

The birth of a new service

Cheryl Boles, Deanna Stuart-Butler, Anne Foale, Northern and Far Western Regional Health Service, Port Augusta Hospital

INTRODUCTION

The Alternative Birthing Project's aim has been to establish alternative maternity services in the Northern and Far Western Regional Health Service – South Australia (based at Port Augusta and Whyalla). For the purpose of this paper, and addressing the theme about improving the health of Aboriginal people at the 8th National Rural Health Conference, its implementation at the Port Augusta site will be our focus in this paper.

REGIONAL CHARACTERISTICS

The Northern and Far Western Region has a population of 53 220 people spread over 756 742 square kilometres giving a population density of 0.1 persons per square kilometre. There are 6002 Aboriginal people in the region, which comprises 11.3% of the total population. It is the largest South Australian geographical region, and it covers the Spencer Gulf cities of Port Augusta and Whyalla and extends to the northern, western and eastern borders of the state. It is the only region in the state that has two main hospitals, one in each of the cities. This region also has the highest proportion of Aboriginal people in any non-metropolitan Department of Health region.

In 2002, 77 Aboriginal women gave birth at the Port Augusta Hospital. Port Augusta Hospital Statistics demonstrate the Aboriginal women fare worse on many maternal and infant health indicators.

Port Augusta Hospital – Aboriginal births

Maternal factors	Aboriginal	Non Aboriginal	
Antenatal visits (<7)	35.7	11.2	7.4
Teenage mothers	19.5	8.6	5.5
Emerg. LSCS	31.2	21.4	16.6
Elective LSCS	18.2	18.0	12.6
Total LSCS	49.4	39.3	29.3
Baby factors	Aboriginal	Non Aboriginal	State average
PMR per 1000	39.0	0	9.9
Birthweight < 2500g	11.7	5.0	7.1
Born <37 weeks	14.3	6.8	8.3

Pregnancy Outcome Unit 2002 in SA

Of particular note is the significantly lower number of antenatal visits, high proportion of teenagers and low birth weight. The comparison of the PMR (Perinatal Mortality Rate) which is 39 per 1000 Aboriginal births and 0 per 1000 non-Aboriginal birth is also significant. The PMR in 2000 for rural and remote SA overall was 29.5 deaths per 1000 for Aboriginal babies and 9.9 per 1000 non-Aboriginal babies (Pregnancy Outcome Unit 2000).

Smoking in pregnancy is more prevalent among Aboriginal mothers, with 57 % smoking during pregnancy compared with 21% of non-Aboriginal women (Pregnancy Outcome Unit 2002). Aboriginal Health workers in the region have expressed a serious concern regarding alcohol and substance abuse during the perinatal period. In particular the impact this potentially has on pregnancy and breastfeeding outcomes and effective parenting skills.

WHAT WOMEN AND WORKERS IN THE REGION WANTED

In Port Augusta recommendations from consultants and research has occurred, including information from:

- Regional Aboriginal Birthing project 1995–1998
- Improving Indigenous Birthing Outcomes 2001
- Feeding Aboriginal Babies – What and How? 2003
- Individual feedback to service providers

The recommendations from these consultations have identified the following preferences:

- Aboriginal Health Worker involvement during pregnancy, in hospital and post-natally – preferably developing a relationship with one worker
- Home visits, especially for new mothers, for as long as necessary
- Community-based site for pregnancy checkups, and parenting support (including breastfeeding), drop-in centre for help and information. This needs to be a women’s-only house.
- More Aboriginal workers in the hospital.

There had also been requests from hospital staff and GPs for more assistance with working with Aboriginal mothers and families.

COMMUNITY MIDWIFERY PARTNERSHIPS

In March 2003 two part time midwives were employed in the Community Midwife position based from the Port Augusta Hospital. Initially they focused on antenatal classes, postnatal follow-up, and networking with other local agencies.

In the middle of 2003 the issue of indemnity insurance developed between the GPs practising obstetrics and the State Government. At the height of this situation GPs decided not to practice obstetric care. This resulted in several women relocating to Adelaide, Port Pirie or Whyalla to deliver their babies.

Eventually the Pika Wiya Health Service undertook to employ the private doctors on a sessional basis to provide obstetric cover for the women in the area. This meant that all obstetric services were provided at Pika Wiya Health Service and the doctors were covered by their insurance. The Pika Wiya Health Service required that the women’s health staff, with midwifery backup would need to be part of the antenatal/postnatal service. This requirement was agreed to and the community midwives enthusiastically took up the opportunity to make contact with most of the pregnant women who planned to deliver at the Port Augusta

Hospital. The midwives sought to provide clinical assessment support and education in pregnancy, childbirth and breastfeeding for the Aboriginal health workers and the pregnant women involved. At the same time the midwives gained further knowledge in cross-cultural exchange.

At this time Port Augusta was having about 200 births each year, a drop of about 100 since the resident obstetrician had left two years previously and no replacement was yet in place. It was an opportunity for the community midwives to implement a modified continuum-of-care for women during their pregnancy, birth and post-natal period.

