Evaluation of the AMIHS program using original collected qualitative data: a technical report

FINAL

TECHNICAL REPORT 2

June 2019

HUMANCAPITAL Alliance

Creating workforce solutions

MURAWIN PROFESSIONAL SERVICES

About this report

This Technical Report was prepared by Human Capital Alliance and Murawin under the guidance of a structured governance arrangement, a Cultural Reference Group and an Evaluation Advisory Committee. The report was commissioned by the NSW Ministry of Health.

We would like to thank the dedicated members of the Cultural Reference Group, Evaluation Advisory Committee and NSW Ministry of Health, whose support and assistance throughout the evaluation has been invaluable.

The term Aboriginal is used in this report to refer to both Aboriginal and Torres Strait Islander people.

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Suggested citation

Cowles, C., Vale, C., Kelleher, K., Stanford, D. and Ridoutt, L. (2019) *Technical Report: Evaluation of the AMIHS program using original collected qualitative data.* NSW Ministry of Health, Sydney.

Aboriginal life view – a holistic view of health

The evaluation of the Aboriginal Maternal and Infant Health Service (AMIHS) has been undertaken on the premise that understanding the health of Aboriginal people first requires the acknowledgement of the profound effects of colonisation and consequential intergenerational trauma and, therefore, the critical need for trauma-informed practices and services.

> *"Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community. It is a whole of life view and includes the concept of life-death-life*."
>
> National Aboriginal Health Strategy 1989

Valuing the Aboriginal Voice

The 2016-18 evaluation has sought to privilege Aboriginal ways of being, knowing, and doing by ensuring that Aboriginal community members' and health professionals' voices are valued for their cultural understanding and knowhow. It also sought to acknowledge the effects that the social and cultural determinants of health (Lowitja Institute, 2014) have had in the design and delivery of services for Aboriginal people.

An important aspect of the evaluation has been the integral involvement of Aboriginal people in all aspects of the evaluation process. A Cultural Reference Group was established in the early stage of the evaluation, designed to bring Aboriginal community voices into all aspects of the governance of the evaluation. The evaluation team worked closely with the CRG throughout the evaluation. A deep listening methodology was engaged by the evaluators throughout the qualitative interview process and writing of this report to hear the voices of women having Aboriginal babies, their partners, extended families and communities who have used or are using AMIHS and others involved with AMIHS to ensure their voices are conveyed.

Aboriginal leadership, guidance and reflections have been integrated into these evaluation findings in a wide range of ways, including the following key mechanisms:

- the inclusion of Aboriginal stakeholders in the initial stages of framing the evaluation research questions and the evaluation framework more broadly
- the selection of Murawin and HCA as Aboriginal and non-Aboriginal evaluators working in partnership
- close engagement and collaboration with the Aboriginal members of the Cultural Reference Group and the Evaluation Advisory Committee
- involvement of Aboriginal researchers in all qualitative data collection and analysis
- presentation of emerging findings with Aboriginal stakeholders, including AMIHS workers, through a workshop to consider how best to present draft findings
- presentation of integrated evaluation findings in storyline form to align with Aboriginal cultural practices for conveying meaning to an issue and transference of knowledge.

Acronyms and abbreviations

ACCHS	Aboriginal Community Controlled Health Services
AH&MRC	Aboriginal Health and Medical Research Council of NSW
AHW	Aboriginal Health Worker
AMIHS	Aboriginal Maternal and Infant Health Service
AMS	Aboriginal Medical Service
CEE	Centre for Epidemiology and Evidence
CFH	Child and family health
FaCS	Family and Community Services
FIRS	Field Implementation Rating Scale
FTE	Full-time equivalent
HCA	Human Capital Alliance
KPI	Key Performance Indicator
LHD	Local Health District
NGO	Non-government organisations
NH&MRC	National Health and Medical Research Council
NRT	Nicotine replacement therapy
SDM	Service Delivery Model
TSU	Training Support Unit

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Background

Over the past 20 years, there have been a number of improvements in Aboriginal maternal and infant health in NSW. From 2001 to 2017 the proportion of Aboriginal mothers commencing antenatal care before 14 weeks gestation increased from 46.1% to 68.1% and the proportion commencing before 20 weeks increased from 64.7% to 83.9% (CEE, 2019). Over the same period, the proportion of Aboriginal mothers aged 19 years and under decreased from 20.8% to 12.3% and smoking in pregnancy for Aboriginal mothers declined from 59.0% to 42.4% (CEE, 2019).

However, significant inequities between Aboriginal and non-Aboriginal populations remain. In 2017 in NSW, 42.4% of Aboriginal mothers smoked during pregnancy compared to 7.2% of non-Aboriginal mothers and 12.3% of Aboriginal mothers were aged 19 years and under compared to 1.5% of non-Aboriginal mothers (CEE, 2019). Aboriginal mothers also continue to experience poorer birth outcomes than non-Aboriginal mothers.

The Aboriginal Maternal and Infant Health Service (AMIHS) is a NSW Health funded maternity service for Aboriginal families that aims to improve health outcomes for mothers and babies. AMIHS uses a continuity of care model in which Aboriginal Health Workers (AHWs) and midwives work together and with other services to provide high quality antenatal and postnatal care. Some of the essential elements of the AMIHS Service Delivery Model (NSW Health, reviewed 2014) include:

- being accessible, flexible and mobile
- working with other services to provide integrated care for women and families
- being involved in community development and health promotion activities
- supporting women and families to transition from AMIHS to child and family health services.

An evaluation of AMIHS was published in 2005 and this second evaluation was commissioned and commenced in 2016.

Method

Three separate evaluation data sources were created for this part of the research and drawn upon to develop findings either independently or collectively. The three data sources were:

- *Document review*: involved collating and reviewing the annual reports from all AMIHS sites and other core program documentation related to the implementation of AMIHS since its inception in 2000. Program activity data from the document review formed an important cross-reference with Managers' Survey data.

- *Managers' Survey*: Managers of all AMIHS sites in NSW completed an online survey to collect information on the implementation of AMIHS at the site level.

- *Qualitative data collection*: data collected for the evaluation was undertaken through interviews and focus group discussions with stakeholders in program operational settings (the 'case studies') and interviews with stakeholders with a statewide or peak body perspective (the 'Statewide Stakeholder interviews').

The primary source of qualitative data was collected from six case studies. Just on 140 consultation interviews were undertaken across the case study sites, the vast bulk of which were done face-to-face. The main stakeholder categories interviewed were clients (40 or 28%), AMIHS staff (26 or 19%), LHD workers (31 or 22%) and partner organisations (20 or 14%). All interviews with Aboriginal clients

were led by an Aboriginal female evaluation team member. Interviews with other Aboriginal stakeholders, including community members and AHWs, were undertaken by Aboriginal and non-Aboriginal evaluation team members experienced in conducting cross-cultural consultations. All interviews were undertaken in a location or mode nominated by the interviewee to ensure they were comfortable and at ease during the interview.

The implementation data from the survey and document review (where relevant) was entered into a database and subsequently analysed mostly as quantitative data through standard descriptive statistical methods.

All qualitative data were collected, transcribed and then analysed once each case study site had been completed. Thematic analysis of the data was undertaken by first organising the data by case study site. Themes were compiled by the team and reviewed for similarities and differences. Differences and similarities between each case study site and, where relevant, each stakeholder group, were assessed against the list of themes and subthemes. This process was used to confirm and seek agreement on an initial set of codes and themes for analysis of the data.

Findings

From the qualitative data analysis and during the data collection process of case studies and stakeholder interviews, 14 separate themes emerged. These themes were further explored where possible through data analysis from the document review and the Managers' Survey. Each of the themes are presented according to one of the following four evaluation research objectives:

1. explore client, staff and stakeholder experiences and perspectives of AMIHS
2. identify and describe the ways in which AMIHS is being implemented, at state and local levels
3. investigate the extent to which AMIHS is reaching its target population(s)
4. investigate the impact of AMIHS on the health outcomes of Aboriginal babies and their mothers.

1. Explore client, staff and stakeholder experiences and perspectives of AMIHS

The AMIHS program is valued

Clients, communities and partnering services widely valued the AMIHS program. Clients valued the service because they felt a sense of security and comfort and staff, particularly AHWs, were viewed as approachable. Clients also valued the service because AMIHS staff were observed as going above and beyond expectations to provide support for a variety of their needs and efforts were made to engage fathers in the antenatal and postnatal care where relevant.

The AHW role was considered by various stakeholders at all case study sites to be a central feature of the program, providing an important link to community.

AMIHS is a culturally appropriate service

AMIHS was considered by most stakeholders, including most clients, to be a culturally appropriate service, because AMIHS staff demonstrated a willingness to incorporate the knowledge, values and choices of clients as part of providing support. Several stakeholders felt that greater efforts were required by the broader health system, beyond visible cultural symbols, to respect and respond to the values and choices of Aboriginal people as part of service delivery. This would make transitions from AMIHS care to other parts of the health system less confronting.

Experiences of racism

Some AMIHS staff, managers, LHD staff and clients across and within all case study sites reported instances of racism within the health system. They discussed how racism was sometimes blatant and overt, such as through damaging comments made by health professionals directly to clients. Stakeholders also reported that racism had an impact on the delivery of AMIHS where it was not always valued by other colleagues. Several AHWs also reported experiencing racism in the workplace where they felt Aboriginal culture was not being valued or recognised in workplace structures, practices and processes.

2. Identify and describe the way in which AMIHS is being implemented, at state and local levels

The implementation of the AMIHS program across all of its sites is guided by a Service Delivery Model (SDM) with specifications for 10 'essential [program] elements'. An analysis of implementation of AMIHS across service sites was benchmarked to nine of these essential elements[1]. The qualitative data collected for this study suggests that, in the perception of clients, AMIHS workers and other stakeholders, all the elements remain important although some are potentially more crucial than others.

Description is provided below of those elements where variation between AMIHS sites was identified as noteworthy.

Element 1: Antenatal and postnatal care to 8 weeks

There was considerable variation between AMIHS case study sites in the duration of the postnatal relationship with clients, a circumstance which (based on program document data) seems to reflect a more general issue. The AMIHS SDM proposes an eight-week period of postnatal care, although the NSW Ministry of Health (the Ministry) allows for judgement of what is appropriate based on the woman's birth recovery and the baby's health. Whether variation between sites is justifiable is difficult to determine, however, in the case study sites the cause was reported to be at least in part due to resourcing constraints. Shorter postnatal periods of support were believed by some AMIHS staff to be associated with poorer outcomes.

There was also variation between sites in AMIHS involvement in intrapartum care. Although intrapartum care is not an essential element of the AMIHS SDM[2], just over one-third of AMIHS sites (38%, n = 17) have some involvement in intrapartum care. Many clients reported experiencing a loss of cultural safety during the birthing period and despite the efforts of some sites to ameliorate this problem most AMIHS staff remain concerned about this part of maternity care.

Element 2: Being accessible, flexible and mobile

The flexibility of service delivery strategies provided by AMIHS staff was identified by many stakeholders, but especially clients, as a key element of success of the program. Some of the specific features of service flexibility mentioned by stakeholders included home visits, working holistically around the [total health] needs of clients, and a willingness to support clients in the context of their families and other support networks.

[1] It was determined that valid data for the tenth element - adherence to NSW Health policies and procedures, including those that protect and promote the safety, welfare and wellbeing of children and young people – was not likely to be obtained through the evaluation method components.

[2] The AMIHS SDM notes that some AMIHS programs may be able to provide midwifery care during labour and birth if there is a caseload or midwifery group practice in place to ensure the necessary back up and support to make this model sustainable.

In some sites, flexibility of delivery is hampered by infrastructure constraints. For example, the results of the Managers' Survey indicated that only half (50%, n=23) of the AMIHS sites had dedicated access to a vehicle for staff to outreach to clients and that the majority of the rest had access to a shared vehicle resource. In just over a third (37%, n = 17) of sites managers did not think the conditions of work (e.g. allowance for out of normal hours of work, support to do home visits) matched program needs.

Element 3: Transition to child and family health services

AMIHS sites self-rated their relationship with local child and family health (CFH) services very highly - a majority (82.6%, n=38) rated their relationship as very effective or extremely effective. Despite the high ratings reported in the Managers' Survey, the case study work indicated that the process of referral and handover to the relevant local child and family service could be variable. Based on case study data (admittedly a small sample) the least effective handover arrangements seemed to occur when handovers were being made between different organisations (e.g. between LHD services and ACCHSs or vice versa) or across organisational boundaries (e.g. from maternity care to community care).

Element 5: Community development and health promotion

Community development and health promotion are central and unique features of the AMIHS SDM. The findings from different forms of analysis (Managers' Survey, document review, case study interviews) provided somewhat inconsistent evidence, but overall suggest that for many AMIHS sites health promotion and community development was not a 'central' feature of the site service delivery implementation.

Just over half of the AMIHS sites had staff time and/or funding dedicated to health promotion and community development activities. Weight of evidence suggests most of the rest of the sites undertook these activities opportunistically *within the clinical care activities* and with limited planning and structure. These efforts were supported by occasional group education interventions.

In the case study sites, a "lack of time" was the primary reason offered by AMIHS staff and managers to explain limited activity in this area, and available time being prioritised to the clinical care. Where health promotion and community development activities were being delivered well, which they were in two out of six case study sites, they were widely considered by stakeholders to have strongly positive impacts.

Element 6: Effective collaboration with other services

Between all AMIHS sites there was considerable variation in the quality of relationships between AMIHS and key partner service providers. On average, the Managers' Survey indicated that AMIHS sites had the strongest relationships with mainstream maternity services, allied health workers (including social workers) and obstetricians. Relationships for almost two-thirds of relevant AMIHS sites with ACCHS were rated as 'neither effective nor ineffective', or 'ineffective'. Similarly, relationships with key partner services (given the health issues of many AMIHS clients – see below) such as mental health and drug and alcohol were rated as 'neither effective nor ineffective', or 'ineffective' (average rating of 2.5 and 2.7, respectively, on a scale of 1 to 5, where 5 = extremely effective from 46 responses)[3].

[3] Collaborative relationships can be diminished for many reasons including, in the case of many community based mental health and drug and alcohol services, restrictive client intake policies that limit client referrals only to incidences of severe mental illness. Exploration of the cause of poorer relationships was out of scope for this study.

Element 7: Supporting workforce development and learning

Workforce development and clinical supervision of AMIHS AHWs and midwives is a core component of the AMIHS SDM. Various learning and development opportunities were provided to AMIHS staff at the commencement of their employment and throughout via the Training Support Unit (TSU) and other externally available off the job learning opportunities (from the LHD and other sources). Most AMIHS staff in case study sites felt that more training and development opportunities were required to develop their skills, particularly in relation to supporting clients with complex and high-risk issues.

Across all case study sites, AMIHS staff (particularly AHWs) reported that clinical supervision was poorly structured and irregular, and highly dependent on individual manager interest and commitment. Without a commitment to provide clinical supervision, many AMIHS staff reported feeling undervalued and unsupported to manage the challenges of their roles.

The SDM provides no strong direction on staffing levels, but many AMIHS staff and managers interviewed in case study sites felt that the allocation of staff and resources to the AMIHS program was insufficient to meet the needs of the client population. This perception is possibly exacerbated by some AMIHS staff and managers feeling that the relationship between levels of staffing and service workload was variable across AMIHS sites, with some services looking to be "under the pump" while others appeared to be much better resourced.

Element 8: Building and sustaining effective community partnerships

While another central tenet of the SDM, there was considerable variation between AMIHS sites in their level of engagement with the community. Managers indicated through the survey that a majority of AMIHS sites (89%, n=41) had consulted the community in the past five years. Structured consultation was undertaken by less than half of the sites (45.7%, n = 21) and largely on an irregular or *ad hoc* basis. The survey results indicated that just under one-quarter of AMIHS sites (23.9%, n = 10) had an active Women's Reference Group.

3. Investigate the extent to which AMIHS is reaching its target population

AMIHS is well placed to support clients experiencing complex and high-risk issues

AMIHS was viewed by most stakeholders as being ideally placed to support clients experiencing complex and high-risk issues, particularly for the non-maternity related issues such as mental health, drug and alcohol use, and child protection issues. Stakeholders at all case study sites reported that while many women and families only needed the standard antenatal and postnatal support as outlined in the SDM, there were also many clients accessing AMIHS who required more complex, intensive and sustained support from AMIHS staff.

While there were challenges to support such clients, many stakeholders talked about how AMIHS staff strived to provide holistic and wrap-around support. Of course, some stakeholders reported that there were often limits to the support that could be provided or the outcomes that could be achieved, including as noted above when sufficiently strong partner organisation relationships had not been crafted.

Pathways to access AMIHS

Clients, AMIHS staff, managers, LHD staff and ACCHS stakeholders reported that AMIHS could be accessed by clients through a variety of pathways. This included formal pathways through the health

system and informal pathways through the local community ensuring that clients were offered antenatal and postnatal care through AMIHS.

At all case studies, it was reported that most clients were able to easily access or 'find' the program. However, at each site there were also instances where the pathways to access the AMIHS program were described as not always clear or were impeded by various obstacles.

Location of AMIHS

AMIHS is delivered in a variety of settings. Interviews at the case study sites indicated that there were aspects of each setting that can support or hinder effective implementation of the program. The Managers' Survey found that over 60% of AMIHS sites operated out of LHD-managed community health centres, with the most common other settings being either co-location within a local ACCHS (either managed by the ACCHS or by the local LHD; 11%) or being delivered from within the maternity service of a local hospital (9%). Despite over half of settings being in a community health setting, there seemed to be no apparent ideal setting or location for the service, based on client or AMIHS staff interview data.

No clear evidence emerged from the data whether AMIHS should be delivered by an LHD or ACCHS. A variety of views were expressed by stakeholders, but preferences for where AMIHS should be delivered were more closely related to local factors such as accessibility of the site, local 'politics', desire for anonymity in small communities, or respect for the staff working in the LHD or ACCHS.

4. Investigate the impact of AMIHS on the health outcomes of Aboriginal babies and their mothers

AMIHS has contributed to positive health and social outcomes

The case study interviews (clients, AMIHS staff and managers) indicated that AMIHS sites have contributed to positive health and social outcomes for clients and their families. There were different ways that sites had been able to influence positive change such as for breastfeeding and increased confidence in parenting. The interviewees also indicated that some outcomes were easier to measure and observe, but additional ways of measuring and perceiving success were required.

Prevalence of smoking and the challenge of cessation

As part of the AMIHS program, AMIHS staff (in partnership with referral agencies) aim to address smoking cessation with clients. Across all case study sites, AMIHS staff, managers and LHD staff reported that smoking was a challenging health behaviour to address due to a range of entrenched attitudes around smoking. Stakeholders also felt that there were unrealistic expectations for what could be achieved during one pregnancy and that more resourcing was required to effectively address rates of smoking.

Discussion

Strongly positive stakeholder impressions

Across case study sites, there was strong support for the AMIHS program, and it was well-liked by nearly all clients, their families and community members. The six case study sites were carefully selected in terms of service type and setting, we are therefore confident that a similar finding would be obtained at other AMIHS sites in NSW.

Information collected from most stakeholders, including most clients interviewed, revealed a widespread belief among stakeholders that AMIHS is reaching the population who are likely to benefit most from the program - a population overrepresented by mothers experiencing coexisting health and psychosocial issues while they are using AMIHS services.

Analysis of the qualitative data also found that most stakeholders believe that AMIHS is impacting positively on a range of client health and welfare issues that go beyond the boundaries of traditional maternity care but are thought to be highly influential on both mother and baby health. More nuanced ways of measuring progress in these outcomes (for instance, are families more aware of passive smoking risks on babies and children) has been identified as a needed area of development and exploration.

Opportunities for improvement

Most evaluation models assume that if a program is correctly implemented, consistent with the program logic, then the projected short, medium and long-term outcomes should eventuate. The AMIHS SDM, the template for implementation that translates the program logic, seeks to provide a unique and distinctly culturally appropriate program within the broader health system. It utilises a model of maternity care focussed on individualised and women-centred care backed by strong and ongoing community engagement and sustained and structured health promotion effort.

The analysis of Managers' Survey data indicated (and subsequent observations in case study sites confirmed) that variations exist across the AMIHS sites in the ways that specific site services were implemented. Variation generally equated to a deviation from the intended implementation path of one or more SDM essential elements. It was not always clear from available data why the AMIHS model was not implemented as intended, including whether the deviation was appropriate for specific local circumstances. However, in the case study sites resource constraints, particularly in relation to staffing resources, were reported to be the most common reason for deviation from the SDM.

Variation in implementation of the SDM elements across AMIHS sites is only an issue if it impacts on program effectiveness, that is, if adherence to particular elements is important. Of the nine SDM 'essential elements' examined in this study, all, to varying degrees, were determined based on client, worker and other stakeholder perceptions to be important to the delivery of successful program outcomes. Hence, the majority of stakeholder perceptions were that an impact was being felt where deviation in implementation from the SDM was being experienced.

The areas where deviation from the SDM is potentially having the greatest effect, and from where improved outcomes from AMIHS were perceived to most likely derive are:

Community engagement – only a minority of AMIHS sites undertake regular, planned and structured engagement with their communities. Less than one-quarter of sites (24%) - currently have a Women's Reference Group. Those that currently have a Women's Reference Group testify to its importance.

Health promotion –most (95%) AMIHS sites reported undertaking some form of health promotion work and just over half (52%) have staff time and/or funding dedicated to health promotion and community development activities. However, there is strong evidence to suggest that the remaining sites rely almost exclusively on opportunistic health promotion effort undertaken within the clinical occasion of care.

Staffing - several stakeholder respondents believed workload demands in many AMIHS sites had become greater than current staff allocation could adequately satisfy. The mostly qualitative data available to this component of the evaluation does not provide enough evidence to validate stakeholders' beliefs about understaffed sites. Analysis on this issue, by combining data from the Quantitative Technical Report with data from the Managers' Survey, will be undertaken for the Final Report.

Service partner relationships - the majority of AMIHS sites have been able to develop effective relationships with some external service partners but not others. Specifically, the Managers' Survey highlighted only moderate levels of AMIHS partner relationships across most sites with housing, drug and alcohol and mental health service providers, a finding largely corroborated through the case study data findings. These are key areas of need for many AMIHS clients and were reported as important forms of support.

Workforce development and supervision of practice – currently, professional development and practice supervision were generally considered by stakeholders in case study sites and statewide interviews to be at best ad hoc and insufficient to satisfy all the learning needs to support effective practice in a complex service delivery context. Clinical supervision was reported to be unstructured and irregular, especially for AHWs. Cultural supervision was considered important by staff but was rarely available to them.[4]

Conclusion

The qualitative data reported in this study provides a strong indication that the program is highly valued by clients and perceived by most stakeholders as contributing to better maternal and child health outcomes for Aboriginal mothers and their babies. Clients appreciate the non-judgemental and person-centred nature of the service and the culturally appropriate and holistic approach to mother and baby health and wellbeing.

There was a strong perception that the AMIHS program is supporting women experiencing a higher level of health and welfare complexities. But AMIHS was viewed by many stakeholders as an appropriate program to support such clients because it was flexible, and clients could be connected with other services.

The SDM, which consists of 10 essential elements, overall is being implemented as intended and appears to be having a positive impact on health and social outcomes for Aboriginal families and communities. But there are some elements of the model that were found to be more crucial than others to ensure the uniqueness of AMIHS in comparison with other maternity services and to ensure that the program outcomes can be achieved.

The non-clinical type SDM elements (e.g. involvement in health promotion and community development, working collaboratively with service partners, building community partnerships) appear to be the elements that are crucial, but which are most likely to be implemented with some deviation from the model. There is a strong sense that these deviations from the intended model, at least in some sites, are the result of an undersupply of staff (AHW and midwife) in comparison to service demand.

Where possible, reducing the level of variation in the implementation of essential elements of AMIHS represents a useful direction to improve this highly respected program.

[4] A definition of 'cultural supervision' can be found in the section *'Clinical supervision of AMIHS staff'* in Evaluation Objective 2 of the main report.

A. Introduction

Size and nature of the health issue

Over the past 20 years, there have been important improvements in Aboriginal maternal and infant health in NSW. These include increased access to early antenatal care, a decline in risk factors such as smoking in pregnancy and teenage pregnancy and improved birth outcomes.

From 2001 to 2017 the proportion of Aboriginal mothers commencing antenatal care before 14 weeks gestation increased from 46.1% to 68.1% and the proportion commencing before 20 weeks increased from 64.7% to 83.9% (CEE, 2019). Over the same period, the proportion of Aboriginal mothers aged 19 years and under decreased from 20.8% to 12.3% and smoking in pregnancy for Aboriginal mothers declined from 59.0% to 42.4% (CEE, 2019). In addition, rates of low birth weight (less than 2,500 grams) and perinatal mortality have improved. In 2017, the rate of perinatal mortality for babies born to Aboriginal mothers was 12.7 per 1,000 births compared to 18.2 per 1,000 births in 2001 (CEE, 2019). From 2001 to 2017, the proportion of low birth weight babies born to Aboriginal mothers decreased from 13.5% to 11.1% (CEE, 2019).

However, significant inequities between Aboriginal and non-Aboriginal populations remain. In 2017 in NSW, 42.4% of Aboriginal mothers smoked during pregnancy compared to 7.2% of non-Aboriginal mothers and 12.3% of Aboriginal mothers were aged 19 years and under compared to 1.5% of non-Aboriginal mothers (CEE, 2019). Aboriginal mothers also continue to experience poorer birth outcomes than non-Aboriginal mothers. In 2017, the rate of perinatal mortality among babies born to Aboriginal mothers was 12.7 per 1,000 births compared to 8.2 per 1,000 births among babies born to non-Aboriginal mothers (CEE, 2019). Similarly, 11.1% of babies born to Aboriginal mothers were low birth weight, compared to 6.5% of babies born to non-Aboriginal mothers, and 11.7% of Aboriginal babies were born prematurely (less than 37 weeks gestation) compared to 7.2% of non-Aboriginal babies (CEE, 2019).

Despite these disparities, relatively little is known about the kinds of programs and services that are effective in improving the health and wellbeing of Aboriginal mothers and babies. Recent reviews have found a growing number of studies evaluating such programs and services. While these studies tend to report positive participant outcomes, their true effectiveness is uncertain due to poor study quality (Jongen et al., 2014; Kildea and Van Wagner, 2013). Examples of methodological limitations of studies include small numbers, short-term evaluation data and a lack of comparison data. (Rumbold and Cunningham, 2008; Bywood, Raven and Erny-Albrecht, 2015). There is therefore a need to conduct rigorous impact evaluation of initiatives seeking to improve the health of Aboriginal mothers and babies (Brock, Charlton, and Yeatman, 2014).

Description of the program

The Aboriginal Maternal and Infant Health Service (AMIHS) is a NSW Health funded maternity service for Aboriginal families that aims to improve health outcomes for mothers and babies.

AMIHS uses a continuity of care model in which Aboriginal Health Workers (AHWs) and midwives work together and with other services to provide high quality antenatal and postnatal care. Care starts as early as possible in pregnancy, continues through pregnancy and after the baby is born. The length of time postnatal care is provided varies but can be up to eight weeks postpartum.

The AMIHS Service Delivery Model (SDM) (NSW Health, reviewed 2014) outlines the principles, objectives and essential elements of the AMIHS program. Some of the essential elements of the AMIHS SDM include:

- Being accessible, flexible and mobile – to ensure AMIHS is accessible to local communities' services are adapted to the local needs and context and are provided in a range of locations including in women's homes, community health centres, ACCHS, antenatal clinics and child and family health (CFH) centres. Transport is also provided to support women accessing AMIHS and other services to which they are referred.
- Working with other services to provide integrated care for women and families – this includes the local ACCHS (where that is not the actual service provider), mainstream maternity services and other government and non-government services.
- Being involved in community development and health promotion activities – these are led by the AHW and are conducted with the local Aboriginal community members and organisations.
- Supporting women and families to transition from AMIHS to CFH services – strategies include clear referral processes and shared visits in the antenatal and postnatal periods (midwife, AHW and CFH nurse).

Most AMIHS services are delivered by local health districts (LHDs) through public maternity and community health services, and some are delivered by ACCHS. LHDs and ACCHSs are given a certain level of autonomy in how they implement and adapt the program to meet local needs.

The Ministry coordinates and supports the implementation of AMIHS at a state level, this includes:

- Developing and reviewing program guidelines (for example the SDM and Workforce and Recruitment Plan).
- Funding a Training Support Unit (TSU) to provide specific education and training for AMIHS staff[5] (this is additional to the core training and development provided by LHDs/ ACCHSs that deliver AMIHS).
- Monitoring and evaluating the program, including annual reporting and routine data collection through the AMIHS Data Collection (AMDC) reporting system.
- Coordinating an AMIHS and Building Strong Foundations (BSF) network to communicate information to and between services across the state.
- Providing education and training opportunities based on areas of identified need such as smoking and alcohol cessation, breastfeeding support and trauma-informed care.
- Offering an annual exchange visit program, which supports AMIHS teams visiting and learning from other AMIHS sites across the state.

In most areas where AMIHS is provided there are a range of alternative maternity services on offer. This can include mainstream antenatal clinics and case load midwifery/team midwifery provided by public hospitals, GP shared care (by private providers or through an ACCHS) or private obstetricians. A number of LHDs also offer antenatal and postnatal outreach services for mothers and families based on the needs of the local population (accessing both Aboriginal and non-Aboriginal populations). In addition, there are a few Commonwealth funded maternal and infant health programs such as New Directions Mothers and Babies Services and the Australian Nurse-Family Partnership Program[6]. These programs are mostly delivered by ACCHS and sometimes by LHDs. The presence of these different programs can confound the ability to attribute changed maternal and infant outcomes to a specific service, including to AMIHS.

[5] The TSU also supports the Building Strong Foundations for Aboriginal Children, Families and Communities program (BSF), an early childhood health service for Aboriginal families in NSW.

[6] http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-maternal-health-lp

AMIHS was initially funded in 2000/01 and, following an action-research evaluation, was expanded in 2008/09. Funding is provided to LHDs and ACCHSs, who undertake local planning to determine where AMIHS is delivered. This means that the number and location of AMIHS sites can change over time based on community needs.

