



Commonwealth Department of  
Health and  
Family Services

# *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*



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We hope that what we have written reflects as fully as possible all contributions. We apologise for any omissions and hope that this project will help to develop better services to support Aboriginal and Torres Strait Islander women and their families, to ensure that Indigenous infants receive the best nutrition and start in life.

## **Copyright and disclaimer**

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# Abbreviations

ABS	Australian Bureau of Statistics
AMS	Aboriginal Medical Service
ATSIC	Aboriginal and Torres Strait Islander Commission
BGHS	Bega Gambirringu Health Services
BRAMS	Broome Regional Aboriginal Medical Services
CHASP	Community Health Accreditation and Standards Programme
FTT	Failure to thrive
FYCS	Family, Youth and Community Services
HACC	Health and Community Care
IBCLC	International Board Certified Lactation Consultant
KAMSC	Kimberly Aboriginal Medical Services Council
NACCHO	National Aboriginal Community Controlled Health Services
NAIDOC	National Aboriginal and Islander Day of Celebration....
NGO	Non-government organisation
NMAA	Nursing Mothers' Association of Australia
NPY	Ngaanyatjarra Pitjantjatjarra Yankunytjatjara Women's Council
NTP	Ngunytju Tjitji Pirni Aboriginal Corporation
NSW	New South Wales
NT	Northern Territory
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services
QH	Queensland Health
RFDS	Royal Flying Doctor Service
SA	South Australia
TAFE	Technical and Further Education
TPHU	Tropical Public Health Unit
UNICEF	United Nations International Children's Emergency Fund
UQ	University of Queensland
VAHS	Victorian Aboriginal Health Service
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

## The review team

This review was conducted at the same time and in conjunction with an audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal and Torres Strait Islander women. The findings of that audit are reported separately. The roles and responsibilities of the people involved in the two projects are listed below.

### Steering group

This consisted of representatives of the three consortium members. They were responsible for overseeing the management plan and monitoring the progress and quality of the projects.

- Professor Mary E Black, Professor of Public Health in the Department of Social and Preventive Medicine, Northern Clinical School, University of Queensland, Cairns.
- Dympna Leonard, Senior Public Health Nutritionist at the Tropical Public Health Unit (TPHU) in Cairns.
- Sandra Tanna, former Project Officer (Women's Issues), Apunipima Cape York Health Council, now manager of Mookai Rosie Bi-Bayan, an accommodation and support facility for Aboriginal women from Cape York and Gulf of Carpentaria communities who come to Cairns to give birth and for Aboriginal children who come to visit health specialists.
- Dr Ozren Tomic, Health Planner for the Apunipima Cape York Health Council.

### Project team

The project team conducted the review, consulted with Indigenous advisers, analysed the contributions, conducted site visits and drafted this report and the accompanying booklet. Its members, their areas of expertise, main roles and responsibilities for both projects are listed below:

- Mary Ellen Miller, Organisational Psychologist: project manager, telephone interviews, site visits and reporting for the interventions review project in Victoria, Queensland and New south Wales, reporting of policy implications.
- Therese Engeler, Midwife, Family and Child Health Nurse, Lactation Consultant: principal for the interventions review project, literature review, telephone interviews, site visits and reporting for the interventions review project in New south Wales and Queensland.
- Dr Anita Groos, Public Health Nutritionist: principal for the training audit project, site visits and reporting for the interventions review project in Western Australia and the Northern Territory.

- Mary Anne McDonald, Public health Consultant: project planning, interventions review analysis and reporting.
- Adjunct Professor Ian Siggins, Department of Social and Preventive Medicine, University of Queensland, Brisbane: data management, analysis and reporting.
- Jo Winterbottom, Journalist: editing of tender documents and draft reports.
- Tim Blumfield, Research Assistant: Internet and university handbook searches for the training audit.
- Lorene Johnson, Research Assistant: secretarial and database support.

## Commonwealth Steering Committee

Briefing and guidance was provided by the Commonwealth Steering Committee.

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- Dawn Plested, Director, Health Issues Section, OATSIHS.
- Jan Streatfield, OATSIHS.
- Jill Guthrie, OATSIHS.
- Polly Sumner, Nunkuwarrin Yunti Inc, Adelaide (also representing the National Aboriginal Community Controlled Health Organisations [NACCHO]).
- Mavis Gold, Aboriginal Health Coordinator North Coast, Public Health Unit, NSW.
- Margaret Campbell, Healthy Public Policy Unit, Public Health Division, Department of Health and Family Services.

## Indigenous advisers

The Indigenous advisers listed below provided guidance to the project team on local health and community networks, appropriate Indigenous community representatives, and pertinent local issues. They also provided information and advice on interventions and the review methodology, as well as assessing the work of the project team to ensure it was relevant to and representative of Indigenous communities.

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### Northern Territory

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## Queensland

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Cindy Shannon, Associate Professor, Indigenous Health Program, University of Queensland, Herston.

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## South Australia

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## Victoria

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## Western Australia

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# Executive Summary

## Introduction, background and terms of reference (Chapter 1)

In April 1997, the Office for Aboriginal and Torres Strait Islander Health Services (OATSISHS), in conjunction with the Healthy Public Policy Unit (both of the Commonwealth Department of Health and Family Services), commissioned two projects as part of the national initiative 'Health Throughout Life: Maternal Health—Increasing Rates of Breastfeeding in Australia'. This report looks at different ways in which health service providers promote and support breastfeeding and appropriate infant nutrition. It is accompanied by a book which will be published in 1998<sup>1</sup>. The idea behind the book is to share information about what is going on—it contains examples from around Australia of breastfeeding and infant nutrition projects and suggests ways in which people could develop new projects. A second report focuses on training opportunities for Aboriginal and Torres Strait Islander health workers and other primary health care practitioners in breastfeeding support and infant nutrition<sup>2</sup>.

There is concern about the high rate of infections in and hospitalisation of Indigenous infants, the effects of colonisation on traditional feeding practices, the persistence of outdated information and shortfalls at health service and community level. Good nutrition for infants, including the benefits conferred by breastfeeding, are seen as essential to ensuring better immediate and long-term health.

This chapter reviews the terms of reference and scope of the project. The project was completed by a team of public health consultants supported by a consortium of three institutions—the Department of Social and Preventive Medicine, University of Queensland, Cairns; Queensland Health's Tropical Public Health Unit, Cairns and the Apunipima Cape York Health Council. A national network of Indigenous advisers and a Commonwealth steering committee provided advice and guidance.

## Literature review (Chapter 2)

Breastfeeding is the ideal source of nourishment for a baby and confers multiple health and other benefits. Good food at the right time is essential for the short and long term health of a child. Traditional feeding practices were to breastfeed for periods of up to four years and on occasion longer, and introduce nutritious bush foods. Epidemiological data from around Australia notes that Indigenous Australians now have a lower breast-feeding rate than non-Indigenous Australians, except where a traditional lifestyle has been maintained. The reasons for changes are reviewed, including the effects of colonisation and current failures in knowledge, information and health

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1 Giving Aboriginal and Torres Strait Islander babies the best start in life: supporting breastfeeding and good food choices for infants. Stories and ideas from around Australia. Commonwealth Department of Health and Family Services, 1998.

2 Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal or Torres Strait Islander women. Commonwealth Department of Health and Family Services, 1997.

systems. Economic, social and other factors also play a part. The health and growth of Indigenous children and their relation to food is discussed, together with a review of national and international breast-feeding promotion strategies.

### **Methodology (Chapter 3)**

The approach took into account the culturally valid understandings of Aboriginal and Torres Strait Islanders in relation to health and health care especially where infant nutrition was concerned. Consultation in developing both review tools and the general approach was, within the constraints of a tight time frame, extensive. This process was facilitated by the national network of Indigenous advisers. Background information was collated using a literature search, a scan of policy documents and other relevant papers. A semi-structured guide for telephone interviews and an intervention assessment tool enabled data to be collated and analysed. Submissions were gathered between May and August 1997, using known contacts from a variety of sources, a national media call for submissions and a targeted distribution of flyers. Organisations were classified by type and State or Territory.

### **Results (Chapter 4)**

Sixty-five organisations provided formal responses, 46 of which were useful for the purposes of this report, and 36 of which were current. Of these, 22 were specifically targeted to Indigenous people. Contributions in the areas of community development, health promotion, information and counselling and support strategies are reviewed. Interventions supported women and their families in a variety of ways, including planning breastfeeding choices during pregnancy, establishment of breastfeeding, maintenance of breastfeeding, management of breastfeeding problems, introduction of first foods, assessing babies' health, referral to lactation consultants and access to mother-to-mother support groups. Thirteen respondents reported some kind of formal evaluation, and 8 reported data collection on breastfeeding.

The 46 projects are summarised and a subset of 13 are described in detail, together with comments from those involved on effective aspects and suggestions for future development.

### **Summary of findings and discussion (Chapter 5)**

This section summarises common themes from submissions, interviews and site visits. Issues relating to breastfeeding are covered more thoroughly than those relating to the introduction of other foods. This reflects participant responses and time constraints. Breastfeeding and infant nutrition are not seen as a priority issue by all providers. Variations in perspective between urban providers, where in general breastfeeding rates are lower, and those in remote rural areas was marked. Resources, combined with social and political action are key. Examples of State policies that take a long-term view to promote breastfeeding and appropriate infant nutrition are reviewed. Multiple approaches are needed. Sustainable funding and the importance of pro-active services emerged as strong concerns. Competence of health staff to diagnose, manage and refer is often constrained by a lack of expertise or workplace support to exercise skills. Strong emphasis was given to understanding that infant nutrition issues need to be placed within the wider context of women's lives—the effect of lost parenting skills in the 'stolen generation' is noted. A resounding theme was the need for health policies to address erroneous assumptions about technical aspects and community dynamics—examples of these are given. The simplistic view that 'information will solve the problem' is challenged. A large gap is noted in research and evaluation.

## Recommendations (Chapter 6)

The aim of these recommendations is to develop and sustain an environment which supports Aboriginal and Torres Strait Islander mothers to breastfeed and to provide appropriate food for their babies. OATSISHS has a critical leadership role to play in ensuring that this is achieved.

With these aims in mind the following recommendations are made.

### Policy and information

- A national breastfeeding and infant nutrition policy should be developed using the example of the Northern Territory Health Services Breastfeeding Policy and Strategic Plan 1994–2000.
- National Aboriginal and Torres Strait Islander goals and targets need to be developed which include specific targets relating to breastfeeding, infant nutrition and growth. These should be based on those agreed by the Australian Health Ministers' Advisory Council in July 1997.
- A nation-wide health information system should be developed which includes indicators of breastfeeding and infant nutrition practice, in order to inform local, State and national agencies about progress towards the above goals and targets.
- Breastfeeding needs to be recognised as the physiologically normal way for a mother to feed her child. The current practice of emphasising the protection offered by breastfeeding implies that the breastfed baby is specially 'privileged' and receives health protection and benefits over and above the norm. Materials should present breastfeeding as being normal and the entitlement of every child.
- Health facilities where Indigenous mothers give birth need to be supported to adopt 'best practices' policy and protocol, such as those detailed in the *WHO/UNICEF Baby Friendly Hospital Initiative*. This should enable those facilities to support breastfeeding for Indigenous babies and particularly for 'high risk' babies (e.g. low birth weight, premature or born to mothers with diabetes).
- Accreditation systems for hospitals, community health services and Aboriginal Medical Services should include criteria on breast feeding and infant nutrition practice and protocols (such as the *WHO/UNICEF Baby Friendly Hospital Initiative* guidelines).
- Women's health policy and women's health initiatives at national, state and local levels should specifically include breastfeeding, which has many benefits for the health of women as well as babies.
- Continuity of funding needs to be seen as a necessity in program planning at all levels. Community and health staff commitment is jeopardised when funding is not sustained at critical times, impacting not only on the immediate situation but also future initiatives. When programs are transferred from one jurisdiction to another (e.g. from national to State level), current and future funds should be quarantined to ensure program continuity.

### Staff expertise

- Appropriate training for Indigenous health staff in breastfeeding and infant nutrition should be developed, provided and promoted. Detailed training recommendations for Indigenous and non-Indigenous staff are included in the companion national report on Training<sup>3</sup>. Expertise in breastfeeding, infant nutrition and the relationship between nutrition, infection and growth needs to be developed.

- A career path needs to be developed for Indigenous health workers who may become specialists in the area of maternal and child health and/or breastfeeding and infant nutrition.
- Hospitals where Indigenous mothers give birth should employ Indigenous staff with appropriate expertise in breastfeeding and infant nutrition. Indigenous health staff are also needed in other health settings utilised by Indigenous mothers and families.
- Accreditation systems for hospitals, community health services and Aboriginal Medical Services should include criteria in respect of staff expertise in breastfeeding and infant nutrition.
- Recommendation 247 of the Royal Commission into Aboriginal Deaths in Custody concerning training of mainstream staff in health and cultural sensitivity issues should be implemented at all levels of the health system.
- A clearing house for information on programs and projects relating to breastfeeding and infant nutrition should be established to facilitate networking and experiential learning from elsewhere. This could include a website and the book<sup>4</sup> produced to accompany this report.
- Further work needs to be done to develop a training and resource kit and revisit and update the NSW Department of Health and the Nursing Mother's Association of Australia Thallikool Infant Nutrition kit for Health Workers.
- Health staff be given clear and unambiguous information about the rare situations where breast feeding is medically contraindicated because of risks of infection to the baby. The current information in the NHMRC document Infant feeding guidelines for Australia is ambiguous, and health staff are uncertain about the advice they should be providing, particularly in relation to hepatitis B, hepatitis C and HIV.

## Service management

- Service managers should be supported to develop, implement and evaluate initiatives relating to breastfeeding and infant nutrition. This can be done by establishing a small, nationally mobile expert team on whom health providers can call for advice and support in project design and particularly for evaluation strategies.
- Breast feeding and infant nutrition objectives should be incorporated into routine service provision and evaluated. Provision must be made for this in service planning and funding.
- Protocols for the assessment of nutrition, growth and development are needed. Staff need to be able to assess growth and nutrition and give appropriate advice for the feeding of the well, sick and convalescent child. The important inter-relationship between infection, nutrition and failure to thrive must be incorporated in staff practice and in training.
- Service managers should ensure that services are available, physically accessible (including outreach and mobile services as required) and culturally appropriate for Indigenous clients.
- Health information systems should be used for active follow-up and support for a mother in the early years of her baby's life, rather than passive reliance on the mother to present for care.
- Linkages between services should be established/strengthened to enable staff to access specialist services, and track mothers and children where substance misuse, alcohol misuse, violence and other factors place mothers and children 'at risk'. Concerns about confidentiality should be addressed and not seen as a barrier to linkages.

<sup>3</sup> Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal and Torres Strait Islander women. Commonwealth Department of Health and Family Services, 1997.

<sup>4</sup> Giving Aboriginal and Torres Strait Islander babies the best start in life: Supporting breastfeeding and good food choices for infants. Stories and ideas from around Australia. Commonwealth Department of Health and Family Services, 1998.

## Research

- Research needs to be conducted into health service factors which appear to have a major impact on the establishment and maintenance of breastfeeding. Factors affecting healthy mothers and babies include early hospital maternity discharge programs. Factors affecting 'at risk' mothers and babies include aspects of neonatal care of low birth-weight babies and babies born to mothers with gestational diabetes.
- Research should be conducted into the relationship between nutrition and infection in Indigenous infants and young children. There is, as yet, no comprehensive Australian study into the relationship between morbidity of young Indigenous children and feeding practices.
- The determinants of infant feeding and social and economic barriers to breastfeeding and good infant nutrition in Indigenous communities need to be identified.
- The lactation capacity and breastmilk composition of mothers who are chronically undernourished and/or alcohol misusers need to be assessed. The research on lactation by undernourished women has been conducted in settings where the usual diet is very different from that of Indigenous Australians (e.g. the Gambia).
- The 'when' and the 'what' of food needs for preterm, low birth weight and failure to thrive infants should be ascertained. Current advice assumes a well nourished mother and child.
- Epidemiological data on breastfeeding is best compiled as part of a routine health information collection system, as specified in the section on policy and information.
- The components of effective health promotion in Indigenous communities need to be identified. Health promotion strategies and materials should be evaluated for effectiveness in knowledge transfer and facilitating behavioural change.

## Community and family support

- An integrated health promotion initiative to promote breastfeeding and good infant nutrition among the Indigenous community should be developed and implemented. This initiative must be national in extent but locally relevant. It should have multiple target groups, including school-aged children, women of child-bearing age, fathers and uncles, grandmothers and aunts, as well as the general Indigenous community. Evaluation and impact assessment should be an integral feature of this initiative.
- Resources which can be adapted for local usage, need to be designed as part of this initiative for national usage. The resources should present breastfeeding as the norm and include robust, substantial and reliable information about feeding children, especially the introduction of first foods and links to growth and development.
- A one-to-one counselling system for breastfeeding Indigenous women should be established, similar to the peer counselling system of the Nursing Mothers Association of Australia. However, the use of unrelated, young, volunteer peers may not be appropriate for Indigenous women. A system for Indigenous mothers should build on the knowledge, skills and authority of older family and community women. Training should acknowledge and build on the knowledge and experience of these key people, as well as provide them with up to date knowledge and skills.
- Health literacy programs, incorporating information on breastfeeding and infant nutrition, should be made widely available in Indigenous communities. This could build on innovative work in Western Australia, the Northern Territory, New South Wales and Victoria.

- Workplace policies and practices to support breastfeeding should be described and promoted in Indigenous settings. Community employment and development programs would be a good place to start.
- Stores servicing Indigenous communities should be assessed with respect to their compliance with the *WHO International Code of Marketing of Breastmilk Substitutes*.
- Food security (i.e. access at all times to food necessary to maintain good health) needs to be assessed, and where necessary, improved in remote, rural and urban Indigenous communities.

## Chapter 1

# Introduction

### Background to this Review

The Office of Aboriginal and Torres Strait Islander Health Services, in conjunction with the Healthy Public Policy Unit (both of the Commonwealth Department of Health and Family Services), commissioned this report. It contains a review of current interventions and identification of 'best practice' currently used by community based Aboriginal health service providers in promoting and supporting breastfeeding and appropriate infant nutrition. The aim of this review is to identify 'best practice', which effectively encourages prolonged breastfeeding and appropriate introduction of additional food for Aboriginal and Torres Strait Islander infants.

Among Aboriginal and Torres Strait Islander communities, there is great concern about the high rate of infections and hospitalisation of infants. Breast feeding is the physiologically normal way to feed a baby, and there is a substantial body of research demonstrating that babies fed with breastmilk substitutes (i.e. bottle-fed) are more prone to infections and more likely to be hospitalised, even in affluent situations. Feeding by breastmilk substitutes is costly, and also contributes to a slower postpartum recovery of the mother. Language differences, lack of information and economic imperatives may lead to improper mixing of breastmilk substitution formulas or the use of ordinary fresh or dried milk. Research indicates that breastfeeding is particularly important for the 'high risk' child, such as low birth weight babies or babies of mothers with diabetes. These 'high risk' babies are over-represented among the Indigenous population. There are also issues relating to the timing of introduction and types of foods given to Indigenous babies.

Indigenous Australians traditionally breastfed their babies, and colonisation has adversely affected breastfeeding practices in Aboriginal and Torres Strait Islander communities. Studies reveal that Indigenous Australians have lower rates of breastfeeding than non-Indigenous Australians, except where a traditional lifestyle has been maintained. In addition, prevalence and duration of breastfeeding has been shown to be related to socio-economic variables, the age of mother and the spacing of children, with lower and shorter duration of breastfeeding associated with lower socio-economic groups, teenage mothers and women with several children close together. Aboriginal and Torres Strait Islanders are over-represented in each of these circumstances.

The growth reference standards currently in use in Australia are based on growth patterns of non-breastfed babies. As the growth velocity of breastfed babies is slower than that of non-breastfed babies, there is difficulty in interpretation of growth trends. On a simplistic level, the differing pattern of growth in breastfed infants may be interpreted as growth faltering. This sometimes prompts a switch from breastfeeding on the grounds that the mother is 'not producing enough' breastmilk. The timely introduction of appropriate solid foods is an important factor in this context: breastfeeding supplies all nutritional needs for the first six months of life, after which time solids should be introduced.

There are issues relating to breastfeeding and infant nutrition which are common to Indigenous and non-Indigenous people. Even within non-Indigenous communities, it appears that the established knowledge and information systems are falling well short of the needs of parents in providing consistent and good information about breastfeeding and infant nutrition. This is exacerbated in Aboriginal and Torres Strait Islander communities: whatever information and support is available through health providers, it may be of little relevance when local customs, languages and traditions are taken into account.

The support and promotion of breastfeeding in Aboriginal and Torres Strait Islander communities has been identified as a priority in several recent high-level Indigenous forums. These include the National Aboriginal Health Strategy, the Queensland Aboriginal and Torres Strait Islander Food and Nutrition Strategy, the Aboriginal and Torres Strait Islander Health Policy, Meriba Zageh for Diabetes (Torres Strait Island diabetes strategy), the Apunipima Cape York Health Council 1996 Women's Conference, and the Northern Territory Breastfeeding Policy and Strategic Plan.

Infant feeding decisions, like many other parenting decisions, are often made under the close scrutiny of family and friends. The parents are subject to judgment according to the latest trends of their social group and the inconsistent advice of health providers. These pressures are no different for Aboriginal and Torres Strait Islander parents, and are perhaps even aggravated by lack of culturally-appropriate health services as well as confusion due to a possible clash of cultures.

In carrying out this review, the team kept in mind that the great majority of Aboriginal and Torres Strait Islander women receive their antenatal, birthing and postnatal care in mainstream health settings. Numerous studies reveal that, while the decision whether or not to breastfeed is based on a complex range of variables, information available during antenatal care and support during the early postnatal period are important factors in the decision to breastfeed. Similarly, information and support during the postnatal period is important for the successful establishment and continuation of lactation. Hence, when looking at interventions which impact on breastfeeding and infant nutrition in Aboriginal and Torres Strait Islander communities, it is imperative to consider mainstream services such as hospitals and community health centres.

The review was conducted over five months, and draws together major findings from past research (literature review), an extensive scan of relevant reports and documents, contributions to the review, interviews of service providers and site visits to relevant services. It looks at the range of health care services which are used by Aboriginal and Torres Strait Islander people, both those which operate independently and those in mainstream services such as hospitals, community health services, general practitioners, obstetricians, specialist paediatric services and health promotion officers. All State and Territory Departments of Health were contacted about their relevant policy, project and program activity.

This report looks at the variety and nature of current services, interventions and programs and includes findings and conclusions on elements that enhance or limit the effect of interventions. It describes current service models, and identifies suitable, effective interventions for use by community-based Aboriginal and Torres Strait Islander health services. We also make recommendations for the future development of effective interventions.

It is envisaged that this report will guide policy, service delivery and resource development in promoting and supporting breastfeeding and appropriate infant nutrition in community controlled Aboriginal health services, and in mainstream health services used by Aboriginal and Torres Strait Islander women.

## Terms of reference

This report comprises one of two associated reports as part the national initiative Health throughout Life: Maternal Health—increasing rates of breastfeeding in Australia. The other report <sup>5</sup> looks at what training in breastfeeding and infant nutrition is available for Aboriginal health workers and others providing health services for Aboriginal and Torres Strait Islander women.

The Commonwealth commissioned the study: A review of current interventions, and identification of 'best practice', currently used by community based Aboriginal health service providers in promoting and supporting breastfeeding and appropriate infant nutrition.

We were asked to:

1. identify and review interventions currently used by community based Aboriginal and Torres Strait Islander health service providers in promoting and supporting breastfeeding and appropriate infant nutrition;
2. identify examples of 'best practice' and provide recommendations on suitable, effective interventions for use by community-based Aboriginal and Torres Strait Islander health service providers, in the promotion and support of breastfeeding and appropriate infant nutrition; and
3. prepare a written report on the outcomes of the review, which includes recommendations for effective interventions and 'best practice' in straight-forward language and in a style that takes account of Aboriginal and Torres Strait Islander culturally-valid understanding of health and health care.

In April 1997, this was expanded to cover the following points:

- the focus was to be on interventions providing support and assistance to women to maintain breastfeeding, not just provision of information, and interventions suitable for use by Aboriginal medical services and others delivering primary health care services; and
- the target audience for the report was Indigenous health care services, but a secondary audience was the broader health system. It might also form a basis for policy discussion and good practice guidelines at regional or local levels.

The essential outcomes of the review were:

- the identification of innovative programs and approaches that support Indigenous mothers in breastfeeding and providing appropriate infant nutrition;
- an assessment of their effectiveness, with an emphasis on sustainability and how they might be useful in other settings;
- clear recommendations on future policy direction and on ways in which the Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS) may focus its efforts for greatest effect in the future; and
- the identification of priorities for future research and program development and evaluation.

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<sup>5</sup> Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professional providing health care to Aboriginal and Torres Strait Islander women. Commonwealth Department of Health and Family Services, 1997.



## Chapter 2

# Literature review

### History

Knowledge of traditional infant feeding in Indigenous Australians has emerged through studies of groups who had limited contact with Western civilisation until recent times. While there are variations in cultural practices and beliefs about breastfeeding and infant nutrition, some common practices are evident. Traditionally, Aboriginal and Torres Strait Islander people breastfed for long periods, up to four years. The survival of infants depended on the provision of breastmilk (Hitchcock, 1989). There were various birth ceremonies and customs designed to ensure a plentiful supply of milk. Information regarding women's business such as infant feeding was passed from woman to woman through the generations (Carter et al., 1987). A woman other than the mother, usually a family member, would breastfeed the infant if necessary. Infants were breastfed exclusively until six months of age, when, in some groups, foods such as turtle eggs and soft fruit were introduced. Small pieces of food such as fish and vegetables were also given and pre-mastication by the mother was practised (Hitchcock, 1989).

### Present situation

Although information about current infant feeding practices in Indigenous communities is relatively scarce, contemporary studies reveal an erosion of breastfeeding practice amongst Aboriginal and Torres Strait Islander people. A study in Western Australia investigated breastfeeding practices in three different communities—remote, partly urbanised, and urban. Breastfeeding rates were highest for the more remote communities, with 100 per cent of mothers breastfeeding at three and six months and 90 per cent at two years. The prevalence of breastfeeding decreased with increasing proximity to urban areas (Gracey et al, 1983). Other studies have also found that, in urban communities, Indigenous breastfeeding rates are substantially lower and are similar to breastfeeding rates of non-Aboriginal mothers of low socio-economic background (Cox, 1981; Phillips and Dibley, 1983).

Even in remote areas where there are high rates of breastfeeding, failure to thrive may occur after six months of age. This has been attributed in part to exclusive breastfeeding for periods longer than six months and to the introduction of inappropriate first foods.

According to the 1995 National Aboriginal and Torres Strait Islander Survey, in which over 15,700 Aboriginal and Torres Strait Islander people were interviewed, 71 per cent of children aged 12 years and under had been breastfed as infants. Of these, 27 per cent were breastfed for 12 months or longer. Breastfeeding was more prevalent in rural areas, where 80 per cent of children were breastfed (ABS, 1995:14). The fact that a higher rate of breastfeeding was found amongst rural Aboriginal and Torres Strait Islander communities was consistent with other studies (Gracey et al., 1981; Rae, 1994; Pape, 1996).

An urban study by the Victorian Aboriginal Health Services found that while 85 per cent of infants were breastfed initially, only 50 per cent continued to be breastfed at three months of age. Moreover, 51 per cent of the infants received foods other than breastmilk before four months of age (Thorpe, 1994). In a study in the Northern Territory in 1992, the rates of exclusive breastfeeding for Indigenous babies in urban areas were 93 per cent at hospital discharge, 39 per cent at three months of age and 24 per cent at six months (Rae, 1994). Rae urges caution in the interpretation of the data owing to the small sample size and loss to transience of a number of participants (89 lost to follow-up by six months out of 492 original participants). The reasons given by mothers for discontinuing breastfeeding were perceived insufficient milk supply, sore or cracked nipples and difficulties in attachment or sucking. Less frequently cited reasons were mastitis, a sick baby, a dislike of breastfeeding and return to paid employment. Other issues raised were partner not happy with feeding choice or wanting to help feed the baby, embarrassment, body image and inadequate public facilities (Rae, 1994).

In keeping with the findings of other research, the Northern Territory study found breastfeeding rates amongst the rural Indigenous communities were significantly higher than for the urban communities. In the rural sample, 96 per cent of babies were breastfed from birth, 95 per cent at three months and 93 per cent at six months (Rae, 1994).

A subsequent study by Pape in the Northern Territory shows breastfeeding initiation rates of 91 per cent within the Indigenous Australians studied. At three months this rate had dropped to 65 per cent, and at six months only 52 per cent were being breastfed (Pape, 1996).

Studies in Indigenous communities indicate average breastfeeding initiation rates are high with a rapid decline in breastfeeding rates in the first few months. Breastfeeding is more prevalent in rural communities which have maintained more traditional breastfeeding practices and lifestyle. Reasons most often cited by women for discontinuing breastfeeding include perceived insufficient milk supply, physical discomfort, inconvenience and incompatibility with social or work arrangements.

Studies have found a correlation 'between the introduction of bottle feeding and a depression in the weight gain velocity of Aboriginal children—the cause being multi-factorial, incorporating inadequate hygiene, incorrect milk concentrations and infestations and infections of the gastrointestinal and respiratory tracts' (Hitchcock, 1989).

Problems observed with bottle-feeding Indigenous children include the use of inappropriate breastmilk substitutes such as modified cow's milk, both fresh and dried, and inadequate sterilisation of bottle-feeding equipment in conditions where this is difficult to achieve. These issues impact directly on the infant's health.

The early introduction of solid foods and inappropriate fluids is evident in some Indigenous communities. This may interfere with the protective mechanisms of breastmilk and allow the flourishing of opportunistic organisms (Gabriel, 1996:13). The greatest risk of disease to the infant is during the introduction of foods and fluids other than breastmilk. It is therefore essential to develop programs which address optimum timing for the introduction of solid foods, methods of food preparation, suitable available foods and the use of easily cleaned utensils to decrease the risk of contamination (CAN Bulletin 1992, cited in Gabriel, 1996). Delayed introduction of food or insufficient feeding can also contribute to undernutrition.

## Health benefits of breastfeeding

The human infant is designed to be breastfed. Consequently, breastfeeding provides unique health benefits to both mother and child which are lost to the non-breastfed child. Breastmilk is species specific: 'it has been adapted throughout human existence to meet nutritional requirements of the human infant to ensure optimal growth, development and survival' (Riordan, 1993:105). Breast milk not only supplies all nutrients required by an infant in the first six months of life, but protects against many common ailments and infections. It is the foundation for growth and development in later life (Akre, 1991).

### Benefits to the mother

There are benefits for lactating women in the immediate post-partum period and the longer term. Immediate post partum benefits include rapid uterine involution, faster return to pre-pregnancy body weight (Dewey et al, 1993) and contraceptive effects (Short, 1994). In the long term, breastfeeding has been found to be protective against pre-menopausal breast cancer (Siskind et al, 1989; Kelsey and John, 1994), epithelial ovarian cancer (Rosenblatt, 1993) and cervical cancer (Brock et al, 1989). It has also been shown to offer protection against osteoporosis (Cummings et al, 1984).

### Benefits for the infant

Breastfeeding offers the baby protection against gastrointestinal, chest, ear and urinary tract infections (Akre, 1991). The exact mechanism for this is largely unknown (Cunningham et al, 1991), but the specific anti-infective properties of breastmilk, as well as the passive and active immunity conferred by breastmilk, play a part in the protective process (Riordan, 1993). Furthermore, breastmilk contains immunoglobulins, which provide some immunity to early childhood disease. One study found that breastfed infants had significantly higher antibody levels than artificially-fed infants following vaccination against polio virus, diphtheria and tetanus toxoid (Hahn-Zoric et al, cited in McCauley, L, 1994). Breast milk also stimulates the development of the infant's own immune system (Akre, 1991).

Breastfeeding has been found to have a beneficial effect on cognitive development (Lanting et al, 1994) and visual acuity (Makrides et al, 1995). It has also been associated with a decreased risk of development of insulin dependent diabetes (Mayer et al). Pettitt et al (1997) also recently found in Pima Indians that breastfeeding was associated with a lower prevalence of non-insulin dependent diabetes amongst children of diabetic mothers.

In addition to the documented medical and nutritional benefits of breastfeeding, there are also psychological benefits to mother and child. Breastfeeding necessitates regular close interaction and skin contact between mother and baby. Mothers who have successfully breastfed relate the feelings of immense satisfaction and fulfilment it has given them (Kitzinger, 1979; Minchin, 1993).

A study which investigated the cognitive development of children who were born pre-term found those who had received breastmilk for at least one month had significantly improved cognitive development compared with those who had received no breastmilk (Lucas et al, 1992). Studies amongst children born at term are producing similar results (Bauer et al, 1991).

### Economic benefits

There is little doubt the benefits of breastfeeding are not limited to health, but extend into financial and economic benefits to individual households and the community at large. As breastfed infants

have been shown to be less susceptible to early childhood ailments, substantial savings are possible by reducing the prevalence of illness attributable to artificial feeding of infants. Reflecting national concern at the cost of maintaining the existing health care system, health services are increasingly required to provide benefits in a cost-effective manner. Drane (1997) estimated that a minimum of \$11.5 million could be saved each year in health care costs alone in Australia, if the prevalence of exclusive breastfeeding to three months was increased from 60 per cent to 80 per cent.

In addition, families benefit financially by not having to purchase infant formula and feeding equipment, as well as saving on medical bills.

## Introduction of solid foods

The introduction of solid foods to infants is not supported by research activity or by clear messages and targets. There is a lot of ambiguity about what to advise. Although the dietary guidelines for children and adolescents (NHMRC, 1995) cover this topic under the heading of 'enjoy a wide variety of nutritious foods', the messages appear to be primarily based on the case of a healthy and well-nourished mother and infant pair. More research is required to identify the food needs of poorly nourished mothers and babies. Extracts of the guidelines relating to the timing and type of solid food to be introduced are summarised below; the guidelines also cover suggestions on how this food should be introduced (NHMRC, 1995, p. 35-36).

### When should solid foods be introduced?

- The NHMRC guidelines recommend the introduction of solid foods between 4 and 6 months of age, when infants can begin to adapt to different foods, textures and modes of feeding.
- Although foods introduced at four months may not contribute significantly to nutrition, their gradual inclusion ensures that by six months of age, when these foods become important nutritionally, the infant is more likely to be able to cope with them.
- At this age, the infant's appetite and nutritional requirements are generally no longer satisfied by milk alone and stores of several nutrients (such as iron and zinc) are often falling.

However, it has been suggested that introduction of food before six months can reduce milk production. As first foods tend not to be nutrient rich, the baby may thus end up with a lower net intake of nutrients than if it was exclusively breastfed. Again further research is needed to clarify these issues—it may be that the present assumption of 'one size fits all' is incorrect.

Possible consequences of the inappropriate timing of introduction of solid foods are:

- introduction too early may lead to increased morbidity due to diarrhoea and food allergies, under-nutrition due to the normal decrease in maternal milk production as the baby suckles less; and
- introduction too late may lead to faltering growth, decreased immune protection, increased diarrhoeal disease, anaemia and malnutrition when exclusive breastfeeding becomes inadequate.

