

Exploring satisfaction among women having a First Nations baby at one of three maternity hospitals offering culturally specific continuity of midwife care in Victoria, Australia: A cross-sectional survey

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ABSTRACT

Background: Continuity of midwife care is recommended to redress the inequitable perinatal outcomes experienced by Aboriginal and Torres Strait Islander (First Nations) mothers and babies, however more evidence is needed about First Nations women's views and experiences of their care.

Aims: This study aimed to explore levels of satisfaction among women having a First Nations baby, who received maternity care at one of three maternity services, where new culturally specific midwife continuity models had been recently implemented.

Methods: Women having a First Nations baby who were booked for care at one of three study sites in Naarm (Melbourne), Victoria, were invited to complete one questionnaire during pregnancy and then a follow up questionnaire, 3 months after the birth.

Results: Follow up questionnaires were completed by 213 women, of whom 186 had received continuity of midwife care. Most women rated their pregnancy (80 %) and labour and birth care (81 %) highly ('6' or '7' on a scale of 1–7). Women felt informed, that they had an active say in decisions, that their concerns were taken seriously, and that the midwives were kind, understanding and there when needed. Ratings of inpatient postnatal care were lower (62 %), than care at home (87 %).

Conclusions: Women having a First Nations baby at one of three maternity services, where culturally specific, continuity of midwife care models were implemented reported high levels of satisfaction with care. It is recommended that these programs are upscaled, implemented and sustained.

Issue

Due to the known benefits, continuity of midwife-led care models for First Nations women are recommended in maternity policy.

What is already known

Targeted maternity programs for First Nations women require community-led approaches in service planning, delivery, and evaluation.

What this paper adds

This paper adds to the gap in the literature in terms of understanding the views of First Nations women who received continuity of midwife care in an urban setting.

Introduction

In Australia, Aboriginal and Torres Strait Islander (First Nations) women and newborns continue to experience inequitable perinatal outcomes [1,2]. Numerous government policies recommend that the mainstream maternity system must improve its capacity to meet the needs of First Nations women by partnering with communities to implement and sustain evidence-based programs [3,4]. Continuity of midwife-led care throughout pregnancy, birth and the postpartum period is one such strategy [3]. Caseload midwifery is a type of midwife-led continuity where a woman has 24/7 telephone access to a primary caseload midwife (and one or two backup midwives) who

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provides care throughout pregnancy, labour and birth, and in the early postnatal weeks.

The benefits of caseload midwifery have been well documented [5, 6], and for First Nations women, continuity of midwife care has been associated with fewer preterm births, more frequent antenatal care, higher rates of exclusive breastfeeding at discharge [7], decreased levels of tobacco use, and increased feelings of trust and safety [8]. These are important findings, as numerous studies have reported that First Nations women can experience challenges within the maternity system, such as culturally unsafe practices inhibiting access to appropriate care [9–11] and experiences of racism contributing to inequitable outcomes [12,13]. In Australia it is recommended that caseload midwifery models are expanded [3], given that only approximately 15 % of women can receive caseload midwifery care [14]. First Nations women are even less likely to have access, due to factors such as models being available to women with ‘low-risk’ pregnancies only and lack of culturally specific programs [11]. At the national level, it is recommended that Birthing on Country (BoC) models of care are implemented [3]. These are community-led, holistic, comprehensive, strengths-based maternity care models for First Nations women, providing First Nations babies with ‘the best possible start in life’ [15]. Evidence-based frameworks, such as the RISE framework, have been developed to guide the implementation of BoC models in Australia [16]. Continuity of carer is one of the principles that underpins BoC [17], and BoC services featuring continuity of midwife care have demonstrated benefits for First Nations women and newborns [7].

The Baggarrook Yurrongi project was a translational partnership project between La Trobe University, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and three major tertiary centres located in Naarm (Melbourne), Victoria. The overarching aim was to implement and sustain midwife continuity models for First Nations women, and women expecting a First Nations baby. The new models commenced in 2017 and led to a 21-fold increase in the number of women having a First Nations baby receiving caseload midwifery care [18]. Only 34 First Nations women had ever received caseload midwifery at any of the three sites previously, increasing to 703 First Nations families during the study period [18]. Exploring the views and experiences of women having a First Nations baby was a key aim of the project.

Seeking valid and reliable feedback from women about their satisfaction with care is an important measure of quality [19]. Collating the views of women offers opportunities for future improvement, [20–22] and the Australian National Safety and Quality Health Service Standards emphasise the importance of partnering with consumers for service evaluation [23]. For targeted First Nations women’s health programs, it is essential that local First Nations women are involved in monitoring and evaluation, for assurance of quality and tracking of progress [24]. Engaging local First Nations women in the design, implementation, and evaluation of targeted models of care is also recommended in national maternity service policy, which recognises that women-reported well-being and experience outcome data is a key enabler of the woman-centred care strategic framework [3].

Recent evaluations of First Nations specific maternity programs that include continuity of midwife care provide evidence of successful implementation [7,8,18], with recommendations to scale-up these programs [7,18]. However, a systematic review has identified a shortage of evidence in relation to midwife continuity models for First Nations women in urban contexts [25], and more evidence is needed in relation to First Nations women’s cultural needs when birthing in an urban setting [26]. A cross-sectional study, which used a culturally tailored survey explored satisfaction among First Nations women having a baby in Queensland, recommended enabling more choice for women by increasing access to strength-based, continuity of care programs [27]. Other studies that have explored First Nations women’s views have not specifically included satisfaction as an outcome measure, with variations in methods, terminology and measurement tools used [8,28–31].

All the identified studies reported that First Nations women responded positively to models aiming to increase continuity of midwife care [8, 27–31]. A 2017 meta-synthesis found that overall, continuity of midwife care enhances the ability of the system to meet the needs of First Nations women [11].

