ATTACHMENT SB 4

This is the attachment marked "**SB 4**" referred to in the witness statement of Stephanie Janne Brown dated 9 July, 2015.

Maternity care with the Women's Business Service at the Mildura Aboriginal Health Service

Abstract

Objective: To assess and contrast views and experiences of women attending the Women's Business Service at the Mildura Aboriginal Health Service with those of rural women attending public maternity services who participated in a Victorian statewide survey conducted in 2000.

Methods: Face-to-face interviews were conducted with clients of the Women's Business Service (n=25) using a structured interview schedule based on the Victorian Survey of Recent Mothers 2000. Comparisons were made with rural women who had participated in the 2000 survey and had received public care for their pregnancy (n=333).

Results: Compared with rural participants in the 2000 survey, women who attended the Women's Business Service were significantly more likely to say care providers kept them informed (OR 20.63, 95% CI 3.27-853.75), midwives were never rushed during check-ups (OR 22.24, 95% CI 3.50-921.47), and to say they were happy with medical care (OR 5.79, 95% CI 1.68-30.67). Eighty per cent of interview participants described their antenatal care as 'very good'. Fewer women rated intrapartum care (64%) or postnatal hospital care (43%) as 'very good'. Compared with rural participants in the statewide survey, women attending the Women's Business Service were significantly more confident about looking after their baby in the first week at home (OR 9.08, 95% CI 2.95-37.01), and less likely to want additional help or advice (OR 0.21, 95% CI 0.04-0.73).

Conclusions: Women using the Women's Business Service were significantly more positive about many aspects of their care than women attending other rural public maternity services. The study lends support to the view that Aboriginal community-controlled health services are well placed to provide appropriate and accessible care to Indigenous women.

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This paper reports the findings of an exploratory study that sought to investigate the views and experiences of women who had received maternity care from the Women's Business Service (WBS) based at the Mildura Aboriginal Health Service (MAHS). The study was designed to facilitate comparisons with a statewide Victorian survey conducted in 2000. Three population-based surveys of recent mothers have provided a rich source of comparative data for evaluating organisational changes in the provision of maternity care in Victoria over a 10-year period.[1] However, all three surveys have under-represented women born overseas of non-English speaking backgrounds and Indigenous women, highlighting the need for other approaches to encourage participation of Indigenous women and women of non-English-speaking background in health services research.[2,3]

The MAHS commissioned an evaluation of the WBS to: (i) investigate views and experiences of women using the program, and (ii) document the views of care providers regarding the operation of the program. The study involved interviews with a sample of 25 women who had recently had a baby and received some or all of their antenatal care from the WBS. The interviews were conducted using a modified version of the questionnaire developed for the Victorian Survey of Recent Mothers 2000.

The WBS is a community-controlled primary health care service that operates alongside the general medical clinic at the MAHS. It was established in May 2000 with recurrent funding from the Victorian Department of Human Services. The program aims to provide personalised care that takes a holistic view of health during pregnancy. Primary health care and pregnancy screening are provided by a registered midwife and an Aboriginal maternal health worker. The service provides antenatal and postnatal care, health education and information, and support for clients during labour and birth in hospital, or at home. Clients can attend check-ups at the Aboriginal health service or receive visits from the midwife and the health worker at home via an outreach service. Women attending the WBS for pregnancy care are reviewed by the midwife/maternal health worker team every four weeks up to 28 weeks' gestation, two weekly to 36 weeks and weekly thereafter. If appointments are not kept, women are followed up by telephone or during a home visit. All women are given a client-held record and the progress of their pregnancy is noted at each visit. Medical staff at the MAHS provide referrals for women who require or request specialist obstetric care during their pregnancy. The midwife and maternal health worker are available to support clients in hospital during labour and birth and in the postnatal period. The program offers a 24-hour on-call service, and transport to and from hospital for women who need it. Hospital domiciliary midwives liaise with the WBS to co-ordinate the provision of midwife support post discharge, and the MAHS runs a weekly baby clinic that provides information, advice and support for mothers and their babies in the year after birth. The program was developed to provide care for

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Aboriginal women in the Mildura area. Non-Aboriginal women seeking midwife/health worker-led care comprise approximately 25% of the clientele.

