Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Developing a National Strategic Approach to Maternity Services

AUSTRALIAN HEALTH MINISTERS' ADVISORY COUNCIL

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1. ***Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the NSAMS?***
   - Provision of holistic, comprehensive, affordable and collaborative women-centred best practice maternity care that is fully integrated with primary health care and respectful of cultural and individual diversity, and offers women a range of birthing options.

2. ***Do you think there should be a set of values that underpin the NSAMS? If so, could you list the top four values you would like to see included?***
   - Cultural safety and respect for diversity (individuals and groups).
   - Best evidence based midwifery led care.
   - The full integration of maternity care with primary health care that enables holistic, innovative and flexible approaches to maternity services including birthing.
   - Integration of primary and secondary health care systems to enable continuity of antenatal, birthing and postnatal care and continuity of care for highly transient (and often disadvantaged) women to access maternity care in different locations at multiple services, to encourage engagement as they move from place to place.

3. ***Can you outline three or four positive aspects of maternity services in Australia?***
   - Maternity services are part of a broader system that provides universal health care.
   - Strong focus on women-centred care.
   - Australian College of Midwives Guidelines and the standards, codes and values that guide professional midwifery practice that has enabled the development of the Midwifery Group Practice Model
   - The development of stand-alone birthing centres led by midwives supported by hospitals

4. ***What do you think are the three or four key gaps or issues for maternity services in Australia? Of these which is most important to you?***

There needs to be support for self-determination, autonomy and cultural security for Aboriginal women including options for birthing (e.g. birthing suites, home births or facilities away from hospital, introduction of cultural birthing practices and an Aboriginal support person). This particularly includes Midwife-led services provided to Aboriginal women by Aboriginal Community Controlled Health Services (ACCHSs). These services should be available to all Aboriginal women. Aboriginal people show a clear preference for ACCHSs leading to greater

access and better adherence to health care (Vos et al 2010). For example, in 1973 when Congress, the largest ACCHS in the NT, was founded infant mortality rates in the Northern Territory were 200 per 1000 live births. Today, infant mortality rates have declined to around 7.5 per 1000 live births in Alice Springs.

Congress' services include Alukura, a women's specific health service which provides high quality, accessible antenatal care and postnatal care as part of a community controlled comprehensive primary health care service. Birthing has been suspended while a new Midwifery Group Practice is established with a new birthing agreement with Alice Springs Hospital. Through this service, Alukura is able to engage women in health and maternity care. There are 3 key elements of Alukura's underlying philosophy. Firstly, it acknowledges that Aboriginal peoples are distinct and viable cultural groups with their own cultural beliefs, traditions and practices, system of law and social needs. Secondly, it recognises that every woman has the right to participate fully in her pregnancy and childbirth care, and determine the environment and nature of such care. Finally, it recognises that every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions.

Alukura was developed in respect of Aboriginal women's Law and continues to be guided by the cultural values that relate to women's business, by providing a women's only space in which Aboriginal women feel culturally safe and can access high quality antenatal care. The success of this approach can be measured in the improvement that has occurred over time in the access of pregnant women to antenatal care in the first trimester. In 1986-1990 only 21% of pregnant women presented in the first trimester and this had increased to 33% for the period 1991-1995. In recent years the rate has consistently been over 50%. This has probably contributed to the improvement in birth weights for Aboriginal babies in Alice Springs and reducing infant mortality rates.

It is intended to re-establish a midwifery group practice in collaboration with Alice Springs Hospital in the near future, to further improve outcomes for women and their babies. This model will place midwifery care within the realm of primary health care, treating pregnancy, birth and parenting as a normal life events, rather than a hospital/acute episode.

This is the major issue for the Australian maternity services system more generally - the lack of integration of midwifery services into general practice and primary health care. The norm should become that midwives deliver maternity care services within the primary health care setting in partnership with GPs. These same midwives need to be able to follow through and provide birthing services in birthing centres, in hospitals and in the home where appropriate and requested.

5. What four to six key improvements would you like to see in maternity services in Australia? Please consider these from a national perspective.

In the current system, midwives are still primarily hospital based and there needs to be a greater shift into primary care. There needs to be a greater capacity within the Australian primary health care system to ensure midwives are available and working alongside GPs and other health professionals as part of a comprehensive primary health care model. GPs should not be the primary cares in maternity care but have an important role to play in partnership with midwives.