### What foods should be introduced?

The first foods introduced to a baby will establish food taste preferences which can influence eating throughout life. It is an opportunity to accustom a child to the flavours of healthy food such as fruit and vegetables. Conversely, if highly seasoned and/or highly sweetened foods are used as first foods, preferences for these flavours will be developed. (James et al, 1997)

Good first foods are:

- iron-enriched infant cereal at 4–6 months, then vegetables, fruit, meats, poultry and fish are added gradually as the infant becomes accustomed to them; and
- an increasing range and amount of food should be offered in the second six months. Solid foods should provide an increasing proportion of the energy intake because infants grow rapidly during this time. The process should lead to consumption of a wide variety of family foods by the end of the first year of life.

## Health status of Aboriginal and Torres Strait Islander children

Infant mortality rates in Aboriginal and Torres Strait Islander children have dropped considerably in the last 20 years, but they still remain two or three times greater than the national average, depending on the State. In 1993 in the Northern Territory, Aboriginal children accounted for 73 per cent of all deaths, but only 38 per cent of all births. In South Australia, Aborigines accounted for 9 per cent of deaths and only 3 per cent of births. In Queensland in 1994, 86 per cent of child deaths under the age of 12 related to three factors: peri-natal conditions, respiratory disease and infectious illnesses.

## Growth of Aboriginal and Torres Strait Islander infants

From 6 to 30 months of age, the high death rates are likely to be related to infant nutrition. Good nutrition is essential for adequate growth. Present growth monitoring data shows the nutritional intake of Aboriginal and Torres Strait Islanders children is not sufficient for healthy growth.

Gracey says, 'Growth appears to be satisfactory in the first several months of life but average attained weight for age appears to fall below the 50th percentile soon after six months' (Gracey, 1991). This is a typical growth pattern for Aboriginal and Torres Strait Islander infants in many communities, and is associated with repeated infections, especially respiratory and gastrointestinal infections.

There is a synergistic relationship between under-nutrition and infections. The cycle of 'bowel infections, diarrhoea, malabsorption, failure to thrive and decreased resistance to infection leading to malnutrition is well recognised' (Ruben and Walker, 1995).

## Breastfeeding promotion strategies

The problems associated with reduced prevalence and duration of breastfeeding have been recognised internationally for many years. There are a number of Australian projects from which valuable lessons can be learnt. It is not enough simply to provide more health education, hospital policy also needs to be addressed.

Specific breastfeeding promotion programs in the general population have included an intensive program to increase the proportion of primiparous mothers who breastfeed for 4 months or longer (Redman et al., 1995). The program consisted of written materials and group and individual sessions with a lactation counsellor. It also included a visit from a breastfeeding consultant while in hospital after the birth and contact on return home. Breastfeeding until 4 months was more likely among women whose baby did not receive bottle feeding while in hospital and who did not smoke, use the combined oral contraceptive or introduce solid foods before 4 months.

It has been said that no one strategy on its own will achieve substantial increases in breastfeeding rates, but multiple strategies may have a significant impact. A combination of the following strategies is more likely to be effective than one or two on their own:

- implement the World Health Organization (WHO) *Code of marketing of breastmilk substitutes*;
- improve health care practices, for example accreditation by the *WHO/UNICEF Baby Friendly Hospital Initiative*;
- provide breastfeeding education programs in undergraduate and post-graduate health care provider courses;
- encourage the work of community support groups;
- routinely report and record breastfeeding statistics;
- improve the conditions associated with paid employment, e.g. maternity leave and nursing breaks; and
- promote breastfeeding education programs to the community (NMAA, 1997).

Nutritional problems in Indigenous communities are very complex, and will not be alleviated by nutrition education alone; they require social and political action in a framework of community development.

### The international scene

The circumstances and experiences of programs in other countries should also be considered in the Australian context. In the Philippines, concern was raised at the decreasing rates of breastfeeding, and the consequent impact on child health and population growth (Williamson, 1990). Strategies to address this included:

- development and implementation of a breastfeeding program;
- establishment of a national organisation responsible to coordinate and promote national policies;
- amendment of national policy statements;
- involvement of multilateral international initiatives and programs; and
- encouragement of the presence of strongly motivated public servants who promote the policy.

In India, one of the barriers to breastfeeding was found to be health care services themselves (Anand, 1990). Health professionals were providing conflicting, inaccurate and inconsistent information on breastfeeding. Strategies adopted were to:

- review, amend and publish documentation on breastfeeding for national health personnel;
- ensure health providers are independent and the information they give not influenced by breastmilk substitute (formula) manufacturers;
- produce promotional material and utilisation of mass media;
- provide facilities to centralise references and training in major cities;
- collect a list of committed breastfeeding proponents from all over the world;
- study the knowledge, attitudes and practices of paediatricians regarding infant feeding;
- joint research ventures between clinicians and those with resources; and

- address loopholes in the *WHO International code of marketing of breastmilk substitutes* (1990).

In Kenya, strategies to encourage breastfeeding included:

- the recommendation of breastfeeding as soon as possible after delivery, full rooming-in, banning the routine use of supplementary feeding and rearranging hospital timetables to suit mothers and their babies, not staff;
- the effective banning the free supply of infant formula to Kenyan hospitals; and
- stopping the distribution of infant formula, in all hospitals and to institute practices beneficial to breastfeeding mothers (Bradley and Meme,1992).

In this country, changes in knowledge and attitudes of health workers were positive: for example, after the promotion, 83 per cent advocated breastfeeding to new mothers as the feeding method of first choice, compared to 53 per cent before the promotion; 89 per cent advocated rooming-in at all times, compared to 49 per cent before. Changes in practices in maternity facilities were also positive (putting babies on the breast within an hour of birth rose from 14 per cent to 61 per cent). Breastfeeding duration increased from a mean of 12 months in 1977 to 19.5 months in 1989 (Bradley and Meme,1992).

In Brazil, concerns similar to those in the Philippines were expressed about reduction in breastfeeding rates and early cessation of breastfeeding (Ferreira Rea, 1990). Launched in 1981, the Brazilian National Breastfeeding Program aimed to protect, promote and support breastfeeding. The program included:

- TV campaigns and media releases;
- training and updating health professionals regarding breastfeeding;
- encouraging research benefiting the Brazilian National Breastfeeding Program;
- training non-professional health workers;
- convincing administrators to facilitate breastfeeding (e.g. arranging rooming-in facilities);
- including breastfeeding in health studies curricula;
- passing labour laws to protect the working mother, and forming mothers' self-help groups;
- disseminating information on breastfeeding; and
- informing mothers about breastfeeding through personal contact and the media.

In the USA, a study showed the lowest rates of breastfeeding were in young women with low levels of education and income (Long et al, 1995). Strategies to address this included introducing peer breastfeeding counsellors for mothers. Peer counsellors were women who had experience with breastfeeding, and their role was to provide information, counselling and support to prenatal and post-partum women. Contact was made with pregnant and breastfeeding women before and after the birth by phone, home visits and clinic visits.

The study showed that peer counsellor support increased initiation and duration of breastfeeding for at least the first three months post-partum. These results are supported by the research of Glor et al, which showed a positive correlation between breastfeeding initiation rates among native American women and education and support from peer counsellors (Long et al, 1995).

## Implications

There are a number of lessons to be learnt from these programs:

- put the needs of the mother and child first;
- take into consideration cultural requirements;
- involve the whole community;
- ensure national legislation and facilities are available to support breastfeeding;
- provide information which informs and empowers mothers and families; and
- change attitudes and prejudices amongst health professionals.

## Chapter 3

# Methodology

### Project outline and management

Our approach was based on both qualitative and quantitative research and evaluation methods, and attempts to provide a clear and comprehensive overview of effective practice currently used by community based Aboriginal and Torres Strait Islander health service providers in promoting and supporting breastfeeding and appropriate infant nutrition.

The approach took into account Aboriginal and Torres Strait Islanders' culturally-valid understandings of health and health care, especially concerning breastfeeding practices, infant care and support for the choices of women, their partners and families in infant feeding and child rearing. The approach ensures all data gathering methods accommodate the complex social and emotional factors inherent in infant feeding decisions.

The team began the project after acceptance of a detailed project management plan and schedule by the Commonwealth steering committee. Nominated State Indigenous advisers were involved from the start, and other advisers from a range of institutions across the country were consulted. The consortium's extensive training, service, and educational networks greatly assisted in this task.

A tight time frame for tendering and completion of the project presented difficulties in ensuring a comprehensive report which achieved national coverage. Where known to us, we liaised with other groups which tendered for the project, so that the report reflects the range of information and expertise in breastfeeding and infant nutrition in Indigenous communities.

### Initial actions

After the initial meeting with the clients, the review team:

- established a team across large distances, recruited research assistants, and developed a workplan;
- developed research tools;
- developed a publicity flyer and press release, placed calls for contributions nationally and in the Indigenous media;
- distributed a flyer and call for contributions at a National Indigenous health worker conference in Sydney;
- gathered contact lists from Commonwealth, State, Indigenous and other sources, and made a list for a mail-out to ensure coverage of the terms of reference;
- confirmed the Indigenous State and Territory advisers (see Chapter 1 above) and liaised with them about the extent of the mail-out;

- consulted State advisers, OATSIHS, and all team members at every stage of development of the letters, flyers, and tool;
- created a data-base and completed mail-out;
- conducted a literature search using Medline, PsychLit, and Social Sciences Index;
- contacted all State and Territory Divisions of General Practice field support officers and all State and Territory Rural Divisions coordination units, and sent modified flyers for distribution to divisions for response;
- developed the research tools into data entry and analysis forms, and as a guide for telephone interviews; developed and tested an intervention rating guide;
- held extensive telephone interviews;
- followed up non-respondents by fax and phone; and
- identified interventions for site visits on the basis of recommendations, data contributed, and State and Territory coverage, urban/provincial and rural/remote mix.

### Interim report

The final phase of the review followed acceptance of a mid-term interim report in June. This reporting phase gave the review team an opportunity to discuss issues of interest and to report progress to date.

In the weeks after this meeting, follow-up continued, and all written contributions, phone interviews, and results of site visits were entered in the database, and analysed for the purposes of this report.

### Data sources

The review targeted six main sources of information:

- a scan of literature and key policy documents;
- an invitation to contribute to the review;
- interviews with individuals and groups of stakeholders;
- key informant interviews with service providers and managers;
- observation and site visits; and
- review of promotional and teaching material.

We looked at several key issues when considering the effectiveness of interventions:

- the nature of supportive action, and the service's provision of technically excellent, up-to-date information and advice;
- resources attached to services;
- the extent to which Aboriginal and Torres Strait Islander people used the intervention;
- how the intervention considered the cultural and social context of Indigenous mothers and their children with regard to breastfeeding and infant nutrition;
- how the intervention ensured women could receive support at home or in familiar surroundings, without being removed from normal social supports;

- provision for follow-up of ‘at risk’ women and families;
- inclusion of efforts/policies that promote supportive environments for breastfeeding e.g. breastfeeding in the workplace, reformed local food store purchasing and pricing policies;
- how the intervention could be strengthened or made more effective; and
- the major strengths and weaknesses of the intervention.

## Identification of providers, program managers and departments

The Indigenous advisers to the project provided information on the services used by large numbers of Aboriginal and Torres Strait Islander people. They assisted in identifying government and non-government service settings in their State. Particular attention was given to Aboriginal and Torres Strait Islander community-controlled services, such as Aboriginal Health Services, and initiatives such as the Congress Alukura in Alice Springs.

Since the majority of Aboriginal and Torres Strait Islander women receive antenatal, birthing and postnatal care in mainstream settings, services such as hospital antenatal and maternity units, the Royal Flying Doctor Service, community health services, GP practices, obstetric and paediatric services, child care centres, health promotion officers and pharmacy staff were all considered.

Peak provider groups such as the national and State branches of the Nursing Mothers Association of Australia, and all the Divisions of General Practice, were contacted. Every State and Territory Department of Health was contacted about any relevant policies, projects or programs. It was anticipated that many activities would be part of existing general services, and not necessarily separate interventions or services specifically targeted to Aboriginals and Torres Strait Islanders.

All State and Territory Health Departments and one hospital in each region of the Aboriginal and Torres Strait Islander Commission (ATSIC) were selected for invitation to participate in the review. In addition, the Directories of Community Health Services for each State or Territory were used as a basis for selection of a community health or childcare service in each ATSIC region.

Community based non-government organisations (NGOs) were drawn from a list provided by the Nursing Mothers’ Association of Australia (NMAA). Divisions of General Practice drawn from a Commonwealth list were contacted with the assistance of State and Territory field support officers and rural divisions coordinating units.

### Categories

The categories of health service types and organisations canvassed during the Review were:

- **Category B1** Aboriginal Health Services
- **Category B2** Mainstream services eg hospitals, community and child health centres
- **Category B3** Community-based non-government organisations, private health services
- **Category B4** Special funded projects
- **Category B5** Peak Aboriginal and Torres Strait Islander organisations
- **Category B6** State health departments
- **Category B7** Aboriginal and Torres Strait Islander community based groups

The interventions have been reviewed in these categories, grouped according to service setting: urban and rural; those which operate independently, and those which operate within mainstream settings and provide services for Aboriginal and Torres Strait Islander people. Representation from the six States and Territories has been sought.

All State and Territory Departments of Health were contacted in relation to their relevant policy, project and program activity. A sample of services such as hospital antenatal and postnatal units, community health services, GP practices, obstetric and specialist paediatric services, child care centres, health promotion officers and pharmacy staff were also included.

### **Indigenous health and nutrition service providers**

Commonwealth Department of Health and Family Services listings of funded specialist community-based health and other Indigenous services formed the basis for an inclusive database for mail-out of information, inviting Aboriginal health services to contribute to the review. Where possible, specialist alcohol and other drug services were excluded.

Special projects were identified on the basis of the literature review, research networks of principal investigators, as well as State and Territory adviser input. This category also included bodies with a particular interest in the area of breastfeeding and infant nutrition for Indigenous people, as identified by the Commonwealth Department of Health and Family Services. There is some overlap with the Aboriginal Health Services (B1) category.

Peak Aboriginal and Torres Strait Islander groups were identified from a listing provided by NACCHO and included ATSIC regional councils. Indigenous women's groups were identified from participants in a recent ATSIC evaluation study focusing on women.

### **The mailed invitation to contribute to the review**

The original mailing lists were based on updated and edited lists of service providers supplied through the Department of Health and Family Services. The consultants' databases provided listings for peak groups, service providers, program leaders, and community-based organisations. The result was comprehensive on the basis of geographic setting, service type, and catchment target groups.

In some categories, multiple invitations were sent to the same organisation—for example, to the chairpersons and the senior health workers of Indigenous organisations, or unit heads and health promotion officers in mainstream services. Altogether, 530 invitations to participate were made to these 427 organisations, as follows:

### Categories of service providers contacted (n=427)

Category	Type of service provider	Number
B1	Aboriginal Health Services	122
B2	Mainstream: hospitals, community health services, child health services, GPs	171
B3	Community based: NGOs	15
B4	Special projects	7
B5	Peak Aboriginal and Torres Strait Islander groups	82
B6	State/ Territory Departments of Health	15
B7	Aboriginal and Torres Strait Islander women's groups	15

### Invitations to participate by category and State or Territory (n=530)

State	B1	B2	B3	B4	B5	B6	B7	Total
ACT	2	3	1	0	3	0	0	9
TAS	1	3	1	0	4	2	1	12
NSW	44	45	2	3	10	1	3	108
NT	41	8	2	3	23	2	7	86
QLD	23	36	3	1	25	3	1	92
SA	19	21	2	0	6	2	1	51
VIC	27	36	3	0	12	2	1	81
WA	55	19	1	1	10	3	2	91
	212	171	15	8	93	15	16	530

## Development of instruments and data collection procedures

A system of review and consultation included the development of a checklist to guide the examination of identified interventions and their conduct. This list was not all-inclusive, but focused on key areas of inquiry related to the terms of reference for the review. This standardised guide was used by the team to assess interventions, and weighting was allocated for different features. To complement subjective elements of the assessment, the intervention rating tool provided some common objective criteria as a basis for comparing interventions.

The development of the invitation letter setting out the issues to be addressed, and the checklist criteria, were built on the expertise of the consortium and project team members, and input from the project's Indigenous advisers.

### The intervention assessment tool

Aspects of the intervention	0	1	2
<p>Accessibility</p> <p>Ability of intervention to provide care within women's own environment</p> <p>Integration of intervention within existing services</p> <p>Breastfeeding &amp; infant nutrition policy and/or guidelines</p> <p>Promotion of breastfeeding and appropriate infant nutrition</p> <p>Sustainability</p> <p>Community participation</p> <p>Referral to lactation consultants, nutritionists and mother support groups</p> <p>Monitoring and evaluation</p>	<p>Not easily accessed by Aboriginal &amp; Torres Strait Islander women and their families</p> <p>Not at all—clinic based and no facility to provide community care</p> <p>No evidence of integration within existing service</p> <p>No policy or guidelines regarding breastfeeding and infant nutrition used</p> <p>No breastfeeding promotion</p> <p>Totally dependent on outside initiative and/or funding</p> <p>Service is not used by local community</p> <p>Not aware of services or groups available to support breastfeeding and appropriate infant nutrition</p> <p>No monitoring or evaluation mechanisms in place</p>	<p>Moderately accessible</p> <p>Some ability to provide community care</p> <p>Some integration with existing service</p> <p>Unwritten policy to promote breast breastfeeding and appropriate infant nutrition</p> <p>Some breastfeeding promotion activity</p> <p>Initiated or funded at local level</p> <p>Limited acceptance and support of community</p> <p>Limited use of resources such as lactation consultants, nutritionists and/or mother support groups</p> <p>Informal efforts made towards assessing client satisfaction and effectiveness of intervention</p>	<p>Actively promotes accessibility by Aboriginal and Torres Strait Islander mothers and families</p> <p>Home &amp; community care available as required</p> <p>Is completely integrated within existing service</p> <p>Has written policy or follows NHMRC <i>Guidelines for Infant Feeding</i> and/or <i>Dietary Guidelines for Children and Adolescents</i> or State equivalent</p> <p>Has a specific breastfeeding promotion focus</p> <p>Self reliant and sustainable in the long term</p> <p>Well accepted and supported by community</p> <p>Staff and mothers utilise lactation consultants, nutritionists and/or mother support groups</p> <p>Formal evaluation either in process or has been conducted.</p>

Also informing the inquiry was the analysis of relevant reports such as Sahn DE, Lockwood R, Scrimshaw NS (eds), *Policy Evaluation in Methods for the Evaluation of the Impact of Food and Nutrition Programs*. UN University 1984: 252–264. This publication suggests scoring policies for action strategies. The checklist was also guided by criteria set out in the WHO *Baby friendly hospitals initiative* and in ‘best practice’ standards such as the NHMRC *Infant Feeding Guidelines for health workers*, the WHO *International code of marketing of breast milk substitutes* (1985), the WHO/UNICEF *Declaration of the survival and protection of children* (1991), State government documents such as the *Northern Territory breastfeeding policy* (1996), and independent resources such as *Thallikool—Infant nutrition resource kit for Aboriginal health workers* (1988) and the NMAA’s *Resource booklet for breastfeeding policies and patient care guidelines*.

## Procedures for data collection

### Submission

The invitation to make a submission to the review was advertised and mailed. The closing date for returns was listed as 2 June, allowing 2–3 weeks for responses. Each invitation had an identifying code to allow tracking of responses by category. Responses were invited by variety of means, including fax, telephone, written submission, or a simple expression of interest. A national press release was issued later, and gave a closing date of 10 June 1997.

The letter attached to each mailed invitation highlighted the importance of each service’s input, as well as the benefits of potentially enhanced access to information on effective strategies and funding. The independence of the consulting group was also emphasised, and reassurances were given regarding protecting individual identities in the process of analysis, if it was requested. In recognition of the workload of most services, responses were accepted until 11 July 1997.

### Telephone interviews

Telephone interviews were conducted to investigate, in further depth, a number of critical issues highlighted in the written responses or raised by the State advisers and key stakeholders. Preliminary calls and, if necessary, follow-up calls were made to locate the appropriate spokesperson and arrange a convenient time to talk at length.

A semi-structured interview protocol was designed and tested before application. Only experienced interviewers familiar with the issues conducted the interviews. These discussions generally followed the same format, although the flow of conversation dictated the sequence in which the items were addressed. The interviewer recorded relevant information in a prepared standard format. On completion, interviewees were thanked and asked if they would like a copy of the final report. Telephone interviews averaged between 40 and 60 minutes. Honest and open responses were elicited. It was stressed that the respondent had the option to provide information in a non-identifiable form. It was also emphasised that the review was not to find fault, but to enhance the resource and information base supporting Indigenous infant nutrition.

### Case studies

Based on recommendations from State advisers and responses received from the field, the team selected and visited interventions and services in five States to see at first hand the special elements of the activity contributing to their success. Site visits were made to Ngua Gundi Early Childhood Centre in Rockhampton; the Aboriginal Medical Service in Woolloongabba; Grace Close and

Colleagues in Sydney; the Nursing Mothers' Association at Southern Cross University in Lismore; the Victorian Aboriginal Health Service in Fitzroy; Ngunytju Tjitji Pirmi Aboriginal Corporation in Kalgoorlie; Ngaanyatjarra Pitjantjatjarra Yankunytjatjara Women's Council and Congress Alukura in Alice Springs; the Strong Women and Healthy Kids Projects in Darwin; Bega Garbiringu Health Services in Kalgoorlie; and the Regional Aboriginal Medical Services in Broome. The Durri Gulibahn Program at Kempsey Medical Service was also chosen as a case study, although the project's time frame did not permit a visit.

## Responses

<b>Contributions to the review (n=46)</b>		
<b>Category</b>	<b>Description</b>	<b>Contributions received</b>
B1	Aboriginal Health Services	16
B2	Mainstream: hospitals, community health, child health, GPs	11
B3	Community based: NGOs	6
B4	Special projects	9
B5	Peak Aboriginal and Torres Strait Islander groups	0
B6	State/Territory Departments of Health	2
B7	Aboriginal and Torres Strait Islander women's groups	2

In a number of organisations, detailed responses were obtained from more than one representative, and several contributed valuable written reports or other materials.

<b>Contributions by category and State or Territory (n=46)</b>								
	<b>B1</b>	<b>B2</b>	<b>B3</b>	<b>B4</b>	<b>B5</b>	<b>B6</b>	<b>B7</b>	<b>Total</b>
NSW	3	1	3	1				8
NT	3	1	1	1			1	7
QLD	2	6		3				11
SA	2	2	2				1	7
TAS				2				2
VIC	1	1		1		1		4
WA	5			1		1		7
<b>Total</b>	<b>16</b>	<b>11</b>	<b>6</b>	<b>9</b>	<b>0</b>	<b>2</b>	<b>2</b>	<b>46</b>

## Response rate

The percentage of those who were invited to submit and responded is low in absolute terms. Nevertheless, the time frame of two months, the extensive follow-up and flexible methods of response mean that the responses received have probably exhausted the identification of significant interventions. It is unlikely that the call for public submissions, editorial coverage generated by the national press release, the advice of State and Territory advisers, and word-of-mouth recommendations by respondents would leave many projects of significance unidentified.

## Types of interventions

For the purpose of this review, breastfeeding or infant nutrition interventions were classed as any of the following:

- an activity as part of routine health care or community based services;
- a supportive action and advice which is part of a routine service such as antenatal screening;
- a special project, program or community activity especially funded to raise awareness of the benefits of breastfeeding and provides advice and support to women, families and communities;
- activities that provide information and advice;
- community development activities that aim at making the social environment more supportive of women starting breastfeeding, continuing breastfeeding, and during the introduction of first foods to babies; and
- a demonstration project.



## Chapter 4

# Results

### Characteristics of interventions

Sixty-eight organisations provided formal responses to the request for information. Of these, 46 replies were regarded as useful for the purposes of this Report. Others reported no services relevant to this project or no current relevant services. Thirty-six of these 46 contributions identified themselves as current interventions, 5 as interventions that had now ceased, and 5 did not indicate their current status.

Many respondents had difficulty responding within the tight deadlines and several expressed concern at the frequency with which they are asked to participate in projects which have unrealistic timeframes and do not consider the already considerable workload of staff.

Twenty-three of the 46 interventions were specifically designed to target Aboriginal and Torres Strait Islander people; 22 were general population interventions used by Aboriginal and Torres Strait Islander women; and one was a general population intervention not used by Aboriginal and Torres Strait Islander women.

<b>Total formal replies to invitation</b>	<b>68</b>
Interventions specifically for Aboriginal and Torres Strait Islander people	23
General interventions used by Aboriginal and Torres Strait Islander women	22
General intervention not used by Aboriginal and Torres Strait Islander women	1
No current intervention	22

These 46 services described their intervention sites as follows.

<b>Location of interventions</b>	
Major metropolitan settings	9
State-wide projects	4
Provincial centres	16
Both provincial and major metropolitan centres	1
Rural towns	9
Remote communities	6
Serving both a rural town and remote communities	1

The services described the setting in which their intervention was delivered as follows.

<b>Settings where the interventions are delivered</b>	
In a home or community setting	10
Community-based health care centres	16
In both home and community-based health care centres	14
Hospital-based settings	3
In both hospital and home-based settings	1
In an accommodation facility	1
General or unspecified	1

The respondents characterised the manner of their intervention in the following categories.

<b>How the interventions are delivered</b>	
Services to promote and support breastfeeding and infant nutrition integrated into routine health care provision and delivered opportunistically	28
Stand alone special projects or one-off demonstration projects on breastfeeding and infant nutrition	7
Specifically funded breastfeeding and/or infant nutrition projects with trained workers supplementing routine health care	7
Voluntary community worker	1
No details	3

The length of operation of services varied widely—from two months to 20 years.

## Strategies

The range of strategies used by these interventions was described in the following combinations.

<b>Strategic components of the interventions</b>	
Community development, health promotion, information giving, counselling and support strategies	15
Health promotion, information giving and counselling	10
Information and counselling	2
Counselling and support	1
Community development, health promotion and information giving	2
Health promotion and information giving	2
Information, counselling and support	4
No details	10

## How interventions support women

Thirty-one respondents described the following ways of working with women and the elements of interventions:

### Planning breastfeeding choices during pregnancy

- Education and information in early pregnancy in antenatal classes or in one to one antenatal visits in women's homes.
- Shared care processes with maternity hospitals.
- Breastfeeding promotion workshops where new mothers, expectant mothers and carers are invited to lunch with an educational and social support emphasis.
- During alcohol and drug assessment and treatment of pregnant women with problems.
- Education in the ward via videos.
- Young mothers' club for support.
- Education.
- Nursing Mothers' Association training of Aboriginal health workers to provide basic information to pregnant women about their breastfeeding choices.
- Contact by lactation consultant at 30 weeks by letter and 36 weeks by phone.
- Breastfeeding information and videos.
- As part of the support provided in accommodation services for remote women, before birthing in major hospitals.
- Visiting maternal and child health nursing sessions in Aboriginal Medical Services.

### Establishment of breastfeeding

- Daily home visits day 2 or 3.
- Infant feeding support group in Aboriginal Medical Services.
- Outreach and liaison with the hospital by Aboriginal Medical Services.
- Videos on breastfeeding on the ward.
- Nurses in maternity units assist at the time of birth and during admission.
- Liaison with the Nursing Mothers' Association by an Aboriginal Medical Service.
- Visits to mothers in hospital by a mainstream community health service.
- Referrals to the Nursing Mothers' Association.
- Implement *Baby friendly hospital initiatives*.
- Visits in hospital by Aboriginal health workers.
- Visit by lactation consultant in hospital.
- Aboriginal support person provided for women who need it in hospital, with advice and support about the establishment of breastfeeding.

## Maintenance of breastfeeding

- Home visits continued for as long as required; observation, advice and support.
- Reinforcing breastfeeding at every opportunity; also supporting women in choices, and giving information on sterilising and what formulas to use.
- Give advice on how to avoid problems.
- React to mothers who present with problems.
- Provide counselling and support as requested.
- Referral to lactation consultants.
- Women able to contact the local hospital if necessary 24 hours a day.
- Dispel myths around breastfeeding.
- Education: posters, pamphlets and education using discussion, videos and slides to explain lactation.
- Word-of-mouth education by peer educators.
- Postnatal support, including support in maintaining breastfeeding.
- AMS staff are trained in breastfeeding management.
- In remote traditional communities the women's culture is strong, and health service providers rely on these networks to support feeding mothers.
- Provide practical assistance to allow younger mothers who want to stop breastfeeding because they feel limited in their study or social lives.

## Management of problems

- Feeds are observed and advice given.
- Advice, information, phone contact and follow-up, counselling and support are given.
- Clinic advice, counselling and support are followed by home visits.
- Postnatal care includes support during breastfeeding problems.
- AMS doctors provide management for women with problems and babies with low weight gain.
- Handouts and leaflets are provided.
- Referral to lactation consultants is available.
- Mothers and babies may be readmitted to the hospital for a day.
- Counselling that aims to get to the bottom of the problem whether it is emotional, physical, or relationship, and help that is appropriate.
- Involvement of the whole family in the solution to the problem.
- Provision of reassuring information to dispel myths.
- Aboriginal health workers are trained to advise on how to overcome problems.
- Lactation consultant is available 24 hours a day by pager.
- Education programs are available, which also include discussion of nutrition and drug/alcohol consumption and breastfeeding.

## Introduction of first foods

- Advice is given at baby checks on the importance of introducing solids at an appropriate age, and what is appropriate food.
- Pamphlets are available.
- Information is given at the time of vaccination.
- Doctors give advice whenever they see women and babies.
- Nutrition programs at AMS give education support and advice.
- Aboriginal Health workers trained to give advice on the introduction of first foods.
- Health workers give advice and support as part of general care.
- Developmental checks by maternal and child health nurses.
- Ensuring the mother knows that it is not good to start babies on solids too early.
- Referral back to the hospital if necessary due to failure to thrive.
- Monitoring iron levels and giving feedback to mothers, with explanation and advice.
- Working with community stores to supply more fresh food at reasonable prices.

## Assessing their babies' health

- Early childhood nurses advise mothers on what to watch for in terms of growth, sleep, fever etc.
- Growth and development screening and at the time of vaccinations.
- Check-ups at six weeks and at immunisation points.
- Through medical services.
- Counselling and encouraging parents to call in if worried.
- Screening and feedback of results and education of remedial action with regard to nutrition or whatever.
- Babies are weighed in the home: if they are sick or not doing well the Aboriginal health worker will transport the mother and baby to see the doctor.

## Referral to lactation consultants

- Referral if necessary (“but referral is not possible where there are none”).
- “Some people don’t like them and prefer family networks”.
- Some doctors are trained and accredited as lactation consultants.
- Refer to other health professionals as needed.
- Many midwives at the hospital are lactation consultants.
- “Because referral to another professional is seen as criticism, we have to use low key methods of relaying advice health professional to health professional”.

## Access to mother-to-mother support groups

- Hospitals run groups.
- Mother support group run by remote community hospital.
- Mothers' support group on remote community set up by maternal and child health nurse.
- Clinics act as venues for personal support groups (“we have no specific breastfeeding groups due to lack of resources”).
- Liaison with the local Nursing Mothers' Association.
- Encouragement of key community members to act as role models.
- Provide and facilitate a family support group of feeding mothers with babies under one year.
- New parents support groups to discuss nutrition—mainly happens within family groups, not amongst groups of strangers.

*“An infant support group is being established, but none at the moment—it is hard to organise group activities”.*

## Evaluation

Only 13 respondents reported any level of formal evaluation. The majority of these evaluations were internal process evaluations:

- nine said they had no formal evaluation; and
- 23 respondents provided minimal or no information on which to judge the level or type of evaluation.

## Data collection on breastfeeding

- eight respondents said they did not collect data on breastfeeding;
- eight indicated that they did collect data on breastfeeding; and
- the remaining respondents did not supply enough information to judge the extent and nature of data collection.

The section that follows summarises the responses above in more detail, arranged by the categories of service approached in this intervention project.

## Aboriginal health services

### New South Wales

#### North Coast Aboriginal Breastfeeding Project

(See also case study 9 on page 98)

This project was established in October 1994 with funding for a 12-month period. It was established in response to high infant morbidity and mortality in Aboriginal communities in the north coast region of NSW. Low rates of breastfeeding were identified as a possible factor influencing the health of the children. A steering committee for the project was established so that an organisational framework and a network of contacts were developed. Steering committee members included the project officer, the program coordinator, parenting coordinator, a NMAA counsellor and an Aboriginal health educator. The project involved running initial focus groups in selected areas in order to determine the values and barriers to breastfeeding, prior to implementing education programs. Programs were conducted through Early Childhood Health Centres, schools, antenatal groups, women's groups and TAFE.

#### Self-assessed strengths of this project were:

- Aboriginal health worker employed as Project Officer;
- a support network established, for example NMAA;
- the support of the Aboriginal health workers; and
- staff having an understanding of the problems and issues facing Indigenous women.

#### Self-assessed weaknesses:

- large geographical area;
- lack of ongoing funding; and
- fathers were not included in the project; need to do so in future.

#### Thallikool Aboriginal Outreach Program

(See also case study 10 on page 100)

Thallikool started in 1983 with the aim of training Aboriginal women to become breastfeeding counsellors using the Nursing Mothers' Association of Australia model. This model was found to be inappropriate and was subsequently adapted for use by Aboriginal and Torres Strait Islander women. Seven Thallikool programs were conducted in Casino, Lismore, Maclean/Yamba, Tweed Heads, Murwillumbah, the Gold Coast and Woodridge. One of the two women who trained during the first program is Grace Close, who subsequently went on to assist in the management of the program. Ms Close is currently employed within the Health Promotion section of the Aboriginal Health Unit of the NSW Department of Health.

None of the trainees completed their training and so the project did not succeed in achieving its original objectives. However, there were other benefits in that all of the women subsequently gained employment. One of the outcomes of the project was the development of the Infant Nutrition Kit for Aboriginal Health Workers. in collaboration with the Aboriginal Health Unit, NSW Department of Health. This kit includes a book, flip-charts and video, *Babies of the Dreamtime*.

*The self-assessed strengths of the project/service were:*

- mutual trust and respect;
- sharing of information;
- individual approach to each community; worked out their own way of supporting mothers in breastfeeding; and
- grass roots approach.

*The self-assessed weaknesses of the project/service were:*

- learning and so made mistakes;
- originally tried to impart too much information; and
- did not fully appreciate the cultural and social context of the Aboriginal community.

### **Durri Aboriginal Corporation Medical Service—DjuliGalban Project**

(See also case study 12 on page 106)

The DjuliGalban program was initiated in 1992. Two full-time health workers and a part time midwife staff the program. Services are provided both within the medical service and on an outreach basis to outlying settlements. Services provided by the program include antenatal care, which identifies clients at high risk and who benefit from extra care during the pregnancy.

Antenatal classes are conducted, as well as birth support to mothers who request it. Postnatal support is provided by daily home visits for the first week following discharge from hospital and then two to three times weekly for the next five weeks. This intensive postnatal support has been a major factor in increasing the duration of breastfeeding. Early childhood services are also provided, with growth and development screening incorporated with immunisation. 'Koori Baby Day' is held once a month and transport is provided.

The aims of the DjuliGalban program are to:

- reduce the morbidity and mortality associated with pregnancy, birth, the post partum period and during childhood;
- increase breastfeeding rates;
- increase the immunisation rates of all children 0–5 years;
- increase the level of nutrition of all children 0–5 years and pregnant women; and
- increase the level of attendance of Aboriginal women to Women's Health Screening programs

Since the inception of the project in 1992:

- breastfeeding rates have increased;
- immunisation rates have increased; and
- there has been an increase in the number of clients using the early childhood and immunisation services.

