The WA Goldfields Aboriginal Community Antenatal Program – A Community Midwifery Initiative

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Abstract

Aim

To investigate the acceptability and satisfaction with the Aboriginal Community Antenatal Program by staff in the program and partner agencies.

Design

A Strengths, Weaknesses, Opportunities and Threats framework guided the research and data collection methods. Mixed methodology was used, accessing qualitative and quantitative information from data bases, program and supporting agency staff. Quantitative data were analysed through a social sciences statistical package. Qualitative data were identified through questionnaires and analysed using thematic analysis.

Setting

Remote Aboriginal communities in the Goldfields region of Western Australia.

Participant sources

Twenty two participants including program and supporting agency staff.

Main outcome measures

This study measures acceptability and satisfaction of program antenatal and pre-conception activities by program staff and partner agencies.

Results

Qualitative results indicate acceptability and satisfaction with the program, identifying a range of organisational, staffing, cultural and interagency issues relating to a model of service provision. Quantitative data suggested positive program outputs from service delivery.

Conclusion

Findings suggest the Aboriginal Community Antenatal Program and partner agencies are increasing provision of community based pre-conception and antenatal health services and enhancing collaboration between a range of health provider agencies, with partnerships between Aboriginal and non-Aboriginal program staff contributing to an emerging model of community antenatal care.

Issue

Little is known about the acceptability and satisfaction of community Aboriginal antenatal and pre-conception programs using partnerships between community midwives and Aboriginal maternal support workers in remote Australian regions.

What is already known

Aboriginal antenatal and pre-conception health and education is linked to a range of physical, psychosocial and cultural issues. Community midwifery models of care are needed to facilitate responsive strategies for vulnerable clients.

What this paper adds

Evidence that combined expertise, local knowledge and cultural brokerage attributes of community midwives and Aboriginal maternal support workers have potential to develop a culturally relevant model of community antenatal and pre-conception care.

Introduction

The ability of Aboriginal women in remote areas of Australia to access community based antenatal care is important for the health and wellbeing of the women, their families and children. The Aboriginal Community Antenatal program is a community midwifery led strategy designed to address accessibility of pre-conception and antenatal care in the Goldfields region of Western Australia using a partnership between midwives, Aboriginal Maternal Support Workers and other service providers.

Program Description

The Western Australian Country Health Service (WACHS) Goldfields Aboriginal Community Antenatal Program was funded under the Council of Australian Governments (COAG) National Priority Partnership Agreement for Indigenous Early Childhood, targeting Indigenous Early Childhood Development. Community midwives and Aboriginal maternal support workers work in a partnership team to provide pre-conception health services and support vulnerable pregnant Aboriginal women not accessing existing antenatal services in the Goldfields region of Western Australia, also collaborating with two Aboriginal Community Controlled Health Organisations (ACCHOs) and local hospitals as partner agencies. Registered nurses and Aboriginal Health Workers (AHW) working within community health services also assist when needed.

The model of community support is flexible, with a community midwife and Aboriginal maternal support worker making contact with antenatal women and partners in their homes or community health centres, depending on client preference. Secondary school males and females receiving safe sex education have health education sessions in schools or out of school locations such as recreation centres. Liaison with schools and community youth support agencies facilitates these health education groups. Antenatal referrals are made by a range of agencies such as general practitioners, ACCHOs and local hospitals in addition to local community midwife and Aboriginal maternal support worker knowledge.

Aboriginal maternal support workers are local Aboriginal mothers who are well-respected within their community with formal qualifications not being pre-requisites to the position. The importance of their role is to have good communication skills to liaise with their local community, providing a culturally supportive role for the community midwife and clients. Recruitment is undertaken locally through local Aboriginal networks, with regular training in antenatal issues being provided by the local community health service. Community midwives have qualifications as Registered Nurses and Midwives. Additional credentials such as Masters degrees and Eligible Midwife endorsement are desirable but not essential employment criteria. AHWs hold accredited clinical and health promotion qualifications (Australian Indigenous Health*InfoNet*, 2015).

