



***NORTHERN METROPOLITAN
COMMUNITY HEALTH SERVICE***

The Community Midwives Project

**An Evaluation of the Set-up of the Northern Women's
Community Midwives Project
(Auspiced by Northern Metropolitan
Community Health Service, South Australia)**

June 1998 – November 2000

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In the publishing of this Evaluation we wish to recognise the invaluable support and forward thinking of Dr Brian Pridmore (1939 - 2003). Brian's commitment and belief in the contribution of midwifery to the care of women was a unique gift during the period of set-up of this Project.

Forward

As someone who has been involved with the Project since the days of the very first proposal, I welcome this evaluation particularly as it identifies the process of setting the project up and the issues that arose as the Project developed. It will be a very useful resource for all those who are wanting to set up similar models within the community health settings across Australia. The NWCMP sets a gold standard for midwifery as a public health strategy and this evaluation articulates the importance of such an approach and the developments that are necessary to move away from an acute care approach to midwifery practice towards an integrated model based in the community.

My impression of the Evaluation is that it presents a ‘warts and all’ and accurate documentation of the hurdles that needed to be overcome – practical and ideological – and as such is an important resource. I think it accurately reflects the triumph of this project providing a collaborative, community based midwifery service to a surprisingly large number of women given the ‘teething problems’ experienced. I also think the Evaluation identifies correctly the importance of a primary health care approach to midwifery and that it pays tribute to all involved who stood by the Project and believed in its importance, not least the midwives, community health services and local providers of maternity services.

I would strongly support a follow up evaluation that studies the subsequent era of NWCMP as it settled down and matured with confidence. Clearly, further independent evaluation needs to address new data as well as that which was not able to be studied in this evaluation. It will be important to look further as how the midwives collaborate with both community and hospital agencies, at women’s evaluation of their care and at subsequent outcomes for women and their babies.

I think that all concerned can be proud of their achievements and that the evaluation pays tribute to the determination and support that has led to the success of the NWCMP. I hope the evaluation will be published and distributed widely.

Nicky Leap

Midwife

Original Advisory Panel Member

Member for CMP

Executive Summary

Introduction

The Community Midwifery Project commenced in 1998 following application for funding from the Commonwealth Alternative Birthing Services Program. The Program is the first publicly funded midwifery led continuity of carer model in South Australia. The project is unique in Australia as it promotes access to women, including young women, Aboriginal women and those from socially disadvantaged backgrounds, living in the northern metropolitan area of Adelaide. Midwives worked in collaboration with other health professionals as required. The Project offers homebirth, birthing centre and hospital birth options to women and addresses social isolation and disadvantage by linking closely with community groups and relevant targeted services.

Midwives are internationally recognised as the most appropriate primary health care professionals to take responsibility for coordinating the care of women during their pregnancy, collaborating and communicating with other health care providers as required. Community based midwifery continuity of carer models have been implemented in many countries.

National Health and Medical Research Council (NHMRC) and other Government recommendations and documents have identified midwifery led continuity of carer models as a model that should be available to all Australian women. The philosophy of care embraced by midwifery led care is that women are the centre of care, and care focuses on the woman's unique and individual needs, expectations and aspirations rather than on the needs of the institution or professionals involved.

The northern suburbs of Adelaide were chosen as the preferred site to commence this Project as access to health services is a critical issue for this population. The Project has given women in this area a choice of maternity care that emphasized a known caregiver, continuity throughout pregnancy, birth and the postpartum period and holistic care.

Project Evaluation Methodology

The external evaluation of this Project commenced in 1999, following funding secured by Flinders University from The Australian Health Commission, Health Enhancement Research Grant and the School of Nursing at Flinders University. Data collection ceased at the end of September 2001 when the Project secured permanent funding as a core service of the Northern Metropolitan Community Health Service.

Both qualitative and quantitative data were collected using multiple methods of collection from clinical outcomes, questionnaires, interviews, focus groups, a time and motion study and records and documents of the implementation of the Community Midwifery Project (CMP). This evaluation primarily reflects a community midwifery perspective. Costing was beyond the scope of this evaluation.

Description and Evolution of the Project

The initial model of the CMP, instituted in 1998, evolved over the period of evaluation. A range of challenges to midwives working in such models became evident during the start up period. These included: limitations of a nursing award for midwifery models, challenges of hierarchical structures, need for negotiation with hospitals, test ordering and prescribing rights, and the cumbersome nature of creating institutional change. Fundamental to these challenges was the requirement within the model for an enlarged scope of midwifery practice.

These challenges were addressed in turn and by the end of the evaluation period the model was beginning to operate as originally envisioned.

Birthing Outcomes

CMP clients required a range of social and special support, often falling into a “high needs” category. A large proportion of CMP clients were under the age of twenty years, and the service was accessed by a significant proportion of Indigenous women. The CMP offered a meaningful choice of birthplace including homebirth.

The outcomes for births were comparable to those of South Australia as a whole, with the additional finding that CMP clients chose pain relief significantly less frequently and had a decreased rate of episiotomies compared to State outcomes. There was no evidence of negative trends that differed from State outcomes.

Successes and Barriers: the Experience of the Project

Hospital midwives identified CMP care as being qualitatively different to hospital midwifery care, offering midwives a change to work in a wider scope. They suggested that CMP care was of specific advantage to particular women who could benefit from the continuity of care model.

Qualitative analysis of interview data from all respondents identified major themes which could be characterized as having presented barriers to the success of the Project, as well as themes which were seen as crucial to the eventual success of the establishment of the Project as a permanently funded Programme. These were: lack of understanding of the community based caseload midwifery model, competition, status of midwifery, safety/risk, links built, empowerment of women, empowerment of midwives. The interplay of these themes is important in understanding the experience of the evolution of the Project.

Discussion

The Alternative Birthing Services Program has enabled the Project to lay the foundation for the establishment of a unique service. The CMP model demonstrates the potential to offset costs to the community by an early intervention approach that provides comprehensive maternity care across acute and community settings. Disadvantaged women have accessed a service which has provided meaningful choices in their pregnancy and birthing, in a context of continuity of care. Despite many challenges in making institutional change, the CMP has provided a broad scope of practice for midwives in a publicly funded, community based service that has demonstrated positive outcomes for midwives and for women.

Recommendations

- 1. Dedicated funding for evaluation must be set at an appropriate level and included in the budget at the outset of all such Projects**
- 2. Data collection processes need to be determined at the outset of all such Projects to ensure uniform and appropriate data collection, including measures of client satisfaction**
- 3. Data collection which tracks the provision of community based midwifery caseload care should look to relevant international data collection examples**
- 4. Consultation with hospitals before setup of all such Projects is necessary to enable better understanding and support from the outset**
- 5. DHS, NMCHS and CHS recognize that where birth care is moved out of the acute sector, better communication is required across community and acute sectors to facilitate safe and effective provision of care and for evaluation purposes**
- 6. DHS further the NHMRC (1998) recommendations to facilitate prescribing, test ordering and interpretation and hospital clinical privileging for midwives, which are fundamental to midwife-led models**
- 7. DHS work with the ANF to support the development of appropriate awards to remunerate community-based, caseload practice statewide**
- 8. DHS recognize and support the value of community based antenatal and postnatal care, which may include intensive home visiting, as responding appropriately to the needs of disadvantaged populations**

- 9. DHS recognize and support the role of the midwife in postnatal care in the community, and its value in early intervention approaches, particularly when provided in continuity relationships**
- 10. A cost benefit analysis of CMP care compared to mainstream maternity care, with particular attention to early intervention and prevention principles**
- 11. DHS and CHS promote the effectiveness of the CMP model, particularly in meeting the needs of disadvantaged populations**
- 12. DHS and NMCHS provide support, based on the experience of this Project, to other geographical regions and communities who wish to develop such a service**
- 13. NMCHS prioritize a mechanism for exploring client satisfaction with the services of CMP**
- 14. DHS and NMCHS recognize the barriers to uptake of CMP care by Culturally and Linguistically Diverse Background (CLDB) women due to insufficient funds for translation services**
- 15. DHS recognize and support the value of the CMP's provision, within the public system, of a choice of birthplace, including homebirth**
- 16. The CMP continue to provide a home birth option for low risk pregnancies**
- 17. The CMP continue to foster relationships with the local Indigenous community and provide a safe and appropriate birthing service for these women**

Chapter 1

Introduction

The Community Midwives Project (CMP), which received funding from the Commonwealth Alternative Birthing Services Program (ABSP), involved establishing a publicly funded, community based caseload midwifery service, offering continuity of midwifery care through pregnancy, birth and the postpartum period, to meet the maternity health needs of women residing in the northern metropolitan area of Adelaide.

1.1 Alternative models of care in Australia and internationally

In Australia, women giving birth within the public health system have had very limited opportunities to access midwifery models of care. The care that has been available, even for low risk pregnancies, has been increasingly medicalised and fragmented, with the majority provided in large tertiary level hospitals. This care has been criticised for the high incidence of interventions involved (NMAP 2002).

In other countries, notably New Zealand, the United Kingdom, Canada and the Netherlands, women have a wider range of options, particularly in relation to women-centred midwifery led models of care, which are community based. In these countries, midwifery services are often delivered in models that emphasise a relationship between the midwife and the woman, where the midwife works as a primary care giver in continuity throughout the progress of pregnancy, birth and the postpartum period.

The midwife is internationally recognised as “the most appropriate and cost effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications” (WHO 1999).

The International Definition of the Midwife states:

A midwife is a person who, having been regularly admitted to a midwifery education program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be recognised and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service (International Confederation of Midwives 1990).

Very few midwives in Australia have had the opportunity to work to the full scope of practice described by the International Definition of the Midwife. Indeed, compelling evidence shows that workplace experience for Australian midwives has become extremely fragmented, so that many midwives find themselves poorly skilled across the full scope of midwifery practice (Tracy et al. 2000). When midwives are unable to work to their full potential, they are also unable to offer women a range of choices of birthing options.

The National Health and Medical Research Council (NHMRC) document, *Options for Effective Care in Childbirth* (1996), promoted the option of collaborative midwifery models of care, where midwives work as the primary care provider for women with uncomplicated pregnancy and childbirth, as one that should be available to all Australian women. The 1998 NHMRC document, *Review of Services Offered by Midwives'* concluded from a review of randomised controlled trials of a range of midwifery models of care that, “overall, women are more satisfied with models of care with extended responsibilities for midwives compared with conventional care, and medical interventions usually were used less frequently” (NHMRC 1998:24), while having no adverse impact on the health outcomes of women and babies.

Midwifery led care, of which the Community Midwives Project is an example, subscribes to a philosophy of care that is woman-centred, focusing on the woman’s unique and individual needs, expectations and aspirations, rather than on the needs of the institutions or professionals involved. The provision of midwifery care in a “continuity of care

model” is often described as “carrying a caseload” – in which a midwife cares for designated clients through the continuum of pregnancy, birth and the postpartum period. There is increasing evidence that midwifery continuity of care models are satisfying for both women and midwives, while also reducing interventions in labour (Homer et al. 2001).

1.2 Alternative Birthing Services Program (ABSP)

The Alternative Birthing Services Program, a Commonwealth funded initiative, was established in response to a perceived need for a range of alternatives for care in childbirth. The program was guided by a philosophy of care which emphasised the role of the midwife as primary care giver and recognised that pregnancy and childbirth are usually normal life events, requiring minimal intervention. Equally, the program offered financial incentives to the States and Territories to trial and develop models of public maternity service provision which offered alternatives to the existing hospital setting, including birth centres and home births.

In 1987, the NHMRC Women’s Health Committee recommended that women choosing homebirth should have access to appropriately trained and resourced health professionals, including community based midwives (NHMRC 1987). Phase One of the ABSP (1989-1993) provided some capital funding for the establishment of birth centres across the States and Territories and a contribution for independent midwives providing home birth services. The second phase of the ABSP intended to promote choices within the public health system for birthing women, emphasising midwife based services which offered continuity, active partnership with women, and appropriate models of care for Aboriginal and Torres Strait Islander women. In addition to promoting an understanding of a range of maternity care options among consumers and care providers, the ABSP provided incentives for the States and Territories to trial models which could then be maintained within standard services (Thiele & Thorogood 1997).

1.3 Why the North? A community profile

The northern metropolitan area of Adelaide is defined by the boundaries of 6 local government areas of Playford, Salisbury and Tea Tree Gully. The resident population of northern Adelaide is approximately 350 000. The following excerpts from the 1996 Census data describe some of the socio-demographic features that characterise the general population living in this area, with comparisons to the rest of the State where applicable (ABS 1996A).

Education

At the 1996 Census, 38.9% of persons aged 15 years or more in the northern Adelaide region had either left school when they were 15 years old or younger, or never attended. This rate is higher than the overall State figure of 35.8% (ABS 1996A).

Unemployment

The unemployment rate as calculated from the 1996 Census data was 12.2%. This was higher than the rate for South Australia, which was 10.4% at the time.

Index of Relative Disadvantage

The Australian Bureau of Statistics developed Socio-Economic Indexes for Areas (SEIFA) from the 1996 Population Census Data:

The SEIFA summarises a large number of socio-economic variables into a single measure that can be used to rank areas (from highest to lowest, and vice versa) on a broad socio-economic scale. Relatively advantaged areas have a high SEIFA while relatively disadvantaged areas have a low SEIFA. The index was designed to have an average across all Australia of 1000...The Index of Relative Disadvantage for the Northern Adelaide region was 948, below the national average of 1000 and the South Australian figure of 984. The local government area of Tea Tree Gully (C) (Council) recorded the region's highest index of 1047 while the region's lowest index score of 786 was recorded in Elizabeth (C) (ABS 1996B).

Financial Support Payments

During 1998-99, 7218 financial support payments were made to persons living in the northern region of Adelaide. The purpose of these payments is to provide emergency financial assistance. The number of financial support payments during this period is equivalent to 22.2 per 1000 per head of population. This is higher than the South Australian rate of 16.9 per 1000 per head of population. At the Local Government Area (LGA) level, the majority of financial support payments in the northern Adelaide region (2447) were in Salisbury(C). The highest rate per 1000 population (57.6) was recorded in Elizabeth (C) (DHS 2000).

Domestic Violence

The number of intake assessments for domestic violence (DV) related matters in northern Adelaide almost doubled over five years (1994-99). The 880 domestic violence assessments in the northern Adelaide region during 1998-99 is equivalent to 2.7 per 1000 head of population. This is higher than the South Australian rate of 1.9 per 1000 population. At the LGA level, the majority of domestic violence assessments in the northern Adelaide region (348) were in Salisbury (C). The highest rate per 1000 population (6.0) was recorded in Elizabeth(C) (DHS 2000). These rates may reflect higher reporting or other variables. Domestic violence occurs across all communities.

Adolescents at Risk

During the 1998-99 financial year there were 794 adolescents at risk (AR) assessments conducted in Northern Adelaide. These assessments are arranged to address issues relating to parent child conflict, runaway, school problems, suicide/in danger from self, drug/alcohol abuse and/or family conflict. The number of adolescents at risk assessments during 1998-99 was equivalent to 2.4 per 1000 head of population. This was higher than the South Australian rate of 2.1 per 1000 population. At the LGA level, the majority of AR assessments in the Northern Adelaide region (241) were in Salisbury (C). The highest rate per 1000 population (6.8) was recorded in Elizabeth (C) (DHS 2000).

Together these socio-demographic features describe a community that is relatively disadvantaged in comparison to most other Local Government Areas in South Australia. The northern Adelaide community profile and demography can be summarised as follows:

- The outer north has a rapidly growing population with the largest percentage in the young cohorts
- The outer north has the highest proportion of Aboriginal people living in the metropolitan area (1.3% of all persons living in this area)
- The unemployment rate is high, with a large number of people on benefits and pensions (including many women on sole parent benefits)
- The education levels are low with people employed in predominantly unskilled or semi skilled occupations
- 9.1% of mothers in this area are teenage mothers (compared to State mean of 5.6%)
- In 1999 20.4% of mothers were sole parents, compared with the State average of 13.5%

This profile highlights the fact that access to appropriate health services (including maternity services) in terms of distance, time, cost and relevance, is a critical issue for this community. Addressing a range of social and demographic challenges is crucial in order to ensure good maternal and child health outcomes. The Community Midwives Project, under the auspice of Northern Metropolitan Community Health Service (NMCHS) and funded by the Commonwealth. Alternative Birthing Services Program, was sited in the northern suburbs to target, in particular, disadvantaged women, young women and Aboriginal women, in order to offer these populations a choice of maternity care that emphasized a known caregiver, continuity throughout pregnancy, birth and the postpartum period and a holistic approach.