*The self-assessed strengths of the project/service were:*

- the two Aboriginal health workers, local women, who have had their own children and understand what the problems faced by the clients; and
- utilisation of the AMS and the other Aboriginal health workers.

*The self-assessed weaknesses of the project/service was:*

- lack of ongoing funding.

‘In examining the impact of any program, the history of Aboriginal people in the area must be remembered. The community must first develop trust in the health providers in order for any program to be effective and be utilised.’ (DjuliGalban, 1993/1996 Report, Durri Aboriginal Corporation Medical Service, Kempsey NSW.)

## Northern Territory

### Wurli Wurlijang Aboriginal Health Service, Katherine

This community-controlled health service describes its services as being offered within a cultural context. The use of Aboriginal health workers as primary care givers and the provision of transport promote participation for clients. A women’s health team is developing services in antenatal and postnatal care. A midwife recently has been appointed and the service is currently in the process of consulting with the Aboriginal women in the Katherine area to further develop programs for women and children. The nutrition worker is focusing on improving the nutrition of the young Aboriginal women and their babies. A community nutrition program is also in the developmental stages.

*The self-assessed strengths of the project/service were:*

- Aboriginal health workers provide primary care;
- community consultation; and
- availability of community nutrition worker.

*The self-assessed weaknesses of the project/service was:*

- lack of ongoing funding for the midwife, once current funding finishes, they will no longer be able to provide the present service.

‘The nutrition worker has recently reported that the promotion of breastfeeding of babies in this community is not needed. Nutritional issues arise once the baby is weaned.’

‘Access for the community to services is ensured with the organisation providing transport and our model of intervention whereby Aboriginal health workers are the primary care givers’ (Women’s Health Coordinator).

### Anyinginyi Congress Aboriginal Corporation, Tennant Creek

This service provides a wide range of services such as education, sports and recreation, playgroup, arts and crafts, alcohol rehabilitation and dental clinic, as well as health services. The midwife and health workers provide antenatal care, labour support and postnatal care. Child health checks are also promoted, including growth and development screening, support and advice with infant feeding. Infant feeding information is also provided during the antenatal period. Education is mainly on a one-to-one basis. Transport to the clinic is provided and home visits are conducted as needed. Low-birth-weight and underweight babies, and those who are slow to gain weight are provided with special attention and support.

The service values the Northern Territory Breastfeeding Policy guidelines within the NT Department of Health and Community Services’ *Breastfeeding Policy and Strategic Plan 1994–2000*.

*The self-assessed strengths of the project/service were:*

- the service is accessible to local people and those living 'out bush';
- the service is culturally-appropriate in meeting the needs of the local people; and
- the service is free.

The service could be further strengthened by:

- the updating of the growth chart (currently being revised);
- continued support and education of Aboriginal health workers involved in child and maternal health; and
- computer skills training for all the staff (computerised medical records and recall system currently being updated).

'The ongoing involvement of experienced health workers, particularly those specialising in children's health, is fundamental in the support of women and babies attending the Congress service. This is particularly evident with the more traditional women, who may appreciate having explanation/discussions in language.'

'The women presenting for postnatal check or contraception provides for opportunistic check of her baby, weight, chance to discuss feeding, and vice versa.'

'Virtually all new mothers breastfeed. Breastfeeding problems and mastitis are rarely encountered. Most babies seem to sleep with their mothers and breastfeed frequently day and night. There appears to be a tendency to breastfeeding until at least 2–3 years, with some continuing until 5 years of age'

'Sick babies who have been transferred out of town... are often bottle feeding on their return...the problems of distance, separation from other children, unfamiliar environment lead to the parent to return in some cases' (Midwife, Anyinginyi Congress Aboriginal Corporation)

## **Ngaanyatjarra Pitjantjatjarra Yankunytjatjara Women's Council: Nutrition Awareness Project for young mothers and children**

(See also case study 1 on page 67)

The Ngaanyatjarra Pitjantjatjarra Yankunytjatjara (NPY) Women's Council has about 3,000 members, with 16 council workers active in the areas of nutrition, aged care and support, disability support, and domestic violence. All program areas are run on a 'Malparara' system where non-Aboriginal staff have a local Anangu woman working closely with them. The women's council offices are located in Alice Springs but the NPY lands extend across NT, WA, and SA boundaries.

The nutrition project was initiated by senior community women in April 1996, because of strong community feelings about the welfare of particularly very young mothers and their babies. The older women see these young women going into hospital and having problems with their babies getting sick and being skinny, and feel for them. The project therefore developed the different strategies for prevention and education, as well as crisis support if needed. The principle aim of the project is to develop the awareness and knowledge of young mothers about solutions to the problem of failure to thrive (FTT) in their young children, and also to promote health practices and strategies to maintain better health.

Although the senior community women and clinic staff could usually identify the mothers and children most in need of support and advice, the crisis intervention also particularly helped the workers and others to understand the larger picture of the underlying problems which often led to the children becoming FTT. These include late intervention in cases of poor growth, family denial of a problem, misconceptions of what is healthy, and repeated disease and infection presentation.

By March 1997, ten families had been involved with the project for intensive support during stays in Alice Springs hospital and follow-up at the community or during visits to town. The strength of cooperative actions across agencies and support from other sections or programs in the women's council has been really important in these processes. Similarly the possibilities for family meetings and counselling about particular problems have helped to bring about changes important for helping to make these children grow better and become healthier. To support these activities further, the project has recommended that a community-based welfare worker, accountable to a non-government organisation, might better assist those children most 'at risk' of FTT and repeated hospital episodes. Progress towards this is now being made on one of the communities within the NPY lands, with a family welfare worker position identified as part of the community strategic plan. The outreach education and nutrition promotion program has visited eight communities, to run five day workshops with 212 young mothers and children. The project won a SA Excellence in Health Promotion award in May 1997.

To date, only process evaluation strategies have been used as it is too early to expect dramatic changes, and available statistics on hospital admissions have shown little change over the length of time that the project has been running. Individual children involved in the crisis intervention are being tracked as closely as possible through health and other networks. There are plans for a full external evaluation after three years if funds permit.

*The self-assessed strengths of the project/service were:*

- the senior women on the communities are strong and know what is happening and what is needed, so that they have been able to really get involved in planning the program;
- the team is flexible and will talk to individuals about ante or postnatal issues as well if the grandmother or mother suggests it;
- the Anangu nutrition project worker is now able to do almost all of the workshop in language;
- the town support for crisis cases has been really important in giving everyone the 'big picture' of the many problems faced by the young mothers and families. These relationships and communication help to make the hospital less frightening and give the mothers access to someone who cares and will listen to their problems;
- because the women's council is not a health service, it can be much more multi-faceted in the support and advice it offers. This has also made it much easier to work with all the different agencies that might be involved, such as health services, family and/or welfare services, the police and others; and
- for the health system, it has also been able to build important interstate follow-up bridges for children treated in Alice Springs, who return to live on their community in WA or SA.

*Self assessed weaknesses of the project/service were:*

- many of the program's strengths have also been the source of some of the problems that have had to be negotiated;

- because the women's council is not a health service it was at first difficult for the State and Territory health services to accept its nutrition activities. It also has a limited sphere of influence for any changes that might be suggested on the basis of workshop or family and community experiences;
- similarly, the work with stores is made difficult by the turn over of managers and the fact that it might take a little time before changes, in particular take-away food choices, are well accepted by all the community;
- trying to bridge the three States and Territory covered by the NPY lands has not been easy, particularly as the welfare regulations are different and families are mobile;
- many young fathers have other priorities and don't want to get too involved in nutrition activities or looking after very young babies. Also, trying to get other carers to come and stay at the hospital in severe FTT cases is not always possible for the community or hospital; and
- for the early part, the project had eight different one-off grant and funding components or sources to administer. Although some parts are now more likely to be recurrent, others are not, so additional funds still need to be found, and this takes much time.

*The way forward—recommendations from service providers*

The next priority for the team is to be involved in the 'Kungka' career conference which the women's council is organising in July. This will be held near Uluru and give many young girls and women a chance to listen to some really successful Indigenous women who are doing things in business or professions.

Thanks to recent funding enhancements, the team hopes to produce a nutrition manual for mothers over the next year. They have been busy collecting resources for this from the workshops and other sources. There are also seven more communities requesting nutrition workshops. Crisis cases, where families need help to break the cycle of repeated illness and FTT, also keep coming up. They hope that their work with the clinics and staff on the communities will help the clinic to be able to do similar nutrition activities more regularly, to follow on from their first workshops.

## Queensland

### Mamu Medical Service, Innisfail

This Aboriginal Health Service provides antenatal and postnatal care, as well as vaccinations. Education and advice regarding breastfeeding and infant nutrition is given opportunistically at these times. There is no specific breastfeeding and/or infant nutrition focus. There is high accessibility for local Aboriginal and Torres Strait Islander community and some provision for home and community care by health workers.

*The self-assessed strength of this service was:*

- accessibility to Aboriginal and Torres Strait Islander community.

*The self-assessed weakness of the project/service was:*

- lack of suitable and specific breastfeeding and appropriate infant nutrition promotion materials such as video and posters.

*'Most mothers initiate breastfeeding, however many stop breastfeeding in the first month or two.'*

*'Families give advice to mothers regarding infant feeding.'*

*'There are not many places to breastfeed in town.'* (Louisa Birkitt, Medical Officer, Mamu Medical Service, North Queensland.)

### **Krurungal Aboriginal and Islander Corporation, Townsville**

The Townsville Aboriginal and Islander Health Service provides shared antenatal care with Kirwan Hospital and early childhood health services. Breastfeeding and infant nutrition education and advice is integrated within the routine health services. The medical officer states that the service is 'committed to and consistently promotes the benefits of breastfeeding during antenatal care and the first year of life.' However, the service describes itself as 'reactive, not proactive regarding problems with breastfeeding and infant nutrition.'

*The self-assessed strengths of the project/service were:*

- cultural appropriateness of the service;
- people like to use the service;
- holistic care; and
- transport is available.

*The self-assessed weakness of the project/service was:*

- need for extra staff member to provide infant nutrition education and support.

## **South Australia**

### **Nunkuwarnin Yunti, Adelaide**

This is a community-owned independent health service within an urban setting. The services of a nutritionist are available by referral from health clinic or self-referral. The health service provides infant nutrition information and advice as a part of routine health services for mothers and babies.

*The self-assessed strengths of the project/service were:*

- health workers' commitment to their work; and
- learning through conversation.

*The self-assessed weaknesses of the project/service were:*

- need more emphasis on health, nutrition, and community development; and
- need more emphasis on breastfeeding and infant nutrition, particularly for younger mothers.

### **Umoona Tjutagku Health Service Incorporated, Coober Pedy**

This is an Aboriginal Health Service within remote rural mining town, 900 kms from Adelaide, with an Aboriginal and Torres Strait Islander population of 500. One registered nurse and three health workers provide antenatal care and education on a one-to-one basis. Immunisations, infant health checks and growth and development screening are provided by the child and family health nurse. Respondents believe that some mothers choose to bottle feed because of a lack of awareness that breastfeeding and socialising can be combined.

*The self-assessed strengths of the project/service were:*

- accessibility of service;
- long-term staffing—the nurse has worked here for 20 years;
- provide home and community care; and
- culturally-appropriate service.

*The self-assessed weaknesses of the project/service were:*

- need for more administrative support;
- service is moving to new locality, and will be more isolated;
- information sharing systems between different sections could be improved further;
- lack of acknowledgment of health worker clinical skills;
- very early discharge from hospital, even if babies are small; and
- young mothers often do not ask for support and may live communally which makes it difficult for health workers to counsel individuals.

*The way forward—recommendations from service providers*

- standard breastfeeding and infant nutrition care plans and “at risk” concepts, to further prompt health workers and emphasise holistic and opportunistic advice and support in this area;
- greater emphasis on checking nipples and nipple care as part of preventive action during antenatal care;
- a youth health worker with emphasis on health promotion and prevention could further support the current structures;
- additional resources are needed for education and advice on the timing and type of solid foods to be introduced; and
- no evaluation activities have been carried out, but there are plans to collect more information on breastfeeding rates as part of the community midwife initiative.

## Western Australia

### Daniladilba Aboriginal Medical Service, Gumilybirra Women’s Health Clinic

This women’s health service provides well women’s clinics, antenatal, postnatal, immunisation, growth and development screening. Promotion of breastfeeding and infant nutrition is integrated into these opportunities. Hearing health and child development worker services are to be established. This service has some educational resources such as videos, posters and pamphlets, but these need to be more up-to-date and locally relevant.

This Aboriginal Medical Service has been conducting training for mainstream service providers in cultural sensitivity and Aboriginal and Torres Strait Islander Health issues. This is done on a fee-for-service basis. Staff acknowledge the need to increase the role of health workers in the local hospital. This requires formal and informal improvements. An example, which illustrates how this might be achieved, is the current model of shared antenatal care between general practitioners and hospitals. The service has not been formally evaluated.

*The self-assessed strengths of the project/service were:*

- Aboriginal health service which is community based, community controlled and accessible;
- Aboriginal health workers are the primary care givers;
- mobile unit, increases accessibility, able to treat people in their own home; and
- very user friendly, private clinic rooms.

*The self-assessed weaknesses of the project/service were:*

- working more with the hospital;
- more community education activity; and
- promote greater awareness of service.

## **Perth Aboriginal Medical Service**

This medical service is committed to the promotion of breastfeeding, but says it does not have the resources to do as much as it would like to do. One of the medical officers is a Nursing Mothers' Association of Australia counsellor. Health promotion activities have included the development of a display, 'A to Z of breastfeeding'. The service has provided education for the medical staff regarding the management of breastfeeding problems and encourages staff to join NMAA in order to keep up-to-date with breastfeeding information. There are plans for the health promotion staff to join NMAA and train as an educator or a counsellor.

Some ideas for breastfeeding and infant nutrition initiatives they would like to address in the future are:

- financial support to develop culturally appropriate breastfeeding and infant nutrition literature, posters and a mobile display;
- radio talks (Aboriginal and regional radio) on the benefits of breastfeeding and appropriate infant feeding;
- breastfeeding/infant nutrition calendar (have already organised the photos, and this sort of thing has worked well in the past); and
- the development of a video suitable for showing in waiting rooms (short, tasteful and non-threatening).

## **Bega Garbiringu Health Services**

(See also case study 6 on page 88)

This is an Aboriginal Community Controlled Health Organisation in Kalgoorlie Boulder. It provides antenatal, obstetric and postnatal care for an average of 60 mothers per year. Breastfeeding education and support is integrated within maternity care and child health services. Strategies used include:

- the use of culturally appropriate educational material including posters and videos, use of Nursing Mothers' Association of Australia resource booklets;
- breastfeeding promotion workshops whereby pregnant women, new mothers and carers are invited for lunch with an educational and social support component;
- in-service education of staff regarding breastfeeding and management of problems;

- education, support and breastfeeding information is also provided to grandmothers, aunts and other carers;
- liaison with mother to mother support groups such as NMAA; and
- encouragement of key community members with breastfeeding and role models for community.

One of the staff members is a lactation consultant and nursing mothers' breastfeeding counsellor. This staff member provides lactation management advice and assistance to in-patients at Kalgoorlie Regional Hospital as well as at Bega Garnbirringu.

*The self-assessed strengths of the project/service were:*

- the ongoing nature of the provision of support and information on breastfeeding; and
- access to professional help with a doctor with a specific interest and expertise in the area of breastfeeding.

*The self-assessed weaknesses of the project/service were:*

- lack of funding for a specific project officer to work in this area;
- need for training of Aboriginal health workers in breastfeeding and infant nutrition;
- need to employ an Aboriginal health worker dedicated to maternal health and with skills in breastfeeding management. This staff member would be able to document and evaluate breastfeeding rates and interventions; and
- lack of resources available to enable collaboration with the local NMAA group, to provide training for health workers in breastfeeding at a local level.

*'Several health staff have continued to work and breastfeed; this has worked as a positive role model to clients'* (Medical Officer, Bega Garnbirringu)

### **Ngunytji Tjiti Pirmi Corporation, Kalgoorlie**

(See also case study 5 on page 84)

This Primary Health Care service for mothers and infants has operated since 1993. It was previously affiliated with the Aboriginal Health Service but is now independent and currently based at Kalgoorlie Hospital. When research was conducted into the development of a health service for Aboriginal women and children, some strategies included community development, health promotion, information giving, counselling and support.

Different approaches are used for traditional and urban settings. Traditional areas rely on the extended family, whereas urban areas rely more on the nuclear family. In practice, this may mean that if the mother is not coping with baby care and is caught up with substance abuse, she may be neglecting baby feeding and the baby may not be progressing. Intervention with people who are living a more traditional lifestyle may require negotiation with the head of the family to resolve the situation. An example of this is where a baby was being neglected and the head of the family was approached to intervene. The baby was given to an aunt, who, under Aboriginal law, had legal right to care for the child. Other interventions had not worked. Hospitalisation was prevented and good relations were kept all round.

This response highlights the notion that breastfeeding and appropriate infant nutrition should not occur in isolation from the mother's and family's life circumstances. Also highlighted is the importance of providing access to other services, such as drug and alcohol and mental health services.

Respondents believe that it is necessary to encourage breastfeeding, particularly when one considers the substandard living conditions in which many people have to live.

*The self-assessed strengths of the project/service were:*

- client focused service;
- treat client holistically;
- regularly review service;
- highly skilled health workers; and
- effective referral system.

*The self-assessed weakness of the project/service was:*

- need for specific training for health workers in breastfeeding and infant nutrition.

### **Broome Regional Aboriginal Medical Service, Broome**

(See also case study 7 on page 91)

The Broome Regional Aboriginal Medical Service (BRAMS) is one of the oldest community controlled health services in Australia. It began as a simple general practitioner service in 1978, with the support of one nurse and administrative staff working on a volunteer basis. Following much consultation, the service was expanded and formalised in 1984 to include a field team, public health programs and two outreach services for remote communities. Since then the service has grown to include a health promotion section and an Aboriginal health worker training school.

The public health programs currently operated by BRAMS are chronic diseases, women's health, men's health, kids health, and mental health. The Aboriginal health workers involved spend four days a week on program activities and one day each week at BRAMS clinic. The service has had a computerised patient record system for about 10 years and this is used to develop and implement care plans, which contribute to the preventive activities of the public health programs. The recall system is able to access patient details at each clinic visit and prompt for any preventive checks and/or surveillance activities which may be due. In cooperation with a WA Department of Health pilot immunisation initiative (1993–96) for children under five years of age, an "at risk" concept and system has been developed, which forms the basis of the care plans, community follow-up and home support offered to clients as part of the service. Medical officers and others are able to categorise a child or family as "at risk" on the basis of medical problems, such as premature at birth, but also in response to social, environmental or psychological problems. The children remain in this category until they are 12 years old and clinical, preventive and outreach care can be emphasised and tailored to the families needs.

The 1996–97 Best Practice and Service Delivery project aims to produce a document for general practitioners working with Aboriginal patients and the Aboriginal community. The project will provide information on:

- prevention in primary health care where it relates to Aboriginal health issues;
- the implementation of preventive care through KAMSC information systems; and
- the use of performance indicators and quality assurance.

The guidelines will be oriented towards the whole patient rather than a single disease. Care for chronic conditions takes place mainly in general practice and most patients with chronic disease

have co-morbidity. For this reason care should be patient- rather than disease- orientated. Each health problem and each intervention should be considered in the context of the patients risk profile, to determine priorities for screening, counselling and prophylaxis. There are already many barriers in implementing preventive health care in general practice without the doctor having to synthesise clinical information according to guidelines that are often single disease focused.

Such attempts at integrating sustainable preventive routines are also a part of another cooperative program with the WA Department of Health. This involves a community midwife position to support women during the antenatal period and postnatally until children are one month old. The pilot project has been in operation since February 1996 and an Aboriginal health worker from BRAMS has been permanently assigned to this project since January 1997. Breastfeeding support activities and greater participation by Aboriginal mothers in preventive activities are important components of this initiative.

### *Breastfeeding and infant nutrition interventions*

At the time that the child public health program was begun by BRAMS, discussions with the WA Department of Health led to the decision that immunisation services should not be duplicated. Central records on immunisation status are maintained by the community health section of WA Department of Health and the Kimberley regional base in Derby. Community health clinics have been run at BRAMS in the past but the emphasis now is on follow-up and ensuring continuous care for children. The BRAMS Aboriginal health worker in charge of children under five years of age works closely with the Department of Health Community Health Nurse and Aboriginal health workers employed by this service. BRAMS responsibility focuses on home visits to families for reminder of immunisations due, supervision of medication to be administered, networking with family services, as well as more general support like transport and/or advice. Educational activities on the introduction of solid foods are carried out by the child health clinic. The “at risk’ concept and home follow-up has helped to ensure that children receive the necessary immunisations, and due to its success, it has been extended to the other service delivery activities of BRAMS. Low social status, poor or crowded living conditions and other information can be entered on the child’s file to ensure that all health personnel who come into contact with the child can use appropriate care and support strategies.

The more recent community midwife initiative of the Health Department is based on a needs assessment and survey of women in town some years previously. This recognised the high mortality rates for Aboriginal infants and relative isolation from family support structures for non-Aboriginal women. The BRAMS antenatal Aboriginal health worker cooperates closely with this position and the community health structures. The health worker is involved with routine antenatal care at the clinic, encourages early attendance by pregnant women in the community, provides follow-up and reminders if women are late for their check-ups, arranges hospital visits prior to the birth, establishes referral systems for women and children in hospital, and follows up any problem cases with home visits. If women give birth in a hospital other than Broome, the health worker can also become very involved in family and health service liaison to ensure that appropriate care strategies are in place when the woman and infant are discharged.

These close working relationships have also helped to encourage hospital based midwives to become more interested in the ‘baby friendly’ initiative, and the establishment of a breastfeeding support group for non-Aboriginal women in the community. This group also receives advice and support from a NMAA counsellor based in Port Hedland. Initiatives to encourage Aboriginal women to participate in these meetings and antenatal classes have been hampered by venue problems and frequent staff changes. Within the Aboriginal community, these activities are not yet

recognised as being of high priority, with breastfeeding seen as expected and most mothers committed to making it work even if problems are encountered.

Now that a permanent BRAMS Aboriginal health worker has been identified to work with the community midwife project, further education activities and an initiative to encourage women to participate in antenatal care and postnatal support groups is planned. This will start with a baby day held during NAIDOC week and involve nutrition talks by a senior woman from the community, fun and games, photographs etc. It is hoped that a video can be produced and used in later educational activities, and that regular fortnightly picnics, beach walks or similar activities, which can involve grandmothers as well as young mothers, will encourage greater participation.

*The self-assessed strengths of the project/service were:*

- a holistic health view and coordinated care across all sectors, as well as intensive follow-up and opportunistic advice and support for ‘at risk’ cases, has ensured that the service is responsive to client needs;
- community dynamics—there is a strong expectation within the community that mothers will breastfeed. No stigma is attached to breastfeeding in public places and the majority of mothers are themselves very committed to succeed with breastfeeding. There is relatively low mobility of the Aboriginal community in the town area (two communities on the town outskirts are prior reserves and have strong community control);
- computerised system able to support the ‘at risk’ concept and offer opportunistic, yet targeted, services;
- staff sense of ownership of public health program area, committed and long-term staff members, innovative problem solving approaches and individual client care on a needs basis;
- building trust and teamwork across the service sectors by close working relationships and cooperation;
- national focus on good nutrition and breastfeeding, including the hosting of the 1995 Nutrition Networks conference; and
- health worker training available on site has meant that the courses and skills are relevant to the needs of health workers, and coordinated with community priorities.

*The self-assessed weakness of the project/service was:*

- old rifts between the Western Australian Department of Health community and child health system and BRAMS.

## Victoria

### The Victorian Aboriginal Health Service

(See also case study 11 on page 103)

The Aboriginal Children’s Health Promotional Project began in 1992 when the Koori community in conjunction with the Victorian Aboriginal Health Service (VAHS) developed a range of educational materials and opportunities. The opportunities and materials were aimed at the reduction in the level of recurrent infections in young children due to exposure to passive smoke, as well as the achievement of an increase in the rate of breastfeeding. The use of the resources, educational and community development opportunities developed after very careful and thorough consultation and

formative research has been incorporated into the day to day operation of the VAHS, thereby ensuring the longevity of most aspects of the strategy. The staff at the developmental stage of the interventions were two Koori health workers and a doctor. The responsibility for the promotion of breastfeeding and appropriate infant nutrition is now part of the day to day work of all maternal and child health workers in the health service.

The project is based on two strategies chosen to address community and health worker concerns about the level of recurrent infections in the community's children. The strategies are the reduction of exposure of children to passive smoking and an increase in the initiation and duration of breastfeeding.

The project was designed in four stages:

- 1 a quantitative research phase to supply baseline data against which to evaluate the outcomes of the project;
- 2 a qualitative research phase, to provide information assisting the design of well-targeted educational resources and opportunities, and to supply information on influences on infant feeding beliefs and practices in an urban setting;
- 3 the training of health workers in how to provide accurate and effective information and advice to women about breastfeeding; and
- 4 implementation and evaluation.

The aims of the project were to:

- reduce the level of recurrent infections in young children;
- decrease the level of exposure of babies and young children to passive smoke;
- increase the level of breastfeeding;
- increase the level of support for women breastfeeding in the community;
- increase the level of support for women during pregnancy and immediately after birth and during the infancy of their child, thereby decreasing stress and increasing self esteem and well-being; and
- increase the level of skill and commitment of health staff in the support of women's choices in breastfeeding.

The key activities of the project are:

- establishment of boorai (baby) classes and women's camps in the country, to give mothers a chance to get away from their problems, relax and discuss issues;
- the production and dissemination of video, poster and booklet resources which promote and support breastfeeding;
- the dissemination of research results on the presence of nicotine in the urine of babies as a result of passive exposure to cigarette smoke; and
- the training of health service staff in the provision of accurate and supportive information and skills that promote women's choices with regard to breastfeeding.

This is a highly community-based and community-owned project. The set of interrelated research and intervention strategies and processes has ensured it is extremely well targeted. The intervention itself has generated further resources, such as the highly effective and attractive banners and paintings which were the work of women who attended the camps.

All the resources and opportunities provide excellent examples of how the impact of educational materials and opportunities can be cost-effective in promoting behaviour change by promoting further interpersonal communication among those exposed to the materials and opportunities, and from them to others who do not come into direct contact with the project.

Another level that distinguishes this project from others is its conscious attempt to engage the community in 'a process of cultural development'. This has included strategies to involve the whole community in valuing the pregnant woman, new mothers and their babies. There were specific efforts to widely promote the idea that women need extra support and release from other responsibilities. It is believed the subsequent increase in energy and self esteem amongst mothers will assist in the acceptance of their new status as mothers, which will, in turn, increase the likelihood of mothers' choosing to breastfeed.

*The self-assessed strengths of the project/service were:*

- the evidence base of the project is demonstrated in its adoption of well-documented processes of developing effective methods for public education and community development. The data generated by these processes is community-owned and generated. The emphasis on staff training, the generation of baseline data, and the intention to evaluate against stated aims and objectives also place it ahead of many other worthy projects;
- the community and staff ownership, itself a function of the sound developmental processes and evidence base, is also a key strength; and
- the use of local women in the video and the posters and leaflets makes the campaign credible and promotes role models whom women feel comfortable seeking out for advice and support.

*The self-assessed weakness of the project/service was:*

- the degree of community ownership and sound developmental processes used in this project have meant there have not been any notable problems in its implementation. Although it has not yet undergone any formal outcome evaluation, the evaluative strategy has been planned into the project from its outset. The major problem has been a sustainable funding base for the women's camps. The current interest being shown by other sections of the industry, for example the Anti-Cancer Council, could be a lesson in the need to diversify these kinds of interventions to maintain their longevity.

*The way forward—recommendations from service providers*

The way to promote breastfeeding and good infant nutrition in a sustainable way is through the adoption of an holistic approach to women's and children's health.

There must be attention given, by those who make policy and allocate funds, to the ability of a service such as this to work holistically. Whether or not a woman maintains breastfeeding can depend on whether or not she can get appropriate care for an older child or her own psychiatric problem. No workers are currently funded for taking the woman in her context and dealing with all her issues.

Short term funding leads to a loss of commitment and morale amongst staff and a loss of credibility with the communities they serve. There needs to be serious consideration given to the establishment of evidence based time frames for projects and programs, so that effort is funded for timeframes that can reasonably be argued to be necessary, for any real change to occur and to be measured.

There are many examples where strategies that have been shown to work, such as the alternative birthing program, lose funding for no apparent reason other than that this strategy of the service has had its turn, or to allow bureaucrats to say they are launching a new initiative.

The reporting requirements of Commonwealth and State and Territory funding bodies in service agreements often does not recognise the amount of groundwork that goes into getting one so-called activity unit to counting stage. For example, a woman's attendance at a mothers support group for baby health, breastfeeding information and support, may involve a worker assisting the woman finding a baby sitter for other children, taking the woman shopping and transporting her to and from the meeting. When you are dealing with people who are just surviving, you have to help them do more than just survive if they are ever going to help themselves.

Single issue programs will never be the answer. While breastfeeding needs all hands to the pump, the key, especially in Aboriginal and Torres Strait Islander populations, will be through holistic maternal and child health services that have the resources and staff, trained to assist women with the full range of physical, social, emotional, and spiritual needs of women and their families.

The advice given to all women in mainstream hospitals about breastfeeding is still extremely poor and inconsistent. This poor advice to Aboriginal women has to be undone by community-controlled services postnatally. It will be important that the continuing education of mainstream medical and nursing staff addresses this completely unnecessary failure of the system.

The lack of national capacity to monitor breastfeeding rates needs urgent attention.

There is a need to bring people together on a regular basis who work with Aboriginal and Torres Strait Islander women in pregnancy, birthing and breastfeeding support. This would include traditional midwives, health workers and mainstream service providers.

*“All these recommendations have been said in every report in the last ten years. This means that they are important. But it is more important that someone finally acts on them in a serious and consistent and sustained manner.”*

## Mainstream services: hospitals, community and child health centres

### Queensland

#### Wujal Wujal Primary Health Care Centre

This is general health service, located within a predominantly Aboriginal and Torres Strait Islander community. It provides antenatal care and postnatal care to the local women, as well as child health clinics (growth and development, vaccinations and advice regarding infant feeding). Breastfeeding and infant nutrition education commences during pregnancy at the first antenatal visit. All breastfeeding promotion activities are opportunistic and integrated within routine health services. Education regarding breastfeeding is conducted on a one to one basis. Women leave the community to give birth in Cooktown or Cairns. Health workers are encouraged to bring their breastfed babies to work, which is good role modelling. As this is a small community, health staff have a good rapport with the community. The service has recently been evaluated by CHASP and it suggested a need for more formal health promotion activity.

#### The self-assessed strengths of the project/service were:

- good rapport with the community;
- small community and thus easy to provide follow-up; and
- good working relationship within the health centre between health workers and nurses.

#### The self-assessed weakness of the project/service was:

- need to conduct more formal health promotion activities.

*'Our community is only small.....trying to organise anything to one day or time is difficult. A one to one approach seems to work best.'*

*'Breastfeeding in the Cape York region is well promoted. From 4–6 months solids are introduced, this may include rice cereal, Weetbix or porridge and then gradually what everyone else is eating'*  
(Clinical Nurse Consultant).

#### Cairns Base Hospital

The main elements of this service are:

- lactation consultant service within the Maternity Unit of the Cairns Base Hospital;
- provides one-to-one education and counselling to Aboriginal and Torres Strait Islander maternity clients;
- there are 1,700 births annually, 20 per cent of which are Aboriginal and Torres Strait Islander clients;
- successful application through the Rural Access Program for a Doula Support Program;
- four staff who are International Board of Certified Lactation Consultants (IBCLC) qualified and ten candidates sitting for the exam this year;
- developing a Team Midwifery Project to improve continuity of care;
- respondent concerned at the pressure for shorter length of postnatal hospital stay; and
- mothers of premature babies discharged before baby, difficult to get expressed milk back if mother has returned to community.

*The self-assessed strengths of the project/service were:*

- availability of expertise;
- accessibility; and
- up-to-date knowledge.

*The self-assessed weaknesses of the project/service were:*

- need more health promotion;
- need to provide lactation education to health workers;
- need to help different generations in the wider community; and
- need to create an awareness of counter-productive breastfeeding myths.

### **Inala Child Health**

In spite of the large Aboriginal and Torres Strait Islander population in the area, this mainstream child health centre reports that it sees very few Aboriginal and Torres Strait Islander clients. It requires a child health nurse from Woolloongabba Health Clinic (Aboriginal Medical Service) to visit one or two days a week to encourage Indigenous mothers to visit the clinic.

### **Early Discharge Program, Blue Nursing Service, Palm Beach**

Through the domiciliary and early discharge program, clients are either referred for Gold Coast Hospital, or self-refer. The service provides home visits for seven days following discharge from hospital, or longer if required. It refers clients to the Early Childhood Health Centre. It is involved with the supporting women in the establishment of breastfeeding and would like to be able to provide more long-term follow-up. The service sees very few Aboriginal and Torres Strait Islander clients (five in two years).

*The self-assessed strengths of the project/service were:*

- caring service;
- accessibility; and
- ability to tap into other community resources.

*The self-assessed weaknesses of the project/service were:*

- would like to be able to provide follow-up for longer than seven days; and
- Need to increase knowledge and skills in infant feeding.

### **Yarrabah Community Health Service**

This is a general health service that provides antenatal care and incorporates education regarding breastfeeding as well as early childhood health services, including growth and development screening, immunisation and infant feeding assessment and advice. The service endeavours to incorporate local traditional treatments for things such as teething. Home visits are conducted if necessary. The service recently started up a young mothers club in which elder women talk to the mothers. Women go to Cairns Base Hospital to give birth, about 40 minutes journey by car.

Response indicates high initiation rates of breastfeeding. Solids are generally introduced at 4–6 months, however these are sometimes inappropriate foods such as Weetbix and porridge.

Babies may be eating what the adult members of the family are eating by six months of age.

The respondent believes that breastfeeding and infant nutrition issues are low on the list of health service priorities, compared to issues addressing adult health, such as diabetes programs.

The service is well utilised, mainly due to the immunisation program, which is also used as an opportunity to discuss infant feeding issues. Recommends an alternative to the 'Bounty Bag', which should have a health promotion rather than commercial focus.

*The self-assessed strengths of the project/service were:*

- integration within the community;
- physically and culturally accessible;
- known and trusted by the community; and
- service is non-authoritarian and communicative.

*The self-assessed weaknesses of the project/service were:*

- understaffed—*"I could have ten of me"*; and
- need for educational resources such as videos to show mothers, short videos on iron in diet, first foods, breastfeeding.

*'Lack of suitable resources... is the main stumbling block I've had since I've been here, have searched far and wide to find videos to show to mothers in the antenatal clinics.'*

*'Breastfeeding and infant nutrition issues low down on the list of priorities compared to adult health issues such as diabetes programs'*

(Director of Nursing, Yarrabah Community Health Service, Nth Qld)

## **Thursday Island Maternity Unit, Peninsula and Torres Strait Region**

This service provides maternity care, as well as outreach midwifery service and breastfeeding information, practical assistance and support. The outreach midwifery service provides antenatal and postnatal care to mothers living on the outer islands. During a recent study into infant feeding (TIFS, 1996), the service provided home or community visit follow-up for breastfeeding mothers and babies at three, six and twelve months.

