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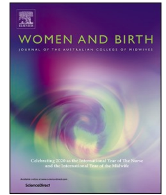

What do women in Australia want from their maternity care: A scoping review

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ABSTRACT

Background: Just over 300,000 women give birth in Australia each year. It is important for health care providers, managers, and policy makers know what women want from their care so services can be provided appropriately. This review is a part of the Midwifery Futures Project, which aims to prepare the midwifery workforce to best address the needs of women. The aim of this review was to describe and analyse current literature on the maternity care needs of women in Australia.

Methods: A scoping review methodology was used, guided by the Joanna Briggs Institute framework. A systematic search of the literature identified 9023 studies, and 59 met inclusion criteria: being peer-reviewed research focusing on maternity care needs, conducted in Australian populations, from 2012 to 2023. The studies were analysed using inductive content analysis.

Results: Four themes were developed: *Continuity of care*, *being seen and heard*, *being safe*, and *being enabled*. Continuity of care, especially a desire for midwifery continuity of care, was the central theme, as it was a tool supporting women to be seen and heard, safe, and enabled.

Conclusion: This review highlights that women in Australia consistently want access to midwifery continuity of care as an enabler for addressing their maternity care needs. Transforming Australian maternity care policy and service provision towards continuity would better meet women's needs.

Problem or Issue

Consumers of maternity care have a right to receive care that meets their needs. Just over 300,000 women give birth in Australia each year. There is significant diversity in the population of people in Australia giving birth. It is important for health care providers, managers, and policy makers to know what women want from their care so services can be provided appropriately.

What is Already Known

Many individual studies and government reports highlight what women want from their maternity care. A literature review published in 2016 synthesised what women wanted in relation to continuity of maternity care but did not investigate the needs of women in other models of care.

What this Paper Adds

This paper synthesises findings from 59 studies focusing on maternity care needs, conducted in Australian populations, from 2012 to June, 2023. Women specifically want continuity of care, especially midwifery continuity of care.

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study. The data are all

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tabled in a supplementary file and available.

Introduction

Over 300,000 births occur in Australia each year. In 2021 the rate of women of reproductive age (15 to 44 years of age) giving birth was 61 per 1000 [1]. Women who access Australian maternity care services are diverse. Over a third were born overseas, 5.0% are Aboriginal and/or Torres Strait Islander, and 2.2% live in remote or very remote areas [1]. Gender diverse people also give birth in Australia, although the numbers are unknown.

Models of maternity care in Australia are grouped into 11 models by the validated Maternity Care Classification System (Table 1) [2]. Midwives, obstetricians, general practitioners, and Aboriginal and Torres Strait Islander health staff largely provide the care, and do so in the public, private, or Aboriginal community controlled sectors [3]. Many nuances exist in the way models of care are configured, depending on the location (home, birth centre, hospital), the provider of care, the sector, and the complexity of women or their babies [4]. Continuity of care is defined in this paper as 'care provided by the same provider, or small team of providers, during pregnancy, labour and birth, and the postnatal periods with referral to specialist care as needed' [5]. Midwifery continuity of care is the most studied model of continuity of care and has been shown in a systematic review to have beneficial outcomes with no adverse effects [6]. Despite the evidence supporting midwifery continuity models, only around one third of models of care offered by health services include continuity, and an even smaller proportion of women access it in their maternity care [2]. This is a global problem; no country around the world has been able to scale up continuity models in their respective maternity care systems such that continuity becomes 'standard care', with the exception of New Zealand [7].

There is significant diversity in the population of people in Australia giving birth. Over one third of women who have recently given birth in Australia were born overseas, with the majority of these migrating from a non-English speaking country [1]. There is wide diversity in the migrant and refugee communities, with different cultural groups facing different challenges [8]. Challenges exist in maternity care for rural and remote women, who made up 2.2% (6823) of those who gave birth in 2021, and Aboriginal and Torres Strait Islander mothers, who accounted for 5.0% (15,437) of women who gave birth [1].

It is estimated 3% of people identify as transgender or gender-diverse [9] and their needs may differ from cisgender women [10], such as requiring staff with training, knowledge, and competency in working with transgender and gender-diverse communities, and affirmation of their gender identity during maternity care [10,11]. Studies globally have reported the needs of this population are not always met during pregnancy care [11–13]. In this paper, we use the term 'woman' as almost all the research has been conducted with women, and recognise gender diverse people also give birth, and their needs are also important. Where we report on literature specifically regarding transgender men and gender diverse people, we use the terminology of the authors of that literature.

