Application of the Human Rights Act of Queensland to the provision of public maternity services in Queensland

Policy brief for the

Queensland Human Rights Commission

Endorsed by:

Maternity Choices Australia

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AMIRCI
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Policy brief for the Queensland Human Rights Commission

The endorsing organisations welcome the opportunity to provide this brief to the Queensland Human Rights Commission (QHRC) with regard to the Human Rights Act of Queensland (HRAQ) and its application to the Queensland government's provision of publicly funded maternity services. This brief specifically highlights evidence and community advocacy for the provision of continuity of midwifery carer services, a high value model of maternity care that achieves improved physical and emotional maternal and infant health outcomes and provides greater protection of childbearing women's human rights during their interactions with maternity services.

Please note that the research evidence referenced in this brief largely predates the COVID-19 pandemic. Since the onset of the pandemic, further concerns have been reported in Queensland and other Australian jurisdictions regarding additional restrictions that have been placed upon childbearing women during their interactions with maternity services [1-5]. The violation of human rights in pregnancy, birth and postnatally during the pandemic through the implementation of similar restrictions globally has been documented by Human Rights in Childbirth [6].The establishment of the HRAQ potentially offers an opportunity for a re-examination, reset and prioritisation by the Queensland government regarding the protection of childbearing women's human rights while accessing publicly funded maternity services.

Introduction

Childbearing women's experiences while engaging with public maternity services will be outlined in this brief, with specific reference to HRAQ s.17 (Right to protection from torture and cruel, inhuman or degrading treatment) and s.37 (Right to health services). This brief will firstly outline that the violation of childbearing women's human rights by maternity services during pregnancy, labour and facility-based childbirth has gained prominent global attention, particularly over the past five to 10 years. Research evidence demonstrating breaches of childbearing women's human rights by Australian maternity services will then be presented, followed by a specific focus on women's interactions with Queensland's publicly funded maternity services. Published research as well as findings from Barnett's doctoral thesis [7] are included.

This brief also refers to community advocacy for the equitable implementation of Queensland government commitments to the 2010-2016 Australian National Maternity Services Plan (NMSP) by a large public health authority. Although Metro North Hospital and Health Service (MNHHS), which is one of the largest public health authorities in Queensland (and Australia), was not named in the community advocacy chapter included in Barnett's thesis [7], MNHHS is identified in this brief for the sake of clarity. While this brief refers to decisions taken by MNHHS and Queensland Health prior to 1 January 2020 (the date from which public entities are required to act compatibly with the HRAQ), key findings are included to illustrate some of the systemic and institutional barriers that hindered the equitable implementation of Queensland government NMSP commitments. Barnett argues that the partial implementation of Queensland government's NMSP commitments by this large public health authority contributed to the exacerbation of existing inequities of access to respectful, evidence-based models of maternity care which arguably provide greater protection, particularly for socioeconomically disadvantaged women, from discriminatory, coercive and non-consented treatment [7]. Since an

independent, comprehensive evaluation of the NMSP appears not to have been commissioned by either the Queensland or federal governments [8-10], it is likely that barriers that prevented the equitable implementation of Queensland government NMSP commitments will remain and hinder future attempts to better protect childbearing women's human rights compatible with HRAQ, unless key lessons are learned and action taken to address these barriers [7].

International context

The mistreatment of childbearing women by reproductive health services during pregnancy and childbirth has been documented for over three decades [11]. Global concerns regarding the systemic mistreatment of childbearing women led to the development of the *Respectful Maternity Care Charter: The Universal Rights of Childbearing Women* in 2011 [12]. The World Health Organisation responded to these concerns by issuing a position statement in 2014 calling for the prevention and elimination of disrespect and abuse during facility-based childbirth [13]. Disrespectful, discriminatory, coercive and non-consented treatment of childbearing women by maternity services occurs across both developing and developed countries, including high-income countries such as Australia, with the principle of universal health coverage underpinning the design of its health system [14-18].

In 2019, the United Nations (UN) Human Rights Council Special Rapporteur on Violence against Women (UN Special Rapporteur) reported on the structural causes underpinning the mistreatment of women by reproductive health services, with a focus on childbirth and obstetric violence [19]. Structural causes identified by the UN Special Rapporteur included discriminatory laws and practices, harmful gender stereotypes, health system conditions and constraints, power dynamics and abuse of the doctrine of medical necessity [19]. Rather than representing isolated or sporadic events, the UN Special Rapporteur reported that the mistreatment of childbearing women during facility-based childbirth is "part of a continuum of the gender-based violence that occurs in the wider context of structural inequality, discrimination and patriarchy" [20]. Further, the UN Special Rapporteur reported that the mistreatment of childbearing women by reproductive healthcare services during childbirth in health facilities is "widespread and ingrained in the health system," and "affects women across all socioeconomic levels" [19].

The mistreatment of childbearing women by maternity services during pregnancy, labour and childbirth is so normalised that it is often overlooked and not recognised as violence against women, including within Australia [16, 19, 21-23]. The UN Special Rapporteur observed that when women who have been mistreated attempt to complain, they are "often silenced or afraid of speaking out because of a fear of taboos, stigma or a feeling that the violence they have experienced could constitute an isolated incident" [19]. Harmful gender stereotypes, arising from "strong religious, social and cultural beliefs" are "further justified by the belief that childbirth is an event that requires suffering on the part of the woman. Women are told to be happy about a healthy baby – their own physical and emotional health is not valued" [19].

