

Access and Engagement of First Nations Women in Maternal and Child Health Services

Catherine Austin

RN, RM, GradDipComHlth, MPH, MHM

Submitted in fulfilment for the requirements for the degree of
Doctor of Philosophy

Institute of Health and Wellbeing
Federation University Australia

28 June 2023

Abstract

This thesis explores and describes the engagement of First Nations women, with children from birth to five years of age, with Maternal and Child Health (MCH) services in Victoria, Australia. Identification of the factors that facilitate, support or hinder these women's engagement with MCH services could strengthen the model of care to effectively engage First Nations women with these services. Access in the early years of a child's life to integrated, effective, community-based services is a well-established predictor of a child's successful transition to school and their lifelong education and employment outcomes. Such access is crucial in a child's first 2,000 days (the period from conception to the child's fifth year), which forms the foundation for a child's lifetime development and health. Prior evaluative studies have shown that participation in MCH services in Victoria improves the health outcomes for children and families, particularly First Nations families. However, First Nations women and their children in Victoria show poorer health outcomes and lower participation in MCH services compared to non-Indigenous persons; this suggests a need to improve the current Victorian MCH service model. This thesis contributes recommendations for such improvements.

The literature review (Chapter 2) identified the absence of a synthesis of qualitative studies of models of care to help guide MCH practice and innovation for all families, especially those at risk of child abuse and neglect. To address this gap, a three-phase qualitative study was conducted in the Glenelg Shire, Victoria, Australia, using narrative inquiry integrated with the Indigenous philosophy 'Dadirri'. 'Dadirri', which emphasises deep and respectful listening, guided the development of the research design; this methodology assisted in understanding Indigenous culture and its sensitivities, building trust with the First Nations peoples involved in the studies, developing open-ended and conversational dialogue, and building respectful relationships. This method enabled First Nations women's voices to be heard and the collection of rich data based on participants' perspectives of and experiences with MCH services in Victoria.

Study One (Chapter 4) recruited First Nations women residing in the Glenelg Shire, with at least one child aged birth to five years, to explore their perceptions and experiences of MCH services and barriers to accessing and engaging with MCH services. Study Two (Chapter 5) compared Study One data with accounts from MCH nurses working in

Glenelg Shire. Study Three (Chapter 6) reviewed a piloting of the Early Assessment Referral Links (EARL) concept (developed by the researcher) that aims to improve First Nations women and their children's access to and engagement with MCH services. EARL involved the core principles of narrative inquiry integrated with 'Dadirri'.

Study One and Two found that enabling factors for access and engagement include interventions that are culturally sensitive and effective; recognise the social determinates of health (SDOH) and social and emotional wellbeing; are timely, appropriate, culturally strong, flexible, holistic and community-based; support continuity of care and communication; and encourage early identification of risk, particularly of family violence (FV), and further assessment, intervention, referral and support in the child's first 2,000 days. Barriers to access and engagement include an ineffective service model built on mistrust, poor communication due to cultural differences between client and provider (particularly around identification and disclosure of woman's risk of FV), lack of continuity of care between services, limited flexibility of service delivery to suit individual needs, and a service model that does not recognise the importance of the SDOH and social and emotional wellbeing.

Study Three results showed that participation of First Nations families in MCH services was consistently above the state average during the pilot period, and several First Nations families were referred to EARL stakeholders and other health professionals during the pilot. Further, there were increases in First Nations children being breastfed, fully immunised and attending Early Start Kindergarten, and identification of First Nations children at risk of abuse or neglect improved (with a significant increase in referrals for FV and child protection and significant decrease in episodes of out-of-home care).

This thesis's findings can support policy development. This research shows that timely, effective, holistic engagement with First Nations women in their child's first 2,000 days, that respects their culture and facilitates genuine partnerships built on co-design and shared decision-making with the Indigenous community, needs to be an essential part of the MCH service model. Additionally, this thesis recommends adopting a strengths-based approach that respects First Nations peoples' child-rearing practices and culture, and providing necessary training to MCH nurses who work with First Nations families.

Keywords: child family health, continuity of care, First Nations women

Acknowledgements

Federation University Australia

I would like to express my sincere gratitude to the following people for their contribution as members of my supervision panel over the duration of my candidature:

Principal Supervisor—Professor Andrew Lewis (Federation University Australia)

Associate Supervisor—Professor Shane Thomas (Federation University Australia)

Professor Danny Hills (Federation University Australia)

Professor Mary Cruickshank (Federation University Australia)

Dr Linda Jones (Federation University Australia)

Dr Jeong-ah Kim (Federation University Australia)

Professor Kerry Arabena (Melbourne University)

Associate Professor Penny Cash (Federation University Australia)

Dr Christina Sadowski (Federation University Australia)

Thank you also to Professor Danny Hills and Professor Mary Cruickshank for their contribution to the published manuscript ‘Models and interventions that aim to promote and support engagement of First Nations women to maternal and child health services from their child’s birth to five years of age: An integrative literature review’ (<https://www.mdpi.com/2227-9067/9/5/636>).

My gratitude extends to the Australian Government Research Training Program, for a Fee Offset Scholarship, which I received through Federation University Australia, and to Federation University Australia for a Stipend Scholarship to undertake my studies.

Most importantly, I am deeply grateful to Professor Wendy Wright, Dean of the Graduate School, Federation University Australia, for her continuous support and patience over the duration of my candidature.

Editorial Services

Thank you to Glenda Harrison and to Capstone Editing for your editing. Capstone Editing provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national ‘Guidelines for Editing Research Theses’.

Indigenous Advisory Committee

I would like to offer my special thanks to my friend and mentor, Professor Kerry Arabena, Managing Director, Karabena Consulting. Kerry is a descendant of the Meriam people from the Torres Strait, whose work has brought her to the forefront of Indigenous affairs in Australia. Kerry’s treasured support as an external co-supervisor was influential in shaping my thesis structure, based on a standpoint that privileges First Nations people. Kerry also assisted me in critiquing the responses of the women from the ‘yarning’ sessions in Study One, and the results of Studies One, Two and Three, and provided counselling and guidance. In addition, Kerry co-authored the peer reviewed manuscript ‘Improving the engagement of Aboriginal families with maternal and child health services: A new model of care’ (<https://doi.org/10.17061/phrp30232009>).

I would like to extend my sincere thanks to Sheree Lowe, Executive Director, Social and Emotional Wellbeing at the Victorian Aboriginal Community Controlled Health Organisation, who is a descendant of the Djab Wurrung and Gunditjmara people, and to Nikki Foy, Executive Manager, Social and Emotional Wellbeing at the Victorian Aboriginal Community Controlled Health Organisation, who is a descendent of the Wadawurrung people. Sheree and Nikki assisted me in critiquing the responses of the women from the ‘yarning’ sessions in Study One and provided counselling and guidance.

My thanks also to Jodie Lovett, Building the Dream worker at Winda-Mara Aboriginal Corporation, who is a descendent of the Gunditjmara/Yorta-Yorta people, Kristy Sanderson, Practice Nurse at Winda-Mara Aboriginal Corporation, who is a descendent of the Wurundjeri people, and Simone Bamblett, Playgroup Coordinator at the Dhauwurd Wurrung Elderly and Community Health Service, who is a descendent of the Gunditjmara people. Jodie, Kristy and Simone assisted me in recruiting the women and co-facilitated the ‘yarning’ sessions. Jodie and Kristy also assisted me in critiquing the responses of the women from the ‘yarning’ sessions in Study One and provided counselling and guidance.

The Victorian Department of Health and Municipal Association of Victoria

I am also very grateful to Dr Jan Browne, Coordinator of External Research Applications at the Centre for Evaluation and Research Evidence, the Victorian Department of Health, and Dr Jane Howard and Dr Lisa Thomson at the Centre for Evaluation and Research Evidence, the Victorian Department of Health, for their support. I would also like to extend this thanks to my sponsors and mentors, Ms Marcia Armstrong, Principal Maternal and Child Health Nurse Advisor, Safer Care Victoria, the Victorian Department of Health, and Ms Helen Lees, Policy Adviser Maternal and Child Health, Municipal Association of Victoria, for their counselling and guidance.

Glenelg Shire's MCH nurses and EARL Stakeholders

Thank you to Glenelg Shire's MCH nurses and the EARL stakeholders for participating in the studies and for their enthusiasm, encouragement and support of the research.

My Family

Finally, I would like to thank my family for their integral support of my commitment to improving the health outcomes of Australia's First Nations children and their families.

Declaration of authorship

I hereby declare that this submission is my own work and to the best of my knowledge it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by others, with whom I have worked at Federation University or elsewhere, is explicitly acknowledged in the thesis. I also declare that the intellectual content of this thesis is the product of my own work, even though I may have received assistance from others in style, presentation, and linguistic expression.

Signed:

28 June 2023

Contents

Abstract.....	i
Acknowledgements	iii
Declaration of authorship	vi
Contents	vii
List of figures.....	xi
List of tables	xii
List of peer-reviewed publications arising from the thesis	xiii
List of abbreviations	xiv
Chapter 1: Introduction to the research: First Nations women’s engagement with Maternal and Child Health services	1
1.1 Rationale for the research.....	1
1.2 Aims and objectives of the research.....	2
1.3 Background to the research: Health and First Nations people	3
1.3.1 The history of Australia’s First Nations peoples	3
1.3.2 The role of maternal and child health in universal early childhood health services in Australia	6
1.3.3 First Nations women and maternal and child health services	12
1.4 The research setting.....	14
1.5 Overview of the thesis structure.....	15
1.6 Chapter summary	19
Chapter 2: Literature review of models and interventions that aim to promote and support engagement of First Nations women to Maternal and Child Health services from their child’s birth to five years of age.....	20
2.1 Introduction	20
2.2 Method	22
2.2.1 Search criteria	22
2.2.2 Search strategy and outcomes	22
2.3 Results	24
2.3.1 Enablers that influence access and engagement of First Nations families to Maternal and Child Health services	37
2.3.2 Barriers that influenced access and engagement of First Nations families to Maternal and Child Health services	40
2.4 Discussion	43
2.5 Limitations	46
2.6 Conclusion.....	46
2.7 Summary	48
Chapter 3: Methodology and overview of research design.....	49
3.1 Introduction	49
3.2 Statement of intention	49
3.3 Aims and significance of the study	49
3.4 Research objectives	50
3.5 Research questions	50
3.6 Methodology and theoretical framework	51
3.6.1 Narrative inquiry	53

3.6.2 Indigenous philosophy	55
3.7 Research setting	58
3.8 Population and sampling	58
3.9 Method and data collection	62
3.10 Data analysis and evaluation	69
3.11 Ethical considerations	71
3.11.1 Informed consent	73
3.11.2 Confidentiality and anonymity	74
3.11.3 Harm and benefit	74
3.11.4 Data security	75
3.12 Research rigour	75
3.12.1 Data verification and validation	76
3.12.2 Limitations of narrative inquiry and Indigenous philosophy	77
3.13 Summary	77
Chapter 4: Study One: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services	79
4.1 Introduction to Study One	79
4.2 Results of Study One	80
4.2.1 Factors contributing to First Nations women never engaged in the Maternal and Child Health service	80
4.2.2 Factors contributing to First Nations women disengaged in the Maternal and Child Health service	82
4.2.3 Factors contributing to First Nations women currently engaged in the Maternal and Child Health service	84
4.2.4 Responses from ACCHO/VACCHO/Indigenous academic consultant	89
4.3 Summary of results of Study One	121
Chapter 5: Study Two: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services	124
5.1 Introduction to Study Two	124
5.2 Results of Study Two	125
5.2.1 The barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia ..	125
5.2.2 Factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia	127
5.3 Summary of results of Study Two	131
Chapter 6: Study Three: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services	133
6.1 Introduction to Study Three	133
6.2 Results of Study Three	134
6.3 Summary of results of Study Three	149
Chapter 7: Discussion of thesis findings	151
7.1 Introduction to the discussion of the thesis findings	151
7.2 Factors that facilitate and support the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia	152
7.3 Factors that hinder the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia	153
7.4 Improving the Victorian Maternal and Child Health service for more effective engagement of First Nations women	153

7.5 Summary of the discussion of the thesis findings	154
Chapter 8: Recommendations to improve First Nations families' access to and engagement with Maternal and Child Health services.....	155
8.1 Introduction	155
8.2 Highlighting enablers that support First Nations women's access to and engagement with Maternal and Child Health services	155
8.2.1 Enabler 1: Timely and appropriate services	155
8.2.2 Enabler 2: Effective, integrated, community-based services that are flexible in their approach	156
8.2.3 Enabler 3: Holistic services	156
8.2.4 Enabler 4: Culturally strong services	157
8.2.5 Enabler 5: Services that encourage earlier identification of risk and need for further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday	157
8.3 Distillation of change to key platforms	160
8.3.1 The quality of service standards	160
8.3.2 Governance	161
8.3.3 Policies	162
8.3.4 Regulations, laws and Acts.....	163
8.3.5 Information sharing	164
8.3.6 Data systems	165
8.3.7 A skilled workforce	165
8.4 Formulation of a more effective model to engage First Nations families.....	167
8.5 The 'Child and Family Health' service model	173
Chapter 9: Research conclusions.....	177
9.1 Introduction	177
9.2 Summary of the outcomes of the literature review	177
9.3 Major findings of the thesis and how they integrate with previous work	181
9.4 Strengths and limitations of the research	184
9.5 Implications for policy and practice, and future research directions	185
Appendices.....	189
Appendix One: Ethics approval of research.....	189
Appendix Two: Letter of support for the research 'Access and Engagement of First Nations Women in Maternal and Child Health Services: An Integrative Review'	195
Appendix Three: PLIS for participation in the research: Study One and Study Two (First Nations women)	196
Appendix Four: Consent for participation in the research: Study One and Study Two (First Nations women)	200
Appendix Five: PLIS for participation in the research: Study Two (MCH nurses)	202
Appendix Six: Consent for participation in the research: Study Two (MCH nurses)	205
Appendix Seven: Early Assessment Referral Links Key Terms of Reference	207
Appendix Eight: Consent to share information: Study Three (First Nations families and EARL stakeholders)	208
Appendix Nine: Invitation to participate in the research: Study Three (EARL stakeholders)	209

Appendix Ten: PLIS for participation in the research: Study Three (EARL stakeholders)	211
Appendix Eleven: Consent for participation in the research: Study Three (EARL stakeholders)	215
Appendix Twelve: Survey Monkey questionnaire for Study Three (EARL stakeholders)	216
Appendix Thirteen: Publication arising from the thesis	219
Appendix Fourteen: Publication arising from the thesis	233
Appendix Fifteen: Publication arising from the thesis	248
Appendix Sixteen: State of Victoria EARL Award media release	255
Appendix Seventeen: Early Assessment Referral Links Award 2011	258
References	259

List of figures

Figure 1.1. Glenelg Shire, South Western Victoria, Australia (DET, 2016a)	14
Figure 1.2. The Storyline: Structural overview of the thesis	16
Figure 1.3. Current siloed approach for Early Years Services in Victoria, Australia.....	18
Figure 2.1. Literature review flow diagram	24
Figure 3.1. The Three Interacted Worlds of Indigenous Philosophy (Institute for Aboriginal Development, 2000)	57
Figure 3.2. The development and evaluation of the EARL concept.....	67
Figure 4.1. Finalised thematic framework map	89
Figure 5.1. Factors contributing to barriers accessing MCH services	126
Figure 5.2. Factors contributing to barriers engaging in MCH services.....	129
Figure 5.3. Finalised thematic framework map	130
Figure 8.1. The National Aboriginal and Torres Strait Islander Early Childhood Strategy (NIAA, 2021).....	159
Figure 8.2. The Continuum of Need service response indicator tool (DET, 2015c)	168
Figure 8.3. The EARL concept.....	170
Figure 8.4. The ecological model of child development (Bronfenbrenner, 1979)	172
Figure 8.5. The proposed ‘Child and Family Health service’ model.....	174

List of tables

Table 1.1. Maternal and child health areas of focus for key child outcomes (from DEECD, 2006)	7
Table 1.2. Key Age Stage (KAS) Framework (from DEECD, 2006)	9
Table 2.1. Models/interventions that promote and support engagement of First Nations families and their access to maternal and child health services from the child's birth to five years of age	25
Table 3.1. Interview guide for all participants: Study One.....	63
Table 3.2. Tailored questions for women accessing different types of maternal and child health services: Study One	63
Table 3.3. Interview guide for all participants: Study Two	64
Table 3.4. Summary of studies' samples, data collected and methods.....	70
Table 4.1. Summary of themes why First Nations women never engaged in the Maternal and Child Health service.....	81
Table 4.2. Summary of themes why First Nations women disengaged in the Maternal and Child Health service	83
Table 4.3. Summary of themes why First Nations women are currently engaged in the Maternal and Child Health service.....	86
Table 6.1. Participation rates of Aboriginal children birth–5 years of age in maternal and child health services in Glenelg Shire, Victoria, Australia	136
Table 6.2. Breast feeding rates of mothers of Aboriginal children participating in the EARL pilot, Glenelg Shire, Victoria, Australia	137
Table 6.3. Immunisation rates of Aboriginal children participating in the EARL pilot..	138
Table 6.4. EARL stakeholder level of difficulty engaging families of Aboriginal children at risk of vulnerability from birth to five years of age	140
Table 6.5. The ability of the EARL concept to improve the identification of risk of vulnerability from birth to five years of age	141
Table 6.6. The ability of the EARL concept to enable smoother transition of children through the life stages of the Early Years	142
Table 6.7. The ability of the EARL concept to improve the outcomes of children from birth to five years of age	143
Table 6.8. The ability of EARL to facilitate coordination between service providers	144
Table 6.9. The ability of EARL to improve the engagement of Aboriginal families with children birth to five years of age	145
Table 6.10. The strengths of EARL	146
Table 6.11. The weaknesses of EARL.....	147
Table 6.12. How the EARL concept could be improved	148
Table 6.13. Other feedback regarding the EARL concept.....	149

List of peer-reviewed publications arising from the thesis

Austin, C., Hills, D., & Cruickshank, M. (2022). Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature Review. *Children*, 9(5), 636.

<https://doi.org/10.3390/children9050636>

Austin, C. (2022). The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services. *Journal of Advanced Nursing*, 79(5), 1815–1829. <https://doi.org/10.1111/jan.15493>

Austin, C. & Arabena, K. (2021). Improving the engagement of Aboriginal families with maternal and child health services: A new model of care. *Public Health Research & Practice*, 31(2). <https://doi.org/10.17061/phrp30232009>

List of abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
CEO	chief executive officer
COAG	Council of Australian Governments
CON	Continuum of Need
DET	Victorian Department of Education
DH	Victorian Department of Health
DHHS	Victorian Department of Health and Human Services
DOHaD	developmental origins of health and disease
DWECH	Dhauwurd Wurrung Elderly and Community Health
FV	family violence
KAS	key ages and stages
LGA	local government area
MAV	Municipal Association of Victoria
MCH	maternal and child health
NCDs	non-communicable diseases
OoHC	out-of-home care
PLIS	Plain Language Information Statement
SDOH	social determinates of health
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAGO	Victorian Auditor-General's Office

Chapter 1: Introduction to the research: First Nations women's engagement with Maternal and Child Health services

This chapter introduces the research; presents the thesis rationale, aims and objectives; outlines the background and historical context; and details the thesis structure. This thesis explores and describes the engagement of First Nations women, with children from birth to five years of age, with maternal and child health (MCH) services in Victoria, Australia. This introductory chapter provides a general background on how and why Indigenous children in Victoria face more health-related challenges than non-Indigenous children (see, e.g., AIHW, 2013, 2018; Cummins, Scott & Scales, 2012; State of Victoria, 2012b, 2012c; Wilson, 2009).

'First Nations' or 'Indigenous' peoples are the direct descendants of the original known inhabitants of a geographic region (Council for Aboriginal Reconciliation, 2000). The Indigenous population in Australia is referred to as 'Indigenous', 'First Nations people/s', 'Aboriginal and Torres Strait Islander people/s', or 'Aboriginal people/s' if the population does not include people from the Torres Strait Islands of Australia (Council for Aboriginal Reconciliation, 2000). The researcher has worked with a diverse population of First Nations peoples across Australia (in the roles of a MCH nurse and Adviser to the Federal Minister of Aboriginal Australians) and is aware that the cultures of First Nations peoples vary across Australia, including their beliefs, identities, history, values and experiences. The researcher also recognises the varied role of Elders, carers, kin and community in the life of First Nations women and their children. Any use of the terminology of 'First Nations', 'Indigenous', 'Aboriginal and Torres Strait Islander', or 'Aboriginal' peoples in this thesis was guided by the Council for Aboriginal Reconciliation (2000), the researcher's Advisory Committee and the Indigenous stakeholders involved in this research.

1.1 Rationale for the research

Access in a child's early years to integrated community-based services that are flexible in their approach, holistic, culturally strong, and recognise the social determinates of health

(SDOH) and developmental origins of health and disease (DOHaD) concepts in the prevention of non-communicable diseases (NCDs) is a proven predictor of a child's successful transition to school and lifelong education and employment outcomes (Shonkoff & Phillips, 2000; Shonkoff, Boyce & McEwen, 2009). Such access is crucial in a child's first 2,000 days (the period from conception to the child's fifth year), as this period comprises the critical period of foetal and child development forming the foundation for a child's lifetime development and health (see Belli, Bustreo & Preker, 2005; Sweeny, 2014; Victorian Auditor-General's Office [VAGO], 2016; WHO, 2018). Prior studies have shown that participation in child and family health services, such as MCH services in Victoria, improve health outcomes for children and families, particularly First Nations families (see, e.g., AIHW, 2015; Austin & Arabena, 2021; VAGO, 2016). For some women, however, accessing healthcare services without a transition or continuity of care results in high levels of fear and anxiety and low attendance at subsequent appointments (see, e.g., AIHW, 2015; Austin & Arabena, 2021; DEECD, 2004a; Green, Renfrew & Curtis, 2000; Homer, Brodie & Leap, 2001; VAGO, 2016). First Nations women and their children in Victoria show poorer health outcomes and lower participation in MCH services compared to non-Indigenous persons; this suggests an urgent need to improve the current Victorian MCH service model (see DET, 2018a; VAGO, 2016).

1.2 Aims and objectives of the research

This thesis aims to explore and describe the engagement of First Nations women, with children aged birth to five years, with MCH services in Victoria, Australia. This thesis contributes information and recommendations for Victorian MCH services to improve First Nations women's access to and engagement with these services. To do this, the thesis systematically reviews the relevant literature, undertakes three empirical studies, draws research conclusions and makes recommendations for Victorian MCH service practice.

This thesis's primary objectives are to:

- 1) explore and understand First Nations women's perceptions of MCH services in Victoria, Australia

- 2) identify what aspect/s of MCH services in Victoria, Australia, need to be changed or strengthened to improve First Nations women's engagement with these services.

1.3 Background to the research: Health and First Nations people

The United Nations acknowledges the rights of children 'to the highest attainable standard of health', with a focus on preventative and primary health care for children, prenatal and postnatal health care for mothers, and diminishing infant and child mortality (United Nations Committee on the Rights of the Child, 2013). Maternal and environmental factors during a child's life, right from conception, can affect their growth, development and lifelong health and wellbeing (Gluckman, Hanson & Buklijas, 2010). The DOHaD concept suggests that initiatives to promote a 'healthy start to life' can reduce the risk of NCDs, predisposed by factors such as unhealthy dietary patterns, reduced physical activity, altered patterns of microbial exposure, tobacco smoking, harmful use of alcohol, and other environmental pollutants (Gluckman et al., 2010).

In countries with a history of colonisation, such as Canada, the United States, New Zealand and Australia, First Nations families show long-term poor health and wellbeing, and their access to services and resources is adversely affected by historical and contemporary SDOH (Anderson et al., 2016; Perris, Brown & Cass, 2008; Rigney, 1999a, 1999b). The WHO (2022) states that SDOH are the circumstances in which people are born, grow, work, live and age, and the conditions and systems shaping their lives. These conditions and systems include economic policies and systems, development agendas, social norms, social policies, political systems (including income and social protection), education, unemployment and job insecurity, working life conditions, food insecurity, housing, basic amenities and the environment, early childhood development, social inclusion and non-discrimination, structural conflict, and access to affordable and quality health services (WHO, 2022). Sections 1.3.1–1.3.3 summarise the history of Australia's First Nations peoples, the role of MCH services in Australia, and the SDOH affecting First Nations people's present-day health outcomes.

1.3.1 The history of Australia's First Nations peoples

To understand First Nations families' long-term poorer health and wellbeing outcomes and their access to services and resources in the present day, the history of Australia's

First Nations peoples must be considered. Aboriginal and Torres Strait Islander cultures have developed over 60,000 years, making them custodians of the world's oldest living culture (Christie, 2006). Prior to British settlement, over 500 First Nations groups inhabited the continent now called Australia (Christie, 2006). Colonial takeover was premised on the assumptions that European culture was superior to all others and that Europeans could define the world in their terms. Under European-imposed international law, a colony could be established by persuading the First Nations inhabitants to submit themselves to a country's overlordship, by purchasing from those inhabitants the right to settle parts of their land, and/or by unilateral possession based on first discovery and effective occupation (Harris, 2003).

Many First Nations men, women and children, who up to that point had been isolated for thousands of years from the diseases that had raged through Europe and Asia, died of introduced diseases to which they had no resistance, such as smallpox, influenza and measles (Behrendt, 2012). Many also died in random killings, punitive expeditions and organised massacres (Bretherton & Mellor, 2006; Dudgeon, Wright, Paradies, Garvey & Walker, 2010). In some cases, diseases were purposively introduced to Aboriginal people, alongside ploys such as poisoned flour, to thin their numbers (Dudgeon et al., 2010). Aboriginals became attracted to Europeans as the only means for food in exchange for labour and became fringe dwellers to white society (Dudgeon et al., 2010). Clergy established missions in the nineteenth century, with little or no government involvement, purportedly to house, protect and 'Christianise' local Aboriginal people (Bretherton & Mellor, 2006). Using Christian texts to guide and justify their actions, missionaries encouraged or forced Aboriginal people to abandon their traditional ways and move into mission settlements and join small European Christian communities.

Prior to colonisation, traditional Aboriginal child-rearing was informed by respect for the land and sea as sacred domains; a range of values emphasising sharing and respect for others, especially one's Elders; the value of kinship; and the authority of older males within families and clans (Hamilton, 1981). With British colonisation came laws and Acts authorising the forcible removal of children from Aboriginal parents based on assimilation policies, which claimed that the lives of First Nations people would improve if they became part of white society. Children were kidnapped and placed in missionaries, with the aim of having them reject their Indigenous heritage and adopt white culture

(Christie, 2006). This process is now referred to as the Stolen Generations (Bretherton & Mellor, 2006). These experiences severely affected and continue to affect First Nations people's SDOH and health outcomes—those of the children forcibly taken, their parents and extended families, their communities, and subsequent generations—comprising part of First Nations well-documented intergenerational trauma (Atkinson, 2002; Harris, 2003; Reynolds, 2006). The removal policies and Stolen Generations continue to affect First Nations families as trauma is inherited through complex parenting practices, behavioural problems, violence, grief, unresolved trauma leading to mental illness, and poor social and emotional wellbeing (Wilkie, 1997). Social and emotional wellbeing is the foundation for these families' physical and mental health. It is a holistic concept incorporating the relationships between individuals, family, kin and community, and which recognises the importance of connection to land, culture, spirituality and ancestry (Freeman et al., 2014).

The intergenerational trauma of the Stolen Generations and other colonial policies is reflected in the present-day high percentage of Indigenous children removed from their parents (VAGO, 2016). In 2021, the rate of Aboriginal and Torres Strait Islander children aged 0–17 years in out-of-home care (OoHC) was 57.6 per 1,000 children across Australia and 103.0 per 1,000 children in Victoria (AIHW, 2021). Aboriginal children in Victoria are approximately 10 times more likely to be subject to abuse or neglect and 11 times more likely to be in OoHC compared to non-Aboriginal children (AIHW, 2021). The high rates of child neglect are consistent with the disadvantaged socioeconomic conditions prevalent in many Indigenous communities, including overcrowding, unemployment and limited access to services (Steering Committee for Review of Government Service Provision, 2014).

Despite measures by the Council of Australian Governments (COAG), the peak intergovernmental forum in Australia, to improve the health outcomes of children in Australia (see, e.g., AIHW, 2013, 2018; COAG, 2008; Cummins, Scott & Scales, 2012; State of Victoria, 2012b; Wilson, 2009), almost half of Indigenous children are identified as being at risk of vulnerability to child abuse or neglect—twice that of non-Indigenous children (ABS, 2021). The *Victoria's Vulnerable Children's Strategy 2013–2022* (State of Victoria, 2013) defined vulnerability as family members being limited in their ability to provide effective care to protect children and ensure their long-term development and

wellbeing. Key risk factors that contribute to making children and their families vulnerable include economic hardship, including related issues such as unemployment and homelessness; family violence (FV); alcohol and substance misuse; mental health problems; disability; and parental history of abuse and neglect (State of Victoria, 2013).

One consequence of these risk factors is Australian Indigenous children being more likely to be born with a low birth weight (i.e., less than 2,500 grams), predisposing them to increased mortality and morbidity rates, including susceptibility to infectious, respiratory, circulatory, aural, oral and parasitic diseases (Burns, Maling & Thompson, 2010; Hancock, 2007; Mohsin, Bauman & Jalaludin, 2006; Sayers & Boyle, 2010). Australian Indigenous children are also more likely to live in single-parent households; experience discrimination and racism in their daily life; be subject to substantiated abuse, neglect or harm and be subject to a care and protection order. They are also less likely to be exclusively breastfed to six months or to participate in childcare, kindergarten and MCH services compared to non-Indigenous children (ABS, 2017; Burns et al., 2010; Smith, Edwards, Martens & Varcoe, 2007).

1.3.2 The role of maternal and child health in universal early childhood health services in Australia

Ensuring women have access to appropriate health care in the antenatal and postnatal periods is vital for mothers' and children's long-term health and wellbeing outcomes (Rumbold et al., 2011). In Australia, ideally, universal early childhood services are accessible for all children, free of charge, and delivered flexibly across all states and territories according to children's and families' service needs, along with other universal, specialist and targeted services within and across sectors (AIHW, 2020; Asaria et al., 2016; OECD, 2018; WHO, 2015). MCH nurses lead the service delivery of child health, and practice is guided by the National Framework for Universal Child and Family Health Services (Australian Health Ministers' Advisory Council, 2011), which outlines the child health services available for all children from birth to eight years of age. The elements of universal child health services include health and developmental surveillance and monitoring, health promotion, early identification of family need and risk, and responding to identified need. Thus, in theory, the delivery of child health services is flexible and responsive to the needs of children and their families. Caregivers can access child health services at any time they require information, advice and support. Initial contact with

universal child health services ideally occurs within the first two weeks of a child's life and is offered as a home visit. Child health services are delivered through a schedule of recommended key ages and stages (KAS) of development. The schedule offers more frequent contacts in the first 12 months of a child's life, and less frequent contacts between two and five years of age (Australian Health Ministers' Advisory Council, 2011).

MCH nurses in Victoria, Australia, also referred to as 'child and family nurses', are nurse-midwives with a postgraduate qualification in Child and Family Nursing. The MCH service in Victoria is part of a broader service system that builds on the identification of individual, family and community needs at the local level. This service includes other practitioners, such as general practitioners, kindergarten and childcare services, early childhood intervention, parenting and family services, school nursing, child protection and other specialists. This service system also includes Aboriginal organisations and services for drug and alcohol abuse, mental illness and FV issues (DET, 2016a).

The MCH service in Victoria has developed and evolved over the years in response to new service delivery models based on integrated evidence-based practices (DEECD, 2004b, 2011a; Sheard, 2007). A 2006 review by the Office for Children and Early Childhood Development identified 35 aspects of child health and wellbeing, learning, development and safety that are essential to children's future or 'outcomes for children' (DEECD, 2006). These outcomes and their indicators are listed in Table 1.1.

Table 1.1. Maternal and child health areas of focus for key child outcomes (from DEECD, 2006)

Topic	Outcome	Indicator
-SIDS -Safe sleeping	-Optimal antenatal and infant development -Parent promotion of child health and development	-Sudden Infant Death Syndrome (SIDS) rate for infants -Proportion of infants put on their back to sleep from birth

Topic	Outcome	Indicator
-Parental Smoking	-Optimal antenatal and infant development -Healthy adult lifestyle	-Proportion of children exposed to tobacco while in utero -Proportion of women who used illicit drugs during pregnancy -Proportion of children and young people exposed to tobacco smoke in the home
-Immunisation	-Free from preventable disease	-Proportion of children who are fully vaccinated
-Breastfeeding -Solids	-Adequate nutrition	-Proportion of infants' breastfed -Proportion of children and young people who eat the minimum recommended serves of fruit and vegetable every day
-Post-natal depression -Sleep intervention	-Good parental mental health	-Proportion of mothers with post-natal depression -The proportion of children and young people who have parents with mental health difficulties
-Injury prevention	-Safe from injury and harm	-Age specific hospitalisation rates from injuries and poisoning
-Family violence	-Free from child exposure to conflict or family violence	-Proportion of mothers exposed to partner violence -Proportion of family violence incidents witnessed by children and young people
-Growth	-Healthy weight	-Proportion of children and young people who are overweight and obese
-Oral Health	-Healthy teeth and gums	-Proportion of children and young people who brush their teeth twice a day

The findings of the 2006 review resulted in the development of a new framework for the delivery of MCH services in Victoria (see Table 1.2). The MCH service now provides universal and enhanced healthcare services for Victorian families with young children from birth to school age/five years old (DEECD, 2006). This is complemented by a 24/7 telephone advice service.

Table 1.2. Key Age Stage (KAS) Framework (from DEECD, 2006)

KAS visit	Health and development monitoring	Intervention	Promotion of health and development
Home visit	<ul style="list-style-type: none"> -Family Health and Wellbeing -Pregnancy, birth, family history -Smoking 	<ul style="list-style-type: none"> -QUIT intervention and referral -Respond to assessments 	<ul style="list-style-type: none"> -Breastfeeding -Immunisation -SIDS: view infant sleep arrangements -Safe Sleeping Checklist
2 weeks	<ul style="list-style-type: none"> -Family Health and Wellbeing -Full physical assessment: includes Developmental Review Hearing risk factors 	<ul style="list-style-type: none"> -Respond to assessments 	<ul style="list-style-type: none"> -Car restraints -Communication, language and play -Injury prevention – Kidsafe
4 weeks	<ul style="list-style-type: none"> -Family Health and Wellbeing Maternal Health and Wellbeing - -Check hips, weight, length, head circumference 	<ul style="list-style-type: none"> -Family Violence safety plan, respond to assessments -Post Natal Depression 	<ul style="list-style-type: none"> -Breastfeeding -Immunisation -Women's health
8 weeks	<ul style="list-style-type: none"> -Family Health and Wellbeing 	<ul style="list-style-type: none"> -Respond to assessments 	<ul style="list-style-type: none"> -Immunisation

KAS visit	Health and development monitoring	Intervention	Promotion of health and development
	<ul style="list-style-type: none"> -Full physical assessment -Developmental Review 		<ul style="list-style-type: none"> -SIDS risk factors
4 months	<ul style="list-style-type: none"> -Family Health and Wellbeing -Developmental Assessment (PEDS/Brigance) -Hips -Weight 	<ul style="list-style-type: none"> -Respond to assessments 	<ul style="list-style-type: none"> -Communication, language and play -Food in first year of life -Playgroup Young Readers
8 months	<ul style="list-style-type: none"> -Family Health and Wellbeing -Full physical assessment -Oral health -Developmental Assessment (PEDS/Brigance) -Hearing risk factors -Infant sleeping 	<ul style="list-style-type: none"> -Sleep Intervention -Respond to assessments 	<ul style="list-style-type: none"> -Communication, language and play -Injury prevention - Kidsafe -Poison information -Sunsmart -Tooth Tips
12 months	<ul style="list-style-type: none"> -Family Health and Wellbeing -Developmental Assessment (PEDS/Brigance) -Weight and height, 	<ul style="list-style-type: none"> -Promote a healthy weight -Respond to assessments 	<ul style="list-style-type: none"> -Communication, language and play -Healthy eating for young toddlers -Immunisation

KAS visit	Health and development monitoring	Intervention	Promotion of health and development
	gait		
18 Months	-Family Health and Wellbeing -Developmental Assessments (PEDS/Brigance) -Oral health -Weight, height, gait	-Teeth cleaning -Respond to assessments	-Communication, language and play -Injury prevention – Kidsafe -Tooth tips
2 years	-Family Health and Wellbeing -Developmental Assessment (PEDS/Brigance) -Weight, height, gait	-Promote a healthy weight -Respond to assessments	-Communication, language and play -Kindergarten enrolment -Young Readers
3–5 years	-Family Health and Wellbeing -Developmental Assessment (PEDS/Brigance) -Vision (MIST) -Oral health -Weight and height, gait	-Promote a healthy BMI -Respond to assessments	-Communication, language and play -Healthy eating and play for kindergarten -Immunisation -Injury prevention – Kidsafe

Women in Victoria are referred to the MCH service by midwives from maternity services after birth, and routine monitoring of child development, parenting support and health promotion services are offered until the child is five years of age. Victorian legislation

mandates that the accoucheur, or nominated official administrative representative, notify the local government area (LGA) in which the mother resides following a birth (termed the Notification of Birth). A MCH nurse from that LGA, or nominated official administrative representative, contacts the mother to offer a home visit by a MCH nurse within two weeks of the child's birth, referred to as KAS 1 (DEECD, 2011a). MCH nurses perform home visits for 95–98% of Victorian mothers, including First Nations mothers, with newborns within the KAS 1 period (DET, 2018a). This system positions MCH nurses to prevent, identify and respond to challenges faced by families with children birth to five years of age, including FV (Shonkoff & Phillips, 2000; Shonkoff et al., 2009). Following the initial visit, two to 10 KAS consultations are generally offered through the MCH centre (see Table 1.2); however, the flexible funding component of the universal MCH model allows the MCH service to devise and implement innovative service models that support service integration and collaboration. Models that promote service integration, for example, include co-location of services, interdisciplinary teams, protocol sharing, joint service delivery and using common assessment frameworks and referral tools (DEECD, 2011a).

The Enhanced Home Visiting service, now known as the Enhanced Maternal and Child Health service, was implemented in 2000 and enables MCH nurses to provide more focused and intensive support to families at risk of vulnerability or experiencing parenting difficulties and to children at risk of harm (DHS, 2004). The Enhanced Maternal and Child Health service supports the needs of children and families at risk of poor outcomes, especially when there are multiple risk factors; these factors commonly include a parent experiencing childbirth as a teenager, psychiatric debility, alcohol or substance abuse, intellectual or physical disability, FV, families with a child with low birth weight, failure to thrive, a disability, a serious illness and/or involvement with child protection services (DEECD, 2011a). MCH nurses respond to parental concerns (e.g., parenting, safety or health issues) and are also enabled to act on their professional observations and judgement (including issuing notifications under the *Children, Youth and Families Act 2005* (Vic)).

1.3.3 First Nations women and maternal and child health services

First Nations women and their children experience significant disadvantage in health outcomes, including FV, compared to their non-Indigenous counterparts (see, e.g.,

AIHW, 2013, 2018; Cummins et al., 2012; State of Victoria, 2012b, 2012c; Wilson, 2009). Studies show that participation in MCH services improves Indigenous families' health outcomes (see, e.g., AIHW, 2015; Austin & Arabena, 2021; VAGO, 2016). For some women, however, accessing mainstream healthcare services without a transition or continuity of care results in high levels fear and anxiety and low attendance at subsequent appointments (see, e.g., AIHW, 2015; Austin & Arabena, 2021; DEECD, 2004a; Green et al., 2000; Homer et al., 2001; VAGO, 2016). Australia has a universal healthcare system in place for the general population, comparable in quality to that in New Zealand, the United Kingdom, and Northern European and Scandinavian countries (DEECD, 2013b; McCain & Mustard, 1999; Shonkoff & Phillips, 2000). However, Australia's progress in improving Indigenous health has been modest compared to other countries (Kruske, Kildea & Barclay, 2006; Thompson, Greville & Param, 2008), and historical events have resulted in Aboriginal and Torres Strait Islander peoples' distrust of government agencies, which influences their engagement with government health services (Kelly & Luxford, 2007).

The current MCH model in Victoria is an example of this. Data from various studies have consistently shown significantly lower participation rates among Indigenous children in the Victorian MCH service compared to non-Indigenous children (see, e.g., AIHW, 2013; DEECD, 2010c; DET 2018b; Cummins et al., 2012; NHMRC, 2002; State of Victoria, 2012a; VAGO, 2016; Wilson, 2009). For example, although 95–98% of Victorian women with newborns are being visited at home within two weeks of birth (VAGO, 2016)—well above the national average (AIHW, 2011)—Indigenous children show consistently lower participation rates compared to non-Indigenous children across all 10 KAS consultations (DET, 2015a; VAGO, 2016). The gap in participation sharply increases between the initial home visit and eight-month consultation, from 4.8% to 18% (DET, 2015a), indicating that a significant proportion of First Nations women accessing the MCH service disengage shortly after their initial enrolment/consult (VAGO, 2016). At the national level, it is further noted that half of Australian Indigenous children are identified as vulnerable (twice that of non-Indigenous children; ABS, 2017), there is well-documented inequality in health outcomes between Indigenous and non-Indigenous children (ABS, 2017), the increasing number of Aboriginal children in OoHC is considered a human rights issue (AIHW, 2017a; HREOC, 1997, 2008) and the rate of FV in Aboriginal families is rapidly increasing (AIHW, 2017a). Therefore, with First Nations women and

their children disengaging from, or never engaging with, MCH services, the families most in need of intense, high-quality care are least likely to receive it (Eapen et al., 2017). This population—First Nations women and their children—are the focus of the present research.

1.4 The research setting

At the time of writing, the population of First Nations peoples in Victoria was estimated to be 66,000 (ABS, 2021). First Nations peoples accounted for 1.0% of Victoria's total population in 2021, up from 0.8% in 2016 and 0.7% in 2011 (ABS, 2011, 2016, 2021). Of the approximately 66,000 people who identified as being 'of Aboriginal and/or Torres Strait Islander origin', 94.2% identified as 'Aboriginal' (ABS, 2021). In Victoria, the majority of Aboriginal and Torres Strait Islander people live in major urban areas (50%), with the remainder distributed across smaller urban centres (35%) and rural areas (15%) (ABS, 2021). The present research was undertaken in the Glenelg Shire, in the Barwon South West region of Victoria (see Figure 1.1). The Glenelg Shire covers an area of 6,219 km² and had a population of 19,665 in 2021 (ABS, 2021).



Figure 1.1. Glenelg Shire, South Western Victoria, Australia (DET, 2016a)

The traditional owners of the area in which Glenelg Shire is located are the Gunditjmara people, who are represented by the Gunditj Mirring Traditional Owners Aboriginal Corporation. According to the ABS (2021), in 2021, 9.6% of Aboriginal children aged birth to 17 years lived in the south western region of Victoria. None of these Aboriginal people identified as Torres Strait Islander people; therefore, they are referred to as 'Aboriginal', 'Indigenous', or 'First Nation' throughout Studies One to Three (Chapters 4–6) of this thesis.

The Glenelg Shire was selected as the research setting primarily due to (1) the high proportion of Indigenous families residing in the region and (2) these families' lower participation rate in MCH services compared to non-Indigenous families (ABS, 2016, 2021). The following statistics are important to note, considering that the prevalence of these risk factors likely leads to poorer health outcomes for Aboriginal mothers and children:

- The median age of Aboriginal mothers in this region is 24 years, compared to 30–34 years for non-Aboriginal mothers (ABS, 2021).
- The Aboriginal women in this region have babies at a younger age compared to the non-Aboriginal women in this region (ABS, 2016, 201).
- The Aboriginal women in this region are five times more likely to have a low birth weight baby compared to the non-Aboriginal women in this region (ABS, 2021; Burns et al., 2010).
- The incidence of FV among Aboriginal women with children aged birth to five years in this region is at least 39% higher than that for non-Aboriginal women in this region (ABS, 2016, 2021). (This is significant as FV is one of the main causes of physical and mental illness among women of childbearing age (DEECD, 2010b; DPCD, 2008), especially when a woman is pregnant or has recently given birth (DEECD, 2010b; Mouzos & Makkai, 2004).)
- This region consists of families considered to be highly disadvantaged and that score poorly on socioeconomic indexes (ABS, 2016, 2021).

1.5 Overview of the thesis structure

As detailed in Chapter 3, narrative inquiry is an interpretative approach from the social sciences that examines human lives through the lens of a narrative or storyline (McAlpine, 2016). Narrative inquiry bridges Western and Indigenous research methodologies, providing a methodological approach of holistic observation from an Indigenous standpoint, without the risk of bias, to challenge and change thinking, ideas and understanding (Nakata, 1998). A narrative approach to the structure of this thesis allowed the researcher to be congruent and in tune with the physical, psychological, social and cultural aspects of the traditional Indigenous methodology of storytelling or 'yarning'. The storyline of this thesis is presented in Figure 1.2.

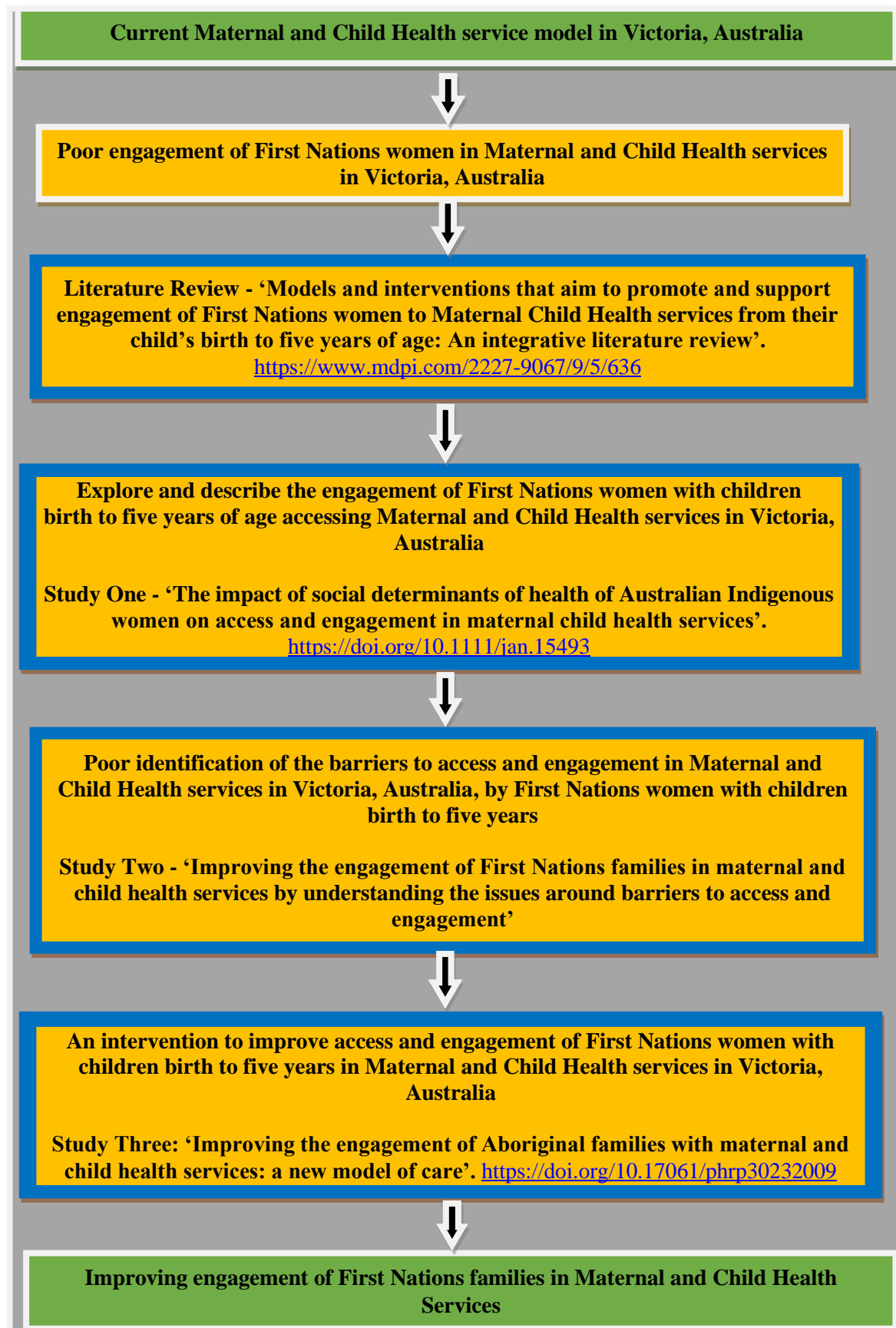


Figure 1.2. The Storyline: Structural overview of the thesis

Chapter 1 has presented the rationale, aims, objectives and background of the thesis, providing the narrative of Indigenous children in Victoria, Australia, continuing to face more health challenges than non-Indigenous children (AIHW, 2013, 2018; Cummins et al., 2012; State of Victoria, 2012b, 2012c; Wilson, 2009).

Chapter 2 undertakes a systematic review of the literature investigating models and interventions to promote and support First Nations families' engagement with MCH services in the period from a child's birth to five years of age. This chapter identifies gaps in the literature that subsequently served as the basis for this thesis's research questions. This integrative literature review has been published in *Children* as 'Models and interventions that aim to promote and support engagement of First Nations women to maternal and child health services from their child's birth to five years of age: An integrative literature review' (<https://www.mdpi.com/2227-9067/9/5/636>).

Chapter 3 details the chosen methodology and research design used to address the identified gaps in the literature. The developed research questions were based on the literature review and shaped by the methodology.

The results of three published studies are then presented in standalone chapters. Chapter 4 presents the results of Study One, based on interviews with 35 First Nations women to explore their perceptions and experiences of MCH services. This study aimed to identify factors that facilitate, support or hinder First Nations women's access to and engagement with MCH services. This study has been published in the *Journal of Advanced Nursing* as 'The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services' (<https://doi.org/10.1111/jan.15493>).

Chapter 5 presents the results of Study Two, based on comparison of the Study One interviews with accounts from 10 MCH nurses to investigate their perceptions of barriers to First Nations women accessing and engaging with MCH services.

Chapter 6 presents the results of Study Three, piloting and assessing the Early Assessment Referral Links (EARL) concept developed by the researcher. This study has been published in *Public Research and Health Practice* as 'Improving the engagement of Aboriginal families with maternal and child health services: A new model of care' (<https://doi.org/10.17061/phrp30232009>). The program logic model presented in this chapter supports a systematic and integrated approach to planning, implementation and

evaluation. It provides the structure for a new MCH model of care that improve the identification and engagement of families with children from conception to five years of age (the first 2000 days), at risk of vulnerability to child abuse or neglect. The framework aims to reduce gaps within service delivery and ensure continuity of care, and allows for the integration of traditional First Nations child-rearing practices, beliefs and practices. The framework also aims to encourage integration and collaboration among early years' service providers, and overcome disciplinary, sectoral, and institutional 'silos' between services' in the life-stages from pre-conception through to the first year of school, portrayed in Figure 1.3.

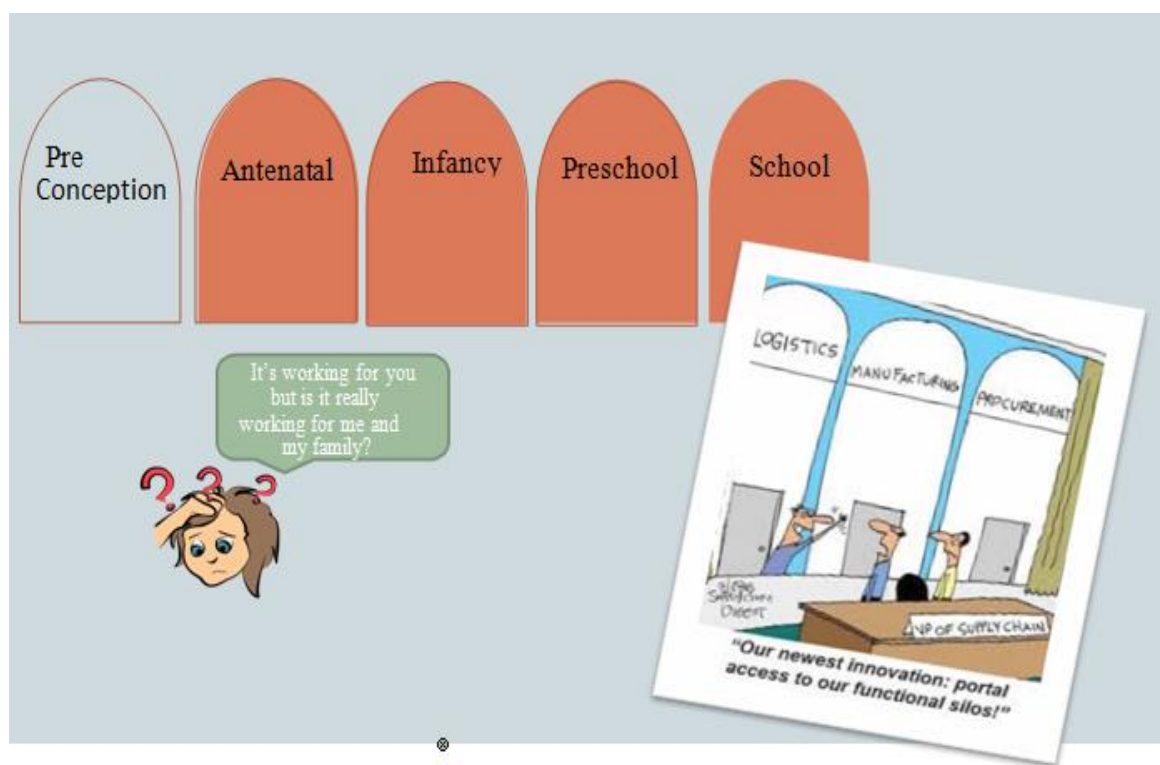


Figure 1.3. Current siloed approach for Early Years Services in Victoria, Australia

Chapter 7 integrates and discusses the findings from the three studies in addressing the research questions.

Chapter 8 presents the recommendations derived from the research findings to improve First Nations families' access to and engagement with MCH services.

Chapter 9 concludes the thesis, providing an overview of the research aims and objectives and a brief summary of the research and methodology employed to achieve these. The chapter restates and summarises the thesis's major findings, discusses the strengths and

limitations of the research, considers the implications for policy and practice, and proposes directions for future research.

1.6 Chapter summary

This chapter has presented the research rationale, aims, objectives and background and the thesis structure. The provided background contextualises this study, orients the reader and provides a basis on which to present the study. The next chapter further situates this research through a review of the relevant literature.

Chapter 2: Literature review of models and interventions that aim to promote and support engagement of First Nations women to Maternal and Child Health services from their child's birth to five years of age

2.1 Introduction

The previous chapter introduced the research and thesis overview. This chapter presents a systematic review of the relevant literature that investigated models and interventions that aim to promote and support engagement of First Nations families and their access to MCH in the period from the child's birth to five years of age, and justification for this research. The research output in this chapter forms part of the storyline 'Access and Engagement of First Nations Women in Maternal and Child Health Services: An Integrative Review' (Figure 1.2.). This research is presented in this chapter, and has been published in the researcher's term of candidature. The published manuscript (<https://doi.org/10.3390/children9050636>) is included in Appendix Thirteen.

The first 2,000 days, the period from conception to the child's fifth year, comprises the critical period of foetal and child development, which forms the foundation for all subsequent development and health throughout the child's lifetime (Belli et al., 2005). The period of early childhood also represents a critical window of opportunity, where high quality health and educational interventions can reap benefits that extend across the life-course (Belli et al., 2005; Sweeny, 2014; WHO, 2018; VAGO, 2016). The United Nations recognises the rights of children 'to the highest attainable standard of health' with an emphasis on primary health care, child health, and preventative health care (Turley, Vanek, Johnston & Archibald, 2018; United Nations Committee on the Rights of the Child, 2013). The need for improved child healthcare for First Nations populations is evident by persistent disparities in child health equity in Australia, Canada, New Zealand, and the United States (Anderson et al., 2016). Ensuring First Nations women have access to appropriate health care in the antenatal and postnatal period is vital for the long-term health outcomes for both the mother and her child (Rumbold et al., 2011).

Many First Nations families deal with ongoing stressors from the intergenerational trauma of the impacts of colonisation (Anderson et al., 2016). This can manifest in psychological distress, grief, smoking and alcohol and drug misuse, mental illness, and/or violence, and thus affect their ability to nurture children (Smylie & Adomako, 2009). Additionally, First Nations families commonly experience strengths such as a strong bond with their family and extended families, which influence the cultural norms on their child rearing practices (Lohar, Butera & Kennedy, 2014; Smylie & Adomako, 2009). These strengths provide opportunities for Maternal and Child Health (MCH) services to support First Nations families, including upstream social determinants of First Nations children's health and wellbeing (Smylie & Adomako, 2009; McCalman et al., 2017).

MCH nurses, also referred to as 'child and family nurses', are uniquely placed in the community to influence the shape of this critical period in a child's life. Participation in the MCH service provides the earliest opportunity to identify, prevent and respond to challenges faced by young families (Shonkoff & Phillips, 2000; Shonkoff et al., 2009). Midwives refer women to MCH services from maternity services after birth, and a schedule of routine monitoring of child development, parenting support, health promotion services, early identification of family needs and responses to these needs are offered until the child is at least five years old. Despite the aims of universal service provision, some harder to reach groups, such as Indigenous and culturally and linguistically diverse (CALD) communities, do not engage with services (Yelland, 2016) or do not sustain visits (Riggs et al., 2012), and economically disadvantaged families are less inclined to access services (Eapen et al., 2017). This brings into effect an inverse care law, which suggests that those who most need more intense and high-quality care are least likely to receive it (Eapen et al., 2017).

It is also recognised that in countries such as North America, New Zealand and Australia, which have a history of colonisation, there is a burden of poor health and wellbeing experienced by their First Nations families, and access to resources and services is adversely affected by historical and contemporary SDOH (Anderson et al., 2016). These parents, in particular, need support services that are accessible, culturally relevant, and acceptable to strengthen their families' health outcomes (Milroy, Dudgeon & Walker, 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009).

Ensuring the optimal design of a model that promotes and supports engagement of First Nations families and their access to MCH services in the period from the child's birth to five years of age is impeded by the lack of knowledge of the relationship between services and children's health outcomes (Turley et al., 2018). The aim of this review, therefore, is to identify what factors support or hinder engagement of First Nations women with children birth to five years of age and their access to MCH services, and what improvements could be made to better improve engagement and access for First Nations women in relation to these services.

2.2 Method

2.2.1 Search criteria

An integrative literature review entails undertaking a systematic search, critique and summary of relevant literature (Torraco, 2016; Whitemore & Knafl, 2005). The inclusion criteria for this review were full text, peer-reviewed journal articles and grey literature of relevant studies that investigated models and interventions that aim to promote and support engagement of First Nations families and their access to MCH in the period from the child's birth to five years of age. The exclusion criteria were study protocols, policy perspectives, discussions of risk factors for specific diseases or practices, descriptions or evaluations of interventions or programs in the antenatal period, reports of pregnancy or birth outcome trends/statistics.

2.2.2 Search strategy and outcomes

Searches were conducted in Medline, PsychInfo, CINAHL, and Scopus databases, and relevant government publications from January 2011 to April 2021 were reviewed for inclusion. Search terms included individual and combinations of the search terms 'matern*', 'child*', 'famil*', 'postnatal', 'service*', 'care', 'health', 'model*', 'intervention*', 'approach*', 'indigen*', 'aborig*', 'torres strait', 'first nation*', 'native', 'engag*', 'interact*', 'uptake*', 'continu*', 'access*'. These terms were used in conjunction with the Boolean operators 'and' and 'or'.

The initial database search identified 732 records, with an additional 99 records identified from grey literature on Google Scholar (47), hand searching and snowballing from the reference lists of included articles (43), and peer referral (9). These searches yielded 831

records. After the preliminary screening of the removal of duplicates (30), 801 records remained. Following a further screening of article titles and abstracts assessed against inclusion and exclusion criteria, 652 records were removed and 149 records remained. After a secondary screening of full text articles against inclusion and exclusion criteria, a further 143 records were discarded and six records remained. These six records were individually assessed by the researchers using the Newcastle-Ottawa scale to assess the quality of the non-randomised studies in the systematic review (Deeks et al., 2003), all six being included in the final review.

Articles and data were analysed by the researchers separately and then collectively, using the principles of thematic analysis (Braun & Clarke, 2021) to identify broad concepts of the barriers and enablers that influenced access and engagement of First Nations families to MCH services. The results of each stage of the literature search are summarised in Figure 2.1.

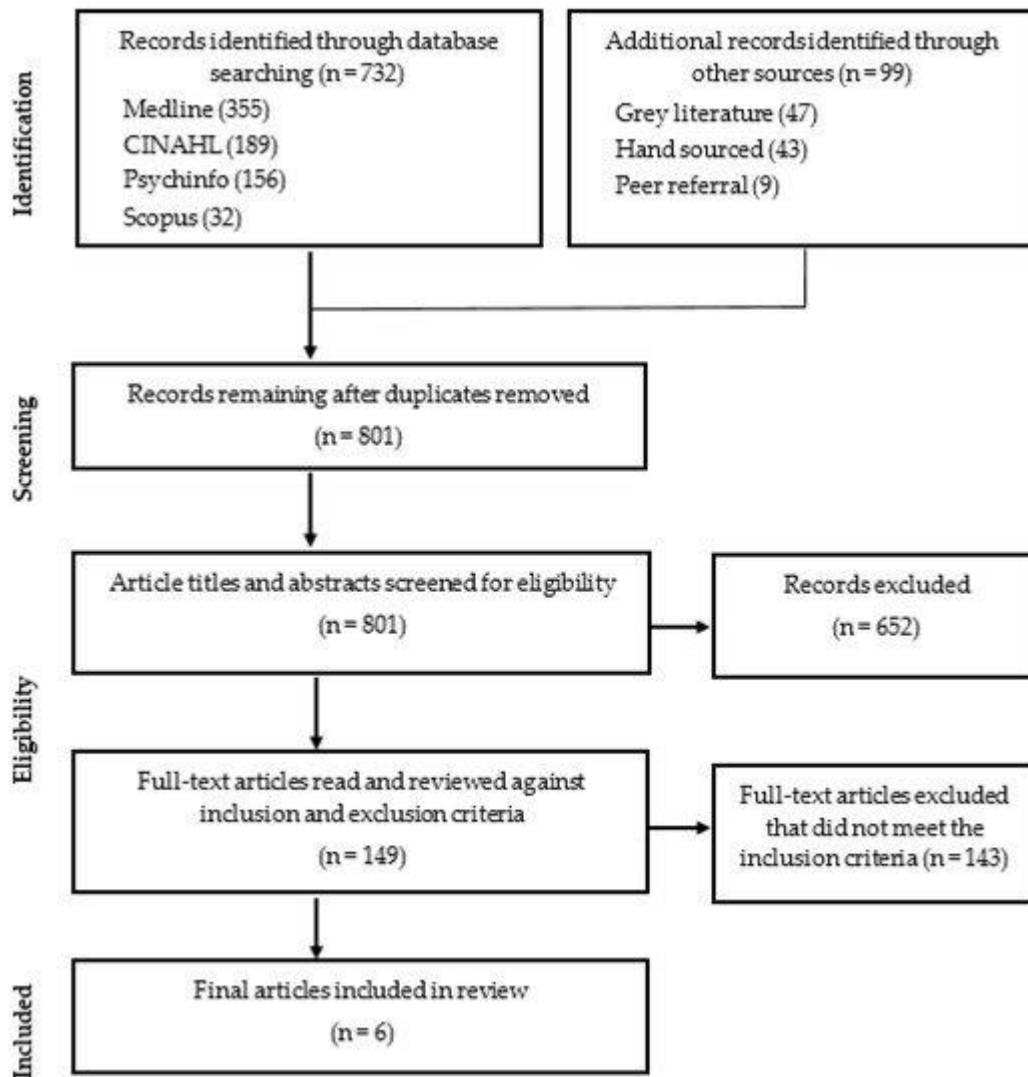


Figure 2.1. Literature review flow diagram

2.3 Results

The review of the literature identified a limited number of studies of models that promote and support engagement of First Nations families and their access to maternal and child health services in the period from the child's birth to five years of age (Table 2.1).

