Midwifery 30 (2014) 317–323

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

'No more strangers': Investigating the experiences of women, midwives and others during the establishment of a new model of maternity care for remote dwelling aboriginal women in northern Australia

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ARTICLE INFO

Article history:
Received 31 August 2012
Received in revised form
2 March 2013
Accepted 17 March 2013

Keywords:
Continuity of carer
Aboriginal
Australia

ABSTRACT

Objective: to describe the experiences of women, midwives and others during the establishment of a new model of maternity care for remote dwelling Aboriginal women transferred to a regional centre in northern Australia for maternity care and birth.
Design: a mixed method design within a Participatory Action Research approach was used. Qualitative findings are presented here. Data for this paper were collected from semi-structured interviews, field notes and observations and analysed thematically.
Setting: the 'top end' of the Northern Territory of Australia.
Participants: a total of 66 participants included six MGP midwives, two Aboriginal Health Workers and one Senior Aboriginal Woman working in the new model; eight hospital midwives; 34 Department of Health staff, three staff from other agencies; and 12 remote dwelling Aboriginal women who used the service.
Findings: the study generated one overarching theme, *it's not a perfect system but it's changing.* This encompassed improvements to the services evident to all participants. Core themes related to the previous maternity service which was described as *the arduous journey*, the new model was seen as *a new way of working* and a resultant *very different journey* occurred for Aboriginal women using the service.
Key conclusions and implications for practice: there was a dissonance between the previous culture of maternity services and the woman centred focus of the new model. Over 12 months initial resistance to the new model diminished and it became highly valued. The transfer of information between the regional service and remote community health centres improved as did the safety and quality of care. Aboriginal women can access continuity of carer in the regional centre for the first time and reported a more positive experience with maternity services. The new model appears to have changed the cultural responsiveness of the regional maternity service; and care provided for remote dwelling women within this service. The qualitative findings inform others seeking to implement a similar model of care for remote dwelling women transferred to a regional centre for birth.

Introduction

The Aboriginal population in the Northern Territory (NT) experiences a large burden of disease. Despite constituting only 32% of the NT population (ABS, 2011) they account for 60% of all Department of Health (DH) clients (DHF, 2008). Maternal and infant health (MIH) outcomes for this population are considerably worse when compared with their non-Aboriginal counterparts. Aboriginal women receive

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http://dx.doi.org/10.1016/j.midw.2013.03.012

less antenatal care, are twice as likely to smoke during pregnancy, have higher rates of teenage pregnancy, low-birthweight infants and are more likely to birth preterm babies (Tew and Zhang, 2010)

In Australia maternity care is predominantly hospital based and in recent years more intensely regionalised. While a minority of midwives work within this medically dominated context midwifery group practices and government funded home birth services have increased in recent years. Remote dwelling Aboriginal women in the NT are required to relocate at 36–38 weeks gestation to the regional centre to await birth (Department of Health and Families, 2009). The social, economic and cultural issues for remote dwelling women leaving their communities to give birth are well described (Panarettor et al., 2002; Watson et al., 2002a, 2002b; Barclay and Kildea, 2006; Kildea, 2006; Dunbar, 2011) and documented in a number of NT reports (NT DHCS, 1992; Kildea, 1999; Banscott Health Consulting Pty Ltd., 2007). At a 2006 workshop, led by researchers, policy makers, health practitioners and Aboriginal women met to explore how MIH services could be improved. Amongst other issues, the attendees' highlighted communication, choice, co-ordination of care, collaboration, and continuity of carer (the 5C's) as issues to be addressed (Barclay and Kildea, 2006).

Midwifery continuity of care/r is defined as ante, intra and postpartum care for a woman provided by a small team of midwives (team midwifery) or one midwife who works with a backup midwife, often in a small team (caseload midwifery) (Hatem et al., 2008; McLachlan et al., 2012). In Australia, caseload models where each woman has a known primary midwife are commonly referred to as Midwifery Group Practices (MGP) (Hartz et al., 2012). These models show significant improvements in MIH outcomes when compared to standard care and address women's specific needs, preferences and expectations (Page et al., 1999; Boxall and Flitcroft, 2007; Hatem et al., 2008; Hartzr et al., 2012).

