



Respectful Maternity Care

Submission to the Inquiry into Maternity Services in the ACT

Safe Motherhood for All Inc.

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1 Introduction

Maternity Services need to be holistic and work in partnership with families in all their diversity to, improve collaboration across the health and welfare sector.

This submission consciously uses the term maternity. Maternity care places the woman at the centre of the care whereas obstetric care and midwifery care place the focus on the professional.

The health and wellbeing of infants and children is critically connected to the health and wellbeing of their mother.

Perinatal wellbeing is a complex concept that is more than the absence of illness, and has been defined as “the cognitive and/or affective self-evaluation of the individual’s life specific to the period before and/or after childbirth, which encompasses a multitude of elements such as physical, psychological, social, spiritual, economical and ecological” (Allan, Carrick-Sen, & Martin, 2013, p. 10). Valuing the achievement of perinatal wellbeing in addition to the prevention of illness corresponds with the World Health Organisation (WHO) recommendations that clinical and psychological safety for pregnant women and mothers needs to be incorporated in the provision of care to increase women’s chances of experiencing positive pregnancy and birth (World Health Organisation, 2018).

Maternity – pregnancy, birth and postnatal recovery - is a normal physiological life event *not an illness* to be treated. Therefore maternity care must be safe both psychologically and physically for women. We need to remember that birth is:

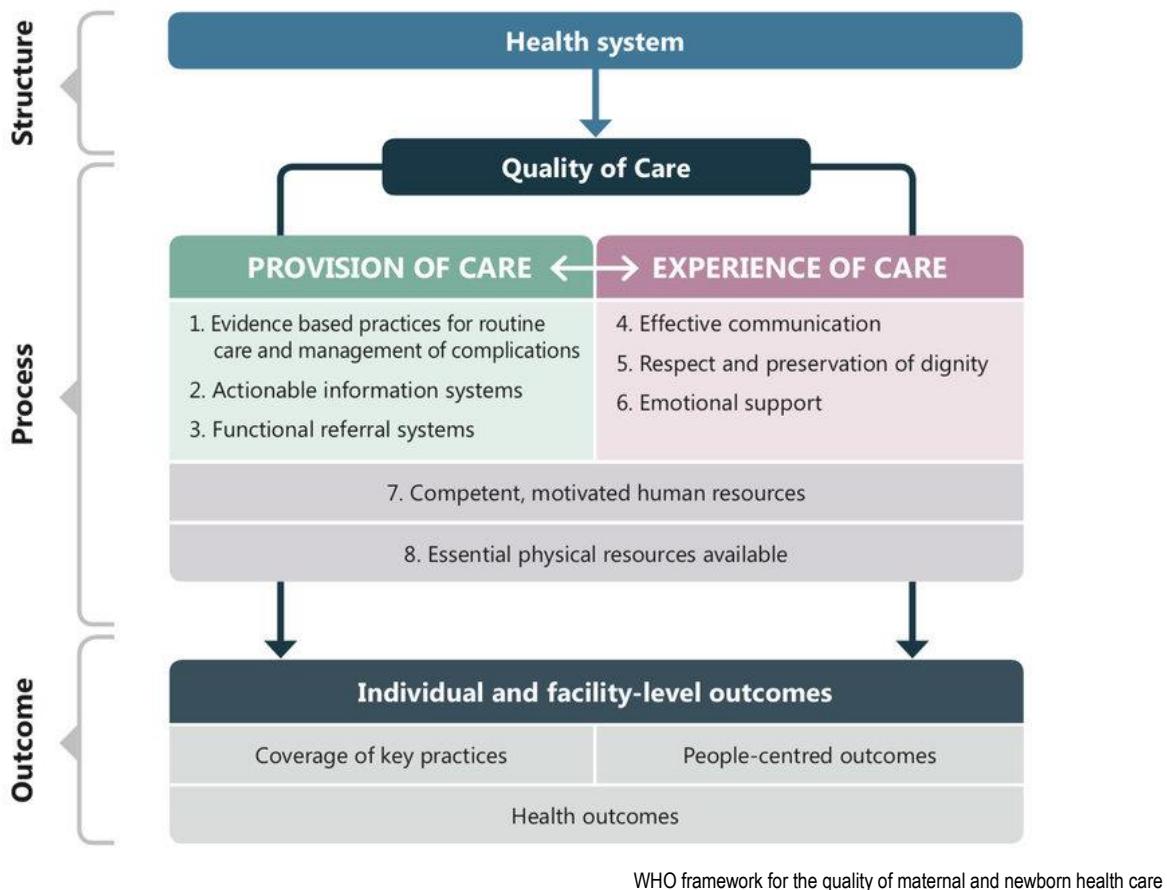
- uncertain but not dangerous for the majority of women.
- safest in a health system where the woman is central to that system; and
- safest when evidenced based care is provided with respect, in a partnership model.

