

Woman-centred care

Strategic directions for Australian maternity services

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Introduction

Australia is regarded as a safe country in which to have a baby and compares well on a number of accepted measures of safety and quality of care. However, as for all systems of health care and service delivery, there are areas for continued improvement. Across states and territories, there are differences in women's access to services, their choice of care and/or carers and the provision of culturally safe care that ensures women are always treated with respect and dignity.

Woman-centred care: Strategic directions for Australian maternity services (the Strategy) provides overarching national strategic directions to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence and international developments.

Background

Australian maternity services are delivered through a mix of public and private services with planning and delivery predominantly undertaken by the states and territories through publicly funded programs and the Commonwealth providing national direction and supporting efforts to improve care and outcomes. In 2015, 97% of women with both low and high-risk profiles gave birth in public and private hospitals.¹ Access to maternity care is largely determined by Australia's health system's structure and funding arrangements including Medicare, specialist and general practice, private health insurance and other Australian, state and territory government health funding models, including for public hospitals.

Maternity services are provided by a range of health professionals (see Glossary) through a number of different models of care (see Appendix B). Pregnancy, birth and parenthood are normal physiological processes, although the journey is not without risk. Women's experiences can also vary based on the provision of care and health status of the mother and baby.

The maternity services system, and health professionals involved in a woman's journey, have responsibility to ensure women are actively involved in decisions regarding their care and, at the same time, provide safe and high-quality care that effectively manages risk to women and their newborn babies. This includes providing information and advice that is easily understood, accounts for risk and care needs and meets the individual circumstances of women and their families.

Three areas inform shared decision-making between the woman and maternity service providers. They are a woman's **preference**, **evidence** as it applies to the woman and the **context of care** provision. The Strategy provides equal weight to each area. Women should be appropriately referred or facilitated to achieve care, if preferences, context and evidence do not align.

Preference: this recognises the preference of women for services and the way they are delivered. The values and principles outlined in the Strategy enable maternity systems and service providers to be more responsive to the woman's voice. Listening carefully to the voices of women will enable service and system level improvements that reflect contemporary practice, evidence and international developments. Co-design and shared decision-making enable women to be actively engaged in the design and delivery of local maternity services.

Context: State and territory governments, together with public and private health services, plan for and provide maternity services to meet the needs of their communities. Factors influencing the provision of maternity services include: the needs of communities, location, availability and attitudes of the workforce and geography of regions. These local contextual factors impact upon the models that may be accessible to women within their community.

Differences in the experience, preferences and views of health professionals can also impact upon the range of models of care available to women. Professional silos and cultural differences commonly affect the ability for maternity services providers to offer multidisciplinary care that promotes women's choice, continuity of care/carer and cultural safety. Furthermore, women's experiences of maternity care can vary across population groups, different cultural and language groups and the individual woman's circumstances.

Evidence: Alongside the context of maternity services in Australia is evidence and research which underpins the development, design and provision of services; and the preferences of women and communities for the delivery of those services at an individual and community level. There is a

growing body of high-quality evidence on a range of models of care, including midwifery continuity of care, obstetric-led care and shared care. In developing services, providers are expected to review the relevant research evidence to assist in informing the design and provision of services. Equally there is a growing body of evidence regarding the outcomes and experiences of care from the perspective of the woman. This should also receive equal weight in the planning and delivery of services.

The values, principles and strategic directions outlined in the Strategy will require genuine collaboration with women, health professionals and services providing maternity care, governments and related agencies.

Consultation

In developing the Strategy, two rounds of public consultation were held. These included the opportunity for online submissions, attendance at workshops, focus groups and webinars. Across the two rounds of consultation over 600 health professionals, service providers and consumers attended the workshops, focus groups and webinars. Over 900 organisations and individuals made submissions. The contribution of so many to the development of the Strategy is acknowledged with appreciation. A shared commitment to safe and high-quality care was always evident in the feedback.

Throughout the consultation process we heard that women wanted continuity of care and carer. Women were clear that access to evidence and information was important for them to make informed decisions regarding their care; they want to be able to choose a model of care that meets their needs and is as close to home as possible; they want their choices respected and they expect health professionals to work together respectfully and collaboratively to support them in their choices.

This Strategy aspires to see the range of models available across Australia (see Appendix B); expanded such that: women are provided with relevant information and evidence; are able to actively make decisions regarding their provider that are respected and are able to access the care model of their choice.

Structure of the Strategy

The Strategy is structured around four values — safety, respect, choice and access. These values are of equal importance and underpin twelve principles for woman-centred maternity care that apply to all health professionals providing maternity services. Together, the values and principles offer an overarching strategic approach for high quality maternity care in Australia.

Strategic directions and supporting rationales are outlined for each principle to provide guidance for states and territories. The Strategy maintains flexibility, in recognition of the diversity in geography, demographics, workforce and service delivery models between and within Australia's jurisdictions. For women, the principles describe how maternity care should be provided.

Enablers for each strategic direction describe the initiatives and activities that can support implementation of the strategic directions. These activities should occur in partnership with women. Together, the values, principles, strategic directions and enablers provide a foundation for the development of jurisdictional and local maternity service planning.

Language, scope and linkages

The Strategy covers the maternity care of women from conception until 12 months after the pregnancy or birth.

In the Strategy, the term 'woman' or 'women' is inclusive of the woman's baby or babies, partner, family and community (see Glossary). The Strategy is based on the understanding that:

- pregnancy and birth are normal physiological experiences, women are experts in their lives and maternity care providers are expert in care provision
- pregnancy, birth and parenthood are life-changing in physical, emotional, social and psychological ways
- maternity care is inclusive of the diverse experiences of women, including their social circumstances (including experience of family violence), cultural and religious background, health, disability, sexual orientation and the gender with which they identify.

The Strategy recognises that the majority of women give birth in hospitals (97%) and of these 74% gave birth in a public hospital.¹ While matters regarding private obstetric care, private midwifery care, private health insurance, Medical Benefits Schedule items and broader workforce issues influence the provision of maternity care, they are subject to other processes and are beyond the scope of this Strategy.

A range of other programs link to the Strategy which is informed by and will inform the work of other government agencies, including the Australian Institute of Health and Welfare (AIHW), the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Medical Research Future Fund (MRFF) and the Independent Hospital Pricing Authority (IHPA). The Strategy will also intersect with other work such as the development of the national electronic pregnancy health record and national strategies including those for Aboriginal and Torres Strait Islander health, women's health, breastfeeding, diabetes, mental health and the stillbirth action plan.

Monitoring and evaluation

One of the key issues raised by stakeholders during consultations was the need for the Strategy to be monitored and evaluated.

The scope of the monitoring and evaluation framework (MEF) mirrors the scope of the Strategy itself. It provides an overarching theory of change logic model which is the conceptual foundation of measuring progress of the strategic directions identified in the Strategy.

The MEF is informed by research and evaluation evidence about the maternity care sector and best practice approaches to monitoring and evaluating complex health interventions, policies and systems. It aligns with the values and principles of the Strategy and acknowledges that local and jurisdictional maternity systems will use the MEF in accordance with any differences and priorities they may have.

In doing so, it provides overarching guidance for jurisdictions in their work to monitor and evaluate improvements in their maternity care systems. It does not provide a one-size-fits all approach to monitoring and evaluating the Strategy, either at a national or jurisdictional level. The Australian Health Ministers Advisory Council (AHMAC) and Ministers will continue to provide advice and direction on future monitoring and reporting on progress with the Strategy.