The Managers' Survey found that 12 AMIHS sites were established in 2000/01 and a further 35 sites were established following funding enhancement in 2008/09. In 2017, there were 44 AMIHS sites delivering services to Aboriginal families in over 80 locations in NSW.

Rationale for the evaluation

An evaluation of AMIHS was published in 2005 after the first set of sites were implemented (NSW Health, 2005). The findings suggested that AMIHS was achieving its goal of providing improved and culturally appropriate antenatal and postnatal care for mothers of Aboriginal babies and their families. The evaluation also identified ways in which the program could be strengthened. However, the evaluation design had some limitations, such as inadequate control of potential confounders in analyses of program impacts.

Following the 2005 AMIHS evaluation, the program was enhanced to increase access to antenatal care, improve uptake of CFH services and reduce levels of antenatal smoking. Smoking during pregnancy is one of the most common preventable risk factors for pregnancy complications and is associated with poor perinatal outcomes such as low birth weight, preterm birth, small for gestational age and perinatal death (Cnattingius, 2004).

Ongoing evaluation of AMIHS is required to investigate whether its objectives are being met, identify ways in which the program can be improved, and contribute to what is known about programs designed to improve Aboriginal maternal and infant health outcomes. Understanding the impact and value of programs like AMIHS is essential to improving the health outcomes of Aboriginal people.

Current evaluation

Over the course of 2016-18, the AMIHS program has been evaluated using a mixed methods design, drawing on information from both existing and new data sources. The evaluation has had six interrelated components:

- a review of program documentation;
- a self-administered survey of AMIHS managers;
- qualitative interviews with key stakeholders;
- case studies of AMIHS sites;
- quantitative analysis of routinely collected administrative data; and
- an economic evaluation.

The aims of the evaluation are to:

1. describe AMIHS program implementation;
2. explore stakeholder experiences and perspectives of the AMIHS program;
3. investigate AMIHS program reach and its impact on Aboriginal maternal and infant health outcomes; and
4. investigate the costs of implementing AMIHS and undertake an economic evaluation.

The evaluation was reviewed and approved by two ethics committees:

- Aboriginal Health & Medical Research Council (AH&MRC) Research Ethics Committee, Reference: 1223/16
- Population and Health Services Research Ethics Committee (PHSREC), Reference: HREC/16/CIPHS/35.

This Technical Report reports on the data collected through **Components 1 to 4**, which incorporated the collection of self-reported site data from annual reports and implementation data from site managers and staff, as well as qualitative data collected via interviews with a range of stakeholders at the statewide and case study level. The evaluation questions are outlined in the AMIHS Evaluation Plan (2016).

The results are arranged by key themes arising from the data analysis and collated by section under **Evaluation Objectives 1 to 4**. This data, and associated analysis, covers the way AMIHS is being implemented, the experiences of the program on the part of all key stakeholders but especially clients, the factors that might be influencing the reach of the program, and qualitative findings about impact on health outcomes. This report should be read in conjunction with the Technical Report on Quantitative Data Analysis (Jalaludin, 2018) and with the AMIHS SDM (NSW Health, reviewed 2014).

This technical report is divided into four sections:

Section A introduces the project and its background

Section B presents the method

Section C details the findings of data analysis according to the evaluation objectives

Section D presents a discussion of the results and commentary on the method.

Aboriginal cultural terminology

AMIHS clients and staff were very consistent in the ways they described AMIHS sites and other services as "culturally appropriate". Examples that were given to describe what was meant by this term included whether services adopted respectful, holistic and flexible service delivery strategies, pursued genuine community engagement, and supported the privileging of Aboriginal worker knowledge and skills in helping health services to become places and experiences where clients and their families would feel "culturally safe". These observations were strongly underpinned by a shared broad concept of health, which included social and cultural aspects of health as well as physical health.

The shared understanding observed by the evaluation team aligns closely with the definition of cultural safety contained in the document "Cultural Safety Framework": National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA, 2016), namely:

> *"Cultural safety is about community and individual empowerment to manage one's own health and wellbeing and social issues. In practice, cultural safety requires health systems to examine their own practices in order to break down the barriers to achieving cultural understanding and responsiveness."*

Respondents also widely agreed on the negative consequences that can and do occur when there is an absence of cultural safety and competence in the health workforce to assure that safety. Strategic Direction 5 of the NSW Aboriginal Health Plan 2013-23 reflects and encapsulates very similar concerns:

> *"Interpersonal racism can be experienced by Aboriginal people through the conduct, attitudes, words or practices of health service staff. Institutional racism is the systemic failure of the organisation to meet the needs of Aboriginal people. This racism, be it interpersonal or*

institutional, has a negative effect on service access and utilisation, and health." (NSW Ministry of Health, 2012).

B. Methods

Study design

The objectives of the current evaluation of AMIHS have been to:

1. explore client, staff and stakeholder experiences and perspectives of AMIHS
2. identify and describe the ways in which AMIHS is being implemented, at state and local levels
3. investigate the extent to which AMIHS is reaching its target population(s)
4. investigate the impact of AMIHS on the health outcomes of Aboriginal babies and their mothers
5. investigate the costs of implementing AMIHS and undertake an economic evaluation of AMIHS.

As outlined below in further detail, this evaluation has had six interrelated components:

Component 1 – a review of program documentation

Component 2 – a survey of AMIHS managers (Managers' Survey) to collect data on implementation patterns

Component 3 – qualitative interviews with key stakeholders

Component 4 – case studies of AMIHS sites (conducted in conjunction with Component 3)

Component 5 – quantitative analysis of routinely collected patient data, and

Component 6 – an economic evaluation.

Component 1 – a review of program documentation

Component 1 was an initial phase of the evaluation which involved the evaluation team working with the Ministry to identify, collate and securely store key program documentation (both statewide and site level material). This body of information provided the relevant background data that was used for review and analysis as needed during the evaluation as a whole. The documents included key funding and policy approvals (dating from the commencement of the program to 2016-17), previous evaluation reports, and annual reports from all sites for all years of operation (where available).

Information from these documents has been used to:

- create a timeline of site commencement
- identify and define the current number of sites in the context of varying interpretations of the term "site" over the course of the program's development
- give the evaluation team an insight into common patterns of service delivery and program activities
- provide the basis for constructing the data collation framework that would form the basis of the Managers' Survey of program implementation data, including workforce data and engagement with other local services
- validate some aspects of the manager survey data
- gain some insight into the challenges that site managers were reporting over time in implementing the program
- supplement the Managers' Survey data as needed during the cluster analysis and case study selection process
- prepare for case study site visits
- assist with interpretation of the economic evaluation data.

Component 2 – a survey of AMIHS managers

Each manager from all the AMIHS sites (n=47) that were thought to be current in early 2017 were invited to complete an online survey to collect information on the implementation of AMIHS at the site level. A stakeholder workshop, which included many AMIHS staff from sites around NSW, was held in August 2016 so that participants could contribute to confirmation of key implementation characteristics of the program and approaches to rating those characteristics. A draft of the survey was piloted with three service managers before being further refined.

A combination of mostly fixed-response and a small number of open-ended questions were included in the survey tool to assess each site's adoption of the AMIHS SDM components. The tool included questions about:

- when the service started
- service catchment area
- implementation costs (in a separate survey tool)
- workforce composition
- types of services delivered
- relationships with service and community partners
- level of community development and health promotion activity
- organisational systems and procedures
- governance and partnerships.

To ensure a good response rate, service managers were followed up by email and telephone. Informed consent was assumed when a completed survey was returned.

The data from the Managers' Survey, along with data from the document review, were used to populate a database that was created using the structure of a data collation instrument or tool known as the Field Based Implementation Rating Scale (FIRS) (Rubin, et al., 1982), a tool that has been long available in the education sector but rarely used in the health sector. The FIRS tool allowed quantitative analysis of the structured survey responses regarding implementation of key parameters of the AMIHS program across service sites and provided a data source for categorising predominant AMIHS implementation models. The FIRS tool also provides an objective continuous rating scale to record the observed level of implementation for the essential program criteria, which assisted in ensuring consistency in data recording. The FIRS analysis process also allowed assessment of the level of site implementation fidelity against the essential elements of the AMIHS SDM using self-reported data from each site.

A comparative analysis of the manager survey data in the FIRS database was undertaken and reported in an interim report to the Ministry and key elements of that analysis are included with Evaluation Objective 2 findings below. In addition, the data in the FIRS database was used to conduct a cluster analysis to look for patterns of program implementation and this analysis is described in further detail in the *Sampling and recruitment* section below.

Component 3 and 4 – qualitative data collection

Qualitative data collected for the evaluation was undertaken through two components:

- interviews with stakeholders with a statewide or peak body perspective (the 'statewide stakeholder interviews').
- interviews and focus group discussions with stakeholders in program operational settings (the 'case studies').

The potential limitations of this data are considered at **Appendix 1**.

Component 3 – qualitative interviews with key stakeholders

Qualitative interviews were undertaken with targeted stakeholders that were closely observing, supporting in some way, or directing (in terms of policy and funding) the AMIHS program. This included coordinating staff, TSU staff, and relevant statewide or national peak organisations.

Interviews and focus groups with these stakeholders were used to gain a more nuanced understanding of:

- predominant service delivery types, including insights into what approaches work (i.e. program success factors) and what may be problematic (i.e. barriers to success)
- the key factors that may influence program implementation and associated outcomes
- stakeholder views on the appropriateness and utility of AMIHS, particularly as it relates to cultural effectiveness and program functionality
- perceived key achievements, areas of most significant change and unintended (or unexpected) outcomes of the program — both positive and negative.

Component 4 – case studies of AMIHS sites

A case study approach was undertaken to allow in-depth exploration of how the AMIHS program is being implemented at the operational level, what factors might be influencing service reach, and the factors that have contributed to successful outcomes for the program. Examination of barriers for implementation and achievement of outcomes was integral to the case study research component.

Six AMIHS sites were selected as case studies. The process used to select case study sites is described in more detail in the following section (see *Sampling and recruitment*).

At the operational or case study level, the key populations from whom data were collected were:

- AMIHS clients (current and former)
- Aboriginal community members (including family members, partners of clients, out-of-home carers, community Elders, and Women's Reference Group members)
- other stakeholders that include GPs, local service agencies receiving or providing referrals to AMIHS
- staff implementing AMIHS (midwives, AHWs, managers)
- local non-AMIHS ACCHS staff
- mainstream maternity services

The information sought from each of these groups is briefly described in the *Data collection* section.

Sampling and recruitment

Selection of case study sites

Data collected through the document review process and the Managers' Survey were used to populate the FIRS tool. The data were then analysed using a cluster analysis technique (Tryon, 1939) to identify the different ways that the AMIHS program was being implemented. Cluster analysis is a useful technique for classifying or identifying groups that are not already known or clearly evident within a data set (Statsoft, 2013). This is done by identifying the similarities (of variables) within groups and the differences between groups. Clustering is strongest or more distinct when there are significant similarities within groups and significant differences between groups.

Five discrete 'clusters' or 'AMIHS service types' were identified into which all sites could be classified.

The five AMIHS service types identified were:

Type 1: Higher ratio midwives and clinic-based

Type 2: AHW led and home visiting

Type 3: AMIHS type

Type 4: Higher ratio AHWs and outreach

Type 5: Higher ratio midwives and home visiting.

Descriptions of these five service types are provided in **Appendix 2.**

The cluster analysis technique did not distinguish between dependent and independent variables. Identification of groups was entirely dependent on the available data but also required the application of knowledge and understanding of the policy and program context to allow for "sense-checking" of emerging patterns. The cluster results were not intended to be understood as precise categories but instead as a guide for further and more detailed exploration of the issues and for testing.

Six representative case study sites were selected from each of the service types (two sites were selected from Service Type 1 - see *Data collection).* The Evaluation Advisory Committee and the Cultural Reference Group were briefed by the evaluation team on the cluster analysis methodology (including the FIRS analysis of the Managers' Survey data) and the results were considered by both groups separately.

Each group provided input for what was considered to be relevant overarching influences in case study site selection, such as geographic location, involvement of ACCHSs and number of babies being born. This information was used by selected Ministry officers (in conjunction with the evaluators) to select representative sites from each service type to ensure: (1) variation in service size (births per annum), (2) coverage of some sites located in an ACCHS, and (3) urban, regional and rural spread of case study sites.

Interview and focus group participant recruitment

Interviews and focus groups were undertaken at each case study site and in the state-level qualitative data collection process. Purposive sampling was undertaken of stakeholders with direct (e.g. clients) or indirect (e.g. policy-level stakeholders) involvement with the AMIHS program.

Prior to visiting each case study site, sampling and recruitment of participants (see *Data collection* for list of stakeholder groups) was undertaken as follows:

1. A list of primary contacts (normally an AMIHS local manager and the AHW) for each site was provided by the Ministry to the evaluation team.

2. A nominated member of the evaluation team-initiated contact by email and telephone with the primary contact at each site to identify and prepare a list of stakeholders to consult in the case study area.

3. The evaluation team worked with and through the primary contact to invite stakeholders to participate and then to coordinate and organise interview times prior to arriving, where possible, in the community. For each site:

    a. client and community interviews were in most cases coordinated by AMIHS staff (primarily the AHW); contact details of clients were only provided to the evaluation team if necessary or if agreed to by the client. This process of recruitment was acknowledged to be open to bias but was deemed to be a more appropriate method of recruiting clients because of the existing relationship between the AMIHS staff and clients. Clients were also encouraged by the evaluation team during interviews to suggest other potential participants. The bias issue is discussed further below in the *Managing bias* section.

    b. contact details of all other workers and key stakeholders were provided to the evaluation team to liaise directly with potential participants.

4. Participants were provided with a Participant Information Sheet and consent form which was completed prior to each interview (see AMIHS Evaluation Plan, December 2016 for relevant templates).

Statewide stakeholders were identified in consultation with the Ministry and participants at a stakeholder workshop led by the evaluators in August 2016. Contact details for stakeholders were provided by the Ministry to the evaluation team. Each stakeholder was contacted independent of the Ministry by a nominated member of the evaluation team by email or telephone and invited to participate in an interview.

Description of sample population

The evaluation team visited the **six case study sites** during the period of November 2017 to May 2018. Table 1 lists the sites selected, the service type the case study represented, the timing of the case study visit, the number of persons from whom data was collected and the type of data collection methods employed.

Table 1: Case study sites and date of visit (ordered by date visited)

Case study sites	Service type	Date visited	# of participants	Type of consultations
1. Broken Hill Maari Ma Health Aboriginal Corporation	Type 1: Higher ratio midwives & clinic-based	November 2017	18	Interviews
2. Parkes AMIHS	Type 5: Higher ratio midwives & home visiting	February 2018	31	Interviews and focus groups
3. Newcastle Birra Li Aboriginal Maternal and Child Health Service	Type 1: Higher ratio midwives & clinic-based	March 2018	23	Interviews and focus groups

Case study sites	Service type	Date visited	# of participants	Type of consultations
4. Coffs Harbour, Galambila Aboriginal Health Service	Type 2: AHW led & home visiting	April 2018	18	Interviews and focus groups
5. Griffith AMIHS	Type 4: Higher ratio AHWs & outreach	May 2018	15	Interviews and focus groups
6. Nowra Binji & Boori Shoalhaven Aboriginal Maternal Infant Child Health Service	Type 3: AMIHS type	May 2018	35	Interviews and focus groups
		Total	140	

A total of 140 individual consultations were undertaken across the six sites. The following table quantifies the number individuals by the stakeholder type who participated in an interview or focus group.

Table 2: Distribution of case study site consultations (interviews/focus groups) by type of stakeholder

Stakeholder type	Number of participants	Type of consultation
Client (current) Aboriginal	28 (26)	Interviews and focus groups
Client (past) Aboriginal	12 (10)	Interviews and focus group
AMIHS AHW	10	Interviews
AMIHS midwife	10	Interviews
LHD worker (e.g. mainstream maternity and hospital staff, Q4NL workers, LHD managers)	31	Interviews
Partner organisation (local referring agencies such as Family and Community Services (FaCS) and non-government organisations (NGOs)	20	Interviews and focus groups
Community member (family members of clients and local elders) Fathers	16 (5)	Interviews and focus groups
Other AMIHS staff	6	Interviews

Stakeholder type	Number of participants	Type of consultation
ACCHS managers and staff	7	Interviews
Total	**140**	

A total of **14 statewide stakeholders** representing five organisations were interviewed for the evaluation. Table 3 provides a listing of the organisations and number of individuals consulted.

Table 3: Distribution of statewide stakeholders interviewed by organisation

Organisation	# of consultations
NSW Ministry of Health ▪ Centre for Aboriginal Health ▪ Workforce Planning and Talent Development Branch ▪ Nursing & Midwifery Office ▪ Health and Social Policy Branch	7
Health Education and Training Institute (HETI)	4
Australian College of Midwives, NSW Branch (ACM)	1
Aboriginal Health and Medical Research Council of NSW (AH&MRC)	1
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)	1
Total	**14**

Data collection

Case study sites

Collection process

Two members of the evaluation team visited each site for two to three days to conduct the interviews and focus groups that had been organised prior to the visit.

All client interviews were led by an Aboriginal female evaluation team member and clients were provided with a $25 grocery voucher as a reimbursement for their time. Interviews with other Aboriginal stakeholders, including community members and AHWs, were undertaken by Aboriginal and non-Aboriginal evaluation team members experienced in conducting cross-cultural consultations and research.

Interviews and focus groups were semi-structured and guided by interview schedules customised for each stakeholder type. Broadly, questions covered the following topics: factors influencing client participation in AMIHS; use of AMIHS components; thoughts on the appropriateness of these components; how AMIHS could be improved; factors influencing the uptake of advice provided by AMIHS staff; impact of AMIHS on the health and wellbeing of clients and their families; and what makes a maternity service accessible and appropriate for Aboriginal families.

The interviews and focus groups were approximately one hour in length but ranged from 20 minutes to 90 minutes. At the start of each interview, participants completed a consent form. The majority of interviews (n=137) were conducted in person and only three were conducted by telephone. Interviews with clients were predominantly undertaken in a private meeting room at the location of the AMIHS site (in a separate building from where the service is delivered). Interviews were also undertaken at community centres, ACCHSs, and in client homes (if requested by the client).

Interviews with all other stakeholders (AMIHS AHW and midwife, LHD staff, partner organisations, community members, other AMIHS staff, ACCHS managers and staff and statewide stakeholders) were predominantly conducted in a meeting room or private office at the stakeholder's place of employment.

Role of AMIHS staff

At each of the case study sites, the AMIHS managers, AHWs and/or midwives assisted with identifying and contacting participants and coordinating interview times with the visiting evaluation team, including organising a suitable meeting room or space. In some cases, AMIHS staff assisted client and community members with transport to and from the interview locations because they had limited access to transport, and they did not want to be interviewed in their home.

A potential bias is acknowledged in relation to the involvement of AMIHS staff in identifying and recruiting clients and community members. It is acknowledged that these clients and community members contacted through AMIHS staff may have been more likely to provide a more positive perspective of the AMIHS program. However, the cultural safety of clients was considered a higher priority for the evaluation and, therefore, the existing relationship and rapport of AMIHS staff was recognised as a valuable asset to ensure engagement by clients and community members.

Prior to identifying client participants, the evaluation team emphasised to each site contact person the importance of seeking a variety of voices for the benefit of the evaluation. Accordingly, AMIHS team members were not present for interviews or focus groups to allow clients to provide uninhibited and confidential discussions.

Statewide stakeholders

Semi-structured interviews with statewide stakeholders were undertaken between March and September 2018. The interviews were distributed among the evaluation team members, with up to two evaluation team members coordinating and conducting each consultation. The interviews were approximately one hour in length, ranging from 30 minutes to 90 minutes, and all were either audiotaped and transcribed (some interview subjects declined the request to record) and/or had detailed handwritten notes taken by evaluation team members.

Interviews were primarily conducted in person in a private room or office at the stakeholder's place of employment. One interview was conducted by telephone. The interviews were guided by a semi-structured interview schedule which promoted the collection of data against core elements of the program but allowed flexibility for the evaluators to explore specific issues that were relevant to that stakeholder's role and interest in the program, funding and policy context.

Broadly, the interview questions covered the following topics: how AMIHS was being implemented; perceived success in establishing systems, policies and procedures to implement AMIHS; effectiveness of partnerships with AMIHS; recruitment, retention and development of AMIHS staff; factors for delivering culturally appropriate service through AMIHS; the appropriateness, utility and sustainability of AMIHS; impact of AMIHS on the health and wellbeing of clients and their families; and, improvements that could be made to the AMIHS model.

Data capture and storage

Once interviews and focus groups were completed, interviews were transcribed by team members and by an external transcriber. Transcripts completed by the external transcriber were reviewed and cross-checked with audio recordings by team members to assess accuracy of the transcription. Transcripts and personal notes for interviews were then reviewed by team members and the text coded according to agreed themes (see 'Data Analysis' below). This process enabled a high level of immersion by the evaluation team members in the data.

A spreadsheet of persons interviewed (with the interview subjects de-identified and uniquely coded according to case study site and stakeholder type) was maintained separately from the interview data files in a secure server. Interview text data files were identified only by interviewee unique identifier code, which meant that they could be re-identified if they wanted to withdraw from the study or if a quote or data detail needed to be checked.

Statement of researcher reflexivity

Researcher reflexivity considers how the researchers balance their own perceptions and experiences relevant to the study and the potential implications for data collection and analysis. Reflexivity is commonly described as:

> *"… the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome".* (Berger, 2015)

Some of the common subjectivities that were managed by the evaluation team are described in the following sections.

Prior assumptions, experience and independence of the evaluators

An important issue for consideration was whether the evaluation team members' role as evaluators facilitated open and honest responses from participants. The evaluation team considered how their professional background, personal experiences, background and prior assumptions as either Aboriginal or non-Aboriginal people would impact on the interactions with stakeholders and the data collection process. The team was also mindful they could be viewed as being connected with, or not being sufficiently independent from, the Ministry and 'government' more generally. These issues could have influenced what was shared by stakeholders or some stakeholders might have been wary of talking about their personal experiences and perspectives about AMIHS.

The evaluation team managed these by explaining the purpose of the evaluation and providing a brief introduction about the professional background and experience of the evaluators at the commencement of each interview or focus group. It was also emphasised that stakeholders could withdraw their consent and information from the evaluation at any time. This was important to ensure stakeholders understood the role of evaluators and that stakeholders understood their rights as participants in the evaluation.

During interviews open-ended questioning and prompts were used to encourage stakeholders to speak openly. This strategy was important to reassure stakeholders that their viewpoints were valid, to ensure they were at ease to discuss their perspectives and experiences, and to ensure that information was accurately collected by the interviewers.

Awareness of the interview location

Most interviews were undertaken in or within the vicinity of an AMIHS site, primarily because this was the most convenient location for stakeholders, including clients. Several interviews with clients were

undertaken in clients' homes. In the case of non-AMIHS stakeholders, interviews in their workplaces tended to be more convenient for them. The evaluation team were conscious that they were visitors in stakeholders' workplaces and homes and allowed the stakeholders some control over the interview in terms of pace and duration. Interviews were scheduled at mutually convenient time and location for the evaluation team members and stakeholders. However, the needs of stakeholders were given priority by the evaluation team wherever that was achievable.

Managing bias

The evaluation methodology was designed to minimise bias by ensuring a broad range of stakeholder perspectives about the AMIHS program were obtained. During the analysis phase and in the course of reporting findings, an attempt was made by the evaluation team to ensure data was not presented as being representative of just one stakeholder type or a conglomeration of views. Rather, information was analysed and reported by comparing similarities and differences between, within and across groups. Where relevant, a majority view was presented but it was equally important to acknowledge individual experiences and perspectives.

Potential for distress

The researchers were aware that there was a potential for participants to become distressed, particularly client and AMIHS staff participants, in relation to the AMIHS program and any other related issues that might be disclosed during the interviews and focus groups.

All client interviews were led by a female Aboriginal team member. Matching clients by gender and cultural background was an important strategy to ensure clients were at ease to discuss their perspectives and experiences, which may have included highly sensitive information. Where possible, interviews with other Aboriginal stakeholders were led by an Aboriginal team member. Where this was not possible, stakeholders were offered the option to be interviewed at a different time and/or place by an Aboriginal team member. However, stakeholders indicated that they were content to be interviewed by a non-Aboriginal team member when offered this choice.

While there were some discussions and disclosures about personal circumstances and experiences, no interviewees appeared to be, nor communicated directly, that they were feeling significantly distressed. In instances where stakeholders did become somewhat upset during an interview, evaluation team members would stop the interview to confirm whether the stakeholder wanted to continue. In all those cases, the stakeholders wanted to proceed with the interview. If necessary, AMIHS staff members who were familiar with clients were on standby to provide support and appropriate referral if an incident of distress arose for interviews with clients. At the end of all interviews where sensitive information and disclosures were made, evaluation team members informally discussed the issues raised and reflected on whether the stakeholders appeared comfortable with the interview process and information shared.

Data analysis

All qualitative data were collected, transcribed and then analysed once each case study site had been completed.

Preliminary analysis of the data commenced during the data collection process as part of an iterative collection and analysis process. During interviews and focus groups, the evaluation team directed lines of enquiry depending on responses provided by participants, either where common themes were emerging or where the researcher was seeking more detail and understanding. Information was continuously reviewed and compared both within and across interview teams to identify similarities and differences between sites, participant groups and responses to specific questions. This process is

called constant comparative method (Charmaz, 2014). If necessary, questions were modified for subsequent case study sites.

Summary notes and impressions were developed at the end of each case study site by the visiting team members. At the conclusion of each site visit, general impressions and key emerging issues were discussed with the broader evaluation team.

Thematic analysis of the data was undertaken by first organising the data by case study site. Using summary notes and impressions, each team member who visited the case study sites developed a preliminary list of themes and subthemes that emerged from the data. Themes were compiled by the team and reviewed for similarities and differences.

A one-day team workshop was held once all case study visits were completed. The initial set of themes and subthemes compiled by the qualitative evaluation team members was presented and discussed with all 13 members of the broader evaluation team at the commencement of the workshop. The qualitative evaluation team members together then reviewed and assessed the differences and similarities between each case study site and (where relevant) each stakeholder group and against the list of themes and subthemes. This process was used to confirm and seek agreement on an initial set of codes and themes for analysis of the data.

Following the workshop, the qualitative evaluation team members read and coded the transcripts for the case study sites they visited for relevant or meaningful phrases and sections of the transcripts related to the codes and themes. NVivo software was used to collate the transcripts and interview notes and to manage coding. One team member re-read each transcript to check for consistency of coding. Codes were modified and revised as required to best represent the data and then arranged according to emerging themes. Final themes were reviewed and discussed by the qualitative evaluation team to confirm accuracy of interpretation of the data.

Maintaining qualitative rigour

Rigour and validity for this evaluation was enhanced through the use of the comprehensive model developed by Thomas and Magilvy (2011). The model utilises processes and methods to ensure credibility, transferability, dependability and confirmability of the evaluation and has been applied to the case study sites and stakeholder consultations.

Credibility

A reflexive research approach was adopted for all stages of the research process from the formulation of the interview questions, during the recruitment process, and through the data collection and analysis stages (see *Statement of researcher reflexivity*).

During the interviews the visiting evaluation team members researchers would summarise, reflect and feedback information to participants to confirm or clarify information provided.

Data was deliberately collected from a variety of data sources - namely, the types of stakeholders (clients, AMIHS staff, community members, etc.), geographic locations and AMIHS service types. This ensured that a variety of perspectives were collected in relation to the implementation and experience of the AMIHS program.

Transferability

Transferability and applicability of the case study findings can be assessed through several ways. A mix of case study sites were selected by service type and geographic location across NSW. The sampling and recruitment process was designed to ensure a broad sample from nine different stakeholder groups. These processes, together with a description of the case study settings, the main themes of the findings and key information from the Managers' Survey, allows transferability and applicability

of the findings to be assessed between case study sites and more broadly to other similar AMIHS contexts.

Dependability

Five team members were involved in data collection to ensure credibility of the information being collected. At the end of each case study site visit, the evaluation team discussed the data that had been collected, including observations and reflections on the delivery of the interviews and focus groups and their individual perspectives of the experience of participants. Coding of the data was also undertaken jointly between the researchers to verify the validity of the analysis.

Confirmability

Confirmability of the data was enabled through triangulation of data collected from multiple stakeholders and through multiple data collection methods. This allowed for exploration of the levels of agreement within and between stakeholder groups and to assess level of consistency across the data collection methods. A 'sense-checking' process with the Ministry, the Cultural Reference Group and the Evaluation Advisory Committee of the data to ensure clarity and completeness of findings also contributed to the confirmability of the findings.

C. Findings

Evaluation Objective 1. Explore client, staff and stakeholder experiences and perspectives of AMIHS

The AMIHS program is valued

In case study sites, the AMIHS program was highly valued by clients, communities, colleagues[7] and other partner agencies and services. Clients, including fathers, reported that they valued the service because they felt comfortable and familiar with the service and they felt supported by AMIHS staff.

AHWs were identified by interviewees from all stakeholder groups as being an important element for why the service was valued by clients and communities. Despite this, there were instances described at some of the case study sites where AHWs did not feel valued by their colleagues or by the broader health system.

Clients value the service

Across all case study sites, clients talked about valuing the service because they felt secure and comfortable to access AMIHS and they felt that AMIHS staff went above and beyond minimum care levels to support them in meeting a range of needs.

AMIHS provides a sense of security and comfort

Many clients talked about AMIHS providing a sense of security and assurance during what could be a joyous but vulnerable time in their life. Put simply by one client:

> *"AMIHS makes a big difference."*
>
> *AMIHS client #8*

Several clients compared the support and security experienced through AMIHS to the love, support and nurturing provided by a mother or a family:

> *"It's like another mum, with a taxi! That's what [name of service] is like, another mum."*
>
> *AMIHS client #22*

> *"Not having a mum it's good to have them. It's good to be close to them. It's like they build you up, how they do the classes, wrapping baby. They don't bombard you with information, they just prepare you."*
>
> *AMIHS client #6*

AMIHS was also seen by several clients to create a sense of comfort and ease where they could be honest and uninhibited about their concerns.

