

# **SERVICE DELIVERY MODEL**

## **Aboriginal Maternal and Infant Health Service**

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## 1 Introduction

The Aboriginal Maternal and Infant Health Service (AMIHS) Service Delivery Model outlines the philosophy, aims, objectives and essential elements including staffing attributes of the state-wide AMIHS. This is the model Area Health Services and Aboriginal Community Controlled Medical Services must base new AMIHS programs on and also refer to when re-orienting existing sites to ensure they deliver the core elements of AMIHS.

All NSW Health policies and procedures apply.

## 2 Philosophy

The NSW Aboriginal Maternal and Infant Health Service is committed to improving the health of Aboriginal families and babies in NSW by providing a high quality service that is culturally sensitive, woman centred, based on primary health care (PHC) principles and provided in partnership with Aboriginal peoples. AMIHS builds on the universal maternity services that are available in NSW and expressed in the *NSW Framework for Maternity Services*. The philosophy is expressed through seven broad values<sup>1</sup>. These are presented in Figure 1.

### Figure 1: Values of the NSW Aboriginal Maternal and Infant Health Service

**Cultural Respect** – recognising the unique place that Aboriginal and Torres Strait Islander people have in Australian society.

**Social Justice** - enabling Aboriginal people to have their physical, social, emotional and spiritual needs met and have greater control over the decision-making processes which affect their lives.

**Participation** - facilitating involvement by people in the issues which affect their lives based on autonomy, shared power, skills, knowledge and experience.

**Equality** - challenging the attitudes of individuals, and the practices of institutions and society, which discriminate against and marginalise people.

**Access** – facilitating access to services by Aboriginal people and working towards ensuring that those services are culturally respectful and appropriate.

**Learning** - recognising the skills, knowledge and expertise that people contribute and develop by taking action to tackle issues that impact on the wider social determinates of health.

**Collaboration** - working together to identify and implement action, based on mutual respect of diverse cultures and contributions.

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<sup>1</sup> Adapted from the values of community development: <http://www.cdx.org.uk/what-is-community-development>

### 3 Guiding principles

The AMIHS service model is expressed through a number of guiding principles that are derived from the philosophy and values and builds on their responsibility as maternity services in NSW. These are: (1) a broad and social view of health; (2) partnership with women and the Aboriginal community; (3) primary health care principles; (4) cultural respect and competence; (5) community development and (6) woman centred care. All AMIHS services must express these guiding principles in their development and implementation. Prospective evaluation of the implementation process and the outcome indicators are important components to build in at the initiation of the service.

1. AMIHS takes a **broad and social view of health** encompassing physical, social and emotional, cultural and spiritual wellbeing of individuals and communities<sup>1</sup>. AMIHS recognises that the social and emotional wellbeing of Aboriginal people is affected by a range of social determinates of health<sup>2</sup>. Health promotion and community development activities are important components of AMIHS and contribute to ensuring this broad and social view of health is taken.

2. AMIHS has **effective partnerships** to ensure that the expertise of Aboriginal communities is brought to the health care processes. Partnerships between Area Health Services (AHS) and the Local Aboriginal Community Controlled Health Services (ACCHS) are essential to the success of AMIHS. Strong partnerships with General Practice are critical for the provision of quality, integrated care to women in pregnancy.

3. AMIHS uses a **primary health care** framework that encompasses equity, access, the provision of services based on need, community participation, collaboration and community-based care. Primary health care involves using approaches that are affordable, appropriate to local needs and sustainable<sup>3</sup>. Primary health care means that care is provided in community-based settings as part of a universal service and provides women and the Aboriginal community with opportunities for participation in the development and implementation of services. Staff in the AMIHS need to be able to provide care in a flexible manner which includes access to transport and provide home visiting services.

4. AMIHS believes that **cultural respect and competence**<sup>4</sup> shapes the provision of health services. Understanding of, and a respect for, Aboriginal culture is fundamental to achieve improved Aboriginal health outcomes<sup>5,1</sup>. Education in cultural respect and communication should be provided to all NSW Health staff including all AMIHS staff<sup>6</sup>.

5. AMIHS works with **community development** processes to achieve its aims. Community development is “the process of developing active and sustainable communities based on social justice and mutual respect. It is about influencing power structures to remove the barriers that prevent people from participating in the issues that affect their lives. Community Development expresses values of fairness, equality, accountability, opportunity, choice, participation, mutuality, reciprocity and continuous learning”<sup>7</sup>.

