



“Safe, connected, supported in a complex system.” Exploring the views of women who had a First Nations baby at one of three maternity services offering culturally tailored continuity of midwife care in Victoria, Australia. A qualitative analysis of free-text survey responses

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ABSTRACT

Background: In Australia, continuity of midwife care is recommended for First Nations women to address the burden of inequitable perinatal outcomes experienced by First Nations women and newborns.

Aims: This study aimed to explore the experiences of women having a First Nations baby who received care at one of three maternity services in Naarm (Melbourne), Victoria, where culturally tailored midwife continuity models had been implemented.

Methods: Women having a First Nations baby who were booked for care at one of three study sites were invited to participate in an evaluation of care. Thematic analysis was used to analyse qualitative data from responses to free-text, open ended questions that were included in a follow-up questionnaire at 3–6 months after the birth.

Results: In total, 213 women (of whom 186 had continuity of midwife care) participated. The global theme for what women liked about their care was ‘Safe, connected, supported’ including emotional and clinical safety, having a known midwife and being supported ‘my way’. The global theme for what women did not like about their care was ‘A complex, fragmented and unsupportive system’ including not being listened to, things not being explained, and a lack of cultural safety.

Conclusions: Culturally tailored caseload midwifery models appear to make maternity care feel safer for women having a First Nations baby, however, the mainstream maternity care system remained challenging for some. These models should be implemented for First Nations women, and evidence-based frameworks, such as the RISE framework, should be used to facilitate change.

Statement of significance

Issue:

Continuity of midwife-led care for First Nations women is recommended in maternity policy. For targeted First Nations programs to be effective, the perspectives of First Nations women should be included in service planning, delivery, and evaluation.

What is known:

First Nations women (and women having a First Nations baby) reported high levels of satisfaction with culturally tailored

midwife continuity models implemented at one of three tertiary maternity services in Melbourne, Australia.

What this paper adds:

This paper provides an in-depth understanding of the elements of care which women found supportive and those that were negative/challenging. Women reported feeling safe and supported in the culturally tailored model, in what can be a complex, fragmented and unsupportive system.

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Introduction

Aboriginal and Torres Strait Islander (First Nations) women and newborns experience inequitable perinatal outcomes. [1,2] Government policy and First Nations health strategies recommend improving maternity service provision by partnering with First Nations communities to implement evidence-based programs. [3,4,5] One such program called Baggarrook Yurrongi (“Woman’s Journey” in Woi-wurrung language) was a partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and three metropolitan Victorian maternity services that explored the capacity of the services to implement culturally tailored caseload midwifery for First Nations women (and non-First Nations women having a First Nations baby). [6] The program was successfully implemented in three services in Naarm (Melbourne), with an exponential increase in the number of First Nations women having access to a caseload midwife. [6].

Across all three sites, the culturally tailored models included proactively offering continuity of care from a known hospital-based midwife, in conjunction with additional specialist teams as needed. The hospital-based midwives received cultural safety training provided by VACCHO, who was a project partner organisation and is the state peak body for Aboriginal health. The culturally tailored model included the option for women to have all hospital-based care, or to have the continuity model of care in conjunction with community Aboriginal health services (including a community-based midwife) via a shared care arrangement. [7] The midwives also worked with Aboriginal Hospital Liaison Officers (AHLOs) from the Aboriginal Health Units at the sites. The culturally tailored model aimed to enhance, rather than replace existing Aboriginal health services. Engagement between the AHLOs and the midwives, and women’s access to cultural activities was site specific. For example, AHLOs at one of the sites coordinated regular ‘Yarning Circles’ for women and the caseload midwives, and another site had an established ‘Koori Maternity Service (KMS) program’.¹

Listening to the voices of First Nations women is critical for the success of First Nations maternity programs. [3] A key aim of the Baggarrook Yurrongi project was to explore women’s satisfaction, experiences, and views of their care, adding to the small number of studies exploring the impact of continuity of care models for Aboriginal families living and birthing in urban settings. [8] One previous study conducted in regional Victoria compared the experiences of 25 First Nations women who received continuity of care within an Aboriginal Community Controlled Health Organisation (ACCHO) with other rural women who gave birth in Victoria and participated in a state-wide survey. [9] ACCHOs are primary healthcare services that are established and governed by Aboriginal community members and are founded on social models of health, providing culturally appropriate and holistic health services that address the social determinants of health. [10] First Nations women in the ACCHO continuity model were more likely to say they were kept informed, the midwives were not rushed, and they were satisfied with their care compared to the other women. [9] More recent evidence found First Nations women who accessed a midwife continuity program in Sydney NSW experienced accessibility, preparedness for birth, and feelings of trust. [11] A systematic review that included studies from Australia and Canada reported that continuity of midwife care is valued by First Nations women, and negative experiences are more likely to occur when there is lack of access to culturally tailored services and continuity of care. [12] Only one study in the review included the views of urban First Nations women who accessed continuity of midwife care. [13].

We have previously reported that women having a First Nations baby at one of the three metropolitan services that implemented culturally

tailored continuity of care in the Baggarrook Yurrongi study reported high satisfaction with their maternity care. [14] Two hundred and thirteen women from the study participated in a telephone survey between three and six months after the birth, and the vast majority felt informed, that they were actively included in decision making, that their concerns were taken seriously, and that midwives were kind, understanding and readily available. [14].

In the Baggarrook Yurrongi telephone survey we also asked a number of open-ended questions in order to further explore and understand women’s responses to questions about their care. Analysis of open-ended questions is important to help explain women’s responses, [15,16] and to provide context and depth of understanding, [16] which is particularly important for populations that may be marginalised. [17] Qualitative data from free-text survey comments are recognised as an important data source for interpreting complexities in women’s health care experiences, because participants are enabled to address relevant issues. [15].