In March 2020, the UN's Committee for the Elimination of Discrimination Against Women (CEDAW) made its first decision relating to obstetric violence [24]. In response to a complaint brought by a Spanish woman regarding being subjected to unnecessary medical interventions during pregnancy and birth (conducted without

her consent by public hospital staff), the CEDAW urged the Spanish government to adopt public policies to combat the mistreatment of pregnant women, including providing health professionals and people working in the judicial system with adequate professional training regarding women's reproductive health rights [24].

Australian context

Childbearing women in Australia have also reported experiencing disrespectful, discriminatory, coercive and non-consented treatment during pregnancy and childbirth [7, 25-35]. This mistreatment occurs within a national context in which community and professional organisations and government-commissioned reviews have called for reform of the Australian maternity services system over several years [22, 23, 36-39]. A broad coalition of community and midwifery organisations launched the National Maternity Action Plan (NMAP) in 2002, which called for national leadership and consistency in the provision of high quality, cost effective and evidence-based maternity services by the federal, state and territory governments [40]. The NMAP recommended that universal access to continuity of midwifery carer services, in collaboration with medical professionals and other specialists as required, be available to all Australian women within the public health system [36].

Sustained advocacy resulted in a national Maternity Services Review [37] and the establishment of the inaugural 2010-2016 National Maternity Services Plan [NMSP; 41]. The NMSP's vision included the statement that "appropriately trained and qualified maternity health professionals will be available to provide continuous care to all women" [41]. This vision was reinforced by a specific commitment (NMSP Action 1.2.1) that state and territory governments would "facilitate increased access for public patients to midwifery and medical practitioner continuity of carer programs". State and territory governments also committed to work to develop consistent approaches to clinical privileging, admitting and practice rights for private eligible midwives in public healthcare settings (NMSP Action 1.2.2). Implementation of this commitment would mean that women who could afford to pay the gap between private midwifery fees and the Medicare rebate would be able to engage a private midwife to obtain care in the community throughout their pregnancy and postnatal period. These women could birth in a public hospital, cared for by their private midwife, as long as their midwife was credentialed to practise in that hospital.

Continuity of midwifery carer services are cost effective to provide, improve the quality of maternal healthcare and facilitate mothers' physical and emotional wellbeing [42-45]. A significant reduction in preterm birth for Aboriginal and Torres Strait Islander women has also been achieved through a continuity of midwifery carer service in Brisbane, the Birthing in Our Community program [46]. The strength of research evidence for the provision of this model of care has led senior researchers in Australia and the United Kingdom to question whether it is ethical to ignore the evidence and deprive women of the benefits associated with a known and trusted midwife, particularly for vulnerable populations of women who are at greater risk of adverse outcomes [42, 47, 48]. Despite this evidence and community advocacy over several years, it is estimated that between less than 10% [49] and 20% of women in Australia [50] can access publicly funded continuity of midwifery carer services.

A related reason for increasing women's access to continuity of midwifery carer services is the prevention and/or reduction of childbearing women's exposure to health-damaging conditions, such as discriminatory, coercive and non-consented treatment during their interactions with maternity services. For example, socioeconomically disadvantaged women are more likely to experience stigma and discrimination in their interactions with maternity service providers [51] and are more likely to experience adverse health outcomes [52], yet typically are less likely than socioeconomically advantaged women to access continuity of midwifery carer services [53, 54]. Increasing the provision of continuity of midwifery carer services for vulnerable groups of women has therefore been recommended, given its association with advocacy, individualised care and enhanced outcomes [51, 52, 54].

Although an evaluation framework was built into the NMSP [41], and the COAG Health Council tasked the Australian Health Ministers' Advisory Council (AHMAC) to evaluate the NMSP in 2016 [55], an independent NMSP evaluation was not commissioned to inform the National Strategic Approach to Maternity Services (NSAMS), endorsed by the COAG Health Council in late 2019 [8, 9, 56]. Three Australian states and territories, namely, Victoria, New South Wales (NSW) and the Australian Capital Territory (ACT) have, however, conducted parliamentary inquiries into maternity services within the past few years [31, 57, 58]. The Victorian Parliamentary Inquiry into perinatal services, for example, reported that birthing women in Victoria had medical procedures performed on them without their consent and recommended a state-wide review with respect to childbearing women's rights [31]. In the ACT, another human rights jurisdiction, the Parliamentary Committee reported interpersonal and structural discrimination toward childbearing women and stated that maternity services should protect and respect human rights [58].

Despite compelling evidence regarding the mistreatment of childbearing women by Australian maternity services, the NSAMS merely stated that "women have reported that their choices are not always respected" [56]. The framing of this national policy document illustrates the continuing reluctance by Australian federal, state and territory governments to acknowledge the evidence and implement strategies to combat the mistreatment of childbearing women by Australian maternity services. In stark contrast to the NSAMS, a comprehensive illustration of the violation of Australian women's sexual and reproductive health and human rights during pregnancy and childbirth was provided in chapters of the recently published book *Birthing outside the system: The canary in the coal mine* and by Human Rights in Childbirth in its submission to the Australian Human Rights Commission's "Free and Equal: An Australian conversation on human rights" consultation process [22, 59].

