

Maternity Consultation Report

Executive Summary of the
state-wide maternity
consultation 2007



Health Networks Branch

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Executive summary

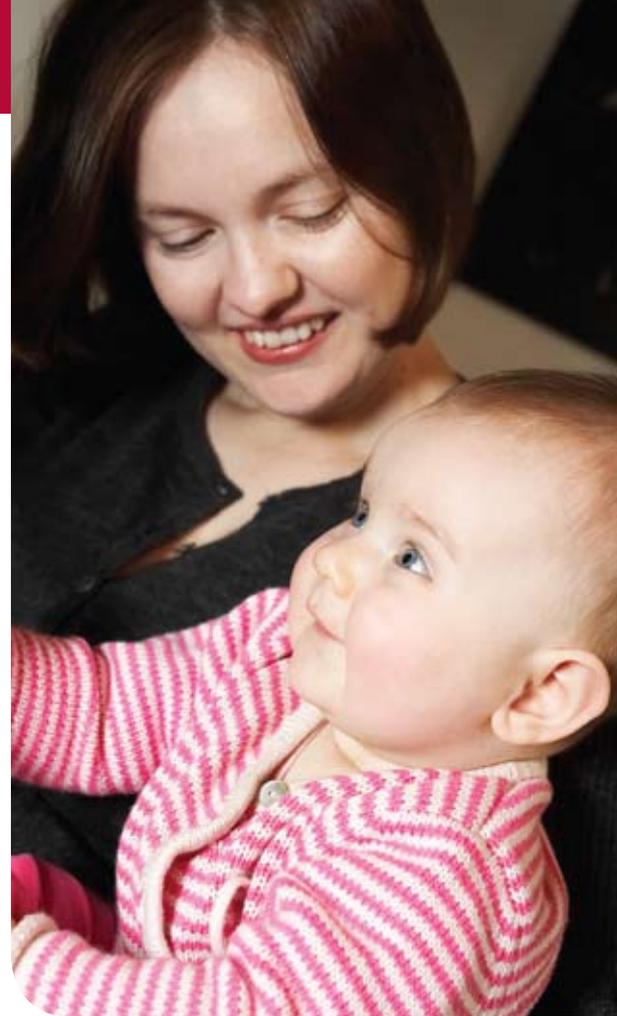
The maternity care consultation was a three-stage process, which commenced in November 2005. It is one of the most extensive consultation processes WA Health has undertaken and demonstrates WA Health's commitment to developing policy through community and health professional consultation and engagement. The consultation has identified the community's and health professionals' key issues, needs, concerns and solutions in maternity care for WA.

This summary of feedback will assist health service providers and planners better understand the needs, desires and aspirations of the community that they serve.

Key themes arising from the consultation include:

- Pregnancy and birth is a normal physiological life event.
- Equitable, safe, high quality, evidenced based care is fundamental for all women and will remain as the foundation of effective maternity services in WA.
- Service delivery will be sustainable, adequately resourced and aim to provide continuity of carer.
- Maternity care will be women and family focused, offer appropriate choice and support, and be accessible as close to home as possible.
- Health disparities and inequalities must be minimised for WA women and babies.
- Maternity services should be essentially community based wherever possible, with an emphasis on continuity of care.
- Strategic alliances, partnerships, and networks in maternal and newborn services should be developed, strengthened and supported.
- Community knowledge of the different roles that health professionals within maternity services provide and how to access these services is sometimes poor.
- Women need to understand that some birthing options as well as some highly specialised antenatal and post natal screening, treatment and management services cannot be offered close to home due to geographical and workforce constraints.
- Women need to have adequate, appropriate and consistent information about maternity care in order to make informed choices.
- Transfer to a large centre to give birth impacts on a family and a community. It is important to ensure that accommodation and transport services adequately support women and their families to minimise the impact of social dislocation.
- Strengthen partnerships with non-government sector agencies such as Ngala, Australian Breastfeeding Association, Red Cross, Aboriginal Medical Services and Birthrites: Healing After Caesarian Inc to support and educate women and their families.





Introduction

The maternity care consultation was a three-stage process, which commenced in November 2005. It is one of the most extensive consultation processes WA Health has undertaken and it demonstrates WA Health's commitment to developing policy through community and health professional consultation and engagement. Recommendations to improve maternity care in WA have been made in past reviews and reports over recent years including *The Douglas Report; WA State-wide Obstetric Services Review; the Health Reform Committee Report; The Clinical Services Framework; Models of Maternity Care: A review of the evidence; The Future Directions of Maternity Care; and Improving Maternity Choices: Working Together Across WA. A Draft Policy*. Each report and review was consistent in recommending an integrated approach to maternity care and has acted as a catalyst in the development of the maternity policy and improvements to maternity care. The consultation has identified the community's and health professionals' key issues, needs, concerns and solutions in maternity services for WA.

Methodology used for the consultation and the development of the maternity policy

The maternity policy development has evolved through a three-stage process. These were:

- Stage 1. A pre-consultation with health professionals and the Health Consumers' Council of WA to develop the initial discussion paper "Future Directions in Maternity Care".
- Stage 2. The discussion paper "Future Directions in Maternity Care" was released to the public for comment in November 2006 and closed in January 2007.
- Stage 3. The final most comprehensive and detailed stage of development, which has been the most widely distributed consultation in WA Health. It included:
 - the commissioning of an independent review of the research literature into models of maternity care titled "Models of Maternity Care: A review of the evidence"
 - the development of the draft policy "Improving Maternity Choices" and its public release for comment
 - focus group sessions with health professionals, hospital-based consumer groups and advocacy groups
 - community forums, Aboriginal forums and bush meetings
 - one on one meetings with key stakeholders
 - a state-wide telephone survey titled "Maternity Services Survey, July 2007" which surveyed over 1500 women between the ages of 16 and 50
 - a telephone hotline, teleconferences and videoconferences
 - the convening of the Maternity Reference Group to assist in guiding the policy development and direction
 - an independent evaluation of the consultation process through the Telethon Institute of Child Health Research.

Throughout the three stages of the consultation submissions were received in a variety of formats and included over 270 written submissions. More than 215 community members attended public forums and meetings were held with over 250 health professionals. Staff from the Health Networks Branch travelled to as far north as Kununurra, way out east to Warburton and as far south as Esperance to maximise the ability for the community to “have their say”.

Maternity Reference Group (MRG)

The principal role of the MRG is to act as a reference and advisory group to the Department of Health (DOH) in the development of the maternity policy. The MRG has been pivotal in assisting the DOH manage the vast volume of feedback from the third phase of the consultation process. The group has provided advice on recommendations to alter the draft policy based on the independent research report findings and any other supporting evidence provided by respondents to support their recommendations or views. Overall the MRG has formed an agreed stance and provided advice on the policy directions for the development of women and family focused, safe and high quality, effective and accessible maternity services in WA.