This review is a part of the overarching Midwifery Futures project, which aims to develop knowledge so we can build a midwifery workforce that meets women's needs. To better target services and improve outcomes in maternity care, it is important to understand the needs of those accessing maternity care, as conceptualising the needs of stakeholders adds meaningful value, and results in better clinical care [14]. These findings will be used in the ongoing Midwifery Futures project as we build workforce models designed to address women and gender-diverse people's needs. A literature review published in 2016 synthesised what women wanted in relation to continuity of maternity care, but did not investigate the needs of women in other models of care [4]. We could not find a recent synthesis of what women want from Australian maternity care. This study aimed to address this gap in the literature. The aim of this review was to describe and analyse current literature on the maternity care needs of women in Australia, such that future maternity care initiatives can better address the needs of women.

Table 1
Major categories for models of maternity care in Australia.

Care Model	Definition
Combined care	Antenatal care provided by a private doctor/midwife in community. Intrapartum/early postnatal care provided in a public hospital by hospital midwives/doctors. Postnatal care may continue in home/community by hospital midwives.
General practitioner obstetrician care	Antenatal care provided by a GP-O. Intrapartum care provided in either public or private hospital by the GP-O in collaboration with the hospital midwives. Postnatal care provided by GP-O and hospital midwives.
Midwifery group practice caseload care	Antenatal, intrapartum, and postnatal care provided within a publicly funded caseload model by a group of known midwives, in collaboration with doctors in the event of identified risk factors
Private midwifery care	Antenatal, intrapartum and postnatal care is provided by a privately practicing midwife/group of midwives in collaboration with doctors in the event of identified risk factors.
Private obstetrician and privately practicing midwife joint care	Antenatal, intrapartum, and postnatal care provided by a privately practicing obstetrician and midwife from the same collaborative private practice.
Private obstetrician (specialist) care	Antenatal care provided by a private specialist obstetrician. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician in collaboration with hospital midwives. Postnatal care is provided in the hospital by the private specialist obstetrician and hospital midwives.
Public hospital high risk maternity care	Antenatal and intrapartum care is provided to those with medically high risk/complex pregnancy by specialist public hospital maternity care providers. Postnatal care is provided by hospital midwives.
Public hospital maternity care	Antenatal care is provided in hospital outpatient clinics by midwives and/or doctors and may have specialist clinics. Intrapartum and postnatal care is provided in hospital by midwives in collaboration with doctors as required.
Remote area maternity care	Antenatal and postnatal care is provided by a remote area midwife/group of midwives, sometimes with a remote area nurse/doctor and sometimes by telehealth or fly-in-fly-out arrangements. Intrapartum care is provided in a regional or metropolitan hospital, requiring relocation prior to birth.
Shared care	Antenatal care is provided by a doctor/midwife in the community, in collaboration with hospital maternity staff, with an agreed upon schedule. Intrapartum care usually takes place in hospital-by-hospital midwives and doctors, in collaboration with the community provider
Team midwifery care	Antenatal, intrapartum, and postnatal care is provided by a small team of rostered midwives in collaboration with doctors in the event of identified risk factors.

Models of care as identified by the Australian Institute of Health and Welfare in Maternity care in Australia: first national report on models of care, 2021 [2].

Methods

Approach

A protocol for the review was developed with the guidance of the JBI

methodology [15,16]. A scoping review was undertaken as this approach answers broad questions and allows for the integration of publications using a variety of methodologies in the review [15]. Scoping reviews are iterative and reflexive, focusing on breadth rather than depth to ensure all relevant data is synthesised [17]. Quality appraisal was not carried out as the authors wished to gauge the scope of needs rather than critique the quality of the processes used to identify them [15]. The review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) standards [18].

