Literature Review

How can midwifery continuity models of antenatal care better address the needs of Australian Indigenous women?

INTRODUCTION

This paper reviews the literature exploring the experiences of Aboriginal and Torres Strait Islander women accessing antenatal care in Australia, alongside literature comparing standard models of antenatal care against midwifery continuity models of antenatal care. Attention is given to evidence based benefits of midwifery continuity care models, and how these benefits can better address the identified needs of Australian Indigenous women.

The stark health inequalities persistently faced by Aboriginal and Torres Strait Islanders in Australia are well documented, particularly in the areas of maternal and child health (Australian Bureau of Statistics, 2014; Australian Institute of Health and Welfare, 2011; Burns et al., 2013; Fredericks, Adams, & Angus, 2010; Holland, 2014). Despite a committed National focus on closing these gaps, Aboriginal women remain at increased risk of adverse pregnancy and neonatal outcomes compared to other Australian women (Health, 2005; Holland, 2014; Kildea, Kruske, Barclay, & Tracy, 2010a; NSW Department of Health, 2003, 2013; Shah, Zao, Al-Wassia, & Shah, 2011).

Whilst most of the literature attributes a lack of engagement in antenatal care among Aboriginal women as one of the major causes of adverse maternal and perinatal outcomes, others argue that culturally inappropriate maternity service provision and poor quality of care are the major contributory factors (Bar-Zeev, Barclay, Kruske, & Kildea, 2014; Burton & Ariss, 2014; Reibel, Morrison, Griffin, Chapman, & Woods, 2014).

In seeking the views and perceptions of Aboriginal women, research has documented barriers perceived by Aboriginal women accessing antenatal care, including a lack of cultural safety and flexibility in service delivery, and a lack of personalised continuity of care (Wilson, 2009). It is well recognised that midwifery continuity models of care remain at large more flexible and individualised in their delivery of maternity care, potentially placing this delivery model in a more optimal position to better address the needs of Australian Indigenous women.
SEARCH STRATEGY
Several databases were electronically searched for articles discussing the benefits of Midwifery Continuity models of care, as well as the current experiences of Australian Indigenous women accessing antenatal care. Databases included CINAHL complete, Medline, Wiley Online Library, Moseby’s Index, EBSCO, ProQuest, and Informit Indigenous collection.

Two searches were undertaken – the first using key search words such as Midwi* OR Matern* AND Continuity AND Antenatal OR prenatal. The second using key search words such as Antenatal care AND Aboriginal OR Indigenous. These two searches were then combined reducing the number of hits. Limitations were then applied to only include articles in the last 10 years, and PDF full text availability in English. Retrieved results from all databases were then cross referenced to exclude duplications. Abstracts were then read to ensure relevance to topic and non-relevant articles were excluded. Relevant Full Text articles were then reviewed for inclusion.

CRITICAL ANALYSIS
The National Institute of Health Care Excellence, defines the purpose of antenatal care as the “provision of safe and effective care during pregnancy with emphasis on the provision of culturally safe and appropriate education, screening, support, and effective prevention/treatment interventions to ensure the best possible health outcomes for women and their children” (NICE, 2014).

Antenatal care in Australia is currently provided by a diverse range of health care professionals including GP’s, Obstetricians, Midwives, and Aboriginal Health Workers, through a variety of delivery models. Improving access to, and provision of, culturally appropriate antenatal care is a key component to improving antenatal access for Aboriginal women (Reibel & Walker, 2010).

In 2010 the Australian Government designed the National Evidence-Based Antenatal Care Guidelines to improve the consistency and quality in the delivery of Antenatal Care across all states of Australia (Australian Health Ministers’ Advisory Council, 2010). However, research by Rumbold & Cunningham (2011), identified that there still remains wide variations in the design, quality and delivery of antenatal care, with inconsistent outcomes and findings across all different delivery models of antenatal care.
**Engagement of Antenatal Care**

Currently, 4% of all pregnant women in Australia are of Aboriginal or Torres Strait Islander descent, with 52% of these women living in remote or regional areas of Australia (Bar-Zeev et al., 2014). In comparison to other Australian women, Aboriginal women experience disproportionate adverse pregnancy and perinatal outcomes (Australian Bureau of Statistics, 2014; Burns et al., 2013; Fredericks et al., 2010; Holland, 2014; Kildea et al., 2010a).