Community midwives and Aboriginal maternal support workers are based in two geographically isolated service areas of Kalgoorlie-Boulder and Coolgardie, and Leonora-Laverton. Kalgoorlie-Boulder is 595 km from Perth which is the capital city of Western Australia and the main tertiary centre for the state's health services. Coolgardie is 557 km with Leonora and Laverton 830 and 955 km respectively from Perth. (WACHS, 2011).

Aim and of the study

The aim of this evaluation was to investigate the acceptability and satisfaction with the Aboriginal Community Antenatal Program as described by ACAP and partner agency staff.

Literature Review

Internationally, there are established models of care for community midwives providing continuity of care to perinatal clients. In countries with similar health systems to Australia, particularly in New Zealand and Canada, community midwifery enables a primary health care approach, responsive to local needs especially working with clients with health inequalities and social exclusion (Maternity Coalition AIMS (Australia), Australian Society of Independent Midwives, Community Midwifery WA Inc, 2002). There is little available evidence on best practice for community based midwifery care for Aboriginal women. However the evidence based Australian Maternal and Child Health

Model of Care in the Aboriginal Community Controlled Sector (McHugh & Hornbuckle, 2011) identifies best practice elements such as a focus on communication, relationship building, and development of trust; respect for Aboriginal people and their culture; valuing of Aboriginal staff and integration with other services such as a shared care approach.

Aboriginal antenatal health and birthing influences are linked to a range of issues such as cultural safety, social determinants, feelings of shame and choice of health provider (Wilson, 2009). In a recent Western Australian study, young Aboriginal women voiced their needs for pregnancy care as being an open, non-judgemental and respectful support system that respects their choice privacy and confidentiality. A continuous relationship with a known caring team such as an Aboriginal Health Worker and midwife in addition to local Aboriginal women elders and grandmothers were central to trusting relationships during this vulnerable time in their lives (Reibel & Morrison, 2014). Aboriginal women recognise a holistic approach to health with a focus on physical, spiritual, cultural, emotional and social well-being that requires health professionals to consider these aspects when developing and delivering models of care (Zubrick et al., 2004; Reibel & Morrison, 2014).

Parents' pre conception and antenatal health influence children's early and lifelong health trajectories, affecting future education and employment opportunities (WHO, 2008; DFHCSIA, 2008). Links between low birth weight and increased risk of death in infancy and chronic disease have also been established (McHugh & Hornbuckle, 2011; Thompson et al., 2012). Risk factors relating to low birth weight include socioeconomic disadvantage, maternal age and parity, along with mothers' nutritional status and general health during pregnancy (Ashdown-Lambert, 2005). These are all individual or cumulative key determinants for early childhood health and wellbeing.

In Western Australia, young and senior Aboriginal women have identified priorities for pre-conception sexual health education and health promotion, with recommendations being for maternity and community health services to work in partnership with Aboriginal elders, education providers and other related organisations utilising culturally relevant strategies to develop appropriate school and

community sexual and reproductive activities (Reibel & Morrison, 2014). Respectful and reflexive approaches are needed to adapt service delivery to protect clients' values and engagement with meaningful health care practices.

Alcohol and tobacco consumption in pre-conception and antenatal periods affect outcomes for children. Key areas of support need to include pre-conception education in the community and schools, reduction of unplanned pregnancies, routine screening of women of child bearing age, provision of appropriate information to all pregnant women and their families about substance use and risks associated with alcohol use, support for pregnant women with an alcohol dependency to manage withdrawal, and improving quality, availability and cultural appropriateness of maternity services (DoHWA, 2010). Along with recognised risks of respiratory and cardiovascular disease (Centres for Disease Control and Prevention, 2012), smoking and passive smoke inhalation increases likelihood of stillbirth, premature birth and low birth weight in pregnancy, as well as middle ear, asthma and respiratory disorders in the early years (Zubrick et al., 2004). The ability of health professionals to engage clients and affect behaviour change is dependent on an understanding of complexities in underlying causes and risk factors, along with development of culturally relevant strategies.