Chapter 2

Project Evaluation Methodology

2.1 Evaluation framework

The key focus of this evaluation was on the process of setting up the Community Midwives Project. While evaluation processes had been planned to be incorporated from the beginning of the CMP, there were no evaluation funds set aside in the original budget. Funding to the amount of \$14,814.00 was secured by Flinders University of South Australia from the South Australian Health Commission, Health Enhancement Research Grant for an independent, external evaluation of the CMP. With these funds, a researcher was employed on a one-day-a-week basis from October 1999 to November 2000. A further small amount of funding was provided directly by the Flinders University School of Nursing.

The process of data collection began in October 1999. Since few births had occurred under the Project at the beginning of the researcher's term, the thrust of the evaluation was geared towards investigating and recording the development and implementation phase of the CMP, given the uniqueness of this midwife-led model in the public health system in South Australia.

The researcher's contract was extended by the Northern Metropolitan Community Health Service, on a casual basis, until September 2001 with a further contribution of \$28,738 by NMCHS. The period of data collection ceased at the end of September, 2001, when the Project secured permanent funding as a core service of the Northern Metropolitan Community Health Service, renamed the Northern Women's Community Midwifery Programme.

Both quantitative and qualitative methods were utilised for evaluation to investigate the development of the CMP model over a two-year period. This evaluation looks at the

process of setting up the Project, the experiences of the individuals and institutions involved, and identifies barriers encountered and successes achieved. The clinical outcomes of the maternity care provided are also reviewed and analysed. Due to the limited funding available, both costing comparisons and women's experiences of the service were unable to be evaluated. More qualitative data was collected from midwife participants than from organisational participants. In consequence, this evaluation strongly reflects the views and experience of the midwives involved.

2.2 Data collection framework

Both qualitative and quantitative data was collected, using the following strategies:

Clinical outcomes were tracked through a clinical data collection process and analysed.

The history and process of the setting up of the Project was tracked through referring to a range of records and documents generated throughout the process of implementation of the CMP.

A survey questionnaire was administered to staff at one of the hospitals where CMP clients were birthing.

Individual face to face interviews were conducted with key people involved in the planning and implementation of this project, including administrators, midwives, doctors, and CMP Project Steering Committee members.

Focus group interviews were held with hospital midwives and with CMP midwives. Five midwives from one hospital participated in a focus group discussion regarding the establishment of the Community Midwives Program. These midwives came from a variety of areas in the hospital including labour and delivery, postnatal care and domiciliary care. Qualitative data was subjected to thematic analysis and emerging themes are discussed in the context of the national and international literature on midwifery models of care.

The “time and motion” data was conducted over a two-week period during 2001, in which midwives tracked their hours and activities. Data was collated and categorised to identify the ratio between clinical midwifery hours worked compared to administrative roles and the nature of non-clinical work the midwives performed.

Clinical data was transferred from a “Birth Register” maintained by the CMP midwives and cross-checked with clinical records where available. Due to the evolution of record-keeping and the Birth Register over time in the Project, there is a certain amount of missing data in some categories. Where data is missing, this is indicated in the analyses. Comparisons are made to comparable published data for the State, where available, according to Pregnancy Outcome in South Australia: 2000 (Pregnancy Outcome Unit 2001).

Survey questionnaire data was collated, with short-answer responses presented in tables, and longer, open-ended responses recorded.

Qualitative data was subjected to thematic analysis and emerging themes are discussed in the context of the national and international literature on midwifery models of care.

2.3 Evaluation Constraints

As mentioned, funds for evaluation were not available in the initial budget for the Project. Murphy (1998) describes “process evaluation” as an examination of the service’s activities to establish whether the service is operating according to plan, including meeting the needs of the target group. In this case, the target population for the CMP included young, disadvantaged, Aboriginal and often transient women. The ethical considerations and practical difficulties in meaningfully evaluating the experiences of this population group were considerable and were, in the end, beyond the scope of this evaluation. This has been a point of debate, particularly for the midwives working in the Project, who have been very concerned that the appreciation and enthusiasm expressed to them by their clients be reflected in some manner. This is a priority area for further evaluation.

The challenges of performing an accurate costing comparison, to assess whether the costs of the CMP service were comparable to mainstream care, were equally beyond the scope of this evaluation for several structural reasons (including the cost of such an undertaking). The nature of pilot project funding is that it is short term, usually providing a service that is small-scale, novel and supplementary to mainstream care. In many ways, economies of scale will always dictate that small-scale innovation is expensive in comparison to established systems. This would certainly be the case with the CMP, which went through several cycles of funding renewal uncertainty (and resultant reduction of client numbers) during the period of evaluation.

In addition, accurate costings of established maternity services are notoriously difficult to achieve, as there are complex routes of State and Commonwealth funding involved, as well as the participation of a range of professionals in different settings. The potential savings incurred by the prevention of pregnancy complications or obstetric interventions, or by an improved health and social status (through facilitating access to holistic and integrated services) are equally difficult to quantify.

Now that the CMP has become a core service of the Northern Metropolitan Community Health Service, and is running to full capacity, further evaluation funding should be sought to address these outstanding areas.

Chapter 3

Description And Evolution Of The Project

3.1 Project Establishment

This chapter describes the establishment of the Project, its vision and the challenges in the early stages of its development. Staffing of the Project, the community based continuity of care midwifery model and the links with both hospitals and the community are addressed. A brief overview is given of the range of women who accessed the service.

Project Objectives and Expected Benefits

At the outset, the Project objectives were described as follows:

- To establish a safe, viable and responsive community based maternity care program that will provide women with a continuum of care by a known midwife in a variety of settings before, during and after the birth of the baby, including access to homebirths, hospital births and birthing unit births
- To integrate with and provide access to existing primary health care services, supports and networks

Expected benefits included the following:

- Improved outcomes
- Access to a wider choice of maternity and birthing options
- Women and their families/supports will have access to a known midwife before, during and after childbirth

- Active participation of women in determining their own maternity and other health care needs
- Demonstrated knowledge, awareness and utilisation of, existing services and support networks by women and their families/supports
- Active participation of the target populations and their supports in the development and ongoing evaluation of the program
- Lower intervention rates
- Increased access to antenatal care for Indigenous women
- Increased confidence mothering and parenting skills
- Improved service delivery
- Demonstrated knowledge, awareness and referral/recruitment to program by target populations and by other community support services and networks
- Care before, during and after birth will be coordinated, integrated and linked to existing services, supports and networks
- Demonstrated positive health outcomes, with a decrease in problems during the transition to parenthood
- The cost of services within the program will be comparable with maternity options currently available within the public health sector
- Ongoing funding arrangements will be negotiated for continuation of a financially viable program.
- Increased job satisfaction for midwives

3.2 Early History

Application for funding was made to the South Australian Health Commission to fund the Community Midwifery Project (CMP) from the Australian Birthing Services Program (ABSP) Commonwealth funding in 1997. A group of independent midwives had been meeting in Adelaide discussing the possibilities of setting up a midwifery continuity of care model under public funding. The Northern Metropolitan Community Health Service's Regional Women's Health Team coordinated the proposal for this project, initially requesting \$190,221 for an 18 month period. The proposal was delayed for a year

until further funding was secured, and the project was then scheduled to begin in April 1998 and continue for a period of 28 months with a total operating budget of \$518,317.

A community nurse and midwife working at the Northern Women's Community Health Centre, was appointed as the Project Coordinator commencing in June 1998. In collaboration with NMCHS managers and stakeholders she worked for six months laying the foundations for the Project, addressing aspects such as premises, the industrial award for midwifery reimbursement, transportation, clinical privileging, access for midwives to test results, and outreach to target groups. In January 1999, four midwives were hired to fill 3.5 FTE positions. The Project Co-ordinator spent the first six months of the Project setting up the infrastructure for the Project and implementation strategies for the commencement of the provision of midwifery practice.

3.3 Project Scope, Management and Model

From its inception, the Project was designed to give access to continuity of a named midwifery carer to women in the northern suburbs who may otherwise not have the opportunity to have woman-centred care for their childbirth experience. All birthing women were eligible, regardless of any complication with their pregnancy or social situation. In Australia, all women are cared for by midwives during labour and birth, often in a team with doctors. If a woman is under the care of an obstetrician she will also have a midwife involved in her labour and birth care, but rarely a midwife she knows. The philosophy of the CMP ensured that even if the women needed to be under the care of an obstetrician, she would continue to have the care and support of her known CMP midwife.

The Project targeted and promoted access for women, including young women, Aboriginal women, women from culturally and linguistically diverse backgrounds (CLDB) and those from socially disadvantaged backgrounds, living in the Northern Metropolitan area of Adelaide. During the start-up period, CLDB women were not targeted, due to lack of resources for translation services and therefore practical difficulties involved with informing women of a new service.

From the commencement of the Project a Program Advisory Panel (later known as the Steering Committee) was formed to oversee the development of the Project (see Appendix A). The committee was comprised of community members, Project Midwife and/or Coordinator, hospital representation, Northern Metropolitan Community Health Service representation and other representation deemed necessary. The Program Advisory Panel was chaired by the Team Leader of the Northern Women's Community Health Centre and met monthly throughout the implementation stage.

The original Coordinator left the Project in 2000 and there was a number of new midwives employed to replace the midwives who had left. There was a relocation of the Project premises from Northern Metropolitan Corporate Services, Salisbury, to the Northern Women's Community Health Centre, Elizabeth.

The women enrolled in the Community Midwives Program received the majority of their antenatal, birthing and postnatal care and pregnancy screening in the community or in their home with their CMP midwife. The major public hospitals that offer birthing services to women in the northern Adelaide region, the Lyell McEwin Health Service (LMHS), The Queen Elizabeth Hospital (TQEH), the Women's and Children's Hospital (WCH) and the Modbury Hospital (MH), provided access to laboratory and diagnostic service, obstetric and other specialist medical care if needed. These hospitals required women to have at least two appointments antenatally in the hospital of their choice: a booking visit and one visit near the end of their pregnancy. Guidelines for referral and care were negotiated with the participating hospitals (see Appendix B). The CMP allocated midwife would be on call for the women when labour commenced and take responsibility for her care during her labour and birth.

Birthing at home was also an option of care for women who accessed the Community Midwives Program and also met the criteria for homebirth, according to the NHMRC Statement on Homebirths (see Appendix C). Women choosing this option also nominated a backup hospital and their general health and past medical history was assessed, along with their current and ongoing pregnancy care and monitoring.

During the postnatal period the midwives provided care for approximately four to six weeks, referring women and their infants to relevant health or community care agencies that were appropriate for and acceptable to each individual woman when required. If women stayed in the hospital for their early postnatal period, the CMP midwives coordinated appropriate care in consultation with the hospital staff during the hospital stay, and continued care for the woman and her baby in the community once they were discharged.

Midwives saw women for antenatal and postnatal visits either at the women's homes or at the Northern Women's Community Health Centre. This was determined by convenience and availability of transport on the part of the women as well as clinical need. Known CMP midwives were available to women 24 hours a day by pager and often provided advice and reassurance over the phone between visits. When labour began women would contact their known midwife who would respond, by either visiting the woman at home to assess her progress or meeting her at the hospital if she was having a hospital birth.

Funding for transport for the midwives was included in the project funding as it was recognized that provision of care in the home was a fundamental part of this model of care. The northern metropolitan region had a limited public transport system and many women cared for by this program had no access to private transport. Midwives shared access to a number of government cars for these purposes.

Midwives were fully responsible for detecting complications and referring to the appropriate medical specialist through pregnancy, labour, birth and the postpartum period. Each midwife carried a clinical caseload as well as contributing to the administration, public relations and daily management of the program.

3.4 Constraints to Realising the Model

In the Australian context there are serious challenges to midwives providing pregnancy and birthing care on their own responsibility. These have been identified in the NHMRC review of 1998, "*Review of Services Offered by Midwives*" and they impact on the success of initiating models which aim to promote midwifery continuity of care. Some of

the most serious barriers include: a lack of payment mechanisms to reimburse midwives for providing antenatal care outside of hospitals; the lack of prescribing and administration rights; lack of rights to order and interpret relevant tests during pregnancy, birth and postpartum; difficulties in securing clinical privileging.

The CMP also had the challenge of fostering the acceptance of a new model of care for a target population of women who may have rarely had the opportunity to make choices about their healthcare. In addition, there were several practical issues that impacted on the day-to-day operation of the service. Determining an appropriate physical location for a community based midwifery service, to be located outside of a hospital, was problematic. The second issue was supplying appropriate means of transport for midwives to undertake service provision which involved 24-hour on-call work and intensive home visiting. Finally, the nature of short-term funding for the Project severely affected the number of women who could be accepted into care, since the nine-month duration of pregnancy frequently extended beyond certain funding periods. The low numbers of women cared for during the first years of the Project reflect this uncertainty.

3.5 Midwives' employment

Funding for this Project enabled an initial staffing structure (Figure 1) that included a Project Coordinator (Registered Nurse Level 3) and 3 Full Time Equivalent (FTE) Community Midwives (Registered Nurse Level 2). The Project Coordinator was responsible for managing the Project as well as undertaking a limited caseload. This hierarchical structure meant one midwife took responsibility for the workloads and management of the whole team of midwives.

The midwives were remunerated under a nursing award that did not take into consideration the nature of midwifery “caseload” work. This required the midwives to carefully track the time worked, including all visits and phone calls, monitoring this on time sheets. Any overtime or weekend work was either paid at penalty rates or taken as time in lieu. The nature of community base midwifery continuity of care is that a great deal of work will be done at unpredictable hours including night time and weekends. A

nursing award, which is meant to remunerate hourly shift work, was very inflexible in this context.

Initially the Project was set up with a Co-ordinator role as in Figure 1. Through the evolution of the Project there has been a move to a flat structure which facilitates and supports consensus decision making.

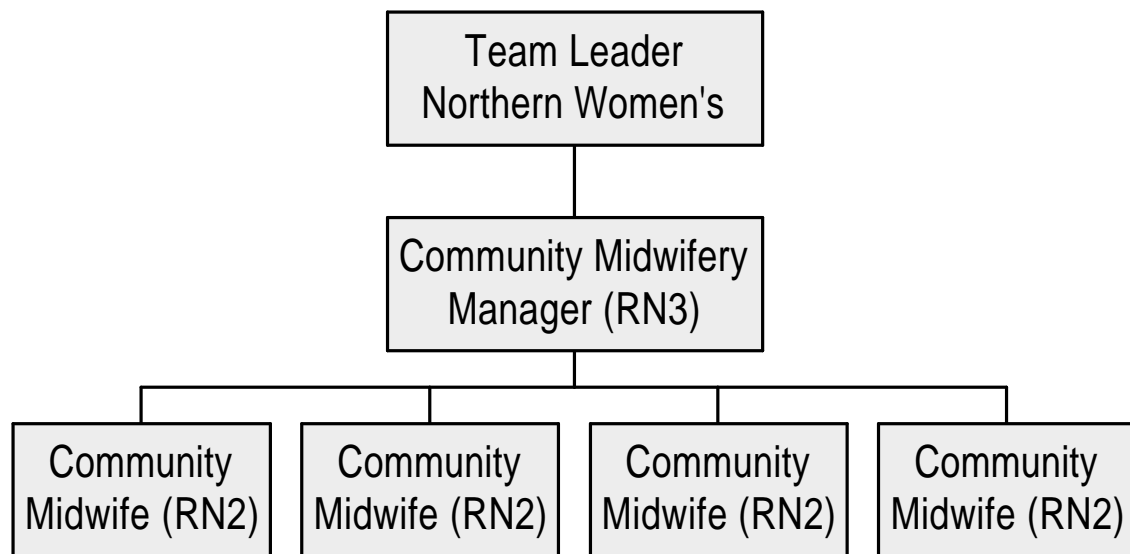


Figure 1: Proposed Staffing Structure at commencement of CMP

At the time of the completion of the evaluation period (2001) the CMP was staffed by 5 midwives – 3 full-time and 2 part-time – equivalent to 4.3 full time equivalent (FTE) positions (Figure 2). The Northern Metropolitan Community Health Service employed each of the midwives directly with the majority of affiliated public hospitals in the northern Adelaide region offering them accreditation and clinical privileges. The line management for the team of CMP midwives was via the Team Leader of the Northern Women’s Community Health Centre, Northern Metropolitan Community Health Service.

