Report of the mid-term review of Victoria's Maternity Services Program

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Abstract

Substantial State Government funding has been committed in Victoria for the enhancement of maternity services. The funding is intended to improve the quality of care for women and meet consumer expectations for choice and continuity of care in maternity services. This paper reports on a mid-term review (the 'Review') of the Victorian Maternity Services Program, which was conducted by the authors on behalf of the Victorian Department of Human Services. Documentary analysis was conducted for the review, and workshops and key informant interviews were held throughout Victoria with midwives, medical staff and Department of Human Services staff. The Review found that there had been many gains as a result of the Maternity Services Program and identified directions for further development. Issues of change and facilitators of change processes in maternity services are highlighted in this article.

Framework for the Victorian Maternity Services Program

In 1998/99, the Victorian Department of Human Services (DHS) introduced funding for a Maternity Services Program (MSP) to be implemented over a 4-year period. Maternity Services Program funding is for public hospital maternity services, as distinct from the care provided for women with private health insurance. The MSP strategy involves providing substantial funding to enhance public maternity services in Victoria. The available funding was $12.9 million in 1998/99, $16.4 million in 1999/2000 and $16.4 million in 2000/2001. $15.7 million is available in 2001/02, and beyond 2002, $14.9m will be recurrent in Funding and Service Agreements.

The broad objectives of the MSP set out by the DHS are to:

- promote measurable improvements in the continuity and quality of antenatal, intrapartum and postnatal care, individualised to the needs of particular women;
- provide women with increased birthing options and with evidence-based information on the benefits and risks associated with different options;
- encourage improvements in models of care in line with best available evidence; and
- improve outcomes through appropriate performance measures and service audits.

The DHS established a mid-term review (the Review) in late 1999 to address, specifically, the first two objectives of the MSP. Those conducting the Review were given three aims:

- to assess to what extent implementation of the maternity services enhancement plans had progressed the first two objectives of the MSP;
- to determine how well the hospital sector was doing in terms of their MSP Plans; and
- to identify areas that required particular attention in the remaining 2 years of the program implementation.

The Review was required to collect and analyse information about major achievements to the end of 2000, as well as any significant barriers to meeting the objectives of the MSP, and to make suggestions and recommendations for overcoming identified barriers. Those conducting the Review adopted a woman-centred approach in that their advice was informed by beliefs that real and informed choices for women in pregnancy, birthing and post-natal services are central to women's good health. In general terms, such a Review involves determining a program's success in achieving its objectives. In line with published literature on review and evaluation (Department of Finance 1994; Wilson & Wright 1993; Hawe, Degeling & Hall 1990), this Review was conducted to assess, on the basis of evidence, how well the MSP was progressing in terms of its appropriateness, effectiveness, efficiency and equity.

Framework for the Review

Historically, women having a baby in Victoria have been seen by a mix of hospital and community-based doctors and midwives, with the medical model traditionally dictating the pattern of care and style of delivery offered to women. Maternity services in Victoria are organised into two distinct types: obstetric models of care and midwifery models of care.

Obstetric models include public hospital clinic care, where women are seen in the traditional obstetric model by registrars or residents, with obstetricians seeing women with clinical problems. Obstetric models of care account for the vast majority of services provided for the 60,000 births that occur each year in Victoria. Hospitals have institutionalised the medical model and its associated maternity practices. Obstetric models include shared care, which represents a 'sharing up' of antenatal care between different practitioners, mainly when the care of a woman is shared between midwives and doctors in public hospital clinics or between GPs and public hospital obstetricians. However, midwives may also share care with a GP in his/her rooms.

Midwifery models of care include caseload midwifery and team midwifery, community midwifery programs and birth centres. Independent midwives also provide maternity services, including homebirths, but do not yet have visiting/admission rights to hospitals and thus were not part of the Review.

Birth centres have been established in a small number of Victorian hospitals, either within the hospital or in separate premises. They are family-centred units with a home-like environment where a team of midwives provide care during all stages of birthing, which is not limited to labour alone. Birth centres encompass caseload or team midwifery models of care in which midwives are the primary carers for women throughout uncomplicated pregnancies. The continued presence of birth centres was recommended in 1999 by the Victorian Birthing Services Review and the Senate Inquiry into Childbirth Procedures (Community Affairs Reference Committee 1999).