In Victoria, there is limited evidence regarding the views and experiences of First Nations women regarding their maternity care. One study evaluated the Women’s Business Service (WBS), a community-controlled maternity program in rural Victoria that included antenatal and postnatal continuity of midwife care, with the possibility of non-clinical support provided by the WBS midwife or maternal infant health worker during labour and birth at the hospital [29]. Women who attended the WBS reported higher levels of satisfaction, compared with other women who were not specifically First Nations but were living in rural Victoria and receiving public maternity care in a similar period [29]. There have been no studies specifically exploring the experiences of First Nations women accessing maternity care in an urban Victorian context to the knowledge of the authors. This paper explores the views of women having a First Nations baby in one of three hospitals that implemented a new culturally specific caseload midwifery model in Naarm (Melbourne), Victoria, with a focus on satisfaction with care.

Methods

A descriptive design [32] was used for this study. The study was co-designed with VACCHO and an Aboriginal Advisory Committee (AAC) [18]. The AAC included First Nations members of the research team, community Elders, First Nations staff from the Aboriginal Health Units at the study sites, a recent First Nations mother, and a representative from VACCHO. The AAC provided input into the study design, eligibility criteria, data collection processes and tools, and community engagement.

Participants

First Nations women and women having a First Nations baby, who were booked for care at one of the study sites during the study period were approached and offered the opportunity to participate. Women were invited to participate regardless of what model of care they had chosen or were able to access; that is whether or not they received the culturally specific caseload midwifery model. Eligible women were booked for antenatal care as a public patient at one of the three study sites, were over the age of 16, spoke English well enough to not require an English translator, and identified either themselves or their baby as First Nations. We aimed to offer all eligible women during the recruitment period the opportunity to participate, however women were not approached if they did not have a live baby, or if the clinical team had reason to advise the woman should not be approached (e.g. acute psychiatric illness or being very unwell).

Participation involved completing two questionnaires – one at recruitment, and a follow up questionnaire between three and six months postpartum.

Recruitment

Research midwives aimed to approach all eligible women (Fig. 1). Recruitment to the study commenced concurrently with the commencement of the new models at each study site. As each site was ready to commence at different time points, recruitment began in March 2017 at site one, October 2017 at site two, and in April 2018 at site three. Most women were approached during a routine antenatal visit. Some women were approached on the antenatal inpatient ward, or on the postnatal ward after birth (if a woman had transferred in for care late in pregnancy or had not been identified as eligible until after birth). The research midwives explained the project and provided women with written information. Women were able to discuss participation in the

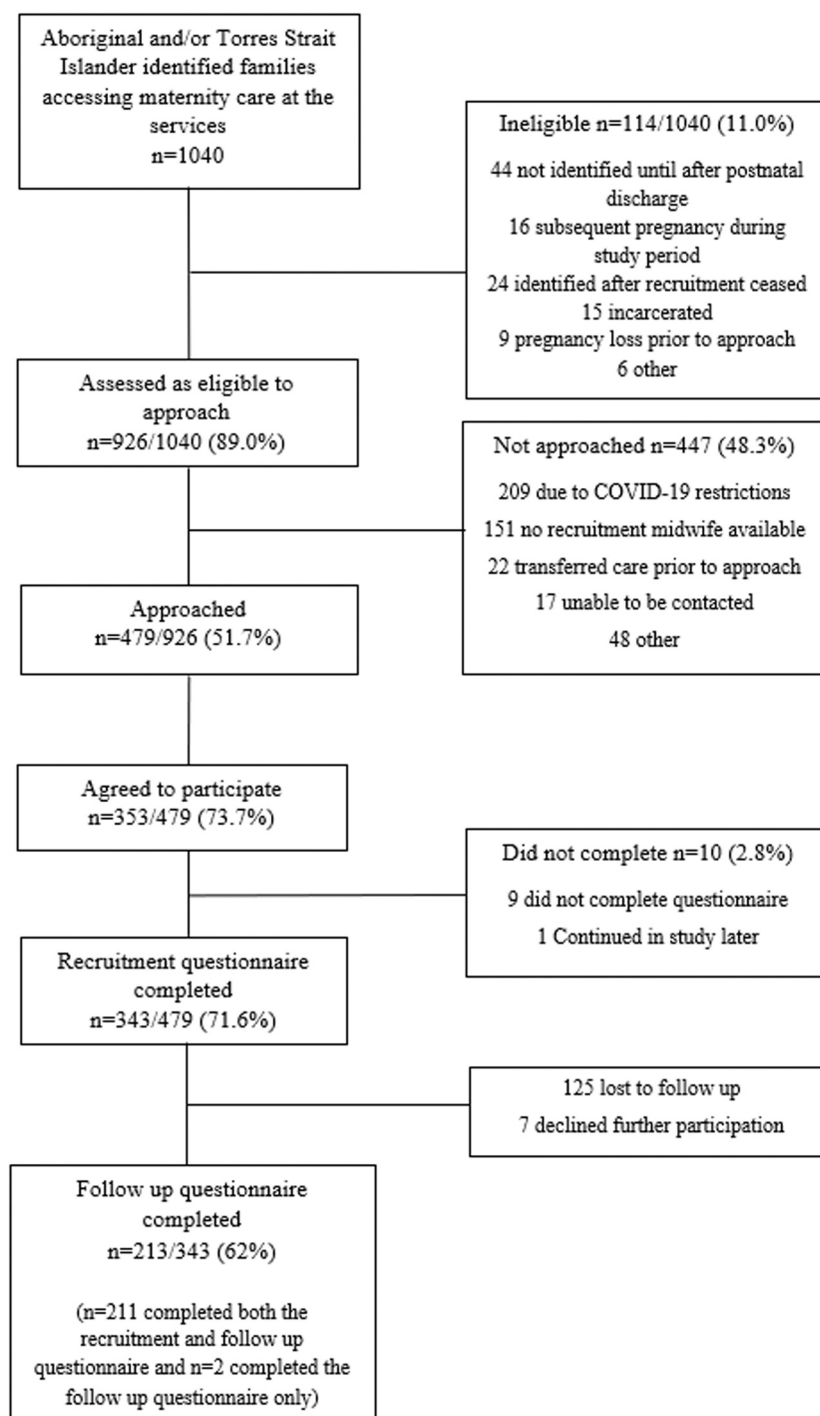


Fig. 1. Participant flow chart.

evaluation with their partner, family, or members of their community, or with the Aboriginal Hospital Liaison Officer (AHLO). Women were informed that participating in the evaluation was voluntary. If a woman agreed to take part, she signed a consent form. In 2020, face-to-face recruitment was impacted by the COVID-19 pandemic, therefore some women were invited to participate by telephone. In this instance, consent was provided using an online link via REDCap (Research Electronic Data Capture), a secure, password protected data management software program [33].

