ORD VALLEY ABORIGINAL HEALTH SERVICE
Aboriginal Corporation
ICN 275
1125 Ironwood Drive KUNUNURRA WA 6743
PO BOX 216 Kununurra WA 6743 Phone 08 9168 1288 Fax 08 9168 2053

To Whom it may concern

We are writing on behalf of the Ord Valley Aboriginal Health Service. We are an Aboriginal controlled health organisation in Kununurra in the East Kimberley, the last town before the WA/NT border, who also service remote communities outside of Kununurra, up to 200kms away often via 4WD tracks that are impassable in the wet season. We are located approximately 3,500kms from Perth (nearly the equivalent of Perth to Sydney).

We have a population of approximately 6,000 in the town, with approximately 2,500 active patients with the majority of these patients being indigenous. As a health service our focus is on indigenous health. Our patients also have low literacy levels, and have rarely left this community let alone been to a city. When we see the necessity to send them to a much larger town or city that has facilities and medical specialists that cannot be accessed in the East Kimberley including by tele-health, we also ensure that all medical issues the patient has that requires services not available in Kununurra are attended to. That is, our patients who have often never been to a city, have multiple appointments to attend, and need to navigate a foreign public transport system (there is no public transport system in the East Kimberley for them to be familiar with this system), often with significantly failing health (why they need to leave the East Kimberley), which is a stressful and fraught ordeal.

1) **How adequately PATS delivers assistance to regional people accessing specialist medical care, including:**

a) **the level of funding applied to the transport and accommodation subsidies provided;**

There is rarely an issue with the funding and accommodation subsidies provided for the patient. However, funding is difficult to access to cover the cost of escorts even when there are important medical reasons for the patient to have an escort. Furthermore, even when an escort may be approved for the transport, the accommodation may not be covered. For example, we recently transferred a pregnant lady to Broome and she had an escort with her, but as soon as she went into hospital the escort had to find and fund their own accommodation; this is not the case when they go to Perth for the same situation.

The other issue to face us in the eligibility of escorts to accompany patients to tertiary hospitals, when we submit a PATS form to the local PATS office the escort is usually rejected. We then have to spend a great deal of time, to write a letter to support the initial claim for an escort, and this still does not guarantee success, the escort still being declined. For some patients this means they will not travel and their health problem(s) are not addressed. This does not help to "close the gap" in the health inequality that exists for our clients.

This is the ruling we have been given for escorts accompanying pregnant ladies. –
PATS Ruling on Child Birth to assist when an escort is requested:

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Applicants, who are entitled to the PATS assistance for the delivery of a child, are eligible for the PATS accommodation subsidy for a maximum of three nights prior to the delivery, unless medical reasons are provided by the GP Obstetrician or specialist Obstetrician as to why the applicant needs to be close to the hospital earlier than this.

Where an applicant lives in a remote area where no birthing facilities exist, then accommodation assistance is available for two weeks prior to the confinement date.

Assistance is not provided for an escort unless there are complications that put the mother or baby's life at risk or in cases when the mother and newborn may need an escort to return home, for example, a multiple birth.

These current rules disadvantage our clients as illustrated in the examples given below.

b) **eligibility for PATS funding;**

The eligibility criteria are strictly adhered to and there is very little allowances given outside these criteria. It is also criteria that is applied to the entire state with no allowances given for the unique communities we live in (very small and very remote, often uneducated people with limited experience), and thus little concept of how these people will get to their appointments without a lot of assistance. It is a daunting ordeal even with an escort.

c) **the administration process;**

As long as the PATS form is approved the first time we submit it, then all is fine. However, if the PATS is not approved the first time, the doctor and other health professionals have to spend considerable time writing a verbose letter to support the initial PATS application, despite all this information already being provided (granted that it is in an abbreviated form) on the original PATS form.

d) **Whether there is consideration of exceptional circumstances; and**

As alluded to above, this is done poorly. There is no genuine consideration for the patients' needs and what they will be when they arrive in Perth or other destinations. It is assumed that if they are able bodied they go alone. Can they read? Will they be able to use public transport? Can they communicate to taxi drivers? Will they feel safe? Is their mental state up to the challenge? We have written down things like this as exceptional circumstances but they apparently don't count.

That is, there is no consideration to how our patients will get to their appointments, which often also involves finding your way around a large foreign ('enormous') tertiary hospital.

2) **Any incidental matters.**

Here are some examples:

a) In February, 2014 a young female client with a 3 month old exclusively breastfeeding baby was referred to King Edward Memorial Hospital for investigation and possible surgery. The Doctor

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completed the PATS form stating the reason why the young women would need an escort to help care for the baby, whilst their mother had investigations and possible surgery. The PATS form was rejected for an escort and we were advised by the PATS office that the baby would not be able to go with the mother. After many discussions, the mother was permitted to take an escort and baby with her. These situations cause much anguish to the mother and family as they are already facing concerns related to their illness and referral to a tertiary centre a long way away from family.

b) A young 2 year old child was sent to Princess Margaret Hospital with a serious illness that required intensive ongoing treatment and monitoring which required the mother and child to remain in Perth for at least 6 months. The father and other sibling wanted to be with the child and his mother to provide support and involvement in his care. The PATS form was rejected. Fortunately other community organisations paid for the fare. However, it caused a great deal of stress for the mother of the child and also the child.

c) An antenatal women who had been consulted via Video Conferencing with King Edward Memorial Hospital staff for mental illness and the specialist psychiatrists communicated that she would require intensive support prior to and following the birth of the baby because of her mental fragility. Her PATS form for patient escort was rejected and the Doctor involved was required to provide further information and discussion to enable this to be approved.