This paper reports on the first stage of the evaluation, involving interviews with 25 past and present clients of the WBS. Findings from the second stage of the study involving interviews with care providers, and with grandmothers from the local Aboriginal community, are described in a report available from the MAHS.[4]

Method

Women's Business Service interviews

Sample. The study aimed to recruit 25 women who had attended the WBS whose child was three to 18 months old at the time of the interviews. Women who were ill or whose infant had died were not approached to participate. The sample size was restricted by: (i) the number of women using the WBS (40 to 50 women per year), and (ii) geographic mobility of women using the service. Funding provided by the Victorian Department of Human Services was sufficient to cover costs of a four-week field trip. Twenty-five interviews was the maximum it was deemed feasible to conduct in this period.

Procedure. Eligible women were identified by WBS staff drawing on patient records of the MAHS. WBS staff made contact with eligible women, provided a brief explanation of the project, organised interview times and introduced the interviewer (SC) to each participant, but were not present during interviews. Written informed consent was sought by SC prior to conducting each interview. Interviews were not tape-recorded. Ethics approval for the study was obtained from the Human Research Ethics Committees of La Trobe University and the Australian National University. The MAHS approved the study and accepted ethics approval from the two universities as there was no Victorian or local Indigenous Health Research Ethics Committee operating when the study was undertaken.

Questionnaire. The interview covered women's views and experiences of care in pregnancy, labour and birth and the postnatal period. Data on obstetric and socio-demographic characteristics were also collected. Overall ratings of care were based on questions which asked: 'On balance, how would you describe your antenatal/labour and birth/postnatal care?' with the following response options: 'very good', 'good', 'mixed', 'poor' and 'very poor'. Open-ended questions were included at the end of each section, inviting women to comment on aspects of their antenatal, intrapartum and postnatal care that they were particularly happy with and/or unhappy with.

Victorian Survey of Recent Mothers 2000

The methods used in the 2000 survey are described in detail elsewhere.[2] Briefly, all women who gave birth in Victoria in two weeks in September 1999 – except those who had a stillbirth, or whose baby was known to have died – were mailed questionnaires five to six months after the birth. The adjusted response fraction, excluding questionnaires returned unknown at the mailing address, was 67% (n=1,616). Participants were representative in terms of parity, method of birth, infant birthweight and place of residence (metropolitan/rural), but younger women (under 25 years), unmarried women, women of non-English-speaking background and Indigenous women were under-represented.

Analysis

The coding schedule and protocols used to analyse the interview data were consistent with the procedures used for the statewide survey.[2] A coding framework for analysis of open-ended questions was developed by SC based on reading all responses to each question. Both authors independently coded all open-ended comments and resolved differences by consensus. Quantitative analysis was conducted using SPSS for Windows[5] and the Statcalc component of Epi Info 2000[6], and involved simple frequencies and calculation of odds ratios. Statistical comparisons were made between the views and experiences of: (i) clients of the Mildura WBS (n=25), and (ii) rural women who participated in the 2000 survey and had received public maternity care (n=333). For statistical analysis, variables measuring women's overall ratings of care were grouped into two categories: responses describing care as 'very good'/all other categories. An *a priori* decision was made to consider all responses other than 'very good' as indicating that some aspect of care could have been better.[2] Post hoc power calculations conducted using Epi Info Version 6[6] showed that the study had 40% power to detect statistically significant differences in key outcome variables comparing WBS clients with rural survey participants with alpha=0.5. The sample was too small for meaningful statistical comparisons between Indigenous and non-Indigenous clients of the WBS.

Results

Forty-four women were identified from WBS records as having given birth or having an expected date of confinement between three to 18 months before the interviews were scheduled to take place (October/November 2002). Fourteen women were excluded because they were not residing in the Mildura area at the time of the study, two because their contact details were unknown, two were too unwell to be interviewed, and one woman was excluded because she had a stillbirth. Twenty-five women were invited to participate. All agreed to take part. Nineteen interviews took place in private homes and six in a consulting room at the MAHS. Interviews ranged in length from 15 to 55 minutes, with a mean of 36 minutes. Occasionally, the woman's partner, children, a friend or relative were present for some or all of the interview. Nineteen women who took part in the interviews were Aboriginal, and six were non-Aboriginal.

