Thursday, 20 April 2017

National Framework for Maternity Services Consultation Response from the Australian College of Midwives

Thank you for the opportunity to respond to this consultation regarding the National Framework for Maternity Services: Incorporating a National Antenatal Health Risk Factors Strategy.

This following response is from the Australian College of Midwives (ACM); the peak professional body for midwives providing private and public services in hospitals, community settings and at home across Australia. The ACM has approximately 5000 members and represents all midwives in the work we undertake by working in partnership with, and providing expert advice to a range of partners and stakeholders including, the Nursing and Midwifery Board of Australia, the Australian Nursing and Midwifery Accreditation Council, federal and jurisdictional government ministers, advisers and policy makers, the National Health and Medical Research Council, and the Australian Commission on Safety and Quality in Health Care. In addition the ACM promotes midwifery through membership of health related communities such as the National Immunisation Forum, and by managing the Australian Baby Friendly Health Initiative to promote best feeding outcome for our future generations.

Our response is underpinned by the knowledge that midwives have a pivotal role in the perinatal journey that women undertake. The evidence clearly identifies that midwives are key to ensuring safe, quality maternity care; and that mothers and communities benefit from access to midwifery continuity of care models.

Does the Vision statement actively reflect a clear goal for the Framework? If not, what should be included?

The ACM supports the vision that women have access to high quality, evidence-based maternity care. However, the ACM has grave concerns about whether the
Vision can be translated into practice due to the lack of clear guidance and plans on how the Vision is to be achieved.

- **‘High-quality’** needs to be defined as different groups (consumers, health practitioners, governments, institutions, managers) may have different expectations around what ‘high quality’ implies. For example, ‘high quality’ may be defined by a one group as ensuring everyone has access to unlimited technology. Alternatively, ‘high quality’ may be defined by another group as access to a known midwife throughout the childbirth continuum;

- **‘Evidence-based care (EBC)’** needs to be defined in light of the processes of informed choice and decision-making which are a vital component of EBC. This includes:
  - respect and support of women and families when their decisions do not necessarily go along with health practitioners’ (or institutions) recommendations;
  - being clear that EBP may encompass a range of research evidence, as well as the practitioner’s own experience and preferences and values of the woman and family; and as such is not solely based on randomised-controlled trials;
  - working with women and families to collectively develop and agree solutions that meet everyone’s needs in areas where clear evidence is not available;
  - education of health practitioners in the review, analysis and understanding of evidence;
  - integration of verified evidence into maternity service policy and guidelines, not just evidence that suits particular agendas eg routine cardiotocography is still advocated in many maternity units despite it having no benefit for low risk women.

**Do the identified Values appropriately guide achievement of the Vision?**

The values are highly desirable; the issues are:

- how they will be enacted, monitored and reported;
- who is responsible for their accountability; and

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• what ramifications there are when those values are not upheld.

Values are highly personal and defined differently according to individuals experience, beliefs and culture etc. For example, a maternity service may state that they respect a woman's choice to have a home birth, yet then put in place a number of insurmountable barriers that actually prevent a woman accessing this choice such as failing to facilitate privately practising midwives' ability to collaborate, consult and transfer.

‘Honesty’ is a Value that should be added and well defined, to ensure that all maternity services and providers provide honest, transparent and informed communication across all levels of services. This addition would align with the proposed Value: ‘Respect’. Including ‘Honesty’ would provide a safe platform and environment for health practitioners to be open about their personal views and beliefs when providing information to women. Inclusion would ensure compliance with all maternity services and provides and go some way to reducing (if not completely preventing) the bullying of women and other care providers (such as midwives) that occurs in maternity services across Australia.

1. ‘Respect’ - By implication, the women's choices must be respected including that to birth at home. Partnership may be a preferable word to use because it is more active than respect and ensures that the woman is actively involved in her care and the decision-making.

2. ‘Accountability’ – this Value should include accountability to women and the wider community, with consequences when values and principles are not adhered to.

3. ‘Excellence’ – this Value needs more thought and definition as it is not currently clear where and how the standard has been set and who by and against what criteria or expectations

4. ‘Leadership’ – guidance should be provided as to how ‘Leadership’ will occur and how it can be accessed. Further details are required outlining and defining the consequences for maternity services or providers when they
does comply and or leadership does not eventuate. The ACM questions how women and the community will be supported and promoted to lead maternity service planning and evaluation?