Table 2.1. Models/interventions that promote and support engagement of First Nations families and their access to maternal and child health services from the child's birth to five years of age

Author/Date/Title	Sample	Type of Study/ Methodology	Thesis/ Intention of Work	Intervention	Results
Barclay, L.; Kruske, S.; Bar-Zeev, S.; Steenkamp, M.; Josif, C.; Wulili Narjic, C.; Wardaguga, M.; Belton, S.; Gao, Y.; Dunbar, T.; Kildea, S. 2014. Improving Aboriginal maternal and infant health services in the 'Top End' of Australia: synthesis of the findings of a health services research program aimed at engaging stakeholders, developing	Baseline data study: Data from 412 mothers and their 413 babies who were recruited from two remote study sites over two years (2004–2006) were audited; 120 h of observation of maternal and child health services and 60 semi-structured interviews were conducted in 3 settings with key stakeholders. Epidemiological studies: An epidemiological investigation of 7560 mothers with singleton pregnancies utilizing the	A mixed-methods health services research program of work was designed, using a participatory approach.	The study consisted of two large remote Aboriginal communities in the Top End of Australia and the hospital in the regional centre that provided birth and tertiary care for these communities. The stakeholders included consumers, midwives, doctors, nurses, Aboriginal health workers, managers, policy makers, and support staff. Data were	1 + 1 = A Healthy Start to Life Project. Focus on health services in the year before and the year after birth to promote a healthy start to life. This became the main health-service-led 'intervention' of the study.	Overall, sustainable improvements in the maternity services for remote-dwelling Aboriginal women and their infants in the Top End of Australia occurred as a result of the midwifery group practice (MGP) intervention. These included significant improvements in maternal record keeping, antenatal care and screening, smoking cessation advice, a reduction in foetal

research capacity and embedding change.	<p>Northern Territory perinatal data set that included births occurring between 2003 and 2005 was conducted.</p> <p>Study of out-of-hospital births:</p> <p>Audit of 32 records of women who birthed locally, detailed field notes, stories collected, and unstructured interviews with 7 locally birthing women and 5 of their family members.</p> <p>Parenting study:</p> <p>Longitudinal interviews and observations with 15 women from each field site from pregnancy until their babies were 12</p>		<p>sourced from hospital and health centre records, perinatal data sets and costing data sets, observations of maternal and infant health service delivery and parenting styles, formal and informal interviews with providers and women and focus groups.</p> <p>Studies examined indicator sets that identify best care, the impact of quality of care and remoteness on health outcomes, discrepancies in the birth counts in a range of different data sets and ethnographic</p>		<p>distress in labour, and a higher proportion of women receiving postnatal contraception advice. Positive experiences of the women and MGP staff were also reported during the first year of the MGP intervention. Continuity of care, provided by appropriately qualified staff as part of the intervention, resulted in improved relationships between the midwives and their clients. The women's engagement with other health services, facilitated by the midwives, also</p>
---	--	--	--	--	--

	<p>months of age.</p> <p>Discussions were held with women and family members and narratives collected.</p> <p>Impact of colonisation of health care in the Northern Territory:</p> <p>An Aboriginal PhD candidate with Aboriginal co-researchers led a study of the quality and nature of health care with a case study on intergenerational learning about birthing.</p> <p>Post-intervention evaluation:</p> <p>A total of 66 participants were interviewed; the audit of the record was repeated; field notes were kept and observations</p>		<p>studies of ‘out of hospital’ or health-centre birth and parenting. A new model of maternity care was introduced by the health service aiming to improve care following the findings of the research. Some of these improvements introduced during the five-year research program were evaluated.</p>		<p>improved. Additionally, overall costs were reduced as a result of a significant reduction in birthing and neonatal nursery costs as a result of the MGP intervention. However, a review of this intervention conducted in 2012 showed further improvement in clinical care was still needed. Some adverse health conditions appeared to increase, possibly due to improved documentation. Specifically, unacceptable standards of infant care and parental support, no</p>
--	---	--	---	--	---

	<p>undertaken in remote sites.</p> <p>Participatory Action Research Study:</p> <p>Baseline data on problems with transfer of information between the regional centre and the remote clinics led to a study by a senior manager and two researchers on improving the system.</p> <p>Costing study:</p> <p>A total of 315 mothers and singleton infants who were clients of the midwifery group practice were compared with 408 mothers with singleton pregnancies from the baseline study post-</p>				<p>apparent consideration for the fluctuation in numbers and complexity of client cases and adequately trained staff with the required skills for providing care for children in an ‘outpatient’ model of care. Adequate coordination between remote and tertiary services was absent, which is essential to improve quality of care and reduce the risk of poor health outcomes.</p>
--	--	--	--	--	---

	<p>midwifery group practice intervention. Data on direct costs from the department's perspective were collected from the first antenatal visit until 6 weeks post-partum, and data on infant costs were collected from birth to 28 days.</p> <p>Benchmarking of neonatal nursery admissions:</p> <p>Records of all 463 neonates born in 2010 and admitted to nursery were benchmarked.</p>				
Bar-Zeev, S.; Barclay, L.; Farrington, C.; Kildea, S. 2012.	A total of 420 women were eligible for the study, sought from 413 medical records at the regional hospital and 400	Mixed-methods study, retrospective cohort study, and key informant interviews.	The study aimed to examine the transition of care in the postnatal period from a regional hospital to a remote	None introduced.	This study found that there was poor discharge documentation, communication, and co-ordination between the

From hospital to home: the quality and safety of a postnatal discharge system used for remote dwelling Aboriginal mothers and infants in the top end of Australia.	at the remote health service. A total of 66 semi-structured interviews were conducted with key health and management staff and 30 administrative staff employed in the health centres; 18 staff from the regional hospital maternity, neonatal, and paediatric units; and 12 other staff providing clinical, administrative, or logistical support for remote-dwelling women during pregnancy, around the time of birth, and during the first year of life.		health service and describe the quality and safety implications for remote-dwelling Aboriginal mothers and their infants.		hospital and remote health centre staff. In addition, the lack of clinical governance and a specific position holding responsibility for the postnatal discharge planning process in the hospital system were identified as serious risks to the safety of the mother and infant.
--	---	--	---	--	---

<p>Homer, C.; Foureur, M.; Allende, T.; Pekin, F.; Caplice, S.; Catling-Paull, C. 2012.</p> <p>‘It’s more than just having a baby’ women’s experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families.</p>	<p>Clinical outcomes for the 353 women who were booked with the Malabar Community Midwifery Link Service and gave birth in the 2007 and 2008 calendar years were collected prospectively from the database.</p>	<p>Clinical outcomes were collected prospectively and quantitatively analysed. Data from the 353 women who were booked with the Malabar Community Midwifery Link Service were transcribed and analysed qualitatively.</p>	<p>The paper evaluates the Malabar Community Midwifery Link Service from the perspective of Aboriginal women who accessed it.</p>	<p>Malabar Community Midwifery Link Service.</p> <p>The intervention aims to improve maternal and infant health by providing culturally appropriate care. The midwives work closely with the Aboriginal Health Education Officer and in a continuity of care model in which women get to know the midwives during the pregnancy.</p>	<p>Accessing the Malabar Community Midwifery Link Service helped women reduce their smoking during pregnancy. Focus group findings showed that women felt the service provided ease of access, continuity of care, and trust and trusting relationships. A total of 353 women gave birth through accessing the Malabar Community Midwifery Link Service, with forty per cent of babies identified as Aboriginal or Torres Strait Islander. Over ninety per cent of women had their first</p>
--	---	---	---	--	--

					visit before 20 weeks of pregnancy.
<p>Josif, C.; Kruske, S.; Kildea, S.; Barclay, L. 2017.</p> <p>The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes: a qualitative analysis.</p>	<p>Data were collected from 25 clinicians providing or managing infant health services in the two study sites.</p>	<p>Semi-structured interviews, participant observation, and field notes were analysed thematically.</p>	<p>The study describes infant health service quality following health system changes in the area.</p>	<p>Health system changes. These reforms included implementation of the Healthy Under 5 Kids (HU5K) program and an education package to support staff to deliver this program. Designated Child and Family Health Nurses and Aboriginal Community Worker positions were also established in the two Healthy Start to Life study sites.</p>	<p>A range of factors affecting the quality of care persisted following health system changes in the two study sites. These factors included ineffective service delivery, inadequate staffing, and culturally unsafe practices. The six sub-themes identified in the data, namely, ‘very adhoc’, ‘swallowed by acute’, ‘going under’, ‘a flux’, ‘a huge barrier’, and ‘them and us’, illustrate how these factors continued following health system changes in the two study</p>

					sites and, when combined, portray a 'very chaotic system'. Improvements are needed to the quality, cultural responsiveness, and effectiveness of the health services.
McCalman, J.; Searles, A.; Bainbridge, R.; Ham, R.; Mein, J.; Neville, J.; Campbell, S.; Tsey, K. 2015. Empowering families by engaging and relating Murri way: a grounded theory study of the implementation of the Cape York Baby Basket program.	In-person interviews of 7 women and 3 of their family members who had received Baby Baskets were conducted. The women, aged 21 to 34 years, were either pregnant or recently pregnant and were from six of the eleven Indigenous communities in Cape York, Australia. Focus groups were	Constructivist-grounded-theory method.	To address the region's poor maternal and child health, the Baby Basket program was developed by Apunipima Cape York Health Council (ACYHC), a community-controlled Aboriginal health organisation located in north Queensland, Australia. The program is an initiative focused	Apunipima Baby Basket program. Engaging and relating Murri way occurred through four strategies: connecting through practical support, creating a culturally safe practice, becoming informed and informing others, and linking at the clinic.	Overall, the Apunipima Baby Basket program intervention enabled sustainable improvements in the areas of maternal and child health. Engaging and relating Murri way occurred through four strategies: connecting through practical support, creating a culturally safe practice, becoming informed and

	conducted with 18 healthcare workers.		on Indigenous women who are expecting a baby or have recently given birth.		informing others, and linking at the clinic. These strategies resulted in women and families taking responsibility for health through making healthy choices, becoming empowered health consumers, and advocating for community changes.
Zarnowiecki, D.; Nguyen, H.; Hampton, C.; Boffa, J.; Segal, L. 2018. The Australian Nurse-Family Partnership Program for aboriginal mothers and babies: Describing client complexity and	Australian Nurse-Family Partnership Program data were collected using standardised data forms by the nurses during their antenatal home visits to 276 clients from 2009 to 2015. These data were used to describe client complexity and adversity in relation to	Mixed-methods study using Family Partnership Program data and qualitative data collected in semi-structured interviews with Family Partnership Program staff and key stakeholders. Family Partnership Program	The Australian Nurse-Family Partnership Program is a home-visiting program for Aboriginal mothers and infants (pregnancy to child's second birthday) adapted from the United States Nurse Family Partnership program. It	The Australian Nurse-Family Partnership Program (ANFPP).	Most clients engaged in the Australian Nurse-Family Partnership Program (ANFPP) were described as 'complicated', with sixty-six per cent of clients experiencing four or more adversities. These adversities were found challenging for

implications for program delivery.	demographic and economic characteristics, mental health, and personal safety. Semi-structured interviews with 11 Australian Nurse-Family Partnership Program staff and key stakeholders explored in more depth the nature of client adversity and how this affected program delivery.	data were used to describe the characteristics of Family Partnership Program clients.	aims to improve outcomes for Australian Aboriginal mothers and babies, and disrupt inter-generational cycles of poor health and social and economic disadvantage. The aim of this study was to describe the complexity of Program clients in the Central Australian family partnership program, understand how client complexity affects program delivery, and the implications for desirable program modification.		program delivery. For example, housing conditions meant that around half of all 'home visits' could not be conducted in the home, being held instead in staff cars or community locations. Extreme poverty, living in insecure housing, and domestic violence (almost one-third of the mothers experiencing more than two episodes of violence in 12 months) affected the delivery of program content and increased the time needed to deliver program content. Additionally, low client
------------------------------------	---	---	---	--	--

					<p>literacy meant written handouts were unhelpful for many, requiring the development of pictorial-based program materials. The rates of breastfeeding and child vaccination, which were higher than comparative national data for Indigenous women and children in remote areas of Australia, were positive aspects of the ANFPP.</p>
--	--	--	--	--	--

Of the six included studies, all were published from 2012-2018. Two were mixed method studies with an intervention that aimed to promote and support access to and engagement of First Nations families to MCH services (Barclay et al., 2014; Zarnowiecki, Nguyen, Hampton, Boffa & Segal, 2018); one was mixed method with no intervention (Bar-Zeev et al., 2012); there was one quantitative study with an intervention (Homer et al., 2012); and there were two qualitative studies with an intervention (Josif et al., 2017; McCalman et al., 2015) that aimed to promote and support engagement of First Nations families and their access to MCH services. All included studies were either conducted across metropolitan (Homer et al., 2012), remote (McCalman et al., 2015; Josif, Kruske, Kildea & Barclay, 2017; Zarnowiecki et al., 2018) or a combination of metropolitan and remote settings (Barclay et al., 2014; Bar-Zeev et al., 2012) in Australian Aboriginal communities.

2.3.1 Enablers that influence access and engagement of First Nations families to Maternal and Child Health services

In this review of the literature, gaps in the research evaluating service models and interventions that enabled engagement of First Nations families and their access to MCH services were identified.

The enablers identified from the six included studies were service models or interventions that are:

- timely and appropriate
- effective integrated community-based services that are flexible in their approach
- holistic
- culturally strong
- encourage earlier identification of risk and need for further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday (the first 2,000 days).

2.3.1.1 Timely and appropriate service models or interventions

From the included studies, it was found that, as MCH services respond to the needs of children and families at risk of poor outcomes, many childhood conditions that pose a risk for poor outcomes, can benefit from early detection and intervention actions (Barclay et

al., 2014; Bar-Zeev et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). For this reason, models or interventions identified in the included studies that enable timely and appropriate service for First Nations families, from conception to the child's fifth birthday, were more successful in supporting access and engagement of those families to MCH services as these models or interventions were seen as mutually valuable to both MCH nurses and to First Nations women (Barclay et al., 2014; Bar-Zeev et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.3.1.2 Effective integrated community-based services that are flexible in their approach

The MCH service is part of a broader service system, which builds on the identification of individual, family and community needs at the local level. The MCH service has the flexibility to devise and implement innovative service models, which support service integration and collaboration while maintaining the universal nature of the service. Examples of models that promote service integration include co-location of services, interdisciplinary teams, protocol sharing, joint service delivery and using common assessment frameworks and referral tools. The included studies showed that effective, integrated community-based services that are flexible in their approach and collaborate with other early years services, enabled more effective access and engagement of First Nations women with children from birth to 5 years into MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.3.1.3 Holistic service models or interventions

It was discussed in the included studies that a strengths-based approach to parenting allows a shift away from a 'problems focus', to instead focus on the inherent strengths of families and communities (Barclay et al., 2014; McCalman et al. 2015). A strengths-based approach recognises and fosters a person's skills, capacities and competencies. This approach recognises that each person has positive attributes, skills and expertise in relation to their lives, and their families. A strengths-based approach aims to enhance motivation, participation and realisation of identified goals and positive outcomes (NSW Government, 2021). As many First Nations families commonly experience the strength of strong bonds with their extended families, ensuring holistic care is planned around the

extended family supports the upstream social determinants of First Nations children's health and wellbeing (Barclay et al., 2014; McCalman et al.2015).

Family-centred healthcare, delivered through primary healthcare services for First Nations children in the period from conception to the child's first five years, is an example of a holistic service model or intervention that provides support for the whole person, not just their mental health needs. The support also considers their physical, emotional, social and spiritual wellbeing using listening, asking and checking as key skills to be able to provide a holistic service. This holistic approach acted as an enabler to support access and engagement in MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.3.1.4 Culturally strong service models or interventions

An enabler identified in the literature, which promotes and supports access to and engagement of First Nations families to maternal and child health services in the period from the child's birth to 5 years of age, are models or interventions that harbour relationships and encourage mutual trust and engagement of First Nations families in the MCH service (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Additionally, this enabler was strengthened when Government and policymakers genuinely acknowledge the historical, cultural and social complexity of First Nations families' birthing and child-rearing principles and practices (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.3.1.5 Service models or interventions that encourage earlier identification of risk and need for further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday

While early years experts have long been aware that the antenatal period to the child's fifth birthday (the first 2,000 days) is an important period of development, the literature reviewed has only recently started to unlock some of the mysteries surrounding the processes by which genes, experiences and environments interact to influence development (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). This requires a model with an

operational and implementation focus that adheres to Indigenous methodologies and knowledge generation, recognition of the centrality of culture, which reinforces and strengthens families and uses a holistic view of health and wellbeing.

New knowledge that has been unveiled in the included studies of MCH service models or interventions that encourage earlier identification of risk and need for further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday as a means to enable access and engagement of First Nations women with children from birth to 5 years of age in MCH services, has served to increase experts' views of the significance of the first 2,000 days and of the urgent need to reform the relevant policies, practices and systems in response to the evidence (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.3.2 Barriers that influenced access and engagement of First Nations families to Maternal and Child Health services

Discussion of the barriers that influenced access and engagement of First Nations families to MCH services, highlighted in the six studies as factors that impacted on the quality of care, service delivery, and outcomes for these families, will be discussed in this review as addressing the barriers may assist to enable access and engagement of First Nations families to MCH services.

The barriers identified from the six included studies were:

- inefficient communication resulting in lack of understanding between client and provider
- cultural differences between client and provider
- poor continuity of care between services
- lack of flexibility in approach/access to services
- a model that does not recognise the importance of the social determinants of health and wellbeing.

2.3.2.1 Inefficient communication resulting in lack of understanding between client and provider

There is major discordance between Indigenous and non-Indigenous views about children's agency and role within the family, influencing access and engagement of First Nations families to MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012). The differences in views to parenting and child rearing between Indigenous and non-Indigenous populations are well documented in countries with a history of European colonisation (Homer et al., 2012). The invisibility of First Nations leadership to inform a greater understanding of, and respect for, First Nations values and beliefs pertaining to parenting and child rearing appears to be a contributing factor (Bar-Zeev et al., 2012). Poor communication among health professionals can result in fragmentation of care (Homer et al., 2012). There is scant evidence of effective communication and documentation systems that facilitate seamless transfer of care from maternity services to MCH services. It is, therefore, unclear how services might be integrated to provide optimal care for First Nations mothers and their families during the early postpartum period (Homer et al., 2012). A fusion between Indigenous and non-Indigenous views about children's agency and role within the family would be a way of contributing to improved health outcomes, which would require greater understanding of and respect for First Nations values and beliefs pertaining to parenting and child rearing. Currently there is little empirical evidence in the literature pertaining to the implementation of these parenting paradigms.

2.3.2.2 Cultural differences between client and provider

Culturally unsafe practice and racist attitudes by clinicians were identified in the included studies as a barrier that influenced access and engagement of First Nations families to MCH services (Josif et al., 2017). Negligible numbers of First Nations staff working in MCH services and perceived racist behaviours by some staff were attributed to this theme (Josif et al., 2017; Bar-Zeev et al., 2012). Racism was identified as a key determinant of health for First Nations people (Josif et al., 2017), and the experience of racism by First Nations people can contribute to poorer health outcomes (Josif et al., 2017). The development of a culturally competent workforce and the development of tools to measure culturally competent care in MCH services is required to address this issue (Barclay et al., 2014). A review of the international Nurse-Family Partnership Program

found that the success of the program is dependent on the compatibility between the characteristics of the client and the program model (Zarnowiecki et al., 2018). It is therefore vital to understand that the adversities of client population, and the challenges that they face, will reflect the likelihood of them accessing and engaging in the services offered to them (Zarnowiecki et al., 2018). Creating a culturally safe practice allows care to be extended to women's and families' social and emotional wellbeing (Zarnowiecki et al., 2018).

2.3.2.3 Poor continuity of care between services

Continuity of care, being a philosophy of care, is concerned with the quality and consistency of care over time. For providers in vertically integrated systems of care, the contrasting ideal is the delivery of a 'seamless service' through integration, coordination and the sharing of information between different providers. In Maternity and MCH services, that refers to service models that incorporate continuity of services and/or continuity of carer across antenatal, labour, birthing and post-natal care. The included studies reported that First Nations women frequently perceive available MCH services as culturally unsafe (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Experiences of First Nations women reportedly view continuity of care as more culturally safe (than existing siloed care) and can result in a greater uptake in health care across antenatal, labour, birthing and post-natal care periods (Barclay et al., 2014). In the study by Homer et al. (2012), the focus group findings showed that women felt the service provided ease of access, continuity of care, and trust and trusting relationships.

2.3.2.4 Lack of flexibility in approach/access to services

In the included studies, access to pre-conception, antenatal and postnatal care was found to often be compromised for First Nations women (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Access to community-based, culturally appropriate services, is often limited for families with low socioeconomic status, and for many women, social isolation is exacerbated when they have a new baby (Homer et al., 2012). McCalman et al. (2015) identified home visiting as a key strategy for creating a culturally safe practice, while providing flexibility in approach and access to MCH services.

2.3.2.5 A model that does not recognise the importance of the social determinants of health and wellbeing

The studies included in the review revealed that comprehensive, holistic models of care assisted in enabling access and engagement of First Nations families to MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). However, the models or interventions that did not incorporate services based on the social determinants of health, were actually perceived as a significant barrier when considering engagement of First Nations families and their access to MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). This supports the theory that the gap in life expectancy for First Nations peoples, in comparison to non-First Nations peoples, can be partially attributed to differences in the social determinants of health, which include the social and environmental conditions in which people live and work (Josif et al., 2017). Examples of these include extreme poverty, welfare dependency, low engagement with work and school, insecure housing, racism, multiple traumas, and domestic violence (Josif et al., 2017).

2.4 Discussion

The aim of this review was to explore current literature and identify existing knowledge that can improve First Nations families' and their children's access to and participation in MCH services in the period from the child's birth to five years of age. Although recent changes to models of maternity care show some positive outcomes (Josif et al., 2017), the included studies indicate that improvements to infant care are required (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Current MCH service systems are often 'fragmented' (Bar-Zeev et al., 2012). Consequently, accessing MCH service often results in high levels of fear and anxiety, and low attendance to subsequent appointments among First Nations women (Sivertsen et al., 2020). The studies included in the review show that a biomedical model of care underpins most mainstream MCH services worldwide, which can be incongruous with traditional Indigenous ways of parenting and child rearing (Sivertsen et al., 2020). The corollary to this lack of understanding of parenting and child rearing practices of First Nations peoples is that health providers from non-Indigenous

backgrounds continue to provide health advice and information from their own cultural perspective (Bar-Zeev et al., 2012).

Additionally, the literature shows limited communication in the transfer of mother and infant care from maternity services to MCH services is sometimes fragmented, inconsistent and ad hoc, resulting in potentially serious clinical consequences for new mothers and their children in this vulnerable period, and impacting on First Nations families' and their children's access to and participation in MCH services (Bar-Zeev et al., 2012). There needs to be improvements to the organisation of MCH care, with a more supportive, continuity of care with parents across the services given priority to encourage access and engagement of First Nations families to MCH services (Barclay et al., 2014). As families' healthcare needs can now only rarely be met by a single professional, multidimensional models of continuity have had to be developed to accommodate the possibility of achieving both ideals simultaneously (Barclay et al., 2014). Where health disparities continue to exist for First Nations women and infants, it is imperative to explore the factors that facilitate continuity of care from the antenatal period to the child's fifth birthday (the first 2,000 days of life).

Healthcare professionals are often inadequately trained and underprepared to work cross-culturally, which further compounds the situation (Sivertsen et al., 2020). As a result, McCalman et al. (2015) report that many First Nations women do not disclose vital health information to healthcare workers with whom they have no relationship. Culturally unsafe practice was identified in the included studies as a barrier that influenced the engagement of First Nations families and their access to MCH services (Josif et al., 2017). Negligible numbers of First Nations staff working in MCH services, and perceived racist behaviours by some staff, attributed to this theme (Josif et al., 2017; Bar-Zeev et al., 2012). An area requiring reform in closing the gap in health outcomes for First Nations women and their children, and the uptake of MCH services, is the development of a culturally competent workforce, and the relationship between client adversity and complexity on the delivery of MCH services for the particular population (Zarnowiecki et al. 2018; Schmied et al., 2011; COAG, 2010).

A key gap in the evidence is that there has not been a synthesis of qualitative studies of a model of care to help guide MCH practice and innovation for all families, especially for children at risk of child abuse or neglect (Barclay et al., 2014; Kruske, Belton,

Wardaguga & Narjic, 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Future studies may benefit from testing the significance of the enablers identified from the six included studies in this review. For example, Homer et al. (2012) reported that the importance of continuity of caregiver was highlighted by study participants, with women describing it as ‘the best part of Malabar’. They valued having a person they could call and having caregivers who knew their story. Additionally, Barclay et al. (2014) state that models of care or interventions that are more inclined to be successful are those based on earlier engagement of families to MCH services and services with a focus on a continuum of care, to alleviate the risk of these families ‘falling through the cracks’.

This review of the literature showed that services must collaborate, be more ‘connected’ and made easier for families to access to ensure that there is adequate support provided (DOH, 2015, 2017; DHS, 2006; DHHS, 2017b; Wathen & MacMillan, 2018). The continuum of care framework, a concept involving an integrated system of care that follows patients over time through a comprehensive array of health services spanning all levels of intensity of care, may facilitate this (Hjortdahl, 1990; Rogers & Curtis, 1980). However, the continuum of care framework traditionally focused on chronological patterns of care, without directly measuring experienced continuity or those aspects of care that translated into connected and coherent care (Hjortdahl, 1990). In order to use the continuum of care framework, to allow multiple agencies to work together to provide a coordinated, comprehensive service to engage First Nations families, a common understanding of the concept of continuity, as a basis for valid and reliable measurement of practice in different settings, is imperative (Barclay et al., 2014).

Unless organisations understand that care that is delivered over time improves outcomes, interventions that encourage continuity may be misdirected or inappropriately evaluated, which can lead to fragmented care. Additionally, Barclay et al. (2014) reported that deficiencies in knowledge, recognition, and support of local culture and child-raising needs in the health system have to be remedied in order for staff to effectively promote health and build resilience with parents of infants at risk of vulnerability to child abuse or neglect. Policy reports and charters, worldwide, urge a concerted effort to enhance continuity through a new model of care (Barclay et al., 2014; Fulop & Allen, 2000; WHO, 1996). Reforms to service design to align with the continuity of care model,

enabling staff to work alongside First Nations women, their families and community leaders, could be an important step forward in addressing the disparities in health between Indigenous and non-Indigenous children (Jongen, McCalman, Bainbridge & Tsey, 2014; Kruske et al., 2012).

The literature reviewed showed that timely, effective, holistic engagement with First Nations women in their child's first 2,000 days, with respect for culture, and forming genuine working partnerships with their community, needs to be an essential part of the MCH service model if they seek to practice within First Nations communities. A strengths-based approach, and a genuine understating of the local First Nations culture, especially related to child-rearing practices, is required to support access and engagement of First Nations women with children from birth to five years of age in MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

2.5 Limitations

Although a rigorous and thorough search strategy was used to identify existing knowledge of models and interventions that promote and support engagement of First Nations families and their access to MCH services in the period from the child's birth to five years of age, it is possible that this integrative literature review did not identify all relevant studies. The studies were screened individually and assessed by the researchers to determine if they met the inclusion criteria. It is possible that relevant models or interventions descriptions or evaluations may have been misclassified. Due to the lack of data internationally, the outcomes of the retrieved studies may not be generalizable to the entire First Nations families worldwide. Additionally, it is impossible to determine any cause-and-effect relationships between interventions described in the included studies and improved engagement of First Nations families and their access to MCH services, as the methodological quality of the intervention studies varied considerably.

2.6 Conclusion

Persistent disparities in pregnancy and birth outcomes between non-Indigenous and Indigenous families highlight the need to prioritise responsive practice in MCH services. The focus of this review was to explore and describe models or interventions that support

the access and engagement of First Nations women with children birth to five years of age in MCH services, with the objective to advance understanding of the current evidence base and inform MCH service development, including the identification of new research priorities.

The findings of the review of the current evidence-based international literature reveal gaps in knowledge on what constitutes a successful model, or interventions, that promote and support access to and engagement of First Nations families to MCH services in the period from the child's birth to 5 years of age. While positive outcomes for MCH programs designed for First Nations families are reported in the literature, few studies have a strong evidence base or employ a sound methodological approach to evaluation (Rumbold et al. 2011; Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). The need for further research regarding the benefit of MCH service models and interventions aimed to encourage earlier identification of risk and identification of children and families who require further assessment, intervention, referral and support through a transdisciplinary approach, ideally from the antenatal period to the child's fifth birthday (the first 2,000 days), is of international importance for First Nations families. It is also of international importance for nursing practice and public health to address the human rights challenge of inequality in health outcomes between First Nations and non- First Nations children, the over-representation of these children in OoHC, and the high rates of their exposure to FV.

Services that increase accessibility and are designed to support First Nations women during their pregnancy and postnatal period are likely to have a positive impact (Panaretto et al. 2007). Furthermore, programs are more likely to be accessed by First Nations women if they are designed in a culturally safe and secure space, using a bi-cultural approach that combines the western biomedical model with Indigenous cultural ways of being, doing and knowing, to support the needs of First Nations families (Rossiter et al., 2019; Simmonds et al., 2010; Martin, 2003). A crucial issue in translating the results of this review into policy or practice to inform models or interventions to promote and support access to and engagement of First Nations families to MCH services in the period from the child's birth to five years of age, would be to ensure that MCH service models focus on the issues most relevant to people's lives, namely the social determinants of

health and wellbeing, and a shared understanding and common language regarding the needs and risks for children and their families. These models would ensure earlier intervention and identification of risk of vulnerability, co-design and collaboration of universal services, more effective engagement of First Nations children in the Universal MCH service, and better transition of these children through the life stages.

Recommendations for the distillation of key platforms for change need to be considered to increase the effectiveness of models of care to engage First Nations families in MCH services, as MCH services are well placed to deliver a proportionate response to both prevention and early intervention of risk of vulnerability, addressing inequities for the most disadvantaged families (Schmied et al., 2015; Schmied et al., 2011; Marmot et al., 2011).

2.7 Summary

This chapter presented the review of the literature and justification for this research. The research output in this chapter forms part of the storyline: ‘Access and Engagement of First Nations Women in Maternal and Child Health Services: An Integrative Review’ (Figure 1.2.). The results of the literature reviewed addresses the intersectionality of both health care access and culture, which is a gap in the current literature, and demonstrates an argument for the development of new theoretical models and frameworks based on the SDOH to address the inequity in health status seen between, and within countries, as is the case in Australia.

Consult with Aboriginal people, sit down with them and have a yarn - if you want to close the gap you need to address the social determinants of health. (DPCD Online survey respondent, 2018)

‘Storytelling’ through narrative inquiry is an opportune theoretical framework to organise this information effectively and create a cohesive research document. Narrative inquiry as a methodology enables a process to not only organise the researcher’s human experiences into meaningful episodes fixed in text that form the thesis, but also the interconnectedness of First Nations women’s ways of being, knowing and doing. The following chapter, ‘Method and overview of research’, will present the theoretical framework underpinning the research methods applied to investigate the research topic.

Chapter 3: Methodology and overview of research design

3.1 Introduction

This chapter details the overall research methodology and research design used in the three studies, including the philosophical framework underpinning the research methods (Bryman, Becker & Ferguson, 2012). This chapter presents the statement of intention, aims and significance of the study, research objectives, research questions, methodology and theoretical framework, research setting, population and sampling, data collection and analysis methods, ethical considerations and methods used to ensure the rigour of the research. This chapter justifies the chosen overall research methodology, while the respective chapters presenting the three studies (Chapters 4–6) provide further detailed discussion of their specific methodologies.

3.2 Statement of intention

The overall intention of this study is to explore and describe the engagement of First Nations women, with children birth to five years of age, with MCH services in the Glenelg Shire, Victoria, Australia.

3.3 Aims and significance of the study

Study One (Chapter 4) aims to explore First Nations women's (with children from birth to five years of age) perceptions and lived experiences of MCH services in the Glenelg Shire, Victoria, Australia, focusing on the factors that facilitate, support or hinder their access and engagement.

Study Two (Chapter 5) aims to further explore barriers to First Nations women accessing and engaging with MCH services in the Glenelg Shire, by comparing the findings from Study One with accounts from MCH nurses working in the Glenelg Shire. This combined findings from Study One and Two will inform recommendations to improve the MCH service model in Victoria, Australia.

Study Three (Chapter 6) aims to pilot and assess a service model that allows for the integration of First Nations child-rearing practices with colonised values, beliefs and practices through a guided mastery approach, shared knowledge, yarning, capacity

building, mutual trust and connection. The study will assess whether the piloted service model improves First Nations women and children's access to and engagement with MCH services.

Exploring First Nations women's access to and engagement with MCH services in Victoria, Australia, will expand our understanding of the intersectionality of health care access and culture—an identified gap in the current literature. Identifying the factors that facilitate, support or hinder First Nations women's access to and engagement with MCH services can support policy development and changes to practice to increase First Nations women and children's health outcomes. The findings can also support enabling policies and systems (Thorpe, Arabena, Sullivan, Silburn & Rowley, 2016) to be implemented to address the human rights challenge of inequality in health outcomes between First Nations and non-Indigenous children (see ABS, 2017), over-representation of First Nations children in OoHC (see AIHW, 2017a, 2017b, 2017c; HREOC, 1997, 2008) and high rates of FV in First Nations families (see AIHW, 2017a, 2017b, 2017c).

3.4 Research objectives

This thesis's primary objectives are to:

- 1) Explore and understand First Nations women's perceptions of MCH services in the Glenelg Shire, Victoria, Australia.
- 2) Identify what aspect/s of MCH services in the Glenelg Shire, Victoria, Australia, need to be changed or strengthened to improve First Nations women's engagement with these services.

3.5 Research questions

To achieve the research aims and objectives, the following research questions were developed from a literature review (see Chapter 2) and shaped by the chosen methodology (see Chapter 3), and addressed in three studies (see Chapters 4–6).

Study One questions:

Q1. What factors facilitate and support the engagement of First Nations women in accessing the Maternal and Child Health service in the Glenelg Shire, Victoria, Australia?

Q2. What factors hinder the engagement of First Nations women in accessing the Maternal and Child Health service in the Glenelg Shire, Victoria, Australia?

Q3. What improvements could be made to the Maternal and Child Health service in the Glenelg Shire, Victoria, Australia, to improve access and engagement for First Nations women?

Study Two questions:

Q1. What barriers do First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia?

Q2. What barriers do First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia?

Study Three questions:

Q1. Did the Early Assessment Referral Links (EARL) model of care facilitate coordination between service providers working in the universal service system to work collaboratively to develop best practice models of service delivery to families with children birth to five years of age at risk of vulnerability to child abuse or neglect?

Q2. Did the Early Assessment Referral Links (EARL) model improve the engagement of First Nations women with children birth to five years of age in your service during the pilot period?

3.6 Methodology and theoretical framework

This predominantly qualitative research uses the methodological principles of narrative inquiry integrated with the Indigenous philosophy ‘Dadirri’. Additionally, Study One and Two use thematic analysis, and Study Three uses a program logic model to support a systematic and integrated approach to planning, implementation and evaluation.

Qualitative research is the process of studying human phenomena, evaluated through the use of words as data (Polit & Beck, 2014). This approach is grounded in the social sciences and is used to provide detail about human values, cultures and relationships (Streubert & Carpenter, 2011). In qualitative research, the researcher critically examines data using an inductive process to move beyond description and towards concept

development, providing an explanation and understanding of the phenomena (Bazeley & Jackson, 2013).

There are several reasons for choosing qualitative research, including the researcher's preferences and experience, the nature of the research problem, the research question/s, and when the data cannot be analysed by statistical interrogation (Creswell, 2013; Gray, Grove & Sutherland, 2017). The qualitative methodology can provide a wealth of detailed information, which affords a deeper understanding of the phenomena despite having a smaller cohort of participants (Patton, 2002). Qualitative research is also immensely useful in exploring phenomena of which little is known (Creswell, 2013).

Qualitative research focuses on participants, their agency and their circumstances in a particular context (Bazeley & Jackson, 2013). Through the research process, a deeper understanding of the particular context is gained by gathering and analysing several data sources. Research participants contribute to the creation of meanings through the data they provide (Bazeley & Jackson, 2013); however, the researcher becomes the primary instrument for interpreting the phenomena through the data and draws on a range of qualitative research methods and strategies (Denzin & Lincoln, 2011). This positioning of the researcher is potentially problematic and something the researcher needs to be aware of; the researcher's own background—experience of class, gender, race, etc.—can potentially influence their interpretation of the data (Denzin & Lincoln, 2011). The researcher must be aware of and, if possible, counter potential bias when interpreting the data.

The researcher recognises that Indigenous pedagogy is poorly understood and not well represented in the health and education agenda (see Andrews & Hughes, 1993; Atkinson, 2002). A core problem is mainstream services' poor understanding of Indigenous knowledge—a knowledge that has flourished for over 65,000 years (see Andrews & Hughes, 1993; Atkinson, 2002). The researcher is a non-Indigenous researcher with extensive experience of working in collaboration with Indigenous communities in Victoria; therefore, the researcher's 'site of struggle' is (1) 'the need to change the idea of non-Indigenous researchers as the experts and to give Indigenous people a strong voice in all parts of research so that it can help to transform the lives of Indigenous people' (Nakata, 1998, p. 15) and (2):

Indigenous people now want research and its designs to contribute to the self-determination and liberation struggles as defined and controlled by their communities. The inability of academia to acknowledge the differences between the two cultures can have a direct effect on the research outcomes and the difference between the emic and the etic data is the applied cultural sensitivity of the researcher. (Pelto & Pelto, 1978, p. 6)

Aileen Moreton-Robinson, whose work is informed by Australian sovereignty principles and an Indigenous feminist standpoint, states Indigenous researchers have a ‘constant battle’ to empower Indigenous knowledge and methodologies as legitimate and fundamental components of research undertaken within Indigenous communities (Moreton-Robinson, 2013). She argues that the use of an Australian Indigenous women’s standpoint must be embraced to accurately convey the sovereignty principles and interconnectedness of First Nations women’s ways of being, knowing and doing, and that this will inadvertently positively affect First Nations women’s access to and engagement with mainstream services. The present research adopts a research design and methodology to this effect, with the aim of making findings and recommendations to increase First Nations women’s access to and engagement with MCH services in Victoria. The narrative inquiry and Indigenous philosophy approaches used in this research are detailed below.

3.6.1 Narrative inquiry

Narrative inquiry is an interpretative approach from the social sciences that examines human lives through the lens of a narrative or storyline (McAlpine, 2016). Narrative inquiry can bridge Western and Indigenous research methodologies, providing a methodological approach of holistic observation from an Indigenous standpoint, without the risk of bias, to challenge and change thinking, ideas and understanding (Nakata, 1998). In the present study, a narrative approach allowed the researcher to be congruent and in tune with the physical, psychological, social and cultural aspects of First Nations women’s storytelling or yarning.

The theory of narrative implies a process whereby a conversation between the researcher and the subject of research becomes fixed in a written text (Clandinin & Huber, 2010). The conversation is a means to understand the participants’ experiences. The phenomena being researched is viewed as being a puzzle, with the researcher and participants adding different pieces to create a clearer picture of the issue (Haydon, Browne & van der Riet,

2018). This can be in reference to an individual's experience but also an exploration of social, cultural and institutional stories (Connelly & Clandinin, 1990). Viewing research as a puzzle is part of the process of thinking narratively (Clandinin & Huber, 2010).

Per Connelly and Clandinin (1990), discussions with research participants shape stories of experiences. Several data collection methods can be used, including field notes, journal records, interview transcripts, surveys, observations, storytelling, letter writing, autobiographical writing, documents such as school and class plans, newsletters and pictures (Ospina & Dodge, 2005). Narrative researchers' recommendations to encourage storytelling will be used in the present study; importantly, this study will use open-ended questions, framed in everyday, culturally appropriate language, that are broad enough to allow respondents to tell their stories. The questions will be worded to elicit narratives, consisting of a minimum number of broad primary questions complemented by probing questions. This approach is supported by narrative inquiry.

Three chief considerations when using the narrative research approach are (1) the relationship between the researcher and their research subjects, (2) how a narrative is developed from experience and orally told stories into a written text and (3) the interpretive nature of narrative research (Connelly & Clandinin, 1990).

Regarding the first consideration, when using narrative inquiry as a theoretical methodology, it is important that the researcher and participants feel comfortable and that there is a sense of equality between them (Fetterman, 1998). Gudmundsdottir (2001) warned of possible a dilemma if the researcher and participants have different interpretations of specific events, or if participants question the interpretive authority of the researcher. Further, it can be difficult to determine whether a particular story is a reflection of the facts in a case or has been inaccurately portrayed by the storyteller (Smith, 1999). In the present study, the first consideration was addressed by (1) taking active steps to ensure mutual respect and trust between the researcher and participants (also a core aspect of interactions with and among First Nations people), (2) including participants' perspectives (including via direct quotations) and (3) using Indigenous frameworks and methods to enable the four essential processes described by Smith (1999)—decolonisation, healing, transformation and mobilisation—to be built into the research practices.

Regarding the second consideration, narrative inquiry is often used in qualitative research studies (Creswell, 2013). As a methodology, narrative inquiry enabled a process to organise the researcher's human experiences as a MCH nurse, with Aboriginal storytelling, to assist the researcher to develop a deeper understanding of Aboriginal womens' perspective on access and participation in MCH services, into meaningful episodes fixed in text that form the thesis. The research demonstrates and discusses the importance of capturing and telling story to influence change.

The narrative approach allows constant interaction between theory and empirical data, making it possible to identify gaps in the literature and understand and gain new knowledge of a phenomenon or experience (Clandinin & Huber, 2010; Ospina & Dodge, 2005). Further, the researcher records their process, which is crucial to ensure research rigour (Clandinin & Huber, 2010). In the present study, using the storytelling and narrative approach linked with Indigenous worldviews and allowed for in-depth data to be collected based on rich, narrative descriptions.

Regarding the third consideration, storytelling emphasises the construction of meaning between the research and participants, and between the researcher and data. Through this process, meaning is found in the collected data and a story is crafted about the experience or phenomenon under investigation (Ospina & Dodge, 2005; Polkinghorne, 1995). Stories become the means of both describing the research process and interpreting the data (Polkinghorne, 1995). This approach was adopted in the present study.

3.6.2 Indigenous philosophy

As previously stated, the researcher is a non-Indigenous researcher with extensive experience of working in collaboration with Indigenous communities and organisations in Victoria; thus, the researcher's site of struggle is the 'Need to change the idea of non-Indigenous researchers as the experts and to give Indigenous people a strong voice in all parts of research so that it can help to transform the lives of Indigenous people' (Nakata, 1998, p. 15). Nakata (1998), Denzin and Lincoln (2008), Henry et al. (2002), Martin (2003) and Rigney (1999a, 1999b) emphasised that research involving First Nations peoples must use an Indigenous standpoint. In addition, a methodological approach of holistic observation and interaction is necessary to truly reflect the plight of First Nations populations, without the risk of bias, for the research to challenge, develop, improve and

change thinking, ideas and understanding. Therefore, in the present study, it was crucial that the research methodology ensured rigour without using emic approaches (Denzin & Lincoln, 2008; Henry et al., 2002; Martin, 2003; Nakata, 1998; Rigney, 1999a, 1999b). To ensure cultural safety in research involving First Nations peoples, precedence must be given to their research methodologies. The literature review (Chapter 2) found that much of the research conducted on First Nations peoples was posited on ethnocentric values of academia and an Anglo–European ethnological focus and excluded Indigenous pedagogical approaches. Thus, the research was biased because the researchers based their observations on the values of their own society, not those of the Indigenous population they researched. Therefore, in the present study, the researcher’s second site of struggle is:

Indigenous people now want research and its designs to contribute to the self-determination and liberation struggles as defined and controlled by their communities. The inability of academia to acknowledge the differences between the two cultures can have a direct effect on the research outcomes and the difference between the emic and the etic data is the applied cultural sensitivity of the researcher. (Peltó & Peltó, 1978, p. 6)

Indigenous pedagogy is poorly understood and not well represented in the education agenda, and applying Indigenous philosophy to contemporary Indigenous discourse is a relatively new approach in academia (Andrews & Hughes, 1993; Saunders et al., 2010; Smith, 1999; Rigney, 1999a, 1999b). Indigenous philosophy underpinned the approaches used in the present study. This philosophy is summarised below.

Indigenous philosophy has three interacting worlds:

- 1) Physical world: Encompasses the land, the sky and all living organisms. The land is food, culture, spirit and Indigenous identity.
- 2) Human world: Encompasses the knowledge, approaches to people, family and rules of behaviour, ceremonies and their capacity to change.
- 3) Sacred world: Encompasses healing (both the spiritual and physical wellbeing of creatures), the lore (the retention and reinforcement of oral history), care of country, the laws and their maintenance (Institute for Aboriginal Development, 2000).

The relationship of these three worlds is illustrated in Figure 3.1.

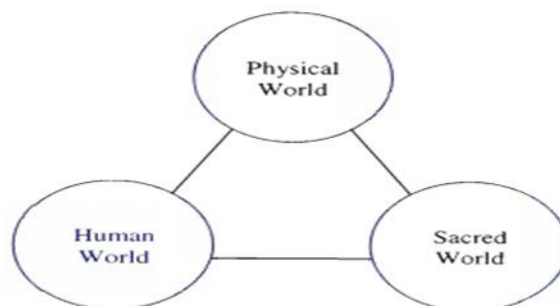


Figure 3.1. The Three Interacted Worlds of Indigenous Philosophy (Institute for Aboriginal Development, 2000)

Aboriginal philosophy comprises the holistic view that the physical world, human world and sacred world are interconnected. These relations and the knowledge of how they are interconnected are expressed in sacred stories or myths. Traditionally contested knowledge occurs when Indigenous knowledge practices engage with non-Indigenous knowledge practices (Christie, 2006). In the present study, the researcher addressed this dilemma by including the researcher's and participants' views in this thesis; this justified the use of narrative inquiry and the Indigenous methodology Dadirri.

Dadirri is a word from the Ngan'gikurunggurr and Ngen'giwumirri languages of the Aboriginal people of the Daly River region, 220 kilometres south of Darwin, Northern Territory, Australia, which means 'deep listening and silent awareness' (Ungunmerr et al., 2022). Dadirri is a practice of 'deep listening' and acceptance, championed by Aboriginal Elder Dr Miriam-Rose Ungunmerr-Baumann, Australian of the Year in 2021 (Ungunmerr et al., 2022; West, Stewart, Foster & Usher, 2012). It is sometimes termed 'Aboriginal meditation', and contains elements of stillness and contemplation similar to that of mindfulness and meditation (Ungunmerr et al., 2022). However, Dadirri is distinct as it encourages 'deep connection inside oneself' and 'to experience belonging to all things to be made whole' (Ungunmerr et al., 2022). As a research methodology, the practice of deep listening is an invitation into culturally congruent ways of learning and knowing. Dadirri used as a research method enables First Nations peoples' voices to be heard to promote change (Ungunmerr et al., 2022; West et al., 2012). 'Deep listening' requires a process of listening to learn and a suspension of judgement (Stronach & Adair, 2014), and Dadirri helps to facilitate two-way communication and a more autonomous environment for participants to share their opinions and build relationships regardless of the power structure (Ungunmerr et al., 2022; West et al., 2012). Dadirri is an open-ended

and conversational approach to interviewing First Nations respondents and emphasises deep and respectful listening.

The researcher has worked with a diversity of First Nations peoples across Australia (as a MCH nurse and Adviser to the Federal Minister of Aboriginal Australians) and is aware of the significant issues that need to be considered when conducting research with First Nations people, including:

- cultural sensitivities when conducting research with First Nations peoples
- any perceived power imbalances between the researcher/s and First Nations participants
- any issues of trust between the researcher/s and First Nations participants.

The present qualitative study used the methodological principles of narrative inquiry integrated with the Indigenous philosophy Dadirri to achieve the research aims and objectives (see Sections 3.3 and 3.4).

3.7 Research setting

This study was conducted in the Glenelg Shire, Victoria, Australia (see Figure 1.1). As previously stated, despite poorer health outcomes for Aboriginal mothers and/or children, their participation rates in MCH services is lower than that of non-Aboriginal women and children. These trends are present in Glenelg Shire, making it an appropriate location to conduct this study. Site A and B were located in Portland, and Site C was located in Heywood, 25 kilometres north of Portland (see Figure 1.1).

3.8 Population and sampling

Stratified purposeful sampling of unique data sources was undertaken in all three studies. Purposeful sampling is a non-random sampling technique that uses one or more criteria to select a particular sample (Burns & Grove, 2017). This method is considered easy to implement because it is inexpensive and accessible (Polit & Beck, 2014). This sampling method aims to produce a sample from which information-rich data relating to the phenomenon of interest can be collected (Patton, 2002). Purposeful sampling involves the identification and selection of individuals or groups of individuals that are particularly knowledgeable or experienced with the phenomenon of interest (Patton, 2002), capable

and willing to participate, and able to articulately communicate experiences and opinions in a reflective manner (Bernard, 2002). Prior literature recommends seven to 10 participants per category and subcategory due to the exploratory nature of the research and the aim to identify underlying thoughts about the topic (Morse, 1995, 2000). Saturation parameters in prior studies using the purposeful sampling method suggest seven to 10 participants is a sufficient sample size for data adequacy, reliability and robustness (Luborsky & Rubinstein, 1995; Sandelowski, 1986).

Study One and Study Two

Study One and Two employed stratified purposeful sampling to recruit 35 First Nations women of all ages residing in the Glenelg Shire, south western Victoria, Australia, with at least one child aged birth to five years, to explore their perceptions and experiences of MCH services (Study One) and barriers to accessing and engaging with these services (Study Two). Stratified purposeful sampling was employed to recruit three unique sub-categories of participants, as defined by their level of engagement in MCH services (current engagement; initial engagement, now disengagement; and no engagement). The sample size was largely determined by the number of respondents available to participate in the study. The site coordinators at the nominated Aboriginal Community Controlled Health Organisations (ACCHOs) contacted all First Nations women engaged with the ACCHOs (and who met the research inclusion criteria; see below) to invite them to participate in the research. To avoid coercion or undue influence, the researcher then asked these women if they would like to participate in the research by discussing the Plain Language Information Statement (PLIS). Recruitment processes allocated sufficient time to communicate a thorough explanation of the study and allow a prospective participant to consider the information before deciding on whether to participation. The number of women interviewed was dependent on when data saturation was reached.

The inclusion criteria were First Nations mothers of all ages, with children birth to five years of age, currently residing in the Glenelg Shire, Victoria, Australia, and:

- currently engaged in the MCH service in the Glenelg Shire, or
- initially engaged, now disengaged, in the MCH service in the Glenelg Shire, or
- never engaged in the MCH service in the Glenelg Shire.

The exclusion criteria were:

- not First Nations mothers
- First Nations mothers who have had a stillbirth
- First Nations mothers who have had their child/children removed from their care.

Women who met the inclusion criteria were invited to participate after:

- full approval of the research had been granted
- each ACCHO was notified of the project and provided with an overview of the project and timeframes
- an Indigenous site coordinator in each ACCHO was appointed to act as the chief point of contact with the project team, assist with recruitment of participants and data collection, and address any cultural sensitivities and help develop trust with participants
- the indicative interview schedule had been finalised.

All interviews were prefaced by a PLIS (see Appendix Three) and consent forms (see Appendix Four) outlining the project and explaining the purpose and intent of the project. The women were informed that their participation was voluntary and that refusal to participate required no explanation and would have no consequences. They were informed that they were free to choose not to answer any question during the interview, without consequence; there would be an opportunity to preview results and transcripts, to withdraw or amend any data during or at the end of the interview or any unprocessed data previously supplied; and they could withdraw their consent to participate and discontinue participation at any time, without consequence. They were also informed that if consent was withdrawn after data had been aggregated and processed, it would not be possible to withdraw non-identifiable data.

In Study Two, a second stratified purposeful sampling of a unique data source was collected. The researcher sought to recruit MCH nurses with clinical experience with First Nations women and their children in the Glenelg Shire to understand these nurses' perceptions of barriers to First Nations women with children aged birth to five years accessing and engaging with MCH services in this region.

The inclusion criterion was:

- MCH nurses employed to work as a MCH nurse in the Glenelg Shire, Victoria, Australia, in 2019.

The researcher, who is a MCH nurse previously employed to work in the Glenelg Shire, contacted the full population of eligible MCH nurses ($n = 10$) to invited them to participate in the study, and all (100%) agreed to participate. Again, the sample size was determined by the number of respondents available to participate in the study. Note, 10 participants meets the previously discussed recommended sample size for this type of research (Morse, 1995, 2000). The researcher consulted with the MCH nurses through face-to-face, in-depth, semi-structured discussion ('yarning') as a whole group in November 2019. The discussions ran for approximately one hour, facilitated by the researcher. All interviews were prefaced by a PLIS (see Appendix Five) and consent forms (see Appendix Six) outlining the project and explaining the purpose and intent of the project. The nurses were informed that their participation was voluntary and that their refusal to participate required no explanation and would have no consequences. They were informed that they were free to choose not to answer any question during the interview, without consequence; there would be an opportunity to preview results and transcripts, to withdraw or amend any data during or at the end of the interview or any unprocessed data previously supplied; and they could withdraw their consent to participate and discontinue participation at any time, without consequence. They were informed that if consent was withdrawn after data had been aggregated and processed, it would be impossible to withdraw non-identifiable data.

Study Three

Assessment of the EARL concept, piloted from 1 July 2009 to 30 June 2014, also employed stratified purposeful sampling of three unique data sources. In a process undertaken prior to the candidature of this thesis, the researcher approached all service providers working with children aged birth to five years residing in the Glenelg Shire to become stakeholders for the EARL pilot. All service providers that were approached ($n = 38$) elected to become stakeholders (100%). The sample reflected the diverse cross-section of organisations and multidisciplinary health professionals providing early years care that were involved in the delivery of and referral to MCH services in the Glenelg Shire. As there were 17 stakeholders based in Portland, 12 in Heywood and nine in Casterton, EARL meetings with the stakeholders were held in all three sites, optimising coverage of the Glenelg Shire. EARL was established in Portland and Heywood in March 2011, and in Casterton in April 2013. Prior to the commencement of the EARL

pilot, stakeholders were provided with the Terms of Reference (see Appendix Seven) for the EARL meetings and a Consent to Share Information to the other EARL stakeholders (see Appendix Eight). Stakeholders were informed that they could withdraw their consent to participate and discontinue participation in the pilot at any time, without consequence. They were also informed that if consent was withdrawn after data had been aggregated and processed from their responses to the survey post-pilot, it would be impossible to withdraw non-identifiable data.

In the second stratified purposeful sampling, all First Nations women with children aged birth to five years living in the Glenelg Shire were approached by the EARL stakeholders from the two local ACCHO's to participate in the pilot. In 2011, all First Nations families approached in Portland and Heywood with children aged birth to five years ($n = 52$; 100%) agreed to participate in the pilot. This number increased in 2013 when EARL was established in Casterton; all First Nations families living in Casterton ($n = 4$; 100%) agreed to participate in the pilot. All First Nations families participating in the EARL pilot were provided with a Consent to Share Information with the EARL stakeholders form (see Appendix Eight). The families were also informed that their participation was voluntary and that their refusal to participate required no explanation and would have no consequences.

In the third stratified purposeful sampling, an invitation to participate in the post-pilot survey (see Appendix Nine) was distributed to those EARL stakeholders who had participated in the full pilot period (1 July 2009 to 30 June 2014; $n = 13$), and all (100%) agreed to participate. A PLIS (see Appendix Ten) and consent to participate in the survey (see Appendix Eleven) were provided to these stakeholders. The survey (see Appendix Twelve) asked stakeholders to identify strengths and weaknesses of the model, asked how the model could be improved, and invited any other comments. The survey responses were evaluated by the researcher during their thesis candidature.

3.9 Method and data collection

For Study One and Two, the researcher contacted the Victorian Department of Health (DH), Municipal Association of Victoria (MAV), Dhauwurd Wurrung Elderly and Community Health (DWECH) ACCHO, Winda-Mara Aboriginal Corporation, and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) for

permission to collect data from individual and small groups of First Nations mothers residing in the Glenelg Shire with at least one child aged birth to five years and to assist with data collection. Peer debriefing with relevant members of the Indigenous Advisory Committee was conducted at this stage of the study to ensure cultural safety and an Indigenous lens for the research, and to assist with development of the research guide and interview questions (see Tables 3.1–3.3).

Table 3.1. Interview guide for all participants: Study One

- Do you know about MCH nurses and the services they provide to young families?
- Are you aware that there are MCH services in your area?
- Do you think these services are (or might be) important for your family?
- Did you receive a home visit by a MCH nurse after your last baby was born?
- What did you think of this visit?
- Was it helpful?
- What did you like about it?
- What didn't you like about it?
- Following the home visit, have you used MCH services with any of your children?
- If yes, what are some of the things that made you decide to use the services?
- If no, why did you decide not to use the service?

Table 3.2. Tailored questions for women accessing different types of maternal and child health services: Study One

- Are you currently using the MCH service?
- If yes [**currently engaged with MCH services**]
- What are the things you like or think are valuable about MCH services?
- What are the things that you do not like about the MCH service?
- Are there things that could be changed that would make the service better for you?
- Do you use the service provided through the ACCHO or the local council?
- Do you have a preference for who provides your MCH service?
- If so, what are the reasons you like that provider more than the others?
- If no [**have attended but no longer engaged**]

- Why did you stop using the MCH service?
- Are there things that you think need to change about the way the MCH service is provided that would improve it?
- What would need to happen for you to start using the MCH service again?
- If you've never used the MCH service [**have never attended MCH**]
- What are some of the reasons you do not use MCH the service?
- Does someone else see your child for health assessments or immunisations?
- If so, who (what service) do you go to for these things?
- Do you have someone you go to if you have questions about parenting or child health and development? If so, who is this? Do they meet your needs?

Table 3.3. Interview guide for all participants: Study Two

- What barriers do First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia?
- What barriers do First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia?

A panel of experts was then consulted to clarify the relevance and clarity of each question/discussion prompt in the indicative interview schedule and establish face validity. This panel comprised of the research project team, an experienced MCH nurse researcher, and key representatives from the Indigenous Advisory Committee. A small number of the target population, independent of the research, piloted the questions. Suggestions from the expert panel and pilot testing were incorporated into the interview schedule design and necessary changes made to the questions/prompts. Following full approval of the research, the chief executive officers (CEOs) of the two ACCHOs were provided with an overview of the project and timeframes, and an Indigenous employee within each ACCHO was appointed by the CEO as a 'site coordinator'. This site coordinator acted as the chief point of contact with the project team and assisted with recruitment of discussion participants, addressed any cultural sensitivities, and helped to develop trust with the participants. Women who met the inclusion criteria were then invited to participate in the research ($n = 47$). Six of these resided in the far northern part

of the Glenelg Shire and did not engage with the two nominated ACCHO sites, so they were excluded from the study ($n = 41$).

For the second stratified purposeful sampling in Study Two, the researcher consulted with the Victorian Department of Health and Human Services (DHHS), Victorian Department of Education (DET) and MAV for permission to collect data from MCH nurses employed in the Glenelg Shire. A qualitative interview guide was developed. The guide used open-ended questions to individualise the responses and reveal MCH nurses' opinions and experiences. The interview guide was assessed by an expert panel of MCH nurses with experience in qualitative research. MCH nurses independent of the research and not employed in the Glenelg Shire ($n = 6$) were recruited for pilot testing to ensure the validity of the study instruments. Suggestions from the pilot testing were incorporated into the interview guide and changes made to the question as necessary. Following ethics approval, the PLIS and consent form were provided to all MCH nurses ($n = 10$) employed in the Glenelg Shire between August and November 2019. The PLIS informed participants of the purpose and intent of the project and how the data were to be collected and used. All eligible MCH nurses participated in interviews ($n = 10$).

The researcher consulted the relevant agencies for permission to collect data from First Nations mothers, with at least one child aged birth to five years, residing in the Glenelg Shire. These agencies included the DHHS, DH, MAV, DWECH ACCHO, Winda-Mara Aboriginal Corporation ACCHO and VACCHO. The researcher consulted traditional owners residing in the two nominated ACCHO regions to assist with the development of the research guide and interview questions, and to ensure the research plan was culturally appropriate. A panel of well-informed and experienced stakeholders and Indigenous knowledge holders was then consulted to confirm the relevance and clarity of each question/discussion prompt in the indicative interview schedule and establish face validity. This panel comprised of the research project team, an experienced MCH nurse researcher, and key representatives from VACCHO and the ACCHO sites. A small number of the target group, independent of the research, piloted the questions. Suggestions from the expert panel and pilot testing were incorporated into the interview schedule design and necessary changes made to the questions/prompts.

Following full approval of the research, as previously stated, the CEOs of the two ACCHOs were provided with an overview of the project and timeframes, and they

appointed an Indigenous employee as a ‘site coordinator’. Women who met the inclusion criteria were then invited to participate in the research ($n = 47$). The PLIS and consent forms were provided to participants, explaining the purpose and intent of the project and how the data were to be collected and used.

Of the 25 women that met the inclusion criteria in Portland, 21 (84.0%) participated in the study, facilitated by the DWECH. Two venues were chosen, at the recommendation of the site coordinator, to increase the recruitment of participants as some mothers engaged in a particular program over another due to ‘bad blood’ at the alternative venue. Eight women were interviewed at the DWECH Service Playgroup (Site A), and 13 were interviewed at the DWECH Service Women’s Group (Site B). Of the 21 women interviewed in Portland, six (28.6%) had never engaged with the MCH service, nine (42.8%) had disengaged from the MCH service, and six (28.6%) were currently engaging with the MCH service. All women ($n = 21$; 100%) identified as ‘Aboriginal’.

Of the 16 women that met the inclusion criteria in Heywood, 14 (87.5%) participated in the study, facilitated by the Winda-Mara Aboriginal Corporation ACCHO in Heywood (Site C). Of the 14 women interviewed in Heywood, four (28.6%) had never engaged with the MCH service, two (14.3%) had disengaged from the MCH service, and eight (57.1%) were currently engaging with the MCH service. All women ($n = 14$; 100%) identified as ‘Aboriginal’.

The researcher consulted with First Nations women through face-to-face, in-depth, semi-structured discussion (‘yarning’) with individuals and small groups at the DWECH and Winda-Mara Aboriginal Corporation ACCHOs between September and December 2021. The discussions ran for approximately one hour each, co-facilitated by key staff from the ACCHOs. Discussions complied with the *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders* (NHMRC, 2018). As the face-to-face interviews were held at DWECH and Winda-Mara Aboriginal Corporation sites, they were conducted in accordance with these ACCHOs’ COVID Safe Plans.

The steps in data collection, analysis and evaluation in Study Three were guided by a program logic model to create the EARL program, implement its activities, and achieve the desired outputs and outcomes. This included consultation with the Aboriginal

community, mapping practices and services, recruiting stakeholders, implementing the pilot, and evaluating the pilot through outcome measures. Throughout this process, the researcher consulted with service providers in the Glenelg Shire who shared a common focus (early years care), philosophy, vision and agreed principles for working with children in their first 2,000 days and their families. All service providers that were approached elected to become EARL stakeholders; the sample thus reflected the diverse cross-section of organisations and multidisciplinary health professionals providing early years care and involved in the delivery of and referral to MCH services in the Glenelg Shire. Figure 3.2 outlines the program logic model used to develop and evaluate the EARL concept.



Figure 3.2. The development and evaluation of the EARL concept

The EARL concept pilot was managed by a coordinator—the author of this thesis—and Glenelg Shire Council was the lead agency. The other stakeholders were a combination of multiple service providers and included local maternity and allied health services, the

DET, the DHHS, local government, and the local ACCHOs representing the First Nations people. ACCHOs are primary healthcare services operated and controlled by the local Aboriginal community, through a locally elected board of management, to deliver holistic and culturally appropriate health care to that community.

The manager of each agency, or their nominated representative, agreed to meet on a regular basis to discuss children and young people at risk of vulnerability to child abuse or neglect who would benefit from integrated support. EARL was funded through the universal MCH program, which is provided through a partnership between the DET and local governments. The program's funding for MCH services is based on the total number of children enrolled in the service. Each participating agency self-funded their attendance of monthly stakeholder meetings.

The EARL concept pilot ran from 1 July 2009 to 30 June 2014. The pilot started in Portland, Victoria, and branched out to incorporate whole-of-shire support. This resulted in Heywood EARL being established in March 2011 and Casterton EARL in April 2013.

Monthly meetings were conducted across the three locations, which encompass a distance of over 100 km within the Glenelg Shire. Where possible, meetings were held at ACCHO sites, to encourage the engagement of those stakeholders and highlight their profile in Aboriginal communities. After signing consent to share their information, the cases of clients at risk of vulnerability were discussed by the group during meetings, or by a sub-group between meetings if more appropriate. This resulted in referrals to other stakeholders as required. At the completion of the five-year pilot, the stakeholders of EARL were surveyed to ascertain (a) if the EARL service model facilitated coordination between service providers to develop best practice models of service delivery for families, with children aged birth to five years, at risk of vulnerability to child abuse or neglect, and (b) if the EARL service model improved the engagement of First Nations women, with children aged birth to five years, with any service during the pilot period.

Although the sample size was relatively small for the three studies, the collected material/data were quite detailed; thus, the researcher determined that the number of participants was sufficient to satisfy the aims of this research (Strauss & Corbin, 1990).

3.10 Data analysis and evaluation

Robust evaluation and data analysis is an integral component of program development and implementation (Patton, 2002). In Study One and Two, data were analysed and evaluated using Braun and Clarke's (2021) six-step process for identifying, analysing and reporting qualitative research using thematic analysis. This six-step process entails familiarisation with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes, and producing a report with the themes found within the data. The audio-recorded data were transcribed by the researcher and subjected to attributional, first and second cycle coding. Through Braun and Clarke's (2021) six-step process, the emergence of themes and patterns—to explore the perceptions and lived experiences of First Nations women, with children aged birth to five years, of the MCH service in Victoria, focusing on factors that facilitate, support or hinder their accessing and engaging with the MCH service—occurred inductively. Peer debriefing was then conducted with the assistance of key members of the Indigenous Advisory Committee. These included an Indigenous academic with experience in interviewing First Nations mothers, a Senior Director from VACCHO and the two site coordinators. This facilitated a collaborative process of creating knowledge from the study and ensured an Indigenous lens was applied to the thematic analysis of the data. Member checking, or participant validation, was conducted with the site coordinators present at the yarning sessions.

In Study Three, data from the EARL concept pilot was evaluated through a program logic model. This model supported a systematic and integrated approach to program planning, implementation and evaluation. The model enabled the researcher to tell the story of how the EARL concept was proposed to work, the intended outcomes, and the change processes underlying the concept. The researcher found the program logic model to be a useful tool for engaging stakeholders in program planning and evaluation, communicating with stakeholders about program concepts, and creating a framework to evaluate the EARL concept. Data were extracted from the DET and DHHS's data systems on the number of Aboriginal women and children referred to stakeholders, MCH service participation rates, number of children enrolled in Early Start Kindergarten, breastfeeding initiation and duration rates, immunisation rates, the number of referrals to child protection, and episodes of OoHC. Data were also obtained from EARL stakeholders at program meetings and via the post-pilot survey.

A summary of the three studies' respective samples, collected data and methods is provided in Table 3.4.

Table 3.4. Summary of studies' samples, data collected and methods

Study	Sample	Data collected	Date	Method/analysis/evaluation
Study One	35 First Nations women with children birth to five years of age living in the Glenelg Shire.	Qualitative data to explore First Nations women's perceptions and experiences of MCH services.	December 2021	Interview/thematic analysis
Study Two	35 First Nations women with children birth to five years of age living in the Glenelg Shire	Qualitative data to explore First Nations women's barriers to access and engagement in MCH services.	December 2021	Interview/thematic analysis
Study Two	10 MCH nurses working in the Glenelg Shire	Qualitative data to explore MCH nurses perceptions of First Nations women's barriers to access and engagement in MCH services.	November 2019	Interview/thematic analysis
Study Three	38 stakeholders participating in the EARL pilot		*March 2011	#Program logic
Study Three	52–56 First Nations families participating in the EARL pilot		*April 2011-April 2013	#Program logic

Study	13 stakeholders		*August	#Survey/Program logic
Three	participating in the post-pilot survey		2014	

* Data collected outside the period of PhD candidature.

Analysis and evaluation conducted during the period of PhD candidature.

