

# Improving Maternity Services: Working Together Across Western Australia

A Policy Framework



Delivering a Healthy WA



## Message from the Minister



It is with great pleasure that I present to you *Improving Maternity Services: Working Together Across Western Australia - A Policy Framework*.

Improving the way maternity care is delivered in Western Australia is an important priority for the Government of Western Australia. The Western Australian Government is committed to developing services in collaboration with the community. It may appear to some that this policy has been a long time in the making but we wanted to ensure that this policy truly reflects the needs and aspirations of the Western Australian community and focuses adequate attention on those groups within our community who most need our help.

The policy framework is a sound example of this Government's commitment to consulting the community on the future directions for our essential services. The statewide consultation, which commenced in November 2005, included special events, media coverage, public meetings, one on one discussions, focus groups and a telephone survey. From Kununurra to Esperance, from Carnarvon to Warburton, community members and health care professionals were encouraged to share their views on maternity care and what was important to them.

Pregnancy, childbirth and early parenting are an important and significant time in a family's life. Most families anticipate pregnancy and childbirth to be a healthy and joyful process, however, when things go wrong they can have disastrous consequences for families if access to specialist care is not within easy reach. For this reason, many women in Western Australia have to leave their community to give birth in a place that is within easy reach of specialist services. This places a great burden on many women and their families. This Government acknowledges its role in ensuring the availability of adequate housing, accommodation and transport services to support these women and their families and is exploring innovative ways to improve this vital infrastructure.

This policy is focused on women and their babies and will see a move to more accessible and safe services for all women across Western Australia. It places a high priority on improving outcomes for Aboriginal women and their babies. It moves away from a hospital based, medically focused model of care toward community based primary care services that are closer to people's homes. Better information about pregnancy and childbirth and a focus on developing a workforce that makes best use of skills rather than being limited by traditional professional boundaries are key themes that I believe will invigorate and strengthen maternity care services in Western Australia for many years to come.

A handwritten signature in black ink, which appears to read 'Jim McGinty'.

Hon Jim McGinty  
Minister for Health

## Message from the Director General



This new Policy Framework for Western Australia has been developed over a long period of time and has included input from women and health professionals from all over the state. The Maternity Reference Group, whom I would like to thank personally, has assisted in the drafting of the policy. I would also like to acknowledge all the Area Health Service staff and community members who took the time to give us their views.

This policy is designed to offer guidance to all those involved in developing and delivering maternity care services. It seeks to improve outcomes for women and their babies by focusing on safety and improving options for pregnancy and childbirth. It reflects women's desire to have an enriched and positive experience through their pregnancy, childbirth and post birth experience. The key themes of safety, continuity of care, information and communication arising from the consultation are clearly reflected in this framework, in conjunction with objectives and strategies that will assist WA Health in the important task of implementing the framework.

Western Australia is one of the safest places in the world to give birth. It is important to maintain this level of safety and give choice to women in childbirth without high levels of intervention. The community and health professionals need to recognise that pregnancy and childbirth is a normal physiological process for most women. Whilst we in Western Australia have very good health outcomes for most mothers and babies, there are some groups within our community where outcomes remain alarmingly poor. This is a particular concern within our Aboriginal community. The framework has placed improving outcomes for the Aboriginal community as its first priority.

A move toward primary care services for healthy women, with a focus on access to specialist services when required, will ensure that maternity services become more woman centred and sustainable. The models of maternity care presented in this framework acknowledge the important roles of each team member and focus on how best to use their skills, whilst acknowledging the need to be more flexible and creative in how we deliver services to women in rural and remote areas.

This Policy will guide the development of maternity services over the next five years. It has been the result of one of the most comprehensive consultation processes ever undertaken by WA Health and I am confident that this new policy framework truly reflects the views of the Western Australian community and those health professionals who provide maternity care.

A handwritten signature in dark ink, reading 'Neale Fong'.

Dr Neale Fong  
Director General

## Acknowledgements

This policy framework is the result of contributions from a large number of organisations and individuals, from across the WA health system and in the community. We would like to thank them for their time and thoughts.

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### Health Networks Branch (Maternity Care Project Team):

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## Executive summary

*Improving Maternity Services: Working Together Across WA* provides a policy framework for maternity services over the next five years. It is the result of significant consultation with the community and health professionals in Western Australia (WA). The framework draws together the evidence in relation to best practice, community expectations and aspirations, as well as the needs of the workforce who are instrumental in providing maternity care.

Birth rates continue to rise in WA and our current workforce projections indicate that we cannot continue to organise services in the same way if we are to provide a quality maternity service in the future. The framework reflects the following themes:

- Pregnancy and childbirth are usually normal physiological events
- Safety for women and babies is paramount
- Continuity of care is critical for quality services
- Maternity care should be community based wherever possible
- Disparities in health outcomes should be minimised.

**The overall goal of the framework is to maintain a high standard of maternity care for all women and their babies whilst particularly focusing on the following themes:**

1. Improve health outcomes for Aboriginal women and babies.
2. Improve the health and wellbeing of women and their unborn babies through better preconception and early pregnancy care.
3. Improve women's experience of pregnancy.
4. Improve women's experience of childbirth.
5. Improve the health and development of infants and address the needs of new parents.
6. Improve safety and accountability in all maternity services.
7. Improve the sustainability of the maternity care workforce and promote clinical leadership and collaboration.

These goals are supported by objectives and strategies that will assist policy makers and service providers in reaching these goals. There are many examples of good practice in WA and some of these stories are presented within this document.

The framework presents several models of maternity care that research literature and practical experience demonstrate are safe and effective within certain contexts and are achievable with the current maternity workforce. A move to increase community based maternity care with greater emphasis on continuity of both care and carer are reflected within the models. An attempt has been made to present models that are known to assist in delivering services that are efficient, effective and acceptable. The models of care are presented to assist Area Health Services to continue to develop a range of maternity care options in consultation with their local communities.



The workforce challenges ahead for WA should not be underestimated. It is hoped that a move toward more woman centred care in the community will allow midwives to fully utilise their skill base and will attract non-practising midwives back into the workforce, as well as encourage others to take up this profession. Recognition of the vital role general practitioners (GPs) and GP obstetricians play in the provision of maternity care needs to be further supported by tangible approaches, such as increasing the availability of clinical training positions and providing opportunities for this workforce to maintain and regularly update their skills. Better use of our highly specialised services across the state will also allow the use of our resources in the best way possible to ensure that women and their babies get the safest, most effective, efficient and appropriate care.





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## Introduction

*Improving Maternity Services: Working Together Across WA* identifies fundamental changes to the current structure and culture of maternity services in WA. These changes have been identified to better reflect the needs of women, babies and their families.

Most public pregnancy care in WA is provided at hospital clinics or in GPs' private rooms and the majority of babies are born in hospital (Maternal and Child Health Unit, 2005). At present, there are limited maternity care options available for women, including only one midwifery-led birth centre in the state and one publicly funded community based homebirth midwifery service. Provision of antenatal, postnatal and newborn care occurs within a range of settings including community health centres, general practice, hospital outpatients and private consulting rooms.

This policy framework aims to expand options for maternity care in WA, enabling more choice and greater continuity of care for a woman and her family. The aim is to shift the focus from highly medicalised, hospital based maternity models of care towards a greater emphasis on community based primary maternity services. This will provide greater options in pregnancy and birth for healthy women with low risk pregnancies outside the current secondary and tertiary hospital system. This shift has been ignited by the community's desire to have a greater say in how and where services are delivered as well as recognition of the significant challenges we face in increasing the workforce supply and sustainability, and curbing the increasingly high rates of medical interventions (Select Committee into Obstetric Services, 2007).

**The policy framework incorporates seven main goals in the areas of:**

- 1. The health of Aboriginal women and babies**
- 2. Preconception and early pregnancy**
- 3. Pregnancy**
- 4. Childbirth**
- 5. Newborn care and parenting**
- 6. Safety and quality**
- 7. Leadership and collaboration.**

WA Health aims to develop, deliver and provide maternal and newborn services that are safe, integrated, effective, and responsive to the individual needs of women and their babies in their community setting. The newly established Women's and Newborns' Health Network will oversee the implementation of this policy in collaboration with the Area Health Services. This policy will enable realignment of services for improved equity and access to maternity services and ensure continual improvement of maternity care in WA.

## Donna's Story

For whatever reason our baby decided he was going to be born on New Years Eve, a whole 13 days before the estimated date. Being from Newman, where no birthing services are available, I did some research and a friend told me about the Family Birth Centre (FBC) in Subiaco. How happy was I when I found that I could have a shared care arrangement between the community midwife, my GP and the FBC? As I wasn't expecting to go into labour for a couple of weeks yet, we were holidaying two hours away from Perth. When I thought I was in labour, I called the Family Birth Centre. Their instruction was to arrive as soon as possible, no detours or alternative routes.

Wow. The last day of the year and I was going to give birth to our baby. We were going to meet this soul that had been entirely dependent on my body for the previous 38 weeks - I was excited. My calmness was due to the mental preparation during my pregnancy. Antenatal classes helped me prepare for what was ahead and enabled me to understand what my body was going to experience. I understood that feeling pain was a good thing. It meant that endorphins (natural pain killers) were being released through my body. Making the choice to experience a labour without drugs seemed logical. Being gentle to my body and mind could only be a benefit to my baby.

A midwife greeted me when we arrived at the Family Birth Centre. I jumped out of the car hugging my pillow. I looked like an excited and energy filled little girl going to her first sleepover. The midwife was surprised to see me so zestful! Not before too long our baby wiggled out for us both to see. My goodness how surreal! Matty and I looked at each other and then at our baby. I didn't know what to do except look. We were finally meeting our little boy.

Matty was soon on the telephone to our mums and the celebrations began. I was learning to breastfeed and felt in top condition, ready to go home. I started drinking my fennel tea. Within three days Fionny was drinking my milk. New Year's Eve and Matty and I curled up together while our little man lay snoozing in the crib beside our bed. There were party celebrations and fireworks all around the city - everyone had a reason to celebrate, ours being the beginning of our journey as a family.



## Background

*Improving Maternity Services: Working Together Across WA* is the product of a detailed statewide consultation with the community and health professionals. The policy has built on past recommendations from WA reports including;

- *The Douglas Report* (Douglas, 2001)
- *The WA Statewide Obstetric Services Review* (Cohen, 2003)
- *The Health Reform Committee Report* (Health Reform Committee, 2004)
- *The Clinical Services Framework* (Health Reform Implementation Taskforce, 2005)
- *The Future Directions of Maternity Care discussion document* (Health Policy and Clinical Reform, 2006)
- *Improving Maternity Choices - Working Together Across WA: A Draft Policy* (Health Policy and Clinical Reform, 2007)
- *Models of Maternity Care: A Review of the Evidence* (Henderson et al., 2007).

Copies of these reports are available on the Women's and Newborns' Health Network site [www.healthnetworks.health.wa.gov.au](http://www.healthnetworks.health.wa.gov.au)

## The statewide draft maternity policy consultation

WA Health is committed to involving the community and health professionals in identifying the key issues, needs, concerns and solutions in maternity care. The maternity care consultation was a three-stage process, which commenced in November 2005. Stage one included consultation with health professionals and the Health Consumers' Council in the development of the initial discussion paper "Future Directions in Maternity Care". Stage two consisted of the release of the discussion paper to the public for comment. The third and final stage of development has been the most comprehensive. It included:

- Commissioning an independent review of the research literature on models of maternity care
- Development of the draft policy "Improving Maternity Choices: Working Together Across WA" and its public release for comment
- Focus groups with health professionals
- Community forums
- Attendance at Aboriginal forums and bush meetings
- One on one meetings with key stakeholders
- Statewide telephone survey (over 1500 women between the ages of 16 and 50)
- Telephone hotline, teleconferences, videoconferences
- The convening of the Maternity Reference Group to assist in guiding the policy development
- Development of the Maternity Consultation Report.

Throughout the three stages of the consultation, submissions were received in a variety of formats, including 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 as far north as Kununurra, east to Warburton and as far south as Esperance to maximise the ability for the community to have their views heard.

## Key themes

Key themes arising from the consultation which form the principles upon which this policy framework is built include:

- Pregnancy and birth are normal physiological life events.
- Equitable, safe, high quality, evidence 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 aimed to provide continuity of carer.
- Maternity care will be woman and family focused, offer appropriate choice and support, and will be accessed 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 will be developed, strengthened and supported.