Are the Principles of the Framework reflective of the needs of mothers, babies and their families? If not, what should be included?

At first glance, the Principles are highly desirable, however, with greater review and analysis the ACM notes that the language used is vague and lacks guidance and we have concerns that there is little thought or planning on how this will be supported or implemented.

Clarity is requested on the term ‘enduring Framework’.

The document states that the Framework will be reviewed every three years, however, no detail is provided on how this will occur, who will undertake the review, the implications for jurisdictions who have not met the terms of the Framework, or what mandate the Framework holds. The lack of clarity creates ambiguity and so does not provide a credible mandate for the Framework.

The Framework has been proposed rather than continuing with the previous plan, or designing a new plan because feedback from a “process evaluation” included “concerns that the NMSP was too prescriptive in its recommended actions for implementation and did not have the flexibility to be applied consistently across the country due to differences in population needs in each jurisdiction”.

The ACM is concerned that there was no reference cited for this process evaluation, or indeed any information made available about the evaluation other than key messages that are not evidenced.

The ACM requests to be advised:
- How was the evaluation carried out and by whom;
- who were the participants;
- what other data was obtained by the evaluation;
The above information is critical for the ACM to be able to provide an honest response to the suggestion of this paper regarding the validity of proposed Framework. As it stands we, along with all others stakeholders providing feedback, have been denied the opportunity to read the process evaluation to inform our understanding of the Framework development. We see this as erroneous oversight that puts the reliability and validity of consultation feedback (from all stakeholders) at risk. The lack of transparency is in direct opposition to the Values of Respect and Honesty which are being espoused in this document as a requirement for midwives and should therefore be enacted with the development of any work that looks to underpin and define practice.

The ACM is further concerned that the reason stated for not maintaining the previous plan was that it was "too prescriptive" The recommended actions in the 2010-15 plan are fundamental to quality maternity services, and few are so extreme that implementation cannot be varied such that it suits local needs and requirements. Therefore, the justification of "too prescriptive" is requested. For example, continuity of midwifery care is accepted both nationally and internationally as a keystone of maternity services. By moving away from an actionable plan to a nebulous Framework, maternity service planning and implementation across the jurisdictions, which is already inconsistent and lacking accountability, will become increasingly fragmented.

Enablers and barriers to the success of the NMSP

Despite minimal feedback from the evaluation being provided. ACM notes that feedback was consistent in identifying that leadership (in the form of MSJIC and jurisdictional reference groups), governance and funding were key enablers and barriers to the success of the NMSP. The current Framework fails to address these critical areas. The ACM recommends that further work is undertaken to provide details on how these will be addressed.

1. **Woman-centred** – It is noted that while most women will identify her partner / family as being significant to her, this is not always the case. Furthermore, there may be occasions when the woman’s desires are not the same as her family. It is recommended the definition on page iii be utilised in the context of the woman-centred principle on p.5.

ACM also recommends adding the following (or similar) to the principle: “Where multiple courses of action are possible, complete, unbiased evidence-based information about all courses of action (including expectant management) should be provided, to enable each woman to make informed choices”.

Midwives and women report frequently that information was given to women in a completely biased way that prevented them from making truly informed decisions, and significantly reduced their choices and self-autonomy.

2. **Culturally safe** – Maternity services reflect an understanding of the diversity between and within cultures, supporting a woman’s wellbeing, and meets the needs of the woman, her partner and/or support network including her community (p.5)

The above principle comment on the definition of woman-centred equally applies to this second principle. Further ACM recommends addition of:

- Cultural safety should be defined the Aboriginal and Torres Strait Islander community⁴, and recognise that cultural safety is what the woman herself feels about the care she receives⁵.
- Health professionals should be educated to recognise that their practice reflect their own beliefs.
- Zero tolerance of racism must be a core feature of maternity services, especially as research is increasingly demonstrating the adverse health impact on people, across generations⁶.

Embedded into the Framework must be:
- All Aboriginal & Torres Strait Islander women have the right to self-determination.
- All midwives and maternity care providers are culturally competent when working with Aboriginal & Torres Strait Islander women and families.

