Midwifery continuity of care for remote women: the central Australian experience

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The Alice Springs Hospital (ASH) is a 189-bed specialist teaching Hospital situated in the Red Centre of Australia. The population in this area is dispersed over 1.6 million square kilometres. This creates unique and rewarding challenges in the delivery of a diverse range of comprehensive health services.

The ASH Maternity Unit consists of 16 antenatal and/or postnatal beds and four birth suites. It is attached to a level-two Special Care Nursery. On average, there are 850 births per annum and approximately 60% of these births are from Aboriginal women who reside either in Alice Springs or remote Aboriginal communities.

Prior to 2009 women in these rural and remote areas accessed maternity care through the hospital, GPs, remote primary health care centres and Congress-Alukura. A critical gap however existed in these services as they lacked continuity of both care and carer throughout a woman's antenatal, labour, birth and postpartum journey, particularly for women living in remote communities.

In attempt to resolve this issue and along with: recommendations from several Government reports including the "Northern Territory (NT) Integrated Maternity Services Report (2008)"; national and international evidence; and a growing demand from women and families, a Midwifery Group Practice (MGP) model of maternity care commenced at ASH in March 2009.

The MGP was set up in a building within the hospital grounds but external to the general and maternity wards. It is easily accessed by women and is situated within walking distance from the main aboriginal hostels and town centre.

The overarching principle of the MGP is the provision of continuity of midwifery carer to each woman by a known midwife. The Primary midwife becomes aware of the woman's social, medical, obstetric and cultural history and a relationship begins to develop. The care experienced by the woman is connected and coherent and the primary midwife provides a bridge for all other care-providers so that the woman's care is not fragmented but consistent, coordinated, collaborative and centred on the woman not the health professionals involved.

Initially MGP only provided care to women without medical complexities. After six months of operation an informal internal evaluation was conducted with key stakeholders. The evaluation recommendations resulted in widening the MGP scope of practice in order to provide care for all women regardless of their pre-existing or pregnancy related morbidities and to include the option of publicly funded home birth for well women. Four years later the MGP is still successfully providing both options of care.

The midwives are employed under an annualised salary which includes an entitlement to receive an allowance at the rate of 31.7% of salary, in lieu of overtime, shift penalties, on-call or restrictive duty payments. In accordance with clause 47.2 of the *Northern Territory Public Sector Nurses and Midwives 2011-2014 Enterprise Agreement*, a Variation to Working Arrangement has been agreed to by the employees and the Australian Nursing Federation, this has the title of Determination 1066.

The original MGP team comprised of five experienced midwives and one new graduate midwife with the provision for one aboriginal health worker (this position was unfortunately unable to be recruited to at that time). Four midwifery positions were funded through the Acute Care Division (ACD). The two other midwifery positions and the Aboriginal Health Worker position was funded by the Northern Territory Closing the Gap and the Council of Australian Government (COAG) Indigenous Early Childhood Development National Partnership. This meant that the MGP could adhere to its primary

objective and provide continuity of carer for all Central Australian women including those living in remote Aboriginal communities. A Memorandum of Understanding (MOU) had to be developed between the ACD and Health Services Division (HSD) to enable this provision of care. This specific funding ensures that at least 30% of women cared for by the program are Aboriginal women from remote communities.

Each MGP midwife cares for a caseload of approximately 32 – 40 women annually (dependant on if they have full or part time employment). As the midwives can only provide care to a set number of women each month there are limitations to the number of women who can access the service. Currently there are significant numbers of women on the waiting list as the demand is greater than the service capabilities. This limitation assisted in providing evidence for the need to expand the practice. Extra funding and support was gained and in 2012 the practice expanded to employ seven fulltime equivalent midwives, two aboriginal health workers, a manager and an administration assistant.

