Aboriginal Health Council of Western Australia

Aboriginal Maternal and Child Health Report

Engagement with Aboriginal Community Controlled Health Services

May 2023

450 Beaufort Street, Highgate, Western Australia, 6003 Ph:(08) 9227 1631 | Fax: (08) 9228 1099

AHCWA | THEAHCWA | www.ahcwa.org.au

Acknowledgement

The Aboriginal Health Council of Western Australia (AHCWA) acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. AHCWA acknowledges the wisdom of Aboriginal elders and leaders, both past and present, and pays respect to Aboriginal communities of today.

About

The Aboriginal Health Council of Western Australia (AHCWA) is the peak body for Aboriginal Community Controlled Health Services (ACCHS) in Western Australia, with 23 Members across the State. AHCWA exists to support and act on behalf of its Member Services, actively representing and responding to their individual and collective needs.

Contents

1.0. Executive Summary

1.1. Background

Aboriginal people experience greater disease burden compared to non-Aboriginal populations.[1] A 2016 report revealed that Aboriginal mothers and children were more likely to experience poorer health outcomes across numerous factors, compared to non-Aboriginal mothers and children.[2] For instance, from 2012-2020, the maternal mortality rate for 'Aboriginal and Torres Strait Islander women was 16.4 per 100,000 women giving birth', compared to the rate for non-Aboriginal women being 5.3 per 100,000 women giving birth (with overall rates increasing with remoteness).[3] Moreover, in 2020, 88 per cent of WA Aboriginal babies were born at a healthy birthweight, compared to 94 per cent of WA non-Aboriginal babies.[4] This is concerning given birthweight is a 'key indicator of infant health and a principal determinant of a baby's chance of survival and good health'[5].

'Aboriginal women are more likely to live remotely, tend to disengage from mainstream maternity services and overall receive less antenatal care than their non-Aboriginal counterparts',[6] with studies suggesting that 'mainstream services do not meet the needs of many Aboriginal women, often breaching cultural norms and expectations'.[7] The Australian Institute of Health and Welfare notes that improvements in pregnancy outcomes are linked to 'ongoing engagement in antenatal care' and stresses the importance of 'culturally appropriate and evidence-based care relevant to the local community'[8]. Further, studies suggest that timely, culturally appropriate services can reduce Aboriginal child and maternal morbidity and mortality.[9]

[1] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. 2020. https://www.indigenoushpf.gov.au/getmedia/f61f0a50-f749-4045-b58f-b2c358db2c6b/2020-summary-ihpf-2.pdf?ext=.pdf (pg. 23).

[2] Western Australia's Mothers and Babies, 2016. 2021. https://ww2.health.wa.gov.au/~/media/Corp/Documents/Reports-and-publications/Perinatal-infant-and-maternal/WA-Mothers-Babies-2016.pdf (pg. xii).

[3] Australian Institute of Health and Welfare. Australia's mothers and babies: Maternal deaths. 2022. https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia#maternal-deaths

[4] Productivity Commission. Table CtG2.1 Live-born singleton babies of healthy birthweight (2500-4499g) (per cent) (a). https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area2

[5] Australian Institute of Health and Welfare. Health of mothers and babies. 2023. https://www.aihw.gov.au/reports/mothers-babies/health-of-mothers-and-babies

[6] WA Country Heath Service. WA Country Health Service Maternal and Newborn Care Strategy 2019–24. 2019. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Strategic-plans/ED-CO-18-83815__eDoc_-_CO_-_2019-03-07_WACHS_Maternal_and_Newborn_Strategy_FINAL_VERSION.pdf (pg. 6).

[7] Simmonds, D.M., West, L., Porter, J., Davies, M., Holland, C., A., Preston-Thomas, O'Rourke, P.K., Tangey, A. The role of support person for Ngaanyatjarra women during pregnancy and birth. 2012. https://doi.org/10.1016/j.wombi.2010.12.007 (pg. 80).

[8] Australian Institute of Health and Welfare. 1.20 Infant and child mortality. 2023. https://indigenoushpf.gov.au/measures/1-20-infant-child-mortality#keymessages

[9] Sivertsen, N., Anikeeva, O., Deverix, J. et al. Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: a systematic review of the literature. 2020. https://doi.org/10.1186/s12913-020-05673-w (pg. 2).

Evidence of limited access to maternal and child health services in remote locations has been attributed to 'inadequate numbers of health professionals, facilities and accommodation; high staff turnover; and limited capacity.[10]

1.2. Purpose of the report

AHCWA currently sits on the Closing the Gap Partnership Planning Group (PPG) One, which is chaired by the WA Department of Health and has representation from other WA government agencies. The purpose of this group is to further WA's progress against the National Agreement on Closing the Gap (the National Agreement) socioeconomic outcome areas (specifically Outcomes 1 and 2), and their associated targets.

- Outcome 1: Aboriginal and Torres Strait Islander people enjoy long and healthy lives.
    - Associated target: Close the Gap in life expectancy within a generation, by 2031.[11]
- Outcome 2: Aboriginal and Torres Strait Islander children are born healthy and strong.
    - Associated target: By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.[12]

As stated, outcome 2's target aims to increase the proportion of Aboriginal children that are born with a healthy birthweight. It is recognised that a healthy birthweight helps to lay the foundations for lifelong health, with healthy birthweight babies having better chances of immediate survival, and good health as children and adults. Although 'most Aboriginal babies are born with a healthy birthweight (89.5% in 2019), the low birthweight rate among Aboriginal babies remains relatively high at 9.2%, compared with 4.9% of non-Indigenous babies'.[13]

In relation to Outcome 2, AHCWA collated feedback from WA ACCHS to capture services available for women and families, key gaps in service provision, and ACCHS' goals in this space. For the purposes of this project, 'maternal and child health' covers preconception care up to the first 2,000 days of life, including postnatal care.

This paper is a summary of findings and associated recommendations from AHCWA's engagement with 15 Member ACCHS. The aim of this paper is to understand the current state of service delivery in relation to maternal and child health, including identifying: the strengths of ACCHS services; the gaps in funding and service delivery; any resources required to improve service delivery; and the way forward.

Maternal service provision across the State varies greatly depending on location, with some clinics undertaking General Practitioner (GP)/hospital shared antenatal care, others extending support into hospitals for a patient's labour and delivery, and a smaller number of ACCHS with fewer resources to provide extensive maternal services. Some ACCHS provide child healthcare including early immunisations, while others rely on WA Country Health Service (WACHS) to provide this service. Further, some clinics

[10] Dossetor, P.J., Thorburn, K., Oscar, J. et al. Review of Aboriginal child health services in remote Western Australia identifies challenges and informs solutions. 2019. https://doi.org/10.1186/s12913-019-4605-0 (pg. 1).
[11] National Agreement on Closing the Gap. 2020. https://www.closingthegap.gov.au/sites/default/files/2021-05/ctg-national-agreement_apr-21.pdf (pg. 17).
[12] Ibid. (pg. 18).
[13] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework: Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies. 2022. https://www.indigenoushpf.gov.au/getattachment/bf116c5d-8fa3-4b7b-b182-6860ea4495a9/birthweight-fa_ihpf_100-may22.pdf. (pg. 1).

provide full child developmental checks, while others have limited resources to provide these child health supports.

Building the capacity of ACCHS to provide culturally secure and autonomous maternal and child health models of care aligns with Priority Reform Two of the National Agreement – Building the Community Controlled Sector[14] and the National Agreement Health Sector Strengthening Plan that states the direction of program funds from mainstream government organisations to the ACCHS sector.[15] It will also have the added benefit of enabling women and children to stay on Country, receiving local care for a longer period of time, which aligns with the aims of the Sustainable Health Review. AHCWA also considers improvements in these areas facilitating cost-savings, with 'the lifetime health impact of interventions delivered by ACCHS [being] 50 per cent greater than mainstream health services'.[16]

1.3. Findings and recommendations

AHCWA's engagement with the ACCHS sector has demonstrated the crucial role that the ACCHS play in providing culturally safe, holistic, maternal and child health care for Aboriginal women and families across WA. The ACCHS have a model of care that is proven to have the best outcomes for Aboriginal health.[17] Despite the complexities of service delivery for maternal and child health care across WA, ACCHS are committed to ensuring a seamless continuity of care for mothers and babies. In order to ensure this continues and to enable ACCHS to build on already established maternal and child healthcare models, resourcing and funding to enable wraparound supports and address gaps in service provision; workforce shortages; discharge summaries; shared provision of care; shared data; and the myriad of issues with the Patient Assisted Transfer Scheme (PATS), must be addressed.

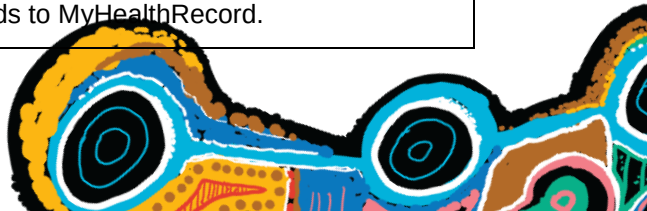
In line with the aims of the PPG and in order to improve the quality of and access to maternal and child health services for Aboriginal women, AHCWA suggests focusing on implementing the nine recommendations as outlined in this paper. Working in partnership and co-design to address these recommendations and therefore the needs of Aboriginal women and children across WA will be a great step forward in achieving the aims of Outcomes 1 and 2 of the National Agreement and their associated targets.

Recommendations for consideration are outlined below.

[14] National Agreement on Closing the Gap. 2020. https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf (pg. 3).
[15] Sector Strengthening Plan: HEALTH. 2021. https://www.closingthegap.gov.au/sites/default/files/2021-12/sector-strengthening-plan-health_0.pdf (pg. 15).
[16] Sector Strengthening Plan: HEALTH. 2021. https://www.closingthegap.gov.au/sites/default/files/2021-12/sector-strengthening-plan-health_0.pdf (pg. 9).
[17] Aboriginal Health Policy Directorate. Outcomes Framework for Aboriginal Health 2020–2030: An outcomes focused approach to funding community-based healthcare services. 2019. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/Outcomes-Framework-for-Aboriginal-Health-2020-2030.pdf (pg. 5).

1.4. Recommendations Summary

Recommendation 1	Work with WA ACCHS to develop solutions to identified areas of need, including exploring options for additional State and Commonwealth funding. Where appropriate, assist with advocacy to the Commonwealth Government to ensure a multi-disciplinary, Aboriginal community-controlled approach to maternal and child health services. Specifically, this should include the following: • Explore opportunities with ACCHS to identify critical areas of need in relation to child and adolescent mental health supports and fund and resource ACCHS to enable children and families to stay on Country for diagnosis and treatment; • Sustainably fund and resource ACCHS to provide wraparound supports to expectant mothers; • Explore options to enable WACHS hospitals to provide transport to and from antenatal hospital appointments; and • Provide sustainable funding to ACCHS that are not funded to provide transport for clients to and from hospital appointments.
Recommendation 2	Work with WA ACCHS to explore opportunities for ACCHS to increase telehealth appointments, thereby reducing the need for PATS and increasing access to services for clients in regional/remote areas.
Recommendation 3	Work with WA ACCHS to identify infrastructure and equipment needs for maternal and child health services and explore options for meeting these needs.
Recommendation 4	In line with Priority Reform Two of the National Agreement on Closing the Gap, support WA ACCHS to implement culturally secure, holistic and multi-disciplinary maternal and child health service models that span prenatal care through to postnatal care, and child health. Based on local needs and capacity, consideration should be given to incorporating Endorsed Midwives, Midwifery Group Practice, wraparound supports and ECHS checks to ensure culturally secure, continuity of care for women and children.
Recommendation 5	In line with Priority Reform Two of the National Agreement on Closing the Gap and the Health Sector Strengthening Plan, work with ACCHS to address salary disparity and other workforce issues, including exploring cross-agency approaches to provide solutions to housing shortages and place-based training.
Recommendation 6	In line with Priority Reform Four of the National Agreement on Closing the Gap, WA Health to prioritise: • Consistent, reliable and timely sharing of patient data and discharge summaries with ACCHS; and • Consistent patient data uploads to MyHealthRecord.



Recommendation 7	In partnership with the ACCHS sector, explore options for improving coordination of care, including travel arrangements, accommodation and general information sharing. This may include funding a coordinator position within Perth and regional hospitals to coordinate care between ACCHS and mainstream, and/or an ALO position to support clients during their relocation.
Recommendation 8	WA Health to complete an audit of the timeliness of all discharge summaries sent to primary health care providers (such as ACCHS) within 24 hours of discharge. Upon completion, commit to sharing these findings with AHCWA, and working with the ACCHS sector to improve these communication pathways.
Recommendation 9	Make changes to PATS to ensure geographical barriers do not impede access to care for Aboriginal mothers travelling off Country for antenatal care and birthing by: • Streamlining processes and provide training to PATS staff (if required) to ensure PATS guidelines are being implemented more consistently across the State; • Expanding the 'escorts' guidelines to include travel subsidies for accompanying children, where alternative arrangements cannot be made; • Expanding the 'escorts' guidelines to include escorts across all necessary antenatal appointments; • Clients receiving payments upfront and in a timely manner, with 'assistance in advance' prioritised; • Increasing funding and resourcing of existing short-stay accommodation facilities and continue investing in increasing accommodation stock to ensure appropriate and culturally safe facilities for birthing mothers; • Increasing PATS accommodation subsidy payments for patients and escorts to reflect increases in state-wide accommodation rates; and • Changing PATS requirements to ensure women travelling for births and high-risk antenatal appointments have the option to travel by airplane, rather than road.