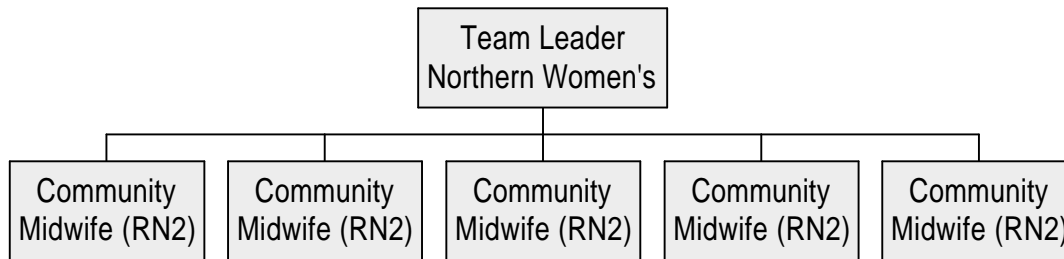


Figure 2: 2001 Staffing Structure of CMP

3.6 Selection of women during the evaluation period

Women living in the northern metropolitan area of Adelaide were able to access the CMP. Women were able to self-refer, be referred by midwives or doctors at the hospitals or by any other care or community agencies. Women who were enrolled in the program and who moved outside of the boundaries of the program during their pregnancy continued to receive care from their designated midwife, providing they birthed at, or maintained clinical links with, one of the hospitals associated with the Community Midwives Project. Priority for placement with the CMP was given to women who were Aboriginal, in their teenage years, or socially or economically disadvantaged, and those choosing homebirth. While the Project’s initial proposal also identified women from culturally and linguistically diverse backgrounds as a target group, there were insufficient resources within the Project for translation or interpretation services, which made promotion of the CMP to this target group extremely difficult.

Unlike the Community Based Midwifery Program based in Fremantle that was funded for women with uncomplicated pregnancy and birth, the CMP accepted women with both “high” and “low risk” obstetric and social needs. This was fundamental to the reality of targeting services for disadvantaged, young or Aboriginal women. Where women experienced a “high risk” pregnancy, the CMP midwife worked in close collaboration with the nominated hospital to provide appropriate care, to monitor and meet the needs of that woman.

Table 1: Women unable to access CMP care

Variable	Number (N=37)	Percentage(%)
Why they contacted the CMP		
Wanted a homebirth	20	54.0
Community Midwifery care preferred	9	24.3
Birthing Unit	4	10.8
VBAC	1	2.7
Other	3	8.1
Service they chose because they could not access the CMP		
Hospital	21	56.7
Independent Midwife	10	27.0
Unknown	6	16.2

Women excluded from participation in the CMP during the evaluation period

Since the beginning of the Project, women from across the Adelaide area have contacted the CMP midwives, hoping that they would be able to utilise the service. Many of these women lived outside the 650km² area serviced by the Northern Metropolitan Community Health Service, which defined the boundaries of the Project. Due either to their location of residence, or the combination of living out-of-area and a full caseload for the CMP, these women were not able to access the services of the community midwives. Information relating to 37 women who were unable to be accommodated on the Project was collated and is presented in Table 1. The Northern Women’s CMP was the only publicly funded woman-centred, continuity of midwifery-led care in South Australia. Many birthing women throughout the State would choose this service if it were available in their area.

Geographic Area Served

From the inception of the Project in 1998 to the completion of this evaluation, 224 of the women who enrolled in the Project came from 43 different postcode areas. An analysis of these postcodes indicated that 66% of women came from 3 specific postcode clusterings (Table 2). Only eight percent of women enrolled in the Project lived outside the boundaries of the target population. Many of these women joined the Project in its infancy when the number of women birthing was relatively low and the midwives were able to service these outlying areas.

As the popularity of the Project increased, the boundaries which the community midwives could service had to be reassessed and the geographical area reduced quite significantly.

Table 2: Postcode distribution of CMP clients

Suburb	Postcode	Number	Percentage
Kilburn Blair Athol	5084	15	7.1
Parafield Gardens	5107	16	7.5
Salisbury Paralowie	5108	20	9.4
Salisbury Park Salisbury Heights	5109	11	5.2
Hillbank Elizabeth Elizabeth Vale Elizabeth Grove	5112	25	11.8

Suburb	Postcode	Number	Percentage
Elizabeth South			
Elizabeth East			
Elizabeth West	5113	36	17.0
Elizabeth North			
Elizabeth Downs			
Elizabeth Park			
Davoren Park			
Smithfield	5114	17	7.6
Smithfield Plains			
Blakeview			
Craigmore			
Andrews Farm			
Other postcodes within the CMP boundaries	5086-5093 5096-5098 5109-5111 5115-5121 5125-5127	56	26.4
Other postcodes outside the CMP boundaries	5000-5083	17	8.0
Total		212	100.00
Unknown		12	100.00

3.7 Links with hospitals

The four major public hospitals that offer birthing services to women living in the northern metropolitan area of Adelaide were not initially all included in key negotiations concerning the set up of the CMP. In the early period births occurred primarily at one particular hospital. Over time, as the number of women in the Project increased, negotiations occurred with the other public hospitals to enable women to make a wider range of birthing choices. Initially the support and commitment of the hospitals varied across the institutions. By the end of the evaluation period, all three hospitals had negotiated accreditation agreements with the midwives in order to support the Community Midwives Program.

One of the factors influencing the interactions with the hospitals involved with the CMP included a major restructuring of maternity services in South Australia during this period. The following changes occurred during the course of the establishment of the CMP:

- Discussions were being held regarding the downgrading of services at The Queen Elizabeth Hospital (TQEH) from a Level 2 facility to a Level 1, which did result in its downgrading in 2000 (uncomplicated newborns of 2500g or greater and 37 weeks gestation or greater) from a Level 2a (2000g or greater and 34 weeks gestation or greater)
- The head of Obstetrics and Gynaecology at the Lyell McEwin Health Service (LMHS) retired and a new head was appointed to take up the position
- The Modbury Hospital was privatised
- There were moves to amalgamate the health services provided by TQEH and LMHS, under the Northern and Western Area Health Services (NWAHS)

The strategy for building links between the CMP and the hospitals initially focused on one hospital where the Project Coordinator had a long standing relationship with staff and which had a strong and supportive midwifery culture. The plan was then to expand to other public hospitals as the model developed. There were few births in the early period of the project and as the births increased it became important to foster links with all the major public hospitals in the region targeted by the CMP.

The process of securing accreditation for CMP midwives to assume clinical responsibility for the births of the women they cared for, at a range of public hospitals, was a very lengthy one. A pivotal planning day was facilitated in October 1999 including a range of stakeholders. Collaboration was sought and agreement reached on moving the Project forward. By 2001, the CMP midwives were caring for women birthing in three hospitals across a large geographic region. The care often involved intensive home visiting, and the numbers of women birthing with the Project were at their highest. The midwives were feeling stressed and accruing many hours of overtime in providing care. In February, a decision was made by the Steering Committee to restrict the geographical area for birth, to optimise the number of births for each midwife per month to and focus on the communities of greatest need and on the major hospitals that provided maternity services in the north.

3.8 Links with the community

One of the key objectives of the Project was to increase the integration of women with a range of other community based services, where appropriate. These services included child health services, Aboriginal health workers, migrant women's associations, counselors, social workers, nutritionists and many other of the services based in the community. The underlying philosophy was to build capacity for women to access community services in their geographical area when and if they needed it.

From the Project's inception midwives were very involved in educating a range of local service providers and agencies about the Project's model and philosophy and making links to facilitate referral. Many working hours were involved in promoting the Project and liaison with other agencies (see Appendix D).

3.9 Pregnancy and Beyond Support Group

A key support group initiated by the CMP was the Pregnancy and Beyond Support Group called "Mums and Mums to Be". The group was facilitated by the CMP midwives, who also invited speakers to address a range of parenting and birthing issues and stimulate discussion. The group met weekly on a Thursday at the Northern Women's Community

Health Centre, near the local shopping mall on the day when government support payments were available. The group has evolved over the period of the Project and later included pregnant women and new mothers with their babies and toddlers.

The underlying philosophy of this model of pregnancy and birth support relies on a peer support strategy, where women ideally develop support systems with other women in their geographical area. This Group also enabled women to meet all the midwives involved in the Project, develop links with community resources and learn from the birth stories of other women in the group. An added benefit was that women were able to find information from the Group that would otherwise have been sought from the midwife at the antenatal assessments, leaving more time for individual issues to be attended to. This concept of social support and education for childbirth has been described by Byrne following the successful implementation of this approach in Deptford, South-East London, with socially disadvantaged women (Byrne 2000; Davies 2000).

3.10 Time and Motion Study

A “time and motion study” was undertaken by the CMP to map midwife activity between January and September 2001. The outcome of this study identified a number of areas of midwife activity that included client contact and travel involved in providing care, professional development, management and administration, networking and publicity, outreach and education, research and development. It became clear there was a 1:2 ratio of hours spent in client contact versus administrative work (see Appendix E). This uneven balance of workload was a result of the newness of such an innovative model and the requirement to inform, build links and promote the services provided to women and the wider community and all relevant agencies. Finding an appropriate balance between the optimum of clinical care and the ongoing need to promote the Project has been a continuing challenge for the CMP.

3.11 Conclusion

This chapter offers an overview of the establishment of the Project from its inception, describing how the initial model of care instituted in 1998 has evolved. A range of

challenges to midwives working in such models quickly became evident during the start-up period: a hierarchical structure for community midwifery practice; the limitations of a nursing award to remunerate midwives working in new models; the need for initial negotiations with the public hospitals involved and the cumbersome nature of creating change in large institutional structures. All of these factors, as well as the challenges of finding mechanisms for midwives to order appropriate tests and prescribe relevant drugs, fall within the challenges of an enlarged scope of midwifery practice. However, during the time of the evaluation, many positive changes occurred to enable the model to begin to reach its potential. This was due to the persistence and ongoing commitment of midwives, NMCHS Management and the Steering Committee

Community based midwifery continuity of care models have been implemented in many countries and evidence has emerged which identifies particular challenges for midwives working in these models. The work of Jane Sandall describes key factors that enable midwives to avoid or manage problems of stress and burnout when working in these models. These factors include: occupational autonomy, emotional and social support at home and work, and the development of meaningful relationships with women (Sandall 1997). During the period of evaluation, the CMP midwives moved towards putting these protective measures in place, to ensure that the model of midwifery care could be fully implemented.

Chapter 4

Birthing Outcomes

From the beginning of the Project until 30 September 2001, a total of 222 women were enrolled. Their ages ranged from 14 to 40 with the median age being 25. The majority of the women (61.1%) resided in the Elizabeth or Salisbury area and were experiencing their first or second pregnancy.

Women from a diverse range of circumstances came to the Community Midwives Project for their antenatal, postpartum and postnatal care. The following “cameos” highlight this diversity and give a “snapshot” of the nature of the care provided by the midwives.

4.1 Cameos

Jessica

Jessica was a 15 year old young Aboriginal woman who lived at home with her mother and siblings. This was her first pregnancy and it was unplanned. Her partner did not live with her, but was supportive. She was booked for a hospital birth. Jessica was referred to the CMP by Family and Youth Services. Her pregnancy had been physically uneventful, however she required assistance with issues of finance, income and housing. The CMP midwife encouraged attendance at a young mothers group for education and support. During the course of Jessica’s care she cut down her tobacco intake from 20 cigarettes per day to 5 per day. She gave birth prematurely, and was supported by intensive home visits to establish breastfeeding.

Debbie

Debbie was a 16 year old young woman who lived in a caravan with her partner. She chose the Community Midwives Project after talking to a Community Midwife at a promotional display at the Elizabeth City Shopping Centre. Since she and her partner had only recently moved from interstate, Debbie had not had a lot of antenatal care. Her booking visit to Lyell McEwin Health Service took place at around 26 weeks gestation. She was keen to utilise the Birthing Unit, however, she was uncertain whether she might yet move away from the northern suburbs, and was aware of the services of Flinders Medical Centre, and the Queen Elizabeth Hospital.

Neither Debbie nor her partner had family in Adelaide, although they had made a few friends since arriving. The CMP midwife assisted with transport, had discussions with medical staff, with the Second Story service Youth Worker, and encouraged links with local aid agencies. As well as routine antenatal testing, a family history resulted in extra testing being requested, whilst working with Debbie's phobia of needles. Extra social support was offered, as well as extra antenatal education. Due to Debbie's age and social situation the CMP midwives were keen to continue to support her should she need to move from the area.

Ruby

Ruby was an 18 year old woman who heard about the CMP from her aunt, who had birthed with the midwives in 1999. Ruby came to the Northern Women's Community Health Centre at 6 weeks gestation. She lived with her boyfriend and this was her first pregnancy. She had supportive family who lived nearby.

Ruby chose to have all routine pregnancy testing. She was a carrier for a genetic disorder which required blood collection from both her and her partner, as well as genetic counselling at the Women's and Children's Hospital. Ruby was well informed about her condition and had managed this independently for many years. She was aware of the implications that it might pose for her baby.

The CMP midwife provided both medical and social support. Ruby still had some contact with her local GP who she intended to see postnatally. She planned to birth at the Lyell McEwin Health Service, Birthing Unit.

Alice

Alice was a Muslim woman who sought the CMP for female-only care and for a home birth. She was referred from the Women's and Children's Hospital Birthing Unit. She was 34, had two teenage children (which had both been uncomplicated vaginal births), and lived by herself. Her husband was overseas and it was not clear whether he would be able to attend the birth due to financial limitations and immigration restrictions. She communicated with her husband as frequently as possible, although this was restricted by his religious commitments and finances. She had returned to Adelaide from overseas and then discovered that she was pregnant.

Alice chose to have all routine pregnancy testing, including ultrasound, with all results in the normal range. She had a history of Hepatitis C, which did not pose a problem during the pregnancy care. A physiotherapist was consulted frequently for a chronic back problem and Alice kept in regular contact with her own GP as well as the hospital antenatal clinic during her pregnancy.

She had strong social links with the Muslim community in Adelaide, and had some family nearby. Some support for social and medical issues was required from the CMP midwives. Alice planned to birth at home, with support from the Community Midwives and possibly also her teenage daughter. The Women's and Children's Hospital was her back-up booking hospital. Strict religious rituals need to be followed shortly after the birth, and these required assistance from Muslim community members.

4.2 Maternal Age

Approximately 75% of women enrolled in the Community Midwives Project were less than 30 years old (Table 3), with 24% under the age of 20. This figure is approximately 4.5 times greater than the State average of 5.3%, for women giving birth under the age of

20 (Pregnancy Outcome Unit 2001) and reflects an effective promotion of this Project to young women living in the northern suburbs.

Table 3: Age of women who have birthed with the Community Midwives Project

Age	Frequency	Valid Percent	% for SA 2000*
Less than 20 years	33	23.6	5.3
20 – 29 years	72	51.4	47.3
30-39 years	34	24.3	44.8
40 or more	1	0.7	2.6
Total	140	100.0	100.0
Missing**	8	-	-
Total	148	100.0%	100.0%

4.3 Maternal Race

Table 4 describes the maternal race of women enrolled in the Community Midwives Project. The majority of women were Caucasian (82.4%), however a significant and increasing number of Indigenous women joined the program - 14.2% compared to the State incidence of 2.5% of birthing women. This was a result of effective liaison between the Community Midwives and the local Aboriginal community based services in the northern metropolitan area of Adelaide.

* Where comparisons are made with S.A. as a whole, the data is taken from *Pregnancy Outcome in South Australia 2000*, Pregnancy Outcome Unit, DHS, Adelaide: 2001.

** Where data is listed as *unknown or missing*, this was often due to changes in record keeping across the life of the Project.

Table 4: Maternal race of women enrolled in the CMP

Race	Frequency	Percent	Valid Percentage	% for SA 2000*
Caucasian	122	54.7	82.4	91.6
Aboriginal	21	9.4	14.2	2.5
Asian	5	2.2	3.4	4.5
Other	0	0	0	1.3
Total	148	66.3	100.0	100.0
Missing**	75	33.7	-	-
Total	223	100.0	100.0	

4.4 Birth Outcomes

By the end of September 2001, 148 women had birthed under the Community Midwives Project. The outcomes for all enrolled women as of September 2001 are presented below (Table 5). There were no stillbirths or neonatal deaths and the 149 live births included one set of twins. The category “outcome unknown” includes the CMP clients who were still pregnant at the time of data collection as well as those women for whom this information was not available, or who were lost to follow up.

Table 5: Pregnancy outcomes for all enrolled women at September 2001

Pregnancy Outcome	Frequency	Percentage
Live birth	149	66.8
Miscarriage	4	1.8
Termination of pregnancy	2	0.9
Withdrew from program	7	3.1
Outcome unknown **	61	27.4
Total	223	100.0

4.5 Births by Year

The number of women who have accessed the Community Midwives Project steadily increased over the duration of the project. There was a slight decline in 2001, but this can be attributed to uncertainty around ongoing funding for the Project to continue and the data collection during this year ceased in September. The number of births for each year are presented in Table 6.

Table 6: Number of births by year

Year	Number of Births	Indigenous Births	% Indigenous Births
1998	2	2	100.0
1999	17	5	29.4
2000	75	9	12.0
2001	54	5	9.3
Total	148	21	14.2

4.6 Location of Birth

Most of the women gave birth at the Lyell McEwin Health Service (LMHS), with the Women's and Children's Hospital (WCH) and The Queen Elizabeth Hospital (TQEH) also popular locations). Home birth continues to be a popular choice for women enrolled in the Community Midwives Project (13.6%), compared to the State incidence of 0.2%

for planned home births in 2000. This option for birthing would rarely be accessed by most women, particularly if socioeconomic disadvantage was an issue, due to the costs associated with privately employing an independent midwife for a home birth.

