

Young Aboriginal Women's Voices on Pregnancy Care

FINAL REPORT - APRIL 2014 Prepared by Tracy Reibel and Lisa Morrison



Government of Western Australia
Department of Health



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ACKNOWLEDGEMENTS

Many people contributed to making sure the voices of young Aboriginal women were clearly heard and the Investigator Team from the Aboriginal Maternity Services Support Unit (Anne-Marie McHugh, Llinos Chapman, Denese Griffin and Heather Woods) and the Telethon Kids Institute (Tracy Reibel and Lisa Morrison) take this opportunity to acknowledge the contribution of all those involved in the successful completion of the project.



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Cover image created by Lisa Morrison: The painting represents the journey taken across the land as we travelled from the sea to the desert and the many meetings we had with women along the way.

PLAIN LANGUAGE SUMMARY

This project wanted to find out from young Aboriginal women what they know about having a baby. In different parts of Western Australia we yarned with pregnant young women and mothers who were 16-21 years of age. We also yarned with other Aboriginal women, including elders, and with health workers (midwives, Aboriginal health workers, doctors and nurses).

Young Aboriginal women said they see health workers about pregnancy care mainly because their mothers, grandmothers, aunties, or sister/cousins tell them to. They mostly go to Aboriginal Health Services. Sometimes, they will go to a local hospital or doctor to keep their business private.

Young women said getting to know the health workers looking after them, like midwives and Aboriginal Health Workers, is very important. When this happens they will keep going back for pregnancy care. They also said they want to feel respected by everyone they see when they are pregnant and when they are having their baby. In some places, going to see a health worker for pregnancy care is too hard because it is too far or there is no transport for them to get to that other place.

The young women also said that if young Aboriginal women do not have family close to them to help when they find out they are pregnant they probably will not see a health worker for pregnancy care.

We also found out that some young Aboriginal women know a lot about being pregnant and having a baby and some know just a bit. They mostly know about eating healthy foods, and not drinking alcohol or smoking when they are pregnant. Sometimes they know about tests the health workers ask them to have. They mostly learn about having a baby from their family. Elder Aboriginal women said that girls and boys need more sexual health education when they are in primary school.

Young Aboriginal women also said they really want to have their partners and family with them at the hospital when they have their baby.

Sometimes young Aboriginal women have to leave their community to go to another place to have their baby. This can be for many weeks and young women miss their families and may be scared when their family is not there to help them and keep them company. The best way to help young Aboriginal women when they leave their community is for family members to go with them. They all need accommodation, transport and support when they are away from their community.

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EXECUTIVE SUMMARY

In Western Australia, the teenage birth rate for Aboriginal mothers is about six-times the rate found among non-Aboriginal teenagers, and represents around one quarter of all Aboriginal births each year. This project was undertaken to improve understanding of young Aboriginal women's knowledge of pregnancy and identify factors that may encourage them to seek early pregnancy care. The study sample was recruited from metropolitan, regional and remote parts of Western Australia including those in the main target group (pregnant Aboriginal women or birth mothers 16-21 years); elder women and other Aboriginal community members; and, health and other professionals working in relevant settings.

Factors associated with early and ongoing contact by young Aboriginal women with pregnancy care include: firstly, the role of female relatives in directing young women to healthcare providers; secondly, access to culturally secure pregnancy care, usually located in Aboriginal Health Services; and, thirdly, the opportunity to build a relationship with a known carer.

Whether a young Aboriginal woman has pregnancy care is most often associated with the advice and support of female family members. An absence of family support is the primary reason for not attending health services for pregnancy care. Effective engagement is most evident where services use midwife/Aboriginal Health Worker models of care, with inclusion of local senior women acting as a link between young women and healthcare providers.

Efforts are being made in many locations to provide culturally secure antenatal services, and it was evident from consistent reporting of regular visits by both young Aboriginal women and service providers this is having a positive effect. Young Aboriginal women identified a need for choice of pregnancy care services, particularly in relation to maintaining their privacy and confidentiality. In very remote communities, access to regular pregnancy care remains a challenge for a range of logistical and resourcing reasons.

Young Aboriginal women's knowledge of pregnancy ranges from being very informed to having a limited understanding. Even so, knowledge of eating healthy foods, and not drinking alcohol or smoking during pregnancy was consistently reported by the target group. Senior Aboriginal women persistently reported the need for more sexual and reproductive health education for Aboriginal children in the primary school years.

The presence of multiple family members to support young Aboriginal women during childbirth is an important cultural practice. The primary area of concern noted in the study relates to young Aboriginal women living in locations without birth services and being required to leave their home communities to attend another location for childbirth up to six weeks prior to their due date. Young women require familial support during a vulnerable time in their lives. A documented patient relocation pathway for those required to leave their home communities would improve the cultural security of antenatal service delivery.

RECOMMENDATIONS

Young Women's Voices on Pregnancy Care

Young women clearly voiced their need for pregnancy care that supports them during a vulnerable time in their lives and:

- respects their choice, privacy and confidentiality at all times and in all service settings,
- is open, non-judgmental and respectful, and includes local Aboriginal women elders and, grandmothers in pregnancy support and education,
- provides a continuous relationship with a known carer (Aboriginal Health Worker/midwife), and,
- support of a family member/partner when travelling and during birthing at the chosen birth hospital.

Young Women's and Senior Women's Voices on Opportunities for Engagement

The crucial role Aboriginal family relationships have in encouraging early and ongoing antenatal engagement by young pregnant Aboriginal women can be used to promote service delivery which:

- Builds relationships with influential local women Elders/community members to support:
 - knowledge exchange about pregnancy and childbirth and associated local cultural practices,
 - dissemination of information about pregnancy care and available services,
 - identification of young pregnant women,
 - identification of the best methods for pregnancy related health promotion, and
 - local Elders/community members to acquire any additional knowledge they need to inform and educate children and young people in their communities about pregnancy and pregnancy care.
- Provides culturally secure models of care, which incorporate the opportunity for young women to have continuity of care, and, promotes outreach;
- Recognises and celebrates Aboriginal culture by way of displaying paintings, artefacts and posters in all hospital and health service settings;
- Improves the cultural competence of health professionals and other service staff through continuous Quality Improvement initiatives.

Locally informed operational and/or reconciliation action plans addressing these actions, would build organisational cultural competence and relationships with Aboriginal people in local communities.

Young Women's, Senior Women's and Service Providers Voices on Relocation for Childbirth

Being required to leave home communities to attend another location for childbirth may be challenging for young Aboriginal women who may be out of their comfort zone in an environment they have not previously experienced.

A documented patient relocation pathway is required to support young Aboriginal women to feel safe. This includes:

- securing appropriate transport from and back to home communities;
- assistance for escort/support people to be present for the duration of the pregnant woman's relocation (including changes of support people over that time);
- accommodation options and social support services at the relocation site, including access to an

Aboriginal Liaison Officer;

- detailed information about the cultural practices/expectations of individual Aboriginal women is forwarded for the information of health service staff at the relocation site.

Young Women's and Senior Women's Voices on Health promotion and Sexual Health Education

To improve knowledge and understanding of pregnancy, and pregnancy care and taking into account local cultural practices and protocols:

- Maternity and Community Health services, in all organisations and regions, work collaboratively with local Elders, the Department of Education and other relevant departments and organisations, to develop and deliver culturally appropriate school and community based sexual, reproductive and pregnancy care health education and health promotion activities.

Examples of existing educational programs include the Core of Life (<http://www.coreoflife.org.au/>) and the Mooditj Leader Program delivered by Family Planning WA.

INTRODUCTION

This project was undertaken to improve understanding of young Aboriginal women's knowledge of pregnancy from their perspective and identify factors that may encourage them to seek early pregnancy care. It was anticipated the information might be used alongside other evidence to develop a framework to guide antenatal service delivery to pregnant Aboriginal adolescents. Underpinning this was the hypothesis: use of antenatal services by adolescent Aboriginals is likely to be improved by the availability of culturally and age appropriate services.

BACKGROUND

Some literature suggests that adolescent pregnant Aboriginal women may have different antenatal care needs to their older counterparts. However, with no systematic collection of antenatal health care contact for any population, it is not possible to confirm the extent of antenatal care for young Aboriginal women. Nonetheless, understanding their specific needs is important information to assist services to develop pathways that encourage young women's attendance at antenatal services. To date, there has been no comprehensive examination of what motivates adolescent Aboriginal women to seek out pregnancy care.

The WA Mothers and Babies Report (2011)¹ noted that in 2009, the teenage birth rate for Aboriginal mothers (97.7 per 1000 women) was more than six-times the rate found among non-Aboriginals (15.4 per 1000 women).

Table 1: Aboriginal Birth <20 & >20 years by Health Region 2009 - 2011

Source: Midwives Notification System : (Ref:MCH12033)

| | Baby's Year of Birth | | | | | |
|-------------------|----------------------|-----|------------------|-----|------------------|-----|
| | 2009 | | 2010 | | 2011 | |
| | Mother's Age /yr | | Mother's Age /yr | | Mother's Age /yr | |
| | <20 | 20+ | <20 | 20+ | <20 | 20+ |
| | N | N | N | N | N | N |
| Region | | | | | | |
| 01 North Metro | 69 | 211 | 46 | 179 | 46 | 190 |
| 02 South Metro | 68 | 250 | 78 | 229 | 86 | 268 |
| 04 Kimberley | 82 | 320 | 85 | 321 | 68 | 296 |
| 05 Pilbara | 32 | 144 | 40 | 163 | 30 | 129 |
| 06 Midwest | 47 | 169 | 47 | 182 | 42 | 145 |
| 07 Wheatbelt | 24 | 69 | 16 | 68 | 12 | 61 |
| 08 Goldfields | 31 | 120 | 25 | 101 | 28 | 90 |
| 09 Great Southern | 9 | 30 | 11 | 37 | 13 | 39 |
| 10 South West | 17 | 53 | 7 | 42 | 15 | 54 |

In order to establish a regional profile of the extent of teen pregnancy, WA Department of Health data on Aboriginal births by Region for 2009-2011 for mothers under and over 20 years of age has been analysed with the results detailed in Table 1. While consistent, the data suggests Aboriginal teenage pregnancy rates are somewhat higher in Perth and areas closer to it than they are in the remoter northern regions of the State, except for the Kimberley region.

While the number of teenage pregnancies to Aboriginal mothers over 2009-2011 was relatively stable, the prevalence of pregnancy during the teenage years has remained high enough to question if there is a need for targeted services for this group.

METHOD

Study design

This project was conducted as a descriptive qualitative study with data collection undertaken using a culturally sensitive, semi-structured interview schedule incorporating a personal and conversational manner known as *yarning*². Individual or group interviews were conducted depending on participant preferences.

The field researchers were an Aboriginal cultural consultant highly experienced in working with young Aboriginal mothers in her role as an Aboriginal Health Worker and a non-Aboriginal researcher with extensive experience in conducting interviews with Aboriginal people.

Governance and Reference Groups

A governance model, inclusive of two reference groups and an investigator team, guided the conduct of the project. The governance model is shown in Appendix 1. The groups were:

Project Reference Group: comprising primarily senior Aboriginal women working in a variety of organisations, government and non-government, as well as non-Aboriginal women working in health service delivery. In accordance with the Terms of Reference, the role of the group was: for members to provide culturally and clinically appropriate advice, comment and feedback to the Investigator Team on a range of processes and procedures relevant to engagement with all consultation groups, and contribute to design of the questions and consultation methodology, dissemination of results, and translation of Project outcomes within the health system.