Other key issues arising from the consultation include:

1. The general lack of community knowledge of the roles that different health professionals have in delivering maternity services and how to access services.
2. The need for women to understand that some birthing options, as well as some highly specialised antenatal and postnatal screening, treatment and management services, cannot be offered close to home due to geographical and workforce constraints.
3. The need for women to have informative, appropriate and consistent information about maternity care in order to make informed choices.
4. The impact that transfer to a large centre to give birth has on the family and community and the importance of ensuring that accommodation and transport services adequately support women and their families to minimise the impact of social dislocation.
5. The role of the non-government sector in providing advocacy, support and education services to women and their babies and the need to acknowledge this role and strengthen partnerships with such organisations. These include Ngala, Australian Breastfeeding Association, Red Cross, Aboriginal Medical Services and Birthrites: Healing After Caesarean Inc.

## The Maternity Reference Group

The principal role of the Maternity Reference Group (MRG) is as a reference and advisory group to the Department of Health (DoH). The group 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 policy, based on the independent research report findings and other supporting evidence provided by respondents to support their recommendations or views. Overall the MRG has formed an agreed stance on the policy directions for the development of maternity care in WA that is women and family focused, safe and high quality, accessible, sustainable and effective.

The maternity consultation, MRG, 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 and fetal outcomes depend upon the health of the woman prior to conception as well as excellence of care in the antenatal, birthing and postnatal period. 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, childbirth and postnatal period (Department of Health/Partnerships for Children, Families and Maternity, 2007).

### Nichola's story

We were a little apprehensive as this was our first experience of the maternity care system in Australia. Our first two girls were born in the United Kingdom. I visited Kaleeya for the first time as an antenatal patient about six months before my due date. I was thoroughly impressed at the Kaleeya open day by the staff, tour, presentation, and the quality of the facilities. All of my questions were answered. Due to the apparent high standards of the maternity team, I was certain that I wanted to have my third child at Kaleeya.

My appointments with the GP obstetricians and midwives were pleasant and well managed. I always felt that I received the appropriate level of care. The Kaleeya staff were always accommodating, professional and flexible when arranging my appointments.

Things moved very quickly on the night of my baby's birth, and the ward team gave me excellent advice and reassurance - not to mention encouragement. My family and I were made to feel very welcome from arrival. We enjoyed a very private birthing experience with the amazing support of two fantastic midwives! Our son was born a healthy 3.8kg with no complications and his two big sisters were welcomed onto the ward within the hour to meet their new little brother! When recovering I was given time and support to establish breast feeding and no one ever made me feel that they were too busy to help. I found sharing a room to be a positive experience and enjoyed the opportunity to receive and give mutual support and also meet another new mum.

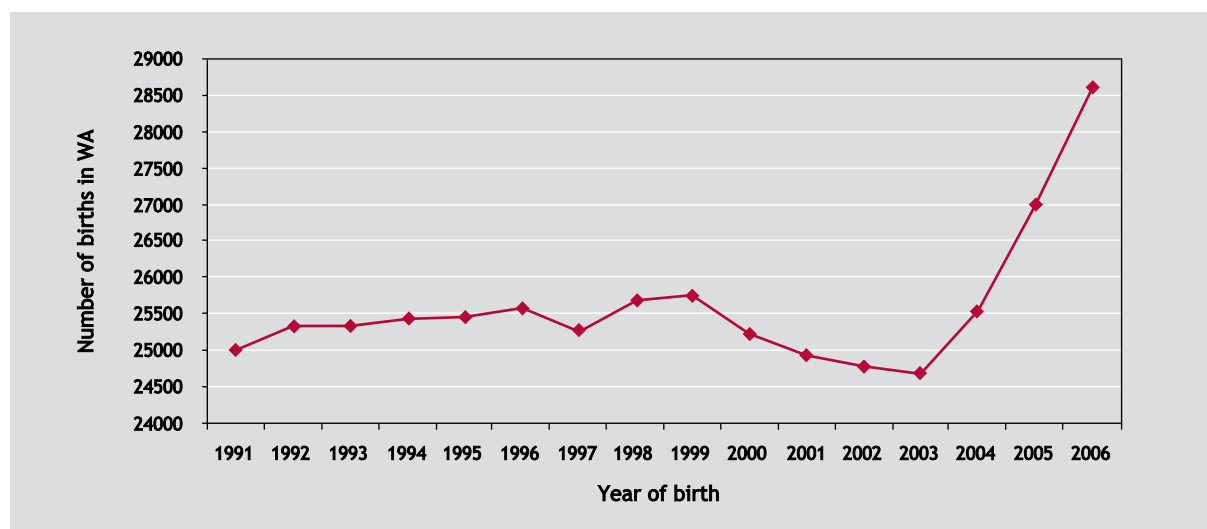
My follow up care after discharge was exceptional. I had free and ready access to visiting midwives and a lactation consultant who helped me through some difficult and emotional times. My first birthing experience in Australia was extremely positive and I thoroughly recommend Kaleeya. I am very grateful to the whole maternity team for providing me with such a high standard of care.

## The state of play in WA

### Number of births

In 2006, 28,587 women gave birth in WA. This shows a substantial increase compared to 23,601 live births in 2002. Figure 1 below shows the annual number of births has been increasing steadily since 2002.

**Figure 1. Trends in the number of births for Western Australia, 1991-2006**

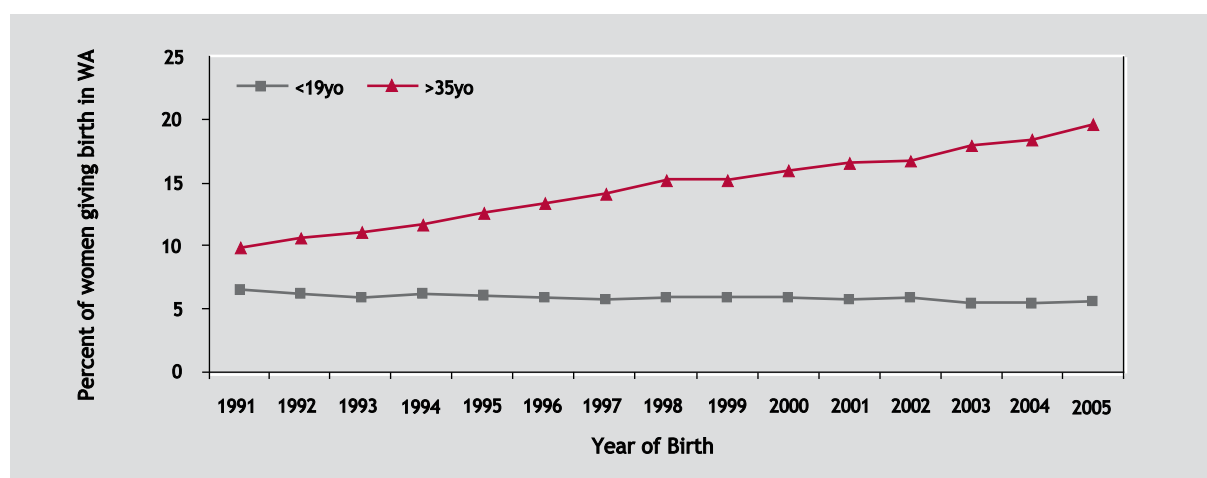


(Source: Maternal and Child Health Unit, 2006).

### Age of mothers

The ages of mothers in 2005 ranged from 12 to 49 years, with an average mother's age of 29.4 years. Figure 2 depicts that over the last 15 years the percentage of mothers aged 35 years and over has increased noticeably, while the proportion of teenage mothers has remained relatively steady.

**Figure 2. Trends in maternal age in Western Australia, 1991-2005**

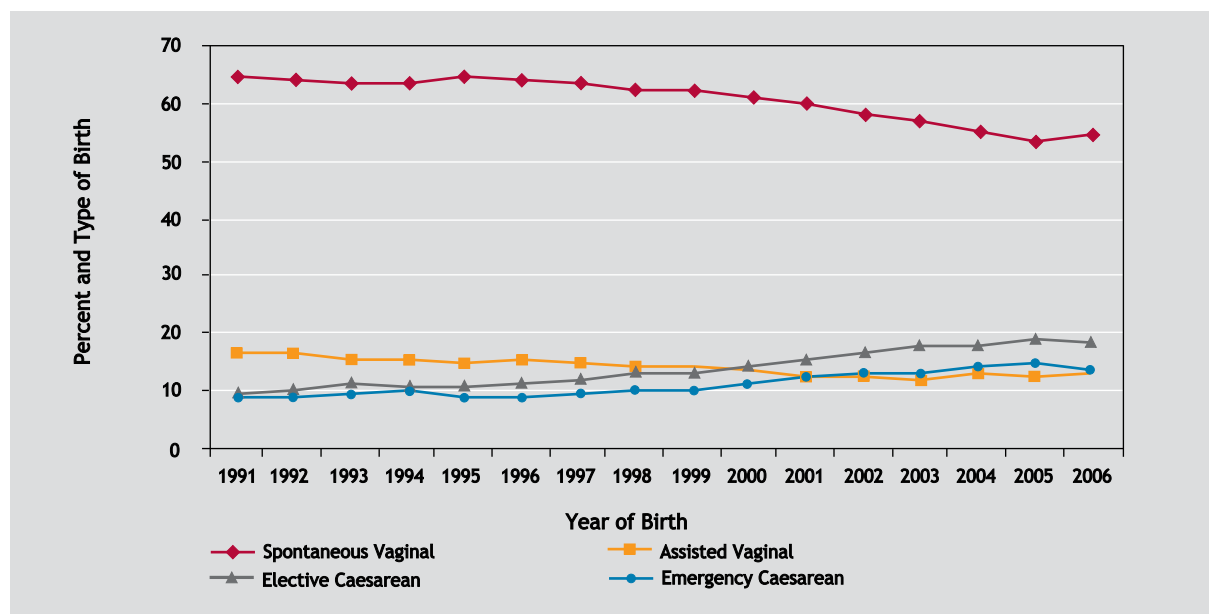


(Source: Maternal and Child Health Unit, 2005).

## Interventions

The types of delivery for women in WA has changed in the last 15 years. Figure 3 shows an increasing number of babies delivered by caesarean section, with a noticeable increase in elective caesarean sections. Over the same period, the number of spontaneous vaginal deliveries has decreased.

**Figure 3. Type of birth for women who gave birth in Western Australia, 1991-2006**

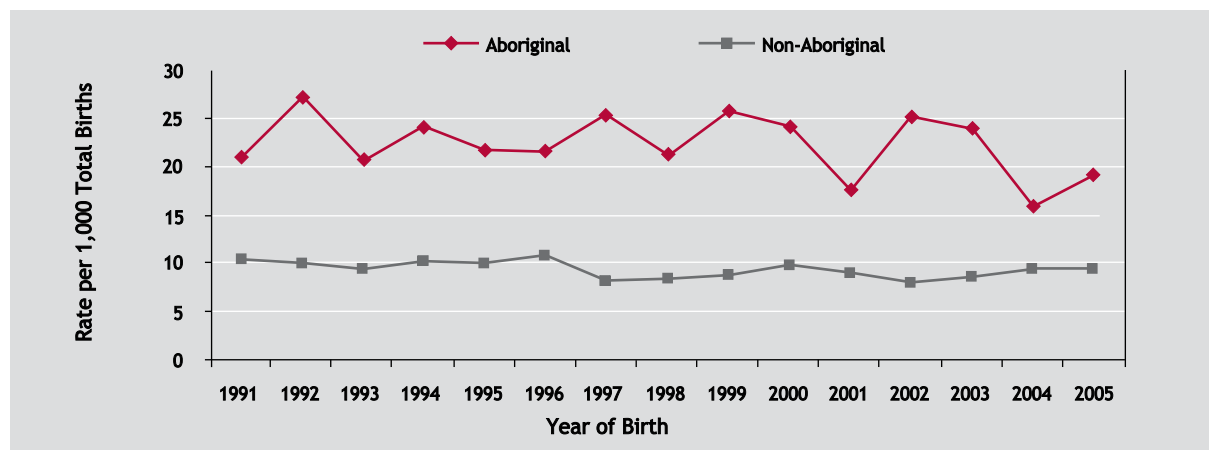


(Source: Maternal and Child Health Unit, 2006).

## Perinatal mortality

In 2005, 273 perinatal deaths at 20 weeks or more gestation were recorded (200 fetal and 73 neonatal deaths). This represents a perinatal mortality rate of 10.1 per 1000 total births. The perinatal mortality rate continues to be substantially higher among babies of women identified as Aboriginal than for those of non-Indigenous women.