Aboriginal women and families in the antenatal period benefit from a culturally safe model of integrated social, emotional and medical care. This offers guidance to address health inequalities and assists in identifying and sustaining changes needed for positive lifestyle changes (McHugh & Hornbuckle, 2011). Aboriginal women have identified choices and preferences as being key features in relation to antenatal care; relationships of respect and trust between young pregnant Aboriginal women and antenatal care providers; knowledge of local communities and cultural practices by antenatal care providers and information enabling pregnant women to be well informed, particularly in regards to their bodies, substance abuse, self-care and care for the developing baby (Wilson, 2009; Reibel & Morrison, 2014). A range of personal, social, cultural and system issues impact on women's attendance at antenatal clinics and health promotion sessions. The use of community based midwives and Aboriginal support workers has been found to foster client engagement (Reibel & Morrion,

2014; McHugh & Hornbuckle, 2011). In order to facilitate trustworthy, culturally relevant support, contemporary models of care need to be developed that recognise local social and environmental influences impacting on care strategies.

Methods of Investigation

This evaluation focuses on a mid-term program review for the period 2010 to 2012 incorporating feedback from ACAP and partner agency staff. This provided evidence for planning, modifying and implementing future program strategies. A Strengths, Weaknesses, Opportunities and Threats (SWOT) framework guided the research and data collection methods, facilitating awareness of internal program strengths and weaknesses along with external opportunities and threats. This has the potential to enhance understanding of how strategies and policies can be strengthened, opportunities augmented and threats minimised (Sasidhar & Gopal Reddy, 2012; Community Toolbox, 2015; Tukundane, Minnaert, Zeelen, & Kanyandago, 2015). A reference group was formed at Kalgoorlie consisting of health service management and Aboriginal and non-Aboriginal staff for research and organisational guidance. The Curtin Centre for Aboriginal Studies also provided cultural oversight for the researcher.

Data sampling

Purposeful sampling was used to contact all ACAP and partner agency participants, with all agreeing to participate. Reassurance was given that declining to participate would not jeopardise employment. Due to the investigation of a unique phenomenon of interest, bias was reduced. However the small cohort numbers are not able to allow generalisation of findings to other Aboriginal populations (Paton, 2002). All participants were given an information letter and consent form. Following their consent, mutually agreeable appointments were made for focus group and individual interviews.

Research population

Twenty one participants were involved in the study, these being ACAP managers (n=3), Community midwives (n=3), Registered Nurses (n=2), Aboriginal maternal support workers (n=4) and Aboriginal Health Workers (n=1) in addition to partner agency managers (n=2), Midwives (n=3), Registered Nurses (n=2) and Aboriginal Support Workers (n=1).

Data collection

Quantitative and qualitative data collection methods including retrieval of statistical program data from document records with semi-structured individual and focus group interviews being undertaken. Interview questions were developed from the SWOT framework (Appendix A). Quantitative reporting requirements from the Western Australian Department of Health were also evaluated. These included review of government health service reports (2011) on key clinical outputs outlined by the Department of Health (DoHWA, 2009) for 2011. No reporting data were available for 2010, due to delays in employment of CMs and no data had been published for 2012. From 7th May to 14th June 2012, qualitative data were collected using three semi-structured focus group interviews with ACAP staff and two with partner agency staff, with an individual face to face interview with one ACAP staff member and individual telephone interviews with two partner agency staff.

All information was kept confidential and non-identifiable. Interviews were transcribed and analysed manually. Approval for this study was granted from WACHS- Goldfields as a quality improvement project with supporting permission from the partner agencies.

Trustworthiness of data

Trustworthiness was demonstrated through credibility, dependability and confirmability of data (Strubert Speciale & Carpenter, 2003; Lincoln & Guba, 1985). Transferability of findings to other Aboriginal communities may not be possible due to discrete cultural differences but the findings have the potential to inform development of future programs. Credibility was maintained through member checks being undertaken at the end of interviews or by email following data transcription.