In the 'top end' of Australia an MGP was established in the regional centre in response to a NT review of maternity services (Banscott Health Consulting Pty Ltd., 2007). It was informed by baseline research from a National Health and Medical Research Council (NHMRC) funded project led by the second author that investigated how the quality, cultural responsiveness and effectiveness of services during pregnancy and the year after birth could be improved. Baseline data from this study showed existing services were highly fragmented and of poor quality with 10% of women avoiding transfer to a regional centre for birth (Ireland et al., 2011; Bar-Zeev et al., in press). The morbidity and rate of hospitalisation of infants was extraordinarily high with admissions commencing early in life (Bar-Zeev et al., 2012). A research based evaluation of the MGP was commissioned by the Department of Health and extended data collected by the NHMRC project.

The MGP delivers a woman-centred model of care for women of all risk status. It aims to improve quality of care within a sustainable and culturally responsive caseload model of maternity care. Logistics and costs of travel appear to make the MGP unique in Australia as does its client group of Aboriginal women from remote communities. Women receive routine pregnancy care in their community with a remote area nurse/midwife or remote outreach midwives who visit from the regional centre as required and a locally based GP or specialist outreach obstetric service which visits three to four times a year.

The MGP comprises six full time equivalent (FTE) midwives; two FTE AHWs who are also enroled as Bachelor of Midwifery students, a Senior Aboriginal woman (SW) from one of the remote communities, a Co-ordinator and Administration Officer. The MGP team is based in a suburban shopping complex three kilometres from the regional hospital. The MGP midwives, AHWs and SW provide care if women are transferred to the regional centre during pregnancy, when they are transferred for birth and in the immediate postpartum period before they return to their communities. Care is provided to approximately 190 remote dwelling Aboriginal women who travel to the regional centre from seven remote 'top end' communities for maternity care each year. The midwives carry a caseload of three women per midwife per month (30–32 women per year). This caseload reflects both the physical health status and complex social circumstances of many of the women.

The goal of this paper is to describe the experiences of women, midwives and stakeholders during the establishment of the new model and to report the effect of the new model of care on the staff and agencies who deliver the service. Maternal and Infant Health outcomes, the role of Aboriginal workers within the model and quantitative data derived from validated instruments describing the effect of the new model on the midwives experience are reported elsewhere (Farrington and Kildea, 2011; Josif et al., 2012)

Method

Setting

The setting was the top end (TE) of the NT of Australia. Covering an area of 1420,970 km^2 the NT has a population of 227,900 people (ABS, 2011). One in three people (32%) are estimated to be of Indigenous origin (ABS, 2011) and four out of five Aboriginal people live in areas classified as remote or very remote (AIHW, 2011). The study was conducted at the largest regional hospital in the NT; the MGP rooms; and two remote communities each located approximately 500 km from the regional centre. Qualitative data were collected between September 2009 and October 2010.

Ethics

Ethics approval was granted by the Human Research Ethics Committee of the NT DH and the Menzies School of Health Research. A Plain Language Statement was provided to all participants and explained prior to commencement of the interview. Written informed consent was obtained from all participants.

Design

The overarching NHMRC study (2007–2012) and Department of Health commissioned evaluation that was undertaken in 2009–2010 drew on a pragmatic, mixed method design comprised of quantitative (clinical and costing data and questionnaires) and qualitative (interviews and observations) data collected concurrently. This allowed for a more comprehensive interpretation of complex research questions than either method alone (Cresswell and Plano Clark, 2007).

Participatory Action Research (PAR) allows researchers to study situations that are often messy, disorderly and proceeding by trial and error (McNiff and Whitehead, 2006). It allows researchers to clarify information and meaning in a cyclical fashion (O'Leary, 2005). An explicit PAR approach was used in the larger investigation and has just been published (Josif et al., 2012). Throughout the NHMRC funded project and the evaluation emerging issues were reported to a small evaluation committee that met nine times and a larger reference group that met five times to inform and modify the implementation of the practice. These groups comprised industry leaders, policy makers and service providers. Careful field notes and audit trails of this process were included in our analysis.

Recruitment

All MGP midwives staff ($n=6$) were invited to participate and agreed. Department of Health ($n=34$) and other Agency staff ($n=3$) were recruited purposively. Two participants from this