> *"I would have been more comfortable with my first pregnancy if I'd had [name of service]. They don't shame if you can't breastfeed."*
>
> *Past AMIHS client #6*

[7] 'Colleagues' refers to other workers in the LHD or ACCHS who work closely with the AMIHS team such as AMIHS managers, Quit for New Life (Q4NL) workers, child and family health (CFH) nurses and mainstream clinicians.

AMIHS is a familiar service to clients

Clients talked about how 'getting to know' the AMIHS staff created a sense of familiarity and that this made staff seem more approachable. Some clients talked about appreciating the efforts made by AMIHS staff to get to know them and to develop ongoing relationship with their families:

> *"And they know all kids by name. They know them all. And they'll ask how they're going, what they're up to, they know how old they are…it's not a job to them. They're invested in the children from the start and they like to do what they do."*
>
> *AMIHS client #9*

Other clients felt that occasional contact with the AMIHS staff outside of the service - that is, seeing them and talking to them when out in the community - meant that they were accessible and approachable:

> *"That I know them. I know them outside of there [the service]. I'm not intimidated at all going in there."*
>
> *AMIHS client #15*

> *"I think it's just a comfort thing. Because we all know each other, and we see each other outside of the four walls of [name of service], it's not intimidating. It's just comfortable – it's the only word I can use to describe it."*
>
> *AMIHS client #31*

Several clients also reported that they accessed AMIHS because it was known in the community as providing friendly and personable support:

> *"I was asked about [name of AMIHS service], I jumped at that! I knew it would be more consistent, friendly and personal.*
>
> *AMIHS client #5*

Clients feel that AMIHS staff go above and beyond

AMIHS was also valued by clients because they felt that AMIHS staff provided support that was responsive to their overall health and wellbeing. Some clients described the focus of AMIHS staff as unwavering and that they went to great lengths to support them. This could include assisting clients with practical things like arranging transport to ensure appointments were attended:

> *"I didn't have transport at the time, and they helped me negotiate a process with the doctor that I could be induced at the right time"*
>
> *Past client #6*

Or, as described by another client, it was the little things that counted - AMIHS staff were available to answer calls, answer questions or just provide support and encouragement:

> *"They [AMIHS team] just keep beside us, helping us and having opportunities on the side for more help, kind of thing. And letting us know there's always help there if we do need it. Things come up with his surgery and just all the little stuff like that, extra addition things we do need and help with the kids."*
>
> *AMIHS client #23*

Involvement of fathers in the AMIHS program

Although the primary focus of AMIHS activity is contact with women and their children, examples were shared during the case studies that demonstrated ways that AMIHS staff strived to engage fathers in the antenatal and postnatal care as part of providing support in context of each woman's family.

Five fathers were either interviewed individually or participated in focus groups, including one father who participated without his partner who was unable to attend the interview. All five fathers were enthusiastic supporters of the AMIHS program.

Fathers and other male relatives were included in the AMIHS program in a range of ways. At one site, fathers were encouraged to attend the weekly playgroup; at another site, a grandfather of an AMIHS baby was part of the family support network for that child and mother. Fathers reflected on the personalised support their partners received, such as being supported to address health issues, or the journey that their partners had taken over the course of several pregnancies due to the support that AMIHS staff had provided.

> *"They really know us, and they always look out for our kids, even though we're not clients anymore. It feels a bit like family. And {mother's name] really looks up to them – they have helped us sort a lot of stuff out over the years and it feels like we are now really on track."*
>
> *Community member #15*

Two fathers reflected on their experience of AMIHS as being protective and supportive for them and their partners to raise their children. As noted by one of the fathers:

> *"I really wish that AMIHS had been around for my older kids. The way I feel now is that I can be part of it all and I don't have to be the "big man" like I used to feel I had to be."*
>
> *Community member #16*

The connection to culture or their families that the program offered was also valued by fathers - Aboriginal and non-Aboriginal alike:

> *"I think it's really cool as a non-Aboriginal dad to know that my kids are getting to be brought up in their mum's culture and AMIHS really helps that. They get us hooked into everything and the kids make friends with other Koori kids. I really like it."*
>
> *Community member #1*

The value of AHWs

AHWs are central to AMIHS

The case study interviews revealed that AHW involvement in the team was considered a central and possibly defining feature of the AMIHS program. The importance of the AHW was such that many stakeholders felt that some elements of the program, such as home visits, would not be effective without the AHWs. One AHW was fully cognisant of the centrality of her role:

> *"To be frank some of these practitioners wouldn't get a foot in the door without us. If we weren't there, some of the women would disengage and the current outcomes would be worse."*
>
> *AMIHS AHW #1*

AHWs were described by stakeholders as having a significant role in bridging the gap between communities and services through lines of kinship, community knowledge and dedication to the community. Stakeholders also felt that AHWs were critical to AMIHS teams to connect with clients and provide support:

> *"The AHW is vital to the rapport building and psychosocial interactions between health and client and the family."*
>
> *AMIHS midwife #8*

AHWs were also described by stakeholders as the 'key' to facilitating engagement with other services because they had knowledge of the local community and appropriate support and services for clients. Some stakeholders considered AHWs to be the key to the AMIHS program because they could bring a

tangible cultural connection that could be the basis for developing trust with clients. As described by one midwife:

> *"The AHW is key. I get that, I get that really, really well. At first, I kind of got it, but I didn't really get it. But I do now. It kind of depends on the type of AHW as well. It can be that just the fact that there is an AHW present just provides that cultural safety. You just feel it and see; it's a trust issue."*
>
> *AMIHS midwife #8*

AHWs are not always valued or respected

Across all case study sites, several stakeholders talked about instances where the role of AHWs was not always fully appreciated or respected. This could affect collaboration between AMIHS and other services or undermine the effectiveness of AHWs to advocate for clients and the delivery of the program. It could also result in AHWs not being properly supported in their roles.

AHWs are not always valued or respected by colleagues

Sometimes the AHW (or the role of the AHW) is reportedly not valued or respected by other (non-AMIHS) colleagues. There could be a lack of understanding or appreciation of the AHW's link with community and their community knowledge to undertake their role:

> *"I've seen [name of AHW] be criticised because sometimes people say she's too involved with the community. Well how can you be too involved with the community? It's your community."*
>
> *AMIHS midwife #9*

Some AHWs also held this perception, saying that while their connection to community was valued by clients, they did not always feel valued or even respected by other staff in the health system. In some cases, AHWs felt that other staff, including managers, questioned their cultural judgement. One AHW felt this undermined her professional and community standing:

> *"I live and breathe life with many of my clients. So, when a clinician speaks over me I get a bit of shame and affects our standing in community," …won't ask [name of AHW] because the midwife needed to correct her because she didn't know what she was doing". I'm recognised in community – it's relational, it's who I am. My work isn't segmented from my life."*
>
> *AMIHS AHW #1*

Some stakeholders reported that instances where AHWs were not respected, or AHWs felt intimidated by more qualified staff, their confidence was eroded and their ability to advocate for AMIHS clients could be undermined.

> *"…they are too scared to say anything to the clinical people because they think that they are qualified or whatever but, I think, they're too frightened to speak up"*
>
> *AMIHS midwife #6*

Some AMIHS staff reported that if the AHW role was not properly understood by managers of AMIHS, it was difficult for AHW's to advocate and influence the focus of their role or the way the program was delivered. As described by one AHW:

> *"It's hard to describe the role that we play as AHWs and that can make it hard to advocate for the value of doing more health promotion work, etcetera – it's easy for line managers to say, 'I don't get what you mean' and that's the end of it. And because there's not a group of us [AHWs], you're just one Aboriginal voice in a white world."*
>
> *AMIHS AHW #4*

Some AHWs also reported that a lack of understanding of the role, and the requirements of the AMIHS program, could result in not being properly supported with clinical supervision, or high expectations being placed on them to deal with every aspect of Aboriginal client contact with the LHD.

AHWs are not always valued by the health system

Several AMIHS staff and LHD staff also talked about observing an attitude within the health system that Aboriginal health work more broadly was inferior comparative to other approaches. As observed by one CFH nurse:

> *"Nurses and social workers at the hospital and other health services tend to look down their noses at Aboriginal health work – they see it as 'dumbed down'."*
>
> *Partner organisation #4*

Some stakeholders felt that because the complexity of the role of AHWs (and the need to walk in 'two worlds') was not properly recognised or understood; the broader health system, as reported by one AHW, therefore did not understand the value of collaborating with AHWs or the pivotal role of AHWs to connect clients with other services.

> *"There's not the recognition of the competing priorities of the role – we're in a grey area – not clinicians, not a social worker but at the end of the day if we're not here then a lot of the other things wouldn't exist. I feel valued by my clients, by my clients but not by the system."*
>
> *AMIHS AHW #1*

Within the structures and processes of the health system, there was also evidence that the AHW role was not recognised in the design of the centralised patient record system, as noted by one LHD worker:

> *"When we went live with e-maternity, a system that was being worked on for years, all the way along it was talked about that all the clinicians and staff will be able to access and input information about clients. Under the roles in the database, there's no AHW."*
>
> *LHD worker #10*

AMIHS is a culturally appropriate service

In the opinion of many AMIHS staff, clients, LHD workers, community members and statewide stakeholders across all case study sites (including the majority of Aboriginal respondents), AMIHS is a "culturally appropriate" program. This was a term that was widely used by interview respondents and was understood to mean that clients were supported through AMIHS in a way that incorporated and respected their choices and values. AHWs were seen by many stakeholders to provide an important visible link between AMIHS and the community, particularly through their demonstrated commitment to cultivating deep connections with the community. Despite this broad support, a variety of stakeholders at all case study sites reported that there were still challenges in ensuring clients got culturally appropriate services across all parts of the maternity and infant care journey and changes were required to improve services.

Incorporating knowledge, values and choices of clients

AMIHS was often described as culturally appropriate because care and support was delivered by AMIHS staff who demonstrated awareness and willingness to provide support that openly respected the cultural knowledge and values of the client. This was demonstrated through incorporating and understanding the value of the family and community to clients, willingness to listen and explore their needs and respect for their perspectives and choices. In many sites, the existence of deep connections and long-standing relationships between the AHW, in some locations the midwife, and the community was noted by clients and community stakeholders as being an important demonstration of the cultural appropriateness of the service.

The AHW, for many stakeholders, provided a visible cultural focus of the AMIHS site and was perceived as a useful way to ensure clients accessed the service and remained engaged. The presence and visibility of Aboriginal staff, as noted by one AHW, was perceived to be comforting for clients:

> *"It's nice to see an Aboriginal person when you're an Aboriginal person laying there on a hospital bed."*
>
> *AMIHS AHW#2*

At most of the sites, visibility of culture and language in the service environment was perceived to contribute to the service being culturally appropriate because it could demonstrate an appreciation of Aboriginal culture. At some sites, Aboriginal artwork, imagery and photographs of clients and babies were displayed. At one site an outdoor pergola had been especially decorated for the service. At another site, efforts were being made to incorporate the local language, as described by an LHD worker:

> *"The AHW managed to get a cultural inclusiveness grant for upgrades at the hospital – there is a big mural done by a local artist, there are cot cards for all babies to say welcome in [the local Aboriginal language]."*
>
> *LHD worker #31*

Challenges with ensuring clients receive culturally appropriate services

Despite the focus of AMIHS to deliver services that valued and respected Aboriginal culture, stakeholders in some case study sites reported that community members did not always view the service as being culturally responsive. This referred to a belief that community members did not believe that they would be respected as Aboriginal people, nor that their needs would be accommodated, or their choices respected. However, such views were largely related to factors external to the delivery of AMIHS. Broader suspicion, mistrust and enduring fear of government services that existed in some parts of communities was reported as contributing to negative assumptions about AMIHS.

AMIHS is not always trusted by the community

Some AMIHS staff felt that delivering AMIHS required a personalised approach to develop trust with clients and properly connect with local communities and they felt this was different to mainstream approaches to health care. However, as noted by one AHW, this could be challenging for some staff and resistance to adapting their practices could generate client mistrust of AMIHS:

> *"Working in cultural ways requires a lot of skill – many people [non-Aboriginal] are freaked out by that and not well prepared. They are also unwilling to do home visits and this attitude also affects the willingness of people to be comfortable to invite them in anyway, for fear of being judged negatively."*
>
> *AMIHS AHW #5*

Clients may also not trust the service based on past negative experiences recounted by family and community members. As described by one midwife:

> *"Some don't trust the service. Because of community talk, gossip, hearsay, it's a choice. It's a woman's choice…We all have our friends who might say something about GPs, etc. White middle-class women have a way of choosing their models. Aboriginal women have a way of choosing their models. It might be that their neighbour said that they did not have a good experience with [name of service] but their sister did. Word of mouth is really strong.*
>
> *AMIHS midwife #8*

When trust is broken with the local community, some AMIHS staff reported that it can be difficult to assure the community that the service can be trusted to deliver respectful and appropriate services. For example, one midwife noted:

"We try really hard to deal with any issues that might arise and we talk to the community regularly to keep on top of things but something that happened years ago, even before our time, can still be remembered and mentioned in the community."

AMIHS midwife #9

Fear of government services

A fear of government services more generally was reported by most AMIHS staff and other stakeholders in case study sites as a reason why some women did not access AMIHS. Fear of government services was described as being directly linked with historical incidents where women's families and communities had been subjected to racism by staff of government services or children had been removed as part of previous government policies and practices. It was also described as being linked to present-day experiences of racism or not feeling welcome or comfortable within health services such as hospitals.

One ACCHS stakeholder at one site reported that some local women had a genuine fear of a risk of intervention from FaCS if they accessed the AMIHS service:

"And I know around child protection stuff, I know in my experience with all of the feedback I've been getting from girls is that they are worried if they go to [name of service] and people are going into their homes, they have a fear of being judged by their home and maybe the way, you know, it's even with their children as well."

ACCHS stakeholder #3

In such instances, government-run services in general (including AMIHS) were viewed with suspicion because there was a fear that individual choices and ways of living would not be respected or that families would be judged negatively against government services' expectations of how they should be living.

Ways to improve cultural appropriateness

Stakeholders across all case study sites alluded to ways that culturally appropriate service delivery could be achieved and maintained. AMIHS staff talked about the ways they were trying to ensure AMIHS was working with the community to build trust in the service. Some AMIHS staff and other stakeholders also talked about the ways that the health system more generally could improve the way Aboriginal culture is incorporated into service delivery.

Strategies used by AMIHS to develop trust with the community

AMIHS staff reported being aware that some parts of their communities (in all case study sites) had a fear of AMIHS as a government service. They also reported that there were instances where there was a risk of removal of children for some families. In such cases, AMIHS staff reported that early engagement with clients was an important strategy to build the capacity and confidence of vulnerable clients. They reported that early engagement could help to allay general fears held by clients and to help them engage with the service or could be part of a more detailed action plan to minimise the risk of removal of children. It was also seen as an important strategy to ensure the program was perceived as an accessible service by the local community.

Some AMIHS staff reported that significant amounts of time and effort were required to build trust with some clients at risk of removal of children. Careful documentation and coordination of supports, and advocating with the local FaCS workers, was also required, as described by one midwife:

"Those girls who have had babies taken away in the past or are generally in a bad place are usually very worried about their baby being taken away this time. The beauty of AMIHS is that we work in ways that allow us to get to know the wider family, so we can all work together to put a plan in place. Of course, there are some situations where there are too many risks and we do end up having to report but I always tell the client what I am doing and why. At that point they know we have pretty much tried everything. But mostly we can find ways to keep the baby

in the family at least and that gives them the best start and the mum the best chance of building a relationship with the baby from the start."

AMIHS midwife#3

Some clients reported that these approaches that were adopted by AMIHS staff were critical to minimise the risk of child protection intervention:

"Yeah – we've both had kids taken off us in the past …. but since we met the girls here [at AMIHS] we've learned heaps about how to be better parents, gotten off drugs and kept our last three kids with us. Things went pretty bad again there for a while, but they stuck with us and believed in us and we're pretty proud of where we are now."

Past AMIHS clients#16

Changes within the health system

Some stakeholders called on the need for more meaningful efforts to improve the ways that the health system incorporates and meets the needs and choices of Aboriginal people.

Culturally competent service delivery, as noted by one AHW, was about ensuring Aboriginal people were able to choose to access a service that they believed valued and upheld Aboriginal culture:

"We are entitled to have care that is holistic and culturally reflective regardless of whether there is a gap or not. It is our choice, as the First Peoples of this nation to engage in healthcare that reflects our values, our spirituality our meanings."

AMIHS AHW #1

A small number of AHWs and several LHD workers reported feeling that some efforts to make health services look more 'Aboriginal-friendly' or culturally appropriate felt tokenistic. Stakeholders observed that these attempts were perceived as largely focussed on making service environments look more visibly welcoming to Aboriginal people by displaying artworks, yet in the same environment they perceived insufficient effort to address more systemic changes such as increasing the level of cultural training clinicians receive. Their message was that incorporating visible cultural symbols in health care settings needed to be accompanied by a set of attitudes and understanding that reflected respect for Aboriginal culture.

Experiences of racism

Incidences of racism were talked about at all case study sites by AMIHS staff, ACCHS staff, mainstream hospital staff and clients. These examples were not directly related to the AMIHS site's operation but reported to occur primarily within the local mainstream health services. The stories shared by stakeholders included numerous incidences of both overt and veiled racial discrimination.

Racism that directly impacts clients

Overt examples of racism reported by stakeholders included instances where direct comments were made by staff in other health services to Aboriginal clients. One AHW described the response given by a hospital clinician in relation to advice given by a grandmother:

"She said to us: 'We can't all go back to the bush'. They still think we're just running around not knowing what we're doing.

AMIHS AHW #5

Experiences of racism were also observed and described as a cause for concern for many staff, including hospital staff. Although they acknowledged that there were systems in place to address racism, they could still point to examples of racism towards Aboriginal people, as described by one mainstream midwife:

"There is still some [incidences of] overt racism; we encourage any instances of racism to be reported. We still do hear some stories that make your hair curl, they can't seem to absorb the historical impact of past policies."

AMIHS midwife #3

Comments could also be subtle yet derogatory, perpetuating negative Aboriginal stereotypes, as described by one AHW:

"Her comments to me about one mother who had gone outside for a walk with a family member, when I queried where she [the mother] was, the staff member's comment back to me was 'oh she's just gone walkabout'."

AMIHS AHW #4

Another hospital-based midwife also felt that racism towards Aboriginal people was part of broader negative or racist attitudes towards patients from culturally diverse backgrounds:

" Look, I think at times people don't understand an individual's circumstances and they don't understand the cultural differences whether it be Aboriginal or an immigrant family. They don't understand the cultural differences within their [patient's] culture that makes other things more challenging."

LHD worker #8

Racism that directly impacts AMIHS

Some stakeholders also talked about racist attitudes that they felt existed within the health system which could have a direct impact on the implementation and delivery of AMIHS.

AHWs at three different case study sites felt that some health professionals viewed AMIHS as a 'transitional' service for Aboriginal people. They felt that this was representative of an unconscious racist attitude that showed Aboriginal culture was not valued or prioritised, or where the differences in the type of care someone should receive or expect were not respected.

"I hear frequently from management through to nurses, midwives in hospital statements like, "Hopefully one day we won't need these services because everyone will just want to come to mainstream". That in itself says to me that they don't know or understand what colonisation has done to us. It wiped out our culture."

AMIHS AHW #1

It was also felt by some stakeholders that racist attitudes had an impact on whether potential AMIHS clients were referred to the program. Some AMIHS staff felt not referring women to AMIHS was an example of racism. As noted by one manager of AMIHS:

"Racism is historically an issue in the catchment area. An obvious example of this is where the NUM is not referring pregnant women to AMIHS."

Other AMIHS staff #1

Within the broader health system, some AHWs reported that other colleagues may express resentment towards the AMIHS program. One AHW overheard the following comment made by a colleague:

"What does [name of AHW] need a car for … why do they need to have a special program."

AMIHS AHW #4

Racism within the workplace

AHWs at most sites talked about experiencing racism in the workplace. Some talked about feeling that the cultural knowledge of Aboriginal staff was not respected within the service, with some AHWs citing

examples of being consulted specifically for their 'cultural' input without any evidence to show that this input had any effect on implementation.

Racism within the workplaces was viewed by stakeholders as having an impact on the employment or career pathway of Aboriginal people, particularly regarding taking on leadership roles. At one site, an AHW and midwife talked about the need to have Aboriginal people in leadership roles to ensure the service was truly culturally appropriate and responsive to the health and social needs of Aboriginal babies and their mothers. However, one ACCHS stakeholder expressed pessimism about AHWs ever being recognised or respected in formal leadership or management roles:

> *"I just don't think they'd get the respect. Because of maybe their qualifications, like, the formal qualifications, but I don't think people value the other knowledge, the stuff that you can't get a certificate for…community, living in the community, working in the community."*
>
> *ACCHS stakeholder #3*

Some AHWs talked about systemic examples of racism that were expressed through workplace structures and processes. At three sites, AHWs talked about not feeling fully heard or acknowledged within their own services. And as described by one AHW, past experiences created a feeling of scepticism and mistrust around whether Aboriginal culture was valued:

> *"It's an Aboriginal led service, we're here, but you still feel like you're under them. It's just how you feel as an Aboriginal person…. because things happen that…even sitting here now I'm thinking, "are you really here to listen to me or are you just behaving like them to tick a box". And it shouldn't be like that but that's how I feel. That is from years of people wanting to talk to you and wanting your time, and then I say, "oh I didn't want that" or "why is that happening". But no, we consulted with you."*
>
> *AMIHS AHW #10*

Training to address racism in the workplace

The importance of improving the cultural competency of health staff in community health services and hospitals was raised at each of the AMIHS case study sites. Regular, consistent and targeted cultural education and training were noted as important strategies to enhance cultural competence to address racist and discriminatory attitudes held by staff within the health system.

At most of the case study sites, access to training was described as being ad hoc or that there had been lengthy periods since doing the training. At each site, there was agreement that all health professionals needed to participate in regular cultural awareness training to ensure current and future AMIHS clients and their families (as well as Aboriginal people more broadly) had a better experience both in the hospital and during antenatal care.

> *"Racism is a priority area of concern within the Ministry and has been elevated to receive more focussed attention. There is a strategy document being developed and will be a major drive of actions. They want to see clients feeling safer to report instances of racism (or just bad practice), a more patient / client centred model of care (this would benefit everyone) and services understanding more about their duty of care obligations."*
>
> *Statewide stakeholder #4*

Evaluation Objective 2. Identify and describe the way in which AMIHS is being implemented, at state and local levels

The AMIHS Service Delivery Model

The AMIHS program principles are well articulated in the SDM; see NSW Health, reviewed 2014) which also outlines the aims and objectives of the model. The document also clearly states the 'essential [design] elements' of AMIHS, with which implementation compliance is deemed very important. The stated elements are:

1. Provision of antenatal and postnatal care to 8 weeks
2. Being accessible, flexible and mobile[8]
3. Having a seamless transition to CFH services
4. Referral to other appropriate services including Brighter Futures
5. Being involved in community development and health promotion activities
6. Working collaboratively with other services including ACCHS
7. Supporting workforce development and lifelong learning
8. Building and sustaining effective community partnerships
9. Having ongoing monitoring and evaluation
10. Adherence to NSW Health policies and procedures, including those that protect and promote the safety, welfare and wellbeing of children and young people[9].

When implementing any program over several administrative boundaries and in up to 47 separate sites, one can expect some variation in implementation approach to occur between sites. Indeed, the SDM explicitly allows for some adaptation to local community needs.

In the following sections of this report, the findings on level of fidelity of implementation of AMIHS sites with the SDM, the nature of variations from the model, and the potential impact of variation are detailed. The findings draw primarily from the Managers' Survey, which was explicitly designed and administered for this purpose, and the qualitative data from case studies and stakeholder interviews.

Element 1: Antenatal and postnatal care to 8 weeks

Within this service model element, stakeholders identified eight possible components of care. Based on data from the Managers' Survey it was found that most sites (between 90% and 100%) provided all of the components of care (Figure 1).

The major point of difference between AMIHS sites noted in Figure 1 was attendance at birth, which is not an essential element of the SDM. Only 38% of sites attend births in some capacity. This finding is supported by the qualitative data – at only one of the six case study sites AMIHS workers were attempting to attend the birthing process, sometimes only in certain circumstances and when physically possible. Those sites reporting through annual reports that they provided birthing support indicated they did so mostly in the form of visits by AHWs and/or midwives during their working week (Monday to Friday daytime hours).

While not demonstrated in Figure 1, the qualitative data also suggests a significant area of divergence between sites is in the duration of postnatal care provided by AMIHS. As noted earlier, LHDs and ACCHSs are given a certain level of autonomy in how they implement and adapt the AMIHS program

[8] Part of this element is the location of the AMIHS service, which is discussed in a later section that details findings on service reach.

[9] This element of the SDM was not included in the FIRS or Managers' Survey since valid data on this element was unlikely to be obtained through these or other evaluation method components.

to meet local needs. This includes how and when AMIHS clients transfer from AMIHS to the local CFH service. Even though the SDM advocates an 8-week postnatal handover period to CFH services, this can vary from as little as 2 weeks to the full 8 weeks. Unfortunately, the Managers' Survey did not specifically seek information from all sites on this issue, but the length of the postnatal AMIHS service period was raised at most case study sites.

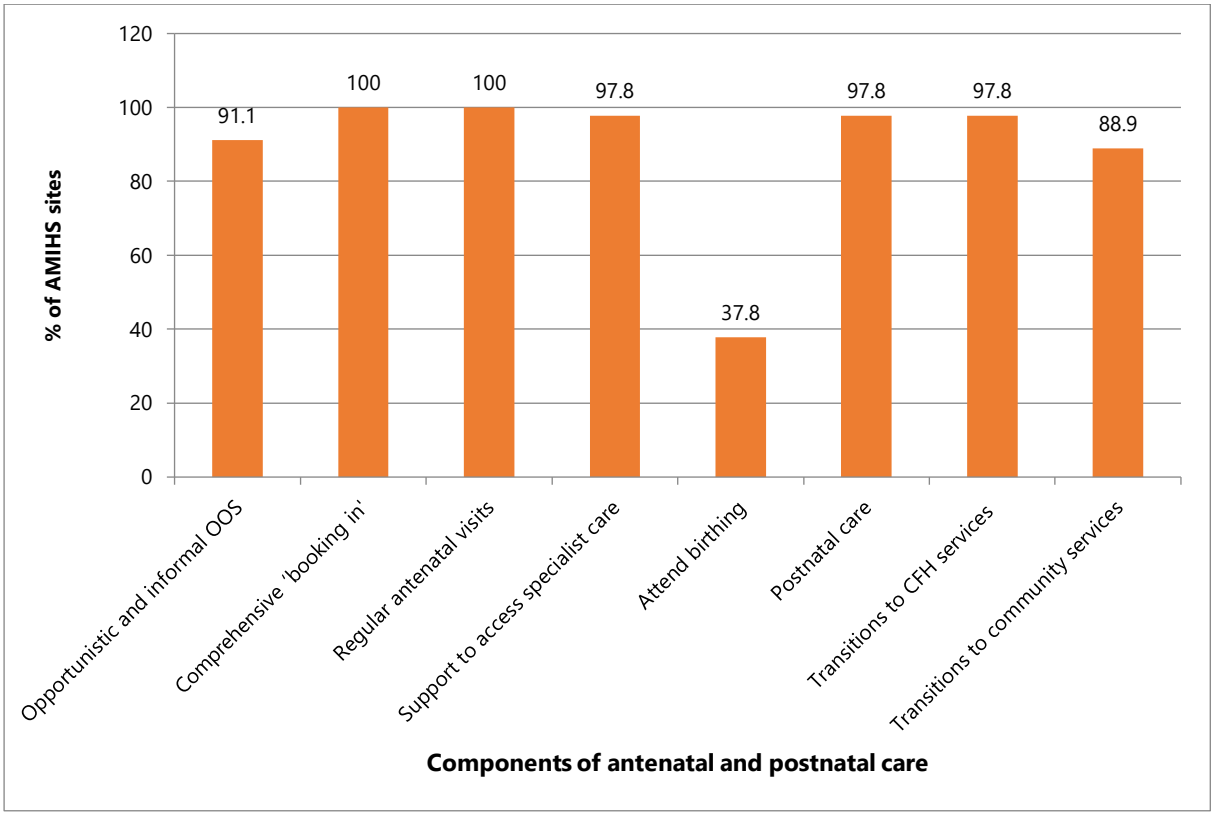

Figure 1: Distribution of AMIHS sites by type of service offered (n = 45): *Source Managers' Survey 2017*[10]

Intrapartum care

Client & family concerns

AMIHS involvement in intrapartum care is not an element of the AMIHS SDM. However, the intrapartum care phase was the period of a client's maternity and infant care journey that they and their families expressed most concern about in the course of the case study visits.

Women using AMIHS services reported being supported throughout their pregnancy by the AMIHS program, but a majority interviewed reported feeling left without trusted support at the most vulnerable point in the maternity care journey – that is, birthing. AMIHS staff members and their managers were very aware of these concerns and reflected in detail on the strategies that they have explored over time to address their clients' needs and concerns.

The document review showed that the main strategy for connecting AMIHS clients to the birthing unit in which they will deliver their baby has been for AMIHS staff to try to build positive relationships with

[10] Abbreviations and definitions for items in Figure 1:

- 'OOS' = 'Occasions of Service'
- 'Transitions to CFH services' = Transitions from the AMIHS program to Child and Family Health services
- 'Transitions to community services' = FaCS, Non-Government Organisation welfare services, etc.

the local maternity unit management and workers[11]. The aim of this strategy, which was also described by AMIHS staff and managers in case study interviews, was to raise the awareness of hospital-based staff that AMIHS clients were well known to the AMIHS service and that this support will continue after the birth.