2.0. Background and context

2.1. Literature Review

Aboriginal people experience greater disease burden compared to non-Aboriginal populations,[18] and Aboriginal mothers and babies are no exception. A 2016 report revealed that Aboriginal mothers and children were more likely to experience poorer health outcomes across numerous measures, compared to non-Aboriginal mothers and children.[19] For instance, from 2012-2020, the maternal mortality rate for 'Aboriginal and Torres Strait Islander women was 16.4 per 100,000 women giving birth', compared to the rate for non-Aboriginal women being 5.3 per 100,000 women giving birth (with overall rates increasing with remoteness).[20] Moreover, in 2020, 88 per cent of WA Aboriginal babies were born at a healthy birthweight, compared to 94 per cent of WA non-Aboriginal babies.[21] This is concerning given birthweight is a 'key indicator of infant health and a principal determinant of a baby's chance of survival and good health'[22]. Specifically, low birthweights (below 2.5 kilograms) increase a baby's risk of developing neurological and physical disabilities[23] and the risk of perinatal death amongst preterm babies for Aboriginal women was 11 times higher than those of a healthy birthweight.[24] Further, the Australian Institute of Health and Welfare (AIHW) reports that from 2015 to 2019, the WA Indigenous infant (less than 12 months) and child (0-4 years old) mortality rates were approximately 3 times higher (2.7 and 3.3 respectively) than their non-Indigenous counterparts.[25]

From a child development perspective, it is well-reported that the first 1,000 days are pivotal to the development of a child's health and wellbeing.[26] During this period, 'exposures to dietary, environmental, hormonal, and other stressors […] have been associated with increased risk of adverse health outcomes'.[27] Particularly, poor nutrition in early life can cause 'irreversible damage to a child's neurological, immune and

[18] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report. 2020. https://www.indigenoushpf.gov.au/getmedia/f61f0a50-f749-4045-b58f-b2c358db2c6b/2020-summary-ihpf-2.pdf?ext=.pdf (pg. 23).

[19] Western Australia's Mothers and Babies, 2016. 2021. https://ww2.health.wa.gov.au/~/media/Corp/Documents/Reports-and-publications/Perinatal-infant-and-maternal/WA-Mothers-Babies-2016.pdf (pg. xii).

[20] Australian Institute of Health and Welfare. Australia's mothers and babies: Maternal deaths. 2022. https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia#maternal-deaths

[21] Productivity Commission. Table CtG2.1 Live-born singleton babies of healthy birthweight (2500-4499g) (per cent) (a). https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area2

[22] Australian Institute of Health and Welfare. Health of mothers and babies. 2023. https://www.aihw.gov.au/reports/mothers-babies/health-of-mothers-and-babies

[23] Australian Institute of Health and Welfare. Health of mothers and babies. 2023. https://www.aihw.gov.au/reports/mothers-babies/health-of-mothers-and-babies

[24] Australian Institute of Health and Welfare. Pregnancy and birth outcomes for Aboriginal and Torres Strait Islander women 2016–2018. 2021. https://www.aihw.gov.au/getmedia/678b2bde-60fb-4bf7-be64-3d092a73ea5e/aihw-ihw-234.pdf.aspx?inline=true (pg. v).

[25] Australian Institute of Health and Welfare. Table D1.20.4: Infant (<1) mortality rates per 1,000 live births, by Indigenous status and jurisdiction, NSW, Qld, WA, SA and NT, 2015–2019. https://www.indigenoushpf.gov.au/measures/1-20-infant-child-mortality/data#DataTablesAndResources; Australian Institute of Health and Welfare. Table D1.20.1: Child (0–4) mortality rates, by Indigenous status and jurisdiction, NSW, Qld, WA, SA and NT, 2015–2019. https://www.indigenoushpf.gov.au/measures/1-20-infant-child-mortality/data#DataTablesAndResources

[26] Moore T, Arefadib N, Deery A, West S. The First Thousand Days: An Evidence Paper. 2017. (pg. 1).

[27] Karakochuk, C. D., Whitfield, K. C., Green, T. J., & Kraemer, K. The biology of the first 1,000 days. 2017. https://doi.org/10.1201/9781315152950 (pg. xv).

physical development'.[28] Regarding developmental milestones, the National Agreement on Closing the Gap (the National Agreement) specifies the need to 'increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent', to ensure 'Aboriginal and Torres Strait Islander children thrive in their early years'.[29] In WA, only 31.3 per cent of Aboriginal children were assessed as developmentally on track across all five domains in 2021, a decrease of 0.1 per cent from 2018.[30] This compares to 34.3 per cent of Aboriginal and Torres Strait Islander children at a national level.[31] According to the 2021 AEDC, Aboriginal children in very remote areas across WA, as well as Aboriginal children living in the most disadvantaged socio-economic areas (as defined in the Index for Relative Socio-Economic Disadvantage), were least likely to be developmentally on track across all five domains (18.6 per cent[32] and 25.9 per cent[33] respectively).

Regarding maternal services, the WA Country Health Service (WACHS) Maternal and Newborn Care Strategy 2019–24 reports that 'Aboriginal women are more likely to live remotely, tend to disengage from mainstream maternity services and overall receive less antenatal care than their non-Aboriginal counterparts'.[34] Further evidence shows that factors, such as geographic isolation, cost, language barriers, and lack of culturally appropriate mainstream services, Aboriginal people experience poorer maternal and child health outcomes, particularly with increasing remoteness.[35] Evidence of limited access to maternal and child health services in remote locations has been attributed to 'inadequate numbers of health professionals, facilities and accommodation; high staff turnover; and limited capacity'.[36]

Furthermore, studies suggest that 'mainstream services do not meet the needs of many Aboriginal women, often breaching cultural norms and expectations'.[37]The AIHW notes that improvements in pregnancy outcomes are linked to 'ongoing engagement in antenatal care' and stresses the importance of 'culturally

[28] Arabena, K., Ritte, R., Panozzo, S., Leah, J., & Rowley, K. First 1000 days Australia: An Aboriginal and Torres Strait Islander led early life intervention. 2016. https://search.informit.org/doi/10.3316/ielapa.787670037757824. (pg. 21).
[29] Productivity Commission. Closing the Gap: Socioeconomic outcome area 4, Target 4. https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area4
[30] Productivity Commission. Table CtG4.1 Proportion of children assessed as developmentally on track in all five domains of the Australian Early Development Census, state and territory and Australia, by Indigenous status. https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area4
[31] Productivity Commission. Table CtG4.1 Children assessed as developmentally on track in all five domains of the Australian Early Development Census (per cent). https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area4
[32] Productivity Commission. Table CtG4A.4 Children assessed as developmentally on track in all five domains of the Australian Early Development Census, state and territory and Australia, by Indigenous status, by remoteness area. https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area4
[33] Productivity Commission. Table CtG4A.5 Children assessed as developmentally on track in all five domains of the Australian Early Development Census, state and territory and Australia, by Indigenous status, by Index of Relative Socioeconomic Disadvantage. https://www.pc.gov.au/closing-the-gapdata/dashboard/socioeconomic/outcome-area4
[34] WA Country Heath Service. WA Country Health Service Maternal and Newborn Care Strategy 2019–24. 2019. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Strategic-plans/ED-CO-18-83815__eDoc_-_CO_-_2019-03-07_WACHS_Maternal_and_Newborn_Strategy_FINAL_VERSION.pdf (pg. 6).
[35] Sivertsen, N., Anikeeva, O., Deverix, J. et al. Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: a systematic review of the literature. 2020. https://doi.org/10.1186/s12913-020-05673-w (pg. 2).
[36] Dossetor, P.J., Thorburn, K., Oscar, J. et al. Review of Aboriginal child health services in remote Western Australia identifies challenges and informs solutions. 2019. https://doi.org/10.1186/s12913-019-4605-0 (pg. 1).
[37] Simmonds, D.M., West, L., Porter, J., Davies, M., Holland, C., A., Preston-Thomas, O'Rourke, P.K., Tangey, A. The role of support person for Ngaanyatjarra women during pregnancy and birth. 2012. https://doi.org/10.1016/j.wombi.2010.12.007 (pg. 80).

appropriate and evidence-based care relevant to the local community'.[38] Further, studies suggest that timely, culturally appropriate services can reduce Aboriginal child and maternal morbidity and mortality.[39]

Research confirms that continuity of care models provide more culturally safe, antenatal and postnatal care.[40] However, a 2020 study indicates there is limited 'evidence of continuity of care for Aboriginal women living and birthing in regional and metropolitan areas'.[41] Specifically, an audit of WA publicly funded antenatal services for Aboriginal women found that approximately three quarters of antenatal services used were not culturally responsive.[42] These factors would presumably have impacts on antenatal appointment attendance. In 2020, WA had the lowest rate of Aboriginal women (who gave birth at 32 weeks or more gestation) attending five or more antenatal visits, at 81.6 per cent, compared to 88.4 per cent nationally.[43] For example, studies indicate a lack of culturally appropriate antenatal care models for Aboriginal women as a contributing factor to cases of congenital syphilis in women, as many of these women have no or limited antenatal care.[44] (Cases of congenital syphilis are considered sentinel events and should not be frequent in developed countries.[45]) It is recommended in the WA Health's Public Health Review of Congenital Syphilis Cases in WA Jan 2019 – June 2021 Summary Report that 'consultation with communities to ensure culturally secure and culturally sensitive antenatal care is […] offered'.[46]

Strong research indicates that when implementing Birthing on Country models (or improving services to align with this model), as well as planning, developing and monitoring Aboriginal maternal services, the RISE Framework is a useful tool.[47] 'The RISE Framework has four pillars to drive important reform: (1) Redesign the health service; (2) Invest in the workforce; (3) Strengthen families; and, (4) Embed Aboriginal

[38] Australian Institute of Health and Welfare. 1.20 Infant and child mortality. 2023. https://indigenoushpf.gov.au/measures/1-20-infant-child-mortality#keymessages

[39] Sivertsen, N., Anikeeva, O., Deverix, J. et al. Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: a systematic review of the literature. 2020. https://doi.org/10.1186/s12913-020-05673-w (pg. 2).

[40] Sivertsen et al. A call for culture-centred care: exploring health workers' perspectives of positive care experiences and culturally responsive care provision to Aboriginal women and their infants in mainstream health in South Australia. 2022. https://doi.org/10.1186/s12961-022-00936-w (pg. 2).

[41] Sivertsen, N., Anikeeva, O., Deverix, J. et al. Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: a systematic review of the literature. 2020. https://doi.org/10.1186/s12913-020-05673-w (pg. 1).

[42] Australian Institute of Health and Welfare. 3.01 Antenatal care. 2022. https://indigenoushpf.gov.au/measures/3-01-antenatal-care

[43] Productivity Commission. Figure SE2d.1 Proportion of Aboriginal and Torres Strait Islander women who gave birth at 32 weeks or more gestation and who attended five or more antenatal visits. https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area2/use-of-antenatal-care

[44] Public Health Review of Congenital Syphilis Cases in WA Jan 2019 – June 2021 Summary Report. 2021. https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Sexual-health/SORG/Public-Health-Review-of-Congenital-Syphilis-Cases-in-WA-Report_Final.pdf (pg. 3, 10); Wu, M. X. Congenital syphilis on the rise: testing and recognition are key. 2021. https://www.mja.com.au/journal/2021/congenital-syphilis-rise-testing-and-recognition-are-key.

[45] Peng, L.W, Gao, Y.J, Cui, Y.l,, Xu, H., & Gao Z.X. Missed opportunities for screening congenital syphilis early during pregnancy: A case report and brief literature review. 2023. doi: 10.3389/fpubh.2022.1073893.

[46] Public Health Review of Congenital Syphilis Cases in WA Jan 2019 – June 2021 Summary Report. 2021. https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Sexual-health/SORG/Public-Health-Review-of-Congenital-Syphilis-Cases-in-WA-Report_Final.pdf (pg. 11).

[47] Kildea S, Hickey S, Barclay L, Kruske S, Nelson C, Sherwood J, Allen J, Gao Y, Blackman R, Roe YL. Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework. 2019. doi: 10.1016/j.wombi.2019.06.013. (pg. 466).

and/or Torres Strait Islander community governance and control. [...] Each pillar [presents mechanisms for] moving from the standard 'western' model of maternity care towards Birthing on Country services.'[48]

A comprehensive literature review was included in the 2010 Aboriginal Maternal and Child Project Strengths and Needs Analysis[49] and associated model of care work undertaken by the AHCWA in 2010.[50] Despite it being over ten years later, many findings are similar and remain relevant today.