Data collection

The initial questionnaire was completed face-to-face following consent, except where recruitment was by telephone, in which case the researcher would read out the questions to the woman and then document her answers onto the hardcopy questionnaire.

The follow up questionnaire was completed via telephone. When women reached three months postpartum, the research assistants/midwives called women to complete the questionnaire. Telephone calls were conducted by First Nations researchers where possible. If no First Nations research assistant/midwife was available, then a non-First

Table 1
Participant characteristics.

	Recruitment questionnaire		Follow up questionnaire	
	n	%	n	%
	(n = 343)		(n = 213)	
<i>Study site</i>				
Site 1	154	44.9	98	46.0
Site 2	84	24.5	54	25.4
Site 3	105	30.6	61	28.6
<i>Age at recruitment (years)</i>				
Mean (SD), range	28 (5.4) 16–44		29 (5.8) 18–44	
< 21	24	7.0	10	4.7
21–25	92	26.8	50	23.5
26–30	109	31.8	74	34.7
31–35	83	24.2	57	26.8
36–40	31	9.0	19	8.9
> 40	4	1.2	3	1.4
<i>First Baby (n = 343/211)</i>				
Yes	158	46.1	102	48.3
<i>Age of baby at follow-up (weeks)</i>				
Mean (SD), range			17 (4.2) 12–39	
<i>Mode of birth (n = 343/211)</i>				
Spontaneous vaginal	-	-	121	57.4
Forceps	-	-	8	3.8
Vacuum	-	-	13	6.2
Caesarean section (planned)	-	-	27	12.8
Caesarean section (unplanned)	-	-	42	19.9
<i>Received caseload</i>				
Yes	-	-	186	87.3
<i>Aboriginal/Torres Strait Islander status (n = 343/211)</i>				
Aboriginal	243	71.0	146	69.2
Torres Strait Islander	9	2.5	7	3.3
Both	10	3.0	9	4.3
Neither	81	23.5	49	23.2
<i>Partnered (n = 340/209)</i>				
Yes	296	87.1	192	91.9
<i>Partner's Aboriginal/Torres Strait Islander status (n = 343/211)</i>				
Aboriginal	136	39.7	77	36.5
Torres Strait Islander	4	1.2	3	1.4
Both	5	1.5	3	1.4
Neither	194	56.6	125	59.2
Unsure	4	1.2	3	1.4
<i>Language spoken at home (n = 343/211)</i>				
English	330	96.2	203	96.2
<i>Aboriginal or Torres Strait Islander language is spoken (n = 342/211)</i>				
Yes	46	13.5	25	11.9
<i>Education (n = 339/209)</i>				
Year 10 or less	63	18.6	31	14.8
Year 11 or 12	114	33.6	58	27.8
Cert 3 & 4 or Diploma	96	28.3	64	30.6
Degree	66	19.5	56	26.8
<i>Studying at pregnancy confirmation (n = 339/209)</i>				
Yes	66	19.5	40	19.1
<i>Was employed at pregnancy confirmation (n = 339/209)</i>				
Yes	215	63.4	149	71.3
<i>Pension/government benefit main source of income (n = 339/207)</i>				
Yes	101	29.8	44	21.3
<i>Health care concession card holder (n = 339/209)</i>				
Yes	155	45.7	79	37.8
<i>Private health insurance (n=337/209)</i>				
Yes	55	16.3	46	22.1
<i>Accommodation (n = 334/204)</i>				
Homeowner/paying off mortgage	66	19.8	48	23.5
Renting	182	54.5	113	55.5
Living with family/friends	60	18.0	35	17.2
Temporary accommodation	9	2.7	3	1.5

Table 1 (continued)

	Recruitment questionnaire		Follow up questionnaire	
Other	17	5.1	5	2.5
<i>Smoking pre-pregnancy (n = 338/208)</i>				
Yes	143	42.4	74	33.6
<i>Smoking at time of survey (n = 336/142)</i>				
Yes	82	24.4	50	35.5
<i>Others smoking at home (n= 334/198)</i>				
Yes	100	30.9	18	9.1

nations researcher would conduct the telephone interview, with the woman's agreement. For all calls the researcher re-confirmed consent with the woman and checked she was in a safe and private space to complete the questionnaire. Women were reminded that the questionnaire included sensitive health questions, and of the option to pause or end the session at any point. The researcher then read out the questions to the woman and documented her responses on a hardcopy questionnaire.

A standardised contact protocol was used for women who requested a call back at a later time, or if women were not able to be contacted in the first instance. If a woman reached six months postpartum and was not able to be contacted, they were then considered 'lost to follow up' and contact attempts were ceased. If a woman contacted the research team to complete the questionnaire after this, they were still able to participate, with a cut-off date set at nine months postpartum. A protocol was also in place in the event that a woman required referral to a particular service for further support. The researchers also were able to provide contact information for each of the AHLOs from the study sites, if a woman wanted to provide feedback to the hospital directly.

