FROM HER TO MATERNITY

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A report to the VACCHO members and the Victorian Department Of Human Services about Maternity services for the Aboriginal woman of Victoria.

Written by Sandy Campbell
Project worker Koori Maternity Services Program
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ARTWORK BY LYN BRIGGS

The painting depicts the connections of all things mother earth gives us.

The Tree of Life stands strong giving shelter to mother and family.

All around the land provides good tucker and bush medicines providing nutrition and healing powers to mother and baby.

The footprints raising from the land represents the growth of the children throughout their life cycle 'growing strong and healthy' in mind and body when nurtured and care for.

'Health does not simply mean the physical well being of an individual but refers to the social, emotional and cultural well being of the whole community. For Aboriginal people this is seen in terms of the whole life view incorporating the cyclical concept of life – death – and the relationship to the land. Health carte services should strive to achieve the state where every individual is able to achieve their full potential as a human being of their community.'

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GLOSSARY

Aboriginal health workers	are a professional body of Aboriginal workers who perform a wide variety of functions to provide culturally appropriate primary health care services to Aboriginal people. These workers are usually employed in Aboriginal health services.
Anaemia	a condition in which there is a reduction of the number of red blood corpuscles (haemoglobin) in the bloodstream.
Antenatal care	medical surveillance and subsequent care occurring before birth.
Boorai	Aboriginal language term referring to pregnancy, babies and children.
Caesarean section	an operation to deliver a baby through an incision in the abdomen.
Diabetes mellitus	a chronic form of diabetes involving an insulin deficiency and excess of sugar in the blood and urine.
Gestation	pregnancy, under normal circumstances lasting between 37 and 42 weeks.
Gestational diabetes	diabetes precipitated by pregnancy.
Glucose tolerance test	a diagnostic test used in pregnancy to detect or rule out diabetes.
Hospital ALO	an Aboriginal liaison officer employed within a hospital to provide a range of services to Aboriginal clients.
Hypertension	abnormally high blood pressure
Intrapartum	physical procedures and emotional events that occur during labour
Koori	an Aboriginal person from South-Eastern Australia (Victoria and New South Wales)
Malpresentation	abnormal positioning of that part of the foetus that is lowest in the mother's pelvis (e.g. breech presentation - buttocks first).
Maternal/Maternity	pertaining to the mother.
Maternity service	a service providing care to women during pregnancy and childbirth.
Midwife	a person formally qualified and registered in a State or Territory to practice midwifery.
Midwifery	the theory and practice associated with the care provided by qualified midwives for childbearing women and their babies.
NH&MRC	the National Health and Medical Research Council. The NH&MRC is a statutory body which advises the community and Commonwealth, State and Territory Governments on standards of individual and public health.
Obstetrician	a medical doctor who specializes in obstetrics.
Obstetrics	the branch of medicine concerned with the care and treatment of women in pregnancy and childbirth.
Parity	relates to the number of times a women has given birth.
Postnatal	occurring after birth and referring to mother and/or baby.
Pre-term	occurring before a pregnancy is at term (that is before 37 weeks gestation).
Proteinuria	the passage of more then minimal amounts of protein in the urine.
Shared antenatal care	the provision of antenatal care that is shared. Generally, some care is provided by hospitals and the remainder by community based professionals (e.g. general practitioners or Aboriginal health service.
Ultrasound scan	a diagnostic test performed using ultrasonic waves used to examine the interior organs and structures of the mother and foetus.
VACCHO	the Victorian Aboriginal Community Controlled Health Organisation.
Well Womens Clinic	a womens health service that provides holistic care, health information, health screening, health counselling, advocacy and appropriate referral.

EXECUTIVE SUMMARY

The Victorian Aboriginal Community Controlled Health Organization is funded to develop the Koori Maternity Services Program. A project worker was appointed to identify characteristics of current maternity services available for Aboriginal women in Victoria. Attention is given to identifying strengths as well as areas for improvement in prevailing systems and practice. A particular focus of the project is to acknowledge gaps in service provision, and to identify the strengths and weaknesses in current inter-agency planning and processes. In addition the project has sort to identify strategies and feasible models of maternity care which will enable culturally appropriate maternity service provision within Aboriginal communities.

The final report of the Ministerial Review of Birthing Services in Victoria (1990: Health Department, Victoria) included the following recommendation:

Recommendation 32
In support of the National Aboriginal Health Strategy, action should be taken to:

- **maintain the role of Aboriginal health workers and liaison officers in hospitals servicing an Aboriginal population;**
- **ensure the continuing involvement of female Aboriginal health workers in the provision of antenatal and postnatal support for Aboriginal women;**
- **investigate the development of education programs on birthing issues for health workers of Aboriginal background, with an emphasis on antenatal and postnatal care; and encourage the participation of Aboriginal women in the planning of health services and the establishment of different models of care.**

This recommendation remains valid for Aboriginal communities around Victoria in the year 2000. The Koori Maternity Services Program presents an opportunity for Aboriginal community controlled health organizations to fulfil or further this key recommendation.

The Koori Maternity Services Program project was presented to the VACCHO membership near its outset. At the statewide meeting held at Wodonga in June 1999, members expressed the view that the available funds were inadequate for effective maternity service provision in all communities. There was a consensus that maternity services for Aboriginal women in Victoria need adequate resources to achieve effective and sustainable implementation at a community level. It was acknowledged that some Victorian Aboriginal communities would not benefit from the Maternity Services Program.

Extensive consultations with community members from Victorian Koori communities have informed the development of key recommendations for the allocation of Koori Maternity Services Program funds. This report details these recommendations for the distribution of resources to Aboriginal health services to enhance maternity services available to the Aboriginal communities of Victoria. The recommendations have further been developed to complement mainstream hospital-based strategies that target Koori women.

Circumstances (related to maternity services) existing in and affecting each Aboriginal community involved in the project are outlined. Explanations of historical and environmental factors instrumental in the construction of current circumstances are included. Options for addressing deficits are proposed and are intended to facilitate the implementation of effective, sustainable and culturally appropriate Aboriginal community controlled maternity services.

Over the coming years, the implementation of the Koori Maternity Services Program will be guided by a reference group of Aboriginal women. The services will be planned, implemented and developed at a community level, by Aboriginal people, for Aboriginal people. These services will not supplant or duplicate existing mainstream initiatives. The aim of the program is to create co-operative partnerships that enable the Aboriginal women of Victoria to access the best possible maternity care. We endeavour to achieve and maintain a standard of excellence.

1. THE CONSULTATION PROCESS

1.1 INTRODUCTION

This section gives an overview to Aboriginal community members and other readers, of how the Koori Maternity Services Program project progressed, who was involved in the consultation process and how the recommendations within this report were formulated.

1.2 GATHERING INFORMATION

A principal focus of the project has been the development of community health plans based on an analysis of data gathered through consultation with Aboriginal people around Victoria. (See Appendix vi) Other data used to establish these community health plans includes estimated Aboriginal birth rates around the state. These figures are not accurate (see 3.4 The Problem With Statistics in Aboriginal Health) and are only used to gauge approximate birth rates.

Aboriginal communities need reliable statistics regarding the Koori birthrate, levels of access to antenatal and postnatal care and factual data regarding birth outcomes. This information is not available in a suitable (accurate) form within Victoria. Implementation of the Koori Maternity Services Program will enhance the collection of valuable health statistics, however improved data collection processes and practices by all providers of health services in Victoria is imperative.
The Koori Maternity Services Program project has involved talking to women about issues surrounding their experiences of pregnancy, childbirth and the care of newborn Aboriginal babies.

In the first instance, interviews were arranged with Aboriginal health workers and hospital based Aboriginal liaison officers in each community (when Aboriginal Liaison Officers were not available they have been contacted by phone). The appropriate health workers are predominately women, themselves mothers and community members. Interviews were conducted with groups of community women and with individuals. These interviews were held in any setting deemed appropriate by the women. For instance; discussions have taken place at Aboriginal community lunches and barbeques, women's health days, women's health meetings and out and about in the wider community (e.g. shopping centres).

Providers of maternity services at hospitals and community health centres (if identified by the local Aboriginal community as preferred service providers) were consulted in each location. These discussions have been with nursing staff of maternity wards and delivery suites (usually midwives), community health nurses, maternal and child health nurses, hospital unit managers and hospital managers. Regional representatives of the Department of Human Services have been contacted. Public health experts representative of La Trobe University and Melbourne University have been generous with their individual contributions to the project.
In all, over 230 people have been directly involved in the consultation process of the Koori Maternity Services Program. Information gathered has been recorded in handwritten diaries. Issues of confidentiality, both for individual participants and for community organizations have been considered a priority throughout the project and in the writing of this report.

Data has been gathered by asking Aboriginal women questions such as:

- How many pregnancies have you had?
- If you had antenatal care during your last pregnancy, at what stage of pregnancy did you first access antenatal care?
- How many antenatal check-ups did you have during your last pregnancy?
- What are the reasons you had no/very little antenatal care?
- Are there things that would make antenatal care easier to access in the future?
- Do you know what the blood tests taken during pregnancy are for?
- Do you think antenatal care is important? Why or why not?
- Can you tell me what you thought was good about the care you received at the hospital?
- Do you think your hospital experience could be improved? If so, what would have made it better?

1. THE CONSULTATION PROCESS

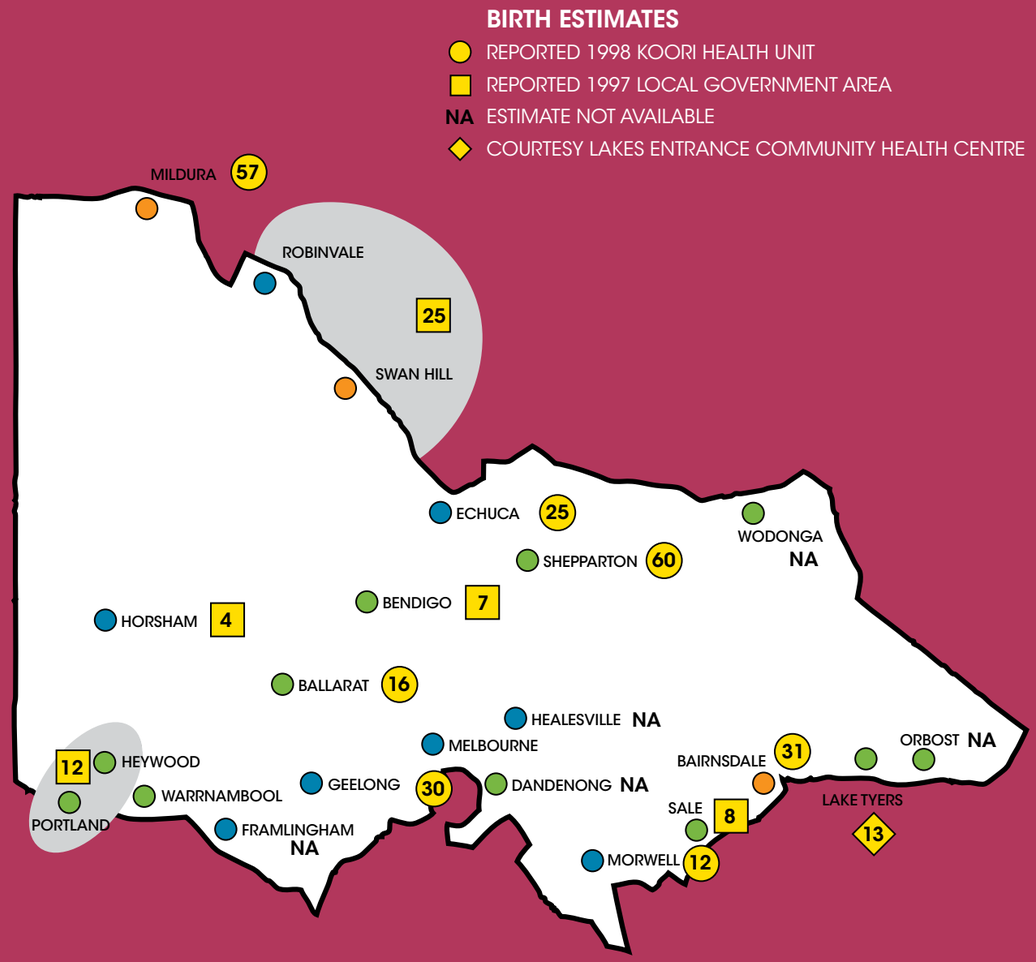
1.2 GATHERING INFORMATION

These questions yield responses that form a significant body of evidence that concern issues of accessibility of services, appropriateness of services, gaps in service provision and strengths and weaknesses inherent in current services.

