



What Do Aboriginal Women Think Is Good Antenatal Care?

Consultation Report

Gai Wilson



**The question should not be,
‘Why do women not accept the
service that we offer?’**

but

**‘Why do we not offer a service
that women will accept?’**

World Health Organization 2005

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Cooperative Research Centre for
Aboriginal Health

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Central Australian Aboriginal Congress Inc.

PO Box 1604, Alice Springs

NT 0871 AUSTRALIA

T: +61 8 8951 4400

F: +61 8 8953 0350

W: www.caac.org.au

Cooperative Research Centre for Aboriginal Health

PO Box 41096, Casuarina

NT 0811 AUSTRALIA

T: +61 8 8943 5000

F: +61 8 8943 5010

E: admin@crcah.org.au

W: www.crcah.org.au

Author: Gai Wilson (wilsong@unimelb.edu.au)

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Project Steering Committee

Leshay Maidment	Congress Alukura Branch Manager [Chair], Central Australian Aboriginal Congress
Donna Ah Chee	Deputy Director, Central Australian Aboriginal Congress
Betty Carter	Cabinet Member, Central Australian Aboriginal Congress
Maureen McCormack	Traditional Grandmother, Alukura Cultural Advisory Committee
Dr Jhansi Lakshmi	Obstetrician, Alice Springs Hospital
Annie Tangey	Coordinator, Sexual and Reproductive Health Program, Ngaanyatjarra Health Service
Jane Mzwakal	Anyinginyi Health Aboriginal Corporation
Sarah Gallagher	Aboriginal Health Worker, Areyonga Clinic

Gai Wilson

The University of Melbourne



Executive Summary

Background

This report documents the first phase of the research project entitled Developing a Health Information System to Support Continuous Improvement in Antenatal Care for Aboriginal Women in the Central Australian Region. The project consisted of four major elements: a literature review; consultations with Aboriginal women; quantitative investigative components; and the implementation and trial pilot of a health information system for antenatal care in the primary health care setting. Funding was provided by the Cooperative Research Centre for Aboriginal Health.

The research was initiated and managed by Congress Alukura, the women's health branch of the Central Australian Aboriginal Congress [CAAC] located in Alice Springs, Central Australia. Congress Alukura provides health services to Aboriginal women based on Traditional Grandmother's Law. The research arose from the 1998 review of Congress Alukura, which identified a lack of information about young Aboriginal women's expressed needs for and views about antenatal services.

Consultation themes

The major research question that the consultation addressed was: What is good antenatal care? There were three parts to this question:

- What elements of antenatal care are identified as being important by Aboriginal women in the Central region?
- What are the features or dimensions of these identified elements?; and
- Which of these features or elements are the most important to Aboriginal women in the Central region?

The beginning point for any discussion about the antenatal care of Aboriginal women, especially those living in remote communities, will usually be grounded in 'Jukurrpa', a complex term with various cultural meanings depending on the particular Aboriginal community. According to Vaarzon-Morel [1998] Warlpiri women refer to it as 'Dreaming' because they believe that most white people have heard of this word. Given that some Dreaming stories as they relate to pregnancy and antenatal care are the foundation of, and inform the services at, Congress Alukura, and that extensive consultations have occurred previously about these matters, this consultation did not aim to explore them further. However, some stories were told during the consultation and some elements of traditional practices have been included in the report but others have not been included for reasons of cultural security.

Methods

The consultation was predicated on the understanding that Aboriginal women are not a homogenous group, rather they are characterised by differences in culture and tradition; language; socio-economic circumstances; places of residence; educational levels; and employment status, among others [Hancock 2006, Homer 2000, Waldenstrom 1995]. In order to obtain a diversity of Aboriginal women's views and experiences, a purposive sampling approach was taken, supplemented, in Alice Springs, by a snowball technique [Auerbach 2003]. The sample dimensions included geographic location [Central Australian remote and urban], language, [Arernte, Anmatyerre, Pitjantjatjara, Luritja, and Warlpiri] and age [18–70]. A total of 136 Aboriginal women living in either eight remote communities or Alice Springs and aged between sixteen and over sixty participated in the consultation. All but one of the young women had recently given birth to a child.

Separate discussions and meetings with young and older Aboriginal women were held. A young female Aboriginal Research Worker conducted most of the discussions with young women in Alice Springs and a young Aboriginal woman or Aboriginal Health Worker led the meetings in remote communities. Traditional grandmothers or senior Aboriginal women conducted the meetings with older women in appropriate places in the remote settings. Information and consent was provided and discussions occurred in various Aboriginal languages and English.

The information provided was analysed inductively to generate and allow unanticipated issues to emerge and then deductively to explore the relevance of elements identified by the project team and the literature review. Similarities and differences between the categories of women were noted. Major themes were identified and summarised as conclusions.

Ethics approval for the project was granted by the Central Australian Human Research Ethics Committee, the Central Australian Human Research Ethics Aboriginal Subcommittee, and the Australian National University Human Research Ethics Committee.

Information gathered during the consultation was reported back to participants via one to one discussions, presentations and workshops, as well as a Community Summary Report.

Findings

The findings are presented according to the seventeen main themes that emerged from the analysis: knowledge of pregnancy and who to tell; shame; carers; safety; nutrition; grog, drugs and smoking; kind of health service; partner and/or father of the baby involved in antenatal care; time of first antenatal visit to a health service; frequency of antenatal visits to a health service; waiting; antenatal health providers; continuity of carer; information provision; ultrasound scan; sit down time at Mt Gillen; and partner and/or father of the baby involved in birth. Within each theme the views of the four main categories of women are ordered in the following way: young Aboriginal women living in Alice Springs; young Aboriginal women residing in remote communities; older Aboriginal women living in Alice Springs; and older Aboriginal women from remote communities.

There were many similarities and differences in views and experiences amongst and between the young women and the older women.

Conclusions

The features of antenatal care identified and discussed by the women incorporated many social and economic aspects, as well as bio-medical and health service-related factors. For example, the need to feel and be safe from violence, the role of their families and partners, the importance of transport and the nature of their relationship with a health provider.

The dimensions of antenatal care were also specifically context dependent. The particularity of the context related to Aboriginal culture, both traditional and changing practices; the degree and influence of Western cultural practice, including medical and health practices; the kind and availability of Western health resources; personal and family experiences; and the nature of the community in which they resided. It follows, therefore, that the conclusions outlined in this report are also context dependent and cannot be generalised.

The consultation concluded that quality antenatal care for many young Aboriginal women needed to include a range of dimensions. The details and features of these dimensions of care varied between the women depending on age, location and specific circumstances, so it is difficult to summarise them here. Consequently, the following outline of the dimensions is indicative only.

Choice was very important to all the young women and included the offer of options and choices related to who and how members of their family participated in the care; the kind of service they attended; the profession, Aboriginality, sex and skills of midwives and Aboriginal Health Workers; the continuity of carer; and confidentiality and privacy.

Safety was also significant, with most women requiring freedom from violence, security of accommodation and a reliable income.

That staff providing antenatal services reflect an understanding of the dimensions of shame, its cultural complexity and its impact on young Aboriginal women's attendance at services and their self-care emerged as an essential component of care.

Of equal importance was a strong knowledge of local communities and relationships of respect and trust between all providers and women. The young and older women emphasised the importance of certain kinds of behaviour by health service staff, including what and how matters were discussed.

Privacy and confidentiality were basic requirements and the degree to which a service met these requirements influenced most women's initial attendance. All the women observed that positive relationships between health service staff and young pregnant women relied on respect for privacy and were damaged by breaches of confidentiality.

Overall, the striking level of consistency and knowledge about good nutrition seemed to suggest that antenatal, and possibly other, nutritional health campaigns have been partially successful. However, it was also clear that more information about women's bodies, substance abuse, self-care and care for the developing baby must be provided to women in Alice Springs and remote communities.

The young women living in Alice Springs seemed to value and appreciate some of the medical treatments and procedures they experienced during their pregnancies, while some young women in remote communities were frightened by and uncomfortable with the ultrasound scan, even though most said it was 'alright'. Once again, trusting relationships with their health

providers and appropriate information will assist young women to make informed decisions about, and improve their experience of, the kinds of procedures they have.

The role of the partner or father of the baby was one topic area where the views of the two groups of young women most noticeably diverged. Generally, all the young women from Alice Springs wanted the father to look after them while they were pregnant, to be involved in the pregnancy, and some wanted him to attend the antenatal appointments. Some wanted the father to attend the birth and others that he just be present at the hospital.

The views of the young women living in remote communities were similar in only one aspect. A few young women thought that the father of the baby could help look after the pregnant woman but they all said that he should have no role at the birth.

The critical issue here is again choice. Many of the young women in Alice Springs wanted to be able to select a service that combined a choice of midwife, continuity of carer and the participation of the father of the baby. These women were also deeply aware and respectful of traditional cultural practices, some were raised within traditional culture and some were with partners who were initiated, traditional men. However, they could and did regularly move between the 'two worlds' of the 'whitefella' and the 'community'. Some would behave in traditionally acceptable ways in some settings and with some members of the family but behave differently with their partners in other settings.

The young women living in Alice Springs expressed a strong desire for services that could be as flexible and adaptable as they were.

It is essential and of the utmost importance that health services are flexible, adaptive and responsive to these preferences so that young Aboriginal women are provided with a range of options for their care and the opportunity and support to exercise their own choices.

Ensuring quality of antenatal care

Dynamic partnerships between services and the young [and older] Aboriginal women who use them, community development programs that are collaboratively designed and implemented, an organisational culture of evaluative inquiry and policies, and systems, protocols, programs and practices that ensure Aboriginal women's views and experiences are being gathered, responded to and implemented are key technologies for the provision of quality antenatal care.

1.0

Introduction

1.1 Background and context

Aboriginal women have identified the health of mothers and their babies as a high priority [Eades 2004, Carter *et al.* 2004]. Many Aboriginal women have very healthy babies; however, Aboriginal women's health continues to be an area of concern, with many Aboriginal women suffering complications of pregnancy and childbirth, and babies having lower birth weights and higher levels of complications compared with non-Aboriginal Australians [AIHW 2006, AMA 2005, Zhao 2004, AIHW 2004, Mackerras 2000]. As such, maternal and child health has been identified as a priority area in key Aboriginal and Torres Strait Islander policy documents, and, in turn, Aboriginal and Torres Strait Islander women and children have been identified as a priority group in numerous mainstream reports and policy documents [DoHA 2006, NT DHCS 2005, Dwyer *et al.* 2004]. Despite this, there is little evidence to guide antenatal care planning for Aboriginal communities [Hancock 2006, Panaretto 2005, Hunt 2002]. In particular:

Aboriginal women's preferences, feelings and encounters with the health system as it impacts on them and their family and community lives during pregnancy and after, is poorly understood and appreciated. Aboriginal women's voices are only infrequently heard, their choices are limited, if any, and they are required to adhere to expectations about what is 'good' care for them during pregnancy...

[Hancock 2006: 4]

The area of Central Australia covered by this report is known as the Alice Springs District of the Central Australian Region and is approximately 540,000 square kilometres.¹ It includes the town of Alice Springs and a number of remote Aboriginal communities.

Aboriginal people living in this region, and Australia as a whole, are by almost all socio-economic indicators:

the most disadvantaged group in Australia. Indigenous people experience much higher unemployment rates, lower average incomes, lower participation and achievement in education and training, much higher rates of incarceration and poorer health and housing situations than non-Indigenous people.

[Jones *et al.* 2005: 23]

The remote communities within the Alice Springs District rural area have an Aboriginal population of approximately 4,936 women and 4,808 men. As with the region as a whole, the

¹ Three remote communities included in this consultation were located just outside the parameters of the region.

median age of Aboriginal women is younger than the Australian median [Jones *et al.* 2005: 9–11]. There is considerable variation between the remote communities in relation to their history, the groups of people who live there and the languages spoken [IAD 2002]. Some consist of only a few families, while others have up to approximately a thousand people [NT Government 2005].

Many remote communities are managed by a local council of Aboriginal people and have a school, a store and a health service. The health facility is a primary health care service administered through a number of different arrangements. In three communities there is an independent Aboriginal community controlled health service and in a further three there is an incorporated Aboriginal health board that is receiving its primary health care services through a combination of an Aboriginal community controlled health service and the Northern Territory Department of Health and Community Services [DHCS]. Therefore, for more than half of the remote Aboriginal population there is an elected health board of Aboriginal people governing the communities' primary health care services either fully or partially. In a further two communities the Aboriginal community government council administers the health service and there is no dedicated health board. However, under the new local government reform agenda these councils will no longer be administering health services across the NT and an alternative provider will need to be found. In the remaining remote communities, many of which are small and scattered, the primary health care services are provided solely by the Remote Health branch of the DHCS and this arrangement covers about a third of the remote Aboriginal population in the Central Australian region. [These figures do not include the Barkly region, as this report only covers the Central Australian District.]

The health services are variable in terms of size and staffing, with most consisting of a core staff of a doctor, nurses and sometimes midwives, as well as arrangements for visiting specialists from the Alice Springs Hospital. Almost all Aboriginal women living in the remote communities in this region travel to Alice Springs prior to giving birth. Most stay at the Mt Gillen Safe Health Centre in Alice Springs, a privately owned medical and antenatal accommodation centre for women only, which provides secure accommodation and meals for pregnant and postpartum women. Nearly all women give birth at the Alice Springs Hospital.

Alice Springs, the major town in the region, is the centre for health, education, business and tourist services. Approximately 27,229 people live in Alice Springs, with 2,539 being Aboriginal women and 2,643 Aboriginal men [Jones *et al.* 2005: 9]. The Aboriginal population predominately live in town camps although many are highly mobile, frequently moving between remote communities and the town of Alice Springs.

There are three main providers of antenatal care for Aboriginal women living in Alice Springs: the Northern Territory Department of Health and Community Services [DHCS] via the Alice Springs Hospital, Congress Alukura and general practice. Congress Alukura is a branch of the Central Australian Aboriginal Congress [CAAC], an Aboriginal community controlled health service. It was developed after Aboriginal women in Central Australia identified a need for a separate and specific Aboriginal women's health service. The aim of the service is to support Grandmother's Law in health and birthing [Carter *et al.* 1987, Ah Chee 2001].

Antenatal services at Congress Alukura are also guided by *The Standard Treatment Manual for Women's Business in Central Australia, "Minymaku Kutju Tjukurpa"*. The manual outlines protocols designed to give the best outcomes for remote area practice in Central Australia, such as the frequency of routine antenatal examinations and screening and diagnostic tests to be conducted throughout pregnancy, as well as interventions to be made in response to common and emergency problems in pregnancy and childbirth.

Congress Alukura has been reviewed several times, most recently in 1998 [Carter *et al.* 1998]. In this review, Carter *et al.* recommended further research to identify the needs and views of young Aboriginal women in relation to antenatal care and birthing and to further develop methods to monitor the quality of antenatal care. As a response to the review's recommendations, Congress Alukura initiated the consultation with Aboriginal women documented in this report.

1.2 Research aims

This report documents the consultation phase of the project *Developing a health information system to support continuous improvement in antenatal care for Aboriginal women in the Central Australian region*. The consultation with Aboriginal women living in Alice Springs and some remote communities in the Central Australian region was a component of the larger research project that aimed to:

- Identify features of quality antenatal care
Main research question: **What is good antenatal care?;**
- Develop indicators of quality antenatal care
Main research question: **How can good antenatal care be measured?;**
- Develop and implement a health information system to monitor indicators
Main research question: **How can a health information system to measure good antenatal care be developed and implemented?;**
- Build the capacity of stakeholder organisations and staff in relation to antenatal care systems; and
- Build the capacity of Aboriginal women to participate in research.

The project consisted of four major elements: a literature review; consultations with Aboriginal women; quantitative and qualitative investigative components; and the implementation and trial pilot of a health information system for antenatal care in the primary health care setting. The trial was to be conducted, in the first instance, at CAAC, Congress Alukura.

The project was funded by the Cooperative Research Centre for Aboriginal Health and implemented by CAAC.

1.3 Research approach

The research approach was predicated on:

- The primary importance of Aboriginal women's experiences and voices;
- A respect for Aboriginal women's diverse values and culture;
- The imperative to ground antenatal care practice firmly in the context and preferences of Aboriginal women and the reality of their lives;
- A commitment to directly link the project activities to program change with the intention to ultimately improve the health outcomes for Aboriginal women; and
- The importance of quality improvement processes.

Consequently the project:

- Was initiated, led and managed by CAAC, an Aboriginal community controlled health service;
- Was overseen by a Steering Committee that included key Aboriginal women from Alice Springs and the Central Australian region;
- Was collaborative, involving an Aboriginal Research Worker and research officers at CAAC, Aboriginal health service staff, antenatal care providers, staff from the Northern Territory Department of Health and Human Services, and university-based researchers;
- Provided research training to Aboriginal staff;
- Shared the knowledge and information gained during the project with other agencies, Aboriginal services and communities, and research communities; and
- Adopted an action research approach.

2.0

Methods

2.1 Research question

The major research question that the consultation addressed was: What is good antenatal care? There were three parts to this question:

- What elements of antenatal care are identified as being important by Aboriginal women in the Central region?
- What are the features or dimensions of these identified elements?
- Which of these features or elements are the most important to Aboriginal women in the Central region?

2.2 Consultation themes

The consultation themes were primarily generated from the research question noted above by the project team during a methods workshop. They were informed by the practice wisdom of the Aboriginal project team members, other CAAC staff, midwives from collaborating agencies, and the literature review undertaken to support all the components of the research. A more detailed list of secondary themes and prompts was developed by the Aboriginal Research Worker, the Aboriginal Young Women's Community Health Education Program Co-ordinator at Congress Alukura and the project Steering Committee. The themes and prompts were subsequently piloted by the Aboriginal Research Worker. All members of the project team involved in this process and the consultation were women.

In addition, as a result of our on-going action research approach to the project, the project team reflected on and discussed the effectiveness of the theme list and prompts after the first two discussions with individual young women living in Alice Springs and then made further minor changes to words and ordering. On two occasions we also added prompts based on information provided in the previous discussions with women. Although the theme lists utilised for the discussions with young and older women living in Alice Springs and remote areas covered essentially the same topics, some wording varied to reflect different sensitivities and situations between the categories of women. The theme list included:

- Tell a love story or tell a story about getting pregnant
- Finding out you're going to have a baby
- Who should care for the pregnant woman?
- Where should the pregnant woman be cared for?
- What does a pregnant woman need?
- What does a pregnant woman need from a health service or a clinic?
- Sit down time.

It was also intended that the discussions would, whenever possible, be directed by the women and follow issues and matters that concerned them. Consequently the theme lists were designed as starting points for the conversations.

An information sheet outlining the project was developed by the Aboriginal Research Worker. It was designed as a flyer and illustrated with cartoons of talking young women and pregnant women. This, and consent forms, were also reviewed by the project team, Congress Alukura staff and the Steering Committee before being utilised for the project.