This aim of this paper was to conduct a more in-depth exploration of the views and experiences of First Nations women (and women having a First Nations baby) receiving maternity care at one of three urban tertiary maternity services where culturally tailored, continuity of midwife care programs had been recently implemented in Naarm, Victoria, Australia, using qualitative, free text data.

Participants, methods, ethics

The study was co-developed in partnership with VACCHO and the Baggarrook Yurrongi Aboriginal Advisory Committee (AAC). The AAC included a representative from VACCHO, community Elders, a recent First Nations mother, First Nations research team members, and staff from each study site’s Aboriginal Health Units. The AAC provided advice relating to community engagement, eligibility criteria, the design of the data collection tools, and provided feedback on research dissemination.

The methodological lens used to frame this research is Critical Race Theory (CRT). Used in other studies relating to First Nations women and birth, [18,19] a CRT lens attempts to contribute to the emancipation of groups where oppression relating to race and racism stem from imposed colonial practices and policies. [20,21] CRT is political, in that it attempts to produce social change by examining power imbalances and social injustices. [22] For First Nations women, birth has been impacted by colonial government policies including land dispossession, restriction of cultural practices, [23] women being excluded from birthing in hospitals, [24] forced removal of children and infants, and ongoing institutional racism. [23,25] Further, the context of this research is that the first author (PMC) positions herself as an Aboriginal woman and midwife, gathering knowledge from predominantly First Nations informants. Rigney [26] names this as Indigenous research. Aspects of feminist research are borrowed, (i.e. women’s liberation from the patriarchy) but Indigenist research harbours a specific focus on colonialism as the systemic oppression. [26].

A descriptive exploratory method was used and included analysis of free-text responses collected by telephone interview as part of a survey when women were between three and six months postpartum. We aimed to approach all eligible women having a First Nations baby, who were booked for care at one of the three study sites (hereafter called site 1, 2, and 3 respectively) during the study period, to participate in an evaluation of their care. To be eligible, women had to be expecting a First Nations baby and booked for care at one of the three study sites. Further detail of eligibility and the proportion of women approached and agreeing to participate is published elsewhere. [14].

Research midwives approached eligible women and invited them to participate. Plain language information was provided about the project and the voluntary nature of participation explained. The option to first discuss participation with their partner, family, or members of their community, or with the AHLO was offered. If a woman agreed to participate, a participant information and consent form was signed.

¹ The Koori Maternity Service (KMS) program is a state-wide program provided across 14 sites that provides culturally safe maternity care for Aboriginal and Torres Strait Islander women and their families during pregnancy.

Women were mostly approached in the antenatal clinic area, or less often in the antenatal inpatient ward, or the postnatal ward after birth (for women transferred in for care late in pregnancy or were not identified as eligible until after birth). Where face-to-face recruitment was precluded due to the COVID-19 pandemic, women were called by telephone and offered participation. Demographic data were collected via a short survey at the time of recruitment, then women were contacted by telephone from three months after the birth.

The questionnaires were based on those previously used by the research team [27] along with data items from similar studies used with permission of the respective authors. [28,29] Structured questions included an exploration of women’s satisfaction with and experiences of care (reported in detail elsewhere [14]), and questions on individual characteristics such as age and the specific First Nations language group women identified with (collected at recruitment, when women completed a brief questionnaire [30]). Open-ended questions (from the follow-up questionnaire) analysed and reported in this paper are:

“Was there anything about your pregnancy care that you were particularly happy/unhappy with?”

“Was there anything in particular with your labour and birth care that you were particularly happy/unhappy with?”

“Is there anything else you would like to tell me about your care in hospital after the birth?”

Data were collected from three months after the baby’s birth by a team of First Nations and non-First Nations researchers. The option to speak to a First Nations researcher was offered if the initial call was by a non-First Nations researcher. The researcher re-confirmed consent and then read the questions out to the woman, documenting her responses on a hardcopy questionnaire. Responses to open-ended questions were transcribed verbatim, and the researchers were able to confirm with women that their responses were recorded accurately. If no contact was established by six months postpartum, women were considered ‘lost to follow up’ and contact attempts ceased. In a few cases where a woman contacted the research team to complete the follow up survey after six-months, the survey was completed and included.

Data were entered onto a secure, password protected data management software, REDCap [31] then imported into Stata 16 for cleaning and analysis. Data cleaning included range and logic checks and checking missing data fields. Data were summarised using frequencies and percentages. For this analysis, two authors (PMc and HMc) completed the initial steps of data immersion and coding of the text separately. Women’s responses for each component of care were analysed separately, but initial coding showed that positive and negative themes were similar across care episodes, so responses were reanalysed with all care components combined. A process described by Attride-Stirling [32] was followed, where basic themes (generated from reoccurring codes from the text) and organising themes (middle-tier themes) were compared and agreed upon. [32] Based on the basic and organising themes, and the researcher’s positionality and methodological lens, the global themes (overarching statements) were chosen. [32] Ongoing two-way discussion and regular meetings between the First Nations researcher (PMc) and the non-First Nations researcher (HMc) ensured Indigenous worldviews were privileged and a sound consensus was reached. [33] The visual thematic networks produced were verified and refined, as the researchers re-read the text to determine that the map accurately represented the text (see Fig. 1 and Fig. 2). To visually illustrate the themes that were generated in the analysis, Fig. 1 was developed as a Birthing Tree, with the intention of representing the voices of First Nations women, while giving reference to First Nations birthing culture. Birthing trees are strongly associated with First Nations birthing and have connected mothers, babies and communities for thousands of years. [23].

Quotes are provided throughout the text, identified with a unique study identification number, model of care received, and the women’s

parity. Additional illustrative quotes are also provided in Tables 2 and 3, where we have aimed to include as many First Nations voices as possible.

Multisite Ethics approval was provided by St Vincent’s Hospital HREC reference number HREC-16/SVHM\223, followed by approval from La Trobe University (HREC 195/16) and all partner organisations. The study was conducted in accordance with National Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research.