Data collection tools

The questionnaires were based on data collection tools previously used by the research team [34] and tools used in similar studies [28,35]. The AAC provided feedback to ensure the questions asked were relevant and culturally appropriate. The initial questionnaire collected information on sociodemographic characteristics including First Nations status, age, education level, place of residence and socioeconomic status i.e. health care card concession holder status, and whether the household received a government benefit as the main source of income [36].

The follow up questionnaire included questions on the model of care women received, (i.e. caseload midwifery, standard care, or the culturally specific Baggarrook Yurrongi caseload midwifery model). The questionnaire also included questions on women's levels of satisfaction with their pregnancy, labour and birth, and postnatal care [34]. Ordinal data were collected in questions where women were asked to answer, for example, 'Always' 'Mostly' 'Sometimes' 'Occasionally' or 'Never', in relation to their interactions with midwives, as well as in 7-point Likert-type scales where women could rate each aspect of care from '1' (Very poor) up to '7' (Very good).

Data management and analysis

Data were entered into REDCap [33] and then imported into Stata 17 [37] for cleaning and analysis. Data cleaning included range and logic checks as well as checking missing data fields and cross checking the hard copy questionnaires. Quantitative data were summarised using frequencies and percentages.

Ethics

Multi-site Ethics approval was received from St Vincent's hospital HREC (reference number HREC-16\SVHM\223), and La Trobe University (HREC 195/16) and all three health services provided site specific

approval. The study was conducted in accordance with National Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research [38].

Results

Data collection was from March 2017 until August 2021, during which time 1040 Aboriginal and/or Torres Strait Islander families were identified and booked for care across the three study sites. Of those, there were 479/926 (51.7 %) of the eligible women that were approached to participate in the evaluation (Fig. 1).

Participant characteristics

Table 1 shows the characteristics of women recruited to the study, and of the women who responded to the follow up questionnaire [36]. Characteristics were similar with the exception of women who participated in the follow up questionnaire being more likely to live in regional/rural areas of Victoria, more likely to have a university degree, less likely to be unemployed, less likely to be a healthcare concession card holder. Just over half the women had a spontaneous vaginal birth (57 %), and most had a partner (87 %), spoke English at home (96 %), were employed (71 %) and had completed some form of tertiary education (57 %). Most women (87 %) had received caseload midwifery care (site 1: 88 %, site 2: 82 %, and site 3: 92 %).

Satisfaction with care

Pregnancy care

Figs. 2 and 5 shows women's overall ratings of their pregnancy care where '1' was 'Very poor', and '7' which was 'Very good'. The majority of women (80 %) rated their pregnancy care positively (either '6' or '7'). Similarly, most women who received a caseload model rated their pregnancy care as either '6' or '7' (81 %), with 70 % of the women who did not receive a caseload model rating their care as '6' or '7'.

We also asked women a number of questions about a range of aspects of their pregnancy care (Table 2). Overall, levels of satisfaction with care were high, with most women 'Agreeing' or 'Strongly agreeing' that they had a say in decisions (87 %), that the midwives kept them informed (93 %), took their concerns seriously (95 %), and asked if they had any questions whilst at check-ups (97 %). Women were happy with their physical and emotional care, and overall there was a pattern of higher levels of satisfaction with caseload care and care provided by midwives, compared with doctors. Women were satisfied overall with the level of information they received about a range of topics during pregnancy (Table 2).

Labour and birth care

Overall, levels of satisfaction with labour and birth care were high. Most women (81 %) rated their care during labour and birth positively ('6' or '7') (see Figs. 2 and 5). The percentages of women who rated their