3.11 Ethical considerations

The researchers were intimately aware of the ethical considerations of this research, specifically those in relation to non-Indigenous researchers conducting interviews directly with Indigenous women to explore their perceptions and experiences of the MCH service. Accordingly, the researchers took steps to ensure the management of their duty of care to participants and any risk to participants. All researchers in the project team were aware of and complied with the *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders* (NHMRC, 2018). The researchers ensured the research complied with the *National Statement on Ethical Conduct in Human Research 2007* (NHMRC, 2007), Section 2.1 Risk and Benefit, via (1) having a number of mechanisms in place to deal with any psychological harms that may have occurred and (2) implementing a monitoring process in the research design.

As previously stated, women who met the inclusion criteria were not invited to participate until:

- full approval of the research had been granted
- each ACCHO was notified of the project and provided with an overview of the project and timeframes
- an Indigenous site coordinator in each ACCHO was appointed to act as the chief point of contact with the project team, assist with recruitment of participants, address any cultural sensitivities and help develop trust with participants
- the indicative interview schedule had been finalised.

The interviews ('yarning') were prefaced by the PLIS (see Appendix Three) and consent forms (see Appendix Four), which outlined the project and explained the project's purpose and intent. The discursive space of the semi-structured questions focused on the

issues reflected in the literature. No participant was required to participate in the discussions. The interviews allowed each participant to talk as much or as little as they felt comfortable with (within their allocated time). The researcher took the lead in asking questions during the discussions, while the nominated site coordinator from the ACCHO carefully monitored participants for signs of distress. The PLIS included information on counselling services relevant to First Nations people and available via phone and online.

The project researcher, who conducted the fieldwork, followed all relevant Federation University policies to ensure the security of recordings and notes during fieldwork. The site coordinators did not have access to these recordings and notes. Each stage of project implementation was overseen and monitored by the principal and associate academic researchers.

To ensure this research met the principles and values for ethical research with Aboriginal and Torres Strait Islander people, the researcher:

- engaged the Aboriginal community to identify their research priorities
- embedded Aboriginal governance, advisory and decision-making in the project
- enacted Indigenous data sovereignty and governance principles
- developed research agreements with the Aboriginal community
- embedded opportunities in the research for capacity building for Aboriginal communities
- embedded opportunities in the research for capacity building of the research team for research with Aboriginal communities (i.e., developing cultural capabilities)
- engaged the Aboriginal community in research implementation
- employed Aboriginal project team members
- engaged the Aboriginal community in the analysis and interpretation of the findings
- disseminated the research results to the Aboriginal community
- involved Indigenous community members as co-authors in publications and co-presenters in presentations
- translated the findings into policy and practice.

Ethics approval was requested from Federation University, the DH and VACCHO.

The research conducted from 2017 to 2020 was deemed ‘low risk’ and approved by the Human Research Ethics Committee of Federation University (project number C17-024) and by the DH’s Centre for Evaluation and Research Evidence (project number DET: 2017_002311).

The research conducted from 2021 to 2023 was deemed ‘higher risk’ (due to the direct consultation with First Nations women) and approved by the Human Research Ethics Committee of Federation University (project number A21-102) and the DH’s Centre for Evaluation and Research Evidence (project number HHSD/21/649865).

VACCHO advised the researcher that approval from an Indigenous Human Research Ethics Committee was not required for this research; however, VACCHO did provide a letter of support for the research (see Appendix Two).

3.11.1 Informed consent

Any research involving participants requires their informed consent, whereby the researcher is ethically and legally required to inform the participants of the requirements of the research. This enables participants to make an informed choice on whether they want to participate in the research. The principle of informed consent is that participants are not coerced or unduly influenced to participate in the research, that they have full understanding of the implications of participation, and their participation is voluntary (Creswell, 2013).

The process for informed consent for this research involved participants expressing an interest in participating after they received and read the information regarding the nature of the research. Potential participants received all details of the research, including a PLIS that outlined the significance and purpose of the research. The PLIS included the details of the student researcher, principal researcher and other researchers involved, so participants could seek clarification on aspect of the research before consenting to participate. Participants were instructed that their completion of the interview or survey would be considered as consent to participate in the research, and that their information would only be used for the purposes of the research and presented as aggregated data. The PLIS stated the requirements of participating in the research (e.g., how long interviews would take); that participation was voluntary; and that participant anonymity

and confidentiality and data security were assured. Consent was implied if participants completed and returned the consent form.

3.11.2 Confidentiality and anonymity

Participant confidentiality and anonymity was maintained by the researcher throughout all phases of the research. During the conduct of the research, disseminated results did not include identifying information. However, confidentiality of information was subject to legal limitations (e.g., subpoena, a freedom of information claim, or mandatory reporting). Strict criteria were followed to maintain privacy and confidentiality of the population samples. Participants were advised that it may be difficult to guarantee anonymity or confidentiality where the sample size is very small or information is obtained through a focus group. All participants were fully informed of the possibility of any future use of data and information. Any restrictions on the use of participants' data and information were recorded and kept alongside the collected data and information.

3.11.3 Harm and benefit

The First Nations women participants were from a population at risk of vulnerability, although data were accessed via official access points. Other participants were not considered to be from a population at risk of vulnerability as classified by the NHMRC. No participants were in a dependent relationship with the researcher, and the researcher did not ask any questions that they would not discuss in a professional capacity. Some participants were known to the researcher on a professional basis due to the researcher being a MCH nurse who had previously practised in the area. The project team worked with participants and key staff from the two nominated ACCHOs to ensure the research was progressing without any adverse effects. Participants were advised verbally and via the PLIS prior to and during the research that if, for any reason, they felt upset or distressed in any way, they could contact their local health services, or culturally suitable counselling support services available 24/7 for Aboriginal people. The contact details for these services were provided in the PLIS.

Participants were likely to benefit both directly and indirectly from the research. Access in the early years of a child's life to timely, appropriate, effective, integrated, community-based services that are flexible, holistic and culturally strong is a predictor of a child's successful transition to school and lifelong education and employment outcomes

(Shonkoff & Phillips, 2000; Shonkoff et al., 2009; VAGO, 2016). Studies have shown that participation in MCH services improves health outcomes for children and families, particularly First Nations families (see, e.g., AIHW, 2015; Austin & Arabena, 2021; VAGO, 2016). The identification of factors that facilitate, support or hinder First Nations women's access to and engagement with the MCH service could lead to improvements in the model of care to effectively engage these women. The qualitative information captured in the present research is expected to provide strong foundations for understanding the barriers to First Nations families accessing and engaging with the MCH service. The resulting recommendations are expected to benefit the MCH service and research participants, their families and communities. These potential direct and indirect benefits outweigh the risk of harm, which was carefully managed throughout the research.

3.11.4 Data security

The student researcher, who conducted all direct fieldwork, followed all relevant Federation University policies to ensure the security of all recordings and notes during fieldwork. Recordings and field notes were conveyed in a locked bag. The site coordinators did not have access to these recordings and notes. On conveyance to the student researcher's home, the recordings and field notes were stored in a locked cabinet; these were converted as soon as was possible to digital files, then stored in a secure Federation University One Drive folder. All returned hard copy surveys were archived (according to university policy) following data entry into SPSS or Excel. Electronic files were kept on the university server and password protected. Following the completion of the research, all materials were archived according to Federation University policies. All stored materials will be destroyed after five years, in accordance with Federation University policy.

3.12 Research rigour

In qualitative research, rigour is strived for to ensure the trustworthiness of the research and results. This involves a process of discipline, adherence to detail and accuracy (Gray et al., 2017). This means a representative sample applicable to this research; specific steps, developed with detail, logically linked together, with a documented audit trail that other researchers can follow; and accuracy of measurements to ensure validity and

reliability. A valid measurement instrument accurately calculates that which it was likely to calculate (Creswell, 2013). However, validity in qualitative research is more problematic than in quantitative research because the more controlled the study, the more difficult to accept that the research situation was authentic (Sandelowski, 1986). In the present study, validity was ensured by having the questions assessed by a panel of experts and pilot testing the questions prior to conducting the research. This identified and resolved any misunderstandings, ambiguities or inaccuracies in the questions prior to the main study (Creswell, 2013). Credibility includes any measures taken to increase the chances of producing credible findings (Creswell, 2013). In the present study, credibility involved logically establishing the research method and ensuring an audit trail that other researchers can follow.

3.12.1 Data verification and validation

Qualitative validity and reliability are the steps a researcher takes to check the accuracy of the collected data and findings (Creswell, 2013). There are no specific strategies for the narrative approach; therefore, the researcher selected strategies commonly used in qualitative inquiry. Creswell (2013) recommends that researchers use at least two strategies in any study. Therefore, for credibility (internal validity), the present study first used member-checking—sharing interview transcripts, analytical thoughts, and/or drafts of the final report with research participants to ensure the researcher was representing the participants accurately. The researcher then had their supervisors assess the data analysis. Finally, the researcher considered and clarified the bias that they, as author of the thesis, brought to the study and their interpretation of the findings. As the author is either a researcher (or co-researcher) in the three studies included in the thesis and the primary instrument of data interpretation (Denzin & Lincoln, 2011), the author/researcher designed and co-ordinated the Early Assessment Referral Links (EARL) concept, and the author/researcher is a MCH nurse, the author/researcher is aware of a potential bias in interpreting the data. There is also the potential for the author's/researcher's own background (past experiences, assumptions and orientation) to influence their interpretation of the data (Denzin & Lincoln, 2011).

This thesis used the reliability strategy of documenting an audit trail, allowing other researchers to authenticate the study findings by following the trail or steps of this study. Therefore, this thesis exhaustively details the procedures used for data collection and

analysis. Strategies for promoting transferability, or external validity, include providing rich and thick description of the data (i.e., highly descriptive, detailed presentations of the setting and, in particular, the findings). This thesis richly describes the participants and presents its findings with narrative participant quotations as supporting evidence. Study One also uses the strategy of employing maximum sample variation via three categories of participants, to allow for greater applicability of the findings.

3.12.2 Limitations of narrative inquiry and Indigenous philosophy

In considering the appropriateness of the narrative approach guided by Indigenous philosophy ‘Dadirri’ for the three studies in this thesis, the researcher considered its appropriateness based on the research purpose, questions and framework, as well as the approach’s limitations. Narrative inquiry is not appropriate for studies of large numbers of participants and is not suitable for researchers who want an easy, unobstructed view of subjects’ lives. Neither of those apply to this research.

In narrative inquiry, the researcher is expected to collect extensive information about participants to fully understand the context of these individuals. Smith (1999) states that qualitative research approaches are popular with nurse-researchers because they acknowledge the subjectivities and meaning of experiences. Nevertheless, there has been little research on the use of Indigenous philosophy in the context of health education and care, particularly MCH. This thesis agrees with and adopts Atkinson’s (2002) view of Dadirri as ‘a process of listening, reflecting, observing the feelings and actions, reflecting and learning, and in the cyclic process, re-listening at deeper and deeper levels of understanding and knowledge building’ (p. 19)—that is, a valid methodological approach and critical lens for data analysis. The use of Dadirri in this research enabled rich, thick descriptions of participants and their experiences to be collected.

3.13 Summary

This chapter provided an overview of the storyline of the research and a contextual foundation on which the study results can be interpreted and presented. This study used the narrative inquiry approach to obtain meaningful information about an event—a model of care (Ospina & Dodge, 2005)—and relate a story about the processes involved in determining the effectiveness of this model through participants’ stories. Therefore, the

narrative approach provided a process of reflection through the inquiry process that enabled a different viewpoint to be ascertained to influence change (Connelly & Clandinin, 1990).

This chapter also described the philosophical framework that underpinned the research methods used to investigate the research questions. Narrative inquiry is one of the five traditional approaches of qualitative research (Bryman et al., 2012) and was chosen as the most appropriate approach for the present study. The researcher selected the narrative inquiry approach to gain insight into First Nations women's perspectives on the MCH service in Victoria via interviews. Thematic analysis was used to identify themes within the narratives. The themes derived from the interview data were expected to answer the research questions and provide recommendations to improve the Victorian MCH model of care. The research outputs shown in Figure 1.2 are presented in Chapters 4–6 (i.e., Studies One to Three). The three studies provide a narrative of the storyline that organises the researcher's human experiences of working as a MCH nurse in Victoria, Australia, into meaningful episodes. Studies One and Two (Chapters 4 and 5) highlight elements of the current Victorian MCH service model that are not effectively engaging First Nations families, and Study Three (Chapter 6) presents a piloted model that does effectively engage First Nations families with MCH services.

Chapter 4: Study One: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services

4.1 Introduction to Study One

This chapter presents the findings of the research output in Study One, and forms part of the storyline shown in Figure 1.2: ‘Explore and describe the engagement of First Nations women with children birth -5 years of age accessing the MCH service in Victoria’. Study One employed stratified purposeful sampling to recruit First Nations women of all ages residing in the Glenelg Shire, South Western Victoria, Australia, with at least one child age birth to five years, to explore their perceptions and experiences of MCH services. As described in section 3.8: Population and sampling and section 3.9: Method and data collection, stratified purposeful sampling was employed to recruit three unique sub-categories of participants, as defined by their level of engagement in MCH services. These three levels of engagement include current engagement; initial engagement, now disengagement; and no engagement in the MCH service in the Glenelg Shire, Victoria, Australia. From the 41 women eligible to participate in the study, 35 consented to participate. This sample size represented 85% of this specific population group, and was largely determined by the number of respondents available to participate in the study.

To achieve the aims and objectives of the research, the researcher asked:

- 1) Why do First Nations women choose/not choose to attend MCH services?
- 2) What do First Nations women find valuable or unhelpful about the MCH service they receive?
- 3) What improvements could be made to MCH services for First Nations families?
- 4) What barriers do First Nations women with children birth to five years of age have to access and engagement in MCH services?

Coded analysis of the individual pieces of data were analysed into two main themes and eight sub-themes to represent the over-arching narrative within the data to help answer the research questions(s) (Braun and Clarke, 2021). The researcher sought further insight and deduction from ACCHO/VACCHO/and an Indigenous academic consultant regarding the significance of some of the data collected from the women. The researcher

believed that this procedure would help to ensure procedural and interpretative rigour, and gain a deeper, comprehensive understanding of Aboriginal women's access and engagement in Maternal and Child Health services. This research has been published in the researcher's term of candidature. The published manuscript 'The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services' (<https://doi.org/10.1111/jan.15493>) is included in Appendix Fourteen.

4.2 Results of Study One

4.2.1 Factors contributing to First Nations women never engaged in the Maternal and Child Health service

All participants (n= 10,100%) interviewed in Site A+B (n= 6, 60%) and Site C (n=4, 40%) answered all tailored questions in Table 3.2 pertaining to this category.

The theme 'intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting two concurrent narratives in Portland (Site A+B), and three concurrent narratives in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'mistrust' and 'miscommunication' in Site A+B and 'mistrust', 'miscommunication', and 'not recognising the Social Determinates of Health' in Site C.

Lee (2020) defines 'intercultural incompetence' as

The inability to demonstrate targeted knowledge, skills and attitudes that lead to effective and appropriate communication with people of other cultures. (p. 261)

The prefix 'inter' indicates the two-way interaction between individuals from two different cultures (Lee, 2020).

Participants overwhelmingly reported the importance of intercultural competence for the development of therapeutic, trusting relationships with health care providers before they accessed and engaged in a service. One participant shared,

The Stolen Generation is still fresh in our minds, these are not stories from a long time ago. These things have happened to our grandmothers. Our grandmothers'

stories are whirling around in our minds. I don't trust white fellas. (Participant B2)

Another participant divulged why she never engaged in the MCH service, saying,

Maternal and Child Health nurses in Victoria are mandated to report risk to our children, so why would we go? (Participant C3)

The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data also presenting two concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C). These concurrent narratives were organised into separate sub-themes, namely 'untimely and/or inappropriate' and 'inflexible in approach' in Site A+B and 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care', and 'not holistic' in Site C, as summarised in Table 4.1.

Table 4.1. Summary of themes why First Nations women never engaged in the Maternal and Child Health service

Site	Theme/s	Sub Theme/s	Enabler	Barrier
A+B (n= 6)	-Intercultural incompetence	-Mistrust		x
		-Miscommunication		x
	-Ineffective service	-Untimely and/or inappropriate		x
		-Inflexible in approach		x
		-Poor access		x
C (n= 4)	-Intercultural incompetence	-Mistrust		x
		-Miscommunication		x
		-Not recognising the Social Determinates of Health		x
	-Ineffective service	-Untimely and/or inappropriate		x
		-Inflexible in approach		x
		-Earlier engagement		x
		-Poor continuity of care		x

		-Not holistic		x
		-Poor access		x

One mother poignantly stated why this theme, and the concurrent narratives, was a barrier for her,

As an Aboriginal woman, we have all these things in your mind when you go and see a service, whether it is FV or our partners or how we raise our children. We are always really listening and thinking as to how to answer their questions. I don't want the nurse to judge me and see me differently if I tell her my stories I don't want to go. (Participant B5)

4.2.2 Factors contributing to First Nations women disengaged in the Maternal and Child Health service

All participants (n= 11, 100%) interviewed in Site A+B (n= 9, 81.8%) and Site C (n=2, 18.2%) answered all tailored questions pertaining to this category in Table 3.2. Similarly, to the responses from First Nations women who had never engaged in the MCH service, the coded data of the responses from this category produced a clear picture of the dataset of factors contributing to First Nations women disengaged in the MCH service. The theme 'intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same three concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'mistrust', 'miscommunication', and 'not recognising the Social Determinates of Health'.

One participant shared,

I didn't feel that my story was being heard and I didn't trust the nurse. She didn't care about my wellbeing. Mob needs safety to tell her story, the trust isn't there so I didn't go back. (Participant B6)

Another participant agreed, saying,

I had a bad experience in the past. I didn't get on with the nurse. I didn't like the tone that she used. Mob do not like authoritative tone when you speak to us. I felt judged and threatened as I thought my children were going to be removed, so I stopped going. (Participant B3)

One mother stated,

I didn't like where the nurse worked, it was clicky, and that's a turn off for many of us. Yeah, the white fellas stick together and don't bother to get to understand us blackfellas and our ways of doin' things, our kinship, our lore. I didn't feel safe, I felt judged. My kids were a bit dirty when we went there one day, and I could see the nurse was judging me. I never went back. (Participant A4)

The importance of the nurse to understand the SDOH were emphasised by some participants. One mother suggested,

Use a strengths based approach when you speak to us. Better understanding of mob, not stereotyping that we are all the same- bad mothers that don't look after our kids properly. (Participant C5)

Another shared,

I won't go to the MCH service now, its toxic! I feel bad enough about myself most of the time, and the nurse does not make me feel comfortable when I am there. She make me feel worse about myself when I'm around her. (Participant B11)

The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same four concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care', and 'not holistic', as summarised in Table 4.2.

Table 4.2. Summary of themes why First Nations women disengaged in the Maternal and Child Health service

Site	Theme/s	Sub Theme/s	Enabler	Barrier
A+B (n= 9)	-Intercultural incompetence	-Mistrust		x
		-Miscommunication		x
		-Not recognising the Social Determinates of Health		x
	-Ineffective service	-Untimely and/or inappropriate		x
		-Inflexible in approach		x
		-Earlier engagement		x

		-Poor continuity of care -Not holistic -Poor access		x x x
C (n= 2)	-Intercultural incompetence -Ineffective service	-Mistrust -Miscommunication -Not recognising the Social Determinates of Health -Untimely and/or Inappropriate -Inflexible in approach -Earlier engagement -Poor continuity of care -Not holistic -Poor access		x x x x x x x x x

Most participants in this category disengaged in the MCH service, as the service was not effective for them. One mother shared,

As an Aboriginal woman people think the worst straight away. I would need the service to suit me better before I go back, don't make it so white! (Participant C6)

4.2.3 Factors contributing to First Nations women currently engaged in the Maternal and Child Health service

All participants (n= 14,100%) interviewed in Site A+B (n= 6, 42.9%) and Site C (n=8, 57.1%) answered all tailored questions pertaining to this category in Table 2. The interpretation of the data in this category, in comparison to the interpretation of aggregated meaning across the dataset, was more complex as some themes and sub-themes were both enablers and barriers to access and engagement in the MCH service.

Similarly, to the responses from First Nations women who had never engaged or disengaged in the MCH service, the theme 'intercultural competence/incompetence' was clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same three concurrent

narratives in Portland (Site A+B), and in Heywood (Site C) as factors which enabled access and engagement, and two concurrent narratives in Portland (Site A+B), and in Heywood (Site C) as factors which were barriers to access and engagement in the MCH service.

The concurrent narratives constructed as separate sub-themes which enabled access and engagement in all three sites were ‘trust’, ‘communication’, and ‘recognises the Social Determinates of Health’.

One participant supported this by saying,

My nurse understands me and looks after my health and wellbeing. She asks me how I am too, not just my baby. I feel safe with her. (Participant A8)

Another stated,

There are posters and flags of Aboriginal culture in the building, I feel safe there. (Participant A9)

The concurrent narratives constructed as separate sub-themes which represented barriers to access and engagement in all three sites were ‘miscommunication’ and ‘not recognising the Social Determinates of Health’.

Interestingly, one participant shared that although she engaged in the MCH service,

I would like better communication with the other services so I don’t have to keep telling my story, and a better understanding of Kinship. (Participant A5)

Another participant said,

I would like the nurse to explain what they do for each visit so I know who else I should see and why they ask things such as DV [domestic violence]. (Participant C7)

A third mother said,

Some of the advice the nurse gives me is a bit westernised, it doesn’t always take in Indigenous ways of doing things. They should be asking us what we want to know. I would like more about Aboriginal health and wellbeing and not white person’s health and wellbeing! VACCHO has got heaps of things that she could use. (Participant C9)

The theme ‘effective/ineffective service’ was also clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites. Constituent coded data presented three concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C) as factors which enabled access and engagement, and five concurrent narratives, common to all three sites, as factors which were barriers to access and engagement in the MCH service. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Portland (Site A+B) were ‘timely and appropriate’, ‘flexible in approach’, and ‘holistic’. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Heywood (Site C) were namely ‘timely and appropriate’, ‘flexible in approach’, ‘continuity of care’, and ‘holistic’.

One participant liked that,

Immunisations are given by the nurse at the same appointment when they are due so I don’t have to go anywhere else for them. (Participant A6)

Another mother said that she likes that,

The MCH nurse works for my ACCHO and the council so I don’t have to tell my story twice. (Participant A7)

The theme ‘ineffective service’ was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same four concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely ‘untimely and/or inappropriate’, ‘inflexible in approach’, ‘poor continuity of care’, and ‘not holistic’ (Table 4.3).

Table 4.3. Summary of themes why First Nations women are currently engaged in the Maternal and Child Health service

Site	Theme/s	Sub Theme/s	Enabler	Barrier
A+B (n= 6)	-Intercultural competence/ Intercultural incompetence	-Trust/Mistrust	x	
		-Communication/Miscommunication	x	x
		-Recognises the Social Determinates of Health/Not recognising the Social	x	x

	-Effective service/Ineffective service	Determinates of Health -Timely and Appropriate/Untimely and/or inappropriate -Flexible in Approach/Inflexible in approach -Earlier engagement -Continuity of care/Poor continuity of care -Holistic/Not holistic -Access/Poor access	x x x x 	x x x x
C (n= 8)	-Intercultural competence/incompetence -Effective service/Ineffective service	-Timely and Appropriate/Untimely and/or inappropriate -Flexible in Approach/Inflexible in approach -Earlier Engagement -Continuity of Care/Poor continuity of care -Holistic/Not holistic -Access/Poor access	x x x x x x x 	 x x x x x

One participant shared,

It would be good to have a Koori Health Care Worker work with the nurse, just to help the nurse understand me better. It's around having Aboriginal people work with the nurse so mob are happy to come in the front door and they are welcomed, listened to, and respected. (Participant A5)

Another said,

Although I have got to know the nurse, it would have been good if I got to know her earlier like at women's group so she could meet pregnant mums there and build a relationship before the bub is born. (Participant B12)

Another mother supported this saying,

It would be good to see the MCH nurse when we mob are pregnant so the nurse can get to know us better and the Koori Maternity nurse can pass on their story before bub is born and shit happens! It's hard to stay on track with a newborn! (Participant A10)

A few participants stated that although they did engage in the service, the service could be made more effective if,

The nurse had more time, especially if I have had lots of problems to yarn about. (Participant C14)

Another mother stated,

The age when my bub is due to see the nurse sometimes doesn't suit me, but there's not a lot of flexibility. I would like to see the nurse more when I need to, not just when she says my baby is due to come in. (Participant C11)

This study provides insight from First Nations women with children aged birth to five years currently residing in the Glenelg Shire, on factors contributing to access and engagement in the MCH service in Victoria, Australia. The findings as a detailed analysis of the thematic framework, where the individual themes and sub-themes were expressed in relation to both the dataset and the research question(s) are summarised in Figure 4.1.

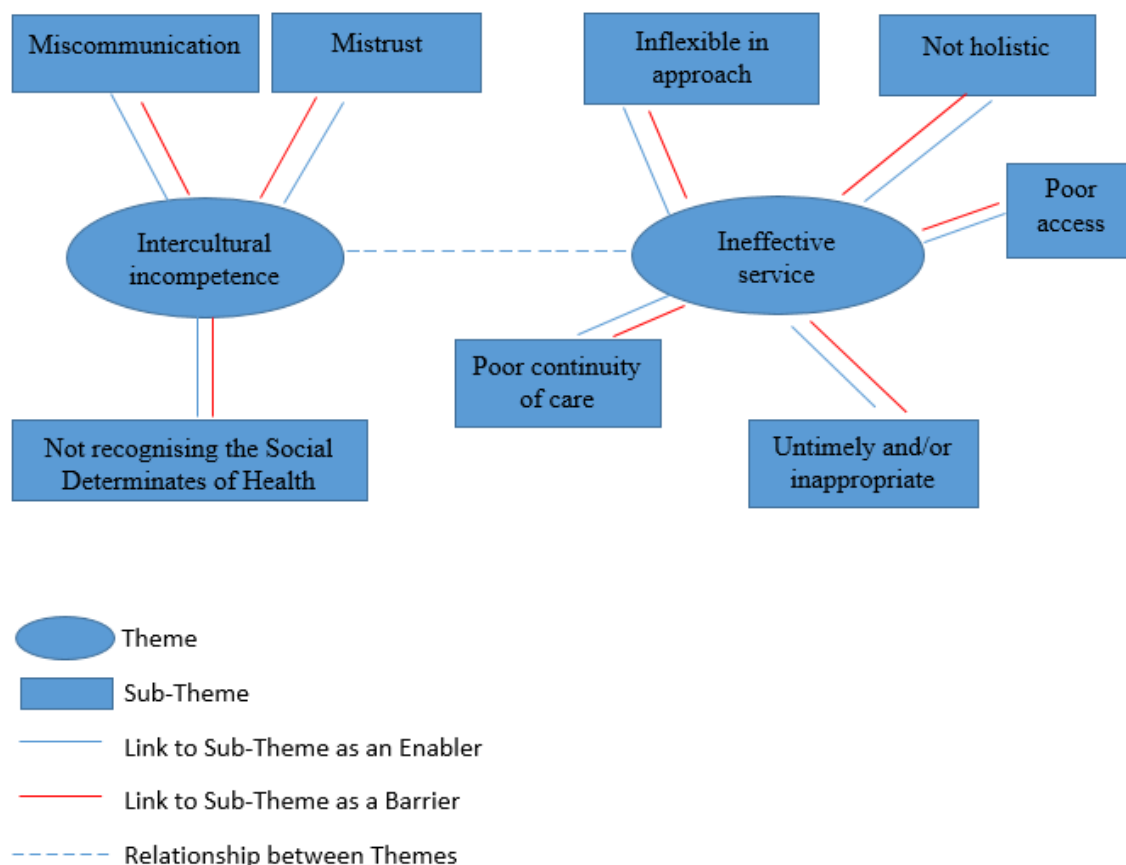


Figure 4.1. Finalised thematic framework map

4.2.4 Responses from ACCHO/VACCHO/Indigenous academic consultant

Following data collection of the interviews of the First Nations Women, and coding by the researcher to allow for critical interpretation, analysis and understanding of the data, the researcher met individually with key members of the Indigenous Advisory Committee to ensure reliability of the researcher's interpretation of the data and cultural sensitivity. The researcher interviewed the two ACCHO site coordinators, then the First Nations Director at VACCHO, and finally the Indigenous academic consultant, to gain a multi-layered insight and deduction of the data, and a deeper, comprehensive understanding of First Nations women's access and engagement in maternal child health services. This collaborative process of creating knowledge is fundamental to the Indigenous philosophy 'Dadirri'.

4.2.4.1 Factors contributing to First Nations women never engaged in the Maternal and Child Health service

Researcher:

‘All participants (n= 10,100%) interviewed in Site A+B (n= 6, 60%) and Site C (n=4, 40%) answered all tailored questions in Table 2 pertaining to this category. Participants overwhelmingly reported the importance of intercultural competence for the development of therapeutic, trusting relationships with health care providers before they accessed and engaged in a service. One participant shared,

The Stolen Generation is still fresh in our minds, these are not stories from a long time ago. These things have happened to our grandmothers. Our grandmothers’ stories are whirling around in our minds. I don’t trust white fellas. (Participant B2)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘It’s a ripple effect, those concerns and feelings are going to be felt each generation of that family tree. Those stories, you know our Elders are our knowledge, our history. They give us those stories. They are our family, they are people we trust and believe in, and as you know, the mainstream services, our people do not 100 percent fully trust those services because of things that can occur. It’s what you are taught from your Elders because of the experiences that have happened to them, those stories can happen to you! I remember my dad saying, he used to say to us if you are naughty, you will get taken away, if you don’t want to get taken away, don’t be naughty! I believe it’s a racist thing. If you go to Indian households, Asian households, a lot of the grandparents are there. It’s the same sort of thing, but when you are Aboriginal, people look at it like, how many people have they got living in that house?! It’s like, when mainstream services come, you know, house has to be clean, no mattresses on the floor, or they will report that, and then we will have DHS on our back. So it’s all those little things you know, services come, house is clean, mattresses off the floor... There’s family there, there’s people supporting that mother there. That’s how it should look. The trust is something that isn’t going to be an overnight fix, it is hurt from generations, and unfortunately, you need somebody in

that service that they can build that trust and so for the following generations that will build up’.

VACCHO’s response:

‘I think the important thing to add to this part is yes that’s what people experience, and even though these issues are coming from women in the South West of Victoria, we hear that across families that we work with. I have come from an education background, working for the Department of Education and Training in previous roles and are constantly having conversations with families around access to MCH. What is interesting about this is that MCH is such an important linkage service of early intervention having the 10 Key Age Stage Milestone Assessments. Because you are being measured against a western system, but you are not a western person, the judgement [of MCH nurses to Aboriginal Families], and what flows from this judgement, that you don’t fit this mould makes women feel like shit, inadequate. What we know from the data is that lack of engagement in this space, whether it’s even before MCH, flows on down the path, and by the time families get to say prep, they have become so muddled in the system, that when you are trying to get families engaged in your service, they already have had about 5 critically challenging situations, whether it’s through the maternity hospital, the MCH service, or whether it’s Kinder, there is always critical incidents and yet these services are so important in our peoples’ lives- the supports that wrap around them so they can have the best start in life’.

Indigenous Academic Consultant’s response:

‘I would agree with those issues. We have seen for example, young mothers in acute mental distress that won’t engage in services for fear of their children being removed. Whether that’s a perception, or they have had a real experience, it doesn’t matter. What matters is the intercultural competence, recognition of the social determinants of health, and that lack of trust which doesn’t facilitate women accessing services that they need. We have also seen unborn child notifications so the women are tagged and then they are watched through the system, rather than being supported. In this instance, it’s important to have Indigenous midwives working with the woman to act as a conduit and a buffer to those services and ensure the services the women engage in are effective and interculturally competent. We have also seen epigenetics and the role that trauma has

made on a cellular level, so there is a deep mistrust and it's hard to comprehend what is going on for these women. The women that have used services such as Maternal and Child Health often have hypervigilance, and the loads of that hypervigilance are often very high, and it is very inhibitive for women to attend mainstream services, or any services, with that trauma and fear'.

Researcher:

'Critically, another participant in the yarning divulged why she never engaged in the MCH service, saying,

Maternal and Child Health nurses in Victoria are mandated to report risk to our children, so why would we go? (Participant C3)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'The mandatory reporting is really any health professional, not just MCH. It's your doctors, your nurses, your dentists, anyone, your schools, teachers at schools, so we need to get the stigma of that decreased'.

VACCHO's response:

'There's' a lot wrapped up in that statement. I see where they are coming from, why would you put yourself in unnecessary potential risk of being reported? The systems and structures don't align, I see this time and time again, where families are being reported based on neglect, which is one of the biggest reports for Aboriginal children, and what often comes from that is it is a values judgement of a western and non-western construct. So I get where this person is coming from, but I also agree with the point that the ACCHO site coordinator is saying by there is many people that families come into contact with, who have the same mandated reporting responsibilities as the MCH nurses, but more awareness of this is required. The mandated services should stay, as they are there to protect our peoples, but there needs to be that overcoming of distrust in all the systems, which leads to, how are the services we attend culturally safe?'

Indigenous Academic Consultant's response:

'I agree, personally, I consider myself quite educated, but I didn't attend Maternal and Child Health for those same reasons. I know the experiences of those that have often say that the kind of gaze of those professionals for whatever reasons that are mandated with responsibility, when they ask our people questions we can tell if we are being supported'.

Researcher:

'Ineffective service was clear as a barrier to access and engagement in the MCH service in all three sites. One mother poignantly stated why this theme and the concurrent narratives was a barrier for her,

As an Aboriginal woman, we have all these things in your mind when you go and see a service, whether it is FV [family violence] or our partners or how we raise our children. We are always really listening and thinking as to how to answer their questions. I don't want the nurse to judge me and see me differently if I tell her my stories I don't want to go. (Participant B5)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'You do have to think or process about what you are going to say because you don't want it to come across and have your child taken away from you, or services involved that is going to impact on you and your family life. Family violence is unfortunately huge in our communities, but is how we can talk about this in a safe way that your respected, your understood, your believed, and the repercussions for saying how things are isn't going to come back and bite you, and make it worse. You might want to stay with your partner for whatever reason and try to work things out, but by disclosing this information, you obviously have to disclose perpetrators and the negative impacts of this can be 100 times worse than the violence whether it's physical, verbal, financial, so people tend not to say anything. You are better off closing your mouth and not saying anything, than saying anything. There are those community connections, even if you aren't related, you are brought up in the same community, so if you are married into a family you have to see them in community and you might get a bad reaction from what you have done to their family, they will see it in that light. These things even happen here, it happens easier in

small communities, but it can even happen in Melbourne because we all attend the same Aboriginal organisations and the events for community’.

VACCHO’s response:

‘It’s the subtle judgement when you attend MCH services though, and in our people’s minds they are thinking “why do you need to know that?” Sometimes the service appears very transactional. The nurse says, “I’ve gotta ask you these questions, is your baby doing this, is it doing that, how are you breast feeding, is the dad around”, all of these things and we think, I’ve just had a baby, I’m sorting myself out, and where are you going with all of these questions? That questioning triggers a whole range of things: Is my baby ok? How is the right way to answer these questions? I’m not going to keep engaging with this service as this makes me feel like shit! This is where we see that drop in MCH participation as there is only so much of that you can take before the mum thinks, I actually don’t have to have this service as there are other structures in our communal setting where we get our advice from- our mothers, our aunties, our sisters...so it’s like, I don’t need that person or structure to tell me things when I’m getting this knowledge from these sources’.

Indigenous Academic Consultant’s response:

‘Again, it’s about the strong corroboration of the women and the protective factor. Intercultural competence between the client and the service provider, and services that are flexible, holistic, timely and appropriate are major influences on women’s capacity to participate in services like Maternal and Child Health. Knowledge of a woman’s birthing story from a professional experience or a society experience or a community experience or an institutional experience we need to make sure that we are protected. We need a humanitarian response from services during our pregnancy and our child’s early years. A communal approach to women’s experiences in services such as Maternal and Child Health is also important, women need to know that they are welcome to bring not only their partner, but their sisters or aunties or anyone else that will be instrumental in raising their child’.

4.2.4.2 Factors contributing to First Nations women disengaged in the Maternal and Child Health service

Researcher:

‘All participants (n= 11, 100%) interviewed in Site A+B (n= 9, 81.8%) and Site C (n=2, 18.2%) answered all tailored questions pertaining to this category in Table 2. Similarly, to the responses from First Nations women who had never engaged in the MCH service, the coded data of the responses from this category produced a clear picture of the dataset of factors contributing to First Nations women disengaged in the MCH service. Intercultural competence was again clearly definable as a barrier to access and engagement in the MCH service in all three sites. One participant shared,

I didn’t feel that my story was being heard and I didn’t trust the nurse. She didn’t care about my wellbeing. Mob needs safety to tell her story, the trust isn’t there so I didn’t go back. (Participant B6)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘The wellbeing, that’s what they are there for. It says Maternal and Child Health! I think it’s the judgement. People all do it in all aspects of our life. We judge people for the way they act, the way they look, the way they parent, the way they live, shouldn’t be a judgement, unless it’s unsafe. If you wrap a baby a different way, if you hold a baby a different way, if it’s not unsafe, what judgement should you have against me? The way that some of our women are looked upon in maternal and child health, in that white environment, and the tone they use to speak to us is disgusting. It’s the judgement, it is really hurtful’.

VACCHO’s response:

‘I agree about the wellbeing factor, as obviously this is the field of work I am in now, Social and Emotional Wellbeing and how that broader, holistic view of health, incorporating the social determinants of health, is really important. I think, not only in the MCH world, but in the many services in health, people really grapple with that and what that means- looking at things more holistically, the interconnectedness, and those types of things. I think that intercultural competency is what they are really taking about here. It’s

rife, everywhere, and it's really difficult to change those types of systems. Like when we talk about systems reform and how we change a whole way of doing, like it's big, and it's complicated, and there is a lot of learning that has to happen in that space, but I feel more like, there has to be a better way to do it. How are those engagement points and conversations? As what we do know, and I know this by working in this space, is how important those checkpoints are, so if there is a developmental delay, how are we going to pick these kids up? How often have we seen kids that haven't been engaged in MCH, may or may not have gone to Kinder, and the first contact with these checkpoints are in prep when they do the prep nurse assessment, and your picking up speech delays, fine motor skills, all of those types of things that should have been picked up earlier. I think that creating cultural safe spaces and culturally competencies in service delivery is the key. I can't emphasise how important that is. It's power when you walk into a service and you feel like you belong there. Like the Maram [Multi- Agency Risk Assessment and Management Framework] training we did recently. They showed a video of the nurse and the Aboriginal woman having a comfortable conversation about risk of FV, and I automatically thought who has that? That's not real! I don't know anyone who has really raved about their MCH experiences when asked about FV!'

Indigenous Academic Consultant's response:

'There is a lot of responsibility put on our women in the way they are meant to present, so services need to be culturally safe for these women. That might mean changing the location of these services or having an Indigenous worker present at these services. Having access to services that are culturally safe is imperative'.

Researcher:

'Another participant in the yarning who had disengaged with the MCH service agreed, saying,

I had a bad experience in the past. I didn't get on with the nurse. I didn't like the tone that she used. Mob do not like authoritative tone when you speak to us. I felt judged and threatened as I thought my children were going to be removed, so I stopped going. (Participant B3)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'It has to come down to cultural awareness. These MCH nurses need to understand that the way you speak to an Indigenous person can come across as threatening, you are better off talking like you would to your neighbour, if you let a swear word go, you are better off speaking like that than come across authoritative because of history, we shut down, back off and don't listen anymore, you've overstepped the mark and you are talking to me as if I'm stupid or useless and you are not listening to what I am saying anyway. Why would we go back to the nurse if we feel like we are doing everything wrong?'

VACCHO's response:

'When you talk about MCH being 'authoritative' in that space, sometimes in their delivery they can be very unaware of how sensitive some of their comments can be, particularly in a sensitive situation. Their comments can be quite direct, but sometimes quite impactful. It just takes one bad experience, and it's so hard to get our people back in the door. Particularly when you have gone in there on not a level playing field, or kind of feeling a little bit vulnerable, your kind of looking for it, and when it comes you say "yeah, see, I knew it, I'm not going back".'

Indigenous Academic Consultant's response:

'I appreciate that Maternal and Child Health nurses might be time precious, so their engagement with clients can be highly transactional, rather than personal. Our people want relationships, they don't want to be poked and prodded and measured and told that they are not doing a good enough job, they want support people on their journey and what would be more powerful is support people with a trauma informed response'.

Researcher:

'Another mother who had disengaged with the MCH service stated,

I didn't like where the nurse worked, it was clicky, and that's a turn off for many of us. Yeah, the white fellas stick together and don't bother to get to understand us blackfellas and our ways of doin' things, our kinship, our lore. I didn't feel safe, I felt judged. My kids were a bit dirty when we went there one day, and I could see the nurse was judging me. I never went back. (Participant A4)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'If you look at each question, there are a lot of the same words that keep reappearing. Judgement, not bothering to understand, not listening, and not feeling safe, culturally safe. The normal experiences that you maternal and child nurses see working with Aboriginal families is something that they have gotten well adapted to take on. All those little things, walking in with their kids with hairs all over them, snotty noses...I think we've built a resilience from services that we receive when that kind of approach happens, our girls are on the back foot to attack to protect themselves and their mob. I know from personal experience, especially where it says here "my kids were a bit dirty", I as a mother was paranoid of my kids looking dirty as my grandparents taught my father who taught me, "don't be dirty", "wear clean clothes", it's ridiculous with these thoughts in their heads that they are going to be judged if we are dirty, "just another Aboriginal kid with a snotty nose, unkept". It's sad, people don't understand. They say, "oh yeah, the stolen generation happened all that time ago, get over it!" It's not something you can get over, it happened to your family, and the things that happen to your family, make you who you are. We are recognising LGBTQIA, why can't we recognise race? The ATSI acronym, I just want to be me! I'm proud of my Aboriginal heritage, but why is that on the forms? Where is that going to and for what reason? Why do we have to be segregated? You are labelling me straight away, by me ticking yes! I don't tick those boxes. I am fearful of the treatment I might get by ticking the boxes. Who cares what culture I am from, does that change who I am as a person? If there is no benefit to us by using a service, don't ask us'.

VACCHO's response:

'I agree with the comments made by the ACCHO site coordinator. Language is such a big thing, words can be quite powerful, but it really centres on a deeper challenge that we have as a nation. The comment, "we are recognising LGBTQIA, why can't we recognise race", that is something from a VACCHO perspective, we have been having a lot of conversations about that. We are going through our rainbow tick, and we are doing compulsory Maram training, but when it comes to cultural training, it's like "do it if you can". What we see across the board in all health and wellbeing, that when we unravel the layers as to why people aren't accessing services, or less in the preventative services and

more in the chronic end. We are talking about MCH nurses here, but they are not alone, there is a lot to be done to build that capability of understanding and how that translates’.

Indigenous Academic Consultant’s response:

‘The location of services are very important for access for our women. Are they in culturally safe areas? Some of our kids are very spirited, they like to get dirty, that’s the way they connect to country. That’s culture. Services need to look at Indigenous women with a cultural lens to ensure intercultural competence and effective services’.

Researcher:

‘One mother who had disengaged with the MCH service suggested,

Use a strengths based approach when you speak to us. Better understanding of mob, not stereotyping that we are all the same- bad mothers that don’t look after our kids properly. (Participant C5)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘Different mobs do things in different ways and that might be confusing for the maternal child health nurse if they come across a Victorian Aboriginal person, then someone from WA or Queensland, they are different and also in that state they have lots of different tribes and they have lots of customs and things, so it could be very confusing from the maternal and child health nurses view if they are seeing one mob from one tribe and then see a different mob and the nurse might say “hang on, this one told me this part about her culture and the way of doing things, and this one (from another tribe) told me something completely different!” The MCH nurses need to black it up! Like grabbing some of the words that we use, if you are around our families, you pick up the language and the lingo, and maybe ask what words are appropriate to use? You might call an Aunty or a Sis “Aunty” or “Sis” and they might not want you to call them that? There is no shame in asking what Aboriginal people want you to call them. If you don’t know, just ask us! As an Aboriginal person, for me, I feel that Mob should be appreciative of you asking them the question. Then they can help you understand it. It has to be the way you ask, not by saying, “what do you want me to call you”, rather than, “is it ok if I call you Aunty or Sis?” It’s the manner in which you people speak means a lot’.

VACCHO's response:

'I think understanding diversity amongst Aboriginal people is really important, and I think that reflects a relationship gap with MCH services'.

Indigenous Academic Consultant's response:

'Services need to change the narrative of how they engage with Indigenous women. For instance a woman who has disengaged with services, they need to talk about them as women who have experienced disengagement in services. Then you can change the construct of that experience. Then there is transparency'.

Researcher:

'Another mother who had disengaged with the MCH service shared,

I won't go to the MCH service now, it's toxic! I feel bad enough about myself most of the time, and the nurse does not make me feel comfortable when I am there. She make me feel worse about myself when I'm around her. (Participant B11)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'She has had a really bad experience there! She wasn't supported, and probably wasn't listened to properly because they didn't get to how she really felt! She can't do anything right, so what's the point in her going, and she's had a lot of experience with this sort of treatment. We need to stop this. Part of the problem is that the MCH nurses are of the generation that we have been warned about, you know, the really old school nurses that were just there to do their job and go home. They have had enough, they are at the end of their working life'.

VACCHO's response:

“Toxic” is a powerful word, without knowing the context of that mum, I would say it is reflective of her broader experiences with mainstream services. I am curious to what has driven that experience. People would mainly use words like “culturally unsafe” or “discriminative”, or that sort of language, so to me, that must have been a really terrible

experience/s for that woman. The hard thing for our mob in country towns, is that there is limited choice of who you get to see as your MCH nurse, and the nurse tends to stay in that job for a very long time. There is a stigma that comes more broadly with working for local government, they are not great places to engage across the board, it is kind of elitist in a way, and that is how they can come across, not just with MCH, but all Council culture in general. So, it is interesting to think about what is all wrapped up in that, but what you see is a kind of flow on effect, so that mum, if she was to have another baby, would not go back into that system’.

Indigenous Academic Consultant’s response:

‘Again, that could be a result of this woman’s hypervigilance coming into those spaces and places with a cultural load and significant life stressors. These women have a different way of conveying their experiences of services’.

Researcher:

‘Ineffective service was similarly clear as a barrier to access and engagement in the MCH service in all three sites for mothers that had disengaged with the MCH service. Most participants in this category disengaged in the MCH service, as the service was not effective for them. One mother shared,

As an Aboriginal woman people think the worst straight away. I would need the service to suit me better before I go back, don’t make it so white! (Participant C6)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘That is always the first thing that is in our minds. That is something that is always on our mind when working with or connecting with mainstream services and that’s why we use our own organisations because people there are working for our people and have a better understanding of our people’.

VACCHO’s response:

‘That goes back to what we were saying a little earlier, when I said, “how do you change a system”. There is a whole kind of structure and model of organisation change and

professional change that needs to occur, so when we think about things like saying “don’t make it so white” like when you think about that, it stems back to how people are trained, where do they get their quals, what are they exposed to, how do you embed that diversity and thinking right from the outset? How do you encourage people to have placement in an Indigenous organisation, to encourage experience in diversity? That is the only way that you are truly going to build a change in practice, through this two-way experience. But it’s hard to do that, if you shoot the relationship down before you even start. I think when people say, “don’t make it too white”, people need to feel comfortable and celebrate it. Like communal living, the extended support system, and being able to understand what people often refer to as “complicated” or “complex”. Like I hear people referring to kinship systems as being “complex”, it’s not really, like it’s actually quite simplistic when you step into it, and you take the time to have the conversation of that. Like we call our sisters our Aunties and they don’t know how it all fits in together, so just sit down and have a yarn about it, and don’t be so judgemental. Who are you to judge, does it matter? Your systems fit in your world, and this system fits in our world! That should be cool as well. Unless there is risk of harm or something like that, MCH nurses have to say “oh yeah, that’s different, but let’s run with that”, and they are not good at that. A lot of the work we are doing in mental health, is talking a lot about lived and living experience in that space, and lots of professionals, such as MCH nurses, are kind of wired to do things, and are trained in a certain way, and it is hard to unlearn that. It’s hard for them to learn how to be a bit flexible without feeling like their world is going to cave in, so I appreciate that side of it, but I think that exposure up front of what you need to do, for instance making the service less white, you kind of have to mandate that kind of stuff and get that exposure to that adversity, and then in the setting space, there are so many good resources now to create an inclusive space, and abundance of art and bits and pieces, and enable your service to be seen. The service has to be able to reflect you that is what we say at VACCHO. You have to be comfortable to be able to bring your whole self to be able to work without being judged, it’s similar in the MCH space. When you look at the service and unpack all the different layers, what is going to make that mum feel comfortable while she is in the MCH space. It may be, how the room is set up, it maybe how you start the conversation, or how you finish it, it may be a timing thing where you are rushing in and rushing out, but if you had a model that allows for a bit of that casualness, then you kind of weave in the requirements and that flow on. One of the other things that we hear a lot is what happens outside the formal relationship. e.g., if the mum

down the street or in the supermarket, like some of our people say there's no acknowledgment or reference. It's probably a professional thing of client- patient confidentially, but from our perspective, it's like, wow that's rude, the nurse must be embarrassed to speak to me out of work. In small town especially, that stuff can be make or break. The stuff happening outside of work should be just as important as what is happening on the inside'.

Indigenous Academic Consultant's response:

'There's a whole range of different strategies in how to make spaces and places culturally safe, and culturally safety means that you have to have visual cues and presence. Having a white landscape, means that there is nothing familiar for Indigenous families, nothing to make them feel welcome and that they will be cherished in that service'.

4.2.4.3 Factors contributing to First Nations women currently engaged in the Maternal and Child Health service

Researcher:

'All participants (n= 14,100%) interviewed in Site A+B (n= 6, 42.9%) and Site C (n=8, 57.1%) answered all tailored questions pertaining to this category in Table 2. The interpretation of the data in this category, in comparison to the interpretation of aggregated meaning across the dataset, was more complex as some themes and sub-themes were both enablers and barriers to access and engagement in the MCH service. Similarly, to the responses from Indigenous women who had never engaged or disengaged in the MCH service, intercultural competence was clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites. One participant supported this by saying,

My nurse understands me and looks after my health and wellbeing. She asks me how I am too, not just my baby. I feel safe with her. (Participant A8)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'We need to celebrate this nurse!'

VACCHO's response:

'I find it interesting that the different people have had different experiences, and the comment that we need to celebrate this nurse. From a research point of view, how do we get this nurse to share her practices of what makes this experience successful for the mother and how did this relationship form, but it also probably depends on the personality of the mum. There may be a lot of dependencies that drive those relationships, or it might be just the style of the nurse, but it may also have a bit to do with the mum and her resilience, it might be her 4th child, she might be older and more comfortable in that space, but it is important when you see things working that you are able to capture that to be able to share that, as when we talk about cultural learning and building, I think a safe space for MCH nurses and other professions when they are figuring this stuff out, is to have a peer who is getting things right to be able to share her learning. Sometimes it is hard for a professional to disclose that there are families that don't want to engage in their services, and they think 'am I not providing a quality service', so shared learning will build on that rather than be judged on your capability or vulnerability. Being able to have that shared learning amongst your peers in the same professional experiences, like communities of practice, it's really important, otherwise how do you learn?'

Indigenous Academic Consultant's response:

'The choice of language, using relationship style language like acknowledging herself and her child and her circumstances, all of those things is how you have a conversation with Indigenous women. That nurse was obviously was genuinely interested in engaging with this mother like that. Having a whole of life, holistic experience with Indigenous women is important'.

Researcher:

'Another mother in the yarning who was attending MCH services stated,

There are posters and flags of Aboriginal culture in the building, I feel safe there.
(Participant A9)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'I have a really big issue with this. The way some of the pamphlets made to be given to Aboriginal people to make us feel comfortable and to make our people feel safe, I look at some of these and think you think I'm a friggin dickhead! The pictures, the illustrations are horrendous! They are cartoony, it's wrong, it makes out as if we are dumber than the rest of society. Maybe if you were out in a remote community where English is not their first language, those type of pictures may work. Printed information in a community should try and relate to that community or tribe. Using their artists and the pamphlets should be presented to community to make sure they approve of them before they are handed out to mob, to make sure they have a community focus and are community driven and the story they are painting is related to the country that we live on. I agree when you do see pamphlets and all that, they are usually pictures of mob from the top end, and not mob from Victoria and that makes me think that society believe that they are no more Aboriginals down here! I feel this way about Acknowledgement or Welcome to Country too. It's like a half arse effort sometimes, like, oh gosh we just have to do it. It has to be heartfelt! It sometimes is an overkill too. Sometimes it isn't necessary. I get really frustrated by that. I turn the tables on this sometimes and give the people education themselves, I say, don't put a Welcome to Country on me just because I am the only Aboriginal in this room, you can do an Acknowledgement of Country! You don't have to be Aboriginal or from that Country to Acknowledge'.

VACCHO's response:

'I think posters, flags, symbols, such as animals specific to the area, whatever, is a good start of how to make spaces culturally safe. I agree with the point that the ACCHO site coordinator is making around place based resources, with people able to connect with their local art and messages, and that it is important to know your local audience, and that you make your service fit for purpose, and whether there are specific people, e.g. Elders or whatnot, that the nurse has to engage with get to know that community better. You can't go wrong with flags, Acknowledgment plaques, posters, celebrating events, as a start though on build the specifics from there. Being seen in community, outside the work that you do, and that's a broader organisational thing, helps build those kind of relationships, so it's just not a NAIDOC event or whatnot, but it has to be a whole of org approach, because if you are just one little person in government, especially local

government, it is hard to change the culture. I think there is a really important point around Victorian Aboriginal people and how they look, or what they look like, because we are so diverse. I think that really triggers a bias in the way that you say your Aboriginal, but you are not fitting my image of an Aboriginal in my head, and how that plays out in a way. So it's important that we get more people exposed to that diversity in skin colour. Another point that was made by one of the mothers is the point around the Stolen Generation. People think that it is so historic, that it is such a contemporized history. Children were still being removed up until the late 70's, Aboriginal people were only being recognised as citizens in 1967, but the term 'terra nullius', people think that was a long time ago, but it's not really. My dad was born in 1954, and he was not born a citizen, but in 1992 is when we challenged the term terra nullius, with the MABO decision, and that is so not that long ago. So when we talk about things like that, people think "oh that was centuries ago" but it is really only one generation ago and these people are still living. So things are flowing on from that, and what that looks like, and the stigma that comes with it, as we have not reconciled that'.

Indigenous Academic Consultant's response:

'Again, the visual cues are important here. It's important to have flags outside or in the building that symbolise acknowledgment of country, or symbols or welcome signs. Some Indigenous women have incredible experiences with vulnerability, and may have had their experiences with trauma reactivated during their pregnancy or labour, so they need to actively see these sort of visual cues to feel safe'.

Researcher:

'Interestingly, one participant shared that although she engaged in the MCH service,

I would like better communication with the other services so I don't have to keep telling my story, and a better understanding of kinship. (Participant A5)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'In my role in Koori Maternity Services is to help build rapport between services, but in that aspect, if they don't like me, they are not going to share their story with me or go to

MCH! For this to work, there really has to be a continuity and a sharing of information across the board somehow so our people aren't telling their stories again and again. Going back to my experience with the Victorian Aboriginal Health Services again, I was one of those mothers going through the program as well as working in it. Through the pregnancy journey with the midwives, both the MCH office and the KMS office were next door to each other, so they would go over antenatally to meet the MCH nurse and the MCH nurse would let the mum know what they do, what to expect when baby comes, this is what is going to happen. When the baby is born, they will go back to the KMS and the KMS nurse would ask if they had any concerns with the MCH service, and is there anything that can be done to support that relationship better. Like the Boori group, where all the mothers come and the MCH nurse is part of organising those events, and everyone is mingling and talking and the relationships are building in those groups, so everybody grabs an understanding of how people don't do things and I suppose a lot of that gets handed over like this. The MCH nurse might not see this, but it gets spoken about and she will find out through the KMS. The woman whilst she is pregnant is seeing the Key Age Stage posters about the MCH service and what they do and building that trust'.

VACCHO's response:

'I totally agree with that mum, we see that and hear that a lot across the board, particularly from my perspective in a social and emotional wellbeing role with VACCHO, as repeating stories can be quite triggering, particularly when you are already in a pretty vulnerable state. So being able to share, and share for the right reasons, and being transparent around where the nurse is taking that information. There is a bit of a responsibility as well as to where the nurse is taking the information, and how she is translating that story, is how the mother would like that story to be replicated'.

Indigenous Academic Consultant's response:

'Ways that Maternal and Child Health services can make Indigenous women feel culturally safe can be as simple as a sensory experience such as rubbing some gum leaves together in the woman's hands and both the nurse and the woman smelling the eucalyptus scent together at the start of their appointment is an easy way to have a part of the woman's country in the room during the consultation and a two-way connection for the woman and the practitioner'.

Researcher:

‘Another participant in the yarning who was engaged in the MCH service said,

I would like the nurse to explain what they do for each visit so I know who else I should see and why they ask things such as DV [domestic violence]. (Participant C7)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘Maybe the MCH nurse could point out, what is going to happen in the next visit, so the mums would think, ‘yes I will go to the next visit, because I want to hear about that’! That’s also where we utilise giving out that information in Boori class that would be a subject we will touch on, and that’s with mothers who are expecting and mothers who have had babies. We would go through the MCH book as some of the subjects of information we would give to the girls for and one of them would be the DV stuff that gets spoken about too. We have a little yarn around the girls experiences and all of that, and it gives them an understanding of what to expect instead of coming into see the maternal child nurse and they ask about DV and you sit there thinking, shit, they are going to take my kids away! They were told that the MCH nurse asking about FV was routine for everybody! I think that helped the fear. They weren’t just asking them because they were black’.

VACCHO’s response:

‘I think it all stems into this prior informed consent notion. It’s sometimes not about what questions are going to be asked, but where it fits into the broader scale of things, like this mum asking, why does the nurse need to know this? If you use the three P’s: Position, Permission, and Probe, So Position- I’m going to ask you a few questions to help provide a better health care, Permission- are you ok if we ask you those questions, as an example the nurse can say, we are going to ask you a whole series of questions that we ask all the mums around this, this and this, and we are going to ask you about (Probe) domestic violence, as we know that in some families when a new baby comes, it adds additional stressors to the family. The stressors can be financial, people aren’t sleeping well, and it’s upset the whole normal balance, so that’s why I’m asking you this. It’s that whole

framing part, but understanding the why, then asking the mother if they are ok if I ask you this. That gives the mother the opportunity to give permission for the nurse to probe, to ask these questions. That gives the person the power of choice. They understand what the nurse wants to know, but it up to them if they give permission to answer the questions, or explore that a little more. I wonder more broadly if a MCH engages a mother, then she chooses to disengage with the MCH service, if there are follow-up conversations by the nurse to that mother around why she has disengaged. Here is no harm in the nurse saying to the mum, I get that you have chosen to disengage, but is there something I can do to make the service better for you? Is there something I can help you with? Or simply, I am just calling to make sure you are going ok, that's my job. People are honest when you do that, I think that gives you a bit more of a response than what you may realise. It might be as simple as the mum saying that she is just generally busy, or she feels like she doesn't need to come to the service, or the more deeper stuff that we have been talking about like, "I don't feel comfortable" or "you don't make me feel comfortable", or "you make me feel judged" and that is where real relationships start to build and form because you start to see the different perceptions, but we are human, right, and it hurts a bit sometimes, or you don't want to be told that you aren't doing a great job, so you don't ask. So there are those human elements to it'.

Indigenous Academic Consultant's response:

'If there was some kind of culturally appropriate video or app that women could watch on their phone with explanation of what is going on in the Maternal and Child Health service, that is another example of transparency which is important for Indigenous peoples. Maternal and Child Health are time pressured in how they do their work, so if they are time pressured in their appointments, these sort of initiatives will help'.

Researcher:

'One mother said that although she was engaged in the MCH service,

Some of the advice the nurse gives me is a bit westernised, it doesn't always take in Indigenous ways of doing things. They should be asking us what we want to know. I would like more about Aboriginal health and wellbeing and not white person's health and wellbeing! VACCHO [the Victorian Aboriginal Community Controlled Organisation] has got heaps of things that she could use. (Participant C9)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘Our Grandmothers and our Elders were the midwives back in the day, they used to do the birthing and they had their routines and even after with the placenta getting buried near a tree and all of that, but customs change with different states and different tribe, so maybe connecting with the local Elders group to see how they do things, how they have taught their community how to do things, and then come together to sort out a model that holistically supports our women. Maybe give them the option to have a choice in what they want to know more about. It comes down to awareness I suppose’.

VACCHO’s response:

‘It is important that the advice given meets the cultural needs of those families. Like Aboriginal ways of Knowing, Being, and Doing- if you have Aboriginal families, you need to invest in building that knowledge, like ‘what can I have a conversation with the families about’, it’s about building that individual notion to building that conversation and that relationship piece further. It does mean that you will be asking different kind of questions. Like we have our SEW Wheel (Social and Emotional Wellbeing Wheel), so we ask questions such as, “am I connected to Country, am I connected to Kinship, am I connected to Land?”, and those types of things. But really it’s those elements around what contributes to our wellbeing, that doesn’t get asked in the MCH process, and never in any medical response or health response, or surveying, has anyone ever asked me about those sort of things. Like, “When is the last time you got to go to Country?”, or “When is the last time you got to be with an Elder?”, and those types of aspects for mum’s wellbeing. Particularly, with mum’s living off Country “When is the last time you have got home, to your immediate family?” There is lots of things the nurse can be doing to suss out that broader social and emotional wellbeing, rather than just the very clinical side of things’.

Indigenous Academic Consultant’s response:

‘That’s just about really being aware of the demographic of the people using Maternal and Child Health services, so the nurse can have cultural nuance about how to deliver effective cultural services to the whole demographic of their clients. That takes time to

source that information, but those things are very important to encourage effective engagement in services’.

Researcher:

‘Effective service was also clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites. One mother said that she attends the MCH service as she likes that

The MCH nurse works for my ACCHO [Aboriginal Community Controlled Health Organisation] and the council so I don’t have to tell my story twice.
(Participant A7)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO’s response:

‘I think probably with my experience in Melbourne, I was the once the liaison officer at the Mercy Hospital and on discharge, you know how you go to your local council for MCH, our women don’t go to their local council, we have our MCH nurse at the Victorian Aboriginal Health Service [VAHS]. So we would have to organise with in-home care for all the paperwork not to go to the local council, but to go to VAHS where the women attend to be seen. So that was a bit of a challenge at the start but that’s how usually the hospital knows now, that if there is an Aboriginal woman, they ask them if they want to go to their local council or do they want to go to the Victorian Aboriginal Health Service? That’s what they have learnt along the years. So what I saw in Melbourne, was the staff from the hospital built that relationship with the Victorian Aboriginal Health Service, and the midwives and MCH nurse that worked at VAHS, so it was a relationship that had all the bridges built. That’s what you want to see. They need to be given a choice of where they want to go! You need a choice of going to your local council or going to your ACCHO, or going to both and try them out and see what they prefer. It’s really important for us to have choice’.

VACCHO’s response:

‘In this one here, discharge from hospital, and connecting services is really critical- that is a really critical point in connecting to the MCH. Simplistic things like advising the mum that the MCH nurse is going to call, it’s not something that is a clear process for some of

the mums at times. MCH nurses starting their engagement with the woman before birthing would help that continuity. I note the site coordinator saying that, saying that if there is a KMS or a Aboriginal Liaison Officer at the maternity hospital, they need to make sure that the discharge services are linked up to MCH. If you have an ACCHO in your area, the hospital should really refer the mum to their Local Government and their ACCHO, so the woman has a choice of what service she wants to see at discharge. Sometimes a mum might want to see the MCH at the Local Government, but also connect to the services within their ACCHO. Like, I don't see a lot of Aboriginal mums linking into mainstream First Time Parent Groups, as there is often other services within the ACCHO that can complement the mainstream service. Often we are always so focused on the service system and how things are invested and those types of things, are aimed at fixing a problem as opposed to investing and celebrating success and just supporting families generally. Families may not be at risk, but they still could be potentially vulnerable, but often programs at birth are focused at the really hard stuff, so sometimes if you are thinking in participating in mum's groups or playgroups, or even parenting programs, its less celebrated than "oh, here is a family who has a number of risk factors so they can join family services so we can put a wrap around them", you know, that's a bit more of a negative stigma, as opposed to "yes, you have had a baby, having a baby is hard, so let's try and wrap services around you to support you".

Indigenous Academic Consultant's response:

'A digital record of a mother's experiences is something that might help in this situation, where she has control over who she might want to share it with'.

Researcher:

'However, another participant shared,

It would be good to have a Koori Health Care Worker work with the nurse, just to help the nurse understand me better. It's around having Aboriginal people work with the nurse so mob are happy to come in the front door and they are welcomed, listened to, and respected. (Participant A5)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'It's like I said before, Aboriginal health workers are the professional of their area, MCH nurses are the professional of MCH. It is my role in the KMS to hopefully fill that gap'.

VACCHO's response:

'I think that's a great idea, this will definitely help continuity and to build trust. If MCH nurses have an opportunity to have formal supervision or debrief sessions, that's the sort of things that can be discussed to help improve the service for Aboriginal families'.

Indigenous Academic Consultant's response:

'This is very powerful. It's not just about providing cultural safety, but about providing cultural experiences. That's a piece that's missing with Victorian Maternal and Child Health services, and the other thing that's missing is the mother crafting from Mothercraft Nurses to teach parenting to those families who's ability to parent has become totally disrupted from the impact of Stolen Generation. Consideration of how that could be adapted into the Maternal and Child Health service could be culturally very beneficial'.

Researcher:

'Another mother who engaged with the MCH service said,

Although I have got to know the nurse, it would have been good if I got to know her earlier like at women's group so she could meet pregnant mums there and build a relationship before the bub is born. (Participant B12)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'I think we have covered that'.

VACCHO's response:

'I think that's a great idea'.

Indigenous Academic Consultant's response:

'Encouraging roles such as the Mothercraft Nurse in the Maternal and Child Health service to work with the woman's extended family, such as the Indigenous toulers, the aunties, and the other support's in a woman's family will offset this experience that a woman might have with the Maternal and Child Health service. Building flexibility in services, having services close to a person's home as possible, those sort of things are really, really powerful to build relationships and trust'.