Maternity care above all, must do no harm – non-maleficence and above all, do good – beneficence. Outcomes of maternity care are enhanced when care:

- focuses on the social determinants of health;
- is provided within a wellness & primary health model of care; and
- is culturally sensitive, valued by the woman and her community.

The World Health Organisation’s vision of quality of care for pregnant women and newborns was 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).



The ACT faces a challenge in achieving high quality, woman-centred maternity care, in a safe respectful environment.

- Firstly, in providing maternity services that honour the childbearing woman's human right to respect, autonomy, dignity and the attainment of the highest level of health.
- Secondly, achieving maternity care that does no harm. The World Health Organisation 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).
- Thirdly, in achieving effective, efficient and appropriate use of the funds available, while maximising the health outcomes for society. The financial costs associated with current maternity care practices create a demand for health services that are not clinically indicated and reduce/limit access to clinical interventions for those who really need them.
- Finally reducing the productivity implications of lost work performance due to ongoing ill health following maternity care.

ACT Maternity Services need to be underpinned by a set of values that support the well-being of women and their children and informed by:

- The Respectful Maternity Care Charter – The Universal Rights of Childbearing Women
<http://www.safemotherhoodforall.org.au/position-statements/respectful-maternity/> and
https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf;
- National Safety and Quality Health Care Standard – Partnering with Consumers
<https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/national-safety-and-quality-health-service-standard-2-partnering-with-consumers/>;

- Australian Charter of Healthcare Rights <https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>;
- World Health Organisation Intrapartum Care for a Positive Childbirth Experience, 2018 <http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/>; and
- The social determinants of health http://www.who.int/social_determinants/en/.

2 The current issues for maternity services in the ACT

2.1 Maternity models of care are not informed by consumer voice and shared decision-making model.

How women experience pregnancy and childbirth is rarely documented or discussed by policy makers, program managers, or healthcare providers. Possible reasons for this lack of consideration and lack of understanding of “well-being” during pregnancy, labour, childbirth, and in the immediate postpartum period is that for some health professionals all that matters is a healthy baby.

Given the opportunity, almost every person and community has a story to tell about pregnancy and childbirth, from their own personal experience or those of their relatives, friends, or fellow community members.

The maternity consumer perspectives are unique. Given their firsthand experience of every stage of maternity care, they are legitimately positioned to evaluate the care and services received, in terms of whether their needs and preferences were met or not, becoming a powerful lever for service quality improvement.

However, quality of care and services is often evaluated by health professionals, while the woman's expectations, needs and perspectives, which were remarkably different, are not usually well understood.

Enhanced engagement with women and their communities, leads to:

- more precise identification of needs;
- greater collaboration on solutions;
- enhanced service delivery;
- enhanced policy, program and service design;
- effective use of available resources; and
- respectful and caring therapeutic relationships.

Enhanced engagement with women also reduces systemic disrespect. Systemic disrespect occurs when organisations, institutions or governments discriminate, either deliberately or inadvertently and whether by act or omission, against women. This form of disrespect reflects the cultural assumptions and societal practices of a dominant group – in this case health professionals and policy makers; so that their practices are seen as the norm to which women should conform. Systemic disrespect regularly and systematically disadvantages child bearing women

A lack of consumer voice can lead to inequality

2.2 Maternity models of care that are not research evidenced based.

In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice, (Commonwealth of Australia, 2009).

As noted above, 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).

Common medicalised practices used routinely in the ACT that are harmful & not evidenced based are:

- Restricting ambulation/different positions during labor and choice of birth position
- Over-use of anesthesia/analgesia;
- Administration of oxytocin at any time before delivery in such a way that the effect cannot be controlled;
- Restricting food and fluids;
- Separation of mother and baby;
- Early cord clamping;
- Routine episiotomy; and
- Lack of continuity of care with a known midwife.

WHO also states:

- Midwives educated and qualified to international standards can provide 87% of services needed by mothers and newborns.
- Women in receipt of WHO recommended midwife-led continuity of care experience a 24% reduction of preterm births, are 16% less likely to lose their baby, and report higher satisfaction with their birth experience.

2.3 Health Professional Practice, Education, Competence and Accountability

The role and scope of the midwife is clearly defined by the International Confederation of Midwives. Midwives work in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period. The midwife practices in a wellness model, understanding that most pregnancies and births are normal biological processes. The midwife is responsible for identifying problems early and referring to the medical officer.

The role of the obstetrician and the scope of practice for an obstetrician is not clearly defined. This needs to be rectified. No definition of an obstetrician could be located on the Australian Health Practitioner Regulation Agency website or the Royal Australian and New Zealand College of Obstetricians and Gynaecologists website. Therefore a possible definition is: a doctor who is trained to intervene when pregnancy does not progress as expected and who has successfully completed an education programme that is duly recognized in the country where it is located who has acquired the requisite qualifications to be registered and/or legally licensed to practice obstetrics; and who demonstrates competency in the practice of obstetrics.