By not providing an escort we are often putting our patients at greater risk as the lack of family support is vital during this period and can greatly affect the mental state of a mother who is at risk. Furthermore, often such supporting documentation is required at short notice as the patient needs to travel relatively urgently (within a short time). This is further complicated as the PATS office in Kununurra has limited opening hours and thus to get the extra paper work required approved within a short time is problematic.

d) One lady in her 50s was required to go to Perth. She had a fractured clavicle, and also recent fistula access in her other arm and is nearly blind. She needed surgery in Perth but was declined an escort and went alone, which required a lot of work for the airline, and her having to ask numerous people for help in Perth, causing her a lot of personal and emotional stress.

The trauma often means the patient will not travel out of the East Kimberley again in the future even if it means they will lose their sight, lose a limb or even die. Again this does not facilitate in 'closing the gap'.

TRANSFER OF PATIENTS TO DARWIN (RFDS and otherwise)

As we are so close to Darwin, most of the patients who need emergency treatment are flown to Darwin by RFDS, and are not accompanied by an escort. There is no family support and the family left behind are stressed as they are unaware of what is happening to their family member.

a) Recently we had a man who was flown to Darwin to be in ICU with multi organ failure. He was given a prognosis that he would not survive, and was put on life support. His nephew (closest living relative) was declined PATS to go up to visit, as the PATS office said he had family in Darwin.

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b) A 36 week pregnant lady with risk factors meaning she needed to deliver in Darwin was also recently declined an escort. She has no family in Darwin and has to spend the last 4 weeks of her pregnancy alone. Furthermore, when she delivers there will be no family support. Because the pregnancy is an at-risk pregnancy, there is the significant potential for a bad outcome for either the baby or the mother. Hopefully everything will work out but experience shows us that this is not always the case.

PATIENTS NEEDING TREATMENT AT A HOSPTIAL (BUT NOT A TERITARY HOSPITAL)

Our local service area looks after a number of smaller aboriginal communities as far away as 200 kms from Kununurra often via 4WD tracks that are usually inaccessible in the wet (e.g. Glen Hill). When patients in these communities need to attend the local hospital (the GP run Kununurra Hospital) for regular appointments to await confinement, they can get accommodation (but only for themselves) that is provided by the hospital but are not entitled to an escort or support person, and often have to be in town from 36 weeks. Therefore, they are also away from home, family and any support.

The Clinical Management Team

Dr Andrew Beveridge – SMO
Kylie Newman – Clinical Services Manager
Victoria Salerno – Maternal and Child Health Manager