Researcher:

'Another mother using the MCH service supported this saying,

It would be good to see the MCH nurse when we mob are pregnant so the nurse can get to know us better and the Koori Maternity nurse can pass on their story before bub is born and shit happens! It's hard to stay on track with a newborn.
(Participant A10)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'The mums need to know that services, like the Maternal Child Health service, are there to help. They are not there to keep track of them, it's not about that, not about keeping tracks on people. They need to know that the MCH service is there to provide support to your child and the mum, and the dad's! The name Maternal and Child Health makes our men think it's secret women's business so they stay away. Change the name to Child and Family services or somethin like that and try and include the men better. Go and see the Elders, get the men's trust too'.

VACCHO's response:

'Yes, I agree with that. The earlier relationships are formed, the better. Continuity of care between `maternity services and maternal and child health services, and earlier engagement in MCH services by women would help the effectiveness of the service'.

Indigenous Academic Consultant's response:

'It is important for the Maternal and Child Health nurses to realise that Indigenous mothers are people in the first instance, they are cultural beings, and Maternal and Child Health nurses have roles and responsibilities to provide a service that nurtures these women. Getting to know them when they are pregnant would assist to build relationships with these women to do that'.

Researcher:

'A few participants stated that although they did engage in the service, the service could be made more effective if,

The nurse had more time, especially if I have had lots of problems to yarn about.
(Participant C14)

What are your perspectives, thoughts, or feelings in relation to this?'

ACCHO's response:

'These days women attending the MCH service feel like they are just a number but the MCH nurse has so much to cover at their appointment, especially if there are needles. They have to do that better, or they are not going to hear the women's stories. I don't know how that can be fixed easily. Some days the nurse would have time for a yarn, but most days they are under the pump, and that's unfortunately the way with many services these days. The way I see it, the yarning doesn't have to be through the MCH appointment, the MCH nurse can come along to our groups, to our events. It's really hard as the Maternal Child Health Nurse has a job to do, and she's seeing many children and families in a day, so sometimes it might look to our mob that they are like on a production line. But that's life. I think that's why the MCH nurses don't ask our mob about FV as they don't have the time to follow through with it! I can see both sides of the coin here. Some mothers will need more time, the health nurse doesn't have more time in her busy schedule. It is unfortunate, but that is the way it is. We can think about having an open day locally so the mums can come and have a yarn and the MCH nurse can join us'.

VACCHO's response:

‘Flexibility around the MCH model is imperative. There’s different ways of going about that, so you’ve got your informal aspects, and then you weave your formal aspects through the model, that’s really critical’.

Indigenous Academic Consultant's response:

‘Time is absolutely of the essence. Maybe Maternal and Child Health can use the ‘waiting time’ as more of a valuable experience, like visual or audio displays in the waiting room relevant to that appointment. Create a powerful cultural experience whilst they are waiting for their appointment to add holistic value to their consultation’.

Researcher:

‘Another mother attending MCH stated,

The age when my bub is due to see the nurse sometimes doesn’t suit me, but there’s not a lot of flexibility. I would like to see the nurse more when I need to, not just when she says my baby is due to come in. (Participant C11)

What are your perspectives, thoughts, or feelings in relation to this?’

ACCHO's response:

‘Like we said before, it would be good if the Maternal Child Health nurse could come to the mothers and the families and have a yarn, rather than the women and the families always having to come and see the nurse when the nurse needs them to come along. If the nurse could tell the mum why she needed to see them then, maybe then they would try and go. They need awareness. Also, if the nurse had an open door like every week so the mums can just drop in for a yarn, no needles or nothing like that, just a yarn, that would help’.

VACCHO's response:

‘I think I answered that in the previous question’.

Indigenous Academic Consultant's response:

‘Building flexibility in services, having services close to a person’s home as possible, those sort of things are really, really powerful to build relationships and trust and provide a service that is culturally competent and effective for that mother and her family’.

4.2.4.4 Summary of feedback from the mothers

Researcher:

‘Yarning with the mothers showed that some mothers go to see the doctor while others like to see the MCH nurse. What has been your observation? Can you shed any light on why this might be?’

ACCHO's response:

‘Maybe they get more respect from the doctor at the ACCHO, or it might be convenience. They also get the offer to be picked up and taken to see the doctor or the health service at the ACCHO. Sometimes the doctor has been there for a very long time and they have built that relationship and trust with that doctor. The doctor also gives them a \$40 voucher when they do their ATSI check, but that is only every 9-12 months, but even that doesn't get people there, because it's just something else they have to do. I think that financial incentives have helped engagement with the doctor at the ACCHO service rather than the MCH nurse at the local government for some individuals, but not the big group as a whole. I know when I worked at the Mercy Hospital, we had a little bit of funding from Closing the Gap and we used to assist the mothers to purchase things whether it be a cot or to buy a pram or a car seat, one of those three options, and they would have that given to them by the end of their second trimester so they got that all ready before baby comes. That was a little incentive for the women to attend their antenatal appointments. I think a community incentive for all families, Indigenous and non- Indigenous would work. Like if you attend all your Key Age and Stage visits, you get a proportion of your kinder fees off, or something like that, if they already get free Kinder’.

VACCHO's response:

‘Maybe the 712 Aboriginal Health checks might be meeting their needs, but also maybe they have had that shared care through pregnancy, and post pregnancy, and they have that relationship with the GP, and sometimes depending on the ACCHO service, there is a little bit of a holistic wrap around service that does have a bit of flexibility. You still have to have an appointment, but you might go and see your GP and then you might see your Aboriginal Health Worker, it's more of a service of interconnected touch points, rather than that one singular service that MCH provides. I would say that the preference for the mums to see the GP at the ACCHO rather than the nurse at council has a lot to do with the existing shared care arrangement, or continuity of care, during their pregnancy, and pre-pregnancy, but also that flexibility in the ACCHO service. There are also other supports that the ACCHOs provide, such as transport, and those types of things, and if you need medication from the doctor, and the doctor can do the check up on the baby, they may feel that this is more convenient for them. The MCH service then becomes irrelevant. I don't think a lot of families see the value of the MCH service. VACCHO can be part of the advocacy to encourage participation in MCH services but the mums don't know what they don't know, and yes, there is all of this stigma around the MCH service, but if it's not framed in the right way, or they don't understand the value of it, then they are going to say “I don't want to go”. If framed more positively, the mum might say, “this is actually very valuable for my baby or my child” rather than the deficit lens that the MCH service currently has, what's kind of not right, rather than celebrating what the baby IS doing. I don't know whether is the general model of check-points that drive this deficit model, something's right and something's not, but how you can frame that as a strengths base, and celebrate success is what's required to change this’.

Indigenous Academic Consultant's response:

‘The Maternal and Child Health service needs to be better at informing the non- informed consumer about the value of their services. That's about miscommunication. If a mother has low level of literacy and/or a high level of distrust, the Doctor's services in a culturally safe environment may be more suited to some of these women. Again, attending any services should be celebrated and services need to work together to ensure that they are meeting the client's needs’.

Researcher:

‘The issue of communication was raised during the interviews with the mothers. What has been your impression of communication with the mothers, such as the level or quality of the communication?’

ACCHO’s response:

‘It’s just like with everything, the tone you use, facial expressions, you don’t realise sometimes that you are doing a judging look at someone, and they do pick it up. I do hear a lot of the time, Aboriginal Health Workers of course they hear a lot, see a lot, and I know mainstream get a story made about that they don’t make a lot of eye contact, and that’s probably more the top end [of Australia], whereas here, if someone doesn’t look at an Aboriginal with eye contact we think, gosh they are rude! Yes it’s what you have been brought up with, some Elders have taught their people not to look in the eye of a white person, but that’s more top end stuff, but for us mob down here in Victoria, if you are not lookin at us in the eye, you are not listening to what we are saying!’

VACCHO’s response:

‘I think we have covered that earlier’.

Indigenous Academic Consultant’s response:

‘Again, it really depends on the competency of the client, if the mother has a low level of literacy, and a high level of distrust then their whole system will be out of play and they might not be able to hear things correctly, or there might be trauma that does not allow them to listen deeply during the consultation. Giving people culturally appropriate information prior to the consultation, and things they can take home to reflect after the consultation would be very valuable. Access to appropriate information outside the clinic will really help these women, so that is where continuity of services will increase the effectiveness of Maternal and Child Health services’.

Researcher:

‘I am very aware that trust and safety are important factors with the mothers and this came through in the interviews. I would like to hear your views regarding these issues. What is your perception about what some of the mothers shared?’

ACCHO’s response:

‘I think we have covered this in earlier’.

VACCHO’s response:

‘I agree with at statement around trust and safety, and I think the critical part to that is around the time to build that trust, and all the other aspects that we have spoken about today, cascade into that- how do we communicate? How do we remove the stigma? How do we build the competency of the MCH nurse? It’s that system reform that we talk about, and that then that will improve the safety and the trust so it’s all of those elements that build into that. I think the important part that I want to share as a last reflection of that, is that MCH need to look at the shift and the change in its entirety, as if we look at cultural reform process, if people pick up bits and pieces of it, and hope for a holistic change, like they might go “the recommendations are you need to communicate better, you need to provide culturally appropriate communication tools, culturally appropriate services, safe environments, quality trained staff, etc. etc.”, and then you see all of the recommendations and you say “ok, I will do 1, 2 and 3 and will hope that’s enough for systems change and it will all kind of flow”, and I see that so often, but in order to have trust and safety, you need to do the recommendations in its entirety. It doesn’t mean you can’t do this in a stage approach, because you can’t necessarily do everything at once, but you have to do it all. You have to work on the people, and you have to work on the structures at the same time. You can’t do one or the other’.

Indigenous Academic Consultant’s response:

‘Trust and safely are key to our women engaging in any services. Services have to be culturally competent for women to feel safe, which means they have to have good communication, trust, and recognise the social determinants of health’.

4.3 Summary of results of Study One

This study operates by combining elements of the current Victorian MCH service that are not effectively engaging First Nations families, and a concept that does, into a plotted story. This chapter presents the findings of the face-to-face, in-depth semi-structured discussion ('yarning'), with the First Nations women and the insight and deduction of the data from members of the researcher's Indigenous Advisory Team. Coded analysis of the individual pieces of data from the three unique sub-categories of participants, as defined by their level of engagement in MCH services, were analysed. These three levels of engagement include current engagement; initial engagement, now disengagement; and no engagement in the MCH service in the Glenelg Shire, Victoria, Australia. Coded analysis of the individual pieces of data were analysed into themes and sub-themes to represent the over-arching narrative within the data to help answer the research questions as to why First Nations women choose/not choose to attend MCH services? What do First Nations women find valuable or unhelpful about the MCH service they receive? What improvements could be made to MCH services for First Nations families? What barriers do First Nations women with children birth to five years of age have to access and engagement in MCH services?

The researcher's summary of the data into themes from the sub-category 'factors contributing to First Nations women never engaged in the MCH service', included 'intercultural incompetence' and 'ineffective service'. 'Intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting two concurrent narratives in Portland (Site A+B), and three concurrent narratives in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'mistrust' and 'miscommunication' in Site A+B and 'mistrust', 'miscommunication', and 'not recognising the Social Determinates of Health' in Site C. The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data also presenting two concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C). These concurrent narratives were organised into separate sub-themes, namely 'untimely and/or inappropriate' and 'inflexible in approach' in Site A+B, and 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care', and 'not holistic' in Site C.

Similarly, to the responses from 'First Nations women who had never engaged in the MCH service', the coded data of the responses contributing to 'First Nations women disengaged in the MCH service' produced a clear picture of the dataset of factors. The theme 'intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same three concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'mistrust', 'miscommunication', and 'not recognising the Social Determinates of Health'. The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same four concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care', and 'not holistic'.

The interpretation of the data in the category of 'First Nations women currently engaged in the MCH service', was more complex in comparison to the interpretation of aggregated meaning across the rest of the dataset, as some themes and sub-themes were both enablers and barriers to access and engagement in the MCH service. Similarly, to the responses from First Nations women who had never engaged or disengaged in the MCH service, the theme 'intercultural competence/incompetence' was clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same three concurrent narratives in Portland (Site A+B), and in Heywood (Site C) as factors which enabled access and engagement, and two concurrent narratives in Portland (Site A+B), and in Heywood (Site C) as factors which were barriers to access and engagement in the MCH service. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in all three sites were 'trust', 'communication', and 'recognises the Social Determinates of Health'. The concurrent narratives constructed as separate sub-themes which represented barriers to access and engagement in all three sites were 'miscommunication' and 'not recognising the Social Determinates of Health'. The theme 'effective/ineffective service' was also clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites. Constituent coded data presented three concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C) as factors which enabled access and engagement, and five concurrent narratives, common to

all three sites, as factors which were barriers to access and engagement in the MCH service. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Portland (Site A+B) were ‘timely and appropriate’, ‘flexible in approach’, and ‘holistic’. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Heywood (Site C) were namely ‘timely and appropriate’, ‘flexible in approach’, ‘continuity of care’, and ‘holistic’. The theme ‘ineffective service’ was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent coded data presenting the same four concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely ‘untimely and/or inappropriate’, ‘inflexible in approach’, ‘poor continuity of care’, and ‘not holistic’

The researcher then conducted face-to-face, in-depth semi-structured discussion (‘yarning’), with some of the members of the researcher’s Indigenous Advisory Team, including the ACCHO site coordinators who assisted the researcher with recruitment and data collection, the Executive Director of Social and Emotional Wellbeing at VACCHO, and an Indigenous academic consultant, to gain a deeper, comprehensive understanding of First Nations women’s access and engagement in MCH services and ensure reliability of the researcher’s interpretation of the data and cultural sensitivity. These members validated the themes and subthemes generated by the researcher from all three unique sub-categories of participants, as defined by their level of engagement in MCH services. The researcher believed that this procedure would help to ensure procedural and interpretative rigour, and gain a deeper, comprehensive understanding of Aboriginal women’s access and engagement in Maternal and Child Health services. This collaborative process of creating knowledge, is fundamental to the Indigenous philosophy ‘Dadirri’.

Study Two, outlined in the next chapter, aimed to further explore the ‘mistrust’ and ‘fear’ of the MCH service identified in Study One as a barrier to access and engagement of First Nations women. The researcher believes that an understanding of these factors will support advocacy for policy development, and integrate the principles of trauma- and violence-informed care into their practice to increase the physical, emotional, and cultural safety experienced by First Nations women.

Chapter 5: Study Two: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services

5.1 Introduction to Study Two

This chapter presents the findings of the research output in Study Two, and forms part of the storyline shown in Figure 1.2. ‘Improving the engagement of First Nations families in maternal and child health services by understanding the issues around barriers to access and engagement’. The research in Study Two aims to further explore the barriers, identified in Study One that First Nations women with children birth to five years of age have to access and engagement in the MCH service. The researcher believes that an understanding of these factors will support advocacy for policy development, and integrate the principles of trauma- and violence-informed care into their practice to increase the physical, emotional, and cultural safety experienced by First Nations women.

To achieve the aims and objectives of the research, the researcher interviewed the same sample of First Nations women with children aged from birth to five years recruited in Study One to ask what barriers First Nations women with children aged from birth to five years have to access and engagement in MCH services in the Glenelg Shire, Victoria, Australia. Coded analysis of the individual pieces of data were analysed into themes and sub-themes to represent the over-arching narrative within the data to help answer the research questions(s) (Braun and Clarke, 2021). The researcher sought further insight and deduction from key members of the researchers Indigenous Advisory Committee from ACCHO/VACCHO/and an Indigenous academic consultant regarding the significance of some of the data collected from the women. The researcher believed that this procedure would help to ensure procedural and interpretative rigour, and gain a deeper, comprehensive understanding of Aboriginal women’s access and engagement in Maternal and Child Health services. The women’s responses were then compared to data from MCH nurses working in the Glenelg Shire, Victoria, Australia, to investigate MCH nurses’ perceptions of the barriers First Nations women with children aged birth to five years have accessing and engaging in MCH services. From the 10 MCH nurses eligible to participate in the study, 10 consented to participate. This sample size represented 100% of

this specific population group, and was largely determined by the number of respondents available to participate in the study.

5.2 Results of Study Two

5.2.1 The barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia

Researcher:

‘Despite the aims of universal service provision, some harder to reach groups, such as Indigenous and culturally and linguistically diverse communities, do not access services. To help me understand this statistic, could you please tell me your perception or experience of the factors that contribute to the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia?’

All MCH nurses answered this question (n = 10, 100%), but despite encouragement from the site coordinator, not all of the Aboriginal women chose to (n = 12, 34.3%). From the responses shown in Figure 5.1, it was evident that half of the MCH nurses perceived that contributing factors that influence the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire were the woman’s fear of the service (n = 5, 50.0%). Two nurses (n = 2, 20.0%) stated that they believed socioeconomic factors, such as education, employment, finances, money and poverty influence the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire. The remaining MCH nurses perceived that family reasons (n = 1, 10.0%), which included the woman’s partner, family, baby, gender and relationships; history (n = 1, 10.0%), which referred to a history of disengagement in services to the extent that it had become an accepted and normalised; and stress/mental health (n = 1, 10.0%), were contributing factors. In contrast, the majority of the Aboriginal women (n= 20, 57.1%) said that an Indigenous woman’s ‘low self-esteem’ was the main contributing factor that influences the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire. Other factors, shown in Figure 5.1, were ‘lack of belonging’ (n=9, 25.7%) and ‘not being heard’ (n=6, 17.2%).

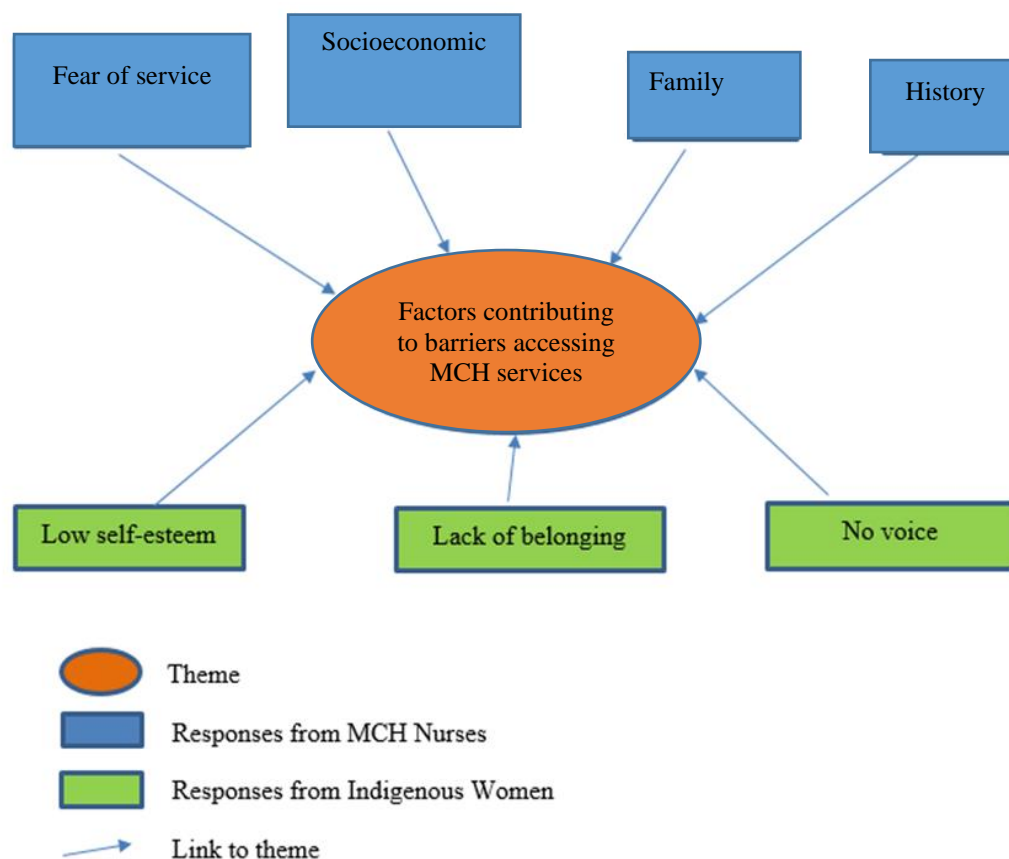


Figure 5.1. Factors contributing to barriers accessing MCH services

The MCH nurses perception of factors that influence the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia, were in stark contrast to the experiences of the Indigenous women who participated in the yarning. The low response rate to this question by the Indigenous women (only one third of the women felt confident to provide an answer), is a conspicuous finding in this research, as over half of the women who did respond cited their poor self-esteem as a major factor contributing to accessing MCH services. Lack of insight by the MCH nurse of factors contributing to access for Indigenous women with children aged birth to five years in their services, and the resistance of these women to discuss this with the MCH nurse, will inevitably lead to poor access and engagement.

5.2.2 Factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia

Researcher:

‘Reported statistics in the Glenelg Shire illustrate that there is a higher percentage of non-engagement of Indigenous women with children aged birth to five years in MCH services in comparison to non-Indigenous women. To help me understand this statistic, could you please tell me your perception or experience of the factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia?’

All participants answered this question. From the responses (see Figure 5.2), a little less than half of the MCH nurses perceived that a contributing factor was ‘acceptance’ (n = 4, 40.0%), which was related to the belief that MCH nurses felt that poor engagement in mainstream services, or non-Indigenous controlled health organisations, was perceived as being ‘normal’ in Aboriginal culture. Other nurses perceived that factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia, was fear (n = 3, 30.0%) and cultural beliefs (n = 2, 20.0%). Fear referred to the fear these families felt towards DHHS, Child Protection and anyone in perceived ‘authority’, including MCH nurses. One nurse perceived that mistrust of the relation to their partner, authorities (such as child protection agencies, including MCH services), community and family.

Many participants agreed they were ‘scared of child protection’, one participant saying that,

We are scared to get the fathers in trouble and that our children will be taken away. (Participant PB10)

Poor rapport/not having developed a relationship with the MCH nurse was cited as a factor that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in 11.4 % (n = 4) of the responses. One participant disclosed,

Mob do not like the authoritative tone when you speak to us. I felt judged so I didn't talk. (Participant PA3)

Another participant said,

As an Aboriginal woman, people think the worst straight away. (Participant PA2)

A little less than 10% of the Aboriginal women cited mistrust of the MCH nurse (n=3, 8.6%) as a contributing factor, one participant stating,

Mob needs safety to tell her story, the trust isn't there. (Participant PA4)

Another participant said,

Maternal and Child Health Nurses in Victoria are mandated to report risk to our children, so why would we attend? (Participant PC3)

One mother stated,

I didn't feel that my story was being heard so I didn't trust the nurse. (Participant PB6)

Another mother said that a contributing factor for her was shame (n = 1, 2.9%), which was about fear of judgement by the MCH nurse, embarrassment and poor self-esteem. This participant disclosed,

I don't want the nurse to judge me and see me differently if I tell her my stories. (Participant PB5)

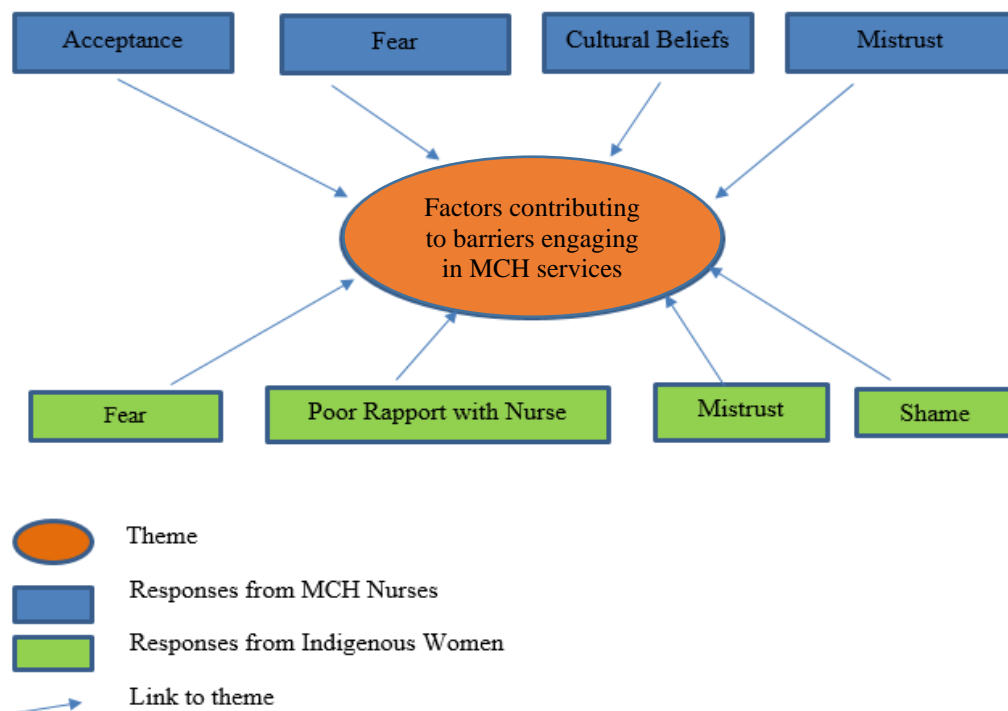


Figure 5.2. Factors contributing to barriers engaging in MCH services

The responses from the Indigenous women and the MCH nurses to factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, were more comparable in this question. The nurses accurately predicted the ‘fear’ and ‘mistrust’ that many Indigenous women feel towards MCH nurses and their services as significant factors, but the MCH nurses did not identify that the strength of the woman’s relationship with them was a significant factor for the woman to engage in MCH services. Better understanding of localised Indigenous culture by the MCH nurse, and improving the continuity of care between services the mother is engaged in MCH services, were factors that facilitated the breakdown of barriers to engaging in MCH services.

Coded data of the responses from the questions produced a coherent and lucid picture of the difference in responses between the MCH nurses and the Indigenous women to represent the over-arching narrative within the data to help answer the research questions (see Figure 5.3).

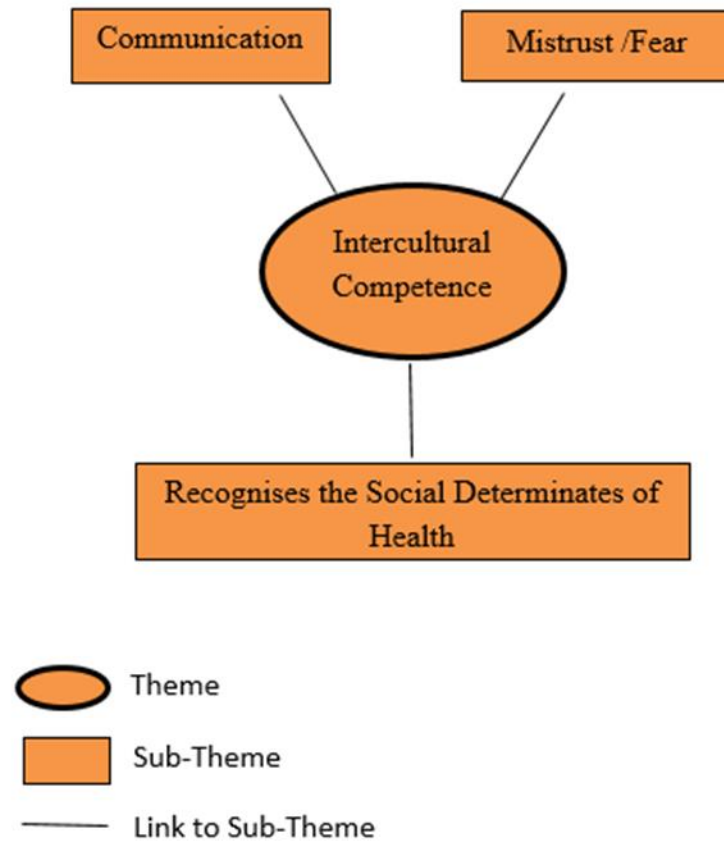


Figure 5.3. Finalised thematic framework map

Constituent data, presenting the same three concurrent narratives, was evident in Portland (Site A+B), and in Heywood (Site C). ‘Intercultural competence’ was clearly definable as a theme for the contrast in responses between the MCH nurses and the Aboriginal women in all three sites, depicting the Indigenous mothers’ experience with discrimination and judgment as barriers to access MCH services. Intercultural competence refers to ‘the ability to demonstrate targeted knowledge, skills and attitudes that lead to effective and appropriate communication with people of other cultures’ (Lee, 2020, p. 261). The prefix ‘inter’ indicates the two-way interaction between individuals from two different cultures (Lee, 2020). Concurrent narratives were constructed as separate sub-themes, namely ‘Mistrust or Fear’, ‘Communication’, and ‘Recognises the Social Determinates of Health’, as common factors around barriers to access and engagement of First Nations families in maternal and child health services.

5.3 Summary of results of Study Two

The MCH nurses perception of factors that influence the barriers First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia, were in stark contrast to the experiences of the Indigenous women who participated in the yarning. The low response rate to this question by the Indigenous women (only one third of the women felt confident to provide an answer), is a conspicuous finding in this research, as over half of the women who did respond cited their poor self-esteem as a major factor contributing to accessing MCH services. Lack of insight by the MCH nurse of factors contributing to access for Indigenous women with children aged birth to five years in their services, and the resistance of these women to discuss this with the MCH nurse, will inevitably lead to poor access and engagement.

The responses from the Indigenous women and the MCH nurses to factors that contribute to the barriers First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, were more comparable in this question. The nurses accurately predicted the ‘fear’ and ‘mistrust’ that many Indigenous women feel towards MCH nurses and their services as significant factors, but the MCH nurses did not identify that the strength of the woman’s relationship with them was a significant factor for the woman to engage in MCH services. Better understanding of localised Indigenous culture by the MCH nurse, and improving the continuity of care between services the mother is engaged in MCH services, were factors that facilitated the breakdown of barriers to engaging in MCH services.

The impacts of colonisation have created a distrust of government agencies and those associations contribute to ongoing dilemmas in Australia’s First Nations peoples’ health (Kelly & Luxford, 2007). Over the past decade, governments have attempted to improve outcomes for First Nations families by implementing measures under the ‘Closing the Gap’ framework (State of Victoria, 2016a). Despite this impetus, some of these families do not engage with services (Yelland, 2016), or do not sustain visits (Riggs et al., 2012), and families experiencing economic and social disadvantages are less inclined to access services (Eapen et al., 2017). Figures show that almost fifty per cent of Aboriginal and Torres Strait Islander children in Victoria are identified as experiencing risk of child abuse or neglect, which is twice that of non-Aboriginal and Torres Strait Islander children (ABS, 2021).

Participation in the MCH service enables the opportunity to prevent, identify, and respond to the challenges faced by families with children aged birth to five years (Shonkoff & Phillips, 2000; Shonkoff et al., 2009). It is therefore crucial that healthcare service models, like the MCH Service, promotes and supports access and engagement of all families. It is also critical that the service providers, in this case MCH nurses, have an understanding of the barriers to access and engagement in their services, to improve participation in these services.

Study Three, outlined in the next chapter, presents the evaluation of a program review of the Early Assessment Referral Links (EARL) concept, developed by the researcher prior to the candidature of this thesis, which aims to improve access and engagement of First Nations women and their children in MCH services. The results of the evaluation of the pilot of this concept through a program logic model, and discussion of the development of a new conceptual universal MCH model of care to improve the identification and engagement of families with children from conception through to five years of age at risk of vulnerability to child abuse or neglect through a transdisciplinary approach, forms part of this thesis.

Chapter 6: Study Three: The Storyline to Access and Engagement of First Nations Women in Maternal and Child Health Services

6.1 Introduction to Study Three

This chapter presents the findings of the research output in Study Three, and forms part of the storyline shown in Figure 1.2. ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’. The published manuscript ‘Improving the engagement of Aboriginal families with maternal and child health services: a new model of care’ (<https://doi.org/10.17061/phrp30232009>) is included in Appendix Fifteen. Study Three presents the evaluation of a program review of the Early Assessment Referral Links (EARL) concept, developed by the researcher prior to the candidature of this thesis, which aims to improve access and engagement of First Nations women and their children in MCH services. The evaluation of the pilot of this concept through a program logic model, outlined in Figure 3.2, forms part of this thesis.

Formation of the EARL concept, piloted from 1 July 2009 to 30 June 2014, also employed stratified purposeful sampling of three unique data sources. In a process undertaken prior to the candidature of this thesis, the researcher approached all service providers working with children from birth to five years of age residing in the Glenelg Shire in 2011 to become stakeholders for the EARL pilot. From the 38 stakeholders eligible to participate in the pilot, 38 consented to participate, and reflected the diverse cross-section of organisations and multidisciplinary health professionals providing early years care that were involved in the delivery of, and referral to, MCH services in the Glenelg Shire. This sample size represented 100% of this specific population group, and was largely determined by the number of respondents available to participate in the pilot. As there were 17 stakeholders based in Portland, 12 stakeholders in Heywood and 9 stakeholders in Casterton, the EARL meetings with the stakeholders were held in all three sites, which optimised coverage of the whole Glenelg Shire. EARL was established in Portland and Heywood in March 2011, and Casterton in April 2013.

In the second stratified purposeful sampling, all First Nations women with children aged birth to five years living in the Glenelg Shire were approached by the EARL stakeholders to participate in the pilot. From the 52 First Nations families eligible to participate in the

pilot, 52 consented to participate. This sample size represented 100% of this specific population group, and was largely determined by the number of respondents available to participate in the study. This sample size increased to 56 in 2013 when EARL was established in Casterton. From the 4 First Nations families eligible to participate in the study, 4 consented to participate. This sample size represented 100% of this specific population group, and was largely determined by the number of respondents available to participate in the pilot.

In the third stratified purposeful sampling, an invitation to participate in the post-pilot survey was distributed in 2014 to those EARL stakeholders who had participated in the full pilot period, 1 July 2009 to 30 June 2014, to ask stakeholders to identify strengths and weaknesses of the model, how could it be improved, and for any other comments. From the 13 stakeholders eligible to participate in the study, 13 consented to participate. The results from each of the questions in the survey were evaluated by the researcher during the period of candidature of this thesis.

Development of EARL involved the core principles of narrative inquiry, integrated with the Indigenous philosophy 'Dadirri', to change existing patterns of conversation and give voice to new and diverse perspectives. A program logic model was used to support a systematic and integrated approach to planning, implementation and evaluation. Outcome measures used to evaluate the EARL concept include stakeholder meetings data, numbers of referrals, and participation rates of women and children in MCH services, and specific health outcomes that could be influenced by the concept. As the sample size of First Nations families participating in the pilot represented 100% of this specific population group, these outcome measures were compared to the measures in the year pre and post the pilot, and comparison to similar data of First Nations families in the State of Victoria, Australia, during the pilot period.

6.2 Results of Study Three

The Early Assessment Referral Links (EARL) conceptual service model was piloted in Portland, Victoria, Australia from 2009-2014. During that time, there were 51 (85%) stakeholder monthly meetings and 9 months when no meeting was held. There were 17 stakeholders in Portland and an average stakeholder meeting attendance rate of 76 percent. Heywood was operational for 3.3 years. During this period, there were 36 (90%)

monthly meetings and 4 months when no meeting was held. There were 12 stakeholders in Heywood and average stakeholder meeting attendance rate was 67 percent. Casterton operated for 2.25 years. During this time, there were 16 (59%) monthly meetings and 11 months when no meeting was held. This site involved nine stakeholders but only five (56%) regularly attended (the lowest attendance and lowest number of meetings of the three sites).

All First Nations families with children birth-five years of age living in the Glenelg Shire during the pilot period who were approached by stakeholders to participate in the EARL pilot did so (2011: $n = 52$, 2013: $n = 56$). All families were of Aboriginal descent. Data from the pilot shows there were a number of Aboriginal families referred to multiple EARL stakeholders, facilitating continuity of care. Among all women participants ($n = 30$), the highest proportion of women were referred to Aboriginal services, such as the ACCHOs ($n = 27$, 90%), Koori Maternity Services ($n = 29$, 97%) and Koori Education Support Services ($n = 21$, 70%). Almost half the women participating in the pilot were also referred to mainstream services providing maternity care ($n = 14$, 47%) and women were also referred to parent support ($n = 12$, 40%) and allied health services ($n = 14$, 47%), including counselling, diabetes educator, dietitian, drugs and alcohol services, early intervention, chronic disease services, exercise physiologist, occupational therapy, podiatry, speech pathology and youth worker. This indicates that women's needs were likely to be identified and met by the EARL concept of care.

During the pilot of the EARL concept, participation rates of Aboriginal children in the MCH service rose to rates above the state average. Before the pilot began, the MCH participation rate for Aboriginal children in Glenelg Shire (54%) was below the state average of 57 percent. By the second year of operation the participation rate was at its highest (89%), and the state average was at its lowest (50%) of the pilot period. The EARL participation rates continued to be higher than the state rate, even after the pilot had finished (see Table 6.1). After an initial increase to 89 percent, participation rates decreased over the subsequent years the pilot was running.

Table 6.1. Participation rates of Aboriginal children birth–5 years of age in maternal and child health services in Glenelg Shire, Victoria, Australia

Aboriginal children	2008-09	2009-10 ^a	2010-11 ^a	2011-12 ^a	2012-13 ^a	2013-14 ^a	2014-15
Children 0–5 years, Glenelg Shire (<i>n</i>)	29	26	47	59	57	61	65
Participation rate children 0–5 years, Glenelg Shire MCH service (%)	53.7	81.3	88.7	85.5	72.2	73.5	62.5
Participation rate: children 0–5 years, State of Victoria MCH service (%)	56.7	60.1	50	59.8	55.1	53.9	55.5

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health Services annual reports (Sharp, Dewar & Barrie, 2016; DET, 2010, 2011, 2012, 2013, 2014, 2015, 2016; DEECD, 2010a; DEECD, 2009a; DEECD, 2009b; DEECD, 2009c).

In conjunction with higher participation rates, the referral of Aboriginal children to EARL stakeholders increased during the pilot period. The highest number of referrals were to nursery equipment (*n* = 56) and the Dolly Parton Imagination Library (*n* = 56) programs, which was 100 percent of all children in the pilot (DHHS, 2019; United Way Glenelg, n.d.; DEECD, 2011b). Additionally, nearly all children in the pilot were referred to allied health programs (*n* = 48, 86%), such as dietetics, speech pathology, dentistry, ophthalmology, physiotherapy and audiology. More than one-third of the children in the pilot were referred to a supported playgroup (*n* = 21, 38%) – a favourable statistic considering there was only one supported playgroup in the Glenelg Shire.

Early Start Kindergarten provides up to 15 hours per week of free or low-cost kindergarten to eligible children aged 3 years, including Aboriginal children or those who have had contact with child protection services (Victoria State Government, 2017). During the EARL pilot, there was a 100 percent participation rate of eligible Aboriginal children in Early Start Kindergarten, all of whom were identified and referred to the program by EARL stakeholders (overall state enrolments to Early Start Kindergarten ranged from 33–51 percent during the same period).

There is strong evidence that breastfeeding gives babies the best start for a healthy life and has health and wellbeing benefits for both the mother and child (de Jager, Skouteris, Broadbent, Amir & Mellor, 2013; Forster et al., 2004; NHMRC, 2012). During the EARL pilot, there was an increase in the percentage of Aboriginal mothers initiating breastfeeding from 67 percent before the pilot to 100 percent 3 years into the pilot, and breastfeeding rates at 6 months increased from 17 percent before the pilot to 76 percent 3 years into the pilot (Table 6.2). Even after the pilot this rate remained high at 54 percent, with the national rates for initiating breastfeeding are around 96 percent, which fall dramatically to around 9 percent at six months duration (Forster et al., 2004; NHMRC, 2012).

Table 6.2. Breast feeding rates of mothers of Aboriginal children participating in the EARL pilot, Glenelg Shire, Victoria, Australia

Aboriginal children	2008-09	2009-10^a	2010-11^a	2011-12^a	2012-13^a	2013-14^a	2014-15
Births (<i>n</i>)	6	19	22	17	17	12	24
Breastfed at birth (%)	67	89	95	100	94	92	84
Breastfed at 2 weeks (%)	50	84	86	100	88	92	79
Breastfed at 3 months (%)	33	79	81	88	82	83	63
Breastfed at 6 months (%)	17	63	64	76	71	67	54

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health services annual reports (DET, 2010, 2011, 2012, 2013, 2014, 2015, 2016; DEECD, 2010; DEECD, 2009c).

Studies show that immunisation is the most effective way of protecting children against previously common life-threatening infections (Hull, Deeks & McIntyre, 2009; Pearce, Marshall, Bedford & Lynch, 2015). During the EARL pilot period, there was an increase in the percentage of Aboriginal children fully immunised in the Glenelg Shire from 84 percent before the pilot to 97 percent by the fourth year into the pilot (state immunisation rates in the same period were 85 percent and 90 percent respectively) (Table 6.3).

Although a moderate increase, the Glenelg Shire consistently achieved higher rates of immunisation compared with those across the state.

Table 6.3. Immunisation rates of Aboriginal children participating in the EARL pilot

Aboriginal children	2008-09	2009-10^a	2010-11^a	2011-12^a	2012-13^a	2013-14^a	2014-15
Births: Glenelg Shire (n)	6	19	22	17	17	12	24
Fully immunised 0–5 year olds: Glenelg Shire (%)	83.57	86.75	91.67	88.50	97.44	94.87	83.57
Fully immunised 0–5 year olds: state of Victoria (%)	84.98	85.94	87.64	87.63	90.14	90.05	89.28

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health services annual reports (DET, 2010, 2011, 2012, 2013, 2014, 2015, 2016; DEECD, 2010; DEECD, 2009c)

FV significantly affects the way a woman raises her child, which ultimately affects the child's development (Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 2001; McCloskey, Figueredo & Koss, 1995). In the first year of the EARL pilot, there was a dramatic increase in the number of Aboriginal mothers/families referred to services to assist with FV, from zero referrals before the pilot to 15 referrals within a year (DEECD, 2010). DET data were not available to ascertain referral rates for the rest of the pilot period. Child protection services are provided by the DHHS and aim to ensure children and young people receive services to deal with the impact of abuse and neglect on their wellbeing and development (Bromfield & Holzer, 2008).

There was an increase in referrals of Aboriginal children residing in Glenelg Shire to child protection services, from three referrals in 2008, the year prior to the EARL pilot, to 27 in the first year of the pilot. This trend remained the year after the pilot was complete, indicating the extent of referrals through EARL.

OoHC services look after children and young people in cases of family conflict or if there is a significant risk of harm or abuse in the family home (Victoria State Government,

2017). After a small initial increase, there was a substantial decrease in the number of episodes of OoHC for Aboriginal children 0–6 years in Glenelg Shire during the EARL pilot period – from 38 percent of Aboriginal children 0–5 years in the shire being in OoHC in the year before the pilot to 4.54 percent in the second year of operation. This compared with a national rate of Aboriginal children in OoHC of 5.17 percent (AIHW, 2013, 2018).

This evaluation was undertaken using a survey with Questions 1 to 6 on a five-point Likert scale (1 = always, 2= usually, 3 = sometimes, 4 = rarely, 5 = never). The addition of ‘never’ was considered an important category to add to provide this option as a response. An open-ended question at the end of the Likert scale asked stakeholders to provide a comment on their response. Questions 7 to 10 were open-ended questions, which asked stakeholders to identify strengths and weaknesses of the model, how could it be improved and for any other comments. No demographic data were collected due to the potentially identifiable nature of these stakeholders. Stakeholders consisted of multiple service providers, including representatives from maternity services, allied health, ACCHOS, DET services, DHHS services and local government services. Some of these stakeholders also identified as Aboriginal and MCH nurses themselves. Surveys were distributed to those EARL stakeholders who had been involved in the pilot and were contactable (n=13) and 13 responded, which was a response rate of 100 per cent. The results from each of the questions in the survey were evaluated by the researcher.

Difficulties in engaging with families

This question asked stakeholders if they or their organisation experienced any difficulty engaging the families with Aboriginal children at risk of vulnerability of child abuse or neglect from birth to 5 years of age. As can be observed from Table 6.4, stakeholders responded that on the whole they ‘sometimes’ (54%) had difficulty engaging with these families. With the next largest response being ‘usually had difficulty’ (38%). There were no stakeholders who identified that there was ‘never’ any difficulty engaging with the families at risk of vulnerability, which is not a surprising response.

Table 6.4. EARL stakeholder level of difficulty engaging families of Aboriginal children at risk of vulnerability from birth to five years of age

Answer choices	Responses n	Responses %
Always	1	7.69
Usually	5	38.46
Sometimes	7	53.85
Rarely	0	0
Never	0	0
Total	13	100

Only nine stakeholders provided an explanation for their responses to this question (69%). Using qualitative narrative analysis, these can be grouped into five categories. Direct quotes are included, which are written in italics. First was the difficulty to engage with these families due to their individual circumstances, such as the prevalence of poor social and health circumstances, including ‘frequent change of accommodation’. This also meant that it was difficult for stakeholders to reach all sectors of the community under these circumstances. Unfortunately, stakeholders believed that some families were either ‘sceptical of the program’ or did not consider it to be important. Interestingly, it was reflected by a stakeholder that they believed that if they were able to ‘connect with the families early’ on, for instance before or at birth, they believed that they could build a relationship and facilitate engagement. Finally, some families already had a Koori health worker and did not want or need to be involved with EARL, which indicates that there are still issues that need to be overcome for families and that maybe earlier engagement may help facilitate these.

Ability to improve the identification of risk

This question asked stakeholders whether the EARL concept of care improved the identification of risk of vulnerability earlier than the current Universal MCH service models. Table 3.5 illustrates that stakeholders believed that EARL ‘usually’ improved the identification of risk earlier (77%) and 24 per cent of stakeholders believed that the EARL concept ‘always’ identified these families earlier. There were no stakeholders that believed the model ‘never’, ‘rarely’ or ‘sometimes’ was able to identify families at risk

better than the current Universal MCH service model. These results indicate that the EARL concept was able to identify risk of vulnerability more effectively than the current MCH service.

Table 6.5. The ability of the EARL concept to improve the identification of risk of vulnerability from birth to five years of age

Answer choices	Responses n	Responses %
Always	3	23.08
Usually	10	76.92
Sometimes	0	0.00
Rarely	0	0.00
Never	0	0.00
TOTAL	13	100

Seven (54%) stakeholders provided a comment to this question. These can be categorised into two broad responses using qualitative narrative inquiry. Generally, stakeholders believed that because EARL included a wide range of appropriate cross disciplinary service providers and were linked to others, including midwives, ‘facilitated easier early identification and engagement of these families’. In addition, this team of service providers ‘worked collaboratively together’ to support the needs of families in their care. These factors increased the engagement with this population and hence the identification of risk factors.

Ability to provide smoother transition through the Early Years

The next question asked EARL stakeholders whether the concept of care enabled smoother transition of children through the life stages of the early years—antenatal, infancy, preschool and school. Their responses are outlined in Table 6.6 which demonstrates that 77 per cent of stakeholders believed that this was ‘usually’ the case and 23 per cent responded that this was ‘always’ so. No stakeholders responded as ‘never’, ‘rarely’ or ‘sometimes’. These results indicate that the aim of this concept was achieved.

Table 6.6. The ability of the EARL concept to enable smoother transition of children through the life stages of the Early Years

Answer choices	Responses n	Responses %
Always	3	23.08
Usually	10	76.92
Sometimes	0	0.00
Rarely	0	0.00
Never	0	0.00
Total	13	100

In relation to the open-ended responses to this question, six (46%) stakeholders provided a reason for their answer. Using qualitative narrative content analysis, these can be categorised into three reasons. First, stakeholders believed that the EARL concept was about ‘building an early relationship of trust with these families and the earlier that this happened then the stronger was the possibility of improving outcomes’ for these vulnerable families and their children. Importantly, stakeholders believed that this relationship also ‘equipped parents with helpful skills’ to enable a smoother transition to happen. This result was achieved through the model because the service providers were ‘working and communicating together’ to support these families. These results indicate again that the aim of the EARL concept have been met as the concept had successfully engaged these families and improved MCH services.

Ability to improve outcomes of those families that engaged

In this question, stakeholders were asked whether the EARL concept of care improved the outcomes of Aboriginal children aged 0–6 years and/or their families that engaged in the pilot through their organisation. From their responses, which are presented in Table 6.7, it was evident that the majority of stakeholders believed that the EARL concept ‘usually’ (69%) improved outcomes, with 23 per cent believing the concept always did. However, not all stakeholders were as confident, with 8 per cent believing this was only ‘sometimes’ the case. This could reflect the fact that it was not always clear to determine the outcome because this can sometimes take some time to occur. Further, feedback about these outcomes may not necessarily filter back to stakeholders due to referrals elsewhere.

At least there were no stakeholders that believed that there were ‘never’ or ‘rarely’ any improvement in outcomes, though this could reflect their positive commitment to the EARL concept of care.

Table 6.7. The ability of the EARL concept to improve the outcomes of children from birth to five years of age

Answer choices	Responses n	Responses %
Always	3	23.08
Usually	9	69.23
Sometimes	1	7.69
Rarely	0	0.00
Never	0	0.00
Total	13	100

From the 46 per cent of stakeholders who provided a written response to this question, it was evident that the majority believed that for those that were engaged with the service, EARL helped many families. This help occurred because stakeholders were ‘able to provide the necessary assistance and education’ such that families were more aware of the support services and ‘felt more confident to engage with services’ and take on information to support their parenting. The only exception to this was for those families that had ‘exceptional or unavoidable circumstances’ that prevented them from being helped. These results again point to the success of EARL in achieving these outcomes.

Ability to facilitate coordination between service providers

This next question asked stakeholders whether the EARL concept of care facilitated coordination between service providers working in the universal service system to work collaboratively to develop best practice models of service delivery to families with children 0–6 years at risk of vulnerability. From Table 6.8, it can be concluded that overwhelmingly, 54 per cent of stakeholders believed that EARL effectively facilitated coordination between service providers, with 39 per cent believing that this ‘usually’ happened. Only 8 per cent of stakeholders believed this ‘sometimes’ happens and nobody responded that it ‘never’ or ‘rarely’ happened.

Table 6.8. The ability of EARL to facilitate coordination between service providers

Answer choices	Responses n	Responses %
Always	7	53.85
Usually	5	38.46
Sometimes	1	7.69
Rarely	0	0.00
Never	0	0.00
Total	13	100

Only 31 per cent of stakeholders provided a possible explanation to their response on the ability of EARL to facilitate coordination between services. This could be grouped into two main categories using qualitative narrative inquiry content analysis: the concept and the people who constituted the service. The EARL concept worked because it ‘broke down the silos that existed between some services’. This was made possible because there were passionate staff that believed in EARL and were able to collaboratively work with other services that facilitated this. The result was that families were less likely to ‘get lost when they transitioned to different services’. There was one suggestion for improvement among the comments, which was the need for more focus on good evidence base data collection. Apart from this comment, it was evident that EARL was successful in achieving its aim of improving MCH services.

Ability to improve engagement

The next question asked stakeholders whether EARL improved the engagement of Aboriginal families with children 0–6 years of age in their service during the pilot period. Overwhelmingly, stakeholders responded that they believed that engagement of families in the service was ‘usually’ (54%) improved and 31 per cent believed this was ‘always’ the case (see Table 6.9). However, 15 per cent of stakeholders believed that EARL only ‘sometimes’ improved the engagement of families. No stakeholders responded ‘rarely’ or ‘never’ improved engagement, which was encouraging.

Table 6.9. The ability of EARL to improve the engagement of Aboriginal families with children birth to five years of age

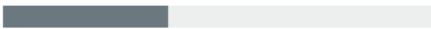
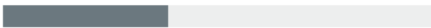
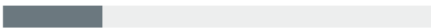
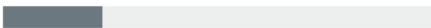
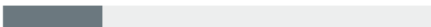
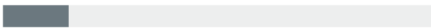
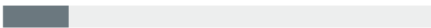
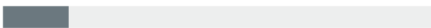
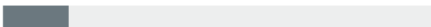
Answer choices	Responses n	Responses %
Always	4	30.77
Usually	7	53.85
Sometimes	2	15.38
Rarely	0	0.00
Never	0	0.00
Total	13	100

From the written responses to this question, 31 per cent of stakeholders provided a possible explanation. Predominately, stakeholders attributed this improved engagement to EARL. This was because the concept provided the avenue for service providers to develop stronger connections and understanding of what individual services provide. In addition, the concept provided a catalyst to facilitate the communication between service providers. However, it was believed that ‘this was largely due to the strength and expertise of the staff at the time’. It was also believed to be because ‘Aboriginal health services were involved... to assist to establish a trust with those in the mainstream health service offering assistance’. These results provide further evidence as to the effectiveness of EARL at achieving the aim of improving MCH services.

Strengths of EARL

In this question, stakeholders were asked to provide what they thought were the strengths of the EARL concept of care. This was an open-ended question, which all stakeholders answered. The responses were summarised by Survey Monkey using text analysis, list view, which grouped data into categories (see Table 6.10) and identified that the most common words mentioned by stakeholders were ‘outcomes’ and ‘services’.

Table 6.10. The strengths of EARL

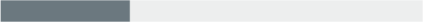
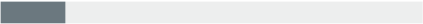
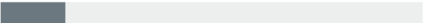
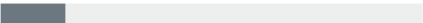
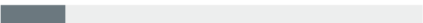
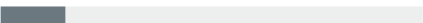
Outcomes		38.46%	5
Services		38.46%	5
Agencies		23.08%	3
Improved		23.08%	3
Professionals		23.08%	3
Early Intervention		15.38%	2
Engagement		15.38%	2
Birth		15.38%	2
Stakeholders		15.38%	2

A further layer of analysis using qualitative narrative content analysis was undertaken to gain a deeper meaning to the responses provided. These were grouped into three broad categories, which identified the strengths of EARL as being the staff, the concept and the outcomes. From the staff point of view, stakeholders believed the strength was the professionals within the concept who were engaged in the process and had the same goal and plan in mind. As for EARL, stakeholders commented that the strengths were the collaboration and communication that was achieved between services working together for stronger outcomes. The result of these two strengths was that EARL provided a more holistic picture, made follow-up of families easier and ultimately improved families access to services. Ultimately, the concept facilitated early identification of families who required extra support, which greatly improved the prevention of family stress and breakdown.

Weaknesses of EARL

The next question asked stakeholders what they thought were the weaknesses of EARL. This was an open-ended question with all 13 respondents answering this question. The responses were summarised by Survey Monkey using text analysis, list view, which grouped them into categories (see Table 6.11) and identified that the most common word mentioned by stakeholders was ‘agencies’.

Table 6.11. The weaknesses of EARL

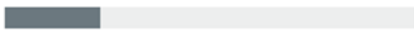
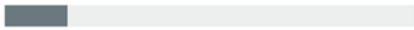

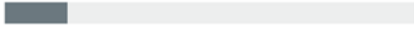
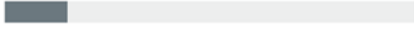
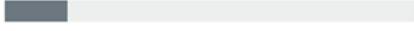
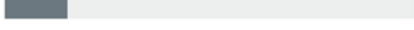
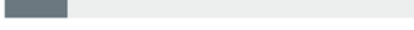
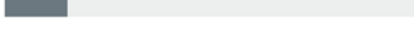
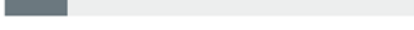
Agencies		30.77%	4
Family		15.38%	2
Engage		15.38%	2
Meetings		15.38%	2
Services		15.38%	2
Support		15.38%	2

A further layer of analysis using qualitative narrative content analysis was undertaken to gain a deeper meaning to the provided responses. These were grouped into three areas regarding staffing, families and future direction. One of the weaknesses identified was change in staff, which resulted in a lack of continuity and not having the same commitment to the service as the previous person or staff not being committed. A further issue with staffing was that stakeholders were not always able to attend the meetings and the community was not well-represented. There was a suggestion that funding needed to be available so that all agencies were able to continue to be involved plus support from the employing agency to facilitate the time taken for meetings. Stakeholders also commented that families were not always easy to engage or continue to be engaged. Further suggestions to enhance the model included the need for a lead agency to help maintain the model and formal referral pathways. A reservation expressed by stakeholders was that they were not sure that the model ‘could be translated to a larger population’. Despite this, there was a belief that it was ‘imperative to make the program continue its success’, which was an acknowledgement of the success of the model.

How could the EARL concept be improved?

The final question asked stakeholders how they thought that EARL could be improved to provide a continuum of supported care through collaboration and integration of services. This was an open-ended question and all stakeholders responded. The responses were summarised by Survey Monkey using text analysis, list view, which grouped them into categories (see Table 6.12). This identified that the most common word mentioned by stakeholders was ‘services’.

Table 6.12. How the EARL concept could be improved

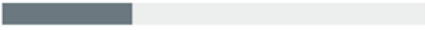
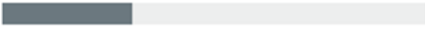
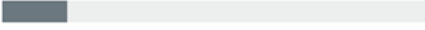
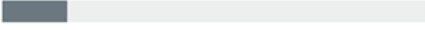
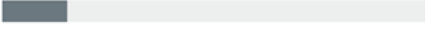
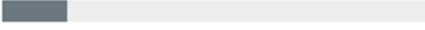
Services		23.08%	3
Lead Agency		15.38%	2
Better Referral Pathways		15.38%	2
Aboriginal		15.38%	2
Believe		15.38%	2
EARL		15.38%	2
Communication		15.38%	2
Meetings		15.38%	2
Ongoing		15.38%	2
Process		15.38%	2

A further layer of analysis using qualitative narrative content analysis was undertaken to gain a deeper meaning to the provided responses. These could be grouped into two broad categories regarding the processes and suggestions for promoting it. The main comments from stakeholders were suggestions for how the processes could be changed to improve the service, such as greater communication between stakeholders and the sharing of ideas. There was also a need expressed for ongoing collaboration, especially with Aboriginal health organisations and communities, as well as the need to secure commitment from stakeholders to make meetings a priority. Further suggestions for improvement included the appointment of a lead agency to be responsible for the concept and better referral pathways. Stakeholders believed that the concept demonstrated success and should be repeated and used for other minority groups. The concept also needed to be promoted more as an effective early intervention program. These all point to the success in EARL as a way to improve MCH services and outcomes for families.

Further feedback

Finally, stakeholders were asked whether they had any other feedback regarding the EARL concept. This was an open-ended question, to which all stakeholders responded. The responses were summarised by Survey Monkey using text analysis, list view, which grouped them into categories (see Table 6.13). This identified that the most common words mentioned by stakeholders were ‘families and model’.

Table 6.13. Other feedback regarding the EARL concept

Families		30.77%	4
Model		30.77%	4
Early Years		15.38%	2
Supported		15.38%	2
Taken		15.38%	2
Local		15.38%	2

6.3 Summary of results of Study Three

This study operates by combining elements of the current Victorian MCH service that are not effectively engaging First Nations families, and a concept that does, into a plotted story. This chapter presents the findings of the pilot of the Early Assessment Referral Links conceptual service model and the results of the survey of the service providers that were recruited to EARL as stakeholders to provide a service to First Nations women with children aged birth to five years of age, living in the Glenelg Shire, Victoria, Australia, to gain a deeper, comprehensive understanding of First Nations women's access and engagement in MCH services.

Development of EARL involved the core principles of narrative inquiry, integrated with the Indigenous philosophy 'Dadirri', to change existing patterns of conversation and give voice to new and diverse perspectives. A program logic model was used to support a systematic and integrated approach to planning, implementation and evaluation. Outcome measures used to evaluate the EARL concept include stakeholder meetings data, numbers of referrals, and participation rates of women and children in MCH services, and specific health outcomes that could be influenced by the concept. As the sample size of First Nations families participating in the pilot represented 100% of this specific population group, these outcome measures were compared to the measures in the year pre and post the pilot, and comparison to similar data of First Nations families in the State of Victoria, Australia, during the pilot period. Results showed that participation of First Nations families in MCH services was consistently above the state average during the pilot period, and a number of First Nations families were referred to EARL stakeholders, and other health professionals, during the pilot. Additionally, there were increases in First

Nations children being breastfed, fully immunised and attending Early Start Kindergarten. Identification of First Nations children at risk of abuse or neglect also improved with a dramatic increase in referrals for FV and child protection, and decreased episodes of OoHC for children.

The next chapter discusses the integrated outcomes of the studies and literature review, and the relationship between the results and research questions. The findings are compared to the current literature to demonstrate this thesis's contributions to the body of knowledge in this area.

Chapter 7: Discussion of thesis findings

7.1 Introduction to the discussion of the thesis findings

This thesis aimed to explore and describe the engagement of First Nations women with children aged birth to five years, in the MCH service in Glenelg Shire, Victoria, Australia. The thesis achieved this aim by undertaking a systematic review of the relevant literature, presenting three empirical studies, and drawing research conclusions and recommendations from the study findings.

As stated in Chapter 1, this thesis's primary objectives were to:

- 1) explore and understand First Nations women's perceptions of MCH services in Victoria, Australia
- 2) identify what aspect/s of MCH services in Victoria, Australia, need to be changed or strengthened to improve First Nations women's engagement with these services.

The research questions were developed from the literature review and addressed in three studies to achieve these aims and objectives. The developed questions are restated below.

Study One questions:

Q1. What factors facilitate and support the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia?

Q2. What factors hinder the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia?

Q3. What improvements could be made to the Maternal and Child Health service in Victoria, Australia, to improve access and engagement for First Nations women?

Study Two questions:

Q1. What barriers do First Nations women with children birth to five years of age have accessing MCH services in the Glenelg Shire, Victoria, Australia?

Q2. What barriers do First Nations women with children birth to five years of age have engaging in MCH services in the Glenelg Shire, Victoria, Australia?

Study Three questions:

Q1. Did the Early Assessment Referral Links (EARL) model of care facilitate coordination between service providers working in the universal service system to work collaboratively to develop best practice models of service delivery to families with children birth to five years of age at risk of vulnerability to child abuse or neglect?

Q2. Did the Early Assessment Referral Links (EARL) model improve the engagement of First Nations women with children birth to five years of age in your service during the pilot period?

Chapters 4–6 presented the outcomes of each study in a standalone chapter. The studies provided insight from First Nations women, with children aged birth to five years, currently residing in the Glenelg Shire, on factors affecting their access to and engagement with the MCH service in Victoria, Australia. The Study One and Two findings were presented as a detailed thematic analysis, with individual themes and sub-themes expressed in relation to the respective dataset and research question(s). The Study Three findings were presented via a program logic model used to support a systematic and integrated approach to planning, implementation and evaluation. Outcome measures used to evaluate the EARL concept pilot included stakeholder meetings data, numbers of referrals, participation rates of women and children in MCH services, and specific health outcomes that could be influenced by the concept.

This chapter presents an integrated discussion of the findings. As the outcomes from all three studies align with the research questions in Study One, this discussion is presented in Sections 7.2–7.4 in answer to the Study One research questions

7.2 Factors that facilitate and support the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia

Some women who participated in the yarning sessions at all three sites in Study One disclosed that they thought the MCH service was effective for them as it supported continuity of care between other services they were engaged in, was timely and was appropriate, flexible in approach and holistic. This finding aligns with prior evidence of models or interventions that promote and support better access and engagement, quality

of care, service delivery and outcomes for First Nations women and their children in MCH services. The literature review (Chapter 2) highlighted that enablers facilitating and supporting First Nations women's engagement with MCH services were service models or interventions that are timely, appropriate, culturally strong, effective, community-based, integrated, and flexible to the holistic needs of the family (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

7.3 Factors that hinder the engagement of First Nations women in accessing the Maternal and Child Health service in Victoria, Australia

Other First Nations women who participated in the yarning sessions at all three sites in Study One disclosed that they thought the MCH service was interculturally incompetent or ineffective for their needs. Some expressed that there was poor continuity of care between maternity services and they either did not trust or communicate well with service staff. Other women felt the service was untimely, inappropriate, or inflexible in approach, and did not recognise their SDOH or holistic principles that align with Indigenous ways of 'knowing, doing and being'. The findings align with prior evidence of factors hindering First Nations women's engagement with MCH services. The literature review (Chapter 2) highlighted the factors of inefficient communication resulting in lack of understanding between client and provider, cultural differences between client and provider, poor continuity of care between services, lack of flexibility in approach/access to services, and a model that does not recognise the importance of the SDOH and wellbeing (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

7.4 Improving the Victorian Maternal and Child Health service for more effective engagement of First Nations women

This study's findings show that providing First Nations women with a role in developing, implementing, monitoring and evaluating plans and programs for MCH services can (1) improve intercultural competence between MCH nurses and First Nations women and (2) support better access, engagement, quality of care, service delivery and outcomes for First Nations women and their children. The findings also support the results of the VAGO's 2014 audit examining the poor engagement of Aboriginal families in a range of

mainstream early childhood, health and human services; the VAGO's (2016) report from that audit confirmed that the issue of accessibility of mainstream services for Aboriginal Victorians was multi-factorial, including the quality of service standards, governance, policies, regulations, laws and Acts, information sharing practices, data systems and a skilled workforce. Identified persistent barriers to Aboriginal families accessing MCH services in Victoria were 'a lack of culturally safe services; a lack of awareness of the services that are available; a lack of required services in the local area; racism; a lack of transport to service delivery; shame, embarrassment, fear' (ACIL Allen, 2015, p. 7). The audit found that ACCHO-based MCH services had a stronger focus on the social and cultural determinants of health and were more flexible and tailored to the needs of Aboriginal children and families (ACIL Allen, 2015; VACCHO, 2015). Co-location of support services provided within the 'culturally safe environment' of ACCHOs encouraged holistic care of Aboriginal families and improved collaboration between the MCH service and other allied health services (ACIL Allen, 2015; VACCHO, 2015). These findings, and those of the later Royal Commission into Family Violence (State of Victoria, 2016b), concluded that there were 'concerns' with the differential response model framing early years services in Victoria in regard to engaging Indigenous families.

7.5 Summary of the discussion of the thesis findings

The findings of the literature review (Chapter 2) and three studies (Chapters 4–6) reinforce the need to review the effectiveness of models of care in engaging First Nations families, as a component of ensuring that MCH services meet the needs of these families. It was found that providing First Nations women with a role in developing, implementing, monitoring and evaluating plans and programs for antenatal and MCH services can (1) improve intercultural competence between MCH nurses and First Nations women and (2) support better access, engagement, quality of care, service delivery and outcomes for First Nations women and their children (Reibel et al., 2010). The next chapter presents recommendations to improve First Nations families' access to and engagement with MCH services.

