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The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services

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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, 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 (Belli 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 (Belli 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 determinates 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 subcategories 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 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 co-ordinator' 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

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?

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 authoritive 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
		Access/Poor access		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

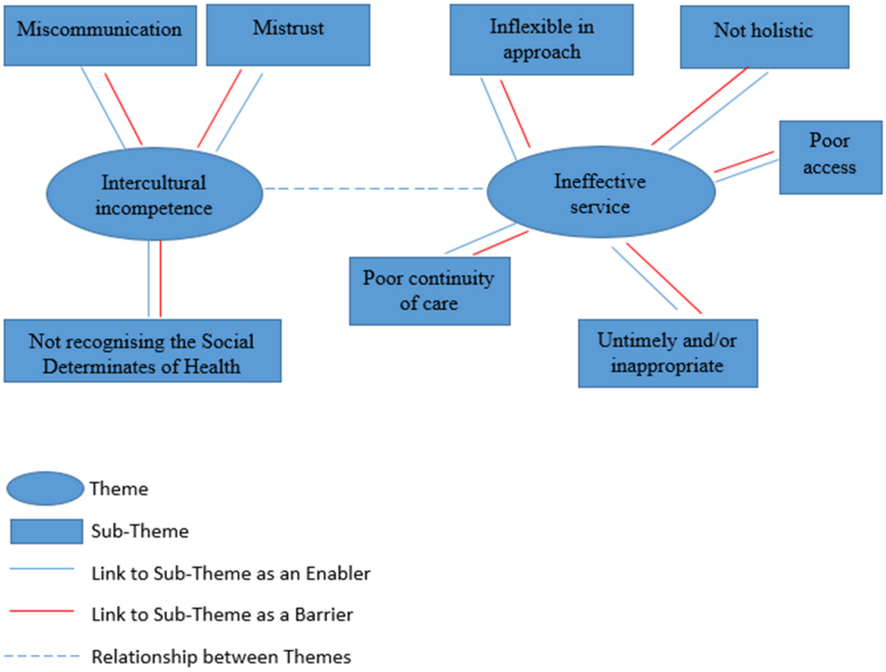

FIGURE 2 Finalized thematic framework map

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 & 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, 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. Outreaching 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.

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