2.3 Ethics

The overall project proposal and work plan was approved by the Central Australian Aboriginal Congress Board. Ethics approval for the project was granted by the Central Australian Human Research Ethics Committee, the Central Australian Human Research Ethics Aboriginal Subcommittee, and the Australian National University Human Research Ethics Committee.

2.4 Sample frame and selection of communities

In order to obtain a diversity of Aboriginal women's views and experiences, especially young women's views, purposive sampling was used. A list of all Indigenous communities in the Central region in the Northern Territory, language maps and demographic data were sourced from the ABS 2001 census and the Northern Territory Department of Health and Community Services population reports and reviewed. The remote communities and the town of Alice Springs were selected as, together, they included Aboriginal women who were diverse in terms of geographic location [remote and urban Alice Springs], language [Arrernte, Anmatyerre, Pitjantjatjara, Luritja, and Warlpiri] and age [18–70].

The sample was further stratified in the following way:

- Young Aboriginal women living in Alice Springs;
- Young Aboriginal women residing in remote communities;
- Older Aboriginal women living in Alice Springs; and
- Older Aboriginal women from remote communities.

Initially ten communities were selected and then letters inviting participation were sent to the Chairperson of the Community Council and the health service. Eight communities expressed an interest in the project and had the capacity to participate. Indicators of capacity to guide this selection included existing women's groups with project officer staff; fully staffed health clinics; Aboriginal health workers; and/or traditional grandmothers who wanted to participate.

2.5 Recruitment of women

Alice Springs

As mentioned above, a purposive sampling approach was taken, supplemented, in Alice Springs, by a snowball technique [Auerbach 2003]. Initially the Information leaflet and a letter of invitation to participate in the project were sent to a range of services in Alice Springs. The leaflet was displayed on noticeboards and staff mentioned the project at meetings with a variety of other service providers. Having recruited a number of Aboriginal women in this way, we then asked the young women to provide us with a list of names of other women who had recently had a baby, were in the desired age range and lived in Alice Springs.

Remote communities

The Co-ordinators of women's centres and/or health services of the selected communities were contacted and were asked if they would participate and if they would identify senior Aboriginal women who could be contacted to discuss the project's purposes and methods and be employed as cultural consultants. In all but one of the communities visited, a senior Aboriginal woman, usually a traditional grandmother or a respected female Aboriginal Health Worker, guided the project team, organised the women's meetings, selected the site for the meetings, invited the women to attend, identified a young woman to organise the young women's meetings and/or gave the team permission to meet with the young women. All women participated of their own accord. The senior Aboriginal women and/or traditional grandmothers were remunerated for their time.

2.6 Participants

A total of 136 Aboriginal women aged between sixteen and over sixty participated in the consultation. Of the women living in Alice Springs, fifteen were aged between eighteen and twenty-five [young women] and twelve were aged between thirty and over sixty [older women]. All young women had recently, or in the past few years, given birth to a child. Almost all had lived in Alice Springs all their lives.

Of the women who were living in the eight remote communities, forty-nine young women were aged between sixteen and twenty-five [approximately] and sixty women were aged between forty and over sixty [approximately]. All but a few of the young women had one or more children.

2.7 Women's meetings and discussions

In Alice Springs one group meeting was held with young women, while the remainder occurred with just one woman and the two or three project team members, usually in the woman's home or a quiet room at Congress Alukura. The Aboriginal Research Worker explained the project, showed the women the information sheet, requested and gained their consent to participate and to record the conversation and, in most cases, led the discussion. All the discussions were in English.

Guidance about how best to approach and meet with women living in remote communities was sought from and provided by senior Aboriginal women at CAAC and the project Steering Committee. Women living in remote communities were invited to attend a women's meeting and/or small group discussion, as mentioned above. The meeting with the older women was conducted first, except in one community where they were held concurrently in different places.

At the older women's meetings, a senior Aboriginal woman, traditional grandmother or Aboriginal Health Worker explained the project, read aloud the information leaflet, in the women's language, and asked if they wanted to participate and, if so, to agree to provide verbal or signed consent. The senior Aboriginal woman, traditional grandmother or Aboriginal Health Worker then translated the questions as they were asked by the project team, sometimes asking questions of us to clarify the meaning. They then translated the answers and we took notes. At most meetings the women spoke a mixture of their language and English. The senior Aboriginal women and/or traditional grandmothers were remunerated for their time and refreshments were provided for all the women and children who attended the meetings.

A similar process occurred at the meetings with the young women except that a traditional grandmother or senior older woman was not present. In three communities a trusted and respected Aboriginal Health Worker did attend; in four, the young women were happy to just meet with the team after we had met with the older women; and, in one, the young women's meeting was cancelled due to a funeral. In the meetings with the Aboriginal Health Worker, although English was mainly spoken, some discussion did occur in the local language and was translated by the Aboriginal Health Worker or some of the women. English was spoken in the other meetings.

The information leaflet and consent forms were translated into Arrernte, Anmatyerre, Pitjantjatjara, Luritja, and Warlpiri.

Reflection

Following all the discussions the team immediately wrote the notes in full and reflected on the process and content of the meetings in order to improve the accuracy of the record and to add further topics for exploration.

A two-way exchange

In an attempt to return the generosity of the women who gave their time freely to the consultation, the researchers provided information to them in response to questions about health services and conditions and gave them health information resources. At most remote communities and one consultation meeting in Alice Springs, the women were given canvases and paints. Over fifteen paintings were produced by the women, with some representing traditional 'dreaming' stories, some paintings of hunting and gathering traditional food, some of significant sites and one represented the 'Anangu telling stories about Anangu girls'. Permission was given by the artists to photograph and reproduce the paintings for use in the final project report. Similarly, permission was also given to photograph some of the women, again for use in the report. Copies of the photographs were also sent to the women concerned following the consultation.

2.8 Analysis

The taped discussions were transcribed and the notes typed. This qualitative data was first sorted according to the theme topics and prompts and then sorted according to the category of women, that is, young Alice Springs women, young remote women, older women from Alice Springs and older women from remote communities. This data was then analysed inductively to generate and allow unanticipated issues to emerge and then deductively to explore the relevance of elements identified by the project team and in the literature review. Similarities and differences between the categories of women were noted. Major themes were identified and summarised as conclusions.

2.9 Feedback

The draft consultation report was discussed in a workshop with women from some of the communities consulted, members of the Steering Committee and project team members. Following some revisions, the consultation report was finalised and formed the basis for a Community Summary Report that was generated for distribution to those communities that had participated in the consultation.

2.10 Methodological strengths and limitations

The strengths of the project methodology included:

- The participation of Aboriginal women in all stages of the research process;
- The sample covered a range of communities and women's perspectives;
- The use of methods to ensure the views of young Aboriginal women were heard;
- Positive effects during the project, for example, some members of the team returned to their workplace with ideas for practice changes consequent on one of the young women's meetings. In this way the consultation was beginning to effect practice styles before it was formally completed;
- Some Aboriginal women had experience of, and exposure to, research methods; and
- Aboriginal ways of sharing information were included, for example, painting and 'talking stories'.

The consultation was limited by a range of factors including:

- The sample size was limited by the budget and timelines;
- Some members of the project team were non-Aboriginal women;
- In remote communities some matters were not explored to ensure cultural safety;
- The project team did not speak any Indigenous languages and relied on senior women, Aboriginal Health Workers and some young women to translate the discussions;
- The method of group meetings probably restricted some women from commenting. This was apparent when some of them spoke more freely when in the company of only one non-Aboriginal team member;
- The sample did not include some young women with severe substance abuse problems; and
- In two remote communities the number of women able to participate was reduced due to sporting events and a funeral.

Limitations of scope

Some issues were raised that were beyond the scope of the project and, while directly related to pregnancy, they were not explored. Issues related to contraception and terminations have been included in the appendix and birthing issues as they related to men have been incorporated into the findings and discussion. Given previous studies related to Congress Alukura, this consultation did not explore the meanings and particular context of Dreaming stories as they relate to pregnancy, despite the fact that some women referred to it and told some stories.

3.0

Findings

This section presents the main themes that emerged from the consultation when young and older Aboriginal women were asked to talk about and discuss the topic, 'What are the important things that young pregnant women need?'. As detailed in the previous section on methods, the women were initially asked very broad open questions followed by more specific questions and prompts aimed at identifying the factors that were important to them.

More than 136 Aboriginal women aged between sixteen and over sixty living in Alice Springs and remote communities in Central Australia participated in the consultation, either in one to one discussions or small group meetings.

The findings are presented according to the seventeen main themes that emerged from the analysis:

- Knowledge of pregnancy and who to tell;
- Shame;
- Carers;
- Safety;
- Nutrition;
- Grog, drugs and smoking;
- Kind of health service;
- Partner and/or father of the baby involved in antenatal care;
- Time of first antenatal visit to a health service;
- Frequency of antenatal visits to a health service;
- Waiting;
- Antenatal health providers;
- Continuity of carer;
- Information provision;
- Ultrasound scan;
- Sit down time at Mt Gillen; and
- Partner and/or father of the baby involved in birth.

Within each theme the views of the four main categories of women are ordered in the following way:

- Young Aboriginal women living in Alice Springs;
- Young Aboriginal women residing in remote communities;
- Older Aboriginal women living in Alice Springs; and
- Older Aboriginal women from remote communities.

The similarities and differences are highlighted.

3.1 Knowledge of pregnancy and who to tell

All the women who participated in the consultation thought that young women knew when they were pregnant, with the exception, perhaps, for the very young girl of twelve or thirteen.

Nearly all the young women living in Alice Springs knew they were pregnant with their first baby within the first four to six weeks, and three knew within twelve weeks. Most knew quite soon that they were pregnant because they had missed a period, two bought pregnancy tests from the supermarket and checked themselves, and two said that they had been unaware of the pregnancy and it was only discovered when they were hospitalised for other conditions.

Their partners, and/or the father of the child, were the first people most of the women told about their possible, and then confirmed, pregnancy.

I went home and told my partner and he was really, really happy.

I told my boyfriend and he said I must have got it wrong. We got into a couple of fights and he hit me in the stomach.

One woman told her mother first then her partner and one other woman told no one. Of those who shared the news with their partners, three kept the information a secret, telling no one else for many months. One was anxious about the 'danger zone' of the first three months; however, the other two were too afraid to tell anyone. In particular, they kept the pregnancy hidden from their parents, as both indicated that they were sixteen at the time and they knew that their parents would disapprove.

I didn't tell anyone else especially my dad because I thought he would disown me.

After six months her mother found out that she was pregnant and told her father.

Dad was really angry... he didn't talk to me for three years.

Others were also still a little concerned at telling their fathers because they would think the women were too young. They were aged eighteen, nineteen and twenty at the time. However, although their fathers were 'disappointed', their families did support them.

Then I had to tell my Mum and Dad. I didn't have to tell my Dad, I made my Mum tell him about it cos me and my Dad were pretty close and I thought he might be a little disappointed that I got pregnant at a young age. But he was real happy.

My parents said sort of, you know, they would support me, they wasn't very happy, but they were going to support me with whatever I do, so yeah. [They thought she was] too young. Just, yeah, sort of silly because they, my mum, had her kids when she was quite young, same age I think, about the same age.

Generally the young women living in remote communities were either too shy to say, not sure or could not recall when they first realised they were pregnant. However, some women said that they knew they were pregnant 'before' the changes in their bodies made it obvious to others. Some mentioned that some young women do know that they are pregnant

When they miss that period when feeling sick.

However, they also said that some women are so young that they do not understand.

Who the young women living in remote communities first told about their pregnancy varied between the women and between communities. Some young women said that they first:

tell friends... [then]... mother, parents... [then]... tell the boyfriend.

Friends were also family members. Conversely, in another community all the young women agreed that:

girl tells her husband or boyfriend... then later tells her mother and grandmother.

girls don't tell their grandmothers... grandmothers only know when they are showing... grandmothers think 'this girl got fat'.

For other women the first person they told about their pregnancy was the 'nurse'. One said that she 'told the nurse first and told my mother', another that she had not told anyone about the pregnancy except the nurse at the health service who had kept her secret, and another that she 'didn't tell other people until showing':

let them just see you changed.

They also said that they did not tell other people because they were shy and that they thought most young women behaved in the same way.

Other women in a different community also thought that many young women 'kept it a secret', while others knew of some 'girls' who 'told everyone'.

Overall, like their counterparts in Alice Springs, some young women in some remote communities knew they were pregnant before telling anyone else and then told their boyfriend or partner, as well as their mothers, family and friends. They also behaved differently depending on if it was their first pregnancy, if they were very young and if they felt shame.

The older women living in remote communities also said that most young women know when they are pregnant.

Not having period [and] always vomiting, vomiting, oh! and sleeping all day ... not lazy ... don't want to get up in the morning.

when they feel funny, their face change... already showing, little bit...

they go to the clinic, checkup. They know if they're pregnant.

However, they thought that very young women were not always aware of what the changes in their bodies meant, for example, their:

period, yeah, some do, some don't ... the younger ones don't know ... not before.

They said that the grandmother or mother knew that the young woman was pregnant before she tells them because:

they see the body change, like face, you know, the face... a little bit lighter.

All the older women living in remote communities thought that the pregnant woman would usually tell her grandmother when she realised that she was pregnant, while some would talk to their mothers, a few to their sisters, cousins and maybe friends. Some, especially with a first child and if the woman was very young, would not tell anyone until 'she had to'.

The older women living in Alice Springs did not discuss this topic.

In summary, the older women living in remote communities had similar views to the young women living in Alice Springs and some remote communities in that they thought that the young women did know when they were pregnant and that some knew quite early in the pregnancy. They also thought that very young women, for example twelve or thirteen year olds, would not know that they were pregnant. The differences between the older women living in remote communities and all the young women, regardless of where they lived, related primarily to the importance of telling grandmothers and their role in assisting the young woman. None of the young women told their grandmothers first.

3.2 Shame

When discussing when a woman knew she was pregnant, all the women mentioned shame and indicated that, for many women, feeling shame is a significant reason for keeping the pregnancy a secret and not seeking assistance from friends, family or health services.

All the young women living in Alice Springs who kept the news of their pregnancy a secret explained that they felt 'shame'. They explained shame in different but related ways.

Shame. My mum didn't find out till I was showing, and she was like 'Oh ... you're pregnant' and all this, she started growling and all that. She was a drunken woman and she started growling and gets drunk all the time. [She said] I didn't tell you to go and get pregnant and all, I didn't tell you to marry that bloke and get pregnant and all that. Shame cos like... my cousin knew that I was pregnant and she would go around telling everybody and they would tease me and all that... like ask you if you are pregnant and how far you are and who you're pregnant [to] and all that.

I taped up my stomach so the bump wouldn't show. It was so tight that it bled. I was still swimming. I was doing all my normal things. I was playing basketball and it really hurt when I ran. I still went to school.

like I felt shame because he gave me something diseased and I was pregnant, you know...

Shame for these young women entails becoming pregnant at a young age; being disapproved of by family; being embarrassed by personal questions from members of the community about the father of the child and the pregnancy itself; and having contracted a sexually transmitted disease.

It was thought that other young women felt shame when they were pregnant for similar reasons including:

shame is like everyone else looking at you... Shame job, I don't want anyone else to know that I'm pregnant. But you'll show it, you know, your stomach will be getting bigger and bigger and fatter and fatter, so really you can't hide it. Sometimes people talk about, 'Who's she pregnant for' or 'Is she really pregnant by him?' and that's just, like, putting that pregnant woman down, you know. I reckon, it's other community members looking at you, and discussing, you know, they just afraid of other people discussing about you. That's what I reckon that a shame job is.

Some women explained that this reticence to be the subject of attention, gossip or discussion was because young women lacked self-esteem and self-confidence.

I think shame, like, no self-respect, they've got no self-respect for themselves. Lack of confidence, I don't think young Aboriginal girls are confident in themselves.

Well, shame to me, you know, this might be a bit, this is my own opinion... It's denying yourself... denying yourself of your worth... you know, like you're not important.

Interestingly, one woman linked a lack of self-esteem amongst young women to aspects of cultural law.

the world I was brought up in, everything was shame... I was living in town, but I lived according to Aboriginal ways... Aboriginal culture, Aboriginal Law. That was denying yourself, your worth, your value. You know, it's a shame job to sit amongst men. Shame job to speak out freely about yourself.

You're not allowed to talk about your, I don't know, that's hard... your emotion, that's what it is... how you're feeling.

Some young women living in Alice Springs thought that transgressing cultural law by becoming pregnant to the wrong man was another reason for feeling shame.

[Shame also can be because] that person's married to first wife, and the second wife gets pregnant... or like wrong skin... because the baby will turn out two skin.

Further, some young Aboriginal women in town feel responsible for maintaining their families' reputation and will feel shame if they think that they have let their families down.

they might think they're going to get rubbished for things that they do all the time, or what they're doing is wrong. They think that they're going to disgrace their family and stuff like that. Like, other people might look down on their families if they see what the girls are doing, like, if they got a boyfriend at a young age, if they're having a baby really young, if they're drinking and smoking and stuff, you know.

Most importantly, some young women said that feeling 'shame' would prevent some women from visiting a health service.

Yeah, well, there's probably shame, you know, to go [to a health service]... they're afraid or embarrassed, yeah.

embarrassed or uncomfortable in their surroundings... like they could be uncomfortable speaking to certain people or talking about certain things when people are around, like family.

Significantly, however, they said that not all young women felt shame when they were pregnant

cos with my nanna, she always taught us don't be shame. There's nothing to be shame for ... my nanna and my mum... they raised us to be confident and speak our minds.

Cos I had a partner who would, who would express, tell me, talk about love, you know. And contact with more people other than Aboriginal people, you know. With Aboriginal people you get the same treatment, which some people say that's a good thing, but sometimes it's not, through my experience. Sometimes you need an outsider to show you outside things, you know... it wasn't until I got to [health service] and talked to white people, doctors and midwives, that they told you how important you were in this whole situation, yeah.

When young women living in remote communities were asked why they do not tell anyone, or only one or two people, that they are pregnant, most said that they:

... don't tell earlier because of shame.

They said that some might feel shame because they did not want to become pregnant.

I think some girls do feel shame and feel bad, you know, oh, I'm going to be a mother now and they feel bad inside... Cos she's pregnant and she want to do nothing about it.

Or it was her first pregnancy.

Why they getting shame? ... Maybe they getting shame, eh, when the first time they having baby ... they always put their jumper like this when they getting pregnant first time... only the first time.

The young women living in remote communities said that a young woman may feel shame if:

she didn't listen to her mother, family, you know, stopping her from walking 'round, you know, making friends with boys.

Importantly, some feel shame, they said, because they do not have mothers to look after them.

*Sometimes mothers leave their children behind and just go...
She might feel she has no one to look after her.*

Or fear of being taunted:

*also she might get shame from friends, young girls, they going to tease me...
She won't be going to school because she's pregnant...*

Some young women living in remote settings also said that feelings of shame could depend on whether the woman is married 'proper way'.

not married, they get shame maybe.