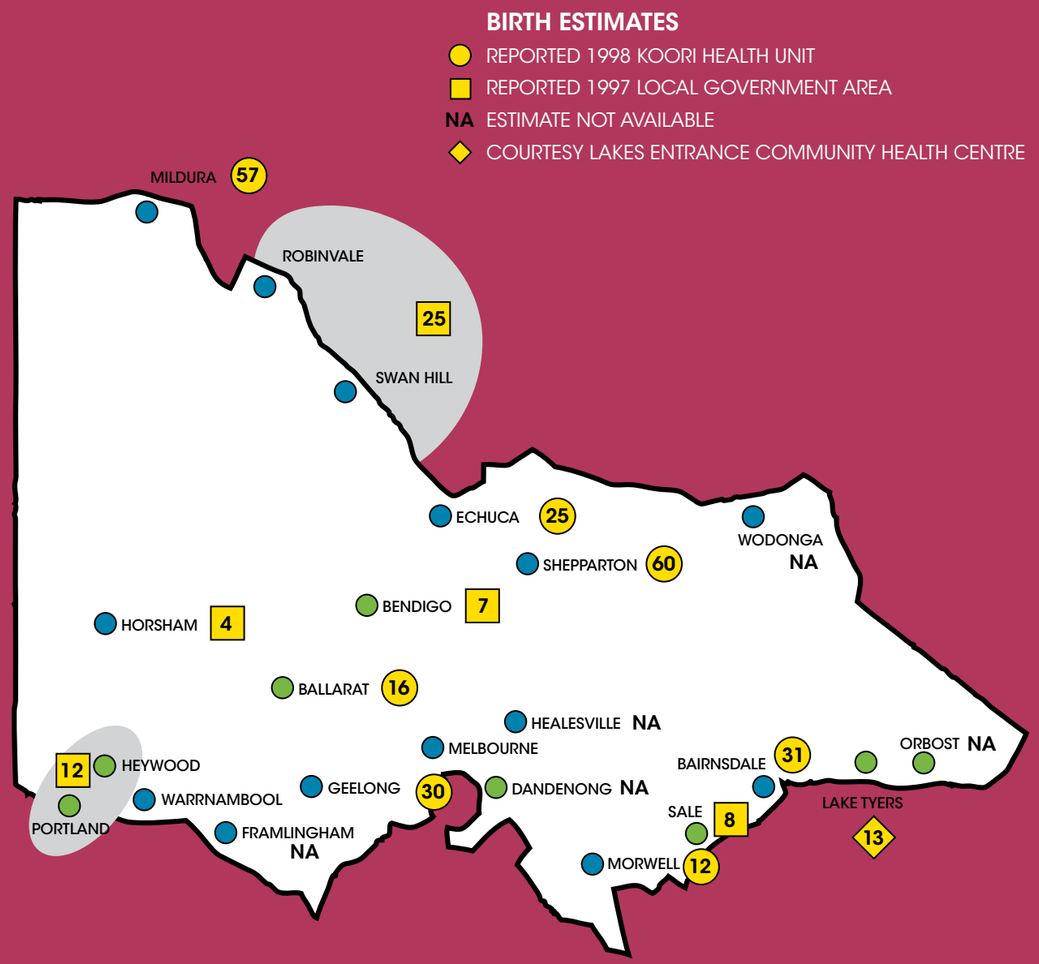
Aboriginal health workers and hospital Aboriginal liaison officers around the state (while not usually specialising in the area of pregnancy) are extremely well informed about current practices of both clients and care providers with regard to maternity services in their locality. Often these workers have been committed to their role in improving the health of their people for many years. They have provided compelling evidence concerning obstacles, as well as strategies to address access issues with regard to maternity services for Victorian Aboriginal women.

The recommendations in this report are reflective of available statistical data (e.g. estimated Aboriginal birthrates, level of current maternity service provision in each area), combined with community perceptions (e.g. of difficulties in access to services, of environmental factors affecting health in the local community) and individual experiences (e.g. of a mother's birthing experience).

APPENDIX I
CURRENT LEVEL OF MATERNITY SERVICE PROVISION AVAILABLE TO VICTORIAN ABORIGINAL COMMUNITIES



APPENDIX II
PROJECTED LEVEL OF MATERNITY SERVICE PROVISION AVAILABLE TO VICTORIAN ABORIGINAL COMMUNITIES



2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.1 INTRODUCTION

This section gives an overview to Aboriginal community members and other readers, of how the Koori Maternity Services Program project progressed, who was involved in the consultation process and how the recommendations within this report were formulated.

There is currently no Aboriginal community in Victoria with an adequate level of resources to offer a maternity service that is both culturally appropriate and complete. Some communities have achieved a great deal in establishing maternity services, though each is constrained when unable to meet identified needs. Communities described in this report as having appropriate maternity services will continue to strive for improvements and to address shortcomings that adversely affect the implementation of otherwise successful health programs. The resources provided by the Koori Maternity Services Program will not address all identified shortfalls in all Victorian Aboriginal communities.

The following is a compilation of short summaries of the circumstances and governing factors influencing access to maternity services at each Aboriginal community involved in the Koori Maternity Services Program. To enhance clarity for readers, communities have been placed into one of three general categories. Analysis of data collected in each Victorian community has enabled an assessment to identify:

I Communities with a **lack** of appropriate maternity services,
II Communities with **some** appropriate maternity services,
III Communities with **existing** appropriate maternity services.

Maps are included to give readers a broad picture of the prevailing circumstances in Victorian Aboriginal communities.

Information regarded as internal community business will not be included. Those wishing to access more detailed information about a particular Aboriginal organization or community are advised to submit a formal request directly to that organization or community.

Readers will notice inconsistencies in estimated birth rates in some locations. These discrepancies have a number of possible causes. For instance; women are often denied the opportunity to identify as Aboriginal where hospital staff members are reluctant to ask this mandatory question. Stereotypical preconceptions of what Indigenous women should look like and how they should behave further complicates attempts to gather accurate health statistics about Aboriginal women and their babies. Aboriginal women who have experienced racism or other indignities in hospitals may choose not to identify themselves. In regions where there is no Aboriginal Liaison Officer employed at the local hospital (to record and report Aboriginal births) the information may never become available to Aboriginal communities.

2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.2 THE STATE OF AFFAIRS IN EACH COMMUNITY

I VICTORIAN ABORIGINAL COMMUNITIES WITH A LACK OF APPROPRIATE MATERNITY SERVICES

MILDURA

There were 60 reported births of Aboriginal babies in Mildura during 1998.

The **Mildura Aboriginal Corporation** employs Aboriginal health workers, an Aboriginal registered nurse and provides a range of health services to the local Aboriginal community. The community does not currently have the resources to offer a maternity service of any kind. A medical officer is available within the organization for two afternoons a week (this position is not funded by the Aboriginal organization). An Aboriginal Liaison Officer is employed at the hospital. This Liaison Officer reported a total of 1032 Koori admissions to the Mildura base hospital during 1998.

Choice of mainstream services is limited in Mildura. The hospital where women attend to have their babies does not offer an antenatal clinic (hospital staff indicated that Mildura Base hospital will come under private management during 2000. The implications of hospital privatisation for the provision of maternity services are not known). Aboriginal women on low incomes bear the onus of seeking out antenatal care providers in the town who are willing to provide a bulk-billing service. Access to contraception is not available via the medical service at their community organization.

The Mildura area has one of the highest Aboriginal birth rates in the state. Border issues complicate service provision with a considerable Aboriginal population base situated in New South Wales seeking services on the Victorian side of the border. Reports from Aboriginal community members and from staff of mainstream maternity services acknowledge that many Aboriginal women do not access adequate antenatal care; inadequacies range from no antenatal care to fragmented care. They do not receive antenatal care to the recommended standards set down by the National Health and Medical Research Council of Australia.

Mildura is an isolated area with one of the greatest needs in terms of the number of babies born, complexities created by border issues, the lack of a well resourced maternity service within the Aboriginal community and the gaps in current mainstream service provision.

The Mildura Aboriginal community needs a comprehensive maternity service. The service will be most successful if a clinical midwife/nurse practitioner is employed part-time to work alongside a full-time Aboriginal health worker. Together, a midwife and health worker can provide a comprehensive screening, referral and health promotion maternity service for Aboriginal women in the Mildura region.

SWAN HILL

There were 14 Aboriginal births reported at the Swan Hill hospital during 1998.

There is currently no appropriate maternity service operating for Aboriginal women in Swan Hill.

A highlight of the service offered by midwives at the Swan Hill hospital is the twenty-four hour, seven days a week 'open door' policy. Mothers can return to the hospital at any time after discharge and their needs will be assessed on the maternity ward. This policy will be advantageous to the Swan Hill Aboriginal community throughout the process of implementing a community/maternity service.

General practitioners provide antenatal care, in Swan Hill. None of the doctors were available for consultation with regard to this program. Time constraints are frequently a controlling factor for rural general practitioners and as such will have an effect on the type of maternity services they can provide.

Staff members at the **Swan Hill & District Aboriginal Co-operative** have established linkages with a number of the local medical officers. An Aboriginal Liaison Officer is available at the local hospital.

The Swan Hill Aboriginal community stands to gain a great deal by implementing a maternity service able to build on established links between the Co-op and mainstream providers.

BAIRNSDALE

There were 31 Aboriginal births reported at Bairnsdale hospital during 1998.

The local hospital has been providing a visiting midwife to the medical centre at **Gippsland & East Gippsland Aboriginal Co-operative** since February 1999. She is available to provide clinical care during pregnancy. This initiative is starting to become more effective because a health worker is now available to work with her during the weekly visits.

Most accounts suggest that Aboriginal women in the area are not currently accessing recommended standards of antenatal care.

Bairnsdale has a high Aboriginal birth rate and the community would benefit by establishing a maternity service that employs a full-time Aboriginal health worker. The aims would be to enhance linkages with the local hospital, to advocate for clients and to promote health in pregnancy in the community.

II VICTORIAN ABORIGINAL COMMUNITIES WITH SOME APPROPRIATE MATERNITY SERVICES

WARRNAMBOOL

An accurate estimate of the Aboriginal birth rate at Warrnambool hospital is not available. There were 4 births reported; however, community members dispute this figure.

Gunditjmara Aboriginal Co-operative has secured resources that will only partially address needs related to maternity services. An effective relationship between the Warrnambool hospital and the Aboriginal community is furthered by the presence of an Aboriginal liaison officer at the hospital.

The community is requesting resources to complete their plans for maternity service provision. They require program running costs and access to a vehicle to enable the provision of an Outreach service.

MOOROOPNA/SHEPPARTON

There were 60 reported Aboriginal births at the Goulburn Valley hospital during 1998.

The provision of an appropriate maternity service has been a priority at the **Rumbalara Aboriginal Co-operative** for a number of years. A sole pregnancy health worker has been instrumental in establishing a comprehensive maternity service that is effective and well utilised by the Aboriginal community. Strong linkages have been forged between the Co-operative and mainstream service providers.

Members of the Mooroopna/Shepparton community believe their maternity service can be improved, with additional workers. The services of another full-time health worker and a registered midwife will result in an ideal level of staffing. At the time of writing, an independent consultant is evaluating this service.

This area has one of the highest Aboriginal birth rates in the state.

2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.2 THE STATE OF AFFAIRS IN EACH COMMUNITY

WODONGA

The Wodonga hospital has employed an Obstetric Aboriginal Liaison Officer to provide services to the Aboriginal community of Wodonga and surrounding areas. There have been ongoing issues surrounding who is responsible for funding the position of a sole Aboriginal worker within the hospital.

The service is well established and if it is to be maintained it will require some resources from the Koori Maternity Services Program.

This position is well supported and valued by both the hospital and **Mungabareena Aboriginal Corporation**.

Choices of mainstream services are limited in Wodonga. Major barriers for Aboriginal women are related to the cost of accessing specialist services. There are no obstetric specialists providing a bulk billing service. One general practitioner in the area (who provides maternity services) provides a bulk billing service.

BALLARAT

There were 16 reported Aboriginal births during 1998.

Aboriginal women in Ballarat have the option of using the Little Clinic as their primary maternity service provider. This impressive midwifery based model of care has been planned to address the needs of young women as well as Aboriginal women. There is no Aboriginal worker involved in formal employment though there is considerable communication between the Little Clinic and the **Ballarat and District Aboriginal Cooperative**.