The statewide detailed consultation, MRG, and past recommendations and reports on maternity care in WA have been paramount in setting a new direction in maternity care. WA Health recognises that good maternal care and fetal outcomes depend upon the health and well being of the mother prior to conception as well as excellence of care in the antenatal, birthing and postnatal periods. Healthy outcomes for women and their babies are dependent upon healthy communities, timely access to adequately resourced maternity facilities and appropriately skilled maternity care providers throughout pregnancy and beyond.

Disclaimer Notice

This report is intended to provide an overview of the feedback gathered from the 12 week statewide maternity consultation. This report includes the views or recommendations of third parties and does not necessarily reflect the views of the WA Department of Health or indicate a commitment to a particular course of action. The WA Department of Health has exercised due care in ensuring the accuracy of the material contained in this report and recognises that the information is from a third parties and may not be verbatim.

The report is made available by the WA Department of Health as a free public service to provide access to information and feedback collated from the 12 week statewide maternity consultation. It is suggested that before relying on the information, users should carefully evaluate its accuracy, currency, completeness and relevance for their purposes, and should obtain any appropriate professional advice relevant to their particular circumstances. The State of Western Australia, the WA Department of Health and their respective officers, employees and agents, do not accept legal liability or responsibility of the Material, or any consequences arising from its use.

Feedback from the 12 week detailed community and Health professional statewide consultation

Statewide key themes and issues

- Birthing is a natural physiological and meaningful event.
- Continuity of care and carer from antenatal to postnatal period is desirable so that women know and are known by the team of maternity health care professionals.
- Women require clear, consistent, and accessible information on maternity services and care throughout WA.
- Women and their families should be empowered to make informed choices and minimise dislocation and isolation.
- Improve school education programs on pregnancy and maternity care.
- Improve transport, accommodation and access to maternity services within Western Australia.
- “Demedicalise” and normalise the maternity care services for better health outcomes.
- Improve the provision and support provided to women and their families at early discharge.
- Improve education, information and support services for breast-feeding.
- Improve the provision and delivery of culturally appropriate maternity services and care i.e. increase the number of Aboriginal people in the maternity workforce.
- Improve the health outcomes and disparities of Aboriginal women and babies.
- Address the effects of the diminishing and ageing maternity workforce that are impacting on maternity service provision.
- Provide initiatives to attract and retain a qualified credentialed maternity workforce.
- Provide additional resources within each region and statewide for the implementation to be effective.
- Recognise geographical differences, population needs and their implications for maternity care and service delivery.
- Develop and improve collaborative working relationships between health regions, health professionals and maternity services.
- Expand the scope of the maternity workforce (i.e. licensing and accreditation issues) and implement alternative models of maternity care.

South Metropolitan Area Health Service key themes and issues

Access issues

- Improve access to allied health services for women and their families.
- Broaden the scope of the Patient Assisted Transport Scheme (PATS) to cover attendance at specialised clinics.
- Address transportation issues for midwives and/or child health nurses providing home visits for women during the antenatal and postnatal periods i.e. how will they get to the women's houses? Will they be expected to use their own cars? etc.
- "What will be the effects of the policy on the transportation of women from regional areas to Perth at 36 weeks for a delivery?"
- "Where will Rockingham women go to give birth if a birth centre isn't developed? Will these women be able to access other birthing centres?"
- "The community and health professionals are confused as to whether Peel is a metropolitan or country health service."
- "In an emergency, how will hospitals other than King Edward Memorial Hospital (KEMH) have the expertise to deal with the transfer of a woman from a home birth?"

Governance

- Clarify governance structure and admitting rights for midwives and GP Obstetricians to hospitals.
- Will it be harder for Peel to get additional funding because they are a private facility compared with a public hospital?

Information and education

- Provide consistent maternity information (i.e. terminology and language) from General Practitioners and/or midwives.
- Educate GPs on the available maternity options and services (regionally and statewide), as they are generally the first point of contact for pregnant women.
- Recognise the importance of maternity choice and education of available options for women and their families.

Models of care

- Acknowledge existing GP models of maternity care that are effectively working within the community.
- Develop guidelines for water births.
- Develop models of maternity care which highlight collaboration and continuity i.e. integrated clinics.
- Identify funding requirements to support the implementation of the models of care.

Maternity services and care

- Peel attempted to secure funding for a birthing centre with a submission of over 500 signatures which was refused by the government. “What maternity services will be developed in Peel to compensate the demands of the growing population, and will there be any resources allocated from the infrastructure developments currently occurring?”
- Provide support to women who choose to home birth i.e. opening services outside of Fremantle.
- The “Early Discharge Program” for first time mothers and mothers who are at greatest risk was very successful i.e. Pinjarra Hospital. It is very important that the midwives who undertake this program are qualified and should also be lactation consultants.
- Breastfeeding becomes a significant problem for mothers once they leave the hospital.
- Recognise the role child health nurses play in the continuity of care for women, their baby and their families.
- Clarify the roles and expectations of midwives and child health nurses in post birth care.

Workforce

- The roles and responsibilities need to be clearly defined in the proposed models of care for maternity services for both health professionals and the community.
- Identify and develop funding requirements and incentives to attract and retain the maternity workforce.
- “There is no workforce to support this [draft] policy.”
- The government needs to lobby for more funding to support additional university places and develop strategies to attract and retain GPs to specialising in obstetrics.
- A faster recruitment process is needed for the maternity workforce.
- “What budget has been allocated or dedicated to this policy?” There needs to be a dedicated budget for areas such as professional development, change management, communication planning etc.
- There are currently 27 obstetricians working in the private system and they will not return to the public health system because they are not looked after in the public system. There is no effective dialogue established to bring private obstetricians back into public health system.
- 95% of Medicare safety net is paid to private obstetricians.
- Public obstetricians do not have access to Medicare.
- Need more information and consultation on workforce [attraction] and retention issues.
- Local government is concerned about the implementation of the community clinics due to funding arrangements - i.e. cost shifting to local governments.
- Credentialing of midwives

North Metropolitan Area Health Service key themes and issues

Aboriginal issues

- Increase the involvement and number of Aboriginal Health Workers in maternity care.
- Improve the provision of culturally sensitive and appropriate care.
- Improve the engagement of Aboriginal women (especially young mums) and their families in antenatal care.
- Individualised care needs to be offered to Aboriginal women within public health services.