Results

Recruitment to the study through to final data collection was from March 2017 to August 2021, with 479 eligible women offered participation. Of those, 343 (71.6%) agreed to participate and completed the recruitment questionnaire, with 213 women (62%) completing the three-month follow-up questionnaire. Table 1 shows the demographic characteristics of the women at recruitment (n = 343) and of those who participated in the follow-up questionnaire (n = 213). Participants identified with 60 First Nations communities from across the Australian continent, and most (87%) who took part in the survey received the continuity of care model (site 1: 88%, site 2: 82%, and site 3: 92%).

Results of the analyses of women’s positive and then negative feedback are presented below. First the global theme is provided, then a description of the four organising themes that emerged from the basic themes.

Table 1
Women’s characteristics.

	Recruitment		Postnatal follow up	
	n = 343	%	n = 213	%
<i>Study site</i>				
Site 1	154	44.9	98	46.0
Site 2	84	24.5	54	25.4
Site 3	105	30.6	61	28.6
<i>Age at recruitment (years)</i>				
Mean (SD, range)	28.3 (5.4, 16-44)		28.8 (5.8, 18-44)	
<i>First Baby</i>			(n = 211)	
Yes	158	46.1	102	48.3
<i>Weeks postnatal at follow up</i>				
Mean (SD, range)	-	-	16.8 (4.2, 12-39)	
<i>Received caseload</i>				
Yes	-	-	186	87.3
No	-	-	27	12.7
<i>Aboriginal/Torres Strait Islander Status</i>			(n = 211)	
Aboriginal	243	71.0	146	69.2
Torres Strait Islander	9	2.5	7	3.3
Both Aboriginal & Torres Strait Islander	10	3.0	9	4.3
Not Aboriginal or Torres Strait Islander	81	23.5	49	23.2
<i>Partnered</i>	(n = 340)		(n = 209)	
Yes	296	87.1	192	91.9
<i>Language spoken at home</i>			(n = 211)	
English	330	96.2	203	96.2
Other	13	3.8	8	3.8
<i>Aboriginal or Torres Strait Islander language spoken</i>	(n = 342)		(n = 211)	
Yes	46	13.5	25	11.9
<i>Education</i>	(n = 339)		(n = 209)	
Year 10 or less	63	18.6	31	14.8
Year 11 or 12	114	33.6	58	27.8
Cert 3 & 4 or Diploma	96	28.3	64	30.6
Degree	66	19.5	56	26.8
<i>Employed at pregnancy confirmation</i>	(n = 339)		(n = 209)	
Yes	215	63.4	149	71.3
<i>Pension/government benefit main source of income</i>	(n = 339)		(n = 207)	
Yes	101	29.8	44	21.3
<i>Health care concession card holder</i>	(n = 339)		(n = 209)	
Yes	155	45.7	79	37.8

Global theme for what women were particularly happy with: ‘Safe, connected, supported’

Women were asked about aspects of their care that they were particularly happy with. Most of the women received continuity of midwife care, either as part of a First Nations specific caseload model (FNCL) or a standard continuity model. The overall global theme was that women felt ‘Safe, connected and supported’. This global theme included four organising themes which were ‘Having my midwife’, ‘Emotional safety’, ‘High quality clinical care’ and ‘Being supported my way’.

Having my midwife

A factor that clearly contributed to women’s satisfaction with care was being able to see the same midwife/midwives throughout their maternity care experience. Women often commented that they ‘liked’ their midwife, describing them as experienced, knowledgeable, or kind. Women liked that midwives knew them more on a personal level, and they didn’t have to retell their stories several times. Women valued the availability and accessibility of their midwife and appreciated being able to call or text their named midwife (or a backup midwife) 24/7, which was highly satisfying and reduced levels of stress and anxiety. Women also commented that being able to communicate with their midwives to arrange or reschedule appointments directly worked well.

“...it was more the fact that I had my own personal midwives. Like, so if I’m at home I thought there was something wrong I could call them because you get their work mobile and they call you back that day or send you a text. Even on weekends I messaged them and they’d get back to me straight away and I think that’s what us Aboriginal women need, do you

know what I mean?” ID 2019, multiparous, First Nations Caseload (First Nations Caseload [FNCL])

Women felt positive about knowing who was going to be supporting them throughout their birth journey and then at home afterwards. Many women described how having their caseload midwife with them during labour or birth made them feel calmer, and more trusting:

“... because I knew her quite well, I felt comfortable and trusted everything she was saying. At the end of the day it was my decision, but I trusted what she said.” ID 3043, multiparous, FNCL

Some women who had previous experiences with mainstream care without continuity reported that they had a more positive experience compared with their past experience:

“I really loved the fact that 9 times out of 10 I seen the same one. So, I knew her on a personal level. Because when I had my son it was completely different, and I made the effort to tell them that I loved how they’re doing things now.” ID 3044, multiparous, FNCL

Emotional safety

‘Emotional safety’ was another theme. Women talked about how the relationship with their midwife/midwives developed over time and contributed to them feeling emotionally safe. Many talked about midwives supporting them and reducing their stress when they were dealing with things such as pregnancy complications, external life stressors or having a history of perinatal loss. Women talked about things like a ‘sense of ease’ with their care, describing feelings of comfort, familiarity, and reassurance. The words ‘connection’ and ‘family’ (see Table 2) were sometimes used to describe their experience.

Table 2
What women liked about their care – illustrative quotes.