Team midwifery and caseload midwifery models of care involve the provision of full midwifery care for women by a group of midwives, but within the hospital environment. Midwives provide continuity of care to women during pregnancy, labour, birth and the postnatal period, and together with community midwifery programs are the accepted alternatives to obstetric-led models (NHMRC 1998). The National Health and Medical Research Council (1996, 1998) decided that valid conclusions can be drawn from randomised trials that compared midwifery models of care with conventional care and showed that midwifery models of care offer significantly higher levels of satisfaction, lower costs and lower intervention rates for uncomplicated pregnancies than do obstetric models of care. Of all of the pregnancies in Australia, 75% are classified as uncomplicated and suitable for midwifery management.

A community midwife program provides full midwifery care for women in their own community, with the option of home or hospital birth, and includes full postnatal support. The West Australian Department of Health is currently funding a community midwife program that will involve 150 births per year. A community midwife has a caseload of approximately 30 patients per year and works in conjunction with other community midwives who provide each other with backup and support (The West Australian 2000).

For this Review, we defined continuity of care as ensuring that a woman is cared for by someone with whom she builds a relationship, someone she knows and whose philosophy and practices she trusts, through all stages of pregnancy, birth and the postpartum period. This may be the same carer or a team of carers. This view is supported by Laslett, Brown & Lumley (1997), who made the distinction between continuity of care and continuity of care-

giver. Their understanding is that continuity of care-giver may be less important to women than the continuity of care. Thus, models of team care that provide continuity of care in terms of both philosophy and practice may be as acceptable to women as a model that provides a single carer throughout the pregnancy, birth and beyond.

Key studies provide much of the background to current activities that are aimed at facilitating change to institutionalised hospital cultures and maternity routines. The negative outcomes of institutionalised routines are the focus of the Baby Friendly Hospital Initiative (UNICEF/WHO 1989), which links declining breastfeeding rates to hospital cultures, lack of breastfeeding policies, encouragement of the use of artificial/supplementary feeding and deficiencies in lactation education and support. The dominance of the obstetric model and the lack of choice offered to women about how, where, with whom and in what environment they can birth is central to struggles about change processes over the last three decades for women's experiences of birth and has generated an extensive literature. Although it is beyond the scope of this article to cover this literature, a brief review is provided.

The World Health Organisation (1996) and the National Health and Medical Research Council (1996) have identified the need for more appropriate and effective use of health care resources in pregnancy and childbirth, recommending enhanced roles for midwives as well as referral to obstetricians when there is a need for specialist expertise. Obstetric intervention rates in Australia are subject to Perinatal Data mandatory reporting requirements by Health Departments in all States and Territories of Australia. NSW provides this information on the Internet, but Victoria does not.

The Statewide Ministerial Review of Birthing Services, *Having a baby in Victoria* (Lumley 1990), drew attention to key issues of concern in maternity services. These included professionally driven practices during pregnancy and birthing; inflexibility in hospital cultures; lack of choice and poor continuity of care through the antenatal to postnatal period; low levels of satisfaction among birthing women in relation to discharge planning, postnatal care and support; a general lack of information about birthing services; and a lack of specific services for women with special needs and accessible information about those services. The Review of Birthing Services has continued to provide aspirations for improved birthing services and provides benchmark recommendations for change to the quality and style of maternity services in Victoria.

At the core of strategies for change is the philosophy about continuity of care for a woman throughout her pregnancy. Brown (1999) defined continuity of care as occurring when a woman sees the same care providers across different stages of antenatal, intrapartum and postnatal care, including labour. Flint (1994) defined continuity of carer in maternity services as a woman having 'someone to be with who she knows and trusts, someone she has been able to build a relationship with' (Flint 1994, p2). In addition, continuity of care in terms of both philosophy and practice are as likely to be as important to a woman as the continuity of her carer (Laslett et al 1997).

A range of medically driven models under the rubric of 'shared care' has evolved in maternity care arrangements. They have been introduced to varying degrees and in varying styles in 42 Victorian hospitals since about 1992. In a 1997 study, Laslett et al (1997) indicated that the expansion of shared care arrangements was not demonstrating improvements in women's satisfaction with antenatal care. These arrangements were again reviewed by Dawson, Brown, Gunn, McNair & Lumley (2000), who found that the rapid expansion of shared care has occurred because women and practitioners apparently see the advantages of alternative systems of care. An additional motivation for shared care arrangements comes from Commonwealth-State financing arrangements, which provide strong incentives for the shift of services from the acute to the community sector (Dawson et al 2000). In practice, this means that antenatal care that was once provided by public hospitals is now offered in the community by doctors, so women are required to pay for the service and claim the Medicare rebate. There is no guarantee that antenatal services will be bulk-billed. There are not yet any financial incentives for the provision of antenatal care by midwives either in hospitals or in the community.