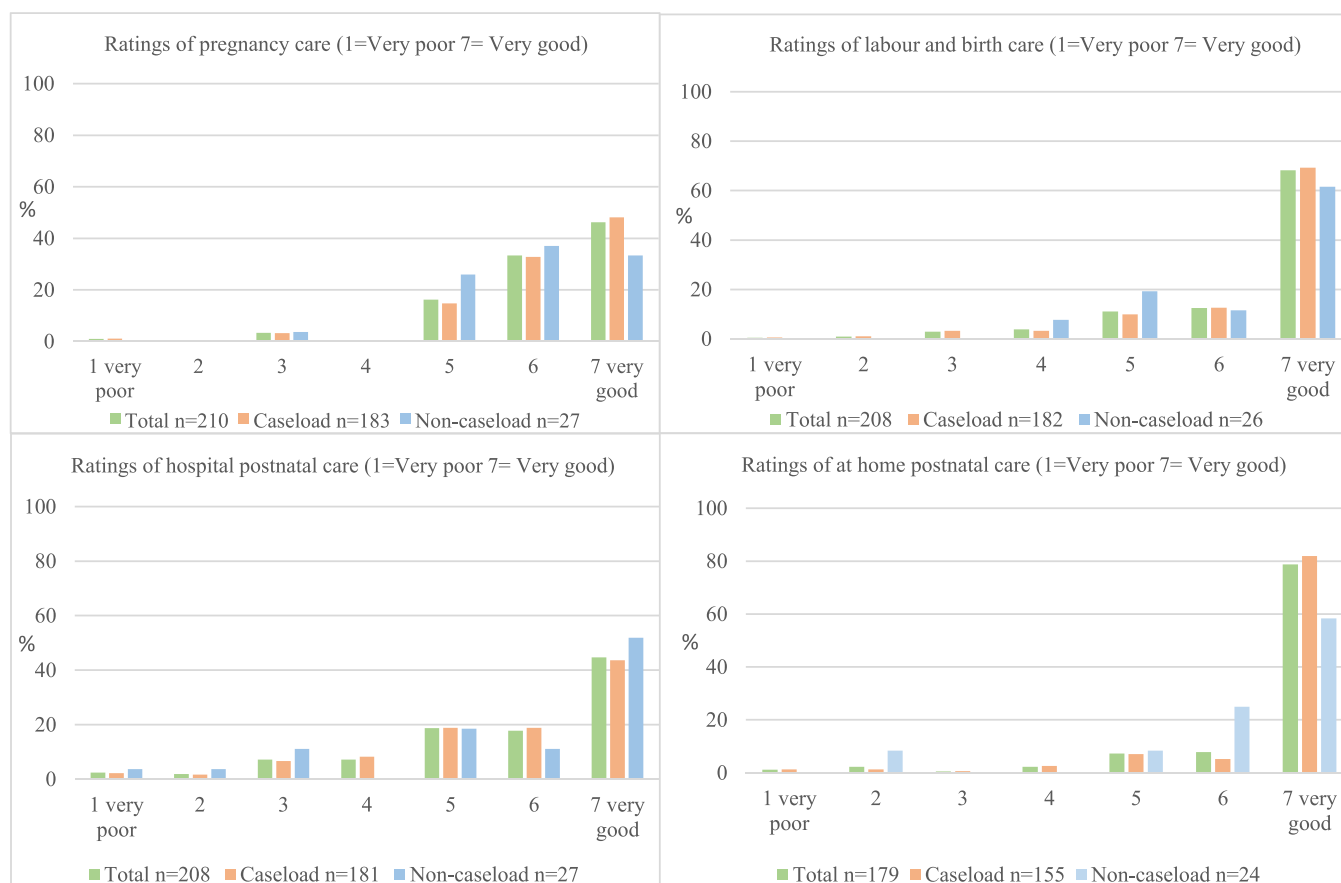


Fig. 2. Overall ratings of care across all 3 study sites.

Table 2
Satisfaction with pregnancy care.

Satisfaction scores (%)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<i>At my check-ups I was always asked whether I had any questions</i>					
All women n = 213	0.5	0.5	1.9	11.3	85.9
Caseload n = 186	0.5	0.5	1.6	10.8	86.6
Non-caseload n = 27	-	3.7	-	14.8	81.5
<i>The midwives kept me informed</i>					
All women n = 204	1.0	2.5	3.4	17.7	75.5
Caseload n = 182	1.1	2.2	3.9	16.5	76.4
Non-caseload n = 22	-	4.6	-	27.3	68.2
<i>The doctors kept me informed</i>					
All women n = 213	3.1	4.9	13.6	26.5	51.9
Caseload n = 162	2.7	4.3	11.8	23.1	45.2
Non-caseload n = 24	4.2	-	20.8	33.3	41.7
<i>I was given an active say in decisions about my care</i>					
All women n = 212	1.4	3.3	8.0	19.8	67.5
Caseload n = 185	1.6	3.2	8.1	17.8	69.2
Non-caseload n = 27	-	3.7	7.4	33.3	55.6
<i>My worries, anxieties, and concerns about my pregnancy and the baby were taken seriously by the midwives</i>					
All women n = 203	1.0	2.9	1.0	15.8	79.3
Caseload n = 182	1.1	3.3	0.6	15.4	79.8
Non-caseload n = 21	-	-	4.8	19.0	76.2
<i>My worries, anxieties, and concerns about my pregnancy and the baby were taken seriously by the doctors</i>					
All women n = 184	2.2	7.6	10.3	20.1	59.8
Caseload n = 159	2.5	7.6	10.1	20.8	59.1
Non-caseload n = 25	-	8.0	12.0	16.0	64.0
<i>The midwives provided reassurance when I needed it</i>					
All women n = 204	1.0	1.0	4.4	13.2	80.4
Caseload n = 183	0.6	1.1	4.4	12.6	81.4
Non-caseload n = 21	4.8	-	4.8	19.1	71.4
<i>The doctors provided reassurance when I needed it</i>					
All women n = 184	1.1	4.3	12.5	25.5	56.52
Caseload n = 159	1.26	5.0	12.0	23.9	57.9
Non-caseload n = 25	-	-	16.0	36.0	48.0
<i>The midwives seemed rushed</i>					
All women n = 202	51.0	25.3	2.1	13.9	6.9
Caseload n = 181	51.9	24.3	3.3	14.4	6.1
Non-caseload n = 21	42.9	33.3	-	9.5	14.3
<i>The doctors seemed rushed</i>					
All women n = 182	33.0	20.3	14.3	19.2	13.19
Caseload n = 157	31.9	21.7	16.6	17.2	12.7
Non-caseload n = 25	40.0	12.0	-	32.0	16.0
<i>My care was provided in a competent way</i>					
All women n = 212	-	2.4	3.3	23.1	71.2
Caseload n = 185	-	2.2	3.2	20.5	74.1
Non-caseload n = 27	-	3.7	3.7	40.7	51.6
<i>I was happy with the physical care I received from midwives</i>					
All women n = 202	2.0	1.5	0.5	17.8	78.2

Table 2 (continued)