Strategic directions for Australian maternity services

Purpose

Woman centred care: Strategic directions for Australian maternity services aims to ensure that Australian maternity services are equitable, safe, woman-centred, informed and evidence-based. Women are the decision-makers in their care and maternity care should reflect their individual needs.

Values and principles

The values (safety, respect, choice and access) principles and strategic directions are based on current evidence and feedback provided by women and health professionals. They are aligned with the *Respectful maternity charter: the universal rights of childbearing women*.²

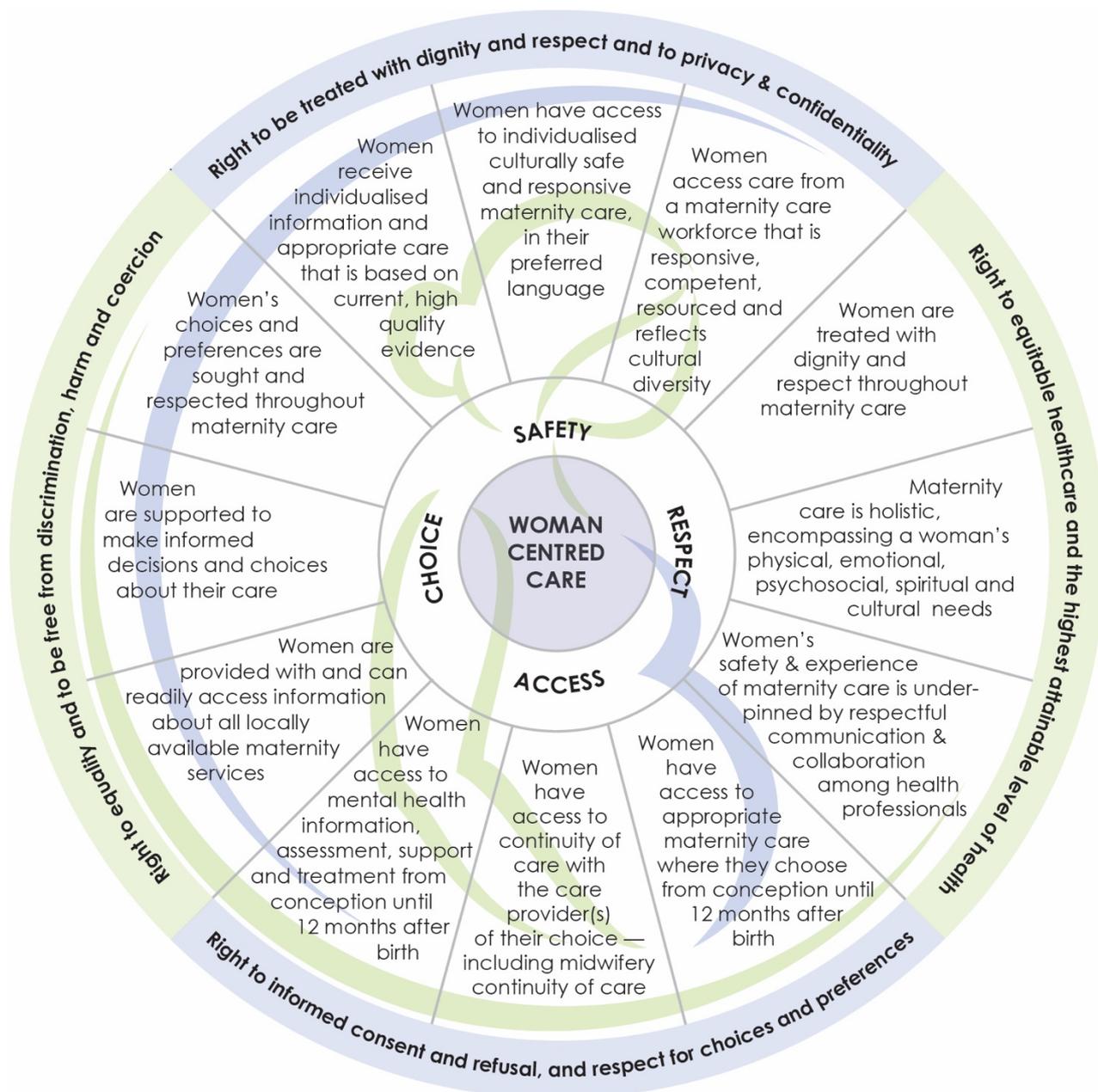


Figure 1 Woman-centred care

The diagram above gives a visual representation of the purpose, values and principles outlined in this document. The inner ring represents the purpose of the document and is surrounded by the values. The rays present the principles and the outer ring the *Respectful maternity charter: the universal rights of childbearing women*.²

1. Safety

1.1 Safety and quality in maternity care

Principle

Women receive individualised information and appropriate care during the perinatal period that is based on current, high quality evidence.

Strategic direction

1. Ensure evidence underpins the design, development and provision of services and continuous quality improvement.

Rationale

Women expect health professionals to provide care in line with available evidence.

Rates of intervention during labour and birth are perceived by women to be high.

Caesarean section rates in Australia are high relative to most OECD countries (34 per 100 live births compared to the OECD average of 27.9 per 100 live births)³ and rates of both emergency and elective caesarean sections have risen over the last decades, with a greater increase in elective than emergency caesarean sections.³

In 2016 in Australia, labour was spontaneous in 48.8% of women with term births (37⁰ to 41⁶ weeks) and induced in 31.2%.¹ For women with post-term births (≥42 weeks), labour was spontaneous in 35.0% of births and induced in 59.8% of births. Among women (of all gestations) whose labour was induced, 60.7% had a vaginal birth, 18.6% had an assisted vaginal birth (forceps or vacuum extraction) and 20.8% had a caesarean section.⁴

Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, women living in regional, rural and remote areas, teenage mothers and women who experience family violence are all more likely to experience poorer outcomes.⁵

The use of evidence-based guidelines has the potential to improve care of women and babies during the perinatal period and ensure consistency of care across health sectors.

The national Pregnancy Care Guidelines⁵ were developed to support the provision of consistent, high-quality, evidence-based antenatal care to Australian women.

Enablers

- The currency of national evidence-based pregnancy care guidelines, including summaries for women, is maintained and their uptake by health professionals promoted.
- Labour and birth are supported by nationally consistent evidence-based guidelines which include summaries for women.
- Implementation of the National Safety and Quality Health Care Standards in maternity services is supported by a standards user guide for maternity services.
- Variation in outcomes and practice in healthcare settings is identified, reported on and improvement guided by clinical care standards relevant to maternity care.
- Continual improvement in the quality of maternity services is supported by further development and public reporting of the National Core Maternity Indicators
- Further research on longer term outcomes of care is completed.
- Application of Maternity Service Capability Frameworks is consistent across both public and private sectors.
- Cultural beliefs and practices including Female Genital Mutilation are considered in assessing and delivering care.

Strategic direction

2. Service providers implement measures to reduce the rates of stillbirth and maternal and neonatal morbidity and mortality in partnership with women.