Culturally and Linguistically Diverse and migrant issues

- Improve access to maternity services i.e. loading prams or strollers into buses can be hard and taxis with baby capsules and baby seats are minimal.
- Provide adequate linkages and support for women and their families to appropriate services i.e. provide support to a woman leaving the hospital through support of a volunteer, advocate and/or hospital social worker.
- Provide home visit programs for women and their families during both the antenatal and postnatal periods i.e. a child health nurse visits more than once for the first child.
- Depression with a woman's first baby is common due to minimal support networks and social isolation for migrant and CaLD women.
- Lack of interpreter services for the diverse languages within the migrant groups. There is limited access to services and limited skills for the diverse languages. It may be culturally inappropriate for a male (including family members) to interpret sensitive information. It is suggested that WA Health liaise with the Department of Immigration to identify the language needs and service requirements for all migrant groups.
- Many migrant and CaLD women prefer a female doctor/obstetrician for the delivery.
- Ethnic women avoid hospital services as they fear being disconnected from their families. They develop "guilt" issues, fear caesareans and feel forced to breastfeed.
- There are extensive differences in medical practice culturally for CaLD and migrant women i.e. in Afghanistan, older community women help deliver babies, although if an episiotomy is required a doctor manages the patient.
- Provide high quality, culturally sensitive maternity services, and promote cultural awareness and respect of different populations.
 - It is inappropriate for male health professionals to shake the hands of a woman in some cultural practices.
 - In some cultures a mother is "baby sat" for 40 days post birth hence the patient visiting hours should be reviewed for cultural appropriateness.
 - Cultural sensitivity is poorly practised when providing antenatal education.
 - Women would like to spend a longer time in the shower for cultural purposes.
- Migrant women are not supportive of home births as they feel it is safer to deliver in hospitals.

- The health service does not do circumcision routinely unless there is a cultural or medical purpose and the child needs to be 12 months post birth within the public sector. It was requested during the consultation that a directory be developed listing the doctors who do circumcisions.

Information and education

- Develop breastfeeding guidelines and support networks for women within the community.
- Improve the provision of information and education to the community on the different options and types of maternity care available within their region and statewide.
- Improve the sharing and accessibility of childbirth information and records between health professionals to ensure continuity of care.
- Develop and provide consistent and clear information and education to women from the preconception to postnatal period. It is suggested that the best method to provide this information to migrant groups is through information sessions with an interpreter, engaging with migrant groups at English classes, or alternatively sending a CD-Rom to them to watch and educate them about maternity care which is culturally appropriate and in their language. This would also assist in women becoming less fearful of pregnancy and childbirth.
- Provide cultural training to ensure consistent information and skills are provided to CaLD and migrant groups e.g. cultural awareness training for health care professionals in how to counsel and deliver information to different cultures.

Maternity care and services

- Provision of the best care and service is about planning, linkages and support.
- Engagement of women during the antenatal period is minimal and needs to be addressed.
- Provide maternity care closer to home.
- The only breastfeeding centre is at KEMH, which does not address the needs of the wider community in Western Australia.
- Increase the options and availability of maternity services and care through providing Family Birth Centres and Community Clinics. The locations of these services need to be accessible and based on community needs.
- Provide multidisciplinary holistic care to women and their families during the antenatal and postnatal periods.
- There is a lack of options available to women who have a caesarean section. Some women expressed the view that they want:
 - partners present for caesareans
 - skin to skin contact with baby
 - prevention of separation following the birth of the baby.

The policy needs to reflect statewide guidelines for elective caesarean section and Vaginal Birth After Caesarean (VBAC). The guidelines should cover issues such as appropriate support personnel in theatre, post operative recovery, visiting hours etc.

- Provide continuity of care and carer within the community either by a team or by an individual.
- Improve the partnership between the private and public health sector to enable continuity and provision of maternity care.
- Some staff felt there is no support for secondary hospitals.
- It is important for women to have choice and informed consent for self-referrals and surgical interventions.
- Ensure antenatal classes are appropriately delivered, inclusive of partners and provide consistent information.
- Minimise the separation of a woman from her family and baby during pregnancy and childbirth as it may have a negative impact on parenting.
- Develop collaborative and seamless models of maternity care within communities.
- Discharge should be stated as “appropriate” not “early” to ensure patient safety is the first priority.
- Improve lactation services (i.e. access, support, resources, equity etc).
- Some staff felt that existing maternity services are not acknowledged and recognised.
- There are major gaps in community-based maternity care.

Workforce

- Increase the funding for maternity workforce and professional development.
- The increased number of births is straining the limited maternity workforce and resources.
- Develop and strengthen mentoring of GP, GP Obstetricians and Obstetricians as there is currently minimal support provided.
- Credentialing nurses to practice as midwives. “Will the Commonwealth assist with this?”
- Changes need to be made to the culture of the maternity workplace and workforce to improve retention, attraction and job satisfaction..

Great Southern

Aboriginal issues

- Aboriginal women are currently encouraged and receive incentives to engage early with the health team in pregnancy i.e. they receive a car capsule 20 weeks or less into the pregnancy, a hand held record etc.
- Provide a multidisciplinary service that includes a social worker, mental health worker, counsellor etc.
- “Hospital accommodation isn’t Noongar friendly.”
- Provide an Aboriginal advocate to act as an Aboriginal liaison officer to improve continuity of care and support between the Aboriginal Health Service (AHS) and the hospital.
- Provide culturally sensitive and appropriate care to Aboriginal people and invest in cultural awareness training for all medical personnel.

Education and information

- Positive attitudes and experiences were found with the “Core of Life”, school program on childbirth and parenting run at high schools for year 9s and 10s. Albany is well supported by community initiatives such as “Best Beginnings”, “Core of Life” and “Bouncing Back”.
- Currently male health workers engage with families and run “Young Dad’s” programs for parenting education in the Great Southern.

Maternity services and care

- Improve early discharge programs for women to ensure that they are supported by family, health workers and a midwife.
- Improve engagement and support provided by child health nurses to high risk women through an earlier visit at the hospital by the child health nurse prior to discharge.
- There is no continuity of care when a woman is transferred to and from King Edward Memorial Hospital.
- There is minimal support for a woman when discharged home.
- There is minimal lactation consultants and information in the community about breastfeeding.
- There is a lack of maternity services and community knowledge of alternative models of maternity care in Albany. It is suggested that community midwifery clinics and/or a family birth centre should be developed.
- Develop alternative accessible options of pre-conceptual care within the community.
- Will funding for proposed community clinics be provided by the Commonwealth or State Government?
- Licensing and accreditation issues with ultrasound facilities that are accessible to women in their first trimester. Is this a government provided service? Residents in Albany are unable to access first trimester screening (Nuchal Fold Translucency). PATS does not cover this test, hence women must choose and pay to travel to Perth for this test.

Models of care

- The shared care model with GPs is effective.
- The community prefers home visiting programs to hospital based programs as the most suitable and appropriate provision of ante and post natal care.
- Sharing of information and records between GPs and hospitals is poor and requires improvement i.e. integrated or electronic records.
- Midwives are under utilised in Albany i.e. minimal assistance in antenatal care.
- The caesarean rate in Albany is 23% for 450-480 births per annum and GPs have commented that the private caesarean rate will not change.

Transport and accommodation

- Limited support is provided by PATS which leads to dislocation of families.
- Develop a “family room” for postnatal recovery.
- No accommodation is available in Perth for families and it is suggested that a Ronald McDonald House be developed for families to reside in Perth.