Queensland context

Following the launch of NMAP in 2002, the Queensland government commissioned an independent, state-wide review of maternity services in 2004. Dr Cherrell Hirst reported that many Queensland women felt disempowered in their interactions with the maternity services system [38]. Women's lack of participation in decision-making and control over what happened to them during labour and birth was a central concern, with some women reporting "a lack of even the most basic human respect from carers" [38]. Women from marginalised social groups reported being treated disrespectfully and experiencing criticism and judgement within the maternity services system [38]. Mary-Rose MacColl later also wrote that some women

responding to this review were punished by health professionals during labour and birth for desiring to exercise some bodily autonomy [60, 61]. Dr Hirst reported that there was no state-wide strategic framework to drive improvements in the quality and safety of maternity services across Queensland and that funding mechanisms were not utilised to incentivise these improvements. Dr Hirst recommended the provision of continuity of carer services, to be predominantly led by midwives within the public health system, in collaboration with medical professionals and other specialists as required [38].

An independent research centre, the Queensland Centre for Mothers and Babies (QCMB) conducted two large, state-wide surveys in 2010 and 2012. These surveys both found that a concerning proportion of childbearing women in Queensland lacked involvement in decision-making during their interactions with maternity services [62, 63]. Qualitative analysis of the Having A Baby in Queensland (HABQ) 2010 survey found that some women reported feeling intimidated, coerced and discriminated against by health professionals [25]. This survey also found that although Queensland women desired continuity of midwifery care, demand for this model of care was not met within the public health services' provision [25]. The HABQ 2012 survey found that for the majority of procedures examined, less than half of women who had these procedures reported having made an informed decision [63]. Higher satisfaction ratings were reported when women accessed continuity of midwifery carer services, leading to recommendations that Queensland Health increase women's access to this model of maternity care [63].

Bec Jenkinson and colleagues [28] examined childbearing women's and clinicians' responses when women declined recommended maternity care in a publicly funded tertiary hospital in Brisbane. This research found that childbearing women who declined recommended treatment were subjected to a range of coercive strategies by clinicians, including manipulation, badgering, punishment, judgement and assault [28]. For example, a clinician participating in this study stated that they had "practically assaulted" a woman by performing an examination on her, even though the woman had explicitly stated that she did not want to be touched [28]. These findings echo those reported from an online survey conducted by Queensland-based researchers in which 38% of respondents were based in Australia [34]. Women also reported that health professionals had lied to and threatened them in order to coerce women into agreeing to medical procedures during childbirth [34].

The Rural Maternity Taskforce was established by the Queensland Health Minister in 2018, following sustained media and community concerns regarding the provision of safe and accessible rural and remote maternity services. This Taskforce also reported that some childbearing women had been provided inaccurate information, subjected to coercive behaviour and non-consented treatment during their interactions with health professionals providing public maternity services [35].

Doctoral research findings

Barnett's doctoral research incorporated a longitudinal, qualitative study, exploring the perinatal transitions of 12 women living in a metropolitan region of Queensland who gave birth during 2015-2016 [7]. (The perinatal period is typically considered to begin at conception and extend through to 12 months following birth.) All the women who participated in this research were Caucasian, heterosexual and partnered, while

most participants were also university educated. Given the relatively privileged group of women who participated in this research, the findings might be considered to provide a “best case” scenario.

Most of the participants gave birth in public hospitals located in the southeast Queensland region and many participants would have preferred to access continuity of midwifery carer services. Some women who sought access to continuity of midwifery carer services did so to protect themselves from the depersonalised and “clinical” treatment that they associated with the provision of standard maternity services. For example, a first-time mother sought continuity of midwifery carer after previously observing how two of her friends had been treated when they gave birth at the local public hospital. Within the organisational psychology literature, a similar strategy, whereby pregnant women and mothers seek to protect themselves from prejudice and discrimination in their paid work by emphasising their individuality has been referred to as “individuation” [64].

This research found that childbearing women exercised limited negotiating power in their interactions with maternity services [7]. They encountered health systems that were, at best, often indifferent to, and, at worst, hostile to facilitating their access to conditions in which their decision-making autonomy was supported. Consistent with international research [14], women became relatively more vulnerable in their interactions with maternity services during late pregnancy, labour, birth and the immediate postnatal period. Power imbalances manifested in multiple ways and included HHS policies and practices that restricted women’s access to evidence-based models of maternity care, limited women’s access to water immersion during labour and birth and limited the number of support people allowed to attend birth.

Women who had established a relationship with a midwife or small group of midwives during their pregnancies appeared to be in a stronger negotiating position during their interactions with maternity services. Access to an advocate better enabled these women to resist pressure from hospital staff to agree to unnecessary and unwanted medical treatment. Consistent with submissions received by the Rural Maternity Taskforce [35], some mothers in this study were also provided inaccurate information by health professionals to coerce their agreement to various procedures. For example, during her labour in a large public hospital, a first-time mother was pressured by the Registrar to agree to a caesarean section. This woman, who had engaged a private midwife, resisted this pressure as she knew, based on her midwife’s assessment of readings from an internally placed monitor, that her baby was not in distress and that the information provided by the Registrar was inaccurate and misleading. Another mother also experienced pressure from public hospital staff to agree to a caesarean section, following the identification of a complication during her labour. With support from her known midwife, this time provided through the public birth centre service, this mother resisted this pressure and proceeded to birth her baby safely vaginally. Public hospital staff had attempted to coerce this mother by emphasising the risks involved in not performing a caesarean section, while downplaying the risks associated with this major surgical procedure [7].

