



SIREN
WA Sexual Health and Blood-borne Virus
Applied Research and Evaluation Network



Curtin University

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Increasing Aboriginal women's engagement with antenatal care services to prevent congenital syphilis in Western Australia: Stories of success and lessons learned

Final report

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Acknowledgements

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The research team also thanks the regional Aboriginal Health Planning Forums and the Aboriginal Community Controlled Health Services that provided support for the study to take place in their regions.

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Acknowledgement of Country

We acknowledge the Traditional Custodians of the lands on which this research was conducted and recognise that these lands have always been places of learning for Aboriginal and Torres Strait Islander peoples. We honour and pay respect to all Aboriginal and Torres Strait Islander Elders – past and present – and acknowledge the important role of Aboriginal and Torres Strait Islander voices and their ongoing leadership.

Note on Language

This research was undertaken in Aboriginal communities in Western Australia and therefore the term Aboriginal has been used throughout the report out of recognition that Aboriginal peoples are the original inhabitants of Western Australia. The research team respectfully recognise Torres Strait Islander peoples also reside in Western Australia.

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Executive summary

This report presents the findings of a qualitative research study commissioned by the Department of Health, Western Australia (WA) in 2021 as part of the response to the ongoing syphilis outbreak in Australia. The purpose of the research was to collect data that would support improved engagement of Aboriginal women in antenatal care and postnatal care to prevent congenital syphilis. The research was conducted by the Sexual Health and Blood Borne Virus Applied Research and Evaluation Network (SiREN) team located at Curtin University in Boorloo (Perth), WA.

The issue

Australia continues to experience a syphilis epidemic which started in 2011 in northern Queensland, was first identified in WA in 2014, and is now endemic across many WA regions (1). Syphilis is a sexually transmitted infection that disproportionately impacts Aboriginal peoples. In 2021, the syphilis notification rate for Aboriginal peoples was more than five times higher than the rate reported for non-Aboriginal people (107.2 per 100,000 and 19.3 per 100,000 respectively) (2). Women of reproductive age account for 50% of syphilis cases in outbreak affected regions in WA (3). Untreated syphilis can have a range of adverse outcomes for pregnant women, including congenital syphilis (4).

Cases of congenital syphilis in WA have increased 180%, from June 2014 to December 2022 with nine of the 14 cases attributed to Aboriginal peoples (3). Contributing factors are many, but disrupted continuity of antenatal care or complete disengagement in antenatal care commonly feature in reviewed cases (5). Congenital syphilis is preventable if screening and treatment occur during antenatal and postnatal care. Western Australian clinical guidelines advise women are screened for syphilis three times during the antenatal period, with an additional two tests recommended at delivery and six weeks postpartum for women living in syphilis endemic regions (4). Syphilis remains a significant public health issue for Aboriginal peoples. This underscores the need for continued advocacy for culturally appropriate health care delivery for Aboriginal peoples.

Our research

- The research was conducted between May 2021 to May 2023, with participants purposefully recruited from WA regions affected by the syphilis epidemic (Figure 1).
- We yarned with Aboriginal pregnant women or mothers with a child under three years old about their experiences of antenatal and postnatal care, including syphilis testing.
- We also conducted semi-structured interviews with health professionals and collected stories of success and lessons learned in engaging Aboriginal women in antenatal care and postnatal care.
- Three experienced researchers conducted the interviews and yarns; two identified as non-Aboriginal. In one region, yarns were co-facilitated in local language with the assistance of a local Aboriginal female.

Ethical approval for the research was provided by the WA Aboriginal Health Ethics Committee (HREC1089) and the Curtin University Human Research Ethics Committee (HRE2021-0753).



FIGURE 1. Research participants

What we found

Our research offers valuable insights into Aboriginal women's perceptions and experiences of antenatal and postnatal care, and how maternal and child health care providers engage Aboriginal women in their services.

- Both Aboriginal women and health professionals identified **trust** as the key factor influencing successful engagement of Aboriginal women in antenatal care.
- Health professionals explained the critical importance of establishing trust with both pregnant Aboriginal women and the broader community. Strategies used to build meaningful and caring relationships included (among others): creating a culturally secure, private, safe space; and exhibiting a non-judgemental attitude and empathy.
- Successful engagement of Aboriginal women in antenatal care included: offering flexible and responsive health care delivery; immersing oneself in the community; increasing health literacy among young people (e.g., school visits); providing preconception care; and good inter and intra agency collaboration.
- Privacy and discretion were key factors in Aboriginal women's reports of positive antenatal care experiences. For some Aboriginal women, pregnancy was a particularly private experience, not celebrated nor shared with others. The provision of private and confidential maternity care helped to minimise feelings of shame experienced by some Aboriginal women.
- There was a genuine desire among Aboriginal women to ensure their babies are healthy. Family and kinship groups provide an important source of health information and motivation to engage in services. Health literacy, along with hearing the baby's heartbeat or seeing the foetus on an ultrasound machine, also influenced engagement in antenatal care.
- A culturally safe clinic space (separate from the main waiting area) and friendly welcoming staff who offered holistic responsive care that addressed women's most pressing needs, was important to Aboriginal women.
- Syphilis knowledge varied among the women, with some women unable to confirm if they had been screened for syphilis during or post pregnancy. Health care professionals offered information and syphilis testing, however receiving multiple tests during an appointment and low levels of English literacy may have impacted information recall by women.
- No challenges were conveyed by health care professionals with engaging women in antenatal syphilis testing, providing a trusting relationship had been established. Good collaboration between midwives and child health nurses facilitated postnatal syphilis testing, however this was generally limited. Some health professionals had low awareness of available resources for syphilis education and limited or inaccurate understanding of some aspects of syphilis testing. This was unsurprising given the complexity of syphilis testing.



Key areas for action

Findings from this research reveal how health care delivery could be improved to engage Aboriginal women in syphilis testing during antenatal care.

Five key areas for action are presented (see Figure 2). Each action area contributes to the enhancement of trust and culturally secure health care provision. This will increase engagement in antenatal care and the likelihood of pregnant women completing the recommended syphilis testing regime.

Example actions are suggested based on the data collected and previous studies, however, these are not prescriptive.

We acknowledge the diversity that exists across Aboriginal communities and emphasise the need to work in partnership with Aboriginal communities to identify issues of concern and co-design localised, community driven responses (6). In doing so, impactful and sustainable change will be realised.

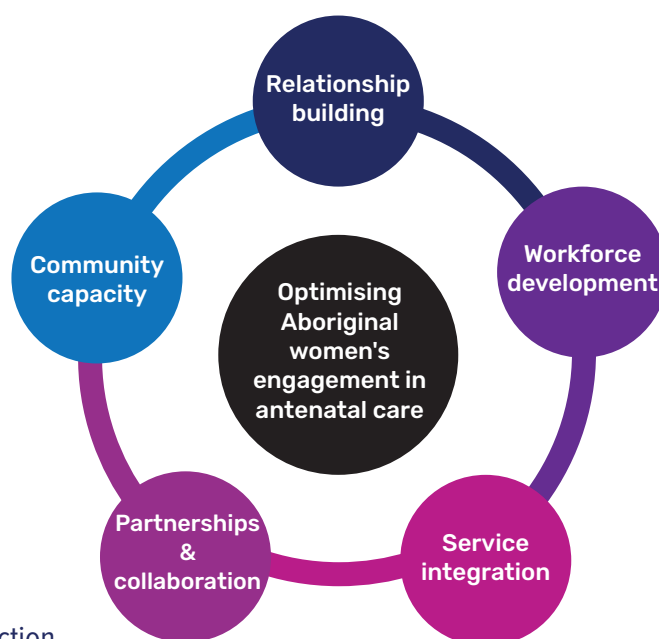


FIGURE 2. Key areas for action

Many of the health care professionals we spoke with are committed to culturally appropriate health care delivery, however, their efforts are sometimes limited by the rigidity of policy requirements. The findings from this research project reinforce previous calls to work alongside Aboriginal communities to co-design solutions that work for local communities to engage safely in healthcare services (24).

Importantly, a commitment to the five key areas for action outlined above will have positive implications beyond the prevention of congenital syphilis. It may also facilitate improved outcomes across the spectrum of maternal and infant health for Aboriginal communities.

Five key areas for action



1. Relationship building

Encourage and support health care professionals to foster relationships with local Aboriginal communities, for example by including relationship building in reporting requirements. Aboriginal peoples will seek information from, and share information with, trusted providers (7, 8, 9, 10, 11). Investing in relationships in early adolescence enables timely provision of preconception care, which can improve the uptake of antenatal care services and birth outcomes (12, 13).