Search strategy

A search strategy combining subject headings and keywords was developed by the research team in consultation with a health librarian (supplementary material). There were three categories of search terms –the person and period (pregnant, maternity, obstetric, childbirth, intrapartum); the needs (need, want, value, perspective) and the location (Australia and then each state and territory). A supplementary file outlines the search terms and an expanded list of synonyms that were combined using Boolean operators, proximity operators, and truncations, along with subject headings to synthesise the search strategy (see supplementary material). Four databases were searched using these terms on 29th June 2023: Medline, Embase, Emcare, and Maternity & Infant Care Database (MIDIRS). Grey literature was excluded. The search was limited to peer-reviewed literature to optimise accuracy and veracity of the findings.

Inclusion criteria

Studies were screened against inclusion criteria of peer-reviewed research focusing on maternity care needs, conducted in Australian populations, from 2012 to 2023. Choosing 2012 as the commencement date for this review optimised the currency of evidence included, as this project aimed to generate findings useful for planning changes to maternity care.

The systematic search conducted on 29th of June 2023 yielded 9023 results. The screening and extraction process was facilitated by Covidence™. After removal of duplicates, 4734 studies underwent title and abstract screening by two researchers (two of L.F., K.S., or C.H.) independently, with 4612 deemed irrelevant, and 122 proceeding to full text screening. From this pool, 59 were independently deemed to meet the inclusion criteria by two researchers (two of L.F., K.S., or C.H.) (Fig. 1). Any conflicts were resolved by consultation within the authorship team.

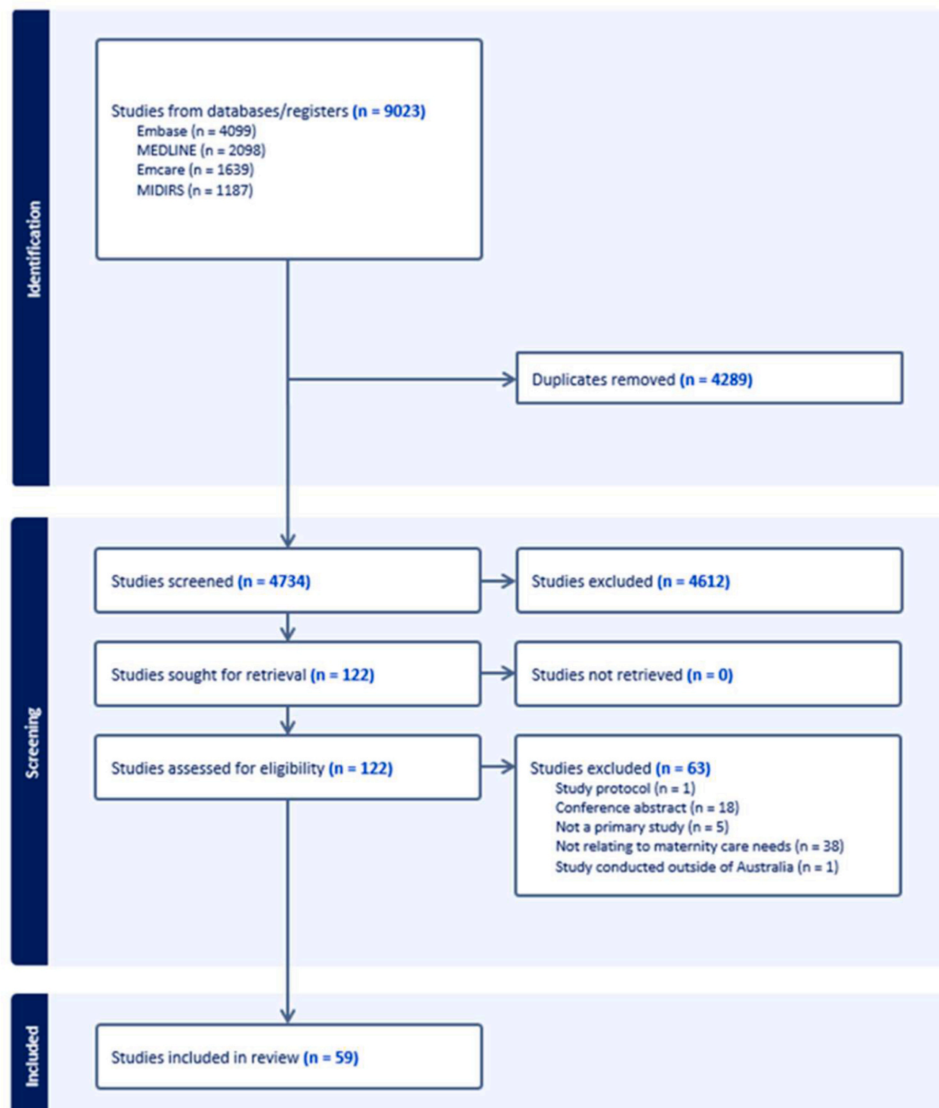

Fig. 1. : Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Diagram for search strategy.