**Figure 4. Perinatal mortality by Aboriginality in Western Australia, 1991-2005**



(Source: Maternal and Child Health Unit, 2005).



### Low birthweight

Birthweight is an important factor affecting the survival of the baby. In 2005 the percentage of low birthweight babies born to Aboriginal women was twice that of babies to non-Indigenous women.

**Table 1. Birthweight distribution and Aboriginality of mother for births in Western Australia, 2005**

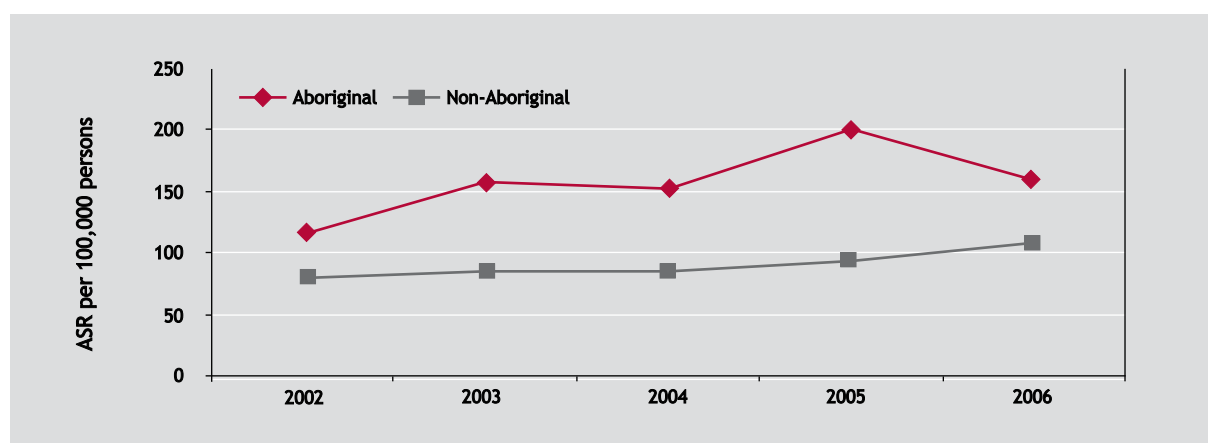
Birthweight (grams)	Aboriginality of Mother				TOTAL	
	Aboriginal		Non-Aboriginal			
	No.	%	No.	%	No.	%
<500	11	0.6	103	0.4	114	0.4
500-999	22	1.3	110	0.4	132	0.5
1000-1499	31	1.8	144	0.6	175	0.6
1500-1999	50	2.9	312	1.2	362	1.3
2000-2499	170	9.9	962	3.8	1132	4.2
< 2500	284	16.5	1631	6.5	1915	7.1
2500-2999	424	24.6	3987	15.8	4411	16.3
3000-3499	563	32.7	9223	36.5	9786	36.3
3500-3999	325	18.9	7694	30.4	8019	29.7
4000-4499	110	6.4	2367	9.4	2477	9.2
≥ 4500	16	0.9	368	1.5	384	1.4
TOTAL	1722	100.0	25270	100.0	26992	100.0

(Source: Maternal and Child Health Unit, 2005).

### Gestational diabetes

Between 2002-2006, the rate of births to women with gestational diabetes was 70% higher in the Aboriginal population than that of the non-Indigenous population.

**Figure 5. Age-standardised birth rates for women with gestational diabetes in Western Australia, 2002-2006**



(Source: Department of Health WA, 2007).

## The seven goals to improve maternity care

### Goal 1: Improve the health outcomes for Aboriginal women and babies.

WA Health recognises that often the needs of some women, particularly Aboriginal women, are not being met by the current system. There is also evidence to indicate that general maternal and baby services may not provide adequate care and assistance to this population.

Child bearing occurs at an earlier age among women who are identified as Aboriginal. In 2005, Aboriginal women represented 6.4% of all women who gave birth; the birth rate was noted to be almost twice as high as for non-Indigenous women. Among births to teenage mothers, the proportion of Aboriginal mothers was seven times greater than that for non-Indigenous women. These figures highlight major issues, particularly with the noted association of the increased risk of premature birth and low birth weights associated with births to adolescent mothers. Adolescent mothers, some of whom experience social disadvantages and low self-esteem, may also demonstrate associated risk taking behaviours such as smoking and alcohol and drug use during their pregnancy (Maternal and Child Health Unit, 2005, NSW Department of Health, 2003).

WA Health recognises that Aboriginal women tend to have larger families, with the percentage of Aboriginal women having five or more children being eight times greater (11.3%) than non-Indigenous women (1.3%) (Maternal and Child Health Unit, 2005). The combination of large families in the Aboriginal population and the increased number of at risk pregnancies, places an overwhelming challenge to health improvements for Aboriginal people. Poor reproductive health in Aboriginal women and the high number of at risk pregnancies can be related to co-morbidities, poverty, alienation and social disruption (NSW Department of Health, 2003).



Perinatal mortality and low birth weight are key indicators of a population's health status and are affected by the standard of living and the level of health care provided. The perinatal mortality rate in 2005 for babies of Aboriginal mothers was 19.2 per 1000 compared with a rate of 9.5 per 1000 for babies of non-Indigenous women. Of concern are the fluctuations in perinatal mortality rates for babies of Aboriginal mothers over the past 15 years (Maternal and Child Health Unit, 2005).

From a geographical perspective in 2005, 36.0% of Aboriginal people resided in the metropolitan area and 63.9% resided in non-metropolitan areas within WA (Maternal and Child Health Unit, 2005). Dislocation of Aboriginal women from their families during pregnancy, childbirth and during the postnatal period has also been identified as a barrier to maternity care and service provision. To provide optimal care for mother and baby, in many rural and remote areas, Aboriginal women need to travel to major regional centres for delivery. However, this necessitates separation from family, community and country during this important time in their lives.

In order to improve the health outcomes of Aboriginal women and babies, WA Health supports and encourages the development of strong, cohesive Aboriginal communities with:

- Empowerment and education of Aboriginal women and families
- Improvement in living standards for Aboriginal families
- Holistic, accessible, culturally appropriate and safe maternity services and health promotion programmes (NSW Department of Health, 2003).

Holistic health comprising of spiritual, cultural, social and emotional wellbeing, environmental and economic health must be addressed to improve generational changes in maternal and child health for the Aboriginal population in WA. WA Health endorses research findings and recommendations in the *Stolen Generations Report*; *WA Aboriginal Cultural Security Implementation Framework*; *Bringing Them Home*; and the *Western Australian Aboriginal Child Health Survey* and supports their use in reconciliation in WA Health for the Aboriginal people and the Australian populations (NSW Department of Health, 2003).

**WA Health aims to improve health outcomes for Aboriginal women and babies through the following areas:**

## Objective 1.1

Improve the cultural appropriateness of mainstream maternity services for the Aboriginal population.

### Strategies

- Provide a collaborative and multidisciplinary team approach to maternity care for Aboriginal women and their families involving midwives, Aboriginal health workers, medical specialists, and GPs.
- Support and instigate Aboriginal cultural awareness education and training for all maternal health care providers.
- Improve access, referral processes and the provision of transport services to Aboriginal women and their families within their communities.
- Establish links with language centres and work in partnership with Aboriginal Medical Services (AMS), Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal community groups to ensure that culturally appropriate services are provided and developed.

- Ensure that the maternity team providing care to Aboriginal women and their families:
  - Supports nutritional and traditional food practices and healthy nutrition
  - Promotes and teaches positive parenting
  - Promotes Aboriginal maternity care as individualised, woman and family focused
  - Provides information on maternity services and offers choices
  - Delivers outreach and home visiting services within their communities

### South Coastal Women's Health Services (SCWHS)

This service provides antenatal and postnatal services that are culturally focussed and delivered through clinics or by home visits as per the client's choice. The locations of these clinics, ease of access and the need for transport assistance was given much consideration. This service works in partnership with other services and agencies, adding capacity and enhancing services, and offers a more comprehensive model of care. This personalised service ensures continuity of care for the client is delivered in a relaxed and informal environment. The service operates an open appointment system that is not rushed. It has a fully equipped crèche, staffed by childcare workers and this area is also utilised as the waiting room and an opportunity for parent education. Care is provided by Aboriginal health workers, midwives, female GPs, mothercraft nurses, and Aboriginal counsellor/educators (South Coastal Women's Health Services, n.d.)

*"I was very surprised by the support given to me at the clinic; they helped me to adjust to my pregnancy, they were very supportive and organised. The clinic is in a very convenient place and having transport available was a great help. Another good thing is that you are seen quicker than if you were in a doctor's surgery and having Aboriginal health workers is good because often places don't have any Aboriginal staff."* Quote from a woman who used SCWHS

#### Objective 1.2

Recognise Aboriginal cultural kinships as the basis of relationships, roles and responsibilities within Aboriginal communities.

#### Strategies

- Establish and support processes whereby grandmothers can contribute in a meaningful way to maternity care through mothercrafting in order to improve the social and emotional health and wellbeing of mothers and babies.

Objective  
1.3

Establish new and support existing culturally appropriate educational programs and antenatal services for Aboriginal adolescents.

**Strategies**

- Increase access to contraceptive services to allow informed choices about contraception for adolescents.
- Support school education programs and packages on pregnancy, childbirth and parenting to Aboriginal adolescents.
- Provide information and counselling about sexually transmitted diseases.
- Develop a culturally appropriate system of antenatal follow up for Aboriginal women and their families who do not regularly attend antenatal services.
- Develop and support the use of a perinatal psychosocial screening tool for Aboriginal women to assist in identifying mothers and infants at risk of a mental illness.
- Establish new and support existing culturally appropriate community peer education programs and antenatal services for Aboriginal women and their families (especially adolescents).
- Support existing and pilot new models of primary maternity care provided by ACCHOs and seek opportunities for greater collaboration and partnership with mainstream services.

The peer education program will create support networks for women (and families), improve resources and information on maternity care, and provide links for communities to available health services. Peer education programs would include:

- The development of Aboriginal-designed resources on pregnancy, labour and birth and infant health.
- The development of an Aboriginal-designed adolescent pregnancy awareness and contraception program.
- The development of an Aboriginal-designed substance abuse, alcohol and smoking reduction or cessation program.



#### Objective 1.4

Establish and develop sustainable Aboriginal women's and maternity programs in conjunction with local Aboriginal health partnerships to effectively address the risk factors associated with Aboriginal perinatal mortality and morbidity.

#### Strategies

- Develop models of care that will reduce Aboriginal perinatal mortality and low birth weight rates.
- Support existing and develop new pilot models of maternity care provided by AMSs and ACCHOs, and seek opportunities for greater collaboration and partnership with mainstream services. An example of this is the partnership between the Geraldton Aboriginal Medical Service and Geraldton Hospital.
- Explore the applicability and opportunities for extending the Strong Women, Strong Babies, Strong Culture program within WA.

#### “Strong Women, Strong Babies, Strong Culture” program

This program was initially established in the Northern Territory and, following evaluation, was found to have profound effects in improving birth weight and the health of mothers and babies in those communities participating in the program. The program has been implemented in the Pilbara, Kimberley and Midwest Health regions to improve maternal health for Aboriginal women. The program relies on and supports senior women in participating communities to provide direct support to pregnant women and their families. The senior women encourage attendance at antenatal care clinics and provide advice on nutrition. Connections and support for involvement in cultural events are important parts of the program. This particular program is one that has a strong community development focus and potentially major health benefits to Aboriginal people. This has a long-term outlook with lasting benefits rather than only treating immediate health problems (St John of God Health Care, 2007).

#### Objective 1.5

Increase the recruitment and development of Aboriginal health workers and Aboriginal people employed in community health services to provide culturally appropriate services and continuity of care for Aboriginal women and babies.

#### Strategies

- Educate and provide training for Aboriginal primary health care workers to support women with mental health issues.
- Ensure Aboriginal health workers are members of the maternity health care team.
- Support the accredited maternal and child health education program for Aboriginal health workers.

- Support the implementation of cultural language interpreters to improve communication and continuity of care.
- Establish stronger linkages between sexual health workers and other health care providers to improve the screening and contact tracing systems for Aboriginal women and babies.
- Support and establish bereavement counselling services for Aboriginal women in partnership with Aboriginal communities.

