Antenatal Care and Perinatal Health: 
How to do it Better in an Urban 
Indigenous Community

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Antenatal care and perinatal health — how to do it better in an urban Indigenous community

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Before I start it is our custom to actually acknowledge the traditional owners and that’s the Ngunnawal people. Also to acknowledge some of the others that I know that are in this audience today. First of all I am just going to show you a structure of an AMS. When I say AMS, that is an Aboriginal Medical Service. TAHS stands for the Townsville Aboriginal Health Service and that’s the organisation that I work for and that’s our staffing structure. It’s quite a large AMS and we deal with a range of issues right across, from our social welfare section, dental, medical, transport, crisis accommodation and that sort of basically gives you an overview of the staffing structure.

And this is now our new structure in terms of the organisation and you’ll note in the highlight there we have got the maternal and child health program. My talk is about how to do it better in an urban Indigenous community. The Townsville Aboriginal Health Service — prior to six months ago we did a lot of research into maternal health care in the Townsville region and it was quite appalling, the conditions and the access to service for our mums and babies so there was a group of us that went out and lobbied to try and develop our own maternal health program, and I would acknowledge Rio Tinto Indigenous Foundation and the Ian Potter Foundation.

Townsville Aboriginal and Islander Health Service

Mums and Babies Program
funded by
Rio Tinto Indigenous Foundation,
The Ian Potter Foundation,
Queensland Health and OATSIH

They actually sponsored us for two years to run our maternal health program. It has only been going for six months. We also acknowledge Queensland Health and the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in terms of all the resources they give us to assist us in this program. The Townsville Aboriginal Health Service has over — probably our active registered patients are around about 10 000.
TAHS, obviously, as I stated before is an AMS. Townsville is a major regional centre of north Queensland and our population is approximately 150,000 and I think Townsville would have one of the largest Indigenous populations in Australia.

The ABS stats in 1996 stated there were about 8500. You could always add another 30 or 40 per cent on that figure because a lot of our people don’t state who’s in that house on that particular night when they do the stats because most of them do live in housing commission and they’re not going to say, “We’ve got 16 people in our home,” so they usually give about four. In breaking up that population we have about 70 per cent Aboriginal and 30 per cent are Torres Strait Islanders. The births in Townsville, and this relates to some of the research that we did prior to our program, was estimated at about 160 births per year in Townsville in the Kirwan Hospital. Approximately 250 to 270 are Indigenous families.

We would argue that’s higher because once again State health doesn’t keep good stats on identifying Aboriginal and Torres Strait Islander people. There’s approximately about 60 to 70 of those babies born — sorry, 180 to 190 were Aboriginal which is about 11 per cent. Torres Strait were 60 to 70 births, which is about 3.5 per cent and I would ask you to remember that 3.5 when we go further on the Torres Strait figures. This slide shows the perinatal mortality in Queensland since 1987. This number is of perinatal deaths per thousand births.

As you can see the rate for the Indigenous people in Queensland is quite high. It was about 25 per thousand. In the Indigenous community in Queensland it was 25 compared to the non-Aboriginal community which was 10 per thousand. On the end we have added Aboriginal births and Torres Strait births separately and, as you can see, the Torres Strait Islanders — and that’s the aqua green on the top part up there —
Pre-term births (births < 37 weeks gestation) — Queensland, Kirwan

Pre-term births in Queensland. Once again, this shows the rate of pre-term births in Kirwan, that the numbers of babies born too early or before 36 weeks. Again, you can see that we have a greater proportion of pre-term births amongst the Aboriginal and Torres Strait Islander population than the non-Indigenous at Kirwan. See Kirwan there. You can see obviously the Torres Strait Islanders are far worse there but however it does pan out when you take it right across Queensland.
Low birth weights, Queensland. Kirwan once again, Townsville shows a high rate of the Torres Strait but then when you go across Queensland it shows the Aboriginals are far worse.

Antenatal care at Kirwan. This table shows us a rough look at the antenatal care attendance pattern at Kirwan Hospital for the period of 1998 and 1999. As you can see once again the percentage of Aboriginal women to have no antenatal care at all was 4 per cent and 5.5 of the Torres Strait Islander women compared with only half of one per cent of non-Indigenous women and approximately 12 per cent of Indigenous women had less than two antenatal visits in 1998 at Kirwan. So, clearly in Townsville at Kirwan Hospital there were many Aboriginal and Islander women who were not receiving adequate antenatal care.