28th August 2013

Voices from the Kimberley

Birthing Practices and Options for Remote Area Aboriginal Women

Kimberley, Western Australia

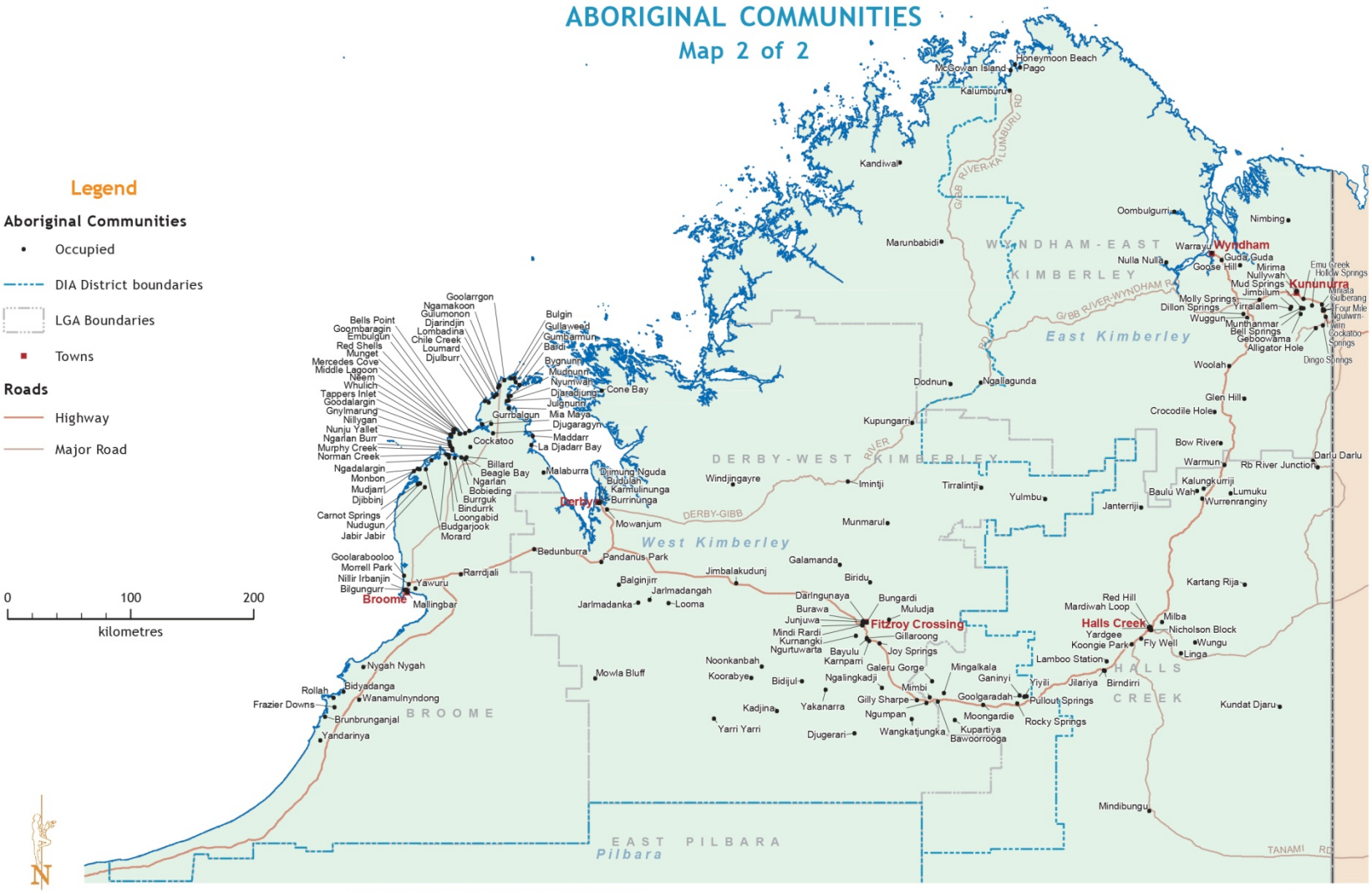
Meleseini Tai-Roche & Millie Hills

Melissa Williams

KIMBERLEY REGION

ABORIGINAL COMMUNITIES

Map 2 of 2

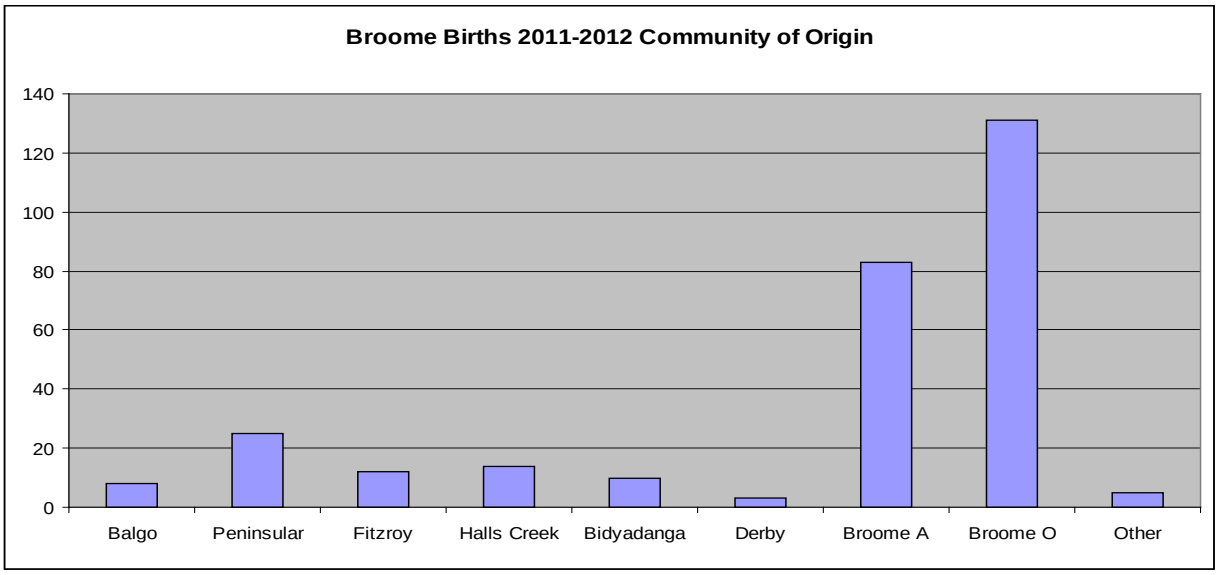


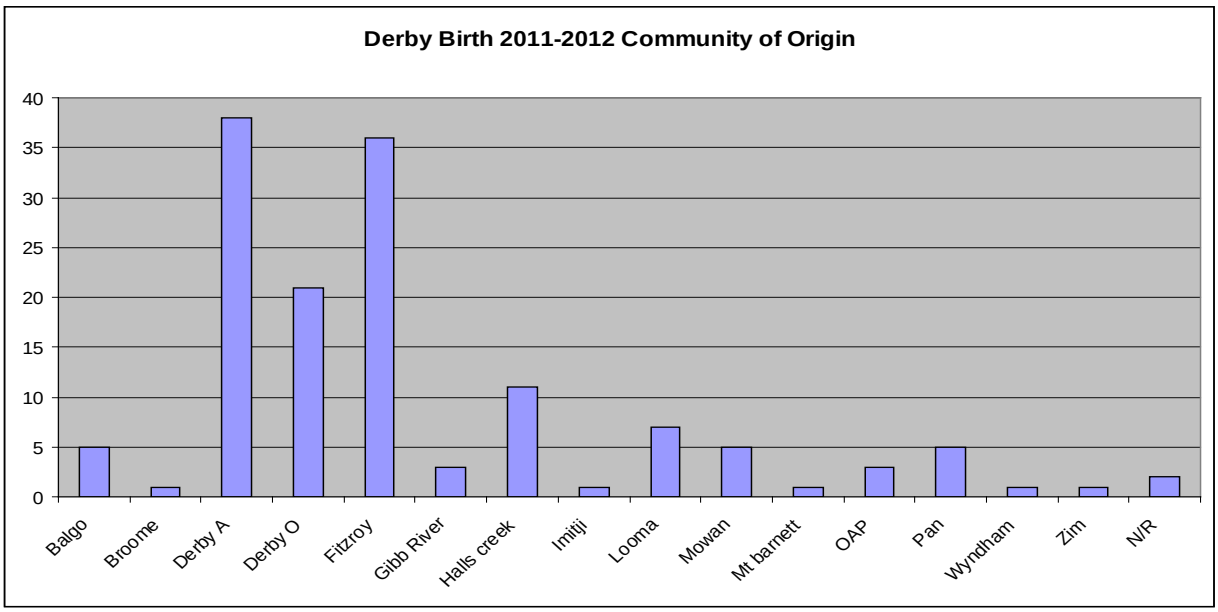
For communities in the remainder of the state, please refer to Map 1 in this set of 2, Western Australia - Aboriginal Communities

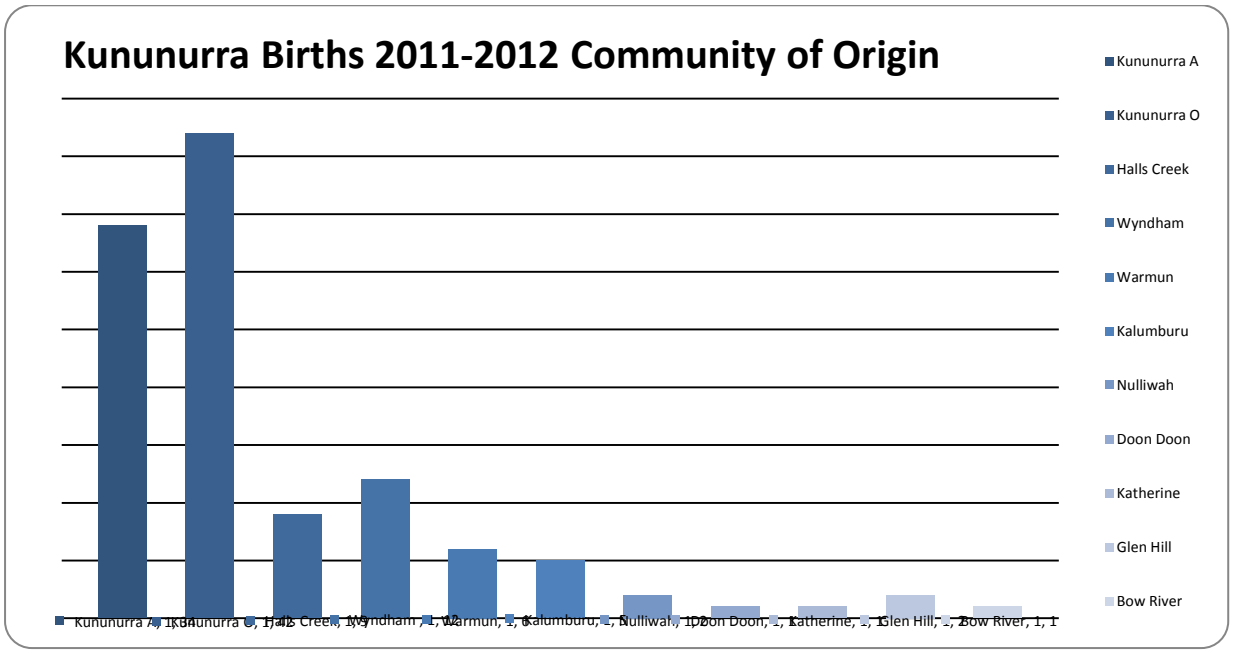
Government of **Western Australia**
Department of **Indigenous Affairs**

Current Kimberley Birthing Services- in brief.

Birth Rate	Broome Hospital	Derby Hospital	Kununurra Hospital	Total
2009/2010	225	172	106	503
2010/2011	258	181	127	566
2011/2012	301	141	119	561
2012/2013	352	138	137	627
Community of Origin (most births)	Broome Dampier Peninsula Bidyadanga Kutjungka	Derby Gibb River Communities Fitzroy Valley Halls Creek Looma Kutjungka	Kununurra Wyndham Warmun Kalumburu Halls Creek Kutjungka	
Gestation to birth	35 weeks	36 weeks	37 weeks	
Accommodation Options	• Private/Family Accommodation • Hotel Accommodation (one hotel in town) • Caravan Park	• Private/Family Accommodation • Derby Hostel Accommodation (8 beds, partner and child can stay depending on availability) • Hotel Accommodation	• Private/Family Accommodation • Wunan Workers Hostel (18 beds, workers get priority, no children or partner allowed) • Hotel Accommodation	
Transport Options from remote communities	• Private vehicle • Greyhound bus +/- mailplane • Charter flight	• Private vehicle • Greyhound bus +/- mailplane • Charter flight • Clinic cars	• Mail Plane • Greyhound Bus • Private vehicle • Half way meet, daily clinic cars	