Young Women's Advisory Group: comprising young women in the target age range and who had a baby. In accordance with the Terms of Reference, the principal role of the Young Women's Advisory Group was to: seek advice from young women members on how to approach other young pregnant women; advice on what questions are appropriate to use and ask; and, to raise issues that might be important to young women that the research team have not previously considered. A summary of the Young Women's Advisory Group meetings and their contribution is provided in Appendix 2.

Investigator Team: comprising representatives from the Telethon Kids Institute and the Aboriginal Maternity Services Support Unit. The investigators were responsible for the overall conduct of the research in consultation with all stakeholder groups and maintenance of communication to all stakeholders of all aspects of the research, including dissemination of outcomes and provide a forum of exchange (update and progress of the research) between the researchers and the sponsors at the Department of Health.

Recruitment and Data Collection Protocols

The researchers were mindful of following correct protocols in seeking out young women for interviews. This sometimes involved approaching senior women via service providers to ask for permission to speak with young women. In other cases, local Aboriginal organisations and community leaders were contacted to invite young women to consultations. The Data Collection Protocol is noted in Appendix 3.

Study cohort

The study sample was recruited from metropolitan, rural, regional and remote parts of Western Australia including:

- Pregnant Aboriginal women or birth mothers 16-21 years.
- Elders and other community members who agreed to meet with the researchers.
- Health and other professionals working in relevant settings (e.g. Aboriginal Medical Services, health and social support services).

The primary target group was extended to include young women who were 21 years at the time of interview, but who had their first child between the ages of 16-20 years. The study excluded anyone aged less than 16 years.

Terminology

Throughout this report the following terms are used:

- **Young Women:** informants from the primary target group (pregnant Aboriginal women or birth mothers 16-21 years).
- **Senior Women:** informants such as grandmothers and aunties, some of who are also service providers.
- **Service Providers:** informants such as midwives, social workers, child health nurses, doctors and Aboriginal health workers.
- **Other Aboriginal Women:** informants such as mothers outside the primary target group (eg over 21 years) and young women without children.
- **Aboriginal Health Service (AHS):** Aboriginal health service is used in this report as a generic term encompassing Aboriginal Medical Services and Aboriginal Community Controlled Health Services.
- **Aboriginal Women:** As the Indigenous population of WA predominantly comprises Aboriginal people, the term Aboriginal is used throughout this report. It is acknowledged that Torres Strait Islander peoples also reside in WA.

Ethics

Study approval was granted by the Western Australian Aboriginal Health Ethics Committee and the Western Australian Country Health Service, Women's and Newborns Health Service, and North and South Metropolitan Health Services Human Research Ethics Committees. Research approval was also granted by the Kimberley Aboriginal Health Planning Forum Research Sub-Committee.

Data management

Informed consent, preceded by a plain language explanation of the research project, was obtained prior to data collection. Some digital recording was agreed to, although field notes were

the principle source of data for analysis. From the collected data, summaries were prepared by region, and de-identified to provide anonymity to participants. These were returned to relevant stakeholders for verification of content.

Data analysis

A constant comparative approach of transcript/field note content to determine themes and sub topics was used, cross checked by the field researchers to uphold thematic validity and support the credibility and trustworthiness of the analysis. Interpretation was applied to themes and sub-topics based on the literature review. The results section was returned to informants to check for accuracy of reporting.

Literature review

To assist with data interpretation, a brief literature review was conducted to identify relevant evidence relating to: standard antenatal care and relevant policy; teenage pregnancy; and, Aboriginal women and culturally secure antenatal care.

LITERATURE REVIEW

The reviewed literature describes standard antenatal care within the Australian clinical context and current policy relevant to the delivery of maternity services to Aboriginal and Torres Strait Islander women. It also summarises what is currently known about teenage pregnancy generally and Aboriginal adolescent pregnancy, and literature referring to culturally secure antenatal care for Aboriginal women.

STANDARD ANTENATAL CARE

The World Health Organisation describes antenatal care as recording medical history, assessment of individual needs, advice and guidance on pregnancy and delivery, screening tests, education on self-care during pregnancy, identification of conditions detrimental to health during pregnancy, and first line management and referral if necessary, provided by a skilled birth attendant (accredited health professional such as a midwife, doctor or nurse)³. Antenatal care coverage is “*an indicator of access and utilisation of care during pregnancy*” with a single antenatal visit not a good indicator of the quality of care. Instead, “*additional indicators may include the number of visits (at least four per pregnancy are recommended) and the timing of the first visit*”⁴, preferably early in pregnancy.

Australian Health Standards define antenatal care visits as being an intentional encounter between a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour. In rural and remote regions there may be circumstances where appropriately qualified Aboriginal Health Workers or nurses perform antenatal care in the absence of medical officers and midwives. In any setting, the Australian Health Professional Regulatory Authority registration is applicable for determining the scope of practice for individual health professionals. The recommended schedule of antenatal visits is monthly up until 28 weeks of pregnancy, fortnightly visits until 36 weeks and weekly thereafter or as determined by a medical officer or midwife⁵.

The Australian Health and Medical Advisory Council (2012) Antenatal Care Guidelines⁶ require application of acceptable clinical standards within any service setting providing antenatal care, while noting that the particular cultural and psychosocial requirements of Aboriginal women also need to be accommodated.

The National Maternity Services Plan endorsed by the Australian Health Ministers Conference in 2010 recognises the importance of maternity services within the health system and provides a national strategic framework. It sets out a clinical services capability maternity framework which includes use of a standard set of capability requirements for maternity by public and private services, premised on four priority areas.

Priority 1 and 2 articulate the requirements for accessible high quality maternity care with Priority 2.2 explicitly stating a need to “*develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people*”⁷. The four priority areas align with ten principles which underpin the Plan. In reference to Priority 2.2, the following principles apply:

- Maternity care places the woman at the centre of her own care. Such care is coordinated according to the woman’s needs, including her cultural, emotional, psychosocial and clinical

needs, close to where she lives.

- Maternity care enables all women and their families to make informed and timely choices in accordance with their individual needs. The planning and provision of maternity care is informed by women and their families.
- Women and families in rural and remote Australia have improved and sustainable access to high-quality, safe, evidence-based maternity care that incorporates access to appropriate medical care when complications arise.
- Governments and health services work to reduce the health inequalities faced by Aboriginal and Torres Strait Islander mothers and babies and other disadvantaged populations.
- Maternity services offer continuity of care across the pregnancy and birthing continuum as a key element of quality maternity care for all women and their babies.
- The potential of maternity health professionals is maximised to enable the full scope of their specific knowledge, skills and attributes to contribute to women's maternity care.
- Maternity services operate within a national system for monitoring performance and outcomes and guiding quality improvement.

In addition to Priority 2.2 are Priorities 1.4.1 and 4.3.1. The first is concerned with implementing and sustaining successful community based maternity care in remote locations and the second focuses on the need to develop a rigorous approach to maternity service planning. Taken together, these priorities and principles are foundational to informing delivery of antenatal care to Aboriginal women across WA, including adolescents.

TEENAGE PREGNANCY

In contemporary terms, adolescent pregnancy is considered a problem for a range of clinical and social reasons, although cultural traditions also shape patterns of family formation and caregiving⁸. In environments where educational and employment opportunities are limited, pregnancy offers advantages and disadvantages, with motherhood representing a rite of passage to adulthood^{9,10,11}. Young women's attitudes, views and vulnerability to pregnancy have been examined in both general and disadvantaged populations. Studies conducted with populations of adolescent women, even when disaggregated by ethnicity, identify characteristics which increase the risk of teen pregnancy, including intergenerational patterns of teenage motherhood and socioeconomic status^{12,13,14,15}.

Other aspects such as variability of attitudes to using contraception across mixed populations of young women aged 14 to 19 years are also consistently reported. In a number of studies fluctuations in contraceptive use has been strongly associated with individual ambivalence to being pregnant. Education aimed at motivating young women to have an opinion either way about pregnancy, is preferable to being ambivalent, as ambivalence increases the likelihood of pregnancy in mid to late teens.

While rates of teen pregnancy have decreased over time for all population groups, rates for Aboriginal adolescents in Australia continue to be higher than for their counterparts. Lewis et al (2009) found that while clinical risk factors such as smoking, anaemia and pregnancy induced hypertension occurred more often for Aboriginal adolescent women, there was little evidence of increased adverse perinatal outcomes in this group compared to a non-Aboriginal population. The same authors also demonstrated the effectiveness of Implanon as a contraceptive for adolescent young women with a previous pregnancy. According to Senior and Chenhall (2008), it is generally understood that teenage pregnancy occurring over 16 years of age is acceptable within Aboriginal communities.

ABORIGINAL WOMEN AND CULTURALLY SECURE ANTENATAL CARE

Aboriginal people's engagement with health services is affected by socio-cultural beliefs and health system arrangements¹⁶. Within the maternity services domain, it is now generally understood that where culturally safe practices are implemented, there is greater confidence among Aboriginal women to access and continue with antenatal care^{17,18,19}.

Much of what is known about culturally safe antenatal care has emerged as a result of listening to Aboriginal women. In response, models of care have increasingly been implemented to meet the cultural and individual needs of Aboriginal women while also maintaining clinical standards^{20,21,22}.

In Western Australia, models of care commonly referred to as Aboriginal Maternity Group Practiceⁱ, have been developed in consultation with local Aboriginal community members and implemented in metropolitan and regional settings to address local requirements and improve access by pregnant Aboriginal women.

The factors that appear to improve Aboriginal women's engagement with antenatal care are:

- Creating effective women/health provider relationships²³
- Supporting women's cultural and individual decision making²⁴
- Maintaining a holistic approach through culturally secure service delivery²⁵
- Culturally competent carers and models of care²⁶.

Some current evidence suggests that young pregnant Aboriginal women may have different antenatal care needs to their older counterparts, and the opportunity to understand their specific needs is important to providing models of care that encourage their attendance at antenatal services^{27,28,29}. It has also been suggested that adolescent pregnant Aboriginal women are less likely to seek pregnancy care, and the more remote the location of residence, the higher the likelihood of not receiving adequate antenatal care remains. The reasons for this are complex and mediated by individual preferences, service availability and cultural norms³⁰. Larkins et al (2009) noted that culturally sensitive, evidence-based antenatal care that links young Aboriginal women to other services may increase access and acceptability particularly for those who are highly disadvantaged³¹. Policies, protocols, programs and practices aimed at this group might also improve delivery of quality antenatal care, positively impacting on birth outcomes^{32,33,34,35}. Crook et al (2013) have identified the effectiveness of providing a bi-cultural approach (Aboriginal and non-Aboriginal staff) which provides women with a choice of who they see. This addresses confidentiality concerns where strong family connections in close knit Aboriginal communities may be a barrier to access³⁶.

As adolescent pregnancies may result in low birth weight and premature birth, both of which have negative impacts on whole of life outcomes for the infant, the antenatal period is deemed crucial for interventions to address factors affecting the health of mother and baby and which impact on birth weight like nutrition, alcohol, tobacco and other substance use^{37,38}. As well as potentially poorer obstetric outcomes, adolescent mothers may also be disadvantaged by poorer educational and economic outcomes^{39,40} although published data on the health of adolescent Aboriginal mothers is limited⁴¹.

ⁱ Aboriginal Maternity Group Practice broadly refers to a culturally secure model of care incorporating a team approach, inclusive of a midwife, Aboriginal Health Worker, and/or Grandmother Liaison role. A Transport Officer and Social and Emotional Wellbeing Officer may also be included. The concept of AMGP is that it is developed in consultation with local community members to meet the needs of local women, is located in a space where Aboriginal women feel comfortable and safe attending and or incorporates an outreach or home visiting service.