'cos, like, when you married up you're alright you're allowed to have a baby but when you single... that's hard.

Women would feel shame if the father of the baby was either already married, from the wrong skin group or had a wife who was jealous.

Maybe [his wife] might hit her.

Older women living in Alice Springs also thought that young women in Alice Springs felt shame when they became pregnant. Although most women did not comment about shame, two older women emphasised that shame was often acutely felt by victims of violence and/or sexual abuse.

A lot of them don't just feel embarrassed or shamed, they feel like they're being downgraded. It's hard to tell [someone else] when someone's degraded their body ... sometimes people turn on you.

then eventually you gotta come out of it and go and see someone ... [no one can help until then] ... you gotta want the help to get the help.

Older women living in remote communities discussed shame at length. Shame was again mentioned as the explanation for why some young women living in remote communities were reluctant to talk about or take action related to their pregnancies, and consistently similar reasons for it were outlined.

The older women thought that shame was felt because it was the woman's first pregnancy and they were very young.

[With the] first one... when they get pregnant they don't tell anybody, then they go to the clinic, they give them tablets, that's when the mother find out.

They thought that shame was often experienced when the young women had to discuss their bodies.

They never talk about it... they wouldn't know what it [period] meant... it's a hush hush thing.

They said that shame was also felt by the young women because the father of the baby was the 'wrong skin'.

They keep it secret to themselves. Sometimes mother gets angry because she finds out ... that girl might have baby for another wrong skin.

and mother care about that, not to have a pregnancy [with the wrong person].

In addition, the older women living in remote communities said that the woman would feel shame if she was expected to discuss the pregnancy with the wrong person. As one woman explained, in her community, due to 'customary law' and skin relations, the pregnant woman could only discuss her pregnancy with some relatives and not others.

For example:

*if Napaltjarrayi been having sex with a man, they might go and see Napangati
or Nampitjunpa.*

The older women thought that fear of family retribution was also a reason why some women felt shame.

grandmother or family might get angry ... fight.

*Because family might say, 'Ooh, you been with a man all the time. You been
stopping with a man all the time.' They might start telling off that young lady ...
and somebody might hit her. Somebody might pick a fight with her ... cause problems.*

They also said that if the father of the child was violent towards the pregnant woman and/or drank too much alcohol, then the woman would feel shame.

*man might be really bad ... flogging her all the time, drunk ... maybe miscarriage...
that happens all the time.*

Most older women living in remote communities said that, in relation to shame and the second pregnancy, the young women were less likely to feel shame due to their age when they became pregnant but would still feel shame if the father was a different man to the father of the first baby; the wrong skin; violent; or frequently drunk.

Some of the older women suggested ways to help a young woman to seek assistance with her pregnancy if she was feeling shame. They included encouraging her sister or 'right' cousin to talk with her; ensuring that traditional grandmothers and a number of female Aboriginal Health Workers were at the health service; and encouraging health service staff to be more aware of cultural practices.

In summary, for the young women living in remote communities, like some of the young women in Alice Springs, feeling shame was an explanation for not telling anyone about the pregnancy, not seeking assistance or help from family members and for not attending a health service early in the pregnancy. Generally their descriptions of and reasons for feeling shame were similar to those given by the young women in Alice Springs; for example, feeling embarrassed at physical changes to their body, being considered too young to be sexually active and fearing the anger or violence of the fathers or relatives. However, there were some significant differences between the two groups of young women. The young women living in remote communities seemed to be more influenced by the more predominant role played by traditional cultural law; for example, they said that they felt shame if the father was from the wrong skin group, or if the father was already married and if they were asked about the pregnancy by people from the wrong skin group. The dimensions of shame that were outlined by the older women living in remote communities were more detailed than those offered by the older women living in town and remarkably similar to those discussed by the young women living in remote communities and in Alice Springs.

3.3 Carers

Overall most young women living in Alice Springs thought that partners or husbands should be the main people to look after the pregnant woman, even though some husbands were unreliable. After husbands, mothers should provide support and care, although some mothers were also too unreliable or too tired from looking after other children. They said that relatives such as sisters or female cousins should also assist the pregnant woman. No woman suggested that her grandmother should be the primary caregiver during the pregnancy.

I see most grandmothers, growing up their children's kids. Cos their children's too busy doing other things, so grandmothers taken over. But it's hard on them too, you know, because some grandmothers are really chronic ill, some of them got heart conditions, they can't lift babies up.

In relation to who did care for them when they were recently pregnant, seven women said that their husbands or partners were the main carers, three were mainly looked after by their mothers, one by her nanna and one had to care for herself with some help from her young children.

Most of the young women living in Alice Springs said that most husbands or partners had looked after them very well.

He was a great support to me and he would be doing things around the house where I wouldn't have to be on my feet for too long. He'd be cooking, he'd be cleaning, I felt real spoilt then. He made sure that I was eating healthy and no stress, so, yeah, just sort of, you know, sheltered me away from that sort of stuff, which was really good... like he had his family telling him what he should be doing as a father.

my husband looked after me... very supportive.

Unfortunately a few women were very disappointed and distressed by their husband or partner's lack of care and behaviour during the pregnancy.

it's hard... I guess cos [my partner] kept drinking and going out. So I was left to look after myself, sort of thing.

Generally young women living in remote communities said that the grandmothers should look after the pregnant woman, with some adding 'traditional grandmothers', 'elders and old ladies':

grandmother, aunty look after girl too.

Grandmothers, aunties, or other female relatives should also accompany the young pregnant woman to the health service. Mothers and sisters would also care for the women.

The young women expressed concern about some pregnant women who have to look after themselves:

stay home, keep feeding, don't run around, don't jump around.

For some this was just self-care but for others it was not a choice and had become necessary because the mother did not want to care for her daughter or had left the community, and/or the family was not functioning well enough to look after the young woman. As one explained:

*some mothers they... say you're going to be a woman now... look after yourself...
and it's really hard with young girls, really sad.*

A few young women living in three remote communities mentioned the role of the partner in caring for the pregnant woman. For example, the partner could:

sit with you... like family.

If you feeling sick you tell him so he can go and get the nurse.

The older women living in Alice Springs provided a very different answer to the question of who should care for the pregnant woman than the young women living in Alice Springs. Most older women indicated that they thought the grandmother, aunty or mother should care for her and provide her with information about what to expect.

*The grandmother... the young person having the baby, she should ask her
grandmother, mother, aunty to tell her story [about] what happens ... about your
showing... your water breaks...*

*Mainly the grandmothers ... or some sort of aunty that could cope with it
... in good spirit that could help her... you gotta be on standby ... show them what
to do.*

Mother if the mother's there.

*Mother but she has had a lot of children and is very tired so not sure she can look
after the pregnant daughter.*

Interestingly, when asked specifically if the partner or husband should care for the pregnant woman, a number of the older women tended to agree with the young women from Alice Springs that there was a role for the male partner. This was because he had been an active partner in creating the baby, he needed to take responsibility for his creation; women and men should share responsibilities and it was unfair to expect women to do all the work.

It's not just up to the woman to do everything.

Unlike the young women from Alice Springs, however, most of whom indicated that their partners had been very supportive, the older women were far more pessimistic about the likelihood of the partners taking up their responsibilities.

just push the pram on pay day...

The one who made her pregnant but he ain't going to stick around.

He should be taking responsibility for what he cooked up but some of them don't ... they only want the women to go home ... only for the money ... poor going to suffer again.

[the men] use them and abuse them.

Some of the older women living in Alice Springs thought that one remedy for this situation was for health and related services to provide assistance, information and counselling to men to support them to change their behaviour and become more responsible for and caring of their partners and their children.

men's health mob got to give information to those men so they know about looking after her.

They need a man's counsellor type of thing... because they need someone to say how they going to... cope... what I'm going to do, how I'm going to help her.

The older women living in remote communities felt strongly about the primary role of grandmothers, and then the secondary role of aunts, sisters or 'cross' cousins in caring for the pregnant woman. Some referred to the importance of the grandmothers and traditional grandmothers to 'talk story' of being pregnant. Although some added a caring role for mothers, another group mentioned that some young women 'live with his parents' because her family will not look after her and that:

sometimes she is looking after herself.

Only one older woman living in a remote community said that the father of the baby should look after the woman; however, one traditional grandmother did say that the young ones like the father to look after them.

In summary, the views of young women living in remote communities differed from the young women living in Alice Springs in two striking ways: the role of the father of the baby and the role of grandmothers. The latter expected and wanted the primary carer to be their male partner and none of them suggested a role for grandmothers. By contrast, a role for the father of the baby was only suggested by a few young women in remote communities, whereas most of them named the grandmother as the primary carer. Both groups of young women nominated mothers as carers in some cases, along with other female relatives. Like the young women living in remote communities, the older women living in remote communities and the older women in

Alice Springs said that the grandmother was the primary carer for the young pregnant woman and then some female relatives. They also indicated that they were aware of some young women in both communities who wanted their male partners to care for them.

3.4 Safety

All the women were asked a general open question about what a pregnant woman needs and almost all of them talked about safety.

For the young women living in Alice Springs, safety generally referred to safety from violence, but also encompassed security within the family, family assistance and financial security.

I think she, like, needs to know that she's safe.

Violence

In the first instance being safe related to physical safety and freedom from violence. Although only two young women living in Alice Springs specifically discussed the trauma they experienced during their pregnancy as a result of an abusive and violent partner, another referred to the places where she felt safe whilst she was pregnant, perhaps implying a fear of violence, and three others talked about five women they knew who were victims of their partners' violence.

For the two who were victims of violence, the physical beatings commenced very early in the pregnancy, within the first twelve weeks, before they had visited any service, and took the form of kicks and punches to the women's stomachs. One of the women was hospitalised and miscarried, while the other woman suffered physical attacks throughout the pregnancy, as well as after the baby was born. She thought that the violence was caused by:

Grog, guilt. Messing around with other women, then coming home to me and taking it out on me. And, like, he would go round and give me STDs while I was pregnant, so that I knew he wasn't right for me.

[When he was drunk] That's when the vicious violence used to come and he'd be scary.

Her family was aware of her partner's violent behaviour and advised her to leave him for her own safety and that of the unborn baby:

When I used to get a hiding and that, and Mum used to see me with a black eye, and she would just sit there and growl at me and stuff. [She would say] 'Could you leave him, you know, find someone decent, I told you before not to go with him.'

Telling his relatives about his violent behaviour was of no assistance because:

his family knew about it, and, like, nothing come around. Like, they didn't tell him to stop... they may have told him, they may not have. But, I used to get the

beatings all the time. So really, I don't reckon he listened to his family.

In the community when you get married up and basically, husband flogging their wife, no one would stick up for you. Cos they think that's their business.

However, she managed to find some help in the form of a restraining order, assistance from a counselling service and good friends who provided emotional support. The restraining order was only of limited value, as 'he knew where I was'; however, the counselling and friends enabled her to feel strong and confident enough to leave him. The woman decided to:

forget about him and, you know, don't put up with that shit, you don't need that shit no more, yeah. I was thinking about the baby more... meaning you're not going to hurt the baby, or hurt me anymore. Yeah.

When discussing violence against other women living in town camps, the women noted that abused women did not always seek help from a service because of the possible consequences.

I think she's scared that he might take off from her and leave her. Like they think that if they go somewhere, when they get back they're going to get in trouble. You know, like, 'Where have you been? What did you do?' All that sort of thing.

like you get some of them that will go away to a woman's shelter and some of them they will just stay with their partner and get bashed up, they won't even get the police sometimes. I think they're just too much in love with them, unless they have got too much children and can't handle them and need their partner's help.

Safety for some of the young women living in Alice Springs also consisted of other dimensions, such as family support. Family assistance to help care for her and/or her other children would be helpful, although sometimes it would also be 'humbug' and cause 'more problems'.

My partner... brought his little brother and cousin [they had no money and they lived at our house]. We had to support them ... drove me nuts... we had to feed and support them... I ended up sending them back because I couldn't handle them.

Feeling safe also incorporated a sense of financial security. Over half of the young women living in Alice Springs mentioned the importance of adequate financial support during their pregnancy. Some had planned ahead and saved money or had partners with regular employment and consequently had felt financially secure, while two others were vulnerable financially due to violent partners. Another mentioned that she felt very anxious due to her partner's unemployment.

I reckon that you need to know that, I don't know, that you're going to have money and you're going to have, cos like I got ... my power got cut off, my phone got cut

off and cos [boyfriend] didn't pay any bills, and it went to shit. Yeah, I just, like, wish I was, like, felt more safer, I guess.

During the discussion about what pregnant women need, five young women living in Alice Springs also mentioned exercise. They said that walking had helped them feel more comfortable and one emphasised that it helped her cope with the demands of her home life. Three also said that they swam during the pregnancy, with one noting that swimming was the best thing to do because she didn't feel fat when she floated.

The young women living in remote communities also mentioned the need to feel safe and to be free from violence. Some of them said that young pregnant women need to keep safe by staying at home and not going out with other young men.

If they are pregnant they can't go out with other fellas.

Young girls, when they get pregnant, they do walk around at night time. Some do get bashed up.

They identified safe places that the women could go to when they needed to escape from a violent person; for example:

they come to the women's centre... or they might go to their family's home and spend the night.

Some said that some women will not want other people to know that they had to go to their family to escape a violent partner.

The older women living in Alice Springs also thought that women needed to be safe during their pregnancy, with someone to talk to her and a home environment that was quiet and stress free.

somebody there to talk to them all the time.

somebody to comfort her.

stay in a place without stress... calm people [because] all sorts of things can happen.

Counselling for girls where home isn't very happy... send girls to [mental health service].

The older women living in Alice Springs said that violence towards pregnant women was an important issue that must be addressed. They thought that there were particular challenges for families and services that tried to respond to violence against women; for example, the fragility of the young women's emotions, that some women tended to return to violent partners, 'they go back to the same situation', and the complications associated with the misuse of:

drugs and alcohol ... any kind, anything they can get their hands on.

A few older women said that services could do little to assist these women until they decided to seek help but, when they did, health professionals should be highly sensitive to the woman's vulnerability, be very attentive, responsive and caring and also try to keep the women safe by giving them information about where they can go and the help they can receive.

The older women discussed, and were divided over, the issues of transport and outreach services, with some women believing that the services should not chase after people who don't want help and others believing that they can at least provide:

buses, go and pick them up.

The older women living in remote communities said that the key needs required by pregnant women were safety, freedom from violence and exercise.

no good laying in bed... [they should] walk around everywhere. Sit in one place get backache.

Violence towards the pregnant woman was of great concern to the older women. They said that violence towards the pregnant woman is often associated with 'too much alcohol' and can cause a 'miscarriage'. The 'mother and grandmother' must care for her:

she goes to stay with her parents for a couple of months... [or a] week.

The older women living in remote communities said that although there can be a role for helpful health service staff, sometimes the health service staff were not sufficiently sensitive or supportive.

In summary, when discussing what a young pregnant woman needed, all the women, regardless of their age or where they lived, talked about the need to feel safe and to be free from violence. All the women mentioned that pregnant women needed strategies to keep safe, including family support and safe houses. Some young women living in remote communities talked about the assistance that police could provide; however, none of the other groups of women mentioned this. Some of the young and older women living in Alice Springs also referred to the positive helpful role of a health service or other services. Although the older women living in remote communities also thought that a health service could be helpful, they were less confident that the staff would provide the sensitive, supportive care that the pregnant woman required. The young women living in Alice Springs also discussed other dimensions of safety, such as financial security. Finally, some of the older women living in remote communities and the young women living in Alice Springs thought that exercise was something that a young pregnant woman needed.

3.5 Nutrition

When asked what a pregnant woman should eat, the young women living in Alice Springs suggested 'lots of' green leafy vegetables, fruit, fish, meat, cheese, milk, pasta, rice, salads and sandwiches, as well as supplements such as iron and folic acid tablets, although, as one woman said:

I couldn't remember to take them every day. I took them whenever I remembered to.

The young women also knew which foods and substances to avoid during pregnancy, such as 'grog', 'gunja', smoking cigarettes, lollies, junk food and takeaways. Many listed the foods their family told them to avoid; for example:

with bush law a lot of, like, the old people say for pregnant women not to eat goannas and perentes cos they will have, like, a hard birth or something.

Well being Aboriginal couldn't eat no bush foods, not good for you when you're pregnant... like, you couldn't have bush meat like kangaroo and goanna and that sort of stuff. My mum told me I'm not allowed to eat it while I'm pregnant, something might happen. I don't know why.

Most of the young women living in Alice Springs said that during their pregnancies they had eaten healthy diets based on foods that they knew were nutritious and assisted the baby's growth and their wellbeing. They noted that they had cravings for various kinds of food and also happily listed those foods that they knew they should have avoided.

I needed watermelon! Beautiful, watermelon and mangoes, watermelon and grapes. Yum. Fish. You know, fish is lovely. I ate a lot of fruit... but I ate a lot of pasta and ice-cream, yum. I was addicted to 'Wendy's' hot dogs, like, I had one of them nearly every day. But yeah, I think you just got to eat what you want, like, I think that's what makes you happy and you're never happy if you don't get what you want, you know.

I'd just be craving for takeaway but ... I always, yeah, had my vegetables, had my meat. I just had cravings for fruit and vegetables. I've never been one for health food [just Maccas]. Later on... Snickers bars and sausage rolls.

Young women living in remote communities also talked about the kinds of foods that were good for them to eat when they were pregnant, including bush tucker and Western foods. They seemed to be well informed about the foods that should be avoided and enjoyed, listing their favourites and the ones they did eat, even though they knew they shouldn't have. In general, they listed a range of vegetables, fruits and meats, with some adding soup and sandwiches. Bush tucker was always listed, as well; for example,

good food for the stomach... always eat bush tucker... bush turkey, echidna, malu², bush banana, goanna ... fruit, vegetables, pumpkin, potatoes, chicken, carrot.

² kangaroo

Foods and substances that should be avoided during pregnancy were specifically identified by most young women.

cakes... sweets like cakes... coca cola.

The women's awareness of good nutrition during pregnancy seemed, in some instances, to be associated with health information programs and health information provision by health providers. Many of the women referred to posters or pictures they had seen of healthy foods, including a poster at the community 'clinic', the 'pyramid' which illustrated healthy and unhealthy foods. Some remembered being taught at 'school' in the community, boarding school and college.

Some learnt at college, they show a video.

Videos were enjoyed partly because they included Aboriginal and non-Aboriginal people in them. It was noticeable that only one woman said that she did not know what foods to avoid during pregnancy.

Most older women living in Alice Springs were also aware of the range of nutritious foods that pregnant women should eat, citing fresh fruit and vegetables and lean meat, as well as what they should avoid, such as takeaway and perentes.

Some say don't eat perentes because [it's] some of them mob's dreaming.