6. AMIHS provides **woman centred maternity care**. Woman centred care implies that care:

- is focussed on the woman’s individual, unique needs, expectations and aspirations, rather than the needs of the institutions or professions involved
- recognises the woman’s right to self determination in terms of choice, control, and continuity of maternity care from a known or known caregivers
- encompasses the needs of the baby, the woman’s family, her significant others and community, as identified and negotiated by the woman herself
- follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary
- is ‘holistic’ in terms of addressing the woman’s social, emotional, physical, psychological, spiritual and cultural needs and expectations<sup>8</sup>.

In AMIHS, woman centred maternity care is provided utilising continuity of care. The definitions of continuity are broad and often confusing. One way to consider continuity is to define it as a hierarchical concept, ranging from the basic availability of information about the woman’s past history to a complex interpersonal relationship between provider and woman, characterised by trust and a sense of responsibility. One way of articulating this hierarchy is outlined in Figure 2<sup>9-11</sup>.

**Figure 2:** Continuity of care as a hierarchical concept

Informational continuity	<ul style="list-style-type: none"> <li>▪ includes having systematic processes whereby the information about each woman is readily available to any health care professional caring for her and can be accessed and communicated among those involved in the care.</li> <li>▪ this is an important aspect of continuity in preventing clinical errors and ensuring safety, but by itself informational continuity might not improve access to, or experience of, care.</li> </ul>
Longitudinal continuity	<ul style="list-style-type: none"> <li>▪ creates a familiar and appropriate setting in which care can occur and should make it easier for women to access care when needed</li> <li>▪ each woman or family has a ‘place’ where she receives most care and a team who assumes responsibility for coordinating the quality of care, including health promotion, education and community development activities.</li> </ul>
Relational continuity	<ul style="list-style-type: none"> <li>▪ the development of personal trust between an individual care provider and a recipient of care</li> <li>▪ an ongoing relationship exists between each woman and a care provider</li> <li>▪ the woman or family knows the provider by name and has come to trust them on a personal basis.</li> </ul>

## 4 Aim

The overarching aim of the AMIHS is to improve health outcomes for Aboriginal women and women with Aboriginal partners during pregnancy and birth and decrease maternal and perinatal morbidity and mortality.

To meet this aim, AMIHS provides community-based maternity care in pregnancy and the early postnatal period and is involved in community development initiatives that promote a healthy lifestyle. The care is provided in a partnership model by midwives and Aboriginal Health Workers/Aboriginal Health Education Officers.

To assist in achieving the aim, the AMIHS will:

- provide an effective, integrated state-wide maternity program for Aboriginal families, that will provide Aboriginal women (and women with an Aboriginal partner) and their babies with maternity services, comprehensive health screening, assessment of their needs and coordinated, accessible support systems
- maintain strong relationships with other relevant health services such as early childhood, child protection, mental health, drug and alcohol services and provide advocacy and support for Aboriginal families within mainstream services.
- provide a voluntary referral pathway to Department of Community Services' (DoCS) early intervention program known as Brighter Futures

## 5 Objectives

The objectives of AMIHS are to:

1. Improve maternity service delivery for Aboriginal families and their babies and contribute to the safety, welfare and wellbeing of Aboriginal children and young people through:
  - the provision of community-based, culturally sensitive, continuity of care for Aboriginal babies and their mothers to 8 weeks postpartum
  - effective local Aboriginal health partnerships and collaboration with the Aboriginal community controlled sector
  - collaboration with medical, obstetric, paediatric and child and family health staff and clear systems for transfer of information between health care providers
  - health promotion initiatives including smoking cessation, drug and alcohol reduction and sexual and reproductive health
  - collaborate with services provided by health and other agencies as required.
2. Increase the awareness of Aboriginal women and Aboriginal communities about pregnancy related issues through community development activities.
3. Develop and maintain effective links with relevant agencies including the

Department of Community Services, Department of Housing and Centerlink, and relevant non-government organisations.

4. Ensure effective training, recruitment and retention of Aboriginal Health Workers (AHW) or Aboriginal Health Education Officers (AHEO) and Aboriginal midwives to AMIHS services including the provision of:

- appropriate management and organisational support from both mainstream and Aboriginal Community Controlled Health Services
- essential infrastructure support - a mobile phone, desk, computer, and a car
- supportive work conditions including peer support, professional development and clinical supervision.

