

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 16 October 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witnesses

Ms Kirstan Flannery, chairperson and co-founder,

Ms Jen Branscombe, programs manager, and

Ms Elizabeth Mazeyko, volunteer bicultural doula, Birth for HumanKIND.

The CHAIR — Welcome to these hearings. All evidence at this hearing taken by the committee is protected by parliamentary privilege, as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof copy of the transcript. We will let you give us a 10-minute brief, and then we would love to ask you some questions.

Visual presentation.

Ms BRANSCOMBE — Thank you for the opportunity to speak today. I would like to start by acknowledging the traditional owners of the land, elders past, present and emerging, the Wurundjeri people of the Kulin nation, and in particular the thousands upon thousands of women who have birthed on these lands before us and have shown a strength and resilience that we can only hope to live up to.

My name is Jen Branscombe. I am the programs manager for Birth for HumanKIND, and sitting with me I have Kirstan Flannery, who is the co-founder and chair and also an experienced doula, and Elizabeth Mazeyko, who is one of our volunteer bicultural doulas and also a trained bicultural health worker. You will be hearing a little bit from each of us today. I promise it will not be 15 minutes from each of us.

I think it is important to preface this submission with the point that, speaking here today, we are not speaking just for ourselves at Birth for HumanKIND and the women that we support directly, but also on behalf of the increasing number of women that we are unable to support, from whom there is a demand for our service but we do not have the capacity to take on, and other community and women's health organisations that we connect with who have not been able to access this inquiry for various reasons.

In particular we wanted to bring along clients to speak in this space, but their feeling was it was not a safe space for them to be and they did not feel comfortable being here. We would welcome the opportunity to bring you to them, should that opportunity arise in the future. I really wanted to make that point initially, because that is at the heart of what we do and how we are trying to change the system — by providing holistic support to women that is accessible to the woman and accessible on her terms.

As you have seen in our submission, we are really speaking to two main points within the terms of reference — the quality and safety of health services and the provision of an appropriately qualified workforce. The reason that I have highlighted those particular words in the two points — 'quality' and 'appropriately qualified' — is because our submission really hinges on a more expansive definition of those two terms, and that we see quality of services not just defined by clinical outcomes but by much more than that, about the woman's experience and other outcomes for the woman.

Similarly for an appropriately qualified workforce, we are looking at a workforce beyond their clinical qualifications and training but also their cultural competency, their ability to access things like interpreters and provide respectful support, women-centred support to women during the perinatal period. That is not a new idea, I know, and this more expansive definition of quality and appropriately qualified is borne really from established documents like the *Australian Charter of Healthcare Rights*, which lays out standards for quality care and the fact that women need to be accessing services that are accessible, that are safe, that are provided with respect and open forms of communication, including access to interpreters, which really then allows for active participation of the woman in her care. These ideas are backed up both by our research and our experiences of the women that we support.

I am going to hand over now to Kirstan, who is going to speak a little bit about the particular support we provide and about our organisation.

Ms FLANNERY — As you can see up on the slide we have got our mission values, but basically in a nutshell our organisation is really passionate about promoting better birth experiences and birth outcomes, particularly for women in disadvantaged circumstances. We do this by offering free one-on-one doula support — and I will explain what a doula is in a moment — education and advocacy, but we will just be focusing on the doula support today for the intention of the inquiry. We believe we offer a mother-centred support approach to maternity care — and the feedback is validating this as well — that addresses some of the challenges and gaps in our maternity system. Jen will touch on those in a moment.

Moving on to the next slide, ‘What is a doula?’, which is basically our core work. We define a doula as someone who provides continuous support — non-clinical, who is professionally trained — to a mother during the antenatal period in terms of birth preparation, continuous support during the labour and the birth, and also support in that early parenting period. She does it by providing emotional support; practical physical support; and also providing information and education so the woman understands what her choices are and how to navigate the maternal health system in a way that makes sense to her and matches her needs.