2.1.1. Jurisdictional Analysis

In other jurisdictions, evidence-based, culturally appropriate, maternal and child health continuity of care models are present, such as the Aboriginal Family Birthing Program in South Australia, Birthing in Our Community in Queensland, Waminda's Birthing on Country Centre of Excellence in New South Wales and Aboriginal Maternal and Child Health services in Victoria. These programs provide services to Aboriginal families from antenatal care through to (in some cases) the first 1,000 days of a child's life.

The Aboriginal Family Birthing Program (AFBP) is facilitated in a purpose-built unit at the Women's and Children's Hospital and provides culturally safe care from pregnancy to six weeks postnatal. The unique aspects of this continuity of care model is that it incorporates an Aboriginal Maternal Infant Care (AMIC) worker. AMIC workers are Aboriginal health professionals that undertake clinical, social and cultural care tasks throughout a woman's antenatal and postnatal period and have training to manage 'imminent unplanned births in a community setting'.[51] Evidence indicates that women value the AMIC role, and more generally, women's attendance in the AFBP facilitates more positive experiences than attendance in mainstream public maternity services.[52]

The Birthing in Our Community (BiOC) program is facilitated in partnership with community-controlled organisations, the Institute for Urban Indigenous Health (IUIH) and Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane, and the Mater Mothers' hospital. Delivered out of the Mums and Bubs Hub, the BiOC program provides continuity of care, from pregnancy, birth and labour, up to six weeks postnatal, 'birthing support, 'Stop Smoking in its Tracks' incentive program, perinatal mental health, breastfeeding support and family support services'.[53] Each woman is cared for by their own 24/7 on-call midwife and is supported by Indigenous health workers and student midwives, doctors, and other health professionals. Evidence reveals that the BiOC program has significantly improved maternal and child health outcomes.[54] Specifically, compared to women receiving standard care, women receiving BioC services were more likely to attend five or more antenatal visits and breastfeed upon hospital discharge,

[48] Kildea S, Hickey S, Barclay L, Kruske S, Nelson C, Sherwood J, Allen J, Gao Y, Blackman R, Roe YL. Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework. 2019. doi: 10.1016/j.wombi.2019.06.013. (pg. 466).

[49] Larson, A., & Bradley, R. Aboriginal Maternal and Child Project Strengths and Needs Analysis. 2010.

[50] Aboriginal Health Council of Western Australia. Maternal and Child Health Model of Care in the Aboriginal Community Controlled Health Sector. 2010.

[51] R. Kirkham, A. Rumbold, E. Hoon, D. Stuart-Butler, V. Moore. Emotional labour and aboriginal maternal infant care workers: The invisible load. 2018. https://doi.org/10.1016/j.wombi.2017.07.001 (pg. 101).; Stamp G, Champion S, Anderson G, Warren B, Stuart-Butler D, Doolan J, Boles C, Callaghan L, Foale A, Muyambi C. Aboriginal maternal and infant care workers: partners in caring for Aboriginal mothers and babies. 2008. https://doi.org/10.22605/RRH883

[52] Middleton, P., Bubner, T., Glover, K., Rumbold, A., Weetra, D., Scheil, W., & Brown, S. 'Partnerships are crucial': an evaluation of the Aboriginal Family Birthing Program in South Australia. 2017. https://doi.org/10.1111/1753-6405.12599 (pg. 25).

[53] https://statements.qld.gov.au/statements/80489

[54] Kildea, et. al. Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial. 2021. https://doi.org/10.1016/S2214-109X(21)00061-9

and were less likely to birth pre-term.[55] A 2019 study reinforces the importance of these results as it discusses how 'Increasing term birth will impact all other Closing the Gap targets (e.g. life expectancy, literacy, year 12 completion rates and employment targets) as babies born preterm are at greater risk of dying in infancy and more likely to be diagnosed with developmental delays that impact school readiness and attainment'.[56]

Both Waminda South Coast Women's Health and Welfare Aboriginal Corporation (Waminda)'s Birthing on Country Centre of Excellence and Aboriginal Maternal and Child Health services (Aboriginal maternal and child health program) in Victoria are exemplar references of Aboriginal community-controlled organisations having self-determination to deliver place-based maternal and child health programs. Waminda's Birthing on Country Centre of Excellence is the first purpose-built birthing centre that is community-controlled and incorporates Birthing on Country principles. Through this program[57], Waminda, whose staff already provide 'community focused, holistic, continuity of midwifery care',[58] will have the opportunity to co-design a culturally secure space for community births.[59] In Victoria, the 2022-23 State Budget committed ongoing funding for the Aboriginal maternal and child health program. It provided 15 Aboriginal Community Controlled Organisations (ACCOs) with funding to deliver universal primary healthcare for children from birth to school age.[60] This flexible funding model for ACCOs and ACCHS to deliver place-based, culturally appropriate services is a key example of how Governments and the Aboriginal community-controlled sector can work together to provide better maternal and child health outcomes for Aboriginal communities.

2.2. Policy Context

Outcomes 1, 2, and 4 of the National Agreement directly affect maternal and child health.

- Outcome 1: Aboriginal and Torres Strait Islander people enjoy long and healthy lives.
  - Associated target: Close the Gap in life expectancy within a generation, by 2031.[61]
- Outcome 2: Aboriginal and Torres Strait Islander children are born healthy and strong.
  - Associated target: By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.[62]
- Outcome 4: Aboriginal and Torres Strait Islander children thrive in their early years
  - Associated target 'By 2031, increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent'.[63]

AHCWA considers that investment in maternal and child health services also supports Outcomes 11 and 12 of the National Agreement – Aboriginal and Torres Strait Islander young people are not overrepresented

[55] Kildea, et. al. Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial. 2021. https://doi.org/10.1016/S2214-109X(21)00061-9 (pg. e651).
[56] Kildea, S., Gao, Y., Hickey, S., Kruske, S., Nelson, C., Blackman, R., Tracy, S., Hurst, C., Williamson, D. and Roe, Y. Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: a prospective cohort study, Brisbane, Australia. 2019. https://doi.org/10.1016/j.eclinm.2019.06.001 (pg. 44).
[57] https://waminda.org.au/maternity/minga-gudjaga/
[58] https://waminda.org.au/2022/10/22-5-million-for-birthing-on-country/
[59] Ibid.
[60] https://www.health.vic.gov.au/maternal-child-health/aboriginal-maternal-and-child-health-aboriginal-led-mch-services
[61] National Agreement on Closing the Gap. 2020. https://www.closingthegap.gov.au/sites/default/files/2021-05/ctg-national-agreement_apr-21.pdf (pg. 17).
[62] Ibid. (pg. 18).
[63] Ibid. (pg. 20).

in the criminal justice system, and Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system.[64]

In addition to the National Agreement, the WA Aboriginal Health and Wellbeing Framework (the Framework) also states that improved maternal and child health is key to ensure healthy life outcomes. Strategic direction 4.1 of the Framework is to 'promote good health across the life course', with the strategic outcome for this direction stating: 'Aboriginal people engage with culturally secure, evidence-based programs and services at transition points across the life course to support ongoing health and wellbeing'.[65]

AHCWA acknowledges that the State Government seeks to invest in Birthing on Country programs, as well as pursue opportunities under the Commonwealth-funded Australian Nurse-Family Partnership Program. As per WA's Closing the Gap Jurisdictional Implementation Plan (WA Jurisdictional Implementation Plan), the WA Government has agreed to 'establish a state-wide program to ensure that all Aboriginal families have access to culturally secure antenatal care', invest 'in an Aboriginal maternity workforce', and provide 'education and support services for maternal health risk factors'.[66] Furthermore, the Sustainable Health Review (SHR) Recommendation 8 states that supporting the health of Aboriginal mothers and babies is a priority and that 'culturally appropriate maternity services provided to Aboriginal mothers and babies is known to have a strong positive outcome on their health and wellbeing'.[67] This sentiment is also reinforced in the WACHS Maternal and Newborn Care Strategy 2019–24, in its mission to 'support country mothers and their families to access high quality maternal and newborn care services closer to home and on country, regardless of where they give birth',[68] and the WA Syphilis Outbreak Response Action Plan Priority Area 5, which emphasises the need to 'increase the uptake of routine antenatal screening in line with state-wide clinical guidelines'.[69]

At a national level, the 2019 report by the Council of Australian Governments Health Council, Woman-centred care: Strategic directions for Australian maternity services, emphasises the importance of 'culturally safe and responsive maternity care'.[70] Strategic direction 3 stipulates the 'Develop[ment] and implement[ation of] culturally safe, evidence-based models of care in partnership with Aboriginal and Torres Strait Islander people and communities', which includes Aboriginal women accessing care through the 'Birthing on Country' model.[71] Similarly, the National Action Plan for the Health of Children and Young

[64] Ibid. (pg. 28, 30).
[65] WA Aboriginal Health and Wellbeing Framework 2015–2030. 2022. https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/12853_WA_Aboriginal_Health_and_Wellbeing_Framework.pdf (pg. 10).
[66] Closing the Gap Jurisdictional Implementation Plan Western Australia. 2021. https://www.wa.gov.au/system/files/2021-09/Implementation%20Plan%20-%20CtG_1.pdf (pg. 49).
[67] Sustainable Health Review: Final Report to the Western Australian Government. 2019. https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf (pg. 71).
[68] WA Country Heath Service. WA Country Health Service Maternal and Newborn Care Strategy 2019–24. 2019. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Strategic-plans/ED-CO-18-83815__eDoc_-_CO_-_2019-03-07_WACHS_Maternal_and_Newborn_Strategy_FINAL_VERSION.pdf (pg. 12).
[69] WA Syphilis Outbreak Response Action Plan. 2020. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sexual-Health/PDF/SORG/SORG-Action-plan.pdf (pg. 10)
[70] COAG Health Council. Woman-centred care: Strategic directions for Australian maternity services. 2019. https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf (pg. 10).
[71] COAG Health Council. Woman-centred care: Strategic directions for Australian maternity services. 2019. https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf (pg. 10).

People 2020 – 2030 highlights the importance of 'Aboriginal and Torres Strait Islander children and young people' as a priority group for investment.[72]

[72] National Action Plan for the Health of Children and Young People: 2020-2030. 2019. https://www1.health.gov.au/internet/main/publishing.nsf/Content/4815673E283EC1B6CA2584000082EA7D/$File/FINAL%20National%20Action%20Plan%20for%20the%20Health%20of%20Children%20and%20Young%20People%202020-2030.pdf

3.0. Engagement and Methodology

3.1. Purpose of engagement process

AHCWA currently sits on the Closing the Gap Partnership Planning Group (PPG) One, which is chaired by the WA Department of Health and has representation from other WA government agencies. The purpose of this group is to further WA's progress against the National Agreement socioeconomic outcome areas (specifically Outcomes 1 and 2), and their associated targets.

Outcome 2's target aims to increase the proportion of Aboriginal[73] children that are born with a healthy birthweight. It is recognised that a healthy birthweight helps to lay the foundations for lifelong health, with healthy birthweight babies having better chances of immediate survival, and good health as children and adults. Although 'most Aboriginal babies are born with a healthy birthweight (89.5% in 2019), the low birthweight rate among Aboriginal babies remains relatively high at 9.2%, compared with 4.9% of non-Indigenous babies'.[74]

In relation to Outcome 2, AHCWA collated feedback from WA ACCHS to capture services available for women and families, key gaps in service provision, and ACCHS' goals in this space. For the purposes of this project, 'maternal and child health' covers preconception care up to the first 2,000 days of life, including postnatal care.

This paper is a summary of findings and associated recommendations that resulted from AHCWA's engagement with Member ACCHS. The aim of this paper is to understand the current state of service delivery in relation to maternal and child health, including identifying: the strengths of ACCHS services; the gaps in funding and service delivery; any resources required to improve service delivery; and the way forward.

AHCWA conducted consultations with 16 ACCHS spread across nearly all WA regions. One ACCHS indicated that they do not currently provide any maternal health services, although this is a future goal. As such, this paper compares responses from the 15 ACCHS that are currently providing maternal and child health services.

Maternal and child health service provision varies greatly depending on location, with some clinics undertaking General Practitioner (GP)/hospital shared antenatal care, others extending support into hospitals for a patient's delivery, and a smaller number of ACCHS with fewer resources to provide extensive maternal services. Some ACCHS provide child healthcare including early immunisations, while others rely on WACHS to provide this service. Further, some clinics provide full child developmental checks, while others have limited resources to provide these child health supports.

[73] Throughout this report, AHCWA uses the term 'Aboriginal' to respectfully refer to all Aboriginal and Torres Strait Islander people across Western Australia.

[74] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework: Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies. 2022. https://www.indigenoushpf.gov.au/getattachment/bf116c5d-8fa3-4b7b-b182-6860ea4495a9/birthweight-fa_ihpf_100-may22.pdf. (pg. 1).

3.2. Methodology

Initial work entailed a literature and data review, including reviewing a 2010 AHCWA Aboriginal Maternal and Child Project Strengths and Needs Analysis. Many needs and issues that were discussed in this earlier analysis are still relevant 13 years later, demonstrating the need for improved investment and systemic change in maternal and child health.