Rationale

Stillbirth and neonatal mortality

In Australia in 2016, there were 6.7 stillbirths per 1,000 births and 2.4 neonatal deaths per 1,000 live births.¹ The most common cause of perinatal death was congenital anomalies (3 in 10 deaths), followed by unexplained antepartum death (stillbirth) and spontaneous preterm birth (both 14 in 100). The leading causes of death vary between stillbirths and neonatal deaths.¹ Between 1995 and 2014, neonatal deaths decreased (3.2 to 2.6 deaths per 1,000 live births) and the stillbirth rate increased (7.0 to 7.1 deaths per 1,000 births).⁶

The [report of the Senate Select Committee on Stillbirth Research and Education](#) recommends the establishment of national stillbirth research funding priorities and development of a national best-practice culturally appropriate education kit for health professionals.⁷

Throughout the experience of stillbirth or neonatal death information and emotional support should be provided with sensitivity, clarity, genuineness and consideration of individual needs for care.⁸

Neonatal morbidity

Aboriginal and Torres Strait Islander babies are almost twice as likely to be born preterm (14 vs 8%) and to be of low birth weight (11.6% vs 6.3%) and 1.5 times more likely to be admitted to a special care nursery or neonatal intensive care unit (24% vs 17%).¹

Maternal mortality

In 2006–16, direct maternal deaths were most commonly due to thromboembolism, amniotic fluid embolism, blood loss from the uterus, hypertensive disorders and sepsis.⁹ Bleeding from sites other than the uterus and complications of pre-existing cardiovascular disease were the most common causes of indirect maternal death.⁹ Maternal deaths were more common among women aged 35 and over and under 20.⁹

Maternal morbidity

Physical injury (e.g. perineal tears) can cause long-term consequences (e.g. pelvic floor dysfunction) if not detected and repaired. The Australian rate of third- and fourth-degree perineal tears is higher than the average for comparable OECD countries (7.2 vs 5.7 per 100 births).³

Some other experiences during the birth may contribute to poorer maternal mental health outcomes (see Section 4).

Women and health professionals may differ in their views on the degree of morbidity experienced.

Enablers

- See Enablers under strategic direction 1.
- Comprehensive, standardised, national maternal and perinatal mortality and morbidity data collections are maintained and linked and publicly reported.
- Services implement strategies to reduce stillbirth in line with the National Stillbirth Action Plan.
- Services implement strategies to reduce maternal and neonatal mortality and morbidity.
- All women are offered a formal birth debriefing with a qualified health professional.
- Bereavement care as close as possible to home is offered to women who experience early pregnancy loss, stillbirth, neonatal death or whose babies have major congenital anomalies. Appropriate support is provided through subsequent pregnancies.
- Bereavement training is provided to all health professionals working in maternity care.
- Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse backgrounds receive culturally appropriate care.

1.2 Cultural safety

Principle

Women have access to individualised culturally safe and responsive maternity care, in their preferred language.

Aboriginal and Torres Strait Islander women

Strategic direction

3. Develop and implement culturally safe, evidence-based models of care in partnership with Aboriginal and Torres Strait Islander people and communities.

Rationale

In 2016, 4.4% of women who gave birth in Australia identified as being Aboriginal and/or Torres Strait Islander.¹ These 13,608 women gave birth to 13,794 babies. Around 1 in 19 (5.2% or 16,479) of all babies born were Aboriginal and/or Torres Strait Islander (based on the Indigenous status of the baby, i.e. where the baby's father was Aboriginal and/or Torres Strait Islander and the mother was non-Indigenous).¹

Evaluated state-based initiatives have found improved outcomes associated with maternity care models that are culturally safe and responsive, provide continuity of care and involve partnerships with Aboriginal and Torres Strait Islander health staff and services.¹⁰

Women from remote communities frequently give birth in larger centres away from their communities.

In Australia in 2017, 0.4% of employed medical practitioners and 1.1% of employed nurses and midwives identified as being Australian born Aboriginal and/or Torres Strait Islander.¹¹

Enablers

- Uptake of the Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women report 2012¹² is supported.
- Strategies relevant to maternity care in the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 and the associated Implementation Plan are implemented.
- Aboriginal and Torres Strait Islander women can access care utilising The 'Birthing on Country' Service Model and Evaluation Framework.¹³
- Existing maternity care providers have been educated in and practice cultural safety.
- Individualised support is provided to women who have to spend time away from their communities during the perinatal period.
- Language services, bilingual workers and Aboriginal maternity liaison officers are accessible.
- Language-specific antenatal clinics that provide antenatal classes and translated information are available
- Strategies in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 are implemented.

Women from culturally and linguistically diverse backgrounds

Strategic direction

4. Develop and implement culturally safe, evidence-based models of care in partnership with women from culturally and linguistically diverse backgrounds and their communities.

Rationale

One-quarter (26%) of mothers who gave birth in Australia in 2016 were born in a non-English speaking country, compared with 23% of women of child-bearing age in the population.¹ The proportion of mothers born in a non-English speaking country has increased from 17% in 2006.¹

Babies of mothers born in non-English-speaking countries were almost twice as likely to be small-for-gestational age than babies whose mothers were born in Australia or other English-speaking countries (13% vs 8%).¹

Mothers who were born in non-English-speaking countries were less likely than women born in Australia to attend antenatal care in the first trimester (61% vs 71%).¹ However, there was no difference in the proportion attending five or more antenatal contacts.

A systematic review identified the following barriers to immigrant and refugee women accessing reproductive health care:¹⁴

- spoken and written language, including issues relating to interpreters
- health professionals' lack of knowledge regarding cultural norms
- systemic barriers relating to the health care system and difficulty navigating the system
- transport difficulties
- cost of services.

The competency standards framework [Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds](#) was recently launched by the Migrant and Refugee Women's Partnership. The Framework has been endorsed by ACM, RANZCOG and 17 other medical colleges and organisations.

It is a comprehensive guide for midwives, obstetricians, GPs, nurses and all other health professionals working with migrants and refugees. There is also a [Guide for clinicians working with interpreters in healthcare settings](#).

Enablers

- Language services and bilingual and bicultural workers and maternity liaison officers are accessible.
- Strategies are developed to improve training in working with interpreters and bicultural workers.
- Training that promotes culturally safe maternity care is developed and provided to all of the workforce.
- Where appropriate:
 - language-specific antenatal clinics that provide antenatal classes and translated information are available
 - internal services in the hospital educate other staff about traditional practices in the specific culture that is targeted
 - local hospital protocols support early follow-up after the birth and language-specific postnatal group education sessions for new parents.
- More people from culturally and linguistically diverse backgrounds work in maternity services.

1.3 The maternity care workforce

Principle

Women access care from a maternity care workforce that is responsive, competent, resourced and reflects cultural diversity.

Strategic direction

5. Design and deliver sustainable maternity services that are safe for the health professionals providing them.

Rationale

Services and models have been limited, reduced or closed due to workforce availability.

Health professionals working in the context of high workloads and stress may experience emotional exhaustion (burnout).

The workforce is not always reflective of the population it serves.

Enablers

- Development and maintenance of skills (including clinical reflection and supervision) of health professionals working in maternity services is supported.
- Development of a workforce with broad generalist skills in rural settings to promote the maintenance of services is supported.
- Outreach and telehealth services are provided to support health professionals and improve access for women in rural and remote areas.
- Pathways are developed to support general practices and obstetric practices to work with midwives.
- Maternity health professionals are supported to work to their full scope of practice and utilise their skills and capabilities to provide care in a range of models to meet community need.
- Service providers facilitate access to review, reflection and audit for health professionals.
- See also strategic direction 7.

2. Respect

2.1. Respectful, holistic care

Principles

Women are treated with dignity and respect throughout maternity care.