Reports from both organizations and from the hospital Aboriginal Liaison Officer recognised that maternity care would be enhanced by the presence of an Aboriginal maternity health worker.

PORTLAND

It was reported that 6 Aboriginal babies were born at the Portland hospital in 1998.

The Portland hospital employs an Aboriginal Liaison Officer who plays a significant role in improving access for Aboriginal women in the area. Portland has the services of a part-time (22 hrs per week) Aboriginal health worker whose position is administered by **Winda-Mara Aboriginal Co-operative** at Heywood.

Portland Hospital has received some general Maternity Services Program funds that will resource targeted maternity programs for Koori women. A hospital worker is currently consulting with Aboriginal communities in the area with regard to how these resources should be allocated. There has been some indication that a clinical midwifery outreach service may become available for Aboriginal women. To enhance the effectiveness of such a service an appropriate Aboriginal health worker should be involved in the project at all stages.

HEYWOOD

The birth rate of Aboriginal babies for the Heywood area is not known.

The Aboriginal women of Heywood have their babies at Portland (a distance of 29 kilometres from Heywood), Hamilton (59 kilometres) or Warrnambool (100 kilometres) hospitals. Antenatal care is available with local general practitioners. **Winda-Mara Aboriginal Co-operative** employs a part time (22 hours per week) female Aboriginal

health worker. The above-mentioned funds received by Portland hospital are also intended for Maternity service provision at Heywood.

SALE

There is no Aboriginal liaison officer at Sale hospital (Gippsland Base Hospital) and the number of Aboriginal births is not known. In 1997 there were 8 Indigenous births in the Wellington local government area in which Sale is situated The Sale hospital has no antenatal clinic available and antenatal classes are provided at a cost. Midwives at the hospital reported that the Aboriginal women they care for generally presented themselves for delivery with evidence of having had a good level of antenatal care.

Community workers identified the Clock Tower clinic as one of the preferred general practices for women seeking outpatient maternity services. Staff members at the Clock Tower clinic were amenable to establishing stronger links with the Aboriginal community.

The **Ramahyuck District Aboriginal Co-operative** employs a female Aboriginal field officer who performs an advocacy and liaison role in the area of women's health. The community has identified a need for a 'family services' worker in the area.

BENDIGO

There was 1 Aboriginal birth reported at the Bendigo hospital during 1998. Community members dispute this figure believing it to be a significant underestimate. During discussions at Dja Dja Wrung Aboriginal Association, the three Aboriginal women in the room were able to name at least four births that they knew of personally. Local government figures for 1997 reported 7 Aboriginal births in the Greater Bendigo area.

The **Dja Dja Wrung Aboriginal Association** is currently undergoing changes that will enable the service to provide a significant clinical component under the umbrella of their association. The community is negotiating with mainstream providers to gain the services of doctors and registered nurses.

LAKE TYERS

Lake Tyers Aboriginal Trust employs a full-time female Aboriginal health worker and a registered nurse. A visiting midwife is provided by the Bairnsdale hospital for 2 hours every eight weeks. A doctor visits Lake Tyers three days per fortnight. A maternal and child health nurse and Aboriginal health worker team provide their services for 5.5 hours each week at Lake Tyers and for 3.5 hours per week at the Lakes Entrance Community Health Centre.

There were 13 Indigenous births in the area between June 1998 and June 1999. (Courtesy of Lakes Entrance Community Health Centre maternal health records)

Transport and lack of resources (e.g. baby capsules) were identified as major issues for the workers at Lake Tyers. The community at Lake Tyers is spread over a large area and distances between houses and the health centre are considerable. Lake Tyers Aboriginal Trust is situated 28 kilometres from medical services at Lakes Entrance.

DANDENONG

Bunurong Medical Service employs two full-time female Aboriginal health workers. There is no targeted maternity service operating from the Aboriginal medical service. The Aboriginal birth rate for the Dandenong area is not known. With additional resources (e.g. specific health worker education and training, transport to provide an outreach service and program running costs) a maternity service could be established with current staffing levels.

ORBOST

There are no Indigenous birth statistics available from the Orbost region.

A **Moogji Aboriginal Council** worker and a local Maternal and Child Health nurse believe that mainstream services are adequate and appropriate for the community at Orbost.

The circumstances at Orbost will continue to be monitored by the Koori Maternity Services Program. Significant changes (for example; in the size of the Aboriginal community at Orbost) will lead to re-evaluation and perhaps re-allocation of resources

2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.2 THE STATE OF AFFAIRS IN EACH COMMUNITY

III VICTORIAN ABORIGINAL COMMUNITIES WITH APPROPRIATE MATERNITY SERVICES

ROBINVALE

There were 5 Aboriginal births reported during 1998. Community members estimate a birth rate of 22 during 1998. There is a significant Indigenous Islander population in the Robinvale region.

The Robinvale Aboriginal community has had an effective maternity service in the past. A successful maternity service pilot project was dismantled in the early 1990's when program funding was discontinued.[10] Access issues are complicated for women in Robinvale because they are required to travel to Mildura to make use of specialist maternity services. Transport for transfers from Robinvale to Mildura (85 kilometres) is a service usually provided by the **Murray Valley Aboriginal Co-operative**. The local hospital provides a number of services both at the hospital (antenatal clinic) and at the Aboriginal Co-operative (maternal and child health). The community has the services of a female doctor at their health centre. Women are transferred to Mildura for delivery.

The Aboriginal community at Robinvale is in a position to support and sustain the implementation of a holistic maternity service at the **Murray Valley Aboriginal Co-operative**. The priorities are furthering linkages with mainstream providers, health promotion through education and information sharing, and advocating for clients as required ensuring women are offered the best available care in the area.

At the VACCHO Annual General Meeting and members meeting held in Melbourne during December 1999, the **Murray Valley Aboriginal Co-operative** reported that the Robinvale community had submitted a proposal to acquire federal resources so that they can provide the services of a paediatrician and a midwife. At the time of writing a community midwife has been employed by the **Murray Valley Aboriginal Co-operative**.

FRAMLINGHAM

The community at Framlingham employ a registered nurse and Aboriginal health workers. Their health service holds regular medical clinics provided by a general practitioner.

Accounts from health workers and community members indicated that they are satisfied with the current level of service existing at the **Kirrae Community Health Service**.

HORSHAM

Goolum Goolum Aboriginal Co-operative has accessed federal resources to employ a worker whose primary focus is the care of women and their children from the age of 0-5 years. This position includes an advocacy and linkage role to improve access to mainstream maternity services for the women of the community. Antenatal and postnatal care is available from general practitioners in the town.

Community members estimate that there are approximately 10 Aboriginal births per year at Horsham.

There is an Aboriginal Liaison officer situated at nearby Dimboola hospital. There were 6 Aboriginal births reported at this hospital in 1998.

ECHUCA

There were 25 Aboriginal births reported at Echuca hospital in 1998.

The **Echuca Health House** has for some months had the services of a visiting midwife from the Echuca hospital. A maternity clinic is held each week at the Health House. All accounts suggest that this is an effective service for the women of the area (which includes women from across the Victorian/New South Wales border).

HEALESVILLE

There are currently no health programs running from the **Coranderrk Koori Co-operative**. The mainstream maternity care provider in Healesville (Yarra Ranges Health Service) employs a male Aboriginal health worker. An Indigenous midwife works in the area and is keen to provide her services to the local community. Holistic service provision by this midwife will be enhanced if she is trained in Reproductive and Sexual Health. This short course is available at Family Planning Victoria.

GEELONG

There were 20 reported Aboriginal births at the Geelong hospital in 1998.

The Aboriginal community in Geelong is in the fortunate position of having an Aboriginal midwife employed at the Geelong hospital. A partnership between the hospital and **Wathaurong Aboriginal Co-operative** has resulted in the provision of a limited though effective maternity service by this Aboriginal midwife.

Wathaurong wants to extend this midwifery role to enhance holistic service provision. It has been recognised that this will be achieved by equipping their identified midwife with a nurse practitioner qualification in Sexual and Reproductive Health from a short course at Family Planning Victoria. Their organization will then provide a clinical midwifery and well women's service.

Linkages to the Geelong hospital are further enhanced by the presence of an Aboriginal liaison officer.

FITZROY

The **Victorian Aboriginal Health Service** provides a maternity service that was established with federal resources. The Koori Maternity Services Program now recurrently funds the service.

Two full-time Aboriginal maternity health workers and a part-time registered midwife are employed in the program. The midwife position is now formally recognised as a Shared Care Provider by major Melbourne obstetric hospitals. The program is comprehensive and flexible and a great deal of client care is achieved with an effective outreach service. The primary focus is to enable the provision of holistic health care for Aboriginal women and their families.

Maternity care provided by the Victorian Aboriginal Health Service (Women's and Children's Area) follows the Clinical-Linkage-Advocacy-Health Promotion Maternity Service Model described within this report.

MORWELL

The Aboriginal community at Morwell has an effective midwifery based maternity service. This was originally an Alternative Birthing Service project funded by the federal government. The Koori Maternity Services Program now provides recurrent resources for the program. Funds for the program are currently administered by the La Trobe Valley Community Health Centre, though the service operates primarily out of **Central Gippsland Aboriginal & Housing Co-Operative**, Morwell.

An outstanding characteristic of the Morwell program is the continuity of care provided by an identified midwife. Holistic care is available during the antenatal period, throughout labour and delivery and in the postnatal period. All accounts suggest this is a service that is greatly valued by the Aboriginal community.

2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.3 THE CLEAR MESSAGES

It is clear that many Koori women are not aware of their high-risk status during pregnancy (See 3.5 for an explanation of risk factors). Women often view their pregnancy as a natural process that requires no medical intervention until labour and delivery. Many Aboriginal women have limited knowledge of the benefits of antenatal care or of what level of care is required to meet the national standards for antenatal care recommended by the National Health a~3 Research Council of Australia.

There are considerable obstacles faced by Aboriginal health workers as they attempt to assist their clients to access appropriate antenatal and postnatal care. Choices for Aboriginal women are often severely limited by gaps in service provision and weaknesses in current services.

Three themes were repeatedly raised by Aboriginal people in the extensive consultations throughout this project. The major themes were:

I Aboriginal community control.

II The need for provision of holistic health care.

Hi A call for recognition of diversity within and between communities in Victoria.

The following discussion highlights the importance of these principles and addresses **Aboriginal community control** in the provision of **holistic health care** which recognizes, respects and reflects **diversity** within and between each Aboriginal community in Victoria.

2.4 PROBLEMS WITH ACCESS TO MAINSTREAM SERVICES

There are common views between communities about the level of accessibility of health services for Aboriginal women seeking care during pregnancy and the immediate post-natal period. Many women described mainstream facilities offered outside Aboriginal community controlled organizations as not compatible with Aboriginal usage. Issues included a perceived negative attitude of hospital staff members, a lack of Aboriginal staff in hospitals, decor devoid of Aboriginal artwork and a lack of information about existing Aboriginal services. Many Aboriginal people described their under-utilisation of mainstream services as a result of the services' failure to address their needs.

Saggers & Gray suggest the following reasons to account for the inaccessibility of mainstream organizations:

- the cultural chasm between Aboriginal patients and health care providers
- the impersonal nature of clinics
- the presence of relatively large numbers of non-Aboriginal people
- the operation of rules which are more convenient for staff than for the benefit of patients
- providers are often judgmental and authoritarian
- common paternalistic, if not racist attitudes which they themselves do not recognise.

Elders of the Victorian communities remember hospital policies that refused treatment to Koories or segregated Aboriginal patients in hospital accommodation. Health policies of the past were designed to 'protect' non-Aborigines from contact with Aboriginal people. These hospitals are the same institutions that participated in government policies of child removal from Aboriginal families. Clearly past 'special provisions' made by hospitals for Aboriginal people were not in any way beneficial to Aboriginal people. Not surprisingly, many Koories perceive hospitals as places of sickness, death and grief rather than places of healing.

Despite this knowledge nearly all Aboriginal women in Victoria have their babies in public hospitals. Sometimes their first presentation at the hospital will be in the first stage of labour. Midwives working in delivery suites around Victoria report that they regularly encounter Aboriginal clients whose antenatal care is non-existent or so minimal that not even a baseline assessment of their health status exists.