Obstetric training does not focus on developing skills to support the natural progression of an uncomplicated labour and birth therefore it is to be expected that this view will influence the care provided. Obstetric training is based upon treating pregnancy and birth as a medical procedure. Obstetricians are surgeons, and surgeons excel at performing surgery. In developed countries,

obstetrician involvement and interventions have become routine in normal childbirth, without evidence of effectiveness.

"Care providers who relied 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 and, ultimately, their integrity." (Hall, et al 2012)

As a consequence medical preference and expediency appears to be taking a priority over best outcomes, with obstetricians often operating according to their own timetable rather than the less predictable schedule of mothers and babies. Is this justified, especially in light of the constraints it places (almost exclusively) on women's choices regarding childbirth and her future health. (NICE Guidelines,2011).

Currently there is no reported of outcomes measures at clinician and service level.

Currently, health care training does not focus on developing skills that promote working:

- in partnership with clients; and
- as a professional team.

2.4 Ineffective and inefficient health services

Maternity care is currently planned about the hospital system and the health professionals with a focus on maternity care ending at 6 weeks post-partum.

The number of handovers of care within maternity is not woman centred, provides fragmented care and increases the risk of poor outcomes. For example, transitioning to parenting is a part of maternity care, yet women receive minimal education on parenting in the antenatal period. After birth, when they are most vulnerable the person who cared for their pregnancy and birth is not available to them and they have to establish another relationship with a maternal and child health nurse.

Preventing chronic disease starts at birth. The impact of the burden of disease in Australia is rising. It's obvious that well-chosen preventive health measures will yield big payoffs to taxpayers down the track. One area that can contribute significantly to the prevention of chronic disease is a focus on maternity care and infant health. A healthy, strong and confident mother gives a baby the best start at birth, influencing the long-term wellness of her child. Diabetes, obesity, mental health and auto immune diseases often have linkages / causes that research shows relate back to maternity care and the early years of life.

Whether a woman breastfeeds her baby—or not—can affect the lifelong health of both. Breastfeeding is the normal biological extension of pregnancy and childbirth. Breast feeding is protective of many chronic diseases and of maternal neglect. The State of the World's Mothers Report (2015) asserts that "Immediate breastfeeding is one of the most effective interventions for newborn survival. Given the fact that breastfeeding contributes both to the physical and economic health and welfare of women and their infants and society at large, not focussing on the impact of birth on breastfeeding is at least misguided and at worst negligent. Women wear the emotional burden when they do not breast feed, yet often it is the birth outcomes that impact on breast feeding rates.

2.5 A focus on mortality as an outcome

High quality, safe maternity care goes beyond measures of mortality and encompasses many parameters.

Efforts to improve maternal health are often viewed simply as measures to avoid maternal death. While mortality rates can be a useful proxy measure for improved health when it comes to setting goals, it is doubtful that any woman, mother, family member, or community considers “good maternal health” to mean simply surviving pregnancy and childbirth. To continue to focus on mortality is doing the ACT community disservice.

By 1980, the maternal mortality rate in Australia had dropped to below 10 per 100,000 live births; (AIHW 2015) and has stayed in this range. However, the data shows there has been no major improvement in maternal mortality over the past 20 years even given the high level of interventions during pregnancy and birth and the subsequent cost to the community. The Caesarean Section rate has risen from under 20% a decade ago; today the number of births ending in major surgery in the ACT has reached 33.7 per 100 live births in 2016.

The high level of intervention has unintended negative consequences - 30 per cent of women report that their birth was traumatic; that they feared for their life, or their baby's life; of these women about 6 per cent go on to develop post-traumatic stress disorder, (Gamble, J, 2011). Caesarean sections are marketed as a safer option yet despite a fivefold increase in caesarean section over recent decades, the incidence of cerebral palsy remains steady at 1:500 births, (McLeannan et al. 2005) & (Cerebral Palsy Organisation 2013).

Maternal Morbidity - “any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman’s well-being”. A great definition as it allows for health conditions to be understood from a woman’s point of view and assessed in terms of how their lives are affected.

The continual rise in obstetric intervention for low-risk women in the ACT is concerning in terms of morbidity for women and cost to the public purse. The findings of one study suggest that a two-tier system exists in Australia without any obvious benefit for women and babies and a level of medical over servicing which is difficult to defend within a system that is bound by a finite health dollar. (Hannah, D et al, 2012). Using UK data, the relative 2009/10 cost of a Caesarean section versus vaginal birth was GBP 2,369 verses GBP 1665 (NICE 2011).

It is acknowledged that safety and quality of care is the overarching goal, however it would be remiss to always use it as an excuse not to change practice. When health professionals talk about safety in relation to birth, they usually are referring to perinatal mortality and women are frightened into complying with the will of their doctors.

The ACT has no true understanding of the real impact of pregnancy and birth and the consequence for our community? We will not understand the true picture of maternity care outcomes until we focus on long term morbidity.