Dawson and colleagues (2000) found that in Victoria, shared care was a fragmented, uncoordinated system of care with little, if any, sharing of clinical responsibilities for the care of individual women. They found 'substantial obstacles, particularly in terms of reaching an agreed philosophy and integrated approach to care' (Dawson et al 2000, p 406). The obstacles, or barriers to change, included uncertainty regarding with whom ultimate responsibility for women's clinical care rests, professional sensitivities, organisational cultures and deficiencies in the models to guide shared care. Dawson and colleagues found that these barriers led to a lack of integration and a lack of continuity of care for women.

A survey conducted in conjunction with the Birthing Services Review (1990) found that the level of satisfaction with their birth experience for women attending public hospital clinics was much lower than it was for those attending private obstetricians or a local GP (Laslett Brown & Lumley 1997). Women's satisfaction with different models of care in Victoria was again assessed in the 1993 Survey of Recent Mothers. The findings confirmed the negative findings about public hospital clinics and the positive findings about private obstetrician care (Laslett Brown & Lumley 1997). Shared care programs varied considerably among hospitals and findings about women's experiences were also widely variable. Laslett et al (1997) cautioned against further expansion of shared care programs before critical review against other models of care was undertaken. In light of the Dawson et al (2000) findings, that caution remains pertinent.

The culture of hospitals has not been conducive to consumer participation in the planning and implementation of services. Victorian hospitals have been slow to incorporate consumer participation in their structures, whether in general services or those specifically for women (such as maternity services), Koori groups or people with culturally and linguistically diverse backgrounds (Draper 1997). The Centre for Mother's and Children's Health (Brown 1999) conducted a Survey of Recent Mothers in 1997 that provided information about women's experiences of and satisfaction with birthing services. The 1997 Survey of Recent Mothers is a repeat of surveys conducted in 1989 and 1993/4. The results of the Survey are based on a cohort of women who gave birth early in the life of the Maternity Services Program. Three separate reports (Bruinsma Brown & Darcy 2001; Darcy Brown & Bruinsma 2001; Brown Darcy & Bruinsma 2001) present the multifaceted findings of this comprehensive research under themes of women's views and experiences of different models of maternity care, continuity of care and early postnatal care.

Review process

The process for the Review was intended to be as inclusive and wide-ranging as possible given the resources available. The review process was aimed at providing opportunities for staff involved with birthing services to discuss the implementation of the MSP. They were encouraged to identify barriers to and facilitators of change.

All DHS Regions provided MSP plans and a range of appropriate documentary information. Documentary analysis of the plans provided understanding of the rationale for the development of proposed initiatives and helped to identify and characterise the approaches being taken and applied to maternity services developments funded by the MSP Strategy. A reference group was established and consultation with key Department of Human Services staff was ongoing through the Review period.

Nine workshops were conducted by the authors in five rural regions and four metropolitan areas. The workshops were well attended by midwives, directors of nursing and nurse unit managers. Information about the project, as well as the Review questions and contact details of the Review team, were made available prior to the workshops to workshop participants.

A total of 22 key informant interviews were conducted during November and December 2000; informants were sampled from every region and network. In order to obtain broad input, interviews were sought with directors of nursing/nurse unit managers, project managers of MSP-funded studies, obstetricians, GP liaison officers, rural general medical practitioners and representatives of consumer groups. Despite considerable effort, the level of engagement of medical practitioners (general practitioners and obstetricians) with the MSP was lower than expected.

Interviews were conducted by the authors, either in person or by phone. After initial contact was made with informants and they agreed to be interviewed, information was sent out to them before the interview. Notes were taken as a record of each interview. All key informant interviewees were offered the opportunity to review their interview notes, and most did so. Written submissions were invited from any relevant personnel. Three additional confidential submissions from midwives were received via this method.

