

Policy Brief #3

ANTENATAL CARE: ACHIEVING EQUITABLE ACCESS

Translating evidence from the Aboriginal Families Study to inform policy and practice

Aboriginal and Torres Strait Islander women are 3-5 times more likely to die during childbirth compared to other Australian women, and 2-3 times more likely to have a stillborn baby, neonatal death, preterm birth and/or low birthweight infant.¹⁻⁶ These inequalities in health outcomes are at least in part attributable to late and/or inadequate access to antenatal care.^{4,7,8}

COAG targets

The National Indigenous Reform Agreement signed by the Commonwealth of Australia and all states and territories in 2009 committed all jurisdictions to working towards: (i) increasing the proportion of mothers receiving antenatal care in the first trimester of pregnancy (defined as less than 14 weeks' gestation), and (ii) increasing the proportion of mothers attending 5 or more antenatal care visits.⁹

There is a strong rationale for focusing on access to antenatal care in the first trimester related to the importance of early identification of potentially modifiable risk factors for poor maternal and child health outcomes.^{10,11} There is less agreement regarding the optimum number of visits for women at low and higher risk in pregnancy.¹²⁻¹⁶ Australian national guidelines recommend 10 visits for women having their first pregnancy with no complications, and 7 visits for women having subsequent uncomplicated pregnancies.¹⁰ Hence, the COAG target of 5 or more antenatal visits reflects a minimum standard in the context of Australian guidelines, especially given the higher rates of pre-existing medical conditions, complex social health issues and pregnancy complications experienced by Aboriginal women.^{17,18}

How wide is the gap?

In South Australia, data reported by the Pregnancy Outcome Unit for the years 2007 to 2011 suggest around a 25-30% difference in the proportion of Aboriginal and non-Aboriginal women attending at least one visit in the first trimester. In 2011, 55% of Aboriginal mothers are recorded as attending their first antenatal visit in the first trimester compared with 80% of non-Aboriginal mothers.⁶ In the same year, South Australian data indicate that 69% of Aboriginal mothers attended 7 or more antenatal visits compared with 92% of non-Aboriginal mothers.⁶

Fig 1. Pregnancy visit in first trimester, South Australia, 2007-2011

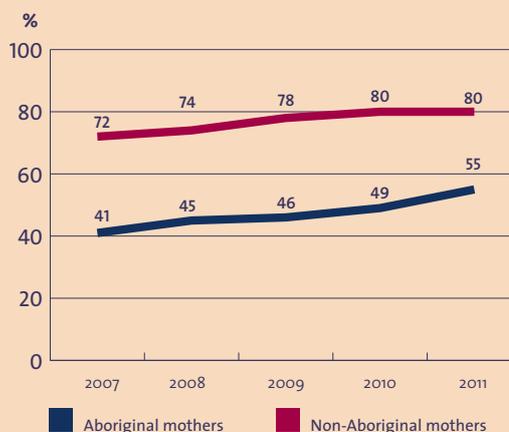
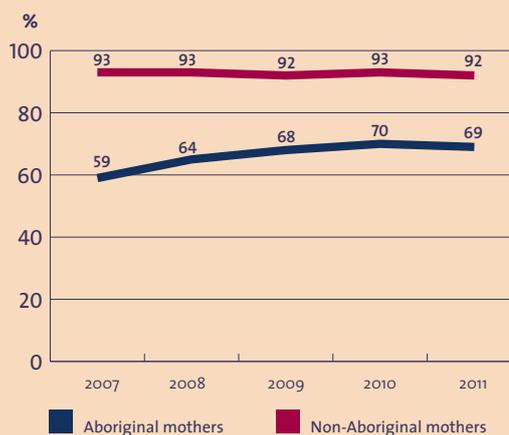


Fig 2. Attended 7 or more visits, South Australia, 2007-2011



What women told us

Of the 344 women who took part in the Aboriginal Families Study, 98% attended antenatal visits in pregnancy:

- 80% had their first visit in the first trimester
- 18% had their first visit between 14-26 weeks
- 2% had their first visit after 26 weeks' gestation
- 90% attended 5 or more visits.

Only 6 (2%) women had no antenatal care in pregnancy.

These results suggest Aboriginal women are participating in antenatal care earlier in pregnancy, and remaining engaged in antenatal care throughout their pregnancies at much higher rates than suggested by routinely collected data.