Social and obstetric characteristics of participants

Table 1 shows the social and obstetric characteristics of interview participants and compares these with the characteristics of rural women receiving public maternity care who participated in the statewide survey. The interview participants ranged in age from 18 to 35 years, with a mean age of 24.6 years. One-quarter were aged less than 20, compared with 4% of rural women.

Interview participants were more likely to have a pension or benefit as their main source of income, to have smoked during their pregnancy, and to have an infant weighing less than 2,500 grams. There were no differences in relation to parity, spontaneous onset of labour, or method of birth.

Women's views of antenatal care

All of the WBS clients had had some or all of their antenatal care with the WBS. Nine women also saw a doctor; seven of these women saw an obstetrician for two or more visits. Table 2 summarises women's views of antenatal, intrapartum and postnatal care comparing rural women receiving public maternity care who participated in the 2000 survey with WBS clients taking part in the evaluation study. Compared with rural survey participants, WBS clients were significantly more likely to say that doctors and midwives always kept them informed, that midwives were never rushed, that they never had to wait more than half an hour, and to say they were always happy with their medical care. A higher proportion of the WBS clients rated their antenatal care as 'very good', although this difference only bordered on statistical significance.

The five aspects of antenatal care that women most often nominated as aspects of care they were particularly happy with were: home visits provided by WBS (16/25); sensitivity, kindness, reassurance and respect shown by care providers (10/25); having care providers who were on-call and easy to contact (9/25); the education and information offered (9/25), and the availability of transport (6/25).

Women's views of care during labour and birth

Two WBS clients had their baby at home and 23 gave birth in hospital. The WBS midwife attended 13 births (11 hospital births and two homebirths). The WBS maternal health worker attended five births. WBS clients were more likely to have known at least one of the midwives who cared for them in labour very well, and to perceive that they had been given an active say in making decisions regarding their care. They were significantly less likely to describe hospital staff as friendly and welcoming when they first arrived at the hospital in labour. There were no statistically significant differences in any of the other measures of women's experiences of intrapartum care.

Open-ended comments about aspects of intrapartum care that

Table 1: Social and obstetric characteristics of participants in the WBS evaluation study and rural participants in the 2000 survey who had received public maternity care.

Characteristic	WBS (n=25) No. (%)	2000 survey (n=333) (ref. category) No. (%)	Odds ratio (95% CI)[a]
Maternal age <20 years			
Yes	7 (28)	13 (4)	9.48 (2.99-29.73)
No	18 (72)	317 (96)	
Pension or benefit main source of income			
Yes	16 (64)	55 (17)	8.79 (3.45-22.86)
No	9 (36)	272 (83)	
Smoking in pregnancy			
Yes	15 (60)	96 (29)	3.70 (1.50-9.23)
No	10 (40)	237 (71)	
Primiparous (first baby)			
Yes	9 (36)	127 (38)	0.91 (0.36-2.26)
No	16 (64)	205 (62)	
Spontaneous onset of labour			
Yes	19 (76)	217 (65)	1.68 (0.62-5.27)
No	6 (24)	115 (35)	
Spontaneous vaginal birth			
Yes	17 (68)	227 (69)	0.96 (0.38-2.53)
No	8 (32)	103 (31)	
Preterm birth (less than 37 weeks)[b]			
Yes	2 (9)	12 (4)	2.36 (0.24-11.61)
No	22 (91)	311 (96)	
Birthweight less than 2,500 g[b]			
Yes	5 (21)	7 (2)	11.84 (2.66-47.42)
No	19 (79)	315 (98)	

Notes:
(a) Odds ratio is calculated for the odds of each characteristic taking rural women receiving public care who participated in the 2000 survey as the reference category.
(b) Twins excluded.
Denominators vary because of missing values.

women were particularly happy with focused on: having options in labour and an active say in decisions about care (11/25), knowing their care givers (9/25), sensitivity, kindness, reassurance and respect shown by care givers (8/25), and feeling informed about what was happening (6/25).