*The self-assessed strengths of the project/service were:*

- families know the midwife because she has looked after them in labour and postnatally;
- continuity of care provided; and
- flexibility of service—may counsel mothers wherever they request assistance, for example while down-town.

*The self-assessed weakness of the project/service was:*

- need more health workers to work with midwife to encourage and help breastfeeding.

## New South Wales

### Community Health Centre, Broken Hill

This intervention is an early childhood health service that has been running for many years, with about two-thirds of all babies born in the area attending the service. There are 300 births per year at Broken Hill Hospital. The staffing consists of three early childhood nurses, a community midwife and a RFDS early childhood nurse. All the staff have had some lactation consultancy training and one is a qualified lactation consultant. Aboriginal health workers are currently being trained. Broken Hill Base Hospital is applying for the *WHO Baby Friendly Hospital Initiative*. The service is conducted from the community health centre with outreach services to outlying areas. Home visits are also provided as well as visits to newly delivered mothers and input into antenatal classes.

Early childhood health services are provided, including education, counselling and assistance with breastfeeding and infant nutrition. No statistics are kept regarding breastfeeding rates; however, the staff believe that breastfeeding rates amongst Indigenous mothers are quite low. The staff emphasised the high impact of social problems such as domestic violence and substance abuse on breastfeeding rates. Mothers are doing their best in the face of huge stresses. Younger mothers, especially the teenagers, are embarrassed to breastfeed in public.

Aboriginal health workers get very little chance to counsel breastfeeding mothers because so few people are breastfeeding and they become deskilled. There is a need to send the Aboriginal health workers to areas where the breastfeeding rates are high, so they can learn about the contexts of breastfeeding and ways of encouraging and supporting breastfeeding.

#### *The self-assessed strengths of the project/service were:*

- dedicated, well-qualified staff;
- good follow-up;
- outreach service to outlying areas;
- involved in teaching Aboriginal health workers; and
- good referral agencies.

#### *The self-assessed weaknesses of the project/service were:*

- need for ongoing funding and staffing;
- need to get into the schools;
- need to identify mothers who are breastfeeding and use them as role models;
- need to collect statistics on breastfeeding;
- need to be accessible and to become involved during pregnancy if possible; and
- need to acknowledge the broader issues and influences upon breastfeeding and infant nutrition.

#### *Ideas from the community health staff and NMAA Broken Hill :*

- use of Aboriginal videos and educational literature;
- nutritional education to mothers;
- send Aboriginal health workers to areas where breastfeeding rates are high, so that skills can be learnt;

- use influential local people as role models;
- find out what the current social and traditional beliefs are and work with them;
- find out what people already know about infant feeding and build on it; and
- ongoing services are important.

*'Aboriginal health workers get very little chance to counsel breastfeeding mothers because so few people are breastfeeding and so they become deskilled. Need to send the Aboriginal health workers to where the breastfeeding rates are high so that they may learn about the contexts of breastfeeding and ways of encouraging and supporting breastfeeding'*  
(Early Childhood Nurse)

## Northern Territory

### Nhulunbuy Child and Maternal Health Clinic

This is an urban child and maternal health clinic. 4.7 per cent of the population is indigenous although few indigenous people live in town. The service provides early childhood health services including routine infant health checks, growth and development screening, immunisation, hearing and vision checks and infant nutrition advice and support. There are very high rates of breastfeeding, where the older women, grandmothers and aunts support and advise young mothers. Wet nursing is also practiced. Traditional medicine is used to treat problems such as low milk supply.

## South Australia

### Child and Youth Health

This is a general health service that provides family and early childhood health services. It varies from area to area in terms of the service available for Aboriginal and Torres Strait Islander families. Strategies which are effective in ensuring accessibility in urban areas, may be different within rural or remote areas. The service employs three Aboriginal health workers within the urban area and they work with Aboriginal Health Services in urban, rural and remote areas.

There is no antenatal care as such; however, contact is made with mothers antenatally and postnatally in the hospital to give information regarding the service. Early childhood services include general health checks, opportunistic immunisations, growth and development screening and information, support and advice regarding infant feeding. Accessibility of the service to Indigenous families is promoted by providing a flexible service that is mindful of social and cultural issues. Nursing staff will travel to where the families are, whether this is a community setting or home. The use of the service by Aboriginal and Torres Strait Islander mothers in Adelaide has increased dramatically since the employment of three Aboriginal health workers. All staff have attended training sessions in cultural sensitivity.

The respondent indicated the need for more work to be done in the area of infant nutrition, including the issue of early introduction of inappropriate first foods and the use of powdered milk, as opposed to formula, when bottle-feeding.

*The self-assessed strengths of the project/service were:*

- highly skilled staff;
- accessibility of service; and
- collaboration with other health service providers.

*The self-assessed weaknesses of the project/service were:*

- need for more resources in terms of time; and
- need more specifically prepared resources for Aboriginal and Torres Strait Islander communities.

### Breastfeeding Support Project: Flinders and Far North Division of General Practice

The Port Augusta Breastfeeding Support Group was established in 1993 through the Women's Health Service to increase breastfeeding rates and duration in Port Augusta. Members of the community and interested health workers were involved. Anecdotal evidence suggested breastfeeding rates were low in the area. The breastfeeding support group believed consistent information and professional support for breastfeeding mothers were lacking. A part-time lactation consultant was employed to provide support, and an Aboriginal health worker was employed to provide a service for the Aboriginal community. The project aimed to increase the duration of breastfeeding amongst women in Port Augusta by updating GPs and other health professionals on common breastfeeding problems and recent changes in management, providing consistent and accurate information to pregnant women and breastfeeding mothers, and early identification of breastfeeding problems and timely intervention.

*The self-assessed strengths of the project/service were:*

- the availability of an Aboriginal health worker to promote and support breast feeding in a culturally appropriate way;
- the education of nurses in community-based settings was enthusiastically received;
- the project had a built-in monitoring and evaluation capacity, which led to some changes in implementation to better meet needs and the modification of some educational resources to meet the needs of women with low literacy;
- the educational materials were developed in consultation with Aboriginal women; and
- the project employed a range of health promotions vehicles—face-to-face counselling and support—radio promos, posters and pamphlets.

*The self-assessed weaknesses of the project/service were:*

- the part-time status of all members of the support team sometimes impeded the coordination of the activities. A regular fortnightly meeting helped somewhat, although that was, of necessity, often very brief; and
- the participation rate by Aboriginal women was lower than expected. This led to the project not gathering much information. Hopefully, the integration of this project with Aboriginal birthing projects will mean that Aboriginal women will meet the support team antenatally, and therefore develop a supportive relationship before breastfeeding problems arise.

*The way forward*

A project application has been made to obtain continuing funding, which would aim to continue the service of the lactation consultant in Port Augusta and extend the service to women in remote areas. It is also hoped that the service can become more comprehensive, dealing with the broad range of parenting and ante and postnatal issues.

It is also hoped that the lactation consultant and the Aboriginal health worker can consult from GPs surgeries, to improve coordination and integration and improve access. A special focus on continuity of care for teenage Aboriginal women is proposed. The establishment of a drop-in centre for breastfeeding and other postnatal problems in the local Community Health centre is also seen as a strategy to increase access and participation.

## Victoria

### The Royal Women's Hospital, Melbourne

The Royal Women's Hospital has recently appointed an Aboriginal women's health project officer to explore issues surrounding the health needs and types of service delivery preferred by Aboriginal and Torres Strait Islander women attending the hospital. The project is in its early stages.

## Community-based non-government organisations, private health services, general practitioners

The groups listed here mainly represent the Nursing Mothers' Association Australia (NMAA) and Divisions of General Practice. The NMAA recognised the importance of this project and greatly facilitated our work by mobilising its extensive resources throughout Australia to assist us.

### NMAA, Nhulunbuy, NT

The NMAA programs are structured for non-Indigenous people. This branch is currently talking about ways that the NMAA model could be made more appropriate to Aboriginal and Torres Strait Islander people. NMAA one-to-one counselling by a stranger may be inappropriate for Aboriginal and Torres Strait Islander mothers. It was emphasised that the NMAA community educator material could be utilised to promote messages that breastfeeding is protective and needs to be continued.

*The self-assessed strength of the project/service was:*

- women's networks.

*The self-assessed weaknesses of the project/service were:*

- need a national approach to breastfeeding and a national register for coordinating activities;
- need a clearing house for Aboriginal and Torres Strait Islander breastfeeding and infant nutrition data;
- need for increase in community education, targeting communities to let them know that by breastfeeding they are currently protecting their children's health; and
- need to develop well targeted resources, eg video, in a natural setting which has little language and can be dubbed over to promote breastfeeding in a traditional perspective.

*'We need a National approach to breastfeeding...need funding to provide a central point: a clearing house of information specifically about Aboriginal and Torres Strait Islander breastfeeding and infant nutrition issues'*

*'Community development model is the most useful modality for breastfeeding promotion within Aboriginal and Torres Strait Islander communities.'* (NMAA counsellor, Nhulunbuy)

### NMAA Wagga Wagga, NSW

The service emphasised that the focus of most of Aboriginal and Torres Strait Islander funding is on adult health and that it is time to recognise that child health is the foundation of adult health. The service reports that one-to-one counselling is a more appropriate approach than relying on mass media campaigns. It was thought that there are only two Aboriginal trainee NMAA breastfeeding counsellors in the country. It was also emphasised that the gap between research findings and policy and resource allocation is too large. Staff indicated that increased initiation and duration of breastfeeding would lead to lower hospitalisation rates of infants with gastroenteritis.

### NMAA Casino, NSW

This service reports that the NMAA programs are based on voluntarism. While volunteers are mostly advantaged people, the problems within Indigenous communities are those universal to disadvantaged people, i.e. lower socio-economic status and a lack of education.

Other infant nutrition programs were mentioned indicating, that they had stopped because of the lack of available Nursing Mothers personnel and the difficulty for the Aboriginal women in coming every week. Future services would need to provide better support for the Aboriginal women. 'The volunteer idea doesn't work, need to have the people employed.' They stated that training could be incorporated into their employment. Also mentioned were the difficulties inherent with one-off funding; for example, the North Coast Aboriginal Breastfeeding Project, where the health worker was trained and then lost to the generalist health field. 'Community expectations rise and then they are disappointed because project is de-funded.'

The traditional NMAA approach is not particularly applicable to Aboriginal and Torres Strait Islander mothers and families. *"Ninety-nine per cent of Aboriginal mothers would not telephone a stranger to talk about breastfeeding problem."* They emphasised that there is a need to gain the trust of the community in order to be a breastfeeding counsellor for Aboriginal women. Staff suggested the use of aunts and grandmothers to be trained as counsellors and the need to identify key older women to train in this role. The promotion by formula companies was also noted to be a problem, as well as the need to improve monitoring of violations of the WHO code.

### **Northern Sydney Division of General Practice, NSW**

This response outlines the shared antenatal care program with Royal North Shore Hospital. There are no Indigenous Australian clients.

### **Mid North Rural Division of General Practice, Obstetrics Project SA**

The project is part of a generalised obstetrics peer review and education program. This project includes the collection of data regarding pregnant women presenting to general practitioners over the past 14 months. It provides services to only ten Aboriginal women, eight of whom initiated breastfeeding.

### **Eyre Peninsula Division of General Practice, Lincoln, SA**

This division has applied for a project to provide support for breastfeeding mothers, particularly for those women who are at risk of stopping breastfeeding in the first month. An initial application was rejected on the grounds that the application did not adequately address how the 'at risk' clientele would be identified. Their current proposal will include an Aboriginal health worker as part of the project team to encourage and support breastfeeding in the Aboriginal community.

## Special projects

These are mainly funded through pilot-type programs from the Commonwealth Department of Health and Family Services. Some are currently operational at the time of writing this report and some have recently had their funding withdrawn.

## Tasmania

### **Family and Child Health Aboriginal Program Family, Child and Community Health, Northern Region**

This project was funded for one year through ATSIC funding in 1995. The program was unable to secure further funding and was, therefore, discontinued. The aim of the project was to 'provide appropriate service that enables community participation and improves access for Aboriginal women, children and their families'. The objectives were: 'To provide an appropriate service that enables community participation and improves access for Aboriginal women, children and their families.'

Activities of the project included health promotion activities and individual client contact within the hospital, in community settings and in the home. This project highlights the importance of training and employing an Indigenous family and child health nurse to work in this area. Another issue mentioned was the perception that the service was inaccessible because it was based at the Launceston General Hospital. Furthermore, the project was controlled by a steering committee auspiced by the Department of Community and Health Service and was therefore perceived to be a mainstream service. The other issue specified was the importance of involving the community in the planning and implementation stages of a project.

#### The self-assessed strength of the project/service was:

- awareness of the need for culturally appropriate and accessible family and child health service for Aboriginal and Torres Strait Islander community.

#### The self-assessed weaknesses of the project/service were:

- one-off funding for a 12 month period only;
- non-Indigenous family and child health nurse; and
- difficulty with data processes.

*'Short term funding arrangements limited the possibilities for collaborative planning of the program'. (Family and Child Health Nurse, northern Region, Tasmania)*

### **Hobart Community Nutrition Unit, Dept. of Community and Health Services**

This service is a breastfeeding public awareness campaign, utilising internal Metro Bus advertising to challenge community attitudes about breastfeeding in public. The campaign has involved a two-month advertising period over May–June 1997, to be followed by post-program evaluation using a community sample interview technique. Formative community research was undertaken to identify community attitudes. It is estimated that the reach of posters is 1.8 million exposures over a two-month period. The result of this research supports the need to implement social marketing strategies to change social mores about breastfeeding.

## Queensland

### Ngua Gundi, North Rockhampton

(See also case study 8 on page 95)

This project originated as a response to poor antenatal clinic attendance by young Indigenous mothers in the area. The original goal was to improve antenatal care compliance with a focus on adolescent mothers. The project is funded by the Commonwealth Birthing Services Project on a year-to-year basis. Ngua Gundi was established four years ago and has seen a total of 400 clients; 130 women have been followed through from pregnancy onwards. A needs analysis at the beginning of the project revealed that Indigenous women were keen to have a service of their own. The women also stated a preference for Indigenous health workers to be employed within the program.

Ngua Gundi staff attribute the success of the program to the fact that the program has been designed by the women themselves following the needs analysis. A midwifery model of care is used which provides continuity of care. The service provides transport for the mothers and will visit mothers in their homes. A mothers' group meets on a weekly basis and the women themselves decide upon the agenda. These sessions have a broader focus than women's and children's health issues; for example, the women invited staff from the Commonwealth Employment Service to a meeting. Three women found employment as a result. Much of the education is provided on a one to one basis. The staff use a checklist to ensure coverage of topics such as breastfeeding and appropriate infant nutrition during antenatal visits which are longer than usual.

The degree of acceptance of the project is illustrated by the high rate of attendance at the centre. Of the Indigenous mothers who delivered at Rockhampton Hospital, 90–95 per cent has been seen antenatally by the staff of Ngua Gundi.

*'I would like to see more Aboriginal women trained as breastfeeding counsellors and lactation consultants'* (Midwife)

### Mookai Rosie-Bi-Bayan, Cairns

This is an accommodation service that was initially established by Aboriginal woman Auntie Rose Richards to care for failure-to-thrive children and their mothers (or escorts) as well as providing accommodation before and after discharge from hospital for pregnant women and children seeing specialists. It also provides transport to and from appointments. As an accommodation service there are opportunities for informal and loosely structured education and support regarding breastfeeding and appropriate infant nutrition. The Mookai Rosie staff and governing committee are working towards formalising this. Mookai Rosie has been successful to date because of the home-away-from-home atmosphere and because the staff and governing committee are culturally-sensitive and conversant with many issues relating to Indigenous people.

*The self-assessed strengths of the project/service were:*

- Aboriginal and Torres Strait Islander designed, managed and staffed;
- strong grandmother support;
- strong personal ties to community;
- good networks with other women's organisations; and
- provides accommodation with a home-away-from-home atmosphere.

*The self-assessed weaknesses of the project/service were:*

- need to secure better funding; and
- need to do more with the target community

### **Midwifery Outreach Program, Cairns Qld**

This service was funded through the Commonwealth Alternative Birthing Services Program. It was to provide a community based midwifery model of care. It is staffed by a health worker and a midwife. The target group does not attend mainstream services and the approach is very low-key and relaxed, with an emphasis on building relationships and trust. The program is under resourced and continued funding is yet to be secured.

*The self-assessed strengths of the project/service were:*

- partnership between health worker with local network and midwife a powerful combination;
- accessibility—actively seeks people out; and
- increased antenatal care attendance.

*The self-assessed weaknesses of the project/service were:*

- lack of ongoing funding;
- short staffed, no backup for annual leave, etc; and
- lack of database support.

## **Victoria**

### **Rumbalara Medical Clinic, Goulburn Valley Koori Women’s Resource Group, Shepparton**

This is a birthing program, funded by the Commonwealth government, providing antenatal and postnatal care, birthing support, antenatal education and early childhood health service. Initially, it was a pilot program but now has recurrent funding. Women have their babies in the local hospital and are often discharged after only two days. There is a high rate of breastfeeding initiation, but this drops off following discharge. Reasons for this include social pressure, the advertising of breasts as sexual objects, and myths surrounding breastfeeding—for example, young women believe that their breasts will sag if they breastfeed. Also, babies may be left with the extended family so that the mother can socialise. Some difficulty was encountered with acceptance by the hospital, with staff not always supportive of the Aboriginal health worker. In the late 60s and early 70s, Aboriginal women were segregated and accommodated on the verandah. The hospital was not viewed in a positive light by the local Aboriginal community because of its past treatment of them. Hospital practices regarding breastfeeding were also suspect—“hospital staff...won’t listen to the mother”.

*The self-assessed strengths of the project/service were:*

- culturally appropriate;
- community-based, owned and controlled;
- flexible and reliable;

- confidential; and
- transport and support provided for the woman.

*The self-assessed weaknesses of the project/service were:*

- need own birthing centre with Aboriginal midwife;
- lack of staff—needs 10 more pregnancy support workers;
- professional isolation; and
- need to educate mainstream service providers in cultural sensitivity.

## Western Australia

### Strong Women, Strong Baby, Strong Culture, Pilbara Public Health Unit, South Hedland

This project is based on the Strong Women, Strong Baby, Strong Culture Program in the Northern Territory. The program has been running in Yandeyarra and Jigalong for one year. The emphasis is on good nutrition during pregnancy. Infant feeding is also part of the approach, dealing with conditions such as FTT and its prevention and treatment. There are plans for breastfeeding education and support.

*The self-assessed strengths of the project/service were:*

- strong program—women like it;
- short term success—results seen in children;
- conducted by local Aboriginal people, therefore easily tailored to local conditions and culture;
- away from birthing program and so men can be involved; and
- high use by eligible women.

*The self-assessed weaknesses of the project/service were:*

- lack of funding;
- need more nutrition workers; and
- need more in-service nutrition education for health workers.

## Northern Territory

### Congress Alukura: Women's health program, Alice Springs

(See also case study 2 on page 71)

In 1984–85, Central Australian Aboriginal women designed the Congress Alukura model, based on much consultation and discussion about their traditional and current birthing experiences. Mainstream methods of health service delivery had been experienced by many Aboriginal women as alienating because they were hospital-based, provided by male and female European health practitioners with little or no cross-cultural understanding, used English as the main language, and had a Western approach to examinations, etc. The result of the consultations and planning was a vision for change and an Aboriginal women's health service guided by the principles of the

Grandmother's Law. In June 1987, funding was finally received for a two year pilot health program which was to be based within the Central Australian Aboriginal Congress and provide ante- and postnatal care, liaison and promote women's checks. In August 1988, another location was found through Aboriginal Hostels Inc. However, this site was soon too small and could not provide for a birthing centre as had been planned. Some land was eventually found and a new building designed and built during 1991–92. The new Congress Alukura was officially opened in October 1994 and now has records for about 4,000 women who use the service. It has come a very long way from the original 34 clients in 1984.

The Congress Alukura now has a female doctor, two midwives, two health workers, a liaison officer who can help with transport and follow-up welfare or other needs for the women and, importantly, a traditional grandmother, who is able to speak seven languages and has had 10 children herself.

In September 1993, the birthing unit at the Alukura saw its first birth, and the story of Julie Whittaker clearly shows the joy and appreciation of delivering Corey in this environment.

Since this time there have been 21 births in the Congress Alukura unit, most of which have been to young mothers having their first baby. The antenatal service and classes are also used by about 80 per cent of women who later deliver in hospital either out of choice or because there may be complications. The Alukura staff feel that women also come much earlier in pregnancy to use the service and the options for classes and one-to-one counselling help give them support for their choices and confidence in caring for the new baby. The staff can give advice on the advantages of breast-milk compared to bottle-feeding, prepare women for common problems and simple measures to overcome them, and give information to help positioning the baby at the breast soon after birth.

The women who are having a normal pregnancy and choose to deliver at the Congress Alukura are able to come and stay at the unit for three weeks before and after the birth. They can bring two of their traditional support people and their youngest child, if necessary. During this time, the Alukura staff are able to give family nutrition advice and demonstrations. Postnatally, women are encouraged to come to the clinic at least once a week for eight weeks, but if they are having any problems they can come every day, and the Congress Alukura is now also able to provide transport to help them with these visits.

Even though it is traditional and most women breastfeed, women still need help and support to establish breastfeeding. Staff at Alukura help with this immediately after birth, for those babies born there, or during the postnatal period for mothers who delivered in Alice Springs or Adelaide hospital. After eight weeks the mothers and babies are referred to the Congress under-fives program for further care and advice. If women are having particular problems, Congress Alukura will keep them at the clinic longer to provide support. When they do move on the Congress makes sure that they are notified and can keep helping the new mother. The Alukura has also been able to help mothers with premature or sick babies who are still in the Adelaide hospital by sending down expressed breastmilk.

The clinic also has many home-made resources for use on communities and in the clinic, as well as videos which can be shown in the waiting area in town. It is also involved with education in schools, and its health worker training program and cross-cultural orientation program are going well. The health worker 'well women' module has been accredited and future plans include the development of a special antenatal module.

The fundamental principles underlying the Congress Alukura model are:

- Aboriginal people are a distinct and viable cultural group with their own cultural beliefs and practices, law and social needs;
- every woman has the right to participate fully in her pregnancy and childbirth care and determine the environment and nature of such care, unless medical complications indicate otherwise;
- every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions or to choose other options as she wishes; and
- a review of the Congress Alukura Pilot Health Program was carried out in June 1989. Until the service is able to computerise its record-keeping, it will be difficult to collate quantitative data on service use and outcomes of educational activities.

*The self-assessed strengths of the project/service were:*

- being able to provide an appropriate service where women feel comfortable and safe;
- respect for the Grandmother's Law and confidentiality of women's business;
- consultation with traditional women throughout the many stages of the Congress Alukura model;
- the building of good relationships and trust with the hospital system and staff;
- providing a separate place which is culturally-appropriate and can cater for all women's health needs, which also often picks up other, undiagnosed, health problems; and
- being able to support women at all stages—providing transport, following up with the hospital and/or welfare system if needed, etc.

*The self-assessed weaknesses of the project/service were:*

- funding has and is a continuing problem for the Congress Alukura, as is the perception that the model has not been well recognised;
- early feelings of the NT Health Department that the Alukura would duplicate the existing services;
- demands of a major proposal on a low resourced program;
- service demands still mean that resources are scarce for traditional activities and outreach to communities and leave the Alukura with a mostly Western clinical base in town. The program is trying to deal with this by focusing more on the community controlled remote locations; and
- the Alukura is unable to address everything, as it is not able to provide a 24-hour service for crisis cases.

## New South Wales

### Minimbah infant and childhood nutrition project

*The service*

The Minimbah Pre-School began operation in 1963 as a project of the Save the Children Fund. In 1987 it came under the control of the Minimbah Aboriginal Corporation. In the early years of its operation, its major aims were to teach children about their own culture, their own good health

and nutrition, about safety, and preparation for primary school. The service has now expanded into a 0–5 program, with 17 staff and a total student enrolment of 105. The types of programs now offered are a Culture Nest, a Literacy Nest, inter-cultural exchange, an otitis media awareness program, a nutrition program and a program of parental workshops.

It is currently seeking funding to establish a health education and promotions facility, which will be complementary to and integrated with the current programs.

Poor infant and pre-school nutrition has been identified by the local community as one of the key factors to Aboriginal children's under-achievement in mainstream schools. The service is also developing a culturally-appropriate health education and promotion training program, targeting children in the 0–7 age group. It will focus on major Aboriginal health issues such as nutrition, otitis media, dietary habits, diabetes, and heart and respiratory disease. It is also hoped the current gap in culturally-appropriate health education and promotions programs will be filled by existing and intended activities.

The service provides workshops, as well as individual and family-focussed activities including nutrition, diabetes, malnutrition and otitis media. All activities target parents, children and other family members as part of an holistic approach to health promotion and in recognition of the importance of the extended family in the improvement and maintenance of health. There is high level of continuing consultation with the local Aboriginal community and local health authorities to inform the content and direction of programs.

#### *The effectiveness of the service*

The service has concrete evidence of its effectiveness in achieving much-improved educational outcomes and health outcomes for present and past students. They cite the achievement of a significant change in the number of Aboriginal children continuing past the legal school leaving age, and increased parental support for education. The role of these successful students as role models for current and future children promotes a snowball effect for both educational and health outcomes.

#### *Factors contributing to its success*

Community ownership and control, a high level of Aboriginal staff, and a holistic approach to health are seen as the service's key strengths. Continuous community consultation also ensures the relevance and appropriateness of programs offered, as well as good attendance and high credibility of health advice offered through the variety of programs. Use of research evidence on the need for action in health and nutrition ensures programs impact on high priority areas. In particular, the early recognition of the role of good nutrition on energy, concentration and motivation to pursue education and to succeed in mainstream primary and secondary schools has been a key element of the services success and its acceptability to the local community. The planned expansion and upgrading of facilities is based on express community need.

The service also displays a high level of attention to planning for the sustainability of its services through highly credible business and strategic planning and capital development plans.

The intersectoral approach of embedding health and nutrition in an educational environment is well thought out. Adult involvement and education, capitalising on parents' care and concern for their children, ensure inter-generational effectiveness, and this in itself increases the likelihood of maintaining behaviour change once it is established.

### *Impeding factors*

As with many other organisations, the service recognises that it is not possible to stand still, and in a situation where demand for services outstrips availability, the need for adequate recurrent funding is probably the most pressing need of this otherwise well-established and innovative service.

## **Peak Aboriginal and Torres Strait Islander organisations**

Some peak groups acknowledged the review, but there was no formal input from the peak organisations canvassed by the project team.

## **State Health Departments**

All State and Territory health departments were invited to contribute to the review. The feedback presented here summarises their response to this initiative.

### **Victorian Human Services and Health**

The manager of the Koori Health Unit cited the Victorian Aboriginal Health Service's child health promotion project and supplied two relevant Koori Health Counts publications, and referred the project to Indigenous organisations active in this field.

### **Health Department of Western Australia**

The Senior Project Officer provided useful contacts and information on the Child and Antenatal Nutrition Bulletin and the Child and Antenatal Nutrition Manual.

## Aboriginal and Torres Strait Islander community-based groups

### **Alice Springs Women's Council, Nutrition Awareness Project for Young Mothers and Children**

The focus of the Council's Nutrition Awareness project is general infant nutrition ('solid food—everybody breastfeeds'). The project began because the senior women in the areas were concerned at the high rates of hospitalisation of their grandchildren. The problem of FTT was identified as a major factor by the women and the local health services. Important aspects of the project are:

- the project was initiated by the women;
- the project is community owned and controlled;
- one of the nutrition officers is from the area and speaks the language;
- the project officers go to the people and not vice versa;
- it has a broad-based, advocacy role in addressing the problems, e.g. the lack of nutritious foods available in stores;
- its is acceptable to the community;
- it is difficult to evaluate effectiveness ( for example, it is too soon to expect changes in admission rates to hospital), but there is good acceptance of the project, and the project staff's intervention is requested from community members, staff, hospital and Department of Family Youth and Community Services; and
- measurement of trends in growth patterns over a three-year period will be conducted subject to funding.

#### *The self-assessed strengths of the project/service were:*

- community owned and operated;
- highly accessible; and
- grass roots project.

#### *The self-assessed weaknesses are:*

- lack of ongoing funding; and
- juggling funding from numerous sources.

### **Murray Valley Aboriginal Co-operative**

This cooperative has a maternal and child health service that visits the centre once a fortnight. The current visiting service is to be supplemented shortly by a position to cover the health needs of children in the 0–6-year-old age group in the local community. They will accompany the domiciliary midwives on home visits.



# Case Studies

## Service or program models of practice

This section presents services and programs from around the country from a range of rural and urban settings. The sites visited by the project team have been chosen through recommendations from state Indigenous advisers, State and Territory health departments and service providers, and on the basis of how they relate to the Review's rating system. While many of the services are developmental and do not describe themselves as exemplars of 'best practice', they do offer some instances of that which works well and some insight into why this may be the case. It also identifies services that have the potential to be truly effective and responsive to need. Case studies have been included to demonstrate the complex issues influencing the choices and behaviour related in breastfeeding and infant nutrition.

The consortium would like to acknowledge the contributions made by the organisations presented in this section of the report. We are most grateful to the individuals who took time out of their very busy schedules to talk to the project team, show them around and share their experiences. The commitment and dedication of people actively involved in supporting women and families during breastfeeding and infant nutrition choices, in their health care, and in facing crises or problems were very clear to the team.

Most of the projects and interventions highlighted as part of these visits have important components that cut across more formal structures or boundaries of health care. Linkages and trust have been built across service delivery settings such as health, welfare, the police and community-based organisations such as women's councils. Within the health system there is cooperation between community-controlled Aboriginal medical services and State or Territory health departments. There are links from research to individual client support and health care, urban facilities reaching out to remote areas, and a general sense of trying to be innovative and flexible in order to support the choices of women and families. There are connections being made between old ways and new ways, with traditional stories and ceremonies linked to modern ante and postnatal medical care, and several projects beginning to cross State and Territory borders.

The importance of community ownership, empowerment and participation comes across in all the case studies, as does the need to try to overcome political or other barriers in the effort to facilitate easier choices and lives for women and their infants. The need to work across cultural boundaries is also highlighted by the number of projects emphasising a side-by-side concept of Indigenous and non-Indigenous workers acting in partnership and providing mutual support. The long-term nature of most staff in positions involved in the care giving and advice elements of projects has allowed for the building of trust with members of the community and ensured that their input is culturally appropriate. Health workers also fulfil important advocacy and mediation roles for

individual clients as they consider their needs beyond the provision of health care to social and other family support.

Aside from the importance of an existing community concern and priority for action in the areas of breastfeeding support and infant nutrition, the practical ideas and strategies for intervention expressed to us by the participants included these views:

- start small, make progress and let things grow in response to community needs;
- include individual counselling and support structures as well as more general health promotion activities;
- wider family involvement, discussions and problem solving for individual cases are often necessary for the successful application of the health strategies learnt by mothers;
- training of community based workers can ensure that advice and support is readily at hand when mothers or families experience problems;
- local resources can be produced as part of workshop or training activities, ensuring that women understand them and that they are relevant to the individual community setting;
- home visits and the ability to provide transport facilitates access to the services available and encourages the building of trust and seeking of advice in an informal setting;
- the building of group support networks through child playgroups or other strategies can present educational opportunities and encourage participation in programs; and
- coordinated care plans plus 'at risk' concepts can ensure that individual clients receive appropriate and targeted advice and support at each point of contact with the health system.

## Case study 1

### **Ngaanyatjarra Pitjantjatjarra Yankunytjatjara Women's Council: Nutrition Awareness Project for young mothers and children, NT**

#### *The service*

The Ngaanyatjarra Pitjantjatjarra Yankunytjatjara (NPY) Women's Council has about 3,000 members, with 16 council workers active in the areas of nutrition, aged care and support, disability support, and domestic violence. All program areas are run on a Malparara system, where non-Aboriginal staff have a local Anangu woman working closely with them. The women's council offices are located in Alice Springs but the NPY lands extend across NT, WA, and SA boundaries.

The nutrition project was initiated by senior community women in April 1996, because of strong community feelings about the welfare of particularly very young mothers and their babies. The older women see these young women going into hospital and having problems with their babies getting sick and being skinny, and feel for them. The project therefore developed the different strategies for prevention and education, as well as crisis support if needed. The principle aim of the project is to develop the awareness and knowledge of young mothers about solutions to the problem of FTT in their young children, and also to promote health practices and strategies to maintain better health.

Although the senior community women and clinic staff could usually identify the mothers and children most in need of support and advice, the crisis intervention also particularly helped the workers and others to understand the larger picture of the underlying problems which often led to the children becoming FTT. These include late intervention in cases of poor growth, family denial of a problem, misconceptions of what is healthy, and repeated disease and infection presentation.

By March 1997 ten families had been involved with the project for intensive support during stays in Alice Springs hospital and follow-up at the community or during visits to town. The strength of cooperative actions across agencies and support from other sections or programs in the women's council has been really important in these processes. Similarly the possibilities for family meetings and counselling about particular problems have helped to bring about changes important for helping to make these children grow better and become healthier. To support these activities further the project has recommended that a community-based welfare worker, accountable to a non-government organisation, might better assist those children most 'at risk' of FTT and repeated hospital episodes. Progress towards this is now being made on one of the communities within the NPY lands, with a family welfare worker position identified as part of the community strategic plan.

The outreach education and nutrition promotion program has visited eight communities to run five-day workshops with 212 young mothers and children. These are usually held at either the women's centre or the clinic, and have helped to make mothers more comfortable about visiting the clinic for weighing the babies and/or advice, as well as giving them good ideas about nutrition for the babies and family. This work with the clinic staff and senior women in the community has also shown that there is a need for earlier use of strategies such as family meetings if children are not doing well. Those mothers that the senior women thought could benefit most from the workshops were specially invited by the nutrition team, but all young mothers were welcome to attend the workshops. The nutrition team and community have also been active in trying to encourage the stores to change some of the foods they stock, so that mothers can have easier access to the kinds of foods they want to make their babies grow healthy.

Two songs, *Hungry little child* and *Growing big and strong*, plus posters for community schools, are also being reproduced in language.

It is not surprising that the project won a South Australian Excellence in Health Promotion award in May 1997.

### Plans for the future

The next priority for the team is to be involved in the Kungka career conference which the women's council is organising in July. This will be held near Uluru and give many young girls and women a chance to listen to some really successful Indigenous women who are doing things in business or professions.

Thanks to recent funding enhancements, the team hopes to produce a nutrition manual for mothers over the next year. They have been busy collecting resources for this from the workshops and other sources. There are also seven more communities requesting nutrition workshops. Crisis cases, where families need help to break the cycle of repeated illness and FTT, also keep coming up. They hope that their work with the clinics and staff on the communities will help the clinic to be able to do similar nutrition activities more regularly to follow on from their first workshops.

### Breastfeeding and infant nutrition interventions

The project goal is to reduce the incidence of FTT on remote Aboriginal communities on the NPY lands of Central Australia.

Objectives are to:

- improve the nutritional status of Anangu children under five years;
- improve the quality and variation of food in the community stores;
- promote the use of bush tucker as a fundamental component of children's diets;
- improve young mothers' knowledge and understanding of nutritional requirements of the children;
- decrease hospital admission rates of Aboriginal children under five years of age and the prevalence of chronic illness; and
- decrease the incidence of children being taken from their families and welfare intervention for children failing to thrive

Practical strategies forming the basis of the intervention:

- introduce solid foods to babies early;
- promote good food for babies;
- reduce consumption of high sugar drinks and take-away food;
- introduce healthy snack alternatives;
- ensure good food supply in community stores;
- break the cycle of FTT once a child has been hospitalised; and
- promote safe hygiene practices and sanitation for children.