## Objective 1.6

**Improve the partnership between Area Health Services and Aboriginal Community Controlled Health Organisations (ACCHOs).**

### Strategies

- Improve the integration of maternal health services for Aboriginal women by developing appropriate regional maternity networks within each centre and country town.
- Improve liaison between Aboriginal women and health care providers at a local level.
- Support active participation of local Aboriginal women and communities in the development and evaluation of Aboriginal maternal health services.

## Objective 1.7

**Increase opportunities for research and evaluation of programs and improve capacity in achieving outcomes, sustainability and promotion of evidence-based practice.**

### Strategies

- Establish research programs to determine what factors may influence poor utilisation of pregnancy care among disadvantaged women in WA.
- Establish culturally appropriate educational programs on sexually transmitted diseases, pregnancy prevention for adolescents, and the long-term effects of adolescent parenting.



## Goal 2: Improve the health and wellbeing of women and their unborn babies through better preconception and early pregnancy care.

It is important to recognise that pregnancy and childbirth, while requiring timely and highly specialised responses when complications occur, are normal physiological processes and not diseases. Planning and preparation for pregnancy with an emphasis on good health and consistent support from professionals will benefit the woman, her unborn baby and her family. It will empower women and their families to make choices that are safe and meet their needs (Department of Health/Partnerships for Children, Families and Maternity, 2007, Department of Health England, 2004, Department of Health Scotland, 2001).

Perinatal screening services offered in WA need to be evidence based with equity of access. Women need to have consistent, adequate and appropriate information about screening services in order to make informed choices (Department of Health/Partnerships for Children, Families and Maternity, 2007). There are several specialist services based at WA's only tertiary maternity hospital, King Edward Memorial Hospital (KEMH). These include specialist high-risk pregnancy and antenatal diagnostic ultrasound services and the perinatal loss service. Promotion of, and appropriate referral to, the specialist support services offered at KEMH will improve a woman's well-being and allow women to access early pregnancy support, especially if they have had previous pregnancy complications i.e. recurrent miscarriage or late pregnancy loss. This referral enables women's access to advice and counselling services including psychological, genetic, social support and other appropriate follow-up services (Department of Health/Partnerships for Children, Families and Maternity, 2007, AHMAC, 2006).

The continuing rise in obesity is of particular concern in pregnancy. Not only does being overweight or obese impact on a woman's ability to conceive, it also increases the chance of serious health issues for both the woman and her baby during pregnancy. Up to 9% of women develop gestational diabetes, with higher rates found in those women who are obese. There is a requirement for all health providers to be aware of the need for promotion of a healthy weight prior to pregnancy, the importance of a healthy diet and exercise throughout pregnancy, early detection of complications and appropriate referral to specialist services when required (Draper et al., 2005, Katzenellenbogen et al., 2003, Sebire et al., 2001, Galtier-Dereure et al., 2000).

### Objective 2.1

Encourage and empower all women of reproductive age to be as healthy as possible.

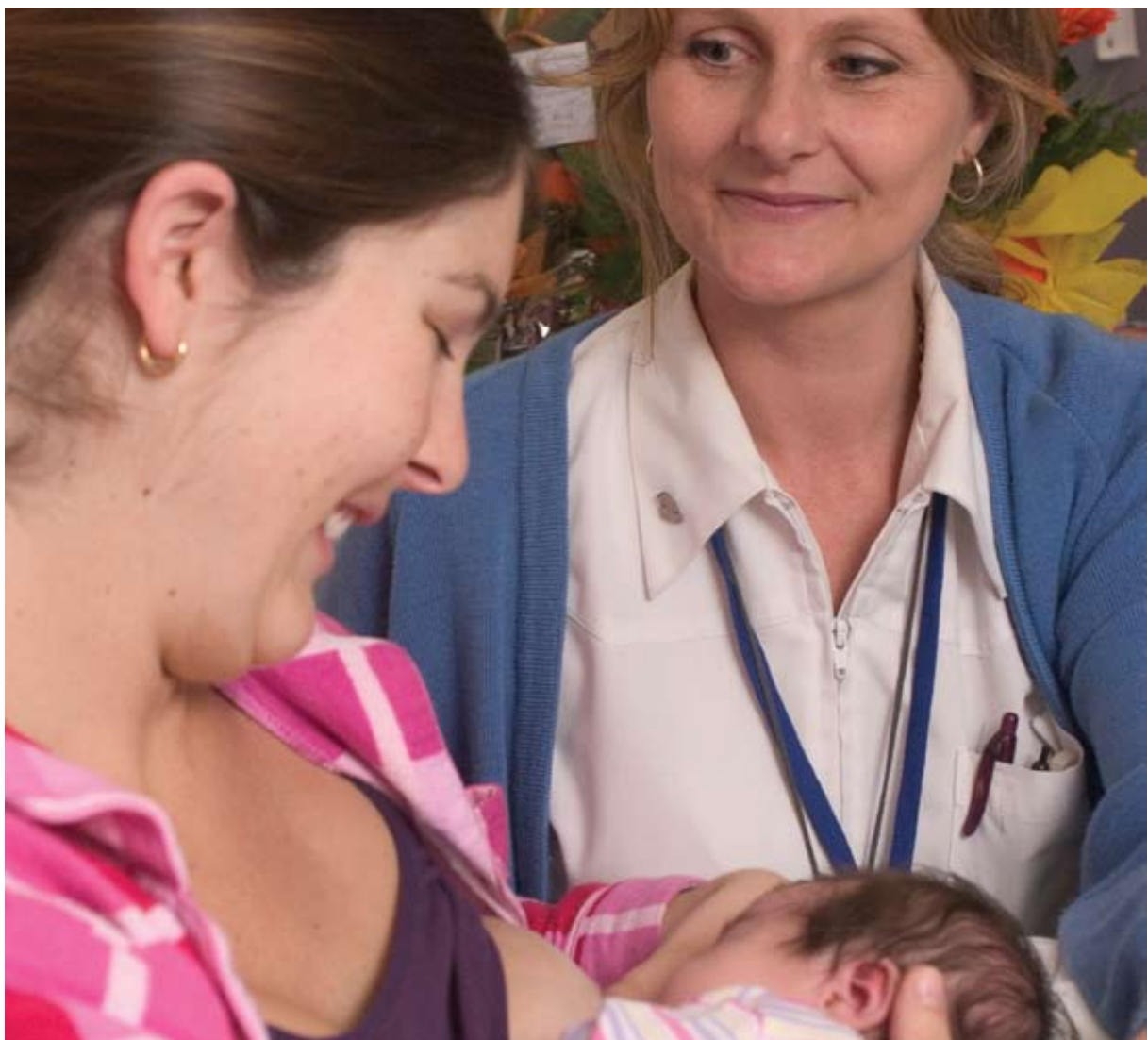
### Strategies

- Strengthen partnerships and collaboration with the Department of Education and Training, school health services and other health care providers to promote health and wellbeing of school aged children and adolescents as a priority.

- Develop DoH information packages which include “branded” evidence based literature promoting exercise, optimal nutrition, smoking and alcohol prevention, and healthy living prior to and during pregnancy, ensuring they are freely available to all women of reproductive age.
- Promote and support primary health care teams (including GPs and midwives) to provide opportunities for women of reproductive age to gain advice and support i.e. information on pregnancy and educational resources on nutrition, folic acid, physical activity, health and infectious diseases which may impact on pregnancy.

### Core of Life

This is an innovative, ‘hands on’ health education program providing current, research based information about pregnancy, birth, breastfeeding and early parenting to both male and female adolescents. The purpose of Core of Life is to achieve better health outcomes for young people and future families in our wider community. Core of Life aims to assist in reducing teenage pregnancy rates; foster increased levels of responsibility and confidence in youth; and facilitate positive community and early childhood development. Core of Life is an ideal addition to secondary schools’ health education programs or programs for youth at risk in the community (Peninsula Health, n.d.).



## Objective 2.2

Improve access to specific preconception, antenatal and specialist services for women with poor obstetric or medical histories, previous poor fetal or obstetric outcomes and for women with complications in early pregnancy.

### Strategies

- Improve and promote consultation and referral pathways to specialist tertiary maternity services.
- Develop statewide guidelines for perinatal screening and specialist referral.
- Develop and disseminate consumer resources explaining perinatal screening procedures including risks and benefits, to enable women to understand the choices available to them.
- Promote and improve awareness of the Perinatal Loss Service (PLS) at KEMH.

### Perinatal Loss Service KEMH

This service has been established to provide comprehensive, continuing and coordinated care for families who have experienced perinatal death and pregnancy loss at KEMH. This includes clinical care and counselling support. This interdisciplinary service comprises a maternal fetal medicine specialist, obstetrician, perinatal pathologist, neonatal paediatrician, chaplain, social worker, clinical psychologist, maternal fetal medicine midwifery consultant, perinatal loss service (PLS) midwifery consultant and other specialists as required. The PLS provides a statewide consultancy service to support health care professionals who provide clinical care to women experiencing perinatal and pregnancy loss.

### Perinatal Pathology Department KEMH

The perinatal pathology department at KEMH offers a statewide non-coronial perinatal post mortem examination service to families in WA who have experienced the loss of a pregnancy. This includes generating mementos in the form of photographs, handprints and footprints. A cremation service is available for stillborn babies of less than 28 weeks gestation (King Edward Memorial Hospital for Women, n.d.).

## Objective 2.3

Increase awareness of the growing trends in obesity and the links with gestational diabetes and other complications throughout pregnancy. Improve early detection and evidence based management of obesity and diabetes both before and during pregnancy.

### Strategies

- Work with key non-government organisation (NGO) partners to promote a healthy weight prior to conception and during pregnancy.
- Ensure early screening and referral for women with body mass index (BMI) >35 to specialist services.

- Ensure screening and appropriate referral to specialist services for women with gestational diabetes.
- Develop local expertise in the management of diabetes in pregnancy, and strengthen the partnerships between the diabetes service at KEMH and other health services to improve the care of pregnant diabetic women.

### Diabetes Service KEMH

The diabetes service is a resource centre for education and management of women with diabetes in pregnancy throughout WA. The education, care and management involves a multidisciplinary team approach including diabetes educators, midwives, dieticians, obstetricians and physicians. The statewide service provides a variety of resources, clinics, education and information sessions for health professionals, women and their families. These include:

- Pre-pregnancy counselling for women with pre-existing diabetes - both Type 1 and Type 2
- Pregnancy care for women with pre-existing diabetes and those found to have gestational diabetes
- Ambulatory stabilisation of insulin treatment
- Shared antenatal care in consultation with GPs, especially for women in rural and remote areas, where their pregnancy is otherwise uncomplicated
- Postnatal review during the immediate post pregnancy period.

(King Edward Memorial Hospital for Women, n.d.).



### Goal 3: Improve women's experience of pregnancy.

It is important to support women, their partners and family members in planning their maternity care. Continuity of care should be emphasised and quality consistent information given to enable informed decision-making. Women have the right to choose who cares for them during their pregnancy and continuity of carer is desirable (AHMAC, 2006). Midwives and GPs are usually recognised as the key providers of maternity care for healthy women with uncomplicated pregnancies (Victorian Government Department of Human Services, 2002). The development of models of care in WA that include midwives and GPs for healthy women with uncomplicated pregnancies, and that integrate with other primary care services and hospitals as required, will expand women's choices in pregnancy and may reduce intervention rates for healthy women.

Antenatal care in the future will be predominantly community based and will provide care for women who have a healthy and uncomplicated pregnancy. For women living in rural and remote communities, this will specifically offer a local service within their community that is more flexible and targeted to their needs. Care should be provided by the most appropriate health professional with women moving between different levels of care according to need.

There are many examples of integrated services being developed as part of general practices, and integrating primary maternity services should take advantage of these pre-existing models. Continuous health assessment throughout pregnancy, taking into account risk, should be undertaken by a multidisciplinary team to enable better continuity of maternity care (AHMAC, 2006). Transition of care should be seamless and underpinned by local guidelines and referral processes (Select Committee into Obstetric Services, 2007).

#### Integrating Primary Care Services

WA Health is currently working to improve the integration of primary care services. In some areas this will mean the establishment of Integrated Primary Care Centres. These centres will provide consumer-focused, integrated primary care and preventative health services. In most cases, the integrated primary care centre will be located within or in association with GP surgeries and health centres. They will bring together a variety of primary care and community services onto a single site to provide more convenient patient access, ensuring appropriate service delivery that meet the needs of the local population. They will build on the strengths of Australia's current general practice system and address current gaps in primary care service provision through supporting GPs to undertake more preventative and population focused care. They will also integrate general practice with other primary care providers, including midwifery, community nursing, community midwives, allied health and other care professionals. Integrated Primary Care Centres will offer care for women who have a healthy and uncomplicated pregnancy. The services provided will include antenatal care, parent education, postnatal, and newborn care, but will not provide birth options. Women will usually still need to have their birth in a hospital or a Family Birth Centre.

