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A comparison of the *Woman-centred care: strategic directions for Australian maternity services (2019)* national strategy with other international maternity plans

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ABSTRACT

Background: In 2019 the Australian government released a guiding document for maternity care: *Woman-centred care strategic directions for Australian maternity services* (WCC Strategy), with mixed responses from providers and consumers. The aims of this paper were to: examine reasons behind reported dissatisfaction, and compare the WCC Strategy against similar international strategies/plans. The four guiding values in the WCC strategy: safety, respect, choice, and access were used to facilitate comparisons and provide recommendations to governments/health services enacting the plan.

Methods: Maternity plans published in English from comparable high-income countries were reviewed.

Findings: Eight maternity strategies/plans from 2011 to 2021 were included. There is an admirable focus in the WCC Strategy on respectful care, postnatal care, and culturally appropriate maternity models. Significant gaps in support for continuity of midwifery care and place of birth options were notable, despite robust evidence supporting both. In addition, clarity around women's right to make decisions about their care was lacking or contradictory in the majority of the strategies/plans. Addressing hierarchical, structure-based obstacles to regulation, policy, planning, service delivery models and funding mechanisms may be necessary to overcome concerns and barriers to implementation. We observed that countries where midwifery is more strongly embedded and autonomous, have guidelines recommending greater contributions from midwives.

Conclusion: Maternity strategy/plans should be based on the best available evidence, with consistent and complementary recommendations. Within this framework, priority should be given to women's preferences and choices, rather than the interests of organisations and individuals.

Statement of Significance

Issue

In 2019 the Australian government released a guiding document for maternity care: *Woman-centred care strategic directions for Australian maternity services* (WCC Strategy), which resulted in mixed responses from health providers and consumers. How this strategy compares to other contemporary maternity plans is undocumented.

What is already known

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Australia is a safe country to give birth in terms of maternal and perinatal mortality but there are increasing rates of obstetric intervention, coupled with restricted access to quality midwifery-led models of care, including out of hospital birth.

What this paper adds

In countries where midwifery is strongly embedded and autonomous, maternity guidelines promote greater contributions from midwives and the realisation of women's human rights. Clarity around a woman's right to make the final decision about her care is lacking or contradictory in the majority of the plans.

Introduction

Background to the development of the WCC Strategy (2019)

In 2019, the Australian government released an updated guiding document for maternity care: *Woman-centred care strategic directions for Australian maternity services* (WCC Strategy). The WCC Strategy was endorsed by the Council of Australian Governments (COAG), the peak intergovernmental forum in Australia [1], to provide overarching national strategic direction that supports Australia's maternity care system and enables improvements in line with "contemporary practice, evidence, and international developments" [1] [p4]. Following the release, disappointment and frustration was voiced by consumers and maternity service providers (especially midwives) due to the minimal incorporation of midwifery continuity of care and out of hospital birth place options. This was especially frustrating as the first Australian National Maternity Services Plan (NMSP, 2010) published in 2011 [2] had provided more consideration of continuity of midwifery care, homebirth and birth centres, and during the subsequent eight year timeframe, further consumer input [3,4] and research evidence in support of these options [5–7] had accumulated.

Prior to the development of the NMSP (2010) an extensive maternity service review was conducted in 2009 [8]. Over 900 submissions were received, 54% from consumers and of these, over 60% requested better access to and support of homebirth [4]. Unfortunately, despite 42 mentions of homebirth (or homebirths/homebirthing) in the interim report, the NMSP concluded "that the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth funded option (at least in the short term)" [8] [p21]. In reference to birth centres (mentioned in 24% of all submissions received) [9], the government recommended "consideration be given to the demand for, and availability of, a range of models of care including birthing centres" [8] [p57]. Support was also given to expanding midwifery continuity of care [8]. The NMSP was published in 2011 with recommendations that models of midwifery care, privately practising midwives, and place of birth options be further explored and supported [2]. Midwives subsequently gained access to Australia's publicly funded health care system (Medicare) and insurance to practice privately, though this support was inequitable when compared to obstetrics. For instance, insurance and Medicare rebates did not extend to intrapartum care at home and midwives were forced to seek collaborative arrangements with obstetricians, with varying success, in order for women to access Medicare rebates [4].

In 2015, with the NMSP due to expire, consumers approached the Commonwealth government for a new maternity plan [3]. The Commonwealth extended the existing plan to 2016 and indicated a new national framework was being developed. When clinicians and consumers accessed the final draft framework in 2017, it was unanimously agreed that it was unsuitable and needed to be abandoned [3].

In October 2017, the development of a new national plan was initiated with greater consultation with stakeholders promised [3]. The new WCC Strategy, as it became known, was prepared by the Office of the Chief Nursing and Midwifery Officer, however issues related to funding maternity care and expansion of available models of care were again excluded during the development phase. This was despite more than 500 consumer submissions overwhelmingly requesting continuity of midwifery carer, access to homebirth and access to timely publicly available data on birth outcomes, less intervention during labour and birth, and accountability for high rates of birth trauma [3].

A second survey and round of consultations with consumers and providers followed. In the subsequently developed draft, emphasis on improving access to continuity of *midwifery carer* was disappointingly modified to a generic reference to 'continuity of care'. In February 2019, frustrated consumers initiated an online campaign via the Maternity Consumer Network that received over 1500 submissions in protest of the draft guideline [3]. Consumers also wrote to the Chief Nursing and Midwifery Officer, and the Australian Health Minister, requesting continuity of midwifery carer be put back in the plan [3].

In 2019, consumers frustrated by the lack of incorporation of their contributions, attended the final Advisory Group consultation for the WCC strategy dressed as suffragettes in protest [3]. Possibly in response, the final draft included the addition that: "Women have access to continuity of care with the care provider(s) of their choice — including midwifery continuity of care" [1] [p16], but not as a standalone priority. Place of birth options, such as home birth and birth centres, were not mentioned at all, despite sustained consumer demand. Frustrations amongst midwives and consumers escalated at this time, as it became apparent that medical organisations such as the Australia Medical Association (AMA) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) had lobbied against the inclusion of continuity of midwifery care in the WCC Strategy [3].

The Australian maternity care context

Overview of birth in Australia

According to the latest national data (2018–19, published in 2020–21), around 300,000 women give birth in Australia each year [10,11]. Of these, 73% live in major cities, 35% are born overseas (26% from non-English speaking countries) [10], and 4.8% identify as Aboriginal and Torres Strait Islander [11]. Around 8.6% of babies are born preterm and 6.6% are low birth weight [11]. Aboriginal and Torres Strait Islander babies are almost 1.5 times more likely to be born preterm or of low birth weight and admitted to a special care nursery or neonatal intensive care unit [11]. Nearly one third of babies have some form of resuscitation at birth [10]. Nationally the overall perinatal mortality rate remains unchanged over the past decade at 9.6/1000 births (stillbirths 7.2/1000 and neonatal deaths 2.4/1000) [11].

Australia is a comparably safe country for women giving birth in terms of maternal and perinatal mortality, but obstetric intervention rates are high and rising annually [11]. Indeed, Australia has some of the highest birth intervention rates in the world. For instance, the 2019 caesarean section rate at 36% ranks as one of the highest in the OECD (27th out of 34 countries in 2017) [11]. Rates for vaginal birth after caesarean section and instrumental birth remain stable at 12%, however, for primiparous women, the instrumental birth rate is higher at 26.2% [11]. In the last decade, the episiotomy rate has increased by 60% (14% in 2008 to 23% in 2018) and the induction rate has increased from 25% in 2008 to 34% in 2018 [10]. Selected primiparous women (under 35, singleton pregnancy, vertex presentation, 37–41 weeks) are being induced at a rate of 47% [11].

Funding of healthcare

Funding for Australian healthcare is complex and comprises government (federal, state and territory) and non-government sector (private health insurers, individuals) contributions [12]. The mix of private and public funded care sees around 25% of women give birth in one of 612 private hospitals under obstetric-led care; and 75% in public hospitals (1359 hospitals), with a mixture of midwifery and obstetric care [12]. Reproductive and maternal health costs are substantial and

estimated at around $7.7 billion, or 7% of the total allocated for health related expenditure (2015–16) [13]. Despite universal health coverage being a cornerstone of Medicare health policy since 1984, Australia has one of the highest rates of out-of-pocket healthcare expenditure per capita, and this has increased more rapidly for obstetric related services than for other healthcare services [12].

Funding is not conditional on consumer feedback, quality improvements, or compliance with Federal health care policy or guidelines. While the Commonwealth supports planning of health services and largely funds General Practitioner (GP) Shared Care, the States and Territories operationalise and deploy maternity services. The private sector remains largely unaffected by most policy/guidelines set by government. Costs to the tax payer and consumers (through out-of-pocket expenses) are far greater for maternity care in the private sector, and remain relatively unchecked [14]. Between 2003 and 2008, the Federal Government Medicare Benefit Scheme (MBS) funding for obstetric services climbed 174% from $77 million to $211 million while the number of babies born only increased 17% from 256,925 to 296,925. The majority of this funding increase was for one item ($130 million), the *Planning and Management of Pregnancy* fee claimed by obstetricians [12]. Thus, maternity service provision in Australia is a complex matrix of stakeholders, collaborators, regulators, funders and changing political will, with the overall outcome being that care is dominated by fragmented, medical models sustained by complex and discriminatory funding mechanisms [12,15].

With this context in mind, this review aims to compare the WCC Strategy to similar international strategies/plans, utilising the four guiding values in the WCC Strategy. We hypothesise that as the WCC Strategy and other international guiding documents claim to be based upon the best available worldwide evidence, that comparable strategies/plans should provide similar core recommendations. In response to consumer and maternity service provider concerns, we wished to assess whether the WCC Strategy is woman-centred, evidence-based, sustainable, and actively supportive of fundamental human rights. Comparing documents to look for differences can be a way to make the premise in a framework visible. As recommendations to government and health services are made according to the WCC strategy, it is critical that recommendations are evidence-based and responsive to consumer demand. We provide further recommendations to facilitate this outcome.

Methods

To address the aim stated above, we obtained and reviewed available maternity strategies/plans published in English from comparable high-income countries. Content from the plans were reviewed and themed by reference to the WCC Strategy guiding values of safety, respect, choice, and access. We then compared and contrasted the positions taken on the values in the respective strategy/plans. Our multidisciplinary team comprising maternity service consumer, legal, obstetric, midwifery, and complementary medicine expertise enabled a reflexive analytical approach, incorporating different perspectives on the findings. We also consulted maternity policy experts who critiqued the paper as it was developed.

Review of maternity plans

We used three avenues to identify and access maternity plans published in English within the time frame beginning 2011–2021. First, a Google Scholar search was performed using the search terms: ‘maternity care’, ‘woman-centred’ ‘plans’, ‘guidelines’, ‘policies’, ‘documents’, ‘respect’, ‘choice’, ‘access’, and ‘safety’. Second, we searched government websites of specific countries of interest. Third, maternity services professionals in countries of interest were contacted by the principal researcher for information not publicly available.

Once collated, data was extracted from each maternity care strategy or guideline by reference to the four keys values in the WCC Strategy and comparatively analysed with each other. To differentiate the WCC Strategy from other strategies/plans reviewed in this paper we use the term strategy when referring to the WCC Strategy and plans when referring to the other documents.

Findings

Analysis of differing maternity strategies/plans

The following eight plans published between 2011 and 2020 were selected for analysis and comparison with the WCC strategy [3]: the first National Maternity Services Plan (NMSP) from Australia [2] and seven international maternity care plans (from England [16], Wales [17], Scotland [18], Ireland [19], Northern Ireland [20], Canada [21], and New Zealand (NZ) [22]). Summaries of each document according to the guiding principles of safety, respect, choice and access are provided in Table 1.

Safety

The documents reviewed address aspects of safety, such as maternal and newborn morbidity and mortality, responsiveness to complications as they arise, emotional and psychological wellbeing, cultural safety, birth as a physiological process, and interdisciplinary collaboration and communication, but with varying emphases. Closing existing gaps in clinical practice is a common focus. Examples include the development of national evidence-based guidelines for postnatal care [3] and the reduction of persisting inequalities between Indigenous and non-Indigenous health outcomes [2,21].

The WCC Strategy and NMSP [2] position woman-centred care in the context of a primary health care ‘wellness’ paradigm that is modifiable if complications arise. This emphasis is likely in response to increasing criticism of the over-medicalisation of birth undermining the facilitation of normal physiological childbirth processes [23–25] for most women.

The WCC Strategy emphasises the need to evaluate longer-term outcomes of care for women, babies, families, and communities, likely reflecting the global concern that a focus purely on the survival of the mother and child [26] has come at the expense of their potential to thrive and transform [27,28]. The Welsh [17] plan adopted a similar approach, stressing the importance of medium- and longer-term outcomes to “secure improved health and wellbeing for mothers and babies” [p1] [17].

The plans/strategy also reflect an increasing world-wide awareness of the serious implications of birth trauma and post-traumatic stress disorder following birth [29]. Perhaps due to the influence of contributors, the WCC Strategy approach was expanded to include both individualised and culturally safe care, with recommendations to specifically educate providers on the needs of Indigenous women, the socially disadvantaged, persons with disabilities, diverse linguistic or religious backgrounds, differing sexual/gender-based orientations, and women who have experienced previous trauma.

The Scottish plan [18] highlights the need to consider the wider impact of pregnancy and childbirth on longer-term outcomes and deliver empathetic care that is balanced with respect to risk and potential harm from both the clinical and the woman’s perspective. The Northern Ireland plan [20] likewise promotes needs beyond just physical safety, including care that is emotionally safe and contributes to a life-enhancing transition to parenthood. This plan states that, for the vast majority of women, straightforward pregnancies, labour and birth will be promoted as a normal birth event through midwifery-led care, with medical interventions only utilised when necessary. The Canadian [21] plan also states that patient safety typically focuses on the “minimisation of medication and clinical care errors, but should apply equally to the promotion of procedures and practices that optimise health” [p1–23]. Additionally, cultural safety needs to be addressed through specific staff training. The Welsh [17], Canadian [21], Northern Irish

Table 1
Maternity guideline approaches to woman-centred care (2011–2021).

Guidelines	Safety	Respect	Choice	Access
1. Woman-centred care Strategic (WCC Strategy) directions for Australian maternity services - COAG Health Council (2019)	-services are individualised, culturally appropriate, equitable, safe, woman-centred, informed & evidence-based, including for Aboriginal & Torres Strait Islander women & women of culturally & linguistically diverse backgrounds -services implement strategies to reduce stillbirth & maternal & neonatal mortality & morbidity -national evidence-based guidelines for postnatal care are developed & implemented -effective sharing of information between services & women -variation in outcomes & practice identified, reported on & improvement guided by clinical care standards -further research on longer term outcomes -maternity care workforce is responsive, competent, resourced & culturally diverse -maternity care providers educated in & practice cultural safety	-women's preferences sought & respected. Services are co-designed according to needs of women & communities -maternity care is dignified & respectful and holistic in approach (encompassing physical, emotional, psychosocial, spiritual & cultural needs) -women's choices, outcomes, & experiences (inclusive of social circumstances, cultural & religious background, health, disability, sexual orientation & gender) are respected. Providers commit to operate according to the 'Respectful Maternity Charter' -Childbirth normal physiological experiences, women are experts in their lives & maternity care providers are expert in care provision -encourage a positive workforce culture based on respectful interdisciplinary collaboration & communication	-nationally agreed tools that traverse all models of care are utilised to assist informed evidence-based decision-making by women, & these choices & preferences are sought & respected by providers -every woman has the right to freedom from coercion -jurisdictions develop processes & communication pathways to support women & health professionals to maintain care partnerships when women decline recommended care -shared decision-making between the woman & maternity service providers incorporates woman's preferences, evidence as it applies to the woman & the context of care provision. The Strategy provides equal weight to each area	-readily accessible easily understood information in the woman's preferred language, about all locally available maternity services & models of care, as well as associated risks & benefits -continuity of care with a provider of their choice as close to home as possible -'Birthing on Country' Service Model & Evaluation Framework for Aboriginal & Torres Strait Islander (ATSI) women -outreach services, telehealth, & specialised models of care when required -mental health information, assessment, support & treatment until 12 months post birth; as well formal debriefing & bereavement care -improved access to care in the postnatal period
2. National Maternity Services Plan 2010- Australian Health Ministers' Conference (2011, plan preceding the WCC Strategy)	-ensure maternity services of high quality, safe, sustainable, evidence-based & culturally appropriate care -an appropriately trained & qualified workforce provides clinically safe woman-centred maternity care within a wellness paradigm, recognising the need to respond to complications in an appropriate manner -balance between the benefits of locally delivered, evidence-based maternity services & care is assessed within a quality & safety framework -health inequalities faced by ATSI mothers & babies, & other disadvantaged populations continue to be reduced -focus upon sustainable, lower capacity rural & remote maternity services networked to higher levels of care as required to reduce increased rural maternal & perinatal mortality rates -the potential of MWs, OBs, GPs & paediatricians & Aboriginal health workers with specific knowledge, skills & attributes are maximised to provide a collaborative, coordinated interdisciplinary approach to maternity service delivery	-that maternity care is woman-centred, & acknowledges pregnancy, birth & parenting as significant life events for women -clinical decisions about medical intervention are informed by the understanding that pregnancy & birth are normal physiological life events -that maternity services are provided in a appropriate & responsive manner according to the individual's cultural, emotional, psychosocial & clinical needs -partnerships between Aboriginal Health Workers, community-based Indigenous workers & Strong Women Workers, Drs, OBs & MWs will enable clinically safe & culturally competent care to be provided to ATSI people	-enable women to make informed & timely choices regarding maternity care, so women feel in control of their birthing experience -continuity of care &, wherever possible, continuity of carer is a key element of quality care is offered and there is increasing demand for midwifery continuity of care models -many women also choose continuity of care from GPs & specialist OBs. These choices should be respected & supported	-women have access to objective, evidence-based information that supports informed choices - access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where women live, including midwifery postnatal care outside hospital settings, for at least two weeks after birth -Right balance between primary level care & access to appropriate medical expertise as clinically required -continuity of care which is collaborative, flexible, integrated -maternity care pathways providing specialised clinical, allied health, social support & neonatal services to vulnerable women -information technology infrastructure that improves access to specialist consultation for women in rural settings -accommodation & transport for ATSI & other remotely located women & family members needing additional levels of non-local care
3. Better Births A Five Year Forward View for Maternity Care in England - National Maternity Review (2016)	-women are provided with high-quality safe care, with professionals working together across boundaries to ensure rapid referral, & access to the right care in the right place -leadership develops a culture of safety both within & across organisations - openness & honesty between professionals & families, should be supported by a system of rapid	-women are provided with continuity of carer, to ensure safe care based on a relationship of mutual trust & respect in line with the woman's decisions -the breaking down of barriers between MWs & OBs, so that they understand & respect each other's skills & perspectives so as to deliver safe & personalised care to women	- full discussion of the benefits & risks associated with each option -a personalised care plan developed, centred on woman, baby & family, based around their needs & their decisions, where they have genuine choice, informed by unbiased information -women should be able to choose their provider & be in control of exercising choices; including support needed during birth &	-women are provided with continuity of carer -unbiased information made available to all women, to help them make their decisions, including health records, the latest evidence & local services -women should have a MW, who is part of a team of 4–6 community-based who know the women & can provide continuity throughout pregnancy, birth & postnatally,

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Table 1 (*continued*)

Guidelines	Safety	Respect	Choice	Access
	resolution & redress, encouraging learning & ensuring that families quickly receive the help they need -investigations conducted when things go wrong are both honest & applied to learning		preference for birth place: birth at home, alongside or freestanding midwifery unit, & hospital birth -to ensure that funding follows the woman & her baby as far as possible, to ensure women's choices drive the flow of money, whilst supporting organisations to work together	with smooth transitions between services -Teams of MWs should have identified OB who understands their service & can advise on issues - MW should liaise with obstetric, neonatal & other services & joined up with community care -improved access to birth in midwifery settings: home or midwifery units
4. The Best Start A Five-Year Forward Plan for Maternity & Neonatal Care in Scotland - Review of Maternity and Neonatal Services in Scotland (2017)	-services are redesigned using the best available evidence, to optimise outcomes & sustainability, & maximise the opportunity to support normal birth processes & avoid unnecessary interventions; taking into account the care continuum & the wider impact of pregnancy & childbirth on long-term outcomes -services for women with the most complex needs should be managed by a core group of experienced consultants at a regional or national level -staff are empathetic, skilled & well supported to deliver high quality, safe services, every time -factors contributing to the rising caesarean section rate should be examined, from both the clinical & woman's perspective & optimal levels of intervention that balance risk & potential harm should be identified & implemented -services avoid over treatment, using intervention only when clinically indicated -women & babies kept together whenever possible which is in line with the expectations of mothers & families & will assist with bonding, attachment & breastfeeding	-regard mother & baby as one entity & put them at the centre of planning & delivery - partners & family members actively encouraged to become integral part of all aspects of maternal & newborn care. -all women (particularly the most vulnerable), are supported with compassion & empathy, & provided with advice & services to promote lifestyle changes, understanding that strengthening women's own capabilities is an important component -women, babies, families & all maternity & neonatal care staff are treated with equal respect, compassion & kindness & services understand the important impact of relationships on outcomes -multi-professional teams are the norm within an open & honest team culture, with everyone's contribution being of equal value -maternity & neonatal teams work cohesively, demonstrating an empowering culture where different views flourish -continuity of carer is important to enable all women to develop respectful & trusting relationships, with non-judgemental staff who are empathetic & knowledgeable about the woman's individual needs	-all women, their babies, their partners & their families should be aware of the support & choices that are available to them, so they can be partners in all stages of care & achieve the best outcomes for them & their family -maternity & neonatal care should be co-designed with women & families from the outset, with information & evidence provided to allow her to make informed decisions in partnership with her family, her MW & the wider care team as required -all women should have an appropriate level of choice in relation to place of birth & a number of choices available including birth at home, birth in an alongside or freestanding midwifery unit, & hospital birth	-all mothers & babies are offered family-centred, safe & compassionate care, recognising own unique circumstances & preferences -women experience continuity of care from a primary MW, across the whole maternity journey -vulnerable families are offered tailored support, such as those with low levels of literacy, or non-English speaking backgrounds -midwifery & obstetric teams are aligned with a caseload of women & co-located for the provision of community & hospital-based services -services & referral pathways are h accessible & high quality and able to incorporate additional care for specific conditions - high-quality postnatal care should be priority including: kangaroo skin-to-skin care for babies in neonatal units & early support for breastfeeding or feeding with breast milk -families have access to appropriate bereavement support before leaving units from appropriately trained staff -access to birth place of choice
5. Creating A Better Future Together: National Maternity Strategy 2016–2026- Irish Dept. of Health (2016)	-women & babies have access to safe, high quality nationally consistent woman-centred care, that best reflects available evidence, in a setting that is most appropriate to their needs -the integrated care model encompasses all the necessary safety nets in line with patient safety principles, & delivers care at the lowest level of complexity, yet has the capacity & the ability to provide specialised & complex care, quickly, if required -pregnancy & birth is recognised as a normal physiological process, & insofar as it is safe to do so, a woman's choice is facilitated -the Strategy is focused on, & responsive to, women & their individual needs. It seeks to rebuild & restore confidence in our services by making them as safe as possible. Patient safety is the first & overriding principle	-all care pathways support the normalisation of pregnancy & birth & women are encouraged & supported to make their individual experience as positive as possible -women & families are placed at the centre of all services & are treated with dignity, respect & compassion -mothers & families are supported & empowered to improve their own health & wellbeing -physical infrastructures are of a high standard, providing a homely, calm & relaxing environment, that best supports a physiological process, as well as respectful of the woman's need for dignity & privacy during childbirth	-pregnant women are provided with appropriate, accessible, clear, consistent & impartial advice on maternity care options, so as to make informed choices -women are offered choice regarding their preferred pathway of care, in line with their clinical needs & best practice -women in the *Supported Care* pathway will give birth in an *Alongside Birth Centre*; women in this care pathway may also choose a homebirth. Women in the *Assisted Care* or *Specialised Care* pathways will give birth in a *Specialised Birth Centre*. -In the *Alongside Birth Centre* women are provided with comfortable low-tech birth rooms; labour aids such as birthing balls & pools & complementary therapy will be welcome alongside natural coping strategies -If intervention required, transfer will be organised & where	-to a 'health & wellbeing' approach to ensure babies get the best start in life. -to integrated maternity care by a multidisciplinary team, with women seeing the most appropriate professional, based on need -every woman will have a named lead healthcare professional who will have overall clinical responsibility for her care -fundamental is the need for continuity of care(r), & one to one care for a woman in labour -all pathways of care to support the normalisation of the birth process as much as possible -where it is determined that, a discrete *Alongside Birth Centre* cannot be justified in a small maternity unit, it is recommended that a designated space within a *Specialised Birth Centre* is provided, with an appropriate environment & processes to ensure woman with normal risk will have a natural

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Table 1 (*continued*)

Guidelines	Safety	Respect	Choice	Access
			possible the same MW will continue care. In an emergency, critical services bought to the woman *BC*	childbirth experience -that standardised health promotion advice & information is available online, & more & better-quality breastfeeding information & education is provided
6. A Strategy for Maternity Care in Northern Ireland 2012--2018 - Dept. of Health, Social Services & Public Safety (2012)	-safety, quality & sustainability of service provision are essential to deliver the best outcomes for mother, baby & family, -all women deserve to receive both physically & emotionally safe care that promotes a safe, positive & life-enhancing transition to parenthood -with further recognition of pregnancy being a normal physiological process, & for the vast majority of women a safe event, the normalisation of birth through MW-led care for straightforward pregnancies & labour will be promoted to, over time, reduce unnecessary interventions, e.g., some caesarean sections. While such interventions are very valuable & in some cases lifesaving, all interventions in labour must be rigorously examined & benchmarked against comparable units -while maternity services in Northern Ireland are safe & of high quality, more needs to be done, e.g., normalisation' of pregnancy & birth will improve outcomes for the mother & baby, & enhance personal experiences -ambulances play a pivotal role in the safe transfer of women, particularly if complications in pregnancy arise -encourage to attend their six-week postnatal appointment	-all patients & clients are entitled to be treated with dignity & respect & should be fully involved in decisions affecting their treatment, care & support -there is a need to assess how maternity services can be delivered to women by respecting individual choice while also ensuring the right care, by the right person, in the right place, at the right time -regardless of which professional leads, prospective parents should be seen as partners in maternity care along with Health & Social Care [HSC] staff, primary care professionals e.g., GPs & health visitors & that care is tailored to individual needs -communication protocol/ pathways are further developed so that all professionals understand their respective roles & responsibilities & that there is sharing of information between the primary, community & hospital interface	-as partners in care, prospective parents need to be given all the information necessary to make informed choices -via provision of universal information, early intervention & support, parents & families can make better life choices, & will be better prepared for pregnancy, the birth of their baby & ongoing care -at the heart, is the need to place women in control of their own pregnancy & to support women & partners to make proactive & informed choices about their lifestyle, self-care, & type of HSC maternity service appropriate to needs -after preliminary assessment, the woman will be supported by the MW to make an informed decision about her antenatal care & the place of birth for her baby, relative to her individual needs. This will occur after a balanced description of the benefits & risks of the different types of maternity settings is provided, including for homebirth & MW & consultant-led units	-to early & appropriate woman-centred information, education, advice, & support during pregnancy, birth & after (including times of bereavement) -to the right information about how they can help themselves & their baby to stay healthy before, during, & after pregnancy must be provided -to evidence-based, written information tailored to parents' needs, with consideration of physical, sensory or learning disabilities, and/or the inability to speak/read English. -to early direct contact of the woman with her local MW who will ensure close liaison with her local GP -to MW-led continuity of care in the community (most women), & appropriate consultant-led care for those with complex needs -to high-quality maternity services with an effective skill-mix of staff -to breastfeeding promotion & postnatal care in the community, comprising of woman-centred home visiting for not less than 10 days, including visits by MWs & maternity support workers
7. Maternity Care in Wales a Five-Year Vision for the Future (2019–2024) - Dept. of Health and Social Services (2019)	-delivery of person-centred, high quality & safe services that secure improved health & wellbeing outcomes for mothers & babies in the short-, medium- & longer-term -that women receive safe & effective care; with risk, intervention & variation reduced wherever possible -collaboration between MWs, GPs & health visitors that is supported by robust communication processes & safe handover of care is essential to providing family centred care -professional groups working together must develop strong interprofessional skills to ensure clear aims, language & culture are shared so as to deliver safe & effective care -breastfeeding throughout pregnancy & into infant life is promoted & supported -all women who feel they require support after birth will have access to a formal debrief	-respectful family-centred care enables women to have control over their behaviour, surroundings & the treatment they receive. This supports meaningful discussions & shared decision making about their pregnancy, labour, birth & postnatal care -that dignity, compassion & respect are core values underpinning the care all women & their families receive; women will be listened to throughout their pregnancy, birth & postpartum care -when a woman's choice is outside of clinical guidance, she will be treated with kindness & respect & be supported by her named Consultant OB &/or Consultant MW to co-produce an individualised care plan -maternity services provide equity to ensure all women & families have individualised care	-all women will be provided with evidence-based information & have opportunity to discuss their maternity care, putting them, their unborn baby & family at the centre -women will receive personalised family centred care, planned in partnership with them & reflecting their choices & health needs -choices in place of birth: with appropriately staffed & resourced community midwifery teams, freestanding midwifery units, alongside midwifery units & obstetric units across Wales. Women at low risk can choose any of the 4 birth settings & all will be provided with information about local birth outcomes to support decision making -women will be offered the option of home labour assessment	-all women will experience continuity of carer (named MW, & if needed a named OB) across the whole of their maternity journey -all women will receive antenatal & postnatal continuity of carer by no more than 2 MWs & 2 obstetric teams -maternity services work collaboratively with public & third sector organisations to prevent & mitigate the impact of social circumstances & adversity on women & their family's lives -educational materials about pregnancy & parenting available in a variety of formats & languages - family members will be offered the opportunity to discuss care and aim to support families staying together wherever possible (i.e dedicated accommodation near neonatal units/)
8. Family-centred maternity & newborn care (FCMNC) in Canada:	-FCNC is informed by research evidence & applies equally in low & higher-risk environments	-respect for pregnancy as a state of health & childbirth as a normal physiological process	-FCNC is where the significance of family support, participation & informed choice are recognised	-to culturally-appropriate & individualised care, recognising distinctive needs for indigenous &

(*continued on next page*)

Table 1 (*continued*)

Guidelines	Safety	Respect	Choice	Access
Underlying philosophy & principles - Public Health Agency of Canada (2017)	-optimal care during pregnancy & birth uses the fewest possible interventions & decisions for intervening are based on the best available quantitative & qualitative evidence, with no single methodology being able to answer every type of research question -patient safety focuses on the minimisation of medication & clinical care errors, but should apply equally to promotion of procedures & practices that optimise health (e.g., supporting & promoting normal birth & optimal infant-feeding practices). -providers able to offer culturally safe care, even in centres without caesarean birth facilities, provided that safety systems (including transport) are available. This involves training in the humanities or psycho-social cultural issues, especially as Indigenous & disadvantaged peoples who have different needs & suffer worse outcomes -supporting early attachment to provide immediate & lasting positive effects to the health of mothers, infants & families	-health care providers are encouraged to support normal physiological birth; medical interventions use should be judicious & appropriate -FCNC requires a holistic approach, encompassing biological, social, psychological, cultural & spiritual well-being -consideration of the spiritual beliefs & practices of diverse cultural groups is needed & to be respected in both normal pregnancies & those with adverse outcomes - FCNC respects the reproductive rights women & that their families play an integral role in decision making -awareness that the attitudes & language of health care providers impacts upon a family's experiences -that greater respect & cooperation between conventional & alternative practitioners is needed, as well as for improving communication between all maternity care providers & their patients regarding the use of alternative/ complementary medicine	-FCNC requires collaboration among chosen care providers including (but not limited to) MWs, family doctors, obstetricians, neonatologists, paediatricians, nurses, nurse practitioners, anaesthetists, childbirth & parenting educators, doulas, breastfeeding advisors, social scientists & community supports -whatever caregiver the woman & her family choose & interprofessional collaboration is necessary for optimal safety -women & their families require knowledge about their care & decision making devoid of coercion - when a choice is possible, the more natural & less invasive option is preferable -training & protocols are provided to indigenous women at low risk of complications to return birthing to the community	culturally diverse groups -care is provided as close to home as possible -companionship for women from family members or other supportive people during labour is encouraged as one of the most significant psychological contributions to the experience of birth -attachment is central to family-centred care & is facilitated by encouraging early parent-infant interaction, initiating skin-to-skin contact at birth & breastfeeding -encouraging review of birth experiences & the challenges faced in the days immediately following birth, to facilitate adjustment to breastfeeding & parenthood
9. New Zealand Maternity Standards - Ministry of Health and District Health Boards (2011)	-maternity services provide are nationally consistent, safe, high-quality services that & achieve optimal health outcomes for mothers & babies	-communication between the Ministry, district HBs & professional colleges will be open, effective & respectful, as it that between maternity service providers -maternity services ensure a woman-centred approach is taken, that acknowledges pregnancy & childbirth as a normal life stage	-women can chose to have continuity of midwifery & obstetric care provided by a secondary or tertiary service -opportunity to provide feedback regarding maternity experiences -frameworks support the provision of continuity of care from a Lead Maternity Carer for primary maternity care throughout maternity journey	-consistent evidence-based information & education services provided for: pre-pregnancy, pregnancy, childbirth, maternity services & care of newborn babies in accessible format - access to funded, nationally consistent, comprehensive, culturally safe & appropriate maternity services, including for those with additional health & social needs. There should be no financial barriers to access

Key: COAG – Council of Australian Governments; ATSI – Aboriginal & Torres Strait Islander; GP – General practitioner; MW – Midwife; OB – Obstetrician; HSC – Health & Social Care; FCNC – Family Centred Newborn Care.

[20], Scottish [18], and English [16] documents stress the need to reduce both intervention rates and variation between services wherever possible.

Some differences between plans were found in the approach to clinical safety. In the Irish plan [19], whilst the overriding focus is on the clinical safety of patients, the normal physiological process of birth is recognised as well as women's choices when considered safe to do so. The NZ standards [22] recommend optimising outcomes for mothers and babies with an overall goal that "women's satisfaction with maternity services increases over time" [p6].

Interprofessional collaboration is emphasised in some plans. The English plan [16] seeks to improve safety by fostering improved inter-disciplinary and organisational collaboration that honestly and openly investigates when things go wrong. Similarly, the Welsh plan (2016–2024) [17] stressed inter-professional collaboration is needed for the safe handover and effective delivery of care.

Respect

In keeping with growing awareness of disrespect and abuse in childbirth [23,30,31], all plans emphasise respect for women, babies, families, and health providers in their interactions with each other. For example, there is a strong focus in the WCC Strategy on respectful care, with references to the White Ribbon Alliance Respectful Maternity Charter [31], albeit the earlier 2011 Charter [32]. The WCC strategy states that providers should identify and respect women's (and partners' and families') preferences, and where possible, incorporate them into maternity service design and delivery. The Scottish [18], Welsh [17], Northern Irish [20], Irish [19], English [16], and Canadian [21] plans highlight the importance of listening to/involving women and families in decisions affecting their treatment, care and support, to promote confidence and develop their sense of personal achievement. The Canadian [21] plan advocates for the delivery of maternity care that is dignified, compassionate, and respectful, and for providers to recognise that attitudes and word choices can impact women's experiences. Several of the plans (WCC Strategy, NMSP, Scottish, Irish, Northern Irish, Canadian, NZ) focus on respecting the normal, physiological experiences of pregnancy and birth to facilitate positive care provision.

Several plans recommend a holistic approach to healthcare (WCC Strategy, Scottish, Canadian, Irish), that is, to consider emotional, psychosocial, spiritual, and cultural needs, along with personal beliefs and experiences in addition to physical outcomes. The WCC Strategy specifically states that this type of respectful care is needed to protect women's autonomy and right to self-determination. The Scottish plan

[18] stresses the need to treat mother and baby as one, promote healthy lifestyle changes, strengthen a woman's capabilities, and to place the woman, her baby and family at the centre of service planning and delivery. The Irish plan [19] also places women and families at the centre of all services, recommending provision of care that empowers and improves health and well-being. Further, to support normal physiological processes, the plan recommends the environment in which the mother resides during and after birth be private, homely, and as relaxing as possible.

Some plans consider respectful interactions in the context of women who decline recommended care. The WCC Strategy recommends processes to maintain respectful care partnerships when, or if, a woman declines recommended care. The Welsh plan [17] states that a woman who chooses options outside clinical guidance must be treated with respect and kindness by her known care providers who will co-produce a new care plan that embraces her preferences.

Several plans refer to interprofessional collaboration as an element of respect. The WCC strategy notes that respectful interdisciplinary collaboration and communication is critical to the promotion of a positive workplace culture. The NMSP [2], and the Northern Irish [20], English [16], Welsh [17], Scottish [18], Canadian [21], and NZ [22] documents similarly emphasise the need for collaborative interdisciplinary teams that, for example, recognise and respect the specific competencies, knowledge bases, and experiences of each team member. In the NMSP [2], and Canadian [21] plans, respectful, kind collaboration with Indigenous health specialists is recommended. The English plan [16] singles out the need to break down barriers between midwives and obstetricians to forge more respectful relationships for the benefit of mothers and babies. The Scottish plan [18] encourages developing an open, honest, and empowering culture between multi-professional teams, so that differing views are encouraged and treated as equal in value. The English plan [16] extends this idea of collaboration to families, recommending that practitioners respect differing views to support rapid resolution and redress, the encouragement of learning, and the appropriate delivery of services when needed. The English [16] and Scottish [18] plans recommend continuity of care for all women to develop trusting, non-judgemental, and respectful relationships with staff who have specific knowledge of an individual woman's needs and choices. Lastly, the Scottish plan [18] acknowledges women's vulnerability during pregnancy and birth, the impact that relationships can have on birth outcomes, and the need to keep mother and baby together wherever possible so as to align with mother's and families' expectations and facilitate bonding, attachment, and breastfeeding.

Choice

Discussions around choice form a significant component in all the plans reviewed. In this section we examine the components of choice detailed in the strategy/plans, such as information required to make informed choice, who the final decision maker is, and choice of model of care and place of birth. The WCC Strategy states that women will be provided with nationally agreed tools to assist informed, evidence-based decision-making, and their preferences and choices will be sought and respected. The WCC Strategy acknowledges every woman's right to freedom from coercion. The Canadian plan [21] affirms respect for women's decision making and freedom from provider coercion. The English [16], Scottish [18], Irish [19], Canadian [21], and Northern Irish [20] plans emphasise the need to offer genuine choice through the provision of all necessary (Scottish, Irish, Northern Irish), unbiased information (Scottish, Canadian, English) centred around individual needs and decisions, and discussions about the risks and benefits associated with birth options. The Scottish plan [18] recommends early support and provision of information and evidence regarding choices to enable informed decision making and the best possible outcomes. The NZ [22], Canadian [21], Northern Irish [20], Irish [19], English [16] and Welsh [17] plans also support provision of evidence based information to support informed choice. In a number of plans, it is also highlighted that this information should be readily available (including online), culturally appropriate, in languages other than English and suitable for those with physical, sensory or learning disabilities.

Who makes the final decision when it comes to choice?

In most of the examined plans, there is a subtle but important shift in the fulcrum of choice from a woman's right to decide to the concept of shared decision-making. This shift has been identified previously as a morphing of the definition of woman-centred care over time which, while subtle, is significant [33]. The change in the focus on where the final choice lays can be seen to shift between, but also within, some of the plans.

Plans for woman-centred care maternity care published 8–10 years ago, for example the NMSP [2], appeared to place the final decision making with women and their families. Care providers were to assist women to make informed and timely choices regarding their care that is responsive to individual preferences and needs, so that women "feel in control of their birthing experience" [p73]. The English plan [16], while not explicit, also recommend that the woman-centred individualised care plan, developed with the woman's family, midwife, and other health professionals, is "based around their needs and their decisions" [p42], "reflects her wider health needs and is kept up to date as her pregnancy progresses" [101] [8].

The right to make autonomous decisions about our own bodies is enshrined in the Universal Declaration on Human Rights and applies equally to pregnant and birthing women [34]. Despite this, the WCC strategy and Irish [19], Northern Irish [20], Scottish [18], Welsh [17], and Canadian [21] plans indicate that maternity care will be co-decided between the woman, her family, and maternity care providers. The WCC Strategy contains internally conflicting statements about the human right to bodily autonomy. For instance, on page 7 it is stated that "women are the decision-makers in their care and maternity care should reflect their individual needs" whereas, on page 4, the discussion changes to shared decision making: "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". Putting a woman's right to make decisions about her body on an equal footing with provision of evidence and context of care is, in substance, a concerted attempt to dilute this fundamental human and legal right [35]. The Northern Irish plan [20] also supplants the woman being 'in control' of her own pregnancy with proclamations that prospective parents are 'partners' in the provision of maternity care. Somewhat concerningly, the Northern Irish plan claims that a balance needs to be struck between respecting individual choices and "ensuring the right care, by the right person, in the right place, at the right time" [p21] is delivered to women.

In the event of a difference of opinion, who decides? The Welsh plan [17] contains conflicting messages on this question: while women have "control over their behaviour, surroundings and treatment they receive" [p4], meaningful discussions and shared decision making must also be supported. The Canadian plan [21] confusingly emphasises, on the one hand, respect for women's reproductive rights, including the right to be "primary decision makers about their own care" [p1–19] but on the other, that women "play a central decision-making role… embedded within a larger concept reflecting trust in women as collaborative health care partners" [p1–19]. It also states that "when a choice is possible, the more natural and less invasive option is preferable" [p1–7]. By contrast, the Irish [19] and Scottish [18] plans are clear: care is to be co-designed, with women's choices being of equal value (Scottish) and only considered when safe to do so (Irish). Whilst women can choose their lead maternity care giver (GP, midwife, or obstetrician) in the NZ [22] plan, it is not clear whether she is viewed as the ultimate decision maker in all aspects of her care. Statements around a woman's right to make the final

decision about her care remain unclear and contradictory in the majority of the plans reviewed.

Choice of model of care/place of birth

The language used to facilitate models of care/place of birth choices is inconsistent across plans, with significant variation in the description of models and what is offered. The WCC strategy asserts that tools traversing all models of care will be utilised to assist women with their choices. As discussed earlier, however, midwifery continuity of carer appeared to be an add on after critique from consumer groups, despite recognition of its value as the highly sought after gold standard of care [5]. In the earlier NMSP [2] continuity of care, and where possible, continuity of carer, was emphasised as being very important to women, as well as key to quality service provisions. While some women may opt for GP and specialist obstetric care, the NMSP acknowledged the increasing demand for midwifery continuity of carer models in both the initial report [8] and the final plan [2]. Nonetheless the recommendation barely made it into practice as only 8–10% of women accessed continuity of midwifery carer models over a decade later [36]. The NZ plan [22] provides women with the option of choosing continuity of midwifery or obstetric carer in either a secondary or tertiary level service. In the Northern Irish [20] plan, continuity of midwifery carer is specified only for women with straightforward pregnancies. In the Irish plan [19], choice is afforded, but only if possible, when a woman is transferred from a lower-risk facility, including from antenatal community care, by a hospital-based midwifery team. By contrast, the English [16], Scottish [18], and Welsh [17] plans emphasise continuity of carer, and advise ALL women receive continuity of care from known midwives and other health provider(s) if required.

The provision of continuity of carer is expressed as integral to all plans reviewed, with the exception of the Canadian plan [21], in which the only recommendation for continuity is in relation to continuous support throughout labour and birth. Additionally, the Canadian plan [21] does not incorporate discussion regarding models of care but does specify that whatever care provider(s) are chosen, whether midwives, nurses, doctors, and other allied health professional (such as doulas and childbirth educators), collaboration is required and key to optimal care and safety.

Providing informed user choice, including of choice of place of birth, is integral to the provision of woman-centred care. In the WCC Strategy, place of birth is not discussed. There is no reference to homebirth or birth centres as safe and viable options for women. This appears a backward step, in light of consumer submissions and the recommendations in the previous 2009 plan to consider "a range of models of care including birthing centres" [8] [p57]. It is a significant omission that no consideration is given to homebirth, especially considering exclusion in 2009 as a "Commonwealth funded option (at least in the *short term*)" [8] [p21] has resulted in no mention, a decade later. Place of birth is discussed in the English [16], Scottish [18], Irish [19], Northern Irish [20], and Welsh [17] plans. In the English plan [16], genuine choice of place of birth is facilitated through access to midwifery care settings (whether at home or in midwifery led units) and the type of support needed during birth. Similarly, the Scottish [18] and Northern Irish [20] plans state that women are assisted, through risk and benefit discussions, to consider choice of birthplace, including home birth, and midwife and consultant led units. The Irish [19] and Welsh [17] plans also recommend full options for lower risk women to birth either at home or in freestanding/or 'alongside birth centres' when skilled care is available, whereas those requiring more complex care are recommended to birth in specialised midwifery or obstetric led centres. In the Canadian plan [21], place of birth options, including homebirth, are not discussed, however efforts to return birthing to the community is encouraged for indigenous women of low-risk.

The Irish plan [19] advocates for choices relating to the environment of the 'alongside birth centre' to facilitate comfort. This includes birthing balls and pools, complementary therapies and natural coping strategies. In cases of emergency, critical services are brought to the woman in the 'alongside birth centre', to maintain the same environment. If women are unable to access a low-risk birth centre, a designated space within the specialist centre with an environment conducive to a normal childbirth experience is recommended.

Both the NZ [22] and English [16] plans use a funding model that facilitates choice in model of care and place of birth. The English plan [16] provides that, since women's choices drive the flow of money, funding should follow the woman' choices and her baby's needs, whilst organisations are still supported to work collaboratively.

Access

Access and choice are closely connected. We have already discussed models of care, and evidence-based, easily understood information for informed decision making in the previous section of this paper. In this part, and in keeping with the documents reviewed, access is about services and staffing.

All plans addressed the need for women to have access to appropriately trained, responsive, competent, resourced, and culturally sensitive workforce, to facilitate the best use of services. Some plans discuss access to the provision of maternity care through a range of new services. In the WCC Strategy, improved access to telehealth, outreach, postnatal, and specialised services, such as transportation and accommodation, mental health support until 12 months post birth, and 'birthing on country' for Australia's First Nations people, is recommended. Similarly, appropriate service and referral pathways are discussed in all plans, some additionally emphasising the need for these to be seamless and accessible in community (English, Scottish, Canadian, Irish, Northern Irish, Welsh) or regional/remote settings (NZ), English, Scottish, Northern Irish, Canadian, Irish). In the NZ [22], Canadian [21] and Welsh [17] plans, these are discussed in relation to specialist services for clinically identified needs, whereas in others plans, reasons are expanded to include the compassionate recognition of individual circumstances, vulnerabilities, and preferences (Scottish, English, Irish, Northern Irish).

Access to culturally appropriate and individualised care is likewise highlighted in the WCC Strategy, as well as NZ [22], and Canadian [21] plans, that is as close to home as possible and inclusive of labour companionship from family and support people (Canadian), in recognition of their important contribution to positive psychological birth experiences. The Welsh plan [17] promotes individualised equitable access and collaboration between public and third sector organisations to mitigate the impact on women facing difficult social circumstances and adversity. The NZ plan [22] stresses there be no financial barriers to access.

Access to high-quality postnatal care is discussed in most plans, with extra support recommended for early breastfeeding promotion and support (English, Scottish, Welsh, Canadian, Irish, Northern Irish). Early skin-to-skin care for babies is also recommended (Scottish, Canadian, Irish), including in kangaroo care in neonatal units (Scottish, Canadian). Access to donor breast milk is further specified in the Scottish [18] plan. The Scottish [18], English [16], Irish [19], and Welsh plans [17] include support services to ensure families can stay together where possible, including providing accommodation to partners and/or mothers/parents of babies in special care. Access to midwifery continuity of postnatal care is recommended in the Scottish [18], and English [16] plans, unless a different carer is chosen (English) or required (Scottish). In the Welsh [17] plan, small midwifery and obstetric teams provide care, whereas in the Irish [19] plan, postnatal care is provided in the community by hospital-based midwifery teams. Continuity of carer throughout the maternity experience is recommended in the NZ plan [22]. The Northern Irish plan [20] further specifies access to a woman-centred midwifery/maternity support workers home visits for at least ten days post birth.

Access to a formal post-birth review or debrief is provided in the WCC Strategy and Scottish [17], Welsh [17], and Canadian [21] plans, as well as bereavement care in the WCC strategy, and the Scottish [18], English [16], Welsh [17], Irish [19], and Northern Irish [20] plans. Opportunity to provide feedback regarding the entire maternity journey is similarly encouraged in the NZ plan [22].

Discussion

The Australian WCC Strategy was designed as an enduring national plan operationalised by the states and territories. The intention was to offer an overarching national strategic direction which developed Australia's maternity care system and enabled improvements in line with contemporary practice, evidence and international developments. We critiqued the WCC Strategy against other maternity plans from comparable English speaking countries (published between 2011 and 2021), under the four values embedded in the WCC Strategy: safety, respect, choice and access, as well as through the lens of consumers and maternity service providers who have voiced concerns. We found significant variation in aspects of maternity care and the positioning and professional autonomy of midwifery in the reviewed plans and guidelines. One overarching difference was notable: where the midwifery profession is strong [37], midwifery models of care and place of birth options were more likely to be discussed and recommended. We suggest that differences in the recommendations in the strategy/plans appear to be due to the political/cultural/ideological lenses applied to the interpretation of the evidence.

There are obvious limitations to this paper and the approach taken. While we sought national plans from the USA, The Netherlands, Scandinavia and European countries, these documents either did not exist nationally, were not available in English, or had not been published in the ten-year timeframe. We did not review other major guidelines or international guiding documents as they were not country specific strategy/plans. Examples include, the World Health Organisation's *Recommendations for Intrapartum Care for a Positive Childbirth Experience* [23] and International Childbirth Initiative's (ICI) *12 Steps to Safe & Respectful MotherBaby-Family Maternity Care* [30]. While consumers, community members, and multidisciplinary researchers were involved in this paper, we focussed on issues of concern raised by midwives and consumers.

Positive aspects of the WCC Strategy when compared to other plans

The term 'woman-centred' in the title of WCC Strategy, including the values of safety, respect, choice, and access, is widely seen as core to quality maternity care provision in Australia. This is reassuring. The essence of these values appeared in every plan reviewed and allowed easy categorisation of concepts, as shown in table one. References to the *Respectful Maternity Charter: the Universal Rights of Childbearing Women* are commendable and they tie well with the values. The WCC Strategy has significant strengths: namely, the strong focus on respectful care, recognition of the need for the national evidence-based guidelines for postnatal care, development and implementation of culturally safe models of care for and with Aboriginal and Torres Strait Islander people and communities, and enhanced care and mental health support from conception to 12 months after the birth.

Other recommendations, while commendable in intent, are less promising because they are unlikely to be operationalised due to lack of funding and efforts shown to date. These include recommendations to use data to inform care, including reporting on Maternity Care Classification System [38] and making women and communities 'active partners' in planning for, and the co-design of, services.

Where the WCC Strategy falls short

In this critique, we identified several areas in the WCC that either fall short of current evidence or have been omitted. As discussed in the introduction, this appears to be the result of protracted medical lobbying and influence. Historical trends substantiate claims that such lobbying holds greater sway than women's voices and scientific evidence. As we noted earlier, continuity of midwifery carer appeared to be an add on to the WCC Strategy, following substantial consumer protests and submission of robust evidence [5]. The WCC Strategy stands at odds in this respect with the English, Scottish, and Welsh plans, which advocate for continuity of midwifery care for ALL women.

Significant implications flow from the WCC Strategy's focus solely on hospital delivery of maternity services, to the exclusion of community-based birth options. There is no mention of homebirth and birth centres in the WCC strategy which, in substance, is a rejection of both oft-stated consumer preferences for these options to be better supported in Australia and evidence to support good outcomes for low risk women [6]. The paucity of birthplace options and access to continuity of midwifery care contributes to women seeking to 'freebirth' and to use unregulated birth providers [39,40]. It appears that, in countries where birth at home and in birth centres is widely accepted, the recommendations in maternity plans were more in line with evidence, human rights, and consumer demands. The exclusion of non-mainstream models of care appears to reflect real-world medical dominance over the provision and dissemination of maternity services [26,41]. Recent research for example, identified that Australian women were not being provided with complete information regarding available models of care by their GPs [42]. This position of power and privilege has negatively impacted collaboration efforts and fostered an 'us versus them' culture hostile to practitioners seen as operating 'outside' the hospital [43]. While there is good guidance with respect to interdisciplinary collaborative care (ICI *12 Steps to Safe & Respectful MotherBaby-Family Maternity Care* [30]; NHMRC National Guidance on Collaborative Maternity Care [44]), achieving this espoused goal is much more difficult in reality [26,41]. The government has additionally missed an opportunity to 'level the competitive playing field' between doctors and midwives through the provision of accessible, timely information to enable consumers to make informed choice [45]. Informed user choice is a cornerstone of patient-centred care that can only be facilitated through the provision of information on the quality and performance of individual practitioners, types of models of care available, and disclosure of administrative and practice limitations of both the maternity provider and health facility [46].

Several important and interconnected areas affecting the delivery of maternity care were treated as outside the remit of the WCC Strategy for reasons that are either politically or financially motivated, or have the potential to cause friction between professional groups. First, the WCC Strategy fails to recommend accountability and transparency mechanisms in relation to private obstetric practice. This sector exhibits high levels of intervention and significant variations between both practitioners and hospitals, raising concerns about unconstrained provision of costly, non-evidence based care [47]. Despite emerging evidence of positive outcomes [48], privately practising midwives are likewise sidelined. Consumer requests for the expansion of this sector as a genuine choice, through better integration into the health system, were ignored. MBS items and broader workforce issues affecting the provision of maternity care were also excluded.

Funding models were also excluded from the remit of the WCC Strategy, even though they are explored in other plans. Funding drives access to, and quality of care, and this currently preferences medical providers. The current MBS fee for service model in Australia fits poorly with the provision of low-risk primary maternity care and does not support continuity of care. While the WCC Strategy alluded to the need to develop funding models to support its aims, discussion on maternity health funding models, such as the Independent Hospital Pricing Authority (IHPA) 2017 report on bundled pricing, was sorely lacking. "Bundled pricing is where a single price is determined to cover a full package of care over a defined period of time, spanning multiple events

and settings of care" [p3] [14]. Bundled pricing has the potential to introduce genuine competition into the sector, improve quality by reducing overservicing, reduce unnecessary costs, and level the playing field between medical and midwifery businesses. RANZCOG has, to date, rejected bundled pricing [49] [p4]. In 2018, the AMA resisted expansion of Medicare coverage to Midwives, stating, "Midwife led care should not become the standard" [50] [p1]. It comes as no surprise that the WCC Strategy was not given a remit to discuss components of any plan to improve the provision of maternity health care.

In addition, the WCC Strategy did not consider the effectiveness of multiple agencies overseeing the maternity care system in Australia. There was no discussion and consequently no call upon the Safety and Quality in Healthcare Commission (SQHC), health policy planners, health professional regulators, and the MBS to collaborate and utilise their legitimate authority and responsibilities to ensure, for instance, hospital accreditation standards, education and practice standards, models of care, and to utilise reliable evidence for best health outcomes, and the enabling of working environments.

Finally, we found inconsistencies in all the documents reviewed around where the final decision making lay when it came to choice and autonomy in maternity care. This is described by Jenkinson et al. [26] as the gap between "espoused and reported practice" [p7]. The right to make autonomous decisions about our own bodies is enshrined in the Universal Declaration on Human Rights and applies, without exception, to pregnant and birthing women. Recent studies indicate that women either feel they weren't given a choice [26,50] or that their wishes were undermined [50,51]. According to Jenkinson et al. [26], when a woman's choices cross the 'clinician's line in the sand', "punishment and judgement" [p5], and even "assault" [p6] (where treatment is imposed without consent) can follow, with the woman 'pitted' against her foetus as a threat and a strategy to control. The authors found that "patriarchy and medical hegemony remained largely unchallenged" [p2], even where the parties had previously agreed on a care plan. This leaves women in a vulnerable position when it comes to choice and autonomy in nearly every strategy/plan we reviewed.

There is little evidence the Monitoring and Evaluation Framework in the WCC Strategy will be implemented and no evidence that the federal government can require states and territories to implement the strategy. This needs to urgently be addressed as the WCC Strategy was published three years ago.

Recommendations for going forward in Australia

We make the following recommendations to ensure the highest possible standard of humanised, equitable, and evidence-based maternity care is available and the WCC Strategy is an effective and genuinely woman-centred plan:

1) Ensure consumers are consulted in a transparent and ongoing way, and are given time at the table with government, policy makers, and service providers in numbers equal to that of the medical profession and other powerful lobbyists combined.
2) Build the Respectful Care Maternity Charter into hospital accreditation, professional codes and education standards, both tertiary and through practical training.
3) Provide financial and administrative support for the full implementation and expansion of 'Birthing on Country' initiatives for Aboriginal and Torres Strait Islander women.
4) Offer all women continuity of midwifery care, including those with complex needs, and engage professional leadership to prioritise, sustain and expand these models of care.

   Support and integrate all place of birth options, including homebirth and birth centres, on equal terms to that currently given only to hospital facilities.
5) The power differential between doctors and midwives during maternity policy discussion and implementation must be acknowledged and addressed.
6) Provide midwifery leadership at the policy, education, and regulation levels so midwifery interests are not subsumed by medical agendas. Midwives must be consulted in a transparent and ongoing way and midwifery professional bodies must get time at the table with government in numbers equal to that of medical professional bodies.
7) Explore MBS funding alternatives to support midwifery care as primary health care and develop implementation strategies for phasing in bundled pricing following transparent consultation with both the ACM and RANZCOG.
8) Oblige practitioners (public and private) who receive publicly funded payment to publish data accessible to all members of the public on the 10 maternity indicators in a timely manner.
9) Provide a transparent plan for monitoring and evaluating the implementation of the WCC Strategy, including those aspects of the Strategy being embedded in health policies at both the state and federal level. Develop and tie Key Performance Indicators to funding that is annually reviewed.

Conclusion

The WCC Strategy provides an overarching national strategic direction to support Australia's maternity care system and enable improvements in line with "contemporary practice, evidence, and international developments" [1] [p4]. While the document reflects an admirable focus on respectful care and postnatal care, the WCC Strategy failed to support continuity of midwifery care, and choice of place of birth options, despite robust evidence in support of both. In addition, there was no emphasis on addressing ill-fitting funding mechanisms that preference medical providers over informed user choice for women. The WCC Strategy also does not acknowledge a significant and continuing issue within the current system, of medical privilege undermining the expansion of midwifery models of care, and the perpetuation of the provision of costly, lower quality, and highly fragmented medicalised maternity care, at the detriment of women's health and choice. We have concerns that as maternity service provision has a matrix of stakeholders and collaborators, failure to effectively engage with all through equal partnership, in particular service users, will render any perceived success of the WCC Strategy as short lived at best, and nugatory at worst. We suggest there is limited confidence that the evaluation frameworks for the WCC Strategy will be effectively enacted to provide genuine, structural improvements to benefit women's health. In countries with an established, valued and autonomous midwifery profession, maternity guidelines appear to better align with evidence. We conclude that maternity strategy/plans should be based on the best available evidence and produce similar recommendations for the provision of midwifery care. Priority must be given to the choices women make and the best available evidence, not the power and interests of organisations and individuals.

CRediT authorship contribution statement

HD designed the study and led the writing of the paper along with **VS**; **SO** undertook the search, data extraction, and assisted writing of the paper; **AS** provided input into the paper regarding the history and processes behind the WCC Strategy, **MK, LJ, BS** and **KS** provided advice and critical review and input into the paper.

Role of the funding source

The Canberra Mothercraft Society provided funding and worked in partnership with WSU to put on a public lecture and support the preparation of this paper to help inform public discussion, strategy and

advocacy. They did not influence the review of the maternity plans but provided critical review and editing suggestions.

Ethical Statement

Ethical approval was not required for this review of publically available maternity service plans.

Conflict of Interest

Lynne Johnson is on the Board of the Canberra Mothercraft Society (CMS) and Mary Kirk is a member of CMS.

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