Takeaway spoil everyone's life... we didn't have these fast foods, only Christmas time but today everyday.

No good, no wonder everyone [has] diabetes with them fast foods.

The older women living in remote communities listed the healthy foods that pregnant woman should eat, including fruit and vegetables, milk, bush tucker, especially lean meat like kangaroo, and emu, turkey, goanna and witchetty grubs. Unfortunately, they said, some of the 'girls' eat 'bad food', such as 'junk food, sweet, the worst' and that some girls 'they buy chips'.

These women particularly mentioned the importance of the supply of good nutritious food to the community.

Get the community to make sure the store is providing them with all that good stuff.

In summary, all the women were aware of the kinds of nutritious food that women should eat whilst pregnant and the foods to avoid. Not surprisingly, perhaps, the younger women, especially the young women from Alice Springs, provided a more detailed list. Some of the young women from Alice Springs and remote communities remembered specific posters and videos about healthy foods. Some young women from Alice Springs were a little sketchy about the best food to eat but had indicated earlier in the discussion that they had other more pressing issues to think about during their pregnancy, such as violence, financial worries or hiding the pregnancy from their families. Nonetheless, they were still aware of the basic foods required

for a healthy pregnancy. Unlike their counterparts in Alice Springs, the young women living in remote communities said that bush tucker was good for them while they were pregnant, as did the older women from remote settings. Only the older women living in remote communities made reference to the importance of food supply or food security issues.

3.6 Grog, drugs and smoking

There was no doubt that the young women living in Alice Springs knew that the use of various drugs and alcohol should be avoided during pregnancy; however, three young women said that they were 'taking drugs' during their first pregnancy. They were 'smoking dope', with two continuing throughout the pregnancy and the other reducing her use of marijuana 'at six months'. Two other women said that although they 'used to smoke gunja' they stopped when they 'found out' they were pregnant. Another three said that they reduced their consumption of alcohol.

I think I only drank once ... yeah, but that was it, yeah, no more, never got drunk or anything cos just knew that the intake of, I just remembered those pictures of the woman smoking or the woman drinking and then they showed the baby inside the tummy and they've got a cigarette or they've got a can, those posters always came to mind.

Most of these young women seemed to be aware of the negative effects of smoking during pregnancy and said that before they were pregnant they smoked cigarettes but that once they discovered they were pregnant they stopped smoking, tried to stop or reduced the number of cigarettes they smoked. All who commented on this indicated that it was extremely difficult to stop smoking entirely and that they struggled to reduce the number of cigarettes they smoked in a day.

I smoke cigarettes, and as much as [friends and clinic staff] tried to persuade me to quit, I wasn't having none of it.

So I smoked through my pregnancy. But, I really, really cut down because I started getting sick if I had more than three a day, so it was good.

when I was pregnant I probably smoked two cigarettes a day, because if I didn't have a cigarette I was really stressed.

I smoked cigarettes [even family said] 'stop smoking'...I used to have to hide from my pop to have a smoke. [I tried to give up] by trying to cut down, smoke less, tried to give up altogether [but it] didn't work.

Young women living in remote communities were also aware of the negative effects of smoking, drinking alcohol and taking other drugs during pregnancy and added that some young pregnant women continued to smoke and drink despite being pregnant.

smoke marijuana, drinking no good.

A few young women suggested that families 'could talk to them' and try to help but that:

it's hard to tell someone to stop.

Importantly in one community the young women thought that chewing tobacco and bush tobacco was not harmful during the pregnancy and that many young women continued to chew both throughout their pregnancy.

Chewing tobacco ok here... bush Pituri is ok, that's alright.

Minkupa ok here and bush Pituri... Minkupa³ little bit strong... bush one's alright.

The young women living in remote communities frequently differentiated themselves from young women staying in Alice Springs, noting that the latter continued with unhealthy habits and behaviours during their pregnancies.

Sometimes they smoking... at Alice Springs these young girls drink, smoke, smoking gunja and taking meth... so that baby sick or heart problem.

The older women living in Alice Springs expressed deep concern about young women using drugs, drinking and smoking during their pregnancies.

Substance abuse and pregnancy don't mix... people shouldn't drink, people shouldn't smoke... tell them it is no good for the baby... show them pictures of stuff that really hit home... hurt baby... gangrene on fingers should be on cigarette packet.

The older women living in remote communities echoed this concern as they commented about the negative effects of smoking, alcohol and other forms of substance abuse.

when they're pregnant they drink and smoke gunja and sniffing ... they're ruining their lives and baby ...

Baby may drink and smoke inside.

³ Minkupa is the term used for log cabin tobacco in this community. A member of the research team present at the consultation meeting, a midwife, informed the women that it was not safe and discussed this with them.

The older women explained the dangers to the young women living in remote communities and thought that:

people who live in town probably they don't listen ... but here most young girls get pregnant, they listen ... [we] talk in language.

Some listen... some don't.

In addition the older women said that it was important to address the behaviour of the men in relation to substance abuse.

They talk to men not to smoke gunja and they listen ... night patrol men, families first, then night patrol.

In summary, all the women seemed to be well informed about the dangers of substance abuse and most of the young women living in Alice Springs specifically said that they had reduced their intake of cigarettes, alcohol and other drugs while they were pregnant. All the women seemed to concur that some young women, whether living in Alice Springs or remote settings, found modifying their actions difficult and that others were living in circumstances that reduced their capacity to solve their problems.

In terms of strategies to assist young pregnant women who had substance abuse problems, the older women living in remote communities believed that speaking to the young ones in their own language was effective and the young women said that they did listen but others did not and that families could assist in some cases. Some of the young women from Alice Springs and remote communities remembered specific posters about the dangers of smoking and drinking during pregnancy. Only the older women living in remote communities mentioned the men's behaviour, how it impacts negatively on the pregnant women and the need to educate or work with some of the men to address their substance abuse issues.

3.7 Kind of health service

For young women living in Alice Springs the kind of health service that they attended for their first pregnancy was very significant. Of the fifteen young women, seven attended the antenatal clinic at the Alice Springs Hospital and eight chose to have their antenatal care for their first pregnancy at Congress Alukura.

The young women had clearly thought about which health service they wanted to attend and why. The two main services available in Alice Springs, Congress Alukura and the Alice Springs Hospital⁴, were selected for very different reasons, with the exception of confidentiality and privacy.

For those who selected the Alice Springs Hospital, perceived safety was important; as one woman explained, she felt 'safer' at the hospital for her first pregnancy but then attended Congress Alukura for her subsequent pregnancies because 'it was more comfortable'. Another mentioned that her mother thought that the hospital was safer for a first pregnancy and that also influenced her choice.

⁴ General practitioners also provide antenatal care in Alice Springs, however only one young woman attended a general practice and only at an advanced stage of her pregnancy.

The fact that their partners could share the experience explained why two women chose the hospital for their antenatal care.

I decided to go to the Alice Springs Hospital only because my partner wanted to be involved in the checkup and all that and cos Alukura only allows women so I couldn't take him down there.

that's why I chose to go to the hospital so he was able to come.

Referral by a general practitioner in private practice was also a reason for attending the hospital.

Confidentiality was a selection factor for most women.

I didn't want to go to Alukura, because I didn't want them knowing I had the STD... they'll look in my file, and it's confidentiality, but still it's a small town. You know, like, they need to tell the workers, you know, you need to keep it private because it is their life we're talking about, not something that you mess around with.

the Health Workers there, you know, I know 'em all, and so I didn't want them to know before my family. So I chose not to go there.

Interestingly, privacy was the reason why three other women selected Congress Alukura rather than the Alice Springs Hospital.

Alukura, at least I would have my privacy there, and everyone wouldn't know.

Being able to select their own midwife and have her care for them during the whole pregnancy was an important factor for most women.

I liked the idea with Alukura that I could pick a [midwife] I liked and stay with her all the way through. At the hospital you get a different one every time you go.

A dislike of the antenatal classes at the hospital was one reason for choosing Congress Alukura.

I didn't want to go and do all that stuff in front of other people... my husband wouldn't do it anyway, he'd go, 'Oh, fuck off, I'm not going there in front of all them white fellas, doing all that kind of stuff'. But I said, too, you know, I'll do what I have to do when the time comes, I don't need to learn how to, you know, do all that sort of stuff.

Lack of awareness of other services was another reason for attending Congress Alukura, as was following a sister's advice and, again, referral from a 'doctor at the hospital'. Congress Alukura's distance from town was a positive factor.

if I went to the hospital and had my checkups there I would have seen my family, and, like, they drink, and I didn't really like the grog smell, you know. So yeah, so I just come straight [to Alukura] cos no drunks hang around, see.

All of the young women living in remote communities indicated that they attended the one local community 'clinic' for their pregnancies [if they were living there at the time]. A few said that they had visited Congress Alukura for other 'checkups' when they went to town and some had attended the Alice Springs Hospital.

Some of the older women living in Alice Springs noted that some of the young women there chose the Alice Springs Hospital for their antenatal care so that their partners could be involved and that some selected Congress Alukura.

None of the older women living in remote communities commented on the young women's selection of services, possibly because there was no choice of service in the community.

In summary, young women living in Alice Springs were the only group of young women to have a choice of antenatal services and the only group that said that the capacity to choose a service was very important to them. Some selected the Alice Springs Hospital because it was perceived to be safer, confidential, private, because their partner could be involved or because they were referred there. Others chose Congress Alukura because they could select their own midwife, it was private, they disliked the antenatal classes at the hospital and they did not know where else to go. All of the young women living in remote communities had no choice of service and made no comment about selecting services, even when they had to attend services in Alice Springs during the pregnancy, a striking difference between them and the young women living in Alice Springs.

3.8 Partner and/or father of the baby involved in antenatal care

For the young women living in Alice Springs the capacity to choose whether partners could accompany them to their antenatal appointments emerged as one of the most important issues. As mentioned above, when selecting the health service for their antenatal care, a number of women spoke about their preference for the Alice Springs Hospital because they wanted their partner to attend. Some young women who selected Congress Alukura for other reasons also said that they would have liked the opportunity to choose if their partner came with them.

And there's no choice here, you know. Come back to no choice of bringing your man.

Some young women also said that their partners had wanted to participate in the pregnancy by accompanying them to their antenatal visits.

He was angry, but he knows [Alukura] is a woman's place, so suppose he just got over it.

There was signs, 'No men allowed out here'. You know, I said to [my partner], 'You can take me out to Alukura', and he said, 'No, you go there yourself, no men allowed there', you know. He said that. Sometimes I can feel him wanting to come, you know.

He wanted to come [to Alukura], it was the first time I'd been here. I was glad that he came along, you know, for the support sort of thing. I would've wanted him to come in ...

I'm just thinking of a couple, there's a couple that would have preferred to have the partner and, yeah, it's like there is a half and half there.

Interestingly, for one young woman, although she adjusted to the 'no men rule', she felt that her partner was upset by the exclusion at the time and that it became more of an issue as time passed.

And now, now I understand. No wonder I couldn't have him come ... cos I've been programed to think when I have a baby it's me, myself and I, and [the father] is not involved, you know, in this process ... and this very thing affected my relationship with him... like I say, he kept track of stuff, you know, with the pregnancy... because of course they're happy to be fathers and you tell them that 'You're a Dad now' and then, yeah, not to be involved is just sad, I think anyway.

These young women adopted strategies to keep their partners informed and involved in the pregnancy, such as relating all that the midwife had said, sharing the information resources with them, asking them to come to the ultrasound scan appointment with them and, in one case, relaying their partner's questions to the midwife.

As long as I told him what happened... he was involved all the way. I never kept him out of anything except, like, when I had visits [to Alukura], I told him everything that happened afterwards, I never left him out of anything. He asked me all the time, 'What happened? How big is it? What does it look like?'

I used to just come back and tell him what, you know, what's said and what happened, yeah, that was alright.

Most of the young women living in Alice Springs who chose the Alice Springs Hospital spoke about how important it was to share the experience with their partner.

He just wanted to know everything about, like, what's going on with the mother ... and what to look for, what to do, what not to do and all that sort of stuff so ...

he was asking a lot of questions every time we went into the Midwife Clinic. Yeah, there was only once where he was unable to come because he had to work that day, but he, he came every time.

I was glad that he had come because he was supportive like that he was supportive of me and as a partner, like, I wanted him to be involved ... to give him an idea of what to expect and just to be involved in seeing our baby grow, hearing our baby's heart beat and all that.

The older women living in town expressed strong opinions about the involvement of male partners or husbands in the pregnancy and antenatal care. Pregnancy and childbirth have, in all traditional cultures in the Central Australian region, been considered matters for women only [Carter *et al.* 1987]. Consequently, any discussion of the participation of men during this time inevitably leads to a discussion about the changing nature of culture and cultural practices and the influence of Western culture and medicine.

All of the older women living in town discussed the changing nature of Aboriginal culture. They spoke about this without being asked questions related to it and indicated a high level of concern about some aspects of the negative changes; for example, a lack of interest by some young people in traditional law and knowledge and the fact that young women were choosing to give birth at the Alice Springs Hospital so that their partners could be nearby. They also identified some actions that people in communities and town, as well as health services, needed to take to address some of the consequences of recent changes; for example, providing increased support and education to men.

In relation to passing on traditional knowledges, there was concern that young women were not listening to the good advice that their grandmothers, mothers or aunties were conveying to them or, worse, were not listening at all.

our grandparents taught us in the sand, in the sand they draw it. These young people don't sit down long enough... don't listen.

They been to school, they think they are above their grandparents.

but they don't want to know... they don't want to listen.

However, during this discussion other older women living in Alice Springs indicated that some young women were interested in the stories the older ladies had to tell and that the older women should assist those who do want to learn. It was suggested that the young women could:

come camp ... with the older ladies and just listen.

We should come in and teach them young girls.

I know all about it... if anybody want the story I will tell it...

I know what happen in older days... my grandmother told me and I can tell you stories from the old people what old people say.

These views about the importance of maintaining traditional knowledges and practices were held at the same time as some of the older women accepted that some young women did not choose to live in accordance with them. For example, they knew that some young women did not attend Congress Alukura, which provides antenatal care in a way that is more in tune with traditional practices, but rather went to the antenatal clinic at the Alice Springs Hospital. As one woman explained, this acceptance was reluctant but pragmatic as:

people are very sick today... when a sick mum have a sick baby, the grandmother get very scared [that's why] they want to go over there [at hospital].

Although they knew that some young women do attend Congress Alukura, they were also aware that some of these young women want their partners to be able to attend their antenatal sessions. As one older women lamented:

Old ladies don't want men coming to Alukura but young ladies are different... times are changing.

In summary, the capacity to choose to involve their partner in their antenatal care was very important to most young women living in Alice Springs. Their reasons for wanting their partners to participate included sharing the excitement and wonder of the pregnancy; sharing the information about the developing baby and the stages of the pregnancy; providing support; and preparing them for fatherhood. As mentioned above, some older women living in Alice Springs knew that some young women wanted their partners to attend the hospital services with them; however, most of the younger women did not seem to share their sense of sadness at the changing culture. It is impossible to compare the views between the two groups of young women, as the young women living in remote communities did not discuss their opinions about the participation of their partner in the antenatal care provided by the local community health service, nor did the older women living in remote communities.

3.9 Time of first antenatal visit to a health service

The young women living in Alice Springs confirmed their pregnancy by visiting a health service; however, the timeframe in which they did so varied depending on their situations. Of the women who knew they were pregnant with their first baby, five visited a health service for a pregnancy test between four to eight weeks, another five visited within eight to twelve weeks, and two presented at a health service at six months.

The two very young women who did not visit a health service until they were six months pregnant had both tried to hide the pregnancy from their family and some friends as they were too frightened to tell their parents and to go to the clinic.

First pregnancy I was just too frightened to go to the clinic ... I was going to this place ... to buy like more alcohol and drugs... I told that lady at the front counter that I need to go to the clinic.

So she took me to the clinic ... and they said I was six months pregnant and then my heart was going ten to one, like, and I was frightened to tell my Dad.

For the young women living in Alice Springs who had subsequent pregnancies, all indicated that they knew they were pregnant early on and that they attended a health service between four and seven weeks.

For the young women living in remote communities, the time of the first visit to the community health service varied due to a range of factors, the most frequent being 'cause shame'. This incorporated many of the dimensions of shame that are discussed above, including waiting until a visiting nurse arrived; waiting for the right Aboriginal Health Worker to come; waiting until they were ready for others to know; not caring about themselves or the baby; and thinking that it was too late for an abortion. As one woman explained:

they don't care about going to the clinic.

some think it's too late, I'm pregnant now, having a baby, some think that and just stay home.

However, some of the young women also thought that women will go to the health service because they do not feel shame; 'when the doctors come'; when they are 'getting a little bit sick'; and when it is time for a 'women's checkup'.

The young women living in remote communities said that they went to the 'clinic' for the first time with their mother, sister or aunty, sometimes with the Aboriginal Health Worker and a few said that they went alone to the clinic and that it was 'alright'. It was not clear if the young women attended the service in the first trimester.

The older women living in remote communities said that the timing of the first visit varied depending on if it was a first or second pregnancy/ (they tend to go earlier with the second pregnancy); if the woman was very young, she may not go until she is three or four months pregnant as 'they too shame to go before'; if a relative saw that she was pregnant and took her in the first two months; and if they are older, they know they are pregnant and will go at two, three or four months. They said that some do not go until they are four or five months pregnant or even later.

The older women thought that the main reason for delaying the first visit was 'shame' and that the young women would often present at the health service saying that they were 'sick' and would wait for the 'nurse' to think of giving them a pregnancy test.

The older women living in Alice Springs did not comment on this matter.

In summary, most of the young women living in Alice Springs attended a health service within the first trimester of their first pregnancy but it was unclear if the young women living in remote communities did so, although some said that they did go to the clinic. Some of the older women living in remote communities thought that some of the young women did go to the clinic within the first trimester of their first pregnancy because they were taken by family members. Some of the young women living in Alice Springs and some young women living in remote communities

did not attend until as late as four to six months due to feelings of shame. The older women living in remote communities also made this observation. All the young women in Alice Springs and some of the young women in remote communities said that they attended a service earlier with their second and subsequent pregnancies. The older women living in remote communities concurred.

3.10 Frequency of antenatal visits to a health service

All young women in Alice Springs thought that it was important for pregnant women to visit a health service when they first realised they were pregnant and to attend antenatal checkups. Most women said that they went to all the checkups even if they couldn't remember the exact number. As one explained, she 'went to checkups every time they told me to come back'. A number of women said that they thought it was particularly important to attend their checkups because they had various conditions that required monitoring, such as gestational diabetes, 'really bad fluid', anaemia or 'the baby might be sick'.