Some women need to travel long distances for specialist services, birth and immediate postnatal care, however community and hospital care in rural and remote areas, when adequately resourced and supported, will provide the majority of antenatal, postnatal and newborn care for most women. Clear discussions on plans for timely referral should occur with women early in their pregnancy and be officially documented to support safe seamless transfer of care when required. Consideration should also be given to transferring care to a location that is close to where a woman has some support base, such as family or friends, to minimise the impact of social dislocation and family separation. In some instances, this may mean transferring care to a service in another state or territory.



**Objective  
3.1**

Improve the holistic assessment of women's circumstances enabling early identification and better management of physical, social and psychological needs.

**Strategies**

- Develop statewide health records that are accessible by all providers of maternity care. These will include health and risk assessments, underpinned by statewide clinical guidelines and protocols. They will include a physical, psychological and social assessment to identify areas of increased need.
- Ensure planning for childbirth occurs early so that arrangements can be put in place for a smooth transition of care when needed.
- Develop strategies that identify and sensitively manage the care of women with special needs such as women in prison, asylum seekers, women from Culturally and Linguistically Diverse (CaLD) groups, women with disabilities and women with other social problems such as substance and drug abuse. These strategies should align with the WA Health Cultural Diversity Policy.
- Support GPs, midwives, other health professionals, Patient Assisted Travel Scheme (PATS) and Royal Flying Doctors Service (RFDS) coordinators in rural, remote and metropolitan areas to work in partnership with women to select the most appropriate place to transfer care, giving due consideration to the woman's social support structures.

**Objective  
3.2**

Provide comprehensive pregnancy, childbirth and early parenting education programs.

**Strategies**

- Evaluate current parent education programs to ensure they address normal pregnancy and childbirth, and the management of complications that may develop during this period.
- Support the collaboration and vital role of NGOs in the provision of pregnancy, childbirth and parenting education.
- Develop consistent evidence based information packages, which is culturally sensitive and meets the needs of CaLD women and women from minority groups on pregnancy, childbirth and early parenting for consumers and health professionals.
- Evaluate education, training and credentialing for childbirth educators on pregnancy, childbirth and parenting.

## Adolescent Antenatal Clinic KEMH

The adolescent clinic at KEMH provides care to adolescents who are under 18 years of age and in their first ongoing pregnancy. Care focuses on the special needs of teenagers and promotes a physically and emotionally safe pregnancy and birth experience. The services offered to adolescents include:

- Support and care during pregnancy
- Guided tour of the hospital
- Information about pregnancy, childbirth and parenting
- Home visiting midwife services
- Assistance with practical issues such as baby gear and accommodation
- Six week postnatal follow-up at the clinic
- Assistance with contraception
- Counselling and support services
- Opportunities to meet other young mothers
- Advice on further education and career opportunities.

(King Edward Memorial Hospital for Women, n.d.).

### Objective 3.3

Improve linkages between primary, secondary and tertiary services in order to facilitate maternity services that are woman and family centred, locally accessible, safe, comprehensive and effective.

### Strategies

- All service providers of maternity care, women and their families will be supported by the review and development of statewide clinical consultation and referral guidelines.
- Develop and promote the use of generic pregnancy health records to assist women to receive consistent information and best practice care.
- Support local integration of primary care services that promote family centred multidisciplinary maternity and health care.
- Establish the Women's and Newborns' Health Network to promote better linkages between service providers and programs.
- Involve women and relevant NGOs in the development of maternity care guidelines, models of care and facilities.



## Goal 4: Improve women's experience of childbirth.

A collaborative team approach to maternity care provision by all health professionals including midwives, GPs, GP obstetricians, obstetricians, paediatricians, physicians and other health professionals is a priority (AHMAC, 2006). It is essential that midwives and GPs be recognised as key providers of maternity care for healthy women with uncomplicated pregnancies and their babies (Victorian Government Department of Human Services, 2002).

Evidence suggests that models of care that provide women with continuity of midwifery and GP care throughout pregnancy, labour, birth and postpartum, incorporating primary health care services and providing some care in the community, are most likely to result in increased satisfaction levels and produce the best health benefits for women and their families (Brown and Bruinsma, 2006, Maternity Coalition Inc WA Branch, 2004, NSW Health, 2003).

It is important that midwives and GPs provide consistent information and continuity of care enabling women to ask questions. This will help women to gain more confidence and be better informed of what to expect when they present to hospital for birth. In addition to evidenced-based and accessible information, women across WA should also be able to access antenatal and postnatal workshops and education sessions to increase their confidence and improve their transition from pregnancy into parenthood (Department of Health/Partnerships for Children, Families and Maternity, 2007). Health professionals should also recognize the importance of partners and encourage them to play an active role in pregnancy and childbirth.



**Objective  
4.1**

Support women to choose how and where they give birth by providing high quality information and evidence based clinical advice, ensuring that the information is accessible.

**Strategies**

- Promote effective partnerships between women, health professionals and relevant NGOs to empower women to choose an appropriate pathway for giving birth. Health professionals should ensure that women have the opportunity and choice to explore all options of maternity care.
- Improve access to comprehensive evidence based information on maternity care options to empower and support women and their partners to make informed decisions. Written information should be discussed and verbal information provided to women and their families, including a health assessment and a discussion of the advantages and risks to allow women and their families to make informed choices regarding 'how' and 'where' they give birth.
- Review, support and promote antenatal and parenting educational sessions and workshops to facilitate information sharing and support.
- Create "branded" information that is current and evidence based so that women can easily recognise information media that is relevant to pregnancy and childbirth. Develop strategies to ensure that women and their families can readily gain access to this information.

**Objective  
4.2**

Increase the capacity for midwives to provide one-to-one care to women throughout pregnancy including during labour and childbirth, facilitating greater individual support, enabling continuity of carer.

**Strategies**

- Implement appropriate models of maternity care that offer continuity of midwifery carer throughout the maternity continuum of care with the support of the GP and hospital services where appropriate. This continuity of carer should continue to provide care where possible, even when additional health professional services are necessary. Services should be configured to best meet the needs and choices of the target population and take advantage of the local clinical expertise available.
- Ensure the continuation and expansion of Family Birth Centres (FBC) across the state. The FBC should be designed and located on a site with an appropriate obstetric service, including anaesthetic support, operative delivery facilities and neonatal resuscitation support.
- Extend the availability of existing community midwifery models of care.
- Ensure midwives are supported within a multidisciplinary team.
- Review and consider the adoption of the Australian College of Midwives National Guidelines for Consultation and Referral.

## Stacie and Don's Story

We live rurally about two hours east of Perth and our hospital can no longer deliver babies there. I wasn't very keen to undergo another caesarean for my birth due to the recovery time of my past experience and I now also had two toddlers to care for, in a relatively remote location. We were unsure as to the support we would receive in attempting a vaginal birth after caesarean (VBAC), given our most recent birth experience and our distance from Perth. Fortunately, we were able to find a doctor who was very supportive of our choice and we planned the birth approach which best suited us, and the doctor's safety parameters.

As my pregnancy progressed to the last weeks, I became very apprehensive and fearful for the safety of our baby's arrival. We visited the doctor at 39 weeks. At this time we ended up choosing an elective caesarean. The process was explained to us and with a date set, we went home to pack and prepare (and still kind of hoping I would go into labour naturally!).

I felt rather sad leading up to the birth, feeling that by planning the whole process in this way it would detract from the natural phenomena that birth should be and had previously been for me. Scarlett's birth had been overwhelming, but her safe arrival was paramount and whilst we wanted this new baby to be safe too, it was still hard to believe it was right for me to be making the choice to have him surgically.

So we thought through what we would have wanted had we had the VBAC we were planning. It was suggested that we have some music we liked (my 16 year old put together a CD with everything from the Muppets to Counting Crows on it!). On the day we asked if the baby could be delivered straight on to my chest (skin to skin) and that the cord be emptied of blood before being cut by my husband. All our requests were received and accepted, which sort of surprised us. The midwives that would be with us were also excited about our birth!

And it was wonderful! Our beautiful little 9lb 15 oz boy was born and delivered straight onto my chest. I was able to hold, kiss and just look at him for the first 20 minutes or so of his life before they took him to be checked over and having that time with him was so special, he was so calm and watchful. The atmosphere in the operating theatre was one of complete support, there was so much kindness surrounding us, (with touches of humour) which continued out into the recovery area and up onto the ward. The staff were extraordinary. Everyone that we had any involvement with, from the antenatal clinic, to the theatre staff, to the lovely women who tidied our room or delivered our meals, to the beautiful souls that helped us through the first few days of Harrison's arrival into this world. It was absolutely the right place for us to have our baby, and we thank everyone who was a part of our birth experience.

Better integration of maternity services, including midwifery, general practitioner, obstetric and neonatal services, enabling greater responsiveness to the needs of mothers and their newborn babies.

### Strategies

- Where a woman chooses an accredited practising midwife as her primary carer for birth, a good partnership should be established with the woman's GP and a local maternity unit.
- Women who decide to birth at home using the Community Midwifery Program (CMP) should have access to appropriate consultation and referral services if required during her pregnancy, birth or post birth periods. A woman and her family must be informed of referral pathways for safe and appropriate transfer should her options for a home birth change to that of a hospital birth during her pregnancy or labour.
- Facilitate better integration of primary care services including primary maternity services.



## Goal 5: Improve the health and development of infants and address the needs of new parents.

A team approach to maternity care will enable better transitions to parenthood as well as assist in achieving better health outcomes for babies. High quality midwifery care, which is provided in both the place of birth and at home, will support the transition to parenthood. Involvement of the woman's GP in the care of the woman and newborn will ensure ongoing, long term continuity of care for the family (Victorian Government Department of Human Services, 2004).

Midwives, health workers and child health nurses attending home visits (both before and after birth) should use every visit as an opportunity to educate and support the woman and her baby to ensure the best health outcomes. Women deemed to require high levels of support should be identified early and linked into appropriate support services to meet their individual needs. A multi-disciplinary, multi-agency approach should be developed and supported for specific needs of women and their babies.

Babies who start their lives in critical conditions require highly specialised care to ensure the best outcome. WA has one of the largest neonatal services in Australia and is considered to be world class in its research and high quality outcomes for neonates. This statewide service will be supported by the Women's and Newborns' Health Network to continue to develop and offer the best of care for these babies.

In August 2007, "The Best Start" report on the inquiry into health benefits of breastfeeding was published. This report discussed national strategies to encourage breastfeeding, factors affecting breastfeeding, the health and economic benefits of breastfeeding, challenges and management of breastfeeding and the establishment of human milk banks throughout Australia (Commonwealth of Western Australia, 2007). WA Health supports the recommendations of this report and recognises the key role of midwives and child health nurses in supporting the establishment and maintenance of breastfeeding.

Community and child health nurses play a critical role in assisting new parents adjust to parenthood as well as providing assessment and interventions for babies and young children with growth, learning or health problems (Department of Health WA, 2006). The WA Health policy is for a universal contact to be offered in the first ten days after birth, as a home visit wherever possible (WA Department of Health, 2006). At present the child health nurses are under considerable pressure in delivering this service due to workforce and resource constraints. Midwives and child health nurses will have to work collaboratively in the future to ensure a seamless service occurs and that those families who need it most are given the support and assistance they require. Timely and accurate information sharing is essential between all health professionals involved in the birth and ongoing care of the mother and baby. A seamless transition from midwifery care to the child health nurse service is essential for the provision of continuity of care (The Australian College of Midwives, 2007).

**Objective  
5.1**

Continue to support and develop integrated statewide neonatal services to facilitate greater responsiveness to the needs of sick babies and their parents.

**Strategies**

- Support the Neonatal Network within the Women's and Newborn's Health Network.
- Ensure that a health professional or health care worker who has been educated, trained and accredited in neonatal resuscitation is in attendance at all births.
- Provide collaborative education and training scenarios for all health care personnel and workers who attend births and provide care to sick babies.

**Objective  
5.2**

Better inform women of the benefits of breastfeeding whilst supporting mothers in their chosen mode of infant feeding.