Maternity care is holistic, encompassing a woman's physical, emotional, psychosocial, spiritual and cultural needs.

Strategic direction

6. Respect women's choices, experiences and outcomes and use woman-reported data to inform quality improvement in maternity care.

Rationale

Women need and deserve respectful care and protection of their autonomy and right to self-determination; this includes individualised care for marginalised women and women vulnerable to poor outcomes and to safeguard maternal and infant health.²

Disrespect and abuse during maternity care are a violation of women's basic human rights.

Women want their experiences and outcomes to be collected, responded to and made publicly available.

Enablers

- Maternity care providers commit to the Respectful maternity charter: the universal rights of childbearing women.
- Woman-reported outcomes, wellbeing and experiences are collected (e.g. using patient-reported experience and outcome measures) and reported as a core part of quality assessment of maternity services.
- A core set of questions is collected to enable national comparability.
- Women are included in maternity service planning and monitoring committees.

2.2. Collaboration among health professionals

Principle

Women's safety and experience of maternity care is underpinned by respectful communication and collaboration among health professionals.

Strategic direction

7. Promote a positive maternity workforce culture based on interdisciplinary collaboration and communication.

Rationale

Women expect all members of the health care team to work collaboratively to support integrated care and care transitions.

Collaboration among all maternity providers improves communication and outcomes and is essential to continuity of care and continuity of carer.¹⁵

The regulatory framework and service leaders have a role to play in setting standards and role-modelling appropriate behaviour.

Respectful interaction between health professionals is highlighted in the codes of ethical practice for doctors and midwives.^{16,17}

Enablers

- Professional colleges and associations for health professionals involved in maternity care endorse this Strategy.
- The roll out of digital patient health records effectively crosses and integrates the maternity services sector.
- Investment occurs in systems to support team-based leadership and interprofessional and intraprofessional cooperation, including interdisciplinary team-based training.

3. Choice

3.1. Information about local maternity services

Principle

Women are provided with and can readily access information about all locally available maternity services.

Strategic direction

8. Develop, provide and maintain access to information about available maternity services.

Rationale

Women want publicly available information to assist them in decision-making.

The [Pregnancy, Birth and Baby website](#)¹⁸ provides information on services and models of care and telephone guidance from maternal and child health nurses or counsellors.

A simple to understand concise summary of the models of care available to pregnant women, and how these differ by facility size and type would assist women in making informed choices.

Enablers

- The [Pregnancy, Birth and Baby website](#) is updated to include current information, with input from health professionals and women.
- Health professionals are supported to provide information on available models of maternity care.
- Locally available models are included in the development of Health Pathways on maternity care to assist in providing health professionals with relevant information.
- Data linkages with Maternity Care Classification System (MaCCS) and National Perinatal Data Collection are developed.
- Maternity service providers contribute data to the MaCCS and findings are publicly reported.

3.2. Informed decision-making

Principles

Women are supported to make informed decisions and choices about their care.

Women's choices and preferences are sought and respected throughout maternity care.

Strategic direction

9. Improve availability of high quality evidence-based, easily understood information about choices in care and associated outcomes during the perinatal period.

Rationale

Women have reported that their choices are not always respected.

Every woman has the right to freedom from coercion.²

Structured antenatal education that is suited to the individual can help women to be informed about pregnancy, birth and parenting.⁵

Having prior knowledge about the risks and benefits of care during the perinatal period enables women to make informed choices about their model of care and informed choices during labour.

Enablers

- As part of antenatal education, women are provided with evidence-based information about options, outcomes and implications of choices made regarding prenatal screening and models of care for antenatal, birthing and postnatal care.
- Nationally agreed tools to support evidence-based decision-making by women are developed that traverse all models of care.
- Jurisdictions have processes and communication pathways to support women and health professionals to maintain a care partnership when women decline recommended care.

4. Access

4.1. Improved access to maternity care

Principle

Women have access to appropriate maternity care where they choose from conception until 12 months after birth.

Strategic direction

10. Co-design and deliver services around the needs and desires of women and communities.

Rationale

Women want to be able to access maternity care in their geographic location.

Around a quarter of Australian births are to women whose usual place of residence is non-metropolitan and antenatal care is least accessible to women living in remote areas.¹

Women in very remote areas are slightly less likely to attend five or more antenatal contacts (90% vs 95% of mothers living in major cities).¹

Babies born to mothers usually residing in more remote areas are more likely to be born preterm (12.9% in very remote areas compared with 8.2% in major cities) and small for gestational age (13% in very remote areas compared with 10% in major cities).¹

Care closer to home reduces the disruptions to family and work life.

Lack of access to maternity services due to geography presents a major safety issue when women travel in unsafe conditions and travel long distances.

Enablers

- Uptake of the Australian Rural Birthing Index is consistent.
- National pathways are developed to support smooth transitions for women between maternity care providers and other services, including family and child health services.
- The sustainability of rural maternity services is enhanced.
- Outreach services and telehealth are provided to enhance maternity care in rural and regional areas.
- Access to specialised models of care for women with a high risk of poorer outcomes is facilitated.
- Services are co-designed with women and communities using appropriate risk assessment tools.

Strategic direction

11. Improve access to care in the postnatal period.

Rationale

Women and service providers have identified an inconsistency in the availability of postnatal care.

Effective postnatal care in the community can prevent short, medium and long-term consequences for the woman and her family.¹⁹

Australia does not have any national evidence-based guidelines or standards for postnatal care.

The use of evidence-based guidelines has the potential to improve care of women and ensure consistency of care across health sectors.¹⁹

The incidence of pre-eclampsia (3%)^{20,21} and gestational diabetes (6%)²² are relatively high and these conditions are associated with an increased long-term risk of chronic disease.²³

Enablers

- National evidence-based guidelines for postnatal care are developed and implemented.
- The definition of 'unqualified neonates' is reviewed and revised.
- Pathways to support smooth transitions for women between antenatal and postnatal services are developed and implemented.
- Implementation of the enduring [Australian national breastfeeding strategy](#) is supported.
- Efforts are made to raise public awareness about the need for long-term chronic disease prevention after a complicated pregnancy.
- Pathways (e.g. using the digital health record) are developed and implemented so that women at risk of chronic disease due to pregnancy complications receive advice (e.g. through general practice).
- See also enablers under strategic direction 13.

4.2. Improved access to continuity of care and carer

Principle

Women have access to continuity of care with the care provider(s) of their choice — including midwifery continuity of care.

Strategic direction

12. Maternity service providers expand the availability of continuity of care and carer models to enable women's choices to be met.

Rationale

Women value and want continuity of care and continuity of carer.^{24,25}

Women should be supported in their choice of carer.

Effective models of maternity care have a focus on the individual woman's needs and preferences, collaboration and continuity of care.⁵ The [Clinical practice guidelines: Pregnancy care](#) promote continuity of care.⁵

Current funding models are seen as supporting a more fragmented approach to care.

Enablers

- Women have access to a range of continuity of care and continuity of carer models in their geographic location.
- Funding models to support access to continuity of care and continuity of carer models in all areas are developed.
- Existing research on models of care is built on and applied.
- Further development and public reporting on available models through the MaCCS occurs.
- Women are active partners in planning for services

4.3. Improved access to mental health support

Principle

Women have access to mental health information, assessment, support and treatment from conception until 12 months after birth.