“

... when I first started there'd be people who'd come in and they'd be a good portion of the way through a pregnancy before they first came to the clinic. But when I'd been there for some time, these teenagers were coming in and asking to have their Implanon removed to start a pregnancy. So we were engaging them before they even got pregnant ... So they were in touch with us regularly while trying to conceive, keeping in touch with us ... and just being able to touch base with them ... it just helped so much. And instead of being reactive with the patients once they were already pregnant, we were being proactive and they were being tested [for syphilis] before they even conceived.” (Participant 6, Health Professional)

“

... when I was interviewed for my position, working with women, I was actually interviewed by our Health Reference committee, female women members at that time, so I was interviewed by six Aboriginal women, senior women. And they instructed me on how it was to work. So they would call me, health workers would ring me and say, a different name, given a bush name then, 'What are you doing when you come in? So, I'll discuss plans with them. I was prompted not to work unless I had one of them with me, which I always did. It was a very different environment to the way people work now.” (Participant 13, Health Professional)

2. Workforce development

Enhance the cultural capability of health care professionals by offering relevant ongoing training and appropriate induction when commencing work in a new community. Improving the cultural competence of non-Indigenous staff can support Aboriginal women to feel safe to access antenatal care (8, 14, 15). In addition, syphilis testing protocols can be confusing. Ensuring currency of clinical knowledge by offering regular training in varied modes of delivery and ensuring new staff are aware of available resources is required.

“

(they) have an evening ... where the age group range is sort of like between 11 and 16 ... it's actually sort of like a very girly night. They do their hair or they wash their hair or they have little massages or they paint their nails or they make something ... I'm invited to go because there's subjects that we talk about which are private, which are women only, and we talk about ... coercion, consent. We talk about periods, breasts, boys ... They've asked me what happened in my rooms. Do they want to come across and have tests, and we'll do breast checks, we'll do STI screenings ... things are normal, natural, but positive in the way of how it's discussed.” (Participant 10, Health Professional)

3. Service integration

Reorient health service delivery to offer health promotion and antenatal/postnatal care in non-clinical settings (e.g., local playgroup) and provide health information during other activities where Aboriginal women congregate (e.g., women's groups; bush picnic). This will encourage the development of trusting relationships with women in the community and ensure that service delivery is more congruent with cultural norms. Previous research has also reported on the importance of extending services beyond the confines of the clinic setting to engage Aboriginal pregnant women, such as offering education while searching for bush tucker (16).

4. Partnerships and collaboration

Enhance collaboration between health care provider roles within and across services to increase continuity of care. Familiarisation of Aboriginal women with key health care providers during the antenatal period, delivery, and post-delivery; establishing partnerships with other services to facilitate referrals that women may need (e.g., refuges, healing, childcare); and supporting holistic healthcare delivery demonstrates care. Continuous care supports the engagement of Aboriginal women in antenatal care and facilitates a positive antenatal care experience (7, 8, 10, 17, 18). When continuity of care by an individual may not be feasible, continuity within a team can help mediate the impacts of high staff turnover (7).

“

... every Wednesday the obstetric GP from the hospital – there's usually about four at any given time – they come across here and run an antenatal clinic here ... So, they [local women] get seen here ... by the obstetric doctors from the hospital ... so they're obviously then the doctors that go onto then birth them in hospital, if they are able to birth here. Then I also have regular meetings with those doctors as well as ... the head of obstetrics ... and I have monthly meetings with them, and we discuss all our high-risk clients ... So, it's continuity of care ... the clients are familiar with them.” (Participant 3, Health Professional)

“

... there is an Indigenous liaison officer who has access to a car. So, I work very closely with her –at the beginning of the week I might say, 'Right, these [women] are our absolute priorities for the week' or 'I actually need to get that woman back in today. She's aware of it. She just needs a lift' or it's literally 'Can you go and find this person and just wherever they are, bring them in at any time. Don't worry if I've got appointments booked all day, just bring them in because they're only in town for two seconds so we've got to grab her while we can.'” (Participant 3, Health Professional)

5. Community capacity

Build the capacity of community members to have a key role in improving health literacy within the community and enhancing the cultural safety of health care services. Family and kinship groups play a critical role in supporting women during pregnancy and are often a key source of health information and motivation to engage with maternal and child health care services. Employment of local community members as health coaches, birth and/or travel companions, or cultural brokers/patient advocates helps to ensure Aboriginal pregnant women receive optimal clinical care in a culturally safe manner, resulting in improved health outcomes. A plethora of research reports on the value in adopting a bicultural approach to antenatal care (16, 18, 19, 20, 21, 22, 23).

Introduction

Since 2015, the Australian Government has declared an infectious syphilis outbreak in central and northern Australia, which includes regions in Queensland, Northern Territory, South Australia and WA (25). Aboriginal peoples are disproportionately affected by the outbreak. In 2021 the syphilis notification rate for Aboriginal peoples was more than five times the rate reported for non-Aboriginal people: 107.2 per 100,000 and 19.3 per 100,000 respectively (2). Women of reproductive age account for 50% of syphilis cases in outbreak affected regions in WA (3).

Syphilis infection is caused by the bacteria *Treponema pallidum* and is most commonly transmitted through sexual contact (4, 26). Congenital syphilis is passed from mother to baby during childbirth or foetal development (26). Cases of congenital syphilis in WA have increased 180% from June 2014 to December 2022 with nine of the 14 cases attributed to Aboriginal peoples (3). While congenital syphilis typically results from complex circumstances, disrupted continuity of antenatal care or complete disengagement from antenatal care are commonly identified contributing factors (5).

Syphilis screening and treatment of pregnant women reduce the likelihood of negative birth outcomes such as



miscarriage, stillbirth, premature labour, and congenital syphilis in the neonate (4). Clinical guidelines advise that pregnant women living in WA are screened for syphilis at their first antenatal visit, 28 weeks gestation, and 36 weeks gestation, or at time of preterm birth (27). Two additional tests are recommended at delivery and six weeks post-partum for women living in syphilis endemic regions.

The most common models of maternity care in Australia in 2022 were public hospital maternity care (40.4%), shared care (15.3%) and midwifery group practice (14.8%) (28). Providers of antenatal care in WA in regional, remote, and very remote locations are Aboriginal Community Controlled Health Services (ACCHSs) and the Western Australian Country Health Service (WACHS). Midwives, general practitioners, and remote area nurses provide antenatal care (7, 26). In some cases, Aboriginal Health Workers may engage with antenatal care staff to increase cross-cultural knowledge and communication skills.

Aboriginal women traditionally seek guidance from female relatives for pregnancy and childbirth, which is considered 'women's business', before seeking antenatal care (29). Women may delay or miss antenatal care due to family duties, limited transportation access, the belief that early care is unnecessary (particularly if they have no adverse symptoms), or the absence of family to help (14, 29). Feelings of shame can also impede engagement in antenatal care, particularly for young or first-time pregnant Aboriginal women (10, 14). A positive relationship and trust with their antenatal care provider is crucial to antenatal care engagement for Aboriginal women (7, 8, 9, 10). For example, Aboriginal women in the





WA Kimberley region appreciated qualities such as being friendly, caring, pleasant to talk to, allowing sufficient appointment time, and having clear communication from their antenatal care provider (7).

In remote WA, low or medium-risk births occur in major town hospitals, requiring travel by vehicle, bus, or charter flight (7, 30). Regional hospitals struggle with discontinuity of staff and lack of coordination between services, especially for Aboriginal pregnant women seeing different clinicians (14). High-risk pregnancies require relocation to Perth four to six weeks before the due date to give birth at a tertiary hospital, which can limit cultural practices and time with family (7, 29). Two research studies involving Aboriginal women from across several WA regions found that Aboriginal women face challenges when relocating for childbirth, including feelings of isolation and loneliness due to the lack of a support person, transport difficulties, and inadequate accommodation options which greatly detracted from

the antenatal care experience (7, 29). Concerns about being separated from family for an extended period of time due to relocation are particularly prevalent among young Aboriginal women, with reports that some avoid antenatal care in the final weeks of their pregnancies and then present at the health service when in labour (29). For birthing Aboriginal women, the presence of family members and the support and comfort they provide represents a great source of strength. Place of birth is also important in maintaining one's connection to country (31).

'Birthing on country' is another model of maternity care (31). Evidence suggests birthing on country would improve maternal and infant health outcomes in Aboriginal people as it maintains a connection to home and country and facilitates engagement in cultural practice. However, there has yet to be progress towards establishing and evaluating birthing on country services (31, 32, 33).

Methodology

Research design

This qualitative research study took place over two years and explored the antenatal and postnatal experiences of Aboriginal women in metropolitan, regional, and remote WA. The study was guided by a social constructivist epistemological theoretical position which requires the researcher to accept that every individual has a unique set of social relationships and interactions which shapes their lived experience, and that there is no universal reality, multiple realities exist (34).

Three researchers from Curtin University conducted the study; one researcher identified as Aboriginal. All investigators were experienced in qualitative research methods and Aboriginal health research or sexual health research. The study was completed in May 2023.