Satisfaction scores (%)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
<i>I was happy with the physical care I received from doctors</i>					
Caseload n = 181	2.2	1.1	0.6	17.1	79.0
Non-caseload n = 21	-	4.8	-	23.8	71.4
<i>I was happy with the emotional support I received from midwives</i>					
All women n = 180	1.7	2.8	10.0	25.6	60.0
Caseload n = 155	1.9	3.2	8.4	23.2	63.2
Non-caseload n = 25	-	-	20.0	40.0	40.0
<i>I was happy with the emotional support I received from doctors</i>					
All women n = 202	2.5	1.5	3.0	15.8	77.2
Caseload n = 181	2.2	1.7	3.3	14.4	78.5
Non-caseload n = 21	4.8	-	-	28.6	66.7
<i>I was happy with the cultural support I received in pregnancy</i>					
All women n = 208	5.7	5.3	10.6	24.5	53.8
Caseload n = 181	5.0	3.9	11.1	23.8	56.4
Non-caseload n = 27	11.1	14.8	7.4	29.6	37.0
<i>I received adequate information about caring for my baby</i>					
All women n = 209	0.5	9.6	8.6	21.0	60.2
Caseload n = 183	0.5	9.8	8.7	21.3	59.6
Non-caseload n = 26	-	7.7	7.7	19.2	65.4
<i>I received adequate information about breastfeeding</i>					
All women n = 203	3.9	12.3	13.8	18.7	51.2
Caseload n = 177	4.0	12.4	12.4	19.2	52.0
Non-caseload n = 226	3.9	11.5	23.1	15.4	46.2
<i>I received adequate information about caring for myself after the birth</i>					
All women n = 209	4.8	12.0	13.8	25.8	43.5
Caseload n = 185	4.9	12.4	13.0	24.3	43.8
Non-caseload n = 27	3.7	7.4	18.5	33.3	37.0
<i>I received adequate information about labour and birth</i>					
All women n = 205	2.9	5.4	10.2	25.4	56.1
Caseload n = 182	2.2	5.0	9.5	25.7	57.5
Non-caseload n = 26	7.7	7.7	15.4	23.1	46.2
<i>I received adequate information about services available to me in the community</i>					
All women n = 211	6.6	14.2	20.4	22.8	36.0
Caseload n = 182	6.6	12.0	22.3	24.5	35.9
Non-caseload n = 27	14.8	29.6	7.4	11.1	37.0
<i>I received adequate information about how long I would stay in hospital</i>					
All women n = 208	7.2	8.2	7.2	24.5	52.8
Caseload n = 182	6.6	7.7	7.7	25.3	52.8
Non-caseload n = 26	11.5	11.5	3.9	19.2	53.9

care positively in each group were 82 % for the women who received a caseload model, and 74 % of women who did not receive caseload.

Other questions related to how women perceived interactions with their midwife/midwives during labour and birth, with positive responses from most women (Fig. 3). Most reported that the midwives were ‘Always’ kind and understanding (90 %), there when needed (84 %), and used words that women could understand (86 %), but less reported ‘Always’ having a say about decisions about their care (72 %) or receiving explanations about what was happening (67 %).

Postnatal care

Women’s ratings of in-patient postnatal care were less positive than for other components of care, however most women (62 %) rated their care positively as either ‘6’ or ‘7’. This increased to 87 % once women were receiving postnatal care at home (Figs. 2 and 5). Fig. 4 shows that on the postnatal ward, less than half of the women ‘Strongly agreed’ that

they received enough advice about looking after their baby (43 %) or their own health (46 %). Just over half (53 %) of women ‘Strongly agreed’ that they received enough information about breastfeeding or that the midwives were encouraging (57 %).

Satisfaction ratings across the continuum

Fig. 5 shows the proportions of women who rated their care positively (‘6’ or ‘7’) across the continuum. Overall women were highly satisfied with pregnancy (80 %), labour and birth (81 %), and domiciliary care (87 %). Women were most critical of their in-patient postnatal care, with 62 % of women rating their care positively.

Discussion

This study explored levels of satisfaction among women having a First Nations baby, who received maternity care at one of three Victorian