Broome Births 2011-2012 Community of Origin
140
120
100
80
60
40
20
0
Balgo
Peninsular
Fitzroy
Halls Creek
Bidyadanga
Derby
Broome A
Broome O
Other


Derby Birth 2011-2012 Community of Origin
40
35
30
25
20
15
10
5
0
Balgo
Broome
Derby A
Derby O
Fitzroy
Gibb River
Halls creek
Imitji
Looma
Mowan
Mt barnett
OAP
Pan
Wyndham
Zim
N/R


Kununurra Births 2011-2012 Community of Origin
Kununurra A
Kununurra O
Halls Creek
Wyndham
Warmun
Kalumburu
Nulliwah
Doon Doon
Katherine
Glen Hill
Bow River

What are the current birthing options for Indigenous women living in remote communities?

'All planned births in the Kimberley occur in hospitals able to offer a reasonably full range of care including fetal monitoring, appropriate induction of labour, instrumental deliveries, caesarean section both emergency and elective, and at least a degree of specialized care for the newborn requiring this. The three hospitals in the Kimberley providing these are Derby, Kununurra and Broome. Unplanned births continue to occur in other facilities and at home. Guidelines around when women should travel out of their communities to these areas vary with the distance from and difficulty of transfer to – for example Wyndham has relatively easy road access to Kununurra and women may well stay at Wyndham until they are in very late pregnancy or early labour, whereas from Kalumburu which is only accessible by air we would like women to leave by 38 weeks at the latest. 37-38 weeks is the average transfer time in an uncomplicated pregnancy. ***Wendy Hughes, Kimberley Regional Obstetrician.***

'Kalumburu Health Clinic does not attend planned deliveries. All women leave on confinement at 36 weeks gestation at the latest. Women at high risk of pre term labour may leave earlier'. ***Melanie Woodhams, Kalumburu Midwife***

'Antenatal clinic services provided by Kununurra Hospital are available on a monthly basis to Warmun and Kalumburu communities. Midwife RAN's attend antenatal and postnatal care between these scheduled visits' ***Amy Ritchie, Kununurra Midwife (YYMS)***

'All planned births in remote Kimberley communities, are planned for either one of our three regional hospitals, or referral to Perth for high risk cases. In general, women receive most care in their remote community with RAN/midwives or in some cases GPs/GP registrars. Usually, travel to town is required for a 19-20 week scan, a repeat scan is indicated at 32-34 weeks, and then handover to hospital staff, and transfer into town occurs anywhere between 36-38 weeks gestation. Increased visits to town are directly proportional to increased pregnancy risk'. ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC)***

'The bus service from Halls Creek leaves either at 9pm or 4am (depending on which way you are travelling. Imagine having to spend hours on a bus, pregnant, swollen feet and unable to sleep' ***Amy Rigano, Halls Creek Midwife (YYMS)***

'We thought we were going to Derby hospital for my daughter in law, and we were planning for that, until we got a phone call last minute saying we needed to go to Kununurra. We don't really know Kununurra, but we were told this is where we needed to go. When we got there, they had no paperwork on my daughter in law, and the doctor said she shouldn't be coming here, and she should be in Broome, closer to Balgo. I felt like any minute they would send me home and leave my daughter in law there by herself. I stayed with her though, long

time, maybe 6 weeks, waiting for baby. When she started with the pains, I stayed with her in that hostel for a while, and then I walked her to the hospital to see the midwives, it's a long walk, but a good walk, to help get the baby to come' ***Deanne, Balgo Community***

What are the impacts on women, their families and their communities, when they need to travel to regional centres or cities to give birth?

'There is a financial strain; we have to look after ourselves and our family while we are away' ***Holly Bedford, Halls Creek Community.***

'Distance is too far in one day for ultrasounds, and taking mum's away from their families to wait for babies' ***Delanie Cox, Moongardie Community.***

'Impacts on women, families and communities are very similar whether Caucasian or Indigenous – impacts are determined by remoteness and include family disruption, particularly for women who have other children. There are many practical difficulties for Indigenous women particularly including accommodation whilst awaiting delivery, food supply, security, emotional support (or lack thereof)' ***Dr. Wendy Hughes, Kimberley Regional Obstetrician.***

'Financial pressures as many families in Halls Creek pool their funds to support large extended families. Women out of town waiting to birth put extra pressure on their financial situation, which at most times is stretched to the limit' Amy Rigano, ***Halls Creek Midwife (YYMS)***

'Family support is poorly supported for remote women travelling to Kununurra to birth. 'Escort' support travellers are only supported by the PATS scheme in the cases of antenatal minors or those with complex medical needs which may result in an extended stay in the birth place. The doctor must request this escort if applicable' ***Glenda Sullivan and Amy Ritchie, Kununurra Midwives.***

