**CONSULTATION 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?

   1. Women in pregnancy, childbirth and early parenting are undertaking healthy processes that are profound and precious events in each woman’s life. Maternity care should, therefore, take an holistic approach, instead of a limited focus on only biomedical risk management strategies.

   2. That women, babies and their families in Australia have access to evidence-based, woman-centered maternity care within a primary sector planning and funding framework, as opposed to tertiary/hospital, in a
range of settings close to where they live, including birth centre and woman’s home if appropriate,
3. That maternity care is holistic and addresses physiological, cultural, psychological, social and emotional wellbeing, in alignment with the WHO definition of health, placing women at the centre of all decisions and care plans, enabling them to make informed choices about their care which are respected by all healthcare providers.
4. With a priority to provide access to continuity of midwifery care by a known midwife or small group of known midwives to all women from conception until six weeks postpartum (Sandall et al., 2016).
5. For women in rural and remote areas to have the option of receiving maternity care (including birthing) in their own community and for Aboriginal and Torres Strait Islander women to have the option of birthing ‘on country’, as defined by them.
6. That women exit the Australian maternity system as strong, confident mothers.
7. That the maternity workforce is supported to be robust, resilient with all clinicians enabled to work to their full scope in order to provide evidence-based, holistic care in partnership with women, in all contexts, including community and private practice.
8. The outcomes of NSAMS clearly align with other Commonwealth strategies such as the National Breastfeeding Strategy.

**References**

<table>
<thead>
<tr>
<th>1. Equity and Access to:</th>
<th>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?</th>
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<tr>
<td>a. Continuity of care models of midwifery for all women, where women have a named midwife or small group of named midwives from conception to six weeks post-partum including women with complex needs, or live in rural and remote communities</td>
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</table>
b. Quality maternity care in a range of settings including access to multidisciplinary health professionals for women experiencing anxiety, depression, psychosis and domestic violence.

c. Public and private provision of homebirth services. High-quality evidence about low-risk pregnancies indicates that place of birth had no statistically significant impact on infant mortality. The lower odds of maternal morbidity and obstetric intervention support the expansion of birth centre and home birth options for women with low-risk pregnancies (Scarfe et al., 2018).

d. Expert support and services for vulnerable and marginalised groups of women.

e. Perinatal mental health services with midwives able to refer and develop careers in this area.

2. Respect: ethical practice based on the UN Declaration of Human Rights, of which Australia is a signatory, including recognition of women’s autonomy, justice, beneficence and non-maleficence, and respect for women’s decision-making and choices, even when they are contrary to professional advice (Kotaska, 2017).

a. Adoption of the Universal Rights of the Childbearing Woman. It would also see maternity care professionals working cooperatively with each other and with women to support women’s choices and facilitate the best possible outcome as determined by each woman for herself. Collaboration includes respect is provided by all health professionals to each other, whatever their designation or role. This is essential in light of the growing evidence that midwives are suffering vicarious and personal trauma in their role (Toohill et al., 2018).

3. Safe: Evidenced-based, meaning based on scientific evidence, health professionals’ and Women’s collective and individual experience, and intuition. Health professionals use this framework for all healthcare decisions and planning, not picking and choosing to suit their own individual preferences. Safety also includes cultural integrity and safety, which includes:

a. The support and implementation of Birthing on Country programs. Greater recognition of the importance of cultural norms and cultural
safety in the maternity care of Aboriginal and Torres Strait Islander peoples. Birthing on Country is a metaphor for the best start in life for an Aboriginal and/or Torres Strait Islander baby.

b. A zero tolerance approach to racism adopted by healthcare services and health professionals, both in care provided to Aboriginal and Torres Strait Islander women, and toward Aboriginal and Torres Strait Islander staff.

4. Woman centered, meaning it:
   a. Enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society
   b. Focuses on a woman’s health needs, her expectations and aspirations
   c. Encompasses the needs of the woman’s baby, and the woman’s family, her other important relationships and community, as identified and negotiated by the woman herself.
   d. Is holistic and recognises each woman’s social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself.