Women's views of care in hospital after the birth

Six of the 23 women who had their baby in hospital returned home within 24 to 48 hours, eight women remained in hospital for three or four days, and nine stayed five days or longer. Less than half the WBS clients described their postnatal care in hospital as 'very good'. This is in marked contrast to ratings of antenatal care (80% described care as 'very good') and intrapartum care (64% rated care as 'very good'). Rural women receiving public care who took part in the 2000 survey also rated postnatal care in hospital less favourably than other stages of pregnancy care. WBS clients were somewhat less likely to rate their postnatal care as 'very good' (43% versus 50%), but significantly more likely to

Table 2: Women's views and experiences of antenatal care, care during labour and birth, care in hospital after the birth and care at home after the birth.

Characteristic	WBS (n=25)	2000 survey (n=333) (ref. category)	Odds ratio (95% CI)[a]
Antenatal care			
Rated their antenatal care as 'very good'	20/25	201/333	2.63 (0.92-9.16)
Felt doctors and midwives always kept them informed about what was happening	24/25	178/331	20.63 (3.27-853.75)
Felt the midwives were never rushed at check-ups	24/25	136/262	22.24 (3.50-921.47)
Said they were always happy with their medical care in pregnancy	22/25	185/331	5.79 (1.68-30.67)
Never waited more than ½ hour to see the doctor or midwife	21/25	56/330	25.69 (8.13-105.48)
Care during labour and birth			
Described their care as 'very good'	16/25	232/332	0.77 (0.31-1.95)
Described staff at the hospital as very friendly and welcoming	11/23	234/330	0.38 (0.15-0.95)
Said they had an active choice in pain relief all the time	20/25	190/299	2.29 (0.80-8.03)
Said they were very happy about what was done to relieve pain in labour	17/25	137/299	2.51 (0.99-6.57)
Knew the midwives that cared for them during labour very well	14/25	36/333	10.50 (4.11-27.10)
Said the midwives and doctors always kept them informed about what was happening	19/25	201/330	2.03 (0.75-6.38)
Always felt the options for managing labour were explained and their views taken into account	18/25	179/322	2.05 (0.78-5.59)
Were happy with their medical care in labour all the time	19/25	221/330	1.56 (0.58-4.91)
Found the midwives very helpful during labour	20/25	248/330	1.32 (0.46-4.65)
Felt they were given an active say in what happened during labour and birth in all cases	19/25	150/329	3.78 (1.40-11.82)
Care in hospital after the birth[b]			
On balance, rated their care in hospital after the birth as 'very good'	10/23	168/330	0.74 (0.29-1.87)
Said their doctors never seemed rushed and too busy to spend time with them in hospital	11/18	93/324	3.90 (1.35-11.55)
Said their midwives never seemed rushed and too busy to spend time with them in hospital	14/23	110/326	3.05 (1.20-7.93)
Experienced breastfeeding problems in hospital	7/23	147/307	0.48 (0.17-1.27)
Said they wanted quite a lot of help and advice with feeding	6/23	152/229	0.18 (0.06-0.50)
Said they were often given information about feeding that was contradictory or confusing	4/22	38/327	1.69 (0.39-5.50)
Described the help and advice they were given about feeding as extremely or very helpful	8/19	193/229	0.14 (0.05-0.40)
Care at home after the birth			
Visited by a midwife/health worker in their first few days at home	22/24	228/332	5.02 (1.19-44.68)
Felt very confident about looking after new baby in the first week at home	21/25	122/333	9.08 (2.95-37.01)
Definitely or possibly would have liked more help and advice during their first week at home	3/25	129/331	0.21 (0.04-0.73)
Would have liked further assistance with breast feeding after leaving hospital	2/24	112/297	0.15 (0.02-0.63)
Definitely or possibly would have liked more help or advice about their own health and recovery since the birth	4/25	139/331	0.26 (0.06-0.81)

Notes:
(a) Odds ratio for the rating of each aspect of care is calculated taking rural women receiving public care who participated in the 2000 survey as the reference category.
(b) Excludes two women whose baby was born at home.
Denominators vary due to missing values.

say that midwives and doctors were never rushed or too busy to spend time with them.