2.6 Gender Equity and the Elimination of Violence against Women

As motherhood is specific to women; issues of gender equity and gender violence are at the core of maternity care. The United Nations Declaration on the Elimination of Violence against Women states:

“the term ‘violence against women’ means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation whether in public or in private life.”

www.un.org/documents/ga/res/48/a48r104.htm

The violation of women’s human rights within maternity services has largely evaded the attention of the Australian community (Freedman & Kruk, 2014). Disrespectful maternity care represents a dimension of violence against women (Jewkes & Penn-Kekana, 2015) and it is imperative that the ACT community acknowledges, minimises and addresses the violence experienced by pregnant women.

While the focus of caregivers appears to be on trying to eliminate fear: of pain, of losing control, of a bad outcome, loss of financial security, loss of reputation, fear has become an inevitable part of the birthing experience. When birth is insensitively managed, clock-watched and interventionist, it can exacerbate existing trauma and may be perceived as violence. (Kitzinger, 2012).

It needs to be noted that in acknowledging that violence happens it is *not* to imply that *all* intervention is violent or unnecessary, nor is it a suggestion that health professionals are not quality care providers.

3 Strategies to improve and enhance maternity care in the ACT.

3.1 Maternity models of care informed by consumer voice and shared decision-making model.

Consumers, especially pregnant women, are the least powerful contingent in the health-care system, even though their knowledge, attitudes, and actions could be the most important influence on their own health and safety. There is an urgent need to develop models of care based on meaningful engagement with maternity consumers so as to enhance the shaping of maternity services affecting women, and to ensure that future strategies and policies are in fact consumer driven.

The National Safety and Quality Health Service Standard 2: Partnering with Consumers requires all health services to partner with women and families in designing and delivering health services and provides the model to create an organisation in which there are mutually valuable outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services; and
- Consumers as partners in their own care, to the extent that they choose.

An inability to consult, engage and collaborate effectively with consumers results in

- a misdiagnosis of the prevailing conditions and causality;
- poorly designed programs and services; and
- a breakdown in trust between the different parties.

To engage effectively with consumers requires the organisation and its staff to:

- give up perceived power positions which are traditionally inherent in the health care culture;
- listen and absorb women’s knowledge;
- learn to stand back and observe what is happening, without overlaying the situation with preconceived assumptions; and
- have the humility to appreciate another viewpoint and respect that viewpoint.

3.2 Maternity models of care that are research evidenced based and provide value

Currently the ACT has a lack of evidenced based primary maternity care, most importantly, lack of access to continuity of midwifery care models compounded by the lack of timely coordinated integrated appropriate care for all women especially for the vulnerable and disadvantaged.

The National Maternity Service Plan defines ‘Continuity of Care’ as: “the practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period” (Commonwealth of Australia, 2011, p. 121).

The philosophy behind continuity models includes: an emphasis on the natural ability of women to experience birth with minimum intervention by monitoring the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle. Continuity of midwifery care works on the assumption that women will labour more effectively, have a shorter stay in hospital and feel a stronger sense of satisfaction and personal control if they have the opportunity to get to know their midwife at the beginning of pregnancy.

What are the elements of continuity of care and carer? All the care required to achieve a healthy pregnancy is provided by one person or a small team. This includes:

- Monitoring the progress of the pregnancy.
- Providing education on pregnancy, labour, birth, post-natal recovery, breastfeeding and parenting.
- In labour, monitoring and care is provided by the health professional who provided your ante-natal care or another known to you.
- Providing the post-delivery care and postnatal care.
- Supports the commencement of infant feeding – breastfeeding or other.
- Supports transitioning to parenting.
- Furthermore midwifery continuity models of care are associated with longer prenatal visits, more education on pregnancy and breastfeeding; prenatal counselling, fewer hospital admissions & 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](#)).

Why does continuity of care and carer matter?

Most women prefer to avoid major intervention in birth, have better outcomes and are more satisfied if they have a normal birth. Research has shown that continuous support in labour from a person other than the woman’s partner or family member delivers a better experience for women. Research has also shown that continuity of care with a known midwife has significantly better outcomes for a woman and her child. A Cochrane Systematic Review based on a 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, labour and postnatally – is associated with a higher level of spontaneous vaginal birth; women are 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 @ http://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early).

A BMC Pregnancy and Childbirth study found that those who received continuity of care through a midwifery group practice were significantly more likely to spontaneously go into labour (rather than taking drugs to induce labour) and were less likely to have a caesarean birth. There were also no differences in serious outcomes for the babies in this study, (<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-46>).

The World Health Organisation supports case load / continuity of midwifery care as safe and cost effective for improving quality of care. There were no adverse outcomes associated with midwife-led care but significant benefits and thus it is recommended that all women should be offered midwife-led continuity models of care. Though midwives have the potential to provide excellent quality of care but socio-cultural, economic and professional barriers must be overcome to allow them to practice to their full potential.

Based on the evidence of better outcomes and lower cost, all women should have access to a midwife as the primary carer. In Norway Denmark, Finland and Sweden, where 70% of births have a midwife as the sole birth attendant, perinatal mortality rates are lower than those of any country in Europe, North America and Australia. New Zealand, gives all women the option of a lead midwife care provider and around 80% choose this option.