Having my midwife	<p><i>“It’s the obvious stuff, it’s really nice to consistently have the same person and know who you will have for the birth and visiting you at home. I really really liked my midwife. The back up one was good too.”</i> ID 3045, multiparous, FNCL</p> <p><i>“I loved seeing the one midwife, it made a huge difference. [My midwife] always knew where we were up to which meant I could bring questions in rather than wasting time on updating a midwife. Being able to call [my midwife] at any time was amazing.”</i> ID 1026, multiparous, FNCL</p> <p><i>“This was my 2nd pregnancy at [name of hospital]. This time was a lot better having one midwife all the way through. Having a different midwife means they don’t know you and you are thrown around.”</i> ID 3045, multiparous, FNCL</p>
Emotional safety	<p><i>“...the midwives were there all the time and they listened to you... She makes you feel welcome you know, like she’s not a midwife or medical staff, she makes you feel like she’s family, like it was someone I’ve known for many years like I could open up to her and tell her what was going on in my life.”</i> ID 2019, multiparous, FNCL</p> <p><i>“I was most happy with the support, the emotional support I got from the [caseload] midwives, each and every one of them. From when I went in early and then when I had the baby and afterwards.”</i> ID 1028, primiparous, FNCL</p> <p><i>“...she always made me feel at ease and you can imagine that that is just such an important thing. And I had a few miscarriages before and the stress of that you know that always plays on your mind...so she just made me feel so relaxed.”</i> ID 2043, multiparous, Standard Caseload</p> <p><i>“...the level of emotional support especially because I basically went through a breakup...[my baby] was sick and I was sick and they were caring and reassuring in that way, and that was just the midwives, the doctors were like robots you couldn’t get anything out of them. Even the midwives on the ward, they were pretty decent even though I didn’t have as strong connection with them like the [caseload] midwives.”</i> ID 1055, multiparous, FNCL</p>
High quality clinical care	<p><i>“...I feel like they followed up pretty well on anything they were looking out for... I always got lots of information as well...I thought the midwives were really good. They were really attentive and helpful.”</i> ID 2072, multiparous, FNCL</p> <p><i>“I just feel like I had the best care like they were so caring and they were listening to me when I was concerned about something they would answer for me or if they didn’t know how to answer it they would get a senior.”</i> ID 1096, multiparous, FNCL</p> <p><i>“There were complications so our little man needed assistance breathing. The staff were absolutely amazing and kept reassuring me and my husband and kept an open line of communication. One, in particular, I think it was the anaesthetist, he was fantastic. He stood next to my husband and helped settled his nerves.”</i> ID 2069, primiparous, Standard maternity care</p> <p><i>“I really loved it, I tell everyone about it! The midwives always made time for me I never felt like I was a chore. I had a high-risk pregnancy and whenever I needed an appointment with a doctor or monitoring or a scan it wasn’t a problem, it happened quickly.”</i> ID 3014, multiparous, FNCL</p> <p><i>“I was really happy that the doctors and midwives agreed with my decision to have a C-section. It alleviated my doubts.”</i> ID 1026, multiparous, FNCL</p> <p><i>“My first pregnancy was purely perinatal, and I didn’t have anything to do with the midwives, other than a couple of appointments. To have midwives for my second pregnancy, it was like chalk and cheese. They have a different way of thinking.”</i> ID 3090, multiparous, FNCL</p>
Being supported ‘my way’	<p><i>“I was really happy that [my midwife] was flexible. When I asked if we could just do a phone appointment instead of me coming in and she was totally fine with that, as long as I had no concerns, and also on the other end of that, like, when I was worried at the very end of my pregnancy, she was like ‘yeah, come in straight away’ and she made time to check me out. So yeah, I think like, being flexible and being available to see me when I needed was really awesome.”</i> ID 3095, multiparous, FNCL</p> <p><i>“...I didn’t want to be induced. I was happy that one of the many doctors did listen and I was monitored closely in that term. I was happy with the monitoring they were doing. That was quite helpful anxiety-wise and knowing that I had the control.”</i> ID 2070, primiparous, Standard maternity care</p> <p><i>“Um just yeah that I was able to be in control and my midwife really stuck to my birth plan and I was adamant that I didn’t want any needles...and even when I was like, ‘I need something!’ she helped me get through it without anything.”</i> ID 1115, primiparous, FNCL</p> <p><i>“I did go into it saying, ‘no I’m not having pain relief’. They were understanding when I got the pain, they were quick to change the plan and work with me.”</i> 3010, primiparous, FNCL</p>