It has been established that Aboriginal women have 'high risk' pregnancies (again see 3.5 Aboriginal Women: A 'High Risk' Group). Their level of risk is such that ideally these women will have access to the best possible care. They require vigilant assessment early in pregnancy. They require careful screening at regular intervals throughout pregnancy. Where more than minor complications exist or arise, referral to an appropriate specialist should be swift. To decrease the known risks, Aboriginal women in Victoria need maternity care that affords opportunities to offer preventative measures and intervention as necessary. It must be affordable, accessible and presented in a form that is appropriate for Aboriginal women.

2.5 EXISTING MODELS OF MATERNITY CARE PROVIDED

A BY ABORIGINAL COMMUNITY CONTROLLED SERVICES

B IN PARTNERSHIP WITH ABORIGINAL COMMUNITY CONTROLLED SERVICES

Effective models of maternity care do exist within some community controlled organisations in Victoria. These services are highly used. The **Victorian Aboriginal Health Service**, Fitzroy, and **Rumbalara Aboriginal Co-operative** at Mooroopna have developed two such services. Each has been planned and implemented by the community it is designed to service. Both services offer antenatal and postnatal care programs that include client education. Workers in the programs have been successful in establishing strong links with key mainstream maternity service providers in their areas. Flow charts illustrating the operation of these two models of care can be found at Appendix IV and V.

The Morwell Aboriginal community now has access to a targeted maternity service. The community employs a community-based midwife specifically to provide care for Aboriginal families of the region. Funds for the service are currently administered through the La Trobe Valley Community Health Service, while it operates primarily from the **Central Gippsland Aboriginal Health & Housing Co-operative**. This service is comprehensive and provides a high level of continuity of care. It is valued and well utilised by the Morwell Aboriginal community.

A partnership between mainstream services and communities can also create an accessible service for Aboriginal women. An Obstetric Aboriginal Liaison Officer at the Wodonga Regional Health Service was appointed after extensive consultation with the Aboriginal community of Albury/Wodonga. The Aboriginal worker specialises in obstetric care and the target group is Aboriginal families during the antenatal and postnatal period. The major aims of this service are:

- To increase the awareness of the health organisations regarding cultural and other needs of Aboriginal families during the antenatal and postnatal period.
- To increase Aboriginal community awareness of services available during the antenatal and postnatal period.
- To improve the health and wellbeing of Aboriginal families during the antenatal and postnatal periods.

There are constraints to the implementation and effectiveness of these services. They include limits on available funds and complexities related to communicating and collaborating with key mainstream services. After a lengthy period of negotiation between organisations, the midwife position at the **Victorian Aboriginal Health Service** has eventually been credentialed as a Shared Care Provider by two major metropolitan obstetric hospitals. It is hoped that supportive and collaborative partnerships such as this one will offer a sanctioned and streamlined service for Aboriginal women that increases care continuity and allows them better access to mainstream services.

2. CIRCUMSTANCES AND GOVERNING FACTORS INFLUENCING ACCESS TO MATERNITY SERVICES IN VICTORIAN ABORIGINAL COMMUNITIES

2.6 MAJOR BARRIERS TO SERVICE IMPLEMENTATION

Aboriginal workers involved in the delivery of maternity services report a range of obstacles they have had to overcome in order to create an appropriate service for the women of their community. The grass roots workers involved in each service strive for continual improvement, and the achievements of these communities have been quite remarkable.

Some Aboriginal communities currently have access to resources that only partially address needs related to maternity services. In these instances community members have suggested combining existing resources with funds from Koori Maternity Services Program in order to complete service provision. This is the case for communities at Warrnambool, Wodonga and Mooroopna/Shepparton.

A visitor to **Rumbalara** (Mooroopna) on antenatal clinic day will find a clinic brimming with expectant mothers. This maternity program was established in March, 1992 and its operation relies heavily on one dedicated full-time pregnancy health worker. The service is effective in principle and operation but would benefit from resources to employ an additional pregnancy health worker and the services of a midwife.

The maternity service at the **Victorian Aboriginal Health Service** is part of the broader Koori Women's and Children's Health Program (established in March, 1996). Here women are presented with a holistic service that offers a midwifery/health worker Shared Care antenatal and postnatal service. Women can access a Well Women's Clinic where Aboriginal health workers and a nurse practitioner/midwife can attend to their needs. The service is flexible, | has a strong outreach component, offers a good level of continuity of care, and generally no appointments are necessary.

The efficacy of community-based models of maternity care can be compromised by poor relationships between Aboriginal services and mainstream institutions (usually public hospitals where women deliver their babies). These issues are important because they stand as barriers to the implementation of new maternity services being planned by Aboriginal communities around Victoria. The Koori Women's and Children's Health Program at the **Victorian Aboriginal Health Service**, and **Rumbalara's** maternity service are examples of successful collaboration and partnerships between Aboriginal community controlled services and mainstream services.

Discord between organisations that provide maternity services is an extension of conflicts between professional bodies of employees involved in the provision of obstetric care (namely midwives, Aboriginal health workers, general practitioners and obstetricians). The provision of health care in Aboriginal communities is clearly a political issue. Additionally, the question of who can provide health care during pregnancy has been the subject of debate in recent years. Providers of existing traditional medical services are reluctant to let go of ineffective forms of care or to accept new models of care.[19] While there is no legal barrier to offering midwifery-based maternity services; there are enormous institutional barriers. The basis of institutional barriers is the conflict that arises when professions (midwives and Aboriginal health workers) challenge the dominant conventional model of care. However, as indicated above it is possible to overcome these barriers through negotiation and collaboration in equal partnerships.

Collaboration between Aboriginal communities, Aboriginal health workers, midwives, obstetricians and general practitioners, staff in maternity hospitals and other relevant services is of crucial importance in achieving an excellent standard of maternity care for Aboriginal women. All these individuals and organisations are key stakeholders and| essential participants. Each has a unique and equally important role to play in service provision.

3. OTHER RELEVANT INFORMATION

3.1 INTRODUCTION

This section provides information that will enhance the understanding of the varied complexities within Aboriginal community health issues. It provides details of the key stakeholders in Koori health, factors affecting Koori women's health status and the influence of mainstream and Koori health services in addressing health issues. It is primarily directed toward non-Indigenous readers.

3.2 VICTORIAN ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

It is not merely a matter of provision of doctors, hospitals, and medicines. Health to Aboriginal peoples is a matter of determining all aspects of their life including control over their physical environment, of dignity, of community self-esteem, and of justice.

National Aboriginal Health Strategy Working Party, 1989.

VACCHO is a state wide body which represents the collective of Aboriginal community controlled health organizations around Victoria. Most of these organizations are multi functional with health as a key part of their responsibility. Each member organization is independent and represented by people from their local community.

The existence of VACCHO ensures that Victorian Aboriginal communities have a forum for strategic planning and a community controlled political voice. It provides coordination of state-wide opinions and direction in regard to health issues affecting the communities it represents. VACCHO is about building know-how, getting resources to local communities and supporting locally planned initiatives. There are currently[23] VACCHO members who meet every three moths at various locations around the state.

3.3 PRINCIPLES OF ABORIGINAL COMMUNITY CONTROL

Aboriginal community controlled health organizations (which are distinct and independent local services) reflect the diversity of Victoria's Indigenous population. While networks exist between the organizations, (VACCHO, for example) each organization operates according to the priorities of the community it serves. VACCHO will not be involved in the internal politics and day-to-day running of its member organizations and the same respectful relationship exists between the members. Ties between separate communities and organizations are supportive though essentially informal.

The heterogeneity of Aboriginal communities must be recognised and acknowledged. Wide-ranging policies and identical models of health care will not be appropriate across diverse communities. This remains true even where the communities are geographically quite close. Being sensitive to the fact that perceived Aboriginal community needs and cultural differences mandate particular kinds of health care is effective and essential[20] Successful initiatives, some of which will be referred to in this report, are planned, developed and evaluated according to needs identified at a local level.

There are many examples of successful Aboriginal community controlled health programs. Ten such examples are described in a National Health & Medical Research Council publication entitled 'Promoting the Health of Aboriginal and Torres Strait Island Communities – Case studies and principles of good practice'. Evaluation of Ngua Gundi The Mother Child Project at Woorabinda in Queensland found:

- a high level of satisfaction among the women who used the service
- improved confidence in communicating with health professionals
- women's greatly improved knowledge about the birth process, care in pregnancy, contraception and immunisation
- that women are seeking antenatal care earlier and attending more frequently
- a significant increase in the number of women attending antenatal classes
- women indicated their choices more frequently

3. OTHER RELEVANT INFORMATION

The Aboriginal community at Woorabinda had clear goals for their birth program from the started Aboriginal health workers were involved in the planning, the implementation and the evaluation of the project at all stages.

The importance of Aboriginal community control has been highlighted for many years in various forums around Australia. The Deputy Chairman for the Council for Reconciliation addressed a Conference held in Melbourne in August 1998 to explore the ethical challenges surrounding Aboriginal health. In his address, Sir Gustav Nossal AC highlighted the fact that appalling Aboriginal morbidity and mortality statistics have not been improving in this country. In the United States, Canada and New Zealand however, measurable statistics show that the gap between the Indigenous people and other people has been closing over the past thirty years. A study tour of New Zealand by a group of esteemed Australian doctors found that Maori people have achieved their improved health status in a climate of absolute self-determination. Maori people now have a life expectancy 6 years less than non-Indigenous New Zealanders. Unimproved life expectancy of Australian Aboriginal people remains 16-20 years shorter than other Australians.

Aboriginal community control provides a framework that permits Aboriginal people to take the initiative in implementing community services that are appropriate, valued, legitimate and effective. Here in Victoria, effective Aboriginal controlled maternity services will be enhanced where equal partnerships can be fostered between Aboriginal health services and mainstream providers. It is possible for mainstream services to provide a cogent and complimentary role in health care for Aboriginal people.

3.4 THE PROBLEM WITH STATISTICS IN ABORIGINAL HEALTH

The provision of resources and the development of targeted health programs are usually based on information accepted as being representative of the health status of Aboriginal people. Inaccuracies, especially large underestimates, have repercussions for individuals and Aboriginal communities.

A recent review of the number of reported Victorian Koori births in 1996 suggests that more than half are not correctly identified. In 1996 there were 448 births in Victoria where the mother was recorded as being of Aboriginal or Torres Strait Islander descent. The 1999 review of these figures involved a process of linking data from three available data sets; midwives data, birth registry data and hospital data. A new estimate of the number of births to Koori mothers was 845. Overall, it was estimated that there were at least 988 births in 1996 (not 448 as previously reported) where either the mother and/or the father was Koori.

It is therefore imperative that funding bodies use valid and reliable data if a statistical basis is to be used in the distribution of resources. In the case of Aboriginal communities where accurate statistical data does not yet exist, consideration must be given to other forms of evidence. Through extensive community consultation and listening objectively to community members, a large body of descriptive qualitative data can be amassed. Where circumstances of poor maternity care exist, this evidence provides coherent explanations, by highlighting the practical domains of the problems.

3.5 ABORIGINAL WOMEN: A 'HIGH-RISK' GROUP

While complications may occur in any pregnancy at any time, it is recognised by the National Health and Medical Research Council that certain categories of women are particularly at risk. National Standards of Antenatal Care (Attached at Appendix iii) highlight risk factors to remind carers of the potential dangers of a pregnancy.

The National Health and Medical Research Council classify Australian Aboriginal women as 'high risk' during pregnancy. This classification is based solely upon Aboriginality. Other general risk factors highlighted in the Standards of Antenatal Care that may affect Aboriginal women include: age (early teenage, later reproductive years), social class (underprivileged), parity (first pregnancies, more than three previous births), dietary aberrations, drug dependence and abuse of alcohol or tobacco, and mental illness. The presence of maternal diseases (diabetes mellitus, anaemia) and unfavourable obstetric histories (previous perinatal mortality, previous premature labour) contribute further to poor pregnancy outcomes for Aboriginal women.

Variation in the needs and expectations of Koori women during pregnancy are a reflection of contemporary Aboriginal lifestyle in Victoria. For instance, Koori mothers are more likely to be younger and to have larger families than non-Indigenous women.

Readers should note that the following figures are a combination of Victorian and national data. There is very little statistical data published for Victoria at present and the national statistics presented are not proxies for characteristics of the Victorian Aboriginal population. This situation highlights the need for careful collection of data that relates to the health of Aboriginal women and their babies in Victoria.

MATERNAL AGE

Early commencement of child bearing is a reality. For the 1994-1996 period, 16.5% of Victorian Indigenous mothers were aged less than 20 years. Nationally 4.8% of non-Indigenous mothers were less than 20 years of age. In Victoria, for the 1996-1998 period, 3.4 % of all women giving birth were aged less than 20 years.