To garner support for the study, answer any questions, and collect feedback to inform the ethics submission (including the data collection tools), the researchers presented the research protocol to the Aboriginal Health Council of Western Australia Clinical Leadership Meeting (June 2021), the Sexual and Reproductive Health Sub-Committee (August 2021) and the Maternal, Child, Youth and Family Sub-Committee (September 2021).

All ACCHSs in WA regions affected by the syphilis epidemic were approached to participate in the study and services expressing interest requested Board approval for engaging in the research. Delays in obtaining approvals were experienced by some services due to restricted capacity and resources during and after the peak of the COVID-19 pandemic. Letters of support from seven ACCHSs and approvals from two regional Aboriginal Health Planning Forums were obtained. Four regions were able to participate during the study timeframes.

Ethical approval for the study was provided by:

- Western Australian Aboriginal Health Ethics Committee (HREC1089, November 2021)
- Curtin University Health Research Ethics Committee – Reciprocal (HRE2021-0753, December 2021).

Data collection involved semi-structured interviews with health professionals involved in delivering antenatal and postnatal care and one-to-one yarning sessions with Aboriginal pregnant women and mothers. Yarning is an Indigenous form of conversation and provides a rigorous and culturally appropriate method of data collection with Indigenous communities (35).

Yarning sessions with Aboriginal women

Purposeful sampling was used to recruit Aboriginal pregnant women and Aboriginal mothers aged 16–39 with a child or children under three years old, who were living in remote, very remote and metropolitan regions of WA, as defined by the [Australian Bureau of Statistics](#). The research team were reliant on the support of participating ACCHSs for recruitment. The majority of women were recruited through the networks of healthcare staff in participating ACCHSs who had existing relationships with Aboriginal women. The capacity of ACCHSs to support recruitment of women varied and there was lower participation than anticipated. Attempts to recruit Aboriginal women using social media also had limited success. Two participants responded to a social media post on Facebook posted by the Aboriginal Chief Investigator.

A yarning guide was developed using a holistic framework to align with Aboriginal views of health, whereby participants were invited to yarn about their pregnancy journey more broadly before focusing on syphilis. Some of the questions were loosely modelled on previous studies (29, 36, 37) and explored participants' sources of support (e.g., "Who has supported you during your pregnancy?") and pregnancy knowledge (e.g., "What do you do to keep yourself and your unborn baby healthy?"). Questions also enquired about access to antenatal and postnatal care, including barriers (e.g., "Is there anything that makes it difficult for you to visit the clinic?") and facilitators (e.g., "What do you find helpful when visiting the clinic?"). Awareness of, and attitudes to, syphilis testing were discussed towards the end of the yarns (e.g.,

"Do you think it's important that pregnant women get tested for syphilis and other STIs during pregnancy?"). Feedback on the guide was sought from an Aboriginal health research team, specifically a female employee who met the eligibility criteria for the study, and was incorporated into the yarning guide. Health professionals from the participating ACCHSs, involved in the delivery of maternal health services, were also invited to review the yarning guide to ensure appropriateness for Aboriginal women in their communities.

Participants were given an information sheet to read or have read to them and asked to sign a consent form if they agreed to participate in the study. Yarns with women were conducted by phone or in person and in English, where possible. Yarning circles had been anticipated for groups of women attending services, however women's preferences were for one-on-one yarns with the interviewer, in private.

In one remote community, a local playgroup and health clinic provided culturally safe and familiar venues with private rooms for researchers to meet with women and conduct yarning sessions in person and confidentially. Women could bring their children into the room where yarns took place. Morning tea was offered to all women and children attending the playgroup when yarns were taking place, whether they participated in the yarns or not (Figure 3).

Also in this community, a local Aboriginal woman provided invaluable assistance to recruit and transport women to yarning sessions and co-facilitated several one-to-one yarns as an interpreter for women who had low levels of English literacy. The interpreter was recommended to the research team by the local ACCHS

who often worked in collaboration with her when seeking to engage the community in research and health promotion activities. The interpreter had strong family ties to the community and was fluent in the local dialect. Payment was provided to the interpreter for her time and expertise.

During the yarns, the interpreter positioned herself alongside the participant and, when needed, would translate the questions asked in English by the researcher into local dialect. The interpreter would then translate the participant's responses into English. To confirm the accuracy of the information received, and for the purposes of the audio recording, the researcher would often repeat the translated information from the interpreter in simplified English to the participant and ask for verbal confirmation.

The presence of a local interpreter facilitated the research process in two ways: minimising barriers to participation for women for whom English was not a first language; and helping to create a culturally safe space for the women to talk about their pregnancy and birthing experiences in their own language. Although the interpreter was key to securing the participation of local women, the research team concede there may be limitations with the data collected from these yarns. The limitations section of the report speaks further to this point.

Duration of yarns ranged from 12 to 59 minutes. The average duration of the yarns with women was 33.8 minutes. To thank women for their time and participation in the study, they each received a \$40 grocery voucher, either a voucher for the local grocery store in their community or an e-gift card.



FIGURE 3: Morning tea during a yarning session

Interviews with health professionals

A combination of purposeful and snowball sampling was used to recruit health professionals for interviews. Personalised email invitations were sent to all health professionals working in the participating ACCHSs and delivering or supporting maternal health services, including doctors, midwives, maternal and child health nurses, health promotion officers, and Aboriginal Health Workers. Follow up emails and/or phone calls to potential participants were often needed. Recruitment continued until data saturation was reached, with consistency in the type of information arising.

An interview guide was developed to capture stories of success (e.g., "Describe a situation where you were successful in engaging a pregnant Aboriginal woman in antenatal care") and lessons learned in engaging Aboriginal women in antenatal and postnatal services (e.g., "What have you or your service tried in the past that did not work so well at engaging pregnant Aboriginal women in antenatal or postnatal care?"). The importance of developing trusting relationships with women in the community was explored given previous research highlighting trust as a critical element for engagement with Aboriginal communities (7, 8, 9, 10, 11). Health professionals were also asked to describe their experiences conducting syphilis testing, best practice for engaging Aboriginal women in antenatal and postnatal care, what would help them to perform their role more effectively, and if there were other models of care that they would like to see trialled in their community. Previous work by Kirkham et al. (21) aided the development of some interview questions.

All interviews were conducted individually, either in person or remotely via phone or online using Microsoft Teams. Duration of interviews ranged from 34 to 144 minutes. The average duration of interviews was 64.3 minutes.

Data analysis

Audio-recordings were transcribed verbatim using a human transcription service and transcripts were checked against the recordings and corrected if needed. Data were aggregated into two datasets for analysis: 1) Aboriginal pregnant women and mothers, and 2) health professionals. NVIVO 12, a data management software tool (38), was used to manage the data.

Yarning and interview data were thematically analysed using an inductive approach guided by Braun and Clark (39), which means that no theoretical framework or assumptions were used to guide the analysis. Transcripts were read and re-read several times and codes were assigned to any content that was relevant to the research aims. Related codes were grouped together and checked for any duplication before developing key themes. Each member of the research team independently coded a sample of the transcripts. The researchers convened as a team on four occasions to critically engage with emerging themes and to reach a consensus on appropriate language. Example quotes from research participants were extracted from the transcripts to illustrate key themes.

Ethical considerations

Yarns and interviews were audio-recorded with participant consent. Consent to use photographs of participants was also obtained. Audio-recordings were deleted once transcripts had been checked and corrected. Transcripts were deidentified and each transcript was given a unique participant code.

All identifying data have been removed in the presentation of the participant quotes in the findings to protect participants' identities and confidentiality. This includes participants' names and ages, names of regions or communities where participants were located, details of partners/other individuals known to participants, details of specific patients or events that could be identifying, and roles/length of service in roles for health professionals. Services participating in the research will not be named, nor the regions where they are based.

Hard copy consent forms were scanned and then destroyed. All electronic data, including consent forms, photographs, NVIVO files, and audio recordings were stored securely in a designated folder on the Curtin University Research drive that is only accessible to the research team.