Currently there are three full-time and five part-time midwives working in the MGP. One of these positions is still allocated to a New Graduate. The eight midwives are separated into three smaller associate teams, with the intention of supporting and providing backup for a woman when her primary midwife is on days off or on unexpected leave. Throughout the pregnancy women have the opportunity to meet their associate midwives to ensure that continuity remains the key principle of the service. The roster is based on a 24/7 on-call system, with each midwife also allocated dedicated days off. This provides continuity of care for the women, but also provides the midwives with down time in order to reduce burn out rates.

There is one Obstetrician linked in with MGP for liaison and collaboration with the MGP Midwives. This enhances the continuity process and enables consistent communication flow, care planning and decision-making between the woman, MGP midwives and the Obstetrician. Consultation and referral processes are led by the 'Australian College of Midwives National Midwifery Guidelines for Consultation and Referral' (2008).

The day to day running of the MGP is dependent on the support and consideration of the Maternity Unit Midwives (MUM's). Their collaborative support and reciprocal cooperation is crucial for the effective functioning of the MGP and its midwives. The MUM's provide essential support for MGP Midwives working with women in labour and birth by providing relief for breaks, meals and similar. When a woman accessing MGP care approaches second stage of her labour in the hospital setting one of the MUM's will be required to support the MGP Midwife in the birthing room. This close liaison makes a significant difference to the MGP midwives' ability to function safely and effectively by enabling appropriate breaks and ensuring thorough communication is achieved. It also enables consistency in the woman's care and ensures that the women, midwives and program are supported and sustainable.

As well as the ASH Maternity Obstetricians and Midwives, the MGP midwives work in collaboration with many other services to ensure women have access to appropriate individualised care. Some of these services include, but are not limited to: Remote Health; Health Development; General Practitioners; Diabetes Educator; Dieticians; Perinatal Mental Health Team; Social Work; Department of Children and Families; Congress Alukura; Aboriginal Liaison Officers; Paediatrics; Anaesthesiologists; Birth and Beyond Education and Parent Resource Centre; Maternal and Child Health Centre and Natural Therapists.

Women are able to self refer to the MGP or can be referred by any healthcare professional. Care is commenced from ten weeks gestation and provided until six weeks postpartum. Within the MGP there are two different models of care provided dependant on where the woman lives.

If a woman lives in a remote Aboriginal community and requires maternity care her journey generally begins with a presentation at her primary health care centre (clinic). Her pregnancy is confirmed and arrangements are then made for the woman to have an ultrasound (Dating scan, Nuchal Translucency

Screening and/or Morphology). All ultrasounds are attended at either ASH or Tennant Creek Hospital (TCH) depending on which is closer for the woman. If the woman has co-morbidities she will also see the ASH obstetric team at this time. Please note TCH does not currently offer birth services and the obstetric team from ASH only visits there monthly.

The majority of the woman's pregnancy and postnatal care is attended in the remote community. The extreme turn over rates of remote staff can create instability within the clinics and fragments the plan of maternity care already in place for women. A midwife may work in the clinic many are staffed with nurses who do not have midwifery registration. A Doctor may visit the community every few weeks but most communities do not have on site doctors.

Remote Aboriginal Communities are generally 200km to 1000km from Alice Springs. Some communities can be accessed by sealed road but most only have dirt roads. Transportation to ASH or TCH for appointments is dependant on what is available in each community. Women may have access to a "Bush Bus" but this option is only available on certain days. Many communities do not have access to such a service and so the woman must make her own travel arrangements. Families may share a car and it may in use elsewhere at the time the woman needs to travel, or the family may not have money for the upfront expensive petrol costs (petrol costs are reimbursed after the travel has taken place).

These transportation problems combined with many other social issues and communication deficits contribute to a lot of ASH appointments not being attended. As a result follow-up plans are often not created. This problem is exacerbated by our current computer systems. We have various computer systems in the NT and none of them are linked to the others. This causes extensive communication issues and contributes to women "falling through the gaps in our health care system."