Some clients were aware of this handover process and prepared for it and some reported positive (or at least an absence of negative) experiences in relation to the birth of their babies. This was particularly the case for women who described themselves as generally quite confident and had already experienced one or more births previously. But for some clients, even though they may have been forewarned, the handover transaction was not clear or acceptable to them and they found it difficult to understand why the AMIHS midwife and/or AHW could not stay with them for the labour. Clients offered numerous comments about this issue, such as:

> *"Yeah. When I was in labour, [name of AMIHS midwife] was like, "I have to go now." And I was like, "You're not going anywhere." She's like, "Yeah, but other ladies are here to take over from me." I was like, "No, you're not." And she stayed, I think, for two hours."*
>
> *Past AMIHS client #2*

One midwife noted:

> *"…they often ask me though "are you going to be there for the birth?". I'd love to say yes…there have been a couple of times where I was on the ward, I did go down to the labour ward and I did sit with the woman. We had to cancel some things to do that but at the time we thought that that was important... I just find that it would be good if they could look at that in the future."*
>
> *AMIHS midwife #6*

While some AMIHS sites were attempting to provide some support during the birthing process, albeit in a limited way, as noted above, most sites were not. This generally did not reflect a view of no need, rather it represented an acknowledgement of the impracticalities and the current financial constraints:

> *"And also we've surveyed, we've had discussions and all of our team would like to embark on intrapartum care. The community want the known carer to continue through labour and birth and immediate postnatal period, that's a real demand. The way our model is with the staffing there is no way we could accommodate with the number of pregnant people we care for and then see them through labour and birth."*
>
> *Other AMIHS staff #3*

A barrier to achieving better continuity of care for AMIHS clients

In most case study sites, AMIHS managers and other program staff felt that hospital maternity staff had a poor understanding of AMIHS and its potential benefits which, in turn, could impede collaboration between AMIHS and hospital maternity services.

> *"A lot of the midwives that work in the maternity unit have never really been exposed to the social health model of care that we use. It seems quite random to them and the comments they make about some of the work we do to support clients make it clear that they think we are not always doing 'proper' midwifery care. What I think they don't realise is that the way we work is*

[11] One AHW had developed a particularly good working relationship with the managers and staff of the local hospital and felt her training as a 'doula' (birthing support worker) was important. She reported that having this additional training enabled her to provide better informed support to women approaching the birthing phase and/or the birthing process where her attendance was invited and approved, even though her role did not involve the provision of any clinical services.

the way that suits our clients best and gives them and their babies the best chance of great outcomes."

AMIHS midwife #3

One statewide stakeholder was sympathetic to the challenges faced by clinicians in considering each woman's priorities and circumstances but noted that there is a clear challenge to be met:

"…in busy birthing environments, it can be difficult for clinicians. If there's a labour ward full of women, all with different risk profiles, all with different preferences and so on, it's very difficult to consciously accommodate everybody. So, I can see where they're coming from in one respect, but I can't accept that clinicians in the 21st century think that a one size fits all approach is the right way to go."

Statewide stakeholder #6

Possible strategies to improve birthing care for AMIHS clients

Without exception, clients were confident that their birthing care could be improved through better integration of their maternity care with the AMIHS team and with the care they receive from the hospital during the birthing process. The ways that were commonly suggested for making these improvements were as follows:

- for the AMIHS team to be involved in the delivery of their babies (either providing midwifery care, general support or both)
- that the AMIHS team would continue to have a lead consultative role in their maternity care, even if they were not actually involved in the delivery of babies
- that their care would only be provided by maternity service providers (all professions and support workers) who have a well-developed understanding of Aboriginal culture and were accepted as such by respected local elders, treat clients and their families with kindness and respect, and understand the importance of using a strengths-based approach to their care rather than a deficit-based approach.

Some AMIHS midwives were open to participating in an enlarged team that would enable them to give clients the security of a known carer that they sought. Some part-time AMIHS midwives who were interviewed were already working part of their working week at the maternity unit as one way of trying to achieve this aim.

Others described attempts that had been made in the past to build up a network of additional, willing and clinically and culturally trained midwives by having staff members from the local maternity unit provide leave cover. However, two managers who had tried to arrange this type of cover reported that some staff had found the experience difficult and were reluctant to come back. In addition, several AMIHS midwives reported that clients tended to delay their attendance at appointments rather than see someone they did not know well or trust, which meant that workloads tended to be heavier than usual upon return from leave.

In one case study site a designated group of hospital midwives had been created to serve AMIHS clients, and these midwives were given specific on-the-job training. The midwives were introduced to clients several weeks before the expected birth.

Although AHWs were cautious about the potential for burn-out if the site service hours were extended to cover evenings and weekends, they were unanimously clear in their view that AMIHS clients needed more support from either Aboriginal workers or carers with a high level of cultural capability. In most of the case study sites, however, the current absence of other local AHWs with capacity to provide this type of support in the hospital setting made this option seem unlikely.

Maternity unit managers in the case study sites reported having large numbers of staff to manage, including permanent staff members along with casual staff who may only work occasional shifts. In one regional hospital, the roster included approximately 80 midwives, with 40 of those being permanent staff members.

Postnatal handover

A good handover is highly valued

The intent of the AMIHS SDM is to promote access to trusted interpersonal care for up to eight weeks after the mother has given birth, during which time a *"process of transition"* to a relevant CFH service will take place[12]. This means that postnatal support in the early weeks will be provided by known workers who understand their clients' personal circumstances and have established a relationship of trust during the antenatal period. Examples of how the value of this relationship and trusted support was expressed by clients included:

> *"[name of midwife] and [name of AHW] know me and my kids and pretty much all of my family now. They don't judge me, and they will call me just to see how I am going and if I am coping with everything."*
>
> *AMIHS client #11*

> *"They didn't judge me for not breastfeeding. Last time (at the hospital), that was shocking – the milk wasn't coming and they grabbed my boob and were squeezing it really hard but still nothing. They made me feel bad – like I was a bad mother and I didn't want to breastfeed. This time, the AMIHS girls suggested I have another try but when it was obvious that it just wasn't happening, they just went 'OK – sometimes that's just the way it is, let's just move on'. I felt like they knew me, and they were just focused on what was right for both me and my baby".*
>
> *AMIHS client #23*

Early handover concerns

Stakeholders, including both service providers and clients, expressed a range of perspectives but a strong theme was that there was a concern that if clients were transitioned out of AMIHS postnatal care too early (i.e. less than four weeks) the positive outcomes achieved through the relationship built between the AMIHS team and the mother during the antenatal period could be undermined.

Specifically, the key concerns raised by stakeholders about a truncated postnatal care period (i.e. compared the SDM recommendation of up to 8 weeks) included:

- the initial post-birth period can be a vulnerable time for some women for their physical recovery and health care needs related to the birth (such as care of stitches), the establishment of breastfeeding, and general adjustment to the arrival of a newborn into the family. One LHD worker described her concerns about what she observes happening to some women who do not have access to AMIHS in the early weeks:

  "By the time someone's found them, they will have given up breastfeeding and be on formula if they're lucky, or milk because formula is expensive. Who's following up their vaccinations, their screenings, whether mum's got contraception?"

[12] The current NSW Health policy requires LHDs to provide midwifery home visiting for at least two weeks after the baby is born, which may extend to six weeks postnatal. The length of time is dependent on the woman's birth recovery and the baby's health. It is important that there is an effective handover of care between maternity to child and family health services.

LHD worker #23

- transport to access CFH services can be an issue for some women and not all CFH services offer home visits beyond the universal health home visit. The issue of transport can be further complicated if they are caring for other children. As another LHD worker observed:

"Those that can't get out of town don't have the check. Six-week check – if they can't get into [nearby town] it doesn't happen. I help them as much as I can with appointments."

LHD worker #20

- the flexibility of service provision can affect access to care. One midwife noted:

"Younger mothers need a very flexible arrangement and are sensitive about being thought of 'as a crack mother'."

AMS/ACCHS stakeholder #2

- some clients reported feeling uncomfortable with inviting new service providers into their home. They talked about a fear of being shamed about their home environment, judgement about their parenting, and some expressed residual fears about the possibility of child protection intervention (even if this is a low risk from a rational perspective in their own circumstances):

"With [name of midwife] and [name of AHW], I don't need to worry – they know me and my kids, they come in, the whole family might be there because that's the way our mob does things – everyone wants to know and to be there for you but they don't care – they just get on with it. And half the time they get asked about other things that someone might be worried about – hey, can you have a look at this?"

AMIHS client #23

- clients reported feeling shame about "re-telling their story" to the CFH worker to confirm their understanding; this was problematic for clients where there had been circumstances of trauma, mental health and/or drug use. They were required to re-visit the issues with a new worker during the early post-birth phase they were feeling vulnerable while adjusting to the arrival of a new baby. As described by one client:

"I didn't like having to tell (the child and family nurse) my whole story again – she got all that stuff from AMIHS, but she wanted to go back over it all again with me which made me feel bad – like I was back there again when I thought I'd put it all behind me. And it wasn't really relevant anyway."

AMIHS client #14

Element 2: Being accessible, flexible and mobile

Level & nature of flexibility

The AMIHS SDM states that the midwife and the AHW must have dedicated access to a vehicle "… *so they can be visible in the community*" (NSW Health, reviewed 2014). The results of the Managers' Survey indicated that half (50%, n=23) of the AMIHS sites had dedicated access to a vehicle for staff to outreach to clients and that the majority of the rest had access to a shared vehicle resource.

Almost all sites (98%, n = 45) provided home visits and some sites only did home visits. Most sites though also offered services through a clinic (91%, n = 42) and a few services only provide support

through a clinic service. About 65% of total AMIHS service delivery was conducted in clients' homes or through other forms of outreach.

Most AMIHS sites (56.5%, n=26) believed working conditions for the AHW and midwife matched the program needs, such as through allowance for out of normal hours of work, support to do home visits, and flexible hours policies. However, just over a third (37%, n = 17) of sites did not think the conditions matched the program needs and three (6.5%) were unsure. Some of the reasons respondents provided for why conditions did not match program needs included:

- inflexible work hours that did not support service delivery, for example home visits out of normal hours
- high and increasing workload, for example staff being shared across AMIHS sites
- insufficient staffing, for example inability to conduct joint visits, impact on ability to take annual leave, positions not being back-filled when staff went on leave.

Some of the findings from the qualitative data illustrated instances where the AMIHS program was not always being delivered as flexibly as possible. Some clients and AMIHS staff for instance felt that greater flexibility was required around service delivery hours including being able to work on the weekend.

> *"Our manager thinks they're doing the right thing by trying to make sure that we are working the same hours as others in our area, including not working hours that are too long. But the program is meant to be flexible so that we can catch the women and their families when it suits them – trying to restrict us to 'normal' office hours just makes the job more stressful and means we can't do our job properly."*
>
> *AMIHS midwife #2*

Several AMIHS staff, AHWs and midwives, also felt that there was not enough flexibility in their scope of practice or how the service was managed so they could effectively support clients. As described by one midwife:

> *"By core business, I think they [other clinicians or managers] mean 'you're my client today I'm going to do your blood pressure, take your measurements, and make sure your scans are up to date', risk factors identified, all those clinical things. The AHW will then identify the psychosocial risks and move that onto the social worker. But it's not always as easy as that. If you're a holistic care provider, you will deal with the other bits [support to deal with social and emotional wellbeing issues]".*
>
> *AMIHS midwife #7*

Several clients and other stakeholders also felt that more flexibility was needed around the choice of AMIHS staff. This was commonly talked about in the context of smaller communities where clients felt uncomfortable or did not trust and respect the AMIHS AHW or midwife at their local site. The reasons for this included a previous falling out with the community by a particular family, a desire to maintain confidentiality around their personal circumstances within the local community, doubts about a worker's competence, or a straightforward personality clash that did not facilitate a relationship of trust. An example scenario as described by one LHD worker:

> *"I came to [local town] one day and there was a [neighbouring town] lady in hospital and she specifically said, "I don't want to work with the [local town] worker, I want to work with you." Well she just can't, can she, and that's a barrier."*
>
> *LHD worker #24*

Stakeholder perspectives on flexible service delivery

Availability of home visits

Stakeholders, including clients and AMIHS staff, reported that home visits were one of the most highly valued aspects of the AMIHS program. Clients reported valuing home visits if they had limited access to transport to attend appointments or they needed to care for other children.

> *"It was so great not to have get all my kids on the bus and try to get down there for check-ups – [AMIHS midwife] comes to my place and does all the checks and everything. It doesn't worry her if there's a big mob in the house – she just gets on with it and doesn't mind if they ask questions and everything."*
>
> *AMIHS client #12*

Depending on where the AMIHS service was located, the cost of transport or parking was reported as being a barrier for some women to attend their appointments. One AHW felt that more effort was required to provide more home visits for women who needed financial assistance:

> *"…they're the ones that need home visiting, they're the ones that come up and we need to pay for parking. Go to them and then they don't have to feel embarrassed to ask for a parking pass or ring up and say I can't come because I've got no money for parking."*
>
> *AMIHS AHW #10*

Some AMIHS staff felt that home visits were a useful opportunity to tailor support that included the client's home and family context. As described by one AHW, home visits often provided a 'window' into how people were living and so they could understand what other supports might be needed for the client and their baby:

> *"…like the kids, like if they're home and their mum can't get them to school or can't get transport to school… things like that, yeah. Or just by how they're living."*
>
> *AMIHS AHW #8*

While home visits were reported to be generally valued by AMIHS clients, some stakeholders reported that not all clients liked home visits because of the fear of being judged by staff entering their home. One AHW reported that some clients feel shame about having someone in their home, at least initially until trust has been established:

> *"Sometimes they won't let us in the house because they might be shamed… we reassure them, and we tell them you know, we're not there to look at the house or judge them. They feel like you're judging them."*
>
> *AMIHS AHW #7*

Holistic and wrap-around support

Stakeholders in case study sites reported that AMIHS staff delivered flexible support by adopting a holistic and non-judgemental approach which involved working around clients' needs and circumstances. All AMIHS staff talked about the need, especially for clients with complex and high-risk issues, to look at the whole person and their specific needs so that they could coordinate a range of supports and services to achieve positive outcomes for the client and their baby. This was described by one AHW:

> *"I think that because of our flexible model and because we do more than just midwifery care and Aboriginal and health work care we're able to really support vulnerable women, whether it be providing housing, assisting them with domestic violence, linking them in with community transport, lots of other things that are really important. I'll tell you this briefly but it probably makes me love the job and why I do it – last year we had a 17-year-old girl doing the HSC that*

was pregnant, and we worked it out together – she actually had a baby a week before she sat her HSC so that felt like a real achievement for her and for us."

AMIHS AHW #3

Several stakeholders reported that holistic support could also include being understanding about why clients missed appointments or providing practical support to clients to ensure they accessed and engage with a service. This included transporting and accompanying clients to attend appointments to ensure clients access services they needed or accommodating various circumstances and following up with clients who missed appointments.

One hospital clinician felt that without the flexibility that AMIHS offers to follow-up with clients and reschedule appointments, there would be women who would not receive antenatal support and care:

"Yeah. So, if there was no AMIHS, there'll be even less antenatal care for these women. They just wouldn't engage well. So, they wouldn't – no they'd miss their appointments and then they'll be told, "You've missed your appointment, you'll come in two weeks' time," and they just won't get followed up. And there's usually lots of reasons why they don't turn up. It's a funeral in the family. You know, there's other things going on."

LHD worker #18

Many AMIHS staff also reported that a holistic approach involved engaging and liaising with other service providers. This was considered an important way to assist clients to engage effectively with other services and to ensure they received necessary care and support. As described by one client:

"They helped me a lot because I had complications with his pregnancy, he was high-risk. So, if I ever wanted to speak to [name of doctor] which was my obstetrician, they would be straight there following up blood tests for me or if I needed forms filled out. I was having to do a lot of travelling to [name of city] … appointment-wise they'd get me in, I just found it really helpful."

AMIHS staff also reported that flexibility was valuable to support clients who may not access the service until the late stages of pregnancy. In such instances, these staff felt it could be challenging to not only provide clinical care but to also develop rapport and trust to ensure all the clients' needs were addressed:

"It's hard sometimes, especially with the girls who turn up in town from other areas and might be escaping violence – they tend to present late so you are trying to think how to build trust and keep them engaged and ticking off in your head the most important clinical things that you need to deal with to have a healthy baby but their biggest concern might be that they don't have somewhere safe to live."

AMIHS midwife #3

Several clients also reflected on the incremental benefit of receiving flexible support from AMIHS staff; they were described as being patient, understanding and encouraging which increased their confidence as a mother. One client described her experience with subsequent pregnancies:

"…the AMIHS girls really believed in me and that really gave me a confidence boost and made me think I could really do a good job as a mum. They are good at explaining stuff and I don't feel shame about asking if I don't really understand things. When the next bub came along, I was already more confident."

Past AMIHS client #16

Element 3: Transition to child and family health services

Relationship of AMIHS with child & family health

The Managers' Survey indicated that AMIHS sites used different strategies to support clients to transition to CFH services. The most commonly used strategy, as illustrated in Figure 2, was to create strong relationships between the AMIHS program and the local CFH service (89.1%, n=41), followed by developing opportunities for the CFH nurses to meet the client and their family in the antenatal period (80.4%, n=37). Shared postnatal visiting and case management of more complex clients was also used by a small number of sites.

In many cases, the relationship between AMIHS and CFH services was fostered by shared service premises (80.4%, n=37) or shared management structures (76.1%, n=35) or both and, also through shared learning experiences (71.7%, n=33).

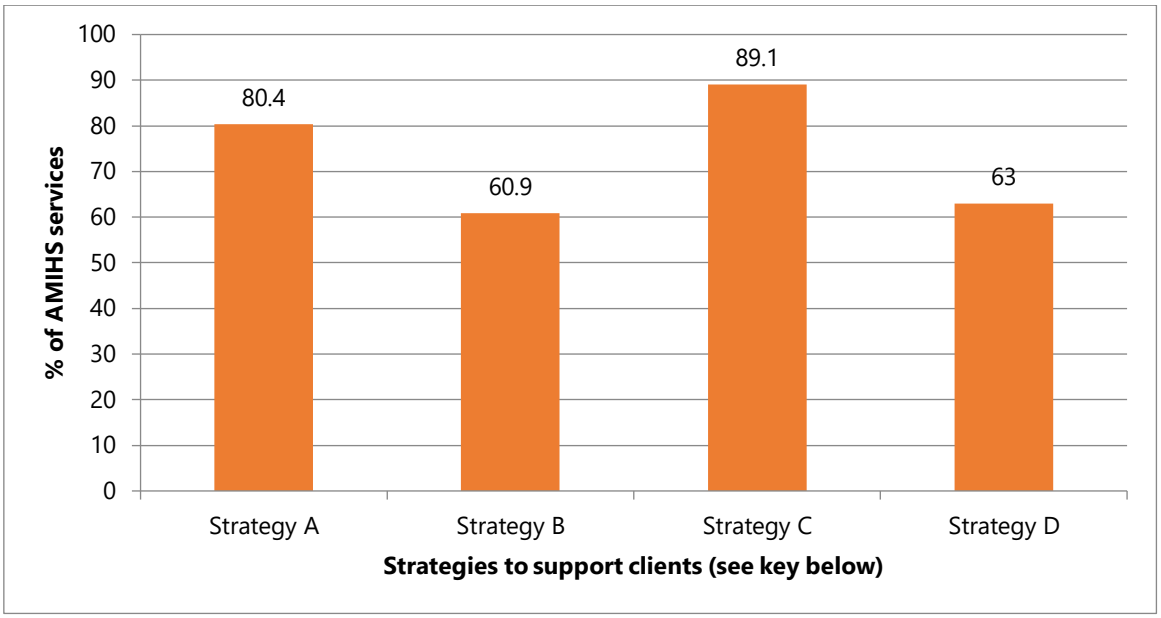

Figure 2: Types of strategies used by AMIHS sites to support client transition to postnatal support (N=46): Source Managers' Survey 2017

Key:

Strategy A.	Opportunities for CFH nurses to meet women and family in the antenatal period
Strategy B.	Shared postnatal visits
Strategy C.	Strong relationships between the AMIHS program and the local child and family service
Strategy D.	Case management of clients with more complex needs

AMIHS sites self-rated their relationship with local CFH services very highly - a majority (82.6%, n=38) rated their relationship as very effective (rating of 4) or extremely effective (rating of 5) (see Figure 3). [13]

[13] Rating scale: 1 = Not at all effective, 2 = Somewhat effective, 3 = Neither effective or ineffective, 4 = Very effective, 5 = Extremely effective

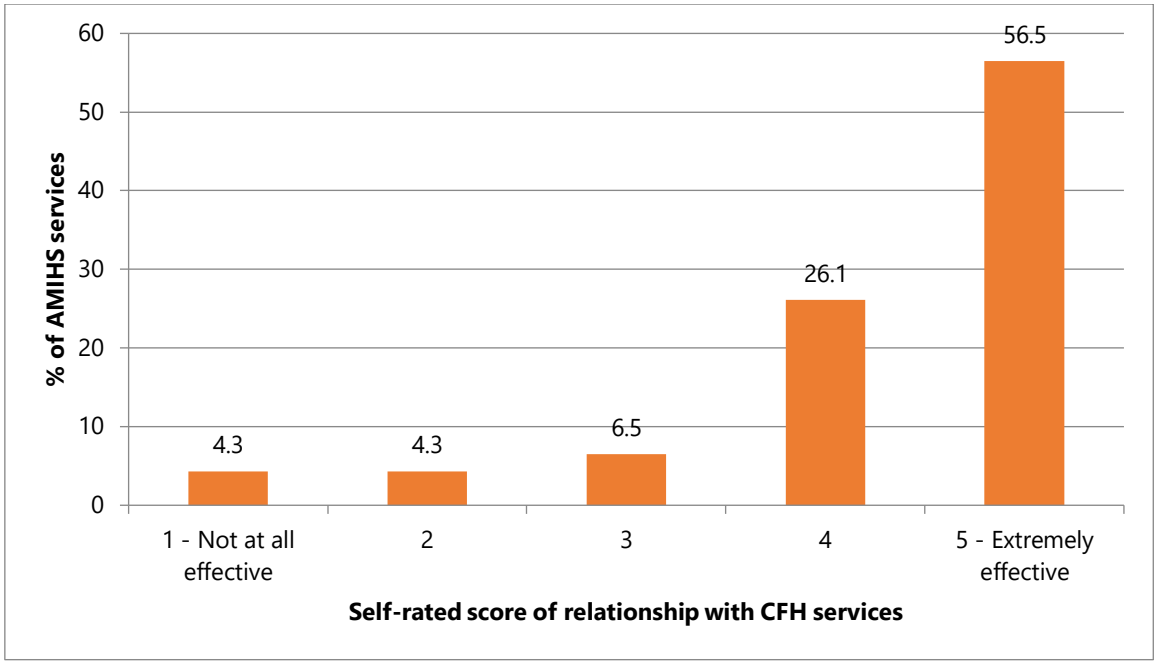

Figure 3: Distribution of AMIHS sites by self-rated score for their relationship with CFH services (n=46): Source Managers' Survey 2017

Handover process

While the manager rating of AMIHS and CFH relationships was generally very effective (in the survey) the case study work indicated that the process of referral and handover to the relevant local child and family service could be variable. Based on data across the six case study sites, the least effective handover arrangements seemed to occur when handovers were being made between different organisations (e.g. between LHD services and ACCHSs or vice versa) or across organisational boundaries (e.g. from maternity care to community care).

A more seamless transition from AMIHS to the CFH service was commonly evident where both programs were 'housed' within the one service. This was strengthened when there was a BSF program included in the service mix, in either an LHD or ACCHS-managed site. Effective coordination and co-location of these programs could enable continuity of care from the antenatal period potentially right through to when a child started school.

A CFH nurse reflected on the value of co-location in offering the chance to build trust from a much earlier time than a formal handover would allow:

> *"The AMIHS girls introduced me to [client name] when she was about seven months pregnant and filled me in on her situation. After that, I was able to keep an eye out for her as she came through the office and by the time it was time for handover, it was a lot easier. She knows we are all looking out for her."*
>
> *LHD worker #13*

These successful handovers relied strongly on a concerted effort by workers to meet regularly and develop a trusted partnership. Where a trusted partnership could not be established or staffing changes had occurred, AMIHS staff reported that the handover process suffered.

Elements 4 and 6: Effective collaboration with other services

Relationship with the Aboriginal Community Controlled Health Service

For seven (15.2%) of the AMIHS sites, there was no local ACCHS or, if one existed, it did not provide a service relevant to AMIHS clients. Five sites (11%) were either managed by an ACCHS or delivered out of an ACCHS location. The nature of the relationship for all other sites (n = 34) is shown in Figure 4. Constructing effective referral pathways was the most common form of collaboration (61.8%, n=21) along with information sharing (44.1%, n=15).

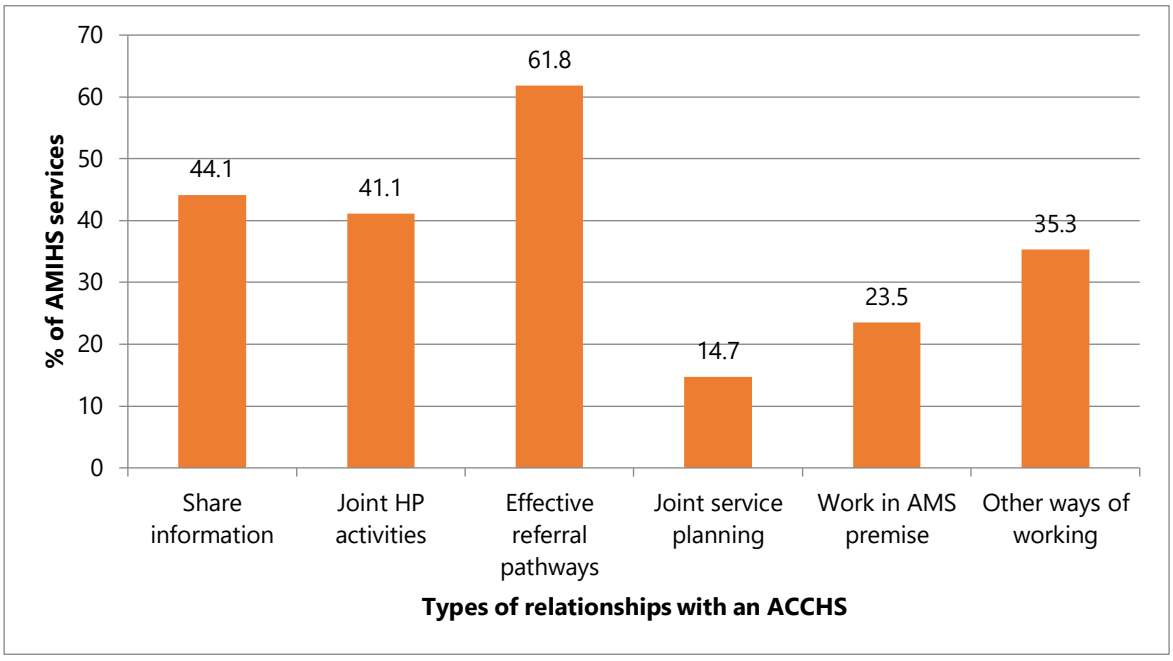

Figure 4: Types of ways AMIHS work with ACCHSs (n = 34): Source Managers' Survey 2017

Just over one-third of AMIHS sites rated their relationship with ACCHSs as being 'very effective' or 'extremely effective' (Figure 5). Data from the case study sites indicated the importance of a workable relationship between the AMIHS site and ACCHS:

> *"Working with the AMS is very important because they know that we're here to do the same job, not competing for clients. They know what we do, and they try to fill gaps and we try to help them to access the hospital and have taken them to the hospital. If the women want to use both services, they can."*
>
> *Other AMIHS staff #2*

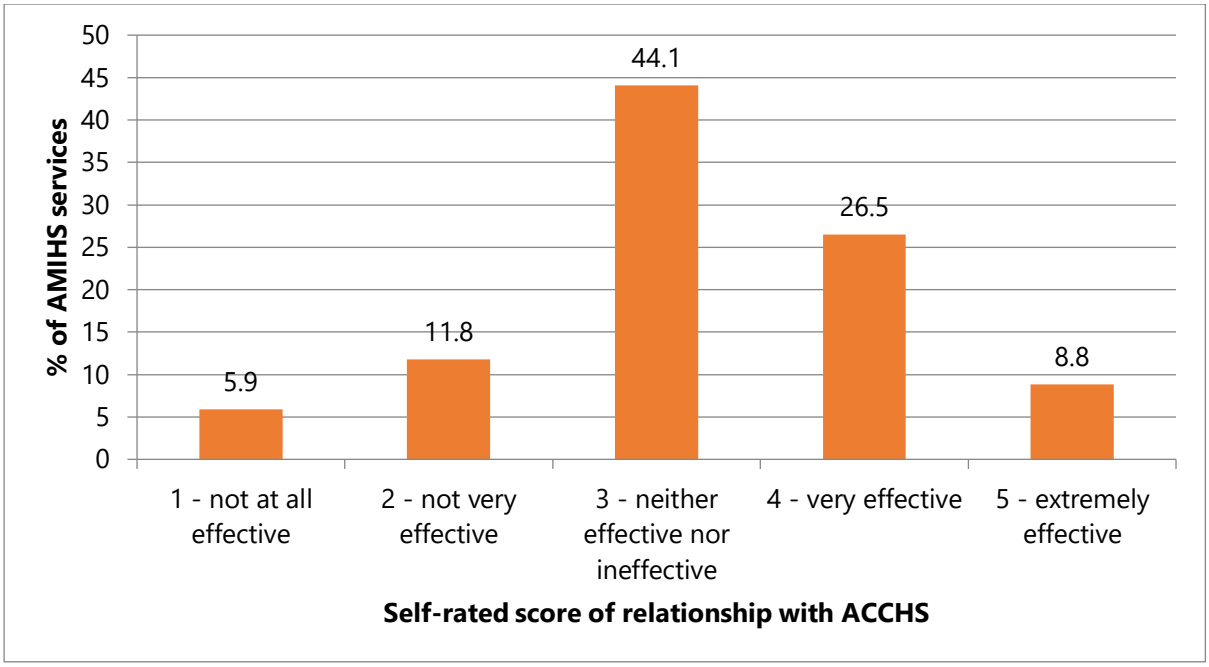

Figure 5: Distribution of AMIHS sites by self-rated score for their relationship with ACCHSs (n = 34): *Source Managers' Survey 2017*

Relationship with other services and agencies

Relationships with other service providers varied in strength. The average scores (between 1 - not at all effective, and 5 - extremely effective) for the relationship between AMIHS sites and a range of identified service types that could be appropriate to the needs of AMIHS clients are shown in Figure 6. Average scores with many types of other services were impacted by managers noting those services as 'not applicable' (and therefore scoring zero).