In the next slide we have got a picture of Carly and her son, Huxley. Carly was the first woman that was provided free volunteer birth support, that gave growth to our organisation basically. Our founder, Mei Lai, offered her free doula support. Carly’s story is not uncommon, and you have heard so many stories throughout this inquiry. She had just moved to Melbourne so she had no support networks. Her mother had passed away within 12 months of Huxley being born. She had socio-economic factors going on that were real barriers to care, and she was also in a place of high levels of anxiety, depression and was self-harming. So Mei Lai was able to come in and offer the kind of support that helped Carly make difficult decisions for herself in choices relating to her care.

Carly was able to better meet the challenges of labour and build confidence and strength to start her parenting journey from a solid foundation, which we all know leads to better outcomes in terms of attachment, bonding and things like that. Part of the reason that this was such a positive experience for Carly was because she had a trusted person she could bring with her to the birth experience so she felt safe, where she received emotional and physical support, and someone that helped her communicate with hospital staff in areas that she was finding challenging and did not know how to do in that really vulnerable time when you are in the midst of labour and birth. Basically she had someone to be with her so she was not alone, and that is what we are finding is one of the key aspects for a lot of the women that we are working with.

Carly is actually now involved in our organisation. She sits on our board as well, and she also helped develop our young pregnancy support group and facilitated that for a little while.

Moving on to the next one, we have got up here a quote from a Cochrane review basically supporting what we are finding through our work, that having a continuous support person who is not part of that woman’s network, that has some level of training and experience is actually — well, here they say ‘appears beneficial’ — providing benefits to the woman in her experience. There is other research that shows the value and benefit from the presence of a support person during labour and childbirth, and that includes the emotional support and information about labour progress, because there is time to explain those things because you are there over a longer period of time, can advise about pain coping techniques and comfort measures, and also support the woman to find ways to advocate for herself when she is wanting to communicate with hospital staff.

The other research that is there, even though there is minimal research around doula support, is that women who receive continuous labour support are actually more likely to give birth spontaneously, be less likely to use pain medications and have an outcome of a caesarean birth, have lower rates of postnatal depression, and be more likely to be satisfied and have shorter labours. So they are just a few examples.

Moving onto the next slide. In the work that we are doing it is not just the women that we are working with or the referrers — who are mainly social workers at the public hospitals or community organisations — increasingly it is midwives making referrals now too. We are actually finding that clinical staff, i.e. the midwives and obstetricians, are really benefiting from the additional support of having the doula present because of what it is lending to the woman’s experience of her feeling safe, calm and confident, and understanding what is happening in a way that hospital staff are maybe needing to focus on other areas. They love knowing that that is all covered for the best experience and outcomes for the mum.

Just moving onto the next slide, we have pulled out some stats and figures from our own work in our organisation in terms of the profile of the women that are linking with us. But I just wanted to pull out the 66 per cent statistic to highlight that quite a high percentage of the women that we are working with — and the women in the community in general — are actually lacking a support person, even though the research and our anecdotal experience of working with them is showing that it is improving their experiences and their outcomes when they are not alone.

Ms BRANSCOMBE — I am just going to speak briefly to some of the challenges that we see women face during the perinatal period before Elizabeth gives an account of her firsthand experience. The challenges that I

will highlight here are drawn from our clients' personal experiences and also from the review of the literature and ongoing discussions with community healthcare providers that we work with. I think one of the most interesting things to highlight is that the research tells us that things like lack of attention to specific cultural issues or restrictions on traditional cultural practices by caregivers are not always the principal focus of a woman's description of negative aspects of her care during the perinatal period.

Women are not expecting the workforce to be experts in cultural history, to be experts in experiences of trauma or violence, or every aspect of a migration experience. Really what it often boils down to is communication problems related to lack of continuity of care or discriminatory or negative caregiver attitudes, which really tells us that a lot of these challenges that women are facing hinge on problems that are surmountable through small changes that we can make to the provision of quality respectful care by a culturally competent workforce. That is my positive take on it.