Wilson (2009) suggests the delivery of pregnancy care to this potentially vulnerable group of pregnant women needs to be situated in a holistic woman centred approach⁴² a feature of the Australian Government Clinical Practice Guidelines – Antenatal Care⁴³. Such an approach is also favoured by the WA Health Maternity Services Framework⁴⁴, but as Hancock notes, Aboriginal women, particularly in remote settings are not always afforded a woman centred approach⁴⁵. This has been noted in detail by Tai-Roche and Hills (2013) in their reporting of birthing practices and options for women residing in the Kimberley region of Western Australia⁴⁶. The authors directly report service provider and community members' views on the negative impacts on women, their families and communities when relocation is required for childbirth; the types and adequacy of antenatal and postnatal care available in remote communities; and, women's lack of access to culturally appropriate birthing environments. Dietsch et al (2011) also noted how the routine removal of women from their home country to regional or metropolitan hospitals, often a significant distance away, is compounded by separation from family, and has the potential to negatively impact on birth outcomes⁴⁷. Some of these issues are noted as problematic in a 2013 report commissioned by the Statewide Obstetric Services Unit and Aboriginal Maternity Services Support Unit. Although not specific to Aboriginal women, the report highlights the scarcity of low cost accommodation and the inability of the Patient Assistance Travel Scheme (PATS) to meet the needs of birthing women⁴⁸ particularly in relation to providing assistance for escorts to accompany women.

There are in excess of 340 births per year to young Western Australian Aboriginal women less than 20 years of age. This accounts for about one quarter of all births to Western Australian Aboriginal women each year and has been a consistent trend over time. However, young Aboriginal women's views about pregnancy care have not been formally documented with the exception of one study conducted in the East Pilbara⁴⁹ with a small group of young women.

In response to the lack of young Aboriginal women's voices on the subject of pregnancy care, this project set out to ask young Aboriginal women currently or previously pregnant and residing in different locations across Western Australia what they know about pregnancy care, why they attend health services and what pregnancy care means to them.

RESULTS

The results focus on participant input from young women in the primary target group with direct quotations used to highlight their voices. This is supplemented with reporting by senior women, service providers and other Aboriginal women.

Consultations were conducted in a variety of rural, regional and remote locations across Western Australia as well as in the Perth metropolitan area. The list of locations visited and a description of participants is noted in Table 2, Appendix 4. Outcomes are generally referred to by health region rather than by location.

In analysis, two distinct thematic domains were apparent. The first was in the area of community and cultural influences, which reflect young women's personal knowledge, community knowledge, and cultural practices associated with pregnancy care. The second related to health service influences, and how arrangements or requirements are associated with young women's engagement with services.

SAMPLE

Eighty four (84) people attended consultations at 19 locations in five health regions across the State and the metropolitan area, between June and November, 2013, including:

- 28 young women (either pregnant or with a baby) aged 16-21 years interviewed either individually (6) or in groups. Six of these young women were also accompanied by their male partners.

Other participants included:

- Grandmothers/mothers/aunties either separately from young women or in group interviews.
- Service providers.
- Mothers (aged over 21 years).
- Young women with no children.

All primary target group participants were Aboriginal. Other participants were predominately Aboriginal women, with the exception of non-Aboriginal service providers. Health regions visited were: Kimberley, Pilbara, Midwest, Wheatbelt, Goldfields and the metropolitan area.

THEMES

The following results provide a detailed description of the two thematic domains identified as influencing young women's engagement with pregnancy care and the sub-topics associated with these. Table 3 provides information as to which informants raised specific issues in which regions. Further detail related to the themes and sub-topics can be found in Tables 4 and 5 in Appendix 5.

1. Domain One: Community and Cultural Influences

Themes: vulnerability; family support; accessing care; and, education.

1.1 Vulnerability

Young women said they were shocked, surprised, excited or scared when their pregnancy was

confirmed. “Being scared” was mainly about telling partners and family members, but also about childbirth.

“Well I didn’t know I was pregnant when I lost my mum. When I found out I was excited but sad because I really wanted my mum there.”

“I was very upset, laying down, sleeping all the time.”

“I’m still coming to terms with being pregnant, it freaks me out.”

“We didn’t know much about anything. I was scared [my sister] was scared, like really scared.”

For some young women having a baby is a choice – *“I am very excited about having a baby and have been telling everyone and mum has put it on Facebook”*. Some pregnancies in this age group are planned. A service provider said teenage pregnancies are *“not generally regarded as a bad thing or tragedy”* and *“babies/children are highly valued and so young women don’t tend to be negative about their pregnancies”*. Even if not planned, it was reported that pregnancy from 16 years on is accepted by most family members, with many senior women reporting their own teenage pregnancies.

There were different responses to very young women (under 16 years) having babies. Almost all young women, senior women and other Aboriginal women were clear that being less than 16 years is too young to have children. Also, when young women are under 16, there is a much higher likelihood of a grandmother having responsibility for the baby. For example, a senior woman reported that she and her son now share care of her grandson, but *“it’s part of our culture, our families [are] very strong”*.

Young women talked strongly about very young women (under 16 years) having babies.

“Because they are too young still and looking for their freedom so they choose that instead of spending time with their kids.”

“Young mums, too young, don’t want to tell anyone, too scared.”

“Some of them have good family support but they go up and down like you know with their relationships they are all over the place.”

One young woman talked about young girls 10-12 who are already meeting up with boys and talking about having sex. These young girls don’t have a lot of adult supervision and do what they want *“There is no mother to talk and explain things to them”*. She thought it would be good to have somewhere where young girls can come, and sit down and see a DVD about what happens when you are having a baby.

Young women without children were also definite about waiting until they are older before having children – *“reckon 21 and older is a good age to have babies...they shouldn’t be having babies at an early age, because they are babies themselves”*.

Most young women said they understand how to prevent pregnancy (talking about Implanon, contraceptive needles and condoms). *“I know a lot of people who get that [Implanon] done at*

16/17". Two young women said they had terminations after their first baby because they weren't ready for another pregnancy. While pregnancies might not be planned they are not necessarily avoided, *"it just happened"* as one young woman put it. Another young woman said that most young people know about using condoms, but some young men *"don't think it is manly to use [condoms] and the young women don't insist they use them"*.

A service provider reported that in her area, because more young women are getting Implanon, there are now more planned than accidental pregnancies in the 16 years and over group. About young women under 16 being pregnant she said:

"Mothers and grandmothers bring their daughters in basically saying 'check her out, do a pregnancy test'; they'll say 'last week she didn't come home, she was out every night'. Some of those mothers are really good and they are trying. I find that the teenagers are really pushing their boundaries out here, the 12/13 years olds, they're really pushing those buttons on their mothers and grandmothers...[who] talk openly and say 'she's been walking the streets – I went to look for her and I tried to get her in'. So they're trying and then I would say with the young, young ones I've had, and there have been a couple, there is more dysfunction and less family support – but it's not always the case."

It is at the time of their first visit to a health service about being pregnant that most young women talked about keeping news of their pregnancy private. They said this was harder if they went to an Aboriginal Health Service (AHS). Young women said they choose which health services to go to (mainly AHS or hospital clinics) to maintain their privacy.

"don't know how you can stop [everyone knowing] as you book your appointment through the front office...you got a lot of Indigenous mob working there and you know what black people are, they like to yarn".

"Sometimes I don't really like going to [the AHS] because they taking a long time to call your name and because everybody talk about that place...I normally go up to the big hospital, I go to [the AHS] when I got an appointment with one of the white women. I see the white people, not the blackfellas."

One young woman said privacy is important because *"it makes you feel good knowing that you can trust [the midwives]"*. Mostly, young women said they prefer to go to an AHS for their pregnancy care.

1.2 Family Support

The importance of family and the support, encouragement and knowledge sharing which occurs between female family members was talked about by everyone.

What young women do about their pregnancy care is mainly influenced by female members of their family, usually a mother or grandmother, but sometimes aunties or sister/cousins. As one young woman said, she was planning on having an Implanon inserted, but became pregnant before getting this done and was very upset when she found out she was pregnant. Her sister was *"going off at her"* and she said *"I'm pregnant, leave me alone"*, so her sister was the first to know. Then she told her mum, and *"she was okay with it"*. During her pregnancy, *"mum was always reminding me about my appointments"*. She had lots of support from her family during pregnancy, and now since she has had her baby. Her mum has always been there, keeping her company *"she's good to talk to"*, especially when she was feeling sad, and helping with the baby.

There is a strong belief that the advice of senior women will be followed by young women. Some service providers also rely on these family relationships to get young women to pregnancy care. A service provider said the Aboriginal Health Worker at the AHS where she works is a much respected elder woman. She said that when the health worker tells young women to come in for their appointments they do, as *“nobody argues with her”*. Also, a midwife working at the hospital meets young women at the AHS during their pregnancy. The service provider said that the young women seem to be more open and relaxed when they go to the hospital *“as that relationship [with the midwife] is there”*.

Family members are also often the ones to remind young women of their appointments, sometimes going with them. Antenatal services often also provide transport and reminders as this helps young women to regularly go for pregnancy care.

“I went to see my doctor, and the doctor told me to go and see a specialist and that’s when they [the health workers] came and picked me up and took me to my appointments”.

Also, senior women working as Aboriginal Health Workers and Transport Officers in some services are linked to young women in their communities. One senior woman reported that she looks for women in the community if they do not attend their appointments. It was also said that young women usually have family support - *“everyone’s got support around here”* but *“the young girls are shy”* so need to be followed up.

Young women, senior women and service providers in all regions reported that young women who do not have active family support are unlikely to have any pregnancy care. In these cases they reported that young women probably do not have family close to them, there might be significant family breakdown, or other issues such as domestic violence may be present.

One senior woman said it is important for service providers to identify people in the community who have a lot of contact with young women, particularly if some do not have supportive family. She explained:

“Some of the young girls who get pregnant, they either had a big falling out with their families, and once they find out their pregnant, the families either help or they don’t care ‘you got there yourself you can go and deal with it.’ And I think that in some of the cases like with young Anne, who is only 16, and on her second baby and she doesn’t know which way to go. She’s stuck in a horrible place and because she’s 16, her little boy is only 6 months, and the only antenatal care she got [then] was because [the midwife] drove to the house. She’s very tiny, very petite. She only eats when he tells her she can eat. So this is where people like that [the midwives] do the antenatal care. I know it’s a difficult situation, but don’t go in there guns firing, but build the trust”.*

“But how do [service providers] find out about these young girls?”

*“If you reach people in the community who have a lot of contact [with young women], that’s how I got Anne to see [the midwife] in the first place because I had the relationship with her. It’s just finding that one person who knows and is also known in the community. It’s trust, see Anne trusts me and [the boyfriend] would never talk to me the way he talks to everyone else”. *pseudonym used.*

Family or senior women's advice is considered to be very important in getting young women to health services for pregnancy care. Pregnancy and birth is considered "women's business", and young women commonly talked about senior women as advisors. Senior women said that young women "*learn about pregnancy from sitting around with grandmothers*". Young women respect their female relatives as the ones who know what to do in pregnancy, and turn to them before doing anything further. In very remote locations, service providers noted the advice and guidance of senior women may be more important to young women than what service providers say. Service providers also said that Aboriginal people working in health settings are an important link between young women and non-Aboriginal midwives and doctors.

1.3 Accessing Care

Young women have different knowledge about pregnancy care. Some don't know much, and some know a lot about pregnancy and childbirth.

What young women know is mainly learnt from their family members, although some also said healthcare providers, mainly midwives, also educate them. Some young women also remembered having education about pregnancy at school. Not many young women had read a lot about pregnancy. Some are very interested and had read books about pregnancy to know more. Typically, young women looked forward to having their baby, but did not always know a lot about what happens to their bodies or their baby during pregnancy.