The most effective relationships existed with mainstream maternity services, allied health workers (including social workers) and obstetricians. Importantly, given the anxieties and concerns that many AMIHS clients were reported to hold regarding child protection (see *Types of complex and high-risk issues experienced by clients* section below), the average rating for relationships between AMIHS services and FaCS child protection agencies was moderate as was the relationship with Brighter Futures agencies. At one case study site, stakeholders reported that the relationship with FaCS was no more than workable.

Less strong relationships with mental health, drug and alcohol and housing agencies (only average at 2.5, 2.7 and 2.5 respectively) were reported through the survey. As will be discussed later in this report, these also tend to be the three most prominent issues contributing to the complexity of the AMIHS client population (see *AMIHS is well placed to support clients experiencing complex and high-risk issues* section below).

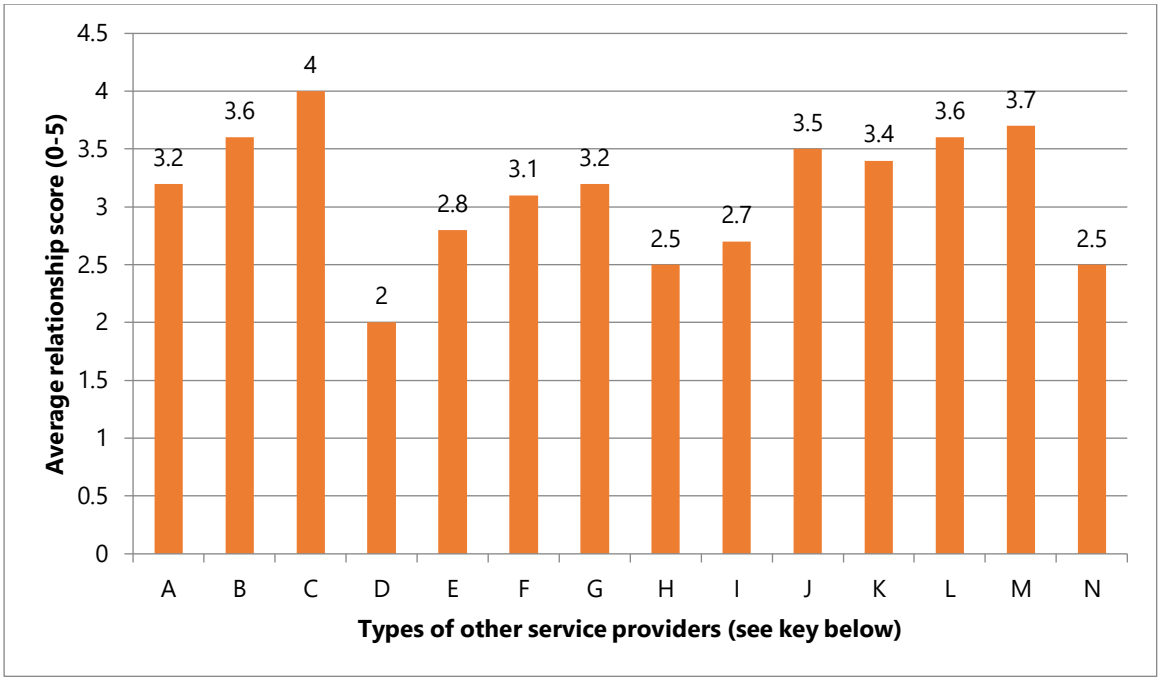

Figure 6: Relationships with other types of services and agencies (n=46): *Source Managers' Survey 2017*

Key to Figure 6:

A=GPs
B=Obstetricians
C=Mainstream maternity services
D=Physicians
E=Paediatricians
F=Domestic and family violence services
G=NGOs – e.g. Mission Australia,
H=Drug and alcohol services
I=Mental health services
J=Social workers
K=FaCS / Brighter Futures
L=FaCS Child Protection
M=Allied Health
N=Housing

The relationship between AMIHS services and general practitioners was moderate with an average score of 3.2. Interviews with stakeholders found that this partnership worked well in some case study sites whereas in others it did not work so well.

Element 5: Community development and health promotion activity

The SDM service element that relates to undertaking community development and health promotion[14] activity is a key factor that differentiates the AMIHS maternity service from other service models. It was also intended to be a key area of AHW leadership in the AHW/midwife partnership. Evidence on levels of AMIHS site community development and health promotion activity derive from an analysis of documentation, the Managers' Survey, and analysis of qualitative data collected from case study sites and stakeholder interviews.

[14] The terms 'health promotion' and 'community development' are frequently used in this report together, following to some extent how they are referenced in the AMIHS SDM. They are obviously different activities and they may be conducted together or separately. It is convenient to refer to them together since it represents a broad area of work that is somewhat unique to the AMIHS program approach to maternity services delivery.

The findings are somewhat inconsistent but in general point to variation between AMIHS sites in the level and nature of effort by the AMIHS workforce directed towards health promotion and community development activity.

Level of community development and health promotion activity

In the Managers' Survey, 65% of sites (n = 30) reported on the proportion of total work time that AHWs and midwives spend on health promotion and community development activities. Most of those 30 sites (n = 24) reported health promotion or community development activity being undertaken by one or both AHW and midwife. For those sites that provided a response, on average the AHWs spent 27% of their time undertaking health promotion and community development tasks, while the midwives spent on average 21% of their time.

For those sites where time distribution to health promotion and community development was not reported (35%, n=16), the non-response could be interpreted in one (or both) of two ways: (1) no separate time was allocated to health promotion and community development activity by either the AHW or the midwife at the site; (2) the manager completing the survey did not know the answer and therefore left a blank response (even though there might have been some allocation of worker time to these activities).

Normally, it would be common practice not to make an assumption about a non-response and certainly not to ascribe a value to non-response records. However, this element of the SDM is considered quite important by stakeholders, so understanding any level of variation between sites in level of activity is vital. Responses to other questions can be examined to guide thinking.

The other obvious question to examine is about dedicated budget allocation for health promotion / community development expenditure. In one-quarter of the sites (25.5%, n = 12) AMIHS staff had specific funds for community development and health promotion but only 19% (n = 9) of sites were able to indicate what proportion of the total AMIHS budget was expended on health promotion and community development. None of the sites that had a non-response to the question of staff time allocation (spread across all LHDs) had a dedicated health promotion budget, but nearly all answered the question "Describe how the service site funds and supports health promotion and community development activities". A common sentiment of these responses was as per the following response from one manager:

> *"The AMIHS service operates 3 days / week, and currently has 43 women to provide the service to. Although the service recognises the importance of community development, there is no time for this to occur. Additional funding would be required for this to occur."*

This exact same sentiment was widely reflected in the case study interviews. While community development and health promotion activity was widely understood to be a core element of the AMIHS SDM, most AHWs, midwives and even AMIHS managers across all AMIHS case study sites bemoaned the fact that it was not being addressed well. As one manager stated:

> *"They probably don't do anything more than the mums and bubs groups. Well, they don't do anything at this stage. Because given their case load and the days they work … "*
>
> *LHD worker #3*

As the quote above suggests, the most common reason offered is lack of time. One AHW offered:

> *"I know it sounds like a lame excuse and we keep saying that we don't have the time, [but] we don't have the time, we don't."*
>
> *AMIHS AHW #2*

Time obviously is a relative commodity and several interview respondents stated that within the time available clinical care is prioritised with clients:

"… as a midwife I'm always inclined to think it's more important to actually deliver midwifery care and – and so that always tends to take priority, yep."

AMIHS midwife #4

Workers were aware of the trade-off and impacts for prioritising clinical care but felt they were required to make a choice. As described by the same midwife:

" … the service has grown so much, the complexities have increased and I guess as a midwife even though I understand the importance of community development and allocating that time … when there are women who need antenatal care out there it's just really difficult to do … to do anything properly is the other thing, you know to – to be able to cross it all out [one-to-one care] and say this is what we're doing is really difficult."

AMIHS midwife #4

Types of health promotion activity

Types of health promotion / community development effort were classified according to the World Health Organization Ottawa Charter principles (WHO, 1986) (see Figure 7). Somewhat contradicting the finding described in the previous section, Figure 7 indicates that nearly every site (n = 44) reported conducting some form of health promotion and community development work.[15]

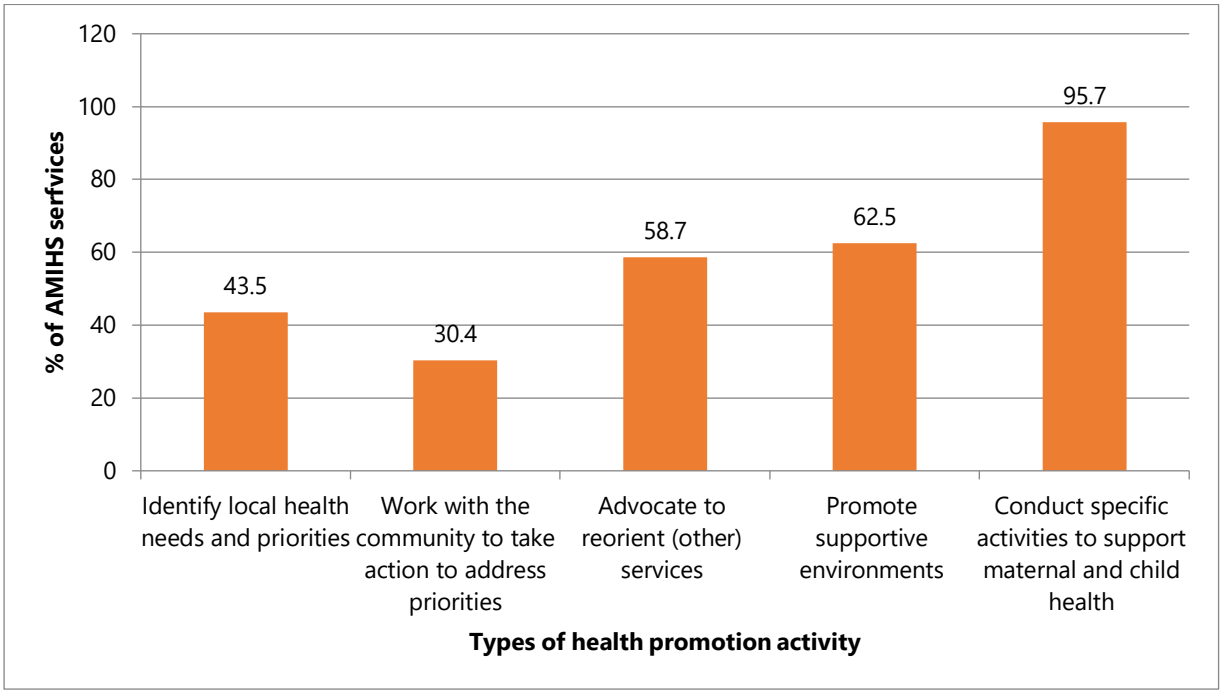

Figure 7: Prevalence of types of health promotion activity undertaken by AMIHS sites (N = 46): Source Managers' Survey 2017

The main type of community development and health promotion activity being undertaken by AMIHS sites, as identified by managers through the survey, was conducting specific activities to support maternal and child health. In health promotion terminology, these activities translate into 'health education'. Over 50% of sites also reported acting to 'advocate to reorient (other) services' and 'promote supportive environments'. Not all the types of health promotion activity defined by WHO are in fact required in the SDM, so some stakeholders argue these findings could suggest that sites are doing more than what is expected.

[15]Note: Figure 7 is not measuring the level of activity, but rather categorising what activity occurs.

The types of specific activities conducted to support maternal and child health are illustrated in Figure 8. The most common activities related to smoking cessation and breastfeeding education (both 93.5% of sites), child health information (86.9%) and nutrition information sessions (78.3%). Bellycasts were also done by many services as a way of connecting and building trust with mothers, promoting cultural pride and increasing positive engagement between the service and the local community. From the Managers' Survey data, it was not possible to measure the level of this health education activity, nor the extent to which it was provided as opportunistic health information as part of a clinical occasion of service or a structured education activity (undertaken for instance in a group setting).

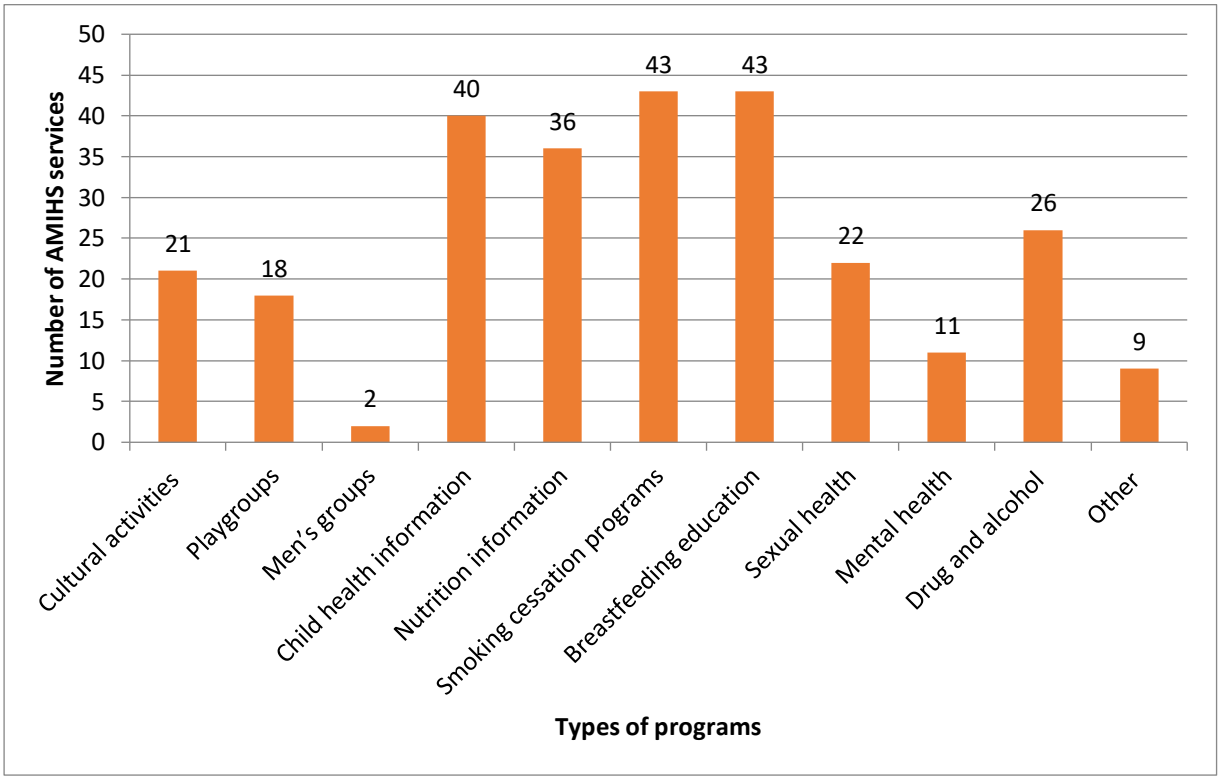

Figure 8: Activities offered by AMIHS sites to support maternal and child health (n = 46): Source Managers' Survey 2017

Most sites conducted these activities in partnership with other health services (e.g. CFH, mental health) (86.9%), NGOs (69.6%), local community groups (65.2%) or ACCHSs (63%).

Some insight into the inconsistent findings can be attained through the qualitative data. At most of the case study sites, AMIHS staff and managers interviewed reported that much of the health promotion and community development activity undertaken in the case study sites was opportunistic in nature and undertaken *within the clinical care activities*. These interventions were also considered to be unplanned and unstructured, as well as entirely dependent on the amount of time available during a visit. One LHD worker noted:

> *"With smoking it's about that contact and having time to have a conversation. When you're time poor, it's a quick discussion … so not going to work. It's the same as breastfeeding, it's having that discussion, it's having that time to mentor the woman, provide her with confidence – education takes time and always the first thing that gets time is the pregnancy care."*
>
> *LHD worker #10*

Across all case study sites AHWs talked about feeling rushed, going from one home visit or occasion of service to another with rarely enough time to talk with the mothers and provide more information. They were concerned that there was not enough time to go through information and ensure that it is understood by the client. Sometimes the rush was due to time constraints, and other times AHWs felt

it was due to the midwife taking the lead during client visits and giving primacy to the 'clinical' activities. One service manager recognised the issue:

> *"During a home visit, workers need to take more time to build relationships with women. I don't think that is ever factored in to the number of clients we see."*
>
> *Other AMIHS staff #6*

Where health promotion was undertaken outside of clinical care, it was noted by AMIHS staff to be primarily through community events such as National Aborigines and Islanders Day Observance Committee (NAIDOC) celebrations and Walk a Mile Koori Style activities. One service talked about engaging with the community via social media platforms. Most of the activities reported by AHWs outside of clinical care were group education and information sessions. One client recipient described the health promotion activity that she participated in as:

> *"Yeah, like nutritional values of meals, and things like that or health and safety about baby things, we do group sessions, like we'd meet at [name of service] for about an hour or two and do things."*
>
> AMIHS client #21

Some activities were reported by some stakeholders to be easier to implement than others. Many AMIHS staff reported in the case study interviews that addressing smoking behaviour was particularly difficult, whereas some staff felt activities that involved a range of health and social benefits such as walking groups were often easier to attract and retain participation. One case study site started a walking group in collaboration with the Q4NL program which staff and clients at the site felt was very successful. On repeating the activity, the AHW found:

> *"… we didn't have to pick them up. They all turned up. So, I could see that they were really interested and motivated to do it. That was the really good thing about it. Whereas, sometimes at appointments, especially with smoking, we've got to drag them, practically. But, with the walking group, they'd turn up without fail."*
>
> AMIHS AHW #5

One father also talked about how much his partner loved the social and fitness activity of the mums and bubs walking group and expressed a desire for something similar for fathers:

> *"Yeah – that group is for the women, but I keep saying 'when's there gonna be a men's walking group?!' This time around I am really into being a hands-on dad for my kids and I think it's good for men to have the chance to talk too. We all want to quit smoking and get healthy but it's hard – this would be something that would work well on a whole lot of levels."*
>
> Community member #15

Leadership of community development tasks

For a range of community development tasks, managers were asked if the task was led by the AHW, the midwife, or if leadership was shared. According to the SDM, ideally the AHW would have a leadership role in these types of tasks.

For those sites where data were provided (ranging from 21 to 26 sites), most often the leadership was shared by the AHW and midwife (Table 4). For each of these questions, almost 50% of managers responded, 'not applicable'. It is not known if a 'not applicable' response meant the activity was not undertaken at the site or the manager did not have sufficient information to provide a response.

Table 4: AMIHS team member leadership of community development (n=26)

Community development task	Led by the AHW	Led by the Midwife	AHW and the midwife undertake task together
Engage with Aboriginal families in the community and support women to access AMIHS (n = 26)	15.4%	3.8%	80.8%
Develop and implement community development activities (n = 21)	19.1%	9.5%	71.4%
Facilitate community participation in program planning and/or evaluation (n = 23)	21.7%	8.7%	69.6%

Source Managers' Survey 2017

Desire to do more

AHWs in general expressed a strong desire to have more opportunities to do health promotion and education, such as providing smoking cessation and breastfeeding support and information in group settings. There was an acknowledgement, though, that this type of work, and especially community development, required a lot of planning and resource development, and therefore commitment of time.

In those sites where an investment in time had been made, AMIHS workers and managers could see the benefit. One midwife noted the benefit of a relatively newly formed reference group to increasing community influence. On the same reference group, an AHW commented:

> *"… It is now well established and meets at the [name of location] for a nice lunch...and yarning about the service and what the community needs. So successful that it is now being called on by the LHD manager to provide input to the hospital upgrade planning."*
>
> *AMIHS AHW #7*

Element 7: Supporting workforce development and learning

Service staffing

The original funding guide for the SDM was that each service[16] be established with one full-time equivalent (FTE) each of AHW and midwife, managing approximately 60 families per year. In 2016-17, AMIHS managers reported that the number of AHWs in AMIHS sites ranged from a low of 0.1 FTE to a high of 3 FTE[17]. On average, each service had 0.76 FTE AHWs. The number of midwives ranged from 0.15 FTE to a high of 4.6 FTE. Total staffing (AHW and midwives) ranged from 0.35 FTE to 5.4 FTE. These staffing figures are strongly influenced by the anticipated number of pregnancies for each site (e.g. a low FTE figure for either the AHW or midwife was characteristic of a site located in a very rural or remote location with low birth numbers). The perceived adequacy of these staffing arrangements based on analysis of case study data is discussed in the *Staffing resources* section below.

[16] There are more AMIHS sites than funded 'services' as the allocation of sites is based on local planning by LHDs and ACCHSs.

[17] Site FTE figures have been drawn from annual reports submitted by each site and, as far as could be determined from the information provided, indicate the intended FTE level rather than current staffing levels.

Most commonly, the FTE ratio for AHWs and midwives was equal (56.5%, n = 26) as per the model specification, but for equal numbers of AMIHS sites (21.7%, n = 10), the ratio favoured either AHWs or midwives (see Figure 9). There was no data to indicate whether the ratios adopted were contextually appropriate or impacting on outcomes.

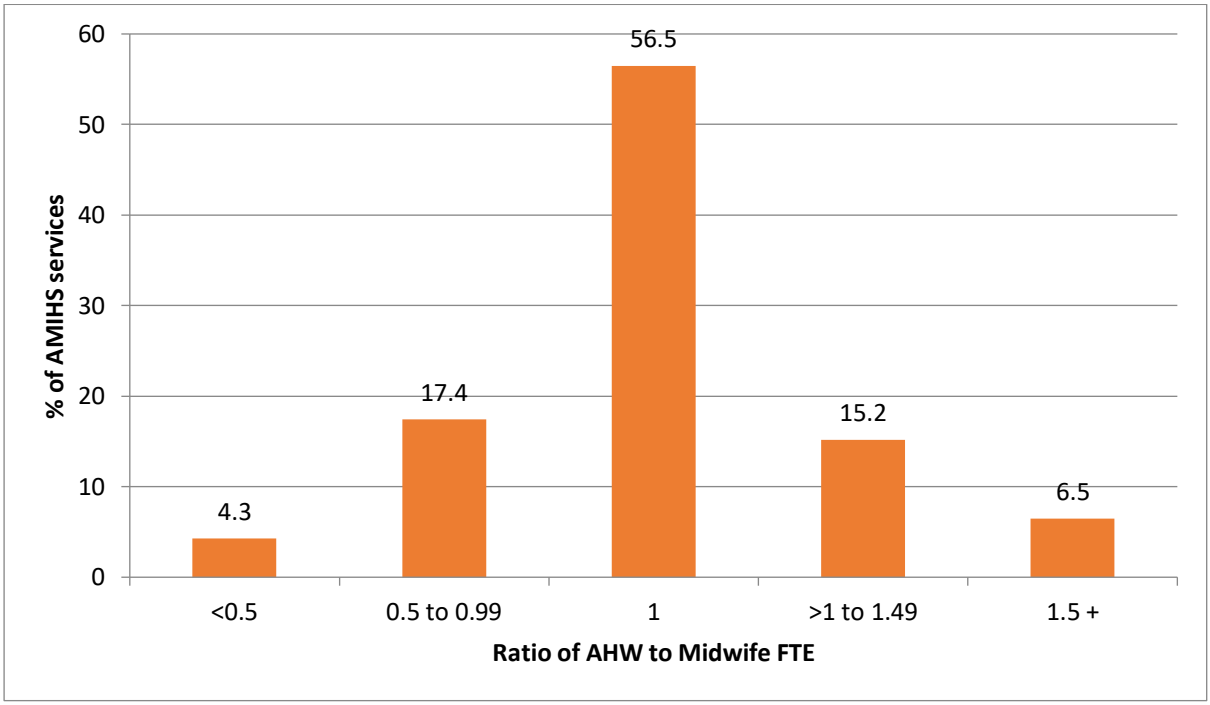

Figure 9: Ratio of AHWs to Midwives for AMIHS sites (n=46): Source Managers' Survey 2017

In 12 of the 46 sites, staff other than the AHW employed to deliver the AMIHS program were identified as being Aboriginal. This included the midwife in three sites. In other sites, persons were identified who might not be employed through the AMIHS budget but were integral to its effectiveness, including an Aboriginal Health Manager and AMIHS Team Leader, Aboriginal Programmes Coordinator, AHW Health Promotion Officer and Aboriginal Family Support Worker.

Managers reported that in the previous 12 months, there had been vacant positions in 54.3% (n =25) of the AMIHS program sites. In most cases where there was a vacancy (18 of 25 service sites), the vacancy involved an AHW and was vacant between 3 and 8 months. In 11 service sites, a vacancy for a midwife had occurred, with vacancy periods being of similar length to that of AHWs. In nine service sites (20%), there was a vacancy for both the AHW and midwife.

In the past five years, 58.7% (n=27) of AMIHS sites reported experiencing difficulty recruiting and/or retaining staff; 19.6% (n=9) for AHWs, 26.1% for midwives (n=12), and 13% for both (n=6). Survey respondents provided more information about some of the factors that they felt made it difficult to recruit and/or retain staff including (in no particular order):

- remoteness of the work
- availability of suitably qualified staff (e.g. locally, suitable qualifications)
- difficulties with working relationship between the AHW and midwife in some sites
- delays in recruitment processes
- attractiveness of work conditions and requirements (e.g. part-time hours, limited professional advancement pathways).

Staffing adequacy

There was strong agreement from most AMIHS staff, managers and some LHD staff in case study sites that the number of staff to client caseloads was often insufficient to meet the needs of, and numbers of, clients. Stated one observer:

> *"Unequivocally no, we do not have enough staff. For the number of births that we see, and I think if you looked at the ratio of midwives to number of births, if we were only going to do four per month, we would be way over that."*
>
> *Other AMIHS staff #3*

This was sometimes observed by stakeholders to be the result of inappropriate or inflexible allocation of staff resources. One midwife observed that the caseload in her site was almost double that of a neighbouring site with similar staffing levels and that the workload seemed more manageable for the neighbouring team as a result.

Some stakeholders also observed what they considered unfavourable staffing levels in comparison with other maternity services. The AMIHS client population was described by many stakeholders as having a higher proportion of clients experiencing multiple complexities. One manager framed the comparison with other services as follows:

> *"In terms of staffing, the expectation of what we do, we've got an expectation to do all this community work and we end up with a case load of women equivalent to well women in mainstream maternity, if not higher, and we're supposed to be doing community stuff as well as midwifery care, we run our own antenatal class, etc. When you look at the ratio of clients, we have to factor in community development which requires a lot of planning, resources development, AHWs are asked to review cultural appropriateness which all takes time. During a home visit, you need to take more time to build relationships with women; I don't think that is ever factored in to the number of clients we see."*
>
> *Other AMIHS staff #1*

At another site, one stakeholder talked about an existing mainstream community midwifery model that had been established to support women and families with a similar range of complex needs but with perceived superior resources support.

> *"There is a maternity model of care, [name of service], to look after vulnerable families. Their numbers are based on 20-25 to one FTE of midwife - there are actually similarities between it and AMIHS. The clients are very similar to a lot of ours – high medical needs, high psychosocial needs. They provide antenatal care, postnatal care up to six weeks. Exactly the same but with a much smaller caseload."*
>
> *AMIHS midwife #10*

Overall, based on the case studies, the rationale or formula for how AMIHS staff and FTE is allocated and managed is unclear. Some sites reported that client numbers were not 'capped' - that is, all referrals were accepted by the service. Other sites talked about taking on additional clients due to the temporary closure of an AMIHS in a neighbouring area. Yet, in that case as described by one AHW, there was no change in staffing hours:

> *"Since I've started in this role, I have said I really want to increase my hours. I've written letters and I've always been told no. I've said that it's not fair for the women, that they don't get that."*
>
> *AMIHS AHW #9*

One manager suggested that the expected ratio of AMIHS staff to clients needed to be clarified to assist sites with workforce planning:

> *"…if there was some sort of consistent framework to draw on then you can say, well actually we don't have this level of staffing or ratio and then we can manage those issues."*

Other AMIHS staff #2

However, currently such clarity was not evident to AMIHS staff and managers and services in the case study sites and, in some instances, it was suggested by stakeholders that fidelity to the AMIHS model was being compromised.

Implications of insufficient resources

The consequence of insufficient staff levels is invariably, if service volume is not reduced, a reduction in time available per unit of activity. One midwife noted that time pressures made providing clients with anything more than antenatal care quite difficult. Another midwife also felt that time was a critical feature of providing a culturally appropriate service where it was necessary to take time to support clients in ways that were meaningful to them:

> *"We do have to be good time managers, but we can't be regimented with Aboriginal health because there are so many social vulnerabilities. There are a lot of strengths too, there's so much for us to learn of what families are doing well."*
>
> *AMIHS midwife #3*

Some AMIHS staff also talked about feeling frustrated that they were unable to deliver support and services according to the prescribed model. Several AHWs talked about feeling ineffective and disempowered in their role because they did not have enough time with clients. Health promotion and education, key responsibilities of the AHW role, were often the first things to be left out. The inability to properly deliver the service was also described by one midwife:

> *"…so, if it was run the way the delivery service plan says, that provides flexible continuity of care, I believe we would get far better outcomes in terms of women coming to their appointments, being more educated about their birth, perhaps having a better birth… improving our breastfeeding rates. But I feel because of the inconsistency and the lack of time…I think we could do a lot more if we had more time to run it as it says [in the model]."*
>
> *AMIHS midwife #4*

One example of a health outcome that many believe could be improved through increased resourcing was smoking cessation. The challenge to address smoking was clearly articulated by one LHD worker, who reported that funding for the Q4NL program ceased at the end of 2016 (this occurred across all LHDs) and the consequent expectation was that smoking cessation would be absorbed by the AMIHS program:

> *"… Quit for New Life program, if it was to be provided as designed you would offer [NRT] at each antenatal visit. That's fine, but if you offer NRT and the woman accepts, gold standard is that she is followed up three, seven days etc. Those above us say 'it's just part of routine care'. Well it's no longer part of routine care because she's not scheduled for an antenatal visit then. So, it's the time to make a follow-up phone call, how's NRT, etc."*
>
> *LHD worker #10*

This example underscores the potential limitation of AMIHS to address these important health outcomes and behaviours if there was the pressure of time and limited resources.