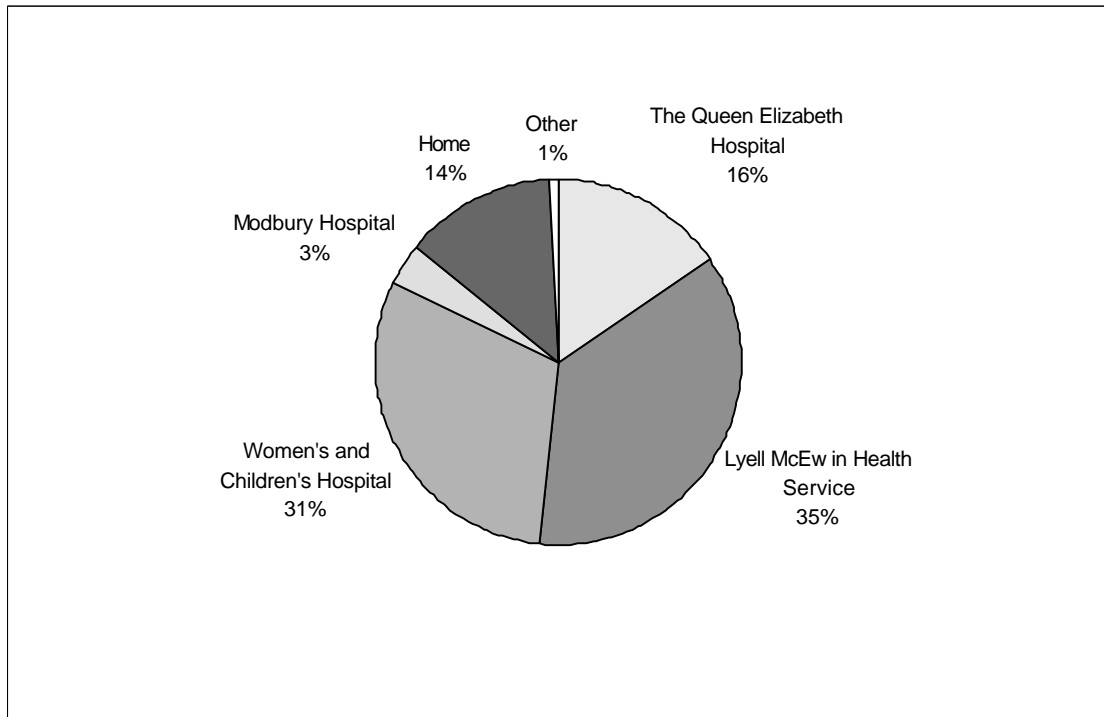


Figure 3: Location of Birth

The proportion of births at different locations has been necessarily influenced by the process of setting up the Project. There has been a shift in the proportion of women birthing at different locations as the Project has progressed. The number of women who birthed at each of the locations is presented in Table 7.

Table 7: Location of Birth

Location	Frequency	Percent	Valid Percentage
The Queen Elizabeth Hospital	23	15.5	15.6
Lyell McEwin Health Service	53	35.8	36.1
Women's and Children's Hospital	45	30.4	30.6
Modbury Hospital	5	3.3	3.4
Home	20	13.5	13.6
Other	1	0.6	0.7
Total	147	98.7	100.0
Missing **	1	0.7	
Total	148	100.0	

4.7 Type of Birth

The numbers relating to type of birth are presented in Table 8, and depicted in Figure 4. The majority of women had a normal spontaneous vaginal birth (68.2%), with a further 14.2% requiring an emergency caesarean section, and 6.1% undertaking an elective caesarean section. There were 2 breech births, 5 women requiring forceps, and 10 requiring a ventouse extraction. These figures are comparable to that of the State as a whole (see Figure 5).

Table 8: Type of Birth

Type of Delivery	Frequency	Percent	Births in SA 2000
VB	101	68.2	61.7
Ventouse	10	6.8	6.3
Forceps	5	3.4	6.4
LSCS (elective)	9	6.1	10.4
LSCS (emergency)	21	14.2	14.8
Breech	2	1.4	0.4
Total	148	100.0	100.0

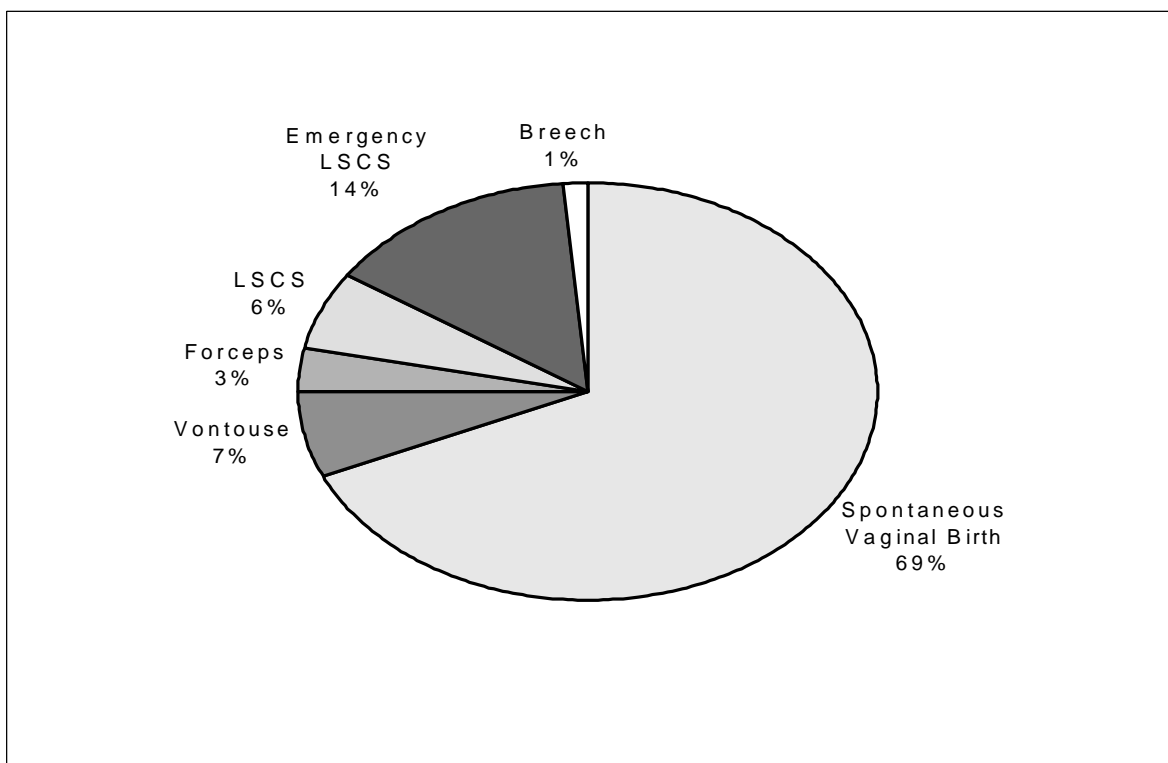


Figure 4: Type of Birth

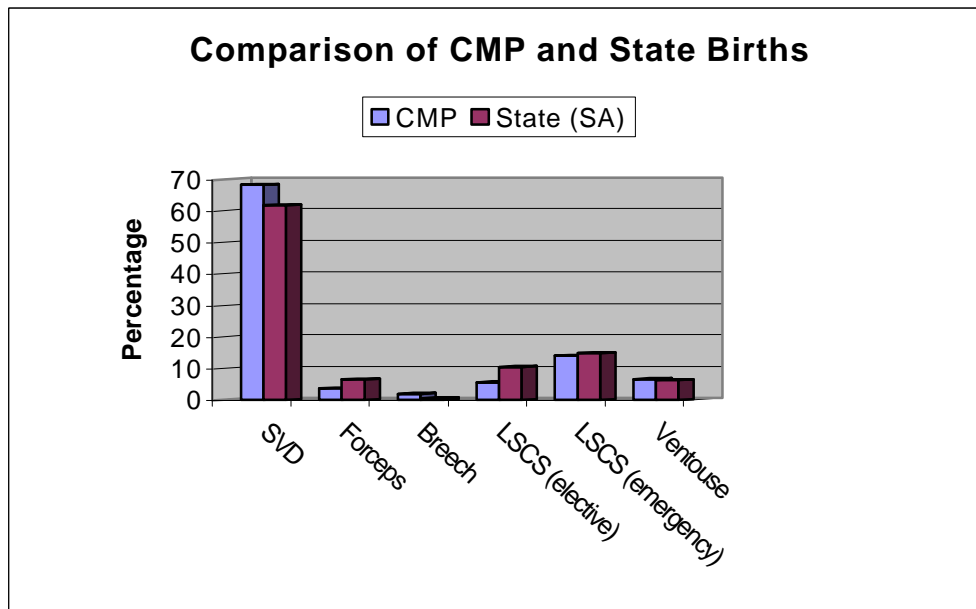


Figure 5: Comparison of CMP and births in South Australia 2000

4.8 Labour – Onset and Length

For most women (69.9%) onset of labour was spontaneous, with a further 22.6% requiring induction. The rate of induction of labour for the State in 2000 was 27.3%. The mean length of labour was 7.74 hours (SD = 6.36), ranging from 0 hours to 29 hours. More than one third of the women (37.7%) chose to have no pain relief during their labour and delivery. For women requesting pain relief during their labour the most common forms of pain relief were epidural (27.6%) and Pethidine (22.0%). Women birthing with the CMP were less likely to use analgesia during labour, as compared to the outcomes for the State as a whole, and this difference was found to be statistically significant. A full list of pain relief usage is presented in Table 9.

Table 9: Analgesia during labour (N=127)

Pain Relief	Frequency	Percentage	Valid Percent	% for SA 2000
None	48	32.4	37.7***	29.5
Nitrous oxide and oxygen	16	10.8	12.6	38.4
Pethidine	28	18.9	22.0	30.8
Spinal	0	0.0	0.0	0.7
Epidural	35	23.6	27.6	34.9
Unknown **	21	14.2	-	-

4.9 Perineal Status after Birth

As Table 10 indicates most women (44.3%) had an intact perineum after delivery, with a further 24.8% requiring repair of a tear, and 9.4% had an episiotomy. The results for tears are not dissimilar to the State average in 2000 of 25.5%, with the CMP having a statistically significantly lower rate for episiotomy, at 9.4%, compared to the 17.3% episiotomy rate in South Australia in 2000. Women who underwent a caesarean section were coded into the “not applicable” category.

Table 10: Perineal status after birth

Perineal Status	Frequency	Percentage
Intact	66	44.3
Tear	37	24.8
Episiotomy	14	9.4***
Unknown	3	2.0
Not applicable	28	19.5
Total	148	100.0

*** sig diff $\alpha=0.05$

*** sig diff $\alpha=0.05$

Table 11: Method of feeding at birth

Feeding Method	Frequency	Percentage
Breastfeeding	128	86.5
Bottle	13	8.8
Breast/Bottle	3	2.0
Breast/Supply	1	0.7
Expressed	3	2.0
Total	148	100.0

4.10 Method of feeding at birth

A high proportion of women chose to breastfeed upon delivery (86.5%). A small number of women chose to bottle feed (8.8%), and 7 women used a combination of feeding methods. These figures are presented in Table 11.

4.11 Birthweight

The birthweight distribution of all births is presented in the Table 4.10 below. The percentage of low birthweight babies (less than 2500 grams) was 8.5% (n=11). The mean birthweight was 3425.06 grams (SD=711.81g), with birthweights ranging from 1160g to 5090g. An analysis of these low birthweight babies showed that they were all born at less than 37 weeks of gestation. If babies born at less than 37 weeks are excluded from the analyses the mean birthweight increased to 3600.01grams (SD=534.46). Birthweights for 102 babies born at 37 weeks or greater ranged from 2540g to 5090g. Of the 149 babies born, 15 had a gestation of less than 37 weeks (12.1%). In South Australia in the year 2000, 8.6% of births across the State had a gestation of less than 37 weeks. The significant proportion of birthweight data which was unavailable may impact on the accuracy of these analyses.

Table 12: Birthweight of babies born in the CMP

Birthweight (g)	Number of Births	Percentage	Valid Percent
<1500	3	2.0	2.3
1500-1999	1	0.7	0.8
2000-2499	7	4.7	5.4
2500-2999	20	13.4	15.5
3000-3499	36	24.2	27.9
3500-3999	37	24.8	28.7
4000-4499	20	13.4	15.5
4500 or greater	5	3.4	3.9
Total	129	86.4	100.0
Missing **	20	13.4	
Total	149	100.0	

4.12 Low Birth Weight of Babies

Of the 149 babies born, 11 weighed less than 2500grams. All of these babies were born prematurely (less than 37 weeks gestation), and thus were considered outliers in the Project population data. Each of these babies has been identified and characteristics relating to the pregnancy are presented in Table 12.

As Table 13 shows, 7 low birth weight babies were born to Indigenous mothers and 4 babies to Caucasian mothers. The smallest baby had a gestation of 27 weeks and required transfer to neonatal intensive care facilities. Six of the mothers (54.5%) experienced antenatal complications, and these may have contributed to birthweight and premature delivery.

Table 13: Characteristics of pregnancies relating to low birth weight babies

Weight (grams)	Gestation (weeks)	Maternal Race	Onset of Labour	Type of Delivery	Antenatal Complications
1160	27	Indigenous	Spontaneous	Spontaneous Vaginal Birth	Yes
1190	32	Caucasian	No labour	LSCS	Yes
1490	35	Indigenous	No labour	Emergency LSCS	Yes
1850	32	Caucasian	Spontaneous	Emergency LSCS	No
2000	Unknown	Indigenous	No labour	LSCS	No
2000	33	Indigenous	Spontaneous	Spontaneous Vaginal Birth	Yes
2010	36	Indigenous	Spontaneous	Spontaneous Vaginal Birth	Yes
2110	36	Indigenous	Spontaneous	Spontaneous Vaginal Birth	No
2225	36	Caucasian	Induction	Spontaneous Vaginal Birth	No
2450	36	Caucasian	Spontaneous	Spontaneous Vaginal Birth	Yes
2490	35	Indigenous	Spontaneous	Spontaneous Vaginal Birth	No

Indigenous Women

Of the 148 women who have had their babies with the Community Midwives Project, 21 identified as Indigenous. This was 14.2% of all births. Thirty-five percent of these women were under the age of 20, with 42.9% experiencing their first pregnancy.

A comparison of the ages of Indigenous and non-Indigenous women are presented in Table 14. As can be seen in this table, there is a greater proportion of Indigenous mothers under the age of 20, and a greater proportion of non-Indigenous mothers aged 20-29 years.

Table 14: Mother's age by cultural background

Age	Frequency	Percentage	Valid %	Frequency	Percentage	Valid %
Less than 20	7	33.3	35.0	26	20.5	21.7
20 – 29 years	6	28.6	30.0	66	52.0	55.0
30 – 39 years	7	33.3	35.0	27	21.3	22.5
40 or more	0	0	0	1	0.8	0.8
Total	20	95.2	100.0	120	94.5	100.0
Missing	1**	4.8	-	7	5.5	-
Total	21	100.0		127	100.0	

4.14 Gestational Age and Birthweight

The mean gestational age differed for Indigenous and non-Indigenous mothers. See Table 4.13 for an overview of results. For Indigenous women the mean gestational age was 36.94 weeks (SD = 3.4), and ranged from 27 to 40 weeks, while for non-Indigenous mothers gestational age ranged from 32 weeks to 41 weeks with a mean of 39.09 weeks (SD = 1.75).

Approximately 47% of Indigenous mothers birthed at less than 37 weeks gestation, and this contributed to the proportion of Indigenous babies (36.8%) weighing less than 2500g at birth. In fact, when babies less than 37 weeks gestation were removed from the analyses there were no babies born to Indigenous mothers that weighed less than 2500g at birth, and the mean weight increased from 2781.32grams (SD = 877.27) to 3298.75grams (SD = 602.44). A much smaller proportion of non-Indigenous mothers (6.5%) birthed at less than 37 weeks of gestation. The mean weight of babies born to non-Indigenous mothers was 3543.06grams (SD = 617.74), rising to 3604.55grams (SD = 532.41) with the exclusion of babies less than 37 weeks gestation.

As Table 15 indicates, there was a statistically significant difference between the number of Indigenous women who birthed at less than 37 weeks gestation, compared to the non-Indigenous women in this program. While there may also appear to be a significant difference in the number of babies with a birth weight less than 2500 grams born to each of these groups, there are insufficient numbers in the non-Indigenous group to statistically justify this.

