigma about Down syndrome and intellectual disability.

5.3.4 Antenatal education

Antenatal education for women – including mental health.

There is not enough information within the strategy around training and education of health professionals on knowing and providing advice to women about modifiable factors that can influence the health of their unborn foetus. An important example of this is advising about alcohol and substance use during pregnancy. This advice needs to commence at preconception, particularly women of child bearing or those planning pregnancy that there is no safe amount of alcohol or other substance use. This advice needs to extend throughout pregnancy and into postnatal care including advice to not consume alcohol while breastfeeding.