ACCHS CEOs and Clinical Leads were asked to participate in interviews (face-to-face or virtual) and to nominate the most appropriate clinical staff to join, such as midwives, GP-Obstetricians and child health nurses. The following information was mostly gathered through interviews with ACCHS, and where possible, other stakeholders. Supplemental information was gathered through observation and review of available documentation, such as funding applications, service statistics and ACCHS publications, e.g., annual reports.

4.0. Findings

There was a great deal of consistency across the ACCHS, despite several different maternal models of care. The following sections identify AHCWA's findings, which have been grouped together under four themes: Funding and resourcing for ACCHS service provision; Workforce; Partnerships and Collaboration; and Patient Assisted Transfer Scheme and Short-stay Accommodation.

4.1. Funding and resourcing for ACCHS service provision

4.1.1. Importance of ACCHS service provision

ACCHS offer a great opportunity to improve the health of Aboriginal mothers, infants and children, with many ACCHS already providing excellent maternal and child health services to their communities. However, all services indicated that they struggle to meet identified gaps in service delivery due to inadequate resources, breaks in continuity of care, and the lack of a shared vision nationally and within WA of what is the appropriate role for ACCHS.

It is widely recognised that antenatal care is of crucial importance and can help with the early identification of preventable risk factors that adversely impact maternal and child health outcomes.[75] Aboriginal mothers who attend five or more antenatal visits during pregnancy are less likely to have a low birthweight baby (7.2 per cent), compared with those who attended two to four antenatal visits (16.9 per cent) or one antenatal visit (24.2 per cent).[76] Further, the risk of a low birthweight baby is 17 times higher amongst Aboriginal women who did not receive antenatal care during their first trimester, when compared to their counterparts who commenced antenatal care during the first trimester.[77] Consequently, access to appropriate, culturally safe and regular antenatal care is critical to address the factors associated with low birthweight.

Given that many ACCHS are located in, and trusted by community, ACCHS are ideally placed to provide consistent antenatal care throughout the duration of a pregnancy. The important role that ACCHS have in leading culturally safe care in community, and the need to ensure mainstream services provide culturally responsive care is highlighted in the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 which identifies culture as a key protective factor for Aboriginal health and wellbeing.[78]

All consulted ACCHS stressed the need for increased funding to ensure sustainable programs that meet the needs of Aboriginal women and children in their communities, which requires access to a culturally secure service and continuity of care. Previous model of care work undertaken by AHCWA in 2010 identified that maternal models of care should be planned and delivered within a community-focussed and culturally secure service to ensure family needs and inequalities are addressed. It outlines that 'integration of

[75] Australian Indigenous HealthInfoNet. Overview of Aboriginal and Torres Strait Islander health status, 2022. 2023. https://healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=691979&title=Overview+of+Aboriginal+and+Torres+Strait+Islander+health+status+2022&contentid=46464_1

[76] Aboriginal and Torres Strait Islander Health Performance Framework. 1.01 Birthweight. 2023. https://www.indigenoushpf.gov.au/measures/1-01-birthweight

[77] Australian Institute of Health and Welfare. Pregnancy and birth outcomes for Aboriginal and Torres Strait Islander women 2016–2018. 2021. https://www.aihw.gov.au/getmedia/678b2bde-60fb-4bf7-be64-3d092a73ea5e/aihw-ihw-234.pdf.aspx?inline=true.

[78] Aboriginal and Torres Strait Islander Health Performance Framework. 1.01 Birthweight. 2023. https://www.indigenoushpf.gov.au/measures/1-01-birthweight.

maternal and child health within a primary health model which values multiagency working is a key means of delivering this model of care'.[79]

Along with meeting commitments under the National Agreement, addressing maternal and child health needs and bolstering the ACCHS sector's capacity to meet these needs, has the added benefit of reducing pressure elsewhere in the health system. For example, one ACCHS suggested that their increased activity in this space has led to reduced pressure on local tertiary services. Another ACCHS explained that identifying pregnancy and booking in visits before 13 weeks has increased from approximately 13 per cent in 2013/14 to 60 per cent now, demonstrating the critical importance of the ACCHS in relation to delivering maternal and child health services in that region.

Addressing maternal and child health needs using a local, place-based model also aligns with the recommendations of the SHR, which aim to shift the health system from a reactive, acute hospital-based system to one focused on prevention, equity, early child health and access to services at home and in the community.

Many ACCHS operate under their own holistic maternal and child health service model that is specific to community needs. ACCHS identified the need for government to support and resource their locally focussed and person and community-centred service models to ensure sustainable, long-term services and improved health outcomes. Without adequate funding and support, these localised models will struggle to achieve their intended outcomes. One ACCHS explained that it is "proven that the model works, we just need funding".

Another ACCHS stated that following community demands for changes to the current public health maternal and child health model, they have developed their own culturally secure, holistic model. However, they also mentioned the difficulty in securing funding to implement this model, explaining that they attempt to source funding from a variety of different streams, including philanthropic, research and mining sectors. The ACCHS explained that there was a clear need for funding models to change and that governments need to sustainably support locally designed models if there is to be real improvements in maternal and child health.

These findings are consistent with recommendations made in literature, which notes that 'more focus on prevention and support, particularly for at-risk mothers, was seen as desirable, including intersectoral and interdisciplinary meetings and a holistic model of care that acknowledged upstream social determinants of health. […] Participants across both hospital and primary health services suggested the need for more flexibility in service delivery and a greater focus on woman-centred care'.[80]

In order to enable adequate and appropriate antenatal support for Aboriginal women, it is crucial that gaps in service provision are addressed. ACCHS often fund support programs and services from their core funding without specific funding to address these identified community needs. Specific findings, gaps and needs related to service provision; particularly ancillary supports are detailed below.

4.1.2. Transport to/from appointments

Transport to and from appointments, particularly at hospitals was identified as a major issue for clients. Eleven of the ACCHS interviewed said they provide transport for community members to and from

[79] Aboriginal Health Council WA. Maternal and Child Health Model of Care in the Aboriginal Community Controlled Health Sector. 2010.

[80] Jones, J., Durey, A., Strobel, N., McAuley, K., Edmond, K., Coffin, J. and McAullay, D. Perspectives of health service providers in delivering best-practice care for Aboriginal mothers and their babies during the postnatal period. 2023. https://doi.org/10.1186/s12884-022-05136-6. (p.8)

appointments. These distances can be extensive with one ACCHS explaining they often drive clients over 350 kilometres each way. Providing transport is an essential activity to ensure clients access health services, including scans, however costs are often absorbed by ACCHS. One ACCHS explained that they fund transport to hospital appointments from their MBS billing and reiterated the importance of providing transport by explaining that "if you can't get the patients there, you're wasting the specialist's time".

Another issue identified in relation to transport was a lack of female drivers, or the need for female support workers to accompany male drivers escorting patients to appointments. One ACCHS explained that there is a crucial need to have a female driver dedicated to maternal antenatal appointments, rather than relying on a driver that supports the clinic more generally; "transport is really important, we used to have a dedicated driver, but now it's shared [with the rest of the clinic]. Would like a dedicated female driver (and community liaison officer)". Having a female driver helps women to feel safe, and a couple of ACCHS reported that having a male driver can be off-putting for some partners.

Supporting clients with transport has additional repercussions on service delivery efficiency as midwives and nurses often take time away from their core work to complete these admin tasks (such as liaising with clients regarding appointments and ensuring they have transport). The clinic driver also loses time when waiting for a client to finish an appointment before returning to the service. This is not necessarily a big issue if the hospital is five minutes away, but in some locations, the hospital can be a lot further; as reported by one ACCHS "One thing to note, especially with the geographical area we have and if you're taking someone to [town 45 minutes away] for an appointment, that's half your day gone because you take them, that's 45 minutes to take them. You wait for them to have their appointment, that's another hour gone".

Another ACCHS explained that they provide transport to appointments, including at hospital (which is paid for through their core funding), but that the hospital doesn't provide transport back, so the client needs to find their own way home. Further, another ACCHS explained that the hospital doesn't pick up or drop off clients, so out of necessity, their driver will pick up people up to 30 kms away. However, many clients can be 100-150 kms away, and need to use their own transport to get to hospital appointments, which can be a major barrier to attendance.

All ACCHS identified transport to and from appointments as an issue and advised that it would be also beneficial for WACHS hospitals to provide transport to and from antenatal hospital appointments.

4.1.3. Wraparound supports during pregnancy

Many ACCHS identified wraparound supports during pregnancy (e.g., social workers; nutrition supports; social and emotional wellbeing supports; family/community support workers; family and domestic violence supports; and smoking cessation supports for pregnant women) as a key area of need. Comprehensive wraparound services ensure that women receive multi-disciplinary, holistic care and support to address several complex social factors. ACCHS noted that pregnancy is often an extremely vulnerable time for the women they care for, especially women with complex issues, and that it is important these women are supported through this time. Similarly, research has found that women with low social support during pregnancy are at risk of substance abuse, adverse mental health impacts and adverse birth outcomes.[81]

[81] Bedaso, A., Adams, J., Peng, W. *et al.* Prevalence and determinants of low social support during pregnancy among Australian women: a community-based cross-sectional study. 2021. doi: 10.1186/s12978-021-01210-y.

Supporting maternal resilience through culturally safe supports, particularly in relation to smoking cessation, are critical protective factors proven to lower the risk of adverse perinatal outcomes, such as early birth, low birthweight, and being small for gestational age.[82]

Many ACCHS reported that barriers to antenatal appointment attendance and accessing appropriate maternal care was compounded by basic social determinants of health, including but not limited to housing, homelessness, family and domestic violence, and alcohol and other drug use. They explained there was a need for more supports to address these issues, particularly for family and support workers that are embedded in the community and act as a liaison between clinical staff and community. These staff are invaluable as they know community and will often engage with clients at home and promote the need to come into the clinic. This demonstrates the commitment and flexibility of many ACCHS to ensure mothers, infants and children are seen for appointments (such as follow up phone calls, letter-dropping and door knocking), thereby exceeding the service that the public system can provide. Another ACCHS explained that they provide a mobile phone with credit to expectant mothers, which enables clients to stay in contact with ACCHS and helps to ensure ongoing care can be provided.

However, some services, report that they may only have males in particular roles, e.g., Tackling Indigenous Smoking, as there is only enough funding for one staff member. This has been identified as problematic as it is not culturally safe. A report from South Australian Health and Medical Research Institute outlines that Aboriginal women have a preference to receive care from female health professionals.[83] A number of ACCHS also suggested that there was a need to invest more into Tackling Indigenous Smoking for pregnant women. This has been corroborated by research which outlines that to the achieve the Closing the Gap target of 91 per cent healthy birthweight by 2031, 'smoking during pregnancy needs to decline from the current rate' of 44 per cent in 2019 to an estimated 27 per cent in 2031.[84]

Specialised social and emotional supports for pregnant women were also flagged as an area of need. Pregnancy can be an extremely difficult time for women emotionally, financially and socially, and support services should be available to reflect this need. A couple of ACCHS expressed major issues with family and domestic violence in their town or region and emphasised the need for further funding to address and support women experiencing this.

Specifically, social workers were emphasised as an area of need in many ACCHS, as they often provide additional logistical support in relation to engaging with the Department of Communities Child Protection, housing organisations, financial support organisations and Centrelink, in addition to providing food support. Access to alcohol and other drug rehabilitation services is also an area that requires extra resourcing, with one ACCHS explaining that it is often difficult to transport clients to these services to get the help required.

[82] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework: Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies. 2022. https://www.indigenoushpf.gov.au/getattachment/bf116c5d-8fa3-4b7b-b182-6860ea4495a9/birthweight-fa_ihpf_100-may22.pdf.

[83] Glover K, Morey K, Rumbold A, Renehan C, Middleton P, Cameron C, Brown S, Clark Y. Systems change to improve Aboriginal and Torres Strait Islander Maternal and Child Health Continuity of Care in South Australia. Aboriginal Communities and Families Health Research Alliance (ACRA), Women and Kids Theme, South Australia Health and Medical Research Institute (SAHMRI); and Intergenerational Health, Murdoch Children's Research Institute (MCRI). 2022. (p. 43).

[84] Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework: Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies. 2020. https://www.indigenoushpf.gov.au/getattachment/bf116c5d-8fa3-4b7b-b182-6860ea4495a9/birthweight-fa_ihpf_100-may22.pdf. (pg. vi).

Two ACCHS also discussed the need for greater provision of Pepi-pods in regional areas. These are provided by WACHS in some regional areas but should be provided directly to ACCHS to dispense to clients.

This highlights the importance of a localised model of care, inclusive of addressing underlying social issues in community that affect health service provision. Maternal health cannot be supported without addressing these complicated social issues. ACCHS are keen to take a proactive and preventative approach, rather than enabling issues to escalate. As such, there is a need to increase funding and resourcing for wraparound support services that address ACCHS needs.