Women are not able to birth in their communities so at approximately 38 weeks gestation a woman will travel to Alice Springs to stay and await labour and birth. She is accommodated in a hostel with other women, men and children from many different Aboriginal communities in the NT, Western Australia and South Australia. If a woman has family in Alice Springs she may choose to stay with them. Sometimes she is accompanied by a family member during this time but often she will be alone, leaving her entire family unit back in the community. If problems arise during the pregnancy, birth or postnatal period a woman may spend several weeks or even months in town away from her family and community. This poses many problems of loneliness, worrying about their other children and if they are being cared for adequately, fear and boredom. Some women chose to travel back to community before birth; others who stay may want a social induction so they can return sooner. Once a woman and her newborn are discharged from the hospital she may return to the hostel to await transportation back to community. She may have to wait a couple of days or weeks until this transportation is available.

Aboriginal women from remote communities are supported to access MGP care as early as possible through the health workers that currently work within each community. If the woman is part of the MGP program her primary midwife works in collaboration with the nurses and or midwife in the community to try and ensure that the woman does not fall through the system gaps.

The woman's MGP midwife will meet the woman when she first comes into Alice Springs whether this is for an Ultrasound or Obstetric appointment. Sometimes women will come to Alice Springs to visit family or watch a football game, the MGP midwife may see her then even if it's just for an introduction and chat. Sometimes the care the women receive in Alice Springs is the only midwifery care they have access to during their entire pregnancy and postnatal periods.

Whenever the woman is in Alice Springs her MGP midwife is her primary care provider. If a woman is transferred to ASH during her pregnancy for a complication her MGP midwife is called to ASH to provide her care. She visits her daily if she is admitted in hospital and provides follow up care if the woman is discharged to a hostel. Whilst the woman is in her remote community, both in the antenatal and postnatal period, the woman and the clinic midwife or nurse have 24/7 access to the MGP team. The woman's MGP midwife will liaise with the community health workers to assist the clinic in routine

and necessary follow up care. When the woman and newborn travels back to community her MGP midwife informs the community of the family's return and follows up with the clinic on their postnatal care.

The other option of care MGP provides is for women who live in the town of Alice Springs. These women can access home or hospital birth services. The woman's primary midwife provides her antenatal care and organises routine ultrasounds and pathology. The woman's care can be provided in the woman's home or at the MGP centre. The midwife is called to the woman's choice of birth place when she is in labour. If the woman is in the hospital setting care is handed over to the maternity ward staff around two to fours hours post birth. The midwife than visits the woman and her family in the woman's home up until six weeks post birth. Care is then handed over to the Maternal and Child Health Centre.

Women have 24/7 access to the triage midwife at MGP from commencement on the program (generally at ten weeks gestation) until they are discharged around six weeks postpartum. One of the eight midwives each day has the role of triage. All phone calls are directed to that midwife for the 24hour period. The MGP midwife either resolves the woman's concerns over the phone or transfers the care to the woman's primary midwife as appropriate. This ensures that the other midwives working get as much rest as possible.

Recommendation

That every woman in Australia has access to models of midwifery continuity of care and carer especially in rural and remote areas in order to decrease maternal and neonatal mortality and morbidity.

Alice Springs – Midwifery Group Practice Outcomes, March 2009 – Dec 2012

	Indigenous		Non-Indigenous		TOTAL	
	No.	%	No.	%	No.	%
Total number of births	306	39.8%	463	60.2%	769	100%
Spontaneous vaginal births	235	41.2%	335	58.8	570	74.1%
Planned homebirth	1	1.5%	64	98.5%.	65	8.45%
Actual homebirth	1	2.4%	42	97.6%	42	5.45%
Stillbirths	3	42.8%	4	57.2%	7	0.9%
Birthed in the community	8	72.7%	3	27.3%	11	1.4%
Primipara	141	39.3%	218	60.7%	359	46.7%
Multipara	165	40.2%	245	59.8%	410	53.3%
Induced births	98	46.6%	112	53.4%	210	27.3%
Caesarean	61	41%	88	59%	149	19.3%
Vaginal breech births	1	14.3%	6	85.7%	7	0.9%
Post partum haemorrhage	47	45.6%	56	54.3%	103	13.4%