Workforce

- A direct entry midwife has no practical use in a small rural health service, as they can't care for non-maternity patients.
- Aboriginal Health Workers are frustrated with the limited scope of practice in their role in maternity care.
- “Where do doulas fit in maternity care?” Could they assist the midwife? “The Eastern States have a Doula training course.”
- Some midwives are frustrated and desire a change in culture from the highly medical structure in maternity care.
- Carry out a workforce survey of midwives to identify what will attract and retain them within the maternity workforce.
- Albany has 11 GPs who practice obstetrics and have credentials in operative Obstetrics and Gynaecology. They have managed and provided maternity care for 10 years in Albany without a specialist Obstetrician.
- Generally women have to pay a “gap” fee for service of care with GPs as there is no bulk billing except for Aboriginal women and health care card holders. However, this varies between practices.
- There is inadequate cover of child health nurses in Albany.
- Some mothers and families feel as though there is a gap in the follow-up of care provided, as some do not receive a child health follow-up post birth. Women and families have indicated they would prefer an extension to the home visiting service provided.

Pilbara and Gascoyne

Aboriginal issues

- All Aboriginal women have to come into Port Hedland to give birth due to multiple risk factors and general poor health. Their families can't support them and there is no appropriate accommodation available.
- Pilbara Indigenous Women's Aboriginal Corporation (PIWAC) are currently building a house for Aboriginal women to reside in but it does not cater for extended families.
- Pilbara Health Service (PHS) are trialling some antenatal clinics in the local Aboriginal Medical Service (AMS).

Accommodation and transport

- Accommodation is a major issue in Port Hedland and the surrounding Pilbara region. It is limited and highly costly for both the community and health professional. This limits women travelling into town to give birth and/or undergo procedures. Limitations in accommodation also have negative impacts on staff recruitment and retention.
- KEMH includes first trimester screening as part of their best practice guidelines although Port Hedland does not offer the service as they do not have an accredited practitioner to undertake the scan. This barrier requires women to travel to private practice in Karratha for screening.
- Women are isolated and dislocated from their families when transferred into town. Partners aren't covered by PATS and there is no childcare for other siblings. Women find the significant proportion of men in the town (due to the mining activity) extremely intimidating.

Models of care

- Health professionals strongly support the concept of group practice and flexibility within the service. There was concern however that it could be problematic in small workplaces.
- The population in the Pilbara has increased dramatically over the last few years, however the infrastructure in Port Hedland has not kept pace. There is increased pressure on all services but in particular child and maternity services due to the influx of young people.
- PHS runs six clinics per fortnight that are always full.

Workforce

- There are concerns in regards to the experience and skills of "job-ready" midwifery graduates. Need to develop a supportive workplace, that provides ongoing clinical supervision and professional development.
- Need to ensure clinical consistency across services in terms of the role of the midwife as it differs dramatically between services due to personality issues and local management practices.
- Extending the scope of practice for midwives would have a major positive impact on workforce shortages.

Kimberley

Accommodation and transport

- Accommodation is a major issue throughout the Kimberley for both patients and staff. A high number of women have multiple risk factors, requiring them to attend a hospital for some aspects of their antenatal care and for their birth. Women are dislocated from their families as there is little or no ability to accommodate family members. Current arrangements for accommodating women in town are inadequate and can be very intimidating for some women. This increases their fear of the health service and isolates them socially.
- Transport is also an issue as they predominantly have to rely on public transport. For some women this means arriving back in town in the middle of the night with a newborn.
- The PATS scheme is inconsistent with “best practice” e.g. first trimester screening is best practice, but is not covered under PATS. PATS is unable to transfer a woman’s partner or family members which leads to social isolation.
- It was generally felt that there were many things that could be done to improve the birthing experience for women in remote areas. For instance, women in Fitzroy are bussed back from Broome at 4 am. The transport that is provided is inappropriate and has a big impact on women’s willingness to use the service. At present some women hide their pregnancy as they do not wish to be removed from their country. Appropriate accommodation with access to a phone and nutritious food was felt to be critical in the provision of quality care. This is currently not consistently available across the Kimberley.

Advocacy and choice

- It was felt that the draft policy did not adequately reflect the needs of women in rural and remote areas. Aboriginal women living in rural and remote communities have very little or no choice in terms of birthing options, choice of carer and encounter major difficulties in accessing a service.
- The Aboriginal population will require effective communication and consultation within their communities to ensure effective maternity care and services are provided and are culturally appropriate.
- Aboriginal women recognised that other issues including adequate housing, transport, employment and education impact on maternity care and health. They felt that many government policies didn’t encourage good choices about pregnancy and care for the Aboriginal population and that incentives such as the “Baby Bonus” from the Commonwealth encouraged very young women to have babies. Many of these young women were not in stable relationships, still took part in risky behaviours and were ill-prepared for motherhood. They believe that this bonus payment should be tied to criteria such as age, living conditions and community or family support.

Collaboration and synergy

- The geography and scarcity of resources across the region are critical factors affecting cooperation. Many AMSs would like to progress the concept of Memorandums of Understanding (MOU) with the local health services to ensure the best use of resources (including expertise). Kimberley Health Service (KHS) already has several MOUs and foresee the expansion of these in the future. It was felt that local collaborations at present operate on goodwill and that the system would benefit from the development of principles to guide health service interactions with AMSs. It was felt that there were some good examples of local collaboration however it

was important to acknowledge solutions to the problems need to be identified. It was also felt that there were opportunities in the Kimberley for better collaboration between AMSs and the local health services.

Cultural competence

- Many of the cultural barriers experienced by Aboriginal women during pregnancy and birth weren't identified in the draft policy and Aboriginal women felt that many health care professionals did not really understand their cultural, spiritual, mental and physical needs. This may lead to increased fear, mental strain and poor outcomes for Aboriginal women.

It was felt that some health care professionals are very culturally supportive but this was personality dependant. It was felt that WA Health needed to better meet the cultural and spiritual needs of Aboriginal women e.g. a story was told of a woman giving birth out of her country in which she had a stillbirth and felt great shame at the prospect of returning to her country. The woman was significantly distressed and the staff at the hospital could not comfort or help her. An Aboriginal Health Worker was able to support her and arrange a smoking ceremony at the hospital. The woman was calmed and although still distressed at the loss of her child, she was able to return to her country without shame. Another story recognised that for some Aboriginal communities, the place where you are born is your country. Some Aboriginal women who are taken to hospital to give birth feel that the child does not belong to her family's country. Some women bury the placenta on her country to recognise the child will belong there. Women state that they were often told that they could not take the placenta home, or they were unaware that this was possible and were too timid to ask.

- Aboriginals living in remote communities are very fearful of hospitals and believe that it is a place you go to die which often makes them passive recipients of care, rather than partners in decision-making.
- Little appreciation is given to the role that women have within a community. In many cases, they are the glue that holds the family together, and quite often the community, hence there is a significant cost to the community when that woman is removed.