Specific nutrition project components:

- outreach and education programs;
- crisis intervention;
- production of a culturally-appropriate nutrition resource manual for use by mothers; and
- store education and recommendations.

Some of the activities or topics covered during the nutrition workshops on communities are:

- food trials and cooking;
- education about when to start feeding babies and appropriate foods;
- food preparation and hygiene;
- three major food groups and healthy eating pyramid for discussions on regular eating and quantities;
- healthy snack alternatives and consequences of feeding babies high sugar and high fat take-away food;
- healthy foods used as a treat, the 'reward system';
- outing for bush tucker and discussion on the importance of this kind of food for babies;
- importance of water for babies, especially when they are sick or the family is travelling long distances;
- group tips for healthy kids and making posters for these;
- cycle of disease and discussion on preventative health for babies;
- tips for feeding difficult children; and
- requests for different foods in the store and store activity on shopping.

### *The effectiveness of the service*

To date, only process evaluation strategies have been used as it is too early to expect dramatic changes, and available statistics on hospital admissions have shown little change over the length of time that the project has been running. Individual children involved in the crisis intervention are being tracked as closely as possible through health and other networks. There are plans for a full external evaluation after three years if funds permit.

### *Factors contributing to its success*

The senior women on the communities are strong and know what is happening and needed, so that they have been able to really get involved in planning the program.

The team is flexible and will talk to individuals about ante- or postnatal issues as well, if the grandmother or mother suggests it.

The Anangu nutrition project worker is now able to do almost the entire workshop in language.

The town support for crisis cases has been really important in giving everyone the 'big picture' of the many problems faced by the young mothers and families. These relationships and communication help to make the hospital less frightening and give the mothers access to someone who cares and will listen to their problems.

Because the women's council is not a health service, it can be much more multifaceted in the support and advice it offers. This has also made it much easier to work with all the different agencies that might be involved, such as health services, family and/or welfare services, the police and others.

For the health system it has also been able to build important interstate follow-up bridges for children treated in Alice Springs who return to live in their community in WA or SA.

### *Impeding factors—lessons to be shared*

Many of the program's strengths have also been the source of some of the problems that have had to be negotiated.

Because the women's council is not a health service, it was at first difficult for the State and Territory health services to accept its nutrition activities. It also has a limited sphere of influence for any changes that might be suggested on the basis of workshop or family and community experiences.

Similarly, the work with stores is made difficult by the turn over of managers and the fact that it might take a little time before changes to take-away food, in particular, are well accepted by all the community.

Trying to bridge the three States and Territory covered by the NPY lands has not been easy, particularly as the welfare regulations are different and families are mobile.

Many young fathers have other priorities and don't want to get too involved in nutrition activities or looking after very young babies. Also, trying to get other carers to come and stay at the hospital in severe FTT cases is not always possible for the community or hospital.

For the early part, the project had eight different one off grant and funding components or sources to administer. Although some parts are now more likely to be recurrent, others are not, so additional funds still need to be found, and this takes much time.

### *Sources of further information:*

Liza Balmer, Valerie Foster (1997). 'Preliminary evaluation of a nutrition awareness project on the prevalence of FTT in remote Aboriginal communities on the Ngaanyatjarra Pitjantjatjara Yankunytjatjara communities of Central Australia'. Collegiate: Royal College of Nursing Journal (in press).

Valerie Foster, Liza Balmer (1997). Nutrition awareness project for young mothers and children by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara. Women's Council Aboriginal Corporation: progress report, March 1997.

## Case study 2

### Congress Alukura: Aboriginal Women's Health and Birthing Service

#### *The service*

In 1984–85, Central Australian Aboriginal women designed the Congress Alukura model, based on much consultation and discussion about their traditional and current birthing experiences. Mainstream methods of health service delivery had been experienced by many Aboriginal women as alienating because they were hospital-based, provided by male and female European health practitioners with little or no cross-cultural understanding, used English as the main language, and had a Western approach to examinations, etc. The result of the consultations and planning was a vision for change and an Aboriginal women's health service guided by the principles of the Grandmother's Law. In June 1987 funding was finally received for a two-year pilot health program which was to be based within the Central Australian Aboriginal Congress and provide ante- and postnatal care, liaison and promote women's checks. In August 1988, another location was found through Aboriginal Hostels Inc. However, this site was soon too small and could not provide for a birthing centre as had been planned. Some land was eventually found and a new building designed and built during 1991–92. The new Congress Alukura was officially opened in October 1994 and now has records for about 4,000 women who use the service. It has come a very long way from the original 34 clients in 1984.

The Congress Alukura now has a female doctor, two midwives, two health workers, receptionist, coordinator, driver, executive secretary, cleaner, liaison officer who can help with transport and follow-up welfare and, importantly, a traditional grandmother who is able to speak seven languages and has had 10 children.

In September 1993, the birthing unit at the Alukura saw its first birth, and the story of Julie Whittaker clearly shows the joy and appreciation of delivering Corey in this environment.

Since this time there have been 21 births in the Congress Alukura unit, most of which have been to young mothers having their first baby. The antenatal service and classes are also used by about 80 per cent of women who later deliver in hospital either out of choice or because there may be complications. The Alukura staff feel that women also now come much earlier in pregnancy to use the service and the options for classes and one-to-one counselling help give them support for their choices and confidence in caring for the new baby. The staff can give advice on the advantages of breastmilk compared to bottle feeding, prepare women for common problems and simple measures to overcome them, and give information to help positioning the baby at the breast soon after birth.

The women who are having a normal pregnancy and choose to deliver at the Congress Alukura are able to come and stay at the unit for three weeks before and after the birth. They can bring two of their traditional support people and their youngest child if necessary. During this time the Alukura staff are also able to give family nutrition advice and demonstrations. Postnatally women are encouraged to come to the clinic at least once a week for eight weeks, but if they are having any problems they can come every day and the Congress Alukura is now also able to provide transport to help them with these visits.

Even though it is traditional and most women breastfeed, women still need help and support to establish breastfeeding. Staff at Alukura help with this immediately after birth, for those babies born there, or during the postnatal period for other mothers who delivered in Alice Springs or Adelaide hospital. After eight weeks the mothers and babies are referred to the Congress under-

fives program for further care and advice. If women are having particular problems Congress Alukura will keep them at the clinic longer to provide support. When they do move on, Congress makes sure that they are notified and can keep helping the new mother. The Alukura has also been able to help mothers with premature or sick babies who are still in the Adelaide hospital by sending down expressed breastmilk.

Most of the women who use the Congress Alukura live in Alice Springs or the town camps, but through the outreach clinics the staff are also able to support and help women in the remote community. The Alukura mobile team visits communities in response to requests and usually stays a week to carry out health promotion and education activities and provide well women checks. Because of the distances involved, staff and funding limitations, most of the communities involved in this program only get visited once a year, but the Alukura may try to do fewer sites visiting more frequently in the future.

The clinic also has many home-made resources for use on communities and in the clinic, as well as videos which can be shown in the waiting area in town. It is also involved with education in schools and its health worker training program and cross-cultural orientation programs are going well. The health worker Well Women's Check Module has been accredited and future plans include the development of a special antenatal module.

### *Breastfeeding and infant nutrition interventions*

Fundamental principles underlying the Congress Alukura model:

- Aboriginal people are a distinct and viable cultural group with their own cultural beliefs and practices, law and social needs;
- every woman has the right to participate fully in her pregnancy and childbirth care and determine the environment and nature of such care, unless medical complications indicate otherwise; and
- every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions or to choose other options as she wishes.

Congress Alukura aims to:

- preserve and recognise Aboriginal identity, culture, law and language in general;
- preserve and encourage Aboriginal women's culture, law and practices in relation to birthing matters or pregnancy, childbirth and the care of mother and baby;
- support each Aboriginal woman in her informed choice of where and how she has her pregnancy care and gives birth to her baby;
- increase awareness and understanding among non-Aboriginal health care providers of the social and cultural needs of Aboriginal women in pregnancy and childbirth;
- encourage mutual respect and understanding between all providers of obstetric care and birthing care;
- give more antenatal care and education;
- give more support in birthing;
- give more postnatal care and information; and
- give more women's checks.

### Objectives of the service:

- to provide a place in Alice Springs, where Aboriginal women, with their chosen relatives, can have pregnancy care and normal deliveries, in a way consistent with their personal, cultural and social needs;
- to support any Aboriginal woman who chooses to give birth in her own country, 'on the ground';
- to develop, through mutual consultation between Aboriginal women, health workers, traditional midwives, Ngangkari, and non-Aboriginal Alukura health staff, a series of health education programs and materials in Aboriginal languages, relating to health problems and care in pregnancy and childbirth;
- to develop through similar mutual consultation a training program for Aboriginal health workers in their own languages, incorporating those traditional Aboriginal 'birthing' and Western obstetric practices that are most appropriate to their role and circumstance;
- to visit each Central Australian Aboriginal community at least once a year, for health educational activities and for women's meetings, to elicit continuing feedback about their birthing needs and preferences;
- to visit and hold women's clinics at least twice a year in those Central Australian Aboriginal communities not regularly serviced by female health staff;
- to advise and support any Aboriginal communities that want to establish their own equivalent of the Congress Alukura; and
- to reduce the infant and maternal mortality and morbidity rates in a culturally appropriate way.

Aboriginal women want the Congress Alukura to be a quiet, totally secure place for women only where family groups can stay together and where Aboriginal women's Law can be respected and passed on.

### Fundamental principles of the service design and development:

- a separate and women only space;
- importance of maintaining and passing on the Grandmothers Law;
- incorporation of traditional practices;
- community-based primary health care;
- holistic approach to health care;
- Aboriginal self-determination and community control;
- cross-cultural education; and
- a culturally appropriate option for health care.

### Congress Alukura functions and components of service delivery:

- self-help family accommodation;
- bush communication network;
- mobile bush service;
- antenatal care and education;

- women's health care and family planning;
- infant and toddler health care;
- nutrition program;
- normal births;
- support for country births;
- postnatal care of mothers and babies;
- cross-cultural health education;
- cross-cultural health worker education;
- orientation for non-Aboriginal health staff; and
- liaison with all providers of obstetric care.

#### *The effectiveness of the service*

A review of the Congress Alukura Pilot Health Program was carried out in June 1989. Until the service is able to computerise its record keeping it will be difficult to collate quantitative data on service use and outcomes of educational activities.

#### *Factors contributing to its success:*

- being able to provide an appropriate service where women feel comfortable and safe;
- respect for the Grandmother's Law and confidentiality of women's business;
- consultation with traditional women throughout the many stages of the Congress Alukura model;
- the building of good relationships and trust with the hospital system and staff;
- providing a separate place which is culturally-appropriate and can cater for all women's health needs, which also often picks up other, undiagnosed, health problems; and
- being able to support women at all stages—providing transport, following up with the hospital and/or welfare system if needed etc.

#### *Impeding factors—lessons to be shared:*

- funding has been and is a continuing problem for the Congress Alukura, as is the perception that the model has not been fully recognised by governments;
- early feelings of the NT Health Department that the Alukura would duplicate the existing services;
- demands of a major proposal onto an insufficiently resourced program;
- service demands still mean that resources are scarce for traditional activities and outreach to communities and leave the Alukura with a mostly Western clinical base in town. The program is trying to deal with this by focusing more on communities in remote locations;
- the Alukura is unable to address everything as it is not able to provide a 24-hour service for crisis cases; and
- lack of funding for regular council meetings.

Sources of further information:

Betty Carter, Eileen Hussen, Lana Abbott, Margaret Liddle, Dr Mary Wighton, Maureen McCormack, Pip Duncan, Pamela Nathan (1987). 'Borning: Pmere Laltyeke Anwerne Ampe Mpwaretyeke. Congress Alukura by the Grandmother's Law.' Australian Aboriginal Studies 1987 Number 1.

Lynore Geia (1996). 'Congress Alukura: by the Grandmother's Law.' Aboriginal and Islander Health Worker Journal, 20(2): 29-31.

Lynore Geia (1996). Arlwekere by the Grandmother's Law: Information Package.

## Case study 3

### Strong Women, Strong Babies, Strong Culture; Northern Territory

#### *The service*

The program began in 1992 with a submission for funding and some pre planning which utilised the knowledge and skills of both Aboriginal people and the medical and nutrition profession. It really started in 1993, with the employment of Lorna Fejo, a widely-known and respected older Aboriginal woman, who worked as project coordinator within the Primary Health and Acute Care Branch in Darwin. Through consultation with a steering committee and Aboriginal women, she was able to coordinate the direction Aboriginal women wanted for the project, which led to the important process of partnership and control, as well as a shared vision. The project thus developed a model that was able to capture the imagination and participation of the Aboriginal community.

The project began in earnest with the training of strong women workers who were selected by three remote Aboriginal communities to work on the program. Workshops are usually 3–5 days long and involve the use of a specially developed resource kit which participants are able to take back for talking with community women. The strong women kit focuses on the five main elements of the Strong Women story. Throughout the workshop, women are also able to share their stories, talk about many other issues like breastfeeding and how to support new mothers in positioning the baby, care of nipples and what to do if there are problems like cracked nipples, how to hold and support the baby, etc. Discussions also include breast care during pregnancy and good foods that help to make sure the mother has plenty of milk for the baby. At the end of the workshops there is usually time for the women to show their appreciation and the knowledge they have gained by producing posters, paintings or quilts about the strong women story.

Following the success of the program in the three trial communities (two in East Arnhem District and one in Darwin Rural District), it was extended to six more communities in the Top End and also began work in the Centre in 1996. A Darwin Rural District, East Arnhem District, and two Alice Springs based coordinators were employed to help with this expansion. In June 1996, two Strong Women workers from WA were trained to take the program to their area in the Pilbara and Kimberley regions. There are now plans to train workers in Cape York in Queensland. Because the program has been widely reported and publicised, there have also been many requests for information and a Strong Women initiative from other States, including Victoria and New South Wales.

#### *Plans for the future*

- to keep training strong women workers for more communities;
- to expand the school education elements particularly for girls in high school so that they are healthy well before their first pregnancy. This will also help to complete the holistic circle which is an underlying thought of much of the program;
- add more training elements, on diabetes in pregnancy, as this is a big problem in the Alice Springs area;
- support further training of strong women workers and the Healthy Kids, Healthy Family project; and
- to incorporate the Strong Women messages into antenatal care protocols, so that it becomes a way of working, rather than a distinct program.

### *Breastfeeding and infant nutrition interventions*

The program began with the plan to consult with Aboriginal women and health workers in a range of communities about poor nutrition and infection during pregnancy, with the aim of developing bi-cultural strategies to reduce the occurrence and effect of these conditions. The original aims have now grown to improve the health of pregnant Aboriginal women in order to reduce the high incidence of low birth weight infants.

Objectives of the Strong Women program are:

- to liaise with Aboriginal women and health workers in the NT to implement strategies to improve the nutritional status of pregnant women and thus improve the birth weight of their babies;
- inform women about services through traditional communication methods; and
- enable non-Aboriginal health workers to acquire knowledge about traditional beliefs and practices, the Strong Women story, and modified antenatal care protocols.

Practical implementation strategies include:

- community based strong women workers are trained and supported by the Northern Territory coordinator of the program, while operational District based coordinators share the story of good nutrition, dangers, protection and prevention, sharing and caring for pregnant women; and
- the women have specialist cultural knowledge and are supported by a traditional grandmother in the community to provide a link between the health system and participation in women's cultural ceremonies relating to pregnancy and childbirth.

The strong women story and training components include:

- nutrition and a healthy diet of locally available bush and store food;
- dangers to pregnant women, using the diagram 'The road to long life, good health and happiness'. Identifying what are the dangers to pregnant women and the many physical, emotional and social dangers faced by Aboriginal people today;
- prevention and protection—what can we do individually and as a community to protect the mother? Using traditional values and customs combined with western style education to combat the bad influences around them;
- sharing information is important—Aboriginal women teach community health nurses traditional antenatal and postnatal care, and community health nurses teach Aboriginal women how to take care of each other using the latest methods of antenatal and postnatal care; and
- caring—sharing knowledge throughout the community, including post-primary girls, so that the community can care for mothers of future generations.

The strong women resource kit and workshop activities have the following headings:

- dangers such as poor weight gain, infections, anaemia;
- benefits of exercise and collecting bush tucker;
- diet and foods for strong families, diabetes in pregnancy;
- health and hygiene;
- traditional smoking ceremonies;

- old ways—ceremony and tribal life;
- ceremony—education and training;
- having strong babies and the cycle of malnutrition; and
- the strong women story and ‘The road to long life, good health and happiness’.

#### *The effectiveness of the service*

Two preliminary evaluations have now been carried out and a further external and quantitative assessment is planned when the program has been extended to further communities. The first process evaluation was carried out in 1994 to document the early stages of the program. A quantitative analysis of outcomes in the initial three pilot communities was carried out in 1996. It found improved health status of pregnant women and their infants at birth.

- The low birth weight rate decreased from 20.3 per cent to 11.5 per cent, a reduction of 43 per cent.
- Women participated in antenatal care at an earlier stage of gestation—this outcome was more pronounced among younger women, women having their first baby, and older multiparous women.
- There was an increase in the mean birth weight of infants of 141 g.
- The pre term birth rate was reduced from 21 per cent to 9.5 per cent, a reduction of 55 per cent.
- From available data, maternal weight at the beginning of pregnancy had increased but no change in weight gain during pregnancy was observed.
- There was little change in the prevalence of anaemia but earlier participation in antenatal care offered the opportunity for initiating treatment before the last trimester.
- The prevalence of some maternal infections during pregnancy was reduced.

#### *Factors contributing to its success*

- Empowerment—community self esteem and people’s pride in doing things for themselves.
- Grant funding for Strong Women workers is administered and controlled by the community non-government organisations involved.
- Family support is emphasised.
- The Strong Women workers form a bridge between the clinic and community people, but are also able to provide counselling for women having problems like postnatal depression.

The strong women workers themselves have also identified some reasons for success:

- the right people selected—Lorna and the Strong Women workers;
- Aboriginal control of project—ownership;
- the project addressed an area that was already a concern for many Aboriginal people;
- formation of partnerships between Yolngu and Balanda;
- project confined to only a small number of communities initially; and
- for Arnhem Land women, the project had strong cultural significance—Raypirri.

### *Impeding factors—lessons to be shared*

There have been many barriers and problems throughout the program, but the program coordinator does not want to talk about or dwell on them.

A current worry is the fact that the program and activities of the Strong Women workers keep getting bigger. Many are involved in the schools education, aged care and other community and health activities, so that the project now needs to be careful of worker 'burn out'.

### *Sources of further information:*

Lorna Fejo, Cheryl Rae (1994). Evaluators' Report: Strong Women, Strong Babies, Strong Culture Project 1992-1994.

Lorna Fejo, Cheryl Rae (1996). Report: Strong Women, Strong Babies, Strong Culture Project 1992-1996.

Lorna Fejo, Cheryl Rae, Beryl Mayanini and Dorothy Mawalkmalwuy, Joyce Gumburawu, Karen Bunyarrapa, Gaypirra, Ruth Pamback, Prudence Pupuli, Rita Tharwaul, Kath Mills, Lois Daniels, Alberta Puruntatameri, May Rosas, Mondullullu Koops, Boyen Yunupingu, Manbanu, Vivienne Hobson, Jenny Cleary, Jackie Boyes (1995). 'Strong Women, Strong Babies, Strong Culture.' In: Nutrition Networks 95. Conference Proceedings: Broome, WA, 59-68.

Lorna Fejo (1996). 'Northern Territory: Strong Women, Strong Babies, Strong Culture Project.' In: Commonwealth Department of Health and Family Services. Sharing Good Tucker Stories: A guide for Aboriginal and Torres Strait Islander Communities. AGPS, Canberra, 107-113.

## Case study 4

### Healthy Kids, Healthy Families Project; Northern Territory

#### *The service*

The project is located within the Food and Nutrition Unit in Darwin, but is aimed at remote Aboriginal communities. It began in early 1996, conducting extensive consultation with communities in the Centre and Top End of the Northern Territory. The community visits and discussions showed that in the Centre there was strong feeling and concern about skinny kids, with some communities already developing their own strategies for helping mothers and families during this time. The story about the Yuendumu feeding program describes some of these activities and the types of things that the project would like to support in other communities.

An Aboriginal steering committee has been formed and several meetings held. In October 1996, a large workshop was run to properly start the project and facilitate the sharing of ideas among communities identified as having a particular interest. Early in 1997, the project team was also very much involved in redesigning the Road to Health chart for children in the NT and this has been incorporated into a Growth Assessment and Action Policy for the Central Australian Population Health Unit and Barkly Health Services. This action policy grew out of an earlier strategic plan for growth assessment and will also be supported in the Top End.

The new chart was designed with two main objectives in mind:

- familiarity—to retain the look of the current chart as much as possible, as there is widespread familiarity with this format; and
- simplicity—to keep the chart as simple as possible with the purposes of assessing the growth (weight, length, head circumference) of an individual child against a reference population, using the direction of the lines of subsequent plotted points as a guide, and reminding the users that food is related to growth.

In the past few months the project has been very busy filming a video Healthy Kids, Healthy Foods to provide a resource for use in communities and training. The video will look at breastfeeding and first foods, linking developmental stages with foods and also the process of growth assessment at the clinic.

The coordinator has also been working closely with one community interested in the project and two other communities have also been identified and some discussions held. In the community most progressed with the project, many meetings have been held and coordinating strategies identified. These are likely to involve Strong Women workers, nutrition workers, FYCS, the clinic, HACC programs. They will be based at the women's centre. There are plans for children's play groups, training and talks on budgeting, as well as nutrition activities. The community is waiting until another meeting after the bush holidays to identify workers who will be further involved in the project and commit firmly to the ideas and plans. The links and trust between the project and the independently-controlled clinic have also been built up over this time, so that a referral system from the clinic to the project and nutrition workers can be established in the future.

#### *Plans for the future*

- To finish the video and develop additional resources for a flip-chart which can be linked into the Strong Women worker training and nutrition worker training.
- Further video to explain the new Road to Health chart.

- The project coordinator will move to the operational structure later this year and become linked to the Strong Women, Strong Babies, Strong Culture Program.
- The training to be offered to nutrition or healthy kids, healthy families workers will be part of an accredited training program developed by Pundullmurra College in Western Australia. Some modification of resource materials, to increase the child nutrition and growth monitoring elements and make them specifically relevant to the Northern Territory, still needs to be done.

### *Breastfeeding and infant nutrition interventions*

The project planned to develop strategies to enable Aboriginal families to better manage the feeding, growth and development of their young children. It was to be a bi-cultural primary prevention program. The goal is to reduce malnutrition among remote Aboriginal children in the 0–2 year age group through education and support.

Project objectives are to:

- include stories about the old and new ways of looking at infant growth, health, illness and child development;
- look at how to include the old and new ways of working out if children in the 0–2 year age group are growing and developing properly; and
- develop and test messages and resources about feeding, growth and development.

Other benefits that the project is expected to deliver due to the focus on diet and nutrition, support by nutritionists, Aboriginal health workers and nutrition workers:

- better growth rates of children in Aboriginal communities;
- Better monitoring of child growth and development within communities;
- Faster response to, and treatment of, failure-to-thrive children by paediatricians;
- Reduced rates of anaemia in children in Aboriginal communities;
- Lower rates of hospitalisation of children; and
- Fewer referrals to specialists for chronic failure-to-thrive children.

### *Practical strategies forming a part of the project*

- To consult widely about community perceptions and feelings about infant and young child growth and development.
- The project is designed to be community controlled. The Healthy Kids, Healthy Families staff will play a supportive role to the community and assist in the organisation of all resources available to the community.
- The project hopes to build strong working relationships with women's resource centres operating in the communities.
- In the communities involved in the project, the project team will try to coordinate support from personnel involved in similar or related projects and programs conducted by Territory Health Services and other government departments (e.g. the Strong Women, Strong Babies, Strong Culture Program, Health Promotions, Environmental Health, Family Youth and Children's Services, etc.).

- Nutrition programs, growth and action policies will be developed to incorporate the training of Aboriginal nutrition workers, specifically in nutrition during early childhood.

*Training components offered as part of the project:*

- The coordinator of the project will conduct training sessions with the community committee to familiarise members with the concepts of the project.
- The coordinator and district nutritionists will conduct training sessions with Aboriginal health workers, clinic staff and community members on the use of the new Road to Health chart to monitor child growth.
- Aboriginal nutrition workers will be trained specifically in nutrition by the district nutritionists, so that they can be a permanent source of advice to parents on diet and nutrition matters.

*The effectiveness of the service*

As the project has only been running for just over a year, no evaluation has been carried out. As yet, there are no firm plans for a later evaluation.

*Factors contributing to its success*

- The communities which are becoming involved in the project already had a strong commitment to health and good food messages. In the Centre particularly, the community focus is already very much on the problem of skinny kids. In one Top End community involved with the project, three health workers based at the clinic already had a strong focus on child health and well being.
- Being able to build on the Strong Women, Strong Babies, Strong Culture Program networks and community based workers.
- Department interest in nutrition through the Northern Territory Food and Nutrition Policy, which has encouraged the development and funding of Aboriginal Nutrition Worker concepts through the existing operational structure, the food and nutrition policy and/or prevention initiatives.
- A commitment to a side-by-side concept in training and working between Aboriginal staff and policy or operational nutrition staff.

*Impeding factors—lessons to be shared*

- Early in the project there has been some confusion and conflict between the separate Healthy Kids, Healthy Families project and the already operating Strong Women program. An independent research project with a focus on young children, planned in some Top End communities, has added to the confusion at the community level.
- For most of the time the project has had only one coordinator and there was the need to be in the office as well as the interested communities.
- Uncertainty about funding has meant that the project will not be able to provide additional financial resources for the employment of nutrition or healthy kids, healthy families workers at the communities.
- The time needed to build community and other service provider trust should never be underestimated.
- Issues about statistical monitoring information on the growth of children and their confidentiality still need to be resolved.

Sources of further information:

Healthy Kids, Healthy Families Workshop Report. 8 October 1996, Darwin.

Healthy Kids, Healthy Families Project Information Guide (1997).

Kumanjayi Napanangka Granites (1995). Yuendumu Cultural Nutrition Program. In: Nutrition Networks 95. Conference Proceedings: Broome, WA:99.

## Case study 5

### Ngunytju Tjitji Pirni Aboriginal Corporation, Western Australia

#### *The service*

The Goldfields Region of Western Australia was chosen as the site for the pilot program because the Aboriginal women of this region have some of the worst outcomes of pregnancy in Australia. Geographic, educational, linguistic, and cultural reasons contribute to a lack of knowledge and access to health resources, information and education.

In the Wongatha language Ngunytju means the 'mother group', Tjitji means the 'little children', and Pirni means 'together'. The name of the program, therefore, gives the meaning of women and children caring together. Ngunytji Tjitji Pirni (NTP) was initiated in 1992 and began in earnest in 1993, with the employment of three workers for the project. An Aboriginal women's management committee comprised of 35 Aboriginal women from the Eastern Goldfields, was established and helped guide and direct the project through its early development. The NTP has since become an incorporated organisation and the committee continues to be active and supportive of project activities.

Funding has been diverse, but the NTP is now based within the Kalgoorlie Hospital grounds, giving easy access to patients and facilities for educational activities. Four Aboriginal health workers currently work on the project as well as the coordinator.

The workplace philosophy of the NTP is to:

- holistically view health problems affecting individual clients, then deal with the person in an understanding culturally acceptable manner;
- provide a health and social network and forum of support for the empowerment of Aboriginal and Torres Strait Islander women in a community based health care agency; and
- promote the role of the Aboriginal health worker in patient care, health planning, service provision and research.

NTP uses community development strategies to improve self-esteem and community spirit, by establishing a forum and social network for empowerment of the project's clients, those who attend the playgroup, and those on the women's committee.

Although initially conceived as a research project, the activities of the NTP team have helped to establish strategies that contribute to improved health and welfare for the clients involved. The NTP improves the health of families by educating and empowering mothers in strategies to maintain health and treat minor illnesses at home, as well as providing early intervention and referral when problems are identified. It also improves access of Aboriginal and Torres Strait Islander people to health care by providing care in their own home environment, by providing reminders, interpreting and transport as well as other support for clients attending other health service appointments (e.g. doctor, ultrasound, clinic nurse). The Aboriginal health workers collect information for research into the patterns of illness and health, to allow identification and targeting of problem areas.

In 1996, the project won a Western Australia Community Services Industry Award for its efforts in the Care for Children category. These awards were created to acknowledge the dedication and commitment of people working for the community and to recognise innovation, excellence and cooperation in organisations which play a vital role in supporting the well-being of Western Australians. The project has also been presented at fora within Australia and overseas.

### Plans for the future

- To expand and work with two more distant communities, as well as the town and fringe groups.
- A five-year focus on ear health is planned from next year and will include further specialist training for the Aboriginal health workers.
- Assistance to the Health Department in extending the model to the East Kimberley area and to continue follow-up and care for children up to five years of age within the Kalgoorlie area.
- The project would like to include a doctor, so that it can extend the types of services and advice it can offer clients.

### Breastfeeding and infant nutrition interventions

The aims of the NTP project are to:

- reduce mortality, morbidity and hospitalisation of Aboriginal expectant mothers and infants in the goldfields region of WA; and
- offer quality maternal and infant health care during antenatal, postnatal and infant periods, delivered by specialised Aboriginal health workers working in a truly culturally appropriate and community owned agency.

The first year of NTP in 1993 was set aside for development and focused on the following objectives:

- establish a culturally-acceptable and appropriate method of health care for Aboriginal women and their infants using a community development model;
- establish a network of social support for Aboriginal women and a forum for their empowerment;
- develop the role of the Aboriginal health worker in patient care, health care planning, provision, and research; and
- develop culturally-appropriate and acceptable methods of health research for Aboriginal people.

By 1994–95 these objectives had been refined, becoming more targeted and aligned with the way the project was progressing. They were to:

- empower Aboriginal women to make informed choices about their own and their families health by culturally appropriate support and education;
- reduce the rates of illness and death of Aboriginal women and children by supplying quality maternal and infant care by trained Aboriginal health worker maternal and infant specialists; and
- collect and analyse information about Aboriginal health, research methods and health care delivery and make it available to Aboriginal people, health care providers and health planning authorities.

Breastfeeding has mainly been encouraged using an individual approach. Unexpectedly, the project has shown how much perseverance is necessary for a mother to fully breastfeed successfully. The magnitude of commitment required is often underestimated by the community at large. Many outside pressures such as advertising and well-meaning advice from health care workers or relatives can confuse mothers. There is a real need for ongoing support and encouragement, which can be provided by the health workers at regular meetings with clients either in the home or at screening visits.

Family nutrition is emphasised in the many morning and afternoon teas that the centre has held. Cooking demonstrations focus on healthy foods and how to prepare them. A library of health promotion material on these subjects has also been gathered together and can be used by the health workers and clients.

- The research component of NTP was designed as a cohort study, following a progressively enrolled cohort of women and infants through pregnancy and infancy over a three year period.
- Referrals of women to the project come from six main sources: the community, the Kalgoorlie Regional Hospital, Bega Garbiringu (formerly Kalgoorlie Aboriginal Medical Service), Community and Child Health Services, the Department for Community Development, and local medical practitioners. A door-knock recruitment drive in Kalgoorlie–Boulder, Coolgardie, and the local Aboriginal communities near Kalgoorlie, was used to followed up formal referrals. More recently, the majority of women involved in NTP activities are previous clients or their relatives.
- The early recruitment activities have formed the basis of much of the further NTP activities, which focus on home visits and individual client support. As the NTP health workers are moving around the communities, on-the-spot advice is often asked for and support can be provided due to the mobility of the health workers and transport facilities provided for clients. Flexibility is essential in providing a service that suits all clients. Some locations are visited once a week and other individuals may be included every day if there is a need.
- The clinical aspects of NTP involve Aboriginal health workers who can use clinical skills to assess and advise clients on appropriate action to enhance their own and baby's well-being. Routine assessments include monitoring of blood pressure, urine, oedema, weight and other screening measures. Babies are also weighed and examined at each postnatal visit.
- The emphasis of the health workers is on finding out how the women are feeling, particularly whether they are getting enough rest, require iron tablets or help with nutrition, and, in terms of the infants, whether there are any problems with feeding, nappy rash, thrush or concerns about ears or eyes. If any problems are identified, the treatment options are discussed and the mother encouraged to make decisions about managing the problem at home, or seeking help from a doctor or other health agency. If family problems are found to be the basis of some of the stresses or problems experienced by the mother, referral and support in getting help from other agencies such as Department of Community Development is also offered.
- Group activities for promotion of nutrition and other baby care and parenting skills have included picnics, cooking demonstrations, a regular child playgroup and a baby show.
- The child playgroup provides further opportunities for education and gives young mothers the chance to socialise, build friendships and share experiences. The child playgroup has also been used to facilitate access and cooperation with the child health nurse and screening and immunisation activities.

### *The effectiveness of the service*

As the project basis is research, detailed and secure computer records have been established for relevant data held on clients of the program. The information is analysed using statistical packages. Some preliminary results have been presented in 1994–95, but the main research evaluation is, at the time of this report, in preparation.

At June 1995, 100 Aboriginal women had been enrolled into the NTP program, 90 babies had reached one year of age and been referred to either the Health Department or Bega Garbiringu.

Each antenatal patient or mother and baby pair had been visited on average once a week. Almost 78 per cent of babies were known to be breastfed at discharge from hospital. Since the program started, there is also reported to have been a dramatic drop in the number of babies admitted to hospital.

#### *Factors contributing to its success*

- Being able to have frequent contact with clients so that trust could be built up. As much as possible individual health workers are responsible for specific patients to ensure that it is always the same person working with the mother or family group.
- Being able to support clients throughout the entire process of antenatal care, the stay in hospital, discharge, postnatal follow-up and infant care—so that mothers are familiar and comfortable with the chosen service on eventual referral to child health programs continuing to five years of age.
- Clients trust in the confidentiality of the information they provide and the Aboriginal health workers who are often related to them, which makes it easier for them to confide about their problems and seek help.
- Ability to approach problems in a cultural way, so that appropriate traditional and family decisions about some children in special situations can be made.
- Support from other health and related service providers as well as the TVW Telethon Institute for Child Health Research in Perth.

#### *Impeding factors—lessons to be shared*

- Early political conflicts about the project and funding concerns were difficult for those involved and led to a high turn over of staff.
- Lack of access to accredited and recognised training specialisations for Aboriginal health workers which can be undertaken without leaving Kalgoorlie.
- Lack of psychiatric services available within Kalgoorlie—special cases have to go to Perth for treatment and this separates mothers from their support networks.

#### *The way forward—key recommendations from service providers*

There is a need for recognised health worker specialisations and accredited training opportunities in the areas of Maternal and Child Health as well as research skills.

#### *Sources of further information:*

Elsie Edwards, Chris Jeffries, Jo Davies, Thelma Carlisle, Maria Calyun, Donna Dimer, Leanne Scardina (1993).

Ngunytju Tjitji Pimi 1993—The First Year.

Ngunytju Tjitji Pimi—Steps into the Future, Report for 1994/95.

Government of WA (1997). Community Services Industry Awards.