Regrettably most women in the ACT 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).

For a considered discussion listen to the podcast - *Making our maternity care the best it can be* at <https://www.spreaker.com/user/pregnancybirthandbeyond/making-our-maternity-care-the-best-it-can-be>

Women should be able to choose an obstetrician; these medical specialists provide an indispensable service in for high risk women. But based on the evidence of better outcomes and lower cost, women should have the option of calling the midwife. ([The Conversation, 2014](#))

- Why are women deprived of comprehensive continuity of care in the ACT?
- What % of women experience comprehensive care provided by continuity of carer in the ACT?
- How is this value for money?

Recommendations

- Provide evidenced based care models that must embed compassion – empathy, sensitivity, non-judgement, tolerance, kindness and caring as well as excellence in clinical practice.
- Increase women's access to continuity of midwifery carer services across the continuum of maternity from preconception to the postnatal period.
- Address the socio-cultural, economic and professional barriers that must be overcome to allow midwives to practice to their full potential so that they may provide excellent quality of care.
- Enshrine effective postnatal care by reducing the number of handovers of care by providing maternity services preferably up to 12 months to support transitioning to parenting and breastfeeding.

- Include a strategy to get the first birth right. One option is to promote a First Baby Campaign to enhance a woman's understanding of childbirth using the Clinical Practice Guidelines: Pregnancy Care that were developed by the Commonwealth Government to help ensure that women in Australia are provided with consistent, high-quality, evidence-based maternity care.
- Report the % of ACT women experience comprehensive care provided by continuity of midwife carer.

3.3 Create effective and efficient maternity services.

The way we are running our maternity services are not sustainable. Maternity care is one the top uses of the health care budget and a top reason for admission to hospital. This does not need to be the case. Maternity care should be provided by primary health services.

The main driver of maternity health expenditure increasing is that health professionals are doing things differently. A pregnant woman today is getting treated very differently from a pregnant woman two decades ago, with no significant improvement in maternal mortality. Doctors are ordering more pathology tests than before, and they're doing more procedures than before. For example:

- Ultrasounds: Two ultrasounds are recommended for a normal pregnancy and ultrasound in the third trimester is of no benefit. Yet women are having an average of 5.2 ultrasounds per pregnancy, (NICE, 2017).
- Induction or augmentation of labour without a medical indication is also shown to increase the intervention rate. (WHO ,2014)
- Continuous electronic foetal heart rate monitoring during labour for women without risk factors has shown to increase the intervention and caesarean section rate. (Devane D, et al; 2017).

To achieve effective and efficient maternity services the ACT needs to focus on achieving maternity models of care 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 philosophy needs to be every woman requires a midwife and some women require an obstetrician. This approach will achieve fairness, accessibility, efficiency and effectiveness.

Recommendations

- Consider innovative models of care that focus on the woman.
Example 1 - provide midwifery led maternity care in community, at health clinics. The midwife who cares for the woman the primary health setting will attend the woman in labour. The Women's Hospital Randwick is currently implementing such a model.
Example 2 – Trial the New Zealand model of maternity care in the ACT.

3.4 Change the Cultural View of Maternity.

Childbirth stands between the two paradigms of nature and nurture. (Ann Oakley; 1980). It is a biological process whereby the woman's body goes through childbirth. The cultural aspects of childbirth are the norms and rules of the society that can affect the outcome of pregnancy and influence the mother in her decision making during childbirth. By being portrayed as an *illness*, pregnancy can be considered dangerous.

Professional attitudes and beliefs are often misconceptions about women based on perceived societal norms and are often founded not just on the notion of superiority but on the fear of failure. Pregnant women are warned of dangers if they do not do what they are told and so the docile and passive pregnant body become objectified by the care givers. Most women submit to this, because of the normality of medicalisation of childbirth, (Oddný Vala Jónsdóttir; 2012). This undermines women's sense of power and control over their bodies.

This cultural view of pregnancy and birth stems from a patriarchal attitude that women must be submissive, passive, and let the experts who know better do the work. This reflects and is perpetuated by deeply rooted historical, social, cultural and power inequalities in society. These attitudes and beliefs find expression in disrespectful behaviours, both in the actions of individuals and in the policies and entrenched practices of health care organisations. The paternalistic model of treatment decision-making, characterised by a care provider taking the active role in treatment decision-making and a passive and acquiescent patient, has been challenged in recent years in favour of alternative doctor-patient partnership models (Thompson & Miller, 2014).

Considerable evidence indicates that respecting choice and partnering with consumers in their own care is associated with a better care experience. A better care experience is associated with better clinical outcomes, enhanced consumer safety and less use of health care (<http://www.safetyandquality.gov.au/>).