Aboriginal women's attitudes to and experiences of antenatal care and postnatal care including syphilis testing

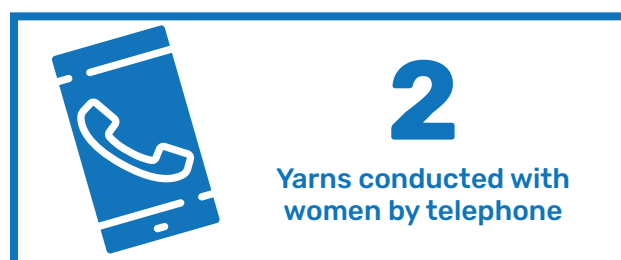
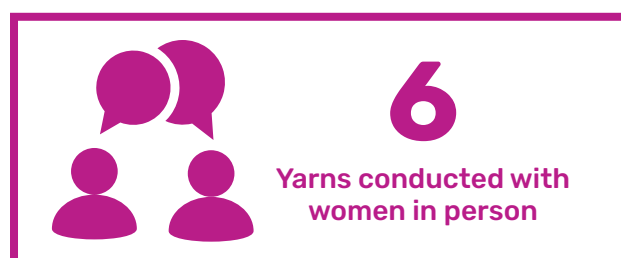
“
I think I did
everything I could ...
with my pregnancy
to make sure
everything was
right.” (Participant A)

Presenting the findings emerging from the yarns with Aboriginal pregnant women and mothers first was intentional. The authors wanted to privilege the voices and experiences of the Aboriginal women who trusted them with such personal stories. Some participants had very low English literacy and were able to participate in their local language aided by an interpreter, a local bilingual Aboriginal woman known to the women.

The limited availability of data did not allow an in-depth thematic analysis. Despite the brevity of women's responses, there was consistency in the experiences reported.

Participant demographics

Yarns were conducted with eight women either in person (n=6) or via telephone (n=2). An Aboriginal female interpreter assisted with four in-person yarns conducted in local language. Seven women were mothers of a child aged three years or younger, while one woman was pregnant with her first child. The participants resided in three of the four participating regions.



Of the seven women who had given birth, five were required to travel to another community for delivery due to the lack of birthing facilities in their community. The travel typically occurred four weeks prior to the women's expected due date, with the expectant mothers unable to travel with other dependants, and in some instances, without a support person.

What is women's experience of pregnancy?

Women received support during their pregnancies, from partners, female family members (e.g., mothers, aunties, sisters), male family members (i.e., fathers and brothers), and friends. Type of support received included emotional support, informational support, and practical support.

“

The father of my child he was unemployed at the time, but as soon as he found out I was pregnant - he was smoking, drinking you know - he stopped that and he got a job to sort of support me, pretty much cold turkey. Which was really hard for a bit since he was battling addiction and things. And yeah, everyone around me, so family, close friends, my brothers, and my dad they supported me mentally, physically, emotionally. Helping me clean, bringing me groceries when I got really big.”

(Participant B)

Women's support networks, along with health service staff, facilitated understandings of what constitutes a healthy pregnancy, providing information on food and drinks to avoid, the impacts of stress on the unborn baby, and the risks of smoking and illicit drug use. Some women proactively sought the information they required, for example using Google.

“

My sister would just tell me always to be careful, eat good food. Always when we went out bush ... she'd be like 'Oh, this is good for the baby, eat this. Oh, don't eat that.'

(Participant H)

Information women acquired during their pregnancies encouraged the adoption of healthy behaviours to ensure the health and wellbeing of their unborn babies.

“

... I smoked a little bit before getting pregnant, but then when I became pregnant, I stopped completely ... I tried to walk a lot, eat healthy food, tried to keep up with all my vitamins and stuff. I just tried to do everything the right way.” (Participant H)

“... I drink [alcohol] a lot when I wasn't pregnant ... I mean for up to like 20 weeks it was like I was always wanting a drink, but then as baby got bigger and pregnancy got more exciting ... like it wasn't in my mind anymore.” (Participant A)

How do women engage with antenatal care?

Women generally agreed that antenatal care was important, with one participant noting, *“To keep them [unborn baby] healthy. And not to pass anything [infections] on.”* (Participant F). Most women reported regular attendance at antenatal care appointments, with some seeking additional appointments, *“I think most of the people I know are in the same boat as me and some people wanted more and more appointments to see how things are going.”* (Participant A).

Extrinsic motivators to engage in antenatal care, such as encouragement by female family members, *“My niece ... And mother ... She told me I had to come and get checked”* (Participant G), typically aided initial presentation at the clinic, reinforcing the important role of family in supporting women during pregnancy.

“

The midwives there, they know family ... they delivered or helped with people in your family ... and my aunty says they're really helpful, 'Hope you get this person, or you can talk to this person.'” (Participant A)

Intrinsic factors, namely connecting with their unborn baby and seeking reassurance that their unborn baby was healthy, *“Coming here to see baby on the ultrasound ... They make sure I'm good and healthy.”* (Participant F), typically facilitated the women's subsequent engagement with antenatal care providers, *“For me, it [clinic visits] was a good thing for reassurance. But for just checking up on the baby, keeping the baby healthy.”* (Participant H).

What do women like about their antenatal care experience?

The attitudes of, and care provided by, health service staff along with privacy and discretion were key factors in the women's reports of favourable antenatal care experiences. Staff who had integrated themselves in the community and invested time and energy in developing relationships with community members were trusted by the community, "... just more engagement [with the community] because I feel like that goes a long way." (Participant H).

“The midwife I had, she was pretty good, really engaged with the community ... she always used to go to the playgroup and engage with the kids and the women there and they always knew her ... they had a lot of respect and trust for her ...” (Participant H)

A friendly, welcoming attitude was also an attribute women favoured in health service staff that helped create a safe environment, "... definitely the workers ... Their attitude it really does make a difference, like just the way they talk, if they're really happy, and they greet you." (Participant B)

The type of care provided to the women was also key in determining how the women perceived their

antenatal care experience. Providing holistic, responsive, continuous care was important.

“

My first midwife ... she worried about, not just the house and me, but she ... also talked to me about situational things and what's going on with my life and planning and things. And even suggested a couple of groups and stuff ... they introduced me to everyone that would be helping me pretty early on and I kept seeing the same people. And they were also linked in with the midwives at the hospital.” (Participant A)

Privacy and discretion were particularly important to the women, "It's private ... a lot of girls go there [clinic]. Not only me." (Participant F), and having a separate space for the antenatal care appointments provoked feelings of comfort and safety, "... it [clinic] felt comfortable at the back just because [sic] not a lot of people." (Participant H).

Interpreter for Participant C: "... a lot of people use that clinic [in remote town], that's why she felt a bit shame... uncomfortable. Here the clinic, the room is at the back... here is a bit more private."

What do women find difficult about antenatal care?

Women mainly reported positive pregnancy experiences, however some women experienced a lack of culturally safe care, "At [hospital] I didn't get referred to any Aboriginal-owned antenatal care groups, or anything like that, or see any Aboriginal workers." (Participant B). Particularly in terms of language barriers and the lack of cultural responsiveness among some health service staff.

Interpreter for Participant C: "Even when the nurses or doctors giving information, they [Aboriginal women] can't process it properly because it's all big, different words."

Similarly, fear of judgement and feelings of shame were reported, which for some women could impede engagement in antenatal care, "... they [women] don't feel comfortable going [to the antenatal clinic] because they might be judged." (Participant D)

Some women also spoke of how the attitudes and treatment of health care staff tainted their pregnancy experience.

The first doctor [male doctor] I went to, after I got pregnant, ... the first question was, 'Oh, so what do you want to do from here? Do you want termination?' I was like, 'No, I don't think I want to, I think I want to keep it,' ... from then on, I tried my best to book appointments with

female doctors, but a lot of those were booked out most of the time.” (Participant B)

Practicalities, such as the cost of antenatal care and transport limitations, featured in some of the women's pregnancy experiences.

“... I didn't know ... that you had to pay for your own ultrasounds, and they were about a few hundred, or something, dollars at the time ... It was lucky I had money in my bank because I was working, but what if I didn't, I'd have to walk out and just book it the next time.” (Participant B)

“It was just a bit hard trying to get everywhere. You've got to go to a different place for the doctor and then to the scan and then there's heaps of people there and it wasn't ideal for me.” (Participant A)

The lack of postnatal care and support was also mentioned:

“

... after I had the baby I didn't have that ... support from the clinic ... I was struggling with breastfeeding. I did feel a bit sad ... having that type of support out here [remote community] would be really good.” (Participant H)

How did women think antenatal care could be improved?

Dominant in the women's suggestions for optimising the pregnancy and birthing experience was the need for culturally safe antenatal care. The employment of Aboriginal workers at the clinics/health services, including in a postnatal support role, was suggested, “... probably give us more access to Aboriginal owned clinics, I guess, and have more Aboriginal workers, like more diversity in the clinics.” (Participant B)

“

It would be good if there were [Aboriginal health workers] ... some girls don't know ... they ought to come to the clinic. They can get help from the Aboriginal person to get them to come. In our language.” (Participant F)

Acknowledging the challenges that exist in increasing the number of Aboriginal staff in healthcare, often due to a small pool of applicants, the need to ensure the cultural competence and sensitivity of non-Aboriginal staff was apparent.

“... maybe more understanding so that when I did cancel, they'd pretty much be like – not say it directly, but gave me the attitude, like ‘This is your fault, make the next appointment.’” (Participant B)

Having a private space for antenatal care appointments along with culturally appropriate resources were further suggestions for ensuring culturally safe antenatal care delivery.