## Case study 6

### Bega Garnbirringu Health Services Aboriginal Corporation, Western Australia

#### *The service*

Bega Garnbirringu Health Services (BGHS) was established in 1983 as a part-time clinic in South Kalgoorlie. From these humble beginnings, the service now operates on a full-time basis and sees 8,000 patients a year. New buildings have recently been completed and allow for future expansion and provision of more specialist services such as eye and ear health on a visiting basis.

A feature of the service is the role of Aboriginal health workers. The health workers are the main point of contact for patients, who are received in a friendly and culturally-appropriate manner. The health workers are able to identify the needs of the patient, to refer patients to the clinic nurse or doctor, or to handle problems themselves.

Bega Garnbirringu means 'sickness gets better'. The service runs a specific women's business clinic called 'Minma Birnee Gu'. In the new buildings, this section is housed in a separate area to ensure a discreet and confidential service. The women's business clinic received a Public Health Association Award in 1994 and sees about 150 women a year for cervical cancer and breast cancer screening. Many of the clients are antenatal or postnatal and are provided with breastfeeding information and support at these visits. BGHS currently has 2,436 women on its database including women from outlying communities, and during 1996 the number female presentations to the clinic was 4,098.

Recently the Health Department of Western Australia has been contracting services from BGHS, with the result that an Aboriginal Liaison Officer is based in the Kalgoorlie regional hospital. BGHS has also received Health Department support to run mental health, women's business, and injuries surveillance programs, as well as the sobering-up shelter funded by the Drug and Alcohol Authority and a health promotions unit by the Aboriginal Health and Programs Branch.

BGHS currently employs 48 staff, 42 of whom are of Aboriginal descent. The Aboriginal Corporation is governed by a committee of 8 people, and is controlled and managed by Aboriginal people. The governing committee meets monthly to receive reports from each section of the service and to provide future direction.

Staffing is broken down under the following headings:

- clinic—medical director, medical officers (male and female doctors), clinic nurse, clinic health workers (one male and three female), child health nurse, women's business health worker, field nurse, fringe dweller health worker, health educator, field officer (bus driver), medical receptionist, clerical trainee;
- administration;
- mental health—coordinator, youth counselling officer, counselling officer;
- health promotions—coordinator, promotions officer, two heart health officers;
- environmental health—three environmental health workers;
- Kalgoorlie Regional Hospital—two Aboriginal liaison officers;
- Mulga Queen Community—community nurse;
- sobering-up shelter—coordinator, two female care workers, two male care workers;

- aged care unit—coordinator; and
- renal health care: health worker.

### *Breastfeeding and infant nutrition interventions*

The aims of BGHS are to provide a holistic primary health care service including clinical, prevention and educational activities, and as part of the health care service, to provide support and education to mothers, expectant parents and other carers to promote breastfeeding in the Aboriginal community.

To assist with education and support on breastfeeding the following activities have been part of routine health care or specific one off activities to improve community awareness.

- Purchase of culturally appropriate educational materials, including posters and videos on breastfeeding.
- Purchase of complete set of NMAA booklets for use by clinic staff and clients.
- A female doctor who is a qualified lactation consultant and trained NMAA breastfeeding counsellor.
- Liaison with NMAA Kalgoorlie–Boulder group.
- Breastfeeding promotion workshops where new mothers, expectant mothers and carers are invited for lunch with an educational and social support component.
- During World Breastfeeding Week 1996, a leaflet was produced and general promotional activities organised, under the heading ‘Make MIMI Milk your Baby’s 1st Choice!’.
- Encouragement of key community members with breastfeeding, to provide role models for other mothers.
- Aside from a transport service for clients attending the clinic, BGHS also provides home visits and practical support to families in crisis (e.g. provision of blankets, baby wear, clothing, laundry and shower facilities where needed). At risk women and families are visited by health workers as part of the service.
- For the 1997 Breastfeeding Awareness Day, there were plans to invite all NMAA members to the child-care component of BGHS. It was hoped that this would foster a two way process to break down barriers and increase support networks. One Aboriginal mother is already a member of the group.
- An eventual aim is to train an Aboriginal woman as a lactation consultant and establish a BGHS version of the NMAA model.

### *The effectiveness of the service*

The services have been provided in a consistent and ongoing manner as part of routine provision of primary health care to women and children. Without a dedicated project officer or dedicated funds it has not been possible to evaluate or document these services more fully.

### *Factors contributing to its success*

- Being able to offer an holistic service, of which the general practice medical component is only a relatively small part and the focus is on the family as a whole.
- Providing a wide range of services to women, including doctors assisting in deliveries at the hospital, with a 24-hour on-call system.

- Providing home visits to monitor mothers during pregnancy and assisting with social issues or problems faced by them.
- All the sectors involved with women and/or families work very well together in Kalgoorlie, so that cooperation and referral systems support the needs of individual clients.
- Being able to provide child immunisation and screening services on a continuous basis, rather than restricting such clinics to once a week. The computerised health screening system alerts health workers to immunisations or other screening activities that are due. In this way the preventive components of the service also become fully integrated and are readily accepted by the community.
- Having a doctor with a particular interest in breastfeeding and qualified lactation consultant has helped to increase awareness and led to hospital strategies to encourage midwives to increase their knowledge and skills in breastfeeding support.

*Impeding factors—lessons to be shared*

- Younger mothers are developing bottle feeding preferences because of their social lives.

*The way forward—key recommendations from service providers*

As well as doctors, nurses or midwives servicing remote areas, health workers also need training in breastfeeding. Across the board clinical standards in this area should be considered.

*Sources of further information:*

BGHS leaflets:

Bega Garribirringu *Sickness Gets Better* Health Services Aboriginal Corporation

*Make MIMI Milk your Baby's 1st Choice!* World Breastfeeding week 1-7 August

## Case study 7

### Broome Regional Aboriginal Medical Service, Western Australia

#### *The service*

The Broome Regional Aboriginal Medical Service (BRAMS) is one of the oldest community-controlled health services in Australia. It began as a simple general practitioner service in 1978, with the support of one nurse and administrative staff working on a volunteer basis. Following much consultation, the service was expanded and formalised in 1984 to include a field team, public health programs, and two outreach services for remote communities. Since then the service has grown to include a health promotion section and Aboriginal health worker training school. BRAMS activities are directed by a community-controlled committee, which is able to make final decisions on all aspects such as employment of staff and service directions. Overall responsibility for administration and coordination of the community-controlled services in the region rests with the Kimberley Aboriginal Medical Services Council (KAMSC).

The service currently has 8,400 permanent residents on file and employs three female doctors (amounting to two positions, with one additional medical position vacant), two registered nurses (amounting to one and a half time positions), six Aboriginal health workers and a regional health services coordinator. The medical officers are able to provide an acute after-hours service for obstetric and other conditions at the Broome Regional Hospital. A number of senior administrative positions are responsible for policies and direction. Other clerical support and driver positions also exist. The outposts coordinated by BRAMS employ four registered nurses and two senior Aboriginal health workers who have equal responsibilities.

The public health programs currently operated by BRAMS are chronic diseases, women's health, men's health, kids health, and mental health. The Aboriginal health workers involved spend four days a week on program activities and one day each week at BRAMS clinic. The service has had a computerised patient record system for about 10 years and this is used to develop and implement care plans, which contribute to the preventive activities of the public health programs. The recall system is able to access patient details at each clinic visit and prompt for any preventive checks and/or surveillance activities which may be due. In cooperation with a WA Department of Health pilot immunisation initiative (1993–96) for children under five years of age an 'at risk' concept and system has been developed, which forms the basis of the care plans, community follow-up and home support offered to clients as part of the service. Medical officers and others are able to categorise a child or family as 'at risk' on the basis of medical problems, such as premature at birth, but also in response to social, environmental or psychological problems. The children remain in this category until they are 12 years old and clinical, preventive and outreach care can be emphasised and tailored to the families needs.

#### *Health planner development*

Beginning in 1986 a major computerisation project was initiated by KAMSC. The health planner system developed uses a patient database with its accompanying demographic data and an age and sex register. The core of the system involves the 60 health care processes that include immunisations, developmental checks, examinations (weight, blood pressure, etc.), investigations (Pap smears, blood tests) and treatments.

Depending on variables such as age, sex, history, current therapy, pathology or geo-social and economic factors, a list of relevant processes is generated. When made dynamic by the addition of time, an individual health plan is generated. These recall patterns can be varied by the user and KAMSC has designed patterns based on local disease spread, practices and demographics.

The individual health plan can be generated at the point of contact and used by doctors and health workers to assist in management decisions. The individual health plans are used to build up a picture of processes due for a community location, a family or any other demographic variable. These lists have been used to drive immunisation programs, syphilis serology follow-up, Pap smear screening and specific disease programs such as for diabetes, rheumatic health disease and hypertension.

To coincide with an update in the information technology of the KAMSC, guidelines are being developed on important areas of Aboriginal health for local use. The 1996–97 Best Practice and Service Delivery project aims to produce a document for general practitioners working with Aboriginal patients and the Aboriginal community. The project will provide information on:

- prevention in primary health care where it relates to Aboriginal health issues;
- the implementation of preventive care through KAMSC information systems; and
- the use of performance indicators and quality assurance.

The guidelines will be oriented towards the whole patient rather than a single disease. Care for chronic conditions takes place mainly in general practice and most patients with chronic disease have co-morbidity. For this reason care should be patient- rather than disease- orientated. Each health problem and each intervention should be considered in the context of the patients risk profile, to determine priorities for screening, counselling and prophylaxis. There are already many barriers in implementing preventive health care in general practice without the doctor having to synthesise clinical information according to guidelines that are often single disease focused.

Such attempts at integrating sustainable preventive routines are also a part of another cooperative program with the WA Department of Health. This involves a community midwife position to support women during the antenatal period and postnatally until children are one month old. The pilot project has been in operation since February 1996 and an Aboriginal health worker from BRAMS has been permanently assigned to this project since January 1997. Breastfeeding support activities and greater participation by Aboriginal mothers in preventive activities are important components of this initiative.

#### *Plans for the future*

- Standard breastfeeding and infant nutrition care plans and 'at risk' concepts to further prompt health workers and emphasise holistic and opportunistic advice and support in this area.
- Greater emphasis on checking nipples and nipple care as part of preventive action during antenatal care.
- A youth health worker with emphasis on health promotion and prevention could further support the current structures.

#### *Breastfeeding and infant nutrition interventions*

At the time that the child public health program was begun by BRAMS, discussions with the WA Department of Health led to the decision that immunisation services should not be duplicated. Central records on immunisation status are maintained by the community health section of WA Department of Health and the Kimberley regional base in Derby. Community health clinics have been run at BRAMS in the past but the emphasis now is on follow-up and ensuring continuous care for children. The BRAMS Aboriginal health worker in charge of children under five years of age works closely with the Department of Health Community Health Nurse and Aboriginal health workers employed by this service. BRAMS responsibility focuses on home visits to families for

reminder of immunisations due, supervision of medication to be administered, networking with family services, as well as more general support like transport and/or advice. Educational activities on the introduction of solid foods are carried out by the child health clinic. The 'at risk' concept and home follow-up has helped to ensure that children receive the necessary immunisations, and due to its success it has been extended to the other service delivery activities of BRAMS. Low social status, poor or crowded living conditions and other information can be entered on the child's file to ensure that all health personnel who come in contact with the child can use appropriate care and support strategies.

The more recent community midwife initiative of the Health Department is based on a needs assessment and survey of women in town some years previously. This recognised the high mortality rates for Aboriginal infants and relative isolation from family support structures for non-Aboriginal women. The BRAMS antenatal Aboriginal health worker cooperates closely with this position and the community health structures. The health worker is involved with routine antenatal care at the clinic, encourages early attendance by pregnant women in the community, provides follow-up and reminders if women are late for their check-ups, arranges hospital visits prior to the birth, establishes referral systems for women and children in hospital, and follows up any problem cases with home visits. If women give birth in a hospital other than Broome, the health worker can also become very involved in family and health service liaison to ensure that appropriate care strategies are in place when the woman and infant are discharged.

These close working relationships have also helped to encourage hospital based midwives to become more interested in the 'baby friendly' initiative and the establishment of a breastfeeding support group for non-Aboriginal women in the community. This group also receives advice and support from a NMAA counsellor based in Port Hedland. Initiatives to encourage Aboriginal women to participate in these meetings and antenatal classes have been hampered by venue problems and frequent staff changes. Within the Aboriginal community, these activities are not yet recognised as being of high priority, with breastfeeding seen as expected and most mothers committed to making it work even if problems are encountered.

Now that a permanent BRAMS Aboriginal health worker has been identified to work with the community midwife project, further education activities and an initiative to encourage women to participate in antenatal care and postnatal support groups is planned. This will start with a baby day held during NAIDOC week and involve nutrition talks by a senior woman from the community, fun and games, photographs etc. It is hoped that a video can be produced and used in later educational activities and that regular fortnightly picnics, beach walks or similar activities, which can involve grandmothers as well as young mothers, will encourage greater participation.

### *The effectiveness of the service*

A holistic health view and coordinated care across all sectors, as well as intensive follow-up and opportunistic advice and support for 'at risk' cases, has ensured that the service is responsive to client needs. No evaluation activities have been carried out but there are plans to collect more information on breastfeeding rates as part of the community midwife initiative.

### *Factors contributing to its success*

- Community dynamics:—there is a strong expectation within the community that mothers will breastfeed. No stigma is attached to breastfeeding in public places and the majority of mothers are themselves very committed to succeed with breastfeeding. There is relatively low mobility of the Aboriginal community in the town area (two communities on the town outskirts are prior reserves and have strong community control).

- Computerised system able to support the ‘at risk’ concept and offer opportunistic, yet targeted, services.
- Staff sense of ownership of public health program area, committed and long-term staff members, innovative problem solving approaches and individual client care on a needs basis.
- Building trust and teamwork across the service sectors by close working relationships and cooperation.
- National focus on good nutrition and breastfeeding, including the hosting of the 1995 Nutrition Networks conference.
- Health worker training available on site has meant that the courses and skills are relevant to the needs of health workers, and coordinated with community priorities.

*Impeding factors—lessons to be shared*

- Old rifts between the Western Australia Department of Health community and child health system and BRAMS.
- Information sharing systems between different sections could be improved further.
- Lack of acknowledgment of health worker clinical skills.
- Very early discharge from hospital, even if babies are small.
- Young mothers often do not ask for support, may live communally and this makes it difficult for health workers to do individual counselling.

*The way forward—key recommendations from service providers*

Additional resources are needed for education and advice on the timing and type of solid foods to be introduced.

## Case Study 8

### Ngua Gundi, Rockhampton, Queensland

#### *The service*

Ngua Gundi was originally established in 1993 as a maternal and child health service for adolescent Aboriginal and Torres Strait Islander mothers. The project has since grown to include older mothers and focuses on antenatal care, birthing support and child health (0–5 years) needs. It is located in suburban North Rockhampton, a provincial town of about 80, 000 people.

The aim of the service is to provide Aboriginal and Torres Strait Islander women and their families a holistic, culturally-acceptable service from conception until the child is five years old.

A study at Rockhampton Base Hospital in 1992 found that 33 per cent of Aboriginal pregnancies were to women aged under 19 years of age, compared to 5.2 per cent in the general population. Also identified were problems such as low antenatal attendance, lower birth-weight of babies in the Aboriginal community (average birth weight 300g lighter than non-Aboriginal babies) and higher infant mortality rates (15.6 per 1,000 live births compared to 8.3 per 1,000 live births).

A needs analysis revealed that women wanted an Aboriginal clinic staffed by female doctors and Aboriginal health workers. They wanted health services that offered full maternal and childcare, with particular emphasis on antenatal and postnatal care, nutrition, immunisations and family planning. Adolescent mothers not presenting for antenatal care could be visited by a midwife in their own home and encouraged to come to the clinic

#### *Breastfeeding and infant nutrition interventions*

Although the project has not had a specific breastfeeding and infant nutrition focus, this model works well and breastfeeding and infant nutrition education, promotion and support are integrated into the maternal and child health service. A most recent planning workshop includes increasing the number of breastfeeding mothers as an objective of the service.

The project was awarded the Australia Day Medallion for a noteworthy contribution to the work of the Queensland Health Department and outstanding service over a number of years. It has recently developed a pregnancy workbook in collaboration with the community which includes information about breastfeeding and infant nutrition.

#### *The service:*

- provides information on care and preparation for pregnancy and birth and birth in a self help learning environment;
- assesses the health of the mother and the baby in the six weeks after the birth;
- monitors the health, growth and development of the children and offers health information, support and referral to other health care providers as necessary on a range of issues, including breastfeeding and infant nutrition interventions;
- provides community midwifery home visiting;
- runs a young mothers group through the centre; and
- runs an under-fives child health program, including education and advice regarding breastfeeding and infant nutrition, immunisation and growth and development checks.

### The effectiveness of the service

The service provides a holistic approach to health care for young Aboriginal and Torres Strait Islander mothers who otherwise may not receive any postnatal and infant care follow-up. Over a cuppa, women can discuss social, financial or health problems at the same visit, in a setting which is homelike and welcoming. They have the opportunity to meet with and gain support from other young mothers and their families. They are involved in all elements of the service, planning its conduct and evaluation. The service provides networks of user-friendly sensitive GPs and other providers. Experts are on tap for correct advice and information. One of the key elements of the service is that it provides the facility for opportunist care and support and active follow-up of at risk cases. The fact that the service provides for small numbers of women and their families is only due to funding allocations and may be no indication of need.

### Plans for the future

The following objectives were developed during a recent planning workshop:

- to provide quality client-focused care for mothers and children during the perinatal period;
- to widen the scope of community involvement in the Ngua Gundi program;
- to provide effective follow-up of children from the perinatal period;
- to review all available education packages for Aboriginal health workers on antenatal, postnatal and childcare issues, with a goal of improving current resources;
- to improve knowledge within the community regarding the effects of smoking in pregnancy and on infants; and
- to increase the number of breastfeeding mothers in the community and monitor the duration of breastfeeding and reasons for weaning.

### Factors contributing to the success of the project

- Involving the Aboriginal and Islander community with the needs analysis, planning and development of the service.
- Ensuring the Aboriginal and Islander community has a sense of ownership of the project.
- The Aboriginal health workers ensure the service is culturally appropriate and work as a bridge between the community and the midwives.
- Attitudes of the service—working together as a team.
- User-friendly environment—with a home-like atmosphere.
- Geographical location—it is situated where people live.
- Transport is provided to clients.

*“The health workers are the key to the success of this program—they have a good rapport with the community and are trusted by the mothers. ... This service works so well that I would recommend it as a model for the general community. ... A major factor contributing to the accessibility of this project is the provision of transport for the mothers. ... We feel that we have a major role to play in terms of advocacy” (Community Midwife, Ngua Gundi)*

*Factors impeding the services—lesson to be shared*

- Lack of secure funding.
- Difficulty in gaining access to information from mainstream services, such as the hospital.
- Lack of back-up service—no funding for replacement staff for annual leave or sick leave.
- Lack of cultural sensitivity of mainstream staff.

*Sources of further information:*

*Woman's Business: A Report Concerning The Care of Pregnant Aboriginal Mothers' Report* (being finalised)

*Bunjulbai Workbook*

## Case study 9

### North Coast Aboriginal Breastfeeding Project, New South Wales

#### *The service*

This project was set up in October 1994 and was funded for a twelve-month period. It was established in response to high infant morbidity and mortality in Aboriginal communities in the north coast region of New South Wales. Low rates of breastfeeding were identified as a possible factor influencing the health of the children. A steering committee for the project was established so that an organisational framework and a network of contacts were developed. Steering committee members included the project officer, the program coordinator, the parenting coordinator, a NMAA counsellor and an Aboriginal health educator. The project involved running initial focus groups in selected areas in order to determine the values and barriers to breastfeeding, prior to implementing education programs. Programs were conducted through Early Childhood Health Centres, schools, antenatal groups, women's groups and TAFE.

#### *Breastfeeding and infant nutrition interventions*

The service aims to:

- promote breastfeeding;
- encourage Aboriginal mothers to attend antenatal classes;
- promote better eating habits; and
- encourage Aboriginal mothers to access breastfeeding support groups such as the Nursing Mothers' Association of Australia.

#### *Objectives*

- To increase awareness among Aboriginal women of the importance of breastfeeding.
- To provide training in breastfeeding for Aboriginal women.
- To increase awareness of low rates of breastfeeding.
- To increase knowledge about a balanced diet during breastfeeding.
- To increase the awareness of the dangers of drug and alcohol in breastfeeding.

Community members voiced concern at the apparent high rates of hospitalisation of Aboriginal children in the region and asked the health staff what they were going to do to improve the health status of the children. Funding was secured through the regional health service for the employment of an Aboriginal health worker as a Project Officer for one year.

#### *The effectiveness of the service*

The service has been based on a response to locally determined needs and draws together an appropriate range of consumers and providers.

#### *Factors contributing to its success*

- The employment of a local Aboriginal health worker as the Project Officer.
- The involvement and commitment of the community to the project.
- Networking and inter-sectoral cooperation with other agencies .
- Rapport with co-workers.

- Combined effort—Indigenous and non-Indigenous people working together.
- Bottom up approach, project developed in response to community concerns.
- Flexibility of project—understanding of cultural and social issues.

#### Impeding factors—lessons to be shared

- Accessing the community.
- One-off, short-term funding—just developing a rapport with the community when the funding ended.
- Overwhelming needs of the communities.
- Breastfeeding low on people’s list of priorities—need to address other issues as well, such as social problems.

*‘If Indigenous health is to be improved; need to start with the health of Indigenous children. ... We need to train our mothers to be able to support other mothers in breastfeeding. ... It is disappointing for communities when projects such as this are not given further funding; we go in and develop a relationship with people and gain their trust, raise expectations and then leave. ... Very important to develop resources specifically for Aboriginal people, for example, videos, posters, and teaching aids.’ (Project Officer, North Coast Breastfeeding Project, NSW)*

#### Recommendation from the service—lessons for the future

*“We’ve lost a lot of the handing down of information from grandmothers. This is in part due to the grandmothers not having breastfed their babies.”*

*“Learning is a two-way process—both parties need to listen and learn”.*

*“We need more specific courses on maternal and child health care for health workers”.*

*“We need to take away the stigma and shame associated with breastfeeding”.*

*“We felt strongly that the whole project be culturally appropriate, including the evaluation”.*

*“It would be great if there was a central clearing house of culturally-appropriate resources, the updating of which needs to be an ongoing process”.*

#### Sources of further information:

North Coast Aboriginal Breastfeeding Project: Final Report Stage 1

Grant Application: Aboriginal Breastfeeding Project

## Case study 10

### Thallikool, New South Wales

#### *Introduction*

We have chosen to present this example to illustrate some of the early work done in the field and the way in which projects can grow from local beginnings to state-wide applications. It also shows the process of learning which occurs over a number of years of sustained interest and effort.

#### *The service*

In NSW in 1983, the NMAA recognised the need to promote breastfeeding as a means of reducing the rate of common ailments in infants, as well as the need to emphasise the positive aspects of traditional practices with regard to breastfeeding and infant nutrition. The most appropriate means of communicating these messages was through Aboriginal women living in the community of interest. The project was supported by Commonwealth Government funds and the NMAA. In 1987, some supporting materials (leaflets and a video, *Babies of the Dreamtime*) were produced. The NSW Department of Health's Aboriginal Health Promotion Section developed the materials from this project into a comprehensive resource kit for use by Aboriginal health workers.

#### *Breastfeeding and infant nutrition interventions*

The first stage of the project, which began in December 1983, was identification and training of two Aboriginal women as trainee outreach workers in the following areas:

- antenatal preparation for breastfeeding;
- the feeding of the new baby;
- the management of problems in breastfeeding; and
- starting other foods.

In total, five Aboriginal outreach workers were trained in this model.

The second stage of the project was the development with the New South Wales Department of Health (Aboriginal Health Promotions Section) of the Thallikool Mother and child pregnancy care and infant nutrition resource kit. This is a state-wide community education resource, including a series of videos (*Babies of the Dreamtime*, *Pregnancy Care*, *Close to the Heart*), leaflets and booklets, targeting Indigenous parents regarding breastfeeding. A state-wide education program was also developed, which targeted Aboriginal health workers and contained information about infant nutrition and breastfeeding. This included training materials and slide presentations with script for commentary on:

- the benefits of breastfeeding;
- before the baby comes—getting ready for breastfeeding;
- breastfeeding in the early days;
- sore nipples, sore breasts;
- breastfeeding problems and what to do;
- introduction of first foods;
- premature and very low birth weight babies;
- information about what to do when mother or baby is sick;

- being a mother, being a father—the breastfeeding experience, night waking, shared beds, other children, relatives;
- breastfeeding and contraception;
- how to express breastmilk; and
- the Aboriginal breastfeeding tradition.

### *The effectiveness of the service*

The training of aboriginal outreach workers originally had two aims. First, the underlying objective was to prepare women for employment, as this was the objective of the source of funds, i.e. the Commonwealth Community Employment Program. This objective was met, in that those women who completed the course (six out of eight enrolled over two stages) either gained employment in related fields, or began health-related courses. Secondly, all participants reported a range of positive outcomes at the personal development level—skill and knowledge acquisition and an increased ability and confidence in helping their community. They expressed the view that the skills and information learned could be used wherever they worked and in a private capacity.

The resource kit for Aboriginal health workers and the range of educational materials developed out of this project have been widely distributed and are cited as resource material by a number of organisations around the country, some 17 years after the inception of the original project. No formal evaluation of the impact or outcome of the kit is available. At the level of process evaluation, it was developed entirely in consultation with representatives of its target groups. The style and presentation of the materials is therefore culturally-appropriate and based on expressed community need at the time. It is attractively presented and meets the requirement of many service providers and trainers for more resources that feature Aboriginal and Torres Strait Islander people.

### *Factors contributing to its success*

The project had considerable advantage at the time of its inception to the resources and commitment of the Nursing Mothers' Association members and organisational infrastructure. The levels of funding were generous, and the support of Commonwealth and ultimately the NSW Health Department were strong both in practical and moral terms. The NMAA 'workforce of trained trainers' was an essential part of the development of the training modules for the outreach workers. This level of input would have added considerable cost to the project had it been developed from scratch. In fact, it is probably fair to say that without that base, the project would have required a level of funding not considered realistic by most funding bodies.

The interest and enthusiasm of the women who were trained in the project and their concern for their community cannot be overrated in its contribution to the short and long-term impact of this initiative.

### *Impeding factors—lessons to be shared*

With the wisdom of hindsight, some of the key individuals involved in the projects recognise that for both trainees under this model and for any materials (training and educational) development, a more holistic approach is necessary. At the level of training Aboriginal women as volunteers in the NMAA mould, it is recognised that volunteering requires an amount of leisure time which comes with a level of social advantage unavailable to many Aboriginal women. The solution to this is the payment of workers during and after their training period. As this level of funding was not sustained, the model is now believed to be of limited long-term use. This does not, however, detract from the spin-off effects of the impact of training the women and the model of resource development.

### *The way forward—key recommendations from service providers*

The formative research for the development of the training and community education resources involved the recording of many hours of conversations with both male and female elders about pregnancy, birthing and breastfeeding. It is felt that the contents of these conversations would provide invaluable resource material for the training of Aboriginal health workers and should also be assessed for their usefulness as the basis of an education campaign targeting young men on their role in the support of pregnant and breastfeeding women.

Any further development of these sorts of educational and training resources has to give more attention to the context of the mother and baby. In particular, the level of drug and alcohol consumption and problems in the mother's environment and her own consumption needs to be acknowledged as a priority area of intervention and support for health workers and for the woman's family. In contexts where alcohol and other drug use are a problem, efforts to promote and support breastfeeding will be undermined without specific efforts to assist communities and individuals to combat the ill effects of consumption.

There is a need for long-term, sustained effort over time. Short-term efforts can only have short-term impacts, and may even be counter-productive.

While mother-to-mother interventions and support are important, there is evidence from other areas of health promotion that suggest that the use of peers is also an effective strategy. This may also be the case in urban areas where the extended Aboriginal family does not exist to the same extent as in the more remote and traditional areas.

It would be a good time to identify male role models around the country who are able to take part in training programs or in public education programs which show young men encouraging and supporting young women in their efforts to breastfeed.

### *Sources of further information*

Ms. Grace Close

Ms Jan Mangelson Nursing Mothers Association

NSW Department of Health

## Case study 11

### The Victorian Aboriginal Health Service

#### *The service*

The Aboriginal Children's Health Promotional Project began in 1992 when the Koori community in conjunction with the Victorian Aboriginal Health Service (VAHS) developed a range of educational materials and opportunities. The opportunities and materials were aimed at the reduction in the level of recurrent infections in young children due to exposure to passive smoke, as well as the achievement of an increase in the rate of breastfeeding. The use of the resources, educational and community development opportunities came about after very careful and through consultation and formative research had been incorporated into the day to day operation of the VAHS, thereby ensuring the longevity of most aspects of the strategy. The staff at the developmental stage of the interventions were two Koori health workers and a doctor. The responsibility for the promotion of breastfeeding and appropriate infant nutrition is now part of the day-to-day work of all maternal and child health workers in the health service.

#### *Breastfeeding and infant nutrition interventions*

The project is based on two strategies chosen to address community and health worker concerns about the level of recurrent infections in the community's children. The strategies are the reduction of exposure of children to passive smoking, and an increase in the initiation and duration of breastfeeding.

The project was designed in four stages: (1) a quantitative research phase, to supply baseline data against which to evaluate the outcomes of the project; (2) a qualitative research phase, to provide information assisting the design of well-targeted educational resources and opportunities, and to supply information on influences on infant feeding beliefs and practices in an urban setting; (3) the training of health workers in how to provide accurate and effective information and advice to women about breastfeeding; and (4) implementation and evaluation.

The aims of the project were to:

- reduce the level of recurrent infections in young children;
- decrease the level of exposure of babies and young children to passive smoke;
- increase the level of breastfeeding;
- increase the level of support for women breastfeeding in the community;
- increase the level of support for women during pregnancy and immediately after birth and during the infancy of their child, thereby decreasing stress and increasing self esteem and well-being; and
- increase the level of skill and commitment of health staff in the support of women's choices in breastfeeding.

The key activities of the project are:

- the establishment of boorai (baby ) classes and women's camps in the country, to give mothers a chance to get away from their problems, relax and discuss issues;
- the production and dissemination of video and poster and booklet resources which promote and support breastfeeding;

- the dissemination of research results on the presence of nicotine in the urine of babies as a result of passive exposure to cigarette smoke; and
- the training of health service staff in the provision of accurate and supportive information and skills that promote women's choices with regard to breastfeeding.

#### *The effectiveness of the service*

This is a highly community-based and community-owned project. The set of interrelated research and intervention strategies and processes has ensured it is extremely well targeted. The intervention itself has generated further resources such as the highly effective and attractive banners and paintings which were the work of women who have attended the camps.

- All the resources and opportunities provide excellent examples of how the impact of educational materials and opportunities can be cost-effective in promoting behaviour change, by promoting further interpersonal communication among those exposed to the materials and opportunities, and from them to others who do not come into direct contact with the project.
- Another level that distinguishes this project from others is its conscious attempt to engage the community in a process of cultural development. This has included strategies to involve the whole community in valuing pregnant women, new mothers and their babies. There were specific efforts to widely promote the idea that women need extra support and release from other responsibilities. It is believed the subsequent increase in energy and self-esteem amongst mothers will assist in the acceptance of their new status as mothers, which will, in turn, increase the likelihood of mothers' choosing to breastfeed.

#### *Factors contributing to its success*

The evidence base of the project is demonstrated in its adoption of well-documented processes of developing effective methods for public education and community development. The data generated by these processes is community-owned and -generated. The emphasis on staff training, the generation of baseline data, and the intention to evaluate against stated aims and objectives also place it ahead of many other worthy projects.

The community and staff ownership, itself a function of the sound developmental processes and evidence base, is also a key strength.

The use of local women in the video and the posters and leaflets makes the campaign credible and also promotes role models who women feel comfortable seeking out for advice and support.

#### *Impeding factors—lessons to be shared*

The degree of community ownership and sound developmental processes used in this project have meant there have not been any notable problems in its implementation. Although it has not yet undergone any formal outcome evaluation, the evaluative strategy has been planned into the project from its outset. The major problem has been a sustainable funding base for the women's camps. The current interest being shown by other sections of the industry, for example the Anti-Cancer Council, could be a lesson in the need to diversify these kinds of interventions to maintain their longevity.

#### *The way forward—recommendations from service providers*

- The way to promote breastfeeding and good infant nutrition in a sustainable way is through the adoption of a holistic approach to women's and children's health.

- There must be attention given by those who make policy and allocate funds to the ability of a service such as this to work holistically. Whether or not a woman maintains breastfeeding can depend on whether or not she can get appropriate care for an older child or her own psychiatric problem. No workers are currently funded for taking the woman in her context and dealing with all her issues.
- Short term funding leads to a loss of commitment and morale amongst staff and a loss of credibility with the communities they serve. There needs to be serious consideration given to the establishment of evidence-based timeframes for projects and programs, so that effort is funded for timeframes that can reasonably be argued to be necessary, for any real change to occur and to be measured.
- There are many examples where even strategies that have been shown to work, such as the alternative birthing program, lose funding for no apparent reason, other than it seems to have had its turn, or to allow bureaucrats to say they are launching a new initiative.
- The reporting requirements of Commonwealth and State and Territory funding bodies in service agreements often do not recognise the amount of groundwork that goes into getting one 'activity unit' to counting stage. For example, one woman's attendance at a mothers support may involve a worker finding a baby sitter for other children, taking her shopping and transporting her to and from the meeting. When you are dealing with people who are just surviving, you have to help them do more than just survive if they are ever going to successfully participate.
- Single-issue programs will never be the answer. While breastfeeding needs all hands to the pump, the key, especially in Aboriginal and Torres Strait Islander populations will be through holistic maternal and child health services, that have the resources and staff trained to assist women with the full range of physical, social, emotional, and spiritual needs of women and their families.
- The advice given to all women in mainstream hospitals about breastfeeding is still extremely poor and inconsistent. This poor advice to Aboriginal women has to be undone by community-controlled services postnatally. It will be important that the continuing education of mainstream medical and nursing staff addresses this completely unnecessary failure of the system.
- The lack of National capacity to monitor breastfeeding rates needs urgent attention.
- There is a need to bring together on a regular basis people who work with Aboriginal and Torres Strait Islander women in pregnancy, birthing and breastfeeding support. This would include traditional midwives, health workers and mainstream service providers.
- 'All these recommendations have been said in every report in the last 10 years. This means that they are important. But it is more important that someone finally acts on them in a serious and consistent and sustained manner.'

## Case study 12

### DjuliGalban–Durri Aboriginal Corporation Medical Service, Kempsey

#### *The service*

The DjuliGalban is a program for women and children, focusing on the health needs of the family during pregnancy and the infant period. It began in 1992, is staffed by a midwife 3 days a week, and two full time Aboriginal health workers. Since its inception, it has seen about 520 clients a year.

Although it is the intention that the service be ongoing, it is dependent on constant lobbying for funding on a regular basis.

The service aims to enhance the well-being of women and children, thereby decreasing associated morbidity in the community. The program services the Aboriginal population in Kempsey, Bellbrook, Miriwinni Gardens, Burnt Bridge, Crescent Head, South West Rocks, Hat Head, and Benalong's Haven (an alcohol rehabilitation unit). The services provided are primary health care and support, antenatal classes and education, as well as ensuring that women who are at higher risk receive extra antenatal care. There is also birth support for women who require it, postnatal support of daily visits for the first week and then 2–3 times a week for the remaining 7 weeks.