Asking women to recall the timing of their first antenatal visit inherently raises the problem of recall bias. It is likely that some women may not have had accurate recall of when initial antenatal care took place. While caution is warranted interpreting these data, routine data collected by hospitals are also subject to information bias. The lower proportion of women identified as attending their first visit in the first trimester in routinely collected perinatal data may reflect under-ascertainment of antenatal visits with community based GPs in the early stages of pregnancy.



Are the AFBP services making a difference?

Just over half (51%) of women in the Aboriginal Families Study received antenatal care via an Aboriginal Family Birthing Program (AFBP) service, 33% attended standard models of (mainstream) public care, 7% attended an Aboriginal Health Service, 6% attended a midwifery group practice and 1% attended a private specialist obstetrician.

The proportion of women attending a first visit in the first trimester (<14 weeks) was:

- 71% in regional mainstream services
- 84% in regional AFBP Services
- 81% in metropolitan mainstream services
- 75% in metropolitan AFBP services.

Compared with women attending regional mainstream services, women who attended regional AFBP services had twice the odds of having their first visit in the first trimester of pregnancy. Small differences with regard to the timing of the first visit were apparent comparing other models of care.

Stronger effects were apparent for women attending regional and metropolitan AFBP services compared to mainstream regional services, with regard to the number of visits. The proportion of women attending a minimum of 5 visits was:

- 83% in regional mainstream services
- 91% in regional AFBP Services
- 89% in metropolitan mainstream services
- 95% in metropolitan AFBP services.

The adjusted odds of attending a minimum of 5 visits were 4 times higher for women attending regional AFBP services, and 12 times higher for women attending metropolitan AFBP services, after accounting for differences in social and obstetric characteristics.

The study provides clear evidence that the strategy of implementing culturally responsive services involving partnerships between AMIC workers and midwives is working to increase access to antenatal care for Aboriginal families.

Reasons for seeking care

We asked women to tell us what their reasons were for seeking antenatal care when they did. The most common reasons were:

- to confirm the pregnancy and gestation (32.2%)
- to get started with pregnancy care (26.8%)
- recognising signs of pregnancy (30.1%).

Of the 61 women who did not attend a pregnancy visit in the first trimester, a third said that they went as soon as they realised they were pregnant.

Other reasons for not receiving antenatal care in the first trimester were:

- not being able to get an appointment
- moving around/being away from home
- lack of transport or cost
- feeling 'scared', 'uncertain', 'shame' or 'in denial' about the pregnancy.

Women who had their own car, and those with post-secondary education were more likely to receive antenatal care in the first trimester. Conversely, women aged 15-19, and women who smoked cigarettes in pregnancy were less likely to receive antenatal care early in pregnancy.

Fig 3. First antenatal visit in first trimester by mothers' age

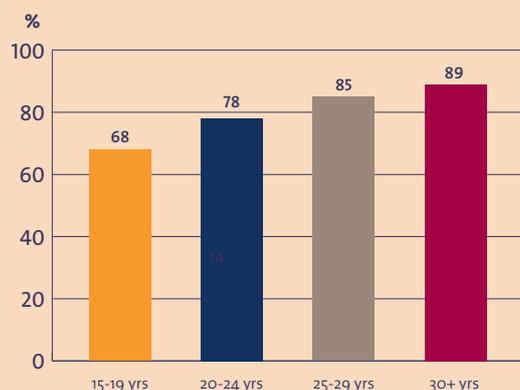
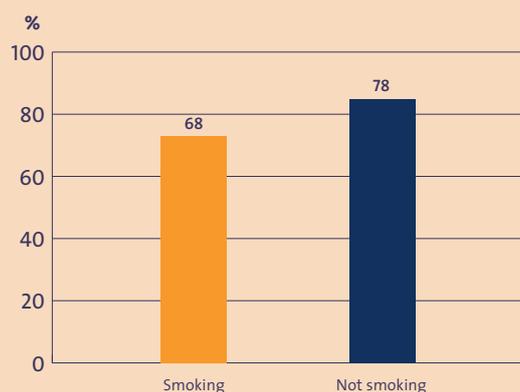


Fig 4. First antenatal visit in first trimester by smoking in pregnancy



How are AFBP services changing practice?