Conversely, research participants who did not have an advocate present in the form of a known midwife appeared to be in a more vulnerable negotiating position. For example, a mother whose access to a publicly provided continuity of midwifery carer

service was withdrawn by the HHS described her birth as a “traumatic experience”. This was partially influenced by the dismissive (possibly degrading) way in which this mother was treated by a public hospital midwife and the lack of “one-to-one” attention that she received during labour, birth and the immediate postnatal period. Other mothers also referred to being treated dismissively by hospital staff following birth, pressured to consent to unwanted and unnecessary interventions, including separation from their newborn babies, and pressured to leave hospital prior to having learned how to breastfeed and physically recovered from birth. Overall, support was provided for a social gradient of wellbeing, whereby socioeconomically privileged mothers were better able to protect themselves from health-compromising conditions in their interactions with maternity services, by employing strategies such as engaging private midwives and/or doulas to birth in hospital and/or for planned home births. Implementing strategies such as these appeared to reduce some of the power and knowledge imbalances that women encountered with maternity services.

Community advocacy for equitable implementation by MNHHS of Queensland government commitments to the National Maternity Services Plan (NMSP)

A case study describing community advocacy for the implementation by MNHHS of Queensland government NMSP commitments was included in a submission prepared for Maternity Choices Australia (MCA, then Australia’s national maternity consumer advocacy organisation) in early 2016 [39]. This submission was sent to MNHHS, the Queensland and federal Health Ministers and the Maternity Services Inter-Jurisdictional Committee (MSIJC), which was responsible for both monitoring the implementation of NMSP commitments as well as for evaluating the NMSP’s implementation. Neither this submission, nor any other community submission, was referenced in the MSIJC’s Final NMSP Report [55]. This was despite confirmation to MCA from the MSIJC Chair that its submission had been received and that MSIJC members had agreed to consider this submission in their preparation of the Final NMSP Report [7]. This submission, however, was later listed as a general reference document by the Office of the Queensland Health Ombudsman in its 2019 *Investigation report: Safety and quality of maternity services across Central Queensland Hospital and Health Service* [65]. The community advocacy case study has since been further developed, presented at national conferences and documented in a chapter of Barnett’s thesis [7, 66].

Although not stated as an explicit NMSP goal, Barnett argues that the implementation of Queensland government NMSP commitments to facilitate increased access to continuity of midwifery carer services would arguably have contributed to preventing and/or reducing some childbearing women’s exposure to health-damaging conditions, such as discriminatory, coercive and non-consented treatment [7]. However, in late 2014, MNHHS committed to only partial implementation of these Queensland government NMSP commitments in its 2015-2020 Health Service Strategy [67]. While MNHHS committed to establish credentialing and practice rights for private midwives at all of its birthing hospitals (consistent with NMSP Action 1.2.2), a matching commitment (NMSP Action 1.2.1), to facilitate increases in access to publicly funded continuity of midwifery carer services was omitted. Even with Medicare rebates, many women could not afford to pay for continuity with a private midwife, unless MNHHS also intended to fund the provision of continuity of care with private midwives for vulnerable groups of women [39]. Although concerns were raised with the MNHHS Board Chair, Chief Executive

and state MPs in early 2015 regarding the exacerbation of existing inequities of access for socioeconomically disadvantaged women which would likely result from this omission, the MNHHS Health Service Strategy was not changed [39].

Following the dissemination of MCA's submission [39] in early 2016, community representatives also made a direct appeal to the then Queensland Health Minister regarding MNHHS's commitment to partial implementation of NMSP commitments. Little action appears to have been taken by Queensland Health to address the exacerbation of inequities arising from MNHHS's decision [7]. After the COAG Health Council decided in April 2016 that the NMSP would be evaluated to inform development of the next national plan, Queensland Health began chairing the Maternity Care Working Policy Group (MCPWG), the national jurisdictional committee which replaced the MSIJC. Community representatives for childbearing women were excluded from this national jurisdictional committee and the MCPWG (chaired by Queensland Health), decided to exclude funding mechanisms and models of care from the terms of reference for the NMSP process evaluation [10]. The exclusion of these key elements from the NMSP process evaluation effectively rendered MCA's submission [39], which referred to MNHHS's commitment to partial implementation of NMSP model of care commitments, invalid [7].

Advocacy regarding inappropriate processes to evaluate NMSP

Community representatives contacted offices of the federal and Queensland Health Ministers, as well as various state and federal Members of Parliament (MPs) expressing concern regarding the administration of the National Framework for Maternity Services (NFMS) project. Following representation by a federal MP in late 2016, the then Queensland Health Minister's response disregarded these concerns and advised that community representatives would have an opportunity to provide feedback on the draft NFMS [7]. Collective criticism from several stakeholder organisations regarding the draft NFMS led to AHMAC's decision in June 2017 to discontinue this national project, which had been managed by Queensland Health.