**Strategies**

- Adopt and implement strategies to promote and support breastfeeding in Western Australia, including providing leadership in the area of monitoring, surveillance and evaluation of breastfeeding data.
- Support breastfeeding education for women and their families during the antenatal period.
- Provide consistent and evidence based advice and information to assist women to breastfeed. Ensure consistent literature is available to support women and their families.
- Support and encourage hospitals to become accredited under the WHO Baby Friendly Hospitals Initiative (The Australian College of Midwives, 2006B).
- Develop a directory of breastfeeding support networks (such as Australian Breastfeeding Association and lactation consultants) that is freely available in antenatal education classes and to new parents.
- Develop outreach programs that support isolated women in rural and remote areas to breastfeed by providing support and information.
- Support the continued development of expertise and research by the Breast Feeding Centre at KEMH.
- Continue to support the pilot human milk bank at KEMH.



## Perron Rotary Express Milk (PREM) Bank KEMH

Sometimes mothers have difficulty producing enough milk while others are producing more milk than their own infant requires. PREM Bank helps these babies and mothers by collecting breast milk from healthy screened donors, processing it to ensure safety, and making it available to infants in need. This offers a better and safer nutritional alternative for preterm infants and can be used instead of formula. PREM Bank is the result of collaboration between the Women and Newborn Health Service, Women and Infants' Research Foundation, and the University of Western Australia (King Edward Memorial Hospital for Women, n.d.).

## The Breastfeeding Centre of WA KEMH

KEMH and the Women and Infants' Research Foundation, together with the Australian Breastfeeding Association have combined to form the Breastfeeding Centre of WA. The Breastfeeding Centre of WA is available for mothers and babies who attended KEMH for their pregnancy and birth. There are four areas of service:

1. Clinical: midwives and lactation consultants assist mothers across the state to breastfeed.
2. Education: The centre provides education for mothers, the community and health professionals at a primary, secondary and tertiary level. The centre has undergraduate and post graduate links with the University of Western Australia, Curtin University of Technology and Edith Cowan University.
3. Community: The centre maintains links to other organisations promoting breastfeeding.
4. Research: The centre conducts research on breast functioning and the difficulties affecting successful breastfeeding.

(King Edward Memorial Hospital for Women, n.d.).

### Objective 5.3

**Increase opportunities for support from a multidisciplinary service for women who have, or are at risk of, postnatal depression and other mental illness.**

### Strategies

- Develop pathways for access to mental health services when required for maternity care across WA.
- Screen all women during the antenatal and postnatal periods for depression using the Edinburgh Postnatal Depression Score and document in their health record.
- Implement statewide referral processes for women recognised as requiring additional mental health support.
- Increase awareness and provide information across WA of support services within the community for mental health illnesses.
- Increase awareness and provide information about the Mother and Baby Unit established at KEMH for women with mental illnesses.



## State Perinatal Mental Health Unit

The State Perinatal Mental Health Unit (SPMHU) is a statewide coordination and consultation program dedicated to ensuring that perinatal mental health services across the state are meeting the needs of WA women and their families. Priority groups targeted by the initiative for service enhancement include CaLD, the Aboriginal populations, and rural and remote communities. SPMHU is a key initiative of the WA State Mental Health Strategy and operates on the premise of inter-agency collaboration in the delivery of services (King Edward Memorial Hospital for Women, n.d.).

### Objective 5.4

Increase support for women and their partners to make a confident and effective transition to parenthood in partnership with midwives, child health nurses, GPs and allied health professionals.

### Strategies

- Develop strategies to support health care providers to enable early return to home for women and their babies from hospital. These will be developed in alignment with a statewide discharge planning process, which will reflect best practice and the provision of community support networks for women and their families.
- Promote safety (cultural, psychological and spiritual) as a key priority by ensuring women are supported in their homes by health care providers such as midwives, child health nurses, Aboriginal health workers, allied health professionals and lactation consultants.
- Establish a process to enable continuity of care between midwives and child health nurses beginning in the antenatal period through to the post birth period.
- Ensure appropriate evidence based information is available for women and their families about immunisation programs for their baby.
- Promote and increase awareness of support services and networks for new parents within their community.



## Goal 6: Improve safety and accountability in all maternity services.

Safety and quality in all WA Health services is of paramount importance. WA Health has adopted the four pillars of clinical governance, including consumer value, clinical performance and evaluation, clinical risk, and professional development and management, to ensure that safety and quality are embedded in all services (Office of Safety and Quality, 2001). WA has a situation where the population is scattered geographically. Risk management is a major issue when ensuring safety in services that are remotely located and are required to be generalist in nature in order to meet the needs of the community.

Regular in-service training and emergency drills including obstetric emergencies, neonatal resuscitation and competency in advanced fetal assessment skills become more difficult to achieve the further the service is from the specialist maternity centre (Victorian Government Department of Human Services, 2002). These issues are not solved easily and require a coordinated and innovative response. Tools such as telemedicine and improvements in broadcast technology should provide greater innovation to support implementation, not just in the availability and provision of remote patient services but also for use in staff development, training and case-conferencing.

WA maternity and newborn services have worked diligently in recent years to create a culture of open disclosure, incident reporting and review of risk management and strategies to improve health care provision and safe care for women and their babies. This change needs to be supported and celebrated.

Monitoring the safety and quality of maternity and newborn services allows service providers to continuously assess their performance. Benchmarking with similar services in Australia also helps to provide feedback on how well WA is doing nationally. The Women's and Newborns' Health Network will support Area Health Services to adopt national core maternity indicators, identify areas for improvement in provision of safety and quality health care and also to benchmark with outcomes of other health care providers.

At present, the increasing rate of caesarean section in WA is of concern. The caesarean section rate in WA for 2005 was 33.9%. What is of particular concern is the number of caesarean births being performed electively prior to 39 completed weeks of gestation. This poses a significant risk to both the mother and the newborn, with respiratory conditions being the most common complication in the newborn (Maternal and Child Health Unit, 2005). This in turn places increased pressure on the statewide provision of neonatal services (Victorian Government Department of Human Services, 2002).

Guidelines for the appropriate use of elective caesarean sections will be developed and implemented statewide to bring WA into line with other health services across Australasia. These guidelines will be evidence based, reflective of the World Health Organisation (WHO) guidelines, and when implemented, will reduce the number of caesarean sections being performed prior to 39 weeks of gestation and will ensure that women are fully informed of the risks of the procedure and future implications.

Consistent clinical guidelines relating to vaginal birth after caesarean will ensure accurate and consistent information is provided to women and their families. These guidelines will be supported by provision of consumer information from their local maternity service providers.

WA Health recognises that the credentialing of midwives, paediatricians, GP obstetricians and obstetricians is the responsibility of each Area Health Service. The Women's and Newborns' Health Network will further develop their role in supporting the development of statewide protocols and ensure there is appropriate and robust leadership and provide advice and direction on where and how services should be planned, developed and delivered.

**Objective  
6.1**

**Increase the opportunity for both the community and health professionals to be involved in the planning, development and provision of local maternity services.**

**Strategies**

- Ensure strong consumer, clinician and NGO engagement in the development of the Women's and Newborns' Health Network.
- Utilise the WA Health Consumer, Carer and Community Engagement Framework in the planning, development and provision of local maternity services.
- Develop communication strategies to ensure that the community is kept informed about the development of maternity services statewide and in their local area.

**Objective  
6.2**

**Strengthen and support patient safety for WA health services and our community through the Safety and Quality Investment for Reform (SQIRe) Clinical Practice Improvement Program.**

**Strategies**

- The Women's and Newborns' Health Network will work with the Office of Safety and Quality and the Perinatal and Infant Mortality Committee to monitor issues of concern and provide expert advice on strategies for improvement.

## **Perinatal and Infant Mortality Committee**

This committee enquires into, and reports to the Executive Director of Public Health on, perinatal and infant mortality. The committee consists of six permanent members and two of the four nominated provisional members. Under the statutory requirements of the Committee, permanent members consist of: -

- Professor of Obstetrics at the University of Western Australia
- a medical practitioner nominated by the Commissioner
- a medical practitioner specialising in neonatal paediatrics at King Edward Memorial Hospital (KEMH) nominated by the KEMH Board
- a medical practitioner specialising in neonatal paediatrics at Princess Margaret Hospital for Children (PMH) nominated by the PMH Board

- a general medical practitioner having not less than 5 years practice outside the metropolitan area nominated by the Australian Medical Association (AMA)
- a medical practitioner specialising in Clinical Epidemiology nominated by the Commissioner

Provisional members consist of:

- a medical practitioner specialising in obstetrics and perinatal care nominated by the Australian College of Obstetricians and Gynaecologists (WA Branch)
- a general medical practitioner with special interest in perinatal care nominated by the State Branch of the Royal Australian College of General Practitioners
- a general medical practitioner nominated by the Commissioner
- a midwife in clinical practice nominated by the State Branch of the Australian Nursing Federation

The Chairman of the Committee is appointed by the Minister for Health from amongst the persons who are permanent members of the Committee. (Department of Premier and Cabinet, 2007).

## Objective 6.3

Reduce the rate of caesarean births performed prior to 39 completed weeks of gestation and support vaginal births after caesareans (VBAC) in hospitals.

### Strategies

- Adopt the use of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) caesarean section and vaginal birth after caesarean section (VBAC) treatment information pamphlets to ensure women and their families are appropriately and adequately educated about the procedures and associated risks. These pamphlets will be supported by the provision of consistent balanced consumer information packages on caesarean sections and VBAC.
- Develop a directory of service providers for appropriate referral and further opinion on caesarean section or VBAC to inform women where they may access alternative birth options if they choose.
- Encourage and support VBAC in a hospital setting led by a collaborative maternity team including midwives and an obstetrician or GP obstetrician.
- Review the current protocols for gaining consent in public hospitals prior to any maternity surgical procedure and ensure a consistent informed consent form is developed, provided and a requirement prior to any maternity surgical procedure performed in an operating theatre.
- Establish a collaborative working party of key stakeholders and NGOs to develop strategies to address the rising rate of caesarean sections as a type of delivery in WA.
- Establish a collaborative working party of key stakeholders and NGOs to develop strategies to address the low rates of VBAC as a type of delivery in WA.
- Provide all women and their families with an appointment post birth to discuss outcomes following her caesarean section or VBAC, her future birth options and accessibility to support services if required.

Implement the National Core Maternity Indicators across WA to better enable health services to identify areas of improvement and benchmark with other like services.

### Strategies

- The Office of Safety and Quality, the Women's and Newborns' Health Network, and Area Health Services will work collaboratively on the implementation and evaluation of the National Core Maternity Indicators.

### Recommended National Core Maternity Indicators

The recommended set of national core maternity evidence based performance indicators include:

1. Smoking cessation advice during pregnancy
  2. Induction of labour rates for selected first births
  3. Caesarean section rates for selected first births
  4. Episiotomy rates for all first births
  5. Third and fourth degree tears for all births
  6. Unassisted vaginal births following a spontaneous onset of labour for selected first births
  7. APGAR score < 6 at 5 minutes for live term infants
  8. Death of baby around time of birth
  9. Significant blood loss within 24 hours following vaginal birth
  10. Support breastfeeding
- (Maternity Reference Group, 2007).



## Goal 7: Improve the sustainability of the maternity care workforce and promote clinical leadership and collaboration.

There has been considerable concern in recent years over the future of obstetric services with predictions of a serious reduction in the availability of GPs and specialist obstetricians. A study conducted by Dr Cameron Loy, Dr Bruce Warton and by Professor James Dunbar in Victoria in 2003 found that the proportion of GPs involved in procedural obstetrics had declined markedly over the past decade and that new GPs entering the workforce with a diploma and overseas doctors entering the workforce would be unlikely to meet the workforce shortfall. The specialist obstetric workforce was also predicted to be inadequately resourced in the future. Indications are that the picture will be similar in WA (Loy, Warton & Dunbar, 2007).

It is not only the medical workforce that is under significant strain. The numbers of midwives is also falling with the average age increasing (Victorian Government Department of Human Services, 2002). The access to a Bachelor of Midwifery course may entice greater interest in entry to the midwifery profession; it also holds promise for Aboriginal health worker articulation into midwifery. However, it is still uncertain as to how these midwives will be effectively deployed in the rural hospital workforce, where nursing skills are quite often also required. This will require further consideration and the development of more flexible service delivery models. The workforce of the future will need to focus on skills, rather than professions.

Non Government Organisations (NGOs) are often overlooked in the review and development of women's and newborns' services. NGOs play a vital role in providing advocacy, education, care and support to women and their families. In order to develop better systems of care and make best use of resources, the NGO sector will need to play a much greater and collaborative role with government organisations and services in the future.