MATERNAL PARITY

More than ten per cent of Victorian Koori mothers have four or more children. National figures indicate that 3.3% of non-Indigenous mothers have four or more children. In Victoria, for the 1996-1998 period, 2.9% of all women had four or more children.

National perinatal statistics provide confirmation that risk factors outlined above are indeed contributing to poor pregnancy outcomes for Aboriginal women. A recent report listed the following 'highlights'.

- Caesarean rates are consistently higher than for non-Indigenous mothers.
- The mean birth weight of babies born to Indigenous mothers is on average 216g less than the mean birth weight for all other births.
- The proportion of low birth weight babies of Indigenous mothers is twice that for babies of non-Indigenous mothers.
- The foetal death rate of births to Indigenous mothers is more than double that for non-Indigenous births.
- Indigenous mothers have more than double the incidence of preterm birth when compared with other mothers.

3. OTHER RELEVANT INFORMATION

3.6 HISTORICAL & ENVIRONMENTAL FACTORS

An understanding and acknowledgement of broad causative issues of poor birth outcomes is imperative if non-Aborigines are to play an effective role in assisting Kooris to improve their health status. The present picture of Aboriginal health has been historically determined by the impact of devastating government policies. Aboriginal people emerged from the assimilation era an impoverished and marginalised group. Immeasurable grief, loss and pain has been inflicted on individuals, their families and communities in every state and territory as a result of government child separation policies. The causes of ill health are not only medical.

Poverty is often a central issue impacting on the health status of Aboriginal people. Poor economic status influences access to quality education, appropriate health care and the many other services enjoyed by the majority of Australians. The health status of Aboriginal people today exemplifies the relationship of social disadvantage and ill-health . Past and current political and economic policies of Australian governments directly effect the social environment of Aboriginal people who live within a more dominant society. Saggers and Gray suggest that since white settlement, time has only cemented the unequal power relations that exist between Aboriginal people and non-Aborigines.[39]

Aboriginal people themselves cannot be held solely responsible for this poor economic and social status. Governments, their bureaucracies and employees of government funded mainstream agencies, must remain mindful of historical, cultural and political factors that have impeded the economic mobility of Aboriginal people in Australian society. The continued presence of debilitating social conditions strongly hinders improvements in health status generally. Australians should be aware of 'where Aborigines have been' if they wish to understand the economic, social and political positions of individuals and communities of today.

3.7 SOME COMPARISONS BETWEEN MAINSTREAM HEALTH SERVICES & ABORIGINAL HEALTH SERVICES

Mainstream health care agencies in Victoria are now implementing changes aimed at improving service responsiveness and effectiveness for Aboriginal people. These agencies cannot address the economic and political domains affecting Aboriginal health, although services can be modified to ensure that the delivery of health care to Koories is more equitable and acceptable. Governments now recognise that health programs must empower Indigenous communities if they are to be successful.

Nearly all Koori babies are born in Victorian hospitals (0.9% are born before arrival at a hospital[41]). These institutions provide high quality health care delivered in a manner structured by institutional protocols and government policies. Mainstream models of health care are designed and delivered to meet the needs of the majority of their clients. Most Australians therefore, enjoy a proficient health care system that is appropriate, accessible and affordable.

For many Aboriginal people the mainstream health care system serves them only in the event of medical emergencies or childbirth. Some individual mainstream health care workers are consistent in delivering services to Aborigines that are thoroughly competent and culturally sensitive. Consistency in appropriate service provision does not exist within institutions. Story after story maintains that contact with hospitals is regularly a traumatic experience for Aboriginal people. This trauma is in addition to that caused by their immediate medical needs.

Health as a concept for Aboriginal people is holistic. It must be achieved in partnership rather than in unequal relationships between client and doctor, or between Aboriginal health services and mainstream agencies. Effective management of health problems includes consideration of physical, cultural, spiritual and emotional, environmental and social aspects. Care extends to the health of families and communities as well as that of individuals.

For Aboriginal people, there are stark differences between Aboriginal health services and mainstream government health services. Aboriginal health services are generally less threatening environments for Aboriginal people. They are vibrant cultural meeting places. For many community members their Aboriginal health service is a way of life that fosters cultural identity and provides a focus for individual and community development. Issues related to Aboriginal health, education, politics, culture and recreation are explored and developed in a safe environment. Aboriginal health services strengthen Aboriginal communities.

3.8 ABORIGINAL HEALTH WORKERS

Aboriginal health workers are 'grass-roots' Aboriginal workers who provide culturally appropriate health services to Aboriginal people. In Victoria, health workers usually work at community controlled Aboriginal health services. They undertake a wide variety of functions to provide effective primary health care services in their communities. Many health workers have completed accredited training and others are willing to undertake it as training becomes available.

Aboriginal health workers have a role that is both central to and essential in the provision of effective maternity services in Victorian Aboriginal communities. Each position is unique. Aboriginal health workers can foster linkages with which to guide their Koori clients through mainstream institutions. As Adams and Spratling have pointed out, health workers will be effective provided they are supported by their communities, and the organizations and agencies of the wider health industry.*[2]

Aboriginal health workers have expressed concern about an artificial division between community controlled Aboriginal health organizations and mainstream service providers.[43] Health workers believe coordinated service provision to be more effective. Partnerships developed at a management level need to be encouraged at a community level to be effective. Aboriginal health workers are the most able and appropriate group to facilitate these improvements.

The health of Aboriginal individuals and communities in Victoria is regularly compromised by complex factors. Health workers who address these issues daily need clear definition of their professional role and appropriate training to fulfill that role. Client care is a process that calls for an holistic approach and the knowledge base of Aboriginal health workers is both broad and specialised. In addition to addressing medical needs, the role of Aboriginal health workers demands consideration of a range of emotional, spiritual and social issues affecting clients and their families.

The benefits of Aboriginal health worker expertise are available to mainstream service providers. A pre-requisite to accessing this knowledge (health knowledge, cultural knowledge, knowledge about the Aboriginal community) is to recognise and value their role in the provision of health care to Aboriginal people. Acknowledgement of and respect for the work of Aboriginal health workers is a first place to start in building enduring professional relationships and networks.

Aboriginal health workers are the key to providing effective care in community based Aboriginal controlled health organizations. Their skills will be an indispensable resource to non-Aboriginal people providing effective maternity care to Aboriginal people.

4. THE MATERNITY SERVICES PROGRAM

In 1998, the State Department of Human Services committed $14.9 million in recurrent funding to enhance public maternity services across Victoria.

The key areas for enhancement are:
- Level and range of services
- Service responsiveness and effectiveness for groups with special needs
- Effectiveness of care models, antenatally, intrapartum and postnatally
- Information for consumers
- Service linkage and interfaces

The broad objectives of the four-year implementation strategy are:
- To promote measurable improvements in the continuum and quality of antenatal, intrapartum and postnatal care: individualised to the needs of particular women.
- To provide women with increased birthing options and with evidence based information on the benefits and risks associated with different options.
- To encourage improvements in models of care in line with best available evidence.
- To improve outcomes through appropriate performance measures and service audits.

The majority of recurrent funding is provided to health care networks and rural regions, on the basis of recent birth numbers, to implement regional Maternity Services Enhancement Plans. The balance of recurrent funding is available to implement the Koori Maternity Services Program.

4.1 THE KOORI MATERNITY SERVICES PROGRAM

The Maternity Services Program is particularly focussing on Koori women. Funding is allocated to enhance existing community-based Aboriginal health services by providing additional and culturally appropriate support to Koori women throughout pregnancy, childbirth and the immediate postnatal period.
From 1999/2000, recurrent funding of $600 000 is committed to the Koori Maternity Services Program. Of this, $108 200 has already been committed to the Victorian Aboriginal Health Service and $67 600 to the La Trobe Valley Community Health Service to further maternity services successfully developed under the Alternative Birthing Services Program. The balance of $424 200 will be allocated in ways to maximise access to appropriate antenatal and postnatal services that will provide support to Aboriginal women living in rural Victoria, as per recommendations of this report.

MAINSTREAM HEALTH CARE PROVIDERS WILL CONTINUE TO HAVE A RESPONSIBILITY FOR PROVIDING APPROPRIATE SERVICES FOR ABORIGINAL WOMEN.

5. MODELS FOR APPROPRIATE MATERNITY CARE

5.1 INTRODUCTION

Clinical antenatal care is a major part of obstetric care. The aim is to safeguard the health of mother and baby by detection of and referral for treatment of maternal diseases (gestational diabetes, anaemia and hypertension) and obstetric disorders (problems related to pregnancy) by routine clinical observations and laboratory investigations. Postnatal care is of equal import and as such must included in all models of maternity care.
Women experiencing pregnancy, childbirth and early motherhood should also have access to appropriate education and information, and support. Aboriginal health workers, midwives and doctors each have bodies of knowledge and skills that are distinct and complementary. Together, and with the support and co-operation of key mainstream institutions, a standard of excellence in maternity service provision for Aboriginal women can be co-ordinated. The service must be Aboriginal controlled, flexible and adaptable and able to address needs in a holistic way.

5.2 TWO MODELS OF CARE

I CLINICAL-LINKAGE-ADVOCACY-HEALTH PROMOTION MATERNITY SERVICE SEE APPENDIX IV

This type of service employs an Aboriginal maternity health worker and a midwife. They work as a complementary team, combining skills to offer a comprehensive service to the Aboriginal women of the local community. The midwife and health worker teams generally the primary antenatal and postnatal care provider. Client care is shared between the Aboriginal health service providers and other specialist providers, usually at public hospitals. The National Health and Medical Research Council guidelines for antenatal care and scheduled visits (to doctors, preferably at the hospital where the mother plans to deliver) are followed for all women.

This type of service offers Aboriginal women:
- careful screening using routine clinical observations and laboratory investigations recommended during all pregnancies.
- assistance with access to routine specialist medical review according to National Health and Medical Research Council guidelines.
- workers available to accompany women to visit a doctor when necessary.
- provision of pregnancy, childbirth, parenting education and a range of other health information in a self-help learning environment.
- prompt referral to appropriate services if complications of pregnancy arise.
- provision of an 'Outreach Service' which offers clinical and other assessments in the home or workplace.
- assistance with access to any service an Aboriginal woman may require during her pregnancy.
- information regarding available service options when seeking maternity services.
- ongoing care and support throughout the postnatal period.

Ready access to specialist medical consultation for Aboriginal clients is recommended for safe and effective implementation of this model. Each woman will ideally have careful specialist medical review on three occasions during pregnancy: at 16 to 18 weeks gestation, at 24 to 28 weeks and at 36 weeks gestation. This is where collaborative links with mainstream services are beneficial, although some communities may prefer to negotiate for the services of a visiting obstetrician. Whatever the arrangement at a community level, an accommodating referral process for specialist care must be offered by mainstream maternity services.

5. MODELS FOR APPROPRIATE MATERNITY CARE

A flow chart included at Appendix iv illustrates how this type of service can operate. This is an example only and may be varied according to local community needs. Variations instituted at a community level should acknowledge that the model of care must remain co-operative. It is a complementary model that recognises the contributions of each different profession in the provision of maternity services. Aboriginal women can use whatever part of the model of care they need during and after pregnancy. Some may wish to have clinical care with a general practitioner or at a hospital antenatal clinic. However, education and information and other benefits will continue to be available to the client. Women are able to decide which part of the service they need to access. The important consideration is that workers are able to ensure that women are offered a high standard of maternity care delivered in an appropriate manner.

The Clinical-Linkage-Advocacy-Health Promotion Maternity Service is operating successfully at the **Victorian Aboriginal Health Service** in Fitzroy, Melbourne. It is part of the Women's and Children's Program at the health service.

On a typical day, the midwife and a health worker will travel to the homes of their clients. They carry a kit which has the medical equipment necessary to perform a complete antenatal screening check. They will assess their clients weight, blood pressure and urine. An abdominal examination checks that the pregnancy is progressing in line with the estimated gestation of their clients pregnancy. The team will record their findings, report or refer any abnormalities and inform the woman of her progress. During the visit, the workers are available to answer any questions, to provide health promotion information, to assist their client with any social problems she may be experiencing, to provide counselling, company or support, to allay fears, to inform her of when her next antenatal check or hospital visit should take place, to inform her about community services she may wish to access and to invite her to the next community boorai (baby) class. The team can be available to visit their clients during hospitalisation and to offer support throughout labour when it is needed. The service continues throughout the postnatal period offering mothers advice and assistance with breastfeeding, care of the newborn as well as strategies to promote and maintain maternal health and well being.