Distribution of responsibilities

The AMIHS SDM states that an "effective partnership between the AHW and the midwife is essential", most commonly interpreted as the team members being equal partners with different responsibilities. The SDM provides limited guidance on where each of the partners should lead, but the AMIHS Workforce & Recruitment Strategy (NSW Health, 2008) suggests through the role description that the AHW should take the lead in:

- providing social support to women and families

- working with Women's Reference Groups or other forms of community consultation
- initiating and carrying out community development and health promotion initiatives
- working with acute maternity services to provide culturally appropriate services
- representing the voice of Aboriginal families on local and area-wide committees.

Managers for each site were asked about which client support and advocacy tasks were led by the AHW or the midwife or if they worked together. For most of these tasks, most of the AMIHS sites indicated that leadership was jointly held between the AHW and the midwife (see Table 5). There was more leadership by AHWs for the tasks "Provide social support to women and families" and "Accompany women to appointments". However, these tasks were still predominantly jointly managed. The task "Provide antenatal and postnatal education and support" was predominantly led by the midwife.

Table 5: Leadership distribution of client support & advocacy tasks (n=46)

Types of community development / health promotion tasks	AHW leadership	Midwife leadership	Jointly managed	Not applicable
Provide antenatal and postnatal education and support	2	25	18	1
Provide social support to women and families	16	2	27	1
Identify appropriate referral pathways and facilitate women accessing services	1	9	35	1
Accompany women to appointments	18	3	24	1
Assist with client communication (e.g. interpreting medical terminology)	7	7	31	1
Develop and monitor case plans	0	22	23	1
Conduct hospital liaison visits with women in the antenatal and/or postnatal period	9	7	26	4
Attend when women are birthing	1	6	10	29
Participate in shared postnatal visits with CFH nurse	9	4	22	11

Source Managers' Survey 2017

Managers were also asked about the number of service development tasks that were led by the AHW or the midwife or if they work together to perform the tasks. Like the other types of tasks, sites mostly indicated that the tasks were jointly managed (see Table 6). Some tasks, if not undertaken jointly, were more likely to be led by the AHW (e.g. "Develop and maintain effective links with local ACCHS", "Advocate for Aboriginal women and families") and others were more likely to be led by the midwife (e.g. "Develop and maintain effective links with mainstream health services", "Conduct data collection").

Table 6: Leadership distribution of service development tasks (n=46)

Types of community development / health promotion tasks	AHW leadership	Midwife leadership	Jointly managed	Not applicable
Develop and maintain effective links with local ACCHS	15	5	19	7
Develop and maintain effective links with mainstream health services	0	15	30	1
Develop and maintain effective links with other agencies (government and non-government)	3	6	35	2
Conduct data collection	5	19	21	1
Participate in program planning and evaluation	1	7	36	2
Work with mainstream maternity services to provide culturally appropriate care	5	5	34	2
Advocate for Aboriginal women and families on local/area-wide committees	14	2	25	5

Source Managers' Survey 2017

The observed division of leadership was broadly in line with that envisaged and described in the AMIHS SDM and the AMIHS Workforce and Recruitment Strategy (NSW Health, 2008), with AHWs taking leadership for community-related tasks and the midwife leading clinical / technical maternity tasks and for relationships with the broader health system and its operating 'culture'. Perhaps the one area of prescribed AHW leadership that was not currently well developed was working with mainstream maternity services to provide culturally appropriate services.

AMIHS working relationships

A perspective on the working relationship between the AHW and midwife at each AMIHS program site was sought through a range of statements that requested a response in the form of strongly disagree (1), disagree (2), neither agree or disagree (3), agree (4) and strongly agree (5). The mean scores for each of the aspects of the working relationship are detailed in Figure 10 (note: a 'not applicable' response was allocated a zero score).

The findings from the survey overall indicated strong alignment with the SDM's proposal for there to be a high degree of equality between the AHW and midwife partners, with scores mostly between 4 and 5 (strongly agree to the two being equal). The strongest areas of agreement (4.5 and 4.6 respectively) were in relation to the AHW and midwife having equal access to training and professional development provided by the TSU and the AHW and midwife having equal access to cultural awareness training.

The lowest level of agreement (3.5 and 2.7 respectively) related to the AHW and midwife having equal access to clinical supervision and the AHW and midwife having equal access to cultural supervision. Data from interviews at the case study sites indicated that clinical supervision for AHWs was poorer than for midwives and cultural supervision was limited for both workforce types.

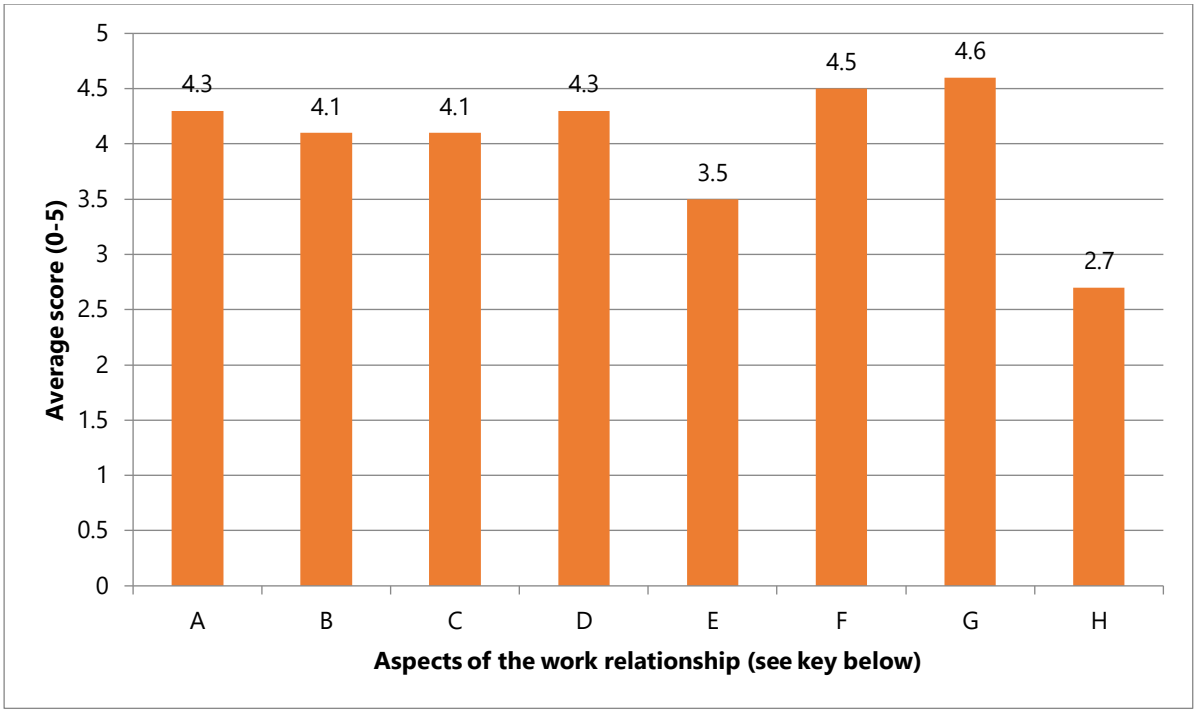

Figure 10: Average rating of the relationship between AHW and Midwife on a range of work aspects (n = 45): Source Managers' Survey 2017

Key to work relationship aspects

A=The AHW and Midwife have an effective working partnership
B=The AHW and Midwife participate in team building activities
C=The AHW and Midwife have access to prompt and effective conflict resolution
D=The AHW and Midwife have equal access to educational opportunities required to support them in their roles
E=The AHW and Midwife have equal access to clinical supervision
F=The AHW and Midwife have equal access to training and professional development provided by the TSU
G=The AHW and Midwife have equal access to cultural awareness training
H=The AHW and Midwife have equal access to cultural supervision

Learning and development of AMIHS staff

The AMIHS SDM outlines a number of mechanisms and requirements for supporting both on-the-job and off the job learning and development needs of AMIHS staff. This includes an orientation program, assessment of skills, professional development opportunities, training in community development, time and access to AMIHS forums and regular clinical supervision. These requirements are the responsibility of both the employers (LHDs and ACCHSs that manage each AMIHS site) to ensure individual learning and development needs are met along with specific off the job providers of learning experiences such as the TSU, run by HETI.

Within the case study sites there was a broadly held perception that workforce development needed to be improved.

Off the job learning opportunities provided by the TSU

At a statewide level, the Ministry funds HETI to operate the TSU, which provides additional education and training for AMIHS staff. The TSU training and development model is underpinned by distance learning methods and an online course (*Strengthening Foundations* which targets new employees),

regular webcasts (structured one-hour panel discussions to which participants can put questions) and at least one face-to-face workshop (approximate 1-2 days).

The *Strengthening Foundations* course[18] consists of four modules specific to Aboriginal maternal and child health as follows:

- Working with Aboriginal mothers & families (Module 1)
- Emotional health of mothers & children (Module 2)
- Health & wellbeing during pregnancy (Module 3)
- Supporting healthy babies & children (module 4).

Interviews at all six case study sites indicated that AMIHS staff felt that the current TSU supports and activities: (1) were insufficient for the workforce needs, and (2) were not being regularly and uniformly utilised. In regard to the latter point, while statistics are kept by the TSU on the number of people who have completed different training programs, it was noted by stakeholders that because the data was not kept as unit personnel records and statistics are reported in aggregate form, it was not possible to accurately confirm who had and had not received training (even basic orientation training).

Much of the current feeling has been generated by changes to the Service Agreement between the Ministry and HETI over time and because for a period there had been additional funding available from the Australian Government. These changes have therefore resulted in changes to TSU staffing and approaches to training and support over time. In the past, the TSU used a model that involved more face-to-face training, a lot of site visits, local training events and some clinical supervision for AHWs (managed by a social worker within the team). In the case study interviews, some AMIHS staff and managers noted their preference for this earlier model because it allowed for more additional support and personalised skill-building.

Other off the job learning opportunities

LHDs and ACCHSs, as AMIHS site employers, have a responsibility to develop and maintain the competencies of their staff.

Many AMIHS staff in the case study sites expressed the view that the LHDs had not uniformly shouldered this responsibility to the extent that would provide them with the training and development they felt was needed. One AHW felt that it was difficult to access training because of LHD funding constraints:

> *"I've asked for the last four years, drug and alcohol, drug and alcohol is a huge thing and I think you can never have enough training especially as an AHW, but everything costs money and you've never got the funds to do anything."*
>
> *AMIHS AHW #3*

One midwife similarly expressed the view that, because of difficulties in arranging for backfilling of her position, it was challenging to seek off the job learning experiences:

> *"They try to arrange staff relief from the hospital for the midwives but there are few midwives willing to do it and even then people tend not to want to come back – the whole paradigm of working in the role is very different to what people do in the hospital or even antenatal clinic and working in cultural ways requires a lot of skill – many people are freaked out by that and not well prepared. … Staff from the hospital are also not used to practising in a way that involves extended family being present, which is a strong cultural expectation in the community."*

[18] This course also targets staff in the Building Strong Foundations for Aboriginal Children, Families and Communities Program (BSF), an early childhood health service for Aboriginal families in NSW.

AMIHS midwife #3

However, staff in at least one case study site reported good access to learning and development opportunities. For instance, an AHW in that site felt that she had been given many learning and development opportunities:

> *"I've been given opportunities since being here, grad dip in Indigenous health promotion. Given study leave and used my leave, and recently went on secondment, there are great opportunities."*
>
> *AMIHS AHW #6*

Some stakeholders perceived that midwives received or had access to more training opportunities than AHWs. Nevertheless, some midwives believed they were not able to get the training support they needed particularly in relation to addressing and managing psychosocial issues that are not traditionally with the scope of midwifery. As described by one midwife:

> *"There has been education on trauma, but we need more information and education, the whole of health needs more information on trauma-informed care. It's loosely thrown about but I'm only just getting to grips with it."*
>
> *AMIHS midwife #6*

More opportunities are needed to develop cultural competence

A common concern expressed by some stakeholders, particularly AHWs, was that there was a training gap for some midwives in developing their competence in understanding of and working with Aboriginal people.

> *"We need more cultural training for clinicians – midwives and CFH nurses …. They get one training course … one-hour face-to-face but this is not enough. Would be good to have some in-depth training. We have had clinicians (including an AMIHS midwife) talk to families inappropriately, the language they use, medical terms, pushy manner."*
>
> *AMIHS AHW #4*

While many midwives in case study sites talked about the need for development of clinical maternity skills, some were equally concerned about developing what they termed "cultural competencies". Midwives and other stakeholders interviewed reflected on the challenges of working closely and intensively with clients which could be a steep learning curve for all involved. Because the AMIHS mode of operation requires a high degree of trust between clients and the AMIHS teams and most midwives employed in AMIHS at present are non-Aboriginal, ongoing training and support was therefore required.

> *"… [AMIHS midwife] made some mistakes at the start and people really picked her up on things. But she bounced back and learned the lessons and now I reckon she could teach a training course in cultural competency, she's that good at it."*
>
> *LHD worker #1*

The NSW-wide cultural awareness training initiative - 'Respecting the Difference' was mentioned at all case study sites. Although it was welcomed, it was generally regarded as insufficient in relation to frequency and depth by some stakeholders. As noted by one AHW:

> *"… [we need] better cultural training for the workers [midwives]. Every six months and something different every six months. It needs to be an ongoing program."*
>
> *AMIHS AHW #6*

One hospital clinician felt that the 'Respecting the Difference' training was sufficient compared to other online modules but felt that more face-to-face training was required more generally:

> *"They're [hospital staff] supposed to do face-to-face cultural awareness training, but we ran a face-to-face maybe five years ago and there's been none since. And I know there are issues at the district level, getting presenters to do it and there's a whole lot of problems at that level that's making it difficult."*
>
> *LHD worker #17*

Clinical supervision of AMIHS staff

In the case study sites, the primary form for creating on-the-job learning experiences was through clinical supervision processes[19]. Clinical supervision is identified as a key element in the implementation of the AMIHS SDM, which indicates:

> *"Clinical supervision is an ongoing regular process that allows time to explore a practice experience, learn from experience and prepare for future similar situations … face-to-face clinical supervision is ideal and this can be provided in a number of ways either individually or as a group."*

Despite this requirement, as with learning and development needs, several case study and statewide stakeholders reported that there was very limited clinical supervision being made available to AMIHS staff, particularly for AHWs.

It should be noted here that the terms 'clinical', cultural supervision, practice supervision or professional supervision were sometimes used interchangeably by some AMIHS staff and managers. [20] It was not always clear if these terms were perceived by stakeholders as similar or different processes. However, at some case study sites, some AMIHS staff expressed explicitly a need for cultural supervision[21] to manage their impacts of dealing with sensitive or traumatic experiences of clients, for example mandatory reporting for child protection issues. Several AMIHS staff termed these experiences as vicarious trauma.

The lack of available clinical supervision and training often left AHWs feeling undervalued in their roles and with little acknowledgment for the challenge of their role of working in two 'worlds' - that of the Aboriginal community and the professionally dominated health services.

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[19] The term 'clinical supervision' can take on many meanings, but an appropriate definition for how it is used in this report is as follows: "*Clinical supervision is a formal and disciplined working alliance that is generally, but not necessarily, between a more experienced and a less experienced worker, in which the supervisee's clinical work is reviewed and reflected upon, with the aims of: improving the supervisee's work with clients; ensuring client welfare; supporting the supervisee in relation to their work, and supporting the supervisee's professional development*." See: http://www.clinicalsupervisionguidelines.com.au/definition-and-purpose
In some circumstances the work of the supervisee is not 'clinical' then the term sometimes preferred is 'practice supervision'. In this report the two terms are synonymous, but only the term 'clinical' supervision is employed. This definition is consistent with that used in the AMIHS SDM.

[20] For consistency the term clinical supervision is used in the report for both midwives and AHWs.

[21] Cultural supervision can be defined as "…the process of being with a skilled, experienced and wise person who respectfully, caringly and honestly supports a worker to reflect on their work in a meaningful way, learn and grow as an Aboriginal worker in the context of working with community." (Victorian Dual Diagnosis Education and Training Unit, 2012, pg. 6). Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) (2016, pg. 8) also describe cultural supervision as *"…a co-created process, grown and developed by an ongoing, professional and collaborative conversation between a worker and their manager (or nominated person)[1], which is culturally-grounded"*. 'Culturally-grounded' supervision is viewed as a necessity to support Aboriginal staff to draw on their local knowledge of connections to family, community, country and culture while working in demanding contexts of loss and grief connected to the history of colonisation and forced removal of children from their families (QATSICPP, 2016).

"…there really is no model for us (AHWs) clinical supervision so it just gets left in the 'too hard' basket."

AMIHS AHW #4

Even though midwives were widely perceived in the case study sites to be able to access clinical supervision more readily than AHWs, several AMIHS midwives interviewed felt under-supported and were at risk of feeling undervalued and under pressure. This was especially the case for Aboriginal midwives, as reported by one AMIHS midwife who witnessed the impact on an Aboriginal midwife at the site who needed to be coached properly and given the opportunity to progress at an appropriate pace to avoid rapid failure and burn-out. In such cases there can be an inclination to put the blame back on the individual and claim they were not ready:

"… They want Aboriginal midwives, but support is needed. I'd be glad to leave my place knowing that there was an Aboriginal midwife in my position."

AMIHS midwife #8

There were some examples of good supervision reported by some of the case study sites, but they tended to depend on the enthusiasm and priorities of individual managers. At one case study site, for example, one manager noted that a maternity manager was very good at supervising both midwives and AHWs but did it informally and "out of the goodness of her heart", which meant that it was largely unsustainable.

Some AHWs reported they had developed informal mentor or peer networks where they could "pick up the phone" and talk through difficult issues or debrief emotional work situations. While this was reported to be helpful, AHWs felt this was not an appropriate substitute for more formal and sustained development structures.

Some midwives were able to access clinical supervision through mainstream maternity services, but there were few local options for AHWs. At some sites, AHWs reported that direct managers did not always understand the need and or importance of an external process. At other sites, where managers where supportive of clinical supervision, the cost of obtaining external supervision could be prohibitive to provide on an ongoing basis.

"Supervision for AHWs requires paying someone external, very expensive, therefore has been sporadic … Internally there is no appropriate cultural supervision but plenty of clinical supervisors, so we leave it open for people to have supervision or not."

Other AMIHS staff #2

Career development and recognition of AHWs

Some stakeholders felt that professional development and clinical supervision needed to be focussed on improving the current roles of AHWs as well as encouraging long-term career development and pathways. Several stakeholders felt that this was particularly important for AHWs because it was felt that they had less scope in their current role and less infrastructure to draw upon to advance their careers compared to AMIHS midwives.

As one statewide stakeholder suggested:

"The outcome that the [organisation] would most like to see is AMIHS being used as a breeding ground for more development of Aboriginal midwives … [the AMIHS program] should be a career pathway objective of employers."

Statewide stakeholder #4

At an operational level, an AMIHS manager expressed a similar sentiment:

> *"In my position I offer what support I can to the AMIHS staff. There is no supervision for the AHWs. Recruitment and retention of AHWs is difficult as there is no career progression, wages are less than positions in other sectors and training resources are scarce … we should be looking to home-grown AMIHS staff who bring their life experience within a cultural context. The specific AHW skills and midwifery skills can be taught and nurtured."*
>
> *Other AMIHS staff #1*

Some stakeholders in case study sites (both Aboriginal and non-Aboriginal) also expressed the view that 'white fella' management structures prevailed in most LHD settings and were partly responsible for difficulties experienced and reported by AHWs. In their view, the structures did not prioritise or value the role of AHWs and therefore training and clinical supervision of AHWs appeared not to be prioritised.

A possible solution to change these management structures was suggested by an AHW:

> *"We need less white management and more Indigenous management. They might well need to tweak the criteria – for instance, look at life skills – if you can demonstrate the skills then help people to get the qualifications needed to be in management. You go up the food chain here and it stops - it's all white."*
>
> *AMIHS AHW #10*

Element 8: Building and sustaining effective community partnerships

Managers indicated through the survey that a majority of AMIHS sites (89%, n=41) had consulted the community in the past 5 years, with most consultation being unstructured (89%, n=41).

Structured consultation was undertaken by 21 (45.7%) of the sites. Of those sites that reported conducting structured consultation, the most common type was through formal reference groups that had been established to support the AMIHS program (30%, n=6; that is 13% of all AMIHS sites). Other types of consultation (21.7%, n=5) included surveys, attending local community events, and joining broader planning forums for Aboriginal health services.

Structured consultation was largely undertaken on an irregular or ad hoc basis (47.7%, n=22). Of those who did meet regularly (n=11), 36.4% met with the community monthly or more, and the rest undertook structured consultation on a quarterly, half yearly or annual basis.

AMIHS sites (n=46) reported consulting (in a structured or unstructured way) with community members (78.3%), playgroups (63%), women's groups (58.7%)[22], Aboriginal Community Controlled Services (30.4%) and Land Councils (21.7%).

Women's Reference Groups are proposed in the AMIHS SDM as an important strategy to promote and support effective community partnerships. The survey results indicated that 23.9% (n = 10) of AMIHS sites had a Women's Reference Group; 23.9% of sites indicated there had been one but that it no longer met, and 52.2% (n = 22) stated there never had been a Women's Reference Group. Facilitation of existing AMIHS Women's Reference Groups or other AMIHS related Reference Groups was normally undertaken by both the AHW and midwife.

Self-rating by the sites for the effectiveness of their consultation with their local community indicated 46.5% (n = 20) rated themselves as effective or extremely effective in their community consultation. As illustrated in Figure 11, a further 11.6% thought they were ineffective and 41.8% considered themselves neither effective nor ineffective. This placed the average AMIHS site as having moderately good community consultation ratings, a finding that was at odds with some of the case study data.

[22] This includes but is not restricted to formally established AMIHS-specific groups.

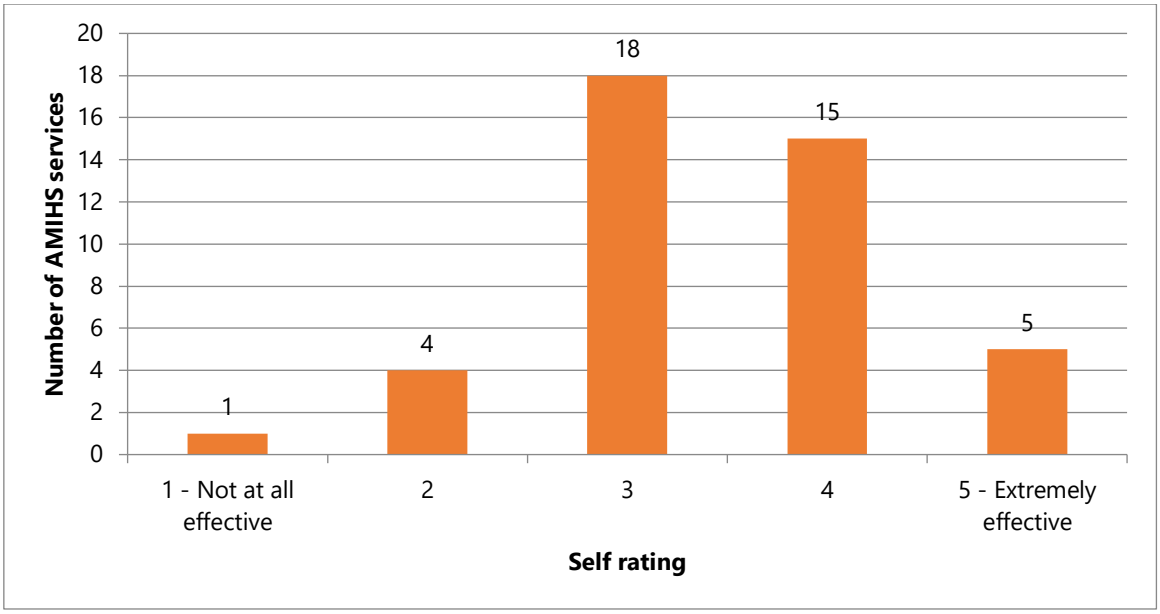

Figure 11: Distribution of AMIHS sites by self-rating of community consultation on a scale from 1-5 (n = 43): Source Managers' Survey 2017

Element 9: Evaluation and monitoring

Most AMIHS sites, according to the Managers' Survey (84.7%, n = 39), had a system for regularly collecting information about the AMIHS program and measuring how it was tracking against the aims, objectives and performance indicators of the AMIHS SDM. This was done through one or more data collection processes as shown in Figure 12. The most common information collected was program/client data (100% of those who responded to this survey item), followed by client feedback (separately collected, 54%, n = 25) and staff feedback (41%, n = 19).

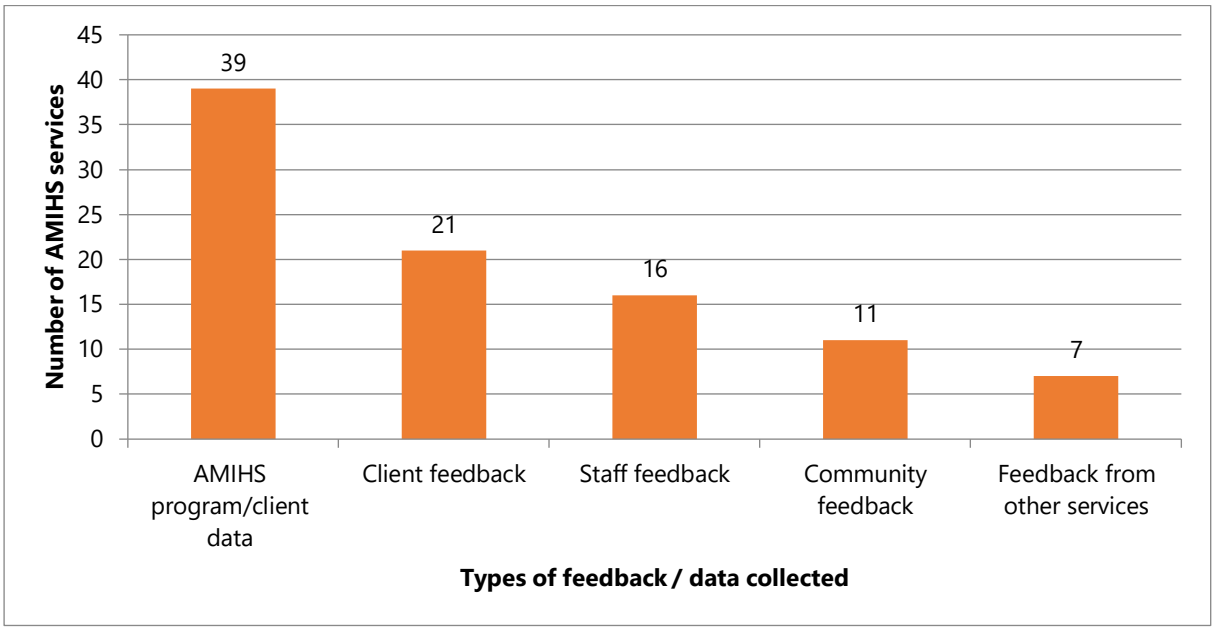

Figure 12: Methods of data collection sources to monitor & track program performance (n=39): Source Managers' Survey 2017

The most common use of collected data was to report back to the LHD and/or the Ministry (94.9%, n=39) and to improve the AMIHS program (76.9%, n=39).

Evaluation Objective 3. Investigate the extent to which AMIHS is reaching its target population

AMIHS is well placed to support clients experiencing complex and high-risk issues

Stakeholders at the case study sites talked about supporting many women and families who were living healthy and stable lives and who only needed the standard antenatal and postnatal support as prescribed by the SDM. However, stakeholders reported that there were also many clients accessing AMIHS who were experiencing complex and high-risk issues and who required more complex, intensive and sustained support from AMIHS staff. High-risk issues included mental health and drug and alcohol issues, as well as experiences of domestic violence and intergenerational trauma.

AMIHS staff often felt that there were many challenges to coordinate and deliver specialist services and support in addition to antenatal and postnatal support. Yet, stakeholders talked about how AMIHS staff strived to provide holistic and wrap-around support which often involved a collaborative and coordinated approach with partnering agencies.

Clients and community members with a range of complex experiences reported feeling supported through the AMIHS program because of being able to access a range of activities and services. But, as reported by AMIHS staff and managers and other stakeholders, there were also limitations to the support that could be provided or the outcomes that could be achieved.

Importantly, AMIHS was described as ideally placed to support clients experiencing high-risk issues, particularly to address child protection issues through early intervention strategies. The AHW was acknowledged as being pivotal to develop such strategies.

Types of complex and high-risk issues experienced by clients

The most common high-risk issues reported at all case study sites were mental health issues, drug and alcohol use, domestic violence, homelessness or unstable housing, young parenthood, or a lack of family support or networks. Many of these issues were often observed as occurring concurrently and the interaction between the multiple issues was seen to increase the vulnerability of clients.

As noted by one AMIHS manager:

> *"The majority have some vulnerability, medical or psychosocial or past history and so a lot of them are high-risk pregnancies…."*
>
> *Other AMIHS staff #2*

Mental health issues were cited as being one of the most common high-risk factors experienced by AMIHS clients across all case study sites, with depression and anxiety being the most common. Some clients also talked about experiencing postnatal depression. Stakeholders observed that mental health issues tended to go hand in hand with a range of other complexities, as noted by one LHD worker:

> *"But I think, you know, obviously women that are using substances and have got a whole lot of stuff going on in their lives have probably got a mental health issue as well."*
>
> *LHD worker #3*

Several AHWs and midwives talked about the occurrence of drug use in some clients:

> *"…but it's really unfortunate because we do have relatively higher risk babies who will be withdrawing [from heroin] …"*
>
> *AMIHS AHW #3*

Domestic violence and intergenerational trauma were also reported by stakeholders at all case study sites and almost always occurred alongside other issues.

These multiple and co-occurring complexities were seen by stakeholders as posing a challenge for AMIHS staff to focus on providing antenatal and postnatal care because such clients required more intensive support. At some case study sites stakeholders felt, when compared to mainstream maternity services, the AMIHS sites were supporting a higher number of clients with psychosocial issues which resulted in higher caseloads for services.