'The canny or brave women hide out, or just hang on too long and so avoid being moved to a bigger centre. I have in mind the recent response to a woman from Kalumburu who does not want to birth in Kununurra, has refused to get on the plane multiple times and intends to birth in Kalumburu. It is much higher risk and all levels of regional health are concerned, but it is very important for this woman' ***Dr. Fiona Kay, Kimberley Regional Paediatrician***

'When they have to leave family behind and go to await delivery at their birth hospital - overwhelmingly they say they do not like to travel on their own, they do not feel as safe' ***Melanie Woodhams, Kalumburu Midwife***

'There is an accommodation crisis in Derby and Broome for these women, especially during the tourist season. There never seems to be a bed available at the Aboriginal hostel in Derby, so women are being put up at motels and hotels (pubs) and have to get their meals from the

hospital. There is no hostel in Broome. There has been some discussions about not allowing escorts because of the lack of accommodation (escorts still require a room when the woman is in hospital). The midwife has to organize the hostel accommodation well in advance for her ante natal women who will deliver in Derby and much of her time is spent organizing transport and accommodation and PATS for her clients'. ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU)***

'City hospital staffs don't have the time to spend with women from remote areas. Ignorant about her remote community. "They just don't know"! Children fret for their mothers, if the mother is away for several weeks, this impacts on the child's health' ***Glenda Sullivan, Kununurra Midwife***

'Jealousy issues and relationship breakdowns during sit down time. The jealousy occurs both ways. Rates of family violence increases' ***Jill Coole, Family Violence & Drug and Alcohol Worker, Broome***

'Fret for those left behind. Are the children being looked after? What's my partner up to? Is he with another woman? Partner humbugs woman on phone, is she seeing another man?' ***Kununurra Women, Kununurra Community.***

'I have to leave my partner at home. He doesn't want that, but mostly we can't afford for all of us to go. He also looks after all our other mob and family' ***Balgo Community***

'Unable to make contact 24/7. No credit on phone. Partner/family only able to make contact when Clinic is open. Some Communities have no mobile reception' ***Glenda Sullivan, Kununurra Midwife.***

'The bond between fathers and new babies is often lost because fathers aren't present during the birth, and miss out on the close connection and experience of the early days' ***Brendan Tai-Roche, Kutjungka Clinics Manager***

'I don't like going to Perth, it was too long, and cold. I felt shame because I don't know anyone. They put me in an Aboriginal Hostel, but I didn't know any of that mob, because they are all Nungas, different from us' ***Martina, Mulan Community.***

'Women demand or being offered unnecessary inductions due their restlessness and eagerness to get back home to be with family' ***Amy Rigano, Halls Creek Midwife.***

'My husband waits till I call him, then he has to drive down that road. He says waiting in town is too long, and too much humbug' ***Billiluna Community Woman***

'The accommodation, transport and travel options have a large impact on stress levels for pregnant women' ***Emily Carter, Marninwarntikura Fitzroy Women's Resource Centre.***

To what extent is antenatal and postnatal care available to women in remote communities, and how willing are women to participate in these services?

'There is a lot of antenatal and postnatal services here, but we see them at the beginning and at the end, mostly because our grandmothers touch our bellies and tell us we are alright...' ***Halls Creek Woman, Halls Creek Community.***

'The regional obstetrician comes to Fitzroy around 4 times a year and is only in town for the equivalent of one day, and the main focus is gynaecological cases. There is support from the DMO at Derby who flies to Fitzroy crossing every 4-6 weeks to see some of the more complex/high risk antenatal women'. ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU).***

'Currently Halls Creek has two full time Midwives, one at Community Health (Western Australian Country Health Service -WACHS) and one at Yura Yungi Aboriginal Medical Service (ACCHS). Women have a choice between Yura Yungi and WACHS'. ***Amy Rigano, Halls Creek Midwife(YYMS).***

'If midwife doesn't do home visit to me after the birth, its 140kms for me to drive into town for check up, so I talk to my midwife on the phone, because it's hard for me to travel the 140kms for regular check ups' ***Delanie Cox, Moongardie Community.***

'Lack of transport is a real issue for a lot of the women preventing them from getting to appointments. There is no driver at community health or an AHW or APO to assist with getting women to appointments/clinics etc in Derby for their ultrasound scans. A weekly bus service organized by the hospital from Fitzroy crossing to derby takes women to derby for confinement and their scans. There is no public transport service, women have to catch the greyhound bus from Fitzroy crossing at 1am to get to Derby at 6am. ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU).***

'Leaving children (often under the age of 3 years) with family. Family violence often prevents women attending confinement as they either fear for their own safety or that of their children. Isolation of being on their own, if unable to fund a partner/escort. Many of these women live from day to day, trying to save $$ for the trip is unachievable' ***Amy Rigano, Halls Creek Midwife (YYMS).***

'The community Midwife is the sole provider of Midwifery care in Fitzroy crossing and practices in isolation. Her average caseload is around 50 -60 and most of these are high risk antenatal women with underlying chronic disease (diabetes, rheumatic heart disease etc)...' ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU).***

'I don't like going to the sister, as sometimes she growls me. I get shame' ***East Kimberley Woman.***

