National Strategic Approach to Maternity Services (NSAMS)
Consultation input template

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I am responding on behalf of an organisation: Yes

Please indicate name of Organisation: Safe Motherhood for All Inc.

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Comment:

Australia faces a challenge in achieving high quality, woman-centred maternity care.

- 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). Most pregnancies follow a normal pattern and therefore the spontaneous onset of labour rates, birthing without intervention rates and the caesarean section rates are too high in Australia.
- 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.

Questions

1. **Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the NSAMS?**

Pregnancy and birth is a normal physiological life event not an illness to be treated. Pregnancy care will be safe both psychologically and physically for women.

Childbearing women will have:

- A health system where the woman is central to that system;
- Care that does no harm;
- Care that is evidenced based, provided with respect, in a partnership model ;

- A continuity of midwifery model of care, supported by a medical model of care for when the need arises;
- Care that focuses on the factors that support her health and well-being rather than on factors that cause disease;
- Care that is culturally sensitive, valued by the woman and her community; and
- The best health outcomes she can for the resources invested in health care.

2. Do you think there should be a set of values that underpin the NSAMS? If so, could you list the top four values you would like to see included?

Yes.

1 **Maternity models of care that protect a woman's fundamental human rights**, requiring 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 relation and dignity in institutions. An example is true informed consent that respects a woman's dignity and autonomy. The current practice of some professionals tends towards risk amplification by selectively emphasising potential risk in some areas of childbirth but not others (e.g. vaginal births).

2 **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.

3 **Maternity models of care informed by:**

- The Respectful Maternity Care Charter – The Universal Rights of Childbearing Women;
- National Safety and Quality Health Care Standard – Partnering with Consumers;
- Australian Charter of Healthcare Rights;
- World Health Organisation Intrapartum Care for a Positive Childbirth Experience, 2018; and
- The social determinants of health.

3. Can you outline three or four positive aspects of maternity services in Australia?

1 The **maternal mortality rate in low** and few women die. However this masks the rising morbidity experienced by women.

2 **A well trained clinical workforce.** However this 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).

3 The National Maternity Service Plan 2010-2015 was an advance on earlier practice placing the woman at the centre of her own care with care that was coordinated according to the woman's needs, including her cultural, emotional psychosocial and clinical needs, close to where she lives.

4. What do you think are the three or four gaps or issues for maternity services in Australia?

1 Maternity models of care that are not informed by consumer voice. We need to develop models of care based on meaningful engagement with maternity consumers/women/mothers.

2 The power imbalances between maternity consumers, their advocates and a maternity services system that provides fragmented care to most Australian women. As a result, many pregnant women/mothers and their advocates are mistreated, bullied and abused within Australia's maternity services system. 20 to 30% of women who birth; experience traumatic, disrespectful and fragmented care.

3 Lack of evidenced based 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.

4 Models of care that do not embed compassion – empathy, sensitivity, non-judgement, tolerance, kindness and caring.

5 Ineffective health services that do not address reproductive and maternal health along a continuum. Maternity care should be expanded to 12 months to include transitioning to parenting especially as many issues arising from birth are not apparent at birth.

5. What four to six key improvements would you like to see in maternity services in Australia?

1 Continuity of Midwifery Carer

- Increase women's access to continuity of midwifery carer services across the continuum of maternity from preconception to the postnatal period.
- 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 the First Baby Campaign to enhance a woman's understanding of childbirth.

2 Health Professional Education, Competence and Accountability.

- Include education on *working in partnership* Human Rights and Respectful Maternity Care in health professional curricula.

- Clearly define the role of an obstetrician and the scope of practice for an obstetrician.
- 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 the annual health professional registration process incorporate an Annual Competency Assessment to ensure 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. How will the Australian public know they are getting value for money, without the publication of clinical audit data? 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.

3 Mechanism for System Accountability

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

Actions required:

- Develop a consistent and standardised minimum dataset to provide an evidence-based platform upon which a national benchmarking program for maternity services could be built.
- Aggregated trended data can be deceptive and therefore not useful. Immediately mandate and implement arrangements for consistent, comprehensive data collection, monitoring and review.
- Require the Australian Commission for Safety and Quality in Healthcare, to 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.
- 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.
- Review financial and insurance systems to ensure best practice and minimise over-servicing.
- Adopt the Robson Classification System for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities.

4 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); and
- Structural Violence - a form of violence where some 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.

Actions are required to:

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

6. Are there specific strategies that you could suggest for rural and remote services and/or Aboriginal and Torres Strait Islander women and/or women from culturally and linguistically diverse backgrounds?

Adopt the Birthing on Country (Joint) Position Statement - 2018 at https://www.midwives.org.au/resources/birthing-country-joint-position-statement-2018.

All women living in rural and remote communities should have access to birthing services in their community, with appropriate back up services such as an obstetric retrieval service similar to neonatal retrieval.

All women must receive culturally sensitive and appropriate care.

Women with disability are invisible when designing maternity services.

7. How will success be measured or how will we know if strategies are being successful?

Maternity care must be part of a respectful relationship where women are empowered to be equal partners in this process Quality of care for pregnant women and their infants has two equal parts that influence each other:

1. The woman's experience of care - effective communication, respect and dignity, and emotional support; and
2. The provider's provision of care - evidence-based practices, actionable information systems, and functional referral systems.

Measurement and Reporting

- Adopt and work toward the WHO target of 85% of births not requiring 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 Australia.
- 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.
- Require the Australian Commission for Safety and Quality in Healthcare to 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
- Publish Maternity Clinical Audit Outcomes in each AHIW Mothers and Babies Report. Report both mortality and morbidity outcomes data. Report consistently trended outcomes data - by parity, by maternal age, by clinician, by place of birth -both public and private, for the period up to three years post birth. Report postnatal depression rates at six weeks postpartum by clinician. Report longitudinal data on the impact of preventable chronic disease for the woman and her child. Report breastfeeding rates at six weeks postpartum by clinician.