Dependability was identified through reviews of data findings by the reference group. An audit trail with raw data, interview transcripts and stages of thematic analyses contributed to data confirmability.

Data analysis

Quantitative data were analysed through the SPSS database program. The flexible approach of thematic analysis was used to investigate the qualitative data, which allowed identification of common themes amongst research participants (Streubert Specziale & Carpenter, 2003). This allowed the identification of implicit and explicit ideas from the data (Guest, MacQueen & Namey, 2012).

Results

As ACAP undertakes both direct client care and facilitation of care in collaboration with partner agencies, caution needs to be taken with data interpretation as no partner agencies were able to provide client attendance and activity records. It is recognised that client numbers are small, however this was an anticipated feature during the development phase of the program.

Quantitative Summary

Clinical service delivery related to the following outputs.

Table 1: Clinical Service Outputs
Provision of clinical advice, support and education to antenatal services delivering care to Aboriginal women
Provision of education and support to reduce harm associated with alcohol use during pregnancy for Aboriginal women
Provision of antenatal care services targeted at young Aboriginal women
Provision of sexual and reproductive health services to young Aboriginal women

Government of WA, Department of Health[13]

Table 2: Partnerships and Community Consultation
Partnerships with other agencies/stakeholders
Community consultations

Government of WA, Department of Health[13]

Throughout 2011, provision of antenatal clinical advice, support and education for Aboriginal women increased in terms of occasions of service and numbers of clients in Kalgoorlie – Boulder and Coolgardie, but decreased for both in Leonora – Laverton, potentially due to delays in recruitment of

a community midwife in this area and Aboriginal population mobility. Kalgoorlie-Boulder and Coolgardie recorded a growth from 23 to 29 clients with occasions of service rising from 130 to 240 in the two reporting periods of January to June and July to December. During the same period, Leonora had a decrease in clients from 10 to six, with occasions of service falling from 35 to 25. Acknowledging small numbers of occasions of service, there were increases in both sites for group educational activities across a range of relevant topics with Kalgoorlie-Boulder and Coolgardie increasing from six to 13 and Leonora from one to two. Attendance for group educational activities is heavily influenced by family and funeral responsibilities.

Precise data was not available for smoking cessation activities and brief interventions on effects of alcohol consumption. However, written reports and qualitative feedback suggest effective opportunistic contact with clients in these areas.

In Kalgoorlie-Boulder and Coolgardie, antenatal contact for young Aboriginal women less than 20 years of age decreased throughout both reporting periods in 2011 from 14 to 10, but increased slightly in Leonora-Laverton from 0 to one. For clients over 20 years of age, contact doubled in Kalgoorlie-Boulder and Coolgardie from nine to 19 and reduced by 50% in Leonora-Laverton from 10 to five. These figures need to be interpreted within pregnancy rates in each region, mobility of clients and varying community midwife employment in all areas. There were 584 babies born in Kalgoorlie-Boulder in 2011 (ABS, 2016). Clients from across the Goldfields region and other bordering communities, such as the Anangu Pitjantjatjara Yankunytjatjara Lands, birth at the hospital in Kalgoorlie. As such, it is difficult to estimate the number of specific births for each ACAP area. Additionally, the community midwives and Aboriginal maternal support workers have contact with clients as they move between the Goldfields, Lands regions and other areas from within the state for family, community and health appointment commitments.

There was a significant increase in sexual and reproductive health group activities in Kalgoorlie-Boulder and Coolgardie from six to 13 with Leonora-Laverton expanding from one to two sessions.

Opportunistic health promotion during routine visits by community midwives and Aboriginal maternal support workers were used to promote healthy behaviours and practices.

Partnerships with agencies and stakeholders were developed and community consultations undertaken throughout the program. Five interagency meetings were held during 2011 in Kalgoorlie-Boulder with working groups being established. Liaison with child health nurses encouraged client transition from perinatal to child health services.