Expectation management

- The draft policy is predominantly metropolitan centric and sets unrealistic expectations in the country.
- It would be extraordinarily difficult to provide continuity of care as described in the document within the Kimberley i.e. not every woman would be able to have her own midwife.
- Many women living in remote communities have poor access to maternity services and/or no birthing options due to multiple risk factors requiring hospital care.

Maternity care and services

- Maternity care in Aboriginal communities is a fundamental issue. Antenatal care is recognised as a paramount area requiring attention with particular concern on nutrition.
- Some women do not wish to leave their community to give birth and in some instances had their mother's assist them with their birth. In these instances, many women do not receive any antenatal care and risk behaviours such as drug use i.e. tobacco and alcohol, go unrecognised.

- Many young Aboriginal women wanted a reward or incentive for participating in antenatal care as they felt as though more would be achieved i.e. reduction in risk behaviours. For instance, if a young woman did not smoke or drink, attended antenatal clinics and education regularly, and had a health pregnancy, she may be able to either stay in her community to give birth (with support), or travel to town much later in her pregnancy. Dislocation from her home and family would therefore be reduced

Workforce

- Declining number of procedural General Practitioners.
- Concern in regards to the impact of direct entry midwives. If the midwives are not nurses, they couldn't be deployed to work in other areas (especially in small towns). This will have significant implications in terms of the numbers of hours work on offer to them.

Goldfields and South East Coastal

Aboriginal issues

- Huge problem with Aboriginal teenage mothers having no antenatal care and not presenting until they are in labour. In the Aboriginal population there is shame linked with teenage pregnancy. It is suggested that education tools and the methodology used for teenager pregnancy awareness need to be improved and should commence in Year 6; high school is too late.
- Communities need to implement social training to deal with shame issues around unplanned pregnancies. Elder women need to be recruited to participate in these education programs.
- The Commonwealth and/or State need to address the baby payment issue in the Aboriginal communities as it encourages young mothers to have more children. It is suggested that to ensure a woman receives antenatal care, the baby payment needs to be linked to attendance at antenatal classes rather than as a bulk payment.
- Area Health Services and the Aboriginal Medical Service need to improve collaboration, their working relationship and partnerships.
- Major gap for Aboriginal women seeking help for postnatal depression. It has been suggested that changing the name of the Regional Mental Health Unit would encourage Aboriginal people to attend, as it will not have a mental health stigma or label.
- Home births would be acceptable for Aboriginal women if they were supported and managed by midwives from the beginning to the end of their pregnancy.
- It is suggested that educational maternity care information for Aboriginal women needs to be printed and a road map could be beneficial in assisting where to seek maternity care and services statewide and within their region.

Choice and type of birth

- Esperance has approximately 220 births per annum and this figure is growing due to the influx of the younger population in the mining industry. It is believed that if there were more midwives, women with high-risk complications would be able to be managed at the hospital.
- Some of the community do not believe that a family birth centre is an option in Esperance. Obstetricians feel as though there aren't enough resources to staff both the maternity ward in the hospital and a home birth centre in Esperance.
- The policy is metropolitan centric and doesn't articulate the needs and requirements of the rural sector.
- There is no choice in rural and remote area so what use is a policy that is offering choice?

Governance

- Need to sort indemnity insurance issues for midwives i.e. home births, midwifery-led care.

Maternity Care and services

- Cost is the driving force causing non engagement in antenatal care classes as the community is required to pay for all antenatal care in Kalgoorlie/Boulder.

- Community antenatal care leads to a loss of income for GP Obstetricians and Obstetricians who already have to pay very high insurance premiums for indemnity.
- Would community clinics be a free service? If so, would it be in competition to existing services in the rural sector?
- GPs believe that home births are suitable if they could recruit more midwives to support the service. Residents in Kalgoorlie/Boulder are provided with home birth as an option at full cost to the consumer (this means they cannot claim health insurance). Therefore, women who may choose home birth are limited by cost.
- A family birthing centre in Kalgoorlie would be great as there is interest in this model and the structure in Kalgoorlie/Boulder lends itself to midwife led care.
- Home visiting in Esperance during the post birth period is severely restricted to a 15-20 km radius out of town. This restricts the visits to town residents i.e. Norseman and Ravensthorpe have no home visiting post birth. Aboriginal women miss out in the communities and are in most need of follow up as they are less likely to return to GP post birth.
- Women from single income families and the Aboriginal population are not accessing antenatal or postnatal care properly.

Service Planning

- Midwives may play a leading role in the management of midwifery led clinics although currently midwives are responsible for a small amount of patient assessment and/or antenatal care.
- In Esperance, all maternity care is managed by a GP, although if the woman is out of Esperance she may receive very little antenatal care due to no availability of a GP. It is suggested that a travelling clinic would be beneficial for the district and could include Norseman and Ravensthorpe.
- Midwives need to be devoted to providing maternity care across the continuum i.e. birth control, sexual health advice etc.
- There is no postnatal home visiting provided by midwives in Kalgoorlie as they only work in the hospital.
- There are no obstetric services (for delivery specifically) at Norseman, which results in mothers from Norseman, Ravensthorpe and other communities commuting far distances to receive antenatal care in Esperance or not receiving care at all.
- Is the health system able to afford these changes? Services are stretched to the limit in the rural sector. If teaching hospitals go over budget they get topped up, although the rural sector has to cut services and stay within budget. If the rural sector doesn't, then their administration staff gets sacked and staff are lost.
- It needs to be sustainable i.e. when times are tight, services or resources should not be cut.

Transport and Accommodation

- Ravensthorpe and Norseman residents have to travel to Esperance to deliver.
- Accommodation is non existent and costly in Esperance.

- Many women have to travel into town to deliver, receive no travel assistance, have no accommodation, have to bring their children with them, require childcare assistance, sit and wait until they go into labour, may not receive any home visiting, may be separated from their family for up to 4 - 6 weeks, and a father and family may be separated from their new child until the mother gets home.
- PATS system is inadequate and doesn't provide adequate support to pregnant women.
- Many high-risk women refuse to leave Esperance (especially the case with the BMI>40 women) and they cease antenatal care once they are told they have to go to Perth. Many women in this situation turn up in labour, which in many cases then becomes an emergency transfer with RFDS. Many doctors refuse to manage unstable women and labours on the tarmac whilst waiting for RFDS.
- Women from single income families and the Aboriginal population are not accessing antenatal or postnatal care properly.