Caring and respectful relationships with healthcare professionals can make the difference between a positive and a negative birth experience, but the basic principles of respectful treatment are sometimes neglected in large-scale healthcare facilities, investigations into failing health services have repeatedly shown. The 7.30 Report on Bacchus Marsh Hospital revealed a profound lack of respect for patient rights that has gone hand in hand with clinical and systemic failings, which compromised patient safety, (Reynolds, 2016). The Mid-Staffordshire public inquiry revealed the impact of failure to respect basic dignity had on patients. The labour ward at Stafford Hospital was implicated in the scandal. Human rights claims brought under Article 3 on behalf of over 100 patients of the Mid-Staffordshire have succeeded, (Francis, 2013). This is a salient reminder that maternity care must be based on respect for human rights.

Maternity models of care that protect a woman's fundamental human rights, as defined in The Respectful Maternity Care Charter – The Universal Rights of Childbearing Women and the Australian Charter of Healthcare Rights, requires attention to the principle of dignity as well as its related principles autonomy, equality and safety. There are three dimensions of dignity; dignity in person, dignity in relations and dignity in institutions.

Recommendations

- That the term maternity care be adopted in the ACT.
- ACT maternity care to be informed by the National Safety and Quality Health Care Standard – Partnering with Consumers - that requires respect for patient rights and engagement in their care.

3.5 Enhance Health Professional Practice, Education, Competence and Accountability.

A well trained clinical workforce has given rise to a health service that overly focuses on the risks which impact 15% of the population to the detriment of the 85% of women who present with no risks. Safer care must focus on services that do no harm to those who use them, rather than just focusing on the potential risk. When health professionals decide to secure their own financial security and manage their own risk, ethics and morality are an inconvenience. Health cannot bloom in such a narrow focus. Risk must always be a carefully monitored and a balance of safety and informed choice, (Commonwealth of Australia, 2009).

Midwives make up the largest proportion of the maternity workforce. When they practice to their full scope of practice society benefits. To change the current service environment is not without its challenges, though this can be achieved with:

- *Recognition and teamwork* – where all health workers should receive adequate recognition for their work and be supported to work in teams with other professionals, lay workers and consumers.
- *Supervision and clear referral pathways* – involving all groups of health is essential to ensure the best quality of care.
- *Formal training* is needed to develop skills provide opportunities for progression can be important in enabling individuals to achieve their potential.
- *Job design and recruitment* - tasks must be defined and recruitment targeted accordingly.
- *Leadership and planning* - Success is based on careful preparation and planning – with a leader, institution or government taking responsibility for all aspects of planning and implementation.

Recommendations

- Work toward standardising what is possible so as to reduce unnecessary care variation and increase the time available for individualized care. Contextualize the care provided to an individual's needs, values and preferences, guided by an understanding of what matters to the person in addition to "What's the matter?"
- Include education on Working in Partnership, Human Rights and Respectful Maternity Care in all health professional curricula and orientation in the ACT.
- As obstetric training does not focus on developing skills to support the natural progression of an uncomplicated labour and birth it is to be expected that this view will influence the care provided. As part of health professional credentialing it is recommended that all health professionals attending to a childbearing woman are competent in supporting the natural progress of pregnancy, birth and post-natal transition to parenting.
- Develop a Maternity Clinical Audit Process. 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. How will the ACT public know they are getting good health outcomes and value for money, without the publication of clinical audit data?

3.6 Mechanism for ACT Health System Accountability

Maternity care is a major industry, big enough that poor performance is significant at the macro-economic level.

The public does not have the information to scrutinise health services. There is a lack of information generally on the outcomes of maternity care in the ACT, and limited information is collected on safety and quality, efficiency and cost-effectiveness. Without rigorous data on targeted variables in an established systematic fashion, we cannot answer relevant questions and evaluate outcomes. The aim is to collect quality evidence that translates into data analysis allowing for convincing and credible understanding of the issues so as to inform future investments, to maximise the return on investment, minimise wastage of limited financial resources, to promote accountability, to support a safety and quality framework for maternity and children and monitor the impact of changing models of care effectively.

Actions required:

- Aggregated trended data can be deceptive and therefore not useful. Immediately mandate and implement arrangements for consistent, comprehensive data collection, monitoring and review.
- Develop a consumer feedback tool and process that elicits the spectrum of a woman's maternity experience – physical, social, cultural, emotional, psychological and spiritual safety in line with the Australian Commission for Safety and Quality in Healthcare Partnering with consumer standard. Ask all women at 6 months post birth for their feedback. There is growing evidence that information provided at this time is more reflective of the actual experience.
- Maternity Clinical Audit Process as above.
- Adopt the Robson Classification System for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities.

3.7 Reduce the Level of Violence Against Childbearing Women

As motherhood is specific to women; issues of gender equity and gender violence are at the core of maternity care. There are two dimensions of violence:

- Intentional use of *interpersonal violence* - -physical abuse, verbal abuse, discrimination, humiliation, negligent withholding of care (e.g. denial of food/water, denial of pain relief, refusing to answer questions; refusing to provide impartial evidenced based information); and
- *Structural Violence* - a form of violence where social structures or social institutions may harm people by preventing them from meeting their basic needs. In maternity it is the use of infrastructure, staffing, and equipment availability to:
 - limit or deny care,
 - inflict unnecessary interventions to suit the organization or staff,
 - failure to obtain consent, and
 - breaching of a person's privacy.