'Antenatal care offered in remote communities is relatively good. Often this is provided by a qualified midwife, and visits are regular, and women are nurtured and engaged. If referral is needed, General Practitioners are available to assist Midwives, and beyond their scope, regional Obstetricians are contactable by phone and email. It is during the handover to hospital centres where the wheels tend to fall off. Care becomes ad-hoc and women tend to become a little lost in the system. Post birth- discharge planning and documentation is seldom received by the primary health clinic/provider' ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC)***

'It is really good now we have the midwife come to Lombadina. Before we always having to travel to Broome to see midwife. It's much better now' ***Djarindjin Community Woman.***

'Limited choice in care provider. There is only one community Midwife and not always a female doctor in Fitzroy crossing, and no obstetric GP. Unless women want to travel very long distances, they have very few options. The midwife's caseload has been up to 50 antenatal women many of whom are teenagers. Teenage pregnancies are common. This is a very difficult area with regards to possible sexual abuse, referrals to DCP,domestic violence, etc....' ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU).***


Do women have access to culturally appropriate birthing practices?

'We don't really have any for birthing, but we do have for after the baby is born' ***Delanie Cox, Moongardie Community.***

'Anecdotal feedback from our clients indicates strongly NO, they do not have access to culturally appropriate birthing care. English is a second language to many women in Halls Creek, they do not feel confident enough to ask for such things. Furthermore they are not aware they have the right to ask'. ***Amy Rigano, Halls Creek Midwife (YYMS).***

'I have had several discussions with women in Balgo and Halls Creek communities about whether or not they traditionally keep their placenta, women told their stories of bush birthing, and their traditional rituals. When asked if they have ever requested to bring their placenta home to country, most women were shocked, and stated that they would have too much 'shame' to ask at the hospital for their placenta, others stated the journey would be too long to carry it' ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC)***

'She wasn't understanding what the doctor and nurses was saying, I am the only one there speaking her language, they said that the baby was caught inside and the cord was wrapped around its neck, they said if she didn't have an operation/caesarean section, that, that baby would die. That young girl was scared, but I could tell her proper way what they were saying, because I'm her mother in law, and I have had children before' ***Deanne, Balgo Community***

'The young girls are too shy, and don't feel confident to stand up for their rights in hospital and during birth' ***Marcia Farrer, Balgo Community.***

What are some successful programs or initiatives that are occurring in remote communities to improve maternal and child health outcomes?

'MGP model of care is the most appropriate for Aboriginal women – it allows women to get to know their midwife prior to birth and if the midwife can also deliver the woman this is the best care available. Combine this with Aboriginal female support staff to travel with women to the hospital and this would be the ideal model' ***Melissa Williams Regional Maternal and Child Health Co-ordinator (KPHU)***

'The New Directions Programs, particularly in Halls Creek have made a difference. I don't know how Halls Creek did without a midwife in the Aboriginal Health Service for so long. The community women love it' ***Millie Hills, Halls Creek Community***

'The Yanan Yambaji Ngamayi Ngurra Ngu Mothers and Babies Program in Halls Creek is an essential and fantastic service. I feel it is actually relatively unique, as it is truly aboriginal led, and focused, and is completely culturally safe. I feel its community development and grassroots base is very much in line with service and consultation requests from the ground, and from the people themselves' ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC).***

'I love working with the mums and bubs with the midwife. I've learnt a lot from the midwife, and that's why I started the Health Worker course, I want to work in the clinic'. ***Michelle Family Support Worker & Aboriginal Health Worker.***

'Models of Midwifery Group Practice which promotes continuity of care and carer has in its fruition, and will continue to make an incredible difference to the quality of care delivered to remote Aboriginal women in the Kimberley. Whilst in community, midwifery care is largely very good, as most are case loaded by community midwives. It is the travel to sit down time, and the impact of such separation that places these (at times already at risk families), into vulnerable circumstances' ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC).***

'Rural Health West financially supporting the remote visiting midwife to attend monthly antenatal clinics in Warnum and Kalumburu' ***Amy Ritchie, Kununurra Midwife.***

'Federal funding supporting the Traditional Medicine role in the East Kimberley, which encourages locally produced bush medicine for community choice of treatment, this includes child health remedies, such as teething and cold and flu medicine' ***Brendan Tai-Roche, Kutjungka Clinics Manager***

'I really liked having the same midwife in hospital; she stayed with me the whole time' ***Balgo Woman, Balgo Community.***

What kind of developments would you like to see in this area, so that remote Indigenous woman have better access to safe and culturally appropriate birthing practices?