The service also provides a monthly immunisation day, with transport to and from the medical service. An infant feeding support group is about to begin to encourage younger mothers to come along and form a network of friends, with the aim of extending the length of breastfeeding through education and support. Because the service is provided in the context of the broader medical service, the women are also able to access medical, dental, audiometry, paediatric support and the services of a diabetes clinic.

#### *Breastfeeding and infant nutrition interventions*

The program provides support and education to women during pregnancy, so that breastfeeding is not an obstacle to them postpartum. It provides regular antenatal classes on breastfeeding and other services are utilised as needed, such as Nursing Mothers. The staff of the program have all breastfed for significant periods, so are credible sources of information and good role models. All staff also attend regular in-service on infant feeding practices, so that skills and knowledge remain up to date. The establishment of breastfeeding is supported by intensive home visits daily in the postpartum period, especially for first-time mothers. Women who have breastfed previously are asked how much support they require, with a minimum of one visit a week.

The introduction of solids is discussed in antenatal classes and again in the six-week follow-up period. Women are given information as to why solids should be introduced at 4–6 months and why they should not be introduced at six weeks. They also discuss the importance of hygiene in the buying, preparation and storage of food and the importance of baby's nutritional status once solids are introduced. The points are regularly reinforced in the infant feeding support group. Any significant problems are referred to the paediatrician.

#### *The effectiveness of the service*

- Data on 3-year trends for breastfeeding rates indicate an encouraging increasing in breastfeeding rates at discharge and at six weeks. The increase has been from 29.8 per cent in 1993–94 to 43.64 per cent in 1995–96. The rates at six weeks includes those women who are both breastfeeding and formula feeding.

- Data on utilisation of early childhood services indicate that the number of client visits has increased from 16.58 clients per month in 1994–95 to 33.17 in 1995–96.
- On the basis of internal evaluation, the service has demonstrated that breastfeeding rates have increased, immunisation rates have increased and there has been an increase in the number of clients using the early childhood and immunisation services.

### *Factors contributing to success*

The Aboriginal Health workers who facilitate the DjuliGalban program have both attended the Aboriginal health workers course through the University of Queensland and attended practical at the maternity hospital. The Aboriginal health workers are the cutting edge for the midwife to gain entry to the homes of the Aboriginal community. Their local knowledge and their knowledge of what is culturally and socially appropriate is the key to the program's success. The workers are also experienced mothers and have lived through the problems that many of their clients face and so provide credible information and support and are seen as accessible role models.

### *Impeding factors—lessons to be shared*

The lack of secure, ongoing funding makes for uncertain working conditions and therefore the capacity to retain experienced staff is reduced. It also makes the planning and purchasing of equipment and tools difficult. The lack of relevant specialist education for health workers in the field of maternal and child health means that there is not optimum ability to give both clinical and care services and advice.

### *The way forward—recommendations from service providers*

*“There is a continuing need for culturally appropriate Maternal and Child Health programs to continue in Aboriginal Medical Services, and to develop in a manner that is relevant to each of the communities.”*

*“There is a great need for the Aboriginal health workers working in the field of Maternal and Child Health to receive culturally appropriate and relevant specialist education, to enable them to give both clinical care and advice.”*

*“The program could be made more effective if it had ongoing funding for an indefinite period...”*

## Case study 13

### Indigenous Youth Health Service, Community Controlled Medical Service, Woolloongabba, Queensland

#### *The service*

The service originated from the recommendations of the Burdekin report into youth homelessness. It was created to address the issue of health for young people and homeless youth in Brisbane, and is a culturally-appropriate service addressing the need for better primary health care for Aboriginal and Torres Strait Islander youth. It is a clear and tangible response to the over-representation of Aboriginal and Torres Strait Islander youth in homeless situations and in prisons.

The founders of the service cite Burdekin's finding that 'Young people who are homeless or at risk of becoming homeless report little interest in their health and a reluctance to seek health care from mainstream health services'. The service pays particular attention to the needs of young Aboriginal and Torres Strait Islander mothers, for whom attendance at mainstream services poses considerable barriers. Recognition of the impact of a lack of adequate antenatal and postnatal care as well as support at the birth has been a key issue for the service.

For young women, the service provides:

- well women's checkups;
- antenatal care which covers information about feeding choices;
- antenatal classes;
- birth control information;
- pregnancy, birth and parenting information and support;
- women's sexual health issues relationship issues;
- domestic violence issues; and
- sexual abuse support.

For young men the service provides:

- stress management services;
- relationship issues support;
- fatherhood support;
- men's sexual health issues;
- domestic violence information; and
- sexual abuse support.

These services are provided in a drop-in setting which is welcoming, and has been decorated by those who use the service. There are cultural and educational videos, a pool table, kitchen facilities, showering facilities, a washing machine and drier, and facilities for art and other hobby activities. The service also provides outreach services in outer suburbs and favourite nightspots.

The service also has a role in networking and intersectoral collaboration to allow ease of referral and help for clients whose need are multiple and complex, and to keep staff in touch with ideas and innovation in sectors other than health that impact positively on the health outcomes for their clients.

It takes the approach that you must befriend young people, earn their respect, and move at their pace if there is to be any credible and lasting impact of advice and support. It has over 300 clients a month.

### *Breastfeeding and infant nutrition interventions*

This intervention is highlighted because of its unique position as a youth service with the intention and capacity to support very young mothers during pregnancy, at the birth of their baby, and afterwards. It also has the capacity to influence the young male partners or friends of the young women to support the mothers both in general and in breastfeeding and the nutritional needs of the mother and baby.

Fatherhood support is a key area of activity. Nurses will talk to young men about how to support their partners and both male aboriginal health worker staff are young fathers who act as role models. Fathers are encouraged to attend antenatal classes. If a young mother is not getting the support she needs and asks for help, the workers can give advice and support to the male partner about how he could consider his choices in the support of mother and baby.

### *The effectiveness of the service*

There has been no formal evaluation, but the continued high level of use—largely through word of mouth recommendation and a high rate of referral from other youth and mainstream services—indicates a high level of appropriateness and effectiveness from the clients' point of view. The service has established good working relationships with the major maternity hospital in the area, and the respect accorded the staff of the service by mainstream providers is another indicator of its effectiveness.

The staff also keep very thorough records. Each worker reports regularly on the number of clients who keep appointments, the number who drop in, the number for whom adequate housing or emergency relief is found, and the number who have gained employment. There is high retention rate of clients once enrolled, and medical staff report that the individual medical records provide rewarding evidence of the impact of the service in terms of improved health outcomes.

### *Impeding factors—lessons to be shared*

One of the major issues faced by the service is that the young men and women have little or no experience of observing mothers breastfeeding, as their generation was largely bottle-fed. The young people themselves are also often transient and use the service on the way to somewhere else. The age group of the clientele and their social needs, coupled with the lack of peer support for young mothers, often results in premature cessation of breastfeeding due to pressures of social life and peers.

By the nature of the target group and their social and economic disadvantage much of the work of the work in ante- and postnatal periods is of a crisis nature. It is only when the health workers have been able to work with the mother to stabilise her situation that nutrition and breastfeeding support can be given and the young person able to act on it. The multiple problems of these young women and the lack of appropriate basic accommodation and financial and social support makes breastfeeding and later nutrition more an issue of the provision of very basic social support in the first instance than anything else.

Work in prisons is a hard battle. The majority of mothers in prison bottle-feed within six weeks. From any point of view, this is a highly at risk population. Many of them, or their partners, are severely drug and alcohol affected.

### *The way forward—recommendations from service providers*

The capacity to provide these young people with the basics of stable and safe accommodation, good food and an alcohol- and drug-free environment would greatly enhance the service's capacity to support breastfeeding and good infant nutrition.

There is a need for more youth workers, especially more female Aboriginal health workers trained in sexual, reproductive and maternal and child health. There needs to be a focus on health promotion, not just on clinical skills.

The current trends by State governments to decrease funds to services previously funded out of 'Burdekin' money must be reconsidered. These services are vital to the goals of any national breastfeeding and infant nutrition program if it is to address the needs of those women and babies who are most 'at risk' and disadvantaged.

### *Sources of further information*

Paul Drahm—Youth Health Worker

Dr. Edi Sottile—Medical Officer

Mary Richards—RN

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## Chapter 5

# Summary of findings and discussion

The findings summarised here represent the aggregation and analysis of data gained throughout the review. It draws together the findings into major themes and concepts from all the sources informing the review—the literature, the service and program interventions across the country, with particular focus on Aboriginal and Torres Strait Islander services, in seven categories. This summary also combines a summary of common themes from submission data, interviews and site visits.

Where findings were peculiar to a particular type of service category, the issues have been highlighted; otherwise this summary is an aggregate of all the major themes and elements of services which may or may not be working and the reasons for this.

The constraints of a short timeframe in which to consult, research and write this report meant we could not address weaning and the introduction of infant foods as thoroughly as breastfeeding. This also reflects the prominence given to the issues surrounding breastfeeding and formula feeding, as opposed to issues around other foods, which appear to be relatively neglected. This is reflected in the NHMRC' Infant feeding guidelines for health workers, which, while discussing breast feeding and formula feeding in detail, does not address the issue of other foods for infants.

### What problem?

Some respondents emphasised that not all providers perceive breastfeeding and infant nutrition as a priority within their Aboriginal and Torres Strait Islander service catchment populations. The variation in perceptions between metropolitan urban providers and remote rural providers was generally quite marked. As demonstrated in this Review, staff attitudes and understanding of the interrelated factors influencing infant feeding behaviour have a significant bearing on the quality and type of support offered to women and their families.

*'The nutrition worker has recently reported that the promotion of breastfeeding of babies in this community is not needed. Nutritional issues arise once the baby is weaned.'* (Women's health coordinator)

Other services echoed the literature in highlighting the issue of early introduction of inappropriate first foods and the use of powdered milk as opposed to formula when bottle-feeding.

However even in those situations where breastfeeding is the normal practice, breastfeeding still needs to be valued and promoted so that such beneficial practices are sustained. Issues around other foods for infants are also important.

## Urban and rural differences

There was little debate on the notion that different approaches should be used for traditional and urban settings. People in areas where a more traditional lifestyle is maintained have the support of extended family networks, whereas those in urban areas rely more on the nuclear family and health professionals. The reliance of urban women on a small family network and/or health care professionals often means the women are influenced by women who themselves did not breastfeed and health professionals who give conflicting or poor advice. In such settings if problems with breastfeeding happen, they can escalate quickly and lead to premature cessation of breastfeeding.

This finding is in line with the evidence that in urban communities, breastfeeding rates are substantially lower and are similar to breastfeeding rates of non-Aboriginal mothers of low socio-economic background. There is significant decline in breastfeeding rates in the first few months, compounded by the early and untimely introduction of solid foods and, sometimes, inappropriate fluids.

In summary, it is clear from the findings and the literature that providers from the range of service settings believe young mothers develop bottle-feeding preferences due to a lack of peer and maternal support, the attitudes and skills of health workers, and to fit in with the demands of their lives. Most importantly, in both rural and remote and urban communities that are drug and alcohol affected, the lack of skilled treatment and support of women with drug or alcohol problems is the major determinant of maternal and infant health and therefore breastfeeding and infant nutrition.

## Resources, combined with social and political action

Information regarding the current infant feeding practices of Aboriginal and Torres Strait Islander communities is relatively scarce. However, the current available literature and this review's findings note the continuing erosion of breastfeeding amongst Aboriginal and Torres Strait Islander people. Even where initiation of breastfeeding rates are thought to be high, there is concern about the maintenance of that rate amid an atmosphere of complacency. There is a potential for a rapid drop in breastfeeding rates as traditional lifestyles are eroded. What is clearly articulated throughout the findings is that in Aboriginal communities, nutritional problems are very complex and will not be alleviated by nutrition education alone, but require social and political action within the framework of community development programs.

Several States have recognised the need to promote breastfeeding as a means of reducing the rate of common infant ailments, and to emphasise the positive aspects of traditional practices. The Koori community, in conjunction with Victorian Aboriginal Health Service's Aboriginal children's health promotional project and the 'Thallikool' project in New South Wales supported by the NMAA and Commonwealth government are two projects which provided testimony towards this view.

These project findings, combined with the overwhelming evidence gained from several other projects and services from around the country, emphasises that no one strategy alone will achieve substantial and sustained increases in breastfeeding rates. Multiple strategies stand a chance of having a significant impact, especially when aimed at bringing about structural change that, put simply, makes healthier food and feeding choices easier, and assists community members to make informed health decisions.

It was the general view that the core elements of effective projects are that:

- the project should ideally be initiated and designed with support by the target community in partnership between community members and those providing technical support;
- the ownership of the program remains firmly within the community;
- that community members are involved actively in all stages of development; implementation and evaluation; and
- strategies should be targeted specifically to community needs

### **Community ownership and partnerships**

Strong views are held on the importance of community ownership, empowerment and participation in all the case studies. Also evident was the need for services to have an impact on overcoming social or other barriers in the effort to facilitate easier choices and lives for women and their infants. The need to work across cultural boundaries was also highlighted by a number of projects, emphasising a side-by-side concept of Indigenous and non-Indigenous workers acting in partnership and providing mutual support.

It is only where programs and projects have been able to retain staff long-term that the building of trust with members of the community has ensured their input is culturally-appropriate. Health workers are seen as the essential element that allows entry into people's homes, which allows for important advocacy and mediation for individual clients.

### **Unsustained funding**

There was strong consensus across all categories of program and service providers on the lack of resources allocated at all levels of government to tackle the problem. The 'pilot syndrome' was a recurring theme, where several respondents emphasised that it is not only the lack of funding, but the resultant despondency generated by one-off funding for a twelve-month period. The despondency related to setting in motion a non-sustainable, although potentially effective, program was remarkable.

It was held that this funding approach demonstrated a complete misunderstanding of the long-term developmental strategies needed by project and programs to deal with complex problems. Strategies need to be developed and tested to address current barriers to improving the conditions associated with better infant nutrition. It was also emphasised that the negative signal this funding strategy sends to recipient communities cannot be overstated.

In conclusion, there was little debate on the overall need for extra funding and staffing to enable breastfeeding promotion and infant nutrition activities to be conducted. Many respondents, from the range of service categories, clearly articulated their frustration in designing and setting up projects and gaining the trust of the community, only to have the funds withdrawn. This not only means failure of the project, but often means that communities lose commitment and energy to be involved again in the future. In summary the resource gaps related to:

- sustained program funding;
- program funding to develop and evaluate resource materials;
- funding and expertise for research and evaluation;

- availability of accredited courses or learning opportunities for both Indigenous and non-Indigenous people from both Aboriginal and mainstream services, to gain skills in management of problems of breastfeeding and infant nutrition; and
- access to clearing house, reference and resource centres around the country.

### **Reactive services**

Respondents emphasised that services should be funded both to react to need and to carry out simple but regular needs analysis. For programs to be effective, it was well argued that they have to be informed by what the current social and traditional attitudes are and work with them. Group sessions, morning teas with particular groups of women, family or friends were identified as useful action research methods. In the context of the Victorian Aboriginal Medical Service, high quality focus group research with both men and women has generated unique information about the antecedents of breastfeeding and infant nutrition choices.

### **Competency to diagnose, manage and refer**

It was held that the skills of Aboriginal and Torres Strait Islander health staff and range of lactation consultants should be acknowledged: however, there is a significant lack of experts throughout mainstream Aboriginal and Torres Strait Islander public health care services. Even where competent Aboriginal and Torres Strait Islander health workers are available, they may not be allowed to exercise their skills. There are obvious difficulties in making any assessment of staff capacities to provide, technically and clinically, high quality and up-to-date information services. There was, however, little debate on the view across all categories that there were wide gaps in client access to expertise among generalist staff who provide the bulk of primary care. Gaps were described in:

- diagnosing, managing and following up common problems associated with infant feeding and nutrition;
- understanding, using and collating information relating to growth monitoring;
- deciding on the nature of appropriate supportive action;
- the provision for supportive follow-up of 'at risk' women and families; and
- developing innovative problem solving approaches and individual client care on a needs basis.

The employment of a female doctor in one service, who is a qualified lactation consultant and trained breastfeeding counsellor, was regarded as an extraordinary exception.

### **Service access—social, cultural and comfort issues**

Strong emphasis was placed on the notion that services are most effective where providers understand that breastfeeding and good infant nutrition do not occur in isolation to other aspects of women's lives. Problems, such as substance abuse within the family unit, impinge on a woman's ability to breastfeed.

There was much evidence to confirm that the use and potential effectiveness of services by Aboriginal and Torres Strait Islander mothers increases dramatically with the employment of Indigenous health workers. The uptake of the service and the outcomes for women experiencing problems are significantly enhanced, where women and their families have access to an Aboriginal

and Torres Strait Islander health/nutrition worker. This is held to be especially true if the staff have some understanding of the client's social context, complemented with expertise in the management of associated physical and/or social problems.

*“The ongoing involvement of experienced health workers, particularly those specialising in children's health is fundamental in the support of women and babies attending the Congress service. This is particularly evident with the more traditional women, who may appreciate having explanation/discussions in language.”* (Midwife rural service)

## Loss of parenting skills—stolen children

It was stressed that in considering the design of services, including the health promotion aspects, recognition has to be given to the loss of parenting knowledge and skills as a direct result of the 'lost generation'. Traditional knowledge regarding parenting issues such as breastfeeding and infant nutrition has, in many cases, been lost to families.

## Linkages

Most of the projects and interventions highlighted as part of the case studies section of this report have important components that cut across more formal structures or boundaries of health care. Linkages and trust have been built across service delivery settings such as health, welfare, the police and community-based organisations, such as women's councils. Within the health system, there is cooperation between community-controlled Aboriginal medical services and State or Territory health departments. There are links from research to individual client support and health care, urban facilities reaching out to remote areas, and an overall sense of trying to be innovative and flexible in order to support the choices of women and families. There are connections being made between old ways and new ways, with traditional stories and ceremonies linked to modern ante- and postnatal medical care. Several projects cross State and Territory borders.

## 'At risk' concepts

There was strong support for standard breastfeeding and infant nutrition care plans and “at risk” concepts to further prompt health workers, and to emphasise holistic and opportunistic advice and support.

On a practical level, there was a notable lack of computerised systems available to support staff in using the 'at risk' concept and in offering opportunistic, yet well-targeted, services. Information systems which support targeted services would also facilitate monitoring and evaluation.

## Outreach mobile services

A strong recurring theme in relation to effective service design was the need for outreach and mobile services, which provide the opportunity for support in a woman's familiar environment and or home. There were clear examples of positive achievements where the mobile community midwifery, outreach nutrition worker and child health model was applied.

## Peer counsellors and networks

Firm arguments were mounted for increasing women's access to peer counsellors who had experience with breastfeeding. In some settings, their role was to provide information, counselling and support to women in the prenatal and postpartum period to assist them in their breastfeeding

experience. Examples were given of how contact was useful with pregnant and breastfeeding women by phone, home visits, clinic visits, both pre and postnatally. It was held that peer counsellor support increased initiation and duration of breastfeeding for at least the first three months postpartum.

It was a general view that services need both to train and facilitate strong networks with peers, grandmothers, and other women's organisations for support.

## Ongoing staff development

There was little debate on the need to recruit more and invest significant resources in training of Aboriginal health workers in breastfeeding and infant nutrition (see associated training audit, reported separately).

It was the exception that services provided education for medical or other staff in the management of breastfeeding problems and encourages staff to join NMAA in order to keep up-to-date with breastfeeding information.

To complement these aspirations, it was clearly articulated that there was a need for recognised health worker specialisations and accredited training opportunities in the areas of Maternal and Child Health as well as research skills.

*“Aboriginal health workers get very little chance to counsel breastfeeding mothers because so few people are breastfeeding and so they become deskilled. There is need to send the Aboriginal health workers to where the breastfeeding rates are high so that they may learn about the contexts of breastfeeding and ways of encouraging and supporting breastfeeding.”(service provider)*

## Where are the opportunities?

There was a significant lack of opportunities for specialist health worker training on site, so courses and skills are relevant to the needs of health workers and are coordinated with community priorities. Currently, generalist training for health workers is offered in a variety of flexible modes, such as block release and work experience. Health workers need to be able to access specialist training in the same way.

Note: see also the separate report on training in breastfeeding support and appropriate infant nutrition.

## Policy—public, institutional and social elements

A resounding theme was the need for health policies to address many erroneous assumptions related to community dynamics, for example:

- a strong expectation within the community that mothers will breastfeed;
- there is no stigma attached to breastfeeding in public places; and
- mothers know how to breastfeed and are themselves committed to succeed with breastfeeding.

Internationally, the issue has earned significant attention in project support and policy development in ways which closely coincide with the aspirations of many service providers taking part in this review. For example:

- review, amend and publish documentation relating to breastfeeding for national health personnel;
- provide sufficient funding base for the targeted production of promotional material and utilisation of mass media;
- provide facilities to centralise reference and training in major centres;
- support ongoing joint research and development ventures between Aboriginal and Torres Strait Islander groups/consumers, universities and service providers; and
- plug the loopholes in the Code of marketing of breastmilk substitutes (1990)

Many providers claim that services lack the backing of a national approach and policy to breastfeeding and infant nutrition. The Territory Health Service's Breastfeeding Policy and Strategic Plan 1994–2000 has been mentioned by respondents as being a useful model.

There was reasonable consensus that women's health policies should include at least some references to breastfeeding which consider the health benefits to the mother associated with breastfeeding. It was reported that this should also include the psychological benefits cited by many women such as feelings of fulfilment and satisfaction.

### **Efforts/policies promoting supportive environments**

There was widespread lack of awareness among providers on the existence of, or their role in advocacy in relation to local, State or Commonwealth government policies on breastfeeding in the workplace, breastfeeding in public facilities and a range of other related issues, including local food store purchasing and pricing policies.

It is believed critical that hospital policy needs to be addressed around the country. It was asserted that it is not enough simply to provide more health education. It was commonly argued that breastfeeding until four months is more likely among women whose baby did not receive a bottle while still in hospital and who did not smoke, use the combined oral contraceptive pill or introduce solid foods before four months.

Hospital-specific policy recommendations included early breastfeeding after delivery, full rooming-in, banning routine use of supplementary feeding and rearranging hospital timetables to suit mothers and their babies rather than hospital staff, paying particular attention to the needs of low birth-weight babies, sick babies and babies of mothers with diabetes.

### **Implications of early discharge**

Clear concern related to early discharge trends in hospitals. Respondents were concerned at the pressure placed on new mothers for shorter length of postnatal hospital stay.

### **Health promotion—integrated strategies**

#### **'Information will solve the problem'**

It would appear from the findings that there is an overwhelming tendency to relate a sense of failure to make an impact, largely on a lack of resources for teaching. Frequently, staff perceived the answer to influencing behaviour to lie predominantly with giving information and advice. While this is seen as a very important strategy, and requiring much greater input (see below) on its own, information can achieve limited results.

In addition, a resolute emphasis from program providers was placed on the need for integrated, coordinated approaches, which combine health promotional activity with:

- low level operational research component;
- training and updating of health professionals and health workers regarding breastfeeding and introduction of first foods, and the inter-relationship between growth, nutrition and infection;
- convincing administrators to facilitate natural breastfeeding (e.g. arranging rooming-in facilities);
- including breastfeeding in health studies curricula;
- implementing labour laws for protecting the working mother;
- form mothers' self-help groups;
- disseminating information on breastfeeding among authorities;
- informing mothers about breastfeeding through personal contact and the media; and
- increasing community education, targeting communities to "let them know that by breastfeeding they are currently protecting their children's health".

*"Information regarding the health protection, which is currently being given to children because they are breastfed, should be made available to communities. This information needs to be at least as overt as the anti-breastfeeding messages embedded in the media and advertising."*  
(Service provider).

## Resources

Many respondents mentioned the lack of suitable teaching aids and a need to develop appropriate flip-charts, videos and posters. These, it was reported, should be short and with little language to allow for dubbing in local languages. Other strategies were:

- the use of culturally-appropriate educational material including posters and videos, and the use of NMAA resource booklets;
- breastfeeding promotion workshops whereby pregnant women, new mothers and carers are invited for lunch with an educational and social support component;
- in-service education of staff regarding breastfeeding and management of problems;
- education, support and breastfeeding information is also provided to grandmothers, aunts and other carers;
- liaison with mother to mother support groups such as NMAA;
- encouragement of key community members to support breastfeeding;
- support of role models for breastfeeding in the community; and
- coordinated care plans plus 'at risk' concepts can ensure that individual clients receive appropriate and targeted advice and support at each point of contact with the health system.

## Sensitivity to differences

Any resource development at the national level must be mindful of the major differences in language, idiom, and practice from one community to another. It has been suggested that, while more resources are needed and there would be economies of scale if resources were centrally produced, there must be a capacity to do local voice and graphic tagging.

## Research & evaluation informing service delivery

With a few exceptions, projects generally lacked the benefit of formal evaluation. This obviously made the assessment of individual services and projects difficult.

## National database

Major comments related to an urgent expressed need for an Australian system for monitoring infant feeding and growth. This could include information on rates of initiation and duration of breastfeeding, introduction of other foods, growth and development of babies and young children, for both the Indigenous community and the general population.

## Operational research

A distinct recurring theme related to the need for funding of small-scale operational research components for all categories of service provision.

Given the perceived lack of community follow-up in some instances, investigation into early discharge programs and their impact upon breastfeeding was a key area identified as needing more and ongoing research. This has implications for the successful initiation of breastfeeding. Other factors including the high obstetric intervention rates amongst Indigenous women, the high prevalence of low birth-weight babies, and the high prevalence of diabetes among Indigenous mothers also have implications for the successful initiation and continuation of breastfeeding which require impact evaluation.

Operational research is needed to clarify appropriate recommendations about feeding for infants, such as the best age and stage for introduction of other foods, the particular needs of undernourished infants and mothers, feeding protocols for sick and convalescent children, etc.

While some believe it to be outside the scope of this review, it was recommended that further research needs to be funded into the community stores in Aboriginal and Torres Strait Islander communities. Research here could focus on two issues—firstly, an assessment of the degree to which stores abide by the *WHO International Code of Marketing Breastmilk Substitutes*; and secondly, their performance in ensuring availability of affordable and healthy food suitable for infants and for other community members.

A set of guidelines for providers to use in considering need assessment, and rapid appraisal techniques to assess effectiveness of interventions, was clearly needed.

The usefulness of ongoing joint research and development ventures between Aboriginal and Torres Strait Islander groups/consumers, universities and service providers was emphasised by service managers.



## Chapter 6

# Recommendations

The aim of these recommendations is to develop and sustain an environment which supports Aboriginal and Torres Strait Islander mothers to breastfeed and to provide appropriate food for their babies. OATSIHS has a critical leadership role to play in ensuring that this is achieved. It is hoped that such an environment would achieve these goals.

- Aboriginal and Torres Strait Islander mothers, their partners and extended families will be well informed about, and will value, breastfeeding.
- Mothers who choose to breastfeed will have expert support from health staff, including high quality information and care during the antenatal period, and competent technical support after the baby is born to initiate and maintain breastfeeding.
- Mothers, partners and families will be well informed about other foods needed by babies to sustain optimal growth and development.
- Health staff will be proactive in assessing child nutrition, growth and development in early life.
- Referral systems will exist to provide additional support to those mothers and infants whose well-being is jeopardised by alcohol and/or substance misuse or by other socio-economic circumstances.
- Health staff supporting the mother during her child-bearing years will include Indigenous staff (preferably with expertise in breast feeding and infant nutrition) at all levels of the health care system.
- Non-Indigenous staff involved in the care of Indigenous mothers and babies will be well-informed and sensitive to cross cultural issues.
- Health facilities used by Indigenous mothers will recognise their role and responsibility in supporting Indigenous mothers to breastfeed. The health facilities will develop and adopt appropriate policy and practices, which are incorporated into the hospital and community health accreditation systems.
- Breastfeeding and good infant nutrition will be supported and valued by Indigenous communities, be they urban, rural or remote.
- Breastfeeding will be supported by workplace (including the Community Development and Employment Program) and childcare policies and practices.
- Breastfeeding and good infant nutrition will be supported by access to affordable, nutritious food. Community stores will have policies and practices conforming with the *WHO International Code of Marketing Breastmilk Substitutes*.

## Policy and information

With these aims in mind, it is recommended that;

- a national breastfeeding and infant nutrition policy be developed, using the example of the Northern Territory Health Services Breastfeeding Policy and Strategic Plan 1994–2000;
- national Aboriginal and Torres Strait Islander goals and targets be developed, which include specific targets relating to breastfeeding, infant nutrition and growth—these should be based on those agreed by the Australian Health Ministers' Advisory Council in July 1997;
- a nation-wide health information system be developed, which includes indicators of breastfeeding and infant nutrition practice in order to inform local, State and national agencies about progress towards the above goals and targets;
- breastfeeding be recognised as the physiologically normal way for a mother to feed her child—the current practice of emphasising the protection offered by breastfeeding imply that the breastfed baby is privileged and receives health protection and benefits over and above the norm should be reduced and materials should present breastfeeding as being normal and the entitlement of every child;
- health facilities where Indigenous mothers give birth be supported to adopt 'best practices' policy and protocol, such as those detailed in the *WHO/UNICEF Baby Friendly Hospital Initiative*. This should enable those facilities to support breastfeeding for Indigenous babies and particularly for high risk babies (e.g. low birth-weight or premature babies and born to mothers with diabetes);
- accreditation systems for hospitals, community health services and Aboriginal Medical Services include criteria on breast feeding and infant nutrition practice and protocols (such as the *WHO/UNICEF Baby Friendly Hospital Initiative* guidelines);
- women's health policy and women's health initiatives at national, state and local levels specifically include breastfeeding which has many benefits for the health of women as well as babies; and
- continuity of funding be seen as a necessity in program planning at all levels—community and health staff commitment is jeopardised when funding is not sustained at critical times, impacting not only on the immediate situation but also future initiatives. When programs are transferred from one jurisdiction to another (e.g. from national to State level) current and future funds should be quarantined to ensure program continuity.

## Staff expertise

- Appropriate training for Indigenous health staff in breastfeeding and infant nutrition be developed, provided and promoted—detailed training recommendations for Indigenous and non-Indigenous staff are included in the companion national report on Training<sup>6</sup> and Expertise in breastfeeding, infant nutrition and the relationship between nutrition, infection and growth needs to be developed.
- A career path be developed for Indigenous health workers who may become specialists in the area of maternal and child health and/or breastfeeding and infant nutrition.
- Hospitals where Indigenous mothers give birth employ Indigenous staff with appropriate expertise in breastfeeding and infant nutrition. Indigenous health staff are also needed in other health settings utilised by Indigenous mothers and families.

<sup>6</sup> Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal and Torres Strait Islander women. Commonwealth Department of Health and Family Services 1997.

- Accreditation systems for hospitals, community health services and Aboriginal Medical Services include criteria in respect of staff expertise in breastfeeding and infant nutrition.
- Recommendation 247 of the Royal Commission into Aboriginal Deaths in Custody concerning training of mainstream staff in health and cultural sensitivity issues be implemented at all levels of the health system.
- A clearing house for information on programs and projects relating to breastfeeding and infant nutrition be established to facilitate networking and experiential learning from elsewhere. This could include a website and the book<sup>7</sup> produced to accompany this report.
- Further work be done to develop a training and resource kit and revisit and update the NSW Department of Health and the NMAA Thallikool Infant nutrition kit for health workers.
- Health staff be given clear and unambiguous information about the rare situations where breastfeeding is medically contraindicated because of risks of infection to the baby. The current information in the NHMRC document (Infant Feeding Guidelines for Australia) is ambiguous and health staff are uncertain about the advice they should be providing, particularly in relation to hepatitis B, hepatitis C and HIV.

## Service management

- Service managers be supported to develop, implement and evaluate initiatives relating to breastfeeding and infant nutrition. This can be done by establishing a small, nationally mobile, expert team on whom health providers can call for advice and support in project design and particularly for evaluation strategies.
- Breastfeeding and infant nutrition objectives be incorporated into routine service provision and evaluated. Provision must be made for this in service planning and funding.
- Protocols for the assessment of nutrition, growth and development are needed. Staff need to be able to assess growth and nutrition and give appropriate advice for the feeding of the well, sick and convalescent child. The important inter-relationship between infection, nutrition and FTT must be incorporated in staff practice and in training.
- Service managers should ensure that services are available, physically accessible (including outreach and mobile services as required) and culturally-appropriate for Indigenous clients.
- Health information systems are used for active follow-up and support for a mother in the early years of her baby's life, rather than passive reliance on the mother to present for care.
- Linkages between services be established/strengthened to enable staff to access specialist services, and track mothers and children where drugs/substance misuse, alcohol misuse, violence and other factors place mothers and children 'at risk'. Concerns about confidentiality should be addressed and not seen as a barrier to linkages.

## Research

- Research be conducted into health service factors which appear to have a major impact on the establishment and maintenance of breastfeeding. Factors affecting healthy mothers and babies include early hospital maternity discharge programs. Factors affecting 'at risk' mothers and babies include aspects of neonatal care of low birth-weight babies and babies born to mothers with gestational diabetes.

<sup>7</sup> Giving Aboriginal and Torres Strait Islander babies the best start in life: Supporting breastfeeding and good food choices for infants. Stories and Ideas from around Australia. Commonwealth Department of Health and Family Services 1998.

- Research be conducted into the relationship between nutrition and infection in Indigenous infants and young children. There is as yet no comprehensive Australian study into the relationship between morbidity of young Indigenous children and feeding practices.
- The determinants of infant feeding and social/economic barriers to breastfeeding and good infant nutrition in Indigenous communities be identified.
- The lactation capacity and breastmilk composition of mothers who are chronically undernourished and/or alcohol misusers be assessed. The research on lactation by undernourished women has been conducted in settings where the usual diet is very different from that of Indigenous Australians (e.g. the Gambia).
- The 'when' and the 'what' of food needs for preterm, low birth-weight and FTT infants be ascertained. Current advice assumes a well-nourished mother and child.
- Epidemiological data on breastfeeding is best compiled as part of a routine health information collection system as specified in the section on policy and information.
- The components of effective health promotion in Indigenous communities be identified. Health promotion strategies and materials be evaluated for effectiveness in knowledge transfer and facilitating behavioural change.

## Community and family support

- An integrated health promotion initiative to promote breastfeeding and good infant nutrition among the Indigenous community should be developed and implemented. This initiative must be national in extent but locally relevant. It should have multiple target groups, including school-aged children, women of child-bearing age, fathers and uncles, grandmothers and aunts, as well as the general Indigenous community. Evaluation and impact assessment should be an integral feature of this initiative.
- Resources be designed as part of this initiative for national usage which can be adapted for local usage. The resources should present breastfeeding as the norm and include robust, substantial and reliable information about feeding children, especially the introduction of first foods and links to growth and development.
- A one-to-one counselling system for breastfeeding Indigenous women be established, similar to the peer counselling system of the NMAA. However the use of unrelated, young, volunteer peers may not be appropriate for Indigenous women. A system for Indigenous mothers should build on the knowledge, skills and authority of older family and community women. Training should acknowledge and build on the knowledge and experience of these key people, as well as provide them with up-to-date knowledge and skills.
- Health literacy programs, incorporating information on breastfeeding and infant nutrition, be made widely available in Indigenous communities. This could build on innovative work in Western Australia, the Northern Territory, New South Wales and Victoria.
- Workplace policies and practices to support breastfeeding be described and promoted in Indigenous settings. Community Employment and Development Programs would be a good place to start.
- Stores servicing Indigenous communities be assessed with respect to their compliance with the WHO *International Code of Marketing of Breastmilk Substitutes*.
- Food security—access at all times to the food needed to stay healthy—be assessed and, where necessary, improved in remote, rural and urban Indigenous communities.