These are some of the challenges we come across that women face during pregnancy. I know through the inquiry that a lot of these have already been spoken to, so I am just going to highlight in particular access to continuity of care models, which are something that for women from migrant, refugee and asylum seeker backgrounds are a really key issue. Particularly for women from these backgrounds, continuity of care can enable better development of trust and rapport and better communication. It reduces the need for them to revisit traumatic memories and offers more time for them to discuss current concerns. It is not common, however, in the conventional maternal health model that many women from migrant, refugee and asylum seeker backgrounds experience. Research suggests that lists can lead to fragmented care provision, and the decrease in continuity of care can also lead to growing fear, distress and trauma in birthing women and the increased medicalisation and intervention-based management of birth.

If we look at some of the issues in childbirth, when I talk about this stage I would just like to give one particular example of a woman that we have supported. She was an asylum seeker who had birthed an earlier child on Christmas Island. She had given birth to the child via caesarean and underwent the caesarean section without being informed that the caesarean was going to happen. Later, pregnant in Melbourne, she was —

The CHAIR — Just on that, was that an emergency caesar or just a caesar?

Ms BRANSCOMBE — It was an emergency C-section. The fact would still stand regardless of the C-section.

The CHAIR — Absolutely. I am just not aware of protocols on refugees.

Ms BRANSCOMBE — When she then came to Melbourne she was referred to us and matched with a doula through our service. She was pregnant with another child and she gave birth to the child with the support of the doula and her husband in the room with her. I highlight this particular case because in reality this birth in Melbourne ended in the same outcome — the child was born by caesarean section — but the outcome for the woman and her husband and the family was vastly different from the outcome on Christmas Island, because she had a doula who was advocating for an interpreter and she had a workforce which provided for that interpreter.

Her social worker spoke to us later about the fact that her husband — who had carried trauma from the previous birth as well as the woman birthing the child — was showing everyone photos of him in scrubs holding the baby. So you can see that just small changes to the provision of respectful care from an appropriately qualified workforce that allowed for interpreters made such a difference to the outcome. That is just one example. Often it is easier to tell a story using one example, although it is a common occurrence.

The CHAIR — It was horrific.

Ms BRANSCOMBE — Then if we look at women after birth, most of the challenges we are seeing here, apart from the challenges we have already discussed, are about access to appropriate postnatal support services, so access to appropriate parenting groups or playgroups and linkage with other services. The maternal child and health nurse network is a really strong network, but you can see that a lot of the dropouts are women who are from culturally and linguistically diverse backgrounds, because the way that parenting groups are set up are not necessarily appropriate for people who do not speak English as a first language and have other complex social factors. I am just going to hand over now to Elizabeth to give a brief personal experience. Elizabeth is a bicultural doula with us — she has supported 23 women with us — but I will let her tell her story.

Ms MAZEYKO — Thank you very much. I come from Uruguay, South America. I immigrated to Australia when I was very, very young. I am a mother of three, and a grandmother of four beautiful children. I really want to share with you the experience that I have had as a woman and as a mother since I came to Australia.

When I came to Australia 40 years ago I did not speak one word of English. I had just fallen pregnant with my third child, and when I went to the hospital I did not actually understand one word they were telling me and asking of me. My baby was born with a cleft palate. I had never heard about that condition before; I had never heard about that. I remember one of the nurses took my baby away and I was terrified, because being in a country with no family, no support — I wish I could have had a doula during that time — it was really very hard for me. They took my baby away for 2 hours. I could not understand why. I was also in the process of grieving for one of my sons before I came to Australia — he had passed away. Then when they brought my baby to me — they knew that I did not speak English — they brought me an Italian interpreter. My language is Spanish. I really appreciated that they were trying to help me but it was not appropriate.