'Build a birth centre in Fitzroy' ***Delanie Cox, Moongardie Community.***

'Fitzroy women would benefit from having a local Aboriginal woman travel with them from Fitzroy cross to the delivery hospital and support them during their stay and birth. This would need to be a paid position and this woman would then provide culturally appropriate advice and care for women when they are birthing' ***Maureen Carter, CEO, Ningilingarri Cultural Health Service***

'Many of the women in Halls Creek are survivors of violence and abuse (sexual, emotional and physical). Making them travel large distances to wait to birth on their own is contributing to poor antenatal and birthing outcomes. What is cheaper, supporting women and partners together for birthing or the cost of the RFDS?'
Amy Rigano, Halls Creek Midwife

'We need a hostel that we can stay, and feel safe, and take our families' ***Balgo Women, Balgo Community.***

'Birthing in Fitzroy Hospital – explore the implications – can they be solved by increasing midwifery & possible blood bank service? ***Jackie Wemyss & Emily Carter, Marninwarntikura Fitzroy Women's Resource Centre.***

'Continued support for community midwives, appropriate hostels, in Broome in particular and attention to food supply' ***Dr Wendy Hughes, Regional Obstetrician***

'Most of the women have a number of social issues going on in their lives and there is no social worker in Fitzroy crossing to help sort some of these issues out' ***Melissa Williams, Regional Maternal and Child Health Co-ordinator KPHU***

'If women do travel to Derby, there needs to be more clinical support and care taken so they are not accessing grog whilst on the stay' ***Jackie Wemyss & Emily Carter, Marninwarntikura Fitzroy Women's Resource Centre.***

'Improved transparency of information across health sectors, so health information can be shared, to improve the quality of maternity care' ***Dr. Stephanie Trust, Medical Director (KAMSC)***

'For continued commute to regional hospitals, innovative ideas for continuity of care, including regional financially supported Doula programs. For women having been consulted repetitively in Halls Creek and the Fitzroy Valley, respectful investment into a birth centre to provide women with genuine choice of birth site' ***Meleseini Tai-Roche, Regional Maternal and Child Health Co-ordinator (KAMSC)***

'I think a culturally appropriate birthing place would be wonderful, but how to meet the needs of all the different groups and their connections to vastly separate lands?' ***Dr Fiona Kay, Regional Paediatrician***

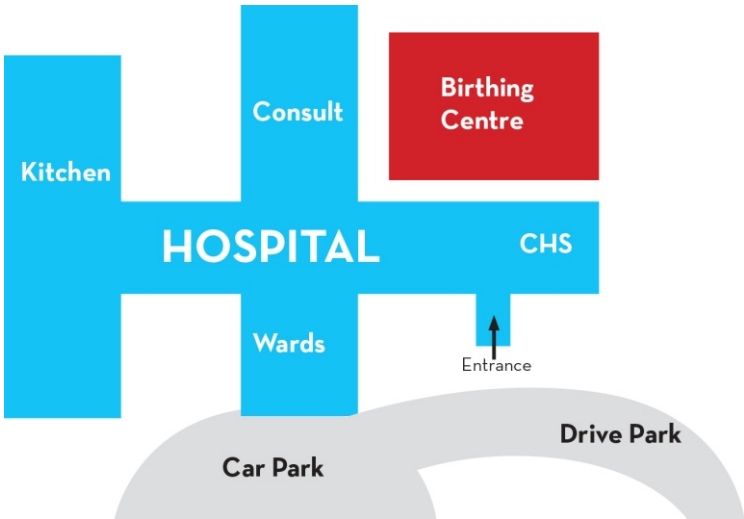
'More Aboriginal midwives and family support workers' ***Amy Rigano, Halls Creek Midwife (YYMS)***

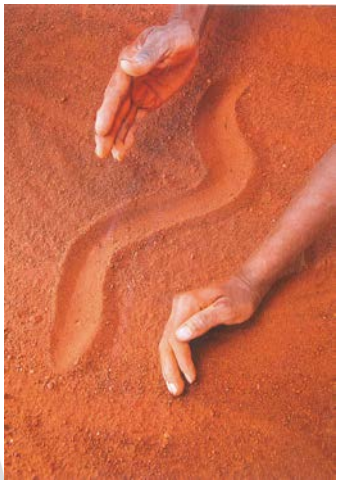
'Women should have an Aboriginal woman go with her to the birth hospital – this should be a paid position – an Aboriginal doula – who can stay with the woman and support her while she awaits her birth' ***Fitzroy Crossing women.***

'We need another midwifery position in the valley. The current midwife has 60 women on her books, which is certainly above the safe standard of 35. We have been petitioning this for four years, with no response' ***Melissa Williams, Regional Maternal and Child Health Co-ordinator KPHU***

'Every woman should be supported at birth by a person of her choice from her own family or that of her partners. All women should be allowed an escort for care to be culturally appropriate. At present only women under 18 years and/or that are high risk can have an escort. They also find not being able to choose their birth hospital very frustrating. Some of the Kalumburu women want to deliver in Royal Darwin Hospital but because it is outside WA and they were not high risk PATS would not fund it. For one woman in particular because she could not have an escort or delivery in Darwin (she felt unsafe in Knx due to fueding) she refused to leave for confinement at 36 weeks, and remained in community until 39 1/2 weeks when she was RDFS out in labour. This causes an untold amount of stress for the woman, her family, the Kalumburu health clinic staff'. ***Melanie Woodhams Kalumburu midwife***

'We want a birth centre in Halls Creek, and we have identified the most appropriate spot' ***Women's Group, Halls Creek Community.***





This document was compiled during April and May 2013. A copy of this document was given to the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs.

The document sits with the Kimberley Aboriginal Health Planning Forum- Regional Maternal and Child Health Subcommittee; and addition and amendment is permitted by the subcommittee as required.

WOT NOW?

Updates 2013 July

- no escorts at all unless **very** special circumstances – and the doctor's recommendation has no impact on this, it is a strict PATS guideline