Chapter 8: Recommendations to improve First Nations families’ access to and engagement with Maternal and Child Health services

8.1 Introduction

This thesis operates by combining elements of the current Victorian MCH service model that are not effectively engaging First Nations families and a concept that does into a plotted story. The primary aim of this research, depicted in the storyline, is to give voice to new and diverse perspectives to enhance MCH services for First Nations families, with a focus on improving their access to and engagement with these services. This chapter discusses the recommendations, derived from the research findings, to improve First Nations families’ access to and engagement with MCH services. These recommendations are categorised and presented under the headings of the ‘enablers’ identified in the six studies in the literature review (see Chapter 2), which were supported by the findings of the three studies in this thesis. Highlighting the enablers that support First Nations families’ access to and engagement with MCH services may facilitate policy changes and implementation of a holistic model of care to better engage First Nations families’ in MCH services.

8.2 Highlighting enablers that support First Nations women’s access to and engagement with Maternal and Child Health services

8.2.1 Enabler 1: Timely and appropriate services

This research’s findings, supported by the literature review, show that engaging a woman antenatally encourages rapport and trust in that service prior to the birth of the child (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009). Engagement of First Nations women in pregnancy, facilitated through collaboration with services that they are already engaged in, such as Koori Maternity Services and/or ACCHOs, will likely improve their engagement with MCH services once their baby is born (Austin, Hills & Cruickshank, 2022; Austin, 2022; Austin & Arabena, 2021). In addition, for a MCH service to be timely and appropriate—and, therefore, improve First Nations women’s access and engagement—the framework for the model needs to be built on

evidence-based practice with a strengths-based narrative, thus moving away from an output focus or deficit model to an outcome focus model (Chamberlain et al., 2019). Therefore, the current MCH model in Victoria requires a systems redesign from its current framework, bound by institutional requirements; there must be thinking and cultural change to support timely and appropriate MCH services for First Nations women and their children.

Genuinely listening to First Nations families to build better policy and services—so that there is no assault, challenge or denial of an Indigenous person’s identity and what they need—will also ensure timely and appropriate MCH services. A multidisciplinary Early Childhood Policy, with appropriate and targeted socioeconomic support, is vital to provide timely and appropriate services that encourage First Nations families to access and engage with MCH services.

8.2.2 Enabler 2: Effective, integrated, community-based services that are flexible in their approach

Effective, integrated, community-based services that are flexible in their approach and designed in partnership with consumers support First Nations women’s access to and engagement with MCH services. This was demonstrated in the three studies’ findings and the literature review (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009). Working with communities to redesign service models to improve how practitioners work together to support families, particularly those families at higher risk of interaction with child protection services, must focus on earlier intervention to ensure that the right support is available for families in an integrated way (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022). Flexible, innovative and inclusive MCH service delivery outreaching to services that First Nations families use, including ACCHOs, playgroups, kindergartens and day-care facilities, will ensure better continuity of care between services and improve First Nations women’s and children’s access to and engagement with MCH services (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022).

8.2.3 Enabler 3: Holistic services

This research’s findings, supported by the literature review (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009), show that holistic services that (a) address the

SDOH and DOHaD concepts in the prevention of NCDs and (b) support the health and wellbeing of First Nations women in the preconception, antenatal and postnatal periods, consequently support First Nations women's access to and engagement with MCH services. To improve First Nations families' engagement with MCH services, MCH nurses should be highly skilled in cultural competency (appropriate to the families and communities they work with), use reflective practice, receive trauma-informed training, cultivate respectful relationships, use innovative practices to engage the non-engaged, practice responsive engagement, use integrated approaches, seek partnerships with professionals, be aware of social and emotional wellbeing, and use place-based models.

8.2.4 Enabler 4: Culturally strong services

This research's findings show that co-design with First Nations women to develop, implement, monitor and evaluate plans and programs for MCH services based on First Nations worldviews, not Western understandings alone, support better engagement of First Nations women and their children in MCH services. In addition, the involvement of ACCHOs to embed cultural competency in child and family services with a cultural narrative when looking at outcome data will ensure culturally strong services and promote First Nations families' access to and engagement with MCH services (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009).

8.2.5 Enabler 5: Services that encourage earlier identification of risk and need for further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday

This research's findings showed that facilitation of early identification and referral of mothers and their children who have experienced risk of vulnerability, such as FV, support First Nations women's and children's access to and engagement with MCH services (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022).

Many of the recommendations stated here could be supported through a commitment by all levels of government—federal, state and local—to work together to improve outcomes for young children and their families. All levels of government have a responsibility to improve the outcomes of First Nations families and reduce the factors contributing to the over-representation of First Nations children in OoHC. This would be further facilitated by clarifying the roles and responsibilities of each level of government; recognising the

key role local government plays in supporting and responding to the needs of children and families at the local level; providing a common set of principles to support how parties will work together to improve coordination, collaboration, information sharing and accountability across the early years system; developing a set of strategic priorities for a united outcome; and employing Indigenous liaison officers. Achieving the *National Agreement on Closing the Gap* target of having 55% of Aboriginal and Torres Strait Islander children on track against the five domains of the Australian Early Development Census (physical health and wellbeing; social competence; emotional maturity; language and cognitive skills; and communication skills and general knowledge) by 2031 requires a coordinated whole-of government-response (see Steering Committee for the Review of Government Service Provision, 2022).

The Closing the Gap framework was developed by COAG in 2008. The objective of the *National Agreement on Closing the Gap* is to enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve equal life outcomes for all Australians (COAG, 2010; Steering Committee for the Review of Government Service Provision, 2022). Closing the Gap is underpinned by the belief that First Nations people having a genuine say in the design and delivery of policies, programs and services that affect them will result in better life outcomes. The 17 socioeconomic Closing the Gap targets aim to improve outcomes in the areas of health and wellbeing, education, employment, justice, safety, housing, land and waters, languages and digital inclusion (Steering Committee for the Review of Government Service Provision, 2022).

Since 2016, the Victorian Government has implemented measures under the Closing the Gap framework to improve outcomes for Aboriginal and Torres Strait Islander people (State of Victoria, 2016a). In February 2020, the Australian Government announced its *National Aboriginal and Torres Strait Islander Early Childhood Strategy*. This strategy's purpose is to direct governments, non-government organisations and communities to collectively support Aboriginal and Torres Strait Islander children to grow up healthy, engaged in education, connected to family and community, and strong in culture (NIAA, 2021). This strategy aligns with achieving the *National Agreement on Closing the Gap* outcomes and supports Aboriginal and Torres Strait Islander communities and their community-controlled services to lead responses to children's needs. It addresses

outcomes across all aspects of young children’s lives, including early learning, health, housing, disability, safety, wellbeing, care and development. Each of the strategy’s goals include the outcomes to be achieved and opportunities for reform, for consideration by government and non-government entities (see Figure 8.1).

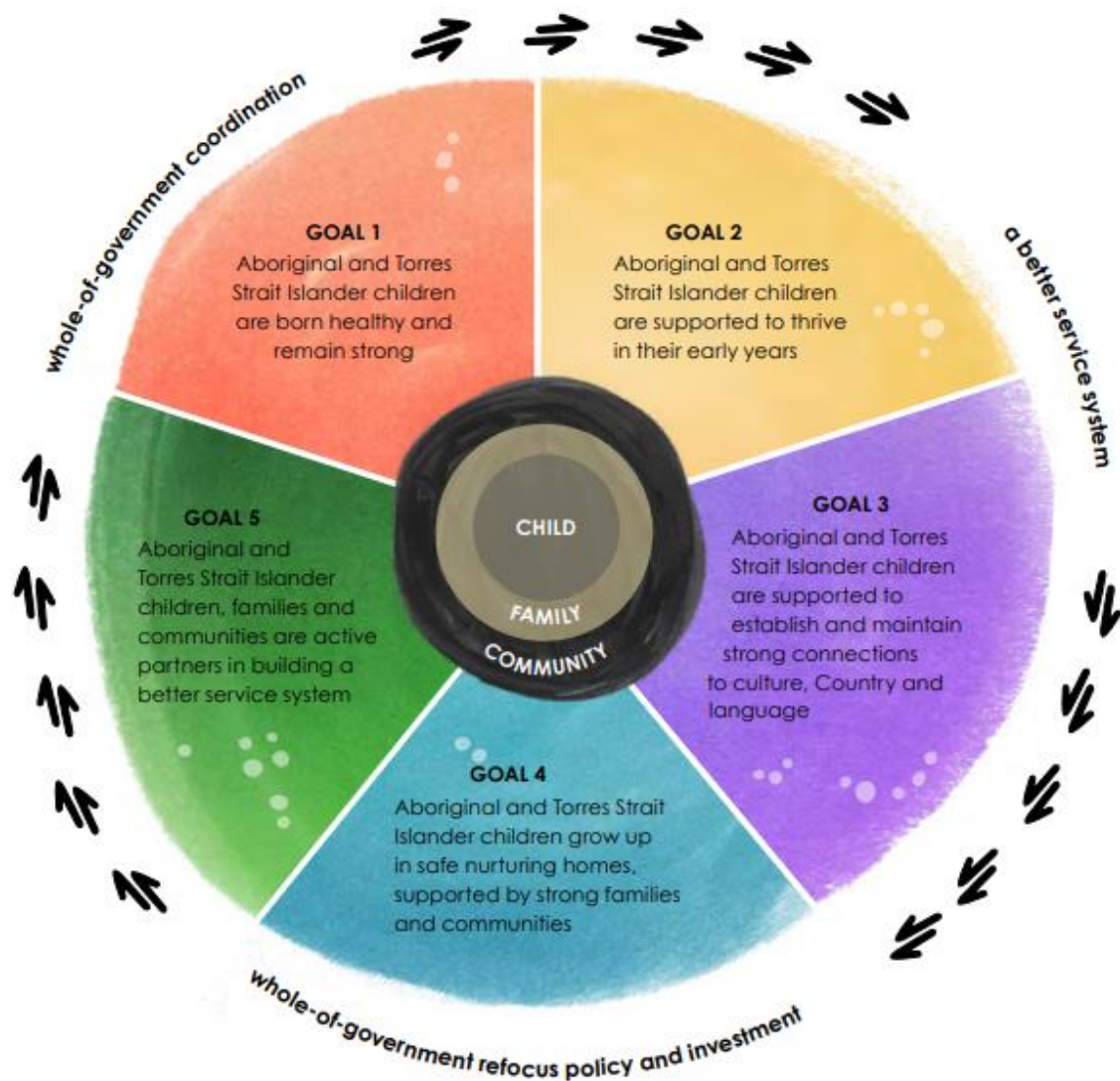


Figure 8.1. The National Aboriginal and Torres Strait Islander Early Childhood Strategy (NIAA, 2021)

Despite this impetus, the latest data (see Steering Committee for the Review of Government Service Provision, 2022) shows the following five Closing the Gap targets are not on track to be achieved:

- children being developmentally on track when they commence school
- OoHC rates

- adult imprisonment
- deaths by suicide
- land and sea rights.

Additionally, there has been only marginal progress towards the Closing the Gap targets relating to:

- life outcomes for children
- better early childhood development with healthier birth weights
- higher rates of school attendance
- lowering youth detention rates.

8.3 Distillation of change to key platforms

This research has found that achieving the recommendations to improve First Nations families' access to and engagement with MCH services requires a distillation of change to several key platforms of the current Victorian MCH service model. This is vital as the data consistently show significantly lower participation rates of Indigenous children in the current Victorian MCH service compared to non-Indigenous children (DET, 2018b; NHMRC, 2002; VAGO, 2016). The VAGO's (2016) report confirmed that the issue of accessibility of mainstream services for Aboriginal Victorians is multi-factorial, including the quality of service standards, governance, policies, regulations, laws and Acts, information sharing practices, data systems and a skilled workforce. These factors are discussed in Sections 8.3.1–8.3.7.

8.3.1 The quality of service standards

This research's findings, supported by the literature review (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009), showed that the quality of the service standards is a key platform that influences the accessibility of services for First Nations families. All organisations that work with children and young people are required to meet Child Safe Standards (ACSQHC, 2012). Further, each standard must promote the cultural safety of Aboriginal children, the cultural safety of children from culturally and linguistically diverse backgrounds, and the safety of children with a disability (ACSQHC, 2012). A review of the current MCH service program standards (DEECD, 2009a) is required to

align them with government reforms and recommendations and thereby provide a MCH service that meets the needs of all families.

The Victorian MCH Program and Documentation Standards; the National Standards for Maternal, Child and Family Health Nurses; and the Victorian Child Safe Standards provide an evidence-based framework for the consistent, safe and quality delivery of the MCH service (MCFHNA, 2017). In theory, these standards support the provision of clinical and corporate governance within the service and provide a systematic approach to improving service delivery and safety. However, audits of the service are not mandatory, as is the case with other early years services (DET, 2016a), and the nurses' accountability to abide by these standards and incorporate actions from the standards into policy and procedure is largely left to the management of the MCH service in each LGA. Local governments are responsible for an ever-increasing workload, alongside the burden of rate capping and associated reductions in services and/or full-time staff; therefore, more funds need to be allocated to ensure the MCH service is more accountable for providing (and able to provide) best practice principles and frameworks that are child and family-centred, strengths-based and culturally competent, with an integrated approach to service delivery and a stronger focus on outcomes (Darbyshire & Jackson, 2005). This focus must be supported by a program logic that is clear, and outcomes must be measured against key policy domains.

8.3.2 Governance

This research's findings showed that the governance, or service provider responsible for the delivery of MCH services, is another key platform that influences the accessibility of services for First Nations families. In 2013, the *Victorian Government Aboriginal Affairs Report* (Victoria State Government, 2013) highlighted the need for the development of strategies to increase Aboriginal participation in MCH services. In response, the DET commissioned a two-part review on Aboriginal families' engagement with the MCH service in 2015. That review found that many Aboriginal families move between mainstream and ACCHO-based MCH services, depending on the quality of the service they receive (ACIL Allen, 2015; VACCHO, 2015). It also found that MCH services delivered through ACCHOs were intensive, flexible and tailored to Aboriginal children and families' needs due to continuation of care, co-location of services, and a culturally safe environment more suitable for identifying Aboriginal women's risk of FV (ACIL

Allen, 2015; VACCHO, 2015). The review recommended that flexibility of the governance of the MCH service (to be responsive to the individual needs of families within different Aboriginal communities) is a key element for effective engagement of Aboriginal families in the MCH service (DET, 2018a).

8.3.3 Policies

Federal and state government early years policies continue to assert the pivotal role that local governments play in the planning and delivery of services for young children and their families. Therefore, this is a key platform influencing the accessibility of services for First Nations families. As identified in this research, an enabler that promotes and supports First Nations families' access to and engagement with MCH services are models or interventions that harbour relationships and encourage mutual trust and engagement of First Nations families (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). This enabler was found to be strengthened when government and policymakers genuinely acknowledge the historical, cultural and social complexity of First Nations families' birthing and child-rearing principles and practices (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

The Victorian Government's Aboriginal health strategy, *Koolin Balit* (State of Victoria, 2012a), stated the need for a strong focus on prevention and early detection of vulnerability, holistic analysis of the social and cultural determinates of health, improved maternal and infant nutrition during pregnancy and childhood, and increased breastfeeding rates. The policy advocated better access to MCH services and earlier referral care pathways, ideally from pre-conception or the antenatal period, was imperative to achieve these aims (State of Victoria, 2012a, 2014a). Local government policies must promote social inclusion and reconciliation, which should be mandated under best practice principles and incorporated into the MCH service model of care, to encourage First Nations families' access to and engagement with MCH services.

A crucial issue in translating the results of this research into policy or practice to inform models or interventions is ensuring that MCH service models (a) focus on the issues most relevant to people's lives (i.e., the SDOH and wellbeing) and (b) have a shared understanding and common language regarding the needs and risks for children and their

families. These models would ensure earlier intervention and identification of risk of vulnerability, co-design and collaboration of universal services, more effective engagement of First Nations children in the MCH service, and better transition of these children through their life stages.

In summary, policy reports and charters worldwide urge a concerted effort to enhance continuity through a new model of care (Barclay et al., 2014; Fulop & Allen, 2000; WHO, 1996). Reforms to service design to align with the continuity of care model, enabling staff to work alongside First Nations women, their families and community leaders, could be an important step forward in addressing the disparities in health outcomes between Indigenous and non-Indigenous children (Jongen et al., 2014; Kruske et al., 2012). By exploring First Nations women's access to and engagement with the MCH service in Victoria, Australia, the present study aims to expand our understanding of the intersectionality of healthcare access and culture—an identified gap in the literature. The identification of these factors is expected to support advocacy for policy development and changes to practice, including the integration of the principles of trauma- and violence-informed care into MCH nurses' practice, and increasing the physical, emotional and cultural safety experienced by First Nations women to improve their access to and engagement with the MCH service. The findings can also support enabling policies and systems (Thorpe et al., 2016) to be implemented to address the human rights challenge of the inequality in health outcomes between Indigenous and non-Indigenous children (ABS, 2017), the over-representation of First Nations children in OoHC (AIHW, 2017a, 2017b, 2017c; HREOC, 1997, 2008) and the high rates of FV in First Nations families (AIHW, 2017a, 2017b, 2017c).

8.3.4 Regulations, laws and Acts

An equitable and culturally competent service system that welcomes and supports all children and their families is imperative to facilitate First Nations families' access to and engagement with MCH services. Culturally competent regulations, laws and Acts, designed with First Nations input or voice, are key platforms for improving First Nations families' access to and engagement with MCH services. This is supported by this research's findings (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022) and the literature review.

8.3.5 Information sharing

This research's findings showed that collaboration with a broad cross-section of the community in which a family resides and other service providers assists to improve access to and engagement with MCH services (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022). Information sharing between stakeholders is, therefore, a key platform that influences the accessibility of services for First Nations families (note the enactment of the *Family Violence Protection Amendment (Information Sharing) Act 2017* (Vic) to facilitate this). This is also supported by the literature review (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). Information sharing is also a key platform for keeping children safe from harm and promoting their wellbeing, which is a priority for the Victorian Government (DET, 2016a).

Over the past decade, many inquiries and reviews have recommended reform to Victoria's information sharing laws to support improved child safety and wellbeing outcomes. These include reviews undertaken by the VAGO, the Coroners Court of Victoria, the Commission for Children and Young People, the Protecting Victoria's Vulnerable Children Inquiry and the Royal Commission into Family Violence (see ACIL Allen, 2015; AIHW, 2017b; DHHS, 2018b; Cummins et al., 2012; State of Victoria, 2017; *Family Violence Protection Amendment (Information Sharing) Act 2017* (Vic)). These reviews found that tragic outcomes can result when services do not have access to the information they need to establish the full picture of risk for a child (see, e.g., ACIL Allen, 2015; AIHW, 2017a, 2017b; Cummins et al., 2012; Department of Health, 2013; State of Victoria, 2017), without which they cannot take appropriate action to protect or support the child and family. For example, the Commission for Children and Young People's 2014–15 annual report (2015) found that of the 27 child death inquiry reports reviewed, 16 reports highlighted issues relating to service coordination, collaboration, communication, information sharing and lack of case conferences between relevant services.

Three interrelated reforms, the Family Violence Information Sharing Scheme, the Child Information Sharing Scheme, and the Family Violence Multi-Agency Risk Assessment and Management Framework, which came into effect for MCH services in 2018, are integral to promoting the wellbeing and safety of children and reducing FV. MCH

services in Victoria are prescribed as information sharing entities under these schemes. As participation in the MCH service provides the earliest opportunity to identify, prevent and respond to challenges faced by young families (Shonkoff & Phillips, 2000; Shonkoff et al., 2009), it is imperative that the MCH service model supports and facilitates optimal access and engagement for all families in these services.

8.3.6 Data systems

To enable collaboration between services, highlighted in Section 8.3.5, data systems between services and other agencies are required to ‘talk’ to one another. This is a key platform that influences the accessibility of MCH services for First Nations families. This is supported by this research’s findings (Austin, 2022; Austin & Arabena, 2021; Austin et al., 2022) and the literature review. Advancement of IT systems and infrastructure to allow this inter-agency systems talk is imperative to support improvement of the MCH service. The DET acknowledges that better information management and data analysis can improve service delivery and performance monitoring and provide greater transparency for decision-making. Technological opportunities continue to emerge that provide new and better ways of delivering services (DET, 2016a). Technology provides an effective and efficient means of sharing information within the MCH service and across services, enabling a seamless service through readily available records of care. Sharing information helps support closer monitoring of children’s progress and outcomes. Additionally, this assists with informing future service delivery (DET, 2016a). Better uptake of modern technology will also allow the MCH service to offer families greater flexibility in how they access child health and information services, essential to addressing the issues raised by the VAGO’s (2016) report.

8.3.7 A skilled workforce

This research’s findings and the literature review (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018) showed that a strong and sustainable MCH workforce supports children engaged in MCH services (Austin & Arabena, 2021; VAGO, 2016). This research’s findings also showed that skilled and culturally competent MCH nurses is a key platform that influences the accessibility of MCH services for First Nations families. To achieve this, the MCH workforce must ensure that it adapts to the evolving landscape of early

childhood support and intervention. MCH nurses must be encouraged to collaborate with a range of other professionals and support continuity of care and child- and family-centred services. Supporting the MCH workforce to develop the skills and competencies necessary to undertake this work is critical. According to the DET (2016a), the resources that may enable these changes include:

- Continued professional development for MCH nurses on identification of risk and their role as mandatory reporters.
- Continued dissemination of changes to the MCH workforce relating to the evidence base underlying the KAS framework to ensure delivery of the most up-to-date health promotion messages, and continued dissemination of evidence-based practice developments to support the delivery of a high-quality service focused on continuous improvement.
- Cultural competency and familiarisation of relevant federal, state and local plans aligned to improving health and education for Aboriginal families. This would include reflective practice, trauma-informed training, respectful relationships, innovative practices to engage the non-engaged, responsive engagement, integrated approaches, partnerships with professionals, and social and emotional wellbeing.

These recommendations are supported in plans such as the *Victorian Aboriginal Affairs Framework 2018–2023* (DPCD, 2018); *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027* (DHHS, 2017a); *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan 2018* (DHHS, 2018c); *Dhelk Dja: Safe Our Way* (DHHS, 2018d); *Aboriginal and Torres Strait Islander Cultural Safety Framework for the Victorian Health, Human and Community Services Sector* (DHHS, 2019); and *Marrung: Aboriginal Education Plan 2016–2026* (DET, 2016c).

The women interviewed in this thesis stated it was vital that MCH nurses understood the means of ‘cultural safety’ from an Indigenous lens: trust, safety, demonstrated respect and understanding, connection to country, ways of knowing, being, doing. These women believed the current MCH model in Victoria has a deficit lens, which is problematic from a cultural perspective. This research has demonstrated that employment of a ‘transition worker’, ideally of Aboriginal descent, into the MCH team could assist to build the capacity and connection between providers and families to ensure children are ‘school

ready' and able to make a smooth transition from kindergarten to primary school (Austin & Arabena, 2021).

This research has shown that MCH nurses should also be aware of the needs and cultural practices of the communities in which they work. This can be through regular surveys or face-to-face interactions with families, being mindful that the definition of 'family' varies between cultures. 'Aboriginal family' has been used to describe a range of people who may be involved in the raising of an Aboriginal child, including the immediate family (e.g., mother, father, siblings, carer, step-parent, adoptive-parent and partner) and extended family (e.g., grandparent, aunts, uncles, cousins and kin). It is acknowledged that typically Aboriginal families encompass a complex familial structure, identified by bloodlines, the system of kinship, connection to country, and the roles and responsibilities of extended family members, which differ in each family (Secretariat of National Aboriginal and Islander Child Care, 2010).

In summary, the recommendations for the distillation of key platforms for change discussed in Sections 8.3.1–8.3.7 need to be considered to improve the effectiveness of models of care to engage First Nations families in MCH services. The formulation of a more effective model is discussed in Sections 8.4 and 8.5.

8.4 Formulation of a more effective model to engage First Nations families

Section 8.3 outlined recommendations for the distillation of change to key platforms that need to be considered to increase the effectiveness of the current MCH service model to engage First Nations families. To implement these changes, it is essential that the MCH service model focus on the issues most relevant to people's lives, namely, the SDOH and wellbeing. The current MCH service model in Victoria is based on the ecological determinants of health and wellbeing (DET, 2016a). For the service to align with federal and state government reforms, the model needs to focus on the SDOH and wellbeing. The Continuum of Need (CON) service response indicator tool (see Figure 8.2) identifies the SDOH and enables a shared understanding and common language regarding the needs of children and their families.

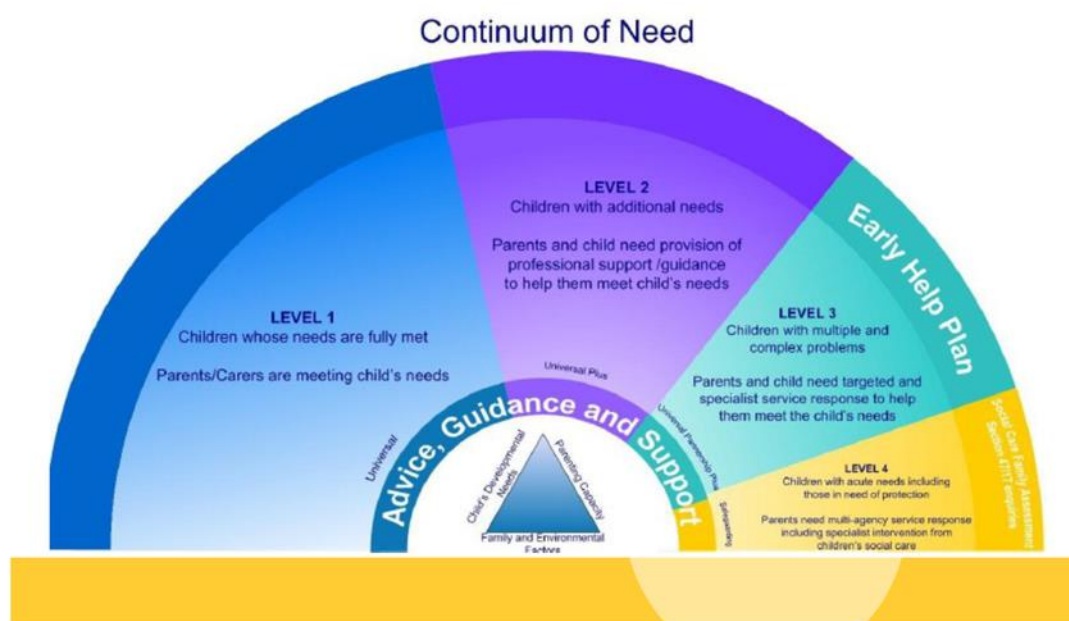


Figure 8.2. The Continuum of Need service response indicator tool (DET, 2015c)

The CON incorporates principles to guide best practice and decision-making while aligning with the *Children, Youth and Families Act 2005* (Vic). Supported policy objectives include (1) promoting children's best interests, with an increased focus on children's development; (2) supporting a more integrated system of effective and accessible child and family services, with a focus on prevention and early intervention; and (3) improving outcomes for children and young people in child protection and OoHC (DET, 2015c; Fox, Stafford, Goodhue, Jackson & Smith, 2015; NSW Government, 2021). Meeting the needs of children in early childhood settings relies on effective cooperation, communication and positive partnerships between all agencies that work with or provide services for children and their families, whether they are statutory or voluntary (DET, 2015c). The CON could be an effective way to engage First Nations agencies and other stakeholders to facilitate First Nations families' engagement with the Victorian MCH service, if the model was based on the principles of this framework. The CON provides a clear understanding of the point at which agencies and professionals respond when additional risks and needs are identified (DET, 2015c). Each level indicates an escalating level of need across a wide range of key indicators, which are categorised by family and environmental factors, parenting capacity and developmental needs. Level 1 is compatible with a child who is achieving and developing at a satisfactory level, with no identified areas of additional need, supported by universal support services. In contrast, Level 4 is compatible with a child who is identified as requiring acute care and

services, is at risk of cumulative harm and may require mandated intervention (DET, 2015c).

A new concept, using the process of narrative inquiry, built on guiding principles and based on best practice and using the frameworks of the CON, has the potential to encourage:

- early intervention
- prevention and sharing responsibility
- transformation of the current OoHC system
- involvement of collaborative teams of healthcare professionals
- seamless transition between the early years services, rather than the current silo-oriented services and poor referral systems.

This model of care has the capacity to be culturally safe, flexible, of a high quality and delivered through clinical practice settings and governance to service the specific needs of a community. This will likely more effectively engage First Nations families in the MCH service, as the EARL concept did.

The development of the EARL concept involved using the core principles of narrative inquiry to change existing patterns of conversations and ways of relating. This gave voice to new and diverse perspectives to improve the MCH service in a particular region (Sharp et al., 2016). The EARL concept supported the depository of best practice in universal services that were flexible and focused on client needs (rather than program guidelines). The services were locally responsive; worked to the strengths, assets and needs of local communities; and grounded in what stakeholders know works. The services were adaptive, continuously improving and responding to change, and client-centred to address their needs. The EARL concept was strengths-based, with a holistic, wrap-around approach to child service using the CON model (DET, 2015b) to monitor the risk of vulnerability and need. It targeted earlier intervention program reform, which was an approach required to address the growing number of children reported at risk of significant harm (see, e.g., ACIL Allen, 2015; AIHW, 2017b; Cummins et al., 2012; DET, 2018a; Melnyk & Fineout-Overholt, 2015; VACCHO, 2015). Further, the concept's framework was based on the co-design approach, which draws on the expertise of service stakeholders to develop effective coordination, collaboration and communication, in line

with the aims of the *Roadmap for Reform* (State of Victoria, 2016a). Through the co-design approach, stakeholders could develop new insights and solutions collaboratively, on an equal basis, to promote effective engagement in universal early years' services through creative and often narrative-based activities. Further, this co-design approach facilitated a multidisciplinary Team Around the Child through information sharing and shared learning. The EARL framework supports a systematic and integrated approach to planning, implementation and evaluation. It provides the structure for a new MCH model of care that improves the identification and engagement of families with children from conception to five years of age (the first 2000 days), at risk of vulnerability to child abuse or neglect. The framework aims to reduce gaps within service delivery and ensure continuity of care, encouraging integration and collaboration among early years' service providers in the life-stages from pre-conception through to the first year of school, portrayed in Figure 8.3.

Most importantly, the EARL concept allowed for the integration of traditional Aboriginal child-rearing practices with colonised values, beliefs and practices through a guided mastery approach, shared knowledge, yarning, capacity building, mutual trust and connection. This was enabled through the use of narrative inquiry, which gave voice to new perspectives.

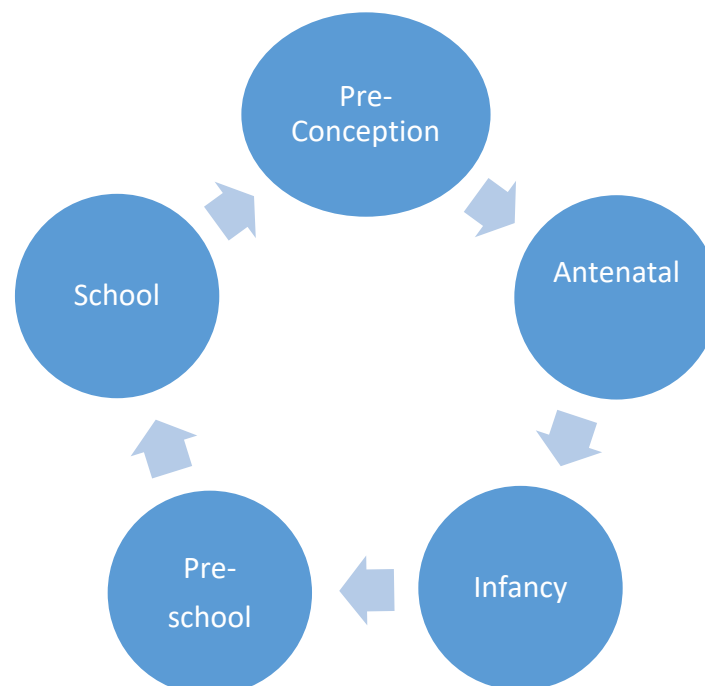


Figure 8.3. The EARL concept

The EARL concept is built on a transdisciplinary approach through the stages of a child's life, from pre-conception to school (see Figure 8.3). This transdisciplinary research approach supported the direction of the research to:

- adapt the existing MCH universal service model to the DET's strategic model direction, including recent early years sector reform evaluations and alternate Enhanced MCH delivery model trials being conducted at the time of research, to more effectively engage Aboriginal and Torres Strait Islander families with children aged birth to five years
- consider a framework that provides clarity to funding allocations that support improved financial management and budgetary planning and provide a foundation that will assist the introduction of changing service models and/or funding allocations by the DET
- discuss delivery model considerations that provide sound return on investment for the community, supporting both clarity of structure and sound continuous improvement principles through appropriate monitoring and performance measures
- consider the inclusion of a basic learning, health and care plan (aligned with the Victorian Early Years Learning and Development Framework) in the My Health and Development Record as a tool to assist to facilitate seamless transition between the child's stages of life from pre-conception to school
- consider the linkage of the My Health and Development Record and 3.5 year MCH consultation with transition to kindergarten and school and from pre-conception and antenatal services to the universal, enhanced and 24/7 telephone line MCH services
- consider a model that can respond to emerging trends in child developmental vulnerability in the community, as depicted by the local Australian Early Development Census data
- review standard and consistent state-wide referral systems, potentially based on the service coordination framework, seemingly supported with the development of a range of continuity of care protocols
- improve collaboration and referral pathways addressing children's early social and behavioural issues
- encourage MCH professionals to work in multidisciplinary teams

- enhance coordinated service responses for vulnerable children and their families through collaboration and information sharing between MCH and other early childhood services via an improved early childhood client management system
- implement a whole-of-government initiative trialling collaborative cross-government teams in support of vulnerable families
- localise approaches to address continuity of care issues between health and MCH services, in partnership with the VACCHO (and ACCHOs), DET, DHHS and MAV
- deliver more culturally responsive and high-quality MCH services for Aboriginal and Torres Strait Islander families, in partnership with Aboriginal communities and ACCHOs, MAV and local councils, built on the co-design framework
- close the gap in MCH participation rates for Aboriginal and Torres Strait Islander families
- reduce the over-representation of Aboriginal children in OoHC.

The CON service response indicator tool is based on the ecological model of child development (Bronfenbrenner, 1979). This model acknowledges the life of each child within social, environmental, political and economic contexts (see Figure 8.4).

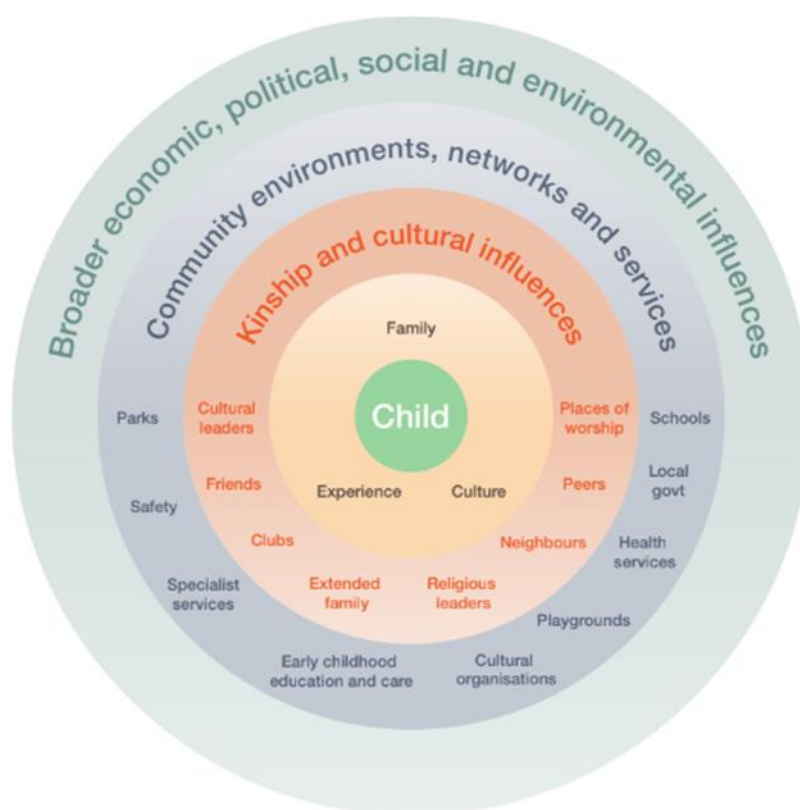


Figure 8.4. The ecological model of child development (Bronfenbrenner, 1979)

8.5 The ‘Child and Family Health’ service model

The EARL concept, built on the best practices and principles of the CON frameworks, is culturally safe, flexible, of a high quality and delivered via clinical practice settings and governance to service the specific needs of a community. The Study Three findings indicated that the EARL concept was more effective in engaging First Nations families in the MCH service than current mainstream approaches. The findings also indicated that these families’ outcomes were improved as a result of the EARL concept.

Stakeholders of the EARL pilot identified that formalised referral pathways were vital to ensure the model’s success. The CON service response indicator tool (DET, 2015c) is an effective way to facilitate referral of Aboriginal families in the Victorian MCH service to Aboriginal agencies and other stakeholders. However, to make effective use of the CON, the lead agency needs to have a clear understanding of the point at which agencies and professionals respond when additional risks and needs are identified (DET, 2015c), which was a weakness of EARL identified by the stakeholders in this research. In view of this, the researcher has formalised the EARL referral pathways (see Figure 8.5). This conceptual service model, developed by the researcher, has the potential to be a validated service model for use in all Australian states and territories, and internationally. The researcher recommends this model be named the ‘Child and Family Health service’, in answer to critics who feel that the current Victorian ‘Maternal and Child Health’ service is based on a matriarchy model that is formed around maternal values of care-taking and nurturing (see ACIL Allen, 2015) and is racist (see ACIL Allen, 2015; Henry, Houston & Mooney, 2004).

Like the CON service response indicator tool (DET, 2015c), each level of the Child and Family Health service model indicates an escalating level of need across a wide range of key indicators, categorised by family and environmental factors, parenting capacity and developmental needs. Level 1 is compatible with a child who is achieving and developing at a satisfactory level, with no identified areas of additional need, supported by universal support services. Level 4 is compatible with a child who is identified as requiring acute care and services, is at risk of cumulative harm and may require mandated intervention (DET, 2015c).

In summary, the literature review showed that First Nations parents, in particular, require support services that are culturally strong, timely and appropriate, and holistic to strengthen their families' health outcomes (Milroy et al., 2014; Shonkoff & Phillips, 2000; Shonkoff et al., 2009). These qualities ultimately improve First Nations families' access to and engagement with these services. However, the literature also shows the lack of comparison between the views of Indigenous women and non-Indigenous service providers (Andrews, 2021) and a conspicuous absence of knowledge on how First Nations women raise their children in the context of the impact of the SDOH and health outcomes on their access to and engagement with health services (Andrews, 2021).

During the consultations with First Nations women in this research, these women shared that their cultural beliefs and practices were largely absent in the policies that affect them. They called for more access to information appropriate to their needs, greater cultural inclusivity and cultural safety in service delivery, and increased investment in existing local programs that were supporting successful outcomes for these women and their families. Locally led, culturally appropriate services that are co-designed and funded by government, consistent with the *Closing the Gap National Agreement*, would assist to support these families to keep their children safe and well.

A new model to engage First Nations families in MCH services—based on a standpoint that privileges First Nations people (as depicted by Moreton-Robinson [2013]) and that addresses the human rights challenge of inequality in health outcomes between Indigenous and non-Indigenous children, the over-representation of Indigenous children in OoHC, and the high rates of Indigenous children's exposure to FV—would support the *Uluru Statement* (First Nations National Constitutional Convention, 2017). Additionally, this new model would align with the vision of the *National Framework for Protecting*

Australia's Children 2021–2031, 'that children and young people in Australia reach their full potential by growing up safe and supported, free from harm and neglect' (AHRC, 2022).

The National Framework (AHRC, 2022) seeks to improve outcomes for children and families with multiple and complex needs, or who are disadvantaged or at risk of vulnerability, including children in OoHC, through actions in four focus areas:

- 1) a national approach to early intervention and targeted support for children and families experiencing vulnerability or disadvantage
- 2) addressing the over-representation of Aboriginal and Torres Strait Islander children in child protection systems
- 3) improving information sharing, data development and analysis
- 4) strengthening the child and family sector and workforce capability (p. 11).

Currently, Australia has seven First Nations Commissioners, Guardians and Advocates. Their role is to advocate nationally on shared priorities to improve the lives of First Nations children, young people, and families. It is a priority of this group to advocate for, and support the introduction of, a National Commissioner to advance the rights of Aboriginal and Torres Strait Islander children across Australia, in collaboration with jurisdictional first nations Commissioners, Guardians and Advocates. Employment of a National Aboriginal and Torres Strait Islander Children's Commissioner would assist to present key issues, identify and address the national advocacy priorities, and recommend actions to be developed by the federal, state and territory governments, to improve the lives of Aboriginal and Torres Strait Islander children, young people and families.

The next chapter concludes this thesis, providing an overview of the research aims and objectives and a brief summary of the research and methodology employed to achieve these. The chapter also restates the major findings, discusses the strengths and limitations of the research, the implications of the findings, and future research directions.

Chapter 9: Research conclusions

9.1 Introduction

This chapter concludes the thesis, providing an overview of the research aims and objectives and a brief summary of the research and methodology employed to achieve these. The chapter then restates the major findings and discusses the strengths and limitations of the research, the implications of the findings for policy and practice, and future research directions to improve First Nations families' access to and engagement with access MCH services.

9.2 Summary of the outcomes of the literature review

Access in the early years of a child's life to integrated community-based services that are flexible in their approach, holistic, culturally strong and recognise the SDOH and DOHaD concepts in the prevention of NCDs is a well-established predictor of a child's successful transition to school and lifelong education and employment outcomes (Shonkoff & Phillips, 2000; Shonkoff et al., 2009). Such access is crucial in a child's first 2,000 days (the period from conception to the child's fifth year), which forms the foundation for a child's lifetime development and health (Belli et al., 2005; Sweeny, 2014; WHO, 2018; VAGO, 2016). Prior evaluative studies have shown that participation in MCH services in Victoria improves the health outcomes for children and families, particularly First Nations families (AIHW, 2015; Austin & Arabena, 2021; VAGO, 2016). However, First Nations women and their children in Victoria show poorer health outcomes and lower participation in MCH services compared to non-Indigenous persons; this suggested a need to improve the current Victorian MCH service model (DET, 2018a; VAGO, 2016).

This thesis aimed to explore and describe the engagement of First Nations women, with children from birth to five years of age, in accessing MCH services in Glenelg Shire, Victoria, Australia. Identification of the factors that facilitate, support or hinder First Nations women's access to and engagement with MCH services could support policy development and changes to practice to increase First Nations women and children's health outcomes.

This research investigated the current state of knowledge in this area by undertaking a systematic review of the literature and identify prior models or interventions that promote and support First Nations families' access to and engagement with MCH services from a child's birth to five years of age. This review was guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2020 statement, to assist the researcher to transparently report why the review was done, what the researcher did, and what the researcher found (Page et al., 2021). The review identified six studies of models that promote and support First Nations families' access to and engagement with MCH services in a child's first 2,000 days.

The review identified a key gap in the literature: the absence of a synthesis of qualitative studies of models or interventions that improve First Nations women's access to and engagement with MCH services. Based on the literature review and chosen methodology (see Chapter 3), the researcher developed research questions to address the identified knowledge gaps and achieve the research aims and objectives.

As discussed in Section 7.1, the outcomes of Study Two and Three align with the Study One research questions. The Study One research questions were:

- 1) What factors facilitate and support the engagement of First Nations women in accessing the Maternal and Child Health service in Glenelg Shire, Victoria, Australia?
- 2) What factors hinder the engagement of First Nations women in accessing the Maternal and Child Health service in Glenelg Shire, Victoria, Australia?
- 3) What improvements could be made to the Maternal and Child Health service in Victoria, Australia, to improve access and engagement for First Nations women?

In relation to these research questions, the literature review found that although recent changes to models of maternity care show some positive outcomes for access for First Nations women and their children (Josif et al., 2017), improvements to infant care are required. This is a factor hindering the effectiveness of these services in engaging First Nations women (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

Where health disparities continue to exist between First Nations and non-Indigenous women and infants, it is imperative to explore the factors that facilitate continuity of care from the antenatal period to a child's fifth birthday (i.e., the first 2,000 days of life). The

literature review found limited communication in the transfer of mother and infant care from maternity services to MCH services, which is sometimes fragmented, inconsistent and ad hoc. This results in potentially serious clinical consequences for new mothers and their children in this vulnerable period and affects First Nations families' and their children's access to and engagement with MCH services (Bar-Zeev et al., 2012). Consequently, accessing MCH services often provokes high levels of fear and anxiety among First Nations women and consequent low attendance at their subsequent appointments (Sivertsen et al., 2020). The literature review showed that services must collaborate, be more 'connected' and be made easier for families to access to ensure that adequate support is provided (DOH, 2015, 2017; DHS, 2006; DHHS, 2017b; Wathen & MacMillan, 2018). The continuum of care framework—a concept involving an integrated system of care that follows patients over time through a comprehensive array of health services spanning all levels of intensity of care—may facilitate this (Hjortdahl, 1990; Rogers & Curtis, 1980). However, the continuum of care framework traditionally focuses on chronological patterns of care, without directly measuring experienced continuity or those aspects of care that translate into connected and coherent care (Hjortdahl, 1990). It was to be imperative to use the continuum of care framework to allow multiple agencies to work together and provide a coordinated, comprehensive service to engage First Nations families. The common understanding of the concept of continuity would serve as a basis for valid and reliable measurement of practice in different settings (Barclay et al., 2014). Unless organisations understand the mechanisms through which care that is delivered over time improves outcomes, continuity interventions may be misdirected or inappropriately evaluated, which can lead to fragmented care. Additionally, Barclay et al. (2014) reported that deficiencies in knowledge, recognition, and support of local culture and child-raising needs in the health system must be remedied for staff to be effective in promoting health and building resilience with parents of infants at risk of vulnerability. Policy reports and charters worldwide urge a concerted effort to enhance continuity through a new model of care (Barclay et al., 2014; Fulop & Allen, 2000; WHO, 1996). Reforms to service design to align with the continuity of care model, enabling staff to work alongside First Nations women, their families and community leaders, could be an important step forward in addressing the disparities in health between Indigenous and non-Indigenous children (Jongen et al., 2014; Kruske et al., 2012).

The reviewed studies showed that a biomedical model of care underpins most mainstream MCH services worldwide, which can be incongruous with traditional Indigenous ways of parenting and child rearing (Sivertsen et al., 2020). The corollary to this lack of understanding of parenting and child-rearing practices of First Nations peoples is that health providers from non-Indigenous backgrounds continue to provide health advice and information from their own cultural perspective, ultimately hindering access and engagement of First Nations women and their families (Bar-Zeev et al., 2012). Healthcare professionals are often inadequately trained and underprepared to work cross-culturally, which further compounds the situation (Sivertsen et al., 2020). As a result, many First Nations women do not disclose vital health information to healthcare workers with whom they have no relationship (McCalman et al., 2015). Culturally unsafe practice was identified in the literature review as a barrier that influenced the engagement of First Nations families with MCH services (Josif et al., 2017). This was attributed to negligible numbers of First Nations staff working in MCH services and perceived racist behaviours by some MCH service staff (Bar-Zeev et al., 2012; Josif et al., 2017). The literature review showed that an area requiring reform in closing the gap in health outcomes for First Nations women and their children, and the uptake of MCH services, is the development of a culturally competent workforce for the particular population (COAG, 2010; Schmied et al., 2011; Zarnowiecki et al. 2018).

In summary, the literature review showed that timely, effective, holistic engagement with First Nations women in their child's first 2,000 days; respect for culture; and forming genuine working partnerships with their community need to be an essential part of the MCH service model to effectively engage First Nations communities. However, the literature review did not find any models or interventions that, in conjunction with a strengths-based approach, have a strong framework to support First Nations culture, especially that related to child-rearing practices, in a MCH setting (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

To address this identified gap in the literature, the researcher conducted three empirical qualitative studies. Research conclusions and recommendations were drawn from these studies' findings.

9.3 Major findings of the thesis and how they integrate with previous work

Three empirical qualitative studies were conducted in the Glenelg Shire, Victoria, Australia, guided by the methodological principles of narrative inquiry integrated with the Indigenous philosophy Dadirri. These three studies provided a narrative of the storyline that organise the researcher's human experiences of working as a MCH nurse in Victoria, Australia, into meaningful episodes. Study One and Two (Chapters 4 and 5) presented elements of the current Victorian MCH service that are not effectively engaging First Nations families, and Study Three (Chapter 6) presented a concept that does, collectively told as a plotted story. This research argued that identification of the factors that facilitate, support or hinder First Nations women's access to and engagement with MCH services could improve the model of care to effectively engage them in these services, and thus improve their health and social and emotional wellbeing. This is important as social and emotional wellbeing is the foundation for the physical and mental health of Aboriginal and Torres Strait Islander children and families. This is a holistic concept, based on the relationships between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual.

This study used the narrative inquiry approach to obtain meaningful information about an event—a model of care (Ospina & Dodge, 2005)—and relate a story about the processes involved in determining the effectiveness of this model through participants' stories. Therefore, the narrative approach provided a process of reflection through the inquiry process that enabled a different viewpoint to be ascertained to influence change (Connelly & Clandinin, 1990).

In Study One (conducted in 2021), the researcher interviewed 35 First Nations women, with children aged birth to five years, to explore the factors influencing their access to and engagement with the MCH service. This study found that enabling factors included interventions that are culturally sensitive and effective; recognise the social determinates of health (SDOH) and social and emotional wellbeing; are timely, appropriate, culturally strong, flexible, holistic and community-based; support continuity of care and communication; and encourage early identification of risk, particularly of FV, and further

assessment, intervention, referral and support in the child's first 2,000 days. Barriers to access and engagement included an ineffective service model built on mistrust, poor communication due to cultural differences between client and provider (particularly around identification and disclosure of woman's risk of FV), lack of continuity of care between services, limited flexibility of service delivery to suit individual needs, and a service model that does not recognise the importance of the SDOH and social and emotional wellbeing.

MCH nurses in Victoria are mandated under the current service model to ask all woman about their risk of FV within the first few weeks of the woman giving birth. Data show that this line of inquiry is often associated with fear, anxiety and low attendance at subsequent appointments, particularly for First Nations women. For example, although 95–98% of Victorian women with newborns are engaging with the MCH service within two weeks of birth, there are consistently lower participation rates of Indigenous women compared to non-Indigenous women after the initial consultation; this indicates that a significant proportion of First Nations women accessing the MCH service disengage shortly after their initial enrolment/consult. Additionally, evidence from prior studies showed that although First Nations people experience high rates of FV, their access to support is lower than their non-Indigenous counterparts due to significant barriers, including discrimination, shame and fear.

Study Two further explored First Nations women's mistrust of the MCH service identified in Study One and the fear that deters these women from disclosing their risk of FV. It was argued that an understanding of these factors will support advocacy for policy development and integration of the principles of trauma- and violence-informed care into MCH service practice to increase the physical, emotional and cultural safety experienced by First Nations women. The researcher compared the interview data from Study One with accounts from 10 MCH nurses. These nurses (1) identified drugs, alcohol, socioeconomic issues, history (which referred to a history of disengagement in services to the extent that it had become an accepted and normalised); and stress as perceived factors influencing FV among First Nations families, and (2) identified First Nations women's acceptance, fear, cultural beliefs and mistrust as reasons for their low reporting of FV. Factors influencing the nurses' ability to identify FV were mistrust and understanding of Indigenous culture. In contrast, First Nations women (1) identified low self-esteem, lack

of belonging, and not being heard as factors that influence FV, and (2) identified fear of child protective services, shame, mistrust and poor rapport with the clinician as contributing to their low reporting of FV. The most significant factors influencing First Nations mothers to disclose FV is fear of losing their child, mistrust, and the process around the questioning. MCH nurses were found to have an integral role in changing their practices and informing policies so that the whole sector is better prepared to address the fear that Indigenous women are experiencing. To facilitate this, it is imperative that all MCH nurses have an understanding of Indigenous culture and a positive relationship within the Indigenous community that they work with, including an authentic comprehension of their needs. Highlighting enablers that support First Nations women's access to and engagement with MCH services may facilitate the emergence of a holistic model of care to better engage these women.

Study Three presented a conceptual model of care that the researcher developed in 2009 and piloted from 2009 to 2014, in collaboration with a broad cross-section of the Indigenous community and other health service providers in the Glenelg Shire, Victoria, Australia. The EARL concept is an example of a holistic model of care that aligns with Indigenous ways of knowing, doing and being and a standpoint that privileges First Nations people. The EARL concept aimed to (1) promote and support better access and engagement, quality of care, service delivery, and outcomes for First Nations women and their children in MCH services, and (2) identify families who require further assessment, intervention, referral and/or support in the first 2,000 days of a child's life. During the pilot, the EARL concept improved the engagement of First Nations families with MCH services, reduced the number of Indigenous children in OoHC, and increased referrals for FV and child protection by providing enabling policy and systems. Study Three provided new knowledge of the benefit of earlier engagement in MCH services, antenatally before maternity services cease, providing a continuum of care and the opportunity to build rapport and trust with MCH services before disengaging with maternity services. EARL improved First Nations women's access to and engagement with health services through recognition of their historical and contemporary SDOH, and the interactions of the SDOH and DOHaD on their health and social and emotional wellbeing.

The three studies' findings were supported by prior literature; for example, the finding that timely, effective, holistic engagement with First Nations women, that respects their

culture and facilitates genuine partnerships built on co-design and shared decision-making with the Indigenous community, is a key element for effective engagement of Aboriginal families in MCH services (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018).

Ultimately, the findings from the literature review and three studies show the need for further research, informed by First Nations peoples' voices, on alternative models and interventions to encourage First Nations families' access to and engagement with MCH services. Most importantly, the findings showed that a MCH service model, like the EARL concept, should allow for the integration of traditional Aboriginal child-rearing practices with Westernised values, practices and beliefs through a guided mastery approach, shared knowledge, yarning, capacity building, mutual trust and connection to facilitate effective engagement and trust in the service. This is of international importance for First Nations families, nursing practice and public health to address the human rights challenge of inequality in health outcomes between Indigenous and non-Indigenous children, the over-representation of Indigenous children in OoHC, and the high rates of Indigenous children's exposure to FV.

9.4 Strengths and limitations of the research

The high rates of participation of First Nations women, with children aged birth to five years, in the three studies is a strength of this research, particularly as the researcher is not Indigenous. Of the 41 women that met the inclusion criteria for Study One and Two, 35 (85.0%) participated in the research. All First Nations women that met the inclusion criteria in Study Three participated in the research (2011: $n = 52$, 2013: $n = 56$).

The validity and reliability of the research is also a strength, as the results among the participants represent true findings among similar individuals outside the study, as evidenced by the literature review (Barclay et al., 2014; Bar-Zeev et al., 2012; Homer et al., 2012; Josif et al., 2017; McCalman et al., 2015; Zarnowiecki et al., 2018). The validity of this research was ensured by having the questions assessed by a panel of experts and pilot testing the questions prior to conducting the main study (Creswell, 2013). The credibility of the research and findings was ensured by logically establishing the research method and having an audit trail.

This research has four main limitations. First the researcher considered and clarified the bias that they, as author of the thesis, brought to the study and their interpretation of the findings. As the author is either a researcher (or co-researcher) in the three studies included in the thesis and the primary instrument of data interpretation (Denzin & Lincoln, 2011), the author/researcher designed and co-ordinated the Early Assessment Referral Links (EARL) concept, and the author/researcher is a MCH nurse, the author/researcher is aware of a potential bias in interpreting the data. There is also the potential for the author's/researcher's own background (past experiences, assumptions and orientation) to influence their interpretation of the data (Denzin & Lincoln, 2011).

Second, the small number of participants in all three studies makes it difficult to protect the anonymity of participants who do not want their stories shared.

Third, although the samples in the three studies are sufficient to accurately and reliably explore and describe the engagement of First Nations women, with children aged birth to five years, with the MCH service in Victoria, Australia, this research does not have a good cross-section of geographical context. Chiefly, there is no representation of participants from metro, regional and remote areas, thus disallowing geographical context from being considered in the synthesis of the data. Further, the samples may be too small for the findings to be generalisable.

Fourth, although a rigorous and thorough search strategy was used to identify existing models and interventions that promote and support First Nations families' access to and engagement with MCH services in the period from a child's birth to five years of age, it is possible that the literature review did not identify all relevant studies. Due to the lack of data internationally, the outcomes of the retrieved studies are likely not generalisable to all First Nations families worldwide. Additionally, it is impossible to determine any cause-and-effect relationships between the interventions described in the reviewed studies and improved engagement of First Nations families with MCH services, as the methodological quality of the studies varied considerably.

9.5 Implications for policy and practice, and future research directions

The persistent disparities in health outcomes between Indigenous and non-Indigenous mothers underscore the need to prioritise responsive practices in MCH services. MCH

nurses have an integral role in changing their practices and informing policies so that the whole sector is better prepared to support First Nations families' access to and engagement with MCH services. Therefore, the perspectives of MCH nurses across all Australian states and territories should be considered in any future research in this area.

Services that facilitate accessibility and are designed to support First Nations women during their pregnancy and postnatal period are likely to have a positive impact on First Nations women's engagement (Panaretto et al., 2007). A crucial issue in translating the results of this research into policy or practice is ensuring that MCH service models (a) focus on the issues most relevant to people's lives (i.e., the SDOH and wellbeing) and (b) have a shared understanding and common language regarding the needs and risks for children and their families. Further, programs are more likely to be accessed by First Nations women if they are designed in a culturally safe and secure space, using a bicultural approach that combines the Western biomedical model with Indigenous cultural ways of 'being, doing and knowing' (Aitken & Stulz, 2018; Martin, 2003; Rossiter et al., 2019; Simmonds et al., 2010). To facilitate this, it is imperative that all MCH nurses have an understanding of Indigenous culture and a positive relationship within the Indigenous community that they work with, including an authentic comprehension of their needs. Providing training to MCH nurses based on the findings of this research and on how to integrate the principles of trauma- and violence-informed care into their practice might increase the physical, emotional, and cultural safety experienced by First Nations women. This would also ensure that MCH nurses provide a service built on best practice guidelines to monitor health and development and ensure the prevention, early detection and intervention for physical, emotional and social factors affecting a child or their family (DEECD, 2011a; DOH, 2015). To help identify the service needs of an Indigenous community, MCH nurses need to ensure accurate identification of Indigenous children aged birth to five years via reliable data collection and recording processes, and 'data matching' with other organisations servicing that community. An accurate census of the population within a community will facilitate better evaluation of any introduced health programs or interventions and help identify gaps in service provision to Indigenous women and children. Outreaching to services that Indigenous families use, such as ACCHOs, playgroups, kindergartens and day-care facilities; attending Indigenous festivals/celebrations; and engaging with women antenatally through collaboration with maternity services, will encourage rapport and trust, and will

promote and support better access, engagement, quality of care, service delivery and outcomes for First Nations women and their children in MCH services.

The imbalance in the number of nurses compared to First Nations women in Study Two who recognise fear as a deterrent for First Nations women to engage in MCH services is a stark reminder of why the problem exists. MCH nurses have an integral role in changing their practices and informing policies so that the whole sector is better prepared to address the fear that First Nations women are experiencing. Although it has been said that MCH nurses are the ‘frontline warriors for our future Elders’ (VACCHO, 2015, p. 9), the present study showed that there needs to be a distillation of key platforms for change to the MCH service model of care to ensure that MCH nurses provide a service that is built on new understanding of Indigenous ways of knowing, being and doing, and best practice guidelines. In addition, this research’s findings showed a significant difference in the perceptions or experiences of nurses and their Indigenous consumers on factors supporting First Nations women’s access to and engagement with MCH services. This requires further research. This research confirmed that a MCH model that supports the depository of best practice in Indigenous-informed services that are locally responsive, flexible and focused on client needs (rather than the program guidelines) is required to address the growing number of Aboriginal women and children reported at risk of significant harm. Most importantly, the findings showed that a MCH service model, like the EARL concept, should allow for the integration of traditional Aboriginal child-rearing practices with Westernised values, practices and beliefs through a guided mastery approach, shared knowledge, yarning, capacity building, mutual trust and connection to facilitate effective engagement and trust in the service.

A key gap in the literature identified in this research is that there has not been a synthesis of qualitative studies of a model of care to help guide MCH practice and innovation for all families, especially those at risk of vulnerability (Barclay et al., 2014; Homer et al., 2012; Josif et al., 2017; Kruske et al., 2012; McCalman et al., 2015; Zarnowiecki et al., 2018). Future studies may benefit from testing the significance of the enablers identified from the six studies review in this thesis. For example, Homer et al. (2012) reported that the importance of continuity of caregiver was highlighted by study participants, with women describing it as ‘the best part of Malabar’. Their participants valued having a person they could call and having caregivers who knew their story. Additionally,

Barclay et al. (2014) stated that models of care or interventions are more likely to be successful if they are based on earlier engagement of families with MCH services and services with a focus on a continuum of care, to alleviate the risk of these families ‘falling through the cracks’.

Further research on MCH service models and interventions aimed at encouraging earlier identification of risk and of children and families who require further assessment, intervention, referral and support through a transdisciplinary approach, ideally from the antenatal period to a child’s fifth birthday (i.e., the first 2,000 days), is of international interest and importance for First Nations families. Such research is also of international importance for nursing practice and public health to address the human rights challenge of inequality in health outcomes between First Nations and non-First Nations children, the over-representation of First Nations children in OoHC and the high rates of First Nations children’s exposure to FV.

Appendices

Appendix One: Ethics approval of research



Annual/Final Project Report

Human Research Ethics Committee

<http://www.federation.edu.au/>

Please indicate the type of report	Final Report
Project No:	A21-102
Project Name:	Improving the Engagement of First Nations Families in Maternal and Child Health Services
Principal Researcher:	Professor Danny Hills
Other Researchers:	Professor Mary Cruickshank (Adjunct Professor) Catherine Austin (Student)
Date of Original Approval:	27 July 2021
School / Section:	Health/Nursing
Phone:	+61 3 53276652
Email:	d.hills@federation.edu.au

Please note: For HDR candidates, this Ethics annual report is a separate requirement, in addition to your HDR Candidature annual report, which is submitted mid-year to research.degrees@federation.edu.au.

1) Please indicate the current status of the project:		
1a) Yet to start	<input type="checkbox"/>	
1b) Continuing	<input type="checkbox"/>	
1c) Data collection completed	<input checked="" type="checkbox"/>	
1d) Abandoned / Withdrawn:	<input type="checkbox"/>	
1e) If the approval was subject to certain conditions, have these conditions been met? (If not, please give details in the comments box below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	<input type="checkbox"/> No
Comments:		

1f) Data Analysis	<input type="checkbox"/> Not yet commenced	<input type="checkbox"/> Proceeding	<input checked="" type="checkbox"/> Complete	<input type="checkbox"/> None
1g) Have ethical problems been encountered in any of the following areas: Study Design Recruitment of Subjects Finance Facilities, Equipment (If yes, please give details in the comments box below)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
Comments: There was ethical issues regarding some of the questions in the interviews relating to Study 2.				

2a) Have amendments been made to the originally approved project?	
<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
2b) If yes, was HREC approval granted for these changes?	
<input checked="" type="checkbox"/> Yes	Provide detail: <input checked="" type="checkbox"/> Yes Application for Amendment to an Existing Project <input type="checkbox"/> Yes Change of Personnel <input type="checkbox"/> Yes Extension Request
<input type="checkbox"/> No	If you have made changes, but not had HREC approval, provide detail as to why this has not yet occurred:
2c) Do you need to submit any amendments now?	
<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes Application for Amendment to an Existing Project <input type="checkbox"/> Yes Change of Personnel <input type="checkbox"/> Yes Extension Request * NB: If 'Yes', <u>download & submit the appropriate request</u> to the HREC for approval: Please note: Extensions will not be granted retrospectively. Apply well prior to the project end date, to ensure continuity of HRE approval.

3a) Please indicate where you are storing the data collected during the course of this project: (Australian code for the Responsible conduct of Research Ch 2.2.2, 2.5 – 2.7)
All hard copy data is being stored and archived according to the university policy and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018). Electronic files are password protected, stored and archived

according to the university policy and complies with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018).

3b) Final Reports: Advise when & how stored data will be destroyed (Australian code for the Responsible conduct of Research Ch 2.1.1)

Any data collected will be kept for a minimum of five years from the date of research publication. Data will be destroyed after a minimum of five years according to the university policy and will comply with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018).

4) Have there been any events that might have had an adverse effect on the research participants OR unforeseen events that might affect continued ethical acceptability of the project?

☒ No

☐ Yes * NB: If 'yes', please provide details in the comments box below:

Comments:

5a) Please provide a short summary of results of the project so far (no attachments please):

5b) Final Reports: Provide details about how the aims of the project, as stated in the application for approval, were achieved (or not achieved). (Australian code for the Responsible conduct of Research 4.4.1)

The aim of this thesis, as stated in the application for approval, is to explore and describe the engagement of First Nations women with children 0-5 years of age in accessing the Maternal and Child Health service in Victoria, Australia, by focusing on the intersectionality of both health care access and culture, which is a gap in the current literature. The primary objectives of the thesis is to gauge:

1. First Nations womens' perceptions of the MCH Service in Victoria, Australia.
2. What aspect/s of the current MCH Service in Victoria, Australia, needs to change, or be strengthened, to improve access and participation of First Nations families in the MCH service.

The aims of this project were achieved, and new knowledge was gathered from interviews with the participants in the research studies regarding the engagement of

First Nations women with children 0-5 years of age in accessing the MCH service in Victoria, Australia and their perceptions of the Maternal and Child Health Service in Australia, including what aspects of the current Maternal and Child Health service in Victoria, Australia, needs to change, or be strengthened, to improve access and participation of First Nations families. The research complied with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018).

6) Publications: Provide details of research dissemination outcomes for the previous year resulting from this project: e.g.: Community seminars; Conference attendance; Government reports and/or research publications

List of Publications arising from the thesis

Austin, C., Hills, D., & Cruickshank, M. (2022). Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature Review. *Children*, 9(5), 636.

<https://doi.org/10.3390/children9050636>

Austin, C. (2022). The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services. *Journal of Advanced Nursing*, 79(5), 1815–1829. <https://doi.org/10.1111/jan.15493>

Austin, C. & Arabena, K. (2021). Improving the engagement of Aboriginal families with maternal and child health services: A new model of care. *Public Health Research & Practice*, 31(2). <https://doi.org/10.17061/phrp30232009>

Presentations

1. Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature Review. Poster presentation at Maternal Child and Family Health Nurses Australia Conference 2022, September 2022, Canberra.
2. Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature

Review. Presentation at the Nursing Virtual Conference 2022, July 2022,
London.