Some senior women said that some young women don't like to go [for pregnancy care], maybe because they are shy or embarrassed about seeing someone about their pregnancy. Sometimes their partner doesn't like them to see someone. In some locations, because there is no one who regularly provides pregnancy care this may be a reason that young women don't go, as they don't know who will be at the clinic and may be shy about meeting someone new.

Some young women remembered having tests but did not always understand what the tests were for. Some young women mentioned blood tests, ultrasounds, gestational diabetes tests, iron infusions/supplements. Ultrasounds were the most frequently mentioned procedure and young women said these made their pregnancy "*seem more real*".

"You want to make sure baby is alright and how big baby is – make sure he is growing well".

"I didn't believe it, I had to take three [pregnancy tests] to make me believe it properly... and I still didn't believe it until we had the ultrasound".

Some service providers reported finding an ultrasound picture useful when talking with young women about their pregnancy and how the baby grows. Having ultrasound available in regions "*has made a huge difference with an influx of women wanting to come to an appointment...they want to come in. They want to see baby*".

Access to free ultrasounds was reported as different between the metropolitan area and services in the regions. Young women in the metropolitan area talked about being charged fees of around \$120, and that not everyone would be able to afford this. No one in regional areas mentioned this as an issue.

Young women mainly thought that regular visits with a midwife or doctor were needed to make sure they have a healthy baby.

“If you are stressing out and don’t have support you are going to start thinking stupid things, you might not keep appointments, you probably won’t eat properly and that’s going to affect the way the baby’s growing”.

Young women commonly talked about healthy behaviours during pregnancy. They said they needed to eat healthy foods and not drink alcohol or smoke during pregnancy. One young woman said she had stopped drinking tea because of anaemia problems, another stopped drinking alcohol and smoking when she found she was pregnant, and another had already stopped drinking alcohol because she had planned her pregnancy.

Some young women knew about anaemia and the need for iron infusions, and another young woman knew her rheumatic heart disease was a problem in pregnancy and she needed to attend the clinic regularly. Another young woman said that smoking and drinking in pregnancy was the cause of her second child’s heart condition. For her third pregnancy she had not smoked or drank alcohol and had care from early in her pregnancy to make sure her most recent baby was healthy.

Young women with partners want them to be involved, including being present for childbirth, but also want their female relatives at the birth of their baby.

“They say that you can have two support people, but you are lucky to have one. They tried to get my husband to go out a couple of times and he said ‘I’m not going anywhere.”

“Out there on the Lands, they want company, a grandmother or aunty or husband or whatever, they still want that company. Let them take family and they will be happy then.”

Senior women said that childbirth is women’s business and young women are highly dependent on the support of female relatives as well as their partners.

1.4 Education

Senior women in all regions talked about the need for more sexual and reproductive health education for children (girls and boys) before sexual activity starts. Some said year 7 (aged 12), some thought perhaps year 6 (aged 11) was a good age for this, and in one location at 10 years of age. The best age for education seemed to be about how early pregnancy was happening in a community (in some locations pregnancy for girls as young as 12 and 13 was noted). Local cultural protocols were also important in working out when, how and who should provide this education. One senior woman said that children need:

“Exposure to [knowledge] in a learning environment, rather than through experimenting, and they can also learn about what programs are out in the community to help them”. Some senior women also want more education for themselves so they can educate young people in their communities. As a senior woman, also a health worker, said, she married at 17 and “didn’t know I was pregnant, my mother in law told me. I didn’t even know how it got there”. Even after she had her first baby, she wasn’t told how to stop

becoming pregnant again. She now works with young women in her community to make sure they have pregnancy care and know what is going on.

2. Domain Two: Service Influences

Themes: trusted provider and relocation

2.1 Trusted Provider

Young women see doctors, midwives, and Aboriginal Health Workers. Most attend an Aboriginal Health Service because: “you get a lot of young girls there” and “there’s more support there, it’s really good”.

Which service they choose depends on what is available, or what transport there is to get to a service. One young woman said she visited her local AHS, but doesn’t always feel confident to ask questions at visits. She prefers to ask family members but she also prefers “to see *the same person*” for her care at the AHS. Many young women said the choice of health services is often limited in regional locations, and transport access also has an impact on which service young women use.

Keeping personal information private when a pregnancy is first confirmed is the main reason for not wanting to attend an AHS at the beginning of pregnancy. Young women said that Aboriginal staff might talk about their pregnancy (or other things) to other community members without their permission. Some young women said they get around this problem by attending an AHS when they know they will see a non-Aboriginal person. Once they had told partners and family members about their pregnancy, this is not considered to be such a problem. Sometimes though young women preferred to go to a hospital, or a doctor, and not an Aboriginal Health Service.

One young woman said she “*felt secure having seen the same midwife for all her pregnancy visits*”. This helped her to feel comfortable and able to talk about her pregnancy because she got to know the midwife. Another said there “*are too many white people up the big hospital*” and she prefers to attend the AHS.

While some young women had seen a doctor, and some a midwife, most young women said they needed to trust whoever they saw. They also said there were differences between doctors and midwives. For example:

“With the doctors you just go in there and have an appointment and that’s all [but] the midwives get you ready.”

“With the midwife, when you see them and they are telling you about what is going to happen when you have the baby, and when you get there it comes back to you. They prepare you more.”

Young women in the metropolitan area have more choices than those in rural and remote locations, and some regional centres provide some choices. Young women said they rely on services providing appointment reminders and transport to help them attend clinics for pregnancy care. Young women mostly prefer to see the same person for antenatal visits. This is because they get to know the person and feel more confident about asking questions about their pregnancy. Young women have a preference for seeing women service providers. However, respect and familiarity with individual healthcare providers is also a factor. Some young women said they are more concerned with being respected by whoever is looking after them. One young woman said, “*I just*

want to be treated with respect, that doesn't happen, there is no respect". This was mentioned by some other young women and some senior women. Hospital staff are more likely to be identified as being disrespectful than community based service providers and young women often said they were *"too shame"* in a hospital environment. This usually meant they were reluctant to ask questions of strangers.

2.2 Relocation

Young women in many locations (particularly in the Midwest, Goldfields and Kimberley) know they need to leave their home communities to have their babies. One young woman in the metropolitan area was also concerned about having to go to a tertiary hospital and instead wanted to go to a hospital closer to her home.

Relocation does not always affect young women's ongoing pregnancy care. Some accepted they need to go away, but are concerned about being away from family for a long time. Some senior women and service providers said the health system requirement for relocation is the main reason young women stop attending their antenatal visits in late pregnancy, but this was not confirmed by any young women in this study. Relocation for childbirth usually occurs between 4-6 weeks prior to a due date where there are no local maternity services. Senior women said that childbirth is the time young women's dependence on family support increases. Young women confirmed their strong desire for their female family members to be present for childbirth. In different consultations, it was explained there is a strong cultural connection for the whole family when a baby is being born.

Service providers said that some young women wait until labour and then go to a local hospital. They know this means being flown out by Royal Flying Doctor Service (RFDS) and not having family with them for childbirth. However, the overall period of time spent away is shorter (3-4 days) than 3-4 weeks or more spent away from family if relocating at 34-36 weeks of pregnancy. Senior women in some locations said that many young women wait until they are in labour, *"most of them do"*, so they will go out on the RFDS.

"Some women have their babies up at the hospital because they leave it to the last moment to come in."

"So they leave it until they are ready to have the baby and then they fly them out."

Senior women also said that relocation for childbirth would be less of a problem if *"family go with them"* and *"even if they limit it to one person getting on the plane with them, that's [better]"*.

Senior women and service providers also talked about how young women are returned to their home communities after childbirth. For some young women, this might mean a long bus journey (for example, 14 hours) with a new baby and they may not have anyone with them. This was thought to be very harsh and unsuitable. Senior women said the Patient Assisted Transport Scheme (PATS) does not support young women who *"cannot be expected to challenge any transport decisions made about how they return home"* and does not support family members/partners to accompany them.

Relocation for diagnostic testing was also noted by service providers as an issue. For example, in the Kimberley region, morphology scans need to be done at Derby, Broome or Kununurra hospitals. Convincing young women of the need for these scans, particularly if they have already had an

ultrasound and the arrangements to get young women to other locations is a problem for service providers. They said that these relocations require admission to a local hospital and an orderly taking a young woman to a bus in the early morning hours to send her to the nearest facility. The reverse occurs for return of the young woman. They said this puts young women off having some aspects of their pregnancy care.

Senior women also talked about other concerns with relocation for childbirth. Many had their own children in locations that now offer no childbirth services. Even though the facilities are still in place there are no onsite medical or midwifery staff (for example, in Meekatharra and Moora). They were disappointed these services no longer operated because it would be easier for everyone if they did. Also, senior women said that people who are known to young women *“as long as they are the right person and work well with local people”* are required to maintain relationships. This doesn't happen when young women have to go away.

Relocation accommodation in the metropolitan area and the regions was also raised as a problem. Some accommodation facilities were seen to be inappropriate, because there was nowhere for family members to stay and help. One senior woman spoke about how young women are supposed to manage having showers or going to the toilet when they don't have family with them. *“What are they supposed to do with the baby? Lock them in their room?”* Some accommodation is considered to be unsafe because both men and women are accommodated. Senior women also said that young women can experience isolation and loneliness when away from home and they are very shy, or *“too shame to speak with strangers”*.

SUMMARY OF RESULTS BY INFORMANT GROUP

The following summarises the data collected from the main informant groups: young women, senior women and service providers.

Young women: are sometimes concerned and sometimes excited about being pregnant. Some young women knew a lot about pregnancy, but most didn't. Most said they understood the need for pregnancy care from early in pregnancy, because they have been told about this by their female relatives.

Young women need familiarity and an ongoing (continuous) relationship with healthcare providers. They place trust in a known carer and this helps them maintain their privacy. The gender of health professionals was not a problem if the young women felt comfortable and confident with an individual, but young women mainly prefer to see women healthcare providers. They noted some problems regarding privacy (and confidentiality) when attending AHS. To get around this, young women select different services, sometimes a hospital clinic, or wait to see a non-Aboriginal staff at an AHS. Young women mainly prefer to attend Aboriginal specific services. They also need appointment reminders and transport to attend pregnancy care.

Family support is very important to young women. Relocation for childbirth is difficult if family members/partners don't or can't go with them. Young women are scared when having their baby and need family support and guidance during this time.

Some young women said more information needs to be available to young women about where they can go for pregnancy care and what choices are available. Ultrasounds were often mentioned

as a highlight of their pregnancy care. For young women in the metropolitan area, the cost of privately provided ultrasounds is a problem. Finally, young women want to be respected by service providers in all settings.

Senior women: are the main people who tell young women to attend clinics for pregnancy care and provide ongoing support to them. Senior women are active in connecting young women to service providers. They want more sexual and reproductive education for girls and boys from around 10 years of age. Senior women in some locations also wanted more education for themselves so they can educate their young family members.

Senior women are concerned about inappropriate accommodation, (particularly in Perth and Geraldton) with limited or no family accommodation available. They said young women are sent away at a vulnerable time when they are highly dependent on family support. Senior women said that PATS does not support young women and does not support family members/partners to accompany them.

Senior women also have a role in following up with young women in communities (for example, links between young women and non-Aboriginal service providers, providing transport for appointment attendance, reminders etc.). They also said that young women tend to trust midwives more than doctors, but this was dependent on individuals.