Aboriginal women are two and half times more likely to experience gestational diabetes and hypertensive disorders in pregnancy, with evidence to suggest that these statistics are modest (Kildea, 2008). More recent research by Shah et al (2011) reported that Aboriginal women experience increased adverse perinatal outcomes including; premature birth, low birth weight, small for gestational age, and still birth. While their research acknowledges that the health of Aboriginal women is significantly influenced by other determinants of health (such as low income, poor housing, sanitation and nutrition), they largely attribute poor pregnancy and neonatal outcomes to poor health service provision and lack of antenatal attendance (Shah et al., 2011).

A recent audit of medical records by Rumbold et al. (2011) concluded that antenatal care amongst Aboriginal women in early pregnancy is currently underutilized. Despite this research being limited due to a lack of National data, its findings were consistent with previous research by Hunt, 2006. In her critical analysis of pregnancy care among Aboriginal and Torres Strait Islander women, Hunt found that Aboriginal women are twice as likely to not attend antenatal care services, and if they do they usually present much later in pregnancy (Hunt, 2006). These findings are also consistent with research by Reibel & Walker (2010), who concur that Aboriginal women access antenatal care far less than non-Aboriginal women, with poorer perinatal outcomes directly related to this underutilization. However, Hunt (2006) contends that Aboriginal women and other disadvantaged population groups who are impacted by other social determinants of health such as unemployment, poor nutrition, sickness, violence, and racism are naturally more likely to have adverse birth outcomes regardless of increased attendance or access to antenatal care (Hunt, 2006).

However more recent research by Beeckman, Louckz & Putman (2010) states that inadequate antenatal care is strongly associated with adverse pregnancy outcomes such as preterm birth, small for gestational age, and still birth. However the authors also acknowledge that evidence for the optimal number of antenatal visits remains at large lacking (Beeckman et al., 2010).
By contrast, a recent retrospective study exploring the quality of antenatal care delivery to Aboriginal women and associated outcomes, found that there was a lack of follow-up of care provided to Aboriginal women where health risks had been previously identified, particularly in the areas of anaemia, urinary tract infections, sexually transmitted infections, and smoking in pregnancy (Bar-Zeev et al., 2014). The authors argue that this poor quality of care and lack of follow-up significantly contributes to adverse pregnancy and neonatal outcomes for Aboriginal women.

**Aboriginal Women’s perceptions**

In order to gain a clearer perspective of why antenatal care is currently underutilized within Aboriginal communities, we need to explore the actual experiences and views of Aboriginal women regarding antenatal care quality, delivery, and access.

In 2009 a consultational report was published, entitled “What do Aboriginal Women Think is Good Antenatal Care”, which documented the findings of a national consultative research project exploring the personal views of Aboriginal women (Wilson, 2009). A total of 136 Aboriginal women participated in this research, between the ages of sixteen and over sixty, from eight different remote communities in the Northern Territory. From this research 6 major, yet fundamental, basic requirements were identified by Aboriginal women as being pertinent to good quality antenatal care. These were: the need to feel safe from violence/racism/shame; the need for their families and partners to be involved if they wished; the importance of transport and ease of access to the service; the importance of trust and continuity with their health care provider; and a preference for a female health care provider (Wilson, 2009).

Furthermore, the Aboriginal women involved in this study stated that they valued care that was multi-dimensional, offering flexibility, options and choices that allowed them to freely honour their cultural beliefs without having to feel shame or judgement (Wilson, 2009). More specifically, these Aboriginal women expressed a desire to attend an antenatal service that allowed a choice of Midwife to facilitate continuity of care, with someone who had local community knowledge, and honoured their privacy and confidentiality, as well as their diverse cultural beliefs (Wilson, 2009). Another quality that was highly regarded, was antenatal care that incorporated education on women’s bodies and health issues such as nutrition, substance abuse, self-care, and care for the developing baby (Wilson, 2009).
When the participants were questioned about barriers they perceived which discouraged them from attending antenatal care, most stated that the frequency of their attendance was directly related to how much they trusted or liked the health care provider (Wilson, 2009). In services that did not provide continuity of carer, this barrier was far more prevalent. In more remote traditional regions, lack of attendance was causally related to young women feeling ashamed of being pregnant, wanting to conceal pregnancy for as long as possible to avoid judgement from their community and health care providers (Wilson, 2009).