These clinics provided another opportunity not previously dreamt of. The families of European decent in the community now had an opportunity to see first hand how the Aboriginal medical service and the staff were able to showcase their skills and professionalism.

OBSTETRIC SUPPORT

Nine months after this program started the hospital was successful in recruiting the services of a specialist obstetrician/gynaecologist. This doctor came with a wealth of experience and more importantly she brought with her a woman centred approach requiring supportive midwifery care.

She began running a specialist service from the hospital and this meant that women who previously went to Adelaide or who might have been offered a Caesarean Section up front had further choices for their obstetric care. These options included:

- shared care with the doctor of their choice
- primary care from midwives and shared with the obstetrician as needed
- midwife/Aboriginal Health Worker shared care with a GP of their choice.

A PILOT PROGRAM FOR A 'CONTINUUM-OF-CARE' MODEL

This climate of co-operation and shared care provided an optimum environment for the introduction of the pilot Alternative Birthing Services Program. In January 2004 we applied for funding from a Commonwealth program called (PHOFA) to establish this pilot program. Five months after getting a positive response to our application we are up and running. In Whyalla the target group comprises mostly teenage girls; and in Port Augusta, where the Aboriginal birth rate is highest outside of the metropolitan area, the program supports mostly young, at risk Aboriginal women (but not exclusively).

CULTURALLY APPROPRIATE MIDWIFERY PRACTICE

This Alternative Birthing 'continuum-of-care' model does break the mould of convention in order to achieve excellence in maternity services. It is innovative in that the model offers case-load care and is led by Aboriginal Maternal and Infant Care workers who are supported by a team of midwives and a GP and/or obstetrician. The program caters for both low and high-risk pregnancies. Risk is assessed in terms of medical and social risk factors. The degree of risk determines the amount of specialist obstetric involvement and referral to other support services. The program aims to give a high degree of culturally appropriate support and care to around 20 Aboriginal women per year.

IMPLEMENTATION OF A TEAM APPROACH

The program began with the employment of a high level project officer for an initial period of 6 months to work at both sites (0.5 FTE each) to develop appropriate protocols and guidelines for practice and to implement the programs.

At the Port Augusta site one of the part time community midwives was contracted to this role to provide the invaluable midwifery perspective and input. Three months later the regional project officer was appointed and was able to take over from where the midwife gradually left off. She had completed job specifications and interview processes for most of the positions on the Aboriginal Maternal and Infant Care (AMIC) teams.

In Port Augusta a shared position for a registered midwife level 1 was advertised and four were interviewed and accepted into the program. Following this, the positions for the AMIC workers was advertised and three were employed to work in the program.

The project Team is made up of four P/T midwives and three P/T Aboriginal Maternal and Infant Care (AMIC) workers. The AMIC workers are rostered for about 12 hours each week (1 FTE) and the part-time midwives divide up a 0.5 FTE position. The role of the AMIC worker is to co-ordinate the team as well as to provide 'hands on' support to the women and their families. They will assign each woman entering the program a primary AMIC worker and midwife from the team – however all members of the team will see all women in the program over the antenatal period. A pamphlet with information about the program and photos of the Team members is made available to participants in the program.

PRIMARY AND ANTENATAL HEALTH CARE

Pregnancy check ups are offered to the woman and are conducted in her home, at an antenatal clinic, at Pika Wiya or another mutually acceptable venue. Assessing each woman for risk factors and educating her about warning signs for potential complications of pregnancy enables primary prevention and early intervention. With such support and information, women are empowered to make decisions about their care, and the health and care of their families.

The focus on health promotion and education prioritises healthy eating (including folate), support to quit smoking and other drugs, physical activity, and the promotion of breastfeeding. A checklist ensures all areas of discussion are covered at the appropriate time and understood adequately.

The team uses locally developed resources including

- *You are having a baby: A book for Aboriginal women*
- *Pregnancy checkups with your doctor* (pamphlet)
- Port Augusta Hospital birthplan
- *Breastfeeding resources: Mummy, I want Ngammias* and other pamphlets and posters.

They have access to relevant State resources e.g. the Pregnancy hand held record, resources developed for Aboriginal women by Health Promotion SA, and resources developed in the SA Breastfeeding project. Health Promotion SA assists with finding appropriate resources and strategies for promoting healthy behaviours in pregnancy. It provides evaluation of these

strategies and is interested in supporting workforce development. The team follows the recommendations in the GP/ Obstetric Shared Care Protocol Booklet from the Department of Health SA to ensure up-to-date best practice. All women in the program are referred to their GP or Obstetrician for assessments at 18, 28 and 36 weeks, unless risk factors develop necessitating a higher degree of medical involvement.

The AMIC workers work with the midwives and other local services to organise and offer antenatal classes as required.