## **6 Essential elements of an AMIHS service delivery model**

This section describes the essential elements of AMIHS programs and provides examples of how these essential elements and the guiding principles can be put into operation.

Programs must be designed in consultation and in line with local context, needs, community relationships and community and health sector expectations. The six guiding principles outlined must be expressed in the design, planning and implementation of the individual program. Community participation in the design, planning and implementation is essential.

Essential elements of the AMIHS service delivery model include:

1. the provision of antenatal and postnatal care to 8 weeks
2. being accessible, flexible and mobile
3. having a seamless transition to child and family health nursing services
4. referral to other appropriate services including Brighter Futures
5. being involved in community development and health promotion activities
6. working collaboratively with other services including local Aboriginal Community Controlled Health Services
7. supporting workforce development and lifelong learning
8. building and sustaining effective community partnerships
9. having ongoing evaluation and monitoring
10. adherence to NSW Health policies and procedures, including those that protect and promote the safety, welfare and wellbeing of children and young people.

These are the minimum requirements for all AMIHS-funded programs (they are not in order of priority). Development, articulation and clarity of the model of care is dependant on the local context and local needs. Each service needs clarity about what the community wants or needs and what the service provides the target groups, the access arrangements and systems for consultation, referral and effective networking.

## 6.1 Provision of antenatal and postnatal care to 8 weeks

AMIHS programs must provide antenatal care, including 'booking in'<sup>11</sup>. Antenatal care may be provided from a variety of settings including Aboriginal Medical Services (AMSs), general practitioners' (GP) rooms, community health centres, midwife clinics, the child and family health centre or in women's homes. The nature of the care provision may on occasions be opportunistic and informal however adequate contemporaneous documentation must be undertaken. Antenatal care may also include accompanying women to hospital-based services to receive care in collaboration with local providers including obstetricians or GPs as required. Antenatal care includes the provision of information and education to women and their families.

AMIHS programs must provide postnatal care to eight weeks postpartum. This will mostly occur in the community either in women's homes or through Aboriginal community-controlled organisations, community health centres or the child and family health centre. Postnatal care should also include a process of transition to child and family health services and may include some visits with both the AMIHS staff and the child and family health nurse to ensure a smooth transition from one service to another. Postnatal care also includes collaboration with other professionals and agencies including mental health, drug and alcohol, DoCS, housing and local family support services.

AMIHS staff will generally make a liaison visit while the AMIHS women are at the antenatal clinic or in hospital during the early postnatal period. This will ensure that continuity of care is maintained and facilitates collaboration with hospital staff. In particular, the AHW/AHEO will undertake this liaison visit and ensure that women feel culturally supported while in hospital.

Some AMIHS programs may be in the fortunate position to provide midwifery care during labour and birth. Providing intrapartum care requires an on call commitment from the midwife and an understanding of the workload. While in many instances it may be possible and desirable (from both the perspective of the women and the midwife or AHW/AHEO), consideration needs to be given to long-term

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<sup>11</sup> Booking in is the first antenatal visit to the public maternity service where a comprehensive history is taken including psychosocial screening and a physical examination is conducted. AMIHS staff are reminded of their responsibilities contained in the *Children and Young Persons (Care and Protection) Act 1998*, which are outlined in the following NSW Health policy directives: PD2006\_104: [http://www.health.nsw.gov.au/policies/pd/2006/PD2006\\_104.html](http://www.health.nsw.gov.au/policies/pd/2006/PD2006_104.html); PD2007\_023: [http://www.health.nsw.gov.au/policies/pd/2007/PD2007\\_023.html](http://www.health.nsw.gov.au/policies/pd/2007/PD2007_023.html); PD2006\_109: [http://www.health.nsw.gov.au/policies/pd/2006/PD2006\\_109.html](http://www.health.nsw.gov.au/policies/pd/2006/PD2006_109.html)

sustainability. Midwives would be required to work in a small team with other midwives in order to provide the necessary back-up and support required for each other to make a success of this model of care. This is possible when midwives can work alongside or within a caseload midwifery group practice of 3-4 midwives. A system where the midwife is on call for long periods of time and alone without relief is unsustainable.