7) The HREC welcomes any feedback on:

- Difficulties experienced with carrying out the research project; or
- Appropriate suggestions which might lead to improvements in ethical clearance and monitoring of research.

8) Signatures

Principal Researcher:	Print name:	Date:	19/05/2023
	Professor Danny Hills		
Other/Student Researchers:	Print name:	Date:	19/05/2023
	Professor Mary Cruickshank		
	Print name:	Date:	02/05/2023
	Catherine Austin		

***Submit to the Ethics Office, Mt Helen campus, by the due date:
research.ethics@federation.edu.au***

Human Research Ethics Federation University

The research conducted from 2017-2020, was deemed ‘low risk’, and was approved by the Human Research Ethics Committee of Federation University (project number **C17-024**). The research conducted from 2021-2023, was deemed ‘higher risk’ due to direct consultation with First Nations women and was approved by the Human Research Ethics Committee of Federation University (project number **A21-102**).

Ethics Approval Department of Health

The research conducted from 2017-2020, was deemed ‘low risk’, and was approved by the Centre for Evaluation & Research Evidence, of the Victorian Department of Health (project number **DET: 2017_002311**). The research conducted from 2021-2023, was deemed ‘higher risk’ due to direct consultation with First Nations women and was approved by the Centre for Evaluation & Research Evidence, of the Victorian Department of Health (project number **HHSD/21/649865**).

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

VACCHO advised that approval from an Indigenous Human Research Ethics Committee is not required for this research but provided a letter of support (Appendix Two).

Appendix Two: Letter of support for the research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services: An Integrative Review’

11 August 2021

Fiona Koop
Coordinator Research Ethics
Ethics and Integrity Office
Federation University Australia
Office F218 / Building F/ Mt Helen Campus



VACCHO
17-23 Sackville Street
PO Box 1328
Collingwood, VIC, 3066
P 03 9411 9411
F 03 9411 9599
www.vaccho.org.au

RE: Support Letter : Research work of Catherine Austin

Dear Fiona

We are writing to you to express our endorsement of the research work of Catherine Austin, Improving engagement of First Nations families in MCH services. This vital research seeks to better understand how engagement with First Nations families can be improved and contributes to the creation of a new model of care.

The proposed research project examines the experiences of Aboriginal women and families accessing Maternal and Child Health Services in Victoria. It builds on existing knowledge and research undertaken by VACCHO in 2014. The research aligns with VACCHO's new strategic plan On Solid Ground, with Thriving in the first three years being a key focus, acknowledging the critical need to engage with Aboriginal families in the early years.

Research that contributes to VACCHO's understanding of Aboriginal mothers and families' experiences and perspectives when accessing services will help improve early childhood outcomes. Aboriginal Qualitative research is essential in the design of sustainable and culturally safe services that meets the needs of Community and considers Aboriginal ways of Knowing, Being and Doing. Ensuring services meet the needs of families will increase engagement and access to early assessment and intervention and resulting in improved outcomes for Aboriginal children.

The researcher has a long history of working in genuine partnership with community members and the Aboriginal Community Controlled Health sector, bringing a high level of cultural safety to the research methods. The participatory approach reduces risks associated with undertaking this type of research.

VACCHO looks forward to seeing this research progress and using the findings to strengthen outcomes for Aboriginal children.

Kind regards

Jill Gallagher, AO
Chief Executive Officer

Appendix Three: PLIS for participation in the research: Study One and Study Two (First Nations women)

Plain Language Information Statement for the Research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’.

PROJECT TITLE:	Access and Engagement of First Nations Women in Maternal and Child Health Services
PRINCIPAL RESEARCHER:	Associate Professor Danny Hills Deputy Dean School of Health Health/Nursing
OTHER/STUDENT RESEARCHERS:	Professor Mary Cruickshank Adjunct Professor Health/Nursing Catherine Austin PhD Student: second year Health/Nursing

TO: The First Nations women invited to participate in this research *to explore and describe the engagement of First Nations women with children birth to five years of age accessing the Maternal and Child Health Service in Victoria, Australia.*

Date: XXXX

Full Project Title: Access and Engagement of First Nations Women in Maternal and Child Health Services

Principal Researcher: Associate Professor Danny Hills

Purpose of project: To review the engagement of Aboriginal families with Maternal and Child Health (MCH) services through consultation with Aboriginal women to explore their perceptions and experiences of MCH services.

Key research aim: To identify factors that facilitate and support, or conversely hinder, access to and engagement of Aboriginal families in MCH services.

The qualitative information captured in the research is expected to provide strong foundations for understanding the barriers that currently affect Aboriginal families' access and engagement in MCH services, which is expected to benefit the participants of this research, their families, and the Indigenous community in the Glenelg Shire.

Project consultation strategy: Recruitment of up to 30 Aboriginal women residing in the Glenelg Shire, Victoria, Australia, with at least one child birth to five years of age. The researchers will consult with Aboriginal women through existing Aboriginal Community Controlled Health Organisations (ACCHO) services, particularly established ACCHO playgroups, co-facilitated by key staff from the ACCHO's through face-to-face, in-depth semi-structured discussion ('yarning'), with individual and small groups. The audio-recorded discussions will run for approximately an hour on the ACCHO sites, co-facilitated by key staff from the ACCHO's, and in line with the National Health and Medical Research Council's Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders (2018).

The purpose of the consultation strategy is to engage with Aboriginal women that:

- are currently engaged with MCH services
- have previously participated in MCH, but are no longer engaged with their MCH service
- have never attended an MCH service.

Key topics:

- Why Aboriginal women choose to / choose not to attend MCH
- Why Aboriginal women choose a particular service model over another (Universal or Enhanced MCH Service)
- What Aboriginal women find valuable or unhelpful about the MCH service they receive
- What improvements could be made to MCH service for Aboriginal families.

Timeframe:

- Week 1-2: Project establishment with site identified
- Week 3-6: Coordination and implementation of the consultation strategy
- Week 7-10: Project analysis and reporting

Limitations

It may be impossible to guarantee anonymity or confidentiality of participants' identity where the sample size is very small or when the research involves focus groups.

Privacy and Confidentiality

There is a possibility that in participating in this research, your de-identified data or information collected may be used by the research team, or others, to inform future research projects. Strict criteria will be followed to maintain privacy and confidentiality of the participants. Any restrictions on the use of participants' data and information will be recorded and the record kept with the collected data and information. Restrictions will be accessible to researchers who want to access those data and information for research. Disseminated results will not include information that identifies individual participants (unless specific permission has been obtained). Confidentiality of information offered is subject to legal limitations (e.g., subpoena, freedom of information claim, or mandatory reporting).

Participation is voluntary, refusal to participate requires no explanation. Participants are free to choose not to answer questions during interview, without consequence. There will be an opportunity for participants to preview results and transcripts and to withdraw or amend any data during or at the end of the interview or any unprocessed data previously supplied. Participants are entitled to withdraw their consent to participate and discontinue participation at any time, without consequence. If consent is withdrawn after data has been aggregated and processed it will not be possible to withdraw non-identifiable data, although consent can still be withdrawn. The project team anticipate that the research will have a low risk to the participant. The project team will collaborate with participants and key staff from the nominated ACCHO sites during the research to ensure that the research is progressing without any adverse effects. Researchers will be guided by the two nominated ACCHO's for advice regarding suitable additional support for the participant, if they believe this will be required.

The student researcher, who will be conducting all fieldwork, will follow all relevant Federation University policies to ensure that the security of all recordings and notes while doing fieldwork. The site coordinator will not have access to these recordings and notes. All hard copy data will be stored and archived according to the university policy. Electronic files will be password protected. Following the completion of the research, all material relating to this research will be archived according to Federation University policies and deleted after five years, according to the same policy.

Ethical guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Questions/Complaints

If you have any questions, or you would like further information regarding the project titled *Access and Engagement of First Nations Women in Maternal and Child Health Services* please contact the Principal Researcher, Associate Professor Danny Hills of the School of Nursing, Federation University Australia.

Email: d.hills@federation.edu.au

Phone: +61 3 53276652

Should you (i.e. the participant) have any concerns about the ethical conduct of this research project, please contact the Federation University Coordinator Research Ethics,

Research Services, Federation University Australia,

P O Box 663 Mt Helen Vic 3353

Telephone: (03) 5327 9765

Email: research.ethics@federation.edu.au

CRICOS Provider Number 00103D

Appendix Four: Consent for participation in the research: Study One and Study Two (First Nations women)

Consent for participation in the Research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’.

PROJECT TITLE:	Access and Engagement of First Nations Women in Maternal and Child Health Services
RESEARCHERS:	Danny Hills (Principal Researcher) Mary Cruickshank (Supervisor) Catherine Austin (PhD Student)

Consent – Please complete the following information:

I _____ of

hereby consent to participate as a subject in the above research study. The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction. I have been given a copy of the Plain Language Information Statement (PLIS) to keep, and freely agree to participate in this project according to the conditions in the PLIS. I understand that my audio responses will be recorded and that all information I provide will be treated with the strictest confidence. Data will be stored separately from any listing that includes my name and address.

- Aggregated results will be used for research purposes and may be reported in scientific and academic journals.
- I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and information/data obtained

from it will not be used.

- I understand the exception to this is if I withdraw after information has been aggregated
- it is unable to be individually identified - so from this point it is not possible to
withdraw my information/data, although I may still withdraw my consent to participate.

The researcher has agreed not to reveal my identity and personal details.

Participant's Name (printed):

Mobile:

Email:.....

Signature.....

Date.....

Thank you for your participation ☺

Appendix Five: PLIS for participation in the research: Study Two (MCH nurses)

Plain Language Information Statement for the Research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’

PROJECT TITLE:	Access and Engagement of First Nations Women in Maternal and Child Health Services
PRINCIPAL RESEARCHER:	Dr Linda Jones School of Health Federation University
OTHER/STUDENT RESEARCHERS:	Dr Jeong-ah Kim School of Health Federation University Catherine Austin PhD Student School of Health Federation University

TO: The Maternal and Child Health nurses invited to participate in this research to identify Maternal and Child Health nurses’ perceptions of the barriers First Nations women with children aged birth to five years have accessing and engaging in their services.

Date: XXXX

Full Project Title: Access and Engagement of First Nations Women in Maternal and Child Health Services.

Principal Researcher: Dr Linda Jones

Purpose of project: To identify Maternal and Child Health nurses’ perceptions of the barriers First Nations women with children aged birth to five years have accessing and engaging in their services.

Key research aim: To identify factors that facilitate and support, or conversely hinder, access to and engagement of First Nations families in Maternal and Child Health services. The qualitative information captured in the research is expected to provide strong foundations for understanding the barriers that currently affect Aboriginal families' access and engagement in MCH services, which is expected to benefit the participants of this research, their families, and the Indigenous community in the Glenelg Shire.

Project consultation strategy: Recruitment of up to 10 Maternal and Child Health nurses working in the Glenelg Shire, Victoria, Australia.

Key topics:

- What barriers First Nations women with children aged birth to five years have accessing and engaging in their services.

Limitations

It may be impossible to guarantee anonymity or confidentiality of participants' identity where the sample size is very small or when the research involves focus groups.

Privacy and Confidentiality

There is a possibility that in participating in this research, your de-identified data or information collected may be used by the research team, or others, to inform future research projects. Strict criteria will be followed to maintain privacy and confidentiality of the participants. Any restrictions on the use of participants' data and information will be recorded and the record kept with the collected data and information. Restrictions will be accessible to researchers who want to access those data and information for research. Disseminated results will not include information that identifies individual participants (unless specific permission has been obtained). Confidentiality of information offered is subject to legal limitations (e.g., subpoena, freedom of information claim, or mandatory reporting). Participation is voluntary, refusal to participate requires no explanation. Participants are free to choose not to answer questions during interview, without consequence. There will be an opportunity for participants to preview results and transcripts and to withdraw or amend any data during or at the end of the interview or any

unprocessed data previously supplied. Participants are entitled to withdraw their consent to participate and discontinue participation at any time, without consequence. If consent is withdrawn after data has been aggregated and processed it will not be possible to withdraw non-identifiable data, although consent can still be withdrawn.

The project team anticipate that the research will have a low risk to the participant. Following the completion of the research, all material relating to this research will be archived according to Federation University policies and deleted after five years, according to the same policy.

Ethical guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Questions/Complaints

If you have any questions, or you would like further information regarding the project titled *Access and Engagement of First Nations Women in Maternal and Child Health Services* please contact the Principal Researcher, Dr Linda Jones of the School of Health, Federation University Australia.

Email: l.jones@federation.edu.au

Should you (i.e. the participant) have any concerns about the ethical conduct of this research project, please contact the Federation University Coordinator Research Ethics,

Research Services, Federation University Australia,

P O Box 663 Mt Helen Vic 3353

Telephone: (03) 5327 9765

Email: research.ethics@federation.edu.au

CRICOS Provider Number 00103D

Appendix Six: Consent for participation in the research: Study Two (MCH nurses)

Consent for participation in the Research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’.

PROJECT TITLE:	Access and Engagement of First Nations Women in Maternal and Child Health Services
RESEARCHERS:	Linda Jones (Principal Researcher) Dr Jeong-ah Kim (Supervisor) Catherine Austin (PhD Student)

Consent – Please complete the following information:

I _____ of

hereby consent to participate as a subject in the above research study. The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction. I have been given a copy of the Plain Language Information Statement (PLIS) to keep, and freely agree to participate in this project according to the conditions in the PLIS. I understand that my audio responses will be recorded and that all information I provide will be treated with the strictest confidence. Data will be stored separately from any listing that includes my name and address.

- Aggregated results will be used for research purposes and may be reported in scientific and academic journals.
- I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and information/data obtained from it will not be used.
- I understand the exception to this is if I withdraw after information has been aggregated - it is unable to be individually identified - so from this point it is not possible to withdraw my information/data, although I may still withdraw my consent to participate.

The researcher has agreed not to reveal my identity and personal details.

Participant's Name (printed):

Mobile:.....

Email:.....

Signature.....

Date.....

Thank you for your participation ☺

Appendix Seven: Early Assessment Referral Links Key Terms of Reference

Purpose

To work collaboratively across agencies to develop protocols that allow for improvement in service delivery outcomes provided to vulnerable men, women, children and their families.

To collaboratively develop best practice models of service delivery to vulnerable women, children and their families.

To enable the sharing of relevant information so that gaps in service delivery to vulnerable women, children and their families can be addressed as soon as they are identified.

Objectives

To improve outcomes through collaboration and integration between services
Promoting a team around the child approach through information sharing, shared learning and best practice.

Membership

The EARL network is an open network from across the Glenelg Shire improving outcomes for all children and their families.

Organisations working with families and children aged 8 and below are welcome to participate, including organisations with a focus on antenatal health.

Frequency and Length of meetings

EARL meetings are to be held bi monthly for approx. 90 min over a variety of venues to be decided at the first meeting

Chair Person

The chairperson's responsibilities are to:

- Schedule meetings and notify other members
- Invite guest speakers when and if required
- Approve agendas and minutes before distribution
- Ensure all discussion items end with a decision, action or outcome where possible.

Secretariat

The secretariat's responsibilities are to

- To ensure minute's agenda and supporting papers are distributed to all members in a timely manner allowing for time for discussion and forward-planning.

Appendix Eight: Consent to share information: Study Three (First Nations families and EARL stakeholders)

CONSENT TO SHARE INFORMATION FORM

CONSENT TO OBTAIN/SHARE INFORMATION

(Pursuant to a function under the Child Wellbeing and Safety Act 2005)

I , authorize, *insert name of insert school* to share/request information pertaining to their involvement with me and my child *insert name* with the following agencies/people:

.....
.....
.....
.....

The request/sharing of information is for a function performed related to the Child Wellbeing and Safety Act 2005. The information shared/requested is subject to the secrecy provisions of the Child Wellbeing and Safety Act 2005. I understand that the information obtained may also need to be shared with others without my agreement if it is in the best interests and related to the safety and well-being of *insert name*.

.....
Signature

/ /

.....
[Please print name]

I have advised "insert client" name the reasons why the information is required, the ways the information may be used and the basis upon which the information may be shared with others under the Child Wellbeing and Safety Act 2005.

.....
Signature

/ /

.....
[Please print name]

Appendix Nine: Invitation to participate in the research: Study Three (EARL stakeholders)

14 August 2014

Dear Colleague

RE: Invitation to take part in research to evaluate the effectiveness of the Early Assessment Referral Links (EARL) model to engage families with Aboriginal and Torres Strait Islander children aged birth to five years of age.

I am currently undergoing my Doctorate Thesis (PhD) at Federation University, Mt. Helen.

Research Title: Access and Engagement of First Nations Women in Maternal and Child Health Services

I have chosen to evaluate the Early Assessment Referral Links (EARL) model, piloted in the Glenelg Shire from July 2009-June 2014, as part of this research. As you are aware, the model aims to improve the identification of families with children from conception to five years of age, who are at risk of vulnerability, for the purpose of identifying and reducing gaps within service delivery and to link those families into local services to provide a continuum of care, so a strong support system is in place before the baby is born. The model's framework is based on effective coordination, collaboration and communication, which is in line with the aims of the Victorian State Government's *Roadmap for Reform: Strong Families, Safe Children*.

As you/your organisation was a stakeholder during this pilot, you have been invited to participate in the survey: *The effectiveness of the Early Assessment Referral Links model to engage Aboriginal and Torres Strait Islander families in universal services*. The research aims, methodology and plan are cited in the Plain Language Statement and Consent Form attached.

The survey will take approximately **5 minutes** to complete. Your feedback will provide insight into the effectiveness of the EARL model to engage families at risk of vulnerability and how the model can be improved to provide a continuum of supported care through collaboration and integration of services and add to the body of knowledge regarding best practice in the field of Maternal and Child Health. This evaluation will lead to further research to develop an appropriate model of care to improve the health, development and wellbeing of Aboriginal and Torres Strait Islander children and their families.

I would be grateful if you would please complete the survey by Friday 31 August 2014.

This survey can be accessed via <https://www.surveymonkey.com/r/WVKYG7Y>

If you have any questions please feel free to contact me.

Yours sincerely

Catherine Austin

Federation University Student Number: 30333551

M: 0428 267 247

E: catherineaustin@students.federation.edu.au

Appendix Ten: PLIS for participation in the research: Study Three (EARL stakeholders)

Plain Language Statement for participation in the research

TO: Organisations involved in the Early Assessment Referral Links (EARL) Pilot—
July 2009 – June 2014

Plain Language Information Statement for the Research ‘Access and Engagement of First Nations Women in Maternal and Child Health Services’

PROJECT TITLE:	Access and Engagement of First Nations Women in Maternal and Child Health Services
PRINCIPAL RESEARCHER:	Dr Linda Jones School of Health Federation University
OTHER/STUDENT RESEARCHERS:	Dr Jeong-ah Kim School of Health Federation University Catherine Austin PhD Student School of Health Federation University

TO: Organisations involved in the Early Assessment Referral Links (EARL) Pilot—
July 2009 – June 2014

Date: XXXX

Full Project Title: ‘Access and Engagement of First Nations Women in Maternal and
Child Health Services’

Principal Researcher: Dr Linda Jones

Date: 14 August 2014

Aim

The aim of this research is to ascertain if the Early Assessment Referral Links (EARL) model of care facilitated coordination, collaboration and communication between services to meet the needs of families and children at risk of vulnerability, in line with the aims of the State of Victoria's Roadmap for Reform: Strong Families, Safe Children.

Methodology

Type of Study: Qualitative Research

A qualitative data analysis will be used in this study to evaluate the validity of the current MCH Service Model to effectively engage Aboriginal and Torres Strait Islander families and ascertain if an alternative model of care, namely the Early Assessment Referral Link (EARL) model, has the potential to be more successful to engage these families and, as a consequence, better identify the risk of family violence for women with Aboriginal and Torres Strait Islander children 0–6 years. The purpose of this framework is to identify and reduce gaps within service delivery and to link those families into local services to provide a continuum of care, so a strong support system is in place before the baby is born. The objective of EARL is to establish a supportive framework for families to prevent a problem occurring rather than services being linked to the families once a problem has occurred.

Scope

This research is a survey of the EARL stakeholders involved in the full pilot period (n = 13) to gauge from their perspective the effectiveness of the EARL model to engage Aboriginal and Torres Strait Islander families and recommendations for improvement of the model. The quantitative data will be analysed through use of SPSS software, proven to be consistently reliable in a variety of social science statistical analysis projects.

Project plan

Phase 1: Plan survey

Phase 2: Distribute survey

Phase 3: Analyse survey

Phase 4: Evaluate survey

Phase	Start	Finish
1	June 2014	July 2014
2	August 2014	August 2014
3	August 2014	September 2014
4	September 2014	September 2014

Limitations

I do not anticipate any limitations to my research as I anticipate full support from DET, MAV and the stakeholders involved in the research as the findings will add to the body of knowledge regarding best practice in the field of MCH and will lead to further research to develop an appropriate model of care to improve the health, development and wellbeing of Aboriginal and Torres Strait Islander children and their families.

Privacy and Confidentiality

It will not be possible to identify any participant in any of the surveys. Where I will talk about data from any of the individual surveys, I will not use names and I will ensure that any information that might identify a person has been removed from the data before it is published or reported.

Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The research was conducted according to the National Statement on Ethical Conduct in Human Research (2007), produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The nature of this research is considered as 'low risk' by the Human Research Ethics Committee of Federation University (project number **C17-024**), the Department of Education and Training (project number **2014_002311**) and the Department of Health and Human Services. The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has advised that approval from an Indigenous Human Research Ethics Committee (HREC) is not required for this research.

Questions/Complaints

If you have any questions, or you would like further information regarding the project titled *Improving the Engagement of First Nations Families in Maternal and Child Health Services* please contact the Principal Researcher, Dr Linda Jones of the School of Health, Federation University Australia.

Email: l.jones@federation.edu.au

Should you (i.e. the participant) have any concerns about the ethical conduct of this research project, please contact the Federation University Coordinator Research Ethics,

Research Services, Federation University Australia,

P O Box 663 Mt Helen Vic 3353

Telephone: (03) 5327 9765

Email: research.ethics@federation.edu.au

CRICOS Provider Number 00103D

Appendix Eleven: Consent for participation in the research: Study Three (EARL stakeholders)

Consent for participation

Date: 14 August 2014

Full Project Title: Access and Engagement of First Nations Women in Maternal and Child Health Services'

CONSENT FORM

I have read and I understand the attached Plain Language Statement.

I freely agree to participate in this project according to the conditions in the Plain Language Statement. I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details.

Participant's Name (printed).....

Signature.....

Date.....

Please complete the survey by Friday 31 August, 2014

via the following link <https://www.surveymonkey.com/r/WVKYG7Y>

Catherine Austin

E: catherineaustin@students.federation.edu.au

Thank You.

Appendix Twelve: Survey Monkey questionnaire for Study Three (EARL stakeholders)

As you/your organisation was a stakeholder of the Early Assessment Referral Links (EARL) model piloted in the Glenelg Shire from July 2009 – June 2014, you have been invited to participate in this survey. Your feedback will provide insight into the effectiveness of the EARL model to engage families at risk of vulnerability and how the model can be improved to provide a continuum of supported care through collaboration and integration of services.

1. Do you or your organisation experience difficulty engaging the families of children birth to five years of age at risk of vulnerability?

Always

Usually

Sometimes

Rarely

Never

Please explain:

2. Does the Early Assessment Referral Links (EARL) model of care improve the identification of risk of vulnerability earlier than current universal service models?

Always

Usually

Sometimes

Rarely

Never

Please explain:

3. Did the Early Assessment Referral Links (EARL) model of care enable smoother transition of children through the life stages of the early years—antenatal, infancy, preschool, school?

Always

Usually

Sometimes

Rarely

Never

Please explain:

4. Did the Early Assessment Referral Links (EARL) model of care improve the outcomes of children birth to five years of age and/or their families that engaged in the pilot via your organisation?

Always

Usually

Sometimes

Rarely

Never

Please explain:

5. Did the Early Assessment Referral Links (EARL) model of care facilitate coordination between service providers working in the universal service system to work collaboratively to develop best practice models of service delivery to families with children birth to five years of age at risk of vulnerability?

Always

Usually

Sometimes

Rarely

Never

Please explain:

6. Did the Early Assessment Referral Links (EARL) model improve the engagement of Aboriginal and Torres Strait Islanders families with children birth to five years of age in your service during the pilot period?

Always

Usually

Sometimes

Rarely

Never

7. What are the strengths of the Early Assessment Referral Links (* EARL) model of care?

8. What are the weaknesses of the Early Assessment Referral Links (EARL) model of care?

9. How can the Early Assessment Referral Links (EARL) model of care be improved to provide a continuum of supported care through collaboration and integration of services?

10. Please provide any other feedback regarding the Early Assessment Referral Links (EARL) model of care:



Article

Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature Review

Catherine Austin ^{1,*}, Danny Hills ^{1,2} and Mary Cruickshank ¹

¹ School of Health, Federation University, Mount Helden, VIC 3350, Australia; d.hills@federation.edu.au (D.H.); m.cruickshank@federation.edu.au (M.C.)

² Health Innovation and Transformation Centre, Federation University, Mount Helden, VIC 3350, Australia

* Correspondence: austincl62@gmail.com; Tel: +61-4-2826-7247



Citation: Austin, C.; Hills, D.; Cruickshank, M. Models and Interventions to Promote and Support Engagement of First Nations Women with Maternal and Child Health Services: An Integrative Literature Review. *Children* 2022, 9, 636. <https://doi.org/10.3390/children9050636>

Academic Editor: Rada K. Dagher

Received: 26 December 2021

Accepted: 27 April 2022

Published: 28 April 2022

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.



Copyright: © 2022 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

Abstract: Background: Studies show that participation in maternal and child health (MCH) services improves health outcomes for First Nations families. However, accessing MCH services can be associated with fear, anxiety, and low attendance at subsequent appointments. Objective: To identify the existing knowledge of models/interventions that support engagement of First Nations women with MCH services in the child's first five years. Methods: An integrative review was undertaken of full-text, peer-reviewed journal articles and grey literature, which were analysed to identify barriers and enabling factors that influenced the engagement of First Nations families with MCH services. Results: Enabling factors that influenced the engagement with MCH services included service models/interventions that are timely and appropriate, and effective integrated community-based services that are flexible, holistic, culturally strong, and encourage earlier identification of risk and further assessment, intervention, referral, and support from the antenatal period to the child's fifth birthday. Barriers to engagement included inefficient communication, lack of understanding, cultural differences between the client and the provider, poor continuity of care, limited flexibility of service delivery to meet individual needs, and a health care model that does not recognise the importance of the social determinants of health and wellbeing. Discussion: Timely, effective, holistic engagement with First Nations women during their child's first 2000 days, which respects their culture and facilitates genuine partnerships built on co-design and shared decision making with the indigenous community, needs to be an essential part of the MCH service model if health care providers seek to practice within First Nations communities. Conclusion: Improving engagement with MCH services is important for First Nations families, nursing practice, and public health.

Keywords: First Nations; maternal and infant health; social determinants of health

1. Introduction

The early years of life are the foundation for lifelong physical, social, spiritual, and emotional wellbeing [1,2]. The first 2000 days, the antenatal period to the child's fifth birthday, comprise the critical period of foetal and child development, which forms the foundation for all subsequent development and health throughout the child's lifetime [3]. The period of early childhood also represents a critical window of opportunity, where optimal health and educational interventions can provide benefits that extend across the life course [3–6].

The United Nations General Assembly [7] acknowledges the rights of children 'to the highest attainable standard of health' with a focus on preventative and primary health care for children, prenatal and postnatal health care for mothers, and diminishing infant and child mortality. The need for improved child health care for First Nations populations is evident by ongoing disparities in child health among the indigenous and tribal populations in Australia, Canada, New Zealand, and the United States [8]. Ensuring First Nations

women have access to appropriate health care in the antenatal and postnatal period is vital for the long-term health outcomes for the mother and her child [9]. First Nations peoples, also referred to as indigenous peoples, are the direct descendants from the original known inhabitants of a geographic region [10].

Many First Nations families deal with ongoing stressors from the intergenerational trauma of the impacts of colonisation [8]. This can manifest in psychological distress or grief, smoking, alcohol and drug misuse, mental illness, or violence and consequently may affect their ability to nurture children [10]. However, First Nations families have strong bonds with their immediate family members and extended families, which influences the cultural norms governing their child rearing practices [10]. These strong family bonds provide opportunities for Maternal and Child Health (MCH) services to support First Nations families and address upstream social determinants of First Nations children's health and wellbeing [10,11].

In Australia, MCH nurses, also referred to as 'child and family nurses', are uniquely placed in the community to influence the shape of this critical period in a child's life [6]. Participation in the MCH service provides the opportunity to identify, or prevent, health risks to children and their families [1,2]. Women are referred to MCH services by midwives from maternity services after birth and are offered a schedule of routine monitoring of child development, parenting support, health promotion services, and early identification of family needs and responses to these needs until the child is at least five years old [6]. Despite the aims of universal service provision, populations such as some indigenous and culturally and linguistically diverse (CALD) families do not engage with services [12] or do not sustain visits [13], and economically disadvantaged families are less inclined to access services [14]. For example, although 95–98 per cent of Victorian women with new-born children are being visited at home within two weeks of birth [6], there are critics of the current Victorian universal MCH service model, especially in relation to the engagement of Aboriginal and Torres Strait Islander families [6,12,14]. This is largely due to the consistently lower participation rates of indigenous children compared to non-indigenous children at all 10 Key Age Stage (KAS) consultations provided within the universal MCH service since the inception of the KAS model in 2009 [6]. This gap increases from the initial home visit to the eight-month consultation, indicating that First Nations women in Victoria are disengaging with the MCH service shortly after their initial enrolment in the service [6]. This brings into effect an 'inverse care law', suggesting that those who need more intense, high-quality care are least likely to receive it [14]. It is also well recognised that there is poor health among indigenous families in countries with a history of colonisation, such as Australia, New Zealand, and Canada, and access to services is adversely affected by historical and contemporary social determinants of health, such as the distribution of power, influence, wealth, and income [8]. Indigenous parents in particular require support services that are culturally strong, timely and appropriate, and holistic to strengthen their families' health outcomes [1,2,15]. Ensuring the optimal design of a model that promotes and supports the engagement of First Nations families and their access to MCH services in the period from the child's birth to five years of age is impeded by the dearth of information on the relationship between specific services and children's health outcomes [16]. The aim of this review, therefore, is to identify the factors that support or hinder the engagement of First Nations women with children from birth to five years of age and their access to MCH services, and the improvements that could be made to enhance engagement and access for First Nations women in relation to these services.

2. Materials and Methods

2.1. Search Criteria

An integrative literature review entails undertaking a systematic search, critique, and summary of relevant literature [17,18]. The inclusion criteria for this review were full-text, peer-reviewed journal articles and grey literature of relevant studies that investigated models and interventions that aim to promote and support the engagement of First Nations

families and their access to MCH services in the period from the child's birth to five years of age. The exclusion criteria were study protocols or policy perspectives, which discussed risk factors for specific diseases or practices, descriptions or evaluations of interventions or programs that exclusively focused on the antenatal period, or reports of pregnancy or birth outcomes.

2.2. Search Strategy and Outcomes

Searches were conducted in Medline, PsychInfo, CINAHL, and Scopus databases, and relevant government publications from January 2011 to April 2021 were reviewed for inclusion. Search terms, singular and in combination, of the search terms 'matern*', 'child*', 'famil*', 'postnatal', 'service*', 'care', 'health', 'model*', 'intervention*', 'approach*', 'indigen*', 'aborig*', 'torres strait', 'first nation*', 'native', 'engag*', 'interact*', 'uptake*', 'continu*', 'access*', were included, in conjunction with the terms 'and' and 'or'.

The initial database search identified 732 records, with an additional 99 records identified from grey literature on Google Scholar (47), hand searching and snowballing from the reference lists of included articles (43), and utilising peer referral (9). These searches yielded a total of 831 records. After the preliminary screening that entailed the removal of duplicates (30), 801 records remained. Following a further screening of the titles and abstracts of articles against the inclusion and exclusion criteria, 652 records were deleted, and 149 records remained. After a secondary screening of full-text articles against the inclusion and exclusion criteria, a further 143 records were excluded, and six records remained. These six records were individually assessed by the authors who helped determine if they met the inclusion criteria, all six being included in the final review. Each stage of the literature search is summarized in Figure 1.

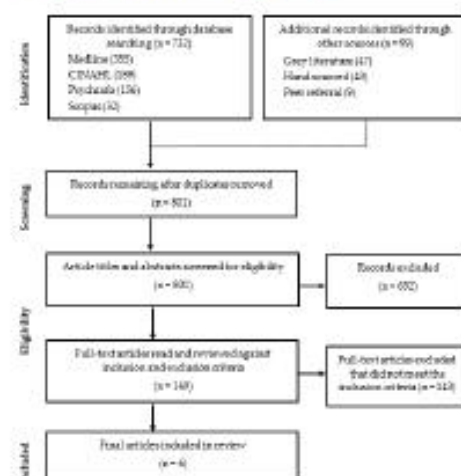


Figure 1. Literature review flow diagram.

Articles were analysed by authors CA, DH, and MC separately and then collectively, using Braun and Clarke's six-step process for identifying, analysing, and reporting qualitative research using thematic analysis [19]. Thematic analysis provided an easily interpretable and concise description of the emergent themes and patterns to identify broad concepts of the barriers and enabling factors that influenced access to and engagement of First Nations families with MCH services. The six-step process included familiarising ourselves with the research articles; generating initial codes; searching for themes; reviewing the themes; defining and naming the themes; and producing a report with the themes found within the research articles.

A summary of the analysed studies is presented in Table 1.

Table 1. Models/interventions that promote and support engagement of First Nations families and their access to maternal and child health services from the child's birth to five years of age.

Author/Date/Title	Sample	Type of Study/Methodology	Thesis/Intention of Work	Intervention	Results
Barclay, L.; Kruskal, S.; Bas-Zeev, S.; Stoerckamp, M.; Josif, C.; Wulili Narjic, C.; Wardaguga, M.; Bolton, S.; Gao, Y.; Dunbar, T.; Kildea, S., 2014, [20]. Improving Aboriginal maternal and infant health services in the 'Top End' of Australia: synthesis of the findings of a health services research program aimed at engaging stakeholders, developing research capacity and embedding change.	<p>Baseline data study: Data from 412 mothers and their 413 babies who were recruited from two remote study sites over two years (2004–2006) were audited; 120 h of observation of maternal and child health services and 60 semi-structured interviews were conducted in 3 settings with key stakeholders.</p> <p>Epidemiological studies: An epidemiological investigation of 7560 mothers with singleton pregnancies utilizing the Northern Territory perinatal data set that included births occurring between 2003 and 2005 was conducted.</p> <p>Study of out-of-hospital births: Audit of 32 records of women who birthed locally, detailed field notes, stories collected, and unstructured interviews with 7 locally birthing women and 5 of their family members.</p> <p>Parenting study: Longitudinal interviews and observations with 15 women from each field site from pregnancy until their babies were 12 months of age. Discussions were held with women and family members and narratives collected.</p> <p>Impact of colonisation of health care in the Northern Territory: An Aboriginal PhD candidate with Aboriginal co-researchers led a study of the quality and nature of health care with a case study on intergenerational learning about birthing.</p> <p>Post-intervention evaluation: A total of 66 participants were interviewed; the audit of the record was repeated; field notes were kept and observations undertaken in remote sites.</p> <p>Participatory Action Research Study: Baseline data on problems with transfer of information between the regional centre and the remote clinics led to a study by a senior manager and two researchers on improving the system.</p> <p>Costing study: A total of 315 mothers and singleton infants who were clients of the midwifery group practice were compared with 408 mothers with singleton pregnancies from the baseline study post-midwifery group practice intervention. Data on direct costs from the department's perspective were collected from the first antenatal visit until 6 weeks post-partum, and data on infant costs were collected from birth to 28 days.</p> <p>Benchmarking of neonatal nursery admissions: Records of all 463 neonates born in 2010 and admitted to nursery were benchmarked.</p>	A mixed-methods health services research program of work was designed, using a participatory approach.	<p>The study consisted of two large remote Aboriginal communities in the Top End of Australia and the hospital in the regional centre that provided birth and tertiary care for these communities.</p> <p>The stakeholders included consumers, midwives, doctors, nurses, Aboriginal health workers, managers, policy makers, and support staff. Data were sourced from hospital and health centre records, perinatal data sets and costing data sets, observations of maternal and infant health service delivery and parenting styles, formal and informal interviews with providers and women and focus groups. Studies examined indicator sets that identify best care, the impact of quality of care and remoteness on health outcomes, discrepancies in the birth counts in a range of different data sets and ethnographic studies of 'out of hospital' or health-centre birth and parenting. A new model of maternity care was introduced by the health service aiming to improve care following the findings of the research. Some of these improvements introduced during the five-year research program were evaluated.</p>	1 + 1 = A Healthy Start to Life Project. Focus on health services in the year before and the year after birth to promote a healthy start to life. This became the main health-service-led 'intervention' of the study.	<p>Overall, sustainable improvements in the maternity services for remote-dwelling Aboriginal women and their infants in the Top End of Australia occurred as a result of the midwifery group practice (MGP) intervention. These included significant improvements in maternal record keeping, antenatal care and screening, smoking cessation advice, a reduction in foetal distress in labour, and a higher proportion of women receiving postnatal contraception advice. Positive experiences of the women and MGP staff were also reported during the first year of the MGP intervention. Continuity of care, provided by appropriately qualified staff as part of the intervention, resulted in improved relationships between the midwives and their clients. The women's engagement with other health services, facilitated by the midwives, also improved. Additionally, overall costs were reduced as a result of a significant reduction in birthing and neonatal nursery costs as a result of the MGP intervention. However, a review of this intervention conducted in 2012 showed further improvement in clinical care was still needed. Some adverse health conditions appeared to increase, possibly due to improved documentation. Specifically, unacceptable standards of infant care and parental support, no apparent consideration for the fluctuation in numbers and complexity of client cases and adequately trained staff with the required skills for providing care for children in an 'outpatient' model of care. Adequate coordination between remote and tertiary services was absent, which is essential to improve quality of care and reduce the risk of poor health outcomes.</p>

Table 1. Cont.

Author/Date/Title	Sample	Type of Study/Methodology	Thesis/Intention of Work	Intervention	Results
Bar-Zeev, S.; Barclay, L.; Farrington, C.; Kildea, S., 2012, [21]. From hospital to home: the quality and safety of a postnatal discharge system used for remote dwelling Aboriginal mothers and infants in the top end of Australia.	A total of 420 women were eligible for the study, sought from 413 medical records at the regional hospital and 400 at the remote health service. A total of 66 semi-structured interviews were conducted with key health and management staff and 30 administrative staff employed in the health centres; 18 staff from the regional hospital maternity, neonatal, and paediatric units; and 12 other staff providing clinical, administrative, or logistical support for remote-dwelling women during pregnancy, around the time of birth, and during the first year of life.	Mixed-methods study, retrospective cohort study, and key informant interviews.	The study aimed to examine the transition of care in the postnatal period from a regional hospital to a remote health service and describe the quality and safety implications for remote-dwelling Aboriginal mothers and their infants.	None introduced.	This study found that there was poor discharge documentation, communication, and co-ordination between the hospital and remote health centre staff. In addition, the lack of clinical governance and a specific position holding responsibility for the postnatal discharge planning process in the hospital system were identified as serious risks to the safety of the mother and infant.
Homer, C.; Fourquet, M.; Alende, T.; Pekin, E.; Caplice, S.; Catling-Paull, C., 2012, [22]. It's more than just having a baby' women's experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families.	Clinical outcomes for the 353 women who were booked with the Malabar Community Midwifery Link Service and gave birth in the 2007 and 2008 calendar years were collected prospectively from the database.	Clinical outcomes were collected prospectively and quantitatively analysed. Data from the 353 women who were booked with the Malabar Community Midwifery Link Service were transcribed and analysed qualitatively.	The paper evaluates the Malabar Community Midwifery Link Service from the perspective of Aboriginal women who accessed it.	Malabar Community Midwifery Link Service. The intervention aims to improve maternal and infant health by providing culturally appropriate care. The midwives work closely with the Aboriginal Health Education Officer and in a continuity of care model in which women get to know the midwives during the pregnancy.	Accessing the Malabar Community Midwifery Link Service helped women reduce their smoking during pregnancy. Focus group findings showed that women felt the service provided ease of access, continuity of care, and trust and trusting relationships. A total of 353 women gave birth through accessing the Malabar Community Midwifery Link Service, with forty per cent of babies identified as Aboriginal or Torres Strait Islander. Over ninety per cent of women had their first visit before 20 weeks of pregnancy.
Josif, C.; Kruske, S.; Kildea, S.; Barclay, L., 2017, [23]. The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes: a qualitative analysis.	Data were collected from 25 clinicians providing or managing infant health services in the two study sites.	Semi-structured interviews, participant observation, and field notes were analysed thematically.	The study describes infant health service quality following health system changes in the area.	Health system changes. These reforms included implementation of the Healthy Under 5 Kids (HUSK) program and an education package to support staff to deliver this program. Designated Child and Family Health Nurses and Aboriginal Community Worker positions were also established in the two Healthy Start to Life study sites.	A range of factors affecting the quality of care persisted following health system changes in the two study sites. These factors included ineffective service delivery, inadequate staffing, and culturally unsafe practices. The six sub-themes identified in the data, namely, 'very adhoc', 'swallowed by acute', 'going under', 'a flux', 'a huge barrier', and 'them and us', illustrate how these factors continued following health system changes in the two study sites and, when combined, portray a 'very chaotic system'. Improvements are needed to the quality, cultural responsiveness, and effectiveness of the health services.

Table 1. Cont.

Author/Date/Title	Sample	Type of Study/ Methodology	Thesis/ Intention of Work	Intervention	Results
McCalman, J.; Searles, A.; Bainbridge, R.; Ham, R.; Mein, J.; Neville, J.; Campbell, S.; Tsey, K., 2015, [11]. Empowering families by engaging and relating Murri way: a grounded theory study of the implementation of the Cape York Baby Basket program.	In-person interviews of 7 women and 3 of their family members who had received Baby Baskets were conducted. The women, aged 21 to 34 years, were either pregnant or recently pregnant and were from six of the eleven indigenous communities in Cape York, Australia. Focus groups were conducted with 18 healthcare workers.	Constructivist-grounded-theory method.	To address the region's poor maternal and child health, the Baby Basket program was developed by Apunipima Cape York Health Council (ACYHC), a community-controlled Aboriginal health organization located in north Queensland, Australia. The program is an initiative focused on indigenous women who are expecting a baby or have recently given birth.	Apunipima Baby Basket program. Engaging and relating Murri way occurred through four strategies: connecting through practical support, creating a culturally safe practice, becoming informed and informing others, and linking at the clinic.	Overall, the Apunipima Baby Basket program intervention enabled sustainable improvements in the areas of maternal and child health. Engaging and relating Murri way occurred through four strategies: connecting through practical support, creating a culturally safe practice, becoming informed and informing others, and linking at the clinic. These strategies resulted in women and families taking responsibility for health through making healthy choices, becoming empowered health consumers, and advocating for community changes.
Zamowiecki, D.; Nguyen, H.; Hampton, C.; Boffa, J.; Segal, L., 2018, [24]. The Australian Nurse-Family Partnership Program for aboriginal mothers and babies: Describing client complexity and implications for program delivery.	Australian Nurse-Family Partnership Program data were collected using standardised data forms by the nurses during their antenatal home visits to 276 clients from 2009 to 2015. These data were used to describe client complexity and adversity in relation to demographic and economic characteristics, mental health, and personal safety. Semi-structured interviews with 11 Australian Nurse-Family Partnership Program staff and key stakeholders explored in more depth the nature of client adversity and how this affected program delivery.	Mixed-methods study using Family Partnership Program data and qualitative data collected in semi-structured interviews with Family Partnership Program staff and key stakeholders. Family Partnership Program data were used to describe the characteristics of Family Partnership Program clients.	The Australian Nurse-Family Partnership Program is a home-visiting program for Aboriginal mothers and infants (pregnancy to child's second birthday) adapted from the United States Nurse Family Partnership program. It aims to improve outcomes for Australian Aboriginal mothers and babies, and disrupt inter-generational cycles of poor health and social and economic disadvantage. The aim of this study was to describe the complexity of Program clients in the Central Australian family partnership program, understand how client complexity affects program delivery, and the implications for desirable program modification.	The Australian Nurse-Family Partnership Program (ANFPP).	Most clients engaged in the Australian Nurse-Family Partnership Program (ANFPP) were described as 'complicated', with sixty-six per cent of clients experiencing four or more adversities. These adversities were found challenging for program delivery. For example, housing conditions meant that around half of all 'home visits' could not be conducted in the home, being held instead in staff cars or community locations. Extreme poverty, living in insecure housing, and domestic violence (almost one-third of the mothers experiencing more than two episodes of violence in 12 months) affected the delivery of program content and increased the time needed to deliver program content. Additionally, low client literacy meant written handouts were unhelpful for many, requiring the development of pictorial-based program materials. The rates of breastfeeding and child vaccination, which were higher than comparative national data for indigenous women and children in remote areas of Australia, were positive aspects of the ANFPP.

3. Results

The review of the literature identified a limited number of studies of models that promote and support the engagement of First Nations families and their access to MCH services in the period from the child's birth to five years of age (Table 1).

All six studies included in the analysis were published between 2012 and 2018. Two were mixed-methods studies with an intervention that aimed to promote and support access to and engagement of First Nations families with MCH services [20,24]; one was a mixed-methods study with no intervention [21]; one was a quantitative study with an intervention [22]; and two were qualitative studies with an intervention [11,23] that aimed to promote and support the engagement of First Nations families with and their access to MCH services. All included studies were either conducted across metropolitan [22], remote [11,23,24], or a combination of metropolitan and remote settings [20,21] in Australian Aboriginal communities.

3.1. *Enabling Factors That Influenced Access to and Engagement of First Nations Families with MCH Services*

In this review of the literature, the gaps in the research evaluating service models and interventions that enabled the engagement of First Nations families with and their access to MCH services were identified. The enabling factors identified from the six included studies were service models or interventions that are timely and appropriate; effective integrated community-based services that were flexible in their approach; holistic service models or interventions; culturally strong service models or interventions; and service models or interventions that encourage earlier identification of the risk and the need for further assessment, intervention, referral, and support from the antenatal period to the child's fifth birthday (the first 2000 days).

3.1.1. *Timely and Appropriate Service Models or Interventions*

Our analyses of the studies included in this review revealed that, as MCH services respond to the needs of children and families at risk of vulnerability, many childhood conditions that pose a risk for poor outcomes can benefit from early detection and intervention actions [11,20,21,23,24]. For this reason, there is a need for models or interventions that enable timely and appropriate services for First Nations families from conception to the child's fifth birthday, such as those identified in all six of the studies included in the review. In particular, the Apunipima Baby Basket program and the Australian Nurse-Family Partnership Program were more successful in supporting access to and engagement of First Nations families with MCH services, as these models or interventions were seen as mutually valuable to both MCH nurses and to First Nations women [11,20,21,23,24].

3.1.2. *Effective Integrated Community-Based Services That Are Flexible in Their Approach*

The MCH service in Australia is part of a larger service system, which builds on the identification of individual, family, and community needs at the local level. The MCH service has the flexibility to devise and implement innovative service models, which support integration and collaboration of services while maintaining the universal nature of the service. Examples of models that promote service integration include co-location of services, where services are located together; interdisciplinary teams, where knowledge comes from a number of different medical specialties; protocol sharing, where structure and language for files between clients and servers are enabled; and joint service delivery, where two or more organisations come together to deliver a joint service using common assessment frameworks and referral tools. The included studies showed that effective, integrated, community-based services that are flexible in their approach and collaborate with other early years services enabled more effective access to and engagement of First Nations women with children from birth to five years of age with MCH services [11,20–24].

3.1.3. Holistic Service Models or Interventions

The studies included in the review reveal that a strengths-focused approach to raising children enables a shift away from a 'problem'-focused model to a strength-focused model for families and communities [20,24]. First Nations families frequently experience the strength of a strong bond with their extended families. Service models or interventions should therefore ensure that holistic care is planned around the whole family and supports family lifestyle factors and the interpersonal social determinants of First Nation children's health and wellbeing [11,20]. Family-centred healthcare, delivered through primary health-care services for indigenous children in the period from conception to the child's first five years, is an example of a holistic service model or intervention that provides support for the person as a whole, not just their individual medical needs. The primary care provider considers women's physical, emotional, social, and spiritual wellbeing using listening, asking, and checking as key skills to be able to provide a holistic service. In the reviewed studies, this holistic approach acted as an enabling factor to support access to and engagement with MCH services [11,20–24].

3.1.4. Culturally Strong Service Models or Interventions

A significant enabling factor identified in the literature, which promotes and supports access to and engagement of First Nations families with MCH services in the period from the child's birth to five years of age, are models or interventions that facilitate strong relationships between the client and the provider and encourage mutual trust and engagement of First Nations families with MCH services [11,20–24]. This is strengthened when government and policy makers genuinely acknowledge the historical, cultural, and social complexity of First Nation families' birthing and child-rearing principles and practices, and recognise the importance of culturally strong service models or interventions [11,20–24].

3.1.5. Service Models or Interventions That Encourage Earlier Identification of Risk and Need for Further Assessment, Intervention, Referral, and Support from the Antenatal Period to the Child's Fifth Birthday (the First 2000 Days)

While professionals working with children in the antenatal period to the child's fifth birthday (the first 2000 days) have recognised that this is a vital period of child development, the literature reviewed has only recently started to understand the mysteries surrounding the processes by which genes, experiences, and environments interact to influence child development [11,20–24]. This requires a model with a focus that adheres to indigenous methodologies and knowledge, which is holistic and culturally strong, such as the service models and interventions in the included studies, in particular, the 1 + 1 = A Healthy Start to Life Project and the Malabar Community Midwifery Link Service. New knowledge that has emerged from these studies has served to increase experts' views of the significance of the first 2000 days and of the urgent need to reform the relevant policies, practices, and systems in response to the evidence [11,20–24].

3.2. Barriers That Influenced Access to and Engagement of First Nations Families with MCH Services

This review identified barriers that influenced access to and engagement of First Nations families with MCH services, including factors that affected quality of care, service delivery, and outcomes for these families. Addressing these barriers may assist in enabling access to and engagement of First Nations families with MCH services. The barriers identified from the six included studies were: inefficient communication resulting in lack of understanding between the client and the provider; cultural differences between the client and the provider; poor continuity of care between services; lack of flexibility in approach/access to services; and a model that does not recognise the importance of the social determinants of health and wellbeing.

3.2.1. Inefficient Communication Resulting in Lack of Understanding between Client and Provider

A discordance exists between indigenous and non-indigenous views about the role of children and their agency within the family, influencing access to and engagement of First Nations families with MCH services [20,22]. As discussed previously, there are consistently lower participation rates of indigenous children compared to non-indigenous children at all 10 Key Age Stage (KAS) consultations provided within the universal MCH service annually since the inception of the KAS model of care in 2009 [6]. This gap increases between the initial home visit to the eight-month consultation, indicating that First Nations women in Victoria are disengaging with the MCH service shortly after their initial enrolment in the service [6]. Homer et al. discuss the differences in views between indigenous and non-indigenous populations in regard to child rearing that are well documented in countries with a history of European colonisation [22]. The absence of leadership from some First Nations communities to inform a greater respect and understanding of First Nations values and beliefs pertaining to parenting and child rearing, highlighted by Bar-Zeev et al., appears to be a contributing factor [21].

Reconciling divergent views between indigenous and non-indigenous peoples about the role of children in the family, which would require greater understanding of and respect for First Nations values and beliefs pertaining to parenting and child rearing, could be a way of contributing to improved health outcomes, as evidenced in the Australian Nurse-Family Partnership Program [24]. Currently, there is little empirical evidence in the literature pertaining to the implementation of these parenting paradigms.

3.2.2. Cultural Differences between Client and Provider

Culturally inappropriate practices and racist attitudes by clinicians were identified in the included studies as barriers that influenced access to and engagement of First Nations families with MCH services [23]. The small numbers of First Nations staff working in MCH services and perceived racist behaviours by some staff were also barriers to access and engagement [21,23]. Racism was identified as a key determinant of health for First Nations people [23], and the experience of racism by First Nations people can contribute to poor health outcomes [23]. The development of a culturally competent workforce and tools to measure appropriate care in MCH services is required to address this issue [20]. A review of the international Nurse-Family Partnership Program found that program performance is critically dependent on the compatibility between the client characteristics and the program model [24]. It is therefore vital to understand that the nature of the client population and the adversities that they face will affect the likelihood of them accessing and engaging in the services offered to them [24]. Creating a culturally safe practice allows care to be extended to women's and families' social and emotional wellbeing [24].

3.2.3. Poor Continuity of Care between Services

Continuity of care, being a philosophy of care, focuses on the quality and consistency of care over time. For providers of integrated systems of care, the ideal is the delivery of a smooth, continuous, and uniformly 'seamless service' through integration, coordination, and the sharing of information between different providers. In maternity and MCH services, this refers to service models that incorporate continuity of services and/or continuity of care across antenatal, labour, birthing, and postnatal care. The included studies reported that First Nations women frequently perceive available MCH services as culturally unsafe [11,20–24]. First Nations women reportedly view continuity of care as more culturally safe (than existing siloed care), which can result in a greater uptake in health care across antenatal, labour, birthing, and postnatal care periods [20]. For example, in the study by Homer et al. [22], the focus group findings showed that women felt the service provided ease of access, continuity of care, and trust and trusting relationships.

3.2.4. Lack of Flexibility in Approach/Access to Services

In the included studies, access to pre-conception, antenatal, and postnatal care was found to often be compromised for First Nations women [11,20–24]. Access to effective integrated community-based services that are flexible or variable in their approach to meet the needs of a specific client are often limited for low-socio-economic-status families. In addition, social isolation for many women is exacerbated by new motherhood [22]. McCalman et al. [11] identified home visiting as a key strategy for creating a culturally safe practice while providing flexibility in approach and access to MCH services.

3.2.5. A Model That Does Not Recognise the Importance of the Social Determinants of Health and Wellbeing

The studies included in the review revealed that comprehensive, holistic models of care assisted in enabling access to and engagement of First Nations families with MCH services [11,20–24]. However, the models or interventions that did not incorporate services that address the social determinants of health, namely, economic stability, access to quality education and health care, neighbourhood and environment, and social and community context, were considered to be a significant barrier for engaging First Nations families in MCH services [11,20,21,23,24]. This supports the theory that the gap in life expectancy for First Nations peoples, in comparison to non-First Nations peoples, can be partially attributed to differences in the social determinants of health, including the social and environmental conditions in which people live and work [23]. Examples of these include extreme poverty, welfare dependency, low engagement with work and school, insecure housing, racism, multiple traumas, and domestic violence [23].

4. Discussion

The aim of this review was to explore the current literature and identify existing knowledge that can improve First Nations families' and their children's access to and participation in MCH services in the period from the child's birth to five years of age. Although recent adaptations to maternity service models of care show some positive outcomes [23], the included studies indicate that improvements to infant care are required [11,20–24]. The current MCH service systems are often 'fragmented' [21]. Consequently, accessing MCH services often results in high levels of fear and anxiety, and low attendance at subsequent appointments among First Nations women [25]. The studies included in the review show that a biomedical model of care underpins most mainstream MCH services, which can be incongruous with traditional indigenous ways of parenting and child rearing [25]. The consequence of the poor understanding of parenting and child-rearing practices of First Nations peoples is that health providers from non-indigenous backgrounds continue to provide health advice and information from their own cultural perspectives [21].

Additionally, the literature shows that the communication on the transfer of mother and infant care from maternity services to MCH services can also be fragmented or inadequate, inconsistent, and ad hoc, resulting in potentially serious clinical consequences for new mothers and their children in this vulnerable period and impacting First Nations families' and their children's access to and participation in MCH services [21]. In order to encourage access to and engagement of First Nations families with MCH services, there need to be improvements to the organisation of child health care, including giving priority to the continuity of supportive relationships with parents across the services [20]. As families' healthcare needs can rarely be met in this modern era by a single professional, multi-dimensional models of continuity have been developed to accommodate the possibility of achieving both ideals simultaneously [20]. Given that health disparities continue to exist for First Nations women and infants, it is imperative to explore the factors that facilitate continuity of care from the antenatal period to the child's fifth birthday (the first 2000 days of life). Earlier engagement with these families, ideally in the antenatal period before the woman is discharged from maternity services, would facilitate the transition between these services and may build greater trust in the MCH service.

Healthcare professionals are often inadequately trained and underprepared to work cross-culturally, which further compounds the situation [25]. As a result, McCalman et al. [11] report that many First Nations women do not disclose vital health information to healthcare workers with whom they have no relationship. Culturally inappropriate practices were identified in the included studies as a barrier that influenced the engagement of First Nations families and their access to MCH services [23]. Small numbers of First Nations staff working in MCH services and the perceived racist behaviours by some staff contributed to this theme [21,23]. An area requiring reform to encourage engagement with MCH services for this population and assist in closing the gap in health outcomes for First Nations women and their children is the development of a culturally competent workforce, which supports client diversity and complexity [24,26,27].

A key gap in the evidence is that there has not been a synthesis of qualitative studies of models of care to help guide MCH practice and innovation for all families, especially those at risk of vulnerability, that is, familial living situations that are considered problematic and in need of professional support [11,20–24]. Future studies may benefit from exploring the significance of the enabling factors identified in the six included studies in this review. For example, Homer et al. [22] reported that the importance of continuity of health care provider was highlighted by study participants, with women describing it as ‘the best part of Malabar’. They valued having a person they could call and receiving care from the same health care provider. Additionally, as highlighted by Barclay et al. [20], models of care or interventions that are more inclined to be successful are those based on earlier engagement of families with MCH services and services with a focus on a continuum of care to alleviate the risk of these families ‘falling through the cracks’.

This review of the literature showed that services must be collaborative, be more ‘connected’, and made easier for families to access to ensure that there is adequate support provided [28]. The continuum of care framework, a concept involving an integrated system of care that follows patients over time through a comprehensive array of health services spanning all levels of intensity of care, may facilitate this [29,30]. However, traditionally, the continuum of care framework has focused on chronological modes of care, without specifically measuring the experienced continuity or the facets of care that translated into intelligible and meaningful care [29,30]. In order to use the continuum of care framework to allow multiple agencies to work together to provide a coordinated, comprehensive service to engage First Nations families, it is imperative that a common understanding of the concept of continuity, as a basis for valid and reliable measurement of practice in different settings, is established [20].

Additionally, Barclay et al. [20] reported that poor knowledge, recognition, and support of diverse culture and child-raising needs in the health system have to be remedied in order for staff to effectively promote health and resilience among parents of children at risk of vulnerability. As urged in the policy reports and charters, worldwide, a concerted effort is required to enhance continuity through a new model of care [20,31,32]. Service design reform to align with the continuity of care model, enabling staff to work alongside First Nations women, their families, and community leaders, could be an important step forward in addressing the disparities in health outcomes between indigenous and non-indigenous children [33,34].

In summary, the literature reviewed showed that timely, effective, holistic engagement with First Nations women in their child’s first 2000 days, which respects their culture and facilitates genuine partnerships built on co-design and shared decision making with the indigenous community, needs to be an essential part of the MCH service model if the health care providers seek to practice within First Nations communities. A critical review of Western models of care that do not support evidence-based best practices for indigenous populations, in conjunction with adopting a strengths-based approach, which respects First Nations peoples’ child-rearing practices and culture, is required to support access to and engagement of First Nations women and their children from birth to five years of age with MCH services [11,20–24].

5. Limitations

Although a rigorous and thorough search strategy was used to identify existing knowledge of models and interventions that promote and support the engagement of First Nations families and their access to MCH services in the period from the child's birth to five years of age, it is possible that this integrative literature review did not identify all relevant studies. The studies were screened individually and assessed by the authors to determine if they met the inclusion criteria. It is possible that relevant models or interventions descriptions or evaluations may have been misclassified. Due to the lack of data internationally, the outcomes of the retrieved studies may not be generalizable to the entire First Nations families worldwide. Additionally, it is impossible to determine any cause-and-effect relationships between the interventions described in the included studies and an improved engagement of First Nations families and their access to MCH services, as the methodological quality of the intervention studies varied considerably.

6. Conclusions

The focus of this literature review was to explore and describe the models or interventions that support access to and engagement with MCH services for First Nations women with from birth to five years of age. Persistent disparities in perinatal outcomes between indigenous and non-indigenous families underscore the need to prioritise culturally responsive practices in MCH services. MCH service models and interventions for First Nations families need to facilitate early identification of risk for children and families who may require further assessment, intervention, referral, and support through a transdisciplinary approach, ideally from the antenatal period to the child's fifth birthday (the first 2000 days). Services that increase accessibility and are designed to support First Nations women during their pregnancy and the postnatal period are likely to have a positive impact. Furthermore, programs are more likely to be accessed by First Nations women if they are designed in a culturally safe and secure space, using a bi-cultural approach that combines the Western biomedical model with indigenous cultural ways of being, doing, and knowing.

A crucial issue in translating the results and recommendations of this review into policy or practice would be to ensure that MCH service models and interventions focus on the issues most relevant to people's lives, namely, the social determinants of health and wellbeing, and a shared understanding and common language regarding the needs and risks for children and their families. In Australia, given the practice of home visitations by MCH nurses after childbirth, MCH services are well placed to address the inequalities for the most disadvantaged families.

Author Contributions: Conceptualisation, C.A.; Methodology, C.A.; Project administration, C.A.; Supervision, D.H. and M.C.; Writing—original draft, C.A.; Writing—review and editing, D.H. and M.C. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of FEDERATION UNIVERSITY AUSTRALIA. (protocol code A21-102, date of approval 25/08/2021).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Conflicts of Interest: The authors declare no conflict of interest.

References

1. Shonkoff, J.; Phillips, D. *From Neurons to Neighbourhoods: The Science of Early Child Development*; National Academy Press: Washington, DC, USA, 2000.
2. Shonkoff, J.; Boyce, W.; McEwen, B. Neuroscience, molecular biology and the childhood roots of health disparities. *JAMA* **2009**, *301*, 2252–2259. [CrossRef] [PubMed]
3. Belli, P.; Bustreo, F.; Preker, A. Investing in children's health: What are the economic benefits? *Bull. World Health Organ.* **2005**, *83*, 777–784. [PubMed]

4. Sweeny, K. *The Influence of Childhood Circumstances on Adult Health*; Report to the Mitchell Institute for Health and Education Policy; Victoria Institute of Strategic Economic Studies, Victoria University: Melbourne, VIC, Australia, 2014.
5. World Health Organisation, United Nations Children's Fund, World Bank Group. *Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential*; World Health Organisation: Geneva, Switzerland, 2018.
6. Victorian Auditor-General's Office Annual Report. Available online: <https://www.data.vic.gov.au/data/dataset/vago-annual-report-2015-16> (accessed on 16 August 2021).
7. UN Committee on the Rights of the Child (CRC). General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24), 17 April 2013, CRC/C/GC/15. Available online: <https://www.refworld.org/docid/51ef9e134.html> (accessed on 11 March 2022).
8. Anderson, I.; Robson, B.; Connolly, M.; Al-Yaman, F.; Bjertness, E.; King, A.; Tynan, M.; Madden, R.; Bang, A.; Coimbra, C.E.A.; et al. Indigenous and tribal peoples' health: A population study. *Lancet* **2016**, *388*, 131–157. [CrossRef]
9. Rumbold, A.; Baillie, R.; Si, D.; Dowden, M.; Kennedy, C.; Cox, R. Delivery of maternal health care in Indigenous primary care services: Baseline data for an ongoing quality improvement initiative. *BMC Pregnancy Childbirth* **2011**, *11*, 16. [CrossRef]
10. Smylie, J.; Adomako, P. *Indigenous Children's Health Report: Health Assessment in Action*; Centre for Research on Inner City Health, Li Ka Shing Knowledge Institute: Toronto, ON, Canada, 2009.
11. McCalman, J.; Searles, A.; Bainbridge, R.; Ham, R.; Mein, J.; Neville, J.; Campbell, S.; Tsey, K. Empowering families by engaging and relating Murri way: A Grounded Theory, study of the implementation of the Cape York Baby Basket program. *BMC Pregnancy Childbirth* **2015**, *15*, 119. [CrossRef]
12. Yelland, J.; Weetra, D.; Stuart-Butler, D.; Deverix, J.; Leane, C.; Kit, J.; Glover, K.; Gartland, D.; Newbury, J.; Brown, S. Primary health care for Aboriginal women and children in the year after birth: Findings from a population-based study in South Australia. *Aust. N. Z. J. Public Health* **2016**, *40*, 418–423. [CrossRef]
13. Riggs, E.; Davis, E.; Gibbs, L.; Block, K.; Szwarc, J.; Casey, S.; Duell-Piening, P.; Waters, E. Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMCH Health Serv. Res.* **2012**, *12*, 117. [CrossRef]
14. Eapen, V.; Walter, A.; Guan, J.; Descallar, J.; Axelsson, E.; Einfeld, S.; Eastwood, J.; Murphy, E.; Beasley, D.; Silove, N.; et al. The 'Watch Me Grow' Study Group. Maternal help-seeking for child developmental concerns: Associations with socio-demographic factors. *J. Paediatr. Child Health* **2017**, *53*, 963–969. [CrossRef]
15. Milroy, H.; Dudgeon, P.; Walker, R. Community life and development programs—Pathways to healing. In *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*; Dudgeon, P., Milroy, H., Walker, R., Eds.; Australian Government Department of the Prime Minister and Cabinet: Canberra, ACT, Australia, 2014; pp. 419–435.
16. Turley, J.; Vaneek, J.; Johnston, S.; Archibald, D. Nursing role in well-child care. Systematic review of the literature. *Can. Fam. Physician* **2018**, *64*, e169–e180.
17. Torraco, R. Writing Integrative Literature Reviews: Guidelines and Examples. *Hum. Resour. Dev. Rev.* **2005**, *4*, 356–367. [CrossRef]
18. Whittemore, R.; Knafl, K. The integrative review: Updated methodology. *J. Adv. Nurs.* **2005**, *52*, 546–553. [CrossRef] [PubMed]
19. Braun, V.; Clarke, V. Using thematic analysis in psychology. *Qual. Res. Psychol.* **2006**, *3*, 77–101. [CrossRef]
20. Barclay, L.; Kruske, S.; Bar-Zeev, S.; Steenkamp, M.; Josif, C.; Wulili Narjic, C.; Wardaguga, M.; Belton, S.; Gao, Y.; Dunbar, T.; et al. Improving Aboriginal maternal and infant health services in the 'Top End' of Australia: Synthesis of the findings of a health services research program aimed at engaging stakeholders, developing research capacity and embedding change. *BMCH Health Serv. Res.* **2014**, *14*, 241. [CrossRef] [PubMed]
21. Bar-Zeev, S.; Kruske, S.; Barclay, L.; Bar-Zeev, N.; Carapetis, J.; Kildea, S. Use of maternal health services by remote dwelling Aboriginal infants in tropical northern Australia: A retrospective cohort study. *BMC Pediatr.* **2012**, *12*, 19. [CrossRef] [PubMed]
22. Homer, C.; Foureur, M.; Allende, T.; Pekin, F.; Caplice, S.; Catling-Paull, C. 'It's more than just having a baby' women's experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families. *Midwifery* **2012**, *28*, e509–e515. [CrossRef] [PubMed]
23. Josif, C.; Kruske, S.; Kildea, S.; Barclay, L. The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes: A qualitative analysis. *BMC Pediatr.* **2017**, *17*, 93. [CrossRef]
24. Zarnowiecki, D.; Nguyen, H.; Hampton, C.; Boffa, J.; Segal, L. The Australian Nurse-Family Partnership Program for Aboriginal mothers and babies: Describing client complexity and implications for program delivery. *Midwifery* **2018**, *65*, 72–81. [CrossRef]
25. Sivertsen, N.; Anikeeva, O.; Deverix, J.; Grant, J. Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: A systematic review of the literature. *BMCH Health Serv. Res.* **2020**, *20*, 829. [CrossRef]
26. Schunied, V.; Kruske, S.; Barclay, L.; Fowler, C. *National Framework Universal Child and Family Health Services*; DoHa, A., Ed.; Australian Government: Canberra, ACT, Australia, 2011.
27. National Indigenous Reform Agreement (Closing the Gap). Council of Australian Governments, 2009. Available online: https://www.federalfinancialrelations.gov.au/content/npa/health/_archive/indigenous-reform/national-agreement_sept_12.pdf (accessed on 16 August 2021).
28. Wathen, C. The role of integrated knowledge translation in intervention research. *Prev. Sci.* **2018**, *19*, 9. [CrossRef]
29. Hjortdahl, P. Ideology and reality of continuity of care. *Fam. Med.* **1990**, *22*, 361–364.