Strategic direction

13. Jurisdictions implement actions to address the unacceptable morbidity and mortality associated with poor perinatal mental health.

Rationale

Up to one in ten women experience depression during pregnancy²⁶ and one in six experience it in the first postnatal year.²⁷ Around one in five women experience an anxiety disorder in late pregnancy²⁸ and one in six in the postnatal period.²⁹ Anxiety and depression frequently occur together.³⁰

Mental health conditions such as bipolar disorder and schizophrenia are less common than depression and anxiety but are associated with a high risk of relapse across the perinatal period.³¹⁻³³ Women with diagnosed schizophrenia or bipolar disorder are more likely than women in the general pregnant population to have obstetric complications (e.g. pre-eclampsia, gestational diabetes).^{34,35}

Women who experience intimate partner violence during pregnancy are four times more likely to report depressive symptoms and ten times more likely to report anxiety symptoms during pregnancy.³⁶ These symptoms frequently persist in the postnatal period²⁷ and affect a woman's ability to form secure infant attachment.³⁷

Suicide in the perinatal period is a leading cause of maternal deaths in Australia⁹ and the rate of maternal deaths due to psychosocial health problems is rising.³⁸

The availability of perinatal mental health services, in particular for acute needs, is variable.

Perinatal mental health screening increases identification of women experiencing symptoms and at risk of depression and anxiety and may be associated with earlier treatment.³⁹

Enablers

- The [Perinatal mental health national action plan](#)⁴⁰ is reviewed, updated where required and implemented.
- The currency of national evidence-based perinatal mental health guidelines (such as [Mental health care in the perinatal period: Australian clinical practice guideline](#))⁴¹ is maintained and their uptake by health professionals promoted.
- The [Australasian health facility guidelines](#)⁴² are updated to include inpatient requirements for perinatal mental health services, including the establishment of mother-baby units in all jurisdictions.
- Australian [Practice guidelines for the treatment of complex trauma and trauma informed care and service delivery](#)⁴³ are adopted.
- There is effective sharing of information between all services involved in a woman's care and with the woman herself.
- Perinatal mental health is included in health professional training and the existing maternity care workforce accesses professional development in perinatal mental health (such as the [Centre of Perinatal Excellence online training package](#)).
- Pathways towards perinatal mental health careers are developed and expanded.
- Perinatal peer support programs are developed and supported.
- Women are educated about the availability of resources such as the [Ready to COPE](#) e-guide to pregnancy.
- See also enablers under strategic direction 11.

Monitoring and evaluation framework

The monitoring and evaluation framework (MEF) supports jurisdictions to monitor and evaluate improvements to maternity care consistent with the values, principles and strategic directions of *Woman-centred care: Strategic directions for Australian maternity services*.

Theory of change logic model

Purpose

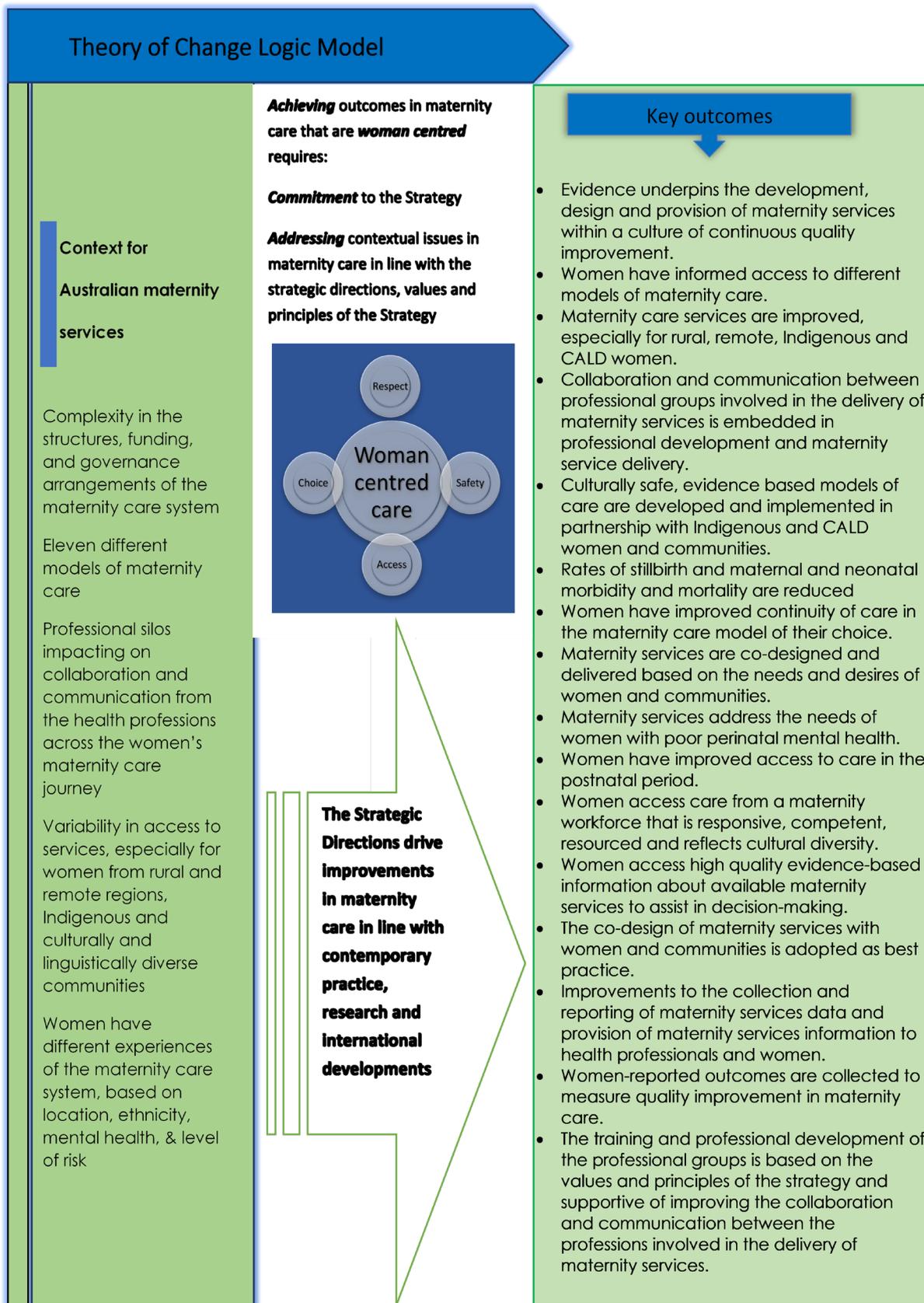
The logic model describes the short, medium and long-term improvements to maternity care in line with the principles, values and strategic directions of the Strategy.

The key components of the logic model cover:

- the nature of Australia's maternity care system and the context in which maternity care is being provided
- the values of the Strategy
- likely 'cause and effect' mechanisms i.e. strategic directions and enablers that are expected to lead to woman-centred care and
- the expected improvements in Australia's maternity system with implementation of local maternity system planning consistent with the values and principles of the Strategy.

The model is presented diagrammatically below.

Figure 2: Theory of Change Logic Model Diagram



Monitoring the Strategy

Overview / purpose of monitoring

Monitoring focuses on the processes and / or outcomes relating to the maternity care system and to maternity outcomes for women within the system. Routine monitoring of maternity care has potential benefits including:

- recording and assessing maternity care trends over time (for example, models of care, maternal and neonatal morbidity and mortality, mode of birth, types of interventions)
- providing an overview of women's population profile, e.g. age, Indigenous, rural and remote, CALD, mental health etc)
- measuring the impact of the Strategy, including identifying improvements in maternity care and outcomes over time.