Summaries of the maternity services plans submitted by maternity services in each region prior to funding being distributed by the DHS were used to assess the progress of hospitals and health services in the implementation of their objectives. As the data collection proceeded, all interviews and workshops were coded and thus de-linked from the data. All of the workshop and interview notes were collated into a single document. Content analysis was undertaken to develop the themes. Drawing on the summaries and the data acquired during the

Review, tables for each region and sub-region (where possible) were constructed to assess the major achievements of the MSP; these were provided in draft form to maternity services for feedback and comment. Fax-back surveys consisting of 2 pages and designed to be quickly completed and returned by fax were sent to nurse unit managers for them to have an opportunity to validate information about progress on initiatives proposed in the maternity services plans.

A consumer review was not a focus of the tender brief, but attention was paid to the involvement of consumers in MSP planning and implementation. Two consumers attended a rural workshop. A small number of interviews were conducted with consumers involved in MSP committees. A senior member of the Victorian Aboriginal Community Controlled Health Organisations (VACCHO) participated in an interview and contributed a comprehensive written submission. Nevertheless, the Review was not expected to gather comprehensive consumer or Koorie input as other concurrent studies have been funded by the DHS to more thoroughly examine maternity services for Koorie women.

Limitations of the Review

The Review was limited by the resources available for the study, given the complexity and range of initiatives and the number of hospitals and health services providing maternity services across Victoria. However, every effort was made to elicit information and to include it in the analysis. The number of key informant interviews was fewer than planned in the categories of GP and obstetrician. The Review was limited by the lack of independent evaluations of hospital and health service projects, for which internal evaluations are the norm. The Review was constrained by the unavailability of expenditure data that could measure activity in hospitals and health services before and after the introduction of MSP funding. While hospitals provided data about their expenditure on MSP projects, the authors were unable to independently assess to what extent cost shifting had occurred between MSP funding and pre-existing programs at the local level. Some anecdotal evidence suggests that hospitals are indeed claiming some activities as MSP-funded when those activities were actually funded by other sources.

It should also be noted that those conducting the Review were told of many issues related to shared care, but issues about shared care were not a focus of the Review. A separate study on shared care has been funded through the MSP and will be reported separately from this Review.

Major themes of the Review

The major themes that emerged from the Review were wide ranging. They concerned issues about defining models of care, continuity of care, collaboration, choice and consumer participation, nursing policy issues, quality improvement, services for women with special needs and funding issues. Recommendations made by the Reviewers, in consultation with the DHS, sought to strengthen facilitators for change, to overcome barriers to change and to identify strategic directions for the MSP. However, for reasons of space, the following discussion will outline the major issues that emerged in the Review, rather than go into detail about the recommendations.

An overarching issue identified by the Reviewers relates to the models of care offered to a woman and her 'birthing options'. 'Birthing options' is a widely used term in relation to maternity services, but we found that it was used loosely and widely interpreted. It is a term that should be given greater clarity in MSP literature by distinguishing between primary and secondary birthing options. In other words, a distinction should be made between the stages of decision-making a pregnant woman makes, which we argue should be recognised as a woman's primary and secondary birthing options. A primary birthing option is made at the outset of a woman's antenatal care and requires a woman to make choices about the model of care (either obstetric incorporating shared care, or midwifery models of care as discussed above) she wishes to have. A woman's secondary birthing options are interpreted by the Reviewers as those relating to the kind of antenatal care and support she will get, the nature of her birthing plan, breastfeeding preparation and education, the mode of her birthing and who she wants to assist her in the birth. These secondary birthing options are about a range of other aspects of a woman's care; her ability to make informed choices about secondary birthing options is underpinned and facilitated by the quality of the information she is given at each stage of her pregnancy.

Best practice in the continuity of care emerged as a central issue, applicable from the antenatal period through to the postnatal period. The Review found that a statewide approach to the documentation of best practice in the continuity of care and best practice guidelines would be of benefit to all birthing services in Victoria. The Review recommended that the MSP should support and encourage hospitals to document best practice models for pre-admission clinics and early midwife involvement in women's care. Best practice in the continuity of care was also dependent on improved linkages between maternity services, general practitioners and maternal and child health services. The Reviewers found that those conducting Maternity Services Program projects in rural and metropolitan areas were encouraged by DHS staff to include local maternal and child health nurse representation, where appropriate, on working parties and reference groups in order to improve the quality of postnatal services for women through the closer working relationships that would develop from such initiatives.