Between the Kalgoorlie-Boulder and Coolgardie sites, there was an increase from one to three community consultations, all centred on ACAP awareness in the community and how partner agencies and community groups could meet client needs. There were no recorded consultations for Leonora-Laverton which would most likely been influenced by the lack of a community midwife. Qualitative responses from ACAP staff also demonstrate that referrals to and knowledge of ACAP services throughout the community were undertaken through client word of mouth.

Qualitative Thematic Analysis

Four themes related to this research on ACAP were highlighted from the data, these being organisational factors, staff factors, cultural issues and interagency issues. Participant responses have been included but their categories have not been included to maintain annonymity.

Organisational factors

Common strengths included allocation of time and resources to build formal and informal partnerships with clients and partner agencies. The ability to provide early education for pre-conception care and in the antenatal period was seen as valuable, particularly with the community midwife being able to offer professional advice to clients immediately without them having to wait to attend a medical clinic.

More staff allocated specifically to antenatal clients and preconception care.

Having the resources and time to put into the antenatal women and build partnerships with them.

Difficulties included recruitment of appropriate staff in addition to the quality and availability of interagency antenatal hand held client records.

There are difficulties in midwifery recruitment. There's a midwifery shortage, especially in rural areas. Midwives need higher competencies especially communication, community outlook and experience, using social model of health. They need a primary health care and health promotion outlook. Need to work in partnership with other agencies.

Get all agencies together to work on antenatal record holder – have an official launch making it community owned. This would enhance the importance of antenatal care that would encourage everyone to use.

Staff factors

Strengths related to the quality of community midwife and Aboriginal maternal support worker relationships, employment of local Aboriginal maternal support workers, WACHS support for them to gain knowledge and competencies, and the community development frameworks in which staff worked. Identified weaknesses were recruitment challenges for appropriate midwives and support workers, and intermittent relationships issues between them.

Team work between the CM and AMSW…is important. The AMSW knows where to find people.

The AMSWs are experienced women in the Aboriginal community who know the community and can get the midwives through the door.

The positive relationship between CM and AMSW is important.

Cultural factors

Employment of community midwives with culturally relevant practice and local Aboriginal maternal support workers were seen as cultural strengths, along with staff asking clients what they wanted from the program. The length of time to develop trust and effective communication with clients, particularly around disclosure of pregnancies, were noted as issues. The need to continue networking

with families and improve understanding of Aboriginal cultural and psychosocial environments was recommended. Issues external to ACAP were related to social determinants such as housing shortages for clients, which is recognised not as a specific cultural issue, and their transient lifestyles.

The service is accessible. They don't like waiting. We can come quickly on their terms.

Aboriginal maternal support workers are community members.

Cultural perception on pregnancy – keeping quiet; "a phase of life" & not an illness, therefore why go for checks? We can do checks without judgement if they're not attending.

Young mothers and antenates don't often have a place of their own – therefore transient and difficult to locate.

Interagency issues

This theme identified strengths of interagency partnership as being the ability of small ACCHSs to offer midwifery led antenatal clinics in collaboration with an ACAP community midwife, improved interagency communication through interagency forums and more choice for antenatal clients. Difficulties included duplication of services between partner agencies, issues with client hand held records, no common shared model of antenatal care and reduced ability to conduct pre-conception sexual health education with some partner agencies. Participants strongly identified a need to continue facilitating interagency and community networking, sharing professional development opportunities and development of a common, shared model of antenatal care.

There's acceptance of ACAP and staff from other agencies.

Interagency collaboration. Working with [community agency] in their premises and with their staff. Asking clients what they wanted and developing sessions to suit.

[This community agency] has no resources – it's better with the ACAP collaboration.

Discussion and Recommendations

It is acknowledged that this review has been from ACAP staff and partner agencies with no client consultation and with limited statistical recording for program activities. As is common in many rural areas, recruitment and retention of suitable staff has been difficult and impacted on this program (Katzenellenbogen, Drury, Haigh & Woods, 2013).