Looking a bit further at the antenatal care of the Torres Strait Islander women who were booked in the Kirwan in 1998 there were 54 women who were identified as Torres Strait Islanders by the midwives. Of these 54, 21 were registered with TAHS (the Townsville Aboriginal Health Service) which was 39 per cent and of the 21 women only eight had come to TAHS during the pregnancy. Finally for the group as a whole only 28 out of the 54, approximately half, had more than four antenatal visits, so virtually had adequate antenatal care for pregnancy.

Why is this so? The history of Indigenous communities in north Queensland and (2) services that were being offered to the young women and I don’t think I need to go into the history of what it was like for Aboriginal and Torres Straight Islander people in...
north Queensland. So, once again it raises questions which perplex our communities and health systems over the last ten years and that the question is why do these statistics remain so dismal. And the answer probably lies in two major areas and, as I stated, that was the history and secondly the Kirwan Hospital wasn’t providing culturally appropriate service.

Pre Mums and babies: two major service providers

- **TAIHS**: walk in service with no appointments
  - Problems: long waits
    - waiting area not child friendly
    - hit and miss: opportunistic
    - no reliable system of following up

- **Kirwan**: appointments for scans and clinics
  - Problems: not culturally friendly
    - long waits in unfriendly environment
    - shared care protocol not tailored for Indigenous women

Pre-mums and babies. This slide looks at some of the reasons why Indigenous women are not attending for antenatal care prior to the year 2000 and I emphasise the year 2000. We are not talking the 60s or 70s, we are talking the year 2000 in Townsville. We have two major service providers of antenatal care, first the Townsville Aboriginal Health Service and it did share antenatal care with the Kirwan Hospital but it was inadequate. TAHS was providing an ad hoc walk-in service with no appointments. There were a lot of problems associated with this service. These primarily related to long waiting times.

At the time we didn’t have a lot of doctors, the clinic was very busy and there was certainly no priorities given to our pregnant women and the waiting area is very small but that will soon sort itself out — we move into a new building next month — and it wasn’t child-friendly. We didn’t have a reliable system to follow up on the antenatal care and it was mostly opportunistic with few hits and lots of misses. Turning to the Kirwan Hospital again there were long waits in an unfriendly environment and not a particularly culturally friendly environment.
How to do it better?

- In August 1999 a forum was organised by the Nutrition Department of the Tropical Public Health Unit in Townsville
- Attended by representatives from most maternal and child health services in the Indigenous community
- Addressed the question of maternal and child health in the Indigenous community in Townsville
- Could we do it better?
- How do we do it better?

How to do it better. In August 1999 a forum was organised by the Nutrition Department of the Tropical Public Health in Townsville specifically to present some of this research that had been done in Townsville and representatives from all the maternal and child health services in the Indigenous community and mainstream communities were invited to attend the forum. The forum basically addressed the questions in maternal and child health in Indigenous communities in Townsville and certainly it generated a fair amount of discussion and certainly the question arose, “Could we do it better and if so, how.”

Forum: conclusions

- A team approach was needed for Indigenous mothers and infants
- Existing services needed to be improved and better co-ordinated
- Transport and education needed to be improved

The forum’s conclusion was that team approach was needed. It also aroused in this community an overwhelming support of all the conclusions that I have just stated. It was really felt a team approach was needed for Indigenous mothers and infants, that existing service needed to be improved and better co-ordinated and certainly we needed to improve in transport and in education for these women and their families.

A collaborative approach. So from this forum a working party was formed which represented all the maternal and child health service provided in Townsville as stated and there really was a commitment to establish or try to improve the situation. This working party was reasonably short lived, however, the process of preparing joint submissions for the funding meant that the communication between the existing service providers could improve immensely.

Collaborative approach, mums and babies program. From that time we established a collaborative approach to maternal and child health service for the Indigenous
community in Townsville. This approach continues to have some hiccups but is proving to be very successful so the people now involved in this collaborative model are the following service providers: ourselves, the Townsville Aboriginal Health Service, Child Health, Tropical Public Health and these are all Queensland health departments I am talking about. Indigenous Health Unit at the JCU, Kirwan Hospital for Women and the Townsville Division of General Practice.

Mums and babies program. The major service provider is ourselves, TAHS, and the dedicated team which comprises of two health workers, one child care worker, one driver, two female doctors. At the present time the team runs the Maternal and Child Health Clinic which is a separate clinic held adjacent to the main medical clinic at TAHS and as I stated earlier we did all sort of try to do our best in our mainstream medical clinic at the Townsville Aboriginal Health Service but it didn’t work. So, we have separated and it’s running in its own little building right next to our medical centre, five mornings a week, no appointments are needed. We’ve established a friendly environment which you will see later on with a playgroup environment for children and women waiting to attend.