In order to achieve continuity of care throughout the pregnancy and birth, midwives who work within multidisciplinary primary health care teams should provide birthing services in local hospitals under the supervision of obstetricians. This can be achieved through the negotiation of

local agreements. These service agreements have previously existed in Alice Springs. The same midwife, or team of midwives, then provides postnatal care from their primary health care setting rather than from hospitals. This shifts the emphasis from hospital care to primary health care which is where maternity care should primarily be provided. There should be a corresponding shift in the funding from hospital midwife positions to general practices and primary health care services to be able to employ midwives who undertake the birthing services in hospitals, birthing centres or at home depending on the choices of women and their level of risk.

Although there have been some positive changes to the way midwifery care is funded to support this sort of change, more needs to be done. The model of salaried midwives working within ACCHS has many advantages over funding models based on Medicare alone, especially in remote and other disadvantaged areas. There could be a specific funding program established to provide midwifery services in at least the areas where market failure has not seen the establishment of such services in the primary health care system outside of hospitals.

In addition, it is clear that many women benefit from additional support in pregnancy and the early years and there needs to be a much broader roll out of service models such as the Australian Nurse Family Partnership (ANFPP). The ANFPP, is a cost effective program that promotes healthy development in pregnancy and early childhood. This program complements and supports midwifery led care in pregnancy. The focus of this program is on the primary carer of the child, usually the mother. The ANFPP aims to:

- Improve pregnancy outcomes
- Improve child health and development
- Improve parents' economic self-sufficiency.

These aims are achieved through a sustained home visitation program, with the mother being visited by the same Nurse Home Visitor and Aboriginal Community Worker throughout the program in order to be able to build and maintain strong trusting relationships. The schedule of home visits occurs weekly, bi-weekly or monthly, depending on the phase of program delivery, commencing no later than 28 weeks' gestation and continue until the child is 2 years of age. An independent evaluation of this service at Congress from 2009 to 2015 (pending publication) has shown that this service has a major impact on reducing child protection involvement and days in out of home care, increasing birth spacing, reducing nutritional disorders such as childhood anaemia and reducing hospitalisations for injury. These benefits have been shown amongst highly disadvantaged and vulnerable families. Further information: Olds D L, Eckenrode J, et al. (1997). "Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial." JAMA 278 (8): 637-643

6. ***Are there specific strategies that you could suggest for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds?***

Midwife-led care, provided through Aboriginal community controlled health services, within a culturally secure, comprehensive primary health care framework (i.e. holistic care for women including health promotion, Aboriginal support staff, transport, other clinical and preventative services). For example, a Midwifery Group Practice (MGP) based in an Aboriginal community controlled health service with an agreement with the local hospital to enable continuity of care for birthing with oversight, attached to a hospital and an obstetrician for the midwives to refer

and collaborate with. This type of service model is best funded through a combination of grants and Medicare and could largely be funded by a combination of the current state and territory government funds that employ midwives in hospitals as well as Medicare. Midwifery services within hospital would then be provided by midwives with visiting rights who work from the primary health care sector rather than through hospital based midwives.

A systematic review has shown that midwife-led care, when compared with medical-led and shared care, '...was associated with several benefits for mothers and babies, and had no identified adverse effects. The main benefits were a reduced risk of losing a baby before 24 weeks. Also during labour, there was a reduced use of regional analgesia, with fewer episiotomies or instrumental births. Midwife-led care also increased the woman's chance of being cared for in labour by a midwife she had got to know. It also increased the chance of a spontaneous vaginal birth and initiation of breastfeeding. In addition, midwife-led care led to more women feeling they were in control during labour. There was no difference in risk of a mother losing her baby after 24 weeks. The review concluded that all women should be offered midwife-led models of care. Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). 'Midwife-led versus other models of care for childbearing women'. Cochrane Database of Systematic Reviews, Issue 4.

7. How will success be measured or how will we know if strategies are being successful?

Measures should have local relevance though feed into national indicators. For Aboriginal women, girls and babies these may include:

- Fewer pregnancies in adolescence
- More women engaged with antenatal care early in pregnancy in the first trimester, more frequent visits during pregnancy (at least 4) and for two months post-partum
- Family planning and increased birth spacing
- Women are satisfied with the service
- Risky behaviours (eg smoking and drinking in pregnancy) are reduced
- Maternal death rates are reduced
- Infant and perinatal mortality is reduced
- There are fewer preterm babies, and fewer low birth weight babies
- Anaemia in mothers and children is reduced.
- Screening rates for domestic violence is increased and reported on
- The number of Aboriginal midwives and Aboriginal support roles has increased.