The Reviewers recommended that continuity of care be broadened to include issues of visiting rights for midwives. The Reviewers believe that visiting rights for midwives is an issue that should be addressed as a matter of priority to ensure that women who choose midwifery care but require admission to hospital have their continuity of care acknowledged as important for their outcomes.

The Review established the need for best practice guidelines for a range of key issues in maternity services. The Reviewers determined that the MSP is a valuable opportunity to provide project funding to develop a range of statewide approaches to a range of matters, including the development of guidelines. The Reviewers also felt that MSP funding could usefully be allocated to develop best practice guidelines for outreach programs, perhaps via the commissioning of a review of a cluster of case studies. A statewide approach to the dissemination of postnatal depression guidelines would also be a good investment of MSP funds. The Reviewers recommended that all regions and networks should ensure that all of their maternity service providers make use of those approved guidelines. Best practice in domiciliary care also needs to be documented, including breastfeeding guidelines (together with guidelines for assessment that encompass risk assessment), for use by all services. A statewide approach could also be taken to quality assurance standards in discharge planning and the provision of postnatal care to address areas of less than optimal provision of appropriate services.

Best practice in consumer issues was also a theme of the Report. Very few MSP projects included consumers in a manner that demonstrated commitment to ongoing consumer group input. However, a few maternity services were engaged with consumer participation and the Reviewers recommended that what comprises best practice in consumer engagement with the development of maternity services should be documented and disseminated widely among maternity services, with a requirement that maternity services increase the level of consumer participation in program planning, implementation and evaluation. The Review found duplication across regions in the development of consumer information, suggesting that a statewide approach to the provision of at least core information for consumers should be investigated.

The need for improved resources for women from non-English speaking backgrounds (NESB) was a strong theme of the data gathered during the Review. Some efforts have been made to provide antenatal information in languages other English, but the Reviewers found that there was also duplication of effort in different parts of the State. One of the recommendations was that the MSP could be used to assist services to share NESB resources across the State and to maximise efforts to provide culturally appropriate information that is available to all maternity services.

The Reviewers found ambivalence among maternity services about making a commitment to the achievement of Baby Friendly Hospital (BFH) status, although there are several maternity services that have gained BFH accreditation, not always with MSP funding. Nevertheless, the MSP provides an opportunity to make policy decisions about whether Baby Friendly Hospital status is a gold standard for maternity services and, if so, this needs to be made clear within the industry. If BFH is to be a gold standard, then incentives should be provided through MSP for services to achieve Baby Friendly status. The framework of the MSP does provide opportunity for the commissioning of a survey of all Victorian maternity services to assess progress of maternity services towards BFH status. Information about which maternity services have received BFH status should be provided on the Internet for consumers.

With regard to lactation support, the Review found that there was considerable progress towards the provision of a qualified lactation midwife in maternity services, but that this is by no means a service that is available across Victoria. The MSP could be used to facilitate the coordination and dissemination of breastfeeding information

across the state and to ensure that such information is available to all hospitals and health service providers of maternity services.

The strength of support for the MSP was evident in the numbers of midwives who participated in this Review. However, many midwives expressed concern about the need for improved transparency and accountability of MSP expenditure at the local level, concern that would appear to well founded in some hospitals. Review and monitoring of the implementation and expenditure of MSP funding would help to ensure that funds are used appropriately and effectively for maternity services developments, and not redirected to other areas of hospital expenditure.

Barriers and facilitators of change

The Reviewers found that barriers to change were quite wide-ranging. They include staffing levels and an overall shortage of midwives in Victoria, which make it difficult for midwives to undertake MSP project work in addition to usual workloads. This restricts the potential of MSP developments. Continuity of care teams were especially difficult to establish because of the demands on staff, although midwives noted that both women and midwives found this model of care to be very rewarding. Barriers to change from within midwifery were also raised by respondents as a problem. As maternity services change, midwives are increasingly expected to work across the continuum of care, but there are insufficient midwives willing or able to work across all of the areas of care that are involved in continuity of care or team midwifery models. 'Traditional attitudes' to midwives who prefer to work only in one area (labour ward or postpartum, for example) were frequently cited as a barrier to change, and it was noted that these attitudes exist among some medical practitioners and midwives themselves. In some cases, midwives themselves were thought to need professional development to facilitate an increase in the provision of options for women and to progress evidence-based midwifery models of care. Nevertheless, obstetricians who were supportive of midwifery models of care were acknowledged as key facilitators of change.