The Maternity Care Classification System (MaCCS) and the Perinatal Data Sets managed through the Australian Institute of Health and Welfare (AIHW) currently provide:

- a 'national' picture of maternity care outcomes and models of care over time
- importantly, limits unnecessary data collection by jurisdictions and maternity services.

Using these existing administrative data sets to monitor maternity outcomes at a national level can provide an overarching picture of improvements in maternity care and outcomes over time.

While routine monitoring does have clear benefits, these data can also be used within specific evaluation studies, primarily to better understand what the data is telling us, i.e. to be able to interpret administrative data collections to answer key evaluation questions that relate more to the reasons for these outcome measures and trends.

Methodology/systems to enable routine monitoring of the Strategy in order to identify progress and improvements.

Individual jurisdictions, and collectively, through the AIHW at a national level, can help to progress the maturity and effectiveness of existing administrative data sets for ongoing monitoring of the Strategy.

The Strategy also makes suggestions to improve and build upon existing maternity data sets, including further enhancements, data linkage, and mandatory provision of maternity data.

The enhancements include the collection of woman-reported outcomes, wellbeing and experiences (e.g. using patient-reported experience and outcome measures) to be reported as a core part of quality assessment of maternity services; as well as a core set of questions to enable national comparability.

The use of existing data collections for routine monitoring assumes any improvements suggested in the Strategy will build upon the work already underway within the Australian Institute of Health and Welfare (AIHW) and other agencies, such as the Australian Commission on Safety and Quality in Health Care (ACQSHC) and help to overcome some of the challenges of using existing maternity data sets for routine monitoring, including:

- data items about maternity care that are not in these existing collection
- differences in the data provided by jurisdictions, and the limitations that this poses in terms of comparability between jurisdictions and maternity services
- level of aggregation, and limitation in extrapolating outcome measures to different parts of the maternity sector or services
- limitations in understanding the factors relating to measures / trends in the data over time
- limitations in being able to link the maternity outcome measures in existing data collections to the specific enablers implemented under the Strategy.

In 2018, the AIHW reported the following achievements which are relevant to using the current data collections for routine monitoring, including:

- the development of nationally consistent maternal and perinatal mortality data collection in Australia with standardised data specifications, annual reporting and data base development
- further progress on developing the data items and type of data to be collected for the psychosocial maternal risk factors (alcohol use during pregnancy, mental health, domestic violence and illicit drug use) that are important contributors to outcomes for mothers and babies
- pilot testing and then the release of an updated data portal module for the maternity models of care (MaCCS) data collection, and
- an update to the Maternity Information Matrix (MIM) to include the most recent information on data collections and data items relevant to perinatal and maternal health.

These, and the enablers suggested in the Strategy should improve the range and type of data that could be used for routine monitoring in relation to the impact of the Strategy over time.

Regular monitoring of maternity care outcomes will enable jurisdictions to:

- identify any issues, both inside and outside of their control
- identify other activities / areas for improvement relating to each Strategic Direction
- report regularly on progress.

Governance arrangements agreed by AHMAC/ COAG for monitoring progress against the Strategic Directions will support assessment of the impact of the Strategy.

The relationship between the routine monitoring activities suggested in this section of the framework and the proposed evaluation activities to demonstrate progress and identify improvements is provided in the next section.

Evaluating the Strategy

Overview / purpose of evaluation

Evaluating the outcomes and impacts of the Strategy complements the monitoring activities, suggested above. The purpose of evaluation is to gain a deeper understanding about changes in maternity care as they relate to the strategic directions.

This section provides guidance and direction to support states and territories to evaluate improvements to maternity care consistent with the principles and values outlined in the Strategy.

It does not suggest a one-size-fits all approach to evaluating the Strategy, at either a national or jurisdictional level. This guidance is intended to enable local and jurisdictional maternity systems to use the advice and direction provided in this section in accordance with any differences and priorities in the design, planning and delivery of maternity care services.

Benefits and challenges of evaluating the Strategy

The benefit of evaluating the Strategy is that well-tailored evaluation studies can:

- identify the impact of the Strategy
- assess where maternity care and services have improved, as well as
- identify areas that require further attention and action.

However, the diverse contexts, numerous programmatic elements, multiple cause and effect mechanisms leading to the desired outcomes from the Strategy create a challenge for evaluating the Strategy as a whole and in focussing on local and individual jurisdictional maternity systems.

Approaches to evaluation

Approaches include conducting baseline studies or analysis of data; process or formative evaluation; outcome evaluation; realist and developmental approaches to answer the range of key questions required to evaluate a broad and complex strategic approach. Evaluation methodologies are likely to include qualitative, quantitative and mixed methods, depending on the type of study and availability of data and information relating to the study. Studies can be conducted separately or concurrently, if related.

Methodological considerations

For each evaluation study, a review of existing research and evaluation evidence is recommended. Where relevant, a logic model should be developed for each study, or where related studies are conducted concurrently, develop nested logics.

As evaluation studies are planned, further development, refinement and more detailed evaluation questions may be required. Studies will also need to identify evaluation criteria and specific methods to be used during the conduct of the study. Co-design methods may also be appropriate. Each study should provide details about evaluation parameters, such as sampling size, locations and periods, in accordance with the type of evaluation approach and methods chosen to answer key evaluation questions.

Existing maternal outcomes data, supplemented with any existing data collection tools, for example validated survey instruments developed for similar studies elsewhere should be used, and if necessary refined and amended to the Australian and relevant cultural contexts, e.g. Aboriginal and Torres Strait Islander women, and culturally and linguistically diverse communities.

Ethical considerations should be assessed, especially studies that directly involve either women or maternity service providers and other health professionals, within sensitive contexts or for at risk women.

Key evaluation questions

The logic model guides the development of the key evaluation questions, including focusing appropriate attention on the most important contextual issues in maternity care and measuring short, medium and longer term outcomes relating to the Strategy. The evaluation questions are also relevant to the monitoring activities proposed in the previous section.

Key evaluation questions
<p>Have key maternity outcome measures, including morbidity and mortality measures, clinical outcomes, access to maternity services etc changed over time?</p> <ul style="list-style-type: none">• Do we understand the differences for women, based on population profile, risk levels, where they live, and socio-economic profile?• What strategies have been put in place by jurisdictions to reduce still birth and maternal and neonatal mortality and morbidity?• Do we understand the factors leading to these changes?
<p>Has the maternity system embraced the need for change to achieve woman-centred care?</p> <ul style="list-style-type: none">• Have maternity care providers committed to the Respectful maternity charter: the universal rights of childbearing women?• Have all professional colleges and associations for health professional involved in maternity care endorsed this Strategy?
<p>Have the strategic directions and enablers been implemented? Have improvements to maternity services been identified?</p>
<p>To what extent has availability and access to a range of care models for women in their geographic location occurred?</p> <ul style="list-style-type: none">• Do women have ready access to information about locally available services?• Is high quality evidence-based, easily understood information about choices in care and associated outcomes during the perinatal period available to women?• Have nationally agreed tools to support decision-making by women been developed?• Has access to specialised models of care for women with a high risk of poorer outcomes been facilitated?• Has the sustainability of rural health services been enhanced?