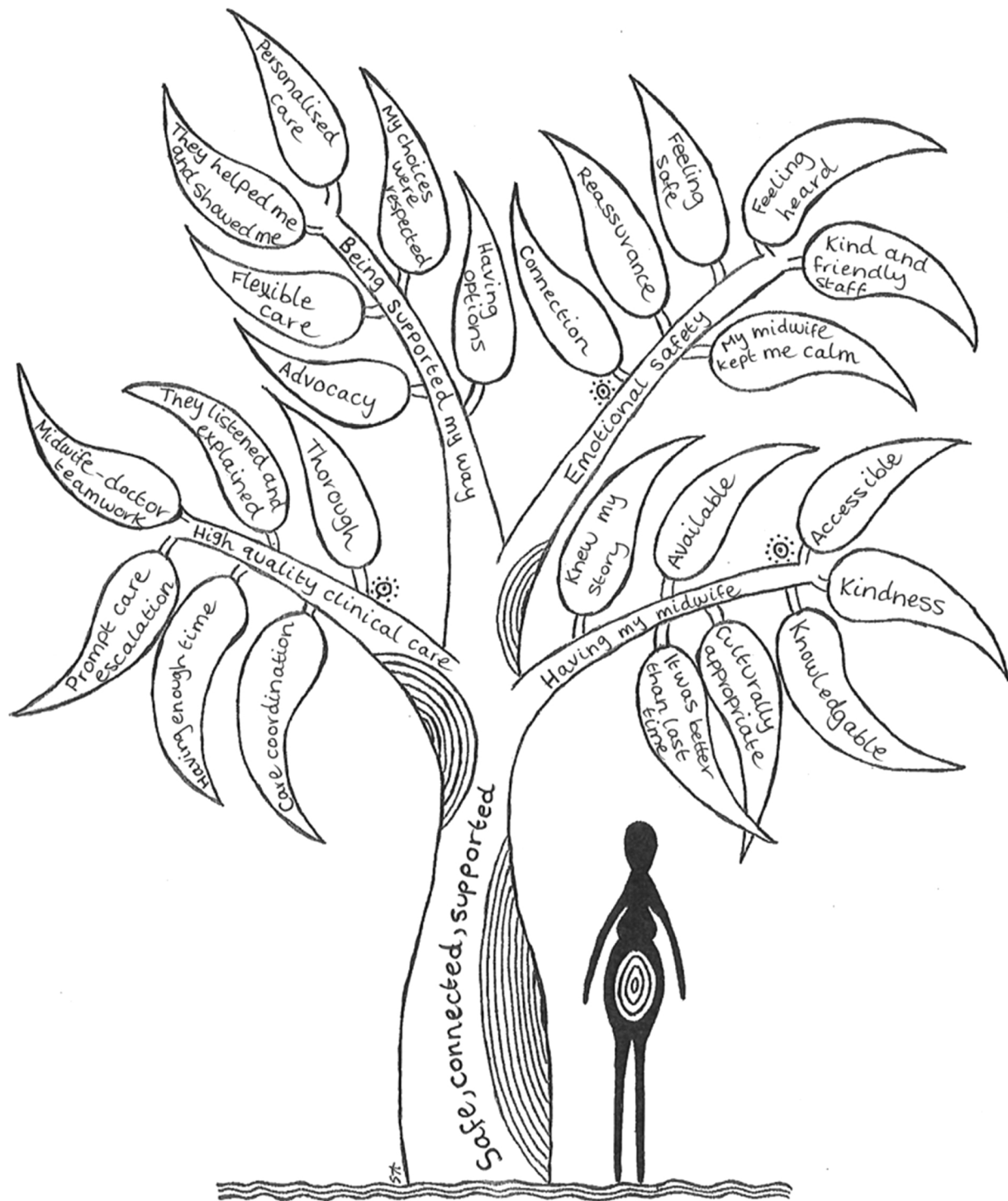


Fig. 1. Thematic analysis visual map of what women liked about their care. Artwork: "Birthing Tree 2" by Shawana Andrews.

"I think the program's great where women have got the midwives to connect with. Having that connection with the workers is important. I think it's really beautiful and you just get to trust that person. It makes mums feel special." ID 3061, multiparous, FNCL

"Once I got to know them [the midwives], it was just comfortable. That was probably the best part of it, you know just feeling comfortable, you know safe...in that relationship...because when you're getting care you don't usually get to have that personal relationship, especially in pregnancy. Yeah, that was nice." ID 3031, multiparous, FNCL

Women also talked about the encouragement they received during

labour and birth, with continuous support, the inclusion of their partner or family members, and debriefing after the birth (see Table 2).

"...[the midwife] was amazing [and] stood by myself the whole time ... pretty much held my hand, not even gonna sugar coat it...and they just reassured me that they were gonna look after me. I had every single doctor and midwife in there encouraging me, every time I felt sick they just fixed it and they listened to me. Every time I looked at my midwife [they] just said to me 'you are doing amazing, you've got this'." ID 2048, multiparous, FNCL

High quality clinical care

High quality, co-ordinated care that women believed was safe for themselves and their babies was another theme. Women valued clinicians really listening to their concerns and clear communication. Some women talked about ‘knowing something was not right’, and that health staff took them seriously, acted quickly, or promptly escalated their care. Advocacy from their caseload midwives, and sometimes from other midwives and doctors, was frequently mentioned. Women also described instances where they felt that they were given information that they needed, understood all of their options, and were able to provide truly informed consent (see Table 2).

“...my [caseload midwives] always took me seriously when I said there was a problem or there was something wrong and they stood up for me ... and with my history, I have complications and I lost my previous baby...so it was really good to have someone in my corner speaking up for me, it was very important to me. To me, that advocacy on my behalf was the most important thing about having the [caseload midwives]. Even if the midwives or doctors on the ward weren't listening, I could call the midwife on the ward and say “This is happening...help!” ID 1070, multiparous, FNCL

The quote below is an example of care co-ordination and collaboration provided in the new model and how it was valued:

“I had Gestational Diabetes. It complicated the situation but they worked the system so that I could also continue having the midwives. My midwife was able to bring everything together from the obstetrician side, gestational diabetes side, and midwifery side.” ID 3017, multiparous, FNCL

Effective pain management (non-pharmacological techniques or otherwise) during labour and birth also emerged as a theme under high quality clinical care.

“Options of pain relief. I was very happy with that. If I was uncomfortable they had options for me. I got that one that feels like bee stings in your back...they made me as comfortable as I could be in other ways, like getting in the shower or turning the lights down. I really appreciated being comfortable and safe in that space.” ID 1153, primiparous, FNCL

“I was very happy that the midwife supported me to get the epidural, I had no pain for the birth and the midwife guided me well for pushing.” ID 2080, primiparous, FNCL

Being supported ‘my way’

Another key factor in women’s satisfaction was feeling that the care they received was individualised and personalised. They valued flexible care, such as midwives helping to schedule appointments at times that accommodated childcare or long-distance travel, telephone appointments or last minute ‘drop in’ appointments. One woman explained that she felt like she was not ‘just another patient’ but was treated as an individual and felt genuinely cared for:

“Ah it was just, the midwives didn't make it about, how do you explain it...like they made it about me and the baby, it was, it actually felt like you were an individual. I don't know how to explain it, it was like they gave you more time, they actually cared about you and the baby, they didn't make it out like you were just another patient like they can just shove you on your way...and I have had that before.” ID 3012, multiparous, FNCL

Women appreciated being given options, and that their choices were respected. This included things like their planned place of birth, mode of

birth, what level of medical intervention they were comfortable with and being ‘in control’ (see Table 2). The quote below is from a woman whose baby was expected to die shortly after birth due to a congenital anomaly. She described the difference it made that her caseload midwife and birth team were able to support her, her way:

“I talked through my birth plan with [my midwife]. Back on Country the tradition is that no male person is to touch the cord while it is still attached. So I asked [my midwife] if in the worst case she could cut it, in case my sister couldn't. And we spoke a lot. Then when [my baby] was born, they intubated her at the end of the bed which was just so special. I asked if she could have delayed cord clamping and the paediatrician had every reason to say no, but he didn't. And because of all this I was able to hold her...and if they didn't I wouldn't ever have been able to hold her alive. And there were so many members of my family there, five to six, and they were able to stay. It was so special.” ID 1014, primiparous, FNCL

Global theme for what women were particularly unhappy with: ‘A complex, fragmented and unsupportive system’

Women were asked to describe aspects of their care that they were unhappy with. The global theme was ‘A complex, fragmented and unsupportive system’. For women who received caseload midwifery care, negative experiences mostly occurred during interactions with staff who were not working in these models. The four organising themes were: ‘A lack of ‘cultural safety’’, [34] ‘Fragmented care’, ‘They didn't listen/didn't explain’ and ‘Unsupportive’.

A lack of cultural safety

There were some examples of culturally unsafe interactions with staff who were not working in the culturally tailored caseload models. Some women felt stereotyped, for example staff assuming that they were using illicit drugs during their pregnancy, and wondered if it was linked to their Aboriginality. Other women perceived a pressure to explain themselves due to an obvious lack of knowledge from staff, particularly around skin colour.

“The doctor asked if ‘ATSI’ was a disease. He had no idea what it meant. He was trying hard to be respectful but was ignorant. Continued to ask questions and his preconceived ideas were bizarre. I didn't enjoy the scan, I felt uncomfortable and had to give a history lesson and explain myself.” ID 1094, primiparous, FNCL

“...they accused me of being a drug user. The midwife just casually said it...I don't know if it was because I had Aboriginal next to my name or the way I look. If [my caseload midwife] wasn't there, it was a totally different attitude.” ID 3081, multiparous, FNCL

Some women commented that hospital processes were not culturally appropriate. A small number of women commented on feeling worried about the Department of Human Services (DHS), linking this worry to their Aboriginality (see Table 3). Some women expressed that cultural safety may also be improved with greater access to Aboriginal midwives and Aboriginal Hospital Liaison Officers, while also recognising the need for ongoing cultural support for non-Indigenous staff.

“...I was surprised that there was no Aboriginal midwife providing care. Having Aboriginal staff working in this model would be the most appropriate and if this can't happen, non-Aboriginal staff need continuous

A complex, fragmented, and unsupportive system

A lack of cultural safety	Fragmented care	They didn't listen or explain	Unsupportive
<ul style="list-style-type: none"> • Culturally inappropriate staff • Wanting better access to Aboriginal staff • Feeling judged or stereotyped • Fear of/actual child removal 	<ul style="list-style-type: none"> • Seeing several different doctors/midwives • Caseload midwife wasn't available • Inconsistent or conflicting advice • Tensions between different health professions 	<ul style="list-style-type: none"> • Questions not answered • Concerns dismissed • Not being told what was happening • Being denied pain relief • Being pressured/pushed into accepting interventions • Lack of informed consent 	<ul style="list-style-type: none"> • Separation from partner/family • Rude hospital staff • Staff are too busy and rushed • Long wait times (in medical clinics and on postnatal ward) • Being sent home/told not in labour • Lack of breastfeeding support

Fig. 2. Global, organising, and basic themes for what women did not like about their care:.

cultural support, as the learning never stops." ID 1023, multiparous, FNCL

Fragmented care

A factor associated with dissatisfaction was when there was a lack of continuity of care. This could be if a woman's caseload midwife was unavailable or if they saw many different midwives or medical staff. Women talked about a lack of consistent advice, which reduced confidence in the clinical care (Table 3).

"...in the later stages my midwife wasn't sort of available, and it went from 1, to 2, and then possible 4 people could have been delivering my baby. I was really annoyed, and anxious and upset, because then it was like, the purpose of the caseload was gone." ID 2007, multiparous, FNCL

"I didn't like that every time I saw a doctor it was someone different. It took up most of the time explaining yourself. Sometimes it felt like you waited 2-3 hours to see the doctor and then were rushed through your appointment and sent back out again." ID 1113, primiparous, Standard caseload (SC)

They didn't listen or didn't explain

Another key factor associated with dissatisfaction was staff not listening or explaining things. For women who received caseload midwifery, these experiences occurred mostly when interacting with health staff other than their caseload midwife/midwives. Sometimes concerns were dismissed, women didn't know what was happening, or didn't know why certain procedures were performed.

"...one of the biggest concerns was the doctors...I lost my previous baby to a placental abruption at 34 weeks...I had another placental abruption ... So with my history it's really difficult when I feel like nobody listened to me and people were saying I was fine but I knew I wasn't...I think that everyone who has a complicated history needs a known midwife, like someone who knows your history." ID 1070, multiparous, FNCL

Women recounted situations where informed consent was not obtained. Some felt rushed or pressured into consenting to procedures.

"They were rough and pushy, tried to do an episiotomy without consent, they lacked the personal care side of stuff. They had the scissors and I was saying 'don't cut me, don't cut me, please please'...My partner had to intervene and say, 'don't cut her'." ID 3013, multiparous, FNCL

Women sometimes negatively commented on being told they were not in labour by staff. This sometimes meant being sent home or being denied pain relief. Other women recalled feeling pain during perineal suturing, but not feeling listened to.

"I kept asking for the epidural and they kept saying "no, you can do it"... She waited until I was 8 cm dilated and I was asking before then...I told them before the birth that if I asked for one, they should listen to me." ID 2081, primiparous, FNCL

Unsupportive

The theme 'unsupportive' included a range of factors mostly related to both the system and the behaviours of some staff. System issues included long wait times with women feeling 'left alone' and 'forgotten about'.