Once they had explained that the baby had a cleft palate, they sent me home four days later — and remember I had no support, I could not speak English. I did not know how to breastfeed the baby properly because every time the baby was put on the breast, the baby's milk was coming through their nose. It was really very hard for me to deal with that situation. At that time it prompted me to say, 'I really need to learn something about immigrant women, women who come from different cultures'.

I chose to come to Australia, but there are some women who have no choice about coming to Australia, and they have had babies in hospitals with no support at all. I have been a doula for the past two years. I was working as a bilingual educator with many different organisations in Victoria. I was thinking, yes, educating women about health and general health is one thing, but what about supporting a mum who is actually going through that situation and experience, which is a unique experience for a woman — if you are a mother, you know what I am talking about — and how we need to support and help them. That is when my heart led me to leave all my other jobs and I became a doula to support these mums.

In the past two years that I joined this organisation I have worked with 23 different women. They come from Somalia, Afghanistan, Iran, Iraq, India, some from Latin America too. I always say, 'Everybody comes with an onion in their pocket'. What is the meaning of an onion in a pocket? Every woman brings their own history, every layer of an onion. They have some problems like domestic violence, being abused, sexual abuse, trauma. Some people have seen all their family killed in their own country, so they are dealing with a lot of things. It is not only the pregnancy, the prenatal and postnatal depression; they have to deal with a lot of things. Having a doula next to her, we can support her — not just holding hands — but support her with a lot of issues. We educate women on how the system in Australia works.

I have noticed when I have worked with a mum at a hospital that the woman even though she is in pain — the baby is going to be born — has a level of anxiety that is high because she is thinking, 'What's going to happen to me? I don't speak the language. What are they going to do? What are all the machines around me?'. We have to take the women through everything — what is going to happen.

If there is any emergency, if anything is happening in the room, we have to explain to the woman, 'Listen, don't be afraid. I'm here with you, holding your hand. I'm here for you to support you emotionally. The midwife is helping you to have a baby, but we are here'. One thing in common that all the mothers have is that they say, 'Without you, I couldn't have done this'. We say, 'Yes, you can do this because you're a woman; your body has decided to do this — having a baby'. But I can understand where the mother is coming from. For me it has been very rewarding, and a privilege actually, to be in those women's spaces and a part of their lives. That is my experience of becoming a doula.

The CHAIR — Thank you so much for coming in today. Are you able to take some questions?

Ms FLANNERY — Yes.

The CHAIR — Thanks for the presentation, and thank you for the work you do as well. It is the second time today we have heard about non-consensual C-sections, and I find it horrifying, to be honest. I cannot imagine what some of the people are actually going through, let alone what happens after that if that is the priority of the person in that level of care. I will let some of my colleagues ask some questions, and we will go from there.

Dr CARLING-JENKINS — I wonder how much the community understands what a doula is. Are you continually trying to explain that: explain what you do, explain your work?

Ms FLANNERY — In a way we are when we use the word ‘doula’, but I think when we put it in a context of a professional best friend, sister or mother they start to understand that, because historically there have always been women supporting women through birth.

Dr CARLING-JENKINS — That is true.

Ms FLANNERY — We just reframe it outside of that word ‘doula’ or we might say birth companion.

Dr CARLING-JENKINS — Excellent. And what kind of training do you have to go through to become a doula or birth companion? I like that; it is a good term.

Ms FLANNERY — It depends because we are not a regulated industry like midwives and nurses are. So there are different kinds of training, from government accredited training that can go for about 32 weeks, I think it is, down to some women offering more informal training of about three days, which we as an organisation do not recognise as qualified training. So it does vary quite a lot.

Dr CARLING-JENKINS — So what do you recognise?

Ms FLANNERY — We recognise the longer training —

Dr CARLING-JENKINS — The 32 weeks.

Ms FLANNERY — Thirty two weeks, or nine months is another training, but most of them do not go beyond one year.

Dr CARLING-JENKINS — Nine months sounds very appropriate, doesn’t it?