## **6.2 Location of the service**

AMIHS programs should be based alongside Community Health, Aboriginal Health or Maternity Units. Regardless of which one of these locations is selected, each AMIHS program must establish links with the other two locations/programs.

It is preferable that, AMIHS programs should be based in the community to ensure a high level of access, visibility and convenience for women. Sites to consider include community health centres, child and family health centres and community controlled Aboriginal Medical Services. Where being community-based is not possible, a regular outreach service into the community is essential. However, being Hospital-based, AMIHS programs particularly in a large hospitals, are far from ideal and may prove difficult for Aboriginal families to access.

Outreach services should also occur for areas that are outside the main town in which they are based. For example, when it is identified that a nearby town has a number of pregnant Aboriginal women but does not have an AMIHS service, a weekly or fortnightly visit to that community will ensure more women have access to AMIHS services. Some rural AMIHS programs will provide a number of outreach services depending on local needs and their location.

## **6.3 A smooth transition to child and family health nursing services**

The smooth transition to the child and family health nursing services requires careful planning. The AMIHS programs cater for women during the antenatal period and until eight (8) weeks after the birth when the transition to the child and family health nurse must occur. The child and family health services must be notified within two weeks of the birth<sup>iii</sup>. Appropriate steps must be in place to ensure this smooth transition through clarity of roles and responsibilities of all service providers involved.

Some strategies to ensure this occurs include:

- Sharing premises with the child and family health nurses
- Opportunities for the child and family health nurse to meet the women and family in the antenatal period
- Shared postnatal visits in the first 8 weeks – midwife and AHW/AHEO and child and family health nurse

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<sup>iii</sup> The AMIHS Key Performance Indicators require that 100% of women and their babies will be referred by the midwife to the local early childhood health service within 2 weeks of birth.

- Having an AHW/AHEO as part of the child and family health nurse team
- Having effective relationships between the AMIHS program and the local child and family health nurse, including shared learning opportunities, shared management structures and premises.
- Respect and understanding of each other's roles and responsibilities amongst the AMIHS program staff and the child and family health nursing staff.

Additional funding for the provision of AMIHS child health services has been secured and will be incorporated into this service delivery model.

#### **6.4 Effective collaboration, consultation and referral**

AMIHS programs work in collaboration with health and other services. Effective consultation and referral includes referral and consultation to local GPs, obstetricians, physicians, paediatricians as required. This also includes working closely with other health and community based services including those providing assistance to victims of domestic and family violence, child protection, drug and alcohol and mental health services. Collaboration and liaison with the DoCS' Brighter Futures Program means that women and families can choose to be linked into DoCS early intervention programs. AMIHS workers should refer to the Working Agreement Paper between AMIHS and Brighter Futures for greater details on the AMIHS referral process to Brighter Futures.

AMIHS programs also work within child protection legislation and this may, from time to time, involve reporting to DoCS. It should be noted that all AMIHS staff are mandatory reporters under child protection legislation and NSW Health policy.

#### **6.5 Involvement in community development and health promotion activities**

AMIHS programs provide access to, and involvement with, community development and health promotion activities. These should be conducted in collaboration with the local Aboriginal community and the women's reference group. The AHW/AHEO will take the lead in community development activities. Examples of community development activities include art programs, play groups, women's support groups and camps, peer education and programs for men. Health promotion activities should focus on local needs and issues but it is likely that these will include topics such as healthy weight management, nutrition, smoking cessation, drug and alcohol reduction and cessation and general information on pregnancy, childbirth, breastfeeding, child health and sexual and reproductive health.

Community development and health promotion activities are often not seen as core business of maternity services. This is not the case for AMIHS programs. In order to meet the guiding principles of a broad and social view of health, it is essential that community development activities receive equal emphasis. Partnerships with community development groups including local art groups or external agencies, who have expertise in community development, may be beneficial as midwives and AHW/AHEOs often need assistance to develop these programs.

The AMIHS community development activities needs to be linked with community development activities and funding provided through other Government programs such as Families NSW and the Aboriginal Child, Youth and Family Strategy (ACYFS) funding.

## **6.6 AMIHS services must be flexible and mobile**

AMIHS programs must be flexible and mobile. The midwife and the AHW/AHEO must have dedicated access to a vehicle so that they can be visible in the community and accessible to women. The programs must provide flexible working conditions for the midwife and AHW/AHEO while ensuring, through management support and clinical supervision, that the professional boundaries and workload are appropriate.