Senior women said that young women need support from known people and Aboriginal specific programs are best for them. Cultural protocols, such as acknowledgement of Aboriginal culture in hospital settings and healthcare providers who show understanding of Aboriginal women's circumstances are important and that young women are likely to be more comfortable with female carers, although young women reported they were less concerned about the gender of the carer. Service Providers: said that most young women understand the need for pregnancy care. They said there is a trend in many locations for young women to start pregnancy care between 12 and 20 weeks, and often before 12 weeks. Some young women from very remote communities are less likely to have care, as service delivery capacity is often limited. A high degree of movement of young people between very remote communities and difficulties with communications also makes it difficult to arrange appointments in some circumstances. In these cases, pregnancy care for young women may be more opportunistic.

Service providers are: active in following up with young women, especially those in remote communities; encourage and support young women to attend pregnancy care; and, foster relationships with senior women in communities. They said that young women seem to prefer one to one care with the same service provider. These relationships provide the opportunity for education on a one to one basis. The use of ultrasound was noted as an effective device for getting young women to attend pregnancy care visits. Many service providers also work closely with Aboriginal Health Workers and senior women in the community to keep young women involved in pregnancy care.

Pregnancy care may stop in the final weeks of pregnancy in some locations. Service providers said this was mainly due to young women having to leave their home community up to 6 weeks prior to their due date. Service providers confirmed that young women need support and the opportunity for a trusting relationship with someone they know. They said many services are striving to achieve this continuity to improve the likelihood of ongoing pregnancy care. Sometimes, young women may not attend visits, and healthcare providers deliver opportunistic care when they are able to meet with young women during pregnancy.

This case study is drawn from an interview between the project Aboriginal consultant and a young woman. Consent has been granted for its use. The young woman's story illustrates many of the issues raised during consultations.

At the time of interview Jane was 18 years old with an 8 month old baby. At 17, she presented at a local hospital because she was feeling sick. Jane was told she was pregnant, and she thinks she was about 6 weeks at that time. She was nervous and shocked and because she is the youngest daughter, and it was hard to tell her mum. All her sisters have children. Jane's mother had talked with her and her sisters about pregnancy and wanted them to have a life before having babies.

She used to have fun before, smoking gunja and drinking. Jane talked about how she and a younger brother would get into trouble and that she had twice been in a remand centre, and found it scary. The second time she started to think that it was not where she wanted to be: "it was an ugly place".

She stopped all of this when she found out she was pregnant and still doesn't do any of these things. Jane sometimes lives at home with her mum, but if they have arguments, she moves to her dad's house. Sometimes she doesn't know where to go. She has her own car and keeps everything in there. She is waiting for her own home and is getting assistance from local agencies.

When she was pregnant Jane attended a young mothers group at the local youth centre, where she met a case worker from Best Beginnings. At the group they talked about staying healthy in pregnancy, and not drinking and smoking. She found out about the group through the AHS where she went for her pregnancy care. She liked going and knew some of the girls there as well. After she had her baby, the case worker visited her at the hospital and they still have close contact.

Jane went to appointments for pregnancy care by herself and that was okay but sometimes she had to wait a long time to see someone. For the first ultrasound, her sister went with her. When she wanted to ask questions, she waited to see the midwife at the AHS. She thinks that pamphlets and books are good to have when you are pregnant and she read a lot. Also her sisters told her about what to expect. She said:

"Sometimes I don't really like to go to [the AHS], because they're taking a long time to call your name and because everybody talk about that place. They tell the whole room. Like they look into your files, that's why nobody really likes going to [the AHS] and I don't really like going. I normally go up to the big hospital, I go to [the AHS] when I got an appointment with one of the white women. I see the white people, not the blackfellas."

When she was having her baby, her mum and sisters were with her. Jane talked about having the epidural before her caesarean section and she found that scary. She talked about her sister having a caesarean and after her sister came home her scar "had burst open" and she had been taken back to hospital. This was just before Jane was due to have her baby and this made her more frightened.

"I was scared, thinking oh my god, I hope I don't have that caesarean, but I had to because he

was stressed and an emergency. And my sister, when she had her baby the cord was wrapped around the baby's neck and now something is wrong with the little girl's hip – it's a bit crooked than the other and even the other leg is bigger than the other and it was scary and I was thinking something would happen to him because I was smoking gunja and drinking and she never used to do that.”

When asked about younger women being pregnant, Jane said they don't understand about having babies. Before she had her own baby she thought she would be able to do what she liked once the baby was born and that she would be able to go smoking and drinking, and she said this is what a lot of young women thought. Jane said that while she isn't worried now about having fun or freedom, because now it is all about her baby, she knows that very young girls don't really understand what having a baby is about. Jane said:

“Well some of these young ones here they don't [care] really, they just have kids and throw them away. It looks like they just have the baby for the money and then dump them with their parents. Cause you look at them, they walk around drunk, stoned, everything. They're younger than me, 14, 15, 13, and they just throw them kids away. They don't care, they think it's a game”. It wasn't until she had her baby that she knew that her life was different now.

“To me, you know, I thought it was fun having a baby. Cause I thought it's just a baby, I can go drinking and smoking gunja you know. Then I just said no, I can't do that...with [the baby] it's just too hard...sometimes I can't even get up to have a shower or toilet you know. Having a baby is very hard”.

Since having her baby Jane has done a TAFE course and plans on doing more education. She goes to community health for baby health checks and immunisations and does this on her own as she doesn't need transport.

She knows one girl, who had a baby at 12, but the grandmother has the baby, and also a cousin who had a baby at 14 or 15, and the baby is also being cared for by the grandmother. “But some of the ones here, they make you wild just looking at them, and some of them younger than [my baby], still newborn. Sometimes they bring the baby with them walking around drunk, fighting with their partner.”

She thinks the very young girls who get pregnant don't have anyone to support them or tell them how to look after themselves. Even though she had her mum and big sisters, she had been like other young women “running away, and getting into stolen cars, having accidents and getting in trouble”, but she said at that time she didn't care. She knew that her mum and sisters were worried about her but she didn't think much about that. Now that she had her own baby, her family say “now you realise” and she does not want her child to do those things.

She also said that living in a house where there is smoking and drinking and arguing is not good for her baby. She spoke about one time when her baby's father and she were fighting – “that's why he was trying to be like his dad, fighting with me, like his dad does with his mum, and that's why he doesn't live with us anymore I told him to go, because he wants to smoke gunja and drink and go and have fun”. She added, “I want to move from [here], get a house, go to another place”.

Table 2

| THEME SUB TOPICS | | Reported by | Region | |
|---|---|--|---|---|
| Domain One: Community and Cultural Influences | Young Women start from a position of: Vulnerability (personal acceptance; privacy; acknowledging/announcing pregnancy/informing family) | Young Women Senior women | Midwest; West Pilbara; Goldfields; Kimberley; Metro Metro | |
| | Young Women are reliant on: Family Support (for guidance, advice, as a source of pregnancy knowledge) | Young Women Senior women | Midwest; West Pilbara; Goldfields; Kimberley; Metro | |
| | When family support is not present the risk of irregular or no antenatal care increases | Service Provider | Midwest; Goldfields; Kimberley; Metro | |
| | Family support has a direct impact on Young Women: Accessing care (knowledge of/direction to care; purpose of visits; self-care; and, concerns about childbirth) | Young Women Senior women Service Provider | Midwest; West Pilbara; Goldfields; Kimberley; Metro Midwest; Wheatbelt; Metro Midwest; Goldfields; Kimberley | |
| | Senior Women(and some Young Women) typically reported the need for: Education (of young girls and boys: in community; in schools; prior to onset of sexual activity (ages 10+), and; senior women/men educated to provide education and information to young people) | Young Women Senior women | Midwest; West Pilbara West Pilbara; Wheatbelt; Kimberley; Metro | |
| | Domain Two: Service Influences | Regular engagement with antenatal care is reliant on a: Trusted Provider (midwife/doctor/other): | Young Women Senior women Service Provider | Midwest (relationship); West Pilbara (relationship, accessibility, choice); Goldfields (relationship, preference); Kimberley (relationship, preference; Metro (relationship, preference, choice, accessibility) Midwest (relationship); Wheatbelt (preference); Metro (relationship) |
| | | These factors represent key elements of culturally secure antenatal services | Midwest (relationship); Metro (relationship); Kimberley (relationship; accessibility; choice); West Pilbara (relationship; accessibility) | Goldfields; Kimberley |
| | | Disengagement with antenatal care is likely impacted by: Relocation (involving leaving family, often for extended periods, being unaccompanied, via inappropriate transport (long bus journeys) and in inappropriate accommodation) | Young Women Senior women Service Provider | Goldfields; Kimberley Midwest; Wheatbelt Goldfields |

DISCUSSION

The results suggest that young Aboriginal women are accessing pregnancy care, and attending regular visits across the course of pregnancy, in keeping with International and Australian standards (AHMAC, 2012). These visits mainly occur in culturally secure services located either at Aboriginal Health Services, or in some locations, Aboriginal specific programs in public hospitals and community based settings. The availability of these services is in line with current approaches to improving culturally secure service delivery to Aboriginal women (Tai-Roche and Hills 2013; AHMAC, 2010 & 2012; Larson and Bradley 2011; Reibel and Walker 2010; Wilson 2008; Mohajer et al 2009; Stewart and Walsh 2011; Kruske et al 2006). The recent advent of models of care broadly referred to as Aboriginal Maternity Group Practice in Western Australia seem to improve young Aboriginal women's access to antenatal care.

Data analysis strongly suggests a typical set of actions leading to young women's engagement with pregnancy care. This starts with a young woman identifying she is pregnant and her vulnerability at this time is expressed through a preference for privacy and not wanting other people to know her business before she has time to tell family members. Young women then usually turn to a female relative, most often a mother or grandmother for advice. Almost without exception, they continue to be reliant on female family members (including in laws) for guidance, advice as to what to do and as a source of knowledge throughout pregnancy. Female relatives (mothers, grandmothers, aunts, sister/cousins) are most often responsible for directing young women to pregnancy care. The first encounter with a service provider may then influence how regularly a young woman continues with antenatal appointments. When this is a positive experience, the young woman is more likely to return for subsequent visits.

The primary motivating factor for young women to first attend for pregnancy care therefore is strongly associated with the advice and assistance family members give to young women when pregnancy is confirmed. Familiarity or a relationship with an individual healthcare provider then seems to be a strong predictor of ongoing antenatal attendance.

Even when a health service is providing an optimal (culturally secure) model of antenatal care, there may be other factors present which influence or interrupt ongoing attendance for pregnancy care. For example, the location of the health service and if young women have transport to get there or, external health system factors such as the requirement to relocate for certain types of diagnostic procedures and/or childbirth, where there are no local childbirth services. Further, the level of support provided by family members, or by a health service, may also influence attendance. Where a positive relationship with a healthcare provider is established this seems to support and encourage ongoing care. These factors are interdependent, and may in turn be influenced by family or community knowledge about pregnancy care, the availability of transport, and, service protocols and policies. To improve attendance, service providers sometimes leverage family relationships to influence young women's engagement with pregnancy care. Without supportive family, young women may not attend any pregnancy care. Service providers who establish connections with influential local senior women to identify and link with young women may have more success in encouraging regular antenatal care for all young women in a community. This is reliant on local service providers establishing authentic relationships with community members and trusting relationships with individual young women (Crook et al, 2013).

All of the young women consulted for this study reported having regular pregnancy care visits, most often with an Aboriginal Health Service, usually from early in pregnancy. Service providers also confirmed that generally, young women are having regular antenatal visits, but this is highly dependent on services taking an active role in managing young women's pregnancy care. This is achieved in a variety of ways, such as using young women's interest in seeing their baby via ultrasound as an opportunity to provide pregnancy care and education. Further, using 'bi-cultural' approaches which combine clinic based and outreach services (Aboriginal and non-Aboriginal healthcare providers) appear to be successful in achieving regular pregnancy care visits by young Aboriginal women.