4.1.4. Child and Adolescent supports

NDIS and mental health/social and emotional wellbeing supports for children and young people were identified by ACCHS as a critical gap. Gaps include initial diagnosis, and supporting children and young people at the start of the NDIS journey, through to case management and appropriate treatment, including managing NDIS plans. Many ACCHS mentioned that children they service often experience mental health issues, intergenerational trauma, and developmental delays, including Foetal Alcohol Syndrome Disorder. Without diagnoses and support, children often end up in out-of-home care or engaging with the Department of Communities Child Protection and possibly the criminal justice system.

One remote ACCHS explained that there are a lot of children and young people experiencing behavioural difficulties and that there are no services in their region to support them. Although there are mental health nurses in their service, they are not trained to work with children and young people. This ACCHS suggested that telehealth is a viable option to link in with child and adolescent mental health supports, explaining that "when you have a child with challenging behaviours, parents are not going to get on a plane and take them to an outpatient appointment".

A couple of ACCHS also expressed that they used to have supports in this area, including a social worker specifically for young people, and that these services were achieving good results, but funding has since ceased, thereby leaving a gap in social supports for children and young people.

Another ACCHS also mentioned that it is difficult to manage complex behaviours in their region. They explained that school staff are transient, and many workers quickly experience burn out. They explained that there is a need for more child health workers, including investing in social and emotional supports specifically for children and young people. Both these services explained that there is limited access to psychologists and there needs to be more frequent access to paediatric psychologists and psychiatrists.

Six ACCHS identified developmental paediatricians as a big gap, with minimal services in regional and remote areas. They reported long waiting lists for paediatricians and developmental checks for children and young people. One ACCHS also explained that they would like to provide the ECHS checks and would like to see funding and staff training to do this.

ACCHS explained there is a critical need for more sustainable funding and resourcing to provide child and adolescent mental health supports on Country.

4.1.5. Telehealth and ultrasound equipment

Some ACCHS raised concerns about patients travelling unnecessarily from remote communities to antenatal appointments. Telehealth appointments can limit the number of journeys pregnant women are taking for antenatal care. Further, through virtual technology, obstetric and gynaecological ultrasounds are

available to complement telehealth appointments, however, many ACCHS do not have access to the required technologies.

Telehealth appointments are also useful for people in regional and remote areas who wish to access specialists that are based in Perth, rather than relying on intermittent visiting specialists. One ACCHS explained that they are interested in providing telehealth appointments, but that some WA Health obstetricians have been reluctant to agree to telehealth sessions.

Two remote ACCHS explained that clients may need to travel to Perth for early antenatal and specialist scans and expressed the need to reduce these visits to Perth which is a massive inconvenience and cost to clients. Two other ACCHS in regional towns explained that they work closely with a private sonographer due to limited availability in the public system. These ACCHS are billed directly by the private sonographer and are required to absorb these costs, rather than passing them on to the client. If ultrasound technology and training was provided to the ACCHS, this would have the dual benefit of reducing the client's need to travel and address extra costs incurred by ACCHS. Alternatively, WA Health could explore options to provide ultrasound telehealth appointments, in collaboration with ACCHS.

4.1.6. Infrastructure

Four of the ACCHS located in larger regional centres noted a need for specific maternal and child health spaces or family centres within their clinics that would act as centralised hubs for women's health, as well as maternal and child health.

These ACCHS explained that having a dedicated centre for maternal and child health which is less "clinical looking" and provides a women and family friendly, safe space for mums and children is crucial. One ACCHS already has a separate space explaining that they "have a separate building just across the car park from the main clinic, which was built so that there was a dedicated space that catered to confidentiality and so that mothers or women planning to get pregnant wouldn't feel any shame". Another ACCHS added that coming into the clinic can provide "a bit of a break from their home situation".

Another ACCHS explained the importance of having a separate space outside the clinic that could provide community education and 'women's only' nights. Further, one ACCHS discussed the importance of holding 'mums and bubs' groups and education sessions covering topics that are requested by clients.

Having a 'one-stop shop' that provides antenatal care, child health and women's health in one place aligns with the ACCHS holistic model of care and Priority Reform Two 'Building the Community Controlled Sector' of the National Agreement. It also enables continuity of care throughout the pregnancy and into early childhood. A maternal and child health centre would assist with attendance for child health checks and would support the mother at this time as well.

The family centre concept was outlined in the previous model of care work undertaken by AHCWA in 2010. This work identified that a maternal and child health program was more likely to be successful if it included the following:[85]

- Community based or community-controlled service;
- A specific service location intended for women and children;
- Providing continuity of care and a broad variety of services;
- A welcoming and safe service environment;

[85] Aboriginal Health Council WA. Maternal and Child Health Model of Care in the Aboriginal Community Controlled Health Sector. 2010.

- Flexibility in service delivery and appointment times;
- Respect for Aboriginal people and their culture;
- Respect for family involvement in health issues and childcare;
- An appropriately trained workforce;
- Valuing Aboriginal staff and female staff;
- Provision of transport; and
- Provision of childcare/playgroups.

Some ACCHS explained that infrastructure more broadly is an issue with clinics running out of space, and little room for staff and visiting specialists. One remote ACCHS explained that they have two clinics that are so tight for space that they see children in the waiting room, where the weighing scales, changing facilities and sink are located.

Recommendation 8 of the 2010 AHCWA Aboriginal Maternal and Child Project Strengths and Needs Analysis[86] identified infrastructure as a key area of need and recommended that ACCHS physical infrastructure should be reviewed and that ACCHS funding should include capital works if needed. This recommendation from 13 years ago is still pertinent today.

4.1.7. Endorsed Midwives

There was strong support for the utilisation of Endorsed Midwives. Four ACCHS explained that they already employ Endorsed Midwives and discussed the benefits of the role. These midwives are experienced, able to work autonomously, bill Medicare, and have an expanded scope of practice which enables them to undertake duties without the need for oversight from a GP. This allows GPs to focus on other priorities and ensures continuity of care as the client does not need to see a variety of different health professionals.

Two of the ACCHS Endorsed Midwives also have collaborative agreements with the hospital, which enables seamless care across the ACCHS and the hospital. ACCHS explained that Endorsed Midwives play an advocacy and translation role, reporting that many clients can feel uncomfortable in the mainstream system, and that being able to support clients in the hospital system was beneficial. One ACCHS explained that “there is a widespread feeling of discrimination at the hospital. We hear it from patients over and over”. Further, they often liaise with hospital midwives and obstetricians regarding care plans and can sit in with clients during their appointments if needed.

Endorsed Midwives are useful to bridge the gap between the tertiary system and hospitals, and are a beneficial part of a holistic, local, continuity of care model. The 2010 AHCWA Aboriginal Maternal and Child Project Strengths and Needs Analysis emphasises this, noting 'solid international, Australian research and local research demonstrate that patient-centred, midwife-run antenatal program which augments basic antenatal services with a holistic approach to women’s health results in greater patient satisfaction, better use of antenatal services and improved health outcomes for mother and baby at no additional cost’.[87]

One interviewed midwife stated she had explored becoming an Endorsed Midwife, however the high cost of professional indemnity insurance meant this was not an option. This differs from the private sector, where Endorsed Midwives can afford these insurance costs through privately paying patients.

[86] Larson, A., & Bradley, R. Aboriginal Maternal and Child Project Strengths and Needs Analysis. 2010. (pg. 11).
[87] Larson, A., & Bradley, R. Aboriginal Maternal and Child Project Strengths and Needs Analysis. 2010. (pg. 5).

Recommendation One: Work with WA ACCHS to develop solutions to identified areas of need, including exploring options for additional State and Commonwealth funding. Where appropriate, assist with advocacy to the Commonwealth Government to ensure a multi-disciplinary, Aboriginal community-controlled approach to maternal and child health services. Specifically, this should include the following:

- **Explore opportunities with ACCHS to identify critical areas of need in relation to child and adolescent mental health supports and fund and resource ACCHS to enable children and families to stay on Country for diagnosis and treatment;**
- **Sustainably fund and resource ACCHS to provide wraparound supports to expectant mothers;**
- **Explore options to enable WACHS hospitals to provide transport to and from antenatal hospital appointments; and**
- **Provide sustainable funding to ACCHS that are not funded to provide transport for clients to and from hospital appointments.**

Recommendation Two: Work with WA ACCHS to explore opportunities for ACCHS to increase telehealth appointments, thereby reducing the need for PATS and increasing access to services for clients in regional/remote areas.

Recommendation Three: Work with WA ACCHS to identify infrastructure and equipment needs for maternal and child health services and explore options for meeting these needs.

Recommendation Four: In line with Priority Reform Two of the National Agreement on Closing the Gap, support WA ACCHS to implement culturally secure, holistic and multi-disciplinary maternal and child health service models that span prenatal care through to postnatal care, and child health. Based on local needs and capacity, consideration should be given to incorporating Endorsed Midwives, Midwifery Group Practice, wraparound supports and ECHS checks to ensure culturally secure, continuity of care for women and children.

4.2. Maternal and child health workforce

Workforce related issues were a key discussion point during interviews with ACCHS. Although it should be noted that these issues are not isolated to the maternal and child health workforce, but to the ACCHS sector workforce, more broadly.

Several ACCHS gave examples of vacant maternal and child health roles, including Child Health Nurses, Midwives, Aboriginal Health Practitioners and Paediatricians, for periods of 2 years or more. When a role is vacant, care can become sporadic having a detrimental impact on ACCHS clients. One ACCHS summarised it by stating the “current model [maternal and child health] is good, but dependent on staff longevity”, with another ACCHS explaining that chronic understaffing makes it harder to provide a service tailored to community and local needs: “It is hard to provide walk-in care when understaffed. This can be

frustrating for many women. One lady wanted walk-in care, which is really hard because I'm fully booked. She then came twice expecting to be seen straight away and got turned away. And then she just refused to come back".

4.2.1. Housing

Given the current housing and rental crisis, it is unsurprising that staff housing availability was a significant issue for ACCHS. The national housing crisis is compounded for some ACCHS, due to their regional and remote locations and competition from private industries, especially mining. Eleven interviewed ACCHS raised housing as an issue in attracting and retaining workforce. This was the highest response of all workforce related issues. Specifically, ACCHS raised the following as issues related to housing workforce:

- Limited availability of rental properties.
- Affordability of rental properties.

Often ACCHS are required to provide accommodation for workforce, which has been normalised in regional and remote locations due to private industry. Two ACCHS from different regional centres reported that they have filled all their staff housing and that there are limited rental properties remaining in their areas. As a result, one of these ACCHS recently appealed to the ACCHS Board to increase housing stock at a cost of $1.4m to accommodate staff.

One ACCHS stated that unless a candidate was already living locally, there would be no possibility of securing accommodation as there are no rental houses available. Another ACCHS stated to rent a four-bedroom house in a regional town would cost $1,500 per week, which is not feasible for maternal and child health roles.

Evidence suggests that in some cases, limited staff accommodation is an 'invisible barrier to health care delivery and often means health staff must fly or drive in/out. This is expensive, time-consuming, and may result in inconsistent healthcare'[88] and less culturally secure health care from a workforce that is not embedded in the community. Consequently, working with ACCHS to identify strategies to increase local workforce is crucial. This will include exploring options to address the housing crisis and increase housing stock in regional and remote areas. It must be noted that a lack of available housing was also mentioned as a barrier to recruitment in metropolitan areas.

4.2.2. Competing Salaries

ACCHS discussed challenges regarding pay parity with public sector and locum salaries. The ability of the public and private sectors to pay higher wages, in combination with additional fees charged by recruitment agencies, exacerbates challenges experienced in an already competitive market.

Six ACCHS emphasised that salary-related issues were a barrier to attracting and retaining a maternal and child health workforce. ACCHS gave examples of private industry, especially mining, offering significantly higher wages than ACCHS can offer.

ACCHS also raised the difficulty in competing with WACHS wages for maternal and child health workforce. One ACCHS reported that staff wages accounts for more than 75 per cent of core funding and is unable to increase wages without further sector funding. Another ACCHS explained that they work closely with WACHS in relation to recruitment - specifically, WACHS assists the ACCHS in recruiting staff, however this

[88] Dossetor, P.J., Thorburn, K., Oscar, J. *et al.* Review of Aboriginal child health services in remote Western Australia identifies challenges and informs solutions. 2019. https://doi.org/10.1186/s12913-019-4605-0 (pg. 10).

occurs when the WACHS hospital workforce is at full capacity. Prior to this informal agreement, wage parity was an issue.

Some ACCHS also reported issues competing with agency contracts that enable locum staff to earn a greater salary, with added benefits, such as bonuses and penalty rates.

4.2.3. Location

Regional and remote ACCHS noted that the staff recruitment pool is limited and that many people are reluctant to move regional/remote areas.

Eight ACCHS stated that the location of the service was an issue in attracting and retaining workforce. As a result, some ACCHS are forced to rely heavily on agency and locum staff.

Two ACCHS also explained that their regional centres may not be as appealing as other regional locations for staff, with one in particular explaining that the negative media representation of the area was off-putting to potential candidates. They explained that they would complete very positive interviews, and then a few days later the individual would withdraw their application explaining that they either have a different role or the location would not be right for them.