Data extraction and synthesis

Data extraction, supported by Covidence™, was performed independently by two researchers, who summarised findings from the included studies using a structured data extraction form. Results from both researchers were aggregated to reach consensus. Relevant quotes from papers were extracted to add to the analysis. To analyse the results, inductive content analysis informed by Elo and Kyngäs' approach, was used [19]. Content analysis is an appropriate choice for analysing multifaceted and sensitive data, and when knowledge is fragmented, as was the case with our research question [19].

Extracted data were transferred to an Excel™ spreadsheet. One author (LF) distilled relevant concepts from the raw data and placed them into groups of meaning. These were grouped into broader categories; generating the subthemes, and eventually preliminary themes. Consultation within the authorship team was undertaken, and the themes and subthemes adjusted accordingly to form the final version of the themes. Additionally, categories prominent from each paper were extracted from the summarised findings and weighted based on how often they appeared. These data were used to construct a 'word cloud' encapsulating core ideas (Fig. 3).

Results

Included studies

In total, 59 studies met the inclusion criteria. Most studies used qualitative methodologies, and each state and territory in Australia was represented (Table 2).

Some studies investigated the maternity care needs of specific Australian populations. Ten studies focussed on Aboriginal and Torres Strait Islander women [20–29], ten on migrant and refugee women [30–39], six on women living in rural and remote areas [40–45], three on larger women (defined as an increased Body Mass Index) [46–48], two on younger women [45,49], two on women with pregnancy complications [50,51], three on the needs of partners/fathers [28,52,53], and one each focussed on gender-diverse birthing people [54], and older women [55]. In addition, there were five studies exploring the maternity care needs of Australian women during the COVID-19 pandemic [20, 56–59]. The remaining studies investigated Australian's maternity care needs generally [60–78].

The maternity care needs of women and gender-diverse people

There were four themes: *being safe, being seen and heard, being enabled,* and at the centre, *continuity of care*. Continuity was interwoven with the other needs identified. Fig. 2 displays the themes and subthemes, and how they related to one another.

Table 2
Number of papers by primary location of focus and design.

Location	Qualitative	Quantitative	Mixed Methods	Total (%)
Australia-wide	6	2	0	8 (13)1
Australian Capital Territory	1	0	0	1 (2)
New South Wales	6	3	2	11 (19)
Northern Territory	1	0	0	1 (2)
South Australia	2	1	1	6 (7)
Tasmania	0	0	2	2 (3)
Queensland	3	5	3	11 (19)
Victoria	7	2	3	12 (20)
Western Australia	7	0	2	9 (15)
Total	**33 (56%)**	**13 (22%)**	**13 (22%)**	**59 (100%)**

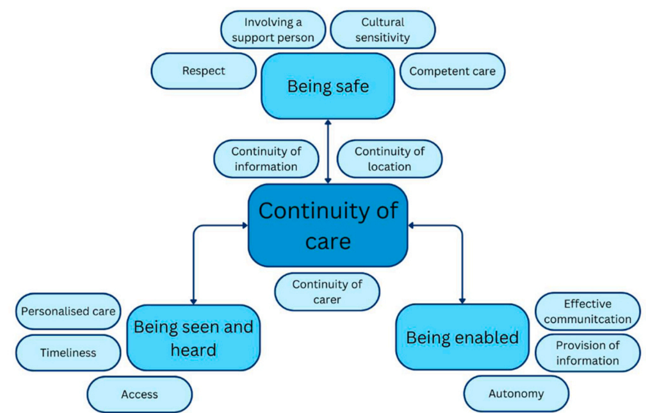

Fig. 2. What women want from maternity care: themes and subthemes.

Being seen and heard

'Being seen and heard' conceptualises being able to access care, and doing so in a timely way, as well as being listened to while receiving care. Personalised care, timeliness of care, and access were key to 'being seen and heard'.

