Literature review summary report:

Successful strategies to increase involvement in antenatal care and to increase duration of breastfeeding that can potentially be applied to the Aboriginal and Torres Strait Islander context

Population Health Services
Central Area Health Service

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Introduction

The report is a summary version of a larger systematic and narrative review report. The report follows on from two recommendations from the recent project ‘The Growth of Young Aboriginal and Torres Strait Islander Children in Central Zone’. The Child Growth project identified a need for emphasis to be placed on accessing antenatal care and looking at what types of antenatal care programs are or could be successful in the Indigenous context. It also highlighted the need to consider ways to increase duration of exclusive breastfeeding until six months and complementary breastfeeding beyond six months.

Purpose

The purpose of the report was to look at what strategies have been shown to be successful at increasing involvement in antenatal care and also increasing the duration of breastfeeding. This was done by looking at strategies that had been evaluated and reported on elsewhere.

In Australia very few evaluated studies have been conducted focusing on access to antenatal care interventions and breastfeeding duration in the Indigenous context. For this reason the report primarily focuses on what interventions have been shown to be successful among the non-Indigenous population of Australia or overseas. The main aim of the report is to look at what has been successful among the population as a whole and consider the potential application to the Aboriginal and Torres Strait Islander context. It is important to note that there may be numerous interventions provided to pregnant Aboriginal and Torres Strait Islander women which may not have been evaluated and / or have not been published.

It must be acknowledged that the factors contributing to the continued health inequalities between Aboriginal and Torres Strait Islander people and other Australians have been described as multiple and interlinked, and include lack of access to appropriate and acceptable health care, socioeconomic factors, environmental factors, socio-political factors and specific health factors (National Aboriginal and Torres Strait Islander Health Council 2004).

Issues to consider when planning an antenatal or breastfeeding intervention within the Aboriginal and Torres Strait Islander healthcare setting

It must be recognised that all Aboriginal and Torres Strait Islander communities are different and in order to implement any intervention the main needs and characteristics of the community must be considered, such as what staff resources are available, what transport is available, who does the community listen to – doctor, nurse or health worker etc.

Many of the studies included in the report used a number of different breastfeeding definitions; therefore it was difficult to compare one study to another. Collection of data
for any intervention should be measurable and consistent with national indicators and their definitions.

The review found there were few publications of high quality in the Aboriginal and Torres Strait Islander context. Reporting all outcomes, even if negative, would enable others to learn from interventions already tried.

The main review did not identify any study that focused on the knowledge, attitudes and practices of Aboriginal and Torres Strait Islander women on the topic of accessing antenatal services or breastfeeding duration. However, many studies concluded that consultation with pregnant women and mothers of infants needs to occur to help guide intervention approaches. This was a key point highlighted by the evaluators of the Strong Women, Strong Babies, Strong Culture program. Improved birth outcomes were attributed to both the health staff and Aboriginal community working together in designing and implementing the intervention.

**Why worry about antenatal care?**

The Central Zone (presently known as Central Area Health Service) Child Growth report indicated that 13.8% of children had a low birth weight and that 21% had been born prematurely (less than 37 weeks gestation). The report identified the association between low birth weight babies and the age of the mother. Mothers aged 18 years or below were more likely to give birth to a low birth weight baby (18.2%) compared to mothers aged 20 to 29 years (12.4%). The report findings also identified a much higher percentage of teenage mothers. One in every four (25%) pregnancies was to a teenage mother compared to six percent in the total population of Queensland.

Prematurity and low birth weights are issues of concern because these children are at greater risk of:

- Infections and delayed development in infancy and childhood
- Obesity and chronic diseases including diabetes, hypertension and renal disease in adult life.

Some of the main reasons for babies being born too early or having a low birth weight are pregnant women smoking, drinking, taking drugs, having sexually transmitted diseases or not eating enough healthy food.

One of the benefits of antenatal care is that it provides an opportunity to help the pregnant woman and her family address some of these issues. The objective of antenatal care is to deliver effective, appropriate screening or preventative treatment interventions. Therefore there needs to be sufficient time given to antenatal care throughout the pregnancy to allow for this to occur.

Four out of the five Aboriginal and Torres Strait Islander health services included in the Central Zone (presently known as the Central Area Health Service) Child Growth report
provided antenatal services. In all four areas the antenatal service provided was a one-to-one clinic. In addition, two of the health services offered home visits and one offered group sessions.

Work to date looking at antenatal care for Aboriginal and Torres Strait Islander women

A recent literature review commissioned by the Commonwealth Department of Health and Ageing summarised nine antenatal care programs that targeted Aboriginal and Torres Strait Islander expectant mothers (Herceg 2005). The review was designed to collate information on interventions that have been shown to improve health outcomes (eg. birth weight) or intermediate health measures (eg. access to antenatal care) in Aboriginal and Torres Strait Islander mothers, babies and young children. Common factors of antenatal care that were identified by this literature review were:

- Community-based and/or community controlled services
- Specific service location intended for women and children
- Continuity of care and a broad spectrum of services
- Integration with other services (hospital liaison, shared care)
- Outreach activities
- Home visiting
- Welcoming and safe environment
- Flexibility in service delivery and appointment times
- Focus on communication, relationship building and development of trust
- Respect for Aboriginal and Torres Strait Islander people and their culture
- Respect for family involvement in health issues and child care
- Having an appropriately trained workforce
- Valuing Aboriginal and Torres Strait Islander staff and female staff
- Provision of transport
- Provision of childcare or playgroups
Summarised results from the systematic review

Which antenatal interventions improved birth outcomes?