Some ACCHS reported weather as a barrier to workforce and service provision, explaining that weather conditions can impact on visiting services and impact staff decisions to move to particular locations.

4.2.4. Childcare

Long waiting lists for early childhood care and the cost of childcare in regional and remote areas were also identified as a barrier to workforce recruitment.

One ACCHS explained that they recently lost their Senior Medical Officer due to the lack of childcare. She was unable to come back to her role after maternity leave as there was a two-year waiting list for childcare in this regional centre, and it is particularly difficult to find childcare for young babies.

One ACCHS is exploring the feasibility of becoming a licenced childcare provider as a means of addressing this significant issue.

4.2.5. Training

Over 25 per cent of interviewed ACCHS raised issues related to workforce training. The issues raised included:

- Cost – ACCHS are often required to pay significant amounts for travel and accommodation for staff to attend training. One ACCHS stated that there are policies that restrict training for staff that are under probation, as ACCHS cannot afford to train short-term staff. This is a protection measure reflective of the significant costs that ACCHS absorb related to training.
- Lack of local and place-based training – ACCHS staff often travel significant distances to undertake training, which impacts on family and community obligations. As, there is a shortage of child health nurses and Aboriginal Health Workers/Practitioners in a number of ACCHS, investing in local place-based and flexible training, particularly for these roles may address some of the needs in this area.
- Endorsed Midwife training – Many ACCHS saw the benefit in having an Endorsed Midwife and would like to encourage and support their midwives to undertake the extra training and hours to become endorsed.

- Ultrasound training – A few ACCHS outlined the need for ultrasound training for staff but explained it can be inconvenient for staff to take time off to undertake this training. One ACCHS explained that they have an ultrasound, but their current Endorsed Midwife can't use it, due to a lack of training, so clients are required to travel to the nearest hospital.

Recommendation 26 of the previous 2010 AHCWA Aboriginal Maternal and Child Project Strengths and Needs Analysis[89] also identified that AHCWA should continue to establish pathways for Aboriginal people to gain health qualifications relevant to maternal and child health, and the development of alternative delivery mechanisms to increase access to further training. This recommendation is still relevant today, particularly in relation to exploring place-based training choices.

Recommendation Five: In line with Priority Reform Two of the National Agreement on Closing the Gap and the Health Sector Strengthening Plan, work with ACCHS to address salary disparity and other workforce issues, including exploring cross-agency approaches to provide solutions to housing shortages and place-based training.

4.3. Partnerships and collaboration

4.3.1. Shared Care Arrangements

Nine ACCHS stated that they had specific shared care arrangements with hospitals pertaining to maternal and child health. These arrangements include formal memorandums of understanding, collaborative agreements and shared care programs such as the Midwifery Group Practice (MGP). ACCHS also reported that they have other informal shared-care arrangements to bolster continuity of care.

Collaboration across agencies and formal shared care arrangements are beneficial to the ACCHS Sector as they provide a reliable avenue for collaborative health care, whilst also facilitating open communication channels. For example, a regional ACCHS has a collaborative agreement with its local hospital that allows for their ACCHS Endorsed Midwife to have access to public maternity units for the purposes of delivering maternity services to their clients. This enables the ACCHS to track their pregnant clients into the hospital, which facilitates the mother's continuity of care. Access to this agreement was made possible under WA Health policy.[90] The ACCHS reported that this agreement works very well, however raised concerns that access to the hospital was linked to the midwife's registration rather than the ACCHS. Thus, if the midwife resigns, the ACCHS would not have access to this continuity of care model.

Furthermore, across the State, ACCHS noted the usefulness of the MGP program and acknowledged that it is beneficial for women to develop a relationship with their midwives prior to birth. This enables the ACCHS and hospitals to work in close collaboration during the antenatal period. As highlighted in Recommendation

[89] Larson, A., & Bradley, R. Aboriginal Maternal and Child Project Strengths and Needs Analysis. 2010. (pg. 11).

[90] Access for Endorsed Midwives into Public Maternity Units Policy. 2022. https://www.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Access-for-Endorsed-Midwives-into-Public-Maternity-Units-Policy

Four, AHCWA suggests consideration is given to establishing a state-wide process to allow midwives to work across both the public system and the ACCHS system to ensure culturally safe, continuity of care.

ACCHS reported that there are also informal partnerships that are beneficial to service provision. For instance, some ACCHS midwives work with WACHS to provide services to communities that are underserviced in the region. Other informal arrangements include doctors working across agencies, as exemplified at a regional ACCHS where a GP-Obstetrician also works at the local hospital once a week. Additionally, one ACCHS reported that WACHS midwives, under the auspices of the ACCHS, are embedded in their service to ensure culturally safe, continuity of care across the duration of a pregnancy.

Moreover, many ACCHS reported that weekly/fortnightly meetings with the local hospital is a useful arrangement to discuss their shared high-risk clients. However, for one remote ACCHS, these meetings were difficult to set up, due to key personnel vacancies and difficulties engaging with some hospital staff. The ACCHS noted that after a change in hospital staff, weekly meetings were finally able to be scheduled.

Other ACCHS raised that these processes were person-dependent and without these good working relationships with government staff, engagement would be a more challenging process. AHCWA considers it is necessary for systemic changes to occur to ensure ACCHS do not continue to rely on informal pathways for information gathering. Informal arrangements are challenging to establish and maintain when they are person-dependent rather than systems-focussed, with one ACCHS explaining, “it must be system dependent because of the transitory feature of rural and remote working - you've got to rely on the system”.

Furthermore, a remote ACCHS reported challenges with patient appointment attendance when patients were required to complete their visiting child specialist appointments at the local hospital, rather than the ACCHS. The ACCHS specified that WACHS are responsible for the child referral system, which is not straightforward. The ACCHS noted that if WACHS worked in greater collaboration with the ACCHS regarding this system, there would likely be better patient attendance rate.

4.3.2. Communication Pathways

Outside of successful partnerships and collaborative agreements, a number of ACCHS raised concerns regarding the limited communication and information sharing by mainstream providers and its impacts on effective shared care. This includes access to birth/discharge summaries and other patient records; organisational access to the Department of Health’s clinical perinatal database (STORK); and more general communication between providers regarding patient wellness.

Over half of the ACCHS interviewed mentioned that they did not receive consistent discharge summaries from hospitals following births. Given ACCHS do not have access to hospital information systems, access to discharge summaries is reliant upon hospital staff completing an appropriate discharge summary and ensuring it is sent to the correct primary health service/general practitioner. AHCWA acknowledges that hospitals have policies regarding discharge summary notifications, however, interviews with ACCHS suggest that in some instances, there is likely a failure in policy implementation. This limited access to data and discharge summaries undermines continuity of care, shared care arrangements and ACCHS’ ability to meet patient needs.

STORK is used across public hospitals to input birth-related data. The data is available within 24 hours of the birth and is sent through its notification system to government health services within 48 hours of the

birth.[91] Unfortunately, the ACCHS sector does not have access to this database, which ACCHS report compromises postnatal healthcare. Nine of the interviewed ACCHS stated that it would be beneficial to have access to STORK data for ACCHS patients, to enable information shared and ensure continuity of care. This would enable ACCHS to maintain an understanding of their client's journey and health needs.

A lack of timely discharge summaries and handover is detrimental to maternal and child health continuity of care, which is at the heart of the ACCHS holistic model of care. Discharge summaries and birth notifications are essential to ACCHS awareness of patient conditions; awareness of when mothers are expected to return to the community; and planning for what supports are required once mothers return. Without adequate information sharing, ACCHS are left in the dark. One remote ACCHS highlighted the importance of adequate hospital handovers and its importance in facilitating care prior to the post-natal 6-week checks. Further, without an adequate handover, as required under National and State Best Practice Guidelines,[92] an ACCHS may not know that a baby has been born. This is extremely problematic, especially for low birthweight babies, who may require either daily or every second day weighs in the immediate period after birth. The flexibility in service delivery by ACCHS allows for frequent checks like these to be completed, however they can only occur with a good handover.

One remote ACCHS highlighted how inadequate hospital handover impacted a mother's postnatal care after a pre-eclampsia episode. Women that experience pre-eclampsia at birth can require a titration of blood pressure lowering medication during their post-partum period. However, after the script runs out, without adequate hospital handover to the GP, an ACCHS is unaware that a woman may require further medication provision and titration of dose. The ACCHS noted that this can be extremely problematic and can present a patient safety issue.

Furthermore, another remote ACCHS noted that discharge summaries may not reach the primary care service due to referral pathways. Specifically, they indicated that due to challenges in getting PATS travel plans approved through primary care ACCHS, patients requiring tertiary care are sometimes referred first to their local or regional hospital, before being referred to tertiary care in Perth. After birth, the patient's discharge summaries are often incorrectly sent to the local or regional hospital, rather than the primary health care provider, such as the ACCHS, as the patient was referred to tertiary care by the hospital. Another ACCHS mentioned a similar scenario occurring when the patient is referred by a specialist, rather than an ACCHS GP. AHCWA would like to highlight that all hospitals have clinical guidelines regarding discharge. For example, WACHS has a robust guideline that states a copy of the discharge summary must be sent to 'the patient's usual GP' and 'must be completed on the day of discharge'.[93] Additionally, a King Edward Memorial Hospital policy stipulates that 'Stork Summaries must be completed and copies

[91] Jones, J., Durey, A., Strobel, N., McAuley, K., Edmond, K., Coffin, J. and McAullay, D. Perspectives of health service providers in delivering best-practice care for Aboriginal mothers and their babies during the postnatal period. 2023. https://doi.org/10.1186/s12884-022-05136-6. (pg. 6).

[92] Jones, J., Durey, A., Strobel, N., McAuley, K., Edmond, K., Coffin, J. and McAullay, D. Perspectives of health service providers in delivering best-practice care for Aboriginal mothers and their babies during the postnatal period. 2023. https://doi.org/10.1186/s12884-022-05136-6. (pg. 4).

[93] WACHS. Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard. 2020. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Policies/Admission-Discharge-and-Intrahospital-Transfer-Clinical-Practice-Standard.pdf?thn=0 (pg. 5, 19).

generated for the patient's: Medical Record [and] General Practitioner', as well as 'Additional copies [...] for referring services and other ongoing care providers e.g. Aboriginal Medical Services'.[94]

AHCWA is also aware that hospitals do not always enter GP details correctly, particularly in the case of ACCHS. To investigate why some discharge summaries are not being received by ACCHS, AHCWA recommends that WA Health complete an audit of the accuracy of the GP information on the discharge summaries of Aboriginal maternity patients attending WA Health hospitals for delivery. The audit should also assess the timeliness of the discharge letters and the completeness of discharge letter uploads to the MyHealthRecord. Upon completion of the audit, AHCWA urges WA Health to commit to sharing these findings with AHCWA, and working with the ACCHS sector to improve these communication pathways. This is consistent with WACHS guidelines which stipulate that 'Heads of Departments are required to: ensure that appropriate training and education are provided regarding accurate documentation and completion of discharge summaries; and monitor discharge summary completion rates to ensure compliance within their department.'[95]

To combat lack of access to hospital information systems and the lack of timely hospital discharge summaries, ACCHS utilise other pathways. For some ACCHS, they become aware of births from community word of mouth. For many other ACCHS, they have effective relationships with hospital staff who are able to forward discharge summaries via fax or mail. One regional ACCHS noted that they receive good discharge summaries because of ACCHS escorts supporting women to travel to/in hospital; and the provision of patient identifiers to alert hospital staff that they are an ACCHS patient. In other instances, some ACCHS lean on their good relationships with hospital staff and regional public health units to access the discharge summaries. For example, a remote ACCHS noted that "midwives help address system failures". They indicated that the ACCHS midwives "are engaged with where their clients are", so when they "haven't heard anything for a while [they'll] get in touch with the hospital". Better information sharing and clinical handovers are essential to promote patient safety and for ACCHS to complete their role in shared care. Consequently, WA Health must prioritise consistent, reliable and timely sharing of patient data and discharge summaries with ACCHS.

Given that ACCHS utilise Communicare and MMEx patient management software platforms, ACCHS note the discrepancy between their digital platforms and some of WA health's paper-based systems. An ACCHS expressed frustration in the amount of paper-based information sharing; as the ACCHS explained that they need to print off their internal notes for the hospital for handover purposes. For this specific ACCHS, this can be time-consuming as these functions are "only as good as the operator using [the database]". MyHealthRecord can help bridge this 'paper-based' and systems gap, given it is a universal database for most clients. However, ACCHS indicated that discharge summaries and patient records are often not uploaded. AHCWA considers this a useful avenue to facilitate greater information sharing given information upload is immediate. Thus, AHCWA suggests WA Health prioritise more consistent patient data uploads to MyHealthRecord.