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

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<td><strong>1.</strong> More women than a decade ago are able to access to continuity of primary maternity care with a known midwife, however this still represents only 8% of all women in Australia. The high quality evidence about continuity of midwifery care models demonstrates benefits for women and their newborns, with no adverse effects (Tracy et al. 2013, McLachlan et al. 2008, Sandall et al., 2016), as well as being a cost-effective strategy (Toohill et al., 2012), protect the emotional wellbeing of women (Renfrew et al., 2016) and midwives (Sidebotham et al., 2017; Fenwick et al., 2018) compared to those providing standard maternity care.</td>
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<td><strong>2.</strong> Midwifery is recognised in legislation as a distinct profession from nursing. Nevertheless, there is still a lack of adequate representation for midwifery at the Nursing and Midwifery Board of Australia, as well as leadership positions in healthcare services.</td>
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<td><strong>3.</strong> Midwives have access to Medicare, although the barriers to private practice, such as insurance and lack of access to hospital facilities, has resulted in a smaller number of midwives than hoped actively engaging.</td>
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<td><strong>4.</strong> High level of education provided to maternity care providers underpinned by robust standards and accreditation processes.</td>
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**References**


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<tr>
<th>4. What do you think are the three or four key gaps or issues for maternity services in Australia?</th>
<th>1. Rural maternity services have been closed, either due to lack of midwifery staff, or as a result of a focus on biomedical risk assessment and management, including a requirement for 24 hour access to surgical and anesthetic cover to be available (Kruske et al., 2016). However, a number of multidisciplinary research projects conducted in western nations refutes the assumption that only when obstetric and anaesthetic services are available, is it safe for women to birth in a maternity unit in her rural community (Birthplace in England Collaborative Group, 2011; Kruske et al., 2016). Maternity services must be provided to women in rural and</th>
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remote areas, including continuity of midwifery carer, and deliver appropriate services to women, including Aboriginal and Torres Strait Islander women. Options should include birth at home/or on country –and should include the evidence based and effective option of alongside or freestanding birth centres (that need to be built). Babies born to healthy women in small rural units (without specialist obstetric / anaesthetic cover) have equivalent health outcomes to those born to healthy women in larger maternity services. For example, Kruske et al. (2016) found that compared to secondary and tertiary level care, healthy women birthing in units without readily available anesthetic / obstetric cover have good clinical outcomes including:

a. No differences in perinatal mortality;
b. No differences or improved outcomes for perinatal morbidity;
c. Improved outcomes for perinatal morbidity;
d. Improved neonatal outcomes;
e. Less caesarean sections.

Managers of such services need to think laterally and implement models that employ midwives to make the services sustainable; such models have been successfully trialled both in Australia and overseas (Durst et al., 2016, Barclay et al., 2014). Rural and remote health services should be funded to ‘grow their own’ midwives in the same way that funding has been provided to the medical profession in schemes such as the Murray-Darling Medical Schools Network.

2. Antenatal education which is not referenced at all in the NSAMS consultation paper) that focuses on improving childbirth and parenting confidence and self-efficacy, and on reducing childbirth fear, is crucial for engendering good childbirth outcomes, where the woman and her partner look back and feel positive / have no regrets about their birth experience, which is associated with improved parental-baby attachment and better family functioning, parental, and infant short and long term outcomes all round.
3. Adequate post-natal care that extends past the first few days after birth, and from hospital into the home and community. Traditionally, postnatal care has been the Cinderella of the maternity services as evidenced by the current lack of national Australian guidelines for the postnatal care of women up to six weeks. This needs to change so that women receive the appropriate care they need and deserve in order to transition into confident and competent mothers, and their babies thrive. Midwifery models of care need to extend six weeks into the postpartum period, providing access to mothers in their home or community clinics. This will significantly address areas of concern including mental health issues following birth. Further, individualised and community benefits of breastfeeding are not being maximised because of the current lack of postnatal support. The National Breast Feeding Strategy, currently under public consultation, will only be achieved by increased education and care planning in the antenatal period, support at the time of birth and immediately afterward to achieve essential outcomes such as skin-to-skin, and ongoing care provision for in the postnatal period to a minimum of six weeks; all of which are provided in a continuity of midwifery care model.