Once pregnancy care commences, young women's ongoing engagement appears to be influenced by healthcare providers, mainly midwives and Aboriginal health workers, and sometimes doctors. Services use active measures including appointment reminders, transport to and from appointments, and follow up home visits where attendance has dropped off. Some also offer incentives to young women, such as baby packs, ambulance cover, or car capsules, to maintain ongoing pregnancy care. It is evident that to achieve regular antenatal visits by young women requires a high degree of healthcare provider/service involvement. Furthermore, making connections with influential senior women in communities may also have a positive impact on antenatal engagement. These factors are necessary inclusions in models of care directed at young Aboriginal women to achieve consistent pregnancy care. Aboriginal Maternity Group Practice models of care implemented in a number of locations throughout Western Australia exemplify these approaches and this study confirms the requirement for culturally competent approaches to the delivery of antenatal care for all Aboriginal women, regardless of their age.

The need for proactive interventions does indicate that young Aboriginal women are not necessarily taking responsibility for their care thus requiring active management by service providers, often in collaboration with family or other community members. This may be due to young women not fully appreciating the importance of antenatal care, which may be associated with sometimes limited knowledge of pregnancy. This interpretation is supported by senior women's persistent reporting of the need for more education for young people in the primary school years to improve understanding of what pregnancy involves and why pregnancy care is important.

Overall, the occasions when young women seem most concerned about their pregnancy is at the time of informing family members and then about childbirth itself. The time in between seems to be mainly associated with passive acceptance that pregnancy is the waiting that happens before the baby comes. Even so, young women consistently reported understanding the need to eat healthy foods, and to not drink alcohol or smoke during pregnancy. These aspects of pregnancy have been targeted in recent times with the production of an array of Aboriginal specific resources about these topics which may be having an impact on young Aboriginal women's understanding of a healthy pregnancy where they have access to the resources. Having an ultrasound to see their baby was most consistently mentioned by young women as a positive aspect of pregnancy care. In the metropolitan area it was noted that a fee may be incurred if attending private facilities for an ultrasound scan or other diagnostic tests. Young women need to be made aware that these aspects of clinical care are available at no cost as part of routine antenatal care in public facilities. Some service providers use ultrasounds as a means to engage young women's interest in their pregnancy, although this needs to occur within the accepted clinical guidelines for the use of ultrasound in pregnancy.

Having a consistent relationship throughout pregnancy with a specified care provider is preferred by young women. Although most young women prefer to see a female health provider, they are also most concerned about having a respectful relationship with whoever they see. Even when confidentiality or privacy was raised as sometimes being an issue, young women preferred to visit known people as this makes them more confident to ask questions. Continuity of care by a known carer (a continuous relationship) is a component of culturally secure women-centred care and has consistently been noted in the literature as essential to improving ongoing antenatal engagement by Aboriginal women with health services (Stamp et al 2007; Ireland et al 2011; Kruske et al 2006; Reibel and Walker 2010). It is also supported by the approach to providing high quality maternity care set out in the National Maternity Services Plan, for example as articulated in Priority 2.2. of the Plan.

In metropolitan, rural, regional and remote locations, many young women attend health services which use a midwife/Aboriginal Health Worker/Grandmother Liaison Officer (as per the Aboriginal Maternity Group Practice model of care) or sometimes involving links with local senior women. Young women in the metropolitan area sometimes use general practitioners for their care, but this is unusual. Most young women seem to prefer attending Aboriginal specific services, although they are selective and sometimes choose, for example, hospital based services to maintain their privacy. Any services which provide a culturally secure or safe environment appear to be welcomed by young women. While this was not always explicit, discussions regarding who best to see in pregnancy clearly indicated a preference for healthcare providers working in Aboriginal specific services, even when these providers were non-Aboriginal. Young women were more likely to report that healthcare providers working in hospitals are not always respectful towards them. This indicates further work is required to improve cultural competence within health service settings, in line with current Western Australian Department of Health protocols and policies.

In very remote communities, for example in the Pilbara, Kimberley and Goldfields regions, service providers confirmed that some young women do not have access to regular pregnancy care from a midwife or doctor. Antenatal care in these circumstances is often opportunistic. In some regions there are also a range of logistical issues associated with providing anything more than basic antenatal checks. This is compounded by young women being very reluctant to leave their communities for clinical checks (such as morphology scans) or to relocate in the weeks prior to their due date for childbirth. The main reported reason for this reluctance was concerned with being away from family and familiar surrounds at a time when they heavily rely on their family members for support. This has also been noted by Tai-Roche and Hills (2013) in their reporting of birthing practices and options for remote area Aboriginal women. The express cultural and psychosocial needs of young Aboriginal women is an important component in developing models of care which facilitate a safe, culturally appropriate and supported birth experience.

Targeted sexual and reproductive health education for Aboriginal girls and boys while they are still in primary school was emphasised in the consultations. Aboriginal specific sexual and reproductive health education programs such as the Core of Life or the Family Planning Association's Mooditj Leader Program may be appropriate for inclusion in the curriculum. Senior women also identified their own need to be better educated in these areas to provide good advice, guidance and education to young people in their families.

WHAT THIS STUDY ADDS TO THE CURRENT EVIDENCE

This study identified a number of factors associated with young Aboriginal women's decision to engage with pregnancy care.

It has demonstrated that the role of female family members in directing and maintaining young women's engagement with antenatal services is crucial. Further, it has established that Aboriginal Health Services, using a 'bi-cultural' approach to providing pregnancy care, are acceptable to young women and they are highly likely to use these services in preference to hospital based services. Exceptions are when a targeted (Aboriginal) and culturally secure model of care is in operation in hospital or other community based service setting. Where there is more than one antenatal service available locally, young women are selective in their use of these to maintain their privacy. Young women expressed a need for more choices in who they see for pregnancy care, as these are often limited in regional areas. Active management of pregnancy care (for example, providing appointment reminders and transport to and from appointments) is necessary to maintain antenatal contact.

The most concerning aspect of pregnancy care for young women is related to relocation from a home community to a regional or tertiary facility to wait for childbirth. As this often entails a minimum of four weeks away from a home community, this is regarded as a significant concern. It was suggested the requirement to relocate may interrupt pregnancy care in the final weeks of pregnancy. In regions, young women may wait until they are in labour before presenting to local health services in the knowledge they will be evacuated by Royal Flying Doctor Service. Accommodation choices when being relocated is also a cause for concern. Many facilities do not allow for family members to stay, some explicitly exclude male partners, and others are considered 'unsafe' for a range of reasons, including complex cultural protocols regarding intra and inter family relationships and contact. Transport options to and from home communities were also noted as sometimes being inappropriate.

From a cultural perspective, being accompanied by multiple family members (for example, a partner, mother, grandmother and sister) for childbirth is confirmed as an ongoing and significant cultural practice. Young Aboriginal women strongly expressed their need to have female family members present to support them and allay their fears.

STRENGTH OF RESULTS

The strength of the data presented in the findings is in the common reporting of experiences of pregnancy care. While some minor differences were evident, mainly on a regional basis, young women reported remarkably similar views and opinions about most aspects of pregnancy care regardless of the location of their home community. Further, senior women and service providers confirmed many aspects referred to by young women.

LIMITATIONS OF RESULTS

The young women consulted for this project were mainly recruited through health services which provide pregnancy care. As such, most participants reported having been involved in regular pregnancy care and this represents a bias in the data. No opportunity presented itself to seek the views of young women with none or limited interaction with antenatal services during pregnancy. Caution is required when considering the findings described in this report, which may not be representative of the experiences of all adolescent Aboriginal pregnant women in all regions of Western Australia.

CONCLUSION

This project has identified how and why some young Aboriginal women access pregnancy care in Western Australia by asking them about their use of services and knowledge of pregnancy. It has identified factors associated with their early and ongoing contact with pregnancy care providers. Firstly, the role of female relatives in directing young women to healthcare providers once pregnancy is confirmed. Secondly, access to a culturally secure pregnancy care service, such as those located in Aboriginal Health Services, is preferred. Thirdly, the opportunity to build a relationship with a known carer is required. Efforts are being made in many locations to provide culturally secure antenatal services, and it was evident from the consistent reporting of regular visits that this is having a positive effect on young women's engagement with pregnancy care.

Senior women and service providers noted that young Aboriginal women are generally compliant regarding pregnancy care because they are strongly influenced by female family members and will follow their advice where there is active family support. There was no evidence in the consultations to support the need for separate antenatal services for young pregnant Aboriginal women. Young women did not indicate they have different needs or require separate services from their older counterparts. A lack of choice for pregnancy care was reported, with some locations providing only one antenatal service. Combined with perceptions of privacy issues, this may influence young women's decision not to seek pregnancy care.

The primary area of concern related to young women being required to leave their home communities to attend another location for childbirth up to six weeks prior to their due date and this is the least culturally secure aspect of pregnancy care in some regions. It was reported that young women often had only one support person, or none, on these occasions. This was most evident in consultations conducted in the Midwest, Pilbara, Goldfields and Kimberley regions. In these regions it was also reported that young women disengage from antenatal care in the final weeks of pregnancy and wait until they are in labour before presenting to a local health service for evacuation. Further efforts need to be made to provide familial support to young women requiring relocation during a very vulnerable time in their lives.

The presence of family members to support young women in childbirth is also an important cultural practice. Therefore, a documented patient journey for young Aboriginal women required to leave their home communities would improve the cultural security of antenatal service delivery. This might include, for example, the availability of appropriate financial provision for escorts, accommodation and transport options to other locations during the final weeks of pregnancy. Establishing a different approach to relocating young Aboriginal women would assist in securing improved life course health gains for mothers and their babies by supporting sustained pregnancy care up to the time of childbirth.

RECOMMENDATIONS

Young Women's Voices on Pregnancy Care

Young women clearly voiced their need for pregnancy care that supports them during a vulnerable time in their lives and:

- respects their choice, privacy and confidentiality at all times and in all service settings,
- is open, non-judgmental and respectful, and includes local Aboriginal women elders and, grandmothers in pregnancy support and education,
- provides a continuous relationship with a known carer (Aboriginal Health Worker/midwife), and,
- support of a family member/partner when travelling and during birthing at the chosen birth hospital.

Young Women's and Senior Women's Voices on Opportunities for Engagement

The crucial role Aboriginal family relationships have in encouraging early and ongoing antenatal engagement by young pregnant Aboriginal women can be used to promote service delivery which:

- Builds relationships with influential local women Elders/community members to support:
 - knowledge exchange about pregnancy and childbirth and associated local cultural practices,
 - dissemination of information about pregnancy care and available services,
 - identification of young pregnant women,
 - identification of the best methods for pregnancy related health promotion, and
 - local Elders/community members to acquire any additional knowledge they need to inform and educate children and young people in their communities about pregnancy and pregnancy care.
- Provides culturally secure models of care, which incorporate the opportunity for young women to have continuity of care, and, promotes outreach;
- Recognises and celebrates Aboriginal culture by way of displaying paintings, artefacts and posters in all hospital and health service settings;
- Improves the cultural competence of health professionals and other service staff through continuous Quality Improvement initiatives.

Locally informed operational and/or reconciliation action plans addressing these actions, would build organisational cultural competence and relationships with Aboriginal people in local communities.

Young Women's, Senior Women's and Service Providers Voices on Relocation for Childbirth

Being required to leave home communities to attend another location for childbirth may be challenging for young Aboriginal women who may be out of their comfort zone in an environment they have not previously experienced.