From a staff and community agency perspective, ACAP appears to be providing benefits for Aboriginal communities in Kalgoorlie-Boulder, Coolgardie, Leonora and Laverton, recognising that psychosocial issues impact on maternal, child and family health (Zubrick et al., 2004). The ability of the community midwives and Aboriginal maternal support workers to understand these complexities appeared to contribute to program strengths. Culture remains a strong element of Aboriginal antenatal and birthing practice both nationally and internationally (Reibel & Morrison, 2014; Kildea & Van Wagner, 2012) which is acknowledged within ACAP and supported from findings in similar models of care in New Zealand and Canada (Kildea & van Wagner, 2012) and Australian best practice indicators (McHugh & Hornbuckle, 2011). The ability of community midwives and Aboriginal maternal support workers to deliver accessible services is a feature of the program, with their own close working relationships being an important attribute of this model of community antenatal delivery. Anecdotal evidence suggests the program is developing respectful and trusting relationships between ACAP team members and with partner agencies. This partnership approach is integral to ongoing program development.

Combined expertise, local knowledge and cultural brokerage attributes of ACAP midwives and Aboriginal maternal support workers and partner agencies have the potential to develop a relevant model of community antenatal and pre-conception care in the Goldfields region which is supported nationally and internationally (James et al., 2010; McHugh & Hornbuckle, 2011). Lack of a common shared model of antenatal care and ability of agencies to share up to date client records impacts on interagency collaboration. It is recognised that environmental impacts such as lack of housing affect the ability of ACAP and agency staff to optimally address client issues. However, development of

collaborative strategies between all partner agencies in addition to other government and non-government organisations may assist in reducing these negative influences.

Although there were staffing difficulties and statistical analyses of program strategies were limited due to small reporting data, the program appeared to be beginning to achieve positive results from activities across all ACAP sites. The commitment of the community midwives and Aboriginal maternal support workers and partner agencies to develop culturally informed, accessible pre-conception and antenatal support services is apparent in the findings of this evaluation. Implications for clinical practice indicate the value of collaborative and respectful partnership approaches between ACAP team members and with community agencies, with culture being recognised as central to program development and strategies.

Recommendations are for the interagency development of a common shared model of antenatal care, ongoing development of health and social support interagency liaison and an end of funding program impact evaluation incorporating client perspectives.

Limitations

It is acknowledged that this evaluation has been from ACAP staff and partner agencies with no client consultation. Limited statistical reporting data has also influenced the findings.

Conclusion

Utilising a community midwife and Aboriginal maternal support worker partnership with interagency collaboration and client outreach, the Aboriginal Community Antenatal Program has potential to be an ongoing community based model of care for pre-conception and antenatal clients in a remote Australian region. The information from this evaluation will inform future development and sustainability of the program. It is anticipated that these findings will contribute to an emerging partnership model, supporting ongoing positive outcomes for the future of the program.

Appendix A

WACHS Goldfields Aboriginal Community Antenatal Program

This questionnaire is designed to explore the COAG funded Aboriginal Community Antenatal Program, to ask what you consider the strengths and weaknesses of the program are, and what you consider to be opportunities for improvement. This information is needed for the ongoing success of the program. All information will be de-indentified.

1. What do you consider the aims of this program are?

2. Strengths

    a) What are the strengths of this program/what is working well?
    b) Why are they working well?

3. Weaknesses

    a) What are the weaknesses of this program/what is not working well?
    b) What are the limitations of the program?
    c) Why is the program not working well?

4. Opportunities

    a) What are the opportunities to change what is not working well?
    b) What are the opportunities to build on what is working well?
    c) Generally, how would you like to see this program move forward?
    d) What is needed for these to happen?

5. Threats

    No organization or program is immune to outside events and forces.

    a) What do you see as the outside events/forces/conditions that pose a threat to the success of this program?
    b) If possible, how may these be addressed by yourselves, the agencies that you work for, the clients, the community that you live in or government? Adapted Community Tool Box http://ctb.ku.edu/en/tablecontents/sub_section_main_1049.aspx

Thank you for your participation in the ACAP evaluation.

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