Ms FLANNERY — Exactly.

Dr CARLING-JENKINS — When does the support start and when does it cease? What is the time frame for a doula?

Ms BRANSCOMBE — Within our organisation?

Dr CARLING-JENKINS — Within your organisation.

Ms BRANSCOMBE — The average gestation at referral is 28 weeks. Some women will come earlier, but the women we support, who are generally marginalised from the system, do not get referred to us sooner than that.

Dr CARLING-JENKINS — Is that because they are not accessing services early?

Ms BRANSCOMBE — It is a lot of different reasons. Young mums in particular might not be accessing services early. Other women might be keeping the pregnancy secret. It also just takes time to get through the system. We do get some self-referrals, but the majority of women are referred either by a hospital or by social workers, so that referral needs to kick in, I guess, and happen for the women to get to us.

As we have been going since 2014 we have started to have some second referrals, so they will then come to us sooner. But generally that is the average currently — 28 weeks — and the package of support that we provide is two to three prenatal visits at a minimum plus on-call support at the birth. So the doula is on call for two weeks prior and two weeks after the due date, and then there are two to three postnatal visits. Those can take any form. The doula may come along to an appointment with a midwife or they may meet them in their home if they have secure, safe housing, or they may meet them in other external settings. That is really based on the relationship between the doula and the client.

Dr CARLING-JENKINS — So it is a very flexible model.

Ms BRANSCOMBE — Yes.

Dr CARLING-JENKINS — Where do you get your funding from?

Ms BRANSCOMBE — Primarily philanthropic funding. We do have some small local government grants that have been specifically related to specific projects, in particular educational projects for young mums, but it is primarily philanthropic funding at this stage. But we are looking to diversify our funding.

Dr CARLING-JENKINS — Is one of the difficulties around funding that it is not an easy program to fit into the traditional kind of funding models that we have?

Ms BRANSCOMBE — That is definitely one difficulty, I think. There are a lot of things that you need to communicate, though not just the role of the doula but also there can be an overarching narrative of, ‘Where does this sit outside the clinical support that a woman might get. We have a public health system that has universal health care. What does this provide?’. So it is finding I guess the right relationships with other organisations and funders that speak the same language that we do, and recognise that —

Dr CARLING-JENKINS — Value what you value.

Ms BRANSCOMBE — Yes.

Ms FLANNERY — Can I just add to that as well: there is such a focus, if mother is healthy and baby is healthy, then everything is fine. So it is also putting value back into the profundity of well-attuned emotional support to the overall experience of reducing distress, fear and trauma rather than just the clinical outcomes.

Ms McLEISH — Can you give me a bit of an idea about the numbers you see each year and the demographics of those?

Ms BRANSCOMBE — In the past year we provided on-call birth support to 83 women. They are all based in Melbourne. Originally they were related to a hospital in terms of geographics, because those were the relationships we had. So about 50 per cent of them were birthing at the Royal Women’s Hospital. We are now seeing an increasing number of women birthing at Sunshine and Northern hospitals and also into the south-east. That is a direct result of relationships built with midwives in those hospitals who see the value of the service we provide and see that they cannot provide it and have been referring to us.

About 40 per cent of our clients speak a primary language other than English. Roughly half of those require interpreter support. Those figures are probably also a little skewed because in some cases we have got people, family members, providing interpreter support, which is not something we advocate at all. But when clients are referred to us that is how they are referred to us at the time. And women are generally — I mean in terms of age demographics — the birthing women. One of our eligibility criteria is women under 23, so through our young mums program we have seen women as young as 15 to 16 and then right up through.

Ms McLEISH — So of the 83, are they all under 23?

Ms BRANSCOMBE — No. Probably about 30 per cent are under 23 years of age.

Ms McLEISH — Backgrounds — Aboriginal?