Structural violence creates conditions where interpersonal violence can occur, shaping gendered forms of violence that place women in vulnerable positions. The Lancet's 2014 Midwifery Series notes that discrimination and abuse is linked to, and reinforced by, systemic conditions, such as degrading, disrespectful working conditions and multiple demands, and can be seen as a signal of a "health system in crisis". It is also tied to power dynamics and the vulnerability of women and their babies during pregnancy and birth.

Action is required to:

- Address the horizontal and structural violence within the health care system; and
- Implement strategies that prevent the systemic mistreatment of pregnant women, mothers and their advocates within the maternity services system.

Disrespectful care can have a lasting and negative impact for the women who experience it damaging their confidence and their sense of worth. It can undermine their ability to perform their mothering role and may also affect their physical and mental health. Disrespectful care, care that diminishes women, leads to birth trauma, post-natal depression and poor maternal attachment. Maternity care must be part of a respectful relationship whereby both views are respected to create a final outcome that empowers the woman, ensures a safe birth of her baby assisted by the help of the health professional when indicated.

Promoting respectful maternity care has been recognized as an important component of:

- a positive care experience; and
- strategies to improve utilization and quality of health services as advocated by the World Health Organisation, UNFPA, White Ribbon Alliance, Global Respectful Maternity Care Council, and the UN Human Rights Committee.

3.8 Change the balance of power in maternity care.

Where there are significant asymmetries in power relations, there are often unfortunately abuses of power. There are massive power imbalances between maternity consumers, their advocates and a maternity services system that provides fragmented care to most ACT women. As a result, many pregnant women/mothers and their advocates are mistreated, bullied and abused within the maternity services system.

Consumers who have to navigate complex, contradictory and sometimes hostile environments are vulnerable to prolonged stress that typically involves emotional exhaustion, detachment, and feeling not heard.

3.8.1 Address the imbalance of power for pregnant women

Pregnant women experience asymmetrical power relations when interacting with the ACT's medically dominated maternity services. This mistreatment is a form of institutionalised gender-bias, or structural disrespect and discrimination, that is largely taken for granted and therefore resistant to change (Sadler et al., 2016).

Specifically, pregnant women have limited access to respectful, woman-centred and evidence based models of maternity care that support their attainment of physical and emotional wellbeing due to structural and cultural deficiencies in the healthcare system (Dawson, McLachlan, Newton, & Forster, 2015; Homer, 2016). These limitations contribute to increasing pregnant women and mothers' exposure to avoidable health damaging conditions, including disrespect, discrimination and mistreatment within healthcare institutions. 20 to 30% of women who birth; experience traumatic, disrespectful and fragmented care. (Origlia, Jevitt, Sayn-Wittgenstein, & Cignacco, 2017; Sutherland, Yelland, & Brown, 2012).

The cumulative effect of these significant power imbalances across multiple life contexts position pregnant women and mothers as a *vulnerable social group based on the intersection of their gender and their occupational/social status as mothers*. The disproportionate costs and lack of good health borne by mothers in Australia requires addressing so as to prevent and minimise their exposure to inequitable conditions and to improve equity in social, economic and health outcomes.

Recommendation

- Address the power imbalances between maternity consumers, their advocates and maternity services.
- Eliminate silos and tear down self-protective institutional or professional boundaries that impede flow and responsiveness.

3.8.2 Address the imbalance of power between health professions.

The balance of power is currently held by the professions that provides the least volume of work.

When a woman engages an obstetrician for their maternity care, they see the obstetrician usually 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 mothering and breastfeeding.

When the volume of work provided by midwives is quantified, it is apparent they are the lead clinician in maternity care. However, though midwives can practice independently, most midwives in Australia are employees of an organisation, bound by the rules of the organisation, often caring for women who have a private obstetrician. This gives rise to significant role conflict and role ambiguity as they have to reconcile Midwifery Professional Practice Standards, with organisational policy and procedure while being directed by an independent practicing doctor. This imbalance exposes midwives to the main risk factors for work burnout:

- having an overwhelming workload;
- limited control;
- unrewarding work;
- unfair work;
- work that conflicts with values; and
- a lack of community in the workplace.

4 Measuring outcomes and promoting accountability

For uncomplicated, healthy women, spontaneous labour and normal birth should be the norm. The only thing required from the clinicians is that they show respect for this process by complying with the first rule of medicine – do no harm; where maternity care is part of a respectful relationship in which women are empowered to be equal partners.

Maternal morbidity is an important indicator of system performance. WHO has developed a conceptual framework for assessing maternal morbidity. It is recommended that the framework inform a model to measure maternal morbidity in the ACT.