Although concerns were raised with the then Queensland Health Minister regarding the administration of this national project by Queensland Health, an investigation into the project's discontinuation appears not to have been undertaken [10]. In response to a Question on Notice in 2018, the Queensland Health Minister explained that the MCPWG had decided to exclude models of care and funding mechanisms from the terms of reference for the NMSP process evaluation as "decisions regarding models of care and funding are made locally, and were therefore, not considered relevant" [10]. This response was incongruous with the NMSP's vision and commitments that state and territory governments would facilitate increased access to continuity of midwifery carer services for childbearing women [41]. The Queensland Health Minister's response was also later contradicted in the Rural Maternity Taskforce report, which stated that Queensland Health has provided funding to support the expansion of continuity of midwifery carer models since 2007 [35]. Further, the ACT Maternity Services Inquiry report in 2020 recommended that the ACT government work with its COAG colleagues to develop funding mechanisms to support women's access to continuity of carer models in all jurisdictions [58]. The Queensland Health Minister also advised that the MCPWG (chaired by Queensland Health) decided not to publish the NMSP process evaluation report "to ensure those people participating in the evaluation felt comfortable providing honest feedback" [10].

Abuses of power including intimidation of community representatives

A related concern regards the treatment of community representatives when they persisted in raising concerns about MNHHS's decision to commit to partial implementation of NMSP commitments [7]. For example, MNHHS sought to intimidate and silence community representatives, including by threatening to remove a community representative from two steering committees. MNHHS subsequently removed two community representatives from one of these steering committees. Although formal complaints were made to MNHHS and the Queensland Ombudsman's office regarding the treatment of community representatives and MNHHS's partial implementation of NMSP commitments, the Queensland Ombudsman's office decided in April 2017 not to investigate the second complaint as it was determined not to fall within its jurisdiction [7].

Similar abuses of power against individuals (including former MNHHS patients and employees) who raised concerns regarding other, unrelated MNHHS policies and practices have recently been reported in mainstream media [68-72]. For example, ABC News reported allegations that MNHHS sought to intimidate and silence a former mental health patient who publicly criticised its services by funding four of its employees to sue this former patient [68]. Further, a corporate lawyer (and former MNHHS employee) who alleged that MNHHS had corruptly provided taxpayer funds to its employees so that they could sue this former patient was sent intimidating documentation by lawyers for MNHHS in an attempt to dissuade him from speaking with the ABC journalist [69].

MNHHS also sent a "Show Cause" notice in January 2020 to an employee, a Nurse Unit Manager, who was a delegate for the Nurses Professionals Association of Queensland [NPAQ; 70, 72]. This action was in response to this employee sharing her concerns regarding the quality of nurse graduate training with a newspaper in November 2019. This notice, which stated that MNHHS could take serious disciplinary action against its employee for breaching Queensland's public servants' code of conduct, was subsequently withdrawn by MNHHS after NPAQ referred the matter to the Industrial Relations Tribunal, alleging that this action breached MNHHS's obligations under the Industrial Relations Act and the new HRAQ [71].

Inconsistent provision of public continuity of midwifery carer services across Queensland

The Queensland government's commitments to the expansion of access to publicly funded continuity of midwifery carer services appear inconsistent. For example, in May 2017 Queensland Health committed to increase women's access to continuity of midwifery carer services in Logan, located within the Metro South HHS catchment [73]. Despite community organisations' advocacy to the then Queensland Health Minister to obtain a similar commitment for women living in the MNHHS catchment [7], MNHHS again omitted to commit to increasing women's access to publicly funded continuity of midwifery carer services in the 2017 Refresh of its 2015-2020 Health Service Strategy [74]. The Queensland Health Minister committed in September 2018 to increase women's access to continuity of midwifery carer services in eight communities, namely, Innisfail, Mossman, Atherton, Emerald, Biloela, Gladstone, Bundaberg and Mackay [75]. (It is understood that the Mossman Midwifery Group Practice (MGP) is no longer in operation.) The Queensland Health Minister also committed to increase access to continuity of midwifery carer services

at Townsville Hospital in June 2019 [76]. In November 2019, Darling Downs Health established a MGP, enabling all women in the Western Cluster to opt to receive continuity of midwifery carer services [77], while Queensland Health committed to establishing a fourth community-based hub providing MGP services in Logan [78].

Disparities in access to publicly funded continuity of midwifery carer services remain, based on factors such as socioeconomic status and geographic location, including within the MNHHS catchment. *The Redcliffe and Bayside Herald* recently supported a "Mums Matter" campaign to increase access to continuity of midwifery carer services within the Moreton North Brisbane region [79, 80]. Based on data provided by Queensland Health, *The Redcliffe and Bayside Herald* reported in August 2019 that approximately only 10% of women birthing at Redcliffe Hospital could access continuity of midwifery carer services, compared with about 20% of women birthing at the Royal Brisbane and Women's and Caboolture Hospitals [80]. Despite these inequities in access across its three birthing hospitals, the MNHHS representative stated that MNHHS did not anticipate expanding access to this model of care [80].