Clients experiencing complex issues feel supported through AMIHS

Several clients who were experiencing high-risk issues talked about feeling supported by AMIHS staff. This support was experienced through regular contact and follow-up:

> *"They do touch base with you to see if you're still in the right - say, mentality space, if you've got any depression kind of thing or anything like that, they just check on everything… "*
>
> *AMIHS client #23*

Support also came in the form of access to activities, such as weekly playgroups, organised by AMIHS:

> *"I only just turned 20, so I don't have many friends with babies being so young, so coming to things like playgroup it helps with communication, otherwise I'd just be sitting at home all the time… And when you have anxiety or depression or anything like that it's good to come to groups and you know everyone."*
>
> *AMIHS client #6*

Other clients talked about feeling supported by additional referrals and services organised by AMIHS staff:

> *"They gave me referrals to the psych when I needed it. Anxiety is an issue for me, I've always had that. I felt supported. "*
>
> *Past client #6*

Some fathers interviewed at two of the case study sites also talked fondly about the support they, and their families, received from AMIHS staff to heal and change past high-risk behaviours. They described experiences of trauma and incarceration and the impact it had on their partner and family. While they acknowledged that the AMIHS staff were primarily there to support the women and children, these fathers expressed a sense of gratitude and felt that support was also open to men to help them become better fathers and partners.

> *"…I look at my life and my family and I can't believe how good it's turned out. I just want to keep learning how to be a better dad and do stuff with my kids and [my partner]. What the girls here [AMIHS team] did for us to help get us sorted out was amazing – we just wouldn't have known where to start."*
>
> *Community member #5*

Limits to the support AMIHS can provide

Despite all efforts to support clients and their families experiencing high-risk issues, AMIHS staff and other stakeholders at case study sites often felt there was a limit to the support they could provide.

Access to mental health services or finding available services was a common concern for AMIHS staff interviewed. A lack of available services, long waiting lists, and complex referral processes to access subsidised support were reported as the primary concerns.

The referral process to obtain a GP mental health plan was noted as being specifically problematic by several AMIHS staff where it was viewed as a drawn-out process. As described by several AMIHS staff, clients could obtain a GP mental health plan which allowed them to access subsidised mental health psychology support. However, an appointment and referral from a GP was first required, followed by booking an appointment with a psychologist. It was reported that each step could result in delays and clients were required to re-tell their story at each step. This could be off-putting for some clients, as described one AHW:

> *"The headache is referring people for psychology and they don't want to go and tell their story again and again."*
>
> *AMIHS AHW #8*

One AHW expressed a strong desire to facilitate easier access to services by having in-house services, including access to a GP:

> *"We have high rate of clients with mental health issues, it would be nice to provide continuity of care, it's important they know who to contact. It would be good to have those workers here. Sometimes there's a long wait list with mental health services and we shop around for the shorter [lists], sometimes refer to AMS, headspace. You need to have a mental health plan from the GP so that can be a lot for the mums to do. If we had our own GP, we could make that process quicker."*
>
> *AMIHS AHW #6*

Some AMIHS staff reported that, despite efforts to connect clients with services, there was a limitation to what they could do if they did not have the skills or knowledge to provide support. This scenario was described by one AHW:

> *"I don't feel comfortable, it's a bit out of my depth. We've had a lot of methadone clients where I'm like oh, I need to know more about this stuff to be able to support somebody…"*
>
> *AMIHS AHW #3*

Stakeholders also reported that the complexity of issues experienced by clients increased the complexity of services and support required. As described by one LHD worker, it was often a challenge for AMIHS staff to judge how to prioritise support:

> *"They've got so much going on in their lives, you know, the boyfriend, homelessness, yeah, age. We always try to make sure there's family support there for her. A lot of the cases there's not, so it's really hard. "*
>
> *LHD worker #5*

Stakeholders also felt that the collective and cumulative impact of complex and high-risk issues limited what outcomes could be achieved for mothers, their babies and their families over the course of one pregnancy. This was a key concern for many, as outlined by one AMIHS manager:

> *"You can't change a life in a pregnancy, it's not possible. You have the opportunity to give as much as the service can, it's not nine months, it's six or seven months – you can't change all of what that person has experienced in that pregnancy. We try really hard, but those things that people rely on for stress or mental health relief, drugs, alcohol, smoking; you can't change all of that in a pregnancy. It's intergenerational."*
>
> *Other AMIHS staff #3*

AMIHS staff also reported that it was often difficult to focus on the desired outcomes of the AMIHS program, such as an increase in breastfeeding rates, because clients had other immediate priorities that needed to be addressed. As described by one midwife:

"I've got one on her second baby that has a UTI and temperatures at 12 days old. We put everything we could into breastfeeding but she's still at home with her mum in an overcrowded house and they don't get on because there's intergenerational trauma…and domestic violence."

AMIHS midwife #8

Child protection

In each of the case study sites, the issue of child protection was talked about by several AMIHS staff, managers, LHD staff, partner organisations and ACCHS stakeholders. While only a small number of client interviews reported direct or indirect experiences with child protection services, the issue of child protection was talked about by a range of stakeholders at each of the case study sites. For the remainder of clients, the issue of child protection was not raised as a personal or general concern.

As reported by several stakeholders, for some clients accessing AMIHS services, risks to children was a reality that needed to be addressed when there was a likely exposure to substance abuse, domestic and violence and unsafe housing. AMIHS staff observed that these same clients had also experienced trauma in their lives which could increase the likelihood of high-risk issues developing that could be harmful to children. To support such clients, it was reported that AHWs played a critical role in coordinating services and peers to develop appropriate responses.

Stakeholders at some of the AMIHS case study sites talked about developing good two-way working relationships with FaCS services and ACCHSs to provide wrap-around support for clients and minimise the risk of removal of children. This approach was described by one CFH nurse:

"If there is a question about whether a baby might be at risk of removal, the AMIHS team are very careful to document everything clearly so that the range of supports is visible to FaCS – aim to keep families together, if it is safe to do so."

LHD worker #2

At two sites, multi-agency meetings and networks such as the Safety Action Meetings (SAMs) which involved FaCS case managers, were also described by AMIHS staff and partner organisations as being a critical vehicle to develop and implement early intervention strategies. The effectiveness of such strategies, however, was reported by stakeholders as being highly dependent on a trusting relationship between AMIHS and FaCS staff.

Impact of child protection history and maternal and infant health care

It emerged from stakeholder interviews that AMIHS is ideally placed to support clients with child protection issues. AMIHS staff talked about providing moral support, education and helping clients to connect with other services. At each case study site, AMIHS staff, LHD staff and clients commented about being aware of Aboriginal women who were not accessing AMIHS because they were fearful of coming to the attention of child protection services. Such women were described as having a history with child protection services and would not access antenatal care either until the very last stages of their pregnancy or would engage with the health system at the time of delivery. This scenario was described by one LHD worker:

"There are a lot of women that are probably high-risk – avoiding FaCS or whatever – don't have any antenatal care. They just come in and birth."

LHD worker #3

AMIHS staff talked about their concerns for such women and their babies and recounted a range of strategies used to build trust with the women and their support networks to create a safety net for them.

Role of the AHW and child protection issues

The case study interviews revealed that AHWs play an important role in encouraging mothers with child protection histories to access antenatal care through AMIHS. In these contexts, the AMIHS AHW was described as instrumental to working with other health professionals to increase engagement with AMIHS by women who were at risk. The AHW was also described as being pivotal to advocate for clients with other services. This benefit was described by an AMIHS midwife:

> *"So, the people who are involved in DOCS/FaCS, she [name of AHW] will make sure that if they've started missing appointments and not doing the right thing, she'll make sure that she goes and sees them and say, "you know, really we need to engage and this really important, we don't want anyone knocking on your door and you don't want reports and all that stuff." She's always very open with those kinds of people about how we can try and make it better for them and work with them."*
>
> *AMIHS midwife #10*

Pathways to access AMIHS

Clients, AMIHS staff, managers, LHD staff and ACCHS stakeholders reported that AMIHS could be accessed by clients through a variety of pathways. This included formal pathways through the health system and informal pathways through the local community. This variety was reported to be important to ensure women could choose to access the AMIHS site and ensure they received antenatal and prenatal care.

At all case studies it was reported that most clients were able to easily access or 'find' the program. Yet, at each site, there were also instances where the pathways to access the AMIHS program were not always clear or were impeded by various obstacles.

AMIHS is accessible to most clients

In the case study sites visited, the AMIHS program was generally well known in the community. A combination of the following factors was reported as being the ways that clients typically accessed the local AMIHS site:

- word of mouth in the local community and/or repeat pregnancies to prompt self-referral
- community "intelligence" of the AHW in particular (i.e. informal community reporting of a pregnancy that prompt the AHW to contact the woman)
- referral from a local ACCHS
- referral from the local hospital pregnancy care clinic.

These pathways for access to AMIHS sites were reported as 'easy' pathways by many clients interviewed. At some sites, clients and community members expressed a strong sense of community ownership and pride in their local AMIHS. Clients also talked about appreciating that there were a variety of pathways to access the program and that there was no judgement about when they accessed the service:

> *"…even though I came to them at 28 weeks, they didn't judge me – they just focused on what my goals should be from that point on."*
>
> *AMIHS client #28*

Some AMIHS staff reported that late engagement (after 20 weeks) with the AMIHS program was more common and more likely to occur if a woman was new to the area and community.

The availability and visibility of an effective and trustworthy AHW was cited by most clients as a reason for wanting to engage with the program, particularly in the first trimester. Some clients also talked

about accessing the program because they felt the AMIHS staff would offer them discretion and respect for their privacy about their pregnancy. Several clients also felt that the flexibility of how the service was delivered, such as the availability of home visits, allowed them to retain their privacy about their pregnancy, particularly in small communities.

Access to AMIHS is not always clear

Awareness and understanding of the program can affect access to AMIHS

Community awareness and understanding of the program

In longer established case study sites, stakeholders reported that the program was well known. In those sites, women in the early stages of pregnancy would contact the midwife or AHW directly, or the AHW finds out about pregnant women early through the 'Koori grapevine' and initiates a home visit.

In other sites the program did not appear to be as well known to the community. For instance, clients in one case study site reported finding out about AMIHS by chance or did not understand what the service was because it was not properly explained by mainstream maternity staff or GPs.

> *"…because I didn't know about it until I heard from [name of friend] and that when I was having my initial contact after, oh, like I'm pregnant, yeah, seen the doctors and then there was – then they said, "Oh, we'll introduce you to [name of AHW]," and that. Like I didn't know there was a newborn maternity person in there."*
>
> *AMIHS client #1*

A community elder expressed the need for developing increased awareness in the local community:

> *"Because they [the service] need a higher profile. I didn't even know what AMIHS was; there'd be a lot of young girls in town who wouldn't even know about it and what it's about."*
>
> *Community member #10*

Referrer awareness and understanding of the program

Several clients reported that they were offered the program by maternity staff or GPs but felt they were not given clear information about the details of the program. As described by one client, this could result in a client declining the program:

> *"Through the midwives, the – at the hospital there, when I had my first appointment. They offered it to me, but I wasn't sure sort of what was involved. They just asked if I wanted it, so I just said no, because I was thinking I don't even know what this is about. I was confused, and they didn't really explain anything. They just asked me and that was it."*
>
> *Past AMIHS client #2*

At some sites stakeholders reported that awareness of the program was low because there was a high turnover of maternity staff.

> "*Probably some room for more knowledge in the maternal unit. Midwives come and go. Unless we keep up the education the awareness won't be as good as it could be."*
>
> *LHD worker #23*

At some case study sites, some clients and AMIHS staff reported instances where hospital and staff did not have a good understanding of the eligibility criteria for the program. It was reported that this affected clients' ability, particularly those who were not aware of the program, to make an informed choice to accept or decline the program.

Identification of Aboriginality and access

Stakeholders, including clients, AMIHS workers and managers, reported that women could encounter difficulties with the processes for identification of the mother and/or baby as Aboriginal.

The most common difficulty with the identification process, as reported by several AMIHS and LHD staff, was when hospital-based staff made assumptions about clients' and their babies' Aboriginality rather than directly asking clients. As described by one AMIHS worker, this could occur at different levels within the hospital:

> *"Women who are having an Aboriginal baby are generally missed at triage but picked up at the booking-in appointment. They would get a letter like all women would to attend a booking-in appointment."*
>
> *Other AMIHS staff #5*

The impact of incorrect identification of Aboriginality was described as twofold: clients would not be offered the AMIHS program or they would be automatically referred to the program without their choice and acceptance of the offer.

Some stakeholders called for more frequent in-service sessions about AMIHS to be delivered within hospitals to minimise the risk of misidentification. As described by one LHD worker, this could also address the issue of correctly identifying the baby's Aboriginality to ensure eligible women are offered the program:

> *"In-service would explain to doctors how to ask people about Aboriginality, "does your partner identify, do you identify", what is [the local AMIHS service] – have the brochures for [AMIHS] up there. And just take a moment to explain. Don't assume that because they're Aboriginal they'll want it. But don't not offer it. So, we have this run of it being offered and when we call them, they have no idea who we are and what we're talking about."*
>
> *LHD worker #23*

Referrers decide when to refer to AMIHS

There were some instances described where the person responsible for referrals to AMIHS was referring to or offering the program based on personal judgement rather than offering the program to all eligible women. For example, if a referrer (such as a clinician on the maternity ward or a GP) assessed whether a client needed a high level of support during pregnancy the client was offered AMIHS; if not, they were not offered AMIHS.

At one site, it also emerged that potential clients were not being referred to AMIHS because it was perceived that there was insufficient capacity of the AMIHS site to support all mothers of Aboriginal babies in that local area. One LHD worker described how she made an assessment to refer or not:

> *"We know that they [the AMIHS team] are struggling with their numbers – too many clients on their books – so we just keep some of the ones who are managing well up here at the clinic for their check-ups."*
>
> *LHD worker #25*

Location of AMIHS

Varied site locations

The results from the Managers' Survey indicated that AMIHS sites were located in a variety of settings (Figure 13), however, they were most commonly located within a community health centre (56.5%, n=26).[23]

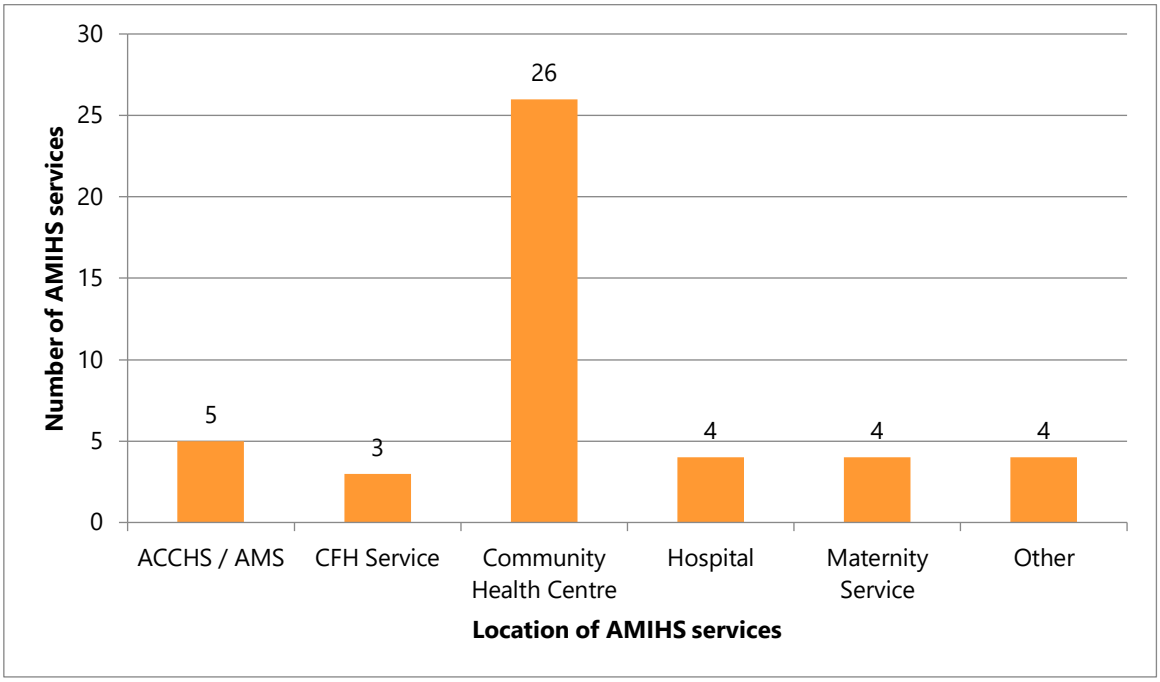

Figure 13: Distribution of AMIHS sites by primary location (n=46) (Source: Managers' Survey, 2017)

Apart from community health centres, other locations included:

- hospital (4 or 9%)
- ACCHS (5 or 11%)
- CFH service (3 or 7%).

Some AMIHS sites offered outreach to other services and some are located within one small town servicing only that community.

There is no ideal location for AMIHS

A range of positive and negative aspects were expressed by stakeholders in case study sites in relation to each of the different locations of AMIHS sites. From the interviews it emerged that there was no 'best' or ideal location for where AMIHS sites should be situated.

Sites that were in a community health setting (i.e. the majority) and were servicing the immediate local community were perceived by stakeholders interviewed to be beneficial for the communities because of strong connections and local knowledge. Some AMIHS staff also felt that a community based setting was more appropriate than a hospital setting to support Aboriginal families:

[23] It is possible that the number of AMIHS sites located within a community health centre is greater than 56% as CFH services are often part of a community health centre.

"I don't think AMIHS should be attached to maternity and gynaecology, it should sit in community health care … Hospitals are basically businesses and therefore not appropriate."

AMIHS AHW #4

Some stakeholders worried that community based AMIHS sites could become distanced and disconnected from obstetrics and maternity units of the local hospital which could have an impact on how the AMIHS site was managed and how it was viewed and understood by the broader system. One midwife worker observed:

"It is still really suitable that AMIHS is delivered out of [a community location] but it's not so good that the management of the site is out at the hospital "tacked on to the end of health"

AMIHS midwife #3

AMIHS sites that were closely connected with or located within a local hospital were seen to be beneficial to quickly connect with other health professionals and services. At one case study site, clients, community members, AMIHS staff and hospital staff were all strongly in favour of the service being located within the hospital. Stakeholders talked about the increased professional support that AMIHS services could access by being in the hospital. As noted by one of the hospital clinicians, there were clinical benefits for the client:

"… so, I pretty much have an opportunity to talk to the AMIHS midwives on a daily basis. And we would discuss any client concerns at the time. We would then work out if the midwife can just continue to provide care or make an appointment for me. Sometimes the midwives will just make an appointment for me and then come and tell me and give me a bit of a head's up about why they booked the patient in."

LHD worker #18

Co-location of the AMIHS site within a hospital was also seen by stakeholders to enable clients to become familiar with and less anxious in the hospital environment where the actual birth would take place. AMIHS staff also reported that hospital tours were also a useful way to acclimatise clients to the maternity ward and hospital.

Some stakeholders, including clients, talked about negative and positive differences between services delivered by the local ACCHS or the local mainstream health services, but it was not clear from the findings whether AMIHS was most ideally located within an ACCHS or LHD.

The more important factors that emerged for where AMIHS should be located were primarily related to local issues and dynamics of the local community. At some sites clients and community members preferred that AMIHS was not connected to the local ACCHS because it allowed them some privacy and anonymity within the small community. As described by one client:

"I only have to go down there, and I know they'll be wondering to themselves, like 'What's she down here for and who's she seeing. We all know about the Koori grapevine!'"

AMIHS client #25

At some sites stakeholders reported that some parts of the community did not like going to the local ACCHS because of local 'politics' or community dynamics., One client appreciated the 'neutral' space of where the AMIHS was located so she could just focus on her pregnancy care:

"…good that they sit here because people can have issues with certain services, so they're not attached to the AMS, they sit up here. Just about having your baby."

Past client #3

At sites where the program was delivered by the LHD, some stakeholders felt that clients were not able to easily locate the program because it had a lower profile compared to other health services.

…people will say "well the services are there – people just have to access them". But they don't even know the services are there and transport is a huge issue.

LHD worker #22

Creating a welcoming service environment

Regardless of where services were located or delivered, a welcoming and familiar service environment was described by many stakeholders at most case study sites as being important to make clients feel comfortable to access AMIHS.

The layout of reception areas of a service was seen by many stakeholders as an important element that needed to be considered as part of service delivery. Clients and AMIHS staff in the case study sites felt that families needed a comfortable and private waiting room, yet this was not always provided for in hospital or community health settings. The visibility of clients by staff was an issue where there were shared spaces with other services, or the layout of the reception area physically blocked the visibility of clients. At some case study sites, it was reported that clients could be waiting for long periods of time because the AMIHS staff did not see the client or vice versa or they were sitting in the wrong waiting area in places like the hospital or community health centre.

The service environment was also sometimes viewed as unwelcoming by clients if there was limited signage and clear direction of where the AMIHS site was located, if clients perceived reception or administrative staff to be rude and inpatient, or if they were required to sit in waiting rooms where there were other patients who were unwell.

"… this is nitpicking too, a separate area for when you do have to go in for appointments so that you and your babies aren't sat with the sick people. That's what I don't like. That's one thing that I've found I'm really uncomfortable with. They did say, like, I had to ask, and they said, 'you can go down and sit in the kitchen.' I know they've got their little child area there, but if they had a separate room for families, you know, because there's nothing worse if I'm sitting there with a blanket or, you know, there's people sitting around you coughing and you've got a newborn baby who isn't immunised. You know?"

AMIHS client #3

Evaluation Objective 4. Investigate the impact of AMIHS on the health outcomes of Aboriginal babies and their mothers

AMIHS has contributed to positive health and social outcomes

The case study interviews indicated that AMIHS sites have contributed to positive health and social outcomes for clients and their families. Interviewees reported different ways that sites have been able to influence positive change such as for breastfeeding and increased confidence in parenting. The interviews also indicated that some outcomes were easier to measure and observe, particularly for short-term positive outcomes, yet different ways of measuring and perceiving success were required to capture long-term positive effects.

Positive outcomes have been achieved in different ways

Whether it be longer or shorter-term outcomes, most stakeholders believed that engaging with women as early as possible in their pregnancy (or even before then) was a critical factor for clients to receive the most benefit and to be linked with other services. As reported by one AMIHS manager:

> *"Seeing women early has the most influence on outcomes."*
>
> *Other AMIHS staff #3*

Several stakeholders noted some success with engaging fathers in both the pregnancy and postnatal processes. One male client indicated his confidence as a dad was much stronger and several others were supportive of breastfeeding and wanted to know more. But still, one LHD worker felt much more could be done:

> *"I'd like to see some male AHWs, not to work with the women but to work with the partners. Huge gap. Where do these young men who are often falling through the cracks go? One male AHW attached to the hospital now does some great work but it's [just] one."*
>
> *LHD worker #22*

There are different ways of measuring positive outcomes

Various outcomes are measured by AMIHS sites in a variety of ways. Routinely collected data are maintained to measure outcomes such as rates of breastfeeding and rates of smoking and quitting, which can allow sites to measure immediate or short-term positive outcomes. Yet, many stakeholders felt that there were other positive (generally long-term) outcomes that were not easily measured but needed to be captured to show the entirety of possible outcomes.

Immediate positive outcomes are easily measured and observed

All stakeholder groups expressed a clear belief that there were some immediate benefits being gained through AMIHS. Stakeholders commonly talked about outcomes for breastfeeding and, while it was acknowledged that much improvement was still required, many success stories were reported by stakeholders. As reported by one client, support to breastfeed was made available through AMIHS:

> *"What help was actually provided [by the AMIHS staff]? – continuity of care. Referring me to services when things weren't going so well. The lactation nurse was able to visit … supporting my goal to be able to breastfeed. They helped me get over the hard times – took a good few months. My care provider was on my side."*
>
> *AMIHS client #11*

One AHW also described how long the process of helping a mother to breastfeed might take, to the extent of requiring sustained work over multiple pregnancies:

"… it happens over multiple pregnancies when you get trust. I made a comment about first baby and commented that she only breast fed for 12 weeks because she didn't know whether he was getting enough. Out of that I was able to ask why she felt that – lots of little yarns – not going through the checklist of education. I can proudly say that her second child is nearly 12 months old and she is still breastfeeding."

AMIHS AHW #1

Another client also reflected on how protracted the process could be and how much support might be required:

"Because I don't have a thyroid, that was another thing, I couldn't breast feed and that was another thing I was really stressed about because I wanted to do that as well, and that wasn't working for me and I didn't have the support there. Totally different this time [supported by AMIHS service], they've got a lactation consultant… she [lactation consultant] came out there, constantly every week, 'how ya going? Do this, do that,' giving me ideas and suggesting things to help to do it."

AMIHS client #26

Measurement of incremental positive outcomes needs to be enhanced and valued

While it was reported that there were outcomes that could be easily measured and observed, many stakeholders interviewed said that AMIHS was achieving broad positive health and social outcomes for clients that were not necessarily well captured quantitatively. It was also felt that there were some positive outcomes that were not being suitably valued or recognised.

The value of small but positive social and health outcomes

As described in a previous section (*Supporting clients experiencing complex and high-risk issues*) many clients who accessed AMIHS sites required support for a range of psychosocial issues, in addition to antenatal and postnatal support. For these clients, stakeholders felt it was important to recognise and celebrate small positive changes that were being achieved. As described by one AHW, this could mean recognising an increase in birth weight of babies between pregnancies, even if it was still below the accepted benchmark

"There's a spectrum of people. You've got to look at the journey. Intergenerational trauma – it is not going to be fixed in one generation. Yes, a 2.2 kilo baby is not great but it's better than a 1.9 kilo baby last time."

AMIHS AHW #1

Positive outcomes can be achieved over multiple pregnancies

Other longer-term benefits identified by stakeholders included a good spacing between pregnancies, healthy babies meeting their milestones and children attending school regularly. At some case study sites, it was reported that these outcomes might happen long after the AMIHS intervention has been completed. But if a woman has repeated access to AMIHS through multiple pregnancies, there can be an ongoing relationship for many years.

Several stakeholders also noted that AMIHS had brought young women into the health system at a point where they are generally well (and therefore had little contact with health services up to that point) and the guided experience gave them the confidence, skills and health literacy to use the system in future. As one stakeholder from a partner organisation noted:

"… the AMIHS service offers direct access for clients to other health services which they might not have attended otherwise."

Partner organisation #3

Generational changes for individuals and communities

Several stakeholders noted the longer-term and flow-on effects of the AMIHS program. A key example was helping young families feel less vulnerable, even if only for the time of being supported by AMIHS. This could be in the form of better protection from domestic violence, or helping to ensure families stay together, providing support for young mums, or helping women feel stronger and more confident as a mother and a person. As one LHD worker observed:

> *"When you have a young healthy mum, who is well supported that's what she does for her family … Women are really strong in the community – if the women are strong, families do much better."*
>
> *LHD worker #22*

The interviews also revealed that, for some clients and their families, their lives had changed in ways that they attributed directly to the relationships they had developed with AMIHS staff. AMIHS staff had helped individuals, sometimes over several pregnancies, deal with substance abuse issues and become more in control of mental health issues.

> *"We as a family have had three years of peace that we otherwise wouldn't have had – the support she has had from AMIHS has gradually helped her to settle down and get the treatment she needed.'*
>
> *Community member #16*

In many small ways, AMIHS could have an impact at the community-level by developing a sense of ownership of the local AMIHS site and raising expectations of maternal and child health outcomes.

Several stakeholders also noted that there were broader impacts and flow-on effects beyond maternity care that were directly linked to AMIHS but were not necessarily captured through routine data collection. As described by one stakeholder, the AMIHS program had the potential to influence career pathways of local Aboriginal women where they observe local role models, can join the health system, advance as professionals and embark on aspirational career paths.

> *"[AMIHS] … raised it to a level of importance so that everybody was wanting to get ahead. And then there was enormous personal support for some of the AHWs who hadn't completed high school to do direct entry midwifery … these were extraordinary women who were mainly grandmothers at 40, AHWs and aspired to do this. And even if they didn't achieve it, the fact that someone in that locality was going to uni from that community, that just changes the culture, and that is part of what I think made some really big differences, really big difference in AMIHS and its respect, and acceptability, but also young women who mightn't even know that person individually seeing that this is a possible career path."*
>
> *Statewide stakeholder #2*

Prevalence of smoking and the challenge of cessation

As part of the AMIHS program, AMIHS team members aim to address smoking cessation with clients as part of antenatal and postnatal care, in partnership with relevant referral agencies and other local service providers. Across all case study sites, AMIHS staff, managers and LHD staff reported that smoking was a challenging health behaviour to address due to a range of entrenched attitudes around smoking. Some stakeholders also felt that there were unrealistic expectations for what could be achieved and that more resourcing was required to effectively address rates of smoking.

AMIHS provides support to quit smoking

Support to quit smoking was reported by some AMIHS staff to generally be provided through informal health promotion discussions as part of antenatal and postnatal care. For support to be effective and

sustainable, some stakeholders felt that support needed to be timely and customised to the needs and context of the client. Where available, referring clients to a Q4NL worker to provide one-on-one cessation support was seen as a highly valuable resource by some AMIHS staff.

Timing is important to provide smoking cessation support

Some AMIHS staff reported that providing information and education as part of routine care was often handled by raising the issue informally during conversations or more formally as part of pregnancy care questions and assessments. In either situation, AMIHS staff talked about needing to make a judgement about the timing for a conversation about quitting smoking, particularly as noted by one AHW, when many clients have other complexities they were balancing in their life:

> *"She does want to give up smoking, I just think, you know what, I'm not even going to go there. I do give her little talks about passive smoking, third-hand smoking and how to deal with the smoking around bub while I'm talking to her, it comes up every now and then, but right now the importance is getting suitable accommodation for this particular client."*
>
> *AMIHS AHW #5*

Another AHW also talked about needing to carefully time questions about smoking and quitting:

> *"We might not do it on that first booking-in because you know there's so much that we have to ask about that sometimes it just doesn't feel right to bang another thing on them…and so it maybe the next time we see them which may not be for another four or five weeks if we see them, if they're booked in but we do always address it…"*
>
> *AMIHS AHW #3*

One midwife described her approach to talk about smoking:

> *"But I do always say in a light-hearted way we are going to ask you that again, like you know – so they're sort of expecting us, but we've already broached it, hopefully in a friendly manner…"*
>
> *AMIHS midwife #4*

Clients benefit from customised smoking cessation support

Some AMIHS staff talked about being pragmatic about providing information and education that was centred on a harm minimisation approach.