Interpreter for Participant C: “She's saying that for her, it's the privacy ... she said if it [antenatal care room at clinic] was a bit more like ... away from everybody else ... Yeah, she'd feel a little bit better.”

“

Probably stuff like posters, because when you're sitting there in a waiting room ... I just like look around and look at the posters, and booklets sometimes. Yeah, probably when a woman first gets pregnant, giving her those types of booklets, information sheets, or even just telling her about the risks, about STIs, especially syphilis, would definitely make a difference, I'd say.” (Participant B)

Although the focus of the research was limited to the engagement of Aboriginal women in antenatal care, the women spoke of the need to educate men in sexual health, with one participant noting the value in employing a male sexual health nurse.

“But it'd be good for the men to have something like that [men's health information sessions], they don't have anything like that. They should get a sexual health male nurse here. Or putting them [someone local who's Aboriginal] through a bit of training – but still having someone there to assist, like a staff.” (Participant H)

What is women's knowledge of syphilis and attitudes and experiences of syphilis testing?

Some women reported knowledge of syphilis, including the impacts on the mother and unborn child, while others had limited or no knowledge. High school, clinic staff, and resources within the clinic were the common sources of syphilis knowledge.

“I've heard about it [syphilis], probably in high school ... I know it's an STI ... I don't know exactly what it does to a person, or anything.” (Participant B)

Some women reported they had been tested for syphilis while others were unsure or could not remember if they had been tested or not.

“

I don't know about syphilis but they were testing me heaps but I didn't think – I don't think anybody told me.”

(Participant A)

Common among the women's experiences was confirmation that blood and urine testing occurred during pregnancy, but understanding the reasoning for such tests was often absent, *“I thought they were just taking blood ... for the baby ...”* (Participant H)

This compliance with testing further illustrates the degree of trust women instil in health professionals when pregnant, with one participant (Participant B) remarking, *“No. I feel like – I did trust them”* when asked if she considered declining any of the testing offered to her during her pregnancy.

Following a brief discussion about the harms of syphilis to the mother and unborn child, women agreed that syphilis testing was important along with information about the risks associated with syphilis during pregnancy, *“... we should be more informed about it [syphilis] ... So, we know the dangers, and everything, and what's going on in our community ...”* (Participant B)

Engaging Aboriginal women in antenatal care and postnatal care including syphilis testing – what works

“Because these women as much as any women in the planet, they want to do the best for their babies.” (Participant 12)

Participant demographics

Fourteen semi-structured interviews were conducted with health professionals (13 females; 1 male). These included clinical staff: nurses (i.e., registered nurse, maternal and child health nurse); midwives (including dual role midwife and child health nurse); doctors (i.e., general practitioner, obstetrician) and one non-clinical role (health promotion). Interviews were conducted individually via telephone and via Microsoft Teams.

Two participants identified as Aboriginal and/or Torres Strait Islander. No language barriers were evident in the interviews, with English a first language for all participants.

Apparent across the participant group was the passion the health professionals possessed for their work, the care and compassion they demonstrated towards their patients, and a genuine desire for equitable and accessible health care delivery for Aboriginal women and the wider Aboriginal community.

It is important to acknowledge the context within which the participants worked. Participants were having to balance the demands of two different ways of working: a non-Aboriginal westernised medical model together with Aboriginal ways of doing and being. Further to this, the impacts of past policies on Aboriginal peoples and the subsequent socio-economical and health inequities many Aboriginal peoples currently experience, also contribute to how Aboriginal women engage with antenatal care services and staff.

Five key themes were generated from the data collected during in-depth interviews with health professionals (Figure 4). There were points of convergence between the findings from the yarns with Aboriginal pregnant women and mothers and the interviews with the health professionals, further strengthening the integrity of the emergent themes.

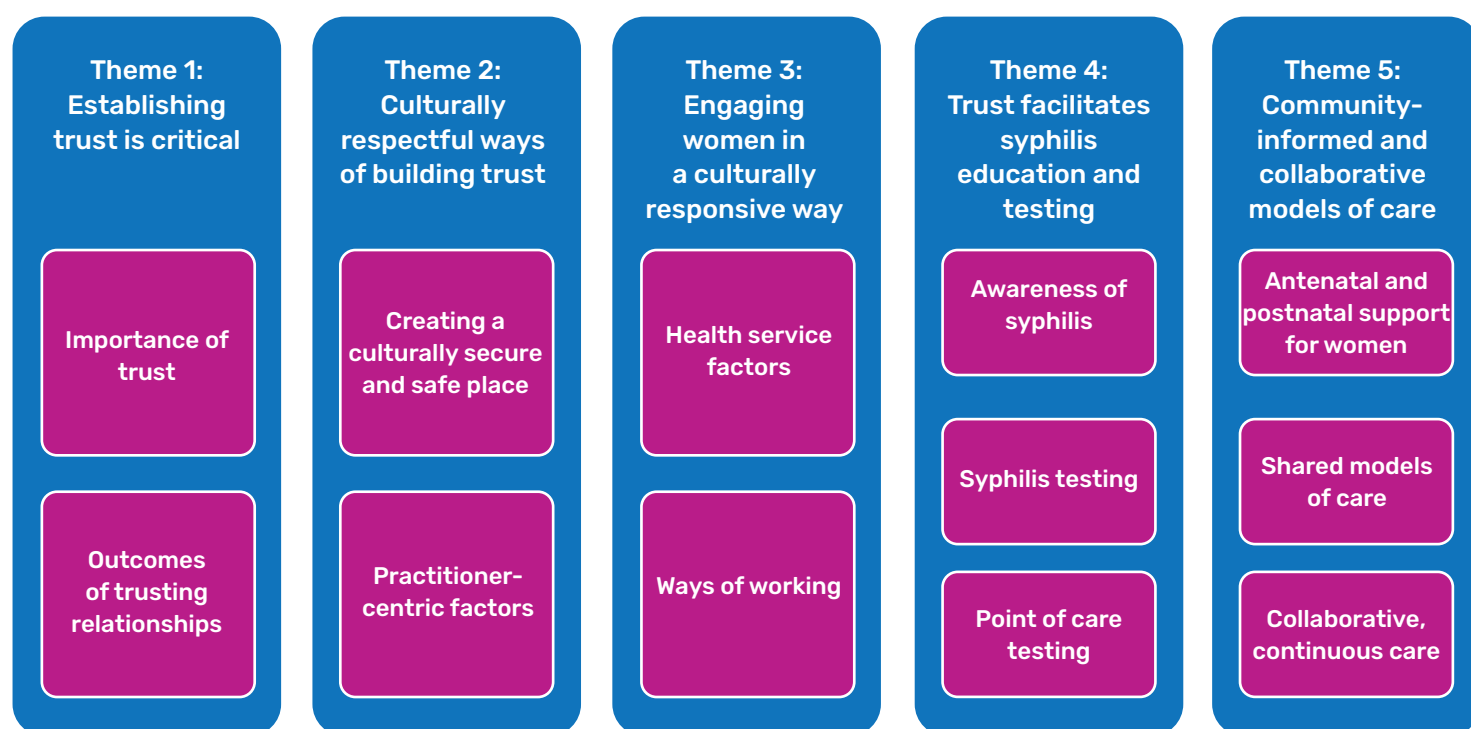


FIGURE 4. Key themes from interviews with health professionals

Key theme 1: Establishing trust is critical

Pervasive throughout the health professionals' discourse was the importance of trust when working with Aboriginal peoples.

“The trust is the most important part of working with community. They have to trust not just you but also the service.” (Participant 8)

“I think it's important that the women trust us as practitioners, and that they feel safe as a consequence of that trust, and also that they feel trusted and believed in ...” (Participant 3)

Participants also remarked on the considerable time investment involved in establishing trust with community.

“

I can say for sure I remember that it took about nine months of me turning up to community regularly, before people really started to let their guard down around me and trust that I was going to keep coming back, and to be bothered telling me their story and getting to know me.” (Participant 6)

“... if you don't build up that trust and that relationship with them, then ... they're not going to come back to you, they're not going to talk to you, they're not going to tell you when things are not great. You know, like when I first meet women, some women will open up straight away. But you know, a lot of women won't, they need a few times to get to know you ...” (Participant 1)

Investing time in developing genuine relationships with community members had positive implications for the health and wellbeing of the community, including the engagement of women in preconception care.