30. Child Protection in Your Hands Framework. In *The First 2000 Days: Conception to Age 5 Framework*; NSW Ministry of Health: North Sydney, NSW, Australia, 2019.
31. Fulop, N.; Allen, P. *National Listening Exercise: Report of the Findings*; NHS Service Delivery and Organisation National Research and Development Programme: London, UK, 2000.
32. World Health Organisation. The Ljubljana Charter on Reforming Healthcare. World Health Organisation, 1996. Available online: https://www.euro.who.int/__data/assets/pdf_file/0010/113302/E55363.pdf (accessed on 16 August 2021).
33. Jongen, C.; McCalman, J.; Bainbridge, R.; Tsey, K. Aboriginal and Torres Strait Islander maternal and infant health and wellbeing: A systematic review of programs and services in Australian primary health care settings. *BMC Pregnancy Childbirth* 2014, 14, 251. [CrossRef] [PubMed]
34. Kruske, S.; Belton, S.; Wardaguga, M.; Narjic, C. Growing up our way, the first year of life in remote Aboriginal Australia. *Qual. Health Res.* 2012, 22, 777–787. [CrossRef] [PubMed]

Contribution of Authors

Name	Paper Design	Data Collection	Data Analysis	Interpretation	Manuscript Writing	Confirmation of contribution
C. Austin	60 %	80%	70%	60%	70%	√
D. Hills	20%	10%	15%	20%	15%	√
M. Cruickshank	20%	10%	15%	20%	15%	√

Appendix Fourteen: Publication arising from the thesis



Received: 29 April 2022 | Revised: 17 October 2022 | Accepted: 31 October 2022
DOI: 10.1111/jan.15493

ORIGINAL RESEARCH: EMPIRICAL
RESEARCH - QUALITATIVE

JAN **WILEY**
Journal of Advanced Nursing

The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services

Catherine Austin

School of Health, Federation University,
Ballarat, Victoria, Australia

Correspondence
Catherine Austin, School of Health,
Federation University, PO Box 663,
Ballarat, VIC 3353, Australia.
Email: austinc62@gmail.com

Abstract

Aims: To explore the impact of social determinants of health and health outcomes of Australian Indigenous women on their access and engagement in maternal child health services.

Design: A qualitative study, guided by the methodological principles of narrative inquiry integrated with the Indigenous philosophy 'Dadirri', and thematic analysis of the data.

Methods: Interviews of 35 Aboriginal mothers with children aged birth to 5 years in December 2021, to explore factors that influence their access and engagement in maternal child health services.

Results: Enabling factors that influence access and engagement of Indigenous women in maternal child health services include service models or interventions that are culturally sensitive and effective. Models that recognize the social determinants of health and well-being, are timely, appropriate, culturally strong, flexible, holistic and effective community-based services that support continuity of care and communication and encourage earlier identification of risk and further assessment, intervention, referral and support from the antenatal period to the child's fifth birthday (the first 2000 days), also support access and engagement. Barriers to access and engagement include an ineffective service model built on mistrust and poor communication from cultural differences between client and provider, a lack of continuity of care between services, limited flexibility of service delivery to suit individual needs and a healthcare model that does not recognize the importance of the social determinants of health and well-being.

Conclusion: Nurses' understanding of Indigenous culture, and the impact of the social determinants of health and health outcomes on the well-being of Indigenous women, is critical to improve their access and engagement in maternal child health services.

Impact: The findings of this research support the benefit of models or interventions that recognize the interactions and effects of the social determinants of health and health outcomes of Indigenous women and their healthcare access.

Patient or Public Contribution: Data from Indigenous mothers residing in the Glenelg Shire with at least one child aged birth to 5 years were collected through face-to-face,

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Author. *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

J Adv Nurs. 2022;00:1–15.

wileyonlinelibrary.com/journal/jan | 1

in-depth semi-structured discussion ('yarning') at the Dhauwurd Wurrung Elderly and Community Health Service and the Winda-Mara Aboriginal Corporation Aboriginal and Community Controlled Health Organizations (ACCHO's) in December 2021, co-facilitated by key staff from the ACCHO's. To ensure cultural safety and an Indigenous lens to the research, consultation with traditional owners residing in the Glenelg Shire was sourced to assist with the development of the research guide and to develop interview questions. A panel of experts was then consulted to clarify the relevance and clarity of each question/discussion prompt on the indicative interview schedule and establish face validity. The panel of experts comprised of the research project team, an experienced Maternal and Child Health (MCH) nurse researcher and key representatives from the Victorian Aboriginal Community Controlled Health Organization (VACCHO) and the ACCHO sites. A small number of the target group, independent of the research, piloted the questions. Any valid suggestions from the expert panel and pilot testing were incorporated into the interview schedule design and clarifications were made to the questions/prompts where appropriate. Following full approval of the research, the Chief Executive Officers (CEO's) of the two ACCHO's were provided with an overview of the project and timeframes, and an Indigenous employee within each ACCHO was appointed by the CEO as a 'site coordinator' to act as the chief point of contact with the project team and assist with recruitment of discussion participants. Women who met the inclusion criteria were then invited to participate in the research. To ensure procedural and interpretative rigour, and to gain a deeper, comprehensive insight and understanding of First Nation women's access and engagement in MCH Services, the ACCHO Site Coordinators, key staff from VACCHO and an Indigenous academic consultant with research experience interviewing Indigenous mothers in 'the first 1000 days' of their child's life, also participated in the analysis of the data.

KEYWORDS

indigenous women, maternal child health nursing, social determinants of health

1 | INTRODUCTION

The early years of life are the foundation for lifelong physical, social, spiritual and emotional well-being (Shonkoff et al., 2009; Shonkoff & Phillips, 2000). The first 2000 days, the antenatal period to the child's fifth birthday, comprise the critical period of foetal and child development, which forms the foundation for all subsequent development and health throughout the child's lifetime (Bell et al., 2005). The period of early childhood also represents a window of opportunity, where optimal health and educational interventions can provide benefits that extend across the life course (Bell et al., 2005; Sweeny, 2014; WHO, 2018; VAGO, 2016). Access in the early years, particularly in the first 2000 days, to timely and appropriate, culturally strong, holistic, effective community-based services that are integrated, but flexible in approach and recognize the social determinants of health (SDOH) and health outcomes, is a proven predictor of the success of a child's transition to school and lifelong education

and employment outcomes, and for providing long-term well-being (VAGO, 2016).

According to the World Health Organization (WHO), SDOH have become pivotal in population and public health, as they can have more impact on health than health care or lifestyle choices (WHO, 2022). Social determinants are 'the non-medical factors' that influence health outcomes. They are the circumstances where people are born, grow, work, live and age, and the conditions and systems shaping their lives (WHO, 2022). These conditions and systems include 'economic policies and systems, development agendas, social norms, social policies and political systems, including income and social protection; education; unemployment and job insecurity; working life conditions; food insecurity; housing, basic amenities and the environment; early childhood development; social inclusion and non-discrimination; structural conflict and access to affordable health services of decent quality' (Senate Standing Committees

on Community Affairs, 2013; WHO, 2022). In the current study, the author focused on the intersectionality of both healthcare access and culture, which is a gap in the current literature and demonstrates an argument for the development of new theoretical models and frameworks based on the SDOH to address the inequity in health status seen between, and within countries, as is the case in Australia.

The United Nations General Assembly (2013) acknowledges the rights of children 'to the highest attainable standard of health' with a focus on preventative and primary health care for children, prenatal and postnatal health care for mothers and diminishing infant and child mortality. Indigenous peoples are the direct descendants of the original known inhabitants of a geographic region (Merriam-Webster, 2021a, 2021b, 2021c). The need for improved child health care for Indigenous populations is evident by ongoing disparities in child health among Indigenous and tribal populations in Australia, Canada, New Zealand and the United States (Anderson et al., 2016). Ensuring Indigenous women have access to appropriate health care in the antenatal and postnatal period is vital for the long-term health outcomes for the mother and her child (Rumbold et al., 2011).

According to Anderson et al. (2016), in countries with a history of colonization, such as Canada, the United States, New Zealand and Australia, there is long-term poor health and well-being burdening their Indigenous families, and their access to services and resources is adversely affected by historical and contemporary SDOH. With British colonization in Australia in 1788 came subsequent laws and Acts that authorized the removal of children from Indigenous parents (Christie, 2006). The Indigenous population in Australia is referred to as 'Aboriginal and Torres Strait Islander' or 'Aboriginal' if the population does not include peoples' from the Torres Strait Islands of Australia (Merriam-Webster, 2021a, 2021b, 2021c). Children were removed from their parents with the aim to reject their Indigenous ancestry and to adapt to white culture (Christie, 2006). This was the process that is now referred to as the Stolen Generations (Bretherton & Mellor, 2006). Assimilation, including child removal policies that absorbed Indigenous children into white society, did not improve the lives of these children (Christie, 2006). Conversely, these experiences have had a severe effect on not only the SDOH and health outcomes of the children who were forcibly taken, but also on their parents and extended families, their communities and generations to follow, who continue to suffer the effects of the removal policies (Harris, 2003; Reynolds, 2006). The impact of the Stolen Generations continue to have a domino effect on Indigenous families, as this trauma is inherited by new generations of children through complex parenting practices, behavioural problems, violence, grief, unresolved trauma leading to mental illness, and poor social and emotional well-being (Wilkie, 1997). These effects are reflected by the high percentage of Indigenous children currently removed from their parents (VAGO, 2016).

2 | BACKGROUND

Maternal and Child Health nurses in Victoria, Australia, also referred to as 'child and family nurses', are nurse-midwives with a postgraduate qualification in Child and Family Health nursing. Women are referred to MCH services by midwives from maternity services after birth, and a schedule of routine monitoring of child development, parenting support and health promotion services are offered until the child is 5 years of age. Over 95% of mothers with new babies participate in the MCH service in Victoria (DET, 2018), which places the nurses in the forefront to prevent, identify and respond to the challenges faced by families with children birth-5 years of age, including family violence (Shonkoff et al., 2009; Shonkoff & Phillips, 2000).

Despite the aims of MCH service provision, some groups, such as Indigenous and culturally and linguistically diverse (CALD) communities, do not engage with services (Yelland et al., 2016) or do not sustain visits (Riggs et al., 2012), and economically disadvantaged families are less inclined to access services (Eapen et al., 2012). Studies show that although participation in MCH services improves health outcomes for Indigenous families (Austin & Arabena, 2021), accessing MCH services can be associated with fear, anxiety and low attendance at subsequent appointments (VAGO, 2016). For example, although 95%–98% of Victorian women with newborns are being visited at home within 2 weeks of birth (VAGO, 2016), there are consistently lower participation rates of Indigenous children compared with non-Indigenous children at all 10 Key Age Stage (KAS) consultations provided within the universal MCH service in Victoria, Australia, since the inception of the KAS model in 2009 (VAGO, 2016). This gap increases at the initial home visit to the 8-month consultation, indicating that a significant proportion of Indigenous women accessing the healthcare service are disengaging shortly after their initial enrolment (VAGO, 2016). This brings into effect an inverse care law, which advocates that families who most need intense, high-quality care are least likely to receive it (Eapen et al., 2012).

Ensuring Indigenous women have access to appropriate health care in the antenatal and postnatal period is vital for the long-term health and well-being outcomes for both the mother and her child (Rumbold et al., 2011). Hence, a model that promotes and supports engagement of Indigenous families and their access in MCH services in the period from the child's birth to 5 years of age, will therefore encourage the identification and disclosure of risk, such as family violence (FV) and intimate partner violence (IPV), and contribute to the long-term health and well-being of the mother and/or her child (Austin & Arabena, 2021).

3 | THE STUDY

This research study is situated within a larger research study, which investigates the development of a service model or intervention that

is culturally sensitive and effective to support access and engagement of Indigenous women in MCH services.

3.1 | Aims

The aims of this smaller research component are to expand the understanding of the complex interactions between SDOH and health outcomes, and its impact among marginalized populations such as women, children, and Black, Indigenous and other People of Colour (BIPOC) by exploring the access and engagement of Indigenous women to the MCH Service in Victoria, Australia.

3.2 | Research questions

Q1. What factors facilitate and support the engagement of Indigenous women in accessing the Maternal and Child Health Service in Victoria, Australia?

Q2. What factors hinder the engagement of Indigenous women in accessing the Maternal and Child Health Service in Victoria, Australia?

Q3. What improvements could be made to the Maternal and Child Health Service in Victoria, Australia, to improve access and engagement for First Nation's women?

3.3 | Design

This research is a qualitative study, guided by the methodological principles of narrative inquiry integrated with Indigenous philosophy Dadirri. Dadirri is a practice of deep listening and acceptance (West et al., 2012). This philosophy used as a research method enables Indigenous voices to be heard (West et al., 2012). According to Stronach and Adair (2014), deep listening requires a process of listening to learn, and a suspension of judgement. West et al. (2012) add that Dadirri helps to facilitate two-way communication and create a more autonomous environment, for participants to share their opinions regardless of the power structure, and build relationships right across the structure. Narrative inquiry is an interpretative approach from the social sciences, which examines human lives through the lens of a narrative, or storyline (McAlpine, 2016). Narrative inquiry bridges Western and Indigenous research methodologies, providing a methodological approach of holistic observation from an Indigenous standpoint, without the risk of bias, to challenge and change thinking, ideas and understanding (Nakata, 1998). A narrative approach allowed the researcher to be congruent and in tune with the physical, psychological, social and cultural aspects of the storytelling or yarning of the Indigenous women.

The author recognizes that Indigenous pedagogy is poorly understood and not well represented in the education agenda (Andrews & Hughes, 1993). The problem lies with mainstream services' poor understanding of Indigenous knowledge that has flourished for over

65,000 years (Andrews & Hughes, 1993). As a non-Indigenous researcher with vast experience working in collaboration with Indigenous communities in Victoria, the author's site of struggle, as depicted by Nakata, is "the need to change the idea of non-Indigenous researchers as the experts and to give Indigenous people a strong voice in all parts of research so that it can help to transform the lives of Indigenous people" (1998, p. 15). Pelto and Pelto (1978) add, "Indigenous people now want research and its designs to contribute to the self-determination and liberation struggles as defined and controlled by their communities. The inability of academia to acknowledge the differences between the two cultures can have a direct effect on the research outcomes and the difference between the emic and the etic data is the applied cultural sensitivity of the researcher" (p. 6). Aileen Moreton-Robinson, whose work is informed by Australian sovereignty principles and an Indigenous feminist standpoint, states that Indigenous researchers have a 'constant battle' to empower Indigenous knowledge and methodologies as legitimate and fundamental components of research undertaken within Indigenous communities (Moreton-Robinson, 2013). Moreton-Robinson (2013) argues that the use of an Australian Indigenous women's standpoint must be embraced as a means to accurately convey the sovereignty principles and interconnectedness of Indigenous women's ways of being, knowing and doing, which will inadvertently have a positive impact on Indigenous women's access and engagement in mainstream services, such as MCH services.

3.4 | Setting

The study was conducted in the Glenelg Shire, a region in South Western Victoria. Site A and B were located in Portland, and Site C was located in Heywood, 25 km north of Portland (Figure 1). This region was selected because there was a high proportion of Aboriginal families residing there (ABS, 2017). Additionally, the reported rate of FV to Aboriginal women in this region was 39% higher than non-Aboriginal women in this region (ABS, 2017; DET, 2018). As none of these Indigenous people identifies as Torres Strait Islanders, the population will be referred to as 'Aboriginal', 'Indigenous', or 'First Nations' throughout the study. Some of the participants in the study refer to the colloquial term 'mob', which identifies Aboriginal people from a particular place or country, and can refer to a family, clan, or community group (Merriam-Webster, 2021a, 2021b, 2021c).

3.5 | Sample/participants

To understand the impact of the SDOH and health outcomes of Australian Indigenous women on their access and engagement in the MCH Service the author sought to recruit Indigenous women with children aged birth to 5 years. The inclusion criteria for this data source were all Indigenous women with children aged birth to 5 years residing in the Glenelg Shire, Victoria, Australia. Stratified purposeful sampling was employed to recruit three unique sub-categories of participants, as defined by their level of engagement



FIGURE 1 Glenelg Shire, South Western Victoria, Australia (DET, 2016)

in MCH services. These three levels of engagement include current engagement; initial engagement, now disengagement; and no engagement in the MCH service in the Glenelg Shire, Victoria, Australia. The sample size was largely determined by the number of respondents available to participate in the study. Based on the literature (Morse, 1995, 2000), evidence-based recommendations for the a priori estimation of sample sizes for each of the categories and sub-categories would be seven to ten participants. The author estimated that data saturation would be achieved by recruiting 10 participants in each category and sub-category. The author deemed a target of seven to ten participants per category and subcategory as appropriate due to the exploratory nature of the research, and the aim to identify underlying thoughts about the topic.

3.6 | Data collection

Although the sample was relatively small for each category and sub-category, the material collected was quite detailed, given the nature of the research, so the author perceived that the number of participants was sufficient to satisfy the aims of this research (Strauss & Corbin, 1990).

The author consulted with Federation University Australia, the Victorian Department of Health and Human Services (DHHS), the Victorian Department of Health (the Department), the Municipal Association of Victoria (MAV), Dhauwurd Wurrung Elderly and Community Health Aboriginal Community Controlled Health Organization, Winda-Mara Aboriginal Corporation, and VACCHO for permission to collect data from individual and small groups of Indigenous mothers residing in the Glenelg Shire with at least one child aged birth to 5 years. Peer debriefing was conducted at this stage of the study to ensure cultural safety and an Indigenous lens to the research. Consultation with traditional owners residing in the two ACCHO's was sourced to assist with the development of the

TABLE 1 Interview guide for all participants

- Do you know about MCH nurses and the services they provide to young families?
- Are you aware that there are MCH services in your area?
- Do you think these services are (or might be) important for your family?
- Did you receive a home visit by a MCH nurse after your last baby was born?
- What did you think of this visit?
- Was it helpful?
- What did you like about it?
- What did you not like about it?
- Following the home visit, have you used MCH services with any of your children?
- If yes, what are some of the things that made you decide to use the services?
- If no, why did you decide not to use the service?

research guide and to develop interview questions in Tables 1 and 2. A panel of experts was then consulted to clarify the relevance and clarity of each question/discussion prompt on the indicative interview schedule and establish face validity. The panel of experts comprised of the research project team, an experienced MCH researcher, and key representatives from VACCHO and the ACCHO sites. A small number of the target group, independent of the research, piloted the questions. Any valid suggestions from the expert panel and pilot testing were incorporated into the interview schedule design and clarifications were made to the questions/prompts where appropriate. Following full approval of the research, the Chief Executive Officers (CEO's) of the two ACCHO's were provided with an overview of the project and timeframes, and an Indigenous employee within each ACCHO was appointed by the CEO as a 'site coordinator' to act as the chief point of contact with the project team and assist with the recruitment of discussion participants. Women who met the inclusion criteria were then invited to participate in the research ($n = 47$). Six of these Indigenous women resided in the far

northern part of the Glenelg Shire and did not engage with the two nominated ACHHO sites, so were excluded from the study ($n = 41$).

The author consulted with Aboriginal women through face-to-face, in-depth semi-structured discussion ('yarning'), with individuals and small groups at the Dhauwurd Wurrung Elderly and Community Health Service and the Winda-Mara Aboriginal Corporation ACCHO's in December 2021. The discussions ran for approximately an hour on the ACCHO sites, co-facilitated by key staff from the ACCHO's and in line with the National Health and Medical Research Council's Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders (2018), to ensure cultural safety of the project. Of the 25 women that met the inclusion criteria in Portland, 84.0% ($n = 21$) participated in the study, which was conducted at the Dhauwurd Wurrung Elderly and Community Health Service ACCHO in Portland, at the Playgroup (Site A, $n = 8$) and at the Women's Group (Site B, $n = 13$). Site B was chosen to compliment Site A at the recommendation of the site coordinator who stated that some mothers chose to engage in one program over another, and therefore holding the yarning circles at both sites would increase the recruitment of participants. Of the 21 women interviewed in Portland (Site A+B), 28.6% ($n = 6$) had never engaged in the MCH service, 42.8% ($n = 9$) had disengaged in the MCH service and 28.6% ($n = 6$) were currently engaged in the MCH service. All women ($n = 21$, 100%) identified as 'Aboriginal'. The age range of the women interviewed in Portland (Site A+B) was 19–28 years, with an average age of 23.4 years. The women had between 1 and 5 children in their care (biological or kinship), with an average of 3.2 children. Of the 16 women that met the inclusion criteria in Heywood, 87.5% ($n = 14$) participated in the study at the Winda-Mara Aboriginal Corporation ACCHO in Heywood (Site C). All women ($n = 14$, 100%) identified as 'Aboriginal'. Of the 14 women interviewed in Heywood, 28.6% ($n = 4$) had never engaged in the MCH service, 14.3% ($n = 2$) had disengaged in the MCH service and 57.1% ($n = 8$) were currently engaged in MCH services. The age range of the women interviewed in Heywood was 20–27 years, with an average age of 22.9 years. The women had between 1 and 4 children in their care (biological or kinship), with an average of 2.9 children. A key principle of 'kinship' in Aboriginal families is that a child may have multiple mothers and fathers, unlike family relations in western society.

3.7 | Data analysis

The audio-recorded data were transcribed by the author and subjected to attributional, first- and second-cycle coding. Data were analysed by the author using Braun & Clarke's six-step process for identifying, analysing and reporting qualitative research using thematic analysis (2021). Thematic analysis facilitated the emergence of themes and patterns, to identify broad concepts of the impact of the SDOH and health outcomes of Australian Indigenous women on their access and engagement in maternal child health services. The

six-step process included familiarization with the data; generating initial codes; searching for themes; reviewing the themes; defining and naming the themes and producing a report with the themes found within the data. Peer debriefing was then conducted using a key Indigenous academic with research experience interviewing Indigenous mothers in 'the first 1000 days' of their child's life, a Senior Director from VACCHO and the two site coordinators who assisted with the interviews to enhance the validity of the research and uncover any bias and assumptions. This process also brought a further set of skills and knowledge to the study and ensured there was an Indigenous lens applied to the thematic analysis of the data. To facilitate trustworthiness of results, a plain language information statement (PLIS) outlining the project and Consent to participate in the research forms was provided to participants prior to the interviews, explaining the purpose and intent of the project and how the data were to be collected and utilized. Participants were also informed that their participation was voluntary, that their refusal to participate required no explanation and that they were free to choose not to answer questions during the interview, without consequence. Participants were advised that there would be an opportunity for them to preview the results and transcripts, and to withdraw or amend any data during, or at the end of the interview, or any unprocessed data previously supplied. Participants were also advised that they were entitled to withdraw their consent to participate and discontinue participation at any time, without consequence, however, that if consent was withdrawn after data had been aggregated and processed, it would not be possible to withdraw non-identifiable data, although consent could still be withdrawn. Member checking, or participant validation, was conducted with the Site Coordinators present at the yarning sessions to check for accuracy and resonance of the participants' responses during the yarning.

3.8 | Ethical considerations

This research was carried out according to the National Statement on Ethical Conduct in Human Research (2018) produced by the National Health and Medical Research Council of Australia. Ethics committee approval was obtained from the author's university, the Department of Health and Human Services (DHHS) in Victoria, and the Victorian Aboriginal Community Controlled Organization (VACCHO).

3.9 | Validity and reliability/rigour

Validity within this research was ensured by having the questions for the interviews assessed by a panel of experts, and pilot testing of the interviews prior to initiation to identify any misunderstandings or inaccuracies in the questions and to decrease the chances of difficulty during the main study (Creswell, 2013). This also provided the author with the opportunity to implement changes to

the interview questions resulting from any feedback from the expert panel and pilot.

4 | FINDINGS

The three groups of Indigenous women, who met the inclusion criteria of the study, were asked about their access and engagement in the MCH Service in Victoria, and their consideration for changes in practice to improve healthcare access. Coded analysis of the individual pieces of data was analysed into two main themes and eight sub-themes to represent the over-arching narrative within the data to help answer the research questions (Braun & Clarke, 2021).

4.1 | Factors contributing to Indigenous women never engaged in the MCH service

All participants ($n = 10$, 100%) interviewed in Site A+B ($n = 6$, 60%) and Site C ($n = 4$, 40%) answered all tailored questions in Table 2 pertaining to this category. The theme 'intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data presenting two concurrent narratives in Portland (Site A+B), and three concurrent narratives in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'mistrust' and 'miscommunication' in Site A+B and 'mistrust', 'miscommunication' and 'not recognizing the Social Determinates of Health' in Site C.

Lee (2020) defines 'intercultural incompetence' as "the inability to demonstrate targeted knowledge, skills and attitudes that lead to effective and appropriate communication with people of other cultures" (p. 261). The prefix 'inter' indicates the two-way interaction between individuals from two different cultures (Lee, 2020).

Participants overwhelmingly reported the importance of intercultural competence for the development of therapeutic, trusting relationships with healthcare providers before they accessed and engaged in a service. One participant shared "The Stolen Generation is still fresh in our minds, these are not stories from a long time ago. These things have happened to our grandmothers. Our grandmothers' stories are whirling around in our minds. I don't trust white fellas" (Participant B2). Critically, another participant divulged why she never engaged in the MCH service, saying, "Maternal and Child Health Nurses in Victoria are mandated to report risk to our children, so why would we go" (Participant C3)?

The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data also presenting two concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C). These concurrent narratives were organized into separate sub-themes, namely 'untimely and/or inappropriate' and 'inflexible in approach' in Site A+B and 'untimely and/or inappropriate', 'inflexible

in approach', 'poor continuity of care' and 'not holistic' in Site C, as summarized in Table 3.

One mother poignantly stated why this theme, and the concurrent narratives, was a barrier for her. "As an Aboriginal woman, we have all these things in your mind when you go and see a service, whether it is FV or our partners or how we raise our children. We are always really listening and thinking as to how to answer their questions. I don't want the nurse to judge me and see me differently if I tell her my stories I don't want to go" (Participant B5).

4.2 | Factors contributing to indigenous women disengaged in the MCH service

All participants ($n = 11$, 100%) interviewed in Site A+B ($n = 9$, 81.8%) and Site C ($n = 2$, 18.2%) answered all tailored questions pertaining to this category in Table 2. Similarly, to the responses from Indigenous women who had never engaged in the MCH service, the coded data of the responses from this category produced a clear picture of the dataset of factors contributing to Indigenous women disengaged in the MCH service. The theme 'intercultural incompetence' was clearly definable as a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data presenting the same three concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely

TABLE 2 Tailored questions for women accessing different types of MCH services

- Are you currently using the MCH service?
- If yes [currently engaged with MCH services]
- What are the things you like or think are valuable about MCH services?
- What are the things that you do not like about the MCH service?
- Are there things that could be changed that would make the service better for you?
- Do you use the service provided through the ACCHO or the local council?
- Do you have a preference for who provides your MCH service?
- If so, what are the reasons you like that provider more than the others?
- If no [have attended but no longer engaged]
- Why did you stop using the MCH service?
- Are there things that you think need to change about the way the MCH service is provided that would improve it?
- What would need to happen for you to start using the MCH service again?
- If you have never used the MCH service [have never attended MCH]
- What are some of the reasons you do not use MCH the service?
- Does someone else see your child for health assessments or immunizations?
- If so, who (what service) do you go to for these things?
- Do you have someone you go to if you have questions about parenting or child health and development? If so, who is this? Do they meet your needs?

TABLE 3 Summary of themes why Indigenous women never engaged in the MCH service

Site	Theme/s	Sub theme/s	Enabler	Barrier
A + B (n = 6)	Intercultural incompetence	Mistrust		x
		Miscommunication		x
	Ineffective service	Untimely and/or inappropriate		x
		Inflexible in approach		x
		Poor access		x
C (n = 4)	Intercultural incompetence	Mistrust		x
		Miscommunication		x
		Not recognizing the Social Determinates of Health		x
	Ineffective service	Untimely and/or inappropriate		x
		Inflexible in approach		x
		Poor continuity of care		x
		Not holistic		x
		Poor access		x

'mistrust', 'miscommunication' and 'not recognizing the Social Determinates of Health'.

One participant shared, "I didn't feel that my story was being heard and I didn't trust the nurse. She didn't care about my wellbeing. Mob needs safety to tell her story, the trust isn't there so I didn't go back" (Participant B6). Another participant agreed, saying, "I had a bad experience in the past. I didn't get on with the nurse. I didn't like the tone that she used. Mob do not like authoritative tone when you speak to us. I felt judged and threatened as I thought my children were going to be removed, so I stopped going" (Participant B3).

One mother stated, "I didn't like where the nurse worked, it was clicky, and that's a turn off for many of us. Yeah, the white fellas stick together and don't bother to get to understand us blackfellas and our ways of doin' things, our kinship, our lore. I didn't feel safe, I felt judged. My kids were a bit dirty when we went there one day, and I could see the nurse was judging me. I never went back" (Participant A4).

The importance of the nurse to understand the SDOH was emphasized by some participants. One mother suggested, "use a strengths-based approach when you speak to us. Better understanding of mob, not stereotyping that we are all the same- bad mothers that don't look after our kids properly" (Participant C5). Another shared, "I won't go to the MCH service now, it's toxic! I feel bad enough about myself most of the time, and the nurse does not make me feel comfortable when I am there. She makes me feel worse about myself when I'm around her" (Participant B11).

The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data presenting the same four concurrent narratives in Portland (Site A + B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care' and 'not holistic', as summarized in Table 4.

Most participants in this category disengaged in the MCH service, as the service was not effective for them. One mother shared, "as an Aboriginal woman people think the worst straight away. I would need the service to suit me better before I go back, don't make it so white" (Participant C6).

4.3 | Factors contributing to indigenous women currently engaged in the MCH service

All participants (n = 14, 100%) interviewed in Site A + B (n = 6, 42.9%) and Site C (n = 8, 57.1%) answered all tailored questions pertaining to this category in Table 2. The interpretation of the data in this category, in comparison to the interpretation of aggregated meaning across the dataset, was more complex as some themes and sub-themes were both enablers and barriers to access and engagement in the MCH service.

Similarly, to the responses from Indigenous women who had never engaged or disengaged in the MCH service, the theme 'intercultural competence/incompetence' was clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data presenting the same three concurrent narratives in Portland (Site A + B), and in Heywood (Site C) as factors which enabled access and engagement, and two concurrent narratives in Portland (Site A + B), and in Heywood (Site C) as factors which were barriers to access and engagement in the MCH service.

The concurrent narratives constructed as separate sub-themes which enabled access and engagement in all three sites were 'trust', 'communication' and 'recognizes the Social Determinates of Health'.

One participant supported this by saying, "my nurse understands me and looks after my health and well-being. She asks me how I am too, not just my baby. I feel safe with her" (Participant A8). Another

TABLE 4 Summary of themes why Indigenous women disengaged in the MCH service

Site	Theme/s	Sub theme/s	Enabler	Barrier
A + B (n = 9)	Intercultural incompetence	Mistrust		x
		Miscommunication		x
		Not recognizing the Social Determinates of Health		x
	Ineffective service	Untimely and/or inappropriate		x
		Inflexible in approach		x
		Poor continuity of care		x
		Not holistic		x
		Poor access		x
C (n = 2)	Intercultural incompetence	Mistrust		x
		Miscommunication		x
		Not recognizing the Social Determinates of Health		x
	Ineffective service	Untimely and/or inappropriate		x
		Inflexible in approach		x
		Poor continuity of care		x
		Not holistic		x
		Poor access		x

stated, "there are posters and flags of Aboriginal culture in the building, I feel safe there" (Participant A9).

The concurrent narratives constructed as separate sub-themes which represented barriers to access and engagement in all three sites were 'miscommunication' and 'not recognizing the Social Determinates of Health'.

Interestingly, one participant shared that although she engaged in the MCH service, "I would like better communication with the other services so I don't have to keep telling my story, and a better understanding of Kinship" (Participant A5). Another participant said, "I would like the nurse to explain what they do for each visit so I know who else I should see and why they ask things such as DV [domestic violence]" (Participant C7). A third mother said, "some of the advice the nurse gives me is a bit westernised, it doesn't always take in Indigenous ways of doing things. They should be asking us what we want to know. I would like more about Aboriginal health and well-being and not white person's health and well-being! VACCHO has got heaps of things that she could use" (Participant C9).

The theme 'effective/ineffective service' was also clearly definable as both an enabler and a barrier to access and engagement in the MCH service in all three sites. Constituent-coded data presented three concurrent narratives in Portland (Site A+B), and four concurrent narratives in Heywood (Site C) as factors which enabled access and engagement, and five concurrent narratives, common to all three sites, as factors which were barriers to access and engagement in the MCH service. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Portland (Site A+B) were 'timely and appropriate', 'flexible in approach' and 'holistic'. The concurrent narratives constructed as separate sub-themes which enabled access and engagement in Heywood (Site C)

were namely 'timely and appropriate', 'flexible in approach', 'continuity of care' and 'holistic'.

One participant liked that "Immunisations are given by the nurse at the same appointment when they are due so I don't have to go anywhere else for them" (Participant A6).

Another mother said that she likes that "the MCH nurse works for my ACCHO and the council so I don't have to tell my story twice" (Participant A7).

The theme 'ineffective service' was similarly clear as a barrier to access and engagement in the MCH service in all three sites, with constituent-coded data presenting the same four concurrent narratives in Portland (Site A+B), and in Heywood (Site C). These concurrent narratives were constructed as separate sub-themes, namely 'untimely and/or inappropriate', 'inflexible in approach', 'poor continuity of care' and 'not holistic', as summarized in Table 5.

One participant shared, "It would be good to have a Koori Health Care Worker work with the nurse, just to help the nurse understand me better. It's around having Aboriginal people work with the nurse so mob are happy to come in the front door and they are welcomed, listened to, and respected" (Participant A5). Another said, "although I have got to know the nurse, it would have been good if I got to know her earlier like at women's group so she could meet pregnant mums there and build a relationship before the bub is born" (Participant B12). Another mother supported this saying, "it would be good to see the MCH nurse when we mob are pregnant so the nurse can get to know us better and the Koori Maternity nurse can pass on their story before bub is born and shit happens! It's hard to stay on track with a newborn" (Participant A10)! A few participants stated that although they did engage in the service, the service could be made more effective if "the nurse had more time, especially if I have had

TABLE 5 Summary of themes why Indigenous women are currently engaged in the MCH service

Site	Theme/s	Sub theme/s	Enabler	Barrier
A + B (n = 6)	Intercultural competence/ Intercultural incompetence	Trust/Mistrust	x	
		Communication/Miscommunication	x	x
		Recognizes the Social Determinates of Health/ Not recognizing the Social Determinates of Health	x	x
	Effective service/Ineffective service	Timely and Appropriate/Untimely and/or inappropriate	x	x
		Flexible in Approach/Inflexible in approach	x	x
		Continuity of care/Poor continuity of care	x	x
		Holistic/Not holistic	x	x
C (n = 8)	Intercultural competence/ incompetence	Trust/Mistrust	x	
		Communication/Miscommunication	x	x
		Recognizes the Social Determinates of Health/ Not recognizing the Social Determinates of Health	x	x
	Effective service/Ineffective service	Timely and Appropriate/Untimely and/or inappropriate	x	x
		Flexible in Approach/Inflexible in approach	x	x
		Continuity of Care/Poor continuity of care	x	x
		Holistic/Not holistic	x	x
		Access/Poor access	x	x

lots of problems to yarn about" (Participant C14). Another mother stated, "the age when my bub is due to see the nurse sometimes doesn't suit me, but there's not a lot of flexibility. I would like to see the nurse more when I need to, not just when she says my baby is due to come in" (Participant C11).

5 | DISCUSSION

This study provides insight from Indigenous women with children aged birth to 5 years currently residing in the Glenelg Shire, on factors contributing to access and engagement in the MCH service in Victoria, Australia. The researcher presented the findings as a detailed analysis of the thematic framework, where the individual themes and sub-themes were expressed in relation to both the dataset and the research question(s). This is summarized in Figure 2.

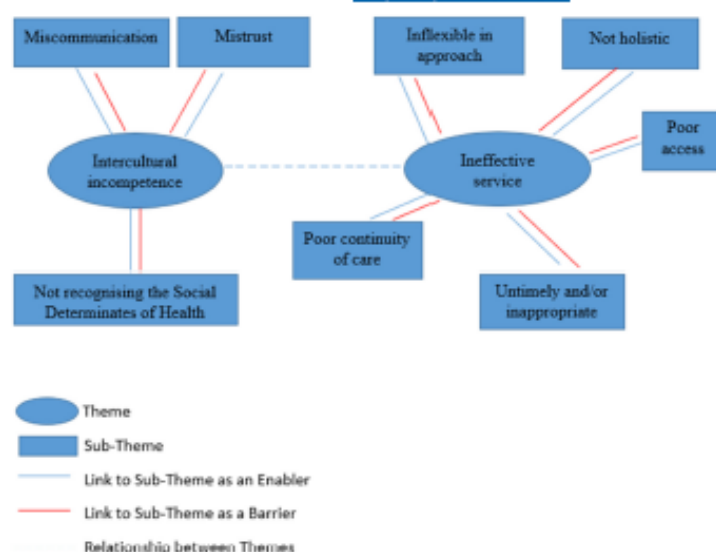
The Indigenous women who participated in the yarning sessions in all three sites disclosed their reasons for having never engaged in the MCH service were barriers they either perceived, or encountered, to access and engage in the MCH service. Factors that influenced their choice were namely that they believed the MCH service was interculturally incompetent, or it was ineffective for their needs. Some women expressed that there was poor continuity of care between maternity services, and they either did not trust or communicate well with the staff at the service. Other women felt that the service was untimely, inappropriate or inflexible in approach, and did not recognize their SDOH or the holistic principles that align with

Indigenous ways of 'knowing, doing and being'. There were no enablers to access and engagement in the MCH service disclosed in the yarning from this group.

Reasons cited for the Indigenous women disengaging in the MCH service, in all three sites, were comparable to those who had never engaged in the MCH service, namely that they believed that the MCH service was interculturally incompetent, or it was ineffective for their needs. Factors that influenced their choice were very similar to the group who had never engaged in the MCH service. There were also no enablers to access and engage in the MCH service disclosed in the yarning for this group.

Findings from the third group of Indigenous women, those who were currently engaged in the MCH service, were more complex as a number of themes and sub-themes were both enablers and barriers to access and engagement in the MCH service. Whilst intercultural competence was an enabler for some women in all three sites, based on established trust and communication, and perception that the service recognizes their SDOH or the holistic principles that align with Indigenous ways of 'knowing, doing and being', for others it was a barrier. Although some women continued to engage in the MCH service, intercultural incompetence, namely due to miscommunication and not recognizing the SDOH was still an issue for their access and engagement in the MCH service in all three sites. Some women from all three sites disclosed that they thought the MCH service was effective for them, as it supported continuity of care between other services the woman was engaged in, timely and appropriate, flexible in approach and holistic. In contrast, other women from all

FIGURE 2 Finalized thematic framework map



three sites believed that the MCH service was still partially ineffective for them, which was a barrier to access and engagement, albeit not enough to choose to disengage in the service. These barriers included untimely or inappropriate services, a service that was partially inflexible in approach, needed improvement in continuity of care between services, and at times was not holistic.

The findings of this study assimilate with existing evidence, including the review of the literature conducted in 2021 by the author as part of a larger study, to identify models or interventions that promote and support better access and engagement, quality of care, service delivery and outcomes for Indigenous women and their children in MCH services. Enablers of the few studies ($n = 6$) found in the review of the literature were service models or interventions that are timely, appropriate, culturally strong, effective community-based services that are integrated, but flexible to suit the holistic needs of the family. Barriers that impacted the access and engagement, quality of care, service delivery and outcomes for Indigenous women to MCH services, were inefficient communication resulting in lack of understanding between client and provider, cultural differences between client and provider, poor continuity of care between services, lack of flexibility in approach/access to services, and a model that does not recognize the importance of the SDOH and well-being.

Additionally, the findings of this research also support the results of the audit conducted by the Victorian Auditor-General's Office (VAGO) in 2014. The audit was established to examine the poor engagement of Aboriginal families in a range of mainstream early childhood, health and human services, including MCH. The report from the audit (VAGO, 2016) affirmed that the issue of accessibility of mainstream services for Aboriginal Victorians was multi-factorial, including the quality of service standards, governance, policies, regulations, laws and Acts, information sharing

practices, data systems and a skilled workforce (VAGO, 2016). Persistent barriers for Aboriginal families to access MCH services in Victoria were identified by the audit as "a lack of culturally safe services; a lack of awareness of the services that are available; a lack of required services in the local area; racism; a lack of transport to service delivery; shame, embarrassment, fear" (ACIL Allen, 2015, p. 7).

In response to the consistently lower participation rates of Indigenous children compared with non-Indigenous children at all 10 KAS consultations provided within the MCH service since the inception of the KAS model in 2009 (VAGO, 2016), and the findings from the VAGO audit (2016), the Department of Education and Training (DET), initiated a review of engagement of Aboriginal families with MCH services. This was a two-phase review, with Phase 1 undertaken during late 2014 by VACCHO (VACCHO, 2015). This phase examined the scope of MCH service provision to Aboriginal families and identification from a local provider perspective of potential factors that affected access to MCH services by Aboriginal families (VACCHO, 2015). Phase 2 of the DET review, which was conducted by ACIL Allen Consulting in 2015, built on the work of Phase 1 but sought to provide a broader understanding of the experiences of Aboriginal families with MCH services and to identify enablers and barriers to their engagement (ACIL Allen, 2015). Both reports found that ACCHO-based MCH services had a stronger focus on social and cultural determinants of the health of Aboriginal people, and were more flexible and tailored to the needs of Aboriginal children and families (ACIL Allen, 2015; VACCHO, 2015). Co-location of support services provided within the 'culturally safe environment' of an ACCHO encouraged holistic care of Aboriginal families and improved collaboration between the MCH service and other allied health services (ACIL Allen, 2015; VACCHO, 2015). These findings, and those of the Royal Commission into Family Violence (State of

Victoria, 2016), concluded that there were 'concerns' with the differential response model framing early years services in Victoria to engage Indigenous families.

Highlighting enablers that support access and engagement of Indigenous women in MCH services may facilitate the emergence of a holistic model of care to engage Indigenous women in MCH services. A new model based on a standpoint that privileges First Nations people, depicted by Moreton-Robinson (2013), that addresses the human rights challenge of inequality in health outcomes between Indigenous and non-Indigenous children, the over-representation of these children in Out of Home Care (OOHC), and the high rates of their exposure to FV, would support the Uluru statement from the heart (First Nations National Constitutional Convention, 2017), a petition by Australian Aboriginal leaders to change the constitution of Australia to improve the representation of Indigenous Australians.

The Early Assessment Referral Links (EARL) concept, developed by the author in 2009 in collaboration with a broad cross-section of the Aboriginal community and other health service providers in the Glenelg Shire, Victoria, Australia, is an example of a model of holistic care that aligns with Indigenous ways of knowing, doing and being and a standpoint that privileges First Nations people. EARL improves access and engagement of Indigenous women in health services through recognition of their historical and contemporary SDOH, and the interactions and the effects of SDOH on their health outcomes and well-being (Austin & Arabena, 2021). The aim of the EARL concept is to promote and support better access and engagement, quality of care, service delivery and outcomes for Aboriginal women and their children in MCH services, and to identify families who require further assessment, intervention, referral and/or support, ideally from the preconception or antenatal periods.

The literature shows the lack of comparison to current knowledge gathered with Indigenous women and non-Indigenous service providers (Andrews, 2021; Moreton-Robinson, 2013) and a conspicuous absence about Indigenous women, children and raising children in the context of the impact of the SDOH and health outcomes of Australian Indigenous women on their access and engagement in maternal child health services (Andrews, 2021). The new knowledge that has emerged from the findings of this study, supported by the existing literature outlined in the discussion, reinforce the need to review the effectiveness of models of care to engage Indigenous families to ensure that MCH services meet the needs of these families. Ensuring that Indigenous women have an integral role in developing, implementing, monitoring and evaluating plans and programs for MCH would improve intercultural competence between the nurses and the women and support better access and engagement, quality of care, service delivery and outcomes for these women and their children in MCH services. This process would align with the priority reforms that have been directly informed by Aboriginal and Torres Strait Islander people under the National Agreement on Closing the Gap (2020), being Formal Partnerships and Shared Decision Making; Building the Community-Controlled Sector; Transforming Government Organizations and Shared Access to Data and Information at a Regional Level. These reforms are central to

the National Agreement on Closing the Gap (2020), and will change the way governments work with Aboriginal and Torres Strait Islander people and communities.

5.1 | Limitations

There are three primary limitations in this study. First, the researcher is the primary instrument of interpretation of data (Denzin & Lincoln, 2011), which is potentially problematic and something of which the researcher needs to be aware. The issue here is the potential effect of the researcher's own background, in which the researcher's experience of class, gender and race can potentially influence their interpretation of the data (Denzin & Lincoln, 2011). As the researcher is a MCH nurse, the researcher is aware of a potential bias that may occur when interpreting the data. Second, due to the small number of participants, protecting anonymity may become an issue for those participants who do not want their stories shared. Third, although the researcher predicts that the three classifications of Indigenous women interviewed will represent a cross section of Aboriginal women's access and engagement in MCH services, and may provide the insight to justify further research in the future with a greater number of participants, the researcher also acknowledges that this study does not have a good cross section of geographical context, including representation of participants from metro, regional and remote areas, disallowing geographical context being considered in the synthesis of the data.

5.2 | Implications for practice

Persistent disparities in health outcomes between non-Indigenous and Indigenous mothers and their children underscore the need to prioritize responsive practices in MCH services. The MCH nurses themselves have an integral role in changing their practices, and informing policies, so the whole sector is better prepared to support access and engagement of Indigenous women and children to their services. Hence, the perspectives from MCH nurses should be considered in future research.

Services that facilitated accessibility and are designed to support Indigenous women during their pregnancy and postnatal period are likely to have a positive impact on engagement (Panaretto et al., 2007). An issue that is crucial to translating the results and recommendations of this study into policy or practice would be to ensure that MCH service models and interventions focus on the issues most relevant to people's lives, namely the SDOH and well-being, and a shared understanding and common language regarding the needs and risks for children and their families. Furthermore, programs are more likely to be accessed by Indigenous women if they are designed in a culturally safe and secure space, using a bicultural approach that combines the western biomedical model with Indigenous cultural ways of 'being, doing and knowing' (Aitken & Stultz, 2018; Martin, 2003; Rossiter et al., 2019; Simmonds et al., 2010). To

facilitate this, it is imperative that all MCH nurses have an understanding of Indigenous culture and a positive relationship within the Indigenous community that they work, including an authentic comprehension of their needs. Providing training to MCH nurses who work with Indigenous families, based on the specific findings of this research outlined in Figure 2, and how to integrate the principles of trauma and violence-informed care into their practice, might increase the physical, emotional and cultural safety experienced by Indigenous women in Australia. This would also ensure that MCH nurses provide a service built on best-practice guidelines to monitor health and development and the prevention, early detection and intervention for physical, emotional and social factors, which may affect the child or their family (DEECD, 2011; DOH, 2013). To help identify the service needs of an Indigenous community, MCH nurses need to ensure accurate identification of Indigenous children birth to 5 years of age by reliable data collection and recording processes, and 'data matching' with other organizations servicing that community. An accurate census of the population within a community will facilitate better evaluation of programs or interventions introduced that aim to improve access and engagement, quality of care, service delivery and outcomes for women and their children in MCH services, and identify gaps in service provision to these women and their children. Outreach to services that Indigenous families use such as ACCHO's, playgroups, kindergartens and day-care facilities; attending Indigenous festivals/celebrations; and engaging with the woman antenatally through collaboration with maternity services will encourage rapport and trust, and promote and support better access and engagement, quality of care, service delivery and outcomes for Indigenous women and their children in MCH services.

6 | CONCLUSION

The findings of this study show that there is a need for further research, informed by Indigenous voices, regarding the benefit of alternative models and interventions that consider the impact of the SDOH on health outcomes of Australian Indigenous women and their access and engagement in MCH services. Most importantly, a MCH service model, like the EARL concept, should allow for the integration of traditional Aboriginal child-rearing practices, with westernized values, practices and beliefs through a guided mastery approach, shared knowledge, yarning, capacity building, mutual trust and connection to facilitate effective engagement and trust in the service. This is of international importance for Indigenous families, nursing practice and public health to address the human rights challenge of inequality in health outcomes between Indigenous and non-Indigenous children, the over-representation of these children in OoHC and the high rates of their exposure to FV.

ACKNOWLEDGEMENTS

Open access publishing facilitated by Federation University Australia, as part of the Wiley - Federation University Australia agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

The author has declared no conflict of interest.

PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.15493>.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ORCID

Catherine Austin  <https://orcid.org/0000-0003-4252-3355>

REFERENCES

- ACIL Allen. (2015). *Exploring aboriginal families' perceptions and experiences of maternal and child health services*. ACIL Allen Consulting.
- Aitken, R., & Stults, V. (2018). Factor analysis to validate a survey evaluating cultural competence in maternity care for indigenous women. *Australian Journal of Advanced Nursing*, 36(1), 25–36.
- Anderson, I., Robson, B., Connolly, M., al-Yaman, F., Bjertness, E., King, A., Tynan, M., Madden, R., Bang, A., Coimbra, C. E., Jr., Pesantes, M. A., Amigo, H., Andronov, S., Armien, B., Obando, D. A., Axelsson, P., Bhatti, Z. S., Bhutta, Z. A., Bjerregaard, P., ... Yap, L. (2016). Indigenous and tribal peoples' health: A population study. *Lancet*, 388, 131–157.
- Andrews, S. (2021). Qualitative analysis at the interface of Indigenous and Western knowledge systems: The Herringbone stitch model. *Qualitative Research*, 21(6), 939–956. <https://doi.org/10.1177/1468794120965365>
- Andrews, D., & Hughes, B. (1993). Best practice in program delivery for Aboriginal and Torres Strait Islander offenders. www.aic.gov.au/media_library/conferences/indigenous2/toby.pdf:21
- Austin, C., & Arabena, K. (2021). Improving the engagement of aboriginal families with maternal and child health services: A new model of care. *Public Health Research and Practice*, 31. <https://doi.org/10.1016/j.phrp.2021.03.009>
- Australia Department of the Prime Minister and Cabinet. (2020). *National Agreement on closing the gap*. Australian Government. <https://www.closingthegap.gov.au/national-agreement-closing-gap-glance>
- Australian Bureau of Statistics [ABS]. (2017). 2016 Census Community Profiles. <http://www.censusdata.abs.gov.au>
- Belli, P., Bustreo, F., & Preker, A. (2005). Investing in children's health: What are the economic benefits? *Bulletin of the World Health Organization*, 83(10), 777–784.
- Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. Sage Publications Ltd.
- Bretherton, D., & Mellor, D. (2006). Reconciliation between aboriginal and other Australians: The stolen generations. *Journal of Social Issues*, 62(1), 81–98.
- Christie, M. (2006). Transdisciplinary research and aboriginal knowledge. *The Australian Journal of Education*, 35, 1–80.
- Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five traditions*. Sage.
- Denzin, N., & Lincoln, Y. (2011). *The SAGE handbook of qualitative research*. Sage.
- Department of Education and Early Childhood Development [DEECD]. (2011). *The maternal and child health guidelines*. www.education.vic.gov.au/Documents/childhood/health/mchsguidelines.pdf
- Department of Education and Training [DET]. (2016). *Maternal and child health, universal service*. <http://www.education.vic.gov.au/>

- childhood/professionals/health/Pages/universalmchservice.aspx
- Department of Education and Training (DET). (2018). *Maternal and child health services annual report 2017–2018*.
- Department of Health (DOH). (2013). *Implementation plan for the national Aboriginal and Torres Strait Islander health plan 2013–2023*.
- Eapen, V., Walter, A., Guan, J., Descallar, J., Axelsson, E., Einfeld, S., Eastwood, J., Murphy, E., Beasley, D., Silove, N., Dissanayake, C., Woolfenden, S., Williams, K., Jalaludin, B., & The 'Watch Me Grow' Study Group. (2012). Maternal help-seeking for child development concerns: Associations with socio-demographic factors. *BMC Health Services Research*, 12(12), 117.
- First Nations National Constitutional Convention. (2017). *Uluru: Statement from the heart*. Central Land Council Library.
- Harris, J. (2003). Hiding the bodies: The myth of the humane colonisation of Australia. *Journal of Aboriginal History*, 27, 79–104.
- Lee, L. (2020). Promoting interpersonal and intercultural communication with Flipgrid: Design, implementation, and outcomes. In M. Kruk & M. Peterson (Eds.), *New technological applications for foreign and second language learning and teaching* (p. 261). IGI Global. <https://doi.org/10.4018/978-1-7998-2591-3.ch013>
- Martin, K. (2003). Ways of knowing, ways of being, ways of doing: A theoretical framework and methods for indigenous re-search and indigenist research. *Journal of Australian Studies*, 76, 203–214.
- McAlpine, L. (2016). Why might you use narrative methodology? A story about a narrative. *Eesti Haridusteaduste Ajakiri*, 4(1), 32–57.
- Merriam-Webster's online dictionary. (2021a). <https://www.merriam-webster.com/dictionary/aboriginal>
- Merriam-Webster's online dictionary. (2021b). <https://www.merriam-webster.com/dictionary/indigenous>
- Merriam-Webster's online dictionary. (2021c). <https://www.merriam-webster.com/dictionary/mob>
- Moreton-Robinson, A. (2013). Towards an Australian indigenous women's standpoint theory: A methodological tool. *Australian Feminist Studies*, 28(78), 331–347.
- Morse, J. (1995). The significance of saturation. *Qualitative Health Research*, 5(2), 147–149.
- Morse, J. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3–5.
- Nakata, M. (1998). Anthropological texts and indigenous standpoints. *Australian Aboriginal Studies*, 2, 3–12.
- National Health and Medical Research Council (NHMRC). (2018). *Ethical conduct in research with aboriginal and Torres Strait islander peoples and communities: Guidelines for researchers and stakeholders*. Commonwealth of Australia.
- Panaretto, K., Mitchell, M., Anderson, L., Larkins, S., Manassis, V., Buttner, P., & Watson, D. (2007). Sustainable antenatal care services in an urban indigenous community: The Townsville experience. *The Medical Journal of Australia*, 187(1), 18–22.
- Pelto, P., & Pelto, G. (1978). *Anthropological research: The structure of inquiry*. Cambridge University Press.
- Reynolds, H. (2006). *The other side of the frontier: Aboriginal resistance to the European invasion of Australia*. University of New South Wales Press.
- Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Duell-Piening, P., & Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMC Health Services Research*, 12(117), 2012. <https://doi.org/10.1186/1472-6963-12-117>
- Rossiter, C., Fowler, C., Hesson, A., Kruske, S., Homer, C., Kemp, L., & Schmied, V. (2019). Australian parents' experiences with universal child and family health services. *Collegian*, 26(3), 321–328.
- Rumbold, A., Bailie, R., Si, D., Dowden, M., Kennedy, C., & Cox, R. (2011). Delivery of maternal health care in indigenous primary care services: Baseline data for an ongoing quality improvement initiative. *BMC Pregnancy and Childbirth*, 11(16). <https://doi.org/10.1186/1471-2393-11-16>
- Senate Standing Committees on Community Affairs. (2013). *Australia's domestic response to the World Health Organization's (WHO) commission on social determinants of health report 'closing the gap within a generation'*. Australian Government.
- Shonkoff, J., Boyce, W., & McEwen, B. (2009). Neuroscience, molecular biology and the childhood roots of health disparities. *JAMA: The Journal of the American Medical Association*, 301(21), 2252–2259.
- Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early child development*. National Academy Press.
- Simmonds, D., Porter, J., O'Rourke, P., West, L., Tangay, A., & Holland, C. (2010). A 'two-ways' approach to improving antenatal education for Ngaanyatjarra women. *Aboriginal and Islander Health Worker*, 34(2), 10–13.
- State of Victoria. (2016). *Royal commission into family violence: Summary and recommendations*, Parl Paper No. 132 (2014–2016).
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications, Inc.
- Stronach, M., & Adair, D. (2014). Dadirri: Reflections on a research methodology used to build trust between a non-indigenous researcher and indigenous participants. *Cosmopolitan Civil Societies Journal*, 6(2), 3859. <https://doi.org/10.5130/ccs.v6i2.3859>
- Sweeney, K. (2014). *The influence of childhood circumstances on adult health*. Report to the Mitchell Institute for Health and Education Policy. Victoria Institute of Strategic Economic Studies, Victoria University; 2014. Contract No: Commissioned report No. 01/2014.
- United Nations Committee on the Rights of the Child. (2013). General comment No. 15(2013) on the rights of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15. <https://www.refworld.org/docid/51ef9e134.html>
- Victorian Aboriginal Community Controlled Organisation (VACCHO). (2015). *Aboriginal families' engagement in maternal and child health services project*.
- Victorian Auditor-General's Office (VAGO). (2016). *Victorian Auditor-General's office annual report*. <https://www.data.vic.gov.au/data/dataset/vago-annual-report-2015-16>
- West, R., Stewart, L., Foster, K., & Usher, K. (2012). Through a critical lens: Indigenist research and the Dadirri method. *Qualitative Health Research*, 22(11), 1582–1590.
- Wilkie, M. (1997). *Bringing them home: Report of the national inquiry into the separation of aboriginal and Torres Strait islander children from their families*. Human Rights and Equal Opportunity Commission.
- World Health Organisation (WHO). (2018). *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. United Nations Children's Fund, World Bank Group.
- World Health Organisation (WHO). (2022). *Social determinants of health*.
- Yelland, J., Weetra, D., Stuart-Butler, D., Deverix, J., Leane, C., Kit, J., Glover, K., Gartland, D., Newbury, J., & Brown, S. (2016). Primary health care for aboriginal women and children in the year after birth: Findings from a population-based study in South Australia. *Australian and New Zealand Journal of Public Health*, 40(5), 418–423.

How to cite this article: Austin, C. (2022). The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services. *Journal of Advanced Nursing*, 00, 1–15. <https://doi.org/10.1111/jan.15493>

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports® (Nursing: Social Science).
- Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).
- Fast and easy online submission: online submission at <http://mc.manuscriptcentral.com/jan>.
- Positive publishing experience: rapid double-blind peer review with constructive feedback.
- Rapid online publication in five weeks: average time from final manuscript arriving in production to online publication.
- Online Open: the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).

Contribution of Authors

Name	Paper Design	Data Collection	Data Analysis	Interpretation	Manuscript Writing	Confirmation of contribution
C. Austin	100 %	100%	100%	100%	100%	√

Appendix Fifteen: Publication arising from the thesis



Improving the engagement of Aboriginal families with maternal and child health services: a new model of care

Catherine Austin^{a,c} and Kerry Arabena^b

^a Federation University Australia, Ballarat, VIC

^b Melbourne School of Population and Global Health, University of Melbourne, VIC, Australia

^c Corresponding author: austinc62@gmail.com

Article history

Publication date: June 2021

Citation: Austin C, Arabena K. Improving the engagement of Aboriginal families with maternal and child health services: a new model of care. *Public Health Res Pract*. 2021;31(2):e30232009. First published 30 July 2020. <https://doi.org/10.17061/phrp30232009>

Key points

- A new model of care is needed to improve Aboriginal families' engagement with maternal and child health services to help address disparity in health outcomes between Aboriginal and non-Aboriginal children
- A trial of a streamlined referral system in one shire in Victoria, Australia, showed increased engagement of Aboriginal families, and positive outcomes including increases in Aboriginal children being breastfed, fully immunised and attending a kindergarten program
- The co-designed, strengths-based model encourages an open network inclusive of organisations working with families and children and, importantly, allows the integration of traditional Aboriginal child-rearing practices with standardised Western healthcare values, beliefs and practices

Abstract

Objectives: Access in the early years to integrated community-based services that are flexible in their approach, holistic and culturally strong is a proven critical predictor of a child's successful transition to school and lifelong education and employment outcomes, providing long-term wellbeing. Studies show that participation in maternal and child health (MCH) services in Victoria, Australia, improve health outcomes for children and families, particularly for Aboriginal families. Poorer health outcomes and lower participation rates for these families in MCH services suggest there is a need for an urgent review of the current service model. The purpose of this paper is to outline the Early Assessment Referral Links (EARL) concept that was trialled in the Glenelg Shire in Victoria, Australia (2009–2014) to improve the engagement of Aboriginal families in MCH services.

Methods: Development of EARL involved the core principles of appreciative inquiry to change existing patterns of conversation and give voice to new and diverse perspectives. A broad cross-section of the Aboriginal community and their early years health service providers were consulted and stakeholders recruited. Regular meetings between these stakeholders, in consultation with the Aboriginal community, were held to identify families that weren't engaged in MCH services and also to identify families who required further assessment, intervention, referral and/or support, ideally from the preconception or antenatal periods. Outcome measures used to evaluate the EARL concept include stakeholder meetings data, numbers of referrals, and participation rates of women and children in MCH services.

Results: Participation of Aboriginal women and children in MCH services was consistently above the state average during the pilot period, and significant numbers of Aboriginal women and children were referred to EARL stakeholders and other health professionals via EARL referrals. Additionally, there were increases in Aboriginal children being breastfed, fully immunised and attending Early Start Kindergarten. Identification of Aboriginal women and children at risk of vulnerability also improved with a dramatic increase in referrals for family violence and child protection, and decreased episodes of out-of-home care (OoHC) for children.

Conclusions: Evaluation of pilot outcomes indicate that the EARL concept improved women and children's access to and engagement with MCH services, and identified more families at risk of vulnerability than the traditional MCH service model, particularly for Aboriginal women and children.

Introduction

Maternal and child health (MCH) services in Victoria support families by providing 10 Key Ages and Stages (KAS) consultations between birth and 3.5 years, to monitor the health, growth and development of children. Although participation of Aboriginal families in MCH services has improved over time, MCH service data indicates lower participation rates for Aboriginal children compared with non-Aboriginal children at all 10 KAS consultations.^{1,2}

This disparity is consistent with the broader inequality in health outcomes between Aboriginal and non-Aboriginal children at a national level.³ Despite measures by federal, state and local governments to improve the health outcomes of these children in Australia, data continues to show that almost half of all Australian Indigenous children are identified as vulnerable – twice the proportion of non-Indigenous children.³ Children are prone to vulnerability if their parents and family have limited capacity to care for and protect them effectively, and to provide for their long-term development and wellbeing.⁴

Key risk factors that contribute to making a child, young person and their family vulnerable include economic hardship – including related issues like unemployment and homelessness, family violence, alcohol and substance misuse, mental health problems, disability and parental history of abuse and neglect.⁴

This evidence suggests that a review of the effectiveness of the current MCH service model of care, particularly for Aboriginal families, is urgently needed. Models of care are widely used in health, providing a clear approach to the way services are delivered, optimally to encourage best practice care and services for an individual or population group as they advance through the stages of a condition, injury or event.⁵ The guiding principles of a model of care are that it is patient centric; flexible; considerate of equity of access; encourages integrated care and efficient utilisation of resources; supports safe, quality care for patients; has robust, standardised outcome measures and evaluation processes and regards innovative ways of organising and delivering care.⁶

To address this issue, the Glenelg Shire Council MCH team devised an approach to improve the identification of families with children from conception to 6 years, who are not engaged in MCH services, or who are at risk of vulnerability. The approach aimed to identify and reduce gaps within service delivery and to link those families

into local services to provide a continuum of care, so a strong support system is in place before a baby is born. Importantly, access in the early years to integrated community-based services that are flexible in their approach, holistic and culturally strong is a proven critical predictor of a child's successful transition to school and lifelong education and employment outcomes, providing long-term wellbeing. This is fundamental to Closing the Gap.⁴

This research was undertaken in the Glenelg Shire in south western Victoria, Australia, where there are an estimated 369 Aboriginal people, representing just under 2% of the population.⁷ Based on the first phase of a three-phase study, this article discusses the development and implementation of the EARL concept, and presents data reflecting the outcomes of the pilot study.