Once the young women living in remote communities had their first contact with the health service, returning for visits when the 'nurse' or Aboriginal Health Worker told them to seemed to have been a common experience, even though they did not always say how many times they attended. There were a variety of ways that the women were reminded about their visits, including letters and personal approaches, and both of these were very specific to the context in which they occurred. It was clear in one community that only trusted, well-known female Aboriginal Health Workers could successfully talk to the young women and encourage them to come to the health service. Other women in different communities indicated that this would not be appropriate for them. Similarly, only some women mentioned that a letter had reminded them of an appointment. Others particularly liked the 'clinic bus', that is, that transport was organised for them. As one explained:

them woman they'll pick up young ladies for checkup.

For some of these young women living in remote communities, the frequency of visits to the health service was in part related to how the women felt about the actual service and staff. [More detail about this is presented in the section 'Antenatal health providers' below.] Needless to say, this varied from one community to the next and over time. In one place the women said that they went to the 'clinic a lot' because:

we like to go to the clinic.

However, in another they quite clearly indicated that they disliked going to the health service but did attend for appointments because they knew that 'they have to go'. One woman said:

I only when... when I was... needed something.

The older women living in remote communities said that most young women went to the 'clinic' many times during their pregnancy to have checkups including blood pressure checks, checkups for diabetes, being weighed and monitoring the baby's heart beat. In some communities traditional grandmothers, grandmothers or other family members took them; the Aboriginal Health Worker would come to fetch them; the nurse would remind the women to come; or the nurse would approach and speak to the 'girls', as she was trusted by them.

The older women living in Alice Springs did not comment on this topic.

In summary, there were noticeable variations between and amongst the young women in relation to the timing of their first visit and the frequency of their attendance for antenatal appointments, regardless of where they lived. As noted above, most young women living in Alice Springs attended early and frequently, with some noticeable exceptions. For young women living in remote communities, it seems that attendance and frequency of visits varies from community to community depending on a range of factors, such as shame and staffing at the health service.

3.11 Waiting

Very little is known about Aboriginal women's views on waiting times, so the consultation included questions about this topic [Hancock 2006].

Most young women living in Alice Springs said that on most occasions they did not have to wait long at Congress Alukura. Some exceptions to this were when a specialist clinic went on longer than expected or when there was an emergency of some kind. Clearly the women understood these situations and although discomfited by the wait they were not overly upset by it. However, they did suggest that staff could have advised them to leave and come another day. As one explained:

they had emergency with one woman, a pregnant lady, they should have just cancelled the other appointments and just said, 'Look, you know, we're pretty busy with this sick lady, we need to concentrate on her for the time being. Can we rebook your appointment?' It would have been easier.

Another said that she found waiting for tests quite frustrating.

Sometimes long wait, sometimes not. Sometimes I had other things to do, and sometimes it wouldn't matter. I don't like it when you have to do the diabetes test, I think it is. Drink that stuff and you sit there for, like, two hours and you're hungry and you're getting tired from sitting there, that's the one I don't like.

Of the women who attended the antenatal clinic at the Alice Springs Hospital, all said that they did not have to wait long.

that was surprising, like when you had an appointment they'd put you in and then it might be, it'd be less than five minutes that you would be waiting, it would be just, like, sort of in between clients with them, and by that time, like, you'd go and do your tests, like urine test and that sort of thing, and then you would come back out and then they are ready to see you.

Young women living in remote communities, when talking about waiting at the health service, referred to the importance of privacy, a women's only space and not having to wait too long. For example:

they take you to the women's side ... feel better ... cos they ask you some questions.

Conversely, at one community, the other comments related to the absence of a women's only waiting room at the community 'clinic' and the problems caused by this because people would see them and 'tell everyone'.

Some said that:

Some girls, they don't want to wait long and they just go home.

Older women living in Alice Springs said that young pregnant women's impressions of the service and the way they are treated are very significant. They shouldn't have to wait 'too long' and the reception staff should welcome them and make them feel comfortable.

that front lady has to be real courteous... make them feel welcome.

They expressed the view that this was particularly important for those women who may feel shame or some anxiety about visiting a health service.

If it's a girl that just been raped or something like that ... a worker should know by the way [she] walks in the room ... take her into a room by herself ... in waiting room, everyone staring at you [so you would] get up and leave.

Most older women living in remote communities said that generally it is a very good idea to have a women's entrance and a separate waiting area.

so women can go and have a privacy to talk to the nurses, health workers ... instead of men in next room, when they walk by and listen. That's why it's better to have men and women separate.

Some, however, said that occasionally it is better for the newly pregnant woman to use the same waiting room as everyone else, otherwise people would gossip about why she was in a special area.

In summary, some young women and older women living in Alice Springs seemed to agree about the importance of being welcomed by the health service staff as they arrived, and most, including the young women living in remote areas, also indicated that it was better if young pregnant women did not have to wait very long. Most young and older women in remote communities referred to the desirability of a women's only entrance or waiting area, as did some of the young women from Alice Springs. The older women from Alice Springs did not mention this.

3.12 Antenatal health providers

The young women living in Alice Springs saw a variety of health professionals when they attended both the Alice Springs Hospital and Congress Alukura. At Congress Alukura and the Alice Springs Hospital most women were cared for during their pregnancy by an Aboriginal Health Worker, a midwife and a doctor, with a few only seeing a midwife and doctor. The only difference was that at Congress Alukura all staff were female.

In terms of what they thought was an important aspect of their care, all the women preferred female health professionals such as doctors, midwives and Aboriginal Health Workers if they had the choice.

At that time you're, like, very shy, you know, yeah, really important, it's bad, like it was bad enough getting some of these things done with the lady, let alone a bloke, yeah.

... like, a bloke can't really understand what it feels to have a baby growing inside you. It's a bit more comfortable, especially for ... like, for pap smear, my maternity and postnatal care and all that.

Male doctors could be accepted by some women if they were just providing care at the birth but this was accepted rather than a preference.

Although the women all preferred to see female health professionals, some had different preferences when it came to the kind of health professional they saw.

Being cared for by a female midwife was the preference expressed by most young women living in Alice Springs. It is significant that most women from Alice Springs wanted a midwife because of her knowledge and skills. In addition, two specifically preferred to receive care from a female midwife rather than a female Aboriginal Health Worker because they thought the midwife had more knowledge and experience; however they did not mind if the Aboriginal Health Worker attended the session as part of their training.

Most women also indicated strong preferences in relation to receiving antenatal care from Aboriginal women. Four women were adamant that they did want to be cared for by a female Aboriginal woman. For example, one said:

Yeah, like, I guess for us Aboriginal people we feel probably more comfortable with Aboriginal people, like, I think that would be the case.

However, another four women specifically said that they *did not* want their care provided by an Aboriginal woman because of privacy matters. As one explained:

cos they will probably go back and start talking about it and that, that's what a lot of these Aboriginal woman look at, like if they've got a family member as a Health Worker or something they're probably afraid that they will go back and tell

someone. Like, cos they might be pregnant to a man that's already married and then, like, go and tell that woman and have big arguments.

No. Doesn't sit with me, only because I know everybody and I'm related to half the town, Aboriginal way, you know. [They]... gossip.

That some young Aboriginal women would listen more to advice and information if it was provided by a white health professional rather than an Aboriginal person was noted by one woman.

Young women living in remote communities exhibited a strikingly consistent preference for female antenatal care providers when they went to the community's health service. They specifically mentioned the 'nurse' or 'sister' and the Aboriginal Health Worker. A few women said that it was 'ok' to see a male doctor but 'only if really sick'.

The profession of the antenatal care provider was relevant to some women, as they said that they preferred to see the nurse because:

She knows what to do...

Aboriginality was important, with most preferring to see an Aboriginal woman, usually the Aboriginal Health Worker. Again the reasons for this varied from community to community and were very context specific. In one community the women said that they would always go to see or speak to the Aboriginal Health Workers first and then the 'nurse'. It emerged that a strong trusting relationship existed between the young women participating in the discussions and the two female health workers, in part because both had been employed by the health service for over ten years. In another community the women spoke about being able to speak in 'language' to the Aboriginal Health Worker. As one young woman explained:

so you can tell them what's happening... and they'll tell the nurse.

For some young women in another community, being 'family members' was a reason to see the Aboriginal Health Worker.

However, it is equally important to note that some women did not wish to be attended to by a particular Aboriginal Health Worker for various reasons: because she had a specific kind of skin relationship to her and was therefore not able to speak with her about her pregnancy; she did not want her to know her private information; did not trust her to maintain confidentiality; did not like the way she treated her; or did not think she was as skilled as the nurse.

cos some of them ... they just learning.

How the women were treated by the health service staff was discussed by some women and was clearly very important to them. The comments about preferred and particular kinds of behaviour were made by women from one community and concerned both the Aboriginal and non-Aboriginal staff. They specified the kind of behaviour that they preferred from a non-Aboriginal female nurse in the health service. These included a preference for clear understandable explanations about pregnancy, ideally in their Aboriginal language; confidentiality; privacy; an understanding of culture as it relates to women's business; sensitivity to the particular needs

of a young woman; and understanding of her family context. In particular, one explained the importance of confidentiality and personal privacy. She said that health service staff should not make assumptions about the sharing of information between young women and their mothers, even when the mother accompanies the young woman to the 'clinic'. She explained:

sometimes all them sisters working at the clinic there sometimes they mention word 'pregnant' loud... they get shame.

If mother is there and if her sick pregnant daughter comes in, the nurse will say, come in here to this little room, and mother says, why, and the sister says she's pregnant... that's not right.

These young women living in one remote community also talked about the behaviour of some female nurses and Aboriginal Health Workers, specifically their teasing. The women disliked the teasing, perhaps because it directly referred to their pregnancy. They gave this example:

Some health workers, some Anangu ladies at the clinic, they get funny with the girls... they'll turn around and tease her... you going to be a young mother...

It was apparent from many of the discussions that many young women living in remote communities wanted health service staff who know a great deal about the people and families in their community, such as the kind of relationships young women have with their mothers, grandmothers and other family members. This was particularly important, some explained, because not all families are supportive or able to care for the young pregnant woman.

Older women living in Alice Springs said that young pregnant women should have a choice of health carer during their pregnancy. They believed that a female health professional should care for the pregnant woman and that she should also be able to choose to see Aboriginal Health Workers. Choice was important for a range of reasons, including:

a lot of Aboriginal people go to Congress [and they are] too scared to talk to the white doctor about their business.

them related.

Some of the older women living in Alice Springs said that outreach services provided by Aboriginal Health Workers were necessary because some pregnant women would not come into the service due to shame and/or violence.

the Aboriginal Health Worker should come to visit [the pregnant woman and ask] is she alright, is she sleeping ok, is she eating ok.

Some of the older women also emphasised that the health professional, whether an Aboriginal Health Worker, nurse or midwife, should establish a caring and trusting relationship with the pregnant woman, especially if they wanted her to return to the service. They thought that this

could be achieved by being friendly, offering the woman some support, not rushing in to ask a lot of questions, leaving time for the woman to raise any issues that she might want to talk about and even suggesting that you meet for 'a coffee' out of working hours.

When people meet you outside the workplace they open up more.

All the older women living in remote communities said that young women should see a female health service provider when they go to the clinic because they will not talk to a male nurse or health worker. Again pragmatic realities were accepted, if not preferred: it was 'alright' if only a male doctor was available.

With regard to the profession of the antenatal care provider, most older women thought that the young women prefer to see a female nurse, especially at their first visit and especially if the 'nurse' was respected and well liked. The older women also said that the health provider's capacity to respond to the particular needs of young pregnant women, such as their feelings of shame, was important and that they must understand how to 'talk' to the young women. For example, the midwife or nurse could ask:

do you want to talk about it to me? ... they may not want to talk ... might want to go away and talk in another area ... just give them that option ... don't just barge in and just ask them... the first thing the doctor will ask you is 'were you drunk?', 'do you drink alcohol?'... they won't come back.

You don't go straight away, 'When did you have your last period?' ... go the long way around and make the person feel comfortable... because they come from a different culture altogether... when I say comfortable ... just talk on that, like when you first meet a person. Don't go straight into the hot water and start asking questions... remember what you're aiming at.

have a good chat with them, gain their trust, make 'em feel secure... words, the way you talk to them means a lot ... especially young ones, that's what they're looking for.

Most older women living in remote communities said that it was important for all health service staff to use simple straightforward English rather than technical terms, 'hospital words', and to rely on Aboriginal Health Workers who speak 'language', as well as interpreters when necessary.

you don't have to talk flash, just talk the way you feel comfortable, they feel comfortable ... you're not disrespecting that person.

They thought that the health service should employ female Aboriginal Health Workers. As one older woman said:

they know their choice, it's up to them.

Opinions on the role of Aboriginal Health Workers varied between the communities; however, all the older women living in remote settings thought that it was very important that the young women could have access to a female Aboriginal Health Worker. In two communities, it was considered that the young women should only speak with a female Aboriginal Health Worker when the pregnancy was confirmed and her family had been informed. Otherwise there was the danger that:

They don't talk to the health worker when they [go]... because she might go and tell everybody else, they think that.

In contrast, in two other communities the older women said that confidentiality was ensured due to the strong trusting relationships between the female health workers and the young women. This appeared to be the case despite different skin relations.

*Well, now, young people now, it's not as strong as it used to be years ago...
Everybody knows a health worker and they know a health worker is there when they are sick... skin name mightn't be the right one... [but] they acknowledge you're health worker.*

All the older women indicated that the role of the Aboriginal Health Worker as a translator and as someone who could communicate between the different cultures was very important:

so she can understand what that lady's saying in that language...so she can explain it to them in [language].

but always try to have an Aboriginal person with [her] because, I tell you what, that's the most important thing because that's bridging.

Some older women in some communities also said that young women prefer the Aboriginal Health Worker to talk about and conduct some of the tests. In one community the older women thought that it was important for the Aboriginal Health Worker to remind the young women about their next appointment.

Somebody gotta tell 'em... health worker gotta go and pick them up.

In another community the opposite view was held, that is, that it is 'not the responsibility' of the health workers to bring the women to the health service.

In summary, there was a striking level of consistency across the age ranges and locations in relation to antenatal health care providers. All the groups of women, irrespective of their age

or where they lived, indicated that young pregnant women prefer female providers and want to be able to choose if they receive care from an Aboriginal Health Worker. The young and older women living in Alice Springs said that this was important because of privacy and confidentiality; the young and older women living in remote settings echoed this and also emphasised the subtleties related to skin relations. Similar views were held by older women living in Alice Springs and young and older women living in remote settings regarding the importance of the Aboriginal Health Worker as a bridge between cultures; a translator of information; and someone who can ease relationships between the 'nurse' and the young woman. Similar views were also held between all of the groups of women regarding the importance of the quality of relationships with nurses and midwives, with trust and sensitivity being key factors. In addition, skilled midwives and nurses were preferred to less-skilled Aboriginal Health Workers by some of the young women living in Alice Springs and remote communities.

3.13 Continuity of carer

Choice was very important to all the young women living in Alice Springs. As mentioned above, they all wanted to see a female health professional and some expressed a preference for an Aboriginal care provider. All the women also said that they wanted to be able to see the same midwife throughout their pregnancy. Having made the choice to go to Congress Alukura, some women wanted to choose who that midwife would be.

Of the women who attended Congress Alukura, most saw the same midwife either every time or most of the time and two saw different midwives. Most women who went to the Alice Springs Hospital saw a number of different midwives and only two saw the same midwife.

I'd see a different midwife every time, like, yeah. Like, at first ... she was like, 'So... here's the form you have to fill out saying that you want one midwife and rah rah rah, you've got to, you know, say that you want this one, and I'll be your midwife, rah rah rah' and then the next week she was in the Middle East, like helping with something. I was just like, 'What?' And then I got [another midwife] and then she went away and did bushwork, like this next week, and so, yeah, it was really silly.

Most young women living in Alice Springs stressed that they thought selecting and then seeing the same midwife was very important. They offered a range of reasons for this including preferring a midwife that they liked, the desire to develop a relationship with her, the importance of establishing a trusting relationship, the need to feel comfortable enough to ask questions about the pregnancy and the chance to raise very difficult subjects.

When discussing her first visit to Congress Alukura, one woman said:

I came in and there was a nice midwife who said, 'How are you going?' and took notes, and asked questions about what's going on in my life, and [she] really took time out to really... listen. I don't know if it was policy or procedure of the place, but, yeah. I don't know if it was that, but it was very nice of her. It's good if

the service does that for Aboriginal people, you know, like, you ask how they're going, if they want to talk about anything that they can't talk to anybody else about.

Another woman who chose Congress Alukura for her care explained why she was able to ask questions and talk about important matters:

Because I trusted the midwife.

Appreciation for the extra support and follow-up offered by her midwife and the service at Congress Alukura was also expressed.

They explained everything to me and, you know, you had your next date set for your next appointment, you had transport available if you needed it. And they would contact you if you didn't go and find out why, and over all I thought that was good, being young, you know, you need that direction sometimes.

I think it's nice just to be acknowledged... they just say, you know, 'Hello, how are you going? If you need a hand, let me know' and I would always go back there.

Although most of the women who attended the Alice Springs Hospital antenatal clinic were unhappy with the lack of choice and continuity of care, one woman was very satisfied with the care she received from the midwife, noting that:

I liked going there because they were open, any questions that I needed to be answered they'd answer it for me, very friendly people up there. I thought at the start I was a bit hesitant in going up there just being Indigenous ... and it was the first baby and wasn't too sure if there was a lot of Indigenous people that went there but then later on [I] just found that, you know ... it's all about me and they would talk about baby and that and just be informative with whatever I would ask, yeah.

However, the opposite was experienced by another woman when she attended.

I think that they should be asking more questions about 'How's everything at home?' 'If you want to talk at all', like 'Come in here and talk', like, 'and cry'. I think, like, some of them weren't really open to that, like they were just checkups and then out, out you go kind of thing. Yeah, I think that they should involve themselves more... I don't think, like, Indigenous people would go to them, you know, like, yeah.

Young women living in remote communities did not specifically mention any views about the continuity of a health carer or midwife, possibly because there was only one community health service in each of the remote communities and often only one or two nurses or one midwife were available.

Most of the older women living in Alice Springs said that it was important that pregnant women be seen by the same person throughout the pregnancy, although the specific profession was not named. It is possible that this encompassed the selected Aboriginal Health Worker and/or midwife.

The older women living in remote communities did not know if the young women wanted to see the same female nurse or midwife and so did not comment about continuity of carer.

In summary, a major difference between the young women living in Alice Springs and those residing in remote settings was the capacity to select a health carer. Those in Alice Springs expressed the desire for continuity of carer, a midwife, and to select from a number of midwives. Continuity of carer was also implied by the older women living in Alice Springs. However, unlike the young women living in Alice Springs, the older women did not emphasise or discuss at any length the issue of a midwife being the person who provided continuous care; rather, there was more discussion about the need for a range of Aboriginal Health Workers to be employed by the services to ensure that the young women had effective choices. As mentioned earlier, it is possible that continuity of carer was not specifically alluded to by those living in remote communities because most health services only have one or two midwives.