In a 2009 Systematic Review that explored the views of marginalised women who either failed to attend antenatal care or attended late in pregnancy, similar barriers affecting engagement with antenatal care were identified (Downe, Finlayson, Walsh, & Lavender, 2009). The marginalised women involved in this study identified that their lack of attendance was directly related to their lack of trust in caregivers and a lack of care, respect and kindness in the care they received. Their decision to attend or not to attend antenatal care was reached through a process of weighing up the benefits of seeking care for their babies against the perceived negative experiences of care encountered. Although this review focussed on marginalised women from America, Australia and Europe, it was non-specific to Aboriginal women so does not fully represent the perceptions of Australian Aboriginal women (Downe et al., 2009).

However, these findings are consistent with more recent research by Rumbold et al (2011) that identified the underutilization of antenatal services by Aboriginal women was predominantly due to inequities in access to care, lack of services that accommodated and honoured their cultural beliefs, and a lack of consistency and quality in the delivery of care (A R Rumbold et al., 2011). This study took form in an audit of the medical records of 535 Aboriginal women from 34 Indigenous community health centres across Australia. This study also highlighted that there was a general lack of follow-up care provided to Aboriginal women who had been previously identified with health risks, further highlighting the need to improve overall quality and effectiveness of service delivery (A R Rumbold et al., 2011).

In a recent qualitative study by Reibel et al (2014), the authors reported additional factors impacting antenatal engagement, including the proximity of the antenatal facility to where Aboriginal women reside, and the availability of known and trusted care providers. If women are required to relocate from their homes and incur challenges and associated costs of transport and accommodation, they are less likely to attend antenatal services (Reibel et al., 2014). Additionally, the authors found that
the influence and perceptions of older female relatives was significantly responsible for directing the engagement of younger Aboriginal women with antenatal care services. If a young Aboriginal woman’s mother or grandmother had experienced a negative encounter with a health care service or provider, their influence strongly guided the health seeking behaviours of younger family members (Reibel et al., 2014).

Throughout the literature one of the most commonly identified barriers for Aboriginal women accessing antenatal care is cultural inappropriateness (Mahara, Duncan, Whyte, & Brown, 2011; Reibel & Walker, 2010; Williamson & Harrison, 2010). There is currently considerable focus on improving cultural safety across all health services, which has triggered a small increase in the provision of primary health care services for Aboriginal communities, namely through Aboriginal Community Controlled Health Services ACCHS) (Alice R Rumbold & Cunningham, 2008). Although published evaluations from these services is scarce, there is some evidence of modest improvements in Aboriginal women accessing antenatal care in the first trimester through these delivery models (Alice R Rumbold & Cunningham, 2008). Furthermore, some ACCHS antenatal care programs reported notable improvements in birth outcomes with fewer preterm births and fewer low birth weight babies. Despite wide variations in the design and quality of these services, and a lack of consistency in findings across all ACCHS antenatal programs, it is worth noting that there were no reports of any health detriments arising out of these delivery models (Alice R Rumbold & Cunningham, 2008).

**Standard models vs Midwifery continuity models of care**

While recent Government initiatives have focussed significantly on improving access to a range of different models of maternity care in Australia, the vast majority of Australian women still access antenatal care through Public Hospital Maternity Clinics - hereby referred to as the Standard model of antenatal care (Commonwealth of Australia, 2009). Through this standard model of delivery, care is largely fragmented and provided by a combination of indiscriminate midwives and medical staff throughout different stages of the pregnancy/birth continuum (Commonwealth of Australia, 2009).

A recent Australian survey of 4,366 vulnerable women across NSW and VIC, assessing women’s perceptions of 5 different models of antenatal care, revealed that the most significant observation over the last decade was the increasing number of women seeking Midwives as their lead maternity carer (Brown, Sutherland, Gunn, & Yelland, 2014). From this research, the following statistics were published: 48% of women in this study identified that their least favoured model of antenatal care
was the public maternity hospital clinic (standard fragmented model), while 74% of women stated that their most favoured model of antenatal care was midwifery continuity (Brown et al., 2014).

The main reasons reported for dissatisfaction with standard models were; the lack of personal care received, the lack of time spent with each women, having to see a different carer at each visit, and that care providers failed to make an effort to get to know them and find out what issues were important to them (Brown et al., 2014). Furthermore, these women stated that due to their complex social and health issues, a standard appointment of 15-30 minutes was not sufficient to identify and address their needs (Brown et al., 2014). Models of care that provided continuity of care by either a GP or a Midwife were shown to be more effective in providing individual and personalised care, education, and support, with women reporting a more positive experience under this model (Brown et al., 2014).