Key evaluation questions
<ul style="list-style-type: none"> • Do current funding models support access to continuity of care models in all areas? • Has the workforce been developed with broad generalist skills to promote the maintenance of maternity services and models of care?
<p>Has women's safety and experience of maternity care improved due to changes in policy and practice across professional groups</p> <ul style="list-style-type: none"> • Have the professions received training and professional development to engender? <ul style="list-style-type: none"> – leadership and interprofessional and intraprofessional cooperation, and – interdisciplinary team-based behaviours? • Has implementation of the National Safety and Quality Health Care Standards been supported by a standards user guide for maternity services?
<p>Are women's voices being heard?</p> <ul style="list-style-type: none"> • Within the existing eleven models of maternity care? • To what extent have woman-reported outcomes, wellbeing and experiences been reported as a core part of quality assessment of maternity services (e.g. using patient experience and outcomes measures)? • Are women involved in the design and planning of maternity services? • Have women from Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities been able to access culturally appropriate and safe maternity care?
<p>To what extent has cultural safety and experience of maternity care for Aboriginal and/or Torres Strait Islander women improved due to the workforce and institutions having become more culturally competent to provide such care?</p> <ul style="list-style-type: none"> • Have appropriate curricula been developed to guide workforce upskilling in cultural competency, guided by respected cultural leaders in maternity care and cultural competency? • Have new partnerships been developed between maternity care providers and appropriate representative community bodies at regional/local level to enhance mutual understanding and cooperation, leading to better planning and oversight regarding pregnancy support, births and postnatal care, for these women? • Has there been progress in developing culturally endorsed tools for measuring cultural safety and have they been trialed in (at least) some Aboriginal, and Torres Strait Islander contexts? • Is there greater availability of Birthing on Country and other group/family support program options for these women? • Is there a clear plan to progress this area overall in place and does it include senior Indigenous women in its management? • Is there evidence that the core maternity indicators are improving for these women?
<p>To what extent has access to care in the postnatal period improved?</p> <ul style="list-style-type: none"> • How has the change to access improved short, medium and long term consequences for the woman and her family? • Have evidence-based guidelines and/or standards for postnatal care been developed and implemented? • How effective were the pathways for women at risk of chronic disease due to pregnancy complications?
<p>Has the morbidity and mortality associated with poor perinatal mental health improved over time?</p>

Key evaluation questions

- Do we understand the factors leading to this improvement?

To what the extent have:

- clinical guidelines, clinical pathways relating to perinatal mental health been adopted in maternity services
- perinatal mental health education for the existing maternity care workforce (such as training as the Centre of Perinatal Excellence online package) been provided
- training in perinatal mental health been provided to health professionals, and
- actions been taken to address the unacceptable morbidity and mortality associated with poor perinatal mental health?

Are maternity care services based on current evidence based practice, research and international developments?

- To what extent have evidence-based clinical guidelines, clinical pathways, risk and quality assessment tools been implemented across maternity services and different models of care?
- Has evidence-based information about options, outcomes, and implications of choices about prenatal screening, antenatal, birthing and postnatal care been provided to women?
- Have variations in outcomes and practice in health care been identified and reported upon?
- Have clinical care guidelines relevant to maternity care been applied?
- Do we understand the factors leading to this improvement?

To what extent have culturally safe, evidence-based models of care been developed and implemented in partnership with appropriate peak bodies representing women from culturally and linguistically diverse backgrounds and their communities?

- Have new partnerships been developed between maternity care providers and appropriate representative bodies at regional/local level to enhance mutual understanding and cooperation, leading to better planning and oversight regarding pregnancy support, births and postnatal care for these women, together with better early follow-up post birth?
- Have appropriate curricula been developed to guide workforce upskilling in working with these women, especially staff capacity to work with interpreters and bicultural workers?
- Is there greater availability of: interpreter services, information in appropriate languages and formats, and job opportunities for these women in maternity care?
- Has there been progress in developing culturally endorsed tools for measuring cultural safety in multicultural contexts, and have they been trialed in (at least) some diverse religious-cultural contexts in cities and in large regional centres where refugee communities have emerged?
- Is there evidence that the core maternity indicators are improving for these women, especially in raising the rates of first trimester antenatal care class attendance, and lowering the rate of small-for-gestational age babies born to women from non-English speaking countries?
- Has there been further research conducted into the apparent reasons for small-for-gestational age babies born to women from non-English speaking countries, and how to address it?
- Is there a clear plan in place to progress this overall area and does it include diverse female cultural leaders in its management?

Key evaluation questions

To what extent have the specific needs of women living in rural and remote areas of Australia across the perinatal period been addressed, including:

- Increased availability and access to a range of continuity of care models for women in their geographic location
- Development of funding models to support access to continuity of care models
- Outreach services and telehealth to enhance maternity care in rural and regional areas
- Outreach and telehealth services to support health professionals in rural and remote areas
- Development and maintenance of skills (including clinical reflection and supervision) of health professionals working in maternity services
- Development of a sustainable workforce with broad generalist skills, including medical and nursing, in rural settings to promote the maintenance of services.

Glossary

Amniotic fluid embolism: A rare obstetric emergency in which amniotic fluid, enters the blood stream of the mother to trigger a serious reaction.

Birthing on Country: Birthing on Country is described as '...a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families'⁴⁴ which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all.

Birth support person: A person or persons chosen by the woman to support them during childbirth. This may be the father, a partner, close friend, sibling, mother or a paid doula.

Caesarean section: An operation in which a baby is born through an incision (cut) made through the mother's abdomen and the uterus (womb).⁴⁵

Co-design: An approach to design attempting to actively involve all stakeholders in the design process to help ensure the result meets their needs and is usable.

Continuity of care: A philosophy that involves shared understanding of care pathways by all health professionals involved in a women's care, with the aim of reducing fragmented care and conflicting advice.

Continuity of carer: Continuity of carer means care provided, over the full length of the episode of care by the same named carer. Relational continuity is provided by the same named caregiver being involved throughout the period of care even when other caregivers are required. Other caregivers may be involved in the provision of care, either as a backup to the named carer or to collaborate in the provision of care, however the named carer remains to coordinate and provide ongoing care throughout.

Cultural safety: Cultural safety is the individual's experience of care they are given, ability to access resources and to raise concerns.⁴⁶

Direct maternal death: Maternal deaths that result directly from complications of pregnancy or its management.⁹

Doula: A person paid to provide emotional support during the pregnancy and birth. Doulas are not healthcare professionals.

Family violence: 'Family violence' may involve partners, siblings, parents, children and people who are related in other ways. It includes violence in many family contexts, including violence by a same sex partner, violence by young people against parents or siblings, elder abuse, and violence by carers in a domestic setting against those for whom they are responsible.⁴⁷ It is also referred to as domestic violence.

First antenatal visit: The first visit specifically for antenatal care following confirmation of the pregnancy.

Generalist: GPs, rural generalists and general specialists who maintain a broad scope of practice

Gestational diabetes: Diabetes that occurs during pregnancy.

Health professional: In this document, 'health professional' refers to any health professional involved in maternity care including, but not limited to, general practitioners, midwives, obstetricians (both specialist and general practitioner), Aboriginal and Torres Strait Islander Health Practitioners, Aboriginal and Torres Strait Islander Health Workers, anaesthetists, neonatal paediatricians, physicians, mental health professionals and allied health professionals. See the [Australian Health Practitioner Regulation Agency website](#) for further details.