"When I went in with worries and complications at 16 weeks, I waited 6 hours all by myself. I thought I was losing the baby." ID 2080, primiparous, FNCL

"During fetal monitoring, after I had been there for 5 hours I was completely forgotten about. When I asked if I could go home I could hear the staff complaining about me. This happened twice." ID 1142, multiparous, FNCL

Women also talked about experiencing unsupportive behaviours from staff outside the caseload model. Words like 'rude', 'dismissive' or 'abrupt' were used. This was particularly the case in the postnatal ward. Some women commented that because it was not their first baby, midwives on the ward assumed they needed minimal support and subsequently did not make themselves available. Participants recalled a lack of support with breastfeeding, caring for their babies, and that the physical environment was not supportive for rest or sleep after the birth. Other women commented that being at home would have been preferable, since their partner wasn't allowed to stay and support in the

Table 3

What women did not like about their care – illustrative quotes.

A lack of cultural safety	<p><i>"I had a weird encounter with a receptionist. She asked whether I had trouble getting a certificate for my Aboriginality as my skin is pale. I don't think she meant this in a negative way but it showed her lack of knowledge and someone else may have been very offended."</i> ID 1104, primiparous, FNCL</p> <p><i>"My initial appointment with the hospital midwife I felt she was judgmental. There was judgment over us not having a plan. This woman made off hand comments about [my partner] being Aboriginal."</i> ID 2002, primiparous, FNCL</p> <p><i>"So my first midwife got the social worker involved and the social worker actually ended up contacting DHS on me... apparently my history and my age is a worry for me having a child and I call bullshit on that...The DHS case got closed 2 weeks after her was born, that's how ridiculous it was... one appointment I had with the social worker was when she said 'don't stress, this isn't a cultural thing' and I was like, 'what do you mean by that?'"</i> ID 3080, primiparous, FNCL</p>
Fragmented care	<p><i>"... There were strong differences in opinion between shifts. There was not a lot of continuity of care. At one point we were told off for doing something that the midwife in the previous shift had told us to do. Our baby was born small and some midwives told us we should be topping up with formula and others thought not."</i> ID 2052, multiparous, FNCL</p> <p><i>"When I was in the pushing stage there were two midwives in the room. There were two doctors outside wanting to come in and intervene. I felt the midwives thought everything was fine but that the doctors wanted things to happen faster. There was tension between them and I felt unsure as to how I should feel or what should happen."</i> ID 1126, primiparous, GP Shared care</p> <p><i>"The induction. I just wish there was more awareness of what was going on. It felt like there was a bit of miscommunication. I'd talked about the induction with my midwives in the lead up. Why we might do this or that. I found when it came to that, the doctors were very much like 'this is the way it's going to be, what you've discussed is not an option'. It felt like a big disconnect between what the midwives thought were ok, and the doctors."</i> ID 3090, multiparous, FNCL</p>
They didn't listen or didn't explain	<p><i>"...no one explained what happened during surgery, which is really bad care, you should be telling people during their stay and it shouldn't be up to me to chase it up. If you're touching someone's human body and providing care they should give you a summary of what they did to you."</i> ID 2083, multiparous, FNCL</p> <p><i>"I felt semi-coerced into agreeing to treatment that I wasn't provided enough information with. They wanted me to sign off on it then and there. I felt as though I didn't know enough about it but they said 'sign now' and I could 'decline later'. I was losing sleep over it. When I walked out I heard her say to her colleague 'oh, that's all done' like it was ticked off. That was the disrespectful part for me."</i> ID 3059, multiparous, Standard maternity care</p>
Unsupportive	<p><i>"Sometimes I would wait for 4 hours and then have to leave to pick up my daughter. Also, the inconsistency of people. I'd see a different doctor every time and I'd have to re-explain everything all over again and then I wouldn't have time to discuss what happened between appointments. They were so rushed."</i> ID 3081, multiparous, FNCL</p> <p><i>"One of the midwives was abrupt and dismissive to my support team immediately after the birth. This made me feel disrespected, and unsafe. My main midwife knew what I wanted and my preferences, then this midwife who didn't know me, was potentially judgmental and belittled the atmosphere in the room. She was very clinical."</i> ID 1023, multiparous, FNCL</p> <p><i>"...some [midwives] were very rude and rushed and it's like they had other things to be doing...like you can't just throw a breast pump and tell me to keep feeding her...I had one midwife stay with me for half an hour to calm me down because the midwife before just didn't care...just told me she was too busy, that was the response I got."</i> ID 3044, multiparous, FNCL</p>

hospital was lacking:

"[My baby] wouldn't stop crying and she wouldn't settle and nobody would help me...and I begged the midwife to take her for like ten minutes so I could sleep and they were just like 'oh I'll just come back after my rounds' or 'I'll be there in a minute' but never came back... so I slept with her in the bed and then someone would come in and be like 'oh you can't do that'. So I just cried for most of the night...just no one would help me. I knew if I went home there would be help for me there, like my partner would be there...I was just so tempted to walk out and go home." ID 2022, multiparous, FNCL

Discussion

We have analysed women's open-ended responses to questions about satisfaction with care in three hospitals where First Nations specific continuity of midwife care models were implemented in Naarm, Victoria. Elevating the voices of First Nations women to move forward and improve birthing services is best practice [35] and is required for the Australian government to enact national maternity service policy. [3] Applying a CRT approach to this research [36] suggests the broader issue to be addressed is that the maternity system needs to enhance its capacity to meet the needs of First Nations women, as a redress of the negative impacts on health outcomes that stem from colonisation. [37] The strong message from women in this study is that the opportunity for a trusting relationship with a known midwife through a culturally tailored continuity of care model facilitated feelings of safety, connectedness, and support. Overall, for women who had previously birthed in the system without a caseload midwife, the newly implemented model was a much more positive and satisfying experience.