This case study illustrates some barriers to the equitable implementation of Queensland government NMSP commitments by MNHHS, one of the largest public health authorities in Queensland (and Australia). These barriers included failures of governance and accountability within the Queensland public health sector, structural discrimination against childbearing women based on factors such as their socioeconomic status and geographic location, and abuses of power, including the intimidation of childbearing women and their representatives for raising concerns regarding the discriminatory impact arising from the partial implementation of Queensland government NMSP commitments by a large public health authority [7].

Conclusion and recommendations

An independent review of Queensland maternity services conducted 15 years ago documented the discriminatory, coercive and non-consented treatment experienced by some childbearing women during their interactions with public maternity services [38]. Since then, independent state-wide surveys and other empirical research have provided further evidence illustrating the systemic nature of this phenomenon. Despite the Queensland government's commitments to the NMSP 10 years ago [41], the vast majority of childbearing women in Queensland cannot yet access continuity of midwifery carer services, a model of maternity care that increases women's access to individualised advocacy and enhanced outcomes while also providing greater protection of women's human rights during their interactions with maternity services. Consequently, childbearing women are afforded relatively limited protection from discriminatory, coercive and non-consented treatment by public health entities, which potentially contravenes HRAQ s.17 (Right to protection from torture and cruel, inhuman or degrading treatment) and s.37 (Right to health services).

We recommend that QHRC considers commissioning an independent review of childbearing women's human rights in relation to their interactions with Queensland public maternity services. This review could provide a baseline from which to inform the development of a strategic, state-wide framework that drives improvements in the safety and quality of Queensland's publicly funded maternity services. We expect that funded commitments to expand childbearing women's access to continuity of midwifery carer services would be included in this strategic, state-wide framework.

References

1. Bradfield, E., *Covid-19 hospital fears lead to spike in homebirth interest from pregnant women*, in *ABC News*. 2020.
2. Rafferty, S. and J. Robertson, *Amid isolation, new mums struggling to celebrate births during pandemic*, in *ABC News*. 2020.
3. Dearnly, R. *The problem with 'one visitor' per patient for women giving birth*. Women's Agenda, 2020.
4. Sinnerton, J., *Mother of all dilemmas: Home birth boom*, in *Courier Mail*. 2020, News Corp Australia: Queensland. p. 12.
5. Lill, J., *Doula calls for exemption to enter birth suite at Brisbane hospital: Pregnant women are being forced to choose between their doula and their partner at a major Brisbane hospital as part of strict COVID-19 precautions*, in *City North News*. 2020, News Corp Australia: The Courier Mail Queensland.
6. Human Rights in Childbirth, *Human rights violations in pregnancy, birth and postpartum during the COVID-19 pandemic*. 2020, HRIC: San Francisco, United States.
7. Barnett, B., *Becoming a mother and mattering in early 21st century Australia: An exploration of women's perinatal transitions and equity in wellbeing*, in *School of Education*. 2020, University of Queensland: Brisbane, Australia.
8. Hanifie, S., *Call for Senate inquiry into reduced maternity services in rural and remote areas*. 2018: ABC News.
9. The Australian Greens, *Senator Janet Rice asks the Department of Health about maternity services*. 2018: https://janet-rice.greensmps.org.au/articles/janet-asks-dept-health-about-maternity-services. p. Video file, 15:30 mins.
10. Queensland Parliament, *Question on notice No.1235 Asked on 19 September 2018*, Health, Editor. 2018: https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2018/1235-2018.pdf.
11. Jewkes, R. and L. Penn-Kekana, *Mistreatment of women in childbirth: Time for action on this important dimension of violence against women.* PLoS Med, 2015. **12**(6): p. e1001849.
12. Respectful Maternity Care Advisory Council and White Ribbon Alliance for Safe Motherhood, *Respectful maternity care: The universal rights of childbearing women*. 2011, W.R.A.: Washington, D.C., United States.
13. World Health Organisation. *Prevention and elimination of disrespect and abuse during facility-based childbirth.* 2014; Available from: https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-data/en/.
14. Bohren, M.A., et al., *How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys.* The Lancet, 2019.
15. Bohren, M.A., et al., *The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review.* PLoS Med, 2015. **12**(6): p. e1001847.
16. Sadler, M., et al., *Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence.* Reproductive Health Matters, 2016. **24**(47): p. 47-55.