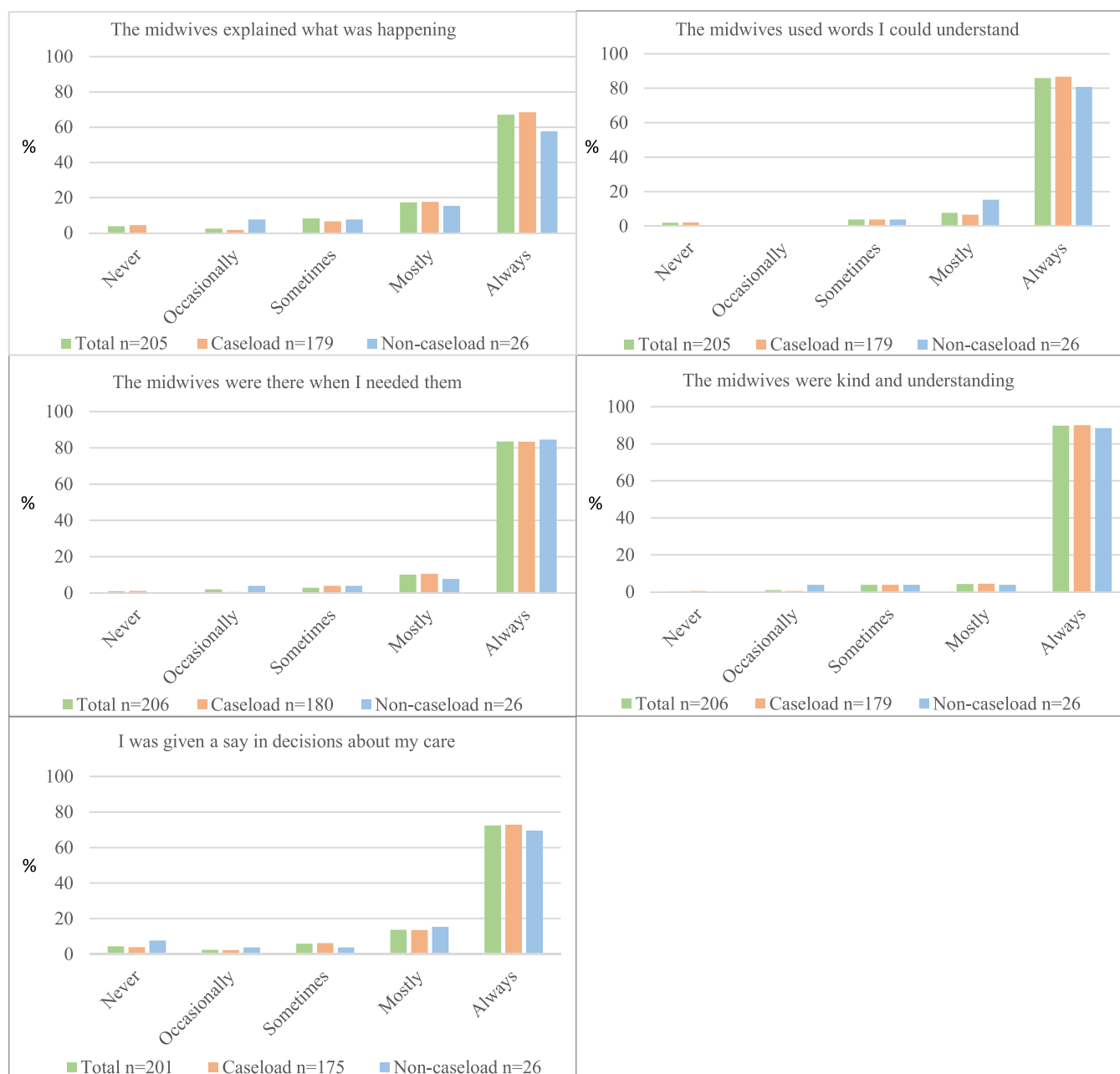


Fig. 3. Ratings of labour and birth care.

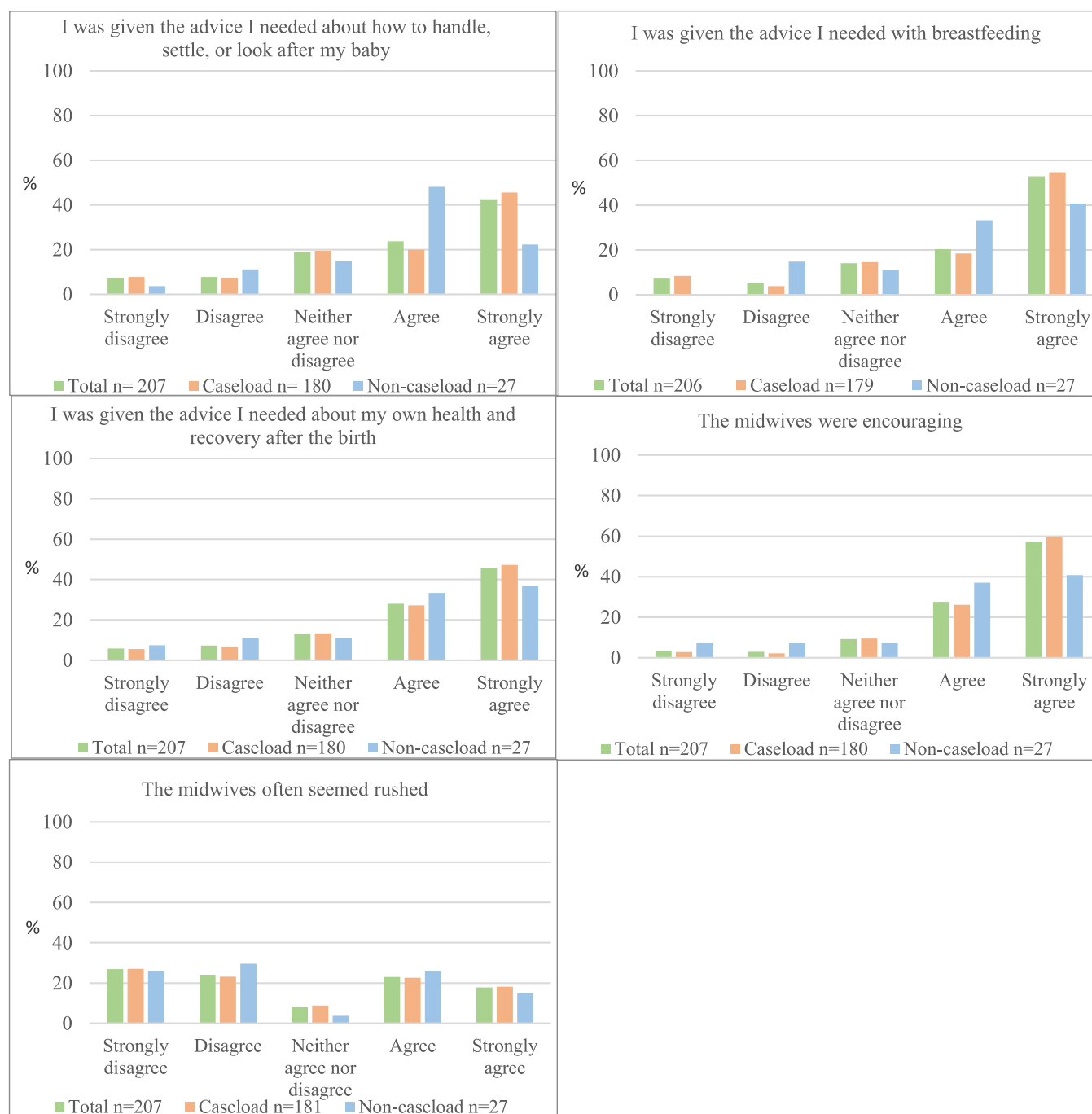


Fig. 4. Ratings of in-patient postnatal care.

tertiary services where new culturally specific caseload midwifery models were implemented on a large scale. We have presented women's views overall, as well as presenting them based on whether they received a caseload midwifery model (n = 186) or if they did not (n = 27). Given that First Nations women and newborns face an excessive burden of inequitable outcomes [1,2], and due to the well researched benefits of continuity of midwife models for women and newborns [6], both national [3] and state [39] policies recommend that First Nations women have greater access to these models. However, there is a lack of data about women's experiences of these models, particularly in urban settings and in Victoria.