Hospital/health service managers have the potential to be either facilitators of or barriers to change. There was a widespread concern from midwives that greater support was needed from management for midwifery models of care to be more fully implemented.

Clearly, the Maternity Services Program itself is a key facilitator of change. Funding in the larger maternity services has enabled the employment of project officers whose ability to provide direction and momentum in projects would make a significant difference to the MSP.

Another driver for change that was identified by respondents was the leadership role exhibited by some nurse unit managers and some team leaders. Respondents at the workshops, in particular, were of the view that greater consumer involvement in planning and evaluation of services would facilitate further change.

Conclusions

The directions of change for midwifery services can be identified in terms of new roles in service provision; considerably increased levels of midwife antenatal care; new and improved services for women with special needs; improved collaboration between hospital maternity services and community care providers; and quality improvements in pre-admission services, domiciliary care and lactation support services. All are underpinned by the professional development of a significant number of midwives, their commitment to continuity of care, and increasing public confidence in their ability to provide evidence-based, high quality maternity services for women. All of the obstetricians and GPs interviewed recognised the value of these general improvements to services to women, especially in the area of pre-admission clinics, pregnancy and birthing information for women, domiciliary care and breastfeeding support.

From a midwifery perspective, there is a journey of change underway in Victoria. From the perspective of medical practitioners, women are receiving improved maternity services. From the perspective of consumers and midwives, much more needs to be done before birthing options can genuinely be said to have increased. Whilst there is wide understanding about the directions of change, continuing support and development is necessary for those changes to be realised to a significant degree.

References

Brown S & Lumley J 1999, *Review of shared obstetric care, Summary report*, Centre for the Study of Mother's and Children's Health, School of Public Health, La Trobe University.

Brown S, Darcy M & Bruinsma F 2001, Victorian survey of recent mothers 2000, early postnatal care. Centre for the Study of Mother's and Children's Health, Melbourne.

Bruinsma F, Brown S & Darcy M 2001, Victorian survey of recent mothers 2000, women's views and experiences of different models of maternity care, Centre for the Study of Mother's and Children's Health, Melbourne.

Community Affairs References Committee, Sen R. Crowley (Chairperson) 1999, *Rocking the cradle: Report on childbirth procedures*, Commonwealth of Australia, Canberra.

Darcy M, Brown S & Bruinsma F 2001, Victorian survey of recent mothers 2000, continuity of care: does it make a difference to women's views and experiences of maternity care?, Centre for the Study of Mother's and Children's Health, Melbourne.

Dawson W, Brown S, Gunn J, McNair R & Lumley J 2000, 'Sharing obstetric care: barriers to integrated systems of care', *Australian and New Zealand Journal of Public Health*, vol 24, no 4, pp 401-6.

Department of Finance 1994, *Doing reviews: a practical guide*, AGPS, Canberra.

Draper M 1997, *Involving consumers in improving hospital care: lessons from Australian hospitals,* Victorian Government Publishing Service, Department of Human Services, Melbourne.

Flint C 1994, *Midwifery teams & caseloads*, Butterworth-Heinemann Ltd, Oxford.

Hawe P, Degeling D & Hall J 1990, *Evaluating health promotion: A health worker's guide*, Sydney, MacLennan and Petty.

Laslett A-M, Brown S & Lumley J 1997, 'Women's views of different models of antenatal care in Victoria', *Birth* vol 24, no 3, pp 81-9.

Lumley J (Chairperson) 1990, *Having a baby in Victoria: final report of the Ministerial Review of Birthing Services in Victoria,* Health Department Victoria, Melbourne.

National Health & Medical Research Council 1996, *Options for effective care in childbirth*, NHMRC, AGPS, Canberra.

National Health & Medical Research Council 1998, *Review of services offered by midwives*, NHMRC, AGPS, Canberra.

The West Australian, Sat 18 Nov 2000, p 18.

United Nations Children's Fund & World Health Organisation 1989, *Protecting, promoting and supporting breast-feeding: the special role of maternity services*, Joint WHO/UNICEF Statement, Geneva.

Wilson G & Wright M 1993, *Review framework for women's health services and centres against sexual assault*, Centre for Development and Innovation in Health, Melbourne.