3.14 Information provision

Most young women living in Alice Springs wanted and received information about the nature of pregnancy, the changes to their bodies, the importance of nutrition, the damage that alcohol, smoking and drugs can cause, how to look after themselves, the development of the baby and the birth process. Most of the women who commented about the provision of information during their antenatal visits were attending the Congress Alukura service.

Just like the, cos they got posters in the rooms of, like, how big the baby gets, and what it's doing at the time and all that sort of stuff, and it really interested me.

I read them every chance I got actually, just to see what my baby was doing inside, you know, how it was coming along. I watched, I've watched a couple of videos on pregnancy and birth, scared the shit out of me.

Two women who had attended Congress Alukura said that they would have liked more information about nutrition and healthy eating during their pregnancy and suggested that a cooking class be offered for the pregnant ladies.

Most of the information was provided by the midwife; however, a number of women also commented on the charts and posters that they had observed in the waiting area and the consultation rooms.

sometimes she'd use certain things, like, she'd use charts... otherwise she'd just explain it. Every month, when I'd come in, she'd tell me, like, what would start happening now... so, I sort of knew what to expect...

A lot of charts about what sort of food you should be eating ... breastfeeding... STIs ... a lot of posters... it was just good reading [the charts] and, yeah, they were really easy to understand. Most of it was just pictures so you didn't have to read too much.

A range of information sources were remembered. Most women enjoyed looking at, and thought they were likely to gain new information from, videos; the books with pictures; booklets or pamphlets; posters; and the models of the pregnant woman and the baby.

They've got a lot of simple picture books and things and they've got, yeah, they have got a lot of books and stuff where they would actually go through, you know, this week this is what's happening and ... yeah, about like folate and all that, sort of vegetables, yeah, yeah and it's in simple, you can understand it, it's not something that you can't understand sometimes.

The waiting area was identified as an important place for information, with one woman suggesting that Congress Alukura:

should put more books out. Books of, like, you know, if you have been in a violent relationship you need to do this, or else you'll be stuck forever... if you read up, read it up and that you probably thought this mob have a good idea, I might speak to them.

Different views were held by the women who attended the antenatal clinic at the Alice Springs Hospital. Some said that they had received more than enough information and others felt that they had not received enough. For example:

they gave me heaps of pamphlets, and then they gave me a little book just about babies growth... there was one there, I can't remember what it was, but it was just more reading than anything and, like, because I had some sort of understanding of it I didn't even bother reading it because it looked too long and I thought, 'Nah, I'm not reading that, you know, maybe later' and I just never got around to it.

just one time, when they went to the hospital, they were treated like ... the partner wasn't treated very nicely... At the hospital, you know, they expect people to be reading up and know everything. It made them feel very uncomfortable.

The young women living in remote communities did not discuss at any length the kind of information that they wanted or received about their pregnancy. Some young women did recall

receiving information from the 'nurse' about how to care for themselves during their pregnancy, the kind of food they should eat and what to avoid. Some recalled watching videos and looking at posters.

However *the older women living in Alice Springs* did discuss this matter and most said that pregnant women needed general information about being pregnant, the effects of 'grog and smoking', sexually transmitted diseases, nutrition, sensible clothing, cleanliness, rest and exercise.

[Pregnant women] shouldn't wear those tight clothes ... cuts skin... affects baby... that tight mark on the body causes a mark on the baby's head. Short clothes, short trousers when pregnant disrespects their body... T shirt is for man ... no lay down all day but walk... lot of rest ... not chasing their husbands... not running around.

They thought that some of this information should be provided by the women's families, for example, their grandmothers 'telling them stories', and some by health services so:

they can read it and talk about it... [and] at school those girls can be taught.

The older women living in remote communities also talked about the importance of providing more information to young pregnant women. Most suggested that information be delivered in a variety of ways including 'talking to the girls' and private one to one sessions conducted by female nurses and Aboriginal Health Workers at schools, as well as the health service; and by providing 'booklets' and 'pictures' in 'language' and videos.

The older women suggested that women benefit from being told and shown information rather than just receiving printed material because:

our people, they pick it up by seeing or hearing.

sometimes maybe traditional way, too, sitting around just telling them.

In addition 'to help with the young people', meetings could be held with the older women, young women, midwife and nurses to discuss women's business such as contraception types, sexually transmitted infections and cervical pap smears.

In summary, most young women living in Alice Springs wanted and received information about the nature of pregnancy, the changes to their bodies, the importance of nutrition, the damage that alcohol, smoking and drugs can cause, how to look after themselves, the development of the baby and the birth process. All the older women living in either Alice Springs or remote settings agreed that young pregnant women required more information about how to care for themselves and their baby. They also concurred that this information should be provided in a range of ways. The young women living in remote communities did not comment.

3.15 Ultrasound scan

The young women living in Alice Springs discussed some of the tests and procedures that they had experienced during their pregnancies. The one most common to them all was the ultrasound. Most women remembered visiting the Alice Springs Hospital in order to have one or more ultrasounds. One woman recalled having four ultrasounds but was unable to explain exactly why she had so many. She thought the first was to see how old the baby was and the last possibly because the baby was overdue.

Most of them recalled feeling pleased with or very excited by the experience. For example, one woman said:

it was good, looking at the baby growing and looking at the pictures, good thing.

Yeah, all right, see the baby move.

Excitement was sometimes accompanied by some anxiety.

Excited, I felt excited, anxious but scared at the same time. Cos I was like, 'Oh my God, I'm going to have a baby, it's mine, I can't just palm it off to somebody, it's not a toy.' At that ultrasound, though, that's when everything started coming into perspective, like fingers and stuff.

It's exciting, bit worrying too, like with the first, you know, if they find something or you know they are not going to tell you there but...

The importance of sharing the experience of first seeing their baby with their partners was mentioned by three women.

He was just that excited about, we both were excited about hearing the noises and we just seeing him first on the ultrasound and the heart beat and all that sort of, yeah, I wanted him to see all that and hear all that.

We went to the hospital for ultrasound. My partner came along. He got the day off work just so he could come along.

He was good, he won't admit it but I seen him crying, I'd seen it! 'I wasn't crying.' 'Yes you was.' Not like balling his eyes out, but I seen tears.

However, not all partners accompanied the women to the ultrasound scan because of their views about traditional cultural law.

**He used to say, 'Nah, shame job, I'm not going with you',
'Well, why, why shame, for you to be with me?', 'Nah, just wrong,
just shame'.**

**he's been initiated and all that. But, like, I don't know, it's just
like, 'I don't want to support you', that's what I reckon. But men
should be involved for their unborn child.**

Most women living in Alice Springs received pictures of the ultrasound image of their baby and they did very different things with them. Some showed their family, some a few friends and some placed them in a photo album.

*Went around to my mum's that day after work... partner showed a couple of his
friends... made it all real ... got them at home [in a] photo album.*

*[Her partner] he'd gotten a whole print out of the baby and I was thinking they only
give two or three as the limit and he came out almost with a whole role... yeah, he
was that excited and he got all the different poses.*

Shame led two women to put the pictures away and not show anyone. As one explained:

*When I had an ultrasound I hid them away... cos just the same as like when you are
pregnant, shame, you won't show anybody.*

The young women living in remote communities did not often mention or discuss in detail any medical tests that they received during their pregnancy, except for 'blood tests'. Nevertheless, some did describe their experience of travelling to Alice Springs for an ultrasound scan. Their experiences and views about the procedure varied between the women regardless of which remote community they lived in. Some travelled with their grandmothers, mothers, sister or friend. Those who were younger seemed to find it a more frightening and 'scary' experience; however, one young woman who had attended boarding school found it 'alright' and not 'scary'. For another, though, it was:

*fun to go into Alice Springs cos you're in town and you're going to ultrasound and
go shopping... you're a long way from your family... [have fun] that's good.*

All the women who mentioned the ultrasound said that they 'liked' the pictures but some did not bring them home or show them to others, because of 'shame', while others showed their 'aunties, mother' and another her boyfriend.

Some of the older women living in remote communities said that the young women travelled to Alice Springs, usually with their grandmother or mother, for an 'ultrasound', with some who went for the first time feeling 'scared', while others did not. However, the:

second time they right, they used to it, they learn.

There was concern about the restricted funding available to support the cost of relatives accompanying the women and the limited bus timetable was a significant problem in some places.

One older woman said that in some cases during the ultrasound procedure:

the workers tell them if it is a girl or a boy... nowadays they tell them [and] they get baby clothes at the store [when they come home].

Most thought that some young women liked seeing the image of the baby on the screen and they brought 'them little pictures' home.

The older women living in Alice Springs did not discuss this topic.

In summary, all of the young women living in Alice Springs seemed to enjoy the opportunity provided by the ultrasound scan to see and take home an image of their baby. However, in contrast to young women in Alice Springs, more of the young women living in remote communities found the ultrasound scan a 'scary' experience even though most of them seemed to like the 'pictures'. A major difference between the two groups of young women was the desire by many of the young women living in Alice Springs to have their partners, or father of the baby, come with them to the ultrasound appointment and share in their excitement. None of the young or older women from remote communities mentioned this possibility.

3.16 Sit down time at Mt Gillen

Some of the young women living in remote communities commented about their 'sit down time' at Mt Gillen in Alice Springs, where they stayed until it was time for their baby to be born at the Alice Springs Hospital.

Some of the young women said that it 'was alright' but for others it was 'lonely' and 'boring'. Most were accompanied by a female relative. Some said that it was good because there was no smoking or drinking allowed and that the women were 'safe from the drunks'. They noted that some of the husbands would still come and 'ask the wife for money'. One mentioned that the food was not good and tasted as though it had been reheated.

Some of the older women living in remote communities also commented about the young women's experiences at Mt Gillen. They said that the young women take their mother, aunty, cousins and sometimes grandmother when they go to Alice Springs and stay at Mt Gillen. Most said that it was a 'safe place' but that the women can become very lonely. A traditional grandmother said that Mt Gillen was 'good' because they can 'have a rest'. She added that although the women usually go with their mother:

sometimes they take themselves.

In summary, the young and older women living in remote communities expressed similar views about the experiences of young women at Mt Gillen; that is, that they were usually accompanied by a female relative; they could become quite lonely; and it was considered to be a safe and quiet place to rest.

3.17 Partner and/or father of the baby involved in birth

Although birthing and postnatal matters were outside the scope of this consultation, some women mentioned their experiences at the Alice Springs Hospital and the role of their partners in the birth of their baby. As many of these comments are relevant to the section above on the role of the partner or father of the baby in antenatal care, they have been included.

Some of the young women living in Alice Springs discussed the role of their partners in the birth of their baby and said that they wanted the opportunity to choose whether their partners would attend the birth of their babies. Some men chose not to attend due to cultural traditions, while others straddled Western and traditional culture and came to the hospital. One woman explained that her partner was respectful of traditional culture but is an:

urban Aboriginal man... respects culture [but also] more modern.

So he came to the hospital for the birth but still did not enter the birthing area.

Another woman would have liked her partner to be more involved but also understood why it was not possible for him.

Like cos my partner, he didn't even want to come into the [birthing] room with me, cos proper way and he's not allowed to. He's like, 'Nah, I'm not going in' and I was, like, 'You helped make it, you come and help', you know, bring it into the world. Yeah. But, a lot of things like that, like he's initiated and stuff, and there's things that I can't say to him, or do to him and stuff like that. Cos when we go out bush and visit his family... they're traditional, they're one eyed, you know, a woman's job is to cook, clean and look after the kids. And I'll do it, like, to save, save peace and everything when we're out there, and do all that sort of stuff, like cleaning and all that shit. But when we're in town, he helps out a lot.

Like, I respect culture and that, like I was brought up, my Mum taught me all those things when I was younger, growing up out bush and in town as well, so I got respect on both sides.

However, after the birth he did enter the birthing area and assist with caring for the newborn and his partner.

The cultural beliefs of one woman rather than those of her partner prevented his involvement in the pregnancy and the birth. She explained that when she went to the hospital for the birth:

I asked him to drop me off and come back later, and he was hurt. He felt like driving the car off the bridge he told me, because I just told him to drop me there and to go and come back, you know... he thought he was never, you know, the wanting, I never wanted him...

Only a few of the young women living in remote communities commented about their experience at the Alice Springs Hospital and the role of partners in birthing.

In relation to their experience at the hospital, one woman said that her aunty had accompanied her for the births of her two children. She indicated that the hospital had been 'alright' but that there had been no Aboriginal Health Worker there at the time.

Some young women living in remote communities said that the lack of cultural knowledge by non-Aboriginal staff, specifically that some topics should not be mentioned in front of family members, even if they are females, was a concern.

One girl... she was sick when she had the little one... and the family was visiting her and ask the nurse. [The nurse said] she's not coming home, she's got the sickness, she gotta stay in hospital and that girl's got shame.

Some also said that the behaviour of some nurses also caused other problems.

The nurse teases 'you smiling now, what happened to you last night?'... some nurses are cheeky. They don't know the right way. I think that is why some girls don't want to go to hospital.

She explained that the Anangu women are offended if the nurse jokes or teases them about their pain or discomfort, even if they are no longer feeling it. Rather, she thought that a:

nurse to, like, um, be kind to them and, um, not to mention any sickness from before or after the baby is born [to] the family and not to get cheeky, uwa, cheeky... and not to tease.

All of the young women living in remote communities who talked about the role of their partner or father of the baby confirmed that they should not be involved in the birth and should wait in the community for the women to return. Some felt that any Aboriginal woman who did have the father present at the hospital had taken on 'whitefella ways'.

white women's do that, palya⁵, but Aboriginal people get shame.

Most older women living in Alice Springs were aware of changing cultural practices in relation to men attending the birth of their child or being in the hospital at the time; however, many of them did not agree with it.

Some people might tell their granddaughters to have the baby at Alukura.

young girls want the baby at the hospital so young fella come sit outside... they don't go inside.

⁵ ok.

That shame prevents some men coming to the hospital despite the wishes of the young mother was also observed by the older women.

They just shame... they just don't want to go in. You ask them to go to the hospital, they say ... 'No, mate, I'll wait for the baby come home'.

Differences between 'town and bush mob' in relation to the practice of traditional law and the presence of the father at the birth or waiting in the waiting room were mentioned.

Community mob never, never go with husband to birth. Those young fellas know, they taught, they know law... they know they can't come... they shouldn't be there because 'Irerrintye'⁶ ... but that waiting room at hospital, that room full of young fellas waiting for their women.

It is worth noting that although, in most cases, the women were unhappy about changes to traditional cultural practices as they relate to men's involvement with birthing, most had been very keen for the men to increase their care for the woman while she was pregnant, as discussed above.

Cultural law is not the only reason that some older women living in Alice Springs thought that men should not be involved in the birth. One woman explained that she felt embarrassed if men were involved in matters to do with her body and birth. She specifically explained that her view was not influenced by cultural factors or related to the views of traditional grandmothers, as she had grown up in the town of Alice Springs rather than a community where traditional law was practised.

No, no, I wouldn't let no man go inside the hospital while I'm having kids, no way. I feel more comfortable with a woman.

Although some older women living in remote communities spoke about traditional practices and pregnancy being 'women's business', others talked about how 'culture' had changed. For example, some said that some young women wanted their husbands to take them to Alice Springs rather than waiting back in the community.

Might be that lady she like to have husband go.

Sometimes husband takes her in and bring her back.

⁶ 'Irerrintye' is an Arrernte word for the avoidance of the mother-in-law and therefore the father should not be at the birth because the mother of the birthing woman is there.

Some stories about traditional birthing practices were told during the consultation, the details of which will not be reproduced here for cultural reasons. It is possible to note the following:

When mother bring the baby out [after giving birth] you don't take 'em to the father, you gotta wait a little longer.

All the time when baby used to be born, they used to be born out bush ... father not allowed to touch it.

It was recognised by the older women living in remote communities that traditional cultural practices were changing and that birthing practices were 'different' now, that 'this is a new generation' and that now:

mother and father bring the baby out... but grandmother go out and smoke it.

One older lady added that:

Husband, wife, baby, they live all as one now.

A more traditional role was preferred in three other communities, for example:

Husband stay at home.

In summary, an awareness of changing cultural practices and the influence of Western medicine and behaviours were observed by most women across the age ranges. Strong differences emerged, however, in their views about the role of the partner or father in the birth of the baby. Most of the young women living in town wanted the father to be at the hospital with only a few preferring that he stay elsewhere, while most young women living in remote communities agreed that the father should wait in the community, with only a few wanting him to accompany her to Alice Springs, but not the hospital. The older women living in Alice Springs were reluctant to accept the changes to traditional cultural practices that some of the young town women displayed; nevertheless, they were also practical and pragmatic, realising that times were changing, that involvement of men may improve relationships between fathers and their children and by accepting that sometimes the hospital was a safer environment for very 'sick ladies'. The older women living in remote communities preferred traditional law and practices to be maintained.

It should be noted that birthing matters were outside the scope of the consultations, therefore no further detailed discussions about this matter were undertaken.

4.0

Discussion and Conclusions

This consultation with young and older Aboriginal women in Alice Springs and some remote communities in the Central Australian region was undertaken by Congress Alukura in order to provide Aboriginal women with the opportunity to identify and discuss the features of antenatal care that were most important to them. It is intended that these aspects of antenatal care will inform continuous improvement in antenatal care at Congress Alukura in the Central Australian region.

It is important to note that the features of antenatal care identified and discussed by the women incorporated many non-medical, as well as bio-medical and health service-related, factors. For example, the need to feel and be safe from violence, the role of their families, the importance of transport and the nature of their relationship with a health provider.

The dimensions of antenatal care these various women identified and discussed were specifically context dependent. The particularity of the context related to Aboriginal culture, both traditional and changing practices; the degree and influence of Western cultural practice, including medical and health practices; the kind and availability of Western health resources; personal and family experiences; and the nature of the community in which they resided.

These conclusions are also therefore context dependent and relate primarily to the town of Alice Springs and those communities in Central Australia where women participated in consultations.

Significantly, there were both differences and similarities of views amongst and between the various young women living in Alice Springs; young women living in different remote communities; the range of older women living in Alice Springs; and various older women from remote communities.

Following the discussion of each of the key aspects that emerged from the consultation, possible topic areas for the development of quality indicators for antenatal care are suggested.

4.1 Choices and preferences

This consultation was predicated on the understanding that Aboriginal women are not a homogenous group, rather they are characterised by differences in culture and tradition; language; socio-economic circumstances; places of residence; educational levels; and employment status, among others [Homer 2000, Waldenstrom 1995].

Not surprisingly then, the women consulted repeatedly indicated a variety of preferences for their antenatal care and a desire to choose from a range of options. This applied to choices within their family and communities and to choices related to health services.

It was clear that being able to make choices was very important to all the young women. Most indicated that they felt strongly about key aspects of their care during their pregnancies.

For example, most young women from the remote communities mentioned preferences for care that were consistent with some traditional practices, such as specifying that they would prefer to be cared for by a female.