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• Midwives and maternity care providers must be educated on the historical factors that influence and impact Aboriginal and Torres Strait Islander people in today’s society.

• Respect of the importance of Aboriginal and Torres Strait Islander traditional culture, lore’s and customs, and the impact this may have on women attending services.

• Understanding that Aboriginal and Torres Strait Islander people are a diverse nation, with over 600 different language groups, with different lore’s and customs depending on the location the woman is from.

• Midwives and maternity care providers should be open to learning about the location they work in, so they can engage women and provide the most appropriate midwifery care in a culturally safe way that is relevant to that community.

• Respect of “Women’s Business”, as birthing has traditionally been sacred women’s business, Midwives and maternity care providers can support Aboriginal and Torres Strait Islander women by facilitating this where possible.

• Importance of supporting women to Birth on Country where possible, and respecting traditional birthing methods.

• Work with Aboriginal and Torres Strait Islander women to continue spiritual and cultural connections to the land through traditional ceremony.

3. **Safe, high quality care** – this principle which states that “maternity care is provided to women and their families within a wellness paradigm” is then contradicted by using the National Antenatal Health Risk Factors Strategy, which focuses on risks. This health risk factors approach visualises women and their babies as a list of risks and conditions, and totally ignores individual, woman-centered assessment and care planning, holistic healthcare, and/or the wider impact of the social determinants of health.

Further, the Principle ends at “responding to the woman’s antenatal health needs”. This ignores the intrapartum and postnatal periods which are equally important periods of time within the childbirth continuum.

4. **Access** - All women, including Aboriginal and/or Torres Strait Islander women, culturally and linguistically diverse women, women living in socioeconomically disadvantaged communities and rural and remote women and their families, have access to high quality, safe, evidence-based maternity care (p.5). This access must
include the woman’s choice of birthing place, including access to birth at home or ‘on country’ (for Australian Indigenous women), supported by a known midwife, general practitioner or obstetrician.

5. **Equity** – this principle is extremely vague and raises questions as to how it will be enacted or assessed. And poses other critical questions such as:
   - who will be responsible for leading;
   - what is the intended outcomes;
   - what funding will be available across all the sectors?

6. **Collaboration** – This has been a standing item on the agenda and detailed in the 2010-15 Plan. However, there continue to be significant barriers erected by maternity services and obstetric providers which prevent midwives from carrying out their core business. Doctors and hospitals are currently not obliged to collaborate with private midwives who are Medicare-eligible. Whereas it is a fundamental condition that private midwives are forced to adhere to before they can practice. Alarmingly, the Australian Medical Association has advised its members that “If you do not want to be part of a collaborative arrangement, or you are unable to reach agreement on the appropriate terms of a collaborative arrangement, then there is no obligation to be part of one. You do not have to commit to being part of a collaborative arrangement for any particular period.” This must be addressed in the Framework to ensure that these barriers are broken down, and accountability is expected from people and services who continue to stop midwives providing care that meets the needs of women in Australia’s community. It is vitally important that all health professionals are able to collaborate and communicate respectfully with each other, whilst always acting in accordance with the value of respect for a women’s choices and the principle of women-centred care. Should this occur transitions from one care provider to another, or collaborations between care providers, would far easier than they are at present.

7. **Sustainable** – midwifery models of care are successful and cost-effective⁸, and must be the key stone of any plan or Framework going forward. There is no reference to the principle of ‘first do no harm’. There is no description of the

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Australian maternity care system as delivering interventions that are ‘too much, too soon’. Aligned with ‘sustainable’ should be a further principle about ‘moving towards normal birth’, which is, in the most part, the best outcome for mothers and babies, as well as a cost-effective and sustainable strategy for maternity services and the wider community.

**Does the Framework provide direction for the planning of maternity services? If not, what should be included?**

The Framework does not give direction for the planning of maternity services. As there has been no systematic evaluation of all the outcomes of the 2010-15 Plan, it is hard to see how this Framework can build on the work already done, or move maternity services forward.