4. There should be midwifery career pathways (child and family health/perinatal mental health/women’s health/sexual and reproductive health/neonatal care) that enable midwives to extend their roles and provide comprehensive wrap around services for women, children and families. This will facilitate effective and efficient workforce utilisation and mobility across clinical and geographical areas.
   a. Enabling Endorsed Midwives to work to their full scope of practice (including prescribing and referral for Medicare itemed services) across the board, including rural and remote areas. It is essential that the expanded role of the Endorsed Midwife is incorporated into publicly funded maternity services (congruent with Australian nurse prescribers and midwifery prescribers in other similar nations) (Small et al., 2016).
   b. All midwives should receive pre-registration education so they are able to prescribe for their scope of practice at initial registration.
5. There should be transparency and consistency across Australia with all policies, guidelines and strategies to reduce inconsistent practices and increase access to care, as evidenced by the Australian Commission on Safety and Quality in Healthcare Second Australian Atlas of Healthcare Variation (second Atlas) (2017).
   a. Related government policies will be joined up and cross referenced e.g. National Breastfeeding Strategy and NSAMS.
   b. There should be national guidelines where there is significant clinical variation e.g. induction of labour and where there are significant gaps e.g. postnatal care.
   c. There will be clear accountability with the strategic approach and decisions will be transparent.
   d. Campaigns such as Choose Wisely should be embedded into healthcare provision to improve the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures (http://www.choosingwisely.org.au).

6. Cross-indexing of NSAMS with current National Breastfeeding Strategy currently being developed, to include funding of the Baby Friendly Health Initiative so that all hospitals are accredited, and BFHI linked to the National Safety and Quality Health Service (NSQHS) Standards (Smith et al, 2018).

References


| a. Of these which is most important to you? | They are all of equal importance |
5. **What four to six key improvements would you like to see in maternity services in Australia?**

<table>
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<tr>
<th>1. Commitment to providing access to continuity of midwifery care models for all women, regardless of risk and place of birth, from conception to six weeks postpartum. With investment in strategies, funding and resources to enable midwives to continue to provide holistic care that supports women to transition to become strong, confident mothers and invests in the wellbeing of the infant.</th>
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<tr>
<td>2. Strategies to reduce medical procedures and tests that lead to the cascade of interventions such as induction of labour and caesarean sections. The impact on the long-term health of offspring born by caesarean (the impact on their human biome) and the health care costs (short and long term) of obstetric interventions and their exacerbation of chronic ill-health are not being adequately addressed (Yang et al., 2016).</td>
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<tr>
<td>a. Stricter parameters around the decision to perform caesarean section, as well as financial disincentives for maternity services that do not comply, are required to reduce both the primary and the repeat caesarean section rate.</td>
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<tr>
<td>b. Evidenced-based clinical targets should be set to reduce unhelpful or harmful medical procedures and tests, supported and encouraged by funding mechanisms.</td>
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<td>3. Barriers to private midwifery must be removed once and for all:</td>
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<tr>
<td>a. A solution to the absence of intrapartum indemnity insurance for Midwives in Private Practice who support women to give birth out of hospital must be found. The current exemption is permissive but does not protect the women or the midwives.</td>
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<tr>
<td>b. All health services must provide access to privately practising midwives, including non-punitive and respectful collaboration between health professional and private midwives and maternity services.</td>
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<tr>
<td>c. The current one way impost on midwives to have a collaborative agreement is discriminatory, biased, and has been proven an insurmountable barrier to access and is disadvantaging women and should be removed.</td>
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</table>
d. The current requirement for three years’ experience before a midwife can be endorsed as a prescriber does not make sense as prescribing is in a midwife’s scope of practice at point of registration. Therefore, education standards be amended to prepare midwives for prescribing at entry to registration.

4. That women who meet appropriate criteria have the option to birth at home supported by a publicly funded or private practice midwife.
   a. Intrapartum indemnity insurance solution needs to be found urgently
   b. Health services must remove barriers to employed midwives providing ‘Secord’ midwife services at a birth at home.
   c. Respectful relationships between midwives, obstetricians and health service managers to facilitate the seamless consultation, referral and transfer from home to hospital, when required.

5. A revision of the organisation of postnatal care provision with a community focus (via continuity of carer) to improve maternal satisfaction with care, and impact positively on workforce (Forster et al, 2014, Forster et al., 2016, McLachlan et al., 2016, Ridgeway et al., 2016, McLauchlan et al., 2009, Morrow et al., 2013).
   a. National standard implemented for the provision of postnatal care education
   b. A review of the current funding model that does not recognise the additional care requirements of a proportion of unqualified babies on postnatal wards.