A documented patient relocation pathway is required to support young Aboriginal women to feel safe. This includes:

- securing appropriate transport from and back to home communities;
- assistance for escort/support people to be present for the duration of the pregnant woman's relocation (including changes of support people over that time);
- accommodation options and social support services at the relocation site, including access to an Aboriginal Liaison Officer;
- detailed information about the cultural practices/expectations of individual Aboriginal women is forwarded for the information of health service staff at the relocation site.

Young Women's and Senior Women's Voices on Health promotion and Sexual Health Education

To improve knowledge and understanding of pregnancy, and pregnancy care and taking into account local cultural practices and protocols:

- Maternity and Community Health services, in all organisations and regions, work collaboratively with local Elders, the Department of Education and other relevant departments and organisations, to develop and deliver culturally appropriate school and community based sexual, reproductive and pregnancy care health education and health promotion activities.

Examples of existing educational programs include the Core of Life (<http://www.coreoflife.org.au/>) and the Mooditj Leader Program delivered by Family Planning WA.

Appendix 1



Figure 1
Governance Model 1 Young Aboriginal Women's Voices on Pregnancy Care

APPENDIX 2

Overview of Young Women's Consumer Advisory Group

Three meetings were held with: December 2012, February 2013 and November 2013.

In total, seven young women in the target age range, all of who had a baby or were pregnant, participated over the course of these meetings, with between 3 and 5 present at each meeting.

The first two meetings were concerned with types of questions that would be asked of young women during the consultations. The Advisory Group members advised which were appropriate (most), but which ones needed to be changed to avoid shame. The final set of questions is shown below.

The Advisory Group members also provided insight into issues of importance to young Aboriginal women when they are having a baby. Primarily, these were:

- Most of them shared the same feelings as to how they reacted when they thought they were pregnant, most felt scared or frightened.
- All had support of their mother's, sister's and family members, and each had an understanding of pregnancy care, and knew that regular check-ups were a part of being pregnant.
- It was also important to have that one person they can see all the way through their pregnancy, as they felt comfortable, than to go to a different person each visit.
- They also stated that it was scary when you had to tell your mum and family that you're pregnant, but also when it came time to have their baby.

Apart from assisting with the development of the questions, the Advisory Group members also provided comment on partners being present during consultations (often not appropriate, but okay if a young woman wanted her partner to be present) and if skype or telehealth consultations were appropriate. The group decided face to face was the best approach. The group were also concerned that young women with no support during pregnancy needed access to a resource booklet that provided them with information on pregnancy care.

Questions agreed by Young Women's Advisory Group as appropriate to ask young women during consultations.

- ***Who do young Aboriginal women tell when they are pregnant and why do they tell this person/people?***

How important is keeping your information private?

Who did you tell about being pregnant (and why)?

What family support do/did you have?

What type of health service do you feel confident to attend?

Do you want options/choices about where you go and who you see?

- ***Who are the young women learning about pregnancy from and does this influence their decision making process?***

Who do/did you trust most to speak with about being pregnant

Did you know who to see about having being pregnant

Outside of your family, is there someone else you want to be able to talk with and get support from?

Where should pregnancy care services be located and who should be there?

Do you prefer a female or male to look after you when you are pregnant?

- ***What do young women know about pregnancy and pregnancy care?***

What do you know about pregnancy care?

Do you think it is important to have regular visits with a doctor or other health worker when you are pregnant?

What sort of information and services do you think you need when you are pregnant?

What concerns do you have about visiting a pregnancy care service?

At the final meeting of the Young Women's Advisory Group in November 2013, the researchers presented a summary of findings to the group. It was agreed that many of the issues which arose during the consultations had been highlighted by the group at the first two meetings.

APPENDIX 3

Data Collection Protocols

Interview Protocol and questions (1:1/small group) for young women, Elder women and community leaders and health service personnel

The Research Assistant and Principle Investigator will conduct all interviews using the following protocol:

1. A positive rapport will be sought with participant/s in the initial stages of the interview, assisted by the RA and PI sharing something relevant about themselves (where they are from, how many children they have, when they had their children, etc). The PI is an experienced interviewer and has worked with Aboriginal people in a range of settings across the State to collect qualitative data. The RA is a research mentee and will be assisted to take the lead in community consultations in addition to acting as a cultural advisor to the PI to assist with promoting a culturally secure approach to consultation processes.
2. The purpose of the research will be clearly explained to participants both verbally and in writing.
3. Written or verbal consent for study inclusion and audio recording will be obtained prior to commencing the interview.
4. In place of, or in addition to, audio recording, written notes will be taken by the PI. Notes capture key points and provide immediate summary material and prompts for field notes. Field notes are then jointly prepared by the PI and RA immediately following interviews to record a detailed summary of the discussion.
5. Participants will be offered the opportunity to read a transcript or summary of the interview in an agreed format (hard/electronic copy/verbal reporting) once these are prepared.

Participants in the young women consultations will be asked questions in relation to the following areas. These questions will be refined once consultation has taken place with the Core Community Consultative group and they have provided advice to the Research Team. For example:

- What do young women know?
 - What do young women know about pregnancy care? Do they think it is important?
 - How do young women access information and services when they suspect they are pregnant? (For example: what do young women do when they think they are pregnant, what options do they have for confirming pregnancy, what is their next step when they confirm their pregnancy, who do they go to, what services or resources do they use?)
 - What concerns do young women have about attending a pregnancy care service (what issues are most prevalent – fear, shame, shyness, lack of knowledge of the importance of pregnancy care)?
- Who are they learning from?
 - How do young women make their decisions about pregnancy care (for example, who do they trust, who are they most confident and comfortable seeing, what are their cultural needs and how important is it to have their cultural needs met)?
 - What level of pregnancy support do young women want (for example, who do they want to provide that support – a family member, a midwife, an Aboriginal Health Worker)?
 - Where should pregnancy care services be located? How important is choice of services?
 - Who should be providing the antenatal service (is seeing the same carer important, who do they most prefer to see during pregnancy (a midwife or general practitioner; how important is the gender of a health worker to young women)

- Who do they tell and why?
 - How important is confidentiality to young women (for example, are young women concerned about who might find out about their pregnancy if they use a service, are they concerned that their information may be shared with other people)?
 - What family support do young women have (do they have stable accommodation, are they still attending school, do they intend to return to school, how do family dynamics impact on their personal choices)?
 - What type of pregnancy care service do young women want to attend (mainstream, youth specific, AMS, local hospital, other)? Or, do they want options?

In the case of a small group interview, questions will act as discussion prompts.

APPENDIX 4

Table 3: Consultation Sites and Participants

| Region | Site Location | Participants |
|--------------|------------------|---|
| Metropolitan | Langford | 4 Grandmothers 4 mothers |
| | Armadale | 3 young mothers 1 grandmother |
| | Kwinana | 6 young mothers (5 male partners) 2 mothers |
| | Rockingham | 1 young mother 2 young women |
| Kimberley | Broome | 3 young mothers 2 service providers |
| | Derby | 1 young mother 1 grandmother 1 service provider |
| | Halls Creek | 1 young mother 2 grandmothers 1 service provider |
| | Fitzroy Crossing | 1 service provider |
| | Bayulu | 3 service providers |
| Pilbara | Newman | 2 service providers |
| | Karratha | 2 young mothers |
| | Roebourne | 2 young mothers 3 service providers |
| Wheatbelt | Moora | Mothers (4), grandmothers (4), a young woman, and a service provider |
| | Pingelly | 1 young mother, 2 mothers 2 grandmothers 1 service provider |
| Midwest | Geraldton | 1 young mother (and male partner) |
| | Mt Magnet | 3 young mothers 1 service provider 2 grandmothers |
| | Meekatharra | 4 grandmothers 2 service providers |
| Goldfields | Kalgoorlie | 2 young mothers 3 service providers |
| | Leonora | 2 young mothers, 1 mother 2 service providers |

APPENDIX 5

Table 4

Theme Domain One : Community and Cultural Influences

VULNERABILITY:

Confirming pregnancy

Home pregnancy tests are commonly used by young women to confirm they are pregnant but they also visit services to have pregnancy tests (because these are free). Many young women talked about being scared about telling family members, even though the news was most often well received. Only one of the young women interviewed expressed anxiety about being pregnant as it was “not her first choice”. The others who were pregnant at the time of interview were accepting of their situation.

Keeping information private

Keeping pregnancy private was mentioned as a problem by some young women in the Kimberley and Pilbara. Specific examples included: making an appointment with Aboriginal front desk staff to see a particular person in a health service as this indicated the reason for the visit. While most young women usually attend a local Aboriginal Medical Service for most things, if they want to keep something private they might try another service (a GP, sometimes a hospital, or a clinic in a different location). Another way around this is waiting to see a non-Aboriginal health provider at the AHS if they do not want Aboriginal staff members to know about.

Informing Family

It was consistently reported that family members, often mothers, but also grandmothers’, aunts or sisters are the first to know about a pregnancy, sometimes before a young woman’s partner knows (where she has a partner). In some cases older female family members, usually mothers, may identify pregnancy before the young woman is aware herself. While young women with partners want them to be involved, it was evident their main source of support and information comes from female family members and most often young women want their mother and other female relatives to be with them for childbirth.

FAMILY SUPPORT:

Guidance on what to do

Young women talked about how mothers, grandmothers, aunts and sisters told them about seeing doctors and midwives when they are pregnant. Young women turned to mothers and grandmothers, aunts (and sister/cousins) for advice and support. The other common feature young women mentioned was being directed by female relatives to see a health provider (usually a midwife or doctor), most often at an Aboriginal Health Service. Most said they relied on others to get them to appointments or they might not go.

Young women without family support

Young women talked about those who are living away from family, or are in families where there is substance abuse or violence or where there is limited supervision or support. They said these young women will be unlikely to go to a health service or have pregnancy care because there is no-one to tell them about this.

Young women had strong views about this believing that very young girls (12-14) have no understanding of what having a baby means. One young woman said about very young girls “some of the ones here, they make you wild just looking at them, and some of them [babies] younger than him, still newborn. Sometimes they bring the baby with them walking around drunk, fighting with their partner”.

Pregnancy knowledge

Most young women are very dependent on family members' advice about what to do when pregnant. For most young women, mothers or grandmothers are the main person to ask questions although for some, an aunty or sister is easier to talk with. What type of knowledge was exchanged in these conversations was not detailed. A few young women were very comfortable seeking advice from service providers, particularly non-Aboriginal providers, where there was an established relationship. Some young women talked about sometimes avoiding talking with Aboriginal staff to maintain privacy, deliberately seeking out a non-Aboriginal person to speak with. A few young women would not discuss pregnancy with their mothers but would with other family members.

ACCESSING CARE

Visiting a health service for pregnancy care

The young mothers consulted in metropolitan and regional areas have visited providers including doctors, Aboriginal Health Services, local hospitals, and obstetricians. Most have seen a doctor and a midwife for pregnancy care, most often in an Aboriginal Health Service. All the young women consulted had no concerns about attending visits at their local services.

Self care

Young women generally knew about looking after themselves in pregnancy. They talked about eating healthy foods and stopping drinking and smoking. They want to have healthy babies, so they do what they are told to do by their family members, Aboriginal Health Workers and midwives. For their regular visits to happen, they sometimes need to be reminded about appointments by text or phone call, because they sometimes forget. Having someone pick them up for appointments is helpful.