“

... there was a midwife that had worked out there for many years. And she was successful in getting women to come in earlier because she already built a relationship and done preconception care – focused on that preconception area. So built relationships with people. So, when they were pregnant, they were, they would come in and see her but she had that relationship, long term relationships with the families.” (Participant 13)

Key theme 2: Culturally respectful ways of building trust

Participants explained how they establish trust with women in the community. Dominant throughout these discussions was recognition of the fundamental role of culture to the health and wellbeing of Aboriginal peoples. With regards to Aboriginal pregnant women accessing antenatal care, one participant remarked “... *they [Aboriginal women] should have the option to be able to maintain their cultural identity through the process and be strengthened because of it.*” (Participant 13)

Creating a culturally secure and safe space and factors relevant to the practitioner, such as strong interpersonal skills and respecting the need for private and confidential maternity care, were important for building trusting relationships with Aboriginal women in the community.

Creating a culturally secure and safe space

Participants offered many examples of how health services worked to engender feelings of cultural safety among Aboriginal patients, echoing findings from the yarns with Aboriginal women. For example, the employment of Aboriginal staff within the health service, whether this be in a clinical role or patient liaison role. Aboriginal staff often have local knowledge that can aid engagement, and the presence of Aboriginal staff can engender feelings of trust in the service.

“I think it's trust, it's having Aboriginal nurses and midwives. We try to have a cultural lens on everything, and I think it's trust in that sense that they know that we're on their side and we can advocate for them and with them, to manage their pregnancy and also the continuity of care. So, they have come to us as patients, their other children might've come to us as patients, aunties and uncles, et cetera, there's a trust in [health service] as a service because of its engagement with the community.” (Participant 8)

In recognition of the importance of adhering to cultural protocols, particularly with regards to men's business and women's business, participants spoke of the value of employing female staff, “*I think having a female*

midwife, without intending to be sexist, having a building where we're all female, there's no males in the building ...” (Participant 9), and commented on the employment of male staff to foster engagement with men in the community.

“

I think having Aboriginal people working on the team is really important, and local people. So local people, Aboriginal people, longer term staff, I think are all more likely to be trusted.” (Participant 8)

“... we had a male nurse, which was great to get the young boys in and some of the men. So our [testing] rates did go up quite significantly with that engagement. That's got a bit more challenging because females, it's not appropriate to be, you know, asking males around sexual health testing if they've been, gone through lore as well.” (Participant 12)

Being an Aboriginal Medical Service (AMS) and working at an AMS helped to instil community members' trust in the service and in staff, “*We're an Aboriginal Medical Service, so this is a more culturally appropriate and safe space.*” (Participant 14)

“

... doing my grocery shopping with my [health service] logo on my shirt I'll get a nod – from people that I would have otherwise not had eye contact with.” (Participant 9)

Participants demonstrated acute awareness of the need to respect culture and work in a way that is sensitive to Aboriginal cultural ways of knowing and being, including displaying art and using visual resources for communication, “I’ve also got loads of local Aboriginal art in my office” (Participant 3) and “... if you give it to them [Aboriginal people] in a pictorial way, they’ll give you a better answer than if you just talk to them.” (Participant 10).

There was also recognition among participants of the role of family in Aboriginal culture and how family members can be key in facilitating attendance at the health service. Participants spoke of how group consultations with women in the community were regular occurrences. Feeling shame is a commonly reported barrier to health service access, particularly for women’s business, and the moral support provided by family and/or peers was said to help ameliorate such feelings.

“

They’re family people, their families are much higher priorities than health, so if you’ve got the whole family coming in, bring them in. Take a room. We’ll make a room. And once they’re in front of you they usually have other stuff. You remove that shame barrier ...” (Participant 9)

“If women are concerned about someone, they might not directly ask them to come up to the clinic ... but they’ll kind of bring them in with them. They’ll create this opportunity that that person gets here without directing them to go to the clinic.” (Participant 13)

Practitioner-centric factors

Strong interpersonal skills were valuable to develop trusting relationships with women in the community, in particular listening, a non-judgemental attitude, and effective communication.

“... open and honest communication, try to be friendly and transparent, and trying to communicate well, communicate in a way that people will understand the importance of health and follow up.” (Participant 7)

“... the relationships build by going and talking, when you get to the community, asking how what you’re wanting to do or what needs to be done ... and listening to what the women think needs to happen.” (Participant 13)

“

Even when you think you’re not being judgemental, so many people bring their own biases and judgement, and just the way they phrase questions and responses do impart judgement ... people just need access to information in a judgement-free environment.” (Participant 6)

Many participants acknowledged the power differentials that exist within the practitioner–patient relationship and the need to dismantle such power imbalances when engaging with women. Similarly, some spoke of how reciprocal relationships can help with building trust among women in the community.

“

Definitely establishing that familiarity, I think of who their family may be or where that family comes from. Because I think it validates them, it makes them the experts instantaneously, not me ... I think as practitioners with any clients, whether they’re Indigenous or not, then it’s easy to assume that we know everything, that they’re seeking our help or our guidance, whereas I think it’s really important to establish that it’s not a one-way street. It’s very much a shared relationship.” (Participant 3)

“

They can teach me far more than my white brain can teach them. And that’s what I’m there for. It’s a lifelong learning thing for me, so every day there’s a different way of doing it. There’s something else that they give to me, they nourish me as much as I’m there to nourish and to give to them.” (Participant 10)

The need to empower women to have agency and make informed choices about their health was discussed, “... aim of antenatal care is to make them independent. Give them choices and informed choices.” (Participant 10)

“... it was important to share that information with them and find out what they knew, and what they wanted to know about, and answer any questions that they had ...” (Participant 6)

Demonstrating respect for confidentiality and ensuring privacy was another means for helping to establish a trustful relationship with women in the community.

“I think trust is the most important thing in community, and if you don't have the trust of the people, and if you're not going to maintain confidentiality, then you just don't have a hope of making things better.”

(Participant 6)

“I think confidentiality is really important as well, so if people feel that the service you're providing is a confidential one, there's more trust.” (Participant 7)

Participants also reported that extending oneself beyond their clinical roles, and leading with good intentions, helped to foster trusting relationships with women, and reinforced the time taken to develop trust.

“So, offering to help and go the extra mile is where ... you make that difference ... Obviously, you don't click with everybody as soon as they walk in the door ... so it's still a matter of time to build that up.” (Participant 1)

“

I think that I had a lot of respect because people knew that my intentions were good, and that really helped with community ... but you have to prove that with consistent effort to engage with community so they can see ... that your intentions are pure and ... you're honest and sincere ... but it takes time to prove that.”

(Participant 6)

Key theme 3: Engaging women in a culturally responsive way

Participants were articulate in describing how working in a culturally responsive way was pivotal to engaging Aboriginal women in antenatal and postnatal care. Factors relevant to the health service, such as the use of incentives, and how health professionals approached their work, for example by immersing themselves in the community, were examples of culturally responsive ways of working.

Health service factors

Interagency and intra-agency collaboration helped considerably in engaging Aboriginal women in antenatal/postnatal care. Participants offered varied examples of collaborative approaches to care, including information sharing among health services as well as between health services and hospitals, facilitating relationships between antenatal patients and hospital staff, and interdisciplinary teamwork.

“I think one of the emphases at [ACHHS name] has been teamwork, so we work in a team, working with nurses, working with Aboriginal health workers, Aboriginal engagement officers. I think that works quite nicely too in terms of trust and encouraging people to attend.”
(Participant 7)





Some participants spoke about how the management of patient information at their respective health services, or how access to My Health Record helped them with identifying women to engage with in the community and see what consultations occurred elsewhere.

"We have a really good patient information system with really good recalls. they get lists of who's due for their next check-up so that they can track people." (Participant 13)

The utility of incentives in engaging Aboriginal women during the antenatal/postnatal period was discussed. These included non-materialistic incentives (i.e., seeing unborn baby on the ultrasound machine), material gifts (e.g., sarong, pram), and the offer of food.

“

... I do have an ultrasound machine, which is really great for engaging families ... we can just have a little scan of her belly and show her the baby, that helps I think sometimes build her bond with the baby ... they will often come in and say, 'Oh, can we do an ultrasound today?' And so, a lot of them will bring their partners in when they want to show, or they'll bring mum, or Auntie, or their kids." (Participant 1)

"Offering up a healthy, wholesome meal that is quite filling ... absolutely makes a difference to the turnout you'll get ... I think probably my engagement with them at the clinic was better because they had that access." (Participant 6)

The offer of a transport service is another effective strategy for removing barriers experienced by women who lack or have limited transport options to attend the health service.

“

... over summer it's a 45-degree day, it's uncomfortable ... we do lots of transport back and forward to the medical service that we are working in ... having transport availability definitely makes a huge difference [with engagement]." (Participant 9)

"... some [women] we will send in a taxi to [hospital] for assessment, if they need it urgently, to ensure that they get all the antenatal check-ups there. We make sure we do as much on site and we try and book the scans ourselves to make it easy, providing transport." (Participant 14)

The physical environment within which health care delivery occurs can also influence women's engagement. Participants spoke of the value of having a separate, discreet space for women's health care, further reinforcing that privacy is important to the women.