Ms BRANSCOMBE — Indigenous women is one of our eligibility criteria. We have six eligibility criteria, which is apart from economic hardship. All women who are referred to us need to be experiencing economic hardship. They can also be new migrants, refugees and asylum seekers, which is about 40 per cent of our clientele; be under the age of 23; women with a history of or experiencing family violence; women with alcohol and other drug issues; women with mental health issues. Have I forgotten any?

Ms McLEISH — So what are the percentages around drug and alcohol and family violence?

Ms BRANSCOMBE — Family violence — let us go back — I would say is about 50 per cent, but the problem is that these are the stats that come back to us on the referral form and often a referrer will select that they are experiencing economic hardship and actually in reality the women are experiencing homelessness, but it is not reported to us because they will just select the most prevalent risk factor.

Ms McLEISH — We have heard earlier about some of the referrals.

Ms BRANSCOMBE — Yes.

Ms McLEISH — And are they single or in relationships?

Ms BRANSCOMBE — A mix. About 65 per cent, or 66 per cent actually, have no support person who is going to be with them at the birth. That is a mix of women who are single parents or have a history of family violence, so the father of the child may be in the picture but will not be a part of the birthing woman's experience. So 35 per cent of our clients will have a partner, who may be present at the birth or may not be present at the birth.

Ms McLEISH — This might sound a little bit from out of left field, but do these people have phones?

Ms BRANSCOMBE — Do they have phones? Yes.

Ms McLEISH — All of them?

Ms FLANNERY — Yes. I have not worked with a client yet — I do not know if you have, Elizabeth — who has not had a phone.

Ms BRANSCOMBE — The only instance may be that they are maybe on month-to-month, as is the case.

Ms McLEISH — But they could have an app?

Ms BRANSCOMBE — They can have an app. Yes, absolutely. That is the primary mode, and also for new migrants, refugees and asylum seekers, the phone holds everything; it holds their life.

Ms McLEISH — So if they have got a phone it must have a lot of English-speaking apps on it.

Ms BRANSCOMBE — Not necessarily.

Ms FLANNERY — I guess it depends on how they install the phone as well.

Ms McLEISH — I suppose it does.

Ms BRANSCOMBE — Yes.

Ms FLANNERY — So they would be receiving all their text messages and what not in their native language.

The CHAIR — Has someone ever, as a party trick, set your language to something else on your phone, and you can never get it back?

Ms BRANSCOMBE — Particularly with the iPhone, any language that is Unicode, which is basically every language besides small ethnic minority languages, can go through that app.

The CHAIR — I must say, Elizabeth, you look like you absolutely hate being a doula up there.

Ms MAZEYKO — I love Aussie babies.

The CHAIR — It must be awesome every day —

Ms MAZEYKO — Yes. I love it.

The CHAIR — looking after different kids. I have just got a question, which I guess is a precursor to Cindy's question. We have heard a little bit today about language barriers and lack of having interpreters. What is your experience with that? We heard from Rebecca from mAdapt who said that one in 86 people, as an average — and I will not quote you on it, Rebecca — had actually seen an interpreter; and we are hearing about these C-sections as well. What is your experience as far as how many people need interpreting services, and what services do you use?

Ms BRANSCOMBE — I think Kirstan has probably got some good examples of particular cases, but I would just say the key is that in many cases some form of interpreters are used. We use TIS, so an on-the-phone

service, and in hospitals there are interpreter services, but it is also about the making available of those services through the hospitals. Staff themselves working in those hospitals may not even be aware that those particular languages are provided. Also there is the point that Rebecca made earlier that interpreters really need to be called upon and be there when the woman needs the interpreter, not at the point that the member of the workforce decides, 'I'm doing this right now. Someone needs to explain this'. It is not just about the availability but also awareness of the availability and awareness of how to use them and when to use them. We probably have an example in particular.