## **6.7 Workforce and professional development**

AMIHS programs need to be committed to workforce development and building individual and team capacity. An effective partnership between the AHW/AHEO and the midwife is essential. The roles of the midwife and the AHW/AHEO and the midwife must be articulated as equal partners with different responsibilities. The midwife and AHW/AHEO team should have shared education, clinical supervision, management support, cultural training and access to ongoing professional development and flexibility. It is essential that the midwife does **not** have line management or organisational responsibility for the AHW/AHEO.

When the AHW/AHEO and the midwife commence employment in AMIHS programs, resources must be made available to ensure effective team building occurs at the outset. Strategies need to be put in place to ensure adequate orientation to the program and the community. Ongoing strategies include team building and access to prompt and effective conflict resolution if this is required.

Managers of AMIHS programs should support and work with the midwife and AHW/AHEO to identify and promote career pathways for the staff. This includes identifying and funding opportunities for ongoing education and continuing professional development and ensuring access to relevant scholarships and training.

The first evaluation of the AMIHS programs (2001-2004) highlighted a number of key factors affecting retention of staff. These included having:

- Effective management and leadership with clear lines of accountability, performance management, clinical supervision and support for education and training
- Clear strategic direction
- Time and effort spent in ongoing team building within the smaller AMIHS team and the wider maternity and child and family health services
- Grievance issues handled with sensitivity, quickly and effectively
- Recruitment of appropriate and committed staff
- Respectful relationships within the team

- Occupational autonomy and flexibility.

Other strategies that should be considered include:

- Rotational programs into AMIHS so that other AHW/AHEOs and midwives have experience with AMIHS
- Access to an orientation program that is supportive and informative
- Access to ongoing shared education, clinical supervision, management support, cultural training and ongoing professional development and flexibility.

Some Midwives and AHW/AHEOs may have limited understanding or appreciation of the process of clinical supervision. Clinical supervision is a relatively new concept for midwives and nurses and may well be unfamiliar to many AHW/AHEOs. The term ‘supervisor’ may conjure up ideas of monitoring, discipline and criticism. Some AHW/AHEOs and midwives will have concerns about the use of the word supervision. Nevertheless, clinical supervision is now a widely accepted term for the processes referred to within this report.<sup>IV</sup> Clinical supervision is an ongoing regular process that allows time to explore a practice experience, learn from experience and prepare for future similar situations. Clinical supervision supports the capacity of the AHW/AHEO or midwives to reflect on practice in a safe environment. Face to face clinical supervision is ideal and this can be provided in a number of ways either individually or as a group. If regular face to face clinical supervision is not feasible or sustainable, alternative modes of contact can be used to provide supportive supervision. For example, the use of telephone supervision, telehealth facilities or through computer communication could be explored.

Clinical supervision should be arranged and in place for the AMIHS staff. It is the responsibility of the employers to ensure that both midwives and AHW/AHEOs receive regular clinical supervision.

## **6.8 Effective community partnerships**

During the planning phase of the AMIHS service, community consultation is essential in order to establish the specific needs and wishes of the local Aboriginal community. This in turn will ensure that an appropriate and sustainable model is developed. The establishment of a community consultation process and/or a Women’s Reference Group will assist in engaging the Aboriginal community, as well as community controlled organisations.

Women’s reference groups are an important strategy to promote and support an enabling model of care and to develop effective partnerships with the Aboriginal community. Women’s reference groups are often led and developed by the AHW/AHEO in the AMIHS program.

Women’s reference groups remain challenging to establish and to maintain

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<sup>IV</sup> Clinical supervision for midwives in this context does not refer to the Statutory Supervision for Midwives that is practised in the UK.

momentum and a sense of purpose. In the past, some AMIHS programs have established their own groups that meet every two to three months and provide ongoing specific guidance on the AMIHS program. Other AMIHS programs have dovetailed with wider AHS community advisory groups or local women's action groups. AHSs should explore these dovetailing approaches as they may be more sustainable.

During the first one to two months of establishing a new AMIHS program involvement of community and service consultation is critical in order to build effective community partnerships. It is essential that the AHW/AHEO and midwife are aware of the services that exist in their local community and have made personal contact with these services and groups. These will include government and non-government services and should be broader than health-related services. Knowledge of the referral pathways and other networks especially within the Aboriginal community is also essential. During these first two months, the program should not start to recruit women – the emphasis is on learning about the community and developing networks.