Better discharge planning and handover, along with potential access to hospital information systems aligns with the National Agreement and WA Implementation Plan's Priority Reform Four, which details the need

[94] King Edward Memorial Hospital - Obstetrics & Gynaecology. Clinical Practice Guideline - Discharge of a Patient. https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Clinical-guidelines/Obs-Gyn-Guidelines/Discharge-of-a-Patient.pdf?thn=0 (pg. 4)

[95] WACHS. Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard. 2020. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Policies/Admission-Discharge-and-Intrahospital-Transfer-Clinical-Practice-Standard.pdf?thn=0 (pg. 6).

for Aboriginal communities and organisations to have 'Shared Access to Data and Information at a Regional Level'.[96] Further, the recommendations also align with Priority area 5.4: Better Health systems in the WA Aboriginal Health and Wellbeing Framework 2015–2030, which stresses how 'increased collaboration with [ACCHS] and improved transition care arrangements, including discharge planning, transfer of patient records and follow-up care is critical.'[97] Need for adequate information sharing predates our consultation - in the 2010 Aboriginal Maternal and Child Project Strengths and Needs Analysis, Recommendation 11 specifies that 'AHCWA […] [engages] with Western Australian Health Department's policies and initiatives in communication and IT, including but not limited to electronic sharing of medical information such as birth notifications, discharge summaries, interoperability of patient information record systems'.[98]

Finally, a regional ACCHS reported that in some hospitals, there are limited systems in place for Aboriginal Liaison Officers (ALOs) employed at the social work department to know if and when an ACCHS referred Aboriginal client is admitted. One ACCHS was concerned that this impacts cultural safety.

The ACCHS indicated that there were minimal social supports for a client once they arrived in Perth. Specifically, they reported concern for women who are discharged from hospital and required to return home to a remote area, explaining that when they are required to wait for over 12 hours for their transport, they have nowhere to go. From a systems perspective, AHCWA suggests that in partnership with the ACCHS sector, WA Health explore options for improving coordination of care, including travel arrangements, accommodation and general information sharing. This may include funding a coordinator position within Perth and regional hospitals to coordinate care between ACCHS and mainstream, and/or an ALO position to support clients during their relocation.

AHCWA considers the following recommendations enablers for WA Health to continue implementing the National Agreement, particularly Priority Reform Three, which seeks to improve mainstream institutions and ensure they 'are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people'.[99] Further, AHCWA considers any reforms made to shared care arrangements and facilitating more culturally secure maternal services should align with the principles of the RISE Framework.[100]

<u>Recommendation Six</u>: In line with Priority Reform Four of the National Agreement on Closing the Gap, WA Health to prioritise:

- **Consistent, reliable and timely sharing of patient data and discharge summaries with ACCHS; and**
- **Consistent patient data uploads to MyHealthRecord.**

[96] Closing the Gap Jurisdictional Implementation Plan. 2021. https://www.wa.gov.au/system/files/2021-09/Implementation%20Plan%20-%20CtG_1.pdf. (pg. 33).
[97] WA Aboriginal Health and Wellbeing Framework 2015–2030. 2015. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/12853_WA_Aboriginal_Health_and_Wellbeing_Framework.pdf. (pg. 19).
[98] Larson, A., & Bradley, R. Aboriginal Maternal and Child Project Strengths and Needs Analysis. 2010. (pg. 9).
[99] National Agreement on Closing the Gap. 2020. https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf (pg. 3).
[100] Kildea S, Hickey S, Barclay L, Kruske S, Nelson C, Sherwood J, Allen J, Gao Y, Blackman P, Roe YL. Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework. 2019. doi: 10.1016/j.wombi.2019.06.013.

Recommendation Seven: **In partnership with the ACCHS sector, explore options for improving coordination of care, including travel arrangements, accommodation and general information sharing. This may include funding a coordinator position within Perth and regional hospitals to coordinate care between ACCHS and mainstream, and/or an ALO position to support clients during their relocation.**

Recommendation Eight: **WA Health to complete an audit of the timeliness of all discharge summaries sent to primary health care providers (such as ACCHS) within 24 hours of discharge. Upon completion, commit to sharing these findings with AHCWA, and working with the ACCHS sector to improve these communication pathways.**

4.4. Patient Assisted Travel Scheme and Short-stay Accommodation

Nearly all ACCHS interviewed raised significant concerns regarding the Patient Assisted Travel Scheme (PATS) as it pertains to maternal and child health.

4.4.1. Consistency and Transparency

It was frequently noted that PATS arrangements often lack consistency and transparency. Specifically, ACCHS reported that PATS offices vary across the state in terms of cultural safety, efficiency, fairness, communication and responsiveness. ACCHS said they frequently follow-up on arrangements to ensure their patients' travel arrangements are appropriate, as they often fall short of meeting patient needs. Specifically, ACCHS expressed that appropriate PATS arrangements can depend on the PATS offices and officers that they liaise with. For instance, a remote ACCHS noted that after a client's flight was cancelled, they required an immediate reschedule, however their local PATS office was unhelpful, whereas a larger regional office was more accommodating to their requests. Furthermore, ACCHS have raised concerns regarding possible individual racism among PATS requests.

To assist women in navigating challenging PATS administrative processes, a remote ACCHS appointed their drivers to accompany women to PATS appointments to assist with the paperwork and act as a support person.

Moreover, further highlighting PATS transparency and inconsistencies, ACCHS indicated that there has been instances where travel plans have not been confirmed, approved or reimbursed appropriately. For instance, a remote ACCHS mentioned that sometimes PATS applications were rejected because PATS officers assumed that travel would be paid for by an Aboriginal Trust, however this is often not within the scope of an Aboriginal Trust. In another example, a regional ACCHS mentioned how some PATS applicants do not receive an email confirming their successful PATS application. They explained that most times the applications are successful, however in some cases, when they do not receive an email confirmation and later find out their application is unsuccessful, this can cause issues. ACCHS added that PATS travel plans are more often approved for birthing transport rather than travel to antenatal appointments and scans.

Furthermore, another remote ACCHS noted an instance where an individual contacted the clinic regarding immediate travel plans that were not booked appropriately. To mitigate the situation, the ACCHS organised

a plane fare under their corporate card, but this fare was not reimbursed. Often ACCHS become responsible for organising travel plans if the PATS process, particularly the accommodation component, is unsuccessful. These activities are not part of the ACCHS core business and increases their workload. Thus, to reduce ACCHS staff burden and ensure Aboriginal patients have appropriate travel plans, AHCWA recommends PATS processes are streamlined, and that there is provision of training to PATS staff to ensure PATS guidelines are being implemented more consistently across the State.

4.4.2. Escorts

ACCHS raised concerns regarding inadequate allowances for partners and children to accompany women to necessary scans and antenatal appointments. Although, AHCWA welcomed the $19.7m commitment in the 2021-22 State Budget which increased the PATS accommodation subsidy and expanded escort eligibility, escort guidelines do not explicitly include travel subsidies for accompanying children. AHCWA is aware of instances where women travelling with children do not receive additional travel subsidies and must pay for accommodation that includes their children themselves. Many ACCHS echoed similar sentiments, with examples of women having dependent children that need to be looked after, specifically children that are being breastfed. For instance, a remote ACCHS detailed how a child needed to go to Perth Children's Hospital, however the breastfeeding mother was told she could not go with her baby. The grandmother was instead approved, but after becoming very stressed, the mother and her baby ended up taking her place. The ACCHS recalled this scenario being a "total waste of resources", in which the mother and baby could have originally been approved to attend.

Moreover, ACCHS mentioned that many women are concerned about leaving their children in someone else's care whilst they attend their appointment, which at times requires them to leave their children behind for over a month. Literature supports this claim as studies suggest 'while away from community and other children awaiting the birth, pregnant women are susceptible to anxiety, stress and depression, and often have particular concerns that their other children may be vulnerable to child protection services in their absence'.[101] For these reasons, there is a risk that those who cannot cover the costs of extra accommodation will either delay or not attend necessary antenatal appointments, or for those travelling for birth, anxieties can be exacerbated if they are travelling without their dependent children. Therefore, AHCWA recommends that 'escorts' guidelines be expanded to include travel subsidies for accompanying children, where alternative arrangements cannot be made.

Furthermore, ACCHS raised concerns about the inability for escorts to accompany women to their antenatal appointments. Currently, PATS only allows for escorts to accompany women when travelling for birth.[102] However, many women from ACCHS, particularly in remote locations, require PATS subsidies to travel to attend high-risk antenatal appointments. For instance, a remote ACCHS mentioned how women that go to Perth for important antenatal screening and assessment scans are not able to be accompanied by their partner, unless their partner pays for travel and accommodation. The ACCHS raised concerns about this, explaining that women are often isolated, without mobile phones, have limited money and are reliant upon food packs, in an unknown metropolitan region which increases anxiety. These unpleasant experiences can also impact their outlook when needing to attend their next antenatal appointments and likely subsequent trip to Perth for childbirth.

[101] Kildea, S., Tracy, S., Sherwood, J., Magick-Dennis, F., & Barclay, L. Improving maternity services for Indigenous women in Australia: moving from policy to practice. 2016. doi: 10.5694/mja16.00854 (pg. 376).
[102] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CC---PATS-Guidelines---Update-2022---Summary-sheets.pdf#page=4 (pg. 3).

Moreover, in some cases, the lack of an escort impacts on women's antenatal attendance rate. Studies reinforce this sentiment emphasising how travelling in isolation from regional and remote locations to Perth for high-risk appointments and births is stressful, and the necessity of a support person to navigate this process is fundamental.[103] A study sampling Ngaanyatjarra mothers highlighted how a support person "who can speak and ask questions on the woman's behalf may prevent misunderstanding[s] and be appropriate in many regions".[104] The study revealed that many young Aboriginal women did not ask questions at their antenatal appointments, noting that it could be due to 'it [being] generally acceptable good manners among Aboriginal Australians, [that] they will wait to be told what they need to know'.[105] This demonstrates the need for an advocate and support person in appointments to ask questions and gain an understanding of next steps. Additionally, the inability of a partner to accompany the mother can also impact on the partner's ability to bond with the child and be a part of the gestational process, which may have follow-on effects for bonding once the child is born. AHCWA acknowledges that PATS guidelines make reference to patients' eligibility for an escort if they 'require cultural or linguistic support'.[106] However, it is clear that this eligibility is not applied consistently in PATS arrangements, across the state. Thus, AHCWA recommends 'escorts' guidelines be expanded to explicitly include escorts across all necessary antenatal appointments.

4.4.3. Fuel Reimbursements

ACCHS have raised concerns regarding the appropriateness of fuel reimbursement options for Aboriginal families who cannot afford the upfront fuel and transportation costs. On many occasions, families are expected to pay costs of fuel up-front and be reimbursed retrospectively.

Given the PATS requirement for 16-hour road travel prior to being eligible for a commercial flight,[107] many Aboriginal people living in remote and very remote areas are required to drive long distances to their antenatal appointments or closest birthing hospital for birth. In some communities, travel to a mainstream service could be over 500km away, which would be associated with very expensive costs. As highlighted in the WA Government's Aboriginal Empowerment Strategy, 'the median equivalised household income for Aboriginal people in Western Australia is about half that of non-Aboriginal people'.[108] Given that many Aboriginal people are surviving on less money than non-Aboriginal people, this upfront cost is often unaffordable for many families, resulting in some ACCHS having to absorb the costs. AHCWA is aware that PATS guidelines stipulate the availability to request 'assistance in advance' for travel and accommodation

[103] Seear, K.H., Spry, E.S., Carlin, E., Atkinson, E.D., Marley, J.V. Aboriginal women's experiences of strengths and challenges of antenatal care in the Kimberley: A qualitative study. 2021. https://doi.org/10.1016/j.wombi.2020.12.009. (pg. 573).
[104] Simmonds, D.M., West, L., Porter, J., Davies, M., Holland, C., A., Preston-Thomas, O'Rourke, P.K., Tangey, A. The role of support person for Ngaanyatjarra women during pregnancy and birth. 2012. https://doi.org/10.1016/j.wombi.2010.12.007 (pg. 84).
[105] Simmonds, D.M., West, L., Porter, J., Davies, M., Holland, C., A., Preston-Thomas, O'Rourke, P.K., Tangey, A. The role of support person for Ngaanyatjarra women during pregnancy and birth. 2012. https://doi.org/10.1016/j.wombi.2010.12.007 (pg. 83-4).
[106] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf (pg. 7).
[107] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf (pg. 13).
[108] The Aboriginal Empowerment Strategy Western Australia 2021-2029 Policy Guide. 2021. https://www.wa.gov.au/system/files/2021-09/Aboriginal-Empowerment-Stategy-POLICY%20GUIDE.pdf (pg. 8).

subsidies, if given notice of 48 hours,[109] however this is reported to be limited in practice. Thus, AHCWA recommends that clients receive payments upfront and in a timely manner, with 'assistance in advance' prioritised.

4.4.4. Accommodation

ACCHS raised PATS concerns regarding the limited appropriate and culturally safe accommodation options, including the lack of available accommodation for dependent children and escorts, available to women travelling to regional or metropolitan hospitals. In WA, when travelling to give birth, many women and families are required to stay in short-term accommodation for approximately four to six weeks near a regional or metropolitan hospitals to give birth. However, ACCHS have expressed great concern regarding the facility space and cultural safety in many of these short-stay accommodation facilities. For example, pregnant women travelling to Perth have access to a women-only short-stay accommodation facility close to the birthing hospital. However, ACCHS have mentioned a number of major limitations with this facility.