## Chapter 7

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## Appendix 1

# Postal and public invitation to contribute

Commonwealth Department of Health and Family Services  
Office for Aboriginal and Torres Strait Islander  
Health Services

## BREASTFEEDING AND INFANT NUTRITION STRATEGY

### Strengthening health services

The Commonwealth Department of Health and Family Services is sponsoring a number of approaches that aim to encourage breastfeeding and the appropriate introduction of additional foods for infants. A part of this approach is to support women's choices and to strengthen health services in supportive action in the area of breastfeeding and good infant nutrition. Two projects have been identified as part of the strategy to promote breastfeeding awareness and appropriate infant nutrition for Aboriginal and Torres Strait Islander women and their families.

### Two projects

Project 1 is an audit of current training in breastfeeding support and infant nutrition for health service providers caring for Aboriginal and Torres Strait Islander women. It will look at relevant course components of selected institutions and organisations providing training for a range of health care providers. Particularly it will look at courses and training opportunities for Aboriginal and Torres Strait Islander Health Workers.

Project 2 is the identification of examples of interventions, services, innovative approaches, and successful projects that support Aboriginal and Torres Strait Islander mothers and families in breastfeeding and appropriate infant nutrition. As well as this general invitation to participate in the project, a selection of health professionals and community based providers is being contacted.

### Collaborative projects

The projects are being conducted as a collaborative effort by three institutions, with project officers based in Brisbane and advisers in each State and Territory. The three organisations involved are:

- the Department of Social and Preventive Medicine, Cairns, University of Queensland;
- the Tropical Public Health Unit, Cairns, Queensland Health; and
- Apunipima Cape York Health Council.

## Sharing of information

Input is being sought from a wide range of education and health service providers. The reports on Project 1 and 2 will be sent to the Commonwealth Department of Health and Family Services by mid-July 1997. They will examine the possible need for the future development of specific courses, training resources or interventions in this area. These reports will then be widely distributed to facilitate the sharing of information on good ideas for training and effective interventions.

## Your valued input

The project team welcomes any comments and suggestions from individuals or groups with an interest in this area, or who are involved in the delivery of health services and information to Indigenous women, parents or other family members caring for infants.

To allow for follow up and inclusion in the review process, submissions or your thoughts on specific projects, programs or courses need to reach us by June 2 1997. Thank you.

## Contact:

The Research Officer  
Breastfeeding and Infant Nutrition Projects  
PO Box 1143 Kenmore QLD 4069  
PH/Fax: (07) 3374 2064  
e-mail: [anigroos@powerup.com.au](mailto:anigroos@powerup.com.au)

## Appendix 2

# Invitation to participate in the review

## BREASTFEEDING AND INFANT NUTRITION STRATEGY

### REVIEW OF INTERVENTIONS

#### What is this Project looking for?

This project is looking at ways in which health services or organisations have:

- developed useful strategies and activities for use by community based Aboriginal and Torres Strait Islander health service providers to promote and support breastfeeding and infant nutrition;
- facilitated interventions that promote breastfeeding, help women and families to continue when difficulties arise;
- developed resources and activities which help women and families in the introduction of first foods to infants; and
- evaluated the impact of interventions or health care activities in this area.

#### What do we mean by intervention?

Interventions may be any of these:

- supportive action and advice which is part of a routine service such as antenatal screening;
- a one-off special project, program or community activity especially funded to raise awareness of the benefits of breastfeeding and to provide advice and support to women, families and communities in their choice of infant nutrition;
- demonstration projects;
- things that are done to help breastfeeding mothers when they have difficulties;
- activities that provide advice and information; and
- community development activities that aim to make the social environment more supportive of women starting and continuing breastfeeding, and adopting good infant nutrition practices.

## How can you participate? You have two options

1. You may like to attach the form below to any reports or documentation you provide or to any written description developed using the attached checklist; or
2. Simply fax this form to 07 3374 2064 or mail it to the address below and the project team will contact you. Closing date for your input is June 2 1997. Thank you.

---

The Research Officer: Review of Interventions

Breastfeeding and Infant Nutrition Projects

PO Box 1143

Kenmore Qld 4069

Ph Enquires 07 374 2064

Name.....Position / job title.....

Service / program.....

Address.....

.....

.....

Postcode.....

Telephone number( ).....Fax ( ).....

Yes, I would like to receive a copy of the final report. please tick

## Some questions to guide your input to this project?

If you use this checklist please refer in your response to the listed number.

1. Can you give a brief description of your intervention? Please include how long the program has been running, how many clients it has had, and how many staff. Is the program a one-off or ongoing?
2. In what setting is your service delivered? Is your intervention part of another service? For example of a vaccination or Maternal and Child Health program and, if so what?
3. How does your intervention support women:
  - at the start of breastfeeding;
  - during breastfeeding;
  - in the management of problems;
  - during the introduction of first foods to babies;
  - in assessing the infant's health?; and
  - to access specialist services such as lactation consultants.

4. How does your intervention facilitate easy access by Aboriginal and Torres Strait Islander people?
5. Is there any information on the extent to which Aboriginal and Torres Strait Islander women and local communities use your service/program and if so please describe?
6. How does your intervention consider the cultural and social context of Indigenous mothers and their children with regard to breastfeeding and infant nutrition?
7. How does your service/program ensure that women can receive support at home or in familiar surroundings without the need to be removed from their normal social supports?
8. What provision is there for supportive follow up of 'at risk' women and families?
9. How does your intervention include efforts/policies that promote supportive environments for breastfeeding and appropriate infant nutrition? For example: breastfeeding in the workplace; local food store purchasing and pricing policies?
10. Has the service/program been evaluated/documented and if so is there a report you can provide?
11. What do you see as the major strengths of your intervention in supporting breastfeeding and appropriate infant nutrition for Aboriginal and Torres Strait Islander people?
12. How do you see your service/program could be strengthened or made more effective? For example: additional resources, national guidelines or tools etc.
13. Are there other issues that you would like to mention?

**We are most grateful for your kind cooperation.**

### Appendix 3

## Invitation covering letter

Dear \_\_\_\_\_,

The Office for Aboriginal and Torres Strait Islander Health Services in the Commonwealth Department of Health and Family Services is sponsoring two Australia-wide projects which will assist with their strategy to promote breastfeeding awareness and appropriate infant nutrition for Aboriginal and Torres Strait Islander women and their families.

The two distinct projects are:

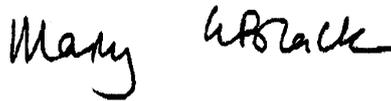
- An audit of current training for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal and Torres Strait Islander women; and
- A review of interventions and the identification of examples of services, innovative approaches and successful projects used by health service providers in promoting and supporting breastfeeding and infant nutrition.

These projects provide an excellent opportunity to contribute to improving the health of Aboriginal and Torres Strait Islander people and help the Commonwealth target resources for better training, research and interventions in the future.

We are keen to gain your input into the second project, the REVIEW OF INTERVENTIONS. I enclose a description of the project and some suggestions to guide your response.

To let people become aware of the project and encourage them to participate, would you please display the enclosed flyer on an appropriate notice board? To meet the Commonwealth's timeframe, we need your contribution by 2 June 1997 to allow a final report to be finished by August.

If you'd like to talk to someone about the project, please feel free to contact the Project Manager, Ms Mel Miller, on (07) 3374 2064, or myself. Of course, we shall make sure you receive a final copy of the report. Thank you in advance for your assistance in this important project.



Mary Black

Appendix 4

# Telephone and face-to-face interview checklist

## Breastfeeding and infant nutrition intervention review

Category \_\_\_\_\_ ID \_\_\_\_\_ State \_\_\_\_\_

1. Name of organisation: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Name of intervention: \_\_\_\_\_
4. Contact officer: \_\_\_\_\_
5. Phone: ( ) \_\_\_\_\_
6. Fax: ( ) \_\_\_\_\_
7. Does the service provider agree to the release of information about their intervention?

Yes / No / Unconfirmed

8. What information about the intervention do we hold on file?

\_\_\_\_\_

9. How would you describe your intervention? (Circle a or b)

- a General population intervention tailored for use in Aboriginal and Torres Strait Islander communities? (Go to 10a)
- b An intervention specifically designed for Aboriginal and Torres Strait Islander people? (Go to 10b)

- 10 a. If the intervention is a general population strategy modified for use in the Aboriginal and Torres Strait Islander community, what modifications were made? How and by whom?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- b. If specifically for Aboriginal and Torres Strait Islander people, was it designed—

by Indigenous people?

by other health professionals?

11. How would you describe your geographic location?
- Major metropolitan area
- Provincial centre
- Rural town
- Remote community
- Other (e.g. Flying Doctor)
12. In what setting is/was your intervention delivered?
- Home/community
- Community based health centre
- Hospital
- Other
13. How is the intervention delivered?
- Opportunistically and integrated into routine health care?
- As a stand alone special project (one-off or demonstration)?
- Specifically funded with trained workers supplementing routine health care?
- Voluntary community workers
- Other
14. Is it a current intervention? Yes / No
15. How long has it been running/did it run? \_\_\_\_\_ Years \_\_\_\_\_ months \_\_\_\_\_ weeks
16. How many staff does it/did it have? \_\_\_\_\_ staff \_\_\_\_\_ volunteers
17. How many clients has it had? \_\_\_\_\_ clients
18. What are/were the intervention's key components or strategies? (Choose any applicable.)
- a Community development
- b Health promotion
- c Information giving
- d Counselling
- e Support
- f Other (please specify)

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19. In particular, how does your intervention support women–
- a in planning their infant feeding choices during pregnancy?  
\_\_\_\_\_
  - b at the start of breastfeeding?  
\_\_\_\_\_
  - c during breastfeeding (establishing and maintaining breastfeeding):  
\_\_\_\_\_
  - d in the management of problems?  
\_\_\_\_\_
  - e during the introduction of first foods to babies?  
\_\_\_\_\_
  - f in assessing the infant's health?  
\_\_\_\_\_
  - g to access specialist services such as lactation consultants?  
\_\_\_\_\_
  - h to access mother to mother support groups?  
\_\_\_\_\_
20. Do you think the intervention or components of it can be used in other settings or communities?
21. Did the intervention specify aims, goals or objectives? Yes / No
- 21B If yes, what were they?  
\_\_\_\_\_
22. Has the intervention been formally evaluated? Yes / No  
(If no, go to Q23, option 2)
- a If yes, can you please send us a copy of the report? Yes / No
  - b If yes, was it an internal or external evaluation? Internal / External
  - c If yes, did it try to evaluate (tick one):
    - the outcomes of the project?
    - the process of its implementation?
    - both process and outcome?

23 (If yes to Q 22) What did the evaluation find about the outcomes of the intervention in terms of:

(If no to Q 22) How would you rate the outcomes of the intervention in terms of:

a achievement of its stated goals and objectives?

---

b its accessibility to Indigenous people?

---

c its impact on the awareness amongst health care workers of the importance of breastfeeding and infant nutrition?

---

d the sustainability of the project over time?

---

24. Did the intervention collect data on initiating and maintaining rates of breastfeeding? Yes / No

25. What are the intervention's strengths?

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26. What are the intervention's weaknesses? How do you think it could be improved?

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27. How does your intervention facilitate easy access by Aboriginal and Torres Strait Islander people?

---

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28. Is there any information on the extent to which Aboriginal and Torres Strait Islander women and local communities use your intervention? If so, please describe:

---

---

---

29. How does your intervention address the need to involve other key people as well as the mother? (e.g. grandmother, aunts, partner)

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30. How does your intervention consider the cultural and social context of Indigenous mothers and their children with regard to breastfeeding and infant nutrition?

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31. How does your intervention ensure women can receive support at home or in familiar surroundings without the need to be removed from their normal social supports?

---

---

32. What provision is there for support of women who are 'at risk' of not breastfeeding, such as hospitalised mothers and mothers of multiple births and of premature infants?

---

---

33. Does your intervention include efforts or policies which promote supportive environments for breastfeeding and appropriate infant nutrition (for example, breastfeeding in the workplace; local food store purchasing and pricing polices)?

---

---

34. Are you familiar with the *WHO International Code of Marketing Breastmilk Substitutes*?

Yes / No

35. Are you familiar with the rights of breastfeeding women under State, Territory and federal human rights and anti-discrimination laws?

Yes / No

36. Are there any other issues you would like to mention?

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---

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Thank you

## Appendix 5

# Organisations invited to participate in the review

## Aboriginal Health Services

### Australian Capital Territory

Winnunga Nimmityjah

### Australian Capital Territory

Aboriginal Medical Service (Redfern)  
Aunt Polly Smith Early Childhood Health Centre  
Biripi Aboriginal Corporation Medical Centre  
Bourke Aboriginal Health Service  
Brewarrina Aboriginal Health Service  
Bulgarr Ngaru Health Service Co-Operative Ltd  
Coomealla Health Aboriginal Corporation  
Daruk Aboriginal Medical Service Co-Operative Ltd  
Durri Aboriginal Corporation Medical Service  
Illawarra Medical Service Aboriginal Corporation  
Ivanhoe Aboriginal Corporation  
Katungul Aboriginal Corporation  
NSW Aboriginal Health Resource Co-operative Ltd  
Oolong Foundation Inc  
Orana Haven Aboriginal Corporation  
Pius X Aboriginal Corporation  
Pius X Aboriginal Corporation  
Richmond Health Service  
South Coast Medical Service Aboriginal Corporation  
South Coast Medical Service Aboriginal Corporation  
Tharawal Corporation Aboriginal Medical Service  
Thubbo Aboriginal Medical Centre Co-Operative Ltd  
Walgett Aboriginal Medical Service Co-Operative Ltd  
Walhallow Aboriginal Corporation  
Waminda South Coast Women's Health & Welfare Aboriginal Corp  
Weimija Aboriginal Corporation  
Wellington Aboriginal Health Service

## Northern Territory

Aherrenge Association Inc  
Alpurrurulam Community  
Ampilatwatja Health Centre  
Anyinginyi Congress Aboriginal Health Service  
Central Australian Health Congress  
Danilba Dilba Medical Service  
Gapuwiyak Community Inc  
Gumatji Association  
Imanpa Community Council Inc  
Laynhapuy Homelands Association  
Laynhapuy Homelands Association  
Miwatj Health Aboriginal Corporation  
Mutitjulu Community Health Service  
Nganyatjarra Health  
Nganampa Health Council  
Nganmariyanga Community Inc  
Ngkarte Mikwekenhe Community Inc  
Northern Land Council (NLC)  
Pintubi Homelands Health Service  
Pintubi Homelands Health Service  
Rumburriya Malandari Council Aboriginal Corporation  
Urapuntja Aboriginal Health Service  
Witjintitja Aboriginal Corporations  
Wulunguru Community Aboriginal Corporation  
Wurli Wurlinjang Health Service Katherine

## Queensland

Aboriginal & Islander Community Health Service—Brisbane  
Aboriginal & Islander Community Health Service—Ipswich  
Apunipima Health Council  
ATSI Health Worker Education Program  
Goolburri Health Advancement Aboriginal Corporation  
Goondir Aboriginal and Torres Strait Islander  
Kalwun Development Corporation Medical Centre  
Mackay Aboriginal & Islander Health Service  
Mamu Medical Service  
Queensland Aboriginal and Islander Health Forum  
Townsville Aboriginal & Islander Health Service Ltd  
Wu Chopperen Medical Service  
Wujal Wujal Primary Care Centre

## South Australia

Aboriginal Health Council of South Australia  
Ceduna Koonibba Aboriginal Health Service  
Ceduna Koonibba Aboriginal Health Service

Dunjiba Community Council Incorporated  
Kalparrin Inc  
Nunkuwarrin Yunti of SA Inc  
Pika Wiya Health Service  
Port Lincoln Aboriginal Medical Service  
Umooona Community Council Incorporated  
Yalata/Maralinga Health Service

## **Tasmania**

Aboriginal Health Service

## **Victoria**

Ballarat Aboriginal Health Service  
Central Gippsland Aboriginal Health & Housing Co-Op Ltd  
Gippsland & East Gippsland Aboriginal Co-op  
Goolum Goolum Aboriginal Co-operative Ltd  
Gunditjmara Aboriginal Co-operative  
Kirrae Whurrong Community Inc  
Ngwala Wilumbong Co-op Ltd  
Ramahyuck District Aboriginal Corporation  
Rumbalara Medical Clinic  
Swan Hill and District Aboriginal Co-Operative  
Victorian Aboriginal Health Service Co-Op Ltd  
Wathaurong Aboriginal Corporation  
Wathaurong Aboriginal Corporation  
West Gippsland Aboriginal Community Co-Operative Ltd

## **Western Australia**

Bay of Isles Aboriginal Community Inc  
Bega Garnbirringu Health Service  
Bibbulung Gnarneep  
Bloodwood Tree Aboriginal Inc  
Broome Regional Aboriginal Medical Service (BRAMS)  
Bundybunna Aboriginal Corporation  
Carnarvon Aboriginal Medical Services (CAMS)  
Coolabaroo Neighbourhood Centre  
East Kimberley Aboriginal Medical Service (EKAMS)  
Geraldton Regional Aboriginal Medical Service (GRAMS)  
Gurlongga Njininj  
Ieramugadu Group Incorporated  
Junjuwa Community Inc  
Kimberley Aboriginal Medical Service Council (KAMSC)  
Marr Mooditj Foundation Inc  
Mawarnkarra Health Service

Milliya Rumurr Inc  
Ngangganawili Medical Service  
Ngoonjuwah Council Aboriginal Corporation  
Ngoonjuwah Council Aboriginal Corporation  
Ngunytju Tjitji Pirni Corporation (NTP)  
Ninga Mia Village Aboriginal Corporation  
Paupiyala Tjarutja Aboriginal Corporation  
Perth Aboriginal Medical Service  
Puntukurnu Aboriginal Medical Service  
Puntukurnuparna (Western District)  
Warralong Aboriginal Health Service  
Warringarri Aboriginal Corporation—Kununurra  
Wheatbelt Aboriginal Corporation  
Yuri Yungi Aboriginal Health Service

## **Mainstream: Hospitals, Community Health, GPs**

### **Australian Capital Territory**

ACT Division of General Practice  
Canberra Hospital  
City Early Childhood Health Centre

### **New South Wales**

Bankstown Division of General Practice  
Barrier Division of General Practice  
Barwon Division of General Practice  
Blue Mountains Division of General Practice  
Bourke Early Childhood Health Centre  
Campbelltown Mawson Park  
Canterbury Division of General Practice  
Coffs Harbour Base Hospital  
Division of General Practice Central Sydney Area  
Division of General Practice Northern Rivers NSW  
Dubbo/Plains Division of General Practice  
Eastern Sydney Division of General Practice  
Fairfield Health Service Division of General Practice  
Family & Child Health Service  
Hawkesbury Division of General Practice  
Hornsby Ku-Ring-Gai Division of General Practice  
Hunter Rural Division of General Practice  
Hunter Urban Division of General Practice  
Illawarra Division of General Practice  
Liverpool Hospital

Liverpool Division of General Practice  
Macarthur Division of General Practice  
Manly Warringah Division of General Practice  
Mid North Coast Division of General Practice  
Murrumbidgee Division of General Practice  
Nepean Division of General Practice  
New England Division of General Practice  
North West Slopes NSW Division of General Practice  
Northern Sydney Division of General Practice  
NSW Central Coast Division of General Practice  
NSW Central West Division of General Practice  
NSW Outback Division of General Practice  
Port Macquarie Division of General Practice  
Royal Hospital for Women  
Shoalhaven Division of General Practice  
South East NSW Division of General Practice  
South Eastern Sydney Division of General Practice  
Southern Highlands Division of General Practice  
St George Division of General Practice  
Sutherland Division of General Practice  
Tamworth Base Hospital  
Tweed Valley Division of General Practice  
Wagga Wagga & District Division of General Practice  
Western Sydney Division of General Practice  
Woy Woy Early Child Health Centre

### **Northern Territory**

Adelaide River Community Health Centre  
Alice Springs Hospital  
Central Australian Division of General Practice  
Darwin Hospital  
Family Youth and Children's Services  
Gove Hospital  
Nhulunbuy Child & Maternal Health Centre  
Top End Division of General Practice

### **Queensland**

Bayside General Practice Division  
Blackwater Child Health Clinic Family Centre  
Blue Nursing Service Lower South Coast/Tweed Centre  
Brisbane Inner South Division of General Practice  
Brisbane North Division of General Practice  
Brisbane Southside Division of General Practice  
Cairns Base Hospital

Cairns Community Health Service Centre  
Cairns Division of General Practice  
Central Queensland Division of General Practice  
Central Western Queensland Medical Division  
Cherbourg Child Health Centre  
Family Health, Cairns Health District QH  
Far North Queensland Division of General Practice  
Gold Coast Division of General Practice  
Gympie Child Health Centre  
Inala Community Health Services Centre  
Ipswich West Moreton Division of General Practice  
Logan Area Division of General Practice  
Mackay Region Division of General Practice  
Mater Misericordiae Mothers Hospital  
Mount Isa Child Health Centre  
North Queensland Division of General Practice  
Redcliffe-Bribie-Caboolture Division of General Practice  
Royal Women's Hospital, Brisbane  
Royal Women's Hospital, Brisbane  
Southern Rural Queensland Division of General Practice  
Southport Child Health  
Southport Child Health  
Sunshine Coast Division of General Practice  
Thursday Island Child Health Centre  
Thursday Island Hospital  
Toowoomba & District Division of General Practice  
Toowoomba Health Services  
Townsville Division of General Practice  
Yarrabah Community Health Service

## **South Australia**

Adelaide Central & Eastern Division of General Practice  
Adelaide Hills Division of General Practice  
Adelaide North East Division of General Practice  
Adelaide Northern Division of General Practice  
Adelaide Southern Division of General Practice  
Adelaide Western Division of General Practice  
Barossa Division of General Practice  
CAFHS—Maitland Child Health Centre  
CAFHS Coober Pedy  
Ceduna Hospital  
Child & Youth Health  
Eyre Peninsula Division of General Practice  
Flinders & Far North Division of General Practice

Mid North Rural SA Division of General Practice  
Murray Bridge CAFHS  
Murray Mallee Division of General Practice  
Riverland Division of General Practice  
Riverland Women's Health Service  
Royal Adelaide Hospital  
South East of SA Division of General Practice  
Yorke Peninsula Division of General Practice

## **Tasmania**

Bridgewater Child Health Centre  
Family, Child & Community Health  
Royal Hobart Hospital

## **Victoria**

Ballarat & District Division of General Practice  
Bendigo & District Division of General Practice  
Caulfield General Medical Centre  
Central Bayside Division of General Practice  
Central Highlands Division of General Practice  
Central West Gippsland Division of General Practice  
Dandenong & District Division of General Practice  
East Gippsland Division of General Practice  
East Grampians Health Service  
Goulburn Valley Division of General Practice  
GP Association of Geelong  
Greater South Eastern Division of General Practice  
Inner Eastern Melbourne Division of General Practice  
Inner South East Melbourne Division of General Practice  
Knox Division of General Practice  
Lilydale & Yarra Valley Division of General Practice  
Mallee Division of General Practice  
Melbourne Division of General Practice  
Melton Child Health Centre  
Monash Division of General Practice (Moorabbin Campus)  
Mornington Peninsula Division of General Practice  
Murray Plains Division of General Practice  
North West Melbourne Division of General Practice  
North-East Valley Division of General Practice  
North-East Victorian Division of General Practice  
Northern Division of General Practice  
Otway Division of General Practice  
Royal Women's Hospital, Melbourne  
Sherbrooke & Pakenham Division of General Practice

South Gippsland Division of General Practice  
Vic/NSW Border & Environs General Practitioners Division  
Wangaratta Hospital  
West Victorian Division of General Practice  
Western Melbourne Division of General Practice  
Westgate Division of General Practice  
Whitehorse Division of General Practice

## **Western Australia**

Belmont Child Health Centre  
Community and Child Health Services  
Eastern Goldfields Medical Division of General Practice  
Fremantle Division of General Practice  
Great Southern WA Division of General Practice  
Greater Bunbury Division of General Practice  
Halls Creek Community Health Service  
Kimberley Community Health Services  
King Edward Hospital  
Koorda CHC  
Kununurra Hospital  
Mid West Division of General Practice  
Osborne Division of General Practice  
Peel & South West Division of General Practice  
Perth Central Coastal Division of General Practice  
Perth Division of General Practice  
Perth South East Division of General Practice  
Rockingham/Kwinana Division of General Practice  
Swan Hills Division of General Practice

## **Community-based NGOs**

### **Australian Capital Territory**

Nursing Mothers' Association ACT

### **New South Wales**

Nursing Mothers' Association Casino  
Nursing Mothers' Association NSW

### **Northern Territory**

Nursing Mothers' Association Nhulumbuy  
Nursing Mothers' Association NT

### **Queensland**

Ms Lily Thompson  
Ms Lori Ryan  
Nursing Mothers' Association QLD

## **South Australia**

Nursing Mothers' Association SA  
Southern Areas Postnatal & Breastfeeding Support Service

## **Tasmania**

Nursing Mothers' Association TAS

## **Tasmania**

Baby Food Action Group  
Nursing Mothers Association of Australia (NMAA)  
Nursing Mothers' Association VIC

## **Western Australia**

Nursing Mothers' Association WA  
Special Projects

## **New South Wales**

Breastfeeding Project, North Coast Public Health Unit  
North Coast Public Health Unit NSW Health

## **Northern Territory**

Central Australian Aboriginal Congress Inc  
Strong Women, Strong Babies, Strong Culture program  
Healthy Kids, Healthy Families Project, Food & Nutrition  
Infant Feeding Education: Resource Review and Development

## **Queensland**

Ngua Gundi Community Health Service

## **Western Australia**

Kimberley Aboriginal Medical Service  
Peak Aboriginal and Torres Strait Islander Groups

## **Australian Capital Territory**

Council for Aboriginal Reconciliation  
NACCHO  
Winnunga Nimmityjah Health Service

## **New South Wales**

Armidale & Districts Services Inc  
Awabakal Newcastle Aboriginal Co-operative Ltd  
Binaal Billa Regional Council  
Bundjalung Tribal Society Limited  
HREOC Aboriginal and Torres Strait Islander  
Kamilaroi Regional Council  
Murdi Paaki Regional Council

North East Indigenous Regional Council  
South Eastern NSW/ACT Indigenous Regional Council  
Sydney Regional Council

## **Northern Territory**

Aboriginal Medical Services Alliance of the NT  
Alice Springs Regional Council  
Angurugu Community Government Council Inc  
Central Land Council (CLC)  
Daguragu Community Government Council  
Garrak-Jarru Regional Council  
Gurungu Council Aboriginal Corporation  
Ilpurla Council Aboriginal Corporation  
Intjartnama Aboriginal Corporation  
Jabiru Regional Council  
Julaikari Council Aboriginal Association Inc  
Maningrida Council Inc  
Miwatj Regional Council  
Papunya Regional Council  
Tangentyere Council Inc  
Tiwi Land Council (TLC)  
Warburton Community Inc  
Yapakuriangu Regional Council  
Yilli Rreuny Regional Council

## **Queensland**

Aboriginal and Islander Community Services  
ATSIC Regional Council  
Cairns & District Regional Council  
Charleville & West Areas ATSI Co-operative for Health  
Gallang Place Aboriginal & Torres Strait Islander Corporation  
Gehgre Aboriginal & Torres Strait Islanders Corporation  
Goolburri Regional Council  
Gumbi Gumbi Aboriginal & Torres Strait Islanders Corporation  
K.A.S.H. Aboriginal Corporation  
Kruungal Welfare & Resource Centre  
Milbi Incorporated  
Mookai & Rosie Bi-Bayan Aboriginal & Islander Corporation  
Mt Isa & Gulf Regional Council  
Mudth Niyleta Aboriginal & Torres Strait Islander Corp  
Mulungu Aboriginal Corporation  
Peninsula Regional Council  
South East Queensland Indigenous Regional Council  
Townsville Aboriginal & Torres Strait Islander Corporation

Townsville Regional Council  
Yaamba Aboriginal & Torres Strait Corporation for Men  
Yulu Burri Ba

### **South Australia**

ATSIC Regional Services Ceduna  
Corporation of the City of Port Augusta  
Indigenous Land Corporation  
Nulla Wimila Kutju Regional Council  
Patpa Warra Yunti Regional Council  
Wangka-Wilurrara Regional Council

### **Tasmania**

Flinders Island Aboriginal Assoc Inc  
Tasmania Regional Aboriginal Council  
Tasmanian Aboriginal Centre Inc

### **Victoria**

Binjirru Regional Council—Ballarat Region  
Binjirru Regional Council—Wangaratta Region  
Coranderk Koori Co-op  
Dandenong & District Aboriginal Co-operative Society Ltd  
Enmaraleek Association Inc  
Lake Tyers Aboriginal Trust  
Mildura Aboriginal Corporation  
Moogji Aboriginal Council  
Njernda Aboriginal Corporation  
Winda Mara Aboriginal Corporation

### **Western Australia**

Kaata-Wangkinyiny Regional Council  
Karlkarniny Regional Council  
Kullarri Regional Council  
Moorditch Kookaak Housing Project  
National Aboriginal Community Controlled Health Organisation  
Ngarda-Ngarlie-Yarndu Regional Council  
WA Association of Aboriginal Medical Services  
Western Desert Regional Council  
Wongatha Regional Council  
Wunan Regional Council

## State Health Departments

### New South Wales

Aboriginal Health Branch, Department of Health

### Northern Territory

Aboriginal Health Promotion, Territory Health Services  
Community Health Program

### Queensland

Aboriginal & Torres Strait Islander Health Unit  
Midwifery Outreach, Women's Health Program  
Torres Strait Regional Authority

### South Australia

Aboriginal Health Div, South Australian Health Commission  
South Australian Health Commission

### Tasmania

Aboriginal Health Council, Community & Health Services Dept  
Community Nutrition Unit, Community & Health Services

### Victoria

Health & Community Services—Southern  
Koori Health Unit, Dept of Health & Human Services

### Western Australia

Health Department of Western Australia  
Health Promotion, Aboriginal Health  
Strong Woman, Strong Baby, Strong Culture Project

## Aboriginal and Torres Strait Islander community-based groups

New South Wales  
Aboriginal Birthing & Breastfeeding Association (ABBA)  
Koolyangarra Family Group Home Aboriginal Corporation  
Nurwen Women's Association

### Northern Territory

Kalano Community Association Incorporated  
Kaltukatjara Community Council Aboriginal Corp  
Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY)  
Nganampa Women's Council  
Strong Women Project

### Queensland

Jundah Women's Information Service

## **South Australia**

Port Lincoln Aboriginal Women's Group Inc

## **Tasmania**

Karadi Aboriginal Women's Corporation

## **Victoria**

Goulburn Valley Koori Women's Resource Group

Murray Valley Aboriginal Co-op. Ltd

## **Western Australia**

Jarndu Yawuru Women's Centre

Strong Women Program

## Attachment 1

# Guidelines to consider for developing new projects

This section is based on the checklist used in the interventions review project to assess and describe services across Australia. The scoring system, or list of ideas, guided the selection of those services and projects to be included as case studies. It represents a summary of what the project team thought to be important elements for success. Since the first development of the checklist, additional ideas and comments have also been included. It has been put in an order that may help to guide you in planning and providing your service or project. It is also a good ideas to plan ways to evaluate your project from the time you first start consultations and developing strategies for service changes.

## 1. Information

Idea	Why?	How?	Comments
Talk to others	Their ideas might be useful ('Best practice' = a good idea that worked for others and may work for you)	Using this booklet as a starting point, get in touch with a project that looks like a good idea to you	Adapt good ideas you find elsewhere in Australia to develop a local model
Don't reinvent the wheel—even more importantly, don't reinvent the flat tyre	Others have already tried different ways of doing things—they may warn you about what is unlikely to work and possible pitfalls	Ask some of those working in this area to comment on your ideas and plans	We found a lot of enthusiasm to exchange ideas and experiences
Get a copy of the full 1997 interventions report <sup>8</sup>	This contains more service descriptions and further information such as useful references and reports	Contact OATSIHS	A report on training for health workers completed at the same time may also be useful <sup>9</sup>
Incorporate existing breastfeeding and infant nutrition guidelines, or consider developing your own	Lots of work has already gone into developing these; why not use them? By using this, you can concentrate on the specific needs where you are working	Look at the summary material in Appendix 2	There may be other guidelines and policies being developed at your State or local level that you could use

<sup>8</sup> 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 infant nutrition. Commonwealth Department of Health and Family Services, 1997.

<sup>9</sup> Audit of current training in breastfeeding support and infant nutrition for Aboriginal and Torres Strait Islander health workers and other health professionals providing health care to Aboriginal and Torres Strait Islander women. Commonwealth Department of Health and Family Services, 1997.

## 2. Approach

<b>Idea</b>	<b>Why?</b>	<b>How?</b>	<b>Comments</b>
Look wider than just the mother and baby—take a holistic approach	Many community factors affect breastfeeding and good infant nutrition	Consider the range of family members and community people involved—elders and other leaders, grandmothers, aunts and other senior women, fathers, teenagers, local health professionals, teachers, store workers, etc.	Consider what is needed so that mothers can actually make changes for themselves and their babies
Enlist community acceptance and support	This is essential for your service to work effectively	Involve communities in planning and design, and also implementation and evaluation if possible	With all the serious issues facing Indigenous people, communities may not immediately see breastfeeding and infant nutrition as a priority—discussing these issues may be important groundwork for your project
Look at your funding	If your project really is going to work, it should be sustainable in terms of longer-term funding	Cost things carefully before you start—look at ways you can include your project in an ongoing service or in some longer-term plans	Short-term funding has been a problem for many of those we contacted

## 3. How will the service be used?

<b>Idea</b>	<b>Why?</b>	<b>How?</b>	<b>Comments</b>
Look at access (can and will people use it?)	The best service in the world is of limited use if clients feel unable to use it	Ask yourself whether all the people you want to involve in the project/service will feel comfortable in using it and be able to get the full benefits of it	Consider people who are hard to reach, such as mothers who are young, live in remote areas, are homeless or unsupported, or who have problems with drug and alcohol misuse

## 4. Details of the service

Idea	Why?	How?	Comments
Specifically include breastfeeding promotion	There is a lot of advice available about bottle-feeding already, and other women in the family may have used this, making it important to give out good information	Make sure the staff on your project have the best and most up-to-date information Use some of the ideas in this booklet	Breastfeeding has an enormous effect on a baby's health and well-being (and also its later health when it grows up), so it is particularly important for small, weak, sick or premature babies, and those born to mothers with gestational diabetes
Consider a holistic primary health care approach	Integration with existing services (making it part of them or linked to them) makes it more likely to succeed	Plan with other services from the start	Liaise with other community resources, like drug and alcohol services, and make sure you work with them and have systems to refer people if necessary
Work out links with other health specialists	This can support what you are doing and allow you to get extra help in solving problems	Check what is available locally—lactation consultants, nutritionists, mother support groups (e.g. NMAA)	If links are well established, accessibility of your service can be increased
Incorporate ongoing data collection	Use this to monitor, evaluate and improve your service or project	Keep basic information on clients, choice of feeding and reasons for any changes	Formal evaluation is essential to give you feedback about your project—is it working? Can changes be made?  It can also be useful when seeking resources later and letting those providing funds know that your project is on track