Methods

Development of the concept involved using the core principles of appreciative inquiry to change existing patterns of conversation and ways of relating, and to give voice to new and diverse perspectives to improve MCH services in this area.⁸ The steps involved in developing the EARL concept included consultation with the Aboriginal community, mapping practices and services, recruiting stakeholders, implementing the pilot and evaluating the pilot through outcome measures. Through this process, the researcher consulted with service providers who shared a common location (the early years setting), philosophy, vision and agreed principles for working with children 0–6 years and their families residing in the Glenelg Shire. All service providers that were approached elected to become EARL stakeholders, and reflected the diverse cross-section of organisations and multidisciplinary health professionals providing early years' care that were involved in the delivery of, and referral to, MCH services locally. Figure 1 outlines the process followed to develop the EARL concept.

The pilot of the EARL concept was managed by a coordinator, who was the chair (the researcher CA). Glenelg Shire Council was the lead agency. The other stakeholders were a combination of multiple service providers and included local maternity and allied health services, Aboriginal Community Controlled Health Organisations (ACCHOs) (representing the Aboriginal community), Victorian Department of Education and Training (DET), Victorian Department of Health and

Figure 1. Development of the EARL concept



Human Services (DHHS) and local government. The manager of each agency, or their nominated representative, agreed to meet on a regular basis to discuss children and young people at risk of vulnerability who would benefit from integrated support. EARL was funded through the Universal Maternal and Child Health program, which is provided through a partnership between the Victorian DET and local governments. The program's funding for MCH services is based on the total number of children 0–6 years enrolled in the service. Each participating agency was self-funded to attend stakeholder meetings on a monthly basis.

The pilot of the EARL concept ran from 1 July 2009 to 30 June 2014. It started in Portland, Victoria, and branched out to incorporate whole-of-shire support. This resulted in Heywood EARL being established in March 2011 and Casterton EARL in April 2012.

Monthly meetings were conducted across the three locations – which stretch over a distance of 100km in the shire in far south western Victoria – and, where possible, were held at ACCHOs to encourage engagement of those stakeholders and highlight the group's profile in Aboriginal communities. After signing consent to share their information, the cases of clients at risk of vulnerability were discussed by the group during meetings, or by a sub-group between meetings if more appropriate, resulting in referrals to other stakeholders as required.

The EARL concept was evaluated using a variety of data from numerous sources, including DET and Department of Education and Early Childhood

Development annual reports.^{7,9–11} Also used were data from stakeholder meetings, rates of Aboriginal women and children referred to stakeholders, MCH services participation rates, number of children enrolled in Early Start Kindergarten, breastfeeding initiation and duration rates, immunisation rates, number of referrals to child protection and episodes of out-of-home care (OOHC).

The research has been approved by the Human Research Ethics Committee of Federation University (project number C17-024), the Human Research Ethics Committee of Department of Education and Training (project number 2014_002311), and the Department of Health and Human Services to use Client Relationship Information Systems and Integrated Reports Information System data. The Victorian Aboriginal Community Controlled Health Organisation advised that approval from an Indigenous Human Research Ethics Committee was not required for this research.

Results

Portland adopted the EARL pilot for 5 years. During that time, there were 51 (85%) stakeholder monthly meetings and 9 months when no meeting was held. There were 17 stakeholders in Portland and an average stakeholder meeting attendance rate of 76%. Heywood was operational for 3.3 years. During this period, there were 36 (90%) monthly meetings and 4 months when no meeting was held. There were 12 stakeholders in Heywood and average stakeholder meeting attendance

rate was 67%. Casterton operated for 2.25 years. During this time, there were 16 (59%) monthly meetings and 11 months when no meeting was held. This site involved nine stakeholders but only five (56%) regularly attended (the lowest attendance and lowest number of meetings of the three sites).

All Aboriginal families with children aged 0–6 years living in the Glenelg Shire during the pilot period who were approached by stakeholders to participate in the EARL pilot did so (2011: $n = 52$, 2013: $n = 56$).⁹ Data from the pilot shows there were a significant number of Aboriginal families referred to multiple EARL stakeholders, facilitating continuity of care. Among all women participants ($n = 30$), the highest proportion of women were referred to Aboriginal services, such as the ACCHOs ($n = 27$, 90%), Koori Maternity Services ($n = 29$, 97%) and Koori Education Support Services ($n = 21$, 70%). Almost half the women participating in the pilot were also referred to mainstream services providing maternity care ($n = 14$, 47%) and women were also referred to parent support ($n = 12$, 40%) and allied health services ($n = 14$, 47%), including counselling, diabetes educator, dietitian, drugs and alcohol services, early intervention, chronic disease services, exercise physiologist, occupational therapy, podiatry, speech pathology and youth worker. This indicates that women's needs were likely to be identified and met by the EARL model of care.

During the pilot of the EARL concept, participation rates of Aboriginal children in the MCH service rose to rates above the state average. Before the pilot began, the MCH participation rate for Aboriginal children in Glenelg Shire (54%) was below the state average of 57%. By the second year of operation the participation rate was at its highest (89%), and the state average was at its lowest (50%) of the pilot period. The EARL participation rates continued to be higher than the state rate, even after the pilot had finished (see Table 1). After an initial increase to

89%, participation rates decreased over the subsequent years the pilot was running.

In conjunction with higher participation rates, the referral of Aboriginal children to EARL stakeholders increased significantly during the pilot period. The highest number of referrals were to nursery equipment ($n = 56$, 100% of all children in the pilot)¹⁰ and the Dolly Parton Imagination Library¹¹ ($n = 56$, 100%) programs. Additionally, nearly all children in the pilot were referred to allied health programs ($n = 48$, 86%), such as dietetics, speech pathology, dentistry, ophthalmology, physiotherapy and audiology. More than one-third of the children in the pilot were referred to a supported playgroup ($n = 21$, 38%) – a favourable statistic considering there was only one supported playgroup in the Glenelg Shire.

Early Start Kindergarten provides up to 15 hours per week of free or low-cost kindergarten to eligible children aged 3 years (including Aboriginal children or those who have had contact with child protection services).¹⁴ During the EARL pilot, there was a 100% participation rate of eligible Aboriginal children in Early Start Kindergarten, all of whom were identified and referred to the program by EARL stakeholders (overall state enrolments to Early Start Kindergarten ranged from 33–51% during the same period).

There is strong evidence that breastfeeding gives babies the best start for a healthy life and has health and wellbeing benefits for both the mother and child.^{15–17} During the EARL pilot, there was an increase in the percentage of Aboriginal mothers initiating breastfeeding from 67% before the pilot to 100% 3 years into the pilot, and breastfeeding rates at 6 months increased from 17% before the pilot to 76% 3 years into the pilot (Table 2). Even after the pilot this rate remained high at 54% (national rates for initiating breastfeeding are around 96%, which fall dramatically to around 9% at six months duration).^{18,17}

Table 1. Participation rates of Aboriginal children 0–6 years of age in maternal and child health (MCH) services in Glenelg Shire, 2008–09–2014–15

Aboriginal children	2008–09	2009–10 ^a	2010–11 ^a	2011–12 ^a	2012–13 ^a	2013–14 ^a	2014–15
Children 0–6 years, Glenelg Shire (n)	29	26	47	59	57	61	65
Participation rate children 0–6 years, Glenelg Shire MCH service (%)	53.7	81.3	88.7	85.5	72.2	73.5	62.5
Participation rate: children 0–6 years, state of Victoria MCH service (%)	56.7	60.1	50	59.8	55.1	53.9	55.5

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health Services annual reports^{7,8,11}

Table 2. Breastfeeding rates of mothers of Aboriginal children in Glenelg Shire, 2008–09–2014–15

Aboriginal children	2008-09	2009-10 ^a	2010-11 ^a	2011-12 ^a	2012-13 ^a	2013-14 ^a	2014-15
Births (n)	6	19	22	17	17	12	24
Breastfed at birth (%)	67	89	95	100	94	92	84
Breastfed at 2 weeks (%)	50	84	86	100	88	92	79
Breastfed at 3 months (%)	33	79	81	88	82	83	63
Breastfed at 6 months (%)	17	63	64	76	71	67	54

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health Services annual reports^{9,11}

Table 3. Immunisation rates of Aboriginal children, 2008–09–2014–15

Aboriginal children	2008-09	2009-10 ^a	2010-11 ^a	2011-12 ^a	2012-13 ^a	2013-14 ^a	2014-15
Births: Glenelg Shire (n)	6	19	22	17	17	12	24
Fully immunised 0–6 year olds: Glenelg Shire (%)	83.57	86.75	91.67	88.50	97.44	94.87	83.57
Fully immunised 0–6 year olds: state of Victoria (%)	84.98	85.94	87.64	87.63	90.14	90.05	89.28

^a Participation rates during the EARL pilot period

Sources: Victoria State Government, Department of Education and Training. Maternal & Child Health Services annual reports^{9,12}

Studies show that immunisation is the most effective way of protecting children against previously common life-threatening infections.^{18,19} During the EARL pilot period, there was an increase in the percentage of Aboriginal children fully immunised in the Glenelg Shire from 84% before the pilot to 97% by the fourth year into the pilot (state immunisation rates in the same period were 85% and 90% respectively) (Table 3). Although a moderate increase, the Glenelg Shire consistently achieved higher rates of immunisation compared with those across the state.

Family violence significantly affects the way a woman raises her child, which ultimately affects the child's development.^{20–22} In the first year of the EARL pilot, there was a dramatic increase in the number of Aboriginal mothers/families referred to services to assist with family violence, from zero referrals before the pilot to 15 referrals within a year.⁷ DET data was not available to ascertain referral rates for the rest of the pilot period.

Child protection services are provided by the DHHS and aim to ensure children and young people receive services to deal with the impact of abuse and neglect on their wellbeing and development.²³ There was a significant increase in referrals of Aboriginal children residing in Glenelg Shire to child protection services, from three referrals in 2008, the year prior to the EARL pilot, to 27 in the first year of the pilot. This trend remained the year after the pilot was complete, indicating the extent of referrals through EARL.

OoHC services look after children and young people in cases of family conflict or if there is a significant risk of

harm or abuse in the family home.¹⁴ After a small initial increase, there was a substantial decrease in the number of episodes of OoHC for Aboriginal children 0–6 years in Glenelg Shire during the EARL pilot period – from 38% of Aboriginal children 0–6 years in the shire being in OoHC in the year before the pilot to 4.54% in the second year of operation. This compared with a national rate of Aboriginal children in OoHC of 5.17%.²⁴

Discussion

Data collected in the pilot phase of the study demonstrates stakeholders' engagement with the EARL model. The monthly EARL meetings were well attended in all three sites with the exception of Casterton, which could have been due to accessibility (Casterton is more than 100 km from Portland and 70 km from Heywood). The use of Skype in meetings was initiated in the last 7 months of the pilot period, which improved the engagement of stakeholders from other sites at the meetings held in Casterton.

Overall, the EARL concept proved successful in engaging Aboriginal families with MCH services, as shown by the rise in participation rates (consistently above the state average) and the significant number of referrals to EARL stakeholders and other healthcare services as a result of the monthly EARL stakeholder meetings. Additionally, the EARL concept may have also contributed to improving the health outcomes of Aboriginal families and children in the Glenelg Shire as

evidenced by the increase in rates in breastfeeding and fully immunised children. The identification of Aboriginal women and children at risk of harm also improved, with dramatic increases in referrals for family violence and referrals to child protection services and an overall decrease in the number of episodes of OoHC for children. The sharp increase in referrals for family violence in the first year of the pilot and lack of subsequent data highlights a need for further research in this area.

Higher referrals to child protection suggest that either stakeholders became more vigilant identifying those at risk or there were more cases overall. Integral to this result is the inclusion of a DHHS family service worker among the EARL stakeholders.

The EARL model of care

The EARL concept is being developed by the researcher into a new model of care, which is evidence based and strengths based, with a holistic, wrap-around-the-child service approach, using the Continuum of Need model²⁵ to monitor the risk of vulnerability/need. The model's framework is based on a co-design process that draws on the expertise of service stakeholders to develop effective coordination, collaboration and communication in line with the aims of the Victoria State Government's Roadmap for reform for child and family services.²⁶ Co-design allows stakeholders to develop new insights and solutions collaboratively to promote effective engagement with MCH services on an equal basis, through creative and often narrative-based activities. Further, the co-design approach facilitates a multidisciplinary team around the child through information sharing and shared learning. The EARL Model of Care encourages an open network inclusive of organisations working with families and children across the stages of life, from preconception to school. Most importantly, the EARL model of care allows the integration of traditional Aboriginal child-rearing practices with standardised Western healthcare values, beliefs and practices through a guided mastery approach, shared knowledge, yarning, capacity building, mutual trust and connection.

Conclusion

To address the disparity in health outcomes between Aboriginal and non-Aboriginal children in Australia, the EARL concept was developed and implemented in the Glenelg Shire in Victoria, Australia. Evaluation of outcome measures, including participation and referral rates during the pilot period suggest that EARL improved the engagement of Aboriginal families with MCH services. Additionally, the EARL concept was able to identify more families at risk of family violence than the current MCH service model. Further research is needed to develop the concept into a model of care to better understand the current barriers MCH nurses face in identifying "at risk" families.

Peer review and provenance

Externally peer reviewed, not commissioned.

Competing interests

CA was the coordinator and chair of the EARL pilot.

Author contributions

CA developed the EARL concept, conducted the research and wrote the manuscript. KA provided support and advice and reviewed the final manuscript.

References

1. Department of Education and Training. Maternal and child health service annual report 2012–2013. Melbourne: State Government of Victoria; 2014 [cited 2020 Jul 14]. Available from: www.education.vic.gov.au/Documents/childhood/providers/support/Victoria%20Statewide%20Report.pdf
2. Fenton C, Jones L. Achieving cultural sensitivity in Aboriginal maternity care. *Int J Health Sci*. 2015;3(1):23–38.
3. Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Canberra: AIHW; 2015 [cited 2020 Jul 14]. Available from: www.aihw.gov.au/getmedia/584073f7-041e-4818-9419-39f5a060b1aa/18175.pdf.aspx?inline=true
4. Victorian Auditor-General's Office. Annual Report 2015–16. Melbourne: VAGO; 2016 [cited 2020 Jul 14]. Available from: www.data.vic.gov.au/data/dataset/vago-annual-report-2015-16
5. Agency for Clinical Innovation. Understanding the process to implement a model of care: an ACI framework. Sydney: NSW Government; 2013 [cited 2020 Jul 11]. Available from: www.aci.health.nsw.gov.au/_data/assets/pdf_file/0009/194715/HS13-036_ImplementationFramework_D5-ck2.pdf
6. Government of Western Australia Department of Health. Models of care. Perth, WA: State of Western Australia; 2020 [cited 2020 Jul 21]. Available from: ww2.health.wa.gov.au/Articles/J_M/Models-of-care
7. Department of Education and Early Childhood Development. Annual report 2009–2010. Melbourne: State of Victoria; 2010 [cited 2020 Jul 14]. Available from: www.education.vic.gov.au/Documents/about/department/200910deecdannualreport.pdf
8. Sharp S, Dewar B, Barrie K. How appreciative inquiry creates change – theory in practice from health and social care in Scotland. *Action Res*. 2018;16(2):223–43.

9. Victoria State Government, Department of Education and Training. Maternal & Child Health Services annual reports 2010-2016. Melbourne: health.vic; 2020 [cited 2020 Jul 22]. Available from: www2.health.vic.gov.au/about/publications/researchandreports?q=maternal&pn=1&ps=10&s=relevance&i=&l=&n=&e=&a=&ac=&df=&dt=&l=&lq=
10. Department of Education and Early Childhood Development. Annual report 2009-2010. Melbourne: State of Victoria; 2010 [cited 2020 Jul 14]. Available from: www.education.vic.gov.au/Documents/about/department/200910deecdannualreport.pdf
11. Department of Education and Early Childhood Development. Annual report 2008-2009. Melbourne: Department of Education and Early Childhood Development; 2009 [cited 2020 Jul 29]. Available from: www.education.vic.gov.au/Documents/about/department/200809deecdannualreport.pdf
12. Victoria State Government. Health and Human Services. Nursery equipment program guidelines. Melbourne: Victoria State Government; Reissued 2019 [cited 2020 Jul 21]. Available from: www2.health.vic.gov.au/about/publications/policiesandguidelines/nursery-equipment-program-guidelines
13. United Way Glenelg. Dolly Parton Imagination Library [cited 2020 Jul 22]. Available from: www.unitedwayglenelg.com.au/causes/dolly-parton-imagination-library/
14. Victoria State Government. Health.vic. Melbourne: Victoria State Government; 2017. Maternal and Child Health Service [cited 2020 Jul 21]. Available from: www2.health.vic.gov.au/primary-and-community-health/maternal-child-health
15. de Jager E, Skouteris H, Broadbent J, Amir L, Mellor K. Psychosocial correlates of exclusive breastfeeding: a systematic review. *Midwifery*. 2013;29(5):506-18.
16. Forster D, McLachlan H, Lumley J, Beanland C, Waldenström U, Amir L. Two mid-pregnancy interventions to increase the initiation and duration of breastfeeding: a randomised controlled trial. *Birth*. 2004;31(3):45-50.
17. National Health and Medical Research Council. Infant feeding guidelines. Canberra: NHMRC; 2012 [cited 2018 July 25]. Available from: www.nhmrc.gov.au/guidelines-publications/n56
18. Hull B, Deeks S, McIntyre P. The Australian childhood immunisation register – a model for universal immunisation registers? *Vaccine*. 2009;27(37):5054-60.
19. Pearce A, Marshall H, Bedford H, Lynch J. Barriers to childhood immunisation: findings from the longitudinal study of Australian children. *Vaccine*. 2015;33(29):3377-83.
20. Holden G, Ritchie K. Linking extreme marital discord, child rearing and child behaviour problems: evidence from battered women. *Child Dev*. 1991;62(2):311-27.
21. Levendosky A, Graham-Bermann S. Parenting in battered women: the effects of domestic violence on women and their children. *J Fam Violence*. 2001;16(2):171-92.
22. McCloskey L, Figueredo A, Koss M. The effects of systematic family violence on children's mental health. *Child Dev*. 1995;66(5):1239-61.
23. Bromfield L, Holzer P. A national approach for child protection: Project report. Canberra: Australian Institute of Family Studies; 2008 [cited 2020 Jul 14]. Available from: aifs.gov.au/cfca/sites/default/files/publication-documents/cdsmac.pdf
24. Australian Institute of Health and Welfare. National framework for protecting Australia's children 2009-2020: technical paper on operational definitions and data issues for key national indicators. Canberra: AIHW; 2013 [cited 2020 Jul 21]. Available from: www.aihw.gov.au/getmedia/bc891123-9d00-40a5-81a4-772ae663a071/15967.pdf.aspx?inline=true
25. Department of Education and Training. Continuum of need service response indicator tool. Melbourne: Department of Education and Training; 2015 [cited 2020 Jul 29]. Available from: www.education.vic.gov.au/school/teachers/support/diversity/real/continuum/Pages/userguide.aspx
26. Department of Health and Human Services. Roadmap for reform: strong families, safe children. Melbourne: State of Victoria; 2016 [cited 2020 Jul 14]. Available from: engage.vic.gov.au/download_file/8422/1560

Copyright: 

© 2020 Austin and Arabena. This article is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International Licence, which allows others to redistribute, adapt and share this work non-commercially provided they attribute the work and any adapted version of it is distributed under the same Creative Commons licence terms. See: www.creativecommons.org/licenses/by-nc-sa/4.0/

7

Contribution of Authors

Name	Paper Design	Data Collection	Data Analysis	Interpretation	Manuscript Writing	Confirmation of contribution
C. Austin	90 %	90%	80%	70%	90%	√
K. Arabena	10%	10%	20%	30%	10%	√

Appendix Sixteen: State of Victoria EARL Award media release



Media release

The Hon Wendy Lovell MLC

Minister for Housing

Minister for Children and Early Childhood Development

Tuesday 25 October 2011

Minister Lovell announces Early Years Awards winners

Playgroups that support Indigenous parents, a program that helps kindergartens build natural habitats in their playgrounds and an initiative to identify pregnant women and new mothers who need additional support have been recognised at the Victorian Early Years Awards, sharing in prizes totalling \$60,000.

Minister for Children and Early Childhood Development Wendy Lovell last night presented the awards for excellent initiatives that improve the health, learning, development and wellbeing of Victorian children between 0 and 8 years.

Ms Lovell congratulated the 14 Early Years Awards finalists for achievements in three categories:

- Better Access to Child and Family Support, Health Services, Schools and Early Education and Care Services;
- Improvements in Parents' Capacity, Confidence and Enjoyment of Family Life; and
- Communities that are more Child and Family Friendly.

Ms Lovell also paid tribute to the category winners - Glenelg Shire Council, Hume City Council and Knox City Council, which each received a framed certificate and \$15,000 for professional development.

The annual Minister's Award was presented to Maribymong and Moonee Valley Local Learning and Employment Network for its work in helping families develop English language skills and linking them with essential early childhood services.

"Now in their sixth year, the Early Years Awards recognise outstanding work in a sector where experienced staff work tirelessly for the benefit of Victorian children and their families," Ms Lovell said.

"I am happy to hear about the results these services are achieving, as they build strong links between services, help parents to improve their skills and create partnerships that promote child and family-friendly communities.

"The Victorian Coalition Government recognises that healthy development throughout the early years is critical if children are to reach their potential.

"That's why we committed an additional \$101 million for early childhood and maternal and child health services in the 2011-12 State Budget," Ms Lovell said.

The Early Years Awards, which were announced at the National Gallery of Victoria last night, are presented during Children's Week each year.

Children's Week is being celebrated from 22 to 30 October.

Early Years Award finalists and winners:

Award Category: Better Access to Child and Family Support, Health Services, Schools and Early Education and Care Services (\$15,000)

- **Anchor Incorporated** – Building Brighter Beginnings
- **Glenelg Shire Council** - Portland Early Assessment Referral Links (PEARL)
- **Grovedale West Primary School** - Family Centred Practice Opening Doors to the Language of Learning
- **Maribyrnong and Moonee Valley Local Learning and Employment Network** - The Braybrook Family Inclusive Language and Learning Support Program
- **Yarra Valley Community Health** - Building Strong N Proud Pathways: Boorai Early Years Transition Program

Winner: Glenelg Shire Council - Portland Early Assessment Referral Links (PEARL)

Highly Commended: Anchor Incorporated – Building Brighter Beginnings

Award Category: Improvements in Parents' Capacity, Confidence and Enjoyment of Family Life (\$15,000)

- **Bluebird Foundation and Northern Bay College Young Parents Access Program** - Dabble 'n' Dance
- **Glenelg Shire Council** - Dartmoor BOUNCE! & Health and Wellbeing Sessions
- **Hume City Council** - Boorais in Hume
- **South West Institute of TAFE** - Victorian Certificate of Applied Learning: Young Parents Program
- **Yarra Ranges Shire Council** - Wellness Connections: Promoting Infant Outcomes at the Interface

Winner: Hume City Council - Boorais in Hume

Highly Commended: Yarra Ranges Shire Council - Wellness Connections: Promoting Infant Outcomes at the Interface

Award Category: Communities that are more Child and Family Friendly (\$15,000)

- Brotherhood of St Laurence - Children's Voices Project
- Knox City Council - Little GreenLeaves: Early Years Sustainability Program
- Hume City Council - The Hume Early Years Partnership
- Wodonga City Council - Southern Rise Education Centre: More than just a building!

Winner: Knox City Council - Little GreenLeaves: Early Years Sustainability Program

Minister's Award (\$15,000):

- Maribyrnong and Moonee Valley Local Learning and Employment Network The Braybrook Family Inclusive Language and Learning Support Program

Media: Alicia Byrne 0409 471 893

Appendix Seventeen: Early Assessment Referral Links Award 2011



THE Portland Early Assessment Referral Links program is led by the Glenelg Shire Council's Maternal Child and Health Service in partnership with Portland District Health, Dhauwurd-Wurrung Elderly and Community Services, St John of God Healthcare – Raphael Centre, Community Connections, Brophy Family Youth Service, and South West Healthcare. At the prize-giving ceremony were (back) Amanda Meryfull (Community Connections), Jodi Nepean (Glenelg Shire), Adele Kenneally (Glenelg Shire), Minister for Children and Early Childhood Development Wendy Lovell, Mayor Bruce Cross, Cassie Austin (Glenelg Shire), Alison Mason (DWECH), Ros Alexander (DWECH), Sharon Kelsey (Glenelg Shire), Sharon Linke (Barwon South West CFA) and (kneeling) Marree Adams (PDH) and Jodie Hutchins (Glenelg Shire).

Picture: SUPPLIED

Children's program wins top prize

TIANA RICHARDSON

A GROUNDBREAKING program aimed at supporting vulnerable newborns and their families has won a prestigious award and a \$15,000 prize that will be used for further development.

Portland Early Assessment Referral Links (PEARL) was named the Victoria's best program for providing better access to child and family support, health services and early education and care services at the Victorian Early Years Awards 2011 earlier this week.

The early intervention program was developed by the Glenelg Shire Council's Maternal Child and Health Service in partnership with Portland District Health, Dhauwurd-Wurrung Elderly and Community Services, St John of God Healthcare – Raphael Centre, Community Connections, Brophy Family Youth Service, and South West Healthcare.

The main focus of the initiative is to support babies and their families who have been identified as vulnerable or at risk.

The program aims to provide early identification and intervention by increasing the number of vulnerable

families accessing early childhood services and thereby decreasing the number of vulnerable families referred to Department Human Service.

Portland District Health's maternity services manager Marree Adams said the pre-emptive approach provided invaluable monitoring and support before an expected baby is born.

Ms Adams said this support reduced the likelihood of more serious problems arising after a child is born.

"The collaborative nature of the program has opened communication between services and allows agencies to share information to identify who might need support and then make sure they are supported," she said.

In its first 18 months the program has already demonstrated successful outcomes, including improvements in antenatal care and a high rate of immunisation for children in the Aboriginal and Torres Strait Islander community.

There has also been a decrease in the number of vulnerable families referred to the Department of Human Services.

Ms Adams said the award was great

recognition for the initiative. "It shows that the collaborative process works and that support services can help families when they need it."

Glenelg Shire Mayor Bruce Cross praised staff at the Portland Child and Family Complex.

"The program was competing against some excellent programs from highly resourced city municipalities and health services making the award even more significant.

"The council was also pleased to be a finalist in the "improvement in parents' capacity" category for the Dartmoor Bounce program which was presented by the Maternal and Child Health service in partnership with Heywood Rural Health and the Country Fire Authority – Barwon South West Region.

"I would like to congratulate our professional and dedicated Maternal and Child Health team headed up by team leader, Cassie Austin and supported by the council's children's services staff," Cr Cross said.

Glenelg Shire Council was a finalist in two categories from more than 100 entries statewide. Only two municipalities from rural Victoria were amongst the finalists.

References

- ACIL Allen. (2015). *Exploring Aboriginal families' perceptions and experiences of Maternal and Child Health Services*. Melbourne, VIC: Author.
- Aitken, R. & Stulz, V. (2018). Factor analysis to validate a survey evaluating cultural competence in maternity care for Indigenous women. *Australian Journal of Advanced Nursing*, 36(1), 25–36.
- Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., ... Yap, L. (2016). Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): A population study. *Lancet*, 388(10040), 131–157.
[https://doi.org/10.1016/S0140-6736\(16\)00345-7](https://doi.org/10.1016/S0140-6736(16)00345-7)
- Andrews, D. & Hughes, B. (1993). *Best practice in program delivery for Aboriginal and Torres Strait Islander offenders*. Retrieved from
<https://www.ojp.gov/ncjrs/virtual-library/abstracts/best-practice-program-delivery-aboriginal-and-torres-strait>
- Andrews, S. (2021). Qualitative analysis at the interface of Indigenous and Western knowledge systems: The Herringbone stitch model. *Qualitative Research*, 21(6), 939–956. <https://doi.org/10.1177/1468794120965365>
- Asaria, M., Ali, S., Doran, T., Ferguson, B., Fleetcroft, R., Goddard, M. ... Cookson, R. (2016). How a universal health system reduces inequalities: Lessons from England. *Journal of Epidemiology and Community Health*, 70(7), 637–643.
<https://doi.org/10.1136/jech-2015-206742>
- Atkinson, J. (2002). *Trauma trails: Recreating song lines—The trans-generational effects of trauma in Aboriginal Australia*. Melbourne, VIC: Spinifex Press.

- Austin, C. (2022). The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services. *Journal of Advanced Nursing*, 79(5), 1815–1829. <https://doi.org/10.1111/jan.15493>
- Austin, C. & Arabena, K. (2021). Improving the engagement of Aboriginal families with maternal and child health services: A new model of care. *Public Health Research & Practice*, 31(2). <https://doi.org/10.17061/phrp30232009>.
- Austin, C., Hills, D. & Cruickshank, M. (2022). Models and interventions to promote and support engagement of First Nations women with maternal and child health services: An integrative literature review. *Children*, 9(5), 636. <https://doi.org/10.3390/children9050636>
- Australian Bureau of Statistics [ABS]. (2011). *Australian Bureau of Statistics*. Retrieved from <http://www.abs.gov.au/>
- Australian Bureau of Statistics [ABS]. (2016). *Australian Bureau of Statistics*. Retrieved from <http://www.abs.gov.au/>
- Australian Bureau of Statistics [ABS]. (2017). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples* (Cat. No. 4704.0, AIHW Cat. No. IHW-6). Canberra, ACT: Australian Bureau of Statistics and Australian Institute of Health and Welfare.
- Australian Bureau of Statistics [ABS]. (2021). *Australian Bureau of Statistics*. Retrieved from <http://www.abs.gov.au/>
- Australian Commission on Safety and Quality in Healthcare [ACSQHC]. (2012). *National safety and quality health service standards (September 2012)*. Sydney, NSW: Author.

- Australian Health Ministers' Advisory Council. (2011). *National Framework for Universal Child and Family Health Services*. Retrieved 3 September 2021, from <https://www.health.gov.au/resources/publications/national-framework-for-universal-child-and-family-health-services?language=en>
- Australian Human Rights Commission [AHRC]. (2021). *Keeping kids safe and well-your voices: December 2021*. Retrieved 25 April 2023, from <http://nla.gov.au/nla.obj-3057237741>
- Australian Institute of Health and Welfare [AIHW]. (2011). *National outcome measures for early childhood development: Development of an indicator-based reporting framework* (Cat. No. PHE 134). Canberra, ACT: Author.
- Australian Institute of Health and Welfare [AIHW]. (2013). *National framework for protecting Australia's children 2009–2020*. Cat. No. CWS 44. Canberra: Author.
- Australian Institute of Health and Welfare [AIHW]. (2015). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015* (Cat. No. IHW 147). Canberra, ACT: Author.
- Australian Institute of Health and Welfare [AIHW]. (2017a). *Child protection Australia 2015–2016*. Canberra, ACT: Author. Retrieved from www.aihw.gov.au/publication-detail/?id=60129558626andtab=3
- Australian Institute of Health and Welfare [AIHW]. (2017b). *Supplementary data tables 2015–2016*. Canberra, ACT: Author. Retrieved from www.aihw.gov.au/publicationdetail/?id=60129558626andtab=3
- Australian Institute of Health and Welfare [AIHW]. (2017c). *Stronger evidence, better decisions, improved health and welfare*. Canberra, ACT: Author. Available from <https://www.aihw.gov.au/>

- Australian Institute of Health and Welfare [AIHW]. (2018). *Family, domestic and sexual violence in Australia 2018*. Canberra, ACT: Author.
- Australian Institute of Health and Welfare [AIHW]. (2020). *Australia's children* (Cat. No. CWS 69). Canberra, ACT: Author.
- Australian Institute of Health and Welfare [AIHW]. (2021). *The Aboriginal and Torres Strait Islander Child Placement Principle Indicators* (Cat. No. CWS 84). Canberra, ACT: Author. Accessed 7 February 2022.
- Barclay, L., Kruske, S., Bar-Zeev, S., Steenkamp, M., Josif, C., Wulili Narjic, C., ... Kildea, S. (2014). Improving Aboriginal maternal and infant health services in the 'Top End' of Australia: Synthesis of the findings of a health services research program aimed at engaging stakeholders, developing research capacity and embedding change. *BMC Health Services Research*, 14, 241.
- Bar-Zeev, S., Kruske, S., Barclay, L., Bar-Zeev, N., Carapetis, J. & Kildea, S. (2012). Use of maternal health services by remote dwelling Aboriginal infants in tropical northern Australia: A retrospective cohort study. *BMC Pediatrics*, 12, 19.
- Bazeley, K. & Jackson, K. (2013). *Qualitative data analysis with NVivo* (2nd ed.). London, UK: SAGE. <https://doi.org/10.1080/14780887.2014.992750>
- Behrendt, L. (2012). *Indigenous Australia for dummies*. Milton, NSW: Wiley Publishing Australia.
- Belli, P., Bustreo, F. & Preker, A. (2005). Investing in children's health: What are the economic benefits? *Bulletin of the World Health Organisation*, 83(10), 777–784.
- Bernard, H. (2002). *Research methods in anthropology: Qualitative and quantitative approaches* (3rd ed.). Walnut Creek, CA: Alta Mira Press.
- Braun, V. & Clarke, V. (2021). *Thematic analysis: A practical guide*. London, UK: SAGE.

- Bretherton, D. & Mellor, D. (2006). Reconciliation between Aboriginal and other Australians: The stolen generations. *Journal of Social Issues*, 62(1), 81–98.
- Bromfield, L. & Holzer, P. (2008). *A national approach for child protection: Project report*. Canberra, ACT: Australian Institute of Family Studies.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Boston, MA: Harvard University Press.
- Bryman, A., Becker, S. & Ferguson, H. (2012). *Understanding research for social policy and social work: Themes, methods and approaches*. Bristol, UK: Policy Press.
- Burns, N. & Grove, S. (2017). *The practice of nursing research: Conduct, critique and utilization* (8th ed.). Philadelphia, PA: Elsevier Saunders.
- Burns, J., Maling, C. & Thompson, N. (2010). Summary of Indigenous women's health. *Australian Indigenous Health Reviews*, 2, 1–24.
- Chamberlain, C., Gee, G., Harfield, S., Campbell, S., Brennan, S., Clark, Y., ... & 'Healing the Past by Nurturing the Future' group. (2019). Parenting after a history of childhood maltreatment: A scoping review and map of evidence in the perinatal period. *PLOS ONE*, 14(3), article e0213460.
<https://doi.org/10.1371/journal.pone.0213460>
- Children, Youth and Families Act 2005* (Vic). Retrieved from
<https://content.legislation.vic.gov.au/sites/default/files/2020-10/05-96aa121%20authorised.pdf>
- Christie, M. (2006). Transdisciplinary research and Aboriginal knowledge. *The Australian Journal of Education*, 35, 1–80.
- Clandinin, D. & Huber, J. (2010). Narrative inquiry. In B. MaGaw, E. Baker & P. Peterson (Eds.), *International encyclopaedia of education* (3rd ed.). New York, NY: Elsevier.

- Commission for Children and Young People. (2015). *2014–15 annual report*. Retrieved from <https://ccyp.vic.gov.au/assets/corporate-documents/CCYP-annual-report-2014-15.pdf>
- Connelly, M. & Clandinin, J. (1990). Stories of experience and narrative inquiry. *Educational Researcher*, 19(5), 2–14.
- Convention on the Rights of the Child. (1989). Adopted 20 November 1989 (entered into force 2 September 1990). United Nations General Assembly. Retrieved from <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>
- Council for Aboriginal Reconciliation. (2000). *Reconciliation: Australia's challenge: Final report of the Council for Aboriginal Reconciliation to the Prime Minister and the Commonwealth Parliament*. Canberra: Author. Retrieved from <http://www.austlii.edu.au/au/other/IndigLRes/car/2000/16/>
- Council of Australian Governments [COAG]. (2008). *National Partnership Agreement for Indigenous Early Childhood Development. National Partnership Agreement between the Commonwealth of Australia and the State and Territory Governments regarding Indigenous Early Childhood Development*. Retrieved 25 July 2018, from http://www.coag.gov.au/coag_meeting_outcomes/2008-10-02/docs/indigenous_early_childhood_NPA.pdf
- Council of Australian Governments [COAG]. (2010). *Indigenous reform*. Retrieved from <http://www.coagreformcouncil.gov.au/agenda/indigenous.cfm>
- Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

- Cummins, P., Scott, D. & Scales, B. (2012). *Report of the Protecting Victoria's Vulnerable Children Inquiry* (vol. 2). Melbourne, VIC: Department of Premier and Cabinet. Retrieved from <http://childprotectioninquiry.archive.vic.gov.au/images/stories/inquiry/volume2/consolidated%20volume%202%20protecting%20victorias%20vulnerable%20children%20inquiry%20report%2027%20january%202012.pdf>
- Darbyshire, P. & Jackson, D. (2005). Using strengths approach to understand resilience and build health capacity in families. *Contemporary Nurse*, 18(1–2), 211–212.
- de Jager, E., Skouteris, H., Broadbent, J., Amir, L. & Mellor, K. (2013). Psychosocial correlates of exclusive breastfeeding: a systematic review. *Midwifery*, 29, 506–518.
- Deeks, J. J., Dinnes, J., D'Amico, R., Sowden, A. J., Sakarovich, C., Song, F., ... European Carotid Surgery Trial Collaborative Group. (2003). Evaluating non-randomised intervention studies. *Health Technology Assessment*, 7(27), iii–173. <https://doi.org/10.3310/hta7270>
- Denzin, N. K. & Lincoln, Y. S. (2008). Introduction: Critical methodologies and indigenous inquiry. In N. K. Denzin, Y. S. Lincoln & L. T. Smith (Eds.), *Handbook of critical and indigenous methodologies* (pp. 1–20). Thousand Oaks, CA: Sage.
- Denzin, N. K. & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Department of Education and Early Childhood Development [DEECD]. (2004a). *Continuity of care: A communication protocol for Victorian public maternity services and the maternal child health service*. Melbourne, VIC: Author.

- Department of Education and Early Childhood Development [DEECD]. (2004b). *Future directions for the Victorian Maternal and Child Health Service*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2006). *The key age stage framework*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2009a). *Maternal and child health program standards*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2009b). *Maternal and child health practice guidelines*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2009c). *Maternal and Child Health Services annual report 2008–2009*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2010a). *Maternal and Child Health Services March data report*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2010b). *Maternal and Child Health Services annual report 2009–2010*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2010c). *The state of Victoria's children 2009: Aboriginal children and young people in Victoria*. Melbourne, VIC: Author.
- Department of Education and Early Childhood Development [DEECD]. (2011a). *The maternal and child health guidelines*. Melbourne, VIC: Author. Retrieved from www.education.vic.gov.au/Documents/childhood/.../health/mchsguidelines.pdf

Department of Education and Early Childhood Development [DEECD]. (2011b).

Maternal and Child Health Service: Nursery equipment program. Melbourne, VIC: Author.

Department of Education and Early Childhood Development [DEECD]. (2011c).

Maternal and Child Health Services annual report, 2010–2011. Melbourne, VIC: Author.

Department of Education and Early Childhood Development [DEECD]. (2012). *Maternal and Child Health Services annual report, 2011–2012*. Melbourne, VIC: Author.

Department of Education and Early Childhood Development [DEECD]. (2013a).

Maternal and Child Health Services annual report, 2012–2013. Melbourne, VIC: Author.

Department of Education and Early Childhood Development [DEECD]. (2013b). *The state of Victoria's children*. Melbourne, VIC: Author. Retrieved from <https://www.vic.gov.au/state-victorias-children-report>

Department of Education and Early Childhood Development [DEECD]. (2014b).

Maternal and Child Health Services annual report 2013–2014. Melbourne, VIC: Author.

Department of Education and Training [DET]. (2015a). *Maternal and Child Health Service annual report 2014–2015*. Melbourne, VIC: Author.

Department of Education and Training [DET]. (2015b). *Continuity of care: A communication protocol for Victorian public maternity services and the Maternal Child Health Service*. Melbourne, VIC: Author.

Department of Education and Training [DET]. (2015c). *Continuum of need service response indicator tool*. Melbourne, VIC: Author.

- Department of Education and Training [DET]. (2016a). *Maternal and child health, universal service*. Melbourne, VIC: Author. Retrieved from <https://www.health.vic.gov.au/primary-and-community-health/maternal-and-child-health-service>
- Department of Education and Training [DET]. (2016b). *Maternal and Child Health Services annual report 2015–2016*. Melbourne, VIC: Author.
- Department of Education and Training [DET]. (2016c). *Marrung: Aboriginal education plan 2016-2026*. Melbourne, VIC: Author.
- Department of Education and Training [DET]. (2018a). *Aboriginal Maternal and Child Health Initiative*. Melbourne, VIC: Author.
- Department of Education and Training [DET]. (2018b). *Maternal and Child Health Services annual report 2017–2018*. Melbourne, VIC: Author.
- Department of Health [DOH]. (2015). *Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Canberra, ACT: Australian Government.
- Department of Health [DOH]. (2017). *Aboriginal health in Australia*. Canberra, ACT: Author. Available from <https://healthinfor.net.ecu.edu.au/learn/health-system/closing-the-gap/publications>
- Department of Health and Human Services [DHHS]. (2017a). *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*. Melbourne, VIC: Author.
- Department of Health and Human Services [DHHS]. (2017b). *Koori Maternity Services guidelines. Delivering culturally responsive and high-quality care*. Melbourne, VIC: Author.

- Department of Health and Human Services [DHHS]. (2018a). *Determinants of health*. Hobart, TAS: Author. Retrieved from http://www.dhhs.tas.gov.au/wihpw/principles/determinants_of_health
- Department of Health and Human Services [DHHS]. (2018b). *Operational performance and quality branch*. Author.
- Department of Health and Human Services [DHHS]. (2018c). *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement, strategic action plan: A partnership between the Victorian Government, Victorian Aboriginal communities and the child and family services sector*. Victorian Government, 1 Treasury Place, Melbourne.
- Department of Health and Human Services [DHHS]. (2018d). *Dhelk Dja: Safe our way – strong culture, strong peoples, strong families*. Victorian Government, 1 Treasury Place, Melbourne.
- Department of Health and Human Services [DHHS]. (2019). *Aboriginal and Torres Strait Islander cultural safety framework for the Victorian health, human and community services sector*. Victorian Government, 1 Treasury Place, Melbourne.
- Department of Human Services [DHS]. (2004). *Aboriginal best start status report*. Melbourne, VIC: Author.
- Department of Human Services [DHS]. (2006). *The state of Victoria's children report*. Melbourne, VIC: Author.
- Department of Planning and Community Development [DPCD]. (2008). *Family violence risk assessment and risk management—Identifying family violence: Maternal and child health nurse's training handbook*. Melbourne, VIC: Author. Retrieved from <http://www.tafe.swinburne.edu.au/CRAF/resources/MCHN%20handbook.pdf>

- Department of Planning and Community Development [DPCD]. (2018). *Victorian Aboriginal affairs framework 2018-2023*. Melbourne, VIC: Department of Premier and Cabinet.
- Dudgeon, P., Wright, M., Paradies, Y., Garvey, D. & Walker, I. (2010). The social, cultural and historical context of Aboriginal and Torres Strait Islander Australians. In P. Dudgeon, H. Milroy & R. Walker (Eds.). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 25–42). Canberra, ACT: Commonwealth of Australia.
- Eapen, V., Walter, A., Guan, J., Descallar, J., Axelsson, E., Einfeld, S., ... The 'Watch Me Grow' Study Group. (2017). Maternal help-seeking for child developmental concerns: Associations with socio-demographic factors. *Journal of Paediatrics and Child Health*, 53(10), 963–969. <https://doi.org/10.1111/jpc.13607>
- Family Violence Protection Amendment (Information Sharing) Act 2017* (Vic).
- Fetterman, D. (1998). *Ethnography: Step by step*. Newbury Park, CA: Sage.
- First Nations National Constitutional Convention. (2017). *Uluru: Statement from the heart*. Alice Springs, NT: Central Land Council Library.
- Forster, D., McLachlan, H., Lumley, J., Beanland, C., Waldenstrom, U. & Amir, L. (2004). Two mid-pregnancy interventions to increase the initiation and duration of breastfeeding: A randomised controlled trial. *Birth*, 31(3), 45–50.
- Fox, S., Stafford, N., Goodhue, R., Jackson, D. & Smith, C. (2015). *Better systems, better chances: A review of research and practice for prevention and early intervention*. Canberra: Australian Research Alliance for Children and Youth.

- Freeman, T., Edwards, T., Baum, F., Lawless, A., Jolley, G., Javanparast, S. & Francis, T. (2014). Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners. *Australian & New Zealand Journal of Public Health*, 38, 355–361.
- Fulop, N. & Allen, P. (2000). *National listening exercise: Report of the findings*. London, UK: NHS Service Delivery and Organisation National Research and Development Programme.
- Gluckman, P., Hanson, M. & Buklijas, T. (2010). A conceptual framework for the developmental origins of health and disease. *Journal of Developmental Origins of Health and Disease*, 1, 6–18. <https://doi.org/10.1017/S2040174409990171>.
- Gray, J., Grove, S. & Sutherland, S. (2017). *Burns and Grove's the practice of nursing research: Conduct, critique and utilisation* (6th ed.). Sydney, NW: Elsevier Saunders.
- Green, J., Renfrew, M. & Curtis, P. (2000). Continuity of care: what matters to women? A review of the evidence. *Midwifery*, 16, 186–196.
- Gudmundsdottir, S. (2001). Narrative research on school practice. In V Richardson (Ed.), *Fourth handbook for research on teaching* (pp. 226–240). New York, NY: MacMillan.
- Hamilton, A. (1981). *Nature and nurture: Aboriginal child-rearing in north-central Arnhem Land*. Canberra, ACT: Australian Institute of Aboriginal Studies.
- Hancock, H. (2007) Low birth weight in Aboriginal babies: A need for rethinking Aboriginal women's pregnancies and birthing. *Women and Birth*, 20, 77–80.
- Harris, J. (2003). Hiding the bodies: The myth of the humane colonisation of Australia. *Journal of Aboriginal History*, 27, 79–104.

- Haydon, G., Browne, G. & van der Riet, P. (2018). Narrative inquiry as a research methodology exploring person centred care in nursing. *Collegian*, 25, 125–129.
- Henry, J., Dunbar, T., Arnott, A., Scrimgeour, M., Matthews, S., Murakami-Gold, L. & Chamberlain, A. (2002). *Indigenous research reform agenda: Rethinking research methodologies*. Casuarina, NT: Cooperative Research Centre for Aboriginal and Tropical Health. Retrieved from http://www.lowitja.org.au/files/crcah_docs/IRRA2LinksMonograph.pdf
- Henry, B., Houston, S. & Mooney, H. (2004) Institutional racism in Australian healthcare: A plea for decency, *Medical Journal of Australia*, 180, 517–519.
- Hjortdahl, P. (1990). Ideology and reality of continuity of care. *Family Medicine*, 22(5), 361–364.
- Holden, G. & Ritchie, K. (1991). Linking extreme marital discord, child rearing and child behaviour problems: Evidence from battered women. *Child Development*, 62, 311–327.
- Homer, C., Brodie, P. & Leap, N. (2001). *Establishing models of continuity of midwifery care in Australia: A resource for midwives and managers*. Sydney, NSW: Centre for Family Health and Midwifery, Faculty of Nursing, Midwifery and Health, University of Technology Sydney.
- Homer, C., Foureur, M., Allende, T., Pekin, F., Caplice, S. & Catling-Paull, C. (2012). ‘It’s more than just having a baby’: Women’s experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families. *Midwifery*, 28, e509–e515.
- Hull, B., Deeks, S. & McIntyre, P. (2009). The Australian childhood immunisation register: A model for universal immunisation registers? *Vaccine*, 27, 5054–5060.

- Human Rights and Equal Opportunity Commission [HREOC]. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney, NSW: Author.
- Human Rights and Equal Opportunity Commission [HREOC]. (2008). *Close the gap: Indigenous health equality summit, statement of intent*. Canberra, ACT: Author.
- Institute for Aboriginal Development. (2000). *Aboriginal art and culture centre*. Alice Springs, NT: Author. <http://www.aboriginalart.com.au/culture/dreamtime.html> 7/7/01.
- Jongen, C., McCalman, J., Bainbridge, R. & Tsey, K. (2014). Aboriginal and Torres Strait Islander maternal and infant health and wellbeing: A systematic review of programs and services in Australian primary health care settings. *BMC Pregnancy and Childbirth*, 14, 251.
- Josif, C., Kruske, S., Kildea, S. & Barclay, L. (2017). The quality of health services provided to remote dwelling Aboriginal infants in the top end of northern Australia following health system changes: A qualitative analysis. *BMC Pediatrics*, 17, 93.
- Kelly, J. & Luxford, Y. (2007). Yaitya Tirka Madlanna Warratinna: Exploring what sexual health nurses need to know and do in order to meet the sexual health needs of young Aboriginal women in Adelaide. *Collegian*, 14(3), 15–20.
- Kruske, S., Kildea, S. & Barclay, L. (2006). Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women and Birth*, 19, 73–77.
- Kruske, S., Belton, S., Wardaguga, M. & Narjic, C. (2012). Growing up our way: The first year of life in remote Aboriginal Australia. *Qualitative Health Research*, 22(6), 777–787. <https://doi.org/10.1177/1049732311432717>

- Lee, L. (2020). Promoting interpersonal and intercultural communication with Flipgrid: Design, implementation, and outcomes. In M. Kruk & M. Peterson (Eds.), *New technological applications for foreign and second language learning and teaching*. IGI Global. <https://doi.org/10.4018/978-1-7998-2591-3.ch013>.
- Levendosky, A. & Graham-Bermann, S. (2001). Parenting in battered women: The effects of domestic violence on women and their children. *Journal of Family Violence*, 16(2), 171–192.
- Lohoar, S., Butera, N. & Kennedy, E. (2014). *Strengths of Australian Aboriginal cultural practices in family life and childrearing* (CFCA Paper No. 25). Melbourne, VIC: Australian Institute of Family Studies. Retrieved from aifs.gov.au/cfca/publications/strengths-australian-aboriginal-cultural-practices-fam
- Luborsky, M. & Rubinstein, R. L. (1995). Sampling in qualitative research: Rationale, issues and methods. *Research on Aging*, 17(1), 89–113.
- McAlpine, L. (2016). Why might you use narrative methodology? A story about a narrative. *Eesti Haridusteaduste Ajakiri*, 4(1), 32–57.
- McCain, M. & Mustard, J. (Eds.). (1999). *Reversing the real brain drain: Early years study, final report*. Toronto, ON: Ontario Children's Secretariat.
- McCalman, J., Searles, A., Bainbridge, R., Ham, R., Mein, J., Neville, J., Campbell, S. & Tsey, K. (2015). Empowering families by engaging and relating Murri way: A grounded theory study of the implementation of the Cape York Baby Basket program. *BMC Pregnancy Childbirth*, 15, 119.
- McCloskey, L., Figueredo, A. & Koss, M. (1995). The effects of systematic family violence on children's mental health. *Child Development*, 66, 1239–1261.

- Maternal, Child and family Health Nurses Australia [MCFHNA]. (2017). *National standards of practice for maternal, child and family nurses in Australia*. Author.
- Marmot, M., Allen, J., Goldblatt, P. et al. (2011). *Fair society, healthy lives: The Marmot review*. Retrieved from <https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>
- Martin, K. (2003). Ways of knowing, being and doing: A theoretical framework and methods for indigenous and indigenist research. In K. McWilliam, P. Stephenson & G. Thompson (Eds.), *Voicing dissent* (pp. 203–257). Brisbane, QLD: University of Queensland Press.
- Melnik, B. & Fineout-Overholt, E. (2015). *Evidence based practice in nursing and healthcare. A guide to best practice* (2nd ed.). Oxford, UK: Lippincott, Williams & Wilkins.
- Milroy, H., Dudgeon, P. & Walker, R. (2014). Community life and development programs –pathways to healing. In *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 419–436). Canberra, ACT: Department of the Prime Minister and Cabinet.
- Mohsin, M., Bauman, A. & Jalaludin, B. (2006). The influence of antenatal and maternal factors on stillbirths and neonatal deaths in New South Wales, Australia. *Journal of Biosocial Science*, 38, 643–657.
- Moreton-Robinson, A. (2013). Towards an Australian Indigenous women's standpoint theory: A methodological tool. *Australian Feminist Studies*, 28(78), 331–347.
- Morse, J. (1995). The significance of saturation. *Qualitative Health Research*, 5(2), 147–149.
- Morse, J. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3–5.

- Mouzos, J. & Makkai, T. (2004). *Women's experience of male violence: Findings from the Australian component of the international violence against women survey*. Canberra, ACT: Australian Institute of Criminology.
- Nakata, M. (1998). Anthropological texts and Indigenous standpoints. *Australian Aboriginal Studies*, 2, 3–12. Retrieved from [https://search.informit.com.au/documentSummary;dn = 151991702568013;res=IELAPA](https://search.informit.com.au/documentSummary;dn=151991702568013;res=IELAPA)
- National Health and Medical Research Council [NHMRC]. (2002). *Child health screening and surveillance: A critical review of the evidence*. Canberra, ACT: Author.
- National Health and Medical Research Council [NHMRC]. (2007). *The National Statement on Ethical Conduct in Human Research 2007*. Canberra, ACT: Author. Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf.
- National Health and Medical Research Council [NHMRC]. (2012). *Infant feeding guidelines*. Canberra, ACT: Author. Retrieved from <https://www.nhmrc.gov.au/guidelines-publications/n56>
- National Health and Medical Research Council [NHMRC]. (2018). *Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders*. Canberra, ACT: Author.
- National Indigenous Australians Agency [NIAA]. (2021). *National Aboriginal and Torres Strait Islander Early Childhood Strategy*. Canberra, ACT: Author. <https://www.niaa.gov.au/sites/default/files/publications/niaa-early-years-strategy-5.pdf>

- New South Wales Government. (2021). *Prevention and early intervention strategies*. Sydney, NSW: Author.
- Organization for Economic Co-Operation and Development [OECD]. (2018). *Early learning matters* [Brochure]. Author. Retrieved from <https://www.oecd.org/education/school/Early-Learning-Matters-Project-Brochure.pdf>
- Ospina, S. & Dodge, J. (2005). It's about time: Catching method up to meaning-the usefulness of narrative inquiry in public health administration research. *Public Administrative Review*, 65(2), 143–157.
- Page, M., McKenzie, J., Bossuyt, P., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... Moher, D. (2021). Updating guidance for reporting systematic reviews: Development of the PRISMA 2020 statement. *Journal of Clinical Epidemiology*, 134, 103–112. <https://doi.org/10.1016/j.jclinepi.2021.02.003>
- Panaretto, K., Mitchell, M., Anderson, L., Larkins, S., Manassis, V., Buttner, P. & Watson, D. (2007). Sustainable antenatal care services in an urban Indigenous community: The Townsville experience. *Medical Journal of Australia*, 187(1), 18–22.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.
- Pearce, A., Marshall, H., Bedford, H. & Lynch, J. (2015). Barriers to childhood immunisation: Findings from the longitudinal study of Australian children. *Vaccine*, 33, 3377–3383.
- Pelto, P. & Pelto, G. (1978). *Anthropological research: The structure of inquiry*. Cambridge, UK: Cambridge University Press.

- Perris, D., Brown, A. & Cass, A. (2008). Addressing inequities in access to quality healthcare for Indigenous people. *Canadian Medical Association Journal*, 179(10), 985–986.
- Polit, D. & Beck, C. (2014). *Evaluating measurements and data quality. Essentials of nursing research: Methods, appraisal and utilisation*. Oxford, UK: Lippincott, Williams and Wilkins.
- Polkinghorne, D. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education*, 8(1), 1–15.
- Reibel, T., Walker, R., Sayers, S. & Boyle, J. (2010). Antenatal services for Aboriginal women: The relevance of cultural competence. *Quality in Primary Care*, 18, 65–74.
- Reynolds, H. (2006). *The other side of the frontier: Aboriginal resistance to the European invasion of Australia*. Sydney, NSW: University of New South Wales Press.
- Riggs, E., Davis, E., Gibbs, L., Block, K., Szwarc, J., Casey, S., Duell-Piening, P. & Waters, E. (2012). Accessing maternal and child health services in Melbourne, Australia: Reflections from refugee families and service providers. *BMC Health Services Research*, 12, 117. <https://doi.org/10.1186/1472-6963-12-117>
- Rigney, L. (1999a). Internationalization of an indigenous anti-colonial cultural critique of research methodologies: A guide to indigenist research methodology and its principles. *Wicazo SA Review*, 14(12), 109–121. Retrieved from <http://www.jstor.org/stable/1409555>
- Rigney, L. (1999b). The first perspective: Culturally safe research practices on or with Indigenous peoples. *Higher Education Research and Development in Higher Education*, 20, 629–636.

- Rogers, J. & Curtis, P. (1980). The concept and measurement of continuity in primary care. *AMJ Public Health*, 70, 122–127.
- Rossiter, C., Fowler, C., Hesson, A., Kruske, S., Homer, C., Kemp, L. & Schmied, V. (2019). Australian parents' experiences with universal child and family health services. *Collegian*, 26(3), 321–328. <https://doi.org/10.1016/j.colegn.2018.09.002>
- Rumbold, A., Bailie, R., Si, D., Dowden, M., Kennedy, C. & Cox, R. (2011). Delivery of maternal health care in Indigenous primary care services: Baseline data for an ongoing quality improvement initiative. *BMC Pregnancy and Childbirth*, 11(16). <https://doi.org/10.1186/1471-2393-11-16>
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(2), 27–37. <https://doi.org/10.1097/00012272-198604000-00005>
- Saunders, V., West, R. & Usher, K. (2010). Finding our voices: Using indigenist research methodology within a PhD. *Australian Journal of Indigenous Education*, 39, 1–7.
- Sayers, S. & Boyle, J. (2010). Indigenous perinatal and neonatal outcomes: A time for preventative strategies. *Journal of Paediatric and Child Health*, 46, 475–478.
- Schmied, V. Kruske, S., Barclay, L. & Fowler, C. (2011). *National Framework for Universal Child and Family Health Services*. Canberra, ACT: Australian Government.
- Schmied, V., Homer, C., Fowler, C, Psaila, K., Barclay, L., Wilson, I., ... Kruske, S. (2015). Implementing a national approach to universal child and family services in Australia: professionals' views of the challenges and opportunities. *Health & Social Care in the Community*, 23(2), 159–170. <https://doi.org/10.1111/hsc.12129>

- Secretariat of National Aboriginal and Islander Child Care. (2010). *Working and walking together: Supporting family relationship services to work with Aboriginal and Torres Strait Islander families and organisations*. Author.
- Sharp, S., Dewar, B. & Barrie, K. (2016) How appreciative inquiry creates change: Theory in practice from health and social care in Scotland. *Action Research*, 16(2), 223–243.
- Sheard, H. (2007). *All the little children: The story of Victoria's baby health centres*. Melbourne, VIC: Municipal Association of Victoria.
- Shonkoff, J. & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early child development*. Washington, DC: National Academy Press.
- Shonkoff, J., Boyce, W. & McEwen, B. (2009). Neuroscience, molecular biology and the childhood roots of health disparities. *JAMA: The Journal of the American Medical Association*, 301(21), 2252–2259.
- Simmonds, D., Porter, J., O'Rourke, P., West, L., Tangey, A. & Holland, C. (2010). A 'Two-Ways' approach to improving antenatal education for Ngaanyatjarra Women. *Aboriginal Islander Health Worker Journal*, 34(2), 10–13.
- Sivertsen, N., Anikeeva, O., Deverix, J. & Grant, J. (2020). Aboriginal and Torres Strait Islander family access to continuity of health care services in the first 1000 days of life: A systematic review of the literature. *BMC Health Services Research*, 20, 829.
- Smith, L. (1999). Decolonising methodologies: *Research and Indigenous peoples* (2nd ed.). London, UK: Zed Books.
- Smith, D., Edwards, N., Martens, P. & Varcoe, A. (2007). 'Making a difference': A new care paradigm for pregnant and parenting Aboriginal people. *Canadian Journal of Public Health*, 98(4), 321–325.

- Smylie, J. & Adomako, P. (Eds.). (2009). *Indigenous children's health report*. Centre for Research on Inner City Health. Retrieved from <https://caid.ca/IndChiHeaRep2009.pdf>
- State of Victoria. (2012a). *Koolin Balit: Victorian Government Strategic Directions for Aboriginal Health 2010–2020*. Melbourne, VIC: Department of Health.
- State of Victoria. (2012b). *Victorian Aboriginal Affairs Framework 2013–2018. Building for the future: A plan for 'Closing the Gap' in Victoria by 2031*. Melbourne, VIC: Author.
- State of Victoria. (2012c). *Family violence risk assessment and risk management framework and practice guides*. Melbourne, VIC: Department of Human Services.
- State of Victoria. (2013). *Victoria's vulnerable children – Our shared responsibility: Strategy 2013–2022*. Melbourne, VIC: Author. Retrieved from <https://trove.nla.gov.au/version/208378539>
- State of Victoria. (2016a). *Roadmap for reform: Strong families, safe children*. Melbourne, VIC: Department of Health and Human Services.
- State of Victoria. (2016b). *Royal Commission into Family Violence: Summary and recommendations* (Parliament Paper No. 132 (2014–2016)). Melbourne, VIC: Author.
- State of Victoria. (2017). *Supporting children and families in the early years: A compact between DET, DHHS and local government (represented by MAV) 2017–2027*. Melbourne, VIC: Author.
- Steering Committee for Review of Government Service Provision. (2014). *Overcoming Indigenous disadvantage: Key indicators 2014*. Canberra, ACT: Productivity Commission.

- Steering Committee for the Review of Government Service Provision. (2022). *National Agreement on Closing the Gap 2022*. Canberra, ACT: Productivity Commission.
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: SAGE.
- Stronach, M. & Adair, D. (2014). Dadirri: Reflections on a research methodology used to build trust between a non-Indigenous researcher and Indigenous participants. *Cosmopolitan Civil Societies Journal*, 6(2), 3859.
<http://dx.doi.org/10.5130/ccs.v6i2.3859>
- Streubert, H. J. & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: Wolters Kluwer.
- Sweeny, K. (2014). *The influence of childhood circumstances on adult health* (Commissioned Report No. 01/2014). Report to the Mitchell Institute for Health and Education Policy. Melbourne, VIC: Victoria Institute of Strategic Economic Studies, Victoria University.
- Thorpe, A., Arabena, K., Sullivan, P., Silburn, K. & Rowley, K. (2016). *Engaging first peoples: A review of government engagement methods for developing health policy*. Melbourne, VIC: The Lowitja Institute.
- Thompson, S., Greville, H. & Param, R. (2008). Beyond policy and planning to practice: Getting sexual health on the agenda in Aboriginal Communities in Western Australia. *Australian and New Zealand Health Policy*, 5(3), 1–8.
- Torraco, R. (2016). Writing integrative literature reviews: Using the past and present to explore the future. *Human Resource Development Review*, 15(4), 404–428.
<https://doi.org/10.1177/1534484316671606>

- Turley, J., Vanek, J., Johnston, S. & Archibald, D. (2018). Nursing role in well-child care. Systematic review of the literature. *Canadian Family Physician*, 64(4), E169–E180.
- Ungunmerr-Baumann, M.-R., Groom, R. A., Schuberg, E. L., Atkinson, J., Atkinson, C., Wallace, R. & Morris, G. (2022). Dadirri: An Indigenous place-based research methodology. *AlterNative: An International Journal of Indigenous Peoples*, 18(1), 94–103. <https://doi.org/10.1177/11771801221085353>
- United Nations Committee on the Rights of the Child. (2013, 17 April). *General comment no. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)* (UN Doc. CRC/C/GC/15). Available at <https://www.refworld.org/docid/51ef9e134.html>
- United Way Glenelg. (n.d.). *Dolly Parton Imagination Library*. Retrieved 22 July 2020, from www.unitedwayglenelg.com.au/causes/dolly-parton-imagination-library/
- Victorian Aboriginal Community Controlled Organisation [VACCHO]. (2015). *Aboriginal families' engagement in maternal and child health services project*. Melbourne, VIC: Author.
- Victorian Auditor-General's Office [VAGO]. (2016). *VAGO annual report 2015–16*. Melbourne, VIC: Author. Retrieved from <https://www.data.vic.gov.au/data/dataset/vago-annual-report-2015-16>
- Victoria State Government. (2013). *Victorian Government Aboriginal affairs report*. Melbourne, VIC: Author. Retrieved from <https://www.firstpeoplesrelations.vic.gov.au/sites/default/files/2019-11/Victorian-Government-Aboriginal-Affairs-Report-2013-final.PDF>

- Victoria State Government. (2017). *Maternal and Child Health Service*. Retrieved 21 July 2020, from www2.health.vic.gov.au/primary-and-community-health/maternal-child-health
- Wathen, C. N. & MacMillan, H. L. (2018). The role of integrated knowledge translation in intervention research. *Prevention Science*, 19(3), 319–327.
<https://doi.org/10.1007/s11121-015-0564-9>
- West, R., Stewart, L., Foster, K. & Usher, K. (2012). Through a critical lens: Indigenist research and the Dadirri method. *Qualitative Health Research*, 22(11), 1582–1590. <https://doi.org/10.1177/1049732312457596>
- Wilkie, M. (1997). *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra, ACT: Commonwealth of Australia. Retrieved from <https://humanrights.gov.au/our-work/bringing-them-home-report-1997>
- Wilson, G. (2009). *What do Aboriginal women think is good antenatal care: Consultation report*. Darwin, NT: Cooperative Research Centre for Aboriginal Health.
- Whittemore, R. & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, 52, 546–553. <http://dx.doi.org/10.1111/j.1365-2648.2005.03621.x>
- World Health Organization [WHO]. (1996). *The Ljubljana charter on reforming healthcare*. Geneva, Switzerland: Author. Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0010/113302/E55363.pdf
- World Health Organization [WHO]. (2015). *Millennium development goals*. Available at https://www.who.int/topics/millennium_development_goals/about/en/

- World Health Organization [WHO]. (2018). *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*. Geneva, Switzerland: Author.
- World Health Organization [WHO]. (2022). *Social determinants of health*. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
- Yelland, J., Weetra., Stuart-Butler, D., Deverix, J., Leane, C., Kit, J., ... Brown, S. (2016). Primary health care for Aboriginal women and children in the year after birth: Findings from a population-based study in South Australia. *Australian and New Zealand Journal of Public Health*, 40(5), 418–423.
<https://doi.org/10.1111/1753-6405.12581>
- Zarnowiecki, D., Nguyen, H., Hampton, C., Boffa, J. & Segal, L. (2018). The Australian Nurse-Family Partnership Program for Aboriginal mothers and babies: Describing client complexity and implications for program delivery. *Midwifery*, 65, 72–81.