Workforce

- Midwives are under-utilised and are not supported by the local health service. They are used as back up to the general RN roster, and maternity care is secondary.
- Increase participation of Aboriginal Health Workers in antenatal care.
- A structured training program needs to be developed for Aboriginal health workers to ensure consistent education is provided to women and girls.
- New graduates express interest in completing the Post Graduate Diploma in Midwifery although the cost is a barrier and the scholarship offered is insufficient to support nurses in achieving the qualification.
- The home visiting nurse is a midwife but she does not practice as a midwife because she does not want to practice in aged care and mental health due to the maternity ward being combined with aged care and mental health patients.
- Antenatal care and postnatal services could be provided to the community at Norseman if they had a midwife. It is not feasible to have an obstetric service at Norseman, but access to antenatal and postnatal care could be made available or accessible to women.
- Recruit more GP obstetricians in the rural sector.
- Frustration and decreased continuity of care due to midwives being unable to prescribe medication.
- Midwives that have advanced midwifery training can't use it in practice.
- Claytons shared care arrangement with GP/Obstetricians. The GP/Obstetricians aren't willing to share the clinical aspects of care with midwives, only allowing them to deliver education, assist with the delivery and visit the women and their families.
- It is suggested that allied health should be involved in home birth and birthing centres.
- Develop specific strategies for the rural sector to reflect the role of GPs.
- Develop strategies to address the decrease in GPs practising maternity care.
- Obstetrics needs to be introduced early into medical training at universities. Note: If patients are moved from hospitals to birth centres there will be no opportunity to train future obstetricians.

- There needs to be flexibility for the rural sector with each area or level of care requiring its own specific model of care.
- Professional development in maternity care is vital for medical trainees, midwives, allied health and GPs. Kalgoorlie is well placed to run professional development with the opening of the new Rural Clinical School. This school has state of the art Telehealth and is currently putting through 27 medical students annually for rural health training.
- Cooperation and cohesion between Federal, State and rural clinical schools need to be improved.

Midwest and Murchinson

Access

- Many of the women we met expressed very high levels of dissatisfaction with the current arrangements for women giving birth in Perth. Everyone recognised the need for safe care, but expressed a wish to give birth in their own region (regional centres) rather than travelling to Perth. One reason for this is that they may have friends or family who live in those towns who could provide support.
- This dissatisfaction was mostly to do with the fact that women are lonely and isolated from their loved ones and can be apart for weeks at a time - they expressed their sense that city staff don't "care" for the woman.
- The inability of a family member or friend to attend under PATS is a key problem.
- One woman commented how upset she'd been when she had to give birth surrounded by strangers. (Her partner was unable to accompany her under PATS.) She'd made friends with one of the women she'd met at Agnes Walsh House and had asked her to attend the birth with her as she didn't want to do it alone. She felt it was inappropriate that she had to invite a stranger.
- Difficulty in accessing the Aboriginal Liaison Service was mentioned. Many women have to make their own way in a cab to the hospital from the airport.
- Telehealth was discussed as an option which could be used more regularly. The point was raised [by health professionals] that the practitioner receives no fees for telehealth consultations which can be a disincentive to using this method.
- It was commented that midwives going out to communities was good for the midwife (as it means they are able to fulfil all aspects of the role of a midwife) and good for the women (who are seen closer to home).

Accommodation in towns/Perth

- The lack of suitable affordable accommodation for rural women [both in Geraldton and Perth] was discussed by many women and health professionals.
- The issue of where a woman stays when her newborn baby is ill and is admitted to KEMH but the woman is not admitted was discussed.
- Some women can be away from home for months (due to complications) and the expense (of accommodation and meals) can be a problem, particularly when those costs have to be paid upfront by the family.
- "Agnes Walsh House... is like a prison for rural women" [expressed by an Aboriginal woman and a non-Aboriginal woman]
- Challenges with transport and accommodation can lead to some women choosing to remain in remote areas until immediately before giving birth which is not good for their health or that of the baby.
- The accommodation [in Perth] can be very sterile - the main issue is a lack of comfort (not only physical but emotional).

Aboriginal issues

- The AMS see many women coming in from remote areas who are almost on the point of giving birth who've had no antenatal care.
- There were a couple of comments about how women had overheard staff in the city making racist comments about Aboriginal women.

Ante-natal care

- There was a comment that “the doctors here are very caring” [small country town] when talking about receiving ante-natal care locally.
- Non-compliance amongst rural/remote women is very high. Staff have to constantly chase them to provide basic care.

Information and education

- Some of the women expressed a desire for someone to talk to them honestly about what to expect in childbirth, particularly for first time mums, many of whom may be quite young.
- Reliable information for new dads was felt to be important. The men have no idea what to expect and there's no information available for them.
- This lack of knowledge (amongst men) sometimes led to men coping badly with the arrival of a new baby, sometimes leading to family violence.
- [Some professionals commented that] there is a need for something like a “men's shed” - where workshops could be run. Somewhere free of charge for men to go and learn from each other.
- Discussed that getting women to sign something saying they understand the risks of their choice is about underlining the importance of, and ensuring you have, informed consent.
- [Rural healthcare workers] expressed a need for consistent information for consumers - for example, access to video materials and publications.

Birth

- Some of the women felt that the options for giving birth at KEMH were inflexible. For example, women said they had to give birth lying on their backs and were not allowed to stand up or squat. It was commented that the local regional hospital was more flexible in this regard.
- It was commented that access to home births in Geraldton is very poor because there is a lack of midwives with appropriate insurance.
- It was discussed [at a public meeting] that as Geraldton is geographically quite compact, everyone will always be quite close to a hospital - i.e. if they had a home birth.
- The issue of care at birth being midwife-led but with a doctor being available within 15 mins was discussed [by health professionals].

Post-natal care

- Some of the women found being told they have to leave the ward within 48 hours of the birth difficult. It was discussed that this may be too early for rural women who are away from home. It was suggested that women be allowed to stay longer in the hospital to help them adjust to having a new baby etc.

- Some women commented that not being asked “when are you leaving” was very comforting, particularly with your first child [about regional hospital].
- Early discharge of women - especially given the high number of young girls (15-16 years old) having babies - is an issue for staff in the local [rural] community. Staff who are already under pressure have to provide additional support to vulnerable girls/women/families.

Family dislocation

- Women talked about the significant impact their absence has on their families. It can sometimes be difficult for men to cope on their own, particularly if they have to look after other young children. This was also discussed by health professionals.

Cultural awareness

- This was discussed, not just in relation to Aboriginal and non-Aboriginal women, but also in regard to city and rural women. It was discussed that rural women, and Aboriginal women in particular, are very modest. They discussed how uncomfortable they felt when a doctor (often male) or midwife who they’d never met before, came into the room while they were in labour, briefly introduced themselves and then proceeded to probe and touch them.
- The cultural gap between women from the country and staff from the city is felt to be significant.
- There is currently no orientation program for country women who are coming to Perth for the first time. For example, when they’re staying at Agnes Walsh House no-one shows them where the shops are. There is no transport for women to use to get around the city which can be daunting if they come from a very small town.
- It was commented that for many women from the country, walking out into a “big city” was very confronting, never mind when they’re either very heavily pregnant or in the first few days after having given birth.
- It was suggested that one way to address some of the issues outlined above would be to train Aboriginal Health Workers who could work in the labour ward and help address some of the cultural barriers.