Table 15: Gestational age, birth weight and cultural background

	Indigenous Women (N=21)	Non-Indigenous Women (N=127)
Mean gestational age (weeks)	36.94	39.09
Gestational range (weeks)	27 – 40	32 – 41
Mean birth weight (grams)	2781.32	3543.06
Weighing less than 2500g	36.8%	3.7%
Gestation <37 weeks	47.1% ^{***}	6.5%
Mean birth weight (grams) where gestation >=37 weeks	3298.75	3604.55
Babies weighing <2500g where gestation >=37 weeks	0	0

Eighty-one percent (n=17) of Indigenous women in the Project had a spontaneous vaginal birth, 14.2% (n=3) had a caesarean section and 4.8% (n=1) had a forceps delivery. The majority of births to Indigenous women were conducted at the LMHS (47.6%), followed by 19% at both QEH and WCH. Of the 17 Apgar scores recorded, 16 babies (94%) had an Apgar score of 8 or more at 5 minutes. One baby had an Apgar score of 7 at 5 minutes. Eighty-one percent of Indigenous women chose to breastfeed their baby.

^{***} sig diff $\alpha=0.001$

4.15 Discussion

Diversity of clients

The women who accessed maternity care through the CMP were diverse, however, a large proportion were “high needs”, requiring a range of social and specialist support. The CMP client base was composed of all “risk” categories, which makes the Project unique in the context of midwifery continuity of care programs where screened, “low-risk” women are selected for care (Thiele & Thorogood 1997). The CMP successfully demonstrates the provision of midwifery continuity of care to women with high needs, maintaining successful links with relevant agencies, while appropriately consulting and referring to specialist care when needed. The collegial support of obstetricians, other health professionals and community health services was fundamental to this achievement.

A successful uptake of the Project by young women is reflected in the high proportion of women under the age of twenty accessing the CMP. Teenage pregnancies are associated with fewer antenatal visits and a higher rate of medical and obstetric complications during pregnancy, including pre-term births, low birthweight and a higher perinatal mortality rate (Zhan & Chan 1991; Westenberg et al. 2002). Access to the CMP by teenage women improved their likelihood of more frequent antenatal visits and appropriate referral and liaison to relevant agencies and specialists as required.

The ever-increasing number of women joining the CMP each year has demonstrated the acceptance of this Project by a range of women, including Indigenous women. In 1999, nearly 30% of all births on the Project were those to Indigenous women. This rate has dropped to approximately 12% of all births in 2000 and 9% in 2001, but this proportionate change was due to a greater uptake of the program in numbers of non-Indigenous women, rather than a decline in the number of Indigenous women utilising the service. The success of the CMP in reaching these women is an important demonstration of the acceptability of this form of care, given that mainstream services are less often accessed by Indigenous people, often due to the lack of provision of culturally appropriate services (NSW Department of Health 2003).

In addition to being an acceptable form of care, participation in the CMP by Indigenous women increased the likelihood of a higher frequency of antenatal visits. A low frequency of antenatal visits has been identified as of particular concern for the care provided to Indigenous women in the State (Pregnancy Outcome Unit 2001). The uptake of the CMP by Indigenous women contrasts with the experience of the Fremantle Community Midwives Project, where no Indigenous women booked with the program during its first phase (Thiele & Thorogood 1997).

A high proportion of the Indigenous clients were teenagers (35%). Westenberg et al. identified that 23.3% of births of Indigenous women in the State in 1996 were those to Indigenous teenagers, who experienced the increased incidence with teen pregnancy of premature birth, low birth weight and small for gestational age infants (2002). Dorman (1997) has identified several critical factors for the success of a community midwifery program, targeting young Aboriginal mothers, in Rockhampton: home visiting, the availability of transport and the provision of a wide range of services and support.

While much remains to be done to successfully care for and improve birthing outcomes for Indigenous teenaged mothers across South Australia, the successful uptake of the CMP by Indigenous teenagers is an important indicator of the promise of this approach.

Place of birth

The CMP successfully provided access to the choice of home birth, as shown by the contrast between the State planned home birth rate of 0.2% and the CMP rate of 13.6%. This striking difference is a testimony to the effective creation of a meaningful alternative for the choice of birth-place. While international literature supports the safety of the choice of home birth for a screened population with skilled caregivers, this has been a rare choice in Australia, due to the unavailability of public health sector options or support. The achievement by the CMP of a significant home birth rate in a socioeconomically deprived region demonstrates successful education about normal birth and birth options, building of confidence in continuity relationships with clients, and a challenge to social inequity.

Women also accessed the choice of birth in hospital birth centres as well as delivery suites. There will continue to be shifts in the pattern of concentrations of births at the various hospitals accessed in the Project, as greater promotion is given to hospitals located in the north western suburbs of Adelaide.

Outcomes and trends

There were no stillbirths or neonatal deaths. The outcomes for births were comparable to rates for the State, with the exception that CMP clients chose pain relief significantly less frequently and had a decreased rate of episiotomy compared to State outcomes. This is in line with other research on midwifery continuity of care models which have been shown to reduce interventions in labour (Homer et al 2001).

The number of births being analysed during the period of this evaluation was small and the amount of data which was unavailable in some categories was significant. Therefore, any extrapolations must be viewed with caution. However, there is no evidence of negative trends that differ from State outcomes and several positive trends emerge in the course of provision of care to a population generally considered “high-needs and high risk”.

In the *Fifteenth Report of the Maternal, Perinatal and Infant Mortality Committee* for the year 2000 in South Australia (DHS 2001), the Committee recommends a “system for continuity of management extending from the antenatal period through to the end of infancy” (DHS 2001: viii) in pregnancies where extreme youth or poor social circumstances have been identified, in order to achieve optimal care. The CMP routinely provides maternity care with exactly this focus and demonstrates the ability to effectively link clients to appropriate services.

Chapter 5

Successes and Barriers: The Experience of the Project

In order to explore the experience of the Project, a qualitative research approach was employed. Information was collected from a number of key people involved in the setting up process of the Community Midwives Project. The experiences of the first nine community midwives employed in the Project (over the years 1998-2001), staff from the Northern Metropolitan Community Health Service, hospital based midwives from The Queen Elizabeth Hospital and the Lyell McEwin Health Service, and members of the Project Steering Group were interviewed or surveyed in this process.

Data was collected using several techniques: focus group interviews, interviews held with individuals, questionnaires. The survey questionnaire data is presented below.

5.1 Survey Data

Eighty self-administered questionnaires were left with the Director of Nursing at one hospital, to be distributed amongst nursing staff working in all areas of maternity services during July to October 2000. Of those eighty questionnaires distributed, 22 (27.5%) were returned to the evaluators and included in the analyses. The questionnaires were returned from staff working in a variety of areas. These are described in Table 16.

Table 16: Area of maternity services for returned questionnaires

Area of maternity services	Frequency	Percentage
Antenatal Clinic	2	9.1%
Labour and Delivery	7	31.8%
Birthing Unit	4	18.2%
Postnatal Ward	3	13.6%
Domiciliary Midwives	2	9.1%
Combination of any of these	4	18.2%
Total	22	100.0

information to inform women of the service.

Most of the respondents knew of the Community Midwives Project (95.5%). This may be an indication of respondent bias, where only staff who had knowledge of the Project responded to the questionnaire. While most respondents knew about some aspects of the CMP, only 27% knew where the Community Midwives were located, while 73% knew how to contact the NWCMP midwives, and 55% knew where to locate

The following section collates responses to a series of questions posed in the survey:

Are there particular groups of women who would benefit from the CMP?

Respondents to the questionnaire identified a number of situations in which the Community Midwives Project would be beneficial to women who would generally attend the maternity services provided at the hospital. The responses presented in Table 17 are an acknowledgment of the unique nature of the CMP's ability to provide continuity of care to women in a community setting. As is indicated in the Table, many of these women have special needs that may have been better met through the Community Midwives Project in comparison to the mainstream care provided by the hospital.

Table 17: Women who would benefit from CMP care

Women who would benefit	Frequency	Percentage
Poor attendees/dislike hospital	10	45.5%
Aboriginal women	7	31.8%
Young women	6	27.3%
Home birth preference	4	18.2%
Low obstetric risk	3	13.6%
Nervous or worried about pregnancy	3	13.6%
Poor support networks	2	9.0%
Isolated women/transport difficulties	2	9.0%

How is hospital care different from CMP care?

The main differences between the different models of midwifery care identified by the hospital based midwives included:

- “A known midwife who provides whole care”
- “Develops greater rapport and understands the needs of that

particular woman”

- “Flexibility to see women in a variety of settings, including their own home”
- “Home birth option”
- “Significantly longer follow-up postnatally”
- “Greater professional freedom for the midwives”
- “Women have individualised, personalised care in a setting of their choosing with one primary caregiver”
- “Build up rapport with small group of midwives and help keep mothers and babies well and informed”
- “Community based, continuity of care”
- “Choice: Home birth is an option”
- “Different philosophy altogether. The care is woman directed within the limits of safety for mother and child.”

There was recognition that the care provided by the CMP midwives addressed many of the lack of continuity of care issues that arise in the hospital setting. Most hospital based

midwives have little opportunity to provide the whole spectrum of midwifery care (antenatal, labour and birth, and postnatal) as they are employed in specific roles within the hospital setting. They are often employed in only one or two of these areas of care and hence cannot provide the continuity of care the community midwifery model promotes.

Some respondents also identified less positive aspects of CMP care as compared to hospital care:

- “More paperwork regarding discharge summaries”
- “Need to be available 24 hours a day”

What postnatal care does the CMP offer?

Respondents to this question recognised the unique services of the community midwifery program and identified a number of characteristics that differed from the care provided by hospital services during this period:

- “The women know the community midwives and the care would be more individualised”
- “Probably more accessible by the client”
- “Continuity of care”
- “The women can page or contact the midwife as they need. They can ring the hospital but they won’t get the same midwife and will not get follow on care, it will be starting all over again each time”
- “Because of the knowledge of the individual and their circumstances built up during the antenatal period, the care given postnatally could be more tailored to the individual needs of the client.”
- “The large period of time (6 weeks) enables a good supportive follow-up in the early settling in period/support for breastfeeding.”

What sort of skills do you think a community midwife needs?

The respondents generally had high expectations of the skills required by a community midwife:

- “Wide experience in all aspects of midwifery care”
- “Good interpersonal skills”
- “Excellent clinical and practical skills”
- “Time management skills”
- “Excellent documentation”
- “Stress management”
- “Flexibility to adapt to different organizations guidelines of practice”

Survey respondents were also free to comment on difficult aspects of the integration of the CMP with the hospital and they identified several key areas of friction:

Better communication is required with the organization when changing appointments etc., and feedback about women expecting to or having undertaken care with that organization would be nice.

I think this program idea is excellent and see it of great benefit to women. My experience with this program has led me to believe that the midwives involved believe and practice with great respect for the women in their care. My only concern is that they do not have practitioner rights within the organization where they sometimes care for their women, I feel they don't respect the organizational and legal requirements expected when conducting care of women with that organization.

They also identified an approach that could have eased the integration process, which has since been incorporated:

A round table conference at the beginning of this project outlining expectations of the community midwives and the organisation's midwifery staff would have prevented much anxiety and inaccurate information.

5.2 Discussion

During the time period the survey was conducted, the CMP midwives had relatively few births at the hospital surveyed. The CMP was uncertain of permanent funding and

hampered in its ability to care for a large number of clients. This sense of impermanence may have contributed to a lack of relevance of the CMP for hospital based midwives and a lack of knowledge about the services and options provided. While many survey respondents were unaware of some of the contact details for the CMP, most respondents identified positive benefits of CMP care. In addition, the benefits of the CMP model for midwifery were seen:

I think that this program is a great concept and should be supported.

In the bigger picture it is probably how we should all work – using ALL our midwifery skills and some extra skills and in collaboration with other health professionals.

5.3 Interview Data

The data from individual and group interviews was merged and analysed as a whole for emerging themes. Interviews that were included in this analysis explored the experiences of the following informants: hospital midwives, CMP midwives, members of the CMP Steering Group, NMHCS management and a doctor. Four major themes were identified

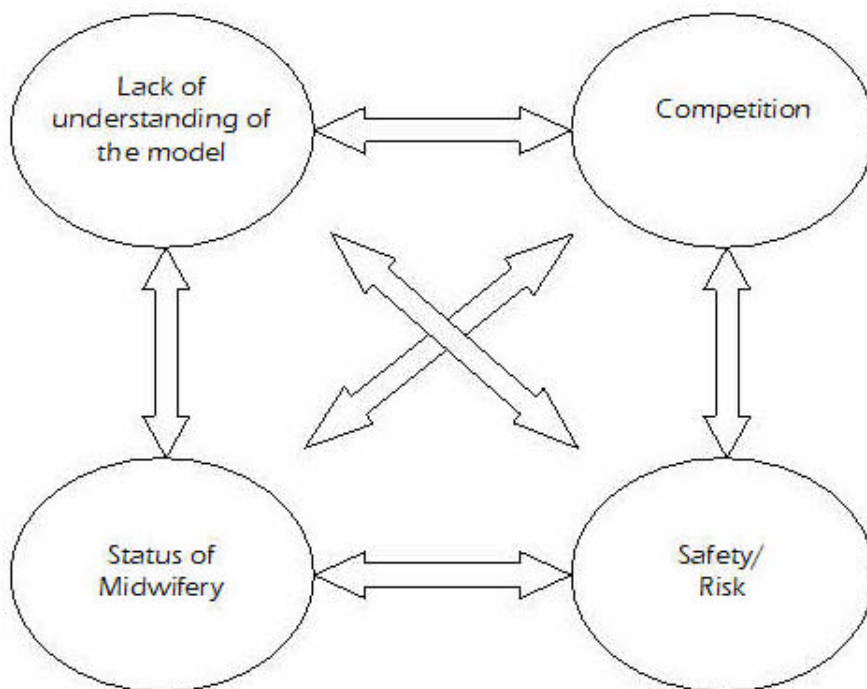
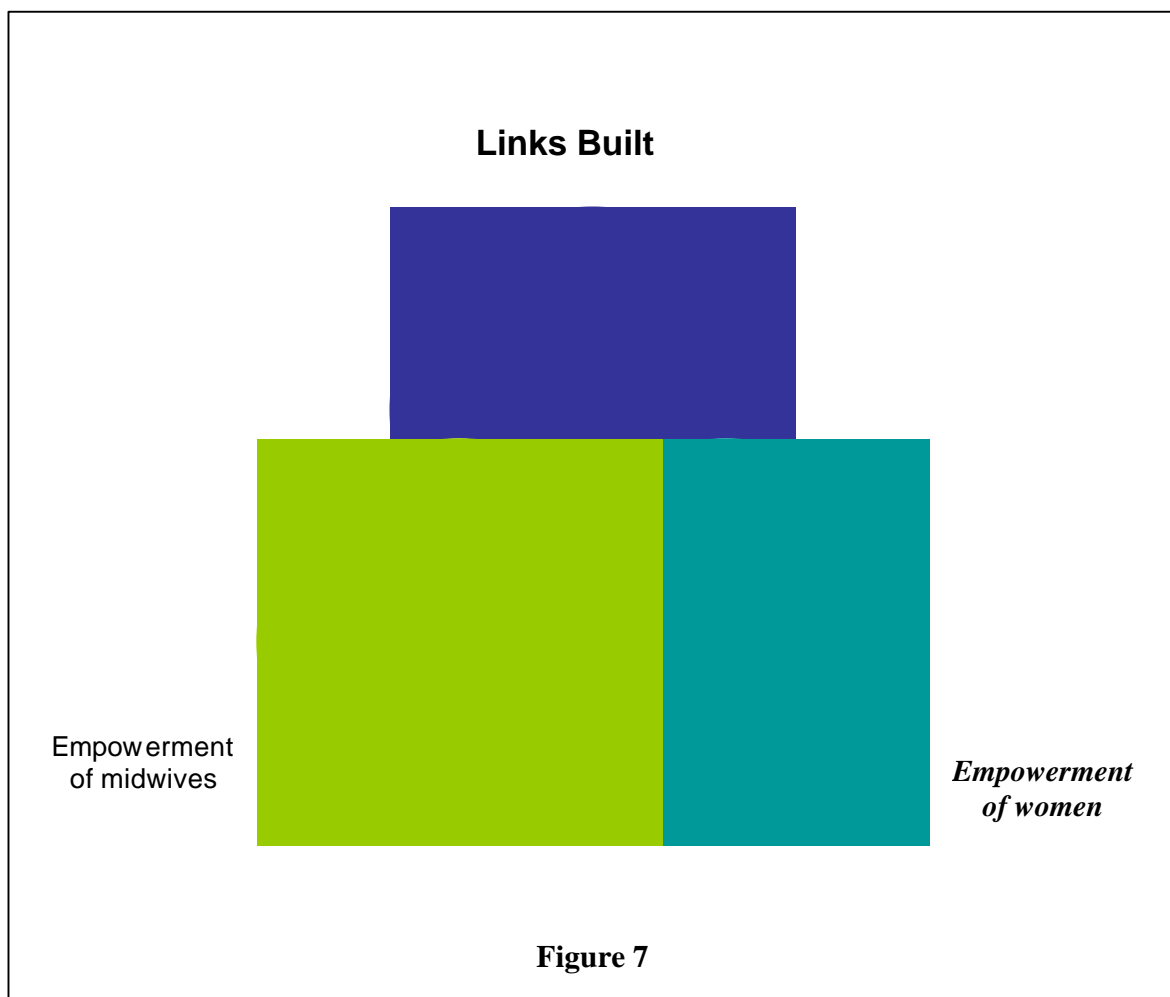


Figure 6

across all of the interview material which could be characterised as having presented barriers to the success of the project. These themes were described as:

- Lack of understanding of the community based, caseload midwifery model
- Competition
- Status of midwifery
- Safety / Risk

These themes and their relationships are depicted in Figure 6.