"So, we have the main medical clinic where all the doctors are working and then the paediatric nurse and myself work out of a child mental health building ... what I'm finding is increasing engagement ... purely because you're not sitting in the main clinic with the general public ... We get the sexual health nurse to come over here regularly." (Participant 9)

Ways of working

Participants remarked on the power of early intervention, community integration, and the involvement of the wider community. Flexibility, opportunistic health care, the provision of continuous care, and the diversity and complexity of health professionals' roles were also identified as important for engaging women in antenatal/postnatal care.

Some participants spoke of the value in developing relationships with young people in the community by either attending the school for education sessions *"... we go down to school and give education, just a general [talk] about sexual health ... from 12- to 15-year-olds"* (Participant 12), or by having opportunistic conversations with young women in the community. This investment in relationships in early adolescence helped with building health literacy among young women and often encouraged attendance at the health service for women's business, including preconception care, as the women matured.

“

... anyone who came into the clinic for any kind of presentation, if they were over a certain age I just always checked their file to see if they'd had a sexual health check any time in the last year, especially in the last three months. And if they were young girls or boys, then I'd talk to them about healthy relationships and domestic violence and things like that ... More so especially the girls because they didn't seem to know about periods and why they got them, where they came from, how babies were made, how babies ate inside the womb, why it's important not to smoke and drink while you're pregnant because the baby gets exposed to all those toxins ... And I feel like I did this with pretty much every female in community of every age, and that took years, and the consults would be a couple hours long ... It was a huge time investment, but it made it a lot easier as the girls grew. Then when it came time for them, to talk about contraception, or when they wanted to stop contraception to try for a baby, because they understood the reasoning behind the importance of the tests.”

(Participant 6)

Prevalent across participant discussions was the efficacy of community integration. Many participants, particularly those in regional and remote communities, spoke of the success they experienced in developing meaningful relationships with community by moving beyond the confines of the clinic to conduct health promotion in various community settings or simply by having a presence in the community in a non-work capacity.

“... do out of hours activities with these ladies, so bush picnics are an ideal time when you've got a cross section of age groups and ... different families ... we'll go digging for witchety grubs, we'll go collecting yellow berries ... I'll just choose what's in my head, I'll take with me like flip charts ... so you can have a conversation.” (Participant 10)

“... being outside of the office is one of the best strategies [for engagement]. We have a social emotional wellbeing team here ... we do barbecues ... the women's health people went out and we delivered cupcakes ... and I handed out my cards as well ... we do an annual concert up here that the health service puts on as well for the community. They did face painting this year ... put on free food for everybody and music and – there's lots of work here being done for engagement.” (Participant 9)

“

What we've found is we can successfully engage more hard-to-reach populations if that team knows the family, they go out, they can meet with them face-to-face and that also overcomes some of the barriers of fear about coming into a service. So, you go out there a few times, you have a cup of tea, have a yarn and, ‘One day, do you mind if I come out and bring you in so that we can see you at [health service]? But I'll be with you so you're not going to be alone' and having that kind of I guess cultural lens on everything so that from the beginning to the end, people are looked after.”

(Participant 6)

Recognising the important role of Elders in Aboriginal communities and the need to work in a culturally respectful way, many participants spoke of how they worked with Elders to facilitate the engagement between younger people in the community and the health service.

“

I didn't exclusively only work with the youths because the grandmothers and the aunties need to come along because they need this information to be able to share it in their language back at home, and to provide accurate information when they're supporting their family members ... I think it's important to involve people at all levels ... just because someone in community is older ... doesn't mean that they're not a valuable support for you to have in community to be able to share knowledge about pregnancy, because they're the ones who will see their grandkids or daughters – starting to maybe show signs of pregnancy and we need them to know to encourage them.” (Participant 6)

“We had a case I think last year of a 16-year-old who was pregnant and wanted to continue with the pregnancy but was so shy and shamed that she didn't want to leave the house and basically didn't come out but we had a couple of Elders go out to her every week to try and get her engaged and got the family support around her, then she delivered, the baby is perfect and she's coping really well with lots of family support.” (Participant 8)

Present in each participant's account was the need for flexibility, *“We've got to have a recognition that compliance is not a patient issue, it's often a doctor and service issue and if we want what we call compliance, then we have to start being more flexible.”* (Participant 8).

Flexibility was demonstrated by responding to the needs of the patient, removing oneself from the rigidity often present in mainstream services by offering home visits, *“I work in such a rigid system with so many policies and procedures in place and very time poor ... you've just got to prioritise the person in front of you. I think that makes a huge difference.”* (Participant 9), and an awareness of the challenges often faced by women and how this can impact attendance at the clinic.

“I'll say to the women, 'Do you want me to pick you up? Do you want me to come to the house? Do you want to come to clinic? Don't say, 'It's nine o'clock at the clinic.' It'll just be, 'What time will work for you?' because some of the women work and they'll say, 'Can I come in after school at three o'clock?' And that sometimes might be the time where I've got to leave and get back on the road, but I'll always try and make it work and say, 'Yeah, if you can come straight away, we'll squeeze it in' And, you know, just try and be as flexible as possible.” (Participant 1)

“... it's easy for us to judge and think that people are just sitting at home all day and that they don't have anything to do so why can't they come and make the appointment at 10 o'clock? But I also understand that that might be pay day and the day after payday is the only time you've got to go to Coles and get food. And so, the priority for your baby check when it's your fourth baby and you've had three normal child deliveries beforehand is lower down on the priority list. I'd just try and be a little bit more flexible.” (Participant 3)

Participants were acutely aware of the barriers to health care access for many Aboriginal peoples and providing opportunistic health care including screening and education was considered crucial for ensuring the health and wellbeing of Aboriginal women in the community, *“It makes for a very messy working day, but those opportunistic engagements are everything.”* (Participant 9)

“... often, it's just that opportunistic, 'If you're here do you want to just give us a wee and we'll do your testing, let's take your blood' ... just gauge how they feel.” (Participant 12)

Participants spoke consistently about the diversity and complexity of their health professional roles, whereby they often extended themselves beyond the specifics of their job titles to address the many needs of the women in their communities, and how important this was in relationship development.

“

Your job description might say, ABCD, but we know that there's this massive grey area all around it ... if you don't go into that grey area ... you're not going to build a relationship with the women ... I always say like, 'I'm half Social Worker, half Midwife.’” (Participant 1)

“
Their social issues impact so heavily on their health. If you didn't help with their social issues, the engagement would be very poor ... Health outcomes are poor because of the social issues.” (Participant 9)

The provision of continuous care was acknowledged by most participants as integral to relationship building and engaging Aboriginal women in antenatal and postnatal care, “Continuity of care in that you see the same midwife throughout the pregnancy.” (Participant 3).

Key theme 4: Trust facilitates syphilis education and testing

Once trusting, meaningful relationships were formed with community, participants were able to broach ‘sensitive’ topics with Aboriginal women, including syphilis. This then laid the foundations for offering syphilis testing.

Participants explained how awareness of syphilis and its impacts during pregnancy were limited among many Aboriginal women.

“

... when the [syphilis] cases started coming we just told them ... ‘just because people look clean doesn't mean they don't have it. And people might have no symptoms so they're unintentionally spreading it.’ And then I would just remind them of the impacts on pregnancy and say, ‘There are going to be babies here that are born damaged if we don't find these infections. If you don't tell me who you've been with, if we don't get you to come in when we need you to, it's going to impact these babies. Someone's baby is going to be damaged or pass away because of this, and we can prevent it.’” (Participant 6)

Participants reported considerable success in engaging antenatal/postnatal women in syphilis testing especially following discussions about the detrimental impacts of syphilis and while also normalising testing. At times, however, it was challenging to have the women present for the first antenatal syphilis screen and the postnatal syphilis screen.

“

... the hard one to get [syphilis test] is the earliest – well probably the six-week postnatal one, but sometimes the one that you will miss is that one ... you're booking bloods ... that's the one that doesn't happen because women won't present.” (Participant 3)

Point of care testing enables testing and treatment of syphilis within a short timeframe. Participants' use of syphilis point of care testing was mixed. Some participants spoke favourably about point of care testing for syphilis as a real advantage when considering the impacts of the infection, its transmissibility, and the mobility of Aboriginal peoples.

“We've instituted the Syphilis Point of Care Program. So ideally, every patient should be screened for syphilis ... and use it as a test and treat model of care ... we've got about a 3% diagnosis rate for our testing, and we've picked up 13 or 16 cases of syphilis ... mostly infectious cases. It [point of care testing] has been effective.” (Participant 14)

Some were critical of point of care testing for syphilis due to the lack of staff trained in using the device, while others felt it was redundant given bloods were often taken for other reasons during the antenatal and postnatal period and women were happy to have blood tests which were more definitive.