Communication - continuity of care

- There were numerous comments about how there is currently little communication/ integration between the services provided locally [in remote communities], regionally, and the services in Perth. Local providers find it difficult to get information about “their” women while they’re in Perth or Geraldton.
- There was consensus that to improve services for women, all parts of the system would need to work together better. Currently, there is a lack of communication between some parts of the system.
- Currently, the lack of shared information makes it difficult for different parts of the system to work together. For example, if an Aboriginal Medical Service (AMS) carries out a blood test, the local GP wouldn’t have access to those results.
- Lack of joined up IT systems [in Geraldton] is seen as a potential barrier to working together better. The possibility of sharing electronic records was discussed [by healthcare professionals].
- There’s a need for different professionals to discuss [maternity services] issues together so they can agree on best/safe care for the woman.

- The need for more streamlined and consistent “carrier information” - the documentation that women carry with them as they go between health professionals - was discussed.
- There was a suggestion that policy makers need to take a wide view and look at the whole family. It’s currently disjointed into women’s, men’s, children’s.

Choice of carer

- Some women expressed a preference not to have to see a GP throughout their pregnancy. They perceived it to be unnecessary given the level of intervention they required (i.e. taking blood pressure etc). They would prefer midwife led care. They felt the care they’d received from GPs so far wasn’t woman centred, “pushed” them into a medical model, and didn’t explain the full range of options that was available to them.
- The issue of financial incentives for GPs to be involved in antenatal care was discussed.
- The importance of trust in the woman/health professional relationship was discussed [by various health professionals] - that can be difficult to establish if there’s no previous relationship with the woman.
- [Some rural/regional health professionals commented that] there are currently no real choices in rural maternity services: women cannot give birth locally; they usually cannot choose which regional or metropolitan centre they’ll go to to give birth; there is no choice of service provider locally because of workforce shortages.

Workforce

- The fact that midwives do not get paid extra despite their additional qualifications (over nursing) was discussed on a number of occasions. The fact that many people self fund their studies was also discussed. It was felt by some that this was a disincentive to people entering midwifery.
- It was also discussed that help with affordable housing and improved access to transport may be an incentive for [regional] midwives.
- The role of community nurses was discussed [by health professionals] in the context of opportunities for an increased role in ante-/post-natal care.
- It was discussed [by some health professionals] that if doctors are only involved in complicated cases this could lead to lower job satisfaction and increased stress levels amongst that group.
- Because planned births do not happen in country areas, it means that local healthcare professionals may not have the necessary experience when it comes to emergency services.
- The transient nature of staffing in remote/rural areas presents a huge problem for consistency and continuity of service provision.
- There is a lot of pressure on rural/remote staff - “mental stress is a big problem”.
- It is very difficult to develop sustainable programs for change. Often, staff set them up and then they leave - sometimes because of the personal challenges they’ve experienced living in the town.

Planning

- The need to recognise that providing care closer to home will incur additional costs was discussed [by rural health professionals].

South-West

Choice

- There is minimal support for women once they have been discharged from hospital.
- Women want early discharge from hospital.
- Many women in the community would like to have a home birth.
- Community advocates believe continuity of care is paramount in maternity services planning.

Information and education

- Provision of clear, appropriate, timely and consistent information and education for both the community and health professionals on maternity care and services is essential.
- Big gap in post birth care at home.
- Encourage family planning to ensure that women and their families are educated and prepared for pregnancy, childbirth and parenting.
- Encourage women and their families to engage with local health care services to provide appropriate, timely and consistent information on maternity education and care.
- Increase the number of community centres and their involvement with the local midwifery teams to increase maternity care options available to women and their families.
- Provide 'fathercrafting' education for partners.
- Breastfeeding information should be provided in the antenatal period.
- Develop clinical guidelines on the use of water during birth.

Maternity Care and Services

- The community would like community midwifery to be more available.
- Develop programs for enrolled and registered nurses to provide breastfeeding and postnatal care support to registered midwives.
- The Bridgetown community is concerned about the increased incidence of home births. They are supportive of home birth as it meets the needs of mothers who don't wish to attend a hospital for their birth although they are concerned about the safety parameters for the mother and baby.
- Provide maternity services closer to home through easier access and transport to specialist services.
- Encourage women to take up home visiting services, as they are currently underutilised because families find the current model intrusive.
- Encourage a multi-disciplinary approach to maternity care.
- Rural and remote issues have not been considered.
- Provision of antenatal and preconception care in the community should be improved.
- Clearly state the duration maternity care is provided post birth.
- Develop guidelines for appropriate transfer and transport of woman and baby.
- PATS is inadequate and need to be reviewed as the criteria for use is unclear.
- Retrieval services need to be reviewed, particularly St John Volunteers Service.

Workforce issues

- A huge culture change will be required for registered midwifery led services within the region.
- The role of the enhanced midwife needs to be considered in the provision of maternity care.
- Embrace courses offered to professionals from non-government organisations e.g. Australian Breastfeeding Association.
- Provide insurance for registered midwives managing a home birth. Introduce credentialing of midwives for this procedure?
- Encourage antenatal led care by a registered midwife.
- Provide information on the Medicare Benefit Scheme available to the community and health professionals in rural and remote areas.
- Minimise the exclusion of Allied Health in maternity care.
- Consider the safety issues in regards to reduced maternity workforce and staff burnout due to work and stress.
- Develop initiatives to minimise the maternity workforce shortages i.e. up skilling current workforce, easier entry process into courses, HECS payment contributions, free courses, and accommodation for staff in rural and remote areas.

Wheatbelt

Choices

- There is limited support for vaginal birth after caesarian in this region.
- Limited maternity care options available in the region due to limited maternity workforce and medical flexibility. Maternity care options are poorly promoted hence women have minimal choice.
- Women need to be educated and empowered to seek choices in maternity care and services.
- Consistent information should be provided from health professionals to the community e.g. stillbirth and legalities surrounding this.
- Minimise family dislocation and separation by addressing issues such as transport, accommodation and locality of birth.
- There is a lack of choice for women in this region i.e. Northam Hospital issues.

Information and Education

- Improve education about pregnancy and childbirth in primary school i.e. education of available maternity choices, options of care, services etc.
- Improve the knowledge, education and information provided to women and their families with regards to availability of maternity services, options and care i.e. Perinatal Loss Service.
- Encourage women to breastfeed (recognise the WHO recommendations and guidelines identifying cultural sensitivities and needs).
- Education for consumers on breastfeeding inadequate.

Maternity care and services

- Shared care is difficult to access depending on proximity to Northam/Swan Districts Hospital.
- There is minimal support and encouragement of the family's involvement in childbirth i.e. this may leave women and families feeling isolated and disempowered.
- There are inconsistent practices in different settings for maternity care.
- Alternative maternity services should be developed and implemented i.e. Doula could assist vulnerable women and their families.
- The community supports the development of a birthing centre in the region.
- Strengthen interagency bonds i.e. between the child health, medical and midwifery fraternities.
- Workforce issues.
- Individuals queried the credentialing and upskilling of health professionals and accountability in maternity care.
- First trimester screening is not available under the Medicare Benefit Scheme.
- Midwives would embrace community care.
- Health professionals have positive attitudes and views towards the proposed shared care model.