Many had thought very carefully about their choices and decisions and articulated the reasons for them; this was particularly so for the young women living in Alice Springs. Interestingly they had often made different decisions for the same reasons. For example, some selected the Alice Springs Hospital and others Congress Alukura because they all wanted staff who would respect confidentiality.

Although the young women from Alice Springs and the remote communities varied in what they wanted choice about, they all indicated the desire to choose some aspects of their care while they were pregnant.

The young women living in Alice Springs wanted to be able to make choices about most aspects of their antenatal care, while the women living in remote communities indicated the desire to choose some aspects. For example, the young women living in Alice Springs explicitly wanted to be able to choose:

- The nature and extent of family involvement in their care;
- The kind of antenatal service they attended;
- The location of the antenatal service they attended;
- From a number of midwives and Aboriginal Health Workers; and
- The role and extent of involvement of their partner or the father of the baby.

They made choices about the above based on the value they ascribed to the following dimensions of care [and other factors]:

- The degree of confidentiality ensured by the service;
- The sex of the professional provider;
- The profession and skills of the antenatal care provider;
- Continuity of antenatal care by the selected midwife; and
- Aboriginality of provider.

Most young women living in remote communities indicated that they wanted to be able to choose:

- The profession of the antenatal care provider;
- The Aboriginality of the provider; and
- From a number of Aboriginal Health Workers.

They valued highly:

- The sex of the professional provider; and
- Privacy and confidentiality.

Some indicated a desire to choose the nature and extent of family involvement in their care, when they would first go to the health service, and whether the father of the baby looked after them while they were pregnant.

All services need to be responsive to women's expressed valuing of and preferences for female providers; Aboriginal Health Workers; and involvement of men, for those women who want them. In addition, all services should be confidential and provide privacy.

It is also important that the quality and characteristics of, and options for, antenatal care are more consistent and equal across the agencies in Alice Springs and between the services in the various communities.

4.2 Understanding shame

There is not a great deal known about shame, as Aboriginal women have not written about it nor have many non-Aboriginal researchers. It has been related to ways of knowing and emotions, has a 'wide currency' and is 'used in a number of contexts' [Morris in Keen 1994].

'Shame' was mentioned by nearly all the young and older women in both Alice Springs and remote communities. It was repeatedly the one-word answer for how they had felt about certain events or why they had acted in certain ways. It became clear that a better understanding of what 'shame' encompasses would be helpful for antenatal care providers.

Young women from Alice Springs thought that they or their friends would feel shame if they became pregnant at a young age; thought that their parents would disapprove of them being sexually active and then pregnant; thought their parents would be angry with them; were asked personal questions about the pregnancy; were asked by friends or community members about the father of the child; became the subject of gossip; if their physical appearance drew attention to them and then people began to ask questions; had broken cultural law because the father was of the wrong skin; or had embarrassed their family.

The young women from remote communities offered a similar but also different list of explanations for shame, including that the woman did not want to become pregnant; she did not want to 'do anything about it'; she had not followed her mother's advice; she was too young; she was not married; her friends would tease her; she would not be able to continue attending school; there was no one to look after her; it was her first pregnancy; the father was from the wrong skin group; the father was already married; they may be threatened with violence by relatives of theirs or the father's; they were victims of violence; they were asked about the pregnancy by people from the wrong skin group; or they were concerned that their private information would be made public by family, friends or health providers.

Older women from town mentioned some of these factors, as well as shame being felt by a pregnant woman as a consequence of sexual abuse. Older women from remote communities discussed a very similar list of reasons for feeling shame as that identified by the young women in their communities. Shame was not always felt with a second baby, sometimes because the woman was older, or married. They also pointed out that some aspects of shame were not necessarily derived from Aboriginal culture but were broader and related to being female and young; for example, feeling embarrassed at being discovered to be sexually active and disliking internal physical examinations by a doctor.

In summary, 'shame' was an explanation for a range of behaviours that resulted in keeping the pregnancy a secret; not seeking help from family or friends; trying to bring about a termination; delaying a first visit to a health service; presenting at a health service for a different reason; not attending antenatal appointments; refusing to discuss the pregnancy with Aboriginal Health Workers or other providers; and sometimes depression or deep unhappiness.

Significantly, however, a number of young women living in Alice Springs said that they did not feel shame when they were pregnant because they had been brought up to feel confident about themselves, they had high self-esteem, they had loving partners who reassured them frequently and because, by mixing with ‘whitefellas’, they had learnt that they did not have to feel ashamed of their body. All these women attended a health service early and frequently during their pregnancy.

Shame, then, is a complex concept, emotion and feeling, the nuances of which vary from person to person and place to place [Keen 1994, Simon 2005]. Whilst it seemed to affect the young women’s behaviour, its complexity means that no simple codified responses would be adequate. Rather, an Aboriginal Health Worker or midwife would need to be patient, to listen, and to be thoughtful and sensitive in order to understand the context and particularity of the young pregnant woman’s situation. They would also need to continue to ensure that there are private spaces for conversation; avoid pressuring the women to speak or to use words; avoid direct questions; suggest a pregnancy test but only in private; offer women choices and options regarding terminations; support the woman in her decision making; validate her choices where appropriate; and reassure her of her own worth.

In remote communities the older women suggested that health service staff could ensure that traditional grandmothers and a number of female Aboriginal Health Workers were at the health service and encourage health service staff to be more aware of cultural practices. This is particularly important as some aspects of shame are specifically related to cultural law, for example, wrong skin relationships, making it very difficult for non-Aboriginal or even some Aboriginal people to intervene.

4.3 Knowledge of local communities: avoiding assumptions about cultural practices and relationships

Given the variety of viewpoints mentioned by the young women living in Alice Springs, it is clearly important for health service staff not to make assumptions about their preferences based only on the fact that they are Aboriginal. Although traditional cultural practices clearly did play some role and did influence some of their decisions, most notably, the role played by the partner and father of the baby, they were nevertheless also affected by Western culture and behaviours. As a few of the women noted, some of their preferences for care were very similar to young pregnant women living in other large cities in Australia; for example, feeling more comfortable with a female nurse or doctor, being cared for by one midwife, being able to discuss matters of concern to them and disliking internal examinations.

Equally, it is also important for providers not to make assumptions about Aboriginal cultural practices. Although many improvements in the training of health service staff have occurred in recent years and many staff in remote communities are more aware of local Aboriginal cultural practices, the tendency for some staff to make simple assumptions about culture based on some knowledge of that culture can be problematic [Williamson and Harrison 2001]. It was made very clear by young Aboriginal women living in remote communities that assumptions should not be made by health service staff about the nature of family relationships and the sharing of information between close female relatives. Similarly, assumptions should not be made about the extent to which traditional cultural patterns of care for young pregnant women are being practiced by their families, even in communities characterised by ‘strong culture’. Some young women were being neglected by their families and were left to look after themselves.

Consequently, the antenatal care offered by health providers to young Aboriginal women within any particular community will be of a higher quality if it is informed by knowledge and understanding of the particular culture, as well as the specific circumstances of the pregnant woman and her family. It is likely that the care will be further improved if there is a vital and responsive inter-relationship between the informed provider and the pregnant woman.

4.4 Building relationships of respect and trust

Respectful and trusting relationships between a young pregnant woman and the nurse/midwife and/or Aboriginal Health Worker emerged as significant aspects of quality care. For most of the young women living in Alice Springs, a trusting relationship where they felt they were listened to and supported by one midwife was critical. It is important to note that confidence in the skill and knowledge of the midwife was an important part of this relationship. Such a relationship, where it did occur, seemed to strongly influence continuing attendance at antenatal care appointments, the uptake of advice and changing of some behaviours, improved self-care, improved self-esteem and, equally importantly, the resolution of, or assistance with, managing important non-medical matters.

I think that they should be asking more questions about 'How's everything at home?' 'If you want to talk at all', like 'Come in here and talk', like, 'and cry'. I think, like, some of them weren't really open to that, like they were just checkups and then out, out you go kind of thing. Yeah, I think that they should involve themselves more... like, yeah.

I came in [to Congress Alukura] and there was a nice midwife who said, 'How are you going?' and took notes, and asked questions about what's going on in my life, and [she] really took time out to really... listen. I don't know if it was policy or procedure of the place, but, yeah. I don't know if it was that, but it was very nice of her. It's good if the service does that for Aboriginal people, you know, like, you ask how they're going, if they want to talk about anything that they can't talk to anybody else about.

They explained everything to me and, you know, you had your next date set for your next appointment, you had transport available if you needed it. And they would contact you if you didn't go and find out why, and over all I thought that was good, being young, you know, you need that direction sometimes.

Respectful and trusting relationships between a young pregnant woman and the nurse/midwife were also important to some young women living in remote communities. In relation to the nurse or midwife, the young women clearly stated when they did or did not 'like' the nurse and indicated that their feelings about her influenced when and if they attended appointments and if they talked to her.

In relation to Aboriginal Health Workers, this consultation confirmed much of what has been written about the significant role performed by them. They can develop relationships with young pregnant women and they can facilitate helpful relationships between young pregnant women and the health service staff. As noted above, in Alice Springs a young woman's acquaintance with an Aboriginal Health Worker clearly influenced her choice of service; they either did or did not select a service, in part, because of the presence of particular health workers.

Importantly, in some remote communities, the Aboriginal Health Worker's knowledge of local families, history, culture and language frequently facilitated a young woman's attendance at appointments, the sharing of important information and the resolution of difficult issues. Where there were Aboriginal Health Workers who were members of the community and had worked there for many years, the young women indicated that they felt 'alright' about, and did talk to the Aboriginal Health Workers about, their pregnancies. This was confirmed by the Aboriginal Health Workers who indicated that most young women came to the 'clinic' when they asked them to and that most young pregnant women received pregnancy care early in the pregnancy. Nevertheless, this cannot be assumed to be the case in all remote communities, as women in other communities said that they would not talk to, or want, an Aboriginal Health Worker to approach them about attending the health service.

Aboriginal Health Workers can provide very important advice to the nurse or midwife on how to 'be with', 'talk to' and build trusting relationships with young pregnant women. Information about nutrition, self-care and any required medications are more likely to be communicated and heard when such relationships are established.

The capacity for the nurse or midwife to develop trusting relationships is particularly important when the young women choose not to confide in the Aboriginal Health Worker.

Philosophies of practice that emphasise partnership, shared decision making, respect and trust are essential.

4.5 Behaviour of health service staff

How the women were treated by the health service staff was frequently discussed and was clearly important to them, again for a variety of reasons. Some of these reasons were related to particular traditional cultural practices, others to more common, ordinary, courteous behaviour. Most of these aspects have been discussed elsewhere in this section; for example, the importance of asking questions about the young woman's situation or listening when she raised issues of importance to her.

Some young women in some remote communities mentioned behaviour by nurses or midwives that was offensive because it contravened aspects of cultural norms for that community. This could be addressed through a variety of strategies mentioned in this section, such as increased knowledge and understanding of a particular culture, improved relationships, perhaps mediated by Aboriginal Health Workers, improved self-reflexive practices for staff, for example cultural safety, opportunities for staff discussion and feedback, and improved orientation and training protocols.

4.6 Safety

Ensuring, as much as is practicable, that young women are safe during their pregnancies is one important aspect of good quality antenatal care. The dimensions of safety included home

environments that were relaxed, happy and calm; freedom from financial stress and anxiety; protection from sexual abuse; and freedom from physical and emotional violence. Clearly, many of these areas are directly outside the remit of the midwife or Aboriginal Health Worker; however, health services can certainly have protocols that will assist their staff to be attentive to these issues, to offer support and understanding, to take action to assist women in relocating to a safe house or shelter, to help find respite care for children or to assist with accessing temporary financial aid.

4.7 Privacy and confidentiality

Most of the women were concerned about privacy and confidentiality and most indicated that it influenced attendance at health services. All the women observed that positive relationships between health service staff and young pregnant women relied on respect for privacy and were damaged by breaches of confidentiality.

Privacy

Privacy seemed to have a number of dimensions. The traditional cultural practices concerned with women's health seemed to be the main reason that young and older women living in remote communities indicated that health services should have separate waiting areas for women and men. Some older women living in Alice Springs were also keen for traditional aspects of culture to be maintained and strongly supported Congress Alukura as a women's only service. The young women living in Alice Springs were more divided in their views, with some preferring the traditional women only aspects offered by Congress Alukura and others rejecting it because they could not be accompanied by their male partners.

A private waiting area was also preferred by some young and older women in remote communities because they were concerned about 'gossip' and desired privacy so that 'everyone' would not talk about them, or tease them.

A private space in which they were seen by the health provider alone seemed to be required by most women. Some women, in remote communities, indicated that the Aboriginal Health Worker could also attend, while others, including some young women living in Alice Springs, specifically did not want the Aboriginal Health Worker to participate.

Any discussion to do with the pregnancy should not occur in the 'public' areas of the health service and should only be mentioned by staff when they are in a private room: this view seemed to be preferred by young women in remote communities and some young women living in Alice Springs, even though the reasons for this desire for privacy varied.

Other aspects regarding privacy or when to involve family members could be discussed or explored by the nurse or midwife as part of developing a trusting relationship with the young woman.

Confidentiality

Confidentiality seemed to refer to any information about them, including the fact of their pregnancy remaining 'secret' or private and certainly not being repeated to any member of the public. Many women living in Alice Springs and in remote communities noted that they could not rely on their information remaining confidential. Some told stories about Aboriginal Health Workers reading the medical files of members of their family even when they were not involved in their health care. Consequently, this is an important aspect of antenatal care that requires more rigorous attention by services in terms of practice, as well as in addressing the community's perception of the confidentiality of the service.

4.8 Information provision

More information about women's bodies, substance abuse, self-care and care for the developing baby must be provided to women in Alice Springs and remote communities. Nearly all the women either suggested this or indicated that they did not know about some of these areas. The older women, in particular, repeatedly requested more information for young women about the consequences of substance abuse.

Both young and older, remote and town-based, women appeared to be well informed about the kinds of foods that should be eaten during pregnancy, as well as the kinds of substances that should be avoided. One exception related to some young women in one community believing that chewing tobacco and bush tobacco was not harmful during the pregnancy.

Chewing tobacco ok here... bush Pituri is ok, that's alright.

Minkupa ok here and bush Pituri... Minkupa little bit strong... bush one's alright.

Overall, the striking level of consistency and knowledge about good nutrition seemed to suggest that antenatal, and possibly other, nutritional health campaigns have been partially successful. This was indicated by young women referring to some specific campaign materials. The apparent success of locally designed and implemented, targeted, funded and sustained health promotion campaigns suggests that other similar campaigns might also be successful. There may be cultural sensitivities that would make other campaigns more challenging but if designed by, and implemented with, local people, these challenges could be addressed.

The kind and content of information provided should reflect the context in which the women live as well as the range of views and the real life pragmatic choices that young women express and make. Therefore, the information needs to reflect specific traditional cultural beliefs and practices relating to antenatal care for some communities, the changing, more Western cultural behaviours more common in Alice Springs, the specific antenatal care services offered by Congress Alukura and the Alice Springs Hospital, and be informed by evidence of effectiveness.

The information should be age specific, reflect various literacy levels and be provided in plain English and a number of Aboriginal languages. To be effective it must be communicated in a variety of ways and mediums: for example, one to one discussions; small women's meetings; through 'story' told by traditional grandmothers; in pictures; drawings; posters; videos with Aboriginal actors/people; and performances.

It is well known, and some younger and older women observed, that information alone will not necessarily result in changed behaviour, particularly in relation to smoking, drinking and other drugs. Supportive counselling can be helpful if it addresses the range of issues occurring in the woman's life, has achievable goals and is delivered by sensitive well-trained staff [Hancock 2006]. Most women who were smoking during the pregnancy had reduced the number or had tried to cease altogether but others struggled with addictions of various kinds. Frequently, the causes of damaging personal behaviour are complex, perhaps related to sexual abuse or to other determinants of health, such as unemployment or an absence of other opportunities [AIHW 2006]. Clearly, such underlying causes need to be addressed. In addition, in the remote communities, food security issues need to be attended to, to ensure the availability and affordability of a range of fresh nutritious fruits, vegetables and other healthy foods.

Ideally, antenatal health promotion programs should emerge from local community development initiatives and be one of a range of strategies implemented by health services to partner with their communities and to network with other health and related service providers in their area. Such relationships might also assist in identifying programs or strategies to address the determinants of health. One example of a partnership was between the Strong Women, Strong Babies, Strong Culture program and traditional grandmothers at one remote community. This seemed to be effective in that the younger women spoke about their knowledge of contraception and nutrition in ways that reflected the information that the older ladies had provided. In another community it was suggested that a meeting be held with the older women, young women, midwives and nurses to discuss women's business, such as contraception types, sexually transmitted infections and cervical pap smears, in order to develop local practical information.

4.9 Medical tests and procedures

Although most women did not discuss antenatal medical tests or procedures at length, many did mention that the purpose of visits to the health service during their pregnancy was to keep well; to have 'checkups'; to have blood tests; to monitor their diabetes or blood pressure; to provide them with supplements; to receive treatments for 'other sickness' like sexually transmitted infections; and to monitor the baby's development. Most young women commented on their ultrasound scan as a result of a direct question about it. The young women living in Alice Springs seemed to value and appreciate some of the medical treatments and procedures they experienced specifically, treatments for sexually transmitted infections, the provision of supplements and the monitoring of the baby's health and the opportunity to see images of their baby consequent on the ultrasound scan. Some young women in remote communities were frightened by and uncomfortable with the ultrasound scan although most said it was 'alright'. Once again, trusting relationships with their health providers and appropriate information will assist young women to make informed decisions about, and improve their experience of, the kinds of procedures they have.

4.10 Role of partner and father of the baby

All of the younger women and most of the older women in Alice Springs referred to the role of the partner or father of the baby during pregnancy and birth. Some of the younger women and one or two of the older women in remote communities also discussed this issue. The role of the father consisted of two key components: supporting and looking after the pregnant woman, and being involved in some way at the birth.

This was one topic area where the views of the two groups of young women most noticeably diverged. Generally, all the young women from Alice Springs wanted the father to look after them while they were pregnant, even if he did not or was not able to. Most wanted the father to be involved in the pregnancy, with some actually wanting him to attend the antenatal appointments. When they could not attend, the women adopted strategies to keep their partners informed and involved in the pregnancy, such as relating all that the midwife had said, sharing the information resources with them, asking them to come to the ultrasound appointment with them and, in one case, relaying their questions to the midwife. Some wanted the father to attend the birth and others that he just be at the hospital. The older women indicated that they were aware of these preferences, with some agreeing with them, in the hope that more involvement would lead to stronger fatherly relationships, and others feeling quite distressed because they felt it indicated a weakening of cultural practices.

The views of the young women living in remote communities were similar in only one aspect. A few young women thought that the father could help look after the pregnant woman but they all said that the father should have no role at the birth.