“I've been sending off formal bloods. Because often a woman will also need full blood count, or rubella serology, or something else as well. So, I can't say I've used the point of care syphilis testing.” (Participant 7)

Key theme 5: Community-informed and collaborative models of care

The need for Indigenising care was palpable across health professionals' responses in relation to best practice in antenatal and postnatal care.

As one participant remarked, best practice is about ensuring

“
[Aboriginal] women
can get the care
that they need,
when they need
it, in a culturally
appropriate way.”
(Participant 8)

Participants were vocal in their support of an Aboriginal-led model of care to optimise care for women. Such a model included Aboriginal leadership, “... a grassroots, more local approach that local people can take ownership of.” (Participant 7), employment of Aboriginal staff, and redefining antenatal care as women's business, “... making it women's business and respecting them culturally ... There's no shame in women's business.” (Participant 9).

Participants emphasised the need to work with the community to ensure service delivery was culturally appropriate and responsive to the needs of the community.

“

... if I went to a new community where I wasn't known, I would sit and talk with women and men in community, and try and find some pregnant women as well of course to talk with, and say, 'What would it have to look like for you to want to come? What makes it worth you coming? What would you want to get out of it? What would you want to learn? What sort of tucker would you want to be offered?' And let them tell me what their buy-in is, let them tell me what makes them comfortable and would motivate them to come.” (Participant 6)

Antenatal and postnatal support for Aboriginal women

Recognising that there is much strength in culture, some participants identified best practice in antenatal and postnatal care as recruiting senior women in the community to offer support to Aboriginal women during pregnancy, delivery, and post-delivery. This was particularly critical for those women who must relocate for childbirth.

“

... I would love to have a bunch of women who are perhaps older women who don't have kids that they need to look after right now, who might be available as a birthing companion for women ... having a bunch of older ladies who are very experienced in how to birth culturally as well who might want to do certain ceremony over the baby or just ... cultural support ... particularly the ones having their first baby, or women who are leaving kids with their partner at home so, you know, have to travel by themselves ... just a support during pregnancy.” (Participant 11)

Shared model of care

Participants also spoke of the importance of a shared model of care which included midwives working in close collaboration with Aboriginal Health Workers to aid the engagement of Aboriginal women in antenatal and postnatal care, and ensure optimal, culturally appropriate care.

“... I find some of the most successful [Aboriginal] health workers I've worked with have been health workers that have come from somewhere else ... they may still speak the language, or they can speak creole and be that safe person and provide cultural safety but they're just not from there. So, they're not related to anyone. They've got no cultural kind of obligations ... an older sort of woman that plays a matriarchal kind of role in the community anyway is a fantastic health worker.” (Participant 3)

“

Aboriginal people employed to be like health coaches or facilitators or like liaisons ... So, health workers don't have to become registered Indigenous Aboriginal Health Practitioners, they could go through a different pathway ... this is more actual wellness coaching, it's working alongside people explaining things, facilitating, setting things up, checking in on people, that kind of thing.”
(Participant 13)

Collaborative, continuous care

Best practice also included Aboriginal women having access to consistent care providers during and post pregnancy. This requires collaboration and communication among health care providers, including hospitals and the Aboriginal health sector, to enhance relationship building with Aboriginal pregnant women.

“... it's going to be many years before we're back to birthing on country. But if the women's still had to go to town to birth ... if there was a better connection between the midwife and community, and a particular midwife, or a couple of midwives in the hospital, and you can introduce her to so that you do have that complete continuity. [currently] once they get to town, they meet a service that they don't know and a midwife that they don't know.” (Participant 1)

“

I go for a weekly meeting at the hospital and review my patients from out here and they give me advice on how to manage them, what further investigation do we need to do, then they've got knowledge of the clients when they come over for their monthly visit ... as part of the care that these women are provided I will talk about, '[Health professional] will be at the hospital. [She's] your person at the hospital. She's your go to.' We don't have a formal meet and greet ... but it's somebody to contact ... a familiar face along the way ... that relationship, definitely, definitely assists.” (Participant 9)

Strengths

This research study has several strengths. To begin, the research team included an Aboriginal Chief Investigator who provided guidance in planning culturally safe research methods and cultural insights during interpretation of the data. Secondly, positioning this research study within a strengths-based framework encouraged a departure from the deficit narrative that often dominates Aboriginal health literature. There is a genuine need to build the evidence base of what is working well in Aboriginal health and acknowledge how the strength that exists within Aboriginal culture is key to facilitating this. Furthermore, ensuring a holistic focus for the yarns with Aboriginal women was critical for encouraging participation. Sexual health can be a taboo and sensitive subject to discuss for many individuals, and engaging in sexual health testing may be associated with feelings of shame and fear of judgement. By focusing on antenatal and postnatal care more broadly, we were able to reduce barriers to participation in the research and understand the context for women engaging in syphilis testing. The support from a bilingual Aboriginal woman when collecting data permitted the participation of Aboriginal women with low English literacy whose voices would otherwise have not been heard.

Although conducted across several WA jurisdictions, the women participating in this research reported similar antenatal and postnatal care experiences, with many aspects confirmed by the health professionals who participated. Lastly, the funder accommodated significant flexibility in the timeframes for the study. This allowed appropriate engagement with ACCHSs, many of which remained stretched in their capacity in the months following the peak of the COVID-19 pandemic and to obtain approvals from ACCHSs and the relevant Human Research Ethics Committees.



Limitations

We acknowledge there are some important limitations to this study, including the considerably smaller number of Aboriginal women participating in the research when compared with the number of health professionals. Several participating ACCHSs expressed great interest in supporting the recruitment of local women for yarns, however minimising the impacts of COVID-19 was a high priority for the ACCHSs at the time of data collection, including the rollout of vaccinations and modifying local pandemic plans. These activities were resource intensive and consequently limited capacity of the ACCHSs to assist with the research.

The limitations associated with the use of an interpreter for some of the participant yarns must also be acknowledged. While interpreters have a critical role in mediating language barriers to passively impart information, some may unknowingly demonstrate selectivity in the information they translate, or misinterpret information, which can impact data integrity. The presence of an interpreter can also limit rapport building between interviewer and participant, which can restrict the depth of the data generated. Notwithstanding these limitations, the research team are strong advocates for the use of interpreters in Aboriginal health research to help build the evidence base required for sustained change and minimise barriers to participation in research.

The findings in this report represent the views of Aboriginal pregnant women and mothers and health professionals in the four participating regions and seven participating ACCHSs. It is acknowledged that different or additional perspectives may be held by Aboriginal women, including those disengaged from antenatal care services, and health professionals in other regions. Lastly, the available funding for this research did not permit sufficient immersion in remote communities to build trust between researchers and potential participants. Future research should allocate sufficient resources to enable more time to be spent in remote communities or with ACCHSs to build trust and increase awareness of the context of services and research participants prior to collecting data.

Concluding comments

This qualitative research study sought to understand stories of success and lessons learned for successfully engaging Aboriginal women in antenatal and postnatal care with a particular focus on preventing congenital syphilis and other syphilis complications including premature labour, miscarriage, and stillbirth. Conducted across four WA regions, the study involved yarns with Aboriginal women aged 16–39 years, who were pregnant or had a child aged three years or younger, and semi-structured interviews with health professionals involved in maternity care.

The findings from this research identified five action areas that are key to the improved and sustained engagement of Aboriginal women in antenatal and postnatal care. The action areas are centred on enhancing trust and ensuring culturally secure health care provision, acknowledging the often complex and varied roles health professionals assume in maternity care.

Improving engagement of Aboriginal women in antenatal and postnatal care requires employment of more Aboriginal people trained in clinical roles. In the interim, our focus should be on building the health literacy and capacity of the broader Aboriginal community to support positive pregnancy outcomes for Aboriginal women, and on building the cultural capabilities and supports available to non-Indigenous health professionals to engage in a culturally safe way with Aboriginal peoples.

The findings from this research study are a valuable advocacy tool for change, reinforcing previous calls to work alongside Aboriginal communities to co-design solutions that work for local communities to engage safely in healthcare services. Importantly, a commitment to the five key areas for action will have positive implications beyond the prevention of congenital syphilis. It may also facilitate improved outcomes across the spectrum of maternal and infant health for Aboriginal communities.



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About SiREN

SiREN is the WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network. SiREN is a partnership between researchers, service providers and policymakers working to strengthen evidence-informed policy and practice in Western Australia.

SiREN aims to:

1. Strengthen the research, evaluation and health promotion skills of people working to promote sexual health or prevent or manage blood-borne viruses.
2. Promote and facilitate opportunities for collaboration between sexual health and blood-borne virus service providers, policymakers and researchers; and
3. Foster links with national sexual health and blood-borne virus research centers and contribute to appropriate national research agendas in order to raise the profile of SHBBV concerns affecting WA.

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