Twenty-four of the WBS clients commenced breastfeeding, 21 were still breastfeeding at four weeks, and 14 at 12 weeks postpartum. All the women who wanted help and advice with feeding during their hospital stay said help was readily available whenever it was needed. However, 13 out of 22 women who commenced breastfeeding in hospital said they were sometimes (9) or often (4) given information about feeding that they thought was contradictory and confusing. In response to the open-ended question at the end of this section of the interview, WBS clients commented frequently on: the sensitivity, kindness, reassurance and respect shown by care givers (9/23), the helpfulness of the staff (7/23), and information received after the birth (6/23).

Women's views of care at home after the birth

Twenty-two of the WBS clients were visited by a midwife or health worker in the first few days after discharge, or in the first few days after birth in the case of the two women who gave birth at home. Staff of the WBS visited 21 women in the sample. Domiciliary midwives from the hospital made home visits to 10 of the 23 women who gave birth in hospital. In contrast, only 69% of rural survey participants received a home visit from a midwife. WBS clients were more likely to feel very confident about looking after their baby in the first week at home, and less likely to want additional help or advice about feeding their baby or their own health and recovery.

Discussion

Birth outcomes of babies born to Indigenous mothers have not improved in Victoria over the past decade.[7-10] Pooled Victorian data for 1996-2000 indicate there were 16.8 perinatal deaths for every 1,000 births to Indigenous mothers, compared with 10.7 perinatal deaths for every 1,000 non-Indigenous mothers.[8-10] Data for 1999-2000 show that 15% of babies born to Indigenous mothers weighed less than 2,500 grams, compared with 7% of babies born in Victoria to non-Indigenous mothers.[9,10] There is also evidence that the proportion of low birthweight infants and preterm births to Indigenous mothers in Victoria may be increasing.[7-10]

WBS clients taking part in the study were younger, more likely to have a very low income, more likely to have smoked during pregnancy, and more likely to have a low birthweight baby than rural participants in the statewide survey who had received public maternity care. The social characteristics and outcomes experienced by WBS clients are similar to those reported for other Victorian Indigenous women, demonstrating that the WBS is reaching the group of women it was established to assist.

Funding for the Mildura WBS was made available by the Victorian Department of Human Services following publication of a report that identified a number of rural areas in Victoria as lacking affordable, appropriate maternity services for Indigenous women.[11] Prior to the introduction of the WBS, public antenatal care in Mildura was only available from general practitioners and obstetricians billed through Medicare. The WBS provides a shared model of care offering women antenatal care, support and advice in their own homes with no associated out-of-pocket costs for care provided by the service. Antenatal care is midwifery led and is facilitated by a trained Indigenous maternal health worker. Women are referred outside the service if specialist care is required.

The philosophy of care underpinning the WBS and other programs provided by Aboriginal community-controlled health services is based on a broad conception of health encompassing the emotional, cultural, social and physical needs of clients. The foundation of the program ensures women access nationally recommended standards of clinical care during pregnancy and childbirth and, beyond that, the WBS model of care is flexible and constantly changing to address a range of other needs as they are prioritised by clients. The community setting of the program enables women to access the WBS for a range of issues, which are not necessarily regarded as within the traditional domain of health care providers. For example, a woman may need help with childcare while she has a check-up or she may want time to have an informal talk about something unrelated to pregnancy that is troubling her. Aboriginal community-controlled health services embrace a holistic philosophy where "health does not simply mean the physical well being of an individual but refers to the social, emotional and cultural well being of the whole community".[12] The model is achieved by involving community members in the process of shaping health programs through ongoing consultation. As summarised by Congress, "the people who use the health service control the health service. They decide what programs are appropriate, and how, when, and where to deliver them".[13] Women participating in the WBS evaluation study clearly valued the service highly. Their views were echoed by the two 'grandmothers' who participated in key informant interviews conducted in the second stage of the study:

> *The Women's Business Service empowers women to be able to say what they want. To give the women a choice. They didn't listen to me when I had my children, but they listened to my daughter and let her do what she wanted to do. She had support in labour. It makes a big difference.*
>
> *It's an important service for the women. Girls are having their first baby, they're reassuring them, and telling them everything. It's good, especially as some girls don't have their mother around.*

The capacity to compare the findings of the interviews with the views and experiences of rural women participating in the statewide survey is a major strength of this evaluation. The positive accounts women gave of their experiences of care provided by the WBS is highlighted by the extent to which their views diverged from those of women accessing mainstream rural maternity services. Greater differences were apparent for antenatal care and postnatal out-of-hospital care (where most care was provided by the WBS), than for care in labour and birth (where medical care is provided by hospital staff, and the role of the midwife and health worker from the WBS is limited to support). A range of reasons have been put forward to account for inaccessibility of mainstream primary health care agencies for members of

Aboriginal communities in Australia. Saggers and Gray suggest that: the cultural chasm between Aboriginal patients and health care providers; the impersonal nature of clinics; the presence of relatively large numbers of non-Aboriginal people; judgemental and authoritarian providers; and paternalistic, if not racist attitudes, which providers themselves do not recognise, are possible impediments to accessing care.[14] The mixed feedback from women concerning their experiences of intrapartum care suggests ongoing difficulties for Indigenous women accessing mainstream public hospital services. The presence and support of staff from the WBS appears to be having a positive impact on the extent to which women feel they have a say in their intrapartum care. However, this is offset by negative feedback about the extent to which women felt welcomed by hospital staff when they first arrived in labour. Feedback about postnatal care was also mixed; only 43% of the women who attended the WBS described their postnatal care in hospital as 'very good' compared with 80% who described their antenatal care in this way. On the other hand, women receiving care from the WBS were much less likely to feel anxious about looking after their baby in their first week at home or to want additional help; a result that is possibly explained by the greater level of support they received after they left hospital, and perhaps also by the fact that the WBS staff were known to them from pregnancy.

The use of different methods for investigating the views of recent mothers (i.e. face-to-face interviews three to 18 months after the birth versus a postal survey five to six months after the birth) is both a strength and a limitation of the study. Face-to-face interviews by an Indigenous researcher (SC) not affiliated with the WBS or the local public hospital resulted in participation of all women approached to take part. In contrast, less than half of Indigenous women invited to take part in the statewide survey returned the questionnaire. Comparisons between the interview and postal survey results need to take into account the possibility that the different methods may have influenced the way in which women answered questions about their care. The fact that SC was introduced by staff from the WBS may have influenced the feedback women gave about the service despite the assurance of confidentiality. None the less, the magnitude of the differences between the views and experiences of WBS clients and rural participants in the statewide survey suggest effects that are not easily dismissed.

Other factors that may have contributed to participation of Aboriginal women in the WBS evaluation include the fact that the study was commissioned by the Aboriginal community organisation responsible for the operation of the service, and the assistance offered by WBS staff in locating prospective participants and introducing the interviewer to women agreeing to take part. If participants are not selected randomly, it is possible for care providers to nominate women likely to have more favourable views and experiences of the program. Selection bias may also occur where eligible participants are those who still have contact with the service. There is also the possibility of differential response bias as women whose experience of care has been lacking may be less likely to maintain contact with services than women who have had a good experience of care. Another limitation of this study is the relatively small number of participants who were interviewed resulting from the practical constraints of the size of the program under review (40-50 births per year), and the limited time frame for completion of the study.