The participation of the partner has a number of advantages for some women living in Alice Springs; for example, the woman feels more supported and sharing the experience of pregnancy contributes to and is a sign of a stronger relationship. For some it also facilitates and possibly strengthens the partner's acceptance of his role as a father. Having noted this, it is also important to remember that many traditional men were, and are, attentive fathers.

The critical issue here is again choice. Many of the young town women wanted to be able to select a service that combined a choice of midwife, continuity of carer and the participation of the father. They wanted to be able to determine the extent of his involvement, when he would be in the room with them and when he would not. Importantly, for some women, the reasons for these preferences are significant and tend to reflect the influence of Western culture, specifically contemporary Western approaches to partnerships and marriage. However, it would be a mistake to assume that the young women were not deeply aware and respectful of traditional cultural practices. For some, these preferences were consistent with their views about a dynamic changing culture, rather than a disregard for older, more traditional practices.

These women were also strikingly adaptable. They were well informed about traditional cultural practices, with some having been raised within traditional culture and some with partners who were initiated, traditional men. However, they could and did regularly move between the 'two worlds' of the 'whitefella' and the 'community'. Some would behave in traditionally acceptable ways in some settings and with some members of the family but behave differently with their partners in other settings.

These women expressed a strong desire for services that could be as flexible and adaptable as they were.

5.0

Ensuring Quality of Antenatal Care

As already noted, the conclusions from the consultation documented in this report suggest some key aspects of antenatal care desired by young and older Aboriginal women living in Alice Springs and in some remote communities. It is essential and of the utmost importance that health services are flexible, adaptive and responsive to these preferences so that young Aboriginal women are provided with a range of options for their care and the opportunity and support to exercise their own choices.

The question, then, becomes how do health services in Alice Springs ensure that they are providing the antenatal care services women want and how do they maintain the provision of those services at the highest quality possible? What are the implications from this consultation?⁷

Health services that provide quality services and are well regarded by the people who use them often have dynamic functioning partnerships with their communities and are characterised by organisational cultures of evaluative inquiry [Wadsworth et al. 2007, Legge and Wilson 1996]. They also often have staff who actively engage in cycles of action research and evaluation, have a variety of well-implemented service systems for continuous quality improvement and accreditation processes, and have service and clinical practice protocols and guidelines [Baillie et al. 2007, Renhardt et al. 2004].

5.1 Dynamic partnerships with young Aboriginal women

Congress Alukura has an established Alukura Cultural Advisory Committee that includes traditional grandmothers and senior community women who provide guidance to the manager and staff about cultural aspects of women's health and wellbeing. However, for a range of complex and culturally related reasons, there is not a similar mechanism that would facilitate the sharing of ideas from young women. Congress Alukura is well placed to generate and maintain an effective partnership with young Aboriginal women living in Alice Springs and, in order to ensure that its services are informed by these women's views and preferences, new ways to engage with them need to be identified. Various community development initiatives would assist in building such partnerships and could be collaboratively designed, implemented and evaluated with young and older Aboriginal women.

5.2 Organisational culture of evaluative inquiry

A range of factors are required if a culture of evaluative enquiry is to be developed and maintained within an organisation. These factors often include senior managers who lead, promote and are committed to action research and evaluation; effective staff development programs in evaluative methods; permission and support to take risks and try out new ideas; annual cycles of review and reflection that are integrated into action research cycles and continuous quality improvement mechanisms; time allocations for evaluative activities; and

⁷ The discussion that follows is limited to the implications from the consultation and does not represent all aspects of the provision of quality antenatal care.

participation in evaluation networks. Funding bodies that recognise the pre-conditions and the requirements for sustainability of such activities are also essential.

Congress Alukura has an established quality assurance process and conducts a variety of funded programs, each with its own reporting and evaluative requirements. These reports are often more likely to involve quantitative methods that, although valuable and useful, are, by their nature, partial representations of the activities undertaken and the effects achieved. Qualitative methods, and narrative evaluations and action research methodologies in particular, can create more full and compelling stories about the complexities of the services provided, the relationships developed with the women who use them and how they have impacted on their health and wellbeing. A combination of all these methodologies can be most effective.

in answer to the questions ‘What does it all mean?’ and ‘Was it actually of value, merit, worth or significance?’ we need ways to identify comparative holistic relativities within the complex real world. In this context, narrative can be an effective method of ‘re-chunking’ rich, complex life back into a manageable way of understanding the bigger picture of more complex realities. The meanings of more abstracted quantitative and qualitative datasets can then also more effectively be understood. This is a kind of ‘hermeneutic’ – just as a grain of sand helps characterise a beach, so also the beach helps to contextualise the grain of sand.

[Wadsworth, Wierenga and Wilson 2007: 4]

An increased focus on narrative evaluation and action research may assist Congress Alukura to represent the complex reality of providing services to Aboriginal women, as well as increase its capacity to respond to their changing expressed needs.

5.3 Health service policies, systems, protocols, programs and practices

It is important that health service policies, systems, protocols, programs and practices reflect, incorporate and guide the implementation of the views and preferences of the people who use them. Clearly these policies, systems, protocols, programs and practices must also be predicated on best practice.

Drawing on the conclusions from this consultation report, the policies, systems, protocols and programs related to antenatal care that were, by implication, most important if the Aboriginal women’s views and preferences were to be fully responded to included the following:

- Systems, models and protocols that allow for flexibility so that women’s preferences can be provided for; support midwife care; provide a choice of midwives; provide a continuity of care by midwives; enable women to select a model of care, from a number of female Aboriginal Health Workers; allow women to involve their partners if they so desire; reflect acknowledgment of socio-economic, housing and transport issues; and emphasise informed decision making.
- Incentives for recruitment and continued employment of female Aboriginal Health Workers who are highly regarded and have significant local knowledge.

- Workload formulas that provide for adequate time allocations for fostering of relationships between staff and young women, grandmothers and mothers, as well as key community organisations; the nurse, midwife or Aboriginal Health Worker to develop a relationship and explore the particular situation of the young woman; sensitive roundabout explorations of the young woman's situation to identify issues of concern such as previous abuse; extra support for young women, especially if it is their first pregnancy, they are currently victims of violence or they are without a partner or family support; and the establishment of professional networks to facilitate partnerships with and referrals to health, housing, financial support and other agencies.
- Orientation and training: in cultural security; in local culture and contexts; on the dimensions of shame; on domestic violence and sexual assault; for non-Aboriginal staff to facilitate their understanding of, and support for, the role of Aboriginal Health Workers; for Aboriginal staff to facilitate their understanding of, and support for, the role of midwives; in styles of practice that facilitate trust and support; in privacy and confidentiality that reflects the complexity of the issue as it relates to Aboriginal and non-Aboriginal staff; strategies to support good communication between non-Aboriginal staff and Aboriginal staff; and training in reflexive practice, action research and narrative evaluation for staff.
- Formal and informal action research and evaluation activities that ensure that Aboriginal women's views and experiences of their care are regularly gathered and responded to by practitioners requesting informal and formal feedback from women; recording of such requests being made and responded to on the antenatal record; monthly critical reflection sessions on episodes of practice and case review by nurses, midwives and Aboriginal Health Workers; implementation of small action research projects by staff; regular reviews of data reports; yearly or twice-yearly reviews of practice and consultation with women including action plans that address the issues identified and result in changed practices.

Congress Alukura has addressed many of the policies, systems, protocols, programs and practices outlined above, as well as many more that were not specifically alluded to by the women who participated in this consultation.

Dynamic partnerships with young [and older] Aboriginal women, an organisational culture of evaluative inquiry and policies, systems, protocols, programs and practices that ensure Aboriginal women's views and experiences are being gathered, responded to and implemented are key technologies for the provision of quality antenatal care.

6.0

Appendix

6.1 Theme list

The theme list:

- Tell a love story or tell a story about getting pregnant
- Finding out you're going to have a baby
- Who should care for the pregnant woman?
- Where should the pregnant woman be cared for?
- What does a pregnant woman need?
- What does a pregnant woman need from a health service or a clinic?
- Sit down time

6.2 Findings on contraception

Contraception and terminations were raised by women during the consultation but were not directly related to the research question on antenatal care. However, Aboriginal women involved in the project considered that the information would be of interest to health care providers and so it has been included here.

All the young women living in Alice Springs said that information about contraception was very important, nevertheless their knowledge and use of contraception varied. Although most indicated an awareness of some kinds, for example, the contraceptive pill and condoms, they also indicated a lack of awareness of other forms of contraception. Four women were unaware of the name of a form of contraception that they had used and could not recall, or were uninformed about, the details relating to the conditions for, and effects of, using such contraception. Three women noted that they had used different kinds of contraception before and between their pregnancies.

Of the eleven women who discussed the form of contraception they were using prior to becoming pregnant, one had an IUD fitted, another used Implanon™, one relied on condoms, three were taking the pill and five used no form of contraception. Of these five, one had decided, with her partner, that she wanted to become pregnant and the other, a single woman, wanted a baby. The others had not thought about becoming pregnant even though they were sexually active.

Their reasons for selecting these different kinds of contraception varied from the least fussy and time-consuming method to the one viewed as most reliable.

I've just sort of, like, known my cycle and things like that, yeah... using condoms.

I just don't really like [the pill] because of the downfalls of some of them, too.

I've heard that, like, I have a cousin that actually got pregnant while she was on the pill, so they're not 100% so the best way is to be using condoms.

Implanon™ is better than some other contraceptions... can be a free girl

I was on the pill... but because I was always probably drinking, and, you know, I probably skipped one now and then, you know... and I'm still like that today... drinking, not drunk but still skipping some, you know.

These women thought that other young women needed more information about contraception, especially those still at school or who had left.

I think, yeah, maybe young people need to be more advised on contraception since everyone's getting pregnant, like there's something in the water. It's like when... I was [in] year 11, there were ten people that got pregnant in my class, like in my year, and they were all under, like, sixteen or so, it was pretty shocking but you get that.

Planned pregnancies were mentioned by three women. They indicated that they and their partners had thought about and planned the spacing of children.

Although not specifically asked, five of the young women living in Alice Springs discussed the possibility of terminating their first or second pregnancy. One indicated that she had a pregnancy terminated at sixteen years old, three said that they had thought about having a termination and one said that she and her partner didn't consider it an option. One added that she had been offered a termination by the health provider she visited.

I felt sad, I felt really, really, really upset. Because I was in my fine time, raging and carrying on, you know... and my thoughts right there and then was 'I'm not going through with it' cos I knew straight away that I had not, a support system, you know. I asked him [the father] his thoughts and views and how he felt about it too, you know. He gave me words that convinced me that I could have the child, yeah. To go through, yeah, with the pregnancy, and the child and everything that goes along with it.

Some of the young women living in remote communities had various levels of knowledge about the forms and uses of contraception. Some had received a little education about how to not get pregnant, some knew about Implanon™ and said that they preferred it to other kinds. Others pulled up their sleeves and pointed to a spot on their arm to indicate that they had Implanon™ inserted. The young women received information about contraception from a variety of sources.

Nurses talk about [it] when baby inside.

Others mentioned that the female Aboriginal Health Worker ‘told story’, other women ‘learnt about being healthy’ from the ‘older ladies’ and others received information about contraception from ‘the Women’s Council’.

Clearly receiving information in the context of traditional culture and from the women who had traditionally taught them was important. The women who were visited by the Women’s Council preferred attending their meetings because the nurse ‘only works at the clinic’, whereas the women from the Women’s Council understand their culture.

We get Women Council come and talk to the girls about needles and Implanon™... talking the teenagers... better that it is Women’s Council I think, they know more about Anangu... they have meetings, talk about our way.

Being taught by traditional grandmothers and older women was also valued. In another community some of the young women had attended meetings at a special place with the older ladies from their community. The older ladies had talked to them about staying healthy and

they talk about girls...

They talk about this, the vagina, and having sex and taking the blood [for tests].

These women thought that ‘maybe’ the girls listened but they said that some young women were too young when they first became pregnant and that not all of the pregnancies were planned.

Young mans and young girls are married [at] twelve, fourteen years old ... sixteen... they underage, they should be at school.

She suggested that the women should be ‘maybe twenty or twenty-one’ when they become pregnant.

It was clear from what some young women living in remote communities said that they had sufficient information about, for example, Implanon™, to plan their pregnancies. Some women from two different communities indicated that they had planned when to have their second children. One said that she had wanted many years between having her babies. Another talked about other women in the community wanting children and deciding to become pregnant.

Sometimes they want to get it [Implanon™] out so they can have a baby.

The option of terminating a pregnancy was mentioned by only one group of young women living in remote communities who explained that some young women decide that they do not want to proceed with the pregnancy. Of these women, some will go to the community’s health service to seek a termination and others will not. Those who do not go to the health service or tell the staff they are pregnant, try to end the pregnancy in their own ways.

That’s why young girls they don’t tell anyone... they do secret way.

Dance at the disco... [and] jump up and down to get rid of the baby... you know, to kill the baby.

That's been happening for a lot of Anangu girls... everywhere.

However, they thought that the health service staff should do more to help the young girls, although one woman was uncertain of how helpful this would be. She indicated that the staff at the health service would have to be very aware of the family situation. Two young women discussed this as follows.

If the young mother, like, if she's pregnant she might want an abortion and maybe they could help her out...

They have a little meeting.

Wiya.⁸

Uwa. Playa.⁹

Maybe.

How they could have an abortion... mum might say, no, I want to have that baby, like that.

Like young girls. Sometimes, like, if you stay away from the clinic a lot that means baby is growing and it's too late to have abortion.

And the clinic could have a meeting with the family about looking after the baby or give that one away.

Older women living in Alice Springs said that women of reproductive age should be provided with a number of contraceptive choices by health professionals. Concern was expressed about the contraceptive pill as a method given that some young women would forget to take it and they considered Implanon™ to be the most reliable method.

Give them options... show them different things.

As they discussed the various contraceptive methods available, it was apparent that, although most older women knew about some forms of contraception, they were unclear about others. Questions were asked about, for example, Implanon™, whether it was possible to become pregnant while fitted with Implanon™, if it was harmful to the baby if the woman did conceive whilst Implanon™ was still inserted and if it effected a woman's chances of becoming pregnant once she had it removed. Despite these uncertainties, many thought the 'needle good' because:

them young girls might not remember to take tablet [contraceptive pill].

⁸ No.

⁹ Yes.

Given that these women may in all likelihood be advising young women about contraception, it may be useful to also make information available to them and other older women.

Contraception should not always just be the woman's responsibility.

Them men should have an operation.

Although the older women living in Alice Springs indicated that they thought men should take some responsibility or treatment of some kind to control their fertility, the younger women did not suggest this. The younger women only discussed the methods they did or did not use to control their bodies. Only one young woman specifically, but indirectly, mentioned the man's role by referring to condoms as a contraceptive device.

The older women living in Alice Springs said that some young women do become distressed and uncertain as to how to proceed when they realise they are pregnant. They require guidance and support from a grandmother, mother or an aunty and they need to be offered options by a health service, options that include a termination.

Those young girls don't know whether to keep the child or get rid of it... like that termination thing ... because sometimes you gotta give them options [it is hard] some of them need that help really badly... but [they] don't know how to ask grandmother or mother or aunty ... you just gotta get a grandmother to come [and help the pregnant woman decide whether to have the baby or not].

That they wanted the option of a termination was expressed by some young town women and a few of those living in remote settings; however, none of them mentioned a grandmother assisting in the decision to have a termination.

The older ladies living in remote communities said that they were responsible for teaching the younger women about 'story', and 'women's business'. They explained, some in very direct language, that this included sex and pregnancy.

Bring young girls out to talk about things like when they get pregnant ... talk about things...[like] pregnancy, sexual, what do you call them, infections ... about sex and not allowed to get pregnant... tell them about she can have one baby, first baby ... [and then use contraception.]

They taught the young women about various forms of contraception, for example, needle ... condoms... they know about condoms but not that thing... DepoProvera.

Implanon™ was mentioned by a woman in another community who observed that the 'young ones' prefer:

the needle in the arm [because] they might forget that pill.

Contraception was very important, they said, because the young women are aged between twelve and eighteen years when they start sexual relationships with boys and some young women drink too much alcohol and then have unprotected sex.

They gotta think about themselves before they get pregnant... some ladies have kid when they're twelve, sometimes.

Girls here have sex... when you're having sex [then you] have two or three babies.

Young people starting early having sex now, they don't realise that they can get pregnant first [time]... they think 'I'm too young to have babies' ... twelve or thirteen [but they] start having babies straight away.

There was a general view that although the older women teach the young ones at school and in the 'bush', they 'need to learn' from them and the health service staff more about contraception, its different forms and how to plan babies.

Terminating a pregnancy was only explicitly mentioned by one older woman, who said that some women want the pregnancy terminated because families demand it and because the father is of the wrong skin.

The older women's view that young women require more information about contraception, sexually transmitted diseases and family planning delivered in the right ways and in a variety of settings by older ladies and health staff was consistent with the opinions of the older women residing in Alice Springs. There was a stronger emphasis on the information being contextualised within the traditional 'stories', even though many of the older women from Alice Springs also wanted the traditional law and knowledges to be taught. These findings are also consistent with the opinions of the young women, most of whom felt that young women required more information on these matters. The particular, local context and culture will inform how and in what form it is to be delivered.

6.3 Findings on men's health

During the discussions about the role of partners, the older women living in Alice Springs raised the topic of men's health. Although in most cases the older women living in Alice Springs were unhappy about changes to traditional cultural practices in relation to men's involvement with birthing, some of them advocated for changes to traditional practices as they related to men's health.

It was considered urgent that men become more informed about health matters, their own and the pregnant woman's. Women had benefited from health information and services provided by the Aboriginal health services in Alice Springs but men did not seem to access them or benefit from them to the same degree. This is a major concern given men's burden of disease, substance abuse problems, mental health conditions and that they often are the perpetrators of violence [AIHW 2006].

One major difficulty in addressing this matter is that aspects of men's health, traditionally, like women's health matters, can only be addressed in certain ways by certain people in particular places.

Men don't like to talk about it openly, they see it as sacred business, men's business [they say] leave that stuff in the bush.

Yeah, they say sacred business, don't talk, but they need to talk.

When you want to talk to the men about diseases, they say leave it in the bush.

They won't talk... [but] they go round giving those diseases to the girls ... white fellas diseases.

This is an obvious hurdle, given that some men must be provided with more information about some of the health conditions they have, receive treatments and, most importantly, talk about their problems with others or with health professionals if their health and that of others is to improve.

Interestingly, none of the young women raised these kinds of concerns about men's health.

7.0

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**Central Australian
Aboriginal Congress Inc.**
PO Box 1604, Alice Springs
NT 0871 AUSTRALIA
T: +61 8 8951 4400
F: +61 8 8953 0350
W: www.caac.org.au



**Cooperative Research Centre
for Aboriginal Health**
PO Box 41096, Casuarina
NT 0811 AUSTRALIA
T: +61 8 8943 5000
F: +61 8 8943 5010
E: admin@crcah.org.au
W: www.crcah.org.au