Several stakeholders talked about being aware that a woman was more likely to quit smoking if others around her were not smoking. Therefore, an important strategy to address smoking with the client, as described an LHD worker, was to work with the whole family:

> *"We can support up to 10 people within the home as well, so Nan, Pop, Aunty, Uncle. And I tend to look a bit outside the box. If I know Aunty comes over every day, then I'll want to support her as well, do you know what I mean, because it has to be a holistic approach supporting the mum and the babies and the kids in the house."*
>
> *LHD worker #24*

Some stakeholders noted that some clients may continue to smoke during pregnancy but might attempt to cut down or quit. Some clients talked about their attempts to quit smoking during pregnancy; for one client this involved cutting down the number of cigarettes as an achievable goal during pregnancy, and for another client it involved both her and her partner making a quit attempt together using NRT patches.

Quit for New Life is a valuable resource

At some of the case study sites, AMIHS staff and managers talked about the value of being able to refer clients to the Quit for New Life (Q4NL) program because it provided clients with consistent one-

on-one support that AMIHS teams did not have time to provide. However, the Q4NL program was not available at all case study sites. Where it was available, there was strong collaboration between the programs which ensured that clients could be quickly supported once a referral is made.

One client who talked about smoking during the interviews felt that the referral to Q4NL was potentially a useful strategy for quitting smoking:

> *"Yeah, it's been helping… I'd like to maybe try and quit smoking through them..."*
>
> *AMIHS client #23*

Smoking is a challenging health behaviour to address through AMIHS

Tobacco smoking by mothers during pregnancy was seen by some stakeholders, primarily AMIHS staff and some LHD staff, to be highly prevalent and an almost intractable issue for many communities. Reduction in rates of smoking is one of the core health behaviours that are intended to be addressed by the AMIHS program as part of routine care, yet, it was talked about by many stakeholders as being one of the most challenging issues for AMIHS staff to tackle. The key reasons were that smoking was normalised for many communities, there were entrenched attitudes about smoking, and in comparison to other issues, smoking was considered a lower priority.

Entrenched attitudes and beliefs around smoking

From some of the stakeholder interviews, it emerged that some clients accessing AMIHS were not taking up smoking in isolation but rather were smoking as a product of living in communities where smoking was accepted and reinforced. Some stakeholders felt that the high prevalence of smoking was strongly linked to common beliefs and misconceptions about the impacts of smoking.

One LHD worker talked about smoking being entrenched in communities and culture:

> *"They don't want to talk about their quitting journey, or they feel ashamed of trying to quit because everyone's smoking. It's socially accepted. Unfortunately, I hate to say it, but it's getting to be our culture. This is our smoking culture and it's not, it never was, how do we change that?"*
>
> *LHD worker #24*

Some AMIHS staff reported that many clients were smoking prior to becoming pregnant, which they felt made it a difficult behaviour to change. Clients living in a household where other people were smokers was also observed by some stakeholders as being a significant barrier for clients to successfully quit smoking during pregnancy.

Several AMIHS staff and LHD staff also reported that some clients saw smoking as benign or relatively harmless because they had not observed the impacts of smoking, or, their own mothers smoked during pregnancy without any noticeable harm. As recounted by one LHD worker, some clients have mentioned using smoking as a tool for weight loss, and, most alarmingly, to give birth to a small baby:

> *"A lot of them do say, "I smoke because I want to have a small baby." It's really sad. And we try and tell them the complications about smoking, explain what could actually happen, that it's not healthy for bub and it's not healthy for you… they don't want it to hurt, when they have baby."*
>
> *LHD worker #5*

Smoking is seen by some as a lower priority

Complex personal circumstances or other psychosocial issues were also noted as contributing to high prevalence rates of smoking and a challenge to address smoking. Some staff reported that smoking was used as a coping mechanism, thereby reinforcing the habit of smoking. Additional psychosocial issues in turn impacted on clients' willingness to make a quit attempt, as noted by one AHW:

"We've had trouble with getting people to do the quit for smoking program, not many people are interested because it's – they've got so much going on in their life taking on another thing you know that's drugs and alcohol, domestic violence, you know it's another thing that they just – yeah, we don't have great success rates…"

AMIHS AHW #3

Another LHD worker also noted that smoking was often seen as the lesser evil in comparison to other drugs or alcohol:

"They'll give up alcohol, from what I believe, before cigarettes. Well, according to the data I've seen, not a lot of women drink during their pregnancy."

LHD worker #3

Meeting the Key Performance Indicators (KPIs) can be difficult

At some sites stakeholders felt there was a mismatch between the on-the-ground reality of supporting AMIHS clients to quit smoking and KPIs set by the Ministry for rates of reduction and uptake of NRT. There was a perception that the targets were viewed in isolation and, as described by one manager, did not factor in other issues occurring in a clients' life:

"The 65% KPI doesn't take into account that someone might have housing issues, domestic violence, they've lost their mother, there are so many things psychosocial issues we're not addressing, that we're just addressing the symptom or the outcome [smoking]."

Other AMIHS staff #2

Additionally, some stakeholders felt the KPIs did not reflect the reality of women's lives or the structure of the AMIHS model and strategies to reduce smoking.

"The KPI for smoking looks at smoking at 'booking-in' but we have no influence over that…"

The expectations to meet the KPIs were viewed by some stakeholders as being unrealistic in terms of the actual time and staff available to provide consistent support for a range of health behaviours as described one LHD worker:

"We're not going to get it over the line for reduction in smoking because we just don't have the time or staffing levels to commit to those things. We were pushing Q4NL and the team embedded in to their practice, but then breastfeeding rates dropped off. There is a high expectation of what each team does at each visit. Clients are not going to tolerate or soak up all of the information."

Other AMIHS staff #3

As described in a previous section (see *Allocation of staff resources*), stakeholders reported that Q4NL program funding had ceased and that it was expected that AMIHS staff would provide quit support as part of routine care. Yet, some staff perceived that the implications of this change were not properly considered in terms of the intensity and consistency of support to quit smoking, potentially resulting in decreased quality of cessation support.

D. Discussion

This report – the second of two Technical Reports on the 2016-18 AMIHS Evaluation – details the findings of analysis of data collected through a review of AMIHS documentation, a survey of managers of all current AMIHS sites, and analysis of 154 consultations with various AMIHS stakeholders.

The following discussion of the findings is organised around the evaluation objectives for the qualitative components of the research and therefore attempts to:

- understand the experiences and perspectives of stakeholders
- identify and describe the ways that AMIHS is being implemented
- describe the reach and demand for AMIHS
- identify and describe the outcomes for clients accessing AMIHS
- describe the unique characteristics of the AMIHS program.

In the following sections, only the more prominent findings and those that represent the most likely areas for quality improvement actions are highlighted.

Client, staff and stakeholder experiences of AMIHS

The AMIHS program is valued

An important finding from the qualitative data was that the AMIHS program was highly valued by clients, their families and community members interviewed in this evaluation. For many women, the service represented a safe space where they were provided with holistic and non-judgemental support in the context of their culture and their communities.

The most important aspects of the program from the perspective of the clients interviewed was the provision of personalised support, familiarity of the AMIHS staff, particularly the AHW, and the efforts AMIHS staff made to ensure clients received the support and services they needed. This gave clients a sense that they were more than just a 'number', particularly when compared to mainstream maternity services. This demonstrated that person-centred care needs to be at the heart of services, where there is a genuine effort to identify and incorporate the needs and wants of clients for their antenatal and postnatal care.

AMIHS is a culturally appropriate service

The findings indicate that AMIHS is a unique and distinct program within the broader health system and delivers a model of maternity care that was largely considered by stakeholders to be culturally appropriate with a committed Aboriginal focus. This was observed, by stakeholders in case study sites, to be demonstrated through the willingness and commitment of AMIHS staff to listen to, and incorporate, the choices and values of clients such as fully acknowledging the importance and context of their family and community.

The AHW was considered by most stakeholders interviewed to be central to the success of the program. The AHW was also noted by stakeholders to provide an important visible link to Aboriginal culture and the local community which was appreciated by clients and community members alike.

And yet, it was evident from the data at most case study sites that greater respect for the AHW role needs to be demonstrated through genuine efforts to seek and incorporate cultural and local community knowledge of AHWs into the delivery of AMIHS. The interview data also highlighted that greater recognition and promotion of AHWs is also required more broadly within the health system

to increase a better understanding of the purpose and demands of the AHW role, but also to ensure they are respected within the structures of the system as part of a suite of health models available to Aboriginal people, so that they can effectively support and advocate for AMIHS clients. The case study data also highlighted the importance of taking the time to develop trust and rapport to engage with clients and communities.

Experiences of racism

Stakeholders who were interviewed for this evaluation reported that many Aboriginal people experience racism when using the NSW health system. Stakeholders reported observing instances of hospital staff making derogatory comments to clients.

Some interviewees in the case study sites also perceived that racism towards the AMIHS program was evident where other staff within the health system did not understand the purpose of the program or value the program for the choice it offered Aboriginal communities. Several AHWs, and some midwives, also reported that racism existed within the structure and practices of the health system where Aboriginal knowledge was not valued or implemented. These findings suggest that the collaboration with other health services and continuity of care of the AMIHS model, particularly to the hospital setting, can be impacted resulting in poor patient experiences for clients and potentially, poor health outcomes. This underscores the importance of engagement and collaboration between AMIHS staff and staff in other health services to increase awareness and understanding of the program.

Implementation of AMIHS

Most evaluation models assume that if a program is correctly implemented, consistent with the program logic, then the projected short, medium and long-term outcomes should eventuate if the model principles and elements remain appropriate.

There are two issues to consider here. First, are the 'essential elements' of the AMIHS model still relevant and considered important to achieving intended maternal and child health outcomes for the population targeted by AMIHS? The qualitative data collected for this study suggests that, in the perception of clients, AMIHS workers and other stakeholders, all the elements remain important although some are potentially more crucial than others.

Second, and given the above, whether the AMIHS program, site by site, has been implemented in line with the AMIHS SDM, or at least in keeping with the spirit of the "essential" elements of the model, becomes an important consideration. Generally, the program is being implemented as intended particularly regarding the 'clinical' elements. However, analysis of the Managers' Survey data indicated, and case study data confirmed, variations exist across the AMIHS sites in the ways that some program elements were implemented–especially the 'non-clinical' elements. While in some case study sites, this seemed to represent an appropriate local adaptation or an unavoidable response to specific service circumstances, in others the rationale for decisions to deviate from the implementation model was not always clear to the evaluation team. For example, at some sites it was not clear why AMIHS teams had not been provided with a dedicated car to conduct home visits or why AMIHS staff, particularly AHWs, had not been allocated dedicated time to plan and deliver ongoing health promotion and community development activities.

Deviations from the SDM potentially represent an undermining of the program logic with potential consequences for the program outcomes.

Where deviations from the AMIHS SDM were found, a lack of time and resources was cited by many stakeholders as the key reason for those variations. For instance, diminished level of effort into health promotion, community engagement, service partner relationship building were all attributed to a lack of time and in that context prioritising the clinical tasks. So too any perceived deficiency in workforce development support was attributed to resource constraints.

Reducing variation within the program and between sites would therefore be an obvious focus for program improvement. In this section some of the key areas of variation are discussed.

Community development and health promotion

Community development and health promotion are core features of the AMIHS program as evidenced by the quote below from the AMIHS SDM:

> *"Community development and health promotion activities are often not seen as core business of maternity services. This is not the case for AMIHS programs. In order to meet the guiding principles of a broad and social view of health, it is essential that community development activities receive equal emphasis."*

There were conflicting findings on the level and nature of the effort devoted across AMIHS sites to health promotion and community development activity. Results of the Managers' Survey suggested that nearly all sites undertook some health promotion work but the survey did not collect information about the depth and quality (planning and structure) of the effort. Case study informants in all but one site strongly indicated that health promotion work consisted mostly of opportunistic health education (as part of occasions of care) supported by only the occasional structured group or community event (for instance providing a stall at NAIDOC Week).

Other results of the Managers' Survey appeared to indicate that at just over half the AMIHS sites, AHW and midwife time were being designated to structured health promotion or community development activity. At these sites, on average the AHWs spent 27% of their time undertaking health promotion and community development tasks, while the midwives spent on average 21% of their time. At the remaining sites, a dedicated time allocation of zero or less than 5% of either the AHW or midwife is consistent with occasional input to a community event.

Overall, the impression formed by the evaluation team from the Managers' Survey, document review and qualitative data findings was that structured (that is, planned and targeted activities as opposed to opportunistic actions within the care process) health promotion and community development effort varied considerably between sites.

There were good examples within the case study sites of health promotion and community development through coordinating community events and activities and establishing and maintaining effective linkages with the local Aboriginal community. At least one Women's Reference Group had been established with rewarding results. In some case study sites effective health promotion activities had been initiated, in particular those that involved women in physical activity. However, more generally community development and health promotion activities were not being implemented beyond mostly short-term and one-off actions.

The primary reasons for the low level of health promotion and community development activity reported by AMIHS staff was that they had limited time and limited resources, compounded often by limited or no dedicated budget for health promotion or community development. AMIHS staff (and especially AHWs) felt they were forced to choose priorities in the allocation of their time, and so they were choosing to invest time in clinical care of clients.

Allocation of staff and resources

At all case study sites, many stakeholders believed that workload demands in their local site were greater than current staff numbers could properly support. Some stakeholders' perceived staff shortages (when compared to service requirements) were sometimes being exacerbated by inflexible staff allocation (between sites) and not always having satisfactory access to the program's core infrastructure (i.e. dedicated access to a vehicle, flexible work arrangements, and funds to support health promotion and community development activities).

Many AMIHS staff reported that insufficient staffing for the workload demands translated into reduced time available for each client and the need to choose priorities in service delivery. As previously noted, at some sites, AMIHS staff reported a tendency to a focus on clinical tasks and this resulted in health promotion and community development not being undertaken properly. While the clinical care of the client should be the highest priority, the need to forego health promotion and community development may inadvertently bypass the cultural and social needs of the client that are the primary focus of the AHW according to the SDM, and a unique feature of the AMIHS model.

The mostly qualitative data available to this component of the evaluation does not provide enough evidence to validate stakeholders' beliefs about understaffed sites. Analysis of the Managers' Survey data indicated this may be a possibility, but it is equally possible that some sites have an oversupply of staff resources. Analysis on this issue, by combining data from the Quantitative Technical Report with data from the Mangers' Survey, will be undertaken for the Final Report.

Transition between AMIHS and other services

AMIHS clients give birth in public hospital maternity units and, although there are exceptions, this intrapartum care is mostly provided by hospital staff rather than AMIHS team members. In the case study interviews, some clients talked about being unhappy about the absence of known and trusted caregivers in the continuity of their care.

The Managers' Survey indicated that generally, there was good cooperation at most sites for transition from AMIHS to the local CFH services. At some case study sites, however, AMIHS staff observed that clients were less likely to continue their engagement with support services if they did not have established relationships with the staff. If handover was too early, there could be an impact on the establishment of breastfeeding and early monitoring for postnatal depression. These findings suggest that AMIHS staff need to be supported to develop well-planned and timed handover processes for clients to ensure good engagement and therefore positive outcomes for mother and baby. AMIHS staff should be sufficiently supported to work collaboratively with maternity staff and to undertake shared visits with CFH staff, as prescribed in the SDM, to allow clients to become familiar and aware of the handover process.

Workforce development and clinical supervision

Many AMIHS staff and stakeholders in the case study sites felt that working within the AMIHS program was demanding. This was because the program aimed to work outside the traditional boundaries of maternity care by supporting the whole person in the context of their family and community. The AHW role was acknowledged by many stakeholders, including AHWs and midwives, as being challenging because they were required to manage their professional obligations alongside their obligations to community; it could be difficult to identify when to 'switch-off', or where their role started and ended, and there was risk of 'burn-out'. Midwives also talked about the challenge of working in unfamiliar territory outside of their clinical knowledge and skills.

To meet the demands of the role, ongoing professional development and clinical supervision for the AHWs and midwives is essential. It is also prescribed in the AMIHS SDM. Currently, however, the availability of both professional development and clinical supervision was generally considered by most AMIHS staff interviewed to be insufficient to satisfy all their learning needs.

The interview data strongly suggests that workforce development, especially clinical supervision, needs to be a key focus of improvement for the delivery of the program. A broad range of skills and knowledge is required of AMIHS staff, particularly to support clients with complex issues and to coordinate relevant services. A greater focus on identifying AMIHS staff learning needs and supporting access to relevant training opportunities is also required. The provision of clinical supervision, identified as the responsibility of LHDs and ACCHSs in the AMIHS SDM, was specifically highlighted by stakeholders at all case study sites as a critical area of need, primarily for AHWs. There was also a

perceived lack of commitment and/or resources to obtain external and independent cultural supervision.

Developing the cultural competence of [non-Aboriginal] AMIHS midwives and non-AMIHS maternity staff within the health system more broadly was identified as an area of need by many stakeholders at all case study sites.

Reach and demand of the AMIHS program

AMIHS is well placed to support clients experiencing complex and high-risk issues

In the case study sites, stakeholders reported that there was a spectrum of women, in relation to health and wellbeing status, that were accessing the AMIHS program. A key finding that emerged from the case study interviews was that many stakeholders reported that AMIHS was supporting many women and their families who were experiencing complex and high-risk issues, in addition to providing antenatal and postnatal support. Mental health and drug and alcohol issues were cited by many stakeholders as being the most common issues for which clients needed additional support. Child protection was also a complex issue that was being addressed by AMIHS staff in the context of AMIHS services.

Importantly, the findings indicated that AMIHS was an appropriate and well-placed program to support and engage with women who might not normally access health services. Yet, supporting clients to address complex and high-risk issues, in addition to antenatal and postnatal support, was reported by many stakeholders to place significant pressure on AMIHS staff, and the site more generally, because more time and intensive support was required to provide women and families with holistic care. AMIHS staff also reported that there were limitations to their own skills and knowledge, particularly in relation to drug and alcohol issues,

Collectively, these findings indicate that AMIHS staff need support to effectively deliver services for clients with complex needs. Management of the program needs to support AMIHS staff to dedicate time to work closely with clients to understand what they need and to collaborate with relevant services and programs. AMIHS staff also need to be supported to access opportunities for specialist training, such as responding to trauma, mental health or drug and alcohol issues, to develop their confidence and skills.

AMIHS delivers flexible support

Many stakeholders across all case study sites reported that AMIHS delivered flexible and customised support to clients and the Managers' Survey indicated that the AMIHS program was delivered in a variety of ways. An important finding was revealed that home visits were considered by many stakeholders, including clients, to be one of the more valuable features of the program. This was especially for clients with limited access to transport or where there were vast geographic distances to travel to services. Home visits, for clients, also created a sense of feeling valued and supported.

While flexibility of the program was highly valued, particularly to support clients experiencing complex and high-risk issues, many stakeholders, reported that a flexible approach was not always possible. The case study findings suggest that management of the program needs to ensure AMIHS staff have flexibility to deliver services, which could include flexible service delivery hours.

Pathways to access AMIHS

Overall, AMIHS was viewed by stakeholders (including clients) as being an accessible program where clients could be referred to AMIHS in a variety of ways. Word of mouth, referral from mainstream

maternity services and 'community intelligence' of AMIHS staff were the most common ways that clients received access to the program.

Yet, many stakeholders at all case study sites reported that the access was not always clear. Some clients were not aware that the program was available and accessed the program by chance. Increased promotion and awareness of the program is therefore critical to ensure communities and hospital-based staff alike, are properly informed about AMIHS.

Issues in relation to identification of Aboriginality were also identified through the case study interviews. Despite clear processes to identify and record the Aboriginal status of mothers (and babies) within the health system, there were instances reported where hospital staff had not explicitly enquired about the Aboriginal status of a mother or her baby, which impacted on whether a client was offered AMIHS. The findings therefore suggest that training and awareness to ensure a systematic approach to identifying and recording Aboriginality is required to ensure that there is a uniform process for referring to AMIHS and staff do not rely on personal judgements and assumptions.

Outcomes from the AMIHS program

AMIHS has contributed to positive health and social outcomes

Within case study sites, many stakeholders reported that engagement with AMIHS had resulted in positive health and social outcomes for clients and their babies. Several stakeholders attributed the flexibility of the program and early engagement as having the greatest impact on outcomes. It was reported that some specific health outcomes, such as breastfeeding and smoking rates were being routinely measured, but not showing significant improvement. Some stakeholders felt that progress towards achievement of these outcomes might be happening, but this was not able to be captured through the current indicators.

The findings suggest that additional ways are required to properly measure the full impact of AMIHS. This could include implementing sensitive measures to track the subtle and incremental changes that can take place over several pregnancies for clients, such as a gradual change in attitude towards breastfeeding, management of drug use or recovery from mental health issues. It could also include measuring clients' confidence to engage with health services more generally and develop their health system literacy. Understanding clients' perspective of AMIHS could also be routinely captured such as whether clients trust AMIHS, whether they feel safe to access AMIHS and whether they feel that the program values their needs and their culture.

Prevalence of smoking and the challenge of cessation

The case study sites highlighted that smoking was a challenging health behaviour to address with clients. At all case study sites, many stakeholders felt that there were high rates of smoking within local communities where smoking was normalised and accepted. The high rates of smoking, coupled with entrenched attitudes and misinformation around smoking, were viewed by some AMIHS staff and LHD workers to impede clients' ability to quit smoking.

The Q4NL program was cited as an important resource to provide intensive and sustained quit support to clients because AMIHS staff reported not always having enough time to follow-up with clients in addition to other supports they were providing. Yet, Q4NL was only being delivered at two of the case study sites as stakeholders reported that funding had ceased at other sites, with the expectation that smoking cessation support would be incorporated into the delivery of AMIHS. Current resourcing within AMIHS program sites to address smoking is therefore potentially insufficient and AMIHS staff require more support to deliver timely and tailored support to clients.

Concluding remarks

In the six case study sites, the AMIHS program was highly valued by clients and their families. The case study sites were carefully selected in terms of a mix of services types and settings, therefore this finding may be transferable to other AMIHS sites in NSW.

Clients appreciated the flexibility, the cultural competence of AMIHS staff, and the person-centred nature of service delivery. Most other stakeholders also believed that AMIHS was a valuable program. Many stakeholders believed the AMIHS population had a higher level of health and welfare complexity than the [eligible] population not using AMIHS. But AMIHS was viewed by many stakeholders as an appropriate program to support such clients because it was flexible, clients could be linked with other services, and AMIHS staff adopted a sensitive and non-judgemental approach.

Overall the program is being implemented as intended and there is a strong perception from most stakeholders that genuine benefits were being obtained. Some of these perceived benefits included social and welfare benefits, such as stable housing and improved mental health and better engagement with health and community services more generally. It was also noted that the impacts of AMIHS could be accruing more slowly than anticipated, possibly over the course of not one but several pregnancies and were therefore difficult to measure.

The evaluation found there was variation between AMIHS sites in how some of the essential elements of the AMIHS SDM were being implemented. Some of these elements were found to be more crucial than others in relation to ensuring the uniqueness of AMIHS in comparison with other maternity services and ensuring that the program outcomes can be achieved.

These elements included the non-clinical type elements (e.g. involvement in health promotion and community development, working collaboratively with service partners, building community partnerships), which also appear to be the elements that are most likely to be implemented with some deviation from the model. There was a strong sense that these deviations from the intended model, at least in some sites, were due to an undersupply of staff (AHW and midwife), and therefore staff time, in comparison to demand for the service.

Where possible, reducing the level of variation in the implementation of essential elements of AMIHS (except where this is a desirable local adjustment) represents a useful direction to improve this highly respected program.

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Appendix 1: Limitations of the data

This report draws on a significant amount of qualitative data collected via 154 interviews with a broad range of stakeholders related to the AMIHS program. This extent of data collection is not unprecedented but forms a very significant body of evidence, nevertheless. Despite the significance of the data collection, though, there remain limitations to the data and analysis that should be acknowledged.

An inherent bias exists within the methodology adopted for the sampling and recruitment of stakeholders that may have affected the depth and breadth of the information collected and the authenticity of the findings presented in this report.

Firstly, the way that purposive sampling was used to recruit stakeholders for interviews may have had some limitations. Stakeholders were invited to participate in interviews based on their involvement and knowledge of the program. There is the potential that some important stakeholders were not invited to participate in interviews because they were unknown to the evaluation team, the Ministry and the advisory committees. However, as a way to counteract this effect, in each case study site participating clients were asked if they knew anyone else who might like to participate and they were invited to share the contact details of the Aboriginal team member or the AHW with any other interested community members (i.e. encouragement of a "snowballing" technique for recruiting other participants). Similarly, all interviewers conveyed an attitude of openness during interviews with staff of AMIHS and other local services to the addition of interviews with other relevant respondents and the addition of interviews occurred on numerous occasions during site visits. Site visit timetabling was also arranged in advance to allow scope for this flexibility.

Secondly, at each case study site AMIHS staff were closely involved in identifying and recruiting relevant stakeholders (and particularly clients) for interviews. While the evaluation team emphasised the importance of seeking a broad and varied perspective from clients (including clients and families that might have not been satisfied with the AMIHS service), a potential bias could have arisen whereby only clients with a positive perspective of AMIHS were recruited for interviews. Although processes to manage privacy and confidentiality and to ensure cultural safety were built into the evaluation method, it is still possible that clients with adverse comments to make about AMIHS did not put themselves forward to be interviewed for fear of being identified or information shared through the interviews being disclosed. As described in the findings, fear of government services is a significant concern for many of the communities visited; therefore, it is possible that clients would have been fearful to share information with the evaluation team.

Similarly, due to the small communities in which AMIHS services are delivered where community members and service providers are often familiar with one another, some stakeholders, more broadly may have been apprehensive to participate and share information, particularly negative information about the AMIHS program or related issues. Despite these potential barriers, the evaluation team were satisfied that dissenting voices were located and interviewed across all aspects of the evaluation, allowing the team to consider any themes or storylines that emerged from that data. Efforts have been made to represent in this report the divergence of views that were observed.

Thirdly, there are limitations to the analysis of the data due to the interpretation of the evaluation team. The individual and collective knowledge and experience of the evaluation team members (both Aboriginal and non-Aboriginal) will inevitably influence what data is highlighted (in the form of themes), how it is interpreted and how the data is presented. This knowledge and experience can also represent a strength in the interpretation and analysis of the data where a deeper meaning, understanding or clarification can be made.

Appendix 2: Description of service types

	Service type characteristics
1. Higher ratio midwives and clinic-based service model	Number of sites: 10 Sites in this cluster most closely represent traditional maternity services. They are predominantly characterised as being midwife-led with a higher ratio of Midwives and delivering a higher proportion of clinic-based services. However, AHWs and midwives undertake tasks together at most sites and there is a high level of agreement that working conditions match program needs.[24] Sites consider community consultation to be 'effective'. They report low levels of community engagement, community development and health promotion activities, but a high level of input from the Aboriginal Health Worker and Midwife into how funds for these activities are expended. Working relationships with local ACCHS are considered 'somewhat effective' but are reported as 'extremely effective' with local CFH services.
2. Aboriginal Health Worker-led and home visiting service model	Number of sites: 13 Cluster 2 sites are predominantly characterised as having a higher ratio of AHWs and, compared to other clusters, more tasks are led by AHW. However, strong collaboration between AHWs and midwives is present across sites in this cluster. Sites report delivering predominantly 'home visit' type services and there is a high level of agreement that working conditions match program needs. Community consultation is considered to be 'somewhat effective'. Sites report a low level of time spent in community engagement, community development and health promotion activities yet a high level of input by the Aboriginal Health Worker and Midwife is reported into how funds for these activities are expended. Sites are also characterised by 'effective' working relationships with ACCHS and 'extremely effective' working relationships with local CFH services.
3. AMIHS type service model	Number of sites: 9 Sites in Cluster 3 are characterised as being most strongly aligned with the documented AMIHS SDM. In general, service delivery is by 'home visits', there is a one-to-one ratio of AHWs to midwives, and tasks are undertaken jointly by the Aboriginal Health Worker and Midwife. Consultation with the community is considered to be 'extremely effective'. There is a high proportion of community engagement, community development and health promotion activities, which are predominantly led by the AHW. But

[24] Responses in relation to working conditions address the following key question in relation to the documented AMIHS model: "Do the AMIHS program working conditions for the Aboriginal Health Worker and Midwife match the program needs, for example allowance for out of normal hours work, support to do home visits, flexible hours policy?"

	Service type characteristics
	a low level of input from the Aboriginal Health Worker and Midwife into how health promotion and community development funds are expended. Sites consider working relationships to be 'effective' with ACCHSs and 'extremely effective' with local CFH services.
4. Higher ratio AHWs and outreach service model	Number of sites: 8 Cluster 4 sites are characterised by outreach service delivery and a higher ratio AHWs. There is generally an equal relationship between the Aboriginal Health Worker and Midwife with most tasks undertaken together or equally likely to be led by either worker. Community consultation is considered to be 'somewhat effective'. There is a high proportion of community engagement, community development and health promotion activities, which are predominantly led by the midwife. But a low level of input from the Aboriginal Health Worker and Midwife into how health promotion and community development funds are expended. Sites consider working relationships to be 'effective' with local ACCHSs and 'extremely effective' with local CFH services.
5. Higher ratio midwives and home-visiting service model	Number of sites: 6 Sites in this cluster are characterised as being least aligned with the documented AMIHS SDM. Sites are generally midwife-led with a higher ratio of Midwives, but AHWs and midwives undertake tasks together at most sites. Sites are characterised by 'home visiting' type service delivery, however, there is very low agreement that working conditions match the program needs. Sites in this cluster report no time spent in community engagement, community development or worker input into funds for these activities are expended. Working relationships with local CFH services were considered 'effective' for this cluster. Half of the sites reported that there was no ACCHSs in their catchment area, while the other half reported an 'effective' to 'extremely effective' relationship.


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