On another day the team will work from their base at the health service to see women who have made prior appointments, or to attend to those women who happen to 'drop in' before, during and after a pregnancy. They will spend the morning holding a boorai class, or accompany their clients throughout hospital antenatal visits.

Aboriginal health workers usually have an intimate knowledge of their clients' medical history and social circumstances and are the key to ensuring problems are addressed before a crisis situation develops. When there is a good relationship between these workers and staff at the hospital, where the woman's care is shared, this information can be disseminated professionally and confidentially.

New maternity services in Aboriginal communities will be implemented and developed resourcefully. They will be flexible to ensure client needs are met. Initially, the workers will spend time networking with mainstream services to promote the existence of the community program. They will develop partnerships and linkages to ensure their clients are able to access the most appropriate and the best mainstream services available. Communication between Aboriginal services and mainstream providers will be effective, on going and supportive.

II LINKAGE-ADVOCACY-HEALTH PROMOTION MATERNITY SERVICE SEE APPENDIX V

This model of care does not necessarily include a clinical component within the Aboriginal health service. It will be most effective in smaller communities where birthrates are lower or where the Aboriginal health service employs a doctor with expertise in the provision of maternity care. A community doctor will be able to provide professional support to the service as well as most of the clinical care required. This model will also be effective where good working relationships exist, or can be fostered between the Aboriginal community and the local hospital where women have their babies. The Aboriginal health worker is responsible for creating strong linkages with appropriate clinical service providers so that the National Health and Medical Research Council Standards of Antenatal Care can be met. The primary focus of the health worker is to ensure that clients are able to access the best clinical services available in their region.

A normal pregnancy is 40 weeks long. Women will have a 'check-up' every four weeks until 28 weeks gestation, every two weeks until 36 weeks gestation and every week until her baby is born. At this stage, clinical care of pregnancy can be provided by registered midwives, general practitioners (preferably with a Diploma of Obstetrics or expertise in the provision of antenatal and postnatal care) or by a specialist obstetrician. The best practice in this model of care will ensure that every Aboriginal woman has specialist medical review on three occasions during her pregnancy; a first visit at 18 to 20 weeks gestation, at 24 to 28 weeks gestation and at 36 weeks gestation. Specialist appointments will be more frequent if complications of pregnancy occur.

Access to appropriate clinical services can be achieved by negotiating with public hospitals to arrange a visiting midwife or visiting obstetrician to see women in the local Aboriginal health service. A community may prefer to use the services of an established general practitioner or community health centre known in the community to be an appropriate service provider for Aboriginal people.

The capacity of the health worker to forge effective linkages with appropriate clinical care providers and to advocate on behalf of her clients is essential to this service. Health promotion strategies are embedded in service provision and are central to the successful operation of this model of care.

This model of care offers Aboriginal women:

- Assistance with access to appropriate clinical care during pregnancy equivalent to the National Health and Medical Research Council Standards of Antenatal care.
- An outreach service throughout the antenatal and postnatal periods.
- Provision of pregnancy, childbirth, parenting education and a range of other health information.
- Access to specialised health worker knowledge regarding the availability of appropriate services and care choices available in the local region.
- Prompt referral to appropriate specialist services if complications of pregnancy arise.
- Assistance with access to any service an Aboriginal woman may require during pregnancy.

A successful example of this model of care operates at **Rumbalara Aboriginal Co-operative** at Mooroopna (Shepparton) in Victoria.

A sole health worker working in the capacity of maternity service provider is responsible for co-ordinating the antenatal and postnatal care of her clients. She will keep records that inform her of when antenatal checks are due. She will make appointments for her clients, attend appointments with her clients whenever necessary, interpret medical terminology used in doctor's rooms and hospitals, provide information related to pregnancy and information about community services her clients may need to access, develop relationships with professional care providers, be available as a key contact for any client follow-up required, counsel and support clients as necessary, hold community antenatal classes and access information for women when requested.

The role of the Aboriginal maternity health worker is complex and requires the full support of mainstream service providers to whom she entrusts her clients care.

5. MODELS FOR APPROPRIATE MATERNITY CARE

5.3 WHAT THE MODELS CAN OFFER ABORIGINAL COMMUNITIES

These models of care include important services not currently available to most rural Aboriginal women in Victoria. A central focus of the clinical-linkage-advocacy-health promotion maternity service model is to provide careful screening and prompt referral for specialist review where complications arise or are suspected. The linkage-advocacy-health promotion maternity service model links women to available services and provides support when she uses these services.

It is clear that Aboriginal women form a high-risk group during pregnancy. Poor client contact with maternity care providers, regardless of the reasons for it, increases the level of risk because there will be fewer opportunities for effective intervention. Community based models of maternity care are vital in Aboriginal communities if women are to be engaged in accessing a good level of care. The outlined models allow for an Outreach component that can take maternity services to where women live. Both models benefit from the health knowledge, cultural knowledge and local community knowledge owned by Aboriginal health workers.

These community-based models of care provide a cost effective, culturally appropriate approach to maternity service provision (See Appendix vii for estimated costs). The clinical-linkage-advocacy-health promotion maternity service model and the linkage-advocacy-health promotion maternity service model are being used effectively at the **Victorian Aboriginal Health Service** and **Rumbalara Aboriginal Co-operative** (respectively). These maternity services can offer more continuity in care, care in the home, appropriate client follow-up, health education information and resources created by Aboriginal people for Aboriginal people, information for women about available care choices and a network of proven services for appropriate referral. One of the greatest advantages of these models of care for Aboriginal women is that workers have the resources and flexibility to respond to additional client needs as they arise. They are holistic models and can enable the provision of a high standard of maternity care to Aboriginal women.

A 1998 review of services offered by midwives found national and international evidence that midwifery care in pregnancy does not have an adverse impact on health outcomes for women and babies when compared with conventional care (i.e. care provided primarily by doctors). This remained true even where trials included high-risk women. Further, the review found what the National Health and Medical Research Council refers to as 'gold standard' evidence of an associated benefit of greater client satisfaction with midwifery care.

The benefit to mainstream maternity service providers is the establishment of effective partnerships with Aboriginal communities. New services in Aboriginal communities will not supplant or duplicate existing mainstream services. It is through the establishment of effective partnerships that Victorian Aboriginal women will benefit from the provision of culturally appropriate, cost effective and accessible maternity care.

6. RECOMMENDATIONS

1. That the implementation of the Koori Maternity Services Program be overseen and guided by Aboriginal women who become participants in the Koori Maternity Services Program Reference Group.
2. That Koori Maternity Services funds continue to be distributed to the **Victorian Aboriginal Health Service**, Fitzroy and to the **Central Gippsland Aboriginal Health & Housing Co-operative**, Morwell to continue established maternity services. Resources for the **Central Gippsland Aboriginal Health & Housing Co-operative** Maternity Service that are currently administered by the Lakes Entrance Community Health Centre should be redirected back to the Aboriginal Co-operative.
3. That Koori Maternity Services Program funds be distributed to establish maternity services at the **Mildura Aboriginal Corporation**, Mildura; at the **Swan Hill and District Aboriginal Co-operative**, Swan Hill; and at the **Gippsland and East Gippsland Aboriginal Co-operative**, Bairnsdale;
4. That a Clinical-Linkage-Advocacy-Health Promotion (See 5.2 - i) maternity service is established at the **Mildura Aboriginal Corporation** and that the program is structured to provide maternity services to Aboriginal women at Mildura and community women living within a 30 kilometre radius.
5. That Linkage-Advocacy-Health Promotion (See 5.2 - ii) maternity services be established at **Swan Hill and District Aboriginal Co-operative**, Swan Hill and **Gippsland and East Gippsland Aboriginal Co-operative**, Bairnsdale. These programs should be structured to provide maternity services to Aboriginal women living within a 30 kilometre radius of the Aboriginal health service at which they are based.
6. That Koori Maternity Service Program funds be distributed to enhance existing resources at **Gunditjmara Aboriginal Co-operative**, Warrnambool; at **Rumbalara Aboriginal Co-operative**, Mooroopna and at **Mungabareena Aboriginal Corporation**, Wodonga.
    - Resources for Warrnambool have been requested to provide transport for an established outreach maternity worker.
    - Resources for Mooroopna (Shepparton) have been requested to employ a part-time registered midwife to complement an established maternity service.
    - Resources for Wodonga are intended to maintain the position of Obstetric Liaison Officer already established and based at the Wodonga Regional Health Service.
7. That $30 000 in recurrent annual funding is retained to sustain health worker education and training and to develop efficient evaluation tools for each service.
8. **It is recommended that those Aboriginal community controlled health services that do not acquire ongoing resources from the Koori Maternity Services Program (because of limitations of available funds) be acknowledged. Further, it is recommended that these organizations are included in evaluations of the program, in order that as future funds become available, these communities have the opportunity to be included in establishing maternity services.**

KOORI MATERNITY SERVICES PROGRAM {K.M.S.P.) PROJECT WORKERS

9. That a full-time project worker and a part-time project worker are employed to co-ordinate the implementation of maternity services in Victorian Aboriginal community controlled health organizations. Ideally these positions would be based at VACCHO, however it is feasible that the project workers could operate effectively from any community in the state. These positions should be ongoing for a period of up to two years.
10. That the K.M.S.P. project workers be responsible for co-ordinating on-going education and training for maternity services Aboriginal health workers. The workers should investigate the feasibility of arranging appropriate training for health workers within Victoria.
11. That the K.M.S.P. project workers be responsible for assisting communities in the implementation, development and initial evaluation of their maternity service programs. This responsibility may extend to assisting communities in acquiring the services of visiting maternity service professionals (e.g. midwives, doctors, obstetrician) if appropriate.
12. That the K.M.S.P. project workers be responsible for ensuring that Aboriginal health services are furnished with adequate resources and equipment for the initial establishment of high quality maternity services.
13. That the K.M.S.P. project workers be available as objective resource persons. The project workers must be able to assist Aboriginal health workers with any difficulties they encounter in the course of their work, both within their communities and in their dealings with mainstream organizations. This support should be available by phone and where necessary in person by attending that community if requested.
14. That the K.M.S.P. project workers investigate obstacles occurring at a government level and at agency levels, where such legislation, regulations, processes and policies may stand as barriers to the provision of maternity care in Aboriginal communities. For instance, steps may be taken to enable the recognition of trained Aboriginal health workers as professionals with an autonomous body of knowledge in the provision of care for Aboriginal people. This investigation should include the complexities of indemnity for Aboriginal health workers employed in the field of maternity service provision.
15. That the K.M.S.P. project workers be responsible for keeping communities informed with regard to innovations occurring in the area of obstetric care (e.g. new diagnostic tools). They will ensure that communities are aware of the existence of useful resources and examples of successful strategies related to maternity services that may be happening in other Aboriginal communities around the country.
16. That when the Koori Support Program is fully established, funds retained by VACCHO for the purpose of implementation be converted to new maternity services in communities not receiving resources in this round of offers. (For example; at Orbost, Portland, Heywood, Ballarat, Sale, Lake Tyers, Bendigo).

EDUCATION AND TRAINING FOR ABORIGINAL HEALTH WORKERS

17. Identified female Aboriginal health workers employed in communities not benefiting from this round of funds of the Koori Maternity Services Program should be given an opportunity to be included in all education and training programs related to Aboriginal women's health.
18. That Aboriginal health workers employed to provide maternity services undertake training via James Cook University, Townsville. The university provides a maternal health worker training course that is Aboriginal owned. The course is offered at a variety of centres around the country. The course involves a total of four weeks theoretical (2 weeks) and clinical (2 weeks) study.
19. That the K.M.S.R project workers investigate the feasibility of maternity services training being developed and conducted within Victoria, in possible partnership with appropriate tertiary institutions.
20. hat Aboriginal health workers employed to provide maternity services should also be encouraged to undertake training in Well Women's Health (including contraception issues), a program surrounding issues of lactation and breastfeeding and care of the newborn and particular training in the detection of postnatal depression.
21. That where possible training should take place within each health worker's own community. Education workshops may be extended and designed to include community members as participants.

6. RECOMMENDATIONS

22. That Aboriginal health workers employed to provide maternity services should have adequate training and knowledge to inform women of the options for maternity care available in their region.

23. That Aboriginal health workers employed to provide maternity services should be aware of the requirement to maintain careful records (including statistical data) in the course of their work. Each worker should be trained sufficiently to carry out this role.