## **6.9 Ongoing evaluation and monitoring**

Ongoing evaluation must be built into the AMIHS model. At a minimum, the service needs to be able to provide evidence of meeting the aims, objectives and performance indicators of the AMIHS. A separate project is in progress to develop a database to reflect this requirement.

## 7 Staffing

An AMIHS team consists of a Aboriginal Health Worker or Aboriginal Health Educator and a midwife. Each member of the AMIHS workforce requires particular skills, knowledge and attributes. In general, each member of the team needs to have knowledge of the philosophy, values and guiding principles of AHIMS and an understanding of how their roles relate to meeting these aspirations.

The AMIHS Workforce and Recruitment Plan which supports the AMIHS Service Delivery Model sets out the attributes and skills sets required by AMIHS staff to deliver the Service Delivery Model. It also outlines a recruitment and orientation process to 'fast track' staff into the AMIHS programs and identifies the workforce's ongoing professional development needs.

### 7.1 Attributes that the midwifery and AHW/AHEO workforce require to work successfully in AMIHS

A number of other attributes are also important including ability to:

- Be non-judgemental
- Be committed and motivated
- Be enthusiastic
- Have an understanding of personal and professional boundaries and obligations
- Have integrity and being able to maintain confidentiality
- Be adaptable and flexible
- Have an ability to work under pressure and to deal with change
- Positive self-esteem
- Demonstrate a commitment to ongoing education and lifelong learning
- Have emotional intelligence<sup>v</sup>.

Knowledge in a number of areas related to effective maternity care and support is necessary including:

- The need for good pregnancy care
- The importance of starting pregnancy care early (ie less than 20 weeks of pregnancy)
- An understanding of the range of pregnancy and child and family health services that are provided in the community
- The importance for pregnant women to take care of themselves in order to give their baby the best start to life
- The role of the AHW/AHEO and the midwife
- The need for care and support to be based in the community.

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<sup>v</sup> Emotional intelligence includes the ability to work effectively in teams, the ability to recognize and respond appropriately to one's own and others' feelings and the ability to motivate oneself and others (Source: Cadman C.;Brewer J.[Journal of Nursing Management](#), 9 (6), 2001: 321-324(4).

## **7.2 Community development**

Community development initiatives are important yet have created challenges for AMIHS programs in the past. This is likely because the team members may lack skills and resources in the planning, implementation and evaluation of community development projects.

Community development projects have been most successful when they have direct relevance to the aims of the AMIHS and tangible benefits, in terms of education, information and empowerment.

The skills, knowledge and attributes necessary to achieve success in community development includes:

- An ability to understand and support/canvass the needs of women in the community and to develop community-driven approaches that will enhance outcomes for women and babies. Women's reference groups or others forms of community consultation are important to identify which projects might be successful and how to undertake implementation.
- An ability to ensure that community development projects have an outcome, for example, linking women to other services or groups
- Capacity to engage all members of the family, especially grandparents and fathers
- The development of effective partnerships with other service and education providers and non-government organisations (NGO) including Brighter Futures, TAFE, community art programs and broader health promotion initiatives (eg. smoking cessation)
- An understanding of the principles of health promotion.

## **7.3 Partnership**

The ability to develop and maintain effective partnerships is an essential skill required for the AMIHS team. Partnerships with the Aboriginal community will ensure that their expertise is brought to the health care processes. Partnerships between Area Health Services (AHS) and the Local Aboriginal Community Controlled Health Services (ACCHS) are critical to the success of AMIHS. Other partnerships that are necessary include Brighter Futures, child and family health services, government and non-government organisations.

Skills and knowledge required to build effective partnerships include:

- Understanding and respecting the skills and expertise of other groups and agencies.
- Understanding the role of different organisations
- Communication skills that promote effective transmission of information.

It is essential that AMIHS teams have time to develop partnerships with groups and agencies. It is often difficult to do this once the program is fully functional and operational.

## 7.4 Additional skills

Additional generic skills, knowledge and attributes include:

- A willingness to work in a small team (midwife and AHW/AHEO) and as part of a wider team within the health service
- An ability to reflect on practice issues and ongoing involvement with clinical supervision, either as a group concept or individually
- A willingness to engage with continuing professional development and life long learning opportunities
- An understanding of the need for capacity building (eg. support for one another to attend training and development opportunities)
- A commitment to ongoing improvement of the AMIHS program through participation in evaluation.