BIRTH

When the woman goes into labour, she is cared for by one of the team midwives. If none of the team midwives are rostered on the ward, the woman's primary midwife is called in to care for her throughout labour and birth. If another team midwife is rostered on the ward at this time she will still contact the woman's primary midwife to discuss any issues; but the team midwife rostered on continues the care of the woman. The woman's AMIC worker is also called to assist and support the woman and her family during this time.

POSTNATAL SUPPORT

The team will continue to care for the woman and her new baby while they are in hospital; supporting her to breastfeed, explaining about required immunisations, assisting with enrolment in Child and Youth Health and facilitating any extra support as required.

After discharge they continue to visit the family up to 8 weeks post delivery. This ensures that the woman and baby have had their postnatal checkups, 8-week immunisations and adequate time for handover to the Child, and Youth Health service, to participate in the Universal Home visiting program, and if required the Sustained Home Visiting program and Learning together program (SA initiatives).

TEAM MAINTENANCE AND FUNCTION

The program and the women's care is co-ordinated by the AMIC workers who are supported by the team of midwives. The three AMIC workers share the 1FTE position so that:

- they are able to support each other
- there are three AMIC workers receiving training and not just one
- the part-time work allows for involvement in other programs
- there is flexibility in rostering
- there is an increase in the rate of sustainability.

The AMIC worker's hours can be divided into three four-hour sessions. They are based on the ward and work from the ward. They work with the women from the program when they are admitted to hospital. They are available to accompany women to X-ray, GP/Obstetrician checkups and appointments to other services. They have an important role as advocate and cultural broker. There are other benefits with having the AMIC workers present on the wards as well. Their higher profile and obvious presence is reassuring to Aboriginal people generally,

and the women in particular, and they have greater opportunities to make a positive impact on the wider population and staff at the hospital. The ward setting provides further opportunities for clinical training. Opportunities are sought by the midwives for the AMIC workers to increase their knowledge and experience of birth, and support them in developing skills to be more active in supporting women during their birth experiences. The AMIC worker is called to assist and support the woman and her family during labour and birth. They take time-off-in-lieu to compensate for the time involved in these activities.

The AMIC worker supports the team of midwives in increasing their knowledge of Aboriginal culture relating to pregnancy, birth and motherhood. They work closely with the Pika Wiya Health Service and the Royal Flying Doctor Service Aboriginal Liaison Officers.

All of the midwives and AMIC workers (and Obstetrician and GPs if available) attend a two-hour meeting every fortnight to discuss issues concerning the program including case-conferencing, rosters, training, resources, reports and evaluation.

A Regional Aboriginal Women's Advisory Group gives advice and direction to the program as part of a broader strategy to improve birthing outcomes for the region. A Management Group of Stakeholders also meets regularly to assist with the commitment and co-ordination between services and sustainability of the program.

EVALUATION

Evaluation of the program is significant to ensure satisfaction for the women and their families and for staff satisfaction. Data collected includes qualitative and quantitative information:

Maternal factors:

- age of the mother
- pregnancy complications
- drug use (including smoking) in pregnancy
- interventions during labour and birth
- method of delivery and indications.

Baby factors:

- perinatal death
- gestational age at birth
- birth weight
- nursery care
- method of feeding
- weight gain of babies
- immunisation rates

Use of services:

- time of their first ante-natal visit
- number and site of ante-natal visits
- education given/checklist of topics discussed
- referrals to other services

Feedback from consumers and providers of services.

A specific indicator for program outcome evaluation will be an increased number of Aboriginal infants with a birth weight >2500 gms. This is considered an overall indicator of, “a populations health status and of the *maternal environment*” (Improving Indigenous Birthing Outcomes Terms of Reference report). It will also allow the program to be assessed in line with the National Women’s Health Program reporting requirements to increase the proportion of Indigenous infants with increased birth weights >2500 per 1000 live births.

Budget is allocated to ensure rigorous external evaluation. The Alternative Birthing project is certainly not perceived as a stand-alone project but as an extension or arm of the women-centred maternity service that is:

- responsive to women and their families needs,
- promotes choice and based on evidence, not merely convention.

Since the introduction of midwifery/ Aboriginal Health worker shared care with the GPs and Obstetricians, significant results have already emerged. There has been a reduction in the Caesarean section rate and the models of care are attracting and retaining staff who may feel drawn to work within the model for greater work satisfaction.

PRESENTERS

Cheryl Boles is a community midwife based at the Port Augusta Hospital. She has had extensive nursing experience working with Aboriginal people in outback Oodnadatta, teaching an Aboriginal primary health care course at TAFE, and through the RFDS. She has worked as the initiating Project Officer for the Alternative Birthing Project. Her work includes antenatal clinics, classes, and postnatal follow-up.

Deanna Stuart-Butler works as an Aboriginal Maternal and Infant Care Worker with the Alternative Birthing Project. Deanna is the State Aboriginal Breast Feeding Project Officer through Child and Youth Health, sponsored by Health Promotion SA in the Department of Health. Her language group is Arabana from the Lake Eyre region of SA. She is the mother of a teenage boy and young girl and has lived in Port Augusta for most of her life, working within the Aboriginal community.