Ms FLANNERY — In my experience of working with women that need interpreters and also from feedback from other volunteers, it is often more the challenge than a report of a really positive experience of being able to access the interpreter when the woman wanted it but also for the duration that she needed it to really understand what was going on. We have had all kinds of situations where an interpreter was refused but there was a continuing need for advocacy and then an emergency situation took place just after the interpreter arrived, which made for such a different experience for that woman undergoing that quick emergency procedure.

Also we are finding quite surprisingly there are concerns around the use of male interpreters. We are quite concerned about it in terms of what the women are holding back or not divulging around their health because they do not want to speak through a male interpreter. The hospitals keep saying, 'Well this is the only option you've got. You've got to work with this'. I think the women are pretty understanding when they need to have a male doctor because there are no female doctors to access, but when it comes to interpreters I think there could be a lot more done in terms of accessing female interpreters.

Just to highlight one really strong example: a woman was referred to our organisation, and it became clear during the working relationship that she had undergone rape. Our volunteer supervisor organised to have counselling take place, with her permission, and went along to the appointment at the hospital with the psychologist. Two psychologists were present. They were both male, and the interpreter that they had organised was male. So the woman decided to say, 'I'm totally fine. Nothing is going on', and that is what they actually wrote as their write-up — 'She's fine. We don't need to see her any further' — and it was not actually addressed.

That is an extreme example, but it is really common. We have had clients where the woman can only access male interpreters, and then the husband is laughing because he has got to go to a hospital for other health reasons and all he can get is a female interpreter. They are like, 'This is crazy. It is laughable. What is going on?'

Ms MAZEYKO — Can I add something to that? Also to sign consent forms is another big problem for mums, because when it is an emergency C-section, people are coming with the papers saying, 'Sign here, sign here'. The women look at me, and I say to them, 'No, we really need to contact an interpreter over the phone because this person is going to have a huge caesarean section, and she must understand what is actually happening to her. She really needs to know what the consent form is. She has to give permission for her body. If you do not know and you just sign that, you might be thinking, 'I didn't understand. Are there any other options that I can have?'. Communication between professionals and interpreters is very important.

Ms EDWARDS — Thanks, everyone. I am a big fan of doulas. I used to be one myself.

Ms BRANSCOMBE — Well done. Do you have any spare time?

Ms EDWARDS — We were not called doulas, we were called support people, of course, which is the standard sort of approach these days.

Ms BRANSCOMBE — It was worth a try.

The CHAIR — She mothers me a bit.

Ms EDWARDS — I know. I do take on that role. I obviously do not attend the same parties that you do, though, because no-one has put a false language thing on my phone.

I have a couple of questions following on from what Paul mentioned in relation to the interpreters. Is there a cost for the interpreter to these people?

Ms FLANNERY — Not to the people.

Ms EDWARDS — Are they sourced through the hospital? Do you have to utilise the hospital's interpreter?

Ms FLANNERY — It depends. We provide TIS interpreting, so if the doula is meeting the client somewhere else — in their house or external to the hospital — then our organisation covers the cost of interpreting through the telephone interpreting services, and the doula does not cover it. If, for example, it is a client that is referred through Foundation House, they will often have in-house interpreters and so then we can use those interpreter services. If it is in hospital, the hospital provides it. It is in-house.

Ms EDWARDS — You mentioned one referral source. Where else do you get your referrals from?

Ms BRANSCOMBE — It is a mix. The primary one is through hospitals, so that is through social workers or midwives in hospitals. That is about 50 per cent currently of our referrals. Then we get referrals from specific services, so homelessness services providing women with housing and other support services will refer pregnant women to us. We also get referrals from migrant and refugee services — for example Foundation House — and who else have I missed?

Ms FLANNERY — AMES, Melbourne City Mission.

Ms BRANSCOMBE — There is generally a mix of migrant support services and hospitals plus specific agencies which support women who are experiencing the risk factors that we support.

Ms EDWARDS — We heard earlier today about a hospital where there is quite a number of pregnant women presenting now who do not have Medicare cards. Is that your experience as well with the group that you work with?