Equally, several other key themes were identified that could be considered as crucial to the eventual success of the establishment of the Project as a permanently funded Programme:

- Links built

- Empowering women
- Empowering midwives

These themes are conceptualised in Figure 7 and will be discussed further on in this chapter. The interplay of these identified themes is an important component of the analysis presented here.

5.4 Theme: “Lack of understanding of the community based, caseload midwifery model”

The Challenge of Integration: Working Out the Model

As this was the first community based continuity of midwifery care model in the public system, caring for women of all social and medical ‘risk’ status, in Australia, it is not surprising that there was no common understanding of the CMP model and its implementation from many quarters.

The challenge of placing a clinical service (midwifery care) in a community health setting, when pregnancy and birth care in Australia has conventionally been an acute care service provided only in hospitals, meant a steep learning curve for all involved.

It had its roots very much in primary health care before it even started, which is unusual. Most ABS funding went to people who didn’t necessarily have that strong political commitment to primary health care and there was a huge awareness out there around women’s needs and the needs of the very disadvantaged in our community.

Although this model is common in other jurisdictions (New Zealand, U.K., Canada, the Netherlands), this has not been the mainstream understanding of the midwife’s role in Australia. The CMP was instituted under ABSP funding in an effort to create an alternative, with a consequent need for education about and promotion of the model of care in the early stages.

There was lively debate as to the roles of midwives and management during the set up:

And this might come back to what we were saying before, maybe the wrong people are representing you, they don't really have the essence of the project. They haven't got the passion....they don't have the concept of what we are doing.

There was a lack of consultation with the midwives. Lack of respect, lack of support, and a notion that we were overpaid 'swanning around in government cars'.

Physical location

The initial physical location of the Project adversely affected the efficiency of the development of the project until the Project was moved from an administrative site of the NMCHS and the midwives were relocated to a dedicated portable unit behind the Northern Women's Community Health Centre in Elizabeth.

The project more or less got up and running but we had nowhere to place it. We couldn't place it in Northern Women's because of space, so we put it down in Salisbury in Commercial Road.

...Not having a suitable working environment, for example - we were in an admin centre with no client contact – that caused problems.

Our visibility has been an issue - having to let women know about us. I have received some comments on how difficult it was for people to find us and contact us.

Initially we faced hostility from the NMCHS workers as they were uncertain of our role and not used to working with shift workers. This was when we were in the admin centre.

Structural challenges

There were substantial structural issues that needed to be addressed to enable midwives to work in the community across the full scope of midwifery practice, taking responsibility for the full provision of antenatal, intrapartum and postpartum care, whilst being remunerated appropriately. Constraints on the full scope of midwifery practice in South Australia include an inability for midwives to legally order routine pregnancy tests, prescribe appropriate drugs for pregnancy and childbirth, rights to admission and discharge from hospital and difficulty establishing valid routes of consultation and

referral. These issues have been recommended for consideration and resolution by the NHMRC since 1996 (NHMRC 1996).

There was a lack of recognition as to the necessity of making such fundamental changes to implement this model. Some participants thought it could be done gradually and this caused friction:

I don't really think they gave it credit for the systems change. They just thought it was a little project - 'its not about systems change, it is no big deal'. I was looking at industrial staffing, I was looking at the legislation around prescribing rights, I'm looking at the issues around accreditation to major hospitals in terms of community networks working with hospitals, I am looking at Aboriginal health.

It's a bit like a ladder...you'll go up the next rung when you feel safe on the one that you're on and you don't go jumping and try to get to the top...it is a step-by-step approach.

Significant challenges were involved with creating an appropriate payment mechanism for the midwives, who were working long hours on-call, rather than office hours. The structure of nursing awards available at the time of the CMP were unable to take into account the work of midwives who were providing care across the full scope of midwifery practice, including on-call caseload responsibilities. Nursing awards have been historically structured to remunerate shift work or standard office hours, with "time off in lieu" (TOIL) credited for overtime work. As midwifery care provided in a community based caseload model inevitably involves "after hours" work (evenings, night-time and weekends) attending labours, births and some urgent home-visits, the available nursing awards could not provide appropriate remuneration.

NMCHS had numerous meetings with the Australian Nursing Federation and the Nurses Board of SA to resolve these complex pay and industrial issues to establish an equitable pay structure.

Northern Metro wanted to pay us from 9-5 and anything after that was TOIL. Most births happen at night, so our real life will not be paid and our non-real life will be, you know. It was awful and laughable.

The pay thing was painful, we never got the same pay from one month to the next.

When you are on call you will get paid an 'on call' rate, when you're called out you are paid at a 'call out' rate', when you are working after 12.30 midday and late in the evening you will get paid 'penalty'.

That was an enormous barrier, an inability to come to some reasonable negotiation of what these midwives should be paid.

We never knew what we were going to get paid and it got to the point where we designed this pay sheet that was so complicated that it proved that the pay structure in the nursing career was mad. The only answer was salary.

The coordinator's role in the setting up of the CMP was particularly challenging because the structural difficulties needed to be addressed before the midwives could be employed to work in the model, yet the funding for the Project was already flowing. There was a slow build-up of clients over the first and second years of the CMP, as the model was clarified and implemented, and one by one hospitals came on board.

What had happened was when we had interviewed the midwives, and we thought we would bring them on, stagger them on because we are saving money, we hadn't got enough women (clients). I had to start bringing women on also, so I would bring women on, but the accreditation got put off at Hospital X, so we had nowhere to go. We could go in and support people but then the midwives were pissed off because they had to go in to support people, which is part of waiting and time and politics.

Accreditation was not in place anywhere when we started. Many months were spent just getting accreditation at one hospital. We were forbidden to go to there initially. No consultation had occurred there - this later proved our greatest barrier.

Just try and imagine the coordinator trying to resolve these things when you bring the midwives on and you don't know how much you are going to pay them. But the Health Commission wanted numbers of women, so the midwives said we have to put up the advertisement (to attract women). I said we really need to sort out the hospital before we put the advertisement up.

Some barriers, like prescribing rights for midwives, were legal ones:

I was piggy in the middle and couldn't solve it because it was legislation and I had got my hands tied.

There were lively and sometimes painful debates about appropriate responsibility structures for midwives working in this model. One debate centred around flat versus hierarchical structures and the role of the Coordinator, and another around the appropriate balance between administrative and clinical work.

They have nobody there to do their work - we have struggled to get administrative support. They want the midwives to go and catch the babies for the numbers, but they also want someone to keep the negotiations going.

The first year was spent mainly on administrative tasks, organizing pamphlets, publicity, procedures and organizing systems. A lot of time we spent on team building, some professional development.

I envisaged working in a well planned, thought out project in a community health centre that supported and nurtured us, respected women, “lived” primary health care and feminist principles and social justice... I was completely wrong in my imaginings about the proportion of admin, politics, negotiation etc. and actual care for women. The reality was a huge percentage of time diverted to this and a tiny proportion of time to the women.

Initially there were problems with the role of the coordinator. Communication was difficult - our roles were not clearly defined. This caused a lot of frustration, especially in regards to negotiations with the hospitals.

We did talk about this flat structure, but we thought because it was so new it needed somebody to develop that stuff and I think at the time it was quite good. It fell down when people came on board expecting that they just go in and do the midwifery. It wasn't quite that simple, there were still things to be done.

Catchment Area

Initially, the intention of the Project was to be focused on the northern region, however over the first two years the midwives accepted women from a wide geographical area, where their births were planned at four different hospitals.

The amount of travel associated with such a large geographical area! I did 1,000km last month on a part-time basis.

So - it was part of our idea that we wanted to work with other agencies and get women to the right places where they feel comfortable and because of the enormous geographical area that we were covering we couldn't do it, because women were scattered and they just couldn't get there.

If you are going to work on creating a non-dependency relationship you have to have a small - a relatively small - geographical patch because you have to get the women to support each other. Now, you can't do that if they're living miles and miles apart. You can't run an antenatal group or postnatal group if women are living all over the place and don't have transport, you know.

The size of the physical area that the project was to cover was ridiculous. It was too big and it meant that we couldn't do the kind of group work with women that we envisaged.

As described earlier, in 2001 this challenge was resolved by the decision to restrict the provision of care to those women living in a smaller geographical area, that served by the NMCHS.

Transport

This model provides intensive home visiting to women which necessitated midwives having independent transport. Reimbursing use of personal cars was seen as being potentially too expensive. A misunderstanding of on-call work in the early period made the use of government cars cumbersome.

If the turn around time to pick up the vehicle is more than 20 minutes - and the midwife is required to use that vehicle (for visits)... and if I went out to tea at my mother's who lives 40 minutes away...

We were told that part-time midwives would have to share a car... we can't share the car because we have to be very confident (that we can respond to women effectively) and we are on call 7 days a week.... How do we get the car to each other?

We worked out some kind of rotation for the four cars until we got the other. It was a real big barrier. They did not understand that once the project was running fully, the implications of being on call.

Changes were made as the project progressed, with the provision of a larger number of government cars for the midwives' use and redefinitions of "personal" versus "business" use.

Data collection

The data collection framework, which was required to be followed by all NMCHS services provided in the community health environment, was inappropriate for tracking the provision of pregnancy and birthing care. This was another example of the challenge of moving a service out of the "acute" sector to the community.

What is really frustrating is that Northern Metro has a huge, to me incredibly inefficient, statistical program.

We waste our time filling out stats that have nothing to do with our work.

Lack of understanding of the model by the "target" population

This new model of midwifery care required education of all sectors involved including the community health sector, midwives, hospitals and pregnant women. The population chosen may have had rare opportunities for making meaningful choices in their health care and therefore required an enormous time commitment from the midwives to raise awareness of what the service provided.

There are not a lot of people around these days who understand what continuity of care is.

Medicalisation of pregnancy for the last 50 years means that the women, in this area (of Adelaide) in particular, have little knowledge or experience of such (midwifery) care. Therefore wider publicity is required - radio, TV, magazines.

It was really meant to be disadvantaged women and particularly Indigenous women and it was meant to be offering women choice around home birth.

We were aiming at the people who perhaps often wouldn't turn up and we knew would have better outcomes if they did in obstetric terms.

We weren't working in a community health centre with the support of the community. These are important issues and people don't understand it.

Change always comes from the middle-classes, I think you know that as historical. If you are focusing on a group of people who do not normally make risky changes in their life because life is tough.... you will have incredible difficulty in getting in touch with these people.

It was recognized that early involvement of the "target" population could have improved this dynamic:

...planning before project implementation with all key stakeholders and consumers, especially Aboriginal women and organizations

Midwives

The midwives employed in the CMP came from different backgrounds, which included hospital based midwifery, independent midwifery and primary-health-focused community midwifery. There was a steep learning curve for those midwives who had not worked across the whole scope of midwifery care and well as adjustments to be made by all the midwives working out of this model.

Another thing to look at is the transition period it takes to start working in this model. I myself have found that it has probably taken me four or five months to actually really get into the system and really enjoy what I am doing. Not that I haven't enjoyed it - but it has been quite stressful changing from one way of working to another. But now I couldn't think of doing anything else.

One challenge was working out the balance of time spent with women antenatally and postnatally.

...there is a lot of high risk and social dependency there. We are not looking after a low risk client load so women are demanding more of our time and so our hours antenatally and postnatally are probably building up a lot quicker than we anticipated.

I also think that in the long term boil down of the project we may well find that this project can't support financially that ideal of doing a lot of home visits.

The independent midwifery model here in this country, particularly where you only have a very small caseload of women who pay you, if you are not careful it is a high dependency model where you spend two to three hours doing 'antenatals' with women. I don't see that as a public health service model.

The midwives experienced enormous job satisfaction in this process despite the challenges of working out the model.

It was interesting for us all. It was a very interesting little group to come together. Fantastic for sharing skills and experience.

The CMP model of midwifery is an ambitious model that implied significant systems change in terms of midwifery industrial awards, prescribing legislation, hospital accreditation processes and the need to bridge the divide between community health and acute services. Many frustrations were experienced by the midwives employed in the CMP during the first years of the Project due to delays in successfully achieving accreditation at hospitals, low client numbers, together with pressure to spend the Project money and this contributed to a high turnover of midwives.

5.5 Theme: "Status of midwifery"

Conventionally it has been only independent midwives in South Australia who have practiced midwifery in a continuity of care model, taking full professional responsibility across the scope of pregnancy, labour and birth and postpartum. It has been a marginalized model in the Australian system.

Independent midwives have been struggling for twenty years. We, as a group of midwives of so many thousand, have been struggling to be represented as midwives. We are still trying...

Recognition of the CMP model was often difficult, since it relied on a recognition of the midwife as a responsible primary caregiver, in the public system, throughout pregnancy and birthing.

You are a professional who has the ability to make decisions when they are warranted. To be able to make the right decisions. Autonomy is vital for the women. If you don't have autonomy, they suffer because you end up pushing them to other people.

If I was an obstetrician it would be assumed that I had the skill to deliver a baby - but not as an 'outside' midwife.

If it had been a new group of doctors, it could have been done...because doctors have been around for a long time and we know what they do. I think that people don't know what a midwife does. They really don't know.

Midwifery's status in Australia as a 'subspecialty' of nursing continues to hamper appropriate remuneration for midwifery work within nursing award structures.

We were doing an extremely difficult job in an extremely difficult situation and we were professional women with lots of skills...this was some pay clerk somewhere who was getting involved with personal feelings about what she thought we should or shouldn't be getting paid.

This 'invisibility' of midwifery may also have contributed to the misunderstanding of the CMP model within the community health setting.

We aren't big fish. We are at the bottom end of politics of the community. We are just a project - causing hell amongst everywhere - but we are still only a project.

The relationships that needed to be built between the CMP and hospitals, as well as a range of community services, were crucial to the effectiveness of the model. In this model midwives were required to work across the interface between community and hospital services and needed the authority and legitimacy to do this. However, the status of the midwives as employees managed by a community health service may have interrupted their ability to easily negotiate these new relationships. This was a point of disagreement.

They needed a manager to deal with this...to talk to the management of those hospitals because managers don't 'talk to midwives'.

It may be because I am not a midwife, but I know I am a lot more cautious and I think sometimes that can be frustrating for a group of midwives who are very skilled and know their business, who have got someone saying 'hang on - hang on a minute'.

They wanted to do it directly themselves, they themselves wanted to go straight to the Health Commission, they didn't want any middle people.

While midwives' autonomy, clinical role and responsibility was expected to be significantly expanded in the CMP model, this was not reflected in their role in negotiating hospital and government relationships.

They have a sort of management level, not all of whom are midwives...who negotiate for them and on their behalf with people out there in the hospitals and in the maternity services. Then there is a kind of hiccup if you like, they are one stage removed from the direct negotiation which they need to be doing in order to collaborate well and be seen as practitioners in their own right, really.

I have experience, lots of experience of developing new models of care and if the midwives don't own the development and if it's imposed on them it's not going to work. This sort of model requires midwives to do more than just do the job, they're actually out there developing it. They have to be the front people, they have to develop relationships with the community with other practitioners, other health professionals.

In Australia the status of midwifery in the obstetric hierarchy requires particular interactions with obstetricians. This undoubtedly played a role in the set up of the CMP, including the negotiation of accreditation to the hospitals involved.

And you know – are obstetricians really comfortable in supporting midwives when they don't have control over the way they work?

5.6 Theme: “Competition”

As has been mentioned previously, this Project evolved during a phase of significant change in maternity services in South Australia. There were structural changes happening at several of the hospitals linked with the CMP, which impacted on the acceptance of the CMP as an alternative service to those offered by the mainstream services. In the context of economic rationalism, there was a resistance to the integration of the CMP model in hospitals. This was also expressed in a distinction between midwives who were hospital employees and 'outside' midwives.