- Big gap in the provision of lactation services i.e. funding required to support and train staff. It is suggested WA Health provides support and funding of an education program for lactation consultants.
- The follow up of the mother and newborn in the community post birth is very limited and inadequate.
- Health services should promote and implement Baby Friendly Hospital Initiatives (BFHI).
- Lack of equity in accessing maternity services and care.
- Access to shared care is non-existent with a GP and/or midwife.

Transport and accommodation

- Transportation of a sick baby to the metropolitan area leads to the dislocation of a family and accommodation issues. It is suggested that a Ronald McDonald House is funded and supported for these families.

Workforce

- Lack of midwives working at the hospital. There are midwives in the community although they are not in the workforce.
- Staff complained that they are burnt out.
- Recruitment is very difficult, if not almost impossible i.e. funding incentives may be required to attract another generation into the maternity workforce.
- The workforce is ageing with a number of GP and GP Obstetricians leaving the workforce.
- Acuity of patients makes working stressful.
- There is a problem with registering direct entry midwives, as they are not generalists.

Summary of the WA Health maternity survey

In July 2007, WA Health developed a maternity survey due to concerns that the draft maternity care policy was not adequately reflecting the public's view of preferred maternity choices and services in Western Australia. The majority of the responses to many community forums were from advocacy groups with particular perspectives and there was some concern that the views of Western Australian women may not be accurately reflected. The draft maternity care policy was meant to reflect the public's view of fair and preferred birthing choices as well as clinical feasibility and expertise and the lack of a population-based perspective was considered problematic. To address this gap, the WA Health maternity survey was conducted to ensure that the views expressed in the draft policy adequately reflect those of the public.

1511 women were interviewed by telephone and asked for their opinion about maternity care services in Western Australia (WA). The women were aged 16 to 50 years and women living in rural WA were over-sampled. The survey had a response rate of 86.8% and a participation rate of 97.4%. Specifically the objectives of the survey were to explore what maternity services women want and to determine whether the results of the survey are reflected in the initiatives outlined in the draft maternity care policy. The survey results only apply to women who have a telephone and can speak English, therefore they do not necessarily represent those women who are unable to speak English, do not have a telephone, or are Aboriginal and living in remote parts of WA.

The main findings of the survey are:

- Less than half of the respondents (45.9%) consider that women in WA are well or very well informed about the available options for maternity care.
- 67.3% of the respondents think that having the same doctor or midwife caring for them was very important and a further 20.4% thought it quite important.
- Almost all the women surveyed wanted a choice of where to have the baby (96.4%). If everything was going well 76.7% would choose to have their baby in hospital, 18.8% would choose to have their baby in a birthing centre and 4.1% would choose to have their baby at home.
- The proportion of women who would choose to have their baby in hospital rose to 96.8% if things were not going well.
- Nine out of ten women rated hospital births as very or quite safe. 70.5% of women thought that having a natural birth in hospital was very safe and 52.3% of women thought that having a caesarean birth in hospital was very safe.
- 32.9% of the women surveyed thought that a birthing centre was very safe and 45.1% rated it quite safe.



- Women who already had children were less likely to say that they would choose a birthing centre compared with women who did not have children.
- 74.8% of the women rated being looked after by an obstetrician as very safe and 20.0% as quite safe.
- 35.6% of the women rated being looked after by a GP as very safe and 36.2% as quite safe. If the care was by a GP team, 22.6% rated that as very safe and 33.1% as quite safe.
- 44.7% of the women rated being looked after by midwife as very safe and 38.0% as quite safe. If the care was by a midwife team, 34.1% rated that as very safe and 36.3% as quite safe.
- 11.1% of the women rated being looked after by family as very safe and 13.8% as quite safe.
- 98.3% of the women said that women should have the choice of who looks after them.
- As a personal choice of who to look after them from conception to just after birth 46.2% would choose an obstetrician to look after them from conception to just after birth. The main drivers of this choice were being resident in metropolitan WA, having private health insurance, thinking that Family Birthing Centres were either “somewhat/not very/not at all safe” and being older than 24 years.
- 17.7% would choose a GP and 3.9% a GP team to look after them from conception to just after birth. Choosing a GP or GP team was also related to living in the most disadvantaged socioeconomic areas as well as not being born in Australia and having less than a tertiary education.
- 20.1% would choose a midwife and 9.2% a midwife team to look after them from conception to just after birth. The choice of a midwife or midwife team was related to not having private insurance, not being born in Australia, thinking that Family Birthing Centres were very or quite safe and living in rural Australia.
- 2.4% would choose family to look after them from conception to just after birth.
- Women who were not born in Australia were more likely to choose a home birth as were women in more disadvantaged socioeconomic areas relative to the least disadvantaged socioeconomic area.
- Almost half of the women surveyed wanted to have the right choose a caesarean birth even if it is not medically indicated (49.5%), but given that choice would not choose a caesarean birth that was not medically indicated (89.4%).
- In contrast, women both want the choice to have a normal birth after having a caesarean birth (93.5%) and would personally choose to have a normal birth (78.7%).
- The only determinant of whether or not a woman would choose a birthing centre was whether or not she considered it to be safe. Even if women considered the birthing centre to be very safe, only 81.2% would choose it as an option and then only if it were on site at the local hospital. If it were off site, then only 36.3% would choose a birthing centre even if they rated it as a very safe option.

Telethon Institute of Child Health Research Evaluation of the Maternity Care Policy Development

The three-stage consultation process adopted during the development of Western Australia's maternity care policy has been independently evaluated as part of WA Health's improvement processes. The Telethon Institute of Child Health Research has conducted the independent evaluation of the consultation process.

Policy Development

The Maternity Care project team from the Health Networks Branch have assisted in the development of the maternity policy and coordinated the three-stage consultation of the maternity policy. The Maternity Reference Group, together with the Maternity Care project team, analysed the feedback from the consultation and redrafted the policy framework in light of this feedback. Major areas for priority action for the final policy include:

1. The community's desire to see maternity outcomes for Aboriginal women and their babies improved as a priority.
2. Low demand for home birth as a birthing option and then only for healthy pregnancies.
3. Women emphasising continuity of care as a greater concern than the location in which they give birth.
4. Women and health professionals both place safety for women and their babies as the highest priority in the delivery of maternity care.
5. Education and improved provision of information on maternity care services and options of care available state-wide and within the WA Health regions.

The policy framework titled "Improving Maternity Services: Working Together Across Western Australia" reflects these priorities. The Women's and Newborns' Health Network will lead the implementation of the policy framework in collaborative partnership with all sectors of WA Health and other government organisations. The policy framework contains seven goals which have specific objectives to address the issues and assist with the implementation. The Area Health Services will remain responsible and accountable for the planning, implementation and the delivery of maternity care services within their region.



 Department of
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Women's Health Services
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