24. That Indigenous midwives at Healesville and Geelong are funded to complete a training program in Sexual and Reproductive Health provided by Family Planning Victoria. This qualification will enable these midwives to provide a comprehensive maternity and well women's health service in their communities.

A ROLE FOR HOSPITALS AND OTHER MATERNITY SERVICE PROVIDERS

25. That hospitals and other mainstream maternity service providers must take necessary steps to ensure that their staff inquire about the Indigenous status of all clients. This must be a mandatory question. All clients should be given the opportunity to identify themselves, rather than staff members making their own assumptions on the basis of their clients' appearance.

26. That hospital policies and those of other mainstream maternity service providers should be adapted to ensure links with Aboriginal organizations providing maternity care in their communities, are developed and sustained. This is particularly important for those mainstream services that provide antenatal care, inpatient care (labour wards and maternity wards) and domiciliary care to Aboriginal women. These policies should be developed collaboratively, and may include the development of Memorandums of Understanding between the relevant hospital and/or other mainstream agencies and Aboriginal community controlled health services or Aboriginal Co-operatives.

27. That hospitals and other mainstream maternity service providers should develop written guidelines to ensure communication between Aboriginal health workers and key professionals (midwives, doctors, obstetricians) is effective and streamlined. All care providers (including Aboriginal health workers) responsible for a particular clients' care must have access to test results and findings of clinical examinations. Procedures for dissemination of information should be developed. These guidelines and procedures should be developed collaboratively.

28. That hospitals and other mainstream maternity service providers should take steps to ensure that Aboriginal health workers are regarded as an integral part of maternity service provision for Aboriginal clients referred from Aboriginal community controlled maternity services.

29. That hospitals and other mainstream maternity service providers include Aboriginal health workers in in-service training that occurs within their organizations.

30. That hospitals and other mainstream maternity service providers investigate the provision of midwife/Aboriginal health worker mentor programs developed collaboratively and designed to be two way education processes that benefit both midwives and Aboriginal health workers.

31. That Aboriginal health workers or other Aboriginal community members should be appointed as representatives on appropriate hospital committees in their regions.

32. That hospitals and other mainstreams maternity service providers should conduct Aboriginal cross cultural staff in service sessions on a regular basis.

33. That hospitals and other mainstream maternity service providers should encourage the referral of Aboriginal women to Aboriginal maternity services if the client is amenable to this referral.

34. That hospitals and other mainstream maternity service providers should access and display consumer information (pamphlets, health promotion booklets) if they are developed by an Aboriginal organization in their area.

35. That hospitals and other mainstream maternity service providers should consider procuring Indigenous artwork (original and by an artist from the local area) to display in their organizations for the enjoyment of all their clients and as a welcoming gesture to Indigenous clients.

36. That where appropriate hospital domiciliary workers should take measures to include an Aboriginal health worker when visiting Aboriginal women in their homes. In doing so the domiciliary workers will be engaged in a three-way education process (between the Aboriginal health worker, the Aboriginal client and themselves). This will assist in putting new mothers at ease and increase the benefits of the visits for Aboriginal women.

GENERAL RECOMMENDATIONS

37. That throughout pregnancy, Aboriginal women should have the opportunity to carry a duplicate copy (original to remain with their primary care givers) of their maternity record with a summary of their general health, obstetric history and their current pregnancy and test results. Patient held records would facilitate communication between carers. This is particularly important for Aboriginal women whose lifestyle is transient.

38. That Aboriginal community controlled health services should consider developing their own antenatal and postnatal records, that are appropriate to the maternity care of Aboriginal women. The records should include a clear outline of recommended standards of antenatal care. It should be written in language that is suitable for caregivers and clients. A patient held record would be beneficial to Aboriginal women if it can involve them in decisions about their maternity care.

39. That the Victorian Department of Human Services take steps to ensure that the maternity services created in Aboriginal communities are recognised by mainstream providers as legitimate and valid models of antenatal care and that collaboration with Aboriginal maternity services where they exist is encouraged. For example; an explanatory letter endorsed by representatives of the Victorian government should be forwarded to all organizations and institutions that play a role in the provision of maternity care for Aboriginal women.

40. That key workers involved in the provision of maternity care in Aboriginal community controlled health services (Aboriginal health workers, managers and co-ordinators of programs, community midwives) attend an annual forum to facilitate information sharing and a team approach to problem solving with regard to the provision of maternity services for Aboriginal women in Victoria. Appropriate methods of evaluation can also be explored at this forum.

41. Evaluation of maternity services resourced by the Koori Maternity Services Program should occur annually. Evaluation should include careful auditing of the health outcomes for mothers and babies that use the services. Review of services should include input from Aboriginal health service staff and relevant staff (midwives, doctors) of the mainstream services also involved in client care, as well as clients themselves.

APPENDIX III. STANDARDS OF ANTENATAL CARE

STANDARDS OF ANTENATAL CARE

The standards of antenatal care and the definition of 'at risk' pregnancies which follow are adapted from the bulletins prepared by the National Health and Medical Research Council.

ANTENATAL CARE

The aim of antenatal care (which is only a part of obstetric care) is to safeguard the health of mother and fetus by detection and treatment of maternal diseases (gestational diabetes, anaemia, hypertension, cardiac disease, renal insufficiency) and obstetric disorders (preeclampsia, fetal growth retardation, incompetent cervix, isoimmunization, multiple pregnancy, breech presentation, cephalopelvic disproportion) by routine clinical observations and laboratory investigations.

1. The patient should consult her doctor during the first 8 weeks of pregnancy.

2. First consultation:
- a) General medical, nutritional, and socioeconomic and demographic history.
- b) Past obstetric history - including previous contraception.
- c) A general physical examination of all systems including:
  - record of height, weight and blood pressure;
  - examination of varicose veins; and
  - the teeth, gums, heart, lungs, breasts and nipples.
- d) Obstetric examination which includes:
  - vaginal examination for detection of abnormalities such as vaginitis or an ovarian cyst. Cytological screening for cervical cancer is recommended;
  - consideration of the size and shape of the bony pelvis
  - correlation of the size of the uterus with the period of amenorrhoea. To check the duration of pregnancy ask patient to write down the date when she first notices fetal movements.
- e) Where duration of pregnancy is in doubt, arrange for ultrasonography to be performed. Ultrasonologists recommend 18 weeks as the preferable time for an ultrasound examination rather than the spread of 14 to 18 weeks.
- f) Haematological investigations, including haemoglobin level, blood grouping with rhesus grouping, serological diagnostic test for syphilis, rubella antibodies, and an antibody test (indirect Coombs) in both Rh-D negative and positive women.
- g) Record the use of all therapeutic substances and significant nontherapeutic substances such as alcohol, tobacco and narcotic substances. Caution the patient regarding the use of drugs (other than iron and folic acid) in pregnancy.
- h) The emotional needs of the patient should be assessed.
- i) Education is of great importance. This should include personal hygiene, dental care, nutrition and diet counselling, antenatal preparation for pregnancy and labour, lactation, parentcraft and contraceptive information.

3. Average intervals for subsequent consultation should be:
- each 4 weeks to 28 weeks; then
- each 2 weeks to 36 weeks; then
- thereafter weekly until delivery.

4. Routine examinations at each consultation to include the following:
- a) weight;
- b) blood pressure;
- c) abdominal examination;
- d) urine examination for protein, sugar and nitrates. Presence of proteinuria warrants further investigation.

5. Women with an identified potential of a high-risk delivery, that is, previous caesarean section, multiple pregnancy or breech presentation, should be considered for referral to an appropriate hospital for delivery.

6. Where there is inappropriate maternal weight gain or uterine growth the following possibilities should be considered:
- a) polyhydramnios;
- b) intrauterine growth retardation;
- c) twinning or multiple pregnancy;
- d) congenital abnormalities.

Any one of these may be an indication for ultrasonography and/or other assessments of fetal well-being.

7. A screening test for gestational diabetes at 26 to 28 weeks and for fetoplacental function at 30 to 34 weeks should be considered in all women.

8. At 30 weeks:
- a) Haemoglobin level should be repeated.
- b) Where Rh negative, the indirect Coombs test should be repeated and again at 36 weeks and 40 weeks.

9. When complications are present or anticipated consultation should be sought promptly and admission to hospital with appropriate facilities should be arranged.

'AT RISK' PREGNANCIES

While obstetric complications may occur in any pregnancy at any time, it is recognized that certain categories of patient are particularly 'at risk'. In these categories, both maternal and perinatal mortality are substantially increased. The accompanying list is presented to remind all those practicing obstetrics of these dangers. It is recommended that patients falling into these groups should be assessed carefully and that if more than minor complications exist, consideration should be given to referral of the case to an obstetrician with special experience.

1. General Factors
- age (early teenage, later reproductive years);
- social class (underprivileged);
- aboriginality;
- parity (primigravida and gravida 4+);
- height (short stature);
- weight (overweight and underweight);
- dietary aberrations;
- drug addiction and abuse of alcohol or tobacco;
- mental disturbance.

2. Maternal Diseases
- cardiovascular disease including hypertension;
- diabetes mellitus;
- anaemias (all types);
- chronic renal disease including recurrent urinary infection;
- past history of venous thrombosis and/or pulmonary embolism.

3. Family History of a Genetic Disorder

4. Bad Obstetric History
- previous caesarean section;
- previous abortion, including habitual abortion;
- previous perinatal mortality;
- previous premature labour or placental insufficiency.

APPENDIX III
STANDARDS OF ANTENATAL CARE

5. Diseases Peculiar to Pregnancy
- preeclampsia;
- rhesus and other blood group incompatibility.

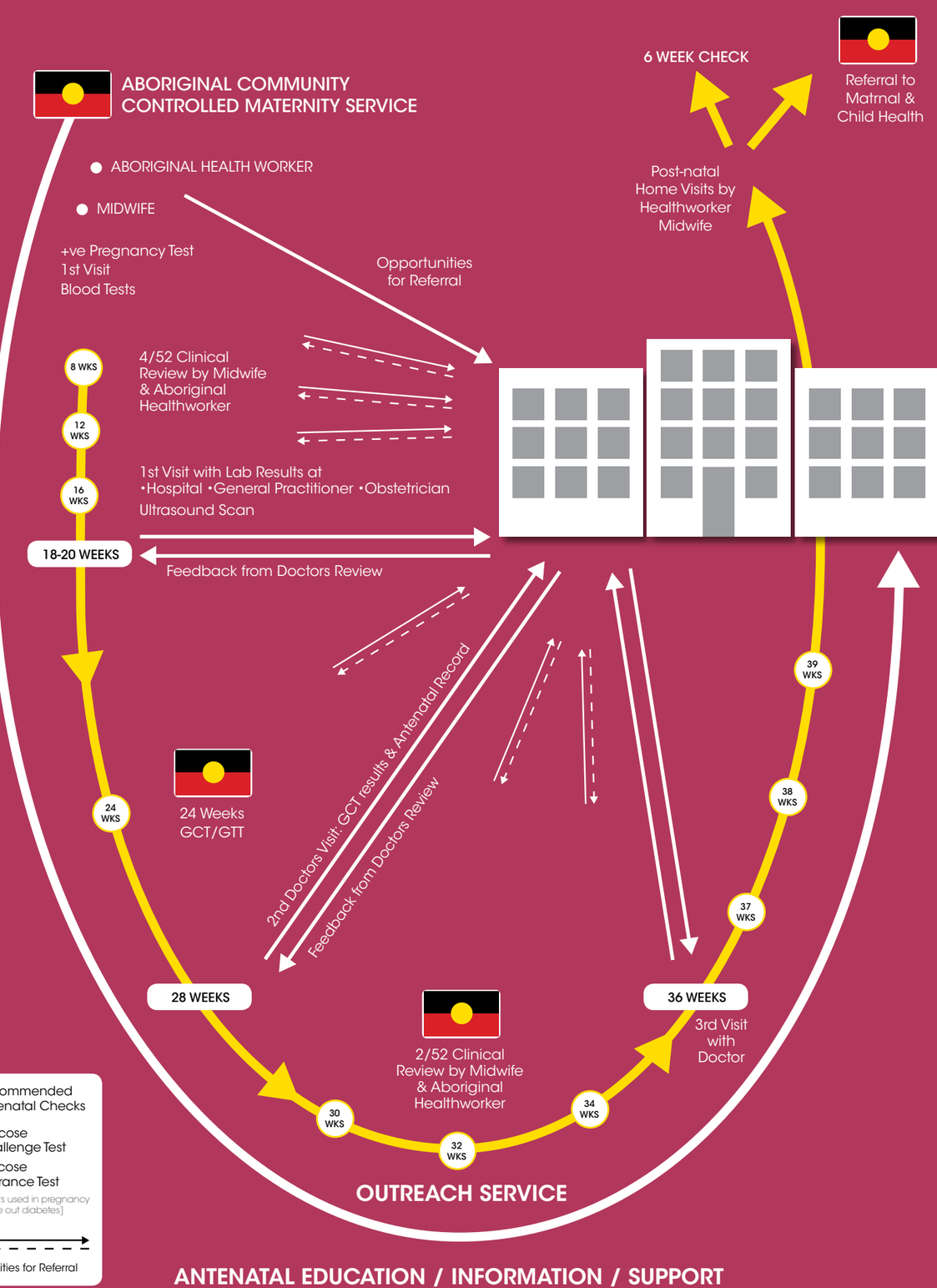
6. Bleeding in Pregnancy
- threatened abortion;
- abruptio placentae;
- placenta praevia.