Some of the staff were hostile...I think they are terribly threatened. I think that is understandable as everyone is losing jobs. Why wouldn't they feel threatened? I think this project was happening at a time of economic rationalism...and everything that the top people wanted to do was about centralizing and dehumanizing. Very bad timing.

On another note, I think that within midwifery as a profession there is an element of denigration of hospital midwives versus independent practitioners which I believe is unhealthy for the profession as a whole because it alienates the majority of midwives. So...where does that put us? It puts the profession in a really weak position similar to some political parties that suffer from 'in-fighting'. We need to be cohesive and supportive, especially as the profession moves through this time of change.

The antagonism experienced by the CMP midwives had the potential to affect the care of their clients.

I am not having these women compromised and put down, and slandered by hostile staff and I am not going to have my integrity compromised because I have not gone through the process of normally saying 'Hi,' (to the obstetrician), 'my name is... I am working on this project, I am a midwife, and this is my experience. I hope we can work together.'

...We gave talks to the hospital, in every department we could think of, and they would eat our sandwiches and turn their backs to us. It was awful... the staff just did what they were told... They knew that (one person) had made it clear that we were not welcome and so they were picking up the culture from above.

...At this hospital, everywhere you go you need a card to open the doors and we did not have one. We had to knock and stand at the door and say 'It's the community midwife' and they would say 'Oh, I'm not sure if you can come in.'

Initially we were only allowed to be support people. This was very difficult...I had to literally beg to attend with a woman undergoing a caesarian section. She was only 16 and Aboriginal but I was told it was only in 'special circumstances' that more than one person could go to theatre, so I had no rights as a support person. In fact I felt that I was not even able to fulfil the role of support person adequately! I felt extremely unwelcome in all areas.

Anyway, it got to the point where we couldn't even... we never knew, if the woman was in surgery or the birth unit. They would only let relatives in. You were not a relative, basically as bad as that. So where was the continuity of care? It made a laughing stock of us as midwives.

The 4 midwives were united and supported each other but we were like 4 rabbits in a minefield surrounded by rabid wolves!

As the process of integration progressed, it became clear that support from the top of the hospital hierarchies was needed to enable midwives who worked on the wards to support the CMP model.

I don't think the midwives understood the role or the services provided by the CMP. In fact they seemed overtly hostile. I am sure they felt threatened. Unfortunately midwives do not support each other or change very well.

Other midwives in hospitals are a barrier to caseload community midwifery.

There was an association of the CMP midwives, who offered homebirth as an option to their clients, with independent midwifery practice which may have been seen by hospital midwives as 'unsafe' or much less safe than hospital midwifery practice and therefore 'inferior'.

Every time somebody does something that the hospital thinks is unusual, it sets it back. It's that fear of 'otherness' and you know they are working with a philosophy that is very different.

I think that hospital staff, once they are well supported and with the right kind of headship will not be a problem. They're not respected so they do not respect someone from outside. I think it is as simple as that...there is no encouragement of people working together supporting each other.

The minute the Director of Nursing and Midwifery says to her staff. 'Today and tomorrow and the rest of history you will support these midwives' and they do. This happened.

It's about establishing trust...mutual trust needs to be established and that is going to take time.

Competition for 'clients' may have been heightened during the evaluation period and the choice of services that women were making could have been seen as a threat, not just to midwives in the hospitals, but also to doctors.

Anything that I represent in terms of midwifery, it's a threat. It's a threat to their income, it's a threat to their power, it's the power based politics.

Client referral to the CMP from the hospitals, in the early years, consisted almost solely of women who refused to attend hospitals for antenatal care, considered 'difficult' clients.

We can care for the 'non-attenders'...they don't really understand the role of the community midwife, so in time, by getting to know each other, hopefully this will improve.

5.7 Theme: "Safety / Risk"

The unique nature of the model and the level of responsibility the CMP midwives assumed meant that they worked under close scrutiny in the hospitals. The importance of adherence to hospital protocols was emphasized by hospital staff as ensuring 'safe' care.

The hospital staff were unsure of our role and were concerned about accountability and legal responsibility issues.

As a midwife...it is important to meet the obstetricians in the hospital so they know who I am, and I think that is part and parcel of what they would expect. I want them to know that the way I work is competent.

The eyes of everyone are on them, so they've only got to make one mistake and do something that doesn't abide by that hospital's protocols, and they're sunk.

Documentation is very important. If midwives using the facilities of this hospital to deliver their clients, don't abide by the protocols of the hospital, they place the admission rights of the whole program in jeopardy.

They were waiting for me to slip up and overly scrutinizing me!

The confusion between the CMP and independent midwifery often focused on risk perceptions of home birth.

A lot of people think because they(the CMP) have employed a couple of independent midwives, the hospitals think that it is kind of like independent midwifery which has got a bad name. You know, independent midwifery in a lot of people's books is not safe practice, so there is a wariness and an assumption that they are not safe practitioners.

The medical perceptions of safety and risk concerning homebirth and clinical competence centred around professional indemnity issues.

My role as a doctor was to ensure the safety of the project. When they started no one had done anything like this in South Australia. It was important that the women were not

getting compromised care and that the staff were adequately protected – the staff on the program had to carry proper insurance and workers comp.

We are all under DHS anyway. They insure us so in terms of their insurance it really doesn't matter if they go to four hospitals or one. They will be covered by DHS and DHS, to their credit, also covered them for home birth. The important thing was - they were insured within the guidelines.

We had to make sure they were appropriately skilled and made sure they understood the policies and procedures of this hospital or whatever hospital they were choosing to go to.

I suppose from a medical point of view we certainly have not had any major disasters.

Responding to the perception of risk was ambiguous for CMP midwives. When a midwife had consulted or transferred appropriately from a low risk setting, there was still the perception that she might have “missed something”:

I would transfer a woman out (of the birthing unit), but the fact that I transferred her out means I should have transferred her out before I knew there was anything going on. So it's never quick enough, soon enough or anything.

5.8 Theme: “Links built”

Over the two and a half years from start-up, the CMP midwives were active in developing crucial links with the hospital and community based services associated with the Project. Despite the initial difficulties, huge progress was made over time.

Strategies employed to solidify relationships with hospitals included: completion of accreditation processes, agreement on protocols, and scheduling regular meetings with midwifery staff, Directors of Nursing and obstetricians. Over time, this resulted in the successful establishment of collegial relationships.

I have had contact with all the Community Midwives and have found them to be professional and also keen to develop a worthwhile and meaningful relationship with the staff at our hospital. It has been their personal commitment and the time they have spent making contacts here which has aided the acceptance of the program.

I think they've broken down all sorts of barriers in some of the hospitals and they're continuing to work on it.

(One hospital)...has a long history of innovations in midwifery and a good reception for independent midwives and they were supportive and welcoming...I enjoyed going there and felt safe as a midwife.

Our community as a whole keep telling us they want us to remain but they don't come here (to this hospital)...I thought this Project may have attracted them - that's why we made it easy for them (the CMP) to get in, get them supported, upskilled so they could work.

The CMP built important links with a range of social services delivered by the Northern Metropolitan Community Health Service, and others, and with the Aboriginal Community. They also fostered links between the women they cared for as clients, making the space for the establishment of social networks.

...It is working from the community and with the community, and into the hospital and back out to the community, linking people to the services they need.

We challenge the fragmented traditional system which has not been accessible to Aboriginal women or woman centred.

We try to provide a culturally appropriate and accessible service. We collaborate with other disciplines to ensure that women get the best outcomes.

...developing links with the Aboriginal community (has been really successful).

The best, best thing is that they have been accessing care to those really disadvantaged women – the percentage of Aboriginal women that they're reaching is fairly high. They're beginning to develop real networks in that community, people are coming to them now and bringing friends. They've done a great job at accessing a population that's very difficult to access and they've made good contacts in the community with people who refer them.

We have proved that a lot of things can be done. It's not to say its impossible - we have shown it is not. It doesn't happen over night, it took us months to set up.

You cannot work in that way without collaborating, you know, you need to work really closely with obstetricians, with paediatricians, with other midwives, with policy makers, with managers – and that's about midwifery kind of growing up.

5.9 Theme: “Empowerment of midwives”

The experience of the CMP, “... has empowered the midwives and the women they care for.” The midwives expressed satisfaction with their role and with the continuity relationships they established with women:

Really working as a midwife.

Developing meaningful relationships with women through continuity of carer.

Developing relationships with women has just been the most rewarding experience.

Not only did the midwives identify that they enjoyed working in a different model, they also took pride in the eventual success of team-building with midwives from different backgrounds and different skills sets. They expressed satisfaction with the level of autonomy and responsibility called for in the CMP model, in which the midwives exercised a wide scope of practice as compared to previous experiences with a restricted scope.

Being involved in homebirth.

Working in a hospital, it is so hard to look out into the community - and it doesn't happen.

That was a really big learning curve for me as well, the antenatal side of it. But I think it's a really fulfilling way to practice.

You get out of it (working in the hospital) and you see all this stuff you had no idea. It's housing, it's community, it's counselling and support, the finances, it's just so much other stuff you don't, you have no idea about - you hadn't even thought about.

Coming out of the mess and being respected as a team at the end – and being able to get together as a team and actually work together as four from extremely different backgrounds.

Your work's not compacted into an eight hour period...quite often it might be over a twelve, fourteen hour period, but you can actually do things for yourself in that time as

well. Learning that flexibility, and understanding that your knowledge level has become quite broad instead of quite specific in a lot of areas.

You are a professional who has the ability to make decisions when they are warranted – to be able to make the right decisions. Autonomy (for midwives) is vital for the woman. If you don't have autonomy, they suffer because you end up pushing them to other people unnecessarily.

They found the peer support provided by their colleagues to be very important.

Avoiding burnout is about being able to make autonomous decisions about when you call on your mates in a group practice for help. It's about having that flexibility to design the way you work around your life...you're able to pick the phone up and say, 'Look, I'm tired - can you come and take over?' It's about having the autonomy to decide when you are tired.

We spent a lot of time meeting last year in a group. We gave each other support to deal with the issues. I now realize we needed time to set up practice guidelines, reach consensus decision making together – that just took time.

To me it's been really valuable as a member of a group, which I've never done before. I mean, I've been part of a big staff but never a small group – it's been great.

My skills were total care in the home, their skills were in labour, birth and afterwards. So we do lots of sharing and exchanging.

There was an expression of a sense of “pioneering” change in midwifery, and of “being political” to make change.

I began to have a raised awareness as a political animal – and to look for those agendas. I spoke privately to other involved parties and was thus more able to negotiate.

I think the midwives are learning to be political...

As a community midwife you are aware of pregnancy as a social event, not an illness in context of other life issues; mental health and emotional issues, domestic violence, child sexual abuse, poverty, unemployment, illiteracy, drug use, homelessness, racism, social isolation, lack of transport, lack of education, child abuse.

We're increasingly being asked to talk at conferences. We've got to the Women's Health Conference next year and then there's a third conference we've been asked to talk to.

You have to experience what the barriers are to find out what you need to make something work.

5.10 Theme: “Empowerment of women”

It was identified that the CMP model of care enabled women in the northern suburbs to make a range of birth choices. Financial barriers were removed to the choice of homebirth, and this process of making meaningful choices was empowering for the women they cared for.

I think it was important that we did it...It gave a number of these women another option.

Paying out of the pocket for a home birth is a huge thing – up in the North the number of women who’ve had home births in the past were next to nothing.

Enabling women to take power and make choices in their lives eg about domestic violence.

Because it is in a women’s health centre...the woman is the focus, she is the person in control...the woman is really number one so you know, that does shift things a lot, who controls who. And I think it’s quite an important thing to mention.

They were respected for what they had to deal with for their life instead of being judged and blamed...their life situation was respected along with the needs of their pregnancy.

Birthing is handed back to women, in a sense, you know, it doesn’t just come from a medical model...you know, it breaks down the power barriers, the power relationships and I think women become greatly informed.

The model of CMP care placed an emphasis on building social links and building social capital. The potential of peer support and education to promote links between women was explored.

We aim to increase women’s self-esteem and personal skills through one-to-one care, group work and links into community health centres.

They have been cared for by midwives who respect their choices, enable them to take control and respect them as individual human beings. The midwife’s allegiance lies with

the woman because the midwife is not employed by the hospital – therefore the midwife serves the woman’s needs and not just the hospital.

They are invited to join a group to share experiences and learn from each other and they are introduced to a wide range of community services.

Last year I had a fourteen year old, and a seventeen year old having her second baby – and what that young woman learned from the seventeen year old I couldn’t have thought of in years! You know, just from them chatting about what it’s like to have a baby and what she did...

They see women in their same social circumstances and their same education level doing these things as an expert – and I think that seeing, rather than actual talking, teaches them more...it’s a peer thing.

We found that the women are becoming less isolated because they’re actually swapping phone numbers and walking to each other’s homes and really supporting each other in the emotional and social issues of their lives as well.

The CMP experienced success in caring holistically for clients – in particular, for teen clients, who face so many challenges.

Continuity allows trust, which means they are more likely to divulge child sexual abuse and domestic violence, drug use, etc. This means you can plan care for labour to prevent trauma, refer women to counsellors expert in these areas, and work on respecting women and their choices, acknowledging them as the experts in their own lives and increasing self esteem.

Teenagers...they’re still young, they haven’t grown up but they’ve been lumbered with adult issues – child sexual abuse, violence, homelessness, verbal and emotional and physical abuse – or financial. Not being understood or listened to by the major services, by anybody...when we start looking after them we take on board everything they say. No matter what it is, we’ll listen to it.

It changes women’s experience of childbirth...it actually changes the whole experience and it’s been shown in research to change outcomes. You know, where midwives give social support and are listening to women, it changes all the outcomes.

Tremendous support of the CMP was demonstrated by young mothers who had been clients. These young women, from disadvantaged circumstances, and as new mothers, felt strongly enough about their experience of care with the CMP midwives to come out

and campaign in support of the CMP on behalf of securing permanent funding. They also promoted the CMP amongst friends and in the community.

Chapter 6

Discussion

The CMP model of care is a midwifery continuity of care model that is unique in Australia. It is based in a primary health care setting and takes a social view of health. The uniqueness of this model centres around care which is offered to all women regardless of socio-economic or medical risk status, provided in the community, throughout pregnancy, labour and birth and the postpartum period with a known midwife.

The Project has now become a core Programme of NMCHS having successfully integrated into the range of community, institutional and medical services relevant to pregnancy and birth care. Given the range of challenges that were raised in piloting the model, credit is due to all those involved in making a success of the integration of this model of care.

This discussion reviews both the challenges to successful integration of the model and ease of evaluation of the model, primarily from a midwifery perspective.

6.1 Evaluation and data collection

The application for funding of this Project in 1997 did not include a budget for evaluation in its initial costing, although there was always the desire on the part of the participants to see the Project appropriately evaluated. There was a lack of recognition of the importance of tracking a range of clinical and client satisfaction data from the outset of the Project, and the added difficulty that the Project bridged community health collection systems and hospital data collection systems, neither of which was capable of reflecting the reality of community based midwifery caseload care. This is in contrast to the ABSP project in Fremantle where evaluators were involved from the beginning in designing a relevant data collection system to track the project (Thiele & Thorogood 1997). This lack of data has to some extent has limited the ability to comprehensively evaluate the CMP.

Over the period of evaluation, as the CMP model has become better understood by all parties, women, midwives, institutions and NMCHS, it has been recognized that there is a need for data collection systems which cross acute and community sectors when tracking maternity services provision. Poor communication across the sectors has continued to be addressed to facilitate the most effective operation of the CMP model in order not to disadvantage the care of women.

6.2 Structural difficulties

State legislation and regulation in South Australia has been inadequate to support a clear status for midwives, as distinct from nurses, which would support structural mechanisms enabling midwives to work easily in continuity community based caseload models. This has had implications in terms of appropriate industrial awards, employment patterns and access to key responsibilities, such as prescribing, test ordering and clinical privileging.

The institution of the CMP was a radical departure from current midwifery models and was a push to change mainstream options. The CMP model incorporated NHMRC recommendations that midwives work as primary care providers, and have access to mechanisms for prescribing and test ordering (NHMRC1996, 1998).

At the time of writing, the CMP are the only midwives in South Australia working in a continuity case load model. The first midwifery award that will reimburse midwives to work in a continuity, case load model has just been negotiated in 2003, at the Women's and Children's Hospital in Adelaide.

The range of structural difficulties that needed to be surmounted to enable the CMP to offer safe and effective care proved frustrating and stressful for the midwives involved in the model. This resulted in a relatively high attrition rate during the period covered by the evaluation. Some of the reasons identified by the midwives included the inability to provide effective clinical care due to institutional barriers, high stress levels, hierarchical conflict and a long and uncertain period of set up.