An antenatal intervention can be made up of numerous components. Successful interventions were found to comprise of one or more of the following components:

- Provision of transport
- Health education delivered face-to-face or through group sessions
- Social and peer support delivered by professionals or other community people
- Telephone contact, although not as effective as face-to-face interventions

What interventions increase attendance and involvement in antenatal care?

- Home visits compared to standard care at health service led to increase in:
  - awareness of community services
  - attendance at childbirth education classes
  - interest from father and extended family

Home nursing interventions were found to be more effective for clients who were considered high risk, such as those who were unmarried, low income and teenage mothers.

- Continuity of care led to increase in:
  - on time hospital admissions (rather than antenatally)
  - attendance at childbirth education classes
  - feeling prepared for labour
  - feeling prepared for childcare

Why worry about breastfeeding duration?

There are many important benefits of breastfeeding for both the mother and baby. Table 1 in the Appendix outlines the health benefits of breastfeeding.

Traditionally Aboriginal mothers breastfed their babies exclusively for six months and have been reported as breastfeeding their child up to four years of age (Mountford 1960). However, limited but recent Australian studies illustrate that there has been a decline in the duration of breastfeeding in many urban and regional areas of Australia among Aboriginal and Torres Strait Islander mothers including north Queensland, Brisbane, Perth and Melbourne (Holmes 1997; Hayman 2000; Binns 2004; Panaretto 2005).

In Australia, it is recommended that our promotion of breastfeeding is in line with the World Health Organisation’s recommended guidelines; i.e. that babies should be
exclusively breastfed until six months of age, before the safe introduction of suitable solids. The Central Zone (presently known as the Central Area Health Service) Child Growth report indicated that while initiation of breastfeeding was fairly high, complementary feeding (i.e. breast and formula feeding) or a complete change to formula feeding was a frequent occurrence often soon after birth (CPHUN 2005).

Table 2 in the appendix outlines the Ten Steps to Successful Breastfeeding the World Health Organisation recommends for every facility providing maternity services and care for newborn infants should adopt.

**What breastfeeding interventions increase the initiation of breastfeeding?**

- Health education
- Breastfeeding promotion packs
- Early mother-infant contact

**What breastfeeding interventions increase the duration of breastfeeding?**

- Group sessions during prenatal period
- Health education delivered in the prenatal period
- Professional support
- Combined face-to-face information, guidance and support
- Early skin-to-skin contact
- Home visits during postnatal period using photos or flip charts (this teaching method could also be effective in home antenatal services)
- Combination of group sessions, home visits and one-to-one sessions
- Rooming in i.e. allowing mothers and infants to remain together for 24 hours a day
- Media campaign and structural changes to the health sector, such as main stream services, for example hospitals, working in partnership with Aboriginal and Torres Strait Islander community controlled organisations
- Peer support programs (in some cases effective and not in others)
- One-to-one education
- Health education sessions delivered in the prenatal period plus telephone call 48 hours after discharge and a visit from lactation consultant one week post birth.

Note – Some studies recommended involvement of professional support whereas other studies found that the effect of the intervention did not vary depending on who provided the intervention i.e. peers or professionals.
Appendix

Table 1: Benefits of breastfeeding

<table>
<thead>
<tr>
<th>Mother</th>
<th>Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Faster recovery for mother to previous health status before pregnancy</td>
<td>• Reduced incidence/protection against many different infections</td>
</tr>
<tr>
<td>• Possible improved bone mineralisation and decreased risk of postmenopausal hip fracture</td>
<td>• Reduced prevalence of asthma</td>
</tr>
<tr>
<td>• Prolonged period of post-partum infertility, leading to increased spacing between pregnancies</td>
<td>• Possible reduced risk of auto-immune disease, such as type 1 diabetes and inflammatory bowel disease</td>
</tr>
<tr>
<td>• Possible accelerated weight loss and return to pre-pregnancy body weight</td>
<td>• Possible reduced risk of developing cow’s milk allergy</td>
</tr>
<tr>
<td>• Reduced risk of pre-menopausal breast cancer</td>
<td>• Possible reduced risk of excess weight gain later in childhood</td>
</tr>
<tr>
<td>• Possible reduced risk of ovarian cancer</td>
<td>• Improved eye sight and muscle and coordination development, which may be caused by polyunsaturated fatty acids in breast milk</td>
</tr>
</tbody>
</table>

Source: Adapted from the National Health & Medical Research Council Dietary Guidelines for Children and Adolescents in Australia

Table 2: Ten steps to successful breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all staff.
2. Train all health staff in skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half hour of giving birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Adapted from World Health Organisation Ten Steps to Successful Breastfeeding (WHO 1998)
Reference List


Engeler, T., McDonald, MA., Miller, ME et al. (1998). Review of current interventions and identification of best practice currently used by community based Aboriginal and Torres Strait Islander health service providers in promoting and supporting breastfeeding and appropriate infant nutrition. Canberra, Commonwealth of Australia.