The relatively small number of women receiving maternity care through the Women's Business Service was the reason for approaching women from three to 18 months postpartum. We deliberately did not approach women with babies less than three months old because of the potential for a 'halo effect' leading to more favourable accounts of maternity care in the immediate weeks after the birth.[15] The potential for recall bias was also a consideration. However, there is evidence to show that maternal recall of pregnancy and birth events remains accurate despite the passage of time.[16,17]

In the second stage of the study interviews with care providers (midwives, obstetricians, staff at the MAHS) highlighted some unresolved issues between care providers who share responsibility for care of women participating in the WBS program.[4] Some informants expressed concern that WBS clients were not receiving specialist care during pregnancy. Key informants also held differing views about the appropriate role of WBS staff during labour and birth (clinical versus support role). The interviews highlighted the need for continuing efforts to construct co-operative and supportive arrangements between agencies to ensure that women are able to access the best possible care in their region.

Conclusions

Women participating in the Mildura WBS evaluation were significantly more positive about many aspects of their care in pregnancy and postnatally than women attending other rural public maternity services. They were less happy with intrapartum and early postnatal care in hospital. These findings lend support to the view that Aboriginal community-controlled health services are well placed to provide appropriate and accessible care to Indigenous women during pregnancy and the postnatal period. The study underlines the importance of ongoing dialogue to facilitate collaborative care between mainstream and Aboriginal community controlled health services.

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References

1. Brown S, Darcy M-A, Bruinsma F. Having a baby in Victoria 1989-2000: continuity and change in the decade following the Victorian Ministerial Review of Birthing Services. *Aust N Z J Public Health* 2002;26(3):242-50.
2. Brown S, Bruinsma F, Darcy M-A, Lumley J. *Victorian Survey of Recent Mothers 2000. Report prepared for the Division of Acute Health, Victorian Department of Human Services.* Melbourne (VIC): Centre for the Study of Mothers' and Children's Health; 2000.
3. Campbell S. *Master of Applied Epidemiology (Indigenous Health)* [Unpublished thesis]. Canberra (ACT): Australian National University; 2003.
4. Campbell S, Brown S. *The Women's Business Service at the Mildura Aboriginal Health Service.* A descriptive evaluation study October-November 2002. Melbourne (VIC): Centre for the Study of Mothers' and Children's Health; 2003.
5. *SPSS*: statistical package for social sciences [computer program]. Version 10. Chicago (IL): SPSS; 1999.
6. *Epi-info*: word processing, database and statistics program for epidemiology on microcomputers. Version 6. Atlanta (GA): Centers for Disease Control and Prevention; 1994.
7. Riley M, Halliday J. *Births in Victoria 1999-2000*. Melbourne (VIC): Victorian Perinatal Data Collection Unit, Department of Human Services; 2001.
8. Riley M, Halliday J. *Births in Victoria 1992-1996*. Melbourne (VIC): Victorian Perinatal Data Collection Unit, Department of Human Services; 1998.
9. Riley M, Halliday J. *Births in Victoria 1996-1998.* Melbourne (VIC): Victorian Perinatal Data Collection Unit, Department of Human Services; 2001.
10. Koori Human Services Unit. *Koori Health Counts. Koori Births in Victoria 1991-2000.* Melbourne (VIC): Koori Human Services Unit; 2003.
11. Campbell S. *From Her to Maternity*. Melbourne (VIC): Victorian Aboriginal Community Controlled Health Organisation; 2000.
12. National Aboriginal Health Strategy Working Party. *National Aboriginal Health Strategy*. Canberra (ACT): AGPS; 1989.
13. *Congress "An organization of Aboriginal people, for Aborignal people, by Aboriginal people"*. Alice Springs (NT): Central Australian Aboriginal Congress Inc; 2003.
14. Saggers S, Gray D. *Aboriginal Health and Society. The Traditional and Contemporary Aboriginal Struggle for Better Health*. Sydney (NSW): Allen Unwin; 1991.
15. Bramadat IJ, Degler M. Satisfaction with childbirth: theories and methods of measurement. *Birth* 1993;20:20-9.
16. Brown S, Lumley J, Small R, Astbury J. *Missing Voices; The Experience of Motherhood*. Melbourne (VIC): Oxford University Press; 1994.
17. Simpkin P. Just another day in a woman's life? Part II. Nature and consistency of women's long term memories of their birth experience. *Birth* 1992;19:64-81.