Personalised care

Women expressed a clear need for 'personalised care' (6 studies) [41, 44,47,54,60,76] or 'woman-centred care' (4 studies) [25,51,59,73]. For some women, their positive birth experience was attributed primarily to personalised care, for example:

> *"I think the reason why I feel that my pregnancy and birth were positive is because I was able to get personalised care."* [60]

They wanted care providers to acknowledge and respect their individualised birth plans [69,76], their individual histories and stories [44], and their personal preferences for pain management [69,71]. Personalised care, including being respected, heard and listended to, was valued more highly than having a particular type of birth [60].

Timeliness

Women wanted care to be timely. This included short waiting times at antenatal clinics [21,34,43] and timely communication of test results [76]. Well organsied clinics that ran to time were considered enablers for women who have commitments such as other children and/or employment [34,43]. For example, a woman from a migrant and refugee community stated:

> *"The timing, not having to sit there for two and a half hours. It's hard to just get to the appointment but knowing that it could run over and you've got other children that need to be picked up or things like that – other priorities* [34]*."*

Being afforded enough time during pregnancy to seek information, share concerns and ask questions [35,60,65] was important, as well having sufficient time with midwives after birth and during the early transition to motherhood [74].

Access. 'Access' was a common theme with several dimensions. Firstly, women wanted and needed maternity close to home. Those living in rural and remote communities expressed particularly strong views on the need for services to be provided locally [42,43,69], for example:

> *"I would like to have a hospital near our rural area for our community people. That would make our life here much easier."* [43].

In addition, they highlighted the need for accessible transport

options attend antenatal appointments and access timely care [29,34, 39]. This seems to be of greater importance for women from migrant and refugee communities as they did not always have access to a car [34,39].

Flexibility of appointment times meant better access, especially recognising women often had work commitments and/or other children to care for [20,27,39,45]. During the peak of the COVID-19 pandemic, being able to access telehealth services was also valued [57].

Lack of access to affordable care was of particular concern to women from lower socioeconomic brackets [34,68]. Access to allied health services during pregnancy and after birth such as dieticians, physiotherapists, and lactation consultants was also needed [46,47,75], and women appreciated when these services and appointments were all in one place [29].

Being safe and feeling safe

Safety was a notable construct in this review. Women talked about the importance of 'being and feeling' safe during their maternity care interactions. Feeling safe included being respected, supported, and being provided with cultural sensitivity and competent care.

Respect. Feeling respected by healthcare professionals was important for ensuring safety during the maternity care experience for women. Non-judgemental care was discussed by Aboriginal and Torres Strait Islander women [25], those from migrant and refugee groups [34], young women [45], and those with a high BMI [47], for example:

> *"Just to feel welcome, and not judged, [...] not feel like we are being judged because we are black."* [23].

Women clearly articulated that they need healthcare providers to be kind, understanding, and sensitive to their physical and emotional needs [63,69,71]. Gender diverse people wanted care to be inclusive and respectful of their preferred pronouns and gender-identities [54]. Finally, the concepts of privacy and confidentiality were considered key elements of respectful maternity care [24,32,36,38,40].

Involving a support person. Many studies discussed the importance of being able to have a support person of choice through their maternity care [60, 68, 69, 78]. This was of particular importance to Aboriginal and Torres Strait Islander women, who wanted their partners at labour and birth as well as other support people such as extended family and elders [23–25]. The facilitation of knowledge sharing between different generations was important. For example, young Aboriginal and Torres Strait Islander women often sought advice of senior women [26]. Similarly, women from migrant and refugee communities identified the importance of having support from their partner and extended family [30, 37, 39] this is exemplified here: .

> *"In my country, [the] father can't come to the delivery room. But I don't know why, I think it's very good, I like [the] father being there, and my husband come to delivery room, it's good for me, very good* [39]*."*

Cultural sensitivity. Cultural sensitivity was needed for women to feel safe. This includes respect for involvement of family members as an important cultural practice for some, such as Aboriginal and Torres Strait Islander women [23–25], and those from migrant communities [30,37]. A Aboriginal and Torres Strait Islander woman illustrates the importance of respect for cultural needs:

> *"[The staff member was] the first person that has ever, um, asked about respecting the wishes of my [being] Aboriginal, and I was, I was shocked about it and I was, I was amazed and that was a good feeling* [23]*."*

Space for other traditional practices during birth were also identified as an important aspect of quality care. Access to Birthing on Country models of care was especially important to Aboriginal and Torres Strait Islander women [21,25]. Likewise, women from migrant or refuges communities identified how important it was to be able to engage in cultural practices such as taking the placenta home, resting during the postpartum period and body alterations such as ear piercing [30,32].