17. Vedam, S., et al., *The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States.* Reproductive Health, 2019. **16**(1).
18. Miller, S., et al., *Beyond too little, too late and too much, too soon: A pathway towards evidence-based, respectful maternity care worldwide.* The Lancet, 2016. **388**: p. 2176-2192.
19. Simonovic, D., UN Human Rights Council Special Rapportuer on Violence against Women, and UN Secretary General, *A human-rights based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*, in *Report of the Special Rapportuer on Violence against Women, its Causes and Consequences*. 2019, United Nations: New York, NY.
20. Office of the United Nations High Commissioner for Human Rights, *Widespread violence and mistreatment of women in childbirth are human rights violations that must end, says UN expert*. 2019, United Nations.
21. Hill, N., *Understanding obstetric violence as violence against mothers through the lens of matricentric feminism.* Journal of the Motherhood Initiative for Research and Community Involvement, 2019. **10**(1 & 2): p. 233-243.
22. Human Rights in Childbirth, *Submission to the Australian Human Rights Commission for its "Free and Equal: An Australian conversation on human rights" process* 2019, HRIC: Sydney, Australia.
23. Dahlen, H., B. Kumar-Hazard, and V. Schmied, *Introduction*, in *Birthing outside the system: The canary in the coal mine*, H. Dahlen, B. Kumar-Hazard, and V. Schmied, Editors. 2020, Routledge: Abingdon, Oxon.
24. Office of the United Nations High Commissioner for Human Rights, *Spain needs to combat obstetric violence - UN experts*. 2020.
25. McKinnon, L.C., S.J. Prosser, and Y.D. Miller, *What women want: Qualitative analysis of consumer evaluations of maternity care in Queensland, Australia.* BMC Pregnancy Childbirth, 2014. **14**(1): p. 366.
26. Keedle, H., et al., *Women's reasons for, and experiences of, choosing a homebirth following a caesarean section.* BMC Pregnancy Childbirth, 2015. **15**(206).
27. Priddis, H.S., H. Keedle, and H.G. Dahlen, *The perfect storm of trauma: The experiences of women who have experienced birth trauma and subsequently accessed residential parenting services in Australia.* Women and Birth, 2018. **31**(1): p. 17-24.
28. Jenkinson, B., S. Kruske, and S. Kildea, *The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis.* Midwifery, 2017. **52**: p. 1-10.
29. Bradfield, E., *Australia's maternity care at 'crisis point' with birth trauma rates increasing*, in *ABC News*. 2019.
30. Lever, C., *"They stand over us with their gloves already on": Women complain of being bullied into painful and traumatic internal examinations during childbirth*, in *Daily Mail Australia*. 2019.
31. Parliament of Victoria, *Inquiry into perinatal services: Final report*. 2018, Parliament of Victoria: https://www.parliament.vic.gov.au/fcdc/inquiries/article/2822.
32. Roy, T., *Untold stories of Canberra's maternity inquiry*, in *ABC News*. 2019.
33. White, D., *Inquiry hears harrowing birth stories*, in *The Canberra Times*. 2019.

34. Reed, R., R. Sharman, and C. Inglis, *Women's descriptions of childbirth trauma relating to care provider actions and interactions.* BMC Pregnancy Childbirth, 2017. **17**(21).
35. State of Queensland (Queensland Health), *Rural maternity taskforce report*. 2019: https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/rural-maternity-taskforce/rural-maternity-taskforce-report.
36. Maternity Coalition, *National Maternity Action Plan: For the introduction of community midwifery services in urban and regional Australia*. 2002.
37. Commonwealth of Australia, *Improving maternity services in Australia: The report of the maternity services review*. 2009, Department of Health: Canberra.
38. Hirst, C., *Rebirthing: Report of the review of maternity services in Queensland*. 2005, Queensland Department of Health: Brisbane, Queensland.
39. Barnett, B. *The perinatal is political: What the expiry of the National Maternity Services Plan means for Australian women and why we need the next Plan*. 2016; Available from: http://www.maternitychoices.org.au/national-maternity-services-plan.html.
40. Newman, L., K.M. Reiger, and M. Campo, *Maternity Coalition: Australia's national maternity consumer advocacy organisation*, in *The 21st century motherhood movement: Mothers speak out on why we need to change the world and how to do it*, A. O'Reilly, Editor. 2011, Demeter Press: Bradford, Ontario. p. 102-113.
41. Commonwealth of Australia, *National Maternity Services Plan*, Health, Editor. 2011, The Australian Health Ministers' Conference: Canberra.
42. Homer, C.S.E., *Models of maternity care: Evidence for midwifery continuity of care.* Med J Aust, 2016. **205**(8): p. 370-374.
43. Sandall, J., et al., *Midwife-led continuity models versus other models of care for childbearing women.* Cochrane Database of Systemic Reviews, 2016. **4**(CD004667).
44. Tracy, S.K., et al., *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial.* The Lancet, 2013. **382**(9906): p. 1723-1732.
45. World Health Organisation, *Strengthening quality midwifery education for United Health Coverage 2030: Framework for action*. 2019, WHO: Geneva, Switzerland.
46. Kildea, S., et al., *Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia.* EClinicalMedicine, 2019. **12**: p. 43-51.
47. Ellwood, D.A. and D. Anderson, *Women's health: Local and global matters of great significance.* Med J Aust, 2016. **205**(8): p. 356-357.
48. Rayment-Jones, H., T. Murrells, and J. Sandall, *An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data--a retrospective, observational study.* Midwifery, 2015. **31**(4): p. 409-17.
49. Dawson, K., et al., *Implementing caseload midwifery: Exploring the views of maternity managers in Australia - A national cross-sectional survey.* Women and Birth, 2016. **29**(3): p. 214-222.
50. McInnes, R.J., et al., *Implementing continuity of midwife carer - just a friendly face? A realist evaluation.* BMC Health Services Research, 2020. **20**(1): p. 304.