A commitment by management to the ongoing development of the midwifery and Aboriginal health workforces<sup>15</sup> is also essential.

## 8 Intended Outcomes/ Key Performance Indicators

AMIHS programs are expected to report against the indicators as set out below. This will include reporting by program, by Area Health Service and at a statewide level. A separate project has been established to assist with these data reporting requirements.

The health outcomes of the AMIHS are:

- To decrease the proportion of young, Aboriginal adolescents 12 -16 years and 17-19 years who become pregnant
- Increase the proportion of Aboriginal women who present before 20 weeks gestation for antenatal care
- Increase in the total number of antenatal visits Aboriginal women have during pregnancy, appropriate to the period of gestation and/or associated medical condition
- Decrease in the proportion of low birth weight Aboriginal infants
- Decrease in the proportion of Aboriginal babies born prematurely
- Decrease in the proportion of Aboriginal perinatal deaths

The expansion of AMIHS seeks to effect changes over time in the following key performance indicators, related to child health and wellbeing:

- Access 80% of the pregnant Aboriginal mothers.
- Provide antenatal education to all women in the program
- Reduce the rate of prematurity in Aboriginal babies to less than 10%
- Increase the access to antenatal care before 20 weeks to 75%
- Reduce perinatal mortality by 10%
- Reduce smoking in pregnancy
- Achieve 100% interventions for smokers

- Reduce low birth weight (<2500gms) by 10%
- Increase the proportion of babies exclusively breast fed at discharge from hospital and at six weeks
- 100% of women and their babies will be referred by the midwife to the local early childhood health service within 2 weeks of birth

Linkages with Brighter Futures would also be expected to have better outcomes for those children and families involved in the program and who may progress within the child protection system, as outlined below:

- Percentage of AMIHS clients eligible for Brighter Futures that take up a referral to the program.(Cohort 1)
- Percentage AMIHS families referred to Brighter Futures that do not agree to participate in the program (Cohort 2)
- Comparison of numbers of reports and re-reports between Cohort 1 and Cohort 2
- For Cohort 1 – six monthly count of number of families still in the program following initial entry (retention rates)
- Comparison of Cohort 1 and Cohort 2 measuring numbers of clients
  - entering child protection, and
  - entering OOHC

Additional local monitoring is being established to examine the effectiveness of the referral pathway to Brighter Futures as well the level of uptake and engagement.

## 9. References

1. NSW Health. *Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System*. Sydney: NSW Health Department, 1999.
2. Henderson G, Robson C, Cox L, Dukes C, Tsey K, Haswell M. Social and emotional wellbeing of Aboriginal and Torres Strait Islander People within the broader context of the social determinates of health. In: Anderson I, Baum F, Bentley M, editors. *Beyond Band-aids: Exploring the Underlying Social Determinates of Aboriginal Health*. Darwin: CRC for Aboriginal Health 2007.
3. Wass A. *Promoting Health: The Primary Health Care Approach*. 2nd ed. Sydney: Harcourt Australia, 2000.
4. NSW Health. *NSW Aboriginal Nursing and Midwifery Strategy 2007-2010*. Sydney: NSW Health Department, 2007.
5. NSW Health. *NSW Framework for maternity services*, 2000.
6. NSW Health. *Aboriginal Workforce Development Strategic Plan 2003-2007*. Sydney: NSW Department of Health, 2003.
7. The Community Development Exchange. What is community development? Sheffield The Community Development Exchange (CDX), unk date.
8. Leap N. *A definition of 'woman-centred' midwifery practice*. Prepared for the Nurses Registration Board of New South Wales. Sydney, 2000.
9. Saultz J. Defining and measuring interpersonal continuity of care. *Annals of Family Medicine* 2003;1(3):134-143.
10. Saultz J, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Annals of Family Medicine* 2005;3(2):159-166.
11. McCourt C, Stevens T, Sandall J, Brodie P. Working with women: Developing continuity of care in practice. In: Page LA, McCandlish R, editors. *The New Midwifery: Science and Sensitivity in Practice*. 2nd ed. Philadelphia: Churchill Livingstone: Elsevier, 2006.