Concerns about childbirth

For some young women, knowing they will be relocated to another place for birth at about 36 weeks is concerning. This was mainly described as being away from home and not having significant family members present for the birth of their baby as they may only be able to take one person with them as a support person, meaning they have to choose. Sometimes a partner cannot go because there may be no accommodation for him. Mothers or grandmothers may not always be available or have other children they are caring for. Sometimes, if young mothers have stayed in their home communities (and not left as required by the health system) they will be flown by RFDS to another location to have their baby. This means they will go alone. Senior women and service providers confirmed that having to relocate for childbirth causes many difficulties for pregnant women. Young women who are required to go away for childbirth often have to stay in a hostel for several weeks, away from family. Often accommodation is not appropriate. Young women get lonely and face childbirth without family and away from their home and this was a cause for concern. Also they are required to come back to their home community on a bus with a new baby. This might be a very long journey and can be very frightening for young women with a new baby.

Education

While some young women reported having received some pregnancy education while at school, the issue of more comprehensive delivery of sexual and reproductive health education was raised by senior women in communities. Several educational programs were mentioned as relevant for Aboriginal young people (core of life, mootij, having a baby). It was generally thought education should happen in schools, but sometimes community based education may be more appropriate. No one identified a cultural reason to not provide education, although in some traditional communities it might be appropriate to separate boys and girls for education by the same gender educator.

Table 5

Domain Two: Service Influences

TRUSTED PROVIDER

| | |
|-----------------------------------|--|
| Options/choices about where to go | Young women in the metropolitan area who first visited a GP were not usually told they have options or choices about who to see. Where young women are connected with family working in Aboriginal specific health services they will most often use these without considering where else they might go. Other young women may rely on GP or local hospital antenatal clinics and do not have knowledge of other options. Young women in regional areas have limited options about who to see for pregnancy care, but do make choices where these are available (for example, seeing a GP in private practice rather than attending an Aboriginal Medical Service). In some regional locations, young women would prefer to go to another service (for example in the next town) but a lack of transport stops them from doing this. |
| Visiting a health service | With guidance from family members, most young women visit a doctor, midwife or health worker. One young woman suggested that a guide needs to be given to young women for them to follow what happens during pregnancy, when to have visits, tests etc. |
| Location of pregnancy care | Young women mostly prefer to visit local services. If young women choose a service where a family member works, location may not be as important as they are likely to be transported to where they need to go or receive a home visit. In regional areas, transport is essential to attending services as public transport is usually non-existent and young women may not have access to a car or a drivers licence. Service providers are proactive in providing pick-ups to ensure that young women make their appointments. This can sometimes involve staff actively looking for a woman to make sure she attends an appointment. |
| Health provider gender | Young women prefer to see female healthcare providers, but understand this is not always possible. This issue seemed to be more prevalent in the Midwest, Pilbara and Kimberley but varied between individuals in these regions. Examples were given of some men being acceptable, but this was largely premised on their individual capacity to be respectful and build trust. |

RELOCATION

| | |
|---------------|---|
| Transport | Young women are very concerned about being relocated for childbirth. While this was primarily reported by senior women and service providers, it remains a legitimate area of concern as it was noted that the requirement for young women to relocate is the principle reason for a drop off of engagement towards the end of pregnancy. It was reported that young women wait until they are in labour to ensure they will be transferred by air for childbirth. While this still results in separation from family, and the certainty they will be unaccompanied, such transfers significantly reduce the time away from the home community. |
| Accommodation | Senior women in particular noted the unsuitability of much of the accommodation provided for young women which also impacts on their reluctance to relocate up to six weeks before their baby is due. There was reporting of isolation and loneliness when away from family during a significant life, family and cultural event, and that young women are particularly susceptible at a time when they require a lot of support. |

REFERENCES

1. Joyce A, Hutchinson M. Western Australia's Mothers and Babies, 2010. Twenty-eighth Annual Report of the Western Australian Midwives' Notification System. Department of Health Western Australia Statistical Series 2012;92.
2. Bessarab D, Ng'andu B. Yarning about yarning as a legitimate method in indigenous research. *International Journal of Critical Indigenous Studies* 2010;3(1):37-50.
3. Neelofur-Khan D. Adolescent pregnancy: unmet needs and undone deeds: a review of the literature and programmes. World Health Organization Department of Child and Adolescent Health and Development. Geneva; 2007.
4. Ibid.
5. Australian Institute of Health and Welfare. Aboriginal and Torres strait Islander health performance framework 2012 report. Western Australia, Canberra; 2012.
6. Australian Health Ministers' Advisory Council. Clinical practice guidelines: antenatal care module Australian Government Department of Health and Ageing. Canberra, <http://www.health.gov.au/antenatal>; 2012.
7. Ibid.
8. SmithBattle L. The vulnerabilities of teenage mothers: challenging prevailing assumptions. *Advances in Nursing Science* 2011;23(1):29-40.
9. Skinner S.R, Smith J, Fenwick J, Hendriks J, Fyfe S, Kendall G. Pregnancy and protection: perceptions, attitudes and experiences of Australian female adolescents. *Women and Birth* 2011;22:50-56.
10. Lockyer S, Kite E. Teenage Pregnancies in East Pilbara Aboriginal Communities. *Aboriginal and Islander Health Worker Journal* 2005;30(5):26-29.
11. Senior K, Chenhall R. 'Walkin' about at night': the background to teenage pregnancy in a remote Aboriginal community. *Journal of Youth Studies* 2008;11(3):269-281.
12. Rosengard C, Phipps M, Adler N, Ellen J. Adolescent Pregnancy Intentions and Pregnancy Outcomes: a longitudinal examination. *Journal of Adolescent Health* 2004;35:453-461.
13. Pereira A, Canavarro M, Cardoso M, Mendonca D. Relational factors of vulnerability and protection for adolescent pregnancy: a cross-sectional comparative study of Portuguese pregnant and nonpregnant adolescents of low socioeconomic status. *Adolescence* 2005;40(159):654-671.
14. Jaccard J, Dodge T, Dittus P. Do adolescents want to avoid pregnancy? attitudes toward pregnancy as predictors of pregnancy. *Journal of Adolescent Health* 2003;33:79-83.
15. Gaudie J, Mitrou F, Lawrence D, Stanley F, Silburn S, Zubrick S. Antecedents of teenage pregnancy from a 14- year follow-up study using data linkage. *BMC Public Health*, 2010;10:63.
16. Couzos, S, Murray, R. Aboriginal primary health care: an evidence-based approach. Oxford University Press, South Melbourne, Victoria, Australia;2008.
17. Australian Health Ministers Advisory Council, 2012
18. Larson A, Bradley R. Aboriginal maternal and child project strengths and needs analysis. Combined Universities Centre for Rural Health and Aboriginal Health. Aboriginal Health Council of Western Australia, Perth; 2010.
19. Reibel T, Walker R. Antenatal services for Aboriginal women: the relevance of cultural competence. *Quality in Primary Care* 2010;18(1):65-74.
20. Office for Aboriginal and Torres Strait Islander Health. Healthy for life: site reports 2005. Commonwealth of Australia National Aboriginal and Torres Strait Islander Child and Maternal Health Exemplar Site initiative; 2005.
21. Rumbold A, Cunningham J.A. Review of the impact of antenatal care for Australian Indigenous women and attempts to strengthen these services. *Maternal Child Health Journal* 2008;12:83-100.
22. Rumbold A, Bailie R, Si D et al. Delivery of maternal health care in Indigenous primary care services: baseline data for an ongoing quality improvement initiative. *Pregnancy and Childbirth* 2011;11:16.
23. Stamp G, Champion S, Anderson G et al. Aboriginal maternal and infant care workers: partners in caring for Aboriginal mothers and babies. *Rural and Remote Health* 2008;8(3):883-895.
24. Ireland S, Wulili-Narjic C, Belton S, Kildea S. Niyith nniyith watmam (the quiet story): exploring the experiences of Aboriginal women who give birth in their remote community. *Midwifery* 2011;27:634-641.
25. Kruske S, Kildea S, Barclay L. Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women and Birth* 2006;19:73-77.
26. Op cit., Reibel and Walker 2010
27. Wilson D. The significance of a culturally appropriate health service for Indigenous Maori women. *Contemporary Nurse* 2008;28:173-188.
28. Mohajer N, Bessarab D, Earnest J. There should be more help out here! a qualitative study of the needs of Aboriginal adolescents in rural Australia. *Rural and Remote Health* 2009;9:1137.

29. Stewart J, Walsh A. Collaborating to make Aboriginal and Torres Strait Islander young people's sexual and reproductive health "everybody's business". *Aboriginal & Islander Health Worker Journal* 2011;35(4):14-15.
30. Op cit., Wilson, 2008
31. Larkins S, Page P, Panaretto K et al. Aboriginal and Torres Strait Islander adolescents and their attitudes and behaviours around relationships, contraception and pregnancy: lessons for policy and practice. Presented at the 10th National Rural Health Conference, Cairns, Queensland; 2009.
32. Ibid
33. Op cit., Larson and Bradley 2010
34. Op cit., Wilson 2009
35. Quinlivan J.A, Evans S.F. Teenage antenatal clinics may reduce the rate of preterm birth: a prospective study. *British Journal of Obstetrics and Gynaecology* 2004;111(6):571-578.
36. Crook L, Longbottom H, White K, Thompson M, Worner F, Waminda Board. Waminda: mums and bubs program. *Aboriginal & Islander Health Worker Journal*, 2010;36(2):17-19.
37. Van der Klis K.A.M, Westenberg L, Chan A, Dekker G, Keane R.J. Teenage pregnancy: trends, characteristics and outcomes in South Australia and Australia. *Australian and New Zealand Journal of Public Health* 2002;26(2):125-131.
38. Koniak-Griffin D, Turner-Pluta C. Health risks and psychosocial outcomes of early childbearing: a review of the literature. *Journal of Perinatal and Neonatal Nursing* 2001;15(2):1-17.
39. Bradbury B. Disadvantage among Australian young mothers. *Australian Journal of Labour Economics*, 2006;9(2):147-171.
40. Larkins S.L, Page R.P, Panaretto K.S, Mitchell M, Alberts V, McGinty S, Veith P.C. The transformative potential of young motherhood for disadvantaged Aboriginal and Torres Strait Islander women in Townsville, Australia. *Medical Journal of Australia* 2011;194(10):551-555.
41. Azzopardi P, Kennedy E, Patton G et al. The quality of health research for young Indigenous Australians: systematic review. *Medical Journal of Australia* 2013;199(1):57-63.
42. Wilson G. What do Aboriginal women think is good antenatal care? Consultation Report Cooperative Research Centre for Aboriginal Health, Darwin; 2009.
43. Australian Health Ministers' Advisory Council. Clinical Practice Guidelines: Antenatal Care – Module Australian Government Department of Health and Ageing, Canberra, <http://www.health.gov.au/antenatal>; 2012
44. Western Australian Department of Health. Improving maternity services: working together across Western Australia; a policy framework. WA; 2007.
45. Hancock H. Low birth weight in Aboriginal babies: a need for rethinking Aboriginal women's pregnancies and birthing. *Women and Birth* 2007;20:77-80.
46. Tai-Roche M, Hills M. Voices from the Kimberley: birthing practices and options for remote area Aboriginal women. Kimberley Aboriginal Health Planning Forum-Regional Maternal and Child Health Subcommittee 2013.
47. Dietsch E, Martin T, Shackleton P et al. Australian Aboriginal kinship: a means to enhance maternal well-being. *Women and Birth* 2011;24:58-64.
48. Marella Health Consulting. The Rural Maternity Patient Journey September 2013 Project Report. Statewide Obstetric Services Unit and Aboriginal Maternity Services Support Unit, Department of Health; 2013.
49. Lockyer S, Kite E. Teenage pregnancies in East Pilbara Aboriginal communities. *Aboriginal & Islander Health Worker Journal* 2006;30(6):26-29.