Women also expressed how critical it was at times to have their own cultural identity reflected in their maternity care providers. Aboriginal and Torres Strait Islander women wanted to receive care from Aboriginal and Torres Strait Islander clinicians just as some women from migrant or refugee communities preferred care professionals from their own culture [22,23,25,29,36]. Access to interpreters was important for women for whom English was not their first spoken language [32–34]. Additionally, some Aboriginal and Torres Strait Islander women preferred female clinicians in line with 'women's business' [20], while women from migrant or refugee groups preferred female caregivers due to their cultural values [32,35,39]. For example:

> *"After birth because I had a tear, they told that a male doctor should come for stitches; I did not like … my husband gave permission, but I am still unhappy about the male doctor who came for stitches. For stitches, [it] should be a female doctor* [35]."

Competent care. Being and feeling safe was underpinned by a woman's assessment of the competence of her care providers. Women stated that they expected to receive quality maternity care from competent individual clinicians, for example:

> *"I mean everyone basically expects to be looked after and to be looked after properly by professionals. That is their job, it's what they were trained to do* [66]*."*

Aligned with competence was the need for evidence-informed care. Many women clearly understood this concept providing examples such as support for breastfeeding and the importance of skin-to-skin contact directly after birth [69,75,76], during emergency care [41] or when there are complications [23,51].

Being enabled

Women desired autonomy to choose their model of maternity care, and to make decisions about what support, interventions (or lack of), and testing they received. Effective communication and the provision of information were seen as important to support women's autonomy.

Effective communication. Effective communication, across the entire childbearing journey, was a clear expectation of a quality maternity care experience. Women wanted information shared with them in ways that facilitated understanding and helped them actively participate in their own care [59,60,67,76], for example:

> *"…everything's explained really easily for me so I could understand … what was going on and what I needed to do* [60]*."*

Effective communication must be clear and straightforward and delivered in a friendly way [27]. This was especially important during the peak of the COVID-19 pandemic, where service provision parameters were constantly changing [57,59]. Communication in an understandable language was an important need for women from migrant and refugee communities, demonstrating the importance of interpreters in maternity care of migrant and refugee women [38].

Provision of information. Access to the provision of information in a timely way was also needed. For example:

> *"Every time I went there, the midwife, she would explain everything. And if I had a question, then I can ask like that, I am not afraid* [39]*."*

Information assisted in the decision-making process, and enabled women to make informed choices [20,31,55,66]. Women wanted information to cover wide variety of topics, such as weight management and nutrition during pregnancy [46,48], detailed information on any

complications [51], and breastfeeding [72]. Information about the whole care spectrum from antenatal to postnatal, needed to be readily available, and readily accessible not just from care providers, but also online from apps or websites [53,72]. Information was also important for partners too, as this enabled them to be more involved in care [28, 52]. Information available in multiple languages was also an important need [33].

Autonomy. Many studies discussed women's desire for autonomy or being in control of one's own care [30,41,55,60,75,76]. Autonomy included being able to have shared or active decision-making processes supported [73] and being able to choose their model of care [44]. Women also valued autonomy in decisions such as pain management [71], antenatal testing [76], induction of labour [62], and positions during labour [78]. Autonomy led to women feeling respected during their maternity care experience for example:

> *"They explained what the risks were, but were very happy to support my decision … I felt very supported and respected."* [60].

Continuity of care. Continuity was presented as the central theme, not only because it was discussed as a need by many women in many studies, but because it was a tool supporting women to been seen and heard, be safe, and be enabled in their maternity care. Over half (32/59) of the studies identified continuity as a need, with, 18 specifically highlighting midwifery models of care as the best way to deliver continuity of care.