Overall, women in this study have reported high levels of satisfaction with their maternity care, echoing findings from previous studies that

have compared caseload midwifery versus standard care [34,40,41] and also with previous studies of continuity of care for First Nations women [8,11,27–31]. Antenatal and intrapartum care were rated highly by the large majority of women. Satisfaction declined during inpatient postnatal care, then increased again once the women were at home. Overall, a pattern of lower levels of satisfaction in the non-caseload midwifery group was identified in the data, however, due to the small number of women who did not receive caseload, the sample size was inadequate to provide sufficient statistical power for comparisons. We were also interested if the site where the woman was receiving care, or the woman's Indigenous status impacted on satisfaction. When comparing percentages between the different study sites and women's First Nations status, there were no differences identified. However, the numbers were

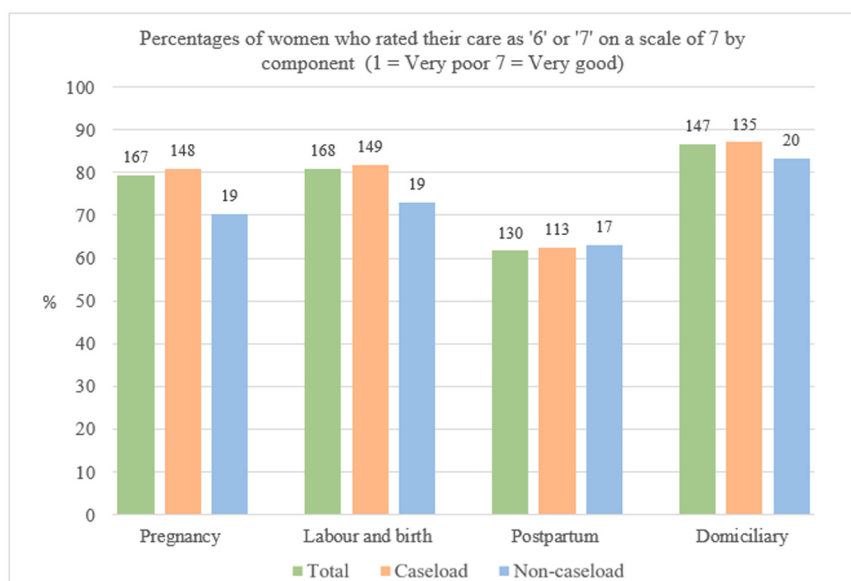


Fig. 5. Ratings across the continuum.

too small within the groups to undertake statistical comparisons.

Collecting satisfaction outcome data from birthing women is recommended in policy as an important means of quality control, [3] as this provides opportunity for health services to understand how care is being perceived by care recipients, as well as any areas for improvement [19]. Nationwide consultation aiming to elevate the voices of First Nations women and girls resulted in the recent Wiyi Yani U Thangani report, which supports that for targeted First Nations birthing programs, community involvement in the design, delivery and evaluation is considered essential for success [24]. The report argues that, while these programs are needed, they will be more likely to meet the needs of First Nations women if a role is maintained for First Nations women in monitoring and evaluating them [24]. The goal of this study has been to provide an opportunity for First Nations women to provide feedback about their care, to directly inform and improve the maternity services that are available.

This study has also presented data on various aspects of care within each phase of the childbearing continuum that contributes to maternal satisfaction overall [34,42]. The psychosocial aspects of pregnancy care have been recognised as critical to satisfaction [43], and women in this study mostly felt that the midwives took their worries seriously, kept them informed, asked if they had any questions, and provided good emotional support. This is likely to be correlated with women's high levels of satisfaction with pregnancy care overall. Patterns of lower satisfaction levels with medical care could be related to women more often reporting that the doctors seemed 'rushed'. Women in this study reported during labour and birth, the midwives kept them informed, they were given a say in decisions, and that the midwives were encouraging. This has also been reported by women who received caseload midwifery in previous studies [34,40,41]. As has been identified in this study, a previous study found that women experienced lower levels of satisfaction with care once on the postnatal ward [44]. Similar to some women reporting that medical staff appeared rushed during their pregnancy care, this was also the case for the midwives on the postnatal ward. Staffing issues and a busy environment on the postnatal ward have previously been recognised as a barrier for midwives to meet the needs of women [45], however, evidence shows that continuity of midwife care can improve women's satisfaction with their in-patient postnatal care, compared with standard care [34,40,41].

Models of care aiming to meet the needs of First Nations women and

newborns should be designed with consideration that First Nations approaches to health are holistic and are underpinned by culture [46]. Importantly, the majority of the women in this study reported that during their pregnancy, they were happy with the cultural support they received. The opportunity to establish a trusting relationship with a known caregiver aligns with First Nations culture [47,48], and maternity services need to ensure adequate resource allocation to allow for care to include First Nations ways of knowing, being and doing. This includes ensuring women have access to care that is holistic, with enough time to build relationships [49], which are core aspects of Birthing on Country models [17]. Previous studies have reported a lack of cultural safety within the maternity system [9,10], which perpetuates inequitable health outcomes for First Nations women and newborns [12]. Corcoran et al. identified that negative experiences often occur where care is fragmented, bearing little opportunity to build a trusting relationship with caregivers [11], and previous findings from the Baggarook Yurrongi project have highlighted the importance that First Nations women place on trust [36]. Therefore, it is important to recognise the success of Birthing on Country programs that have reported positive outcomes for women [7]. In this study women have been very positive about the care they received in hospitals that had introduced a culturally specific, continuity of midwife care model, and this was particularly so for women who received the new model. Considering this, as well as all the known benefits of caseload midwifery, it is recommended that these programs are upscaled, implemented and sustained in areas of Australia where First Nations women do not have access to a known midwife.

Strengths and limitations

To our knowledge, this is the largest study to date exploring satisfaction with care among women having a First Nations baby in Australia where the majority of the women received culturally specific model of caseload midwifery. This study also adds to the gap in the literature in terms of understanding the views of First Nations urban women [25,26]. Another strength of this study was the co-design approach with First Nations people, including input from the AAC. Given the existing high-level evidence of the benefits of continuity of midwife care for women, consultation with First Nations community members resulted in a decision that this should be a translational, implementation study

design (as opposed to a randomised controlled trial). One limitation of this study is that due to the low numbers of First Nations women who did not receive a caseload midwifery model, this study was not powered for statistical comