Second Edition
National Consensus Framework for Rural Maternity Services

Associated Organisations:

Australian College of Midwives

Australian College of Rural & Remote Medicine

CATSINaM
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Unity and Strength Through Caring

Maternity Consumer Network

NAATSIHWP
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners

National Rural Health Alliance

Australian Government
Office of the National Rural Health Commissioner

RACGP
Royal Australian College of General Practitioners

RANZCOG
Excellence in Women's Health

Rural Doctors Association of Australia

RWA Network

Acknowledgement of Country

The Consensus Framework signatories acknowledge the Traditional Owners and Custodians of Country throughout Australia. We acknowledge the ongoing impacts of colonisation and its detrimental effects on the Aboriginal and Torres Strait Islander people of this country.

The signatories recognise and deeply respect the strength and resilience of Aboriginal and Torres Strait Islander people and the continuing connection and relationship to rivers, lands, seas and sky. We are committed to the advancement of improved health outcomes for Aboriginal and Torres Strait Islander people by promoting their expertise, opinions and perspectives through their voices, shared stories, leadership, effective feedback mechanisms and collaborative design processes.

The signatories pay respect to Elders past, present and those leading us into the future and extend that respect to all Aboriginal and Torres Strait Islander people reading this framework.

Suggested citation

Australian College of Midwives, Australian College of Rural and Remote Medicine, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Maternity Consumer Network, National Association of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, National Rural Health Alliance, Office of the National Rural Health Commissioner, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Rural Doctors' Association of Australia, Rural Workforce Agency Network 2025. *Second Edition National Consensus Framework for Rural Maternity Services*.

Contents

Foreword

Family is central to human society. When families are supported and enabled in all their glorious diversity, children are created, nurtured, and grow into strong members of society who in turn support and enable the generations which follow. Healthy conception, pregnancy and birth are vital to this constant cycle of renewal and growth. A reductionist view of who should be involved in the safe and successful creation and care of the child from conception to infancy would have us believe that this is a very small circle indeed: woman, baby and identified maternity care professionals. It takes a view of safety which focusses on this triad and on the biophysical experience. This reductionist view of the needs of maternity care drives the closure of smaller more remote services and the contraction of maternity services into larger more urban settings. Rural and remote communities have been protesting about this approach. It is important that we listen to them.

The National Rural Maternity Forum in August 2023 recognised the need for revision of the National Consensus Framework for Rural Maternity Services to be undertaken by an inclusive expert advisory group. This revision needed to address cultural safety for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people (CALD), respectful maternity care, continuity of care and carer and the co-design and co-development of maternity services with consumers.

It has been my very great pleasure to lead this advisory group as chair and also to lead the smaller editing group who step by step produced a framework that the advisory group reviewed and improved. This has been a truly remarkable piece of work by expert, passionate, and committed clinicians and policy makers who all have deep experience of rural and remote Australian maternity care.

I commend to you this second edition. We envisage it being an essential planning tool for rural and remote maternity services, for communities seeking to improve their access to maternity care, for policy makers wondering what their aim should be and for maternity clinicians plus those who train them as they consider the curriculum to be taught.

I thank each member of the advisory group for their time, the deep respect that each brought to the table and for the energy and vision of how we can have excellence in rural and remote maternity care. I especially thank the members of the editing group who met almost weekly for five months and read, re-read and challenged themselves and each other to articulate the principles and underpinning strategies that had been explored in the National Rural Maternity Forum held in Canberra. And lastly, I thank Clare Brown, senior policy adviser within the Office of the National Rural Health Commissioner who was our secretariat, scribe and muse.

This excellent document is the work of all of you. I now commend it to your organisations to utilise, promote and implement along with advocating for continuous improvement for rural and remote maternity services.

Well done and thank you.

Adjunct Professor Ruth Stewart

MBBS, PhD, FACRRM

Immediate past National Rural Health Commissioner (2020 – 2024)

Chair of the Expert Advisory Group

Signatories to the Second Edition National Consensus Framework for Rural Maternity Services

Listed in Alphabetical Order:

- Australian College of Midwives (ACM)
- Australian College of Rural and Remote Medicine (ACRRM)
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
- Maternity Consumer Network (MCN)
- National Association of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners (NAATSIHWP)
- National Rural Health Alliance (NRHA)
- Office of the National Rural Health Commissioner (ONRHC)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Rural Doctors' Association of Australia (RDAA)
- Rural Workforce Agency Network (RWA Network)

Glossary

TERM	DEFINITION
Aboriginal community control in health services	Defined by the National Aboriginal Community Controlled Health Organisation as *"a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community"* [1]
Birthing in Our Community	An Aboriginal and Torres Strait Islander established community led service for mums, babies and families in South Queensland that delivers a model of maternity care that provides comprehensive and culturally informed maternity and infant health services for Aboriginal and Torres Strait Islander families [2]
Birthing on Country	Birthing on Country can be described as a *"...a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families' which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all"*. [3] See also *Birthing in our Community, Birthing on Country Service Models* and *RISE Framework*.
Birthing on Country service models	*Birthing on Country* and *Birthing on Our Community* service models are maternity services designed and delivered in partnership with First Nations women and their families. They are guided by and incorporate Aboriginal and Torres Strait Islander knowledge and traditional practice, strengthening connection to culture and country, and acknowledge the cultural safety risk of birthing away from Country [3]
Clinical attachment	A period of attachment for the clinician in a different clinical setting that involves clinical oversight of hands-on clinical practice to learn and update specific skills or areas of knowledge. For example, a clinician doing a clinical attachment in a rural hospital that has a birthing unit.
Clinical privileges	Specific to the individual clinician. They represent the range and scope of clinical responsibility that a health professional may exercise within defined limits in a health care facility and relate to the resources, equipment and staff available in the health care facility along with the guidance of clinical service capability frameworks [4]
Co-design	The practice of designing solutions collaboratively with people or communities. For example, it can include bringing together consumers, health workers and service providers together to improve health services with an equal and reciprocal relationship between all stakeholders [5]

TERM	DEFINITION
Continuity of care	Continuity of care is the ability to provide uninterrupted care or service across programs, practitioners and levels over time [6]
Continuity of carer	The same trusted health professional providing care or supervision throughout a woman's contact with the maternity services, including backup arrangements [7]
Credentialing	The process of verifying the qualifications, experience and other professional attributes of clinicians in relation to that professional role within a specific health care setting to provide safe, high quality health care services [8]
Cultural safety	*"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing crucial reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism"* [9]
Cultural safety training	Cultural safety training may be referenced using different terminology in peak organisations and groups across state and territories, for example in some settings it may be referred to anti-racism training and in other settings cultural safety training is used as an umbrella term.
De-skilling	The possible loss of an individual's skills or the capability of a team as a result of underutilisation of the skill or the skill no longer required due to rural maternity service closures or downgrades [10]
Guidelines	Approved evidence-based recommendations for clinicians to deliver appropriate treatment and care within maternity services [11]
Informed decision-making/ choice	The woman and their support people (such as family, carers, friends) are provided with comprehensive information and choices that assist and inform the decision made by the woman. For example, the communication process between a woman and one or more health professionals, central to woman-centred health care. It requires respect for a woman's autonomy and right to self-determination, including the right to accept or decline the offer of certain health care and to change that decision. For a woman to exercise this right to decide, she requires the information that is relevant to her, and have this information provided at an appropriate time [12]

TERM	DEFINITION
Integrated maternity service network	The coordination of activities and programs among healthcare institutions within defined geographic areas for the purpose of improving the delivery and quality of maternity care, enabling seamless integration within the network. Integrated maternity networks include clinicians (midwives, GPs, obstetricians and other health professionals), hospitals and related services to provide the complete spectrum of maternity care for women and their families [13]
Maternity care workforce/ team	Professions involved in the provision of rural and remote maternity care. › Midwives › Rural Generalist and General Practitioner obstetricians › Rural Generalist anaesthetists › General practitioners › Specialist anaesthetists › Specialist obstetricians › Nurses › Allied health practitioners › Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners › Traditional birth attendants › This may also include virtual care providers.
Maternity models of care	Describes how maternity care is provided during pregnancy, birth and the postnatal period. It includes identifying: › The community a model is designed for › The maternity care providers and their role › Aspects of how and where care is provided › The clinical model of care that is the foundation of maternity service delivery [14]
Modified Monash Model (MMM)	Is a model to differentiate areas of Australia in regards to remoteness and population ranging from MMM1 (Metropolitan Areas) to MMM7 (Very remote communities) [15]
Multidisciplinary team	The multidisciplinary team is comprised of health professionals from different disciplines, centred upon the needs of patient and client needs, providing comprehensive care at the right place and time.

TERM	DEFINITION
Open disclosure	Open discussion with the patient/client, their family and carers of adverse events/ incidents that occur while receiving health care. This discussion should occur in a timely and open way. Elements of open disclosure include: › Acknowledgement and an apology or expression of regret › a factual explanation of what happened › an opportunity for the patient, their family and carers to relate their experience › a discussion of the potential consequences of the adverse event › an explanation of the steps being taken to manage the adverse event and prevent recurrence. [17]
Place-based	In a place-based approach, the characteristics of the community and location are brought together in an integrated 'person and place' approach that focuses on outcomes for people. In this context, the community and its needs are at the centre of any development. Involving community in planning, selecting, designing and governing their physical and social infrastructure can be just as important as the facilities and services themselves [18]
Policy	A set of ideas or plan regarding a particular situation that has officially been agreed on by a government, political party, business organisation or a group of people [19]
Procedures	A set of actions that is the official/ agreed on way of doing something [20]
Respectful maternity care	Respectful maternity care is defined as *"... care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment and enables informed choice and continuous support during labour and childbirth"* [21]
RISE Framework	To plan, develop and monitor Birthing on Country services, RISE stands for: › Redesign the health service › Invest in the workforce › Strengthen families; and › Embed Aboriginal and/or Torres Strait Islander community governance and control [22]

TERM	DEFINITION
Rural and remote	The terms 'rural' and 'remote' in this framework are defined using the Modified Monash Model regions 3-7 [15] The MMM classification system is currently under review at the time of writing. If a new classification is brought in to measure remoteness and population, this Framework refers to rural and remote communities consistent with the current definition of MMM 3-7 [15] See also *Modified Monash Model*
Scope of practice	The scope of practice of a profession includes the roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Individual scope of practice is influenced by the context in which they practice, the health needs of people, level of competence and qualifications of the clinician and service providers policies. At times the scope of practice is dynamic, related to specific situation and context of care [23, 24]
Traditional birthing attendants	In Australia, Aboriginal and Torres Strait Islander traditional birth attendants are nominated, respected senior community women, who have integral roles supporting maternal health care in culturally determined ways. Traditional birth attendants acquire and apply intergenerational Aboriginal and Torres Strait Islander knowledge relating to pregnancy, women's wellbeing, and birth skills and practices. They support women, their babies and families across antenatal, birthing and postnatal care in the provision of physical and emotional support. (CATSINaM, personal communication June 23, 2024). Aboriginal and Torres Strait Islander birthing practices have been disrupted by colonisation and dominant Western maternity practices. Importantly, some Aboriginal and Torres Strait Islander communities are investing in the continuity and renewal of culturally safe maternity care for Aboriginal and Torres Strait Islander women and families. One example can be found among the Yolŋu people in North East Arnhem Land, with the inclusion of traditional birth attendants, known as Djäkamirr, during on-country childbirth experiences. (CATSINaM, personal communication June 23, 2024).
Woman and family-centred care	Practice that follows the principle of incorporating the woman's perspective and considering their individual circumstances and needs that can mean care is woman-directed because they are sufficiently and appropriately informed to self-determine their care and level of engagement [18].

This second edition of the National Consensus Framework for Rural Maternity Services supersedes the first edition published in 2008. It provides a set of principles and strategies to frame policy and planning and to support quality maternity services in rural and remote Australia. It provides guidance to enable health services and clinicians to care for and support rural and remote women, their families, and communities.

Background

Over 7 million people live in rural and remote Australia, close to 30% of the population [25]. Compared with people in metropolitan areas, Australians living in rural and remote areas have shorter lives, poorer access to and use of health services, and a greater burden of disease [25]. In addition, rural and remote areas continue to struggle to attract and retain the health workforce, with the existing health workforce maldistributed, becoming scarcer with increasing remoteness [26].

The health risks faced by people living in rural and remote areas begins early, with babies in these regions more likely to be born pre-term, of low birthweight and with increased rates of infant mortality [27, 28]. These issues perpetuate intergenerational cycles of poor health, affecting the lives of families and compounding the disadvantages faced by rural and remote Australians.

Rural and remote women, like all women, want to be close to home during their pregnancies. They want to feel safe throughout their pregnancy and be informed about the choices available to them. Between 1992-2011, there was a 41% reduction in maternity units in Australia, with many of the closures impacting small maternity services in rural areas [29]. Maternity services are not routinely provided in all rural hospitals and the downward trend of closures or intermittent periods of bypass in existing rural maternity facilities is continuing to occur across the country [30]. When birthing services are closed and health professionals with maternity skills leave the community, risks for pregnant rural and remote women increase [31]. As a result, women and families may have to travel significant distances for appointments and deliveries or relocate to a town or city with birthing facilities well before the birth is due. This comes with increased financial, social, cultural, and emotional costs for women and their families.

The need for a National Consensus Framework for Rural Maternity Services

Before the 2008 publication of the Consensus Framework (first edition) there was no agreed set of principles that communities, service providers, decision makers and funders could reference to ensure safe, evidence based maternity care for mothers who live outside of urban centres [32]. The absence of such a framework coupled with ongoing rural maternity service closures and downgrades placed rural and remote women and babies at unprecedented risks to poor health outcomes. Recognising these increased risks, the framework arose from consensus building among professional organisations representing the core disciplines that provide maternity care. These organisations, which were the original signatories were (in alphabetical order) the:

- Australian College of Midwives
- Australian College of Rural and Remote Medicine
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Rural Doctors' Association of Australia
- Rural Health Workforce Australia

The development of a second edition

Fifteen years later in May 2023, a think tank focussing on rural and remote maternity care was hosted in Canberra by ACM and RDAA. As an outcome of the think tank, the Office of the National Rural Health Commissioner, ACM, and the RDAA jointly held a National Rural Maternity Forum on 29 August 2023 in Canberra. Both events were supported by the National Rural Health Alliance.

The forum focused on solutions for the needs of rural mothers and their babies and access to high quality care. Over 70 attendees represented diverse stakeholder groups, including consumers, peak health professional bodies, medical and midwifery colleges, state and territory health departments and services, and the Australian Government Department of Health and Aged Care.

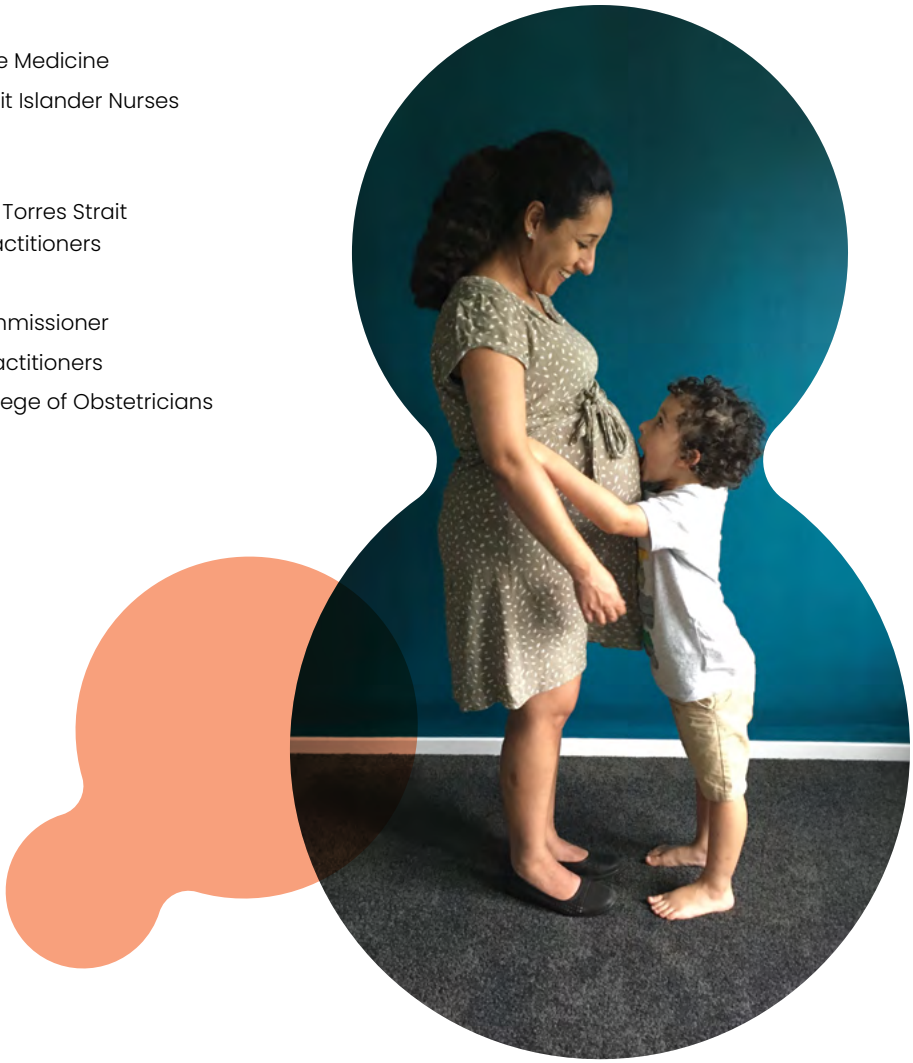
The forum identified priority actions to support rural maternity care including updating the National Consensus Framework for Rural Maternity Services to reflect changes and advances within maternity care since the first iteration in 2008. An expert review advisory group was formed to ensure broad ranging expertise and oversight in the revision and development of the second edition. The advisory group was chaired by the National Rural Health Commissioner, Adjunct Professor Ruth Stewart and included the following organisations (listed in alphabetical order):

- Australian College of Midwives
- Australian College of Rural and Remote Medicine
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Maternity Consumer Network
- National Association of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners
- National Rural Health Alliance
- Office of the National Rural Health Commissioner
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Rural Doctors' Association of Australia
- Rural Workforce Agency Network

Four members of the advisory group formed an editing group with the ONRHC to prepare revised draft versions of the framework with ongoing input from the advisory group. The editing group included clinical experts (midwife and a rural generalist with obstetric advanced skills), a consumer representative and rural health policy experts. The development of the framework was revised and finalised with consensus of all members of the advisory group, who are signatories of this second edition.

Key themes emerged during the review process and as a result, the second edition has a particular emphasis on:

- Respectful maternity care
- Continuity of care and carer
- Delivering culturally responsive maternity care
- Approaches to defining and determining risk
- Acknowledging the importance of co-designing maternity services and delivering place-based multidisciplinary team care.



Respectful Maternity Care

Respectful maternity care is every maternity service's business. Every woman has the right to respectful and dignified health care throughout the pregnancy continuum [21]. However, many women globally still experience disrespectful, undignified, and even abusive practices during pregnancy and childbirth [33, 34, 35].

The provision of respectful maternity care is the responsibility of every maternity health professional [35]. It can be achieved through effective, empathic communication, and genuine meaningful engagement with women and their families, as well as consumer representatives and advocates. This will ensure that care is responsive to each woman's unique needs and preferences, such that support and outcomes for women are not just improved but optimised. With a strong commitment to effecting positive change that will benefit both providers and women, we can make the changes we need to transform the Australian maternity health system to one that exemplifies the provision of respectful maternity care.

Continuity of care and carer

This framework recognises that women choose different models of care and support based on their circumstances, settings and preferences.

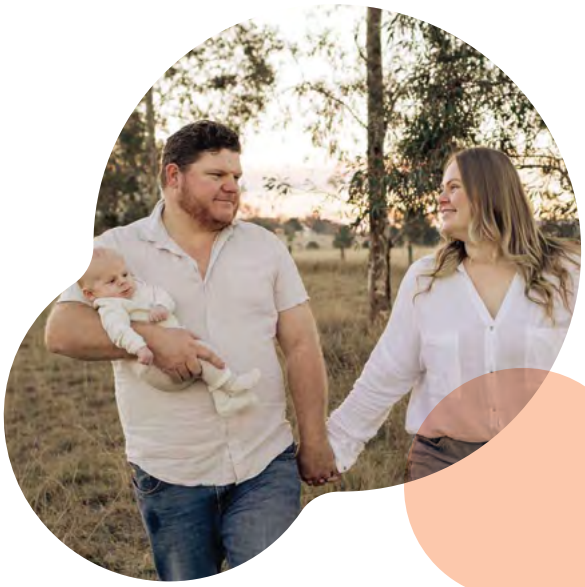
In recognition of the context of rural and remote practice, local models need to have flexibility to facilitate arrangements to support a woman's choice in the way their care is provided. In line with this, the framework emphasises the importance of:

- Rural and remote women having access to continuity of care with the care provider(s) of their choice.
- Rural and remote women having access to woman and family centred culturally safe and appropriate maternity care close to where they live.
- Rural and remote women are supported to make informed decisions and choices about their care in a collaborative manner with care providers.

Midwifery continuity of care (MCoC) models provide the woman and her family continuity of carer with a known midwife through pregnancy, during labour and birth and usually six to eight weeks postnatal. MCoC models are internationally recognised and supported by the highest-level evidence [36] and recommendations from the World Health Organization to improve outcomes for women and babies and improve job satisfaction and workforce retention for midwives.

Women want continuity of care and carer throughout their maternity journey [37, 38] and women with any level of complexity of care benefit from continuity of midwifery care [39]. Evidence based best practice is that women should have access to Midwifery continuity of care regardless of where they live [40]. Australian healthcare policy demonstrates a commitment to MCoC and scale up in both national and jurisdictional maternity strategy documents [41, 42, 43]. This framework recognises the value of midwifery continuity of care as a core feature of service design in the maternity models of care, particularly in public sector hospital services.

GP Obstetricians, Rural Generalists, Obstetrics and Gynaecology specialists, General Practitioners and Aboriginal and Torres Strait Islander Health Workers and Health Practitioners play an important role in providing continuity of care in regional, rural and remote areas in a range of public and private settings. High quality maternity care is achieved by health professionals working closely with the multidisciplinary maternity care team from pregnancy, birth and beyond [44, 45, 46].



Culturally safe and responsive maternity services

Making all health services culturally safe and responsive and free from racism is essential to improving health outcomes of Aboriginal and Torres Strait Islander people and communities and improves overall quality of health provision for all who receive care [47]. All health practitioners and service providers are responsible for providing culturally safe and responsive workplaces and environments for Aboriginal and Torres Strait Islander women and their families. This needs to be guided by and incorporate Aboriginal and Torres Strait Islander knowledge and traditional practice, strengthening connection to culture and country, and acknowledging the cultural safety risk of birthing away from Country [3].

Defining and determining risk

In health, there has been a strong tendency to focus on the health risk factors for the consumer, the professional risk for the clinicians and the business risks for the health service [48]. While the clinical risk component remains a key factor in risk assessment in this consensus framework, the advisory group recognises the need to adopt more holistic approaches to the consideration of risk in maternity care. This second edition intentionally expands the appreciation of risk to also include those that incorporate social, cultural and psychological risks for women, babies and their families as well as for the maternity care team.

Co-designing maternity services and delivering place-based multidisciplinary team care

Rural and remote people deserve high quality health care and are calling for service delivery that is co-designed with community close to home that provides continuity of care by known carers [17]. This requires genuine and respectful community engagement to design contextually and culturally appropriate models of care, and a locally based multidisciplinary team.

Fit for purpose and locally designed rural and remote models of care with structured support for the health professionals who work within them is imperative to addressing current rural and remote health inequities [17]. The maternity care workforce in rural and remote areas is multidisciplinary in nature and can include midwives, rural generalists obstetricians, general practitioners, specialist obstetricians, nurses, allied health practitioners, Aboriginal and Torres Strait Islander health practitioners and workers as well as Aboriginal and Torres Strait Islander traditional birth attendants. Consequently, it is important to consider all members of the maternity care team when looking at rural and remote maternity services.

Statement on the term woman in this framework

The term woman in this framework is respectfully referring to all people who are accessing and experiencing maternity care during their pregnancy, labour, birth and postpartum care in rural and remote Australia, inclusive of differences in age, culture, gender identification, spirituality, religion, capacity and legal status.

Principles and strategies

Principle 1: Culture, leadership and wellbeing

PRINCIPLE	STRATEGIES
1.1 **Maternity services must embed and practice cultural safety and develop strategies to identify and eliminate racism.**	**1.1.1** Maternity services must be reformed to align with the National Agreement on Closing the Gap Priority Reforms. **1.1.2** Reforms to maternity services must involve collaboration and partnering with Aboriginal Community Controlled primary health care and community members/ representatives coupled with education on cultural safety and capability. **1.1.3** Develop and embed specific strategies to focus on identifying and eliminating individual and institutional racism towards Aboriginal and Torres Strait Islander and culturally and linguistically diverse people. **1.1.4** Maternity services must respect, acknowledge and honour Aboriginal and Torres Strait Islander self-determination and ways of knowing, being and doing. **1.1.5** Maternity services must include mechanisms to enable Aboriginal and Torres Strait Islander people to share in decision making.
1.2 **Maternity services must have collaborative leadership approaches to create and sustain respectful and safe workplaces.**	**1.2.1** To adequately meet the needs of maternity service governance there must be representation from both midwifery and obstetric members of the maternity leadership team at the executive level, ensuring they have the appropriate level of delegation and decision-making authority. **1.2.2** Maternity care leaders in all professions must undertake local initiatives to enhance collaboration and respectful workplace culture, strengthening interprofessional leadership. **1.2.3** Maternity services require dedicated midwifery and medical obstetric professional and operational leadership that embodies respect for women, families and staff. **1.2.4** Inclusion of Aboriginal and Torres Strait Islander leadership and governance arrangements to inform maternity services to ensure accessibility and culturally safe and capable care for Aboriginal and Torres Strait Islander women, babies, families and communities. **1.2.5** Emerging maternity care leaders should be supported to develop their leadership skills to ensure succession planning and ongoing representation at executive level.

PRINCIPLE	STRATEGIES
1.3 **Maternity services require a respectful, transparent and well communicated leadership and governance structure with escalation and communication pathways.**	**1.3.1** Maternity service leadership must establish and demonstrate respect for women, families and staff. **1.3.2** Rural and remote maternity services should establish tiered clinical governance structures, including local, integrated service networks and jurisdictional to facilitate escalation and communication pathways.
1.4 **Maternity services must provide support for the psychological safety and wellbeing of women, families and staff.**	**1.4.1** Immediate and ongoing support must be provided for women, family and maternity service staff following clinical incidents, near misses and birth trauma. **1.4.2** Support and training must be provided, and counselling offered for maternity service staff to respect a woman's informed choice when she declines recommended care including for women and families with appropriate referral pathways at the local level. **1.4.3** Maternity services must provide access to clinical disclosure and open disclosure training for the multidisciplinary and leadership team as part of routine clinical governance to enable clinicians and families to be appropriately supported after clinical incidents and near misses. **1.4.4** Maternity services must provide multidisciplinary training in trauma informed care and support, which is contextually appropriate for the women, families and staff in their care. **1.4.5** Maternity services must provide culturally safe work environments and support in the form of cultural and clinical supervision to the Aboriginal and Torres Strait Islander workforce to ensure retention and overall wellbeing.

Principle 2: Safety and quality

PRINCIPLE	STRATEGIES
2.1 **Rural and remote women have a right to informed choice. Health care professionals have a responsibility to provide information to facilitate informed decision making.**	**2.1.1** Service providers must present impartial advice at an appropriate time on all options available to women. These conversations must be evidence-based. **2.1.2** Service providers must provide accessible information about local maternity models of care to consumers. **2.1.3** Women must be provided with balanced comprehensive evidence-based information to assist their choices in maternity care. **2.1.4** To assist women to make informed decisions, service level clinical outcomes data must be available to consumers. **2.1.5** Maternity consumers must have opportunities to give formal and informal feedback about the quality and safety (including cultural safety) of rural maternity services. **2.1.6** Maternity consumers and community representatives must be invited to participate and be included in formal review and feedback mechanisms of the quality, safety and cultural safety of rural maternity services to inform women's choice. **2.1.7** Referrals to healthcare professionals requested by the woman (eg privately practicing midwives, midwifery group practice, general practitioners, rural generalists, obstetricians for primary maternity and early antenatal care) must be facilitated. Availability of the healthcare professionals should be considered and the alternatives if they are not available.
2.2 **Rural and Remote maternity services must be woman and family centred, culturally safe and underpinned by an evidence-based continuous quality improvement culture that acknowledges the realities of rural and remote settings.**	**2.2.1** Multidisciplinary training in respectful maternity care should be facilitated annually (eg ALICE program[1], Better Births with Consent program[2]). **2.2.2** Cultural safety training must be trauma informed and accessible to all maternity care staff. At a minimum, this should include education on culture, values, attitudes, assumption and beliefs that influence perception of and interaction with people, families, community and colleagues to ensure quality safe care. **2.2.3** Cultural safety training should be provided by a reputable Aboriginal and Torres Strait Islander provider. **2.2.4** Rural maternity services must be structured and networked to incorporate quality improvement cycles, evaluation and peer review.

1 The ALICE program is a woman-centred care program for all maternity service team members to develop collaborative leadership capability, providing tools and support to increase effectiveness. The program supports team members to increase skills in working collaboratively with all professional groups in the interest of woman-centred care.

2 The Better Births with Consent Program is a 3 hour workshop consent training for maternal health professionals accessed through the Maternity Consumer Network.

PRINCIPLE	STRATEGIES
2.3 **All rural maternity care facilities should be accredited according to rurally relevant national standards.**	**2.3.1** To ensure clinical service capability can be met in rural maternity services, evidence-based national standards should be developed to reflect the needs of rural communities and support local community co-design. **2.3.2** There should be national alignment in terminology and service level within clinical service capability frameworks. **2.3.3** Clinical service capability frameworks should, by listing the resourcing needed, be used to enable service delivery in rural and remote communities. Where deficiencies are found with respect to applying the Clinical Service Capability Framework, decision makers should work towards enabling service delivery which in some circumstances would include access to caesarean level capability.
2.4 **Maternity care referral pathways must be agreed within the maternity care network to facilitate timely seamless access aligned with the woman's choice and the rural and remote context.**	**2.4.1** Maternity care referral pathways must be articulated and agreed within and between jurisdictions. **2.4.2** Coordinated systems must be developed to support the connected care of mothers, their babies and families within and between jurisdictions. **2.4.3** Adopt national guidelines, protocols (and endorsed jurisdictional guidelines for areas not covered by national guidelines) for use by all professionals providing maternity care. **2.4.4** Consumer feedback on their experience of transfer of care must inform quality improvement cycles in maternity care. **2.4.5** Obstetric advisory and retrieval services must be centrally coordinated with a single point of contact. **2.4.6** Women and families must be informed of the process that supports women, families and carers to escalate concerns if a woman or her baby's condition is deteriorating and they are not satisfied with the clinical response.
2.5 **Risk assessment for women, babies and families should incorporate clinical, social and cultural components and be in place in all systems of care from preconception through to antenatal, intrapartum and postpartum care.**	**2.5.1** Develop and implement contemporary national safety assessment tools that incorporate the social, emotional, cultural, clinical and financial impacts to women, their families and the service. **2.5.2** National evidence-based resources should be developed to support women, their families and clinicians when recommended care is declined.

Principle 3: Access

PRINCIPLE	STRATEGIES
3.1 **Women must have access to culturally safe and appropriate maternity care close to where they live.**	**3.1.1** All women must have access to a continuity of carer model within the public sector and/or Aboriginal Community Controlled Health Service. **3.1.2** Informed by communities, models of care must be responsive to the cultural needs of Aboriginal and Torres Strait Islander women and all women and families in rural and remote communities. **3.1.3** All maternity care models must provide as a minimum, telehealth and outreach access to midwifery and obstetrics care for non-birthing services. **3.1.4** Maternity services and Aboriginal Community Controlled Health Services must co-design culturally safe seamless integration of comprehensive primary and maternity care for the women, babies and families they serve. **3.1.5** Aboriginal and Torres Strait Islander women, babies and families must have access to an expert maternity care team providing culturally safe continuity of care Birthing on Country or Birthing in our Community. **3.1.6** Aboriginal and Torres Strait Islander and culturally and linguistically diverse women and families must have access to services that are responsive to their unique cultural considerations. **3.1.7** Rural and remote maternity services must provide mothers and families access and support to termination of pregnancy and care for miscarriage and imminent or unplanned birth.

PRINCIPLE	STRATEGIES
3.2 **Maternity service planning must embody the principles of community engagement, codesign and co-development.**	**3.2.1** Maternity services must plan a locally relational approach with Aboriginal and Torres Strait Islander community engagement and nurture partnerships and relationships with the Aboriginal and Torres Strait Islander communities they serve to develop culturally safe maternity services. **3.2.2** Maternity service planning and redesign must include women, families, clinicians, and community. All participants should be provided with comprehensive information about the maternity care options in their context, including service limitations. **3.2.3** All rural hospitals must have co-design and co-development of training programs and education. Skill development should support full scope of practice in the multidisciplinary team.
3.3 **Maternity service planning should work within national frameworks to support flex up and flex down service profiles based on availability of relevant maternity workforce and financial implications to the service, families and community.**	**3.3.1** When planning changes to the service profile, the local planners must consider the following: › Cost for families (financial, social, cultural, and psychological) › Patient travel and accommodation › Impact on whole of health service › Staff retention › De-skilling **3.3.2** Maternity service administration and women, families, community, and clinicians should agree to a communication strategy and decision-making processes when planning changes to maternity service provision. **3.3.3** Where antenatal, postnatal, and birthing services cannot be provided locally, adequate financial assistance must be provided to women and their support person who are being transferred outside their own community to access maternity services. Assistance to families should also be considered. For example, a liaison or 'concierge' service to book and coordinate transport and accommodation for Aboriginal and Torres Strait Islander women and culturally and linguistically diverse women.

Principle 4: Models of Care

PRINCIPLE	STRATEGIES
4.1 **Community engagement should underpin the co-design and co-development of place-based models of care for rural and remote maternity services.**	**4.1.1** Adopt the RISE framework[3] or other evidence based frameworks that enables co-design and evaluation with community, consumers, health professionals and system management. **4.1.2** Local women and their families and communities, with local maternity and health care professionals should be supported to co-design services appropriate to their specific environment.
4.2 **Maternity Models of care should be community/ place-based and efficiently utilise skill mix and services to provide best practice continuity of care.**	**4.2.1** Local models of care should be resourced to meet local community need and women's and families' choice. **4.2.2** The local operational management plan and model of care should utilise the full scope of practice of the local team supported by telehealth and visiting specialists to maintain service delivery as needed. **4.2.3** Rural services must be supported to provide multiple options for locally available maternity models of care to ensure that women have a choice. **4.2.4** To facilitate continuity of carer, place-based innovation should be supported.
4.3 **Rural and remote maternity services should promote culturally safe, continuity of care and carer across the maternity continuum and enable women as necessary to access the full multidisciplinary team within the service.**	**4.3.1** In all models of care a woman must have a known carer who provides continuity of care. **4.3.2** Services should use the RISE framework to develop Birthing on Country models of care, providing wrap around culturally safe maternity care for all priority populations. **4.3.3** The composition of the multidisciplinary health team supporting local models of care must be evidence-based and responsive to the needs and preferences of women and of the local community. **4.3.4** Multidisciplinary teams must incorporate interpreters, Aboriginal and/or Torres Strait Islander Health Workers and Health Practitioners, traditional birth attendants and family and cultural support where there is a recognised need in the community to ensure traditional cultural practices form part of routine maternity care. **4.3.5** Local Aboriginal and Torres Strait Islander and culturally and linguistically diverse women must be engaged independently in the design, review and evaluation of maternity models of care.

3 To plan, develop and monitor Birthing on Country services, RISE stands for Redesign the Health Service; Invest in the Workforce, Strengthen Families; and Embed Aboriginal and/or Torres Strait Islander community governance and control.

Principle 5: Infrastructure

PRINCIPLE	STRATEGIES
5.1 **To facilitate rural and remote women's access to the full spectrum of maternity care, infrastructure and support, regional integrated service networks should be developed engaging all providers of maternity care.**	**5.1.1** Investment in infrastructure should be aligned to support community designed maternity models of care. **5.1.2** The maternity care team should have optimal scope of practice, and their credentialing should be consistent with their education qualifications and access agreements. **5.1.3** Establish a set of national standards for rural and remote maternity services and maternity services in the primary care setting.
5.2 **All rural and remote maternity services must be equipped with appropriate technologies to facilitate safe maternity care.**	**5.2.1** Rural and remote birthing services must be equipped with standard equipment to provide necessary and optimal sexual and reproductive health, and pregnancy, birth and postnatal care for women, babies and families. **5.2.2** Rural and remote maternity services must develop and maintain processes for escalation and timely safe transfer. **5.2.3** There must be interoperability of clinical information systems to enable real time continuity of maternity care. **5.2.4** Timely access to ultrasound and pathology for women receiving maternity care must be facilitated.
5.3 **Rural hospitals without maternity services must be prepared to safely manage reproductive emergencies and imminent birth.**	**5.3.1** All hospitals without birthing services must have access to and maintain imminent birthing kits. **5.3.2** Rural facilities must incorporate training for all clinical staff for imminent birthing and reproductive emergencies. **5.3.3** All rural hospitals must have the technologies (including virtual) in place to support the management of reproductive emergencies or imminent birth.
5.4 **Health systems, policies and procedures should be aligned to enable all health care professionals to work to optimal scope of practice in rural and remote birthing services.**	**5.4.1** Nationally consistent terminology and levels for clinical capability frameworks must be established for rural and remote birthing services. **5.4.2** All staff in rural and remote facilities must have access to and practice using evidence-based guidelines for maternity care. **5.4.3** Policies, regulations and legislation must be aligned with the scope of practice of the health care professionals and models of care. **5.4.4** A national digital passport must be established for all health care professionals' documentation including regulatory documentation and credentialing.

Principle 6: Workforce

PRINCIPLE	STRATEGIES
6.1 **The maternity care workforce in Australia must be sustained and enhanced by coordinated strategies that support and respect all members of the maternity care team.**	6.1.1 The local maternity care team should be empowered to identify specific requirements for additional training and professional support needed in their local setting and model/s of care. 6.1.2 Funding must be provided to address short term deficits in the available workforce within the jurisdiction responsible such as the commonwealth and/or state and territory. 6.1.3 To attract, promote and train new providers, access to education should be prioritised for all members of the team. Systems and policies should ensure that all clinicians are enabled to participate in all training for maternity care. 6.1.4 Support should be provided for all members of the maternity care workforce in training to undertake rural and remote clinical placements.
6.2 **There must be targeted attraction, recruitment, and retention strategies for all members of the maternity care workforce.**	6.2.1 Establish scholarship programs for rural and remote maternity services to offer to local residents to study and become maternity service professionals (grow your own). 6.2.2 To support rural services to grow their own workforce, flexible programs should be established with supernumerary positions to support employed and part time training in midwifery and operating theatre staff. 6.2.3 Develop innovative employment models to enable the maternity team to work seamlessly across the community, primary care, and hospital settings. 6.2.4 Establish well supported rural and remote early career positions for maternity clinicians. This must include supports for the transition to rural and remote practice. 6.2.5 Integrated maternity service networks must provide all clinicians, especially early career clinicians, access to clinical attachments to consolidate or develop their skills. 6.2.6 Maternity clinicians should be offered concierge style support on or before commencement in a new rural or remote community. For example: housing, childcare, schools and partner employment. 6.2.7 Recognise the skills of rural maternity clinicians with specific incentives to use, retain and extend their relevant skill set.

PRINCIPLE	STRATEGIES
6.3 **All maternity care team members must have access to local whole of team regular teaching and continuing professional development that supports their scope of practice.**	**6.3.1** On site multidisciplinary maternity care team training should be maximised. **6.3.2** Local whole of team professional development and upskilling relevant to community needs should be scheduled to maximise attendance by all members of the maternity care team. **6.3.3** All members of the multidisciplinary maternity care team regularly participate in locally relevant cultural safety training.
6.4 **Place based workforce planning and solutions for all health professionals must be supported and prioritised to reflect genuine engagement with local communities.**	**6.4.1** A national approach must be developed for rural and remote maternity indemnity arrangements and cover for all maternity care providers in all services. **6.4.2** On-call responsibilities for individual clinicians in rural and remote maternity services must be sustainable. **6.4.3** Adequate on-call remuneration should be provided in state and territory awards for all members of the maternity care team. **6.4.4** Local planning should include the development of capacity to provide sustainable services, including cover for leave and professional development. **6.4.5** Local policy should support management approaches on sustainable workload for instance, ensuring maternity providers receive flexible work options, leave cover and backfill that does not add to existing staff workload.

Principle 7: Funding

PRINCIPLE	STRATEGIES
7.1 **Funding for rural and remote maternity services must be fit for purpose, enabling local and culturally safe community engagement for co-design, co-development and implementation of culturally safe services and integration of primary and secondary care across the maternity continuum.**	**7.1.1** The National Health Reform Agreement bundled maternity funding should be tiered for rurality and remoteness. **7.1.2** Maternity services should have as an option, access to bundled funding to enable midwifery and GP obstetrician models of continuity of care in all settings. **7.1.3** Jurisdictional and Commonwealth funding agreements should include incentives to sustain existing rural and remote maternity services and using evidenced criteria to establish/ enhance maternity services in small rural communities according to MMM area/ rural and remote classification. **7.1.4** Penalties should be applied to services where maternity care is withdrawn without community engagement, and planning. **7.1.5** Additional and quarantined funding should be made available for rural and remote maternity services to undertake the service planning, development and review processes. **7.1.6** Ongoing grant opportunities should be created for the development of innovative service models appropriate to rural communities, including Birthing on Country models and integration within regional service networks.
7.2 **Funding must be quarantined for teaching, training and continuing professional development for the rural and remote maternity care workforce.**	**7.2.1** Jurisdictions should require health services to report annually on professional development activity and other supports for the multidisciplinary rural and remote maternity team within each health service to ensure it is publicly available. **7.2.2** Funding for rural and remote maternity care should reward and incentivise additional quality improvement activities. **7.2.3** Research funds should be directed for examination of the comparative cost effectiveness and clinical outcomes for maternity services according to MMM area/ rural and remote classification. **7.2.3** Funds should be quarantined for development and support of Aboriginal and Torres Strait Islander workforce, for example this could include paid employment of traditional birth attendants.

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