AFBP services enable Aboriginal women to be cared for by an Aboriginal Maternal Infant Care (AMIC) worker in partnership with midwives and doctors. In areas of South Australia where there is an AFBP service, a majority of Aboriginal women chose this option for pregnancy care. The program operates in six regional locations and in Adelaide.

AFBP services were more likely to arrange transport for women to assist them to get to appointments. 68% of women attending an AFBP service and 57% attending an Aboriginal Health Service (outside the AFBP) used transport arranged by a service to get to antenatal visits, compared with around 23% of women attending mainstream services.

One in four women attending AFBP services had an antenatal visit at home, compared with fewer than 2% of women attending mainstream public services.

Compared to women attending mainstream services, women who attended AFBP services were more likely to say that health professionals remembered them between visits and used words they could understand.

Women attending AFBP services were also more likely to say that caregivers helped them to prepare for having their baby, and supported them with things happening in their life.

Things that women found helpful...

- home visits with midwives and AMIC workers
- transport to get to services
- seeing the same AMIC worker
- seeing the same midwife or doctor.

Ongoing challenges...

Many women living in regional and remote areas of South Australia have to travel to Port Augusta or Adelaide for medical care during pregnancy. In many cases this means being away overnight, sometimes for several days or longer. Additional barriers to equitable access for women in this situation are:

- access to low cost, suitable accommodation near to services
- cost of transport
- cost of food and living expenses while away from home
- care of other children, often without any supports.

Considerations for policy and services

Health equity has been defined as the absence of systematic disparities in health (or its social determinants) between more and less advantaged groups.^{17,18} In the Australian context, the greatest health inequalities are experienced by Aboriginal and Torres Strait Islanders, who have poorer health and poorer access to health care at every stage of the life cycle.^{19,20} Health services have a responsibility to make systematic and sustained efforts to overcome barriers to access and utilisation of health services that perpetuate inequalities in health outcomes.²¹ This means doing things differently to address the specific circumstances of Aboriginal families. (It does not mean ‘treating everyone in the same way’ or ‘regarding everyone as equal’). Our findings suggest that some progress towards achieving Australian government targets for overcoming health inequalities is being made in South Australia.

The Aboriginal Families Study provides the first evidence from a population-based study reporting on a range of individual and systems level factors influencing Aboriginal women’s utilisation and engagement with antenatal care. The findings show that the scaling up of Aboriginal Family Birthing Program Services in urban and regional areas of South Australia has been effective in changing the way that Aboriginal families engage with services. This is likely to translate into better outcomes for Aboriginal families over time.

On average, pregnancy and childbirth occur at a much earlier age for Aboriginal women in Australia than for non-Aboriginal women, with the consequence that antenatal care may be the first experience many young women have of health care as a ‘young adult’. Antenatal care is an important ‘window of opportunity’ for getting it right, so that young women and their partners are well supported in pregnancy, and not dissuaded from engaging in future preventive health care for themselves and their children by care that is fragmented, culturally insensitive and sub-optimal.

Providing equitable access to antenatal care for Aboriginal women and families requires continuing efforts to overcome barriers operating at a systems level, and barriers that may exist for individual families and communities.^{22,23} Examples of systems level barriers are lack of transport to get to services, blockages in systems that lead to appointments not being available, social distance between health professionals and clients, and the capacity of caregivers to work in ways that support and engage Aboriginal families. Factors operating for

individual families and communities include the extent to which families know what options are available in local communities, see benefits in accessing services, and feel empowered to negotiate with caregivers to obtain the care they need.

Our findings illustrate that services can and are doing things to address these barriers. AFBP services were much more likely to offer women transport or home visits. Women attending AFBP services and Aboriginal Health Services also reported more positive experiences of interactions with health professionals suggesting that care was better tailored to their needs. The results demonstrate that the involvement of Aboriginal Maternal Infant Care (AMIC) Workers in care of Aboriginal women in pregnancy is key to improving access and health outcomes.

It is important that the AFBP services in regional and urban settings in South Australia continue to be supported, and that all services continue to focus on ways to ensure equitable access to high quality antenatal care for Aboriginal families.

For further information about the Aboriginal Families Study, please contact:

Stephanie Brown

email: stephanie.brown@mcri.edu.au

Donna Weetra

email: donna.weetra@mcri.edu.au

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REFERENCES

References used in development of this policy brief are available from: hmf@mcri.edu.au

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