51. Origlia, P., et al., *Experiences of antenatal care among women who are socioeconomically deprived in high-income industrialized countries: An integrative review.* Journal of Midwifery & Women's Health, 2017. **62**(5): p. 589-598.
52. Lindquist, A., et al., *The impact of socioeconomic position on severe maternal morbidity outcomes among women in Australia: A national case-control study.* BJOG, 2014. **122**(12): p. 1601-9.
53. Sutherland, G.A., J.S. Yelland, and S.J. Brown, *Social inequalities in the organisation of pregnancy care in a universally funded public health care system.* Maternal and Child Health Journal, 2012. **16**(2): p. 288-96.
54. Toohill, J., et al., *Socioeconomic differences in access to care in Australia for women fearful of birth.* Australian Health Review, 2018: p. -.
55. Commonwealth of Australia, *Final Report on the National Maternity Services Plan 2010 - 2015*. 2016, Australian Health Ministers' Advisory Council: Canberra.
56. COAG Health Council (Department of Health), *Woman-centred care: Strategic directions for Australian maternity services*. 2019.
57. Legislative Assembly of New South Wales. *Support for new parents and babies in New South Wales*. 2018; Available from: https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2461#tab-reportsandgovernmentresponses.
58. Australian Capital Territory Legislative Assembly, *Report on inquiry into maternity services in the ACT*, in *Report 10*. 2020: https://www.parliament.act.gov.au/parliamentary-business/in-committees/committees/standing-committees-current-assembly/standing-committee-on-health,-ageing-and-community-services/Inquiry-into-the-Maternity-Services-in-the-ACT.
59. Dahlen, H., B. Kumar-Hazard, and V. Schmied, eds. *Birthing outside the system: The canary in the coal mine*. 2020, Routledge: Abingdon, Oxon.
60. MacColl, M.-R., *Birth wars*. 2009, St Lucia, Queensland: University of Queensland Press.
61. MacColl, M.-R., *For a girl*. 2017, Crows Nest, NSW: Allen & Unwin.
62. Thompson, R. and Y.D. Miller, *Birth control: To what extent do women report being informed and involved in decisions about pregnancy and birth procedures.* BMC Pregnancy and Childbirth, 2014. **14**(62): p. 1-9.
63. Prosser, S.J., et al., *Findings from the Having a Baby in Queensland Survey, 2012.* 2013: Queensland Centre for Mothers & Babies, The University of Queensland.
64. Sabat, I.E., et al., *Understanding and overcoming challenges faced by working mothers: A theoretical and empirical review*, in *Research perspectives on work and the transition to motherhood*, C. Spitzmueller and R.A. Matthews, Editors. 2016, Springer International Publishing: Switzerland.
65. Office of the Health Ombudsman, *Appendix 3 - List of Investigation documents: Safety and quality of maternity services across Central Queensland Hospital and Health Service*. 2019.
66. Barnett, B., *The perinatal is political: Community advocacy for implementation and evaluation of the 2010-2016 Australian National Maternity Services Plan.* Women and Birth, 2019. **32**: p. S8.

67. State of Queensland (Metro North Hospital and Health Service), *MNHHS Health Service Strategy 2015-2020*. 2014: https://metronorth.health.qld.gov.au/wp-content/uploads/2017/11/mnhhs-strategy-full.pdf.
68. Robertson, J., *Unhealthy bureaucracy: Nepotism, defamation claims and millions of taxpayer dollars spent on "indefensible" legal proceedings are at the centre of a scandal at Australia's largest hospital service*, in *ABC News*. 2020.
69. Robertson, J., *Metro North hospital service tried to gag whistleblower over corruption allegations*, in *ABC News*. 2020.
70. Moore, T., *Landmark nurse case to test Queensland's new Human Rights Act*, in *Brisbane Times*. 2020.
71. Moore, T., *Prince Charles nurse wins round one of Human Rights Act challenge*, in *Brisbane Times*. 2020.
72. Sinnerton, J., *Job threat a sick joke: Nurse paying price for speaking to this paper*, in *Sunday Mail*. 2020, News Corp Australia: Queensland. p. 19.
73. State of Queensland (Queensland Health), *Logan Community Health Action Plan*. 2017: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/vision-strategy.
74. State of Queensland (Metro North Hospital and Health Service), *MNHHS Health Service Strategy 2015-2020 (2017 Refresh)*. 2017: https://metronorth.health.qld.gov.au/about-us/publications/health-service-strategy.
75. Poulsen, J., *Victory for our mums*, in *The Sunday Mail*. 2018, News Corp Australia: Queensland. p. 23.
76. Queensland Government (Minister for Health and Minister for Ambulance Services), *Mums-to-be benefit from more midwives at The Townsville Hospital*, S. Miles, Editor. 2019: http://statements.qld.gov.au/Statement/2019/6/28/mumstobe-benefit-from-more-midwives-at-the-townsville-hospital.
77. Queensland Government (Darling Downs Health), *Western Downs introduces MGP program*. 2019: https://www.health.qld.gov.au/darlingdowns/news/western-downs-introduces-mgp-program.
78. State of Queensland (Queensland Health), *Logan Community Health Action Plan 2019-2021*. 2019: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/vision-strategy.
79. Smith, E., *More midwives are needed to allow mums access to better maternity care models*, in *Redcliffe and Bayside Herald*. 2018, News Corp Australia: Quest Community Newspaper. p. 1.
80. Smith, E., *Mums, bubs missing out: Only 1 in 10 births at Redcliffe with best model of care*, in *Redcliffe and Bayside Herald*. 2019, News Corp Australia: Quest Community Newspaper. p. 1, 5.