The Framework espouses evidence-based maternity care, yet the move from a Plan to a Framework does not appear to be evidence-based. It should also be noted that whilst there are outstanding actions from the Plan, those that were adequately funded with realistic timeframes were successfully achieved. This begs the question: why move from a Plan which has been demonstrated to be effective with measurable results, to a Framework that has no outcomes or accountability.

The ACM acknowledges that there have been issues around lack of accountability and transparency with the Plan. For example, the ACM hears frequently of maternity services that put barriers into place to prevent both employed and private midwives from providing successful midwifery programs. Further, maternity services refuse to provide collaborative arrangements and take punitive measures against midwives supporting women’s choice (when/if it goes against the policy of the hospital). The closure of successful continuity of midwifery models that support planned birth at home options are a prime example of changes being implemented with little or no justification or evidence. The ACM believes that the proposed Framework will do nothing to prevent this from continuing but rather, will make it more likely to happen.

In particular, the Framework ignores the considerable benefit of midwives, and midwifery continuity of care\(^9\). Disturbingly, midwives are not even referred to in the

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Definitions section of the Framework, despite being the majority workforce across all maternity services.

Midwifery continuity of care has been consistently shown to be a safe, economic, and appropriate model of care for maternity services for both low risk women, as well as women with complex medical, social and emotional needs.\(^{10,11}\) This also includes ‘birthing on country’ models of care, which greatly improves outcomes for Aboriginal and Torres Strait Islander women. **This action in the previous Plan has not been acknowledged in the Framework.**

The Framework has a strong antenatal, medical focus and ignores the remainder of the childbirth continuum, resulting in a piecemeal approach, rather than a holistic view of maternity. This is evidenced in the emphasis on the National Antenatal Health Risk Factors Strategy (NAHRFS), which is built on a risk-factors approach to medical health conditions, rather than a health promotion, sustainable wellness methodology which takes the whole woman (and family) into consideration.

The Framework focuses on the antenatal period which is an important period when much health promotion, screening, information-sharing and care planning is carried out. Nevertheless, the Framework misses out on the postnatal period when both mother, baby and family need support with ongoing assessment and care planning, and particular help with breastfeeding, mother-baby bonding and mental health. To leave the postnatal period out of the Framework only accentuates the “Cinderella”\(^{12}\) treatment of both facility and community postnatal services, and puts women at risk at their most vulnerable.

The Framework refers to a number of other documents such as the National Breastfeeding Strategy and National Mental Health Plan, which goes some way to explain why the postnatal period has been so woefully neglected in this Framework. However, this is problematic because a number of the other Frameworks and Plans mentioned are currently under review so there is no way of knowing what will be included in them, and how they align with this Framework. Equally concerning is the

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move to refer to other documents, which will further fragment services, especially postnatal services and care, as well as care provided to Aboriginal and Torres Strait Islander women.

Nurses, including child and family health workers have been omitted from this document. They need to be identified as nurses play a part in maternity services, including GP surgeries, special and neonatal care nurseries, and postnatal home visiting programs.

**Does the national antenatal health risk factors strategy adequately define health risk factors that affect pregnant women and their babies?**

The Framework seems to be contradictory. The Framework has been mooted as a high level principles document that is not prescriptive and encourages flexibility; yet much of the Framework focuses on the National Antenatal Health Risk Factors Strategy with very prescriptive dialogue about specific medical conditions and screening.

The sixth of the ten principles underpinning the plan reads, *Maternity care will be provided for all women and their babies within a wellness paradigm, utilising primary health care principles while recognising the need to respond to emerging complications in an appropriate manner.* The trend toward a risk/pathogenic focus as outlined in the sixth principle, as opposed to a salutogenic / wellness paradigm would seem to be incongruent. Aboriginal and Torres Strait Islander people, especially, consider health to be holistic, and that physical health is affected by the social, emotional and cultural wellbeing of both individuals and the broader community. This is true of all people.

When planning and implementing care across the childbirth continuum, a number of key strategies, evidence and resources should be used, not just the National Antenatal Health Risk Factors Strategy; including the National Antenatal Care Guidelines, ACM National Midwifery Guidelines for Consultation and Referral and other internationally recognised sources of evidence such as the Cochrane Database of Systematic Reviews.

Identifying strategies to respond to health risk factors throughout the childbirth continuum will be of far more use than this high-level Framework.
Does the national antenatal health risk factors strategy identify strategies to respond to antenatal health risk factors? If not, what should be included?