### Objective 7.1

**Increase the availability of models of care that acknowledge the best use of skills rather than traditional professional boundaries.**

### Strategies

- Consider development of Integrated Primary Care Centres by Area Health Services.
- Increase the availability of Family Birth Centres co-located near a hospital.
- Increase support, clinical education and training opportunities for the maternity care workforce including midwives and GP obstetricians.
- Increase opportunities for cultural sensitivity and awareness training to meet the individual needs of CaLD and other minority groups.
- Increase access to community midwifery models of care and monitor improvements in home birth services.
- Recognise the role of a woman's support network during birth i.e. family and those present with cultural/kin affiliations.
- Ensure maternity care is responsive to the different cultural expectations of women and their families.



## Objective 7.2

Establish and support the Women's and Newborns' Health Network to foster clinical leadership and bring all interested stakeholders together to plan and develop maternity care services in WA.

The **Women's and Newborns' Health Network** is currently being established within WA Health to improve the integration and coordination of health services through improved interaction and collaboration between service providers and other enabling stakeholders across area health services and institutional boundaries. The Women's and Newborns' Health Network will foster and provide leadership, advice and direction on where and how services should be planned and delivered.

### Role of Women's and Newborns' Health Network

1. Assist in the **planning** of women's and newborns' health services based upon the needs of the population and changes in the health system.
2. Develop **policies** that support the changing needs of the population and foster innovation in our system.
3. Develop **performance measures**, set targets and monitor outcomes for women's and newborns' services.
4. Develop **protocols** to ensure efficiency, effectiveness and safety in the delivery of women's and newborns' services.
5. Invest in **people** to provide skill and knowledge development opportunities.
6. Provide leadership and advise on future workforce planning and the **priorities** on how resources are allocated across the system.

## Objective 7.3

Support and promote the Women's and Newborns' Health Network with the assistance of the State Obstetrics Support Unit (SOSU) in improving safety and developing the maternity care workforce for a range of models of care.

In 2002, the report "*Western Australian Statewide Obstetrics Services Review*" chaired by Dr Cohen recommended, "that a Statewide Obstetric Service is established, supported and funded as a matter of priority". This concept led to the foundation of the Statewide Obstetric Support Unit (SOSU). The unit was created as a statewide advisory and coordinating body that supports the provision of high quality obstetric care in WA, through collaborative activities and supporting the clinicians providing the care. A key emphasis of the unit is on promoting sustainable improvements.

This unit has been in operation for over two years and has suffered from significant recruitment issues during that time. Its role and functions are not well known amongst health care professionals. SOSU would benefit from a communication strategy that promotes its activities across the state as well as the alignment of its priorities with the newly formed Women's and Newborns' Health Network to facilitate dissemination of information and promote leadership across the state.



**Objective  
7.4**

Recognise and support the role of the non government sector in providing advocacy, support and education to women and their families.

**Strategies**

- Undertake a stocktake and gap analysis of all maternity related NGO provided services.
- Ensure NGO inclusion and engagement in the development of the Women's and Newborns' Health Network.



## Models of maternity care

There has been widespread agreement on the benefits of continuity of care by a single provider or a small team throughout pregnancy, birth and early parenting. Continuity of care should be a fundamental aspect of all maternity models of care (AHMAC, 2006). Models of maternity care in WA should have the following attributes:

- The model is desired and accessible by women
- Focuses on the individual needs of the woman
- Offers women and their families greater options for provider of care and place of birth
- Has a primary health focused approach to care and delivery
- Promotes community based care
- Provides continuity of care and carer wherever possible
- Is appropriate for the community and regional needs and requirements
- Delivers best practice, evidence based and safe care
- Is adequately resourced, staffed and economically sustainable.

## A collaborative team approach to maternity care

WA Health will encourage health professionals in maternity care to work collaboratively and in a multidisciplinary team to ensure the best possible maternity care is provided and meets the needs and requirements of the woman and her baby. WA Health aims to ensure that the skills, knowledge and attributes of midwives, GPs, GP obstetricians, obstetricians, paediatricians, neonatologists, anaesthetists, allied health professionals, child health nurses, Aboriginal health workers and other health professionals will be maximised to provide a collaborative and multidisciplinary approach in maternity care (Department of Health/Partnerships for Children, Families and Maternity, 2007, AHMAC, 2006). WA Health aims to promote multidisciplinary learning, respect and trust among the above mentioned disciplines. This collaborative approach to maternity care will assist women to move seamlessly through the levels of care required for the woman and her baby (Victorian Government Department of Human Services, 2002).

### General practitioner

A GP is a registered medical practitioner who is qualified and competent for general practice in Australia. A GP has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care.

### GP obstetrician

A GP obstetrician is a GP who has a diploma in obstetrics from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Obstetrician	An obstetrician is a doctor who specialises in the management and care of pregnant women during labour and birth. An obstetrician has many years of specialist training and experience and is a fellow of the RANZCOG. Obstetricians provide care in secondary and tertiary hospitals in both the public and private sectors.
Midwife	A midwife is a person who has acquired the requisite qualifications to be registered and legally licensed to practise midwifery. Midwives provide care and advice to women during pregnancy, labour and the postpartum period, support births and care for the newborn and the infant. A midwife may practise in hospitals, clinics, community health units, domiciliary conditions or in any other service.
Child health nurse	A child health nurse is a registered nurse with postgraduate qualifications in child and family health. They work in partnership with parents and carers of babies and children 0-4 years and provide care to the family ten days after a child's birth.

## Shared care

Shared care means that a woman's GP shares the pregnancy care with a hospital midwife and/or GP obstetrician and/or specialist obstetrician. Women can receive care with their own GP in the community and then give birth in a local hospital with a midwife, a hospital accredited GP obstetrician or specialist obstetrician if required. If the woman's GP has admitting rights as a GP obstetrician to a local health service, her care can be continued with her own GP for the birth and immediate postnatal care in the hospital if there is an arrangement for such private care, otherwise there may be another mode of service provision within the hospital setting (Select Committee into Obstetric Services, 2007).

Responsibility for the woman's care, including communication and management of abnormal results and findings is shared between the midwife and doctor. Individual care plans are developed within this model in consultation with and between the midwife and doctor. The midwife, GP obstetrician and/or obstetrician can both provide labour and birth care. The midwife provides postnatal care in the hospital whilst the woman is under the care of the GP obstetrician or obstetrician. Following the woman's return to home, a visiting midwife will continue care and then the care is transitioned to the child health nurses and general practitioner (Select Committee into Obstetric Services, 2007)

## Peel Maternity & Family Practice: Caring for mothers and babies

The practice is a general practice and provides care for only maternity patients and their babies in the immediate postpartum period. The practice aims to provide a coordinated and holistic team approach, with a small family atmosphere. The practice provides comprehensive management from conception through the antenatal periods, delivery and postnatal check ups. The practice also provides contraceptive advice and management including Implanon and IUD insertion and removal, as well as PAP smears, STD screening and other minor gynaecological procedures and advice. The practice consists of GP obstetricians and midwives. The GP obstetricians attend the delivery at the local hospital and provide care in hospital after delivery along with the hospital employed midwives. The midwives at the practice also work part time on the maternity unit, so are at times able to care for the patients in labour too. Other doctors may assist with sessions from time to time and a dietician is available for private appointments. The midwives provide much of the day-to-day care with the doctors in a more supervisory role, becoming more involved if problems develop.

### Midwifery models of care

The focus of midwifery care is to provide continuity of care and carer and form partnerships with women and their families as they prepare for childbirth. This includes the care of the healthy woman prior to pregnancy and during all phases of childbearing and early parenting. The midwife establishes partnerships with medical personnel and allied health professionals as needed to facilitate the best care for a mother and her baby. The primary midwife continues to provide midwifery care to women even when specialist medical intervention is required (The Australian College of Midwives, 2006A, Department of Health England, 2004).

Midwifery models of maternity care can be accessed through self-referral or with a referral from their GP in early pregnancy. Midwifery models of care can be provided in group practices, caseload models or team midwifery. Below are descriptions of the dominant models of midwifery care.

#### Midwifery group practice (sometimes known as caseload midwifery care)

Midwifery group practice enables women to be cared for by the same midwife (primary midwife) or a small group of midwives throughout their pregnancy, during childbirth and in the early weeks at home with a new baby (Government of South Australia, 2007).

Midwifery group practices can operate from a community setting. Community Midwifery Program WA (CMP) is an example of a caseload model that offers women the opportunity to give birth at home and in collaboration with other health providers from local maternity units or birth centres. The CMP also offers domiciliary services for women who choose to use the service and birth in hospital.

The majority of antenatal and postnatal care is provided in a woman's home or in clinics with the place of birth being dictated by the woman and/or her health needs or those of her baby (either hospital, home or birth centre) (The Australian College of Midwives, 2006A).

## Team midwifery care

Team midwifery means women are cared for by small teams of midwives who are assigned responsibility for pregnancy, parent education, birth and postnatal care to a given number of women. This gives women more continuity of care and a woman typically meets each midwife in the team at least once during her pregnancy (NSW Health, 2000).

A woman will therefore know the midwife providing care during her birth and postnatal period. There is, however, no guarantee which midwife will attend her during labour and birth. This model allows continuity of midwifery care, has psychological benefits, and assists women to feel well supported, prepared and in control during labour and birth (Department of Health/Partnerships for Children, Families and Maternity, 2007, Frazer, 2006).

### Community Midwifery Program WA

Community Midwifery WA is a non-government organisation funded by WA Health to deliver community based midwifery and childbirth education services. The majority of women on the program birth at home with their primary midwife. A back-up midwife is also present at each birth. When accepting a place on the Community Midwifery Program (CMP), women agree to certain terms of care which ensures referral and transfer guidelines are clearly understood to protect the safety of the woman and her baby, should complications occur during pregnancy or birth. CMP's range of pre and postnatal workshops are designed to empower and support women and their partners to take responsibility for being well informed and well prepared for childbirth and parenting.

### General practice models of care

GPs care for pregnant women in their general practice and offer shared care with hospital or family birth centre midwives, obstetricians and GP obstetricians. GPs without additional obstetric training do not supervise births in hospitals. However, once women have given birth, the GP assumes the follow up care of the woman, her baby and her family (NSW Health, 2003).

GP obstetricians care for women in their general practice, deliver babies and offer shared care with midwives and obstetricians in a hospital. They have credentials to perform obstetric and certain gynaecological procedures and neonatal resuscitation within an accredited hospital setting. GP obstetricians work collaboratively with midwives, obstetricians, paediatricians, and other health professionals who link with hospitals and community groups to provide an integrated multidisciplinary service and support for women and their families (Straton, 2006).

## Consultant led care

Obstetricians provide quality services for pregnant women with pre-existing health problems, previous pregnancy complications and those women who subsequently develop pregnancy complications requiring obstetric intervention and support. Healthy women may choose to see an obstetrician privately for their pregnancy and birth care. A referral from their GP is required to access this service (Maternity Reference Group, 2007).

Midwives and GPs should refer women to obstetricians if pregnancy complications develop, for ongoing care or emergency management. Obstetricians provide pregnancy care, including care for birthing within a secondary or tertiary hospital (Maternity Reference Group, 2007).

### Anaesthetist

An anaesthetist is a doctor who is educated and trained to administer anaesthesia and manage patients medically before, during, and after surgery. They also administer analgesia and anaesthesia during labour and childbirth where required.

### Paediatrician

A paediatrician is a doctor who specialises in care for newborns, babies and children. They have advanced education and training in children's health and are registered with the Australian College of Paediatrics.

### Neonatologist

A neonatologist is a paediatrician who has specialised in newborn medicine.

Paediatricians and neonatologists are critical members of the maternity team and provide both general paediatric as well as more highly specialised services to newborns.

## Locations of maternity and newborn care

### Integrated Primary Care

Integrated Primary Care Centres (IPCCs) will offer primary maternity services to women who have a healthy and uncomplicated pregnancy. This model of care will offer a local service close to home with a community midwife and a GP, and a local community support network.

This service will provide antenatal care, parent education and postnatal and newborn care but will not provide birth options. Women will usually still need to have their birth in a hospital or Family Birth Centre. IPCCs will have links with birthing services and may be integrated with other primary care services to ensure continuity of care and easy access to midwifery, child health nurses, allied health professionals, pathology and ultrasonography, psychological, social and medical services as required.