By the end of the evaluation period, many of these issues had begun to be addressed effectively, enabling the midwives to feel that the model was operating smoothly and that they were gaining recognition and respect for their roles. Jane Sandall has researched successful features of midwifery continuity of care models in the U.K. She identified occupational autonomy as an important factor in the sustainability of caseload midwifery, where the degree to which midwives have control over their work patterns and a say in decision-making are important factors in reducing burn-out and increasing staff retention (Sandall 1997).

6.3 Clinical Outcomes

From the inception of the CMP until the end of the evaluation period the number of clients receiving care was relatively small. The main volume of work undertaken during this time involved the midwives in setting up the model and addressing the structural difficulties as discussed above. The uncertainty of continued funding, with frequent threats of closure of the Project, also restricted client intake.

The resultant small number of births being analysed in this evaluation showed no negative trends that differed from State outcomes and several positive trends emerged. The CMP clients had a higher rate of no use of pharmaceutical pain relief for labour, and lower rate of episiotomies compared to state averages.

Importantly, the CMP had success in terms of meeting Commonwealth Alternative Birthing Services Program (ABSP) targets, providing alternative choice of birth place (home, birthing centre, hospital) and access to care for Indigenous women, teenagers, women in low socio-economic groups and women with high needs.

The choice of CMP by Indigenous women increased their access to relevant antenatal care in contrast with the State averages for attendance for antenatal care by Indigenous women. Home birth was effectively made available as a choice in the public health care system to a population which was not a “previously identified” homebirth population. Quality pregnancy and birthing care was accessed by young mothers, with 24% of CMP

clients under the age of 20, compared to the State average of 5.3% (Pregnancy Outcome Unit 2001).

Not only did the CMP have success in accessing this target group but they also built meaningful relationships with these clients. Young teen mothers were active in the promotion of this project and the drive to secure permanent funding, often appearing with the midwives to speak at public gatherings and conferences

6.4 Costing

Costing the CMP was beyond remit of this evaluation, as discussed in Chapter 2. While it is possible that over time this service may achieve cost neutrality with mainstream maternity services, it is obvious that during the start-up phase (as in any pilot project which needs to create a novel infrastructure outside of mainstream services) there were significant administrative and operational barriers that prevented the midwives from working efficiently in the community based caseload model.

The groundwork has now been laid by the integration of the CMP into the mainstream system to enable the duplication of this model which effectively provides care within an early intervention model.

There were implications inherent in targeting a developmental model of maternity care for a disadvantaged population. Since the Project was “targeted” at the northern suburbs, rather than implemented in response to identified community demand, education of clients to this model of care delivery was necessary. Disadvantaged women were approached to take advantage of something unfamiliar, and encouraged to exercise choice and control in their pregnancy and birthing services, which would rarely have been an option previously.

The geographic setting of the northern suburbs, which is poorly serviced in terms of a transport network, combined with the disadvantaged socioeconomic reality for many of the clients who were without transport to be able to attend clinic visits at the CHC, meant that the CMP needed to undertake home visiting to provide care. This impacted on the

overall clinical load for midwives. Home visiting both antenatally and postnatally must be recognized as an important feature of this model of care in that it can provide effective and appropriate care for disadvantaged women.

6.5 Conclusion

The CMP model demonstrates the potential to offset costs to the community through an early intervention approach. International evidence is accumulating about the importance of such early intervention strategies, which emphasise coordinated linking and referral to appropriate agencies and the value of home visiting (Garrod 2002; Hutchings & Henty 2002). Canadian evidence estimates that for every dollar invested early, including to the system through prevention (Mustard 2002).

The CMP demonstrates the ability to provide antenatal care to women who would not access hospital care. The continuity relationship established enables the linking of women and their families with appropriate care agencies and services. This comprehensive model facilitates the provision of: parenting skills; potential prevention of prematurity; postnatal care including effective breastfeeding support; contraceptive education and access; opportunities for early intervention and referral, linking to appropriate community supports and services. When this form of care is made available, even given the unfamiliarity of the model, there is an increasing trend to subscribe to it (Zadoroznyj 2000).

Initial ABSP funding has enabled the Project participants to lay the foundation for the establishment of a unique service. It's success in achieving core service status is a testimony to the vision and perseverance of the planners, the midwives involved in the set-up period, NMCHS Management and the Steering Committee, the midwives who continue to work in the Programme and the women of the northern metropolitan region who continue to support and champion this form of care. At the time of writing, with permanent funding, enrolment in the CMP continues to grow.

An important recognition of the CMP's struggle was provided by the Australian College of Midwives Inc., when the *Midwives of the Year Award* was awarded to the CMP in May 2001, as a testimony of peer recognition.

Appendix A

Community Midwifery Programme Advisory Panel Members November 1999

Name	Agency
Kay Anastassiadis	Department of Human Services
Di Beveridge	A/DON Obstetrics NWAHS
Heather Gale	Team Leader, Northern Women's Community Health Centre , NMCHS
Ann Brooks	Community Midwife, NMCHS
Monica Geissellbrecht	Community Midwife, NMCHS
Jan Prider	Community Midwife, NMCHS
Brian Pridmore	Obstetrician, TQEH
Jen Byrne	Flinders University
Nicky Leap	Researcher, Flinders University
Rachel Strauss	Director Services and Programs, NMCHS

(This group was later known at the "CMP Steering Committee")

Appendix B



NORTH WESTERN ADELAIDE HEALTH SERVICE
THE QUEEN ELIZABETH HOSPITAL, CAMPUS



*GUIDELINES FOR REFERRAL AND CARE BY THE NORTHERN WOMEN'S
COMMUNITY HEALTH CENTRE, COMMUNITY MIDWIVES PROJECT,
MIDWIVES, ACCREDITED TO THE QUEEN ELIZABETH HOSPITAL.*

Antenatal

1. The woman books with the project midwife but will see a doctor (GP, obstetrician/specialist) for at least two visits (early and late pregnancy) to assess that she is at low risk.
2. There is a valid referral to a specialist obstetrician accredited at TQEH which covers the period of delivery.
Ideally but not necessarily, the specialist will have met woman antenatally.
3. Women book as a hospital patient of the Northern Women's Community Health Centre.

Labour and Delivery.

1. Women admitted by the project midwife will be according to the hospital guidelines.
2. The project midwife remains solely responsible for the care of the woman
3. If the client becomes high risk during her labour a referral to the Delivery Suite Registrar must occur. This fact must be clearly documented in the case-notes
4. Discharge from hospital may be direct from the Delivery Suite.
5. Babies should be examined by a medical practitioner within seven days of delivery. (This may be after discharge if the woman is admitted for the delivery only)

NB. At any time during the antenatal, intra-partum or postnatal period the woman falls outside the guidelines of "low risk" the women must ~~be~~ revert to medical care. The project midwife can remain as a support person.

May 1999

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Teaching Hospitals of
The University of Adelaide and the
University of South Australia

NORTHERN WOMEN'S COMMUNITY MIDWIFERY PROGRAMME

Women booking for delivery at a hospital whether for the birthing unit or the general labour ward (with community midwifery support) should be seen and booked at the hospital early in pregnancy and be reviewed at 36 weeks and at 41 weeks if necessary.

Ideally women booked for home delivery should be reviewed at least once during the pregnancy at their back up hospital.

TIMING OF VISIT

By 16 weeks so they can be offered serum screening and 18 weeks ultrasound.

TO BE SEEN EARLIER (around 8 weeks)

- Age \geq 35
- Previous infant with congenital abnormality
- Known, or possible carrier of genetic disorder
- Active medical disease
- Recurrent miscarriages or stillbirths
- Previous severe toxemia

CONTRAINDICATIONS TO HOMEBIRTH / BIRTHING UNIT

PAST HISTORY (including obstetrics)

- Hysterotomy
- Classical Caesarean Section
- Vaginal repair
- Caesarean Section (home birth only)
- Haemolytic disease
- Previous unexplained stillbirth
- Deep venous thrombosis
- Pulmonary embolism
- Severe anaesthetic difficulties
- Severe or recurrent PPH.

CURRENT HISTORY

- Active medical or psychiatric disease currently requiring treatment.

THIS PREGNANCY

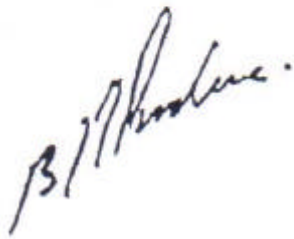
- Multiple pregnancy
- Active infectious disease eg. HIV / TB / Hep B & C
- Placenta Praevia
- Recurrent antepartum haemorrhage
- Substance use
- Isoimmunisation
- Gestational diabetes
- Toxaemia
- Hypertension requiring treatment
- IUGR
- Para 4 or more (for review)
- Haemoglobin $<$ 9.0 gm at 37 weeks
- EFW $>$ 4.5 kgs
- Non vertex
- Active genital herpes

POST DELIVERY

- PPH
- Eclampsia
- Third degree or major tears
- Abdominal pain

NEONATAL

- Apgar (5) < 7
- IUGR
- Weight < 2.5 kg
- Respiratory problems
- Convulsions
- Drug withdrawal problems
- Jaundice
- Congenital abnormality
- Requires prolonged observation



Dr B R Pridmore
11/8/98

Appendix C

The Practice of Midwifery

An internationally recognised definition of a midwife is:

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and the mother. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

In Australia, State legislation regulates the practice of midwifery and there are variations from State to State in the level of responsibility that a midwife may have (e.g. in NSW midwives are accredited to hospitals as independently practising midwives).

Systems of accreditation to or affiliation with obstetric units and a method of delineation of clinical privileges for appropriately educated and independently practising midwives, should be developed by hospitals providing obstetric services.

This will facilitate the coordination between all levels of care provision and promote professional liaison. Quality assurance programmes for homebirth practice can then be developed in order to overcome professional isolation of midwives undertaking homebirth practice and maximise the standard of service provision. Participation in data collection and quality assurance programs should be an integral part of an accreditation process. It is emphasised that homebirth practitioners should notify all planned homebirths to State perinatal data collection units to allow proper collection of data, accurate recording of perinatal statistics, and publication of data nationally.

Definition developed by a Joint Study Group on the Training and Practice of Midwives and Maternity Nurses set up by the International Federation of Gynaecology and Obstetrics, and approved by the Council of International Confederation of Midwives, November 1972.

Commonwealth of Australia 1989

This pamphlet is a supplementary statement to the Report of the Working Party on Homebirths and Alternative Birth Centres 1987

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DEPARTMENT OF
COMMUNITY SERVICES
AND HEALTH

STATEMENT ON HOMEBIRTHS

Approved by the National Health
and Medical Research Council,
Canberra, November 1989



National Health and Medical Research Council

Introduction

Following the release of the Report of the Working Party on Homebirths and Alternative Birth Centres (IDMh session November 1987) many diverse comments were received by the Council from groups and individuals indicative of the highly controversial nature of the subject.

As a follow-up to that report the Council has undertaken an extensive process of consultation to clarify its position on homebirth services.

The Council acknowledges that while less than 1% of Australian women choose homebirth, their right to choose should be respected and the highest possible standard of service should be available to them. As stated in the report of the working party, it has not been possible to determine the safety or otherwise of homebirths in the Australian context.

At the same time, the Council acknowledges the position of the Royal Australian College of Obstetricians and Gynaecologists and its stated policy that it does not accept the premise that homebirths are a safe alternative, nor does it support the concept of midwives operating independently of medical and/or hospital services. The Council further notes that the College also acknowledges the right of women to choose to give birth at home and in this regard that the College sees that it has a clear responsibility to support and develop measures that will ensure, as far as possible, maximum safety in these circumstances.

Appropriate Care for Homebirth

Women who choose to give birth at home should have access to an integrated team of appropriately trained health professionals with adequate resources. This team should include both community based (e.g. registered midwife and/or general practitioner) and hospital-based (e.g. obstetrician and paediatrician) personnel.

Traditional and other non-registered attendants have a role as support persons during homebirths but not as the principal attendant. They may, if required, continue this significant support role in the event of transfer to hospital.

All those planning to have a homebirth should be provisionally 'booked in' to an appropriate hospital and should be encouraged at some time during the pregnancy to consult with the hospital obstetric services.

All newborn infants should be examined in the first week of life by a medical practitioner. The midwife should undertake routine newborn screening, or refer the infant to the appropriate child health services.

Safety Aspects of Homebirth

The WHO Statement on Appropriate Technology for Birth states:

Every woman has the right to proper prenatal care and she has a central role in all aspects of this care, including participation in the planning, carrying out and evaluation of the care. Social, emotional and psychological factors are fundamental in understanding how to provide proper perinatal care. Birth is a natural and normal process, but even 'no risk pregnancies' can give rise to complications. Sometimes intervention is required to obtain the best result.

On occasions, obtaining the best result may require services or treatments which can only be provided in a hospital setting. Planning for homebirths must therefore involve appropriate arrangements for the possibility of transfer to hospital. For this reason coordination, communication and appropriate professional relationships between carers are critically important if the maximum possible safety is to be achieved.

An essential component of homebirth practice is the availability of hospital care, should this be required. A major barrier to providing the safest possible environment for homebirth is ineffective communication between all those who may be involved in providing care (including with hospital-based carers where necessary).

In the event of a transfer to hospital the highest standard of care should be provided; there is no place for punitive attitudes towards women who have planned homebirths, or their carers.

Regular meetings between community and hospital-based professionals including case reviews, workshops and other educational programs will lead to better relationships between providers and a more effective overall service.

Women who are considering homebirth should be counselled regarding the risks associated with child birth as these relate to their particular circumstances. They should be aware that all births carry an inherent risk. In addition to this, they should be advised that there are risks associated with the birth location, whether this be in a hospital or the home. These risks are different in each situation. Risks peculiar to the individual and to her particular pregnancy must also be considered. Where there is a properly integrated approach to homebirth services, the risks associated with this setting, such as delays in transfer, can be reduced.

Women should then be able to make an informed choice regarding place of birth but in making this choice they should be mindful that it is made on behalf of themselves and their infants.

There is a need to develop standard guidelines to assist with the decision-making process relating to the appropriate choice for place of birth.

Appendix D

Community Liaison Initiatives Undertaken by the Community Midwives Programme Midwives

These are groups and agencies that the CMP midwives built links with for purposes of liaison, promotion of the CMP services, linking and referral and community development.

Aboriginal Interagency Forum

Child and Family Forum

Healthy Start Clinical Reference Group, DHS

Handheld Record Steering Group, DHS

North West Children and Families Integration Project

Young Parents and Parenting (Centrelink)

Butt Out for Babies

Kilburn Community Centre

Sefton Park Community Health Centre

Brady St. site of Nunkuwarrin Yunti

Second Story, Child & Youth Health

Child & Youth Health (Elizabeth)

Lynay House (postnatal support group)

Shopfront

Women's Health Statewide

Office for the Status of Women

Childcare Centres

Shine SA

Kids N You

Malvern House

Nursing Mothers (Australian Breastfeeding Association)

Children and Families Link with Cambodian Women

Appendix E

Time and Motion Study

Each midwife collected information for a 2-week period at some time in 2001, by completing diaries to map their activities. The following is a grouping of categories of activities that they were involved in:

- Client services
- On-call
- Travel
- Phone calls
- Administration
- Liaison

Supervision

Professional Development and Training

A time-and-motion analysis of the diary entries was undertaken and it was recognised that administrative tasks were occupying the largest proportion of the midwives' time. Examples of administrative activities are listed below:

CMP Team meetings (allocation, etc)

NWCHC meetings

CMP promotion

Client satisfaction survey planning

Filling in time sheets

Filling in car logs

Completing CHSS statistics forms

Following up test results

Referral letter writing (clinicians, housing, etc.)

Answering mail

Answering email

Filing

Data collection activities

Preparation for presentations at conferences

Public event planning and preparation (i.e.: barbecue)

Pursuing prescribing rights

Participation in DHS 'Young Mothers' research project

Organising childcare for weekly birth Support Group

Handover to colleagues for annual leave

Policy writing: procedures, occupational health and safety

A 1:2 ratio of hours spent in client service and contact versus administrative tasks was calculated.

Appendix F

Interview Questions: Community Midwives Program

Can you describe to me your role with regard to the Community Midwives Program?

Where and when did the idea for the project originate?

Who were the other key players in the developmental stage?

What were their roles?

What was determined first – the model or the need in the northern suburbs?

How was need assessed?

How was the model determined?

Is the current model different to the model that was first envisaged? What has changed?

Were there some difficulties that you could describe? Any major hurdles?

Can you describe the impact they may have had on the project?

What things have worked well?

If it could be done all over again, what things do you think could be done differently and why?

Has it been worth the effort?

Where do you see the project going from here?

Do you think that it is financially viable in its current form?

Could this model work well in other areas, or is it specific to the northern suburbs of Adelaide?

Do you think the program has been well received by women in the area?

Do you think that the program has been well received by other professional groups in this area? (e.g. CAYHS, Nursing Mothers Association, Aboriginal Health Centres)

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