The 2013 Cochrane Review on Midwife-led continuity models versus other models of care for childbearing women, identified many evidence based benefits of Midwifery continuity models (Sandall, Soltani, Gates, Shennan, & Devane, 2013). This review included 13 studies involving 16,242 women, both of low and increased risk of complications (Sandall et al., 2013). Under midwifery continuity models women were less likely to experience antenatal hospitalisation, induction of labour, instrumental birth, preterm birth, amniotomy, episiotomy, and fetal death before 24 weeks gestation (Sandall et al., 2013). Furthermore, it was identified that standard medical led models yielded higher rates of operative and instrumental births and incurred higher costs to the public health system (Sandall et al., 2013).

These findings are consistent with supplementary Australian research that assessed the benefits of midwifery continuity models, which showed that there was a significant decrease in caesarean sections from 18% to 13% in midwifery models compared to standard models, with midwifery continuity models costing considerably less than standard models. Furthermore, maternal satisfaction was greater and overall levels of safety between midwifery continuity models and standard models were equally comparable (Jenkins et al., 2015; McLachlan et al., 2012; Toohill, Turkstra, Gamble, & Scuffham, 2012; Tracy et al., 2013).

There is clearly a dissonance between standard fragmented models of antenatal care and midwifery continuity models. Midwifery led continuity models are based on the fundamental philosophy of woman centred care, empowering women to make informed choices, by personalising care to
address the unique needs of every women (Burton & Ariss, 2014). The midwifery focus is on building relationship and trust with the women and providing individualised education, counselling, and support while ensuring continuity of carer throughout the pregnancy/birth continuum (Burton & Ariss, 2014). Furthermore, in accordance with Midwifery Competency Standards, midwives are required to provide culturally safe care for women and their families, by acknowledging, respecting and incorporating cultural beliefs and customs into their practice (Nursing and Midwifery Board of Australia, 2006). Additionally, midwifery models are well suited to being integrated within primary health care services, which focus on bringing health care services to remote and rural communities, improving access for Aboriginal women (Monk, Tracy, Foureur, & Barclay, 2013).

It is evident from the research that midwifery continuity models of care have many benefits and advantages over standard models of care, with many of these benefits directly addressing the reported needs of Aboriginal women.

**SIGNIFICANCE FOR FUTURE RESEARCH, PRACTICE, and EDUCATION**

There is a paucity of research evaluating whether or not midwifery continuity care models for Aboriginal women will improve overall health outcomes. Further research and evaluation on maternal and neonatal outcomes for Aboriginal women accessing midwifery continuity models is required. However the identified needs and perceptions of Aboriginal women must surely direct our future practice and the design of service delivery.

While Australia is currently committed to extending and enhancing primary maternity services, midwives remain largely underutilized in rural and remote regions, where they could be providing primary maternity care for Aboriginal women (Kildea, Kruske, Barclay, & Tracy, 2010b). Further government investment in establishing primary maternity services in these regions, staffed by midwives as the primary carer to ensure continuity of care and cultural safety is vital for improving the engagement of Aboriginal women accessing antenatal care.

Providing increased education to Aboriginal women regarding the benefits of Antenatal care is worthy of attention, however if Aboriginal women’s needs are not incorporated into the deliver design of antenatal care, increased Education may be incongruous. Further research is warranted in this area.
CONCLUSION

This review highlights the unique and diverse needs of Aboriginal women, and their current perceptions of antenatal care in Australia. According to Aboriginal women, current standard delivery models of antenatal care are lacking in flexibility, individualised and personalised care, continuity, cultural appropriateness, and proximity to rural and remote Aboriginal communities. For these reasons Aboriginal women are currently underutilizing antenatal care, which is causally related to increased adverse maternal and neonatal outcomes.

The evidence based benefits of Midwifery continuity models are well suited to directly address the reported needs of Aboriginal Women. Midwifery continuity models are founded on woman centred care with a primary health care focus. This model of antenatal care offers more flexibility and continuity, and is better equipped to be more responsive to the individual and cultural needs of Aboriginal women.

The identified attributes of good quality antenatal care, as reported by Aboriginal women, provides vital feedback for directing the future design and delivery of antenatal care services to Aboriginal women. Improving the design, quality, delivery and location of antenatal care services is a key component to improving the engagement of Aboriginal women in antenatal care, and thus improving the current health inequities.
REFERENCES:


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