Mums and babies program — significant service providers. Child health in Townsville sends a midwife — that’s the Queensland Child Health in Townsville — and a childcare nurse to TAHS two mornings a week. The Aboriginal and Islander Health Program, Queensland Aboriginal Health Programs, provides TAHS with a health worker for outreach so these additional resources we are getting to the ones I stated before. The Kirwan Hospital shares obstetric care with TAHS, does all the scans and deliveries and some antenatal visits. Kirwan still looks after all the high-risk patients. Kirwan Hospital has not changed a lot, however, we have improved our communication with them quite significantly.

Mums and babies and the service providers. Centrelink comes down once a week and gets people to join up with Medicare, their entitlements and any other issues they may want. Tropical Public Health come and they assist in the breast feeding, nutrition and smoking cessation program. JCU has a collaboration with the Maternal and Child Health Course and that is my team, our team, I should say. Melvina Mitchell is the far one on your left, Sister Kate Stewart, Kim Kennedy is our child care worker, Helene Maloff is one of the State health workers, Kay Kyle is our driver, Dr Vivian Manessis is the bottom one on your left there, Katie Panoretto — Dr Kate Panoretto.

She was actually one of the main drivers in developing this program and she is our senior medical officer, Heather Lee is the co-ordinator of the program and Haylene is from Queensland Health. That was our pre-waiting room where all our mums and babies and dads had to wait in the main room. That is our new child-friendly waiting room and whilst we had the child health worker there she actually helps look after the kids so mum can have her private time in the doctor’s without any worries about her babies.

Mums and babies. We’ve achieved, as I’ve stated before, the two health workers, one midwife, two doctors every day. The outreach health worker works independently daily and comes into the clinic one to two mornings a week. We provide general primary health care every morning for young families and there’s a list of what goes on.
This is quite interesting. Our programs started around in June and you could see how it is actually a reason — we started off with about 120 a month and we are up in the 500 a month of mums and babies. Our pre-term births less than 37 weeks prior to the program, we had 15 or 17 per cent less than 37. The mums and babies — now it’s dropped quite significantly.

Birth weights less than 2500 grams was 16 out of the 88 and that’s dropped quite significantly. Perinatal death, we had five or six per cent. In our program now that’s dropped significantly but we’re still working on that only because our numbers have dropped or have we done something well. We don’t know. The perinatal death per thousand for Aboriginal people prior to the program was 56.8, it is now 18. Antenatal care. Gestation at first visit is how early they are coming in for their first pregnancy antenatal care. It was around about 14 weeks and that hasn’t changed much in our new program.

The number of antenatal visits was around about three and that has doubled. The antenatal time shared because it didn’t exist before, that’s been great, that’s 57. The hospital are only seeing about 10 whereas before it was quite higher than that.

Where do we go now? Current funding for this program is from a private sector. As I stated before we could not develop this clinic without the support of the Rio Tinto Indigenous Foundation and the Ian Potter Foundation. Should this type of program be a core program funding? These programs need Government support to continue.
Conclusion. We can do it better. The response to this program has been overwhelming. It is possible to improve antenatal service. It requires a drive from the community, a commitment, improvement, communication and linkage. Some extra funds — we don’t need huge amounts. We hope next year we can return here with a lot more good stories to tell. There’s one of our little bubs and mum and dad and there’s another little baby, he’s three months old and that’s probably the star of our maternal health program.

AUTHOR

Rachel Atkinson was born on the Rumbalara Reserve and spent 13 years living there before her family was moved to the fringe of a remote town. Rachel spent the last 17 years in Townsville were she has become a significant and valuable contributor to community affairs as an active advocate for equal rights. Rachel has been the CEO of the Townsville Aboriginal and Islander Health Services Limited.

Rachel is keenly interested and involved in family issues, child protection and juvenile justice and has worked with the Department of Family Services and Island Child Care Agency. Rachel also has a personal commitment to improving the health status of Indigenous people and believes the fundamental causes of Aboriginal and Torres Strait Islander health and ill health are based on poverty and powerlessness. Health initiatives must be based on recognition that health is multi-factional and are the result of the interaction of such factors as lack of water in some remote areas, poor housing, unhygienic environment; and personal stress from issues such as unemployment, alcohol and substance abuse, poor education and low self-esteem.