Ms BRANSCOMBE — Yes. It depends. With our education it is a mix. We do an education program called Navigating the Australian Maternal Health System, and depending on the client's visa status they will generally have Medicare cards but not healthcare cards, which means that most things are covered but not all things.

Ms FLANNERY — But we do have clients come through that do not have Medicare cards.

Ms EDWARDS — And you support them to get that Medicare card?

Ms BRANSCOMBE — Yes.

Ms EDWARDS — With the doulas, what is the cost of the training for a doula to become a trained volunteer?

Ms FLANNERY — Just to cite the longer term training that we referenced, it is around anywhere from about \$3500 to maybe \$5000.

Ms EDWARDS — And they have to pay for that themselves? There is no support?

Ms BRANSCOMBE — It is funny that you ask that question, because one of the initiatives we are looking at the moment is trying to recruit bicultural health workers to be doulas, but actually funding the training for them to become trained as doulas and then to become volunteers for our organisation, which is in part a recognition of the cost of the doula training. For many women in the community that cost is insurmountable, I guess. So we are looking at covering the training for the women but also then helping them to develop that as a business on the side, because that also then feeds into so many other positive outcomes for the women who are working.

Ms EDWARDS — As part of that training — maybe you might answer this, Elizabeth — do you have any sort of lactation consultant training or breastfeeding —

Ms MAZEYKO — Yes, we have many people, health professionals, come into the training. My advantage was that I was a bilingual health educator for many, many years, and on women's health it generally was easy for me. But actually in the training there is a lot of consulting professors coming from different hospitals to talk about different things. The training is really very important because you understand how the body is working —

the anatomy of the body — and how the hormones are working at the moment the mum is going to have the baby. When you have to take action all depends on the hormones that are working at that particular time.

The training is very full on. It is not just that you participate in going to the classes but also you really need to do homework. The homework is about consulting with women in the community. It is about documenting experiences. You must also participate in three births before you actually finish the training. By doing that you get feedback from hospitals where you are, from the mums you support and also from the teacher who has been there. But yes, we have a lot. We have a breastfeeding consultant and even people who come in and explain if the mum has a heart condition what particular process she needs. Yes, it is really very full-on training.

Ms EDWARDS — I just have one last question. Within the public health system, particularly the hospitals and the maternity wards, are the doulas accepted and welcomed?

Ms FLANNERY — Yes.

Ms BRANSCOMBE — I would say yes. Definitely it is a good question, because there is this overarching narrative that potentially there is conflict between the non-clinical support person and the clinical support person. But in our experience, in all cases where they actually have the experience and it is not an abstract idea that the midwife is working with the doula as part of a team it is a really appreciated, valued service. We get continued repeated referrals from hospital team members who are working with the doulas.

Ms EDWARDS — Actually I had another question; that was not my last question. I just wondered what the potential or the opportunity is to expand this program into regional communities. I know in my community in Bendigo we have a very large Karen population. Have you thought about the opportunity there?

Ms BRANSCOMBE — Definitely. Scalability is something we think about all the time. It is about dollars and funding, but it is also about ensuring that you have got the right relationships with service providers in the area, the right relationships with the hospitals and the right number of doulas. When doulas are on call, we need to have a certain number of trained doulas in that area so that we can actually deliver on the demand when we open up into regional areas. We have recently been expanding more into Geelong. I know that is not a regional area, but it is a delicate expansion because we need to make sure that we are able to have everything in place. We have brought on doulas and inducted doulas working in that area as a small expansion, but it is absolutely scalable to move into more regional areas.

Ms EDWARDS — How many doulas do you have?

Ms BRANSCOMBE — We have 40 doulas.

The CHAIR — Thank you, Elizabeth, Kirstan and Jen, for coming in today. We have learned so much. It has been invaluable. We will conclude today's hearing. Thank you to our quiet achievers down the end, Hansard, and to our wonderful secretariat as well.

Committee adjourned.