Continuity of care was important for specific groups such as Aboriginal and Torres Strait Islander women [20,21,25–27,29], those from migrant and refugee communities [30,31,33,34,36,39], young women [45,49], women with pregnancy complications [51], and gender-diverse people [54]. Midwifery continuity of care provided the strongest example of desired continuity of care. For example, developing a relationship with a midwife supported a sense of being known, as described by a Aboriginal and Torres Strait Islander woman:

> *She [midwife] was great, yeah. It was a lot easier 'cause she already knew me, we already had that relationship. I find it's different, it's harder when you jump from one midwife to the next* [20]."

Continuity also mitigated some aspects of trauma. For example, women from a refugee background found continuity was especially helpful, as it avoided them revisiting traumatic memories with a new care provider at each care interaction [33]. This was similar for women affected by female genital mutilation [31]. Continuity was also valued by gender-diverse people, as it circumvented the need to repeatedly explain their pronouns and gender identity to staff members [54].

Continuity of carer, location, and information. Women conceptualised continuity of care not just as continuity of carer, but also continuity across locations, and of information [67]. Continuity of, and across, locations was discussed by women in rural and remote areas and Aboriginal and Torres Strait Islander women in remote communities [21,26,27,41], who had to travel many hours or leave their communities entirely to access maternity care. Women appreciated continuity of information, as conflicting advice from different maternity care providers was frustrating [43,47,48,62,63,69,70,76]. This was especially important in the context of the COVID-19 pandemic [57].

Continuity enabling safety and personalised care. Continuity is interlinked with the other themes. For example, Aboriginal and Torres Strait Islander women reported that continuity of care promoted a sense of safety in their maternity care, by being seen by known and trusted providers [26]. Another example linked a feeling of safety to continuity from a midwife:

> *"[I felt] very safe… could be the connection, the relationship and trust with each other when you have just one midwife and they provide full care* [65]."

Women from migrant or refugee groups found continuity enabling, as it ensured clarity in the provision of information; when women were known to staff members there was no revisiting of histories, and no conflicting information given by different health professionals [39]. Continuity allows care providers to know and understand needs better, and thus deliver personalised care [51].

These four themes and their subthemes interlink and build a clear picture of the maternity care needs in Australia. Fig. 3 is a word cloud generated from some of the grouped units of meaning from the raw data and provides a visual summary of findings, highlighting continuity, clear communication, cultural safety, and respect as some of the most commonly arising needs.

Discussion

This scoping review aimed to describe and analyse current literature on the maternity care needs of women in Australia. Continuity of care, particularly midwifery continuity of care, was identified as the central need. Other related needs identified included autonomy, respect, clear communication, a support person being involved, cultural safety, care locally, and provision of information. The findings from this review reflect other work in this space, such as Renfrew et al.'s meta-synthesis of global research on women's views and experiences of maternal and newborn care [79]. The authors found women needed information and education, timely care, knowledge of models of care, and staff who were respectful, kind, and culturally competent [79]. In addition, the consultation phase of COAG Health Council's 2019 *Strategic directions for Australian maternity services* found women needed continuity of care, access to information to make autonomous decisions, respect, and maternity care services in their local area [80]. These ideas are not new. A 2005 review of Queensland's maternity services examined testimonials from over 450 women, and recommended maternity care should be safe, delivered locally by known care providers that follow the women across the continuum of care, and advocated for continuity of care [81].

Continuity of care facilitates the experiences of feeling and being safe, enabled, and seen and heard. A meta-synthesis of women's experiences in continuity of care found midwifery continuity models enable women to feel safe and secure, in control, important, and understood [82]. Despite the evidence and considerable efforts over many years, only a small proportion of women have access to continuity of midwifery care [83], with around one third of models of care offered by health services offering continuity of care [2]. Reorganisation of maternity service provision needs to occur to increase access to continuity of care [4]. For new models to be implemented, collaboration between midwives, obstetricians, paediatricians, and general practitioners is required, with all professionals involved in provision of maternity care having professional respect for the pivotal role that midwives play [4]. Understanding barriers to continuity for rural and remote communities, gender-diverse communities, and other specific population groups is also needed. This will contribute to increasing the number of women and gender-diverse people receiving continuity of maternity care in Australia [4].