Continuous health assessment is needed throughout pregnancy and must be dynamic and take into account the possible changes in risk status of the pregnancy over time. Appropriate and seamless referral guidelines need to be developed and patient held pregnancy health records utilised to enable effective communication and continuity between carers, if handover of care is required (Maternity Reference Group, 2007). IPCC community midwives will continue home visiting throughout the maternity continuum and support the transition of care to a child health nurse, community health services and/or a GP.





A small number of women in WA choose to birth at home with the support of an accredited home birth midwife. Currently in WA, the Community Midwifery Program (CMP) is the only publicly funded and accredited provider of home births. Women can choose to have a home birth with the CMP, which has admitting rights and access to some metropolitan hospitals, should transfer of care be required.

Comprehensive clinical guidelines underpin this service including transfer criteria to KEMH, should complications occur to the woman or baby during any phase of their pregnancy or birth. Women and their babies are followed up with their CMP midwife for six weeks post birth after which the care is transferred to the child health nurse and GP in the woman's community, once discharged from the program. The service has undergone significant changes over the last two years, which has led to improved accountability (Maternity Reference Group, 2007).

Outcomes for this program will continue to be monitored to ensure that WA women and their babies continue to receive quality care. A modest expansion of this service is warranted based on community feedback.



## Family Birth Centre

A Family Birth Centre (FBC) is defined as a freestanding primary maternity unit, which provides 24-hour midwifery care for healthy women who anticipate a healthy and uncomplicated pregnancy and birth. Certain health issues may preclude some women from attending, for example attendance is restricted to women weighing less than 100Kg. These centres will be co-located with a secondary or tertiary hospital to provide timely access to services including obstetric, neonatal and anaesthetic care when required (King Edward Memorial Hospital for Women, n.d.).

The philosophy of birth centre care includes a homelike, non-clinical environment, autonomous midwifery practice, woman and family centred care and a commitment to and belief in normal, physiological birth. The entire birth experience can be as personalised and individual as a woman and her family desires within the limits of safety and quality care. The consideration of individual needs and continuity of carer increase confidence in planning and decision-making for women (Henderson et al., 2007).

Women, their partners and babies return to home within 24 hours of birth and receive follow up care by a visiting midwife who provides continuing care at home. The care of the family is then transferred to the child health nurses and GP in the woman's community. WA Health supports Area Health Services in considering the establishment of more FBCs, co-located with hospitals, to offer the community greater birth place options. The FBCs must have access to on-site obstetric, anaesthetic, neonatal, medical and emergency backup at all times (King Edward Memorial Hospital for Women, n.d.).

Many women who were involved in consultation throughout this process did not know what a FBC was, and when it was explained to them, a large number expressed a desire to access such a service if it was available. Consultation feedback did not support the development of stand alone FBCs.

Most (99%) babies in WA are born in a hospital (Maternal and Child Health Unit, 2005). Midwives, GP obstetricians and obstetricians, anaesthetists, paediatricians, and neonatologists provide care in the hospital setting. Some hospitals have well equipped birthing units supported by emergency theatre access in the event of any obstetric emergency, which may occur during labour and birth. Some hospitals provide only emergency obstetric care, whereas other hospitals provide additional highly specialised services. Whilst not all hospitals provide the same level of service, all care received in WA hospitals must be supported by evidence based guidelines (Maternity Reference Group, 2007).

Where hospitals provide maternity services, women give birth in the labour ward and postnatal care is provided in the postnatal ward for the mother and baby. Return to home is encouraged at a time that is appropriate for the level of care needed. On return home, visiting midwives provide follow up care and then subsequent care is transferred to the child health nurses and GP in the woman's community.

Nursery care for babies requiring minimal support is provided in hospitals with additional supervision and support from paediatricians, and in some instances GPs. Secondary hospitals provide level 1 and level 2 nursery care according to Commonwealth licensing and registration requirements. Paediatricians/neonataologists provide supervision and direction of care for neonates in these nurseries, with nursing care provided by midwives and nurses for neonates who require specialised care. Newborn requirements for more specialised care are stabilised in these settings prior to transfer to KEMH or Princess Margaret Hospital (PMH) (Maternity Reference Group, 2007).

Tertiary level (level 3) nursery care is provided at KEMH and PMH. Level 3 nurseries with intensive care facilities supported by neonatologists and paediatricians are provided at these sites. Statewide retrieval services by the West Australian Neonatal Transport Service (WANTS) are provided through these hospitals for safe transfer of newborns requiring tertiary level of care (Maternity Reference Group, 2007).

## Abbreviations and glossary

**Aboriginal** - in this paper “Aboriginal” refers to all Aboriginal and Torres Strait Islander people.

**Allied health** - professions also involved in health assessment and treatment. Services may be provided through primary health and community care as well as in clinic or hospital settings. Allied Health professions may include clinical psychologists, physiotherapists, occupational therapists, social workers, speech pathologists, audiologists, podiatrists.

**Anaesthetist** - an anaesthetist is a doctor who is educated and trained to administer anaesthesia and manage patients medically before, during and after surgery.

**Antenatal** - concerned with the care and treatment of the unborn child and of pregnant women during pregnancy.

**Appropriate discharge** - discharge home for a mother and her baby from a maternity unit, six or more hours after birth into the care of a visiting midwife service.

**Assisted birth** - birth of an infant through the vagina with the help of instruments such as forceps or a vacuum cup.

**Best practice in maternity care** - care that provides for the best possible outcomes for women and babies in terms of clinical safety and effectiveness. It recognises that different women have different risks in relation to pregnancy and childbirth.

**Caesarean section** - delivery of an infant through a surgical incision in a woman’s abdomen.

**Child health nurse** - registered nurses with post graduate qualifications in child and family health. They work in partnership with parents and carers of babies and children 0-4 years and provide care to the family ten days after a child’s birth.

**Clinical governance** - a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.

**CMP** - Community Midwifery Program WA.

**Consumers** - users of maternity services, for example the pregnant woman and her family.

**Community maternity services** - local services where women and their families can seek support relating to maternity care and early parenting. These clinics can be midwife led, but also incorporate medical and support clinics managed by other health professionals.

**Continuity of care** - care that helps a woman develop a relationship with the same carer, or group of carers, throughout pregnancy, birth and after the birth. All carers share common ways of working and a common philosophy. The aim is to reduce conflicting advice experienced by women.

**Culturally and Linguistically Diverse (CaLD)** - usually refers to people from cultures and backgrounds, who do not use English as their first language.

**Delivery** - birth of the baby and the afterbirth.

**Delivery suite** - the ward, in a maternity unit, where women experience labour and birth.

**Diabetes** - a disorder with high blood sugar levels caused by deficient levels of insulin.

**DoH** - Department of Health.

**Edinburgh Postnatal Depression Score (EPDS)** - a measured score using an assessment tool to reflect a mother's mental wellbeing at a point in time in pregnancy and after birth.

**Elective caesarean section** - birth of a baby through an abdominal incision as a choice by the surgeon (obstetrician or GP obstetrician) on a chosen date and chosen time.

**Emergency or non-elective caesarean section** - unplanned birth of a baby through an abdominal incision for a medical/obstetric reason with evidence of possible compromise to the mother and/or baby.

**Epidural** - a local anaesthetic injected around the spinal sac causing numbness and sometimes lessens movement in the lower part of the body. It usually relieves labour pains effectively.

**Episiotomy** - surgical incision to the perineum during childbirth.

**Evidence based** - the process of systematically finding, appraising and using research findings as the basis for clinical decisions.

**Family Birth Centre (FBC)** - a home like environment where healthy and low risk women can give birth, receive midwifery-led care that provides continuity of care throughout pregnancy, birth and the early postnatal period.

**Fetal assessment** - assessing and monitoring the unborn baby during pregnancy and labour.

**General practitioner (GP)** - a doctor who is qualified and competent in general practice and has the skills to provide whole person, comprehensive, coordinated and continuing medical care.

**Gestational diabetes** - diabetes found in pregnancy; temporary high blood glucose levels in pregnancy.

**GP obstetrician** - a GP obstetrician is a general practitioner who has a diploma in obstetrics from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) or another faculty accredited in Australia by RANZCOG.

**Guidelines** - systematically developed statements that assist in decision-making about appropriate health care for specific clinical conditions.

**Health assessment** - is undertaken throughout pregnancy and includes a holistic assessment so that physical, social and psychological needs are identified and managed appropriately.

**High risk** - women who develop complications in pregnancy, and/or labour, or have a chronic health problem, a chemical substance addiction or a history of serious problems with a previous pregnancy. Where there is a medical complication which has implications on an otherwise healthy pregnancy, labour and birth.

**Home birth** - usually a planned event where the woman decides to give birth at home, with care provided by a midwife or shared care.

**Induction of labour** - starting labour artificially by using drugs or other methods.

**Integrated service** - a multidisciplinary, multi professional approach to service provision.

**Integrated Primary Care Centre** - usually based at a general practice, community clinic or Aboriginal Medical Service. This centre provides multidisciplinary collaborative services including medical, midwifery, nursing, allied health and pathology services.

**Intervention** - clinical procedure in pregnancy, labour or birth, an example being induction of labour, assisted birth or caesarean section.

**KEMH** - King Edward Memorial Hospital.

**Low risk** - women who have no serious health problems or addictions to chemical substances and no history of past serious pregnancy or birth problems. Where there are no complications that implicate an otherwise healthy pregnancy, labour and birth.

**Maternal** - relates to the mother.

**Midwife** - a midwife is a person who has acquired the requisite qualifications to be registered and legally licensed to practise midwifery. Midwives provide care and advice to women during pregnancy, labour and the postpartum period and care for the newborn. A midwife may practise in hospitals, clinics, community health units, domiciliary conditions or in any other service.

**Midwifery group practice** - Midwifery group practice is where women can be cared for by the same midwife (primary midwife) or small group of midwives throughout their pregnancy, during childbirth and in the early weeks at home with a new baby.

**Multidisciplinary care** - a team approach to the provision of healthcare by all relevant medical and allied health disciplines as a means of achieving best practice through their combined collaboration.

**Neonate** - (otherwise known as newborn) refers to a baby from birth until 28 days of life.

**Neonatologist** - a neonatologist is a paediatrician who has specialised in newborn medicine.

**Neonatal Intensive Care Unit (NICU)** - special care nursery for sick and/or premature babies in a tertiary hospital setting.

**Non-Indigenous** - All persons who are not Aboriginal and Torres Strait Islanders.

**Obstetrician** - an obstetrician is a doctor who specialises in the management and care of pregnant women, labour and birth and gynaecology. An obstetrician has specialist education, training and experience and is a fellow of the RANZCOG. Obstetricians provide care in secondary, tertiary and private hospitals.

**Obstetrics** - medical discipline and services relating to the management and care of pregnancy and childbirth.

**Paediatrician** - a paediatrician is a doctor who specialises in care for neonates, babies and children. They have advanced training in children's health and are registered with the Australian College of Paediatrics.

**Paediatrics** - a branch of medicine dealing with the development, care and diseases of children.

**Perinatal** - refers to the period from 20 weeks of pregnancy to 28 days after birth.

**Perinatal mortality** - the statistical rate of fetal and infant death, including stillbirth, from 20 weeks gestation until 28 days after birth (usually expressed as number of deaths per 1000 births).

**Post birth care** - support that is provided after a baby is born, to the mother and the new baby. Also called postnatal care.

**Pre-term labour** - labour occurring at less than 37 completed weeks of pregnancy.

**Protocols** - an adaptation of a clinical guideline or a written statement to meet local conditions and constraints, and which may have legal connotations.

**RANZCOG** - Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

**Shared care** - the provision of care that is shared between GPs, obstetricians, midwives and/or Aboriginal health workers and other specialist team members.

**SOSU** - Statewide Obstetric Support Unit.

**SQuRe** - Safety and Quality Investment for Reform.

**Stakeholder** - any individual or organisation with an interest in maternity care, policies and decision-making.

**Telehealth** - refers to any health services provided by using information and communications technology that removes or mitigates the effect of distance in health care.

**Ultrasound** - a diagnostic test that is performed by using ultrasonic waves and examines the interior organs and structures and in this instance, those of the mother and the unborn baby.

**Uncomplicated birth** - spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and birth. The infant is born spontaneously in the head presenting position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition.

**Vaginal Birth After Caesarean (VBAC)** - birth vaginally following a previous birth by caesarean.

**Woman centred** - the needs of the individual woman provide the focus for the planning, organising and delivery of maternity care.





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