The findings of this study echo the voices of First Nations women in other areas of Australia who also received care through a caseload model. A study conducted in the Northern Territory of Australia reported that First Nations women placed strong emphasis on the benefits of having 'their' midwife, who knew their story. [38] Additionally, women who accessed an urban-based program for First Nations women in Sydney reported feeling supported, relaxed, trusting of their midwives, and more than 'just a number'. [13] Other evidence not focused on First Nations women also shows that women are more satisfied with caseload midwifery, [39] and like this study, women feel safe, trusting, and supported by their caseload midwives. [40] Analysis of these qualitative data provides a deeper understanding of the quantitative data obtained in this study, further explaining the high satisfaction rates. Many comments from women suggested that a respectful relationship with a midwife that was based on trust allowed for genuine shared decision making. This is in line with 'woman-centred care', the principle which underpins midwifery practice in Australia. [41] Respectful relationships and genuine shared decision making help to dismantle the power imbalance that traditionally favours health professionals, and care is more likely to be experienced as culturally safe. [34].

Despite women reporting very positive experiences, it was evident that the broader maternity system remained a challenging space for some women. Outside the caseload model there were many instances where women described not feeling listened to, having concerns dismissed, or experiences of racism. These issues have also been reported by other First Nations women in a qualitative study conducted on Noongar Boodjar (Perth, Western Australia). [24] It has been previously identified that if First Nations women face negative experiences in the maternity care system, it is usually in the context where women have no continuity of care, and no access to culturally tailored programs. [12] In this study, most of the negative experiences reported by women related to service provision that occurred peripherally to, or outside the caseload model. Structural or systemic issues remained, such as care that was at times fragmented and unsupportive, and cultural safety within the broader health service was not guaranteed. Issues raised by some women that were directly related to the culturally tailored midwifery

models were if their primary midwife changed during pregnancy or wasn't available as expected, and some mentioned that they would have liked access to more First Nations staff. Government data shows a shortage of First Nations midwives in Australia, [42] and implementing strategies to increase the First Nations maternity workforce is recommended. [3].

The findings of this study, along with the other evidence of benefit of culturally tailored midwife continuity models suggest that the model should be implemented more widely. To assist with this process, an evidence-based framework, known as the 'RISE framework', has been developed to guide implementation of 'Birthing on Country' services, which include midwife continuity models, across various settings. [43] Rooted in a social justice approach by returning birthing services to First Nations communities, [44] 'Birthing on Country' is a metaphor for giving First Nations women and newborns the 'best possible start in life'. [45] Now recommended in national health policy, [3,4] Birthing on Country services are described as community driven maternity services designed to wrap around First Nations women, providing individualised, holistic care. [46] Identified in the RISE framework are four key pillars required for the implementation and continuation of Birthing on Country services; maternity service redesign, workforce investment, strengthening of First Nations families, and embedding First Nation community control. [43] Models underpinned by these principles help to close the gap in perinatal outcomes. One Birthing on Country service in Queensland reported a reduction in pre-term births, increased antenatal care attendance and increased breastfeeding rates. [46] Therefore, it is recommended evidence-based frameworks, such as the RISE framework, are adopted by maternity services to direct the implementation, upscaling and expanding of First Nations caseload midwifery models.

Strengths and limitations

To our knowledge, this qualitative study that includes the views and experiences of 213 women having a First Nations baby is the largest of its kind. However, it should be noted that there was a 38% loss to follow up, therefore the views of may not be representative of all women recruited to the original cohort. As First Nations women should have substantial involvement in the evaluation of First Nations birthing programs, [35] another strength of this study is the lead author has drawn on both her lived experience and her knowledge of cultural issues as an Aboriginal woman. This is important because First Nations people should be where possible, leading research about First Nations communities. [47] Additionally, the co-designed approach with the project AAC means that every effort was made to ensure that the research process contributes to achieving the aspirations of the First Nations community, and to dismantle any power imbalances between the researchers and the 'researched'. [48] Our findings echo those of studies involving First Nations women from other areas of the continent, increasing the generalisability of the findings. Efforts were made to minimise the risk of recall bias, and the surveys were completed between three and six months postpartum. [49,50].

Conclusion

In response to the disproportionate burden of inequitable perinatal outcomes for First Nations women and newborns, maternity services need to work towards implementing evidence-based, community-led models of care. [3] Three tertiary maternity services in Naarm, Victoria, implemented culturally tailored First Nations continuity of midwife care models, as a partnership project between the state peak body of Aboriginal health in Victoria (VACCHO), and La Trobe University. [6]

Women reported feeling 'safe, connected and supported in a complex system'. Given our findings along with the evidence of benefit of culturally tailored care for women having a First Nations baby, the Baggarrook Yurrongi model (or Birthing on Country models) should be implemented and offered to more First Nations women. Evidence-based frameworks such as RISE [43] should be used to facilitate change.

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Author Contributions

P.McCalman – conceptualisation, methodology, formal analysis, investigation, data curation, writing - original draft, visualisation. F. McLardie-Hore – investigation, writing - review and editing, project coordination. M. Newton – conceptualisation, writing - review and editing, writing, supervision. D. Forster – conceptualisation, methodology, writing - review and editing, supervision, data curation, funding acquisition. H. McLachlan – conceptualisation, methodology, formal analysis, writing - review and editing, supervision, funding acquisition.

Conflict of interest

None declared.

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Project artwork

We would like to acknowledge and give thanks to Shawana Andrews for creating the project's artwork. The concept of the artwork featured in this paper (Birthing Tree 2) was based on the Shawana's original artwork for the project, named 'Birthing Tree'. The original artwork and Birthing Tree story is provided below.



'Birthing Tree' by Shawana Andrews. "This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dughala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come."

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