Australian maternity services are generally successful in addressing the need for competent physical care - as evidenced by low mortality and morbidity, though the rate of improvement has slowed in recent decades [84,85]. However, rising rates of intervention are not being matched by proportionate improvements in physical health outcomes [86,87]. There is increasing recognition that maternity services are not meeting women's psychosocial needs, with high rates of psychological distress and birth trauma [88]. When women are asked about their wishes in relation to autonomy, it is also worth noting the low levels of understanding of human rights in childbirth, not just among women but

Fig. 3. A word cloud displaying the grouped units of meaning which were constructed from the data. The more often a word appears, and larger it is, the more it arose in the data.

clinicians as well (especially as this often conflicts with their workplace culture). This lack of understanding (as well as enculturated compliance in the medical setting, especially in relation to one's unborn baby) will lead to diminished expectations of autonomy from women (and their clinicians), and therefore lack of discussion and exploration in research. This does not abrogate health services from their obligations to provide evidence-based care to women in maternity services. Women, like all other people, have the human right to the "highest attainable standard of health" [89]. International research into safety and quality in health care has also found that the more engaged a person is with their health care decisions, the better their outcomes are likely to be [90]. Health services are obliged to correct this situation and inform women of their human rights in childbirth and actively facilitate informed decision making. Given the priority women place on the safe arrival of their babies, if women understood this, they would be asking for it too.

The current safety and quality benchmarking of Australian maternity care focuses on clinical outcomes which provides a narrow understanding of what aspects of maternity care need to be improved [91]. Further research is required to assess women's (and clinician's) understanding of human rights in childbirth, in addition to a national, validated measure of experiences and outcomes aligned to women's priorities, identified by the 2023 report on the current Australian maternity strategy [92]. This is in line with the findings of this review; physically competent care (ensuring mortality or morbidity does not occur) is only a small part of the maternity care needs, and competent physical care must be paired with holistic care which addresses individual's psychosocial needs.

Our findings highlight that different populations in Australia have different maternity care needs. As a result, the concept of individualised woman centred care is important. Studies identified the maternity care needs of Aboriginal and Torres Strait Islander women as including access to Birthing on Country models, Aboriginal and Torres Strait Islander staff, and cultural sensitivity [20–25,27–29]; while needs of women from migrant and refugee communities include clear communication, access to interpreters as required, female care providers, and cultural sensitivity [30–39]. There was limited evidence focussed on women from rural and remote areas, but it was identified that they also need choice in their model of care, and care to be provided locally [40, 42–44]. Only two studies focussed on the needs of young women, with an emphasis on the importance of non-judgemental care and being listened to [45,49]. There was also limited evidence focussed on the maternity care needs of gender-diverse people, with only one study identified, and that highlighted the importance of individualised, respectful, and gender-inclusive care [54]. More research is required to better understand the needs of all specific populations.

Strengths and limitations

To the authors knowledge, this is the first review collating the maternity care needs of Australian women and gender-diverse people. The scoping review methodology allowed a broad analysis of available evidence and included diverse populations' maternity care needs, specifically Aboriginal and Torres Strait Islander women, migrant and refugee women, rural and remote women, young women, and gender-diverse people. The studies included represented all states and territories of Australia, so the results can be applied nationwide. We also recognise that maternity care systems around the world vary significantly and so what women want in Australia may not be generalisable to other contexts. Despite this, we feel that there are many commonalities that will resonate with women seeking maternity care in other countries.

We did not undertake a quality analysis of included studies. The evidence used in the synthesis is of unknown, and likely variable quality, potentially impacting the reliability of the results. There was limited data available on some populations (e.g., gender-diverse people), so appropriate caution should be applied to translating the findings regarding these populations, though they did broadly mirror those of other population groups. Additionally, over half of included studies focussed on specific and small populations of Australians (eg: Aboriginal and Torres Strait Islander women, migrant and refugee women, gender-diverse people), which may impact generalisability to the wider population.

Conclusion

This review highlights the importance of continuity of midwifery care in maternity care. Continuity facilitates the maternity care needs of women and gender-diverse people being met; feeling safe, enabled, seen, and heard. Currently, only a small proportion of women and gender-diverse people receive continuity of care, requiring a shift in the Australian maternity care landscape towards continuity to enable the needs of women and gender-diverse people to be met.

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Declaration of Competing Interest

Caroline Homer declares she is the current Editor-in-Chief of Women & Birth. The Deputy Editor, Prof Linda Sweet, managed this submission and made the final decision. All other authors have no further conflicts to declare.

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study. The data are all tabled in a supplementary file and available.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.12.003.

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