The image shows the cover of a supplement titled "PRINCIPLES OF THE MATERNAL MORBIDITY MEASUREMENT FRAMEWORK". It is published on behalf of the WHO Maternal Morbidity Working Group. The cover features six numbered principles: 1. Using a woman-centred approach; 2. Understanding that maternal morbidity risks are cyclical; 3. The effects of maternal morbidity can last a long time; 4. Maternal health is a social and economic phenomenon; 5. Living in a supportive environment can lead to better outcomes; and 6. Includes meaningful groupings of maternal morbidity and has strong links with other WHO guidance. At the bottom, it says "READ THE FULL SUPPLEMENT FOR FREE IN IJGO".

A new conceptual framework for maternal morbidity developed by the World Health Organization
Maternal Morbidity Working Group, International Journal of Gynecology & Obstetrics 2018

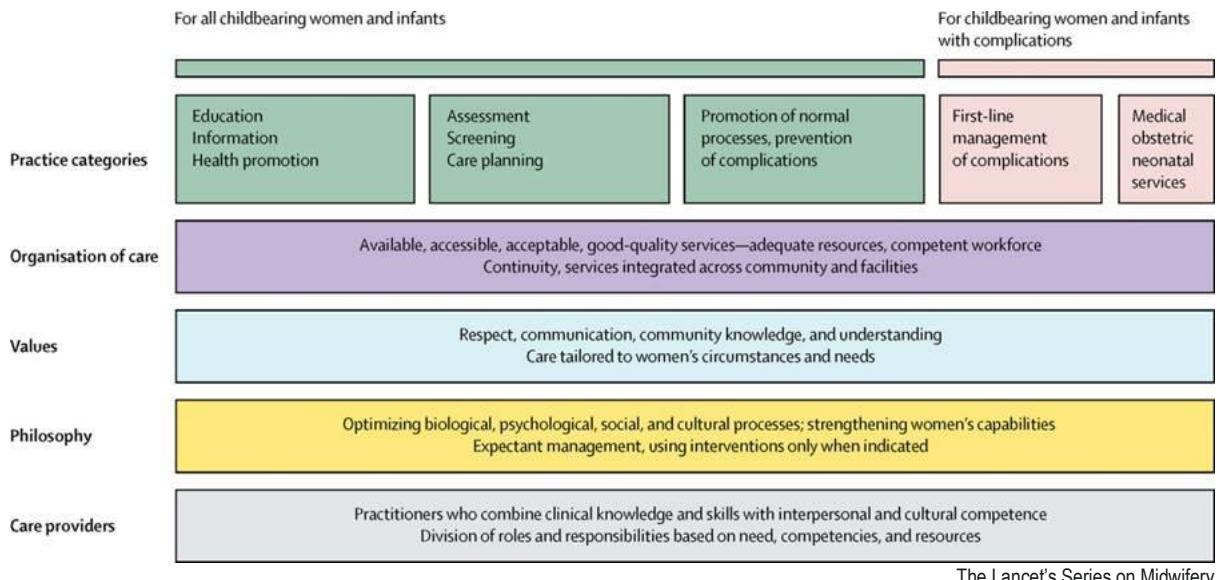
4.1 Measurement and Reporting

- Adopt and work toward the WHO recommendation that 85% of births do not require interventions and work toward a 15% total intervention rate for birth.
- Given the documented benefits of care by a known midwife, adopt performance targets for care by a known midwife. The New Zealand benchmark is 80% of NZ women have a known midwife. This would be a suitable target for the ACT.
- Aim for a spontaneous labour rate of 85%. Spontaneous labour is safest for woman and infant, with benefits that improve safety and promote short- and long-term maternal and infant health. The hormonally-mediated processes of successful lactation and maternal-infant attachment are intertwined and continuous with the biologic processes of parturition.
- Provide a Partnering with Maternity Consumers Report that covers the spectrum of a woman's maternity experience – physical, social, cultural, emotional, psychological and spiritual safety
- Develop a framework to measure maternal morbidity in the ACT
- Publish Maternity Clinical Audit Outcomes in each Annual Report. Report consistent and trended outcomes data. Report mortality and morbidity outcomes data, by parity, type of conception, type of birth, by maternal age, by clinician, by place of birth. Report postnatal depression rates at six weeks postpartum by clinician. Report breastfeeding rates at six weeks postpartum by clinician.
- Report longitudinal data on the impact of preventable chronic disease for the woman and her child.

5 Conclusion – Securing the Future

Failure to account for the woman's worldview in maternity services and not adopting a holistic view of maternity, incorporating just the physical wellbeing of the woman, and not the social, emotional and cultural wellbeing of the individual and their whole community leads to the disrespectful care.

The framework for quality maternal and newborn care, below, provides a model to inform the redesign of ACT maternity services.



All health professionals have a role in ensuring that they provide evidence based respectful care and that the women they care for are empowered to be equal partners in this process.

We need to *remember and respect* that pregnancy & birth for a mother is more than an everyday medical event, therefore we need to put in place responsive, sensitive maternity care systems that cater for the individual, where the *rights* of the mother and foetus and the *interests* maternity care providers are in harmony.

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