6. National standard implemented for the provision of antenatal education

References
Mclachlan, H., Forster, D., Amir, L., Cullinane, M., Shafiei, T., Watson, L.,  
Ridgeway, L., Cramer, R., Mclachlan, H., Forster, D., Cullinane, M., Shafiei, T.,  
*Midwifery*. 29(2), 159-166.  
Women's views of postnatal care in the context of the increasing pressure on postnatal beds in Australia.  
*Women and Birth*, 22, 128-133.  
*Nursing research*, 65(1), p.76-88. |
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<tr>
<th>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?</th>
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<tr>
<td>Cultural safety should be embedded as a key outcome of the NSAMS to create a maternity services system that will benefit all women and their families. Maternity services should be designed, developed, delivered and evaluated for and with Aboriginal and Torres Strait Islander women that encompass some (or all) of the following:</td>
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<td>- they are community based with an Aboriginal and Torres Strait Islander governance framework</td>
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<td>- provide for inclusion of traditional practices</td>
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<tr>
<td>- involve connections with land and country</td>
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<td>- incorporate a holistic definition of health</td>
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<tr>
<td>- value Aboriginal and/or Torres Strait Islander as well as other ways of knowing and learning</td>
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<tr>
<td>- encompass risk assessment and service delivery and are culturally competent</td>
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<tr>
<td>The National Maternity Services Plan [NMSP] (Action 1.4) was to promote access to high quality maternity care for women living in remote areas of Australia (who have no choice but to be evacuated off country to birth). One strategy to resolve this need for forced evacuation off country was to establish maternity services so that women could birth ‘on country’ thereby not breaking their own or their offspring’s connection with land and country (Barclay et al., 2014, Kildea et al., 2016). However, the plan has expired without any significant increases in the number of Indigenous women enabled to birth on country. The NSAMS needs to make this a priority in order to improve maternal and newborn health in rural and remote Indigenous communities. Strategies to improve maternal and newborn health in Indigenous communities have been outlined by Kildea et al., (2016) and include but are not limited to:</td>
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<td>- supporting Indigenous students to enrol and complete midwifery and medical undergraduate courses (Action 3.2 of the NMSP);</td>
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• ensuring culturally competent maternity care (Action 2.2 of the NMSP) to combat the racist attitudes and actions sometimes reported by Indigenous women.

Furthermore, it is essential that the NSAMS integrate the impact of social, cultural, emotional and spiritual risk (as well as medical and obstetric risk) when planning services for Indigenous women (Durst et al., 2016, Josif et al., 2014, Tran et al., 2017, Kildea et al., 2016).

References


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

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<tr>
<th>There will be measurable indicators and targets to be included in the Strategic Approach. All reporting should be transparent including facility level health data (including morbidity and mortality data)</th>
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<tbody>
<tr>
<td>a. Achievement of benchmarks against the ACSQHC maternity indicators should be included in the accreditation standards.</td>
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<tr>
<td>b. The Maternity Care Classification System (MaCCS) should be mandatory (Donnolley, Butler-Henderson, Chapman &amp; Sullivan, 2016). The objective assessment of models of care using the MaCCS is essential and will assist in objective analysis and cost analysis by health economists in order to inform healthcare planning and provision.</td>
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<tr>
<td>c. Woman’s experience and satisfaction, as well as mental health indicators should be collected by facilities and private healthcare providers and included in local and national reporting. Women are experiencing significant birth trauma, much of which is caused by their treatment by healthcare providers, as opposed to clinical outcomes. This means that much of birth trauma can be prevented, and perinatal mental health outcomes improved (Reed, Sharman, &amp; Inglis, 2017). Yearly progress evaluations, conducted by an independent body, that includes engagement with maternity consumer advocacy organisations (such as Maternity Consumer Network and Maternity Choices Australia), will assist in measuring the level of success. Tools for measuring women’s satisfaction such as the ICHOM Standard Set for Pregnancy And Childbirth (<a href="http://www.ichom.org/medical-conditions/pregnancy-and-childbirth/">http://www.ichom.org/medical-conditions/pregnancy-and-childbirth/</a>) (Martin, Hollins Martin &amp; Redshaw, 2017) may be used. Making these progress evaluations publicly available will ensure accountability.</td>
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Named targets for outcomes that the Strategy aims to meet:

- Increased access to continuity of care models for women no matter where they are located – SET A TARGET of 50% of women
- Increased workforce opportunities to work in continuity of care models for midwives to increase sustainability of the workforce – SET A TARGET - beginning at 25% and increasing annually
- Australian College of Midwives to advise research funding bodies to provide targeted calls for research to translate the current evidence

References