ACCHS have also mentioned the lack of supports available in the facility, as the only employee in the facility is a cleaner. Given the lack of employees, the facility is classified as accommodation for 'low risk' women. Women facing mental health challenges or requiring additional assistance need to find an alternative accommodation option.

The facility also does not accommodate children and families to stay with the women, nor overnight visitors, which can exacerbate women's isolation. Additionally, due to the lack of staff, the facility has a lock-out policy, in which women are not allowed to leave through the front entrance past 6pm. The lack of staffing also impedes on the facility environment; women are not able to use the facility's activity space, except for a Tuesday afternoon when a volunteer is available to attend. AHCWA is aware that isolation and inadequate accommodation has caused many women a great deal of duress, and for women who are travelling off Country, they are already greatly vulnerable.

Moreover, ACCHS noted that the facility has limited cooking space which women have reported as inconvenient, particularly for those staying at the accommodation for long periods of time. Although ACCHS have also mentioned the benefit of having meals included at this facility, which is not available at other hostels.

Other limited metropolitan short-stay accommodation is available to Aboriginal people including family-specific accommodation that is tailored to accommodate child-related health appointments, however this is non-Aboriginal specific. There is also a regional short-stay Aboriginal hostel which is not a dedicated facility for maternal health. This is a unisex facility, without separated gendered wings, which was described as "problematic".

To reiterate, AHCWA welcomes the $19.7m commitment in the 2021-22 State Budget which increased the PATS accommodation subsidy. However, many ACCHS raised concerns that the $102.75[110] subsidy is still not sufficient and requires substantial out-of-pocket costs. Specifically, if women are 'higher risk' or have been banned from specific hostels, ACCHS noted that there are very few accommodation options available for this price, and if there are, they are extremely far away from the hospital. Literature points to the impacts

[109] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf (pg. 12).

[110] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf (pg. 15).

of women travelling for birth, away from family and connections to Country[111], and without suitable accommodation options (as highlighted), this only exacerbates the anxieties of travelling off Country. Given the resounding concerns regarding many short-stay accommodation facilities by ACCHS across the State, AHCWA recommends that WA Government increase funding and resourcing of existing short-stay accommodation facilities and that WA Government co-design these facilities in partnership with WA ACCHS. AHCWA acknowledges and welcomes the WA Government's investment in increasing accommodation stock, as highlighted in the three new short-stay hostels being built. However, these accommodation options are mixed gendered facilities and not specific to medical care, let alone maternal care. Thus, AHCWA recommends that there be a continued investment to ensure appropriate and culturally safe facilities are available for birthing mothers.

4.4.5. Long Distance Transport

Some ACCHS raised concerns about transport, more generally. For some remote ACCHS, women enduring the long distances to their antenatal appointments or birth is challenging. For example, a remote ACCHS noted that women travelling by car on unsealed roads and gravel for antenatal appointments and birth is frightening for the woman and clinicians.

As described above, PATS guidelines require women to be over 16-hours travel by road prior to being eligible for a commercial flight. The only exception to this rule is if the patient is required to travel 'more than 350 kilometres one way for cancer treatment', or if the 'referring practitioner or treating specialist certifies air travel is essential for clinical reasons'[112]. Evidence suggests that travelling this distance by road, and unsealed roads particularly, is potentially dangerous for a pregnant woman and child.[113] Therefore, AHCWA recommends that PATS requirements be changed to ensure women travelling for births and high-risk antenatal appointments have the option to travel by airplane, rather than road.

Furthermore, despite flights being the preferred mode of travel for many clients, flights can also be challenging to schedule for remote communities. For instance, a regional ACCHS noted that for some remote communities that they service, flights to the regional centre are only available twice a week. Moreover, many ACCHS have detailed that aligning taxi travel and bus transport is challenging. For instance, in one remote community there is only one bus service to the nearest regional town per week.

Another remote ACCHS noted that some personal vehicles in the community are not suitable for long distance travel, thereby causing challenges when there is limited bus and taxi services available. This was supported by another remote ACCHS which raised how an Aboriginal pregnant woman in a very remote community had transportation challenges due to lack of access to a personal vehicle and public transport:

> *Due to the remoteness of the community, a FIFO midwife completed check-ups, whilst an ALO driver transported the woman to PathWest for blood tests, and doctors for ultrasounds and GP appointments. However, at one point, due to the woman having a high-risk pregnancy, she was*

[111] Corcoran, P. M., Catling, C., & Homer, C. S. Models of midwifery care for Indigenous women and babies: a meta-synthesis. 2017. https://doi.org/10.1016/j.wombi.2016.08.003 (pg. 77).

[112] Patient Assisted Travel Scheme (PATS). 2022. https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/PATS/Subsidies/eDoc---CO---PATS-Guidelines---Update-2022.pdf (pg. 13).

[113] Kildea, S., Kruske, S., Barclay, L., & Tracy, S. 'Closing the Gap': how maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women. 2010. https://search.informit.org/doi/epdf/10.3316/informit.566274648134408 (pg. 9); Dietsch, E., Shackleton, P., Davies, C., Alston, M., & McLeod, M. 'Mind you, there's no anaesthetist on the road': women's experiences of labouring en route. 2010. https://search.informit.org/doi/epdf/10.3316/informit.392037733898980

required to leave the community very quickly at a moment's notice. At the time, the only means of transport from a remote town to a nearby regional centre was via a weekly bus that left in the late hours of the night, arriving at the regional centre at 2am in the morning. A pre-arranged transport service in the regional centre was meant to pick the family up. However, after the bus was delayed by 2.5 hours, the family were isolated. Due to no taxi services operating after midnight, the family were forced to walk with their luggage to the accommodation in town.

This example explicitly highlights issues faced by many families requiring transport to reach their appointments. AHCWA would like to reiterate Recommendation One and its potential mitigating factors regarding this issue.

<u>Recommendation Nine:</u> Make changes to PATS to ensure geographical barriers do not impede access to care for Aboriginal mothers travelling off Country for antenatal care and birthing by:

- **Streamlining processes and provide training to PATS staff (if required) to ensure PATS guidelines are being implemented more consistently across the State;**
- **Expanding the 'escorts' guidelines to include travel subsidies for accompanying children, where alternative arrangements cannot be made;**
- **Expanding the 'escorts' guidelines to include escorts across all necessary antenatal appointments;**
- **Clients receiving payments upfront and in a timely manner, with 'assistance in advance' prioritised;**
- **Increasing funding and resourcing of existing short-stay accommodation facilities and continue investing in increasing accommodation stock to ensure appropriate and culturally safe facilities for birthing mothers;**
- **Increasing PATS accommodation subsidy payments for patients and escorts to reflect increases in state-wide accommodation rates; and**
- **Changing PATS requirements to ensure women travelling for births and high-risk antenatal appointments have the option to travel by airplane, rather than road.**

5.0. Way forward

AHCWA's engagement with the ACCHS sector demonstrates the crucial role that the ACCHS play in providing culturally safe, holistic, maternal and child health care for Aboriginal women and families across WA. The ACCHS have a model of care that is proven to have the best outcomes for Aboriginal health.[114] Despite the complexities of service delivery for maternal and child health care across WA, ACCHS are committed to ensuring a seamless continuity of care for mothers and babies. In order to ensure this continues and to enable ACCHS to build on already established maternal and child healthcare models, resourcing and funding to enable wraparound supports and address gaps in service provision; workforce shortages; discharge summaries; shared provision of care; shared data; and the myriad of issues with PATS, must be addressed.

As detailed in this paper, this work follows on from research carried out by AHCWA in 2010. 13 years later, many of the issues raised remain the same, including the need to ensure ACCHS are empowered and resourced to provide culturally secure, and ongoing continuous care to mothers and children, at birth and into early childhood. Building the capacity of ACCHS to provide culturally secure and autonomous maternal and child health models of care aligns with Priority Reform Two of the National Agreement – Building the Community Controlled Sector[115] and the National Agreement Health Sector Strengthening Plan that states the direction of program funds from mainstream government organisations to the ACCHS sector.[116] It will also have the added benefit of enabling women and children to stay on Country, receiving local care for a longer period of time, which aligns with the aims of the SHR. AHCWA also considers improvements in these areas facilitating cost-savings, with 'the lifetime health impact of interventions delivered by ACCHS [being] 50 per cent greater than mainstream health services'.[117]

In line with the aims of the PPG and in order to improve the quality of and access to maternal and child health services for Aboriginal women, AHCWA suggests focusing on implementing the nine recommendations as outlined in this paper. AHCWA acknowledges that some recommendations may be out of scope for the PPG to implement. However, we consider it necessary to include given its impacts on PPG work plans and possible budget bids. Working in partnership and co-design to address these recommendations and therefore the needs of Aboriginal women and children across WA will be a great step forward in achieving the aims of Outcomes 1 and 2 of the National Agreement and their associated targets.

Recommendations for consideration are outlined below:

[114] Aboriginal Health Policy Directorate. Outcomes Framework for Aboriginal Health 2020–2030: An outcomes focused approach to funding community-based healthcare services. 2019. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/Outcomes-Framework-for-Aboriginal-Health-2020-2030.pdf (pg. 5)

[115] National Agreement on Closing the Gap. 2020. https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf (pg. 3).

[116] Sector Strengthening Plan: HEALTH. 2021. https://www.closingthegap.gov.au/sites/default/files/2021-12/sector-strengthening-plan-health_0.pdf (pg. 15).

[117] Sector Strengthening Plan: HEALTH. 2021. https://www.closingthegap.gov.au/sites/default/files/2021-12/sector-strengthening-plan-health_0.pdf (pg. 9).

Recommendation 1	Work with WA ACCHS to develop solutions to identified areas of need, including exploring options for additional State and Commonwealth funding. Where appropriate, assist with advocacy to the Commonwealth Government to ensure a multi-disciplinary, Aboriginal community-controlled approach to maternal and child health services. Specifically, this should include the following: • Explore opportunities with ACCHS to identify critical areas of need in relation to child and adolescent mental health supports and fund and resource ACCHS to enable children and families to stay on Country for diagnosis and treatment; • Sustainably fund and resource ACCHS to provide wraparound supports to expectant mothers; • Explore options to enable WACHS hospitals to provide transport to and from antenatal hospital appointments; and • Provide sustainable funding to ACCHS that are not funded to provide transport for clients to and from hospital appointments.
Recommendation 2	Work with WA ACCHS to explore opportunities for ACCHS to increase telehealth appointments, thereby reducing the need for PATS and increasing access to services for clients in regional/remote areas.
Recommendation 3	Work with WA ACCHS to identify infrastructure and equipment needs for maternal and child health services and explore options for meeting these needs.
Recommendation 4	In line with Priority Reform Two of the National Agreement on Closing the Gap, support WA ACCHS to implement culturally secure, holistic and multi-disciplinary maternal and child health service models that span prenatal care through to postnatal care, and child health. Based on local needs and capacity, consideration should be given to incorporating Endorsed Midwives, Midwifery Group Practice, wraparound supports and ECHS checks to ensure culturally secure, continuity of care for women and children.
Recommendation 5	In line with Priority Reform Two of the National Agreement on Closing the Gap and the Health Sector Strengthening Plan, work with ACCHS to address salary disparity and other workforce issues, including exploring cross-agency approaches to provide solutions to housing shortages and place-based training.
Recommendation 6	In line with Priority Reform Four of the National Agreement on Closing the Gap, WA Health to prioritise: • Consistent, reliable and timely sharing of patient data and discharge summaries with ACCHS; and • Consistent patient data uploads to MyHealthRecord.

Recommendation 7	In partnership with the ACCHS sector, explore options for improving coordination of care, including travel arrangements, accommodation and general information sharing. This may include funding a coordinator position within Perth and regional hospitals to coordinate care between ACCHS and mainstream, and/or an ALO position to support clients during their relocation.
Recommendation 8	WA Health to complete an audit of the timeliness of all discharge summaries sent to primary health care providers (such as ACCHS) within 24 hours of discharge. Upon completion, commit to sharing these findings with AHCWA, and working with the ACCHS sector to improve these communication pathways.
Recommendation 9	Make changes to PATS to ensure geographical barriers do not impede access to care for Aboriginal mothers travelling off Country for antenatal care and birthing by: • Streamlining processes and provide training to PATS staff (if required) to ensure PATS guidelines are being implemented more consistently across the State; • Expanding the 'escorts' guidelines to include travel subsidies for accompanying children, where alternative arrangements cannot be made; • Expanding the 'escorts' guidelines to include escorts across all necessary antenatal appointments; • Clients receiving payments upfront and in a timely manner, with 'assistance in advance' prioritised; • Increasing funding and resourcing of existing short-stay accommodation facilities and continue investing in increasing accommodation stock to ensure appropriate and culturally safe facilities for birthing mothers; • Increasing PATS accommodation subsidy payments for patients and escorts to reflect increases in state-wide accommodation rates; and • Changing PATS requirements to ensure women travelling for births and high-risk antenatal appointments have the option to travel by airplane, rather than road.