Indirect maternal deaths: Maternal deaths that result from diseases or conditions that were not due to a direct obstetric cause but were aggravated by the physiologic effects of pregnancy.⁹

Informed decision-making:⁴⁸ The two-way communication process between a woman and one or more health professionals that is central to woman-centred health care. It reflects the ethical principle that a woman has the right to decide what is appropriate for her, taking into account her personal circumstances, beliefs and priorities. This includes the right to accept or to decline the offer of certain health care and to change that decision. In order for a woman to exercise this right to decide, she requires the information that is relevant to her.

Instrumental vaginal birth: Vaginal birth involving use of vacuum extraction or forceps.

Intrapartum: During birth.

Jurisdictions: Australian, State and Territory Governments, professional bodies and maternity services.

Low birth weight: Birth weight lower than 2,500g.

Maternity care: Care provided during pregnancy and in the 12 months after giving birth.

Maternity Care Classification System (MaCCS): The MaCCS provides a standardised terminology and descriptive data for maternity models of care. National collation of these data enables analysis and comparisons of maternal and perinatal outcomes between differing models of care.

Neonatal death: Death of a baby aged less than 28 days.

Obstetric injury: Injuries experienced by women during birth. In the setting of a vaginal birth, this usually refers to tears of the skin and other tissues between the vagina and anus.

Perinatal period: The period from conception until 12 months after the pregnancy or birth.

Perineal tear: Tears of the skin and other tissues between the vagina and anus.

Postnatal care: Care of the woman in the 12 months after giving birth.

Pre-eclampsia: A condition in pregnancy associated with high blood pressure, sometimes with fluid retention and proteinuria.

Preterm birth: Birth before 37 weeks pregnancy.

Safety: In this document, safety refers to the cultural, emotional and physical safety of women and health professionals.

Stillbirth: The birth of a baby that has died in the uterus after 20 weeks of pregnancy or reaching a weight of more than 400 g if gestational age is unknown.

Thromboembolism: Obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

Unqualified neonate: The first born of a multiple birth or a singleton who stays in hospital with his or her mother for less than 10 days and is not accommodated in a special care nursery.

Woman or women:⁴⁹ The person giving birth. The term is inclusive of the woman's baby, partner and family. Under this definition the baby is not treated as a separate entity and its welfare is considered only so far as how it affects the mother.

Woman-centred care:⁴⁹ Recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices.

Appendices

A: Representation on the Advisory Group

Co-Chairs

Professor of Obstetrics & Gynaecology and Director of Nursing and Midwifery Services

Representation

- Australian College of Midwives (ACM)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Indigenous Doctors' Association (AIDA)
- Australian Medical Association (AMA)
- Australian and New Zealand College of Anaesthetists (ANZCA)
- Australian Nursing and Midwifery Federation (ANMF)
- Australian Private Hospitals Association (APHA)
- Centre of Perinatal Excellence (COPE)
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
- Council of Remote Area Nurses plus (CRANAPlus)
- Federation of Ethnic Communities Councils of Australia (FECCA)
- Homebirth Australia
- Maternity Choices Australia
- Maternity Consumer Network
- Murdoch Children's Research Institute
- My Midwives
- National Association of Specialist Obstetricians and Gynaecologists (NASOG)
- Obstetrician and Quality expert (Safer Care Victoria)
- Perinatal Society Australia New Zealand (PSANZ)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australian New Zealand College of Obstetricians & Gynaecologists (RANZCOG)
- Royal Australian New Zealand College of Psychiatrists (RANZCP)
- Rural Doctors Association of Australia (RDAA)
- Safe Motherhood for All Inc
- Women's Healthcare & Children's Healthcare Australasia

B: Models of maternity care

Current models of maternity care include the following.⁵⁰

- Private obstetrician (specialist) care: Antenatal care provided by a private specialist obstetrician. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and may continue in the home, hotel or hostel.
- Private midwifery care: Antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives in collaboration with doctors in the event of identified risk factors. Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
- GP obstetrician care: Antenatal care provided by a GP obstetrician. Intrapartum care is provided in either a private or public hospital by the GP obstetrician and hospital midwives in collaboration. Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community.
- Shared care: Antenatal care is provided by a community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff under an established agreement, and can occur both in the community and in hospital outpatient clinics. Intrapartum and early postnatal care usually takes place in the hospital by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).
- Combined care: Antenatal care provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care provided in the public hospital by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
- Public hospital maternity care: Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/or doctors. Care could also be provided by a multidisciplinary team. Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. Postnatal care may continue in the home or community by hospital midwives.
- Public hospital high risk maternity care: Antenatal care is provided to women with medical high risk/complex pregnancies by maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives) with an interest in high risk maternity care in a public hospital. Intrapartum and postnatal care is provided by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives.
- Team midwifery care: Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors. Intrapartum care is usually provided in a hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.
- Midwifery Group Practice caseload care: Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance with collaboration with doctors in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.

- Remote area maternity care: Antenatal and postnatal care is provided in remote communities by a remote area midwife (or a remote area nurse) or group of midwives sometimes in collaboration with a remote area nurse and/or doctor. Antenatal and postnatal care, including high- and low-risk pregnancies, as well as consultations for the management of gestational diabetes is currently provided via telehealth in a number of areas. Alternatively, fly-in-fly-out models can support clinicians in an outreach setting. Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (involving temporary relocation prior to labour) by hospital midwives and doctors.
- Private obstetrician and privately practicing midwife joint care: Antenatal, intrapartum and postnatal care is provided by a privately practicing obstetrician and midwife from the same collaborative private practice. Intrapartum care is usually provided in either a private or public hospital by the privately practicing midwife and/or private specialist obstetrician in collaboration with hospital midwifery staff. Postnatal care is usually provided in the hospital and may continue in the home, hotel or hostel by the privately practicing midwife.

C: Guiding documents

- Australian College of Midwives (2017) [Delivering continuity of care to Australian women: A handbook for hospitals and health services \(4th edition\)](#). Australian College of Midwives: Canberra.
- Australian College of Midwives (2014) [National midwifery guidelines for consultation and referral](#)
- Australian Commission on Safety and Quality in Health Care: [The second atlas of healthcare variation Chapter 3 Women's health and maternity](#)
- Australian Commission on Safety and Quality in Health Care: [The Australian charter of healthcare rights](#)
- Australian Health Ministers Advisory Council: [Final report on the National Maternity Services Plan 2012-2015](#)
- Australian Institute of Health and Welfare: [National Core Maternity Indicators](#) and [Australia's mothers and babies](#)
- Australian Medical Association (2013) [Position statement on maternal decision-making](#)
- Care Quality Commission: [Maternity services survey 2017](#)
- International Childbirth Initiative (2018) [12 steps to safe and respectful motherBaby-family Maternity Care](#)
- UK National Health Service: [National maternity review](#)
- White Ribbon Alliance: [The respectful maternity care charter: The universal rights of childbearing women](#)
- The National Safety and Quality Health Care Standard: [Partnering with consumers](#)
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists: [Maternity care in Australia](#)
- World Health Organization: [Framework for quality of care](#) and as it applies for [pregnant women and newborns; Standards for improving quality of maternal and newborn care in health facilities](#) and the [standards in brief](#).
- WHO (2016) [WHO recommendations: Intrapartum care for a positive childbirth experience.](#)
- Previous National Maternity Services [plan and outcomes](#)

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