There is little mention of Aboriginal and Torres Strait Islander women and families, and their specific cultural birthing needs, or methodologies for closing the gap.

There is no mention of strong community services and networks to support women and families, especially those who are vulnerable, have lost babies, or are at risk of having their babies removed.

There is little discussion about provision of care to women in rural or remote areas, or exploration of how innovative models of care may keep women, especially Aboriginal and Torres Strait Islander women, birthing in their own location.

There is no discussion of specialist services or units for women with mental health illness.

Prevention of still birth, and care of women who have experienced such has been omitted.

Affordability of testing and screening, and the resulting implications for women and families has been ignored. It is no use advising women that they need referrals or extra tests if they are unaffordable. Women from the country cannot afford the accommodation, transport costs, and care for family to take time off work, to travel vast distances for hospital appointments and see medical practitioners. Conversely, women who live less than 150 km from the medical service get no support, for example, a woman who has to come from parts of Newcastle to Sydney has no travel or accommodation recompense. The cost of some treatments are prohibitive, for instance, some women will not buy strips for their glucometers, insulin, or antibiotics, as these medications are too expensive.

Does the Framework effectively highlight key priority areas to improve health outcomes for women and their babies? If not, what else should be included?

Maternity care as primary health care, based in the community, must be at the core of the Framework. This gives women access to community-based services that not only address the physical aspect of a woman’s care as outlined in this document, but is planned around the woman’s wider social context ie is cognisant of the social determinants of health. This should contain choice of place of birth (including
planned home birth) with a community-based midwife who is known to the woman and takes responsibility for coordinating her care throughout pregnancy, birth and the postnatal period.

Given the strong consumer input into earlier maternity service Frameworks and their oft repeated desire to be enabled the choice of birthing at home, there needs to be recognition of a significant number of women’s desire to birth at home with a known midwife or obstetrician.

The section on key enablers is scant, with no solid guidance or recommendations on how enablers are realised in practice. Included needs to be an acknowledgment that more Aboriginal and Torres Strait Islander midwives are required in the workforce to provide appropriate care for Aboriginal and Torres Strait Islander families. Equally, innovative models of care need to be employed in rural and remote areas in order to recruit and retain midwives, which should include a ‘grow your own’ approach to midwifery students and early career midwives.

Do you have any additional comments that you would like to make in relation to the consultation draft for the National Framework for Maternity Services?

Reference 4 (Page 43). ANMAC competency standard superseded by NMBA National competency standards for the midwife:

The definition of ‘continuity of care’ (p 3) is open to misrepresentation (%’small group’ is not defined and nor is the importance of every member of the ‘small group’ being known to the woman). It would be very easy for this definition to lead people into believing that a model of fragmented care was actually providing continuity of care for the woman, which would not be accurate.

The consultation process has been extremely disappointing. The period of time has been too short to gain meaningful feedback and buy-in from across the community, especially consumers. The use of language such as ‘delivery” displays a lack of understanding of woman-centred care, despite it being espoused in the Framework ie “pizza is delivered; women give birth”. This is a basic error which does not install confidence in a Framework that is proposed to take the maternity services into the
future and would have been prevented if more attention had been placed on consulting with consumers.

The ACM has attended various consultation workshops and it was very clear that the consultants had their own agenda, and would not be swayed from it. This included the determination to focus on the National Antenatal Health Risk Factors Strategy and clinical conditions in the antenatal period, rather than having a broader discussion about what was the appropriate approach across the whole childbirth continuum. Despite the very strong message at the forums that continuity of midwifery was an effective model for maternity care, this has been completely ignored as are midwives, in the Framework.

In conclusion, the ACM recommends that a full evaluation of the 2010-15 Plan is carried out and that a new Plan is carried forward that give direction, targets, concrete guidance, and recognition that flexibility across the jurisdictions is required. Further, that transparency and accountability is embedded in the Plan, as well as full recommendations about how to overcome barriers such as funding and leadership. For further information, please do not hesitate to contact Sarah Stewart, Midwifery Adviser, Policy unit: sarah.stewart@midwives.org.au (02 62307333)

Yours faithfully

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