7. Obstetric Difficulties Discovered Antenatally
- malpresentation - especially breech presentation and transverse lie;
- disproportion.
- multiple pregnancy
- placental insufficiency and retarded intrauterine growth;
- prolonged pregnancy (past 42 weeks);
- premature rupture of the membranes.

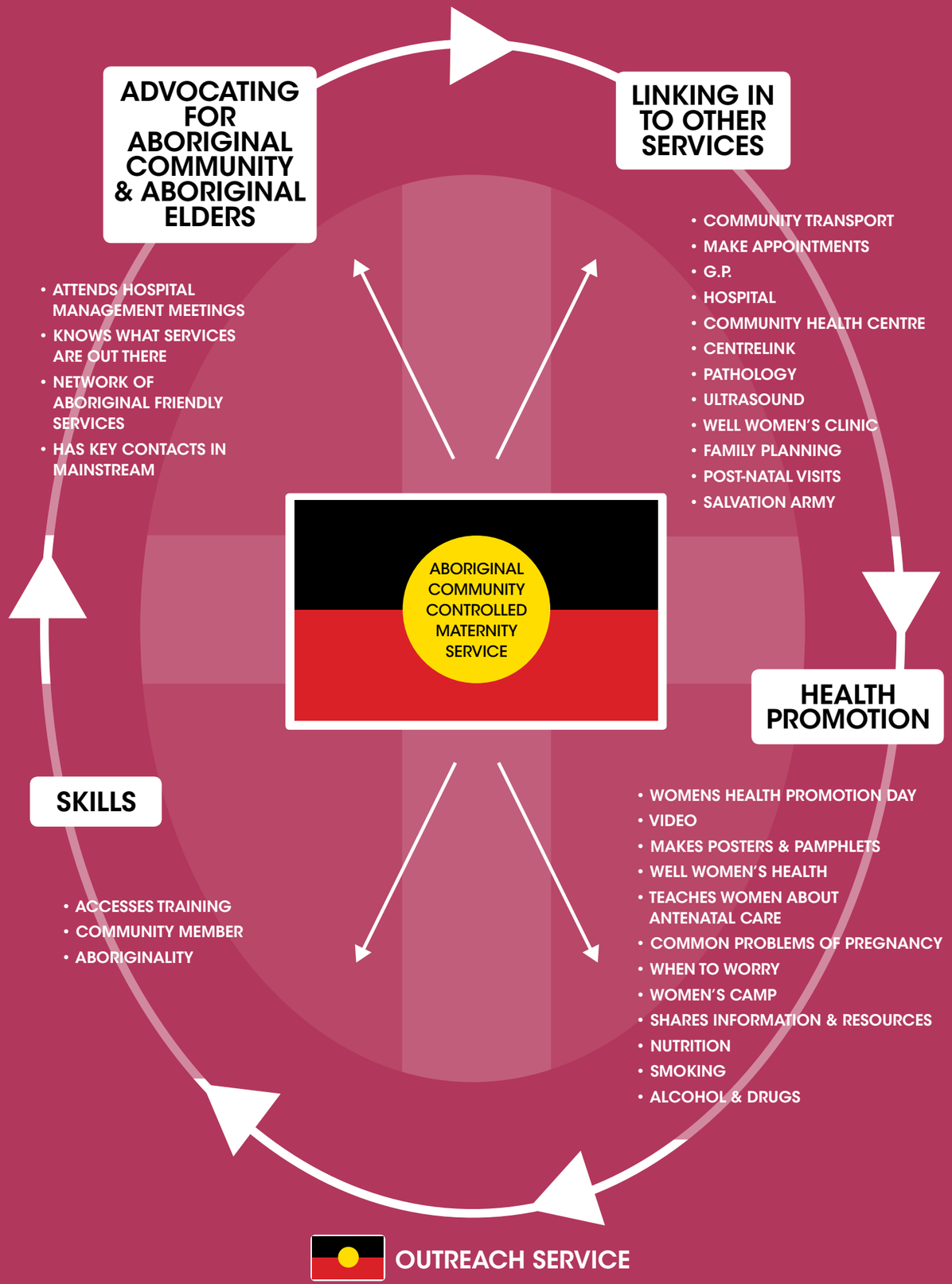
8. Patients Having Inadequate Antenatal Care
- failure to attend for regular antenatal check;
- nonbooked cases;
- late booked cases.

9. Difficulties Discovered During Labour
- failure to progress satisfactorily, including prolonged labour;
- fetal distress;
- malpresentation.

APPENDIX IV
CLINICAL – LINKAGE – ADVOCACY – HEALTH PROMOTION MATERNITY SERVICE



APPENDIX V
LINKAGE – ADVOCACY – HEALTH PROMOTION MATERNITY SERVICE



APPENDIX VI

During the Koori Maternity Services Program project, discussions were held with Aboriginal workers and community members at:

- **Victorian Aboriginal Health Service**, Fitzroy.
- **Mildura Aboriginal Corporation**, Mildura.
- **Swan Hill and District Aboriginal Co-operative**, Swan Hill.
- **Murray Valley Aboriginal Co-operative**, Robinvale.
- **Mungabareena Aboriginal Corporation**, Wodonga.
- **Njernda Aboriginal Co-operative**, Echuca,
- **Rumbalara Aboriginal Co-operative**, Mooroopna. (Shepparton)
- **Ballarat & District Aboriginal Co-operative**, Ballarat.
- **Wathaurong Aboriginal Co-operative**, Geelong.
- **Gunditjmara Aboriginal Co-operative**, Warrnambool.
- **Dhau Wurd-Wurrung Elderly Citizens Association**, Portland.
- **Winda-Mara Aboriginal Corporation**, Heywood.
- **Kirrae Community Health Service – Framlingham Aboriginal Trust**, Purnim.
- **Goolum Goolum Aboriginal Co-operative**, Horsham.
- **Dja Dja Wrung Aboriginal Association**, Bendigo.
- **Ramahyuck District Aboriginal Co-operative**, Sale.
- **Moogji Aboriginal Council**, Orbost.
- **Lake Tyers Aboriginal Trust 'Bung Yanda'**, Lakes Entrance.
- **Gippsland & East Gippsland Aboriginal Co-operative**, Bairnsdale.
- **Central Gippsland Aboriginal Health & Housing Co-operative**, Morwell.
- **Bunurong Medical Service**, Dandenong.
- **Coranderrk Koori Co-operative**, Healesville.

APPENDIX VII
ESTIMATED COSTS OF MATERNITY SERVICE PROVISION

KMS BUDGET	NOTES		
Aboriginal Health Worker Full Time (Grade 2)		rate per hour	
Salary Range Grade 2: 1st Year - 3rd Year			
On Costs			
Superannuation (9%)			
Work Cover (2.5%)			
Annual Leave Loading			
Sick Leave (2 weeks)			
Long Service Leave (approx 1 week per year)			
SUB TOTAL			$0.00
Midwife Full Time (Grade 4a)		rate per hour	
Salary			
On Costs			
Superannuation (9%)			
Work Cover (2.5%)			
Annual Leave Loading			
Sick Leave (2 weeks)			
Long Service Leave (approx 1 week per year)			
SUB TOTAL			$0.00
Mobile telephone			
Program resources			
Health Promotion and Education	[1]		
Staff Debriefing	[2]		
SUB TOTAL			$0.00
TOTAL WORKFORCE			$0.00
Leasing			
Petrol & Oil			
Registration/Insurance			
Repairs & Maintenance			
TOTAL VEHICLE & ASSOCIATED EXPENSES			$0.00
Brokerage ($500 per 30 clients)	[3]		
Professional Development – Aboriginal Health Worker	[4]		
Professional Development – Midwife			
Aboriginal Health Worker Locum (to allow completion of Cert IV)	[5]		
Aboriginal Health Worker Locum (per annum)	[6]		
Midwife Locum (per annum)	[7]		
TOTAL BROKERAGE & STAFF DEVELOPMENT			$0.00
TOTAL COST TO PROVIDE CLINICAL SERVICE			$0.00
Admin Levy (25%)			$0.00
TOTAL FUNDED AMOUNT			$0.00

NOTES:

[1] Play groups; community lunches; antenatal classes; annual KMS day

[2] Incident Debriefing/external Professional Supervision

[3] Discretionary funds of up to $500.00 /client to allow for the cost of ultrasounds; engaging lactation consultants; providing food vouchers/essential equipment for infants

[4] Staff training; professional development; attendance at conferences

[5] Cost of locum/backfill for absence of Aboriginal Health Worker completing Certificate IV qualifications

[6] Cost of locum/backfill for staff absence due to conferences; staff training; KMS Forum; annual and sick leave

[7] ibid

7. ACKNOWLEDGEMENTS

This report is presented following an extensive consultation process with members of Aboriginal communities around Victoria. The contributions and assistance of all the Aboriginal people who have given their time, direction and support throughout are greatly appreciated.

THANK YOU TO...

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The Administrators of Victorian Aboriginal controlled community health organizations.

Aboriginal community members for their generosity and welcoming gestures when we visited their communities.

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The staff of the Women's and Children's Program at the Victorian Aboriginal Health Service.

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Or Sarah Berg (Koori Health Division).

Angela Clarke and Dr Ian Anderson (Melbourne University).

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All the midwives around Victoria who listened with interest as the project was presented to them. The continued support of these professional women will be invaluable to the success of the Koori Maternity Services Program.

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9. CONTRIBUTORS

LYN BRIGGS

Lyn Briggs is an accomplished fine artist. In Victoria, her beautiful artwork is regularly used to promote health programs in Aboriginal communities. Other examples of her work can be found all over the country. She has four sons and two granddaughters. Lyn was born in Narrandera, NSW. She is a Wiradjuri woman and her father is of the Yorta Yorta clan. An experienced Aboriginal health worker, she has been employed at the Victorian Aboriginal Health Service (VAHS), Fitzroy for fifteen years. Lyn graduated from Koori Kollij (Victorian Aboriginal Health Worker Course) in 1984. At the VAHS, Lyn has worked as a medical health worker, medical co-ordinator and medical manager, cervical screening health worker and a women's health worker. She is currently co-ordinator of the Women's and Children's area at the health service.

SHARON HUGHES

Sharon Hughes was born in Wongan Hills, Western Australia. She was raised in Mullewa, 300 kilometres north east of Perth. Sharon is one of eight children in her Aboriginal family. She now lives in Melbourne and works as a Koori Eduction Development Officer. Prior to this she was a Koorie Educator at Thornbury Primary School for five years. Sharon uses various mediums to express her artwork. Apart from paints, pencils and paper she is a talented emu egg carver. Her emu eggs have been exhibited at NAIDOC celebrations on a number of occasions and her work has been purchased by American and Swiss collectors of Australian Aboriginal art. On the pages of this report you will find graphics selected form one of her drawings.

SANDY CAMPBELL

Sandy Campbell was born in Roma, Queensland. Her Aboriginality follows her father's line. She trained as a registered nurse at the Toowoomba General Hospital in Queensland and as a midwife at the Royal Women's Hospital in Brisbane. She qualified as a nurse practitioner in Sexual & Reproductive Health (Family Planning Victoria) in 1997. Sandy has worked in the area of Aboriginal health at various community controlled health services around the country since 1987. She now lives and works in Melbourne. Sandy is currently studying law (part-time) at la Trobe University.

10. NOTES

NOTES

VACCHO

Victorian Aboriginal Community Controlled Health Organisation Inc
5-7 Smith Street, Fitzroy VIC 3065

Telephone: 03 9419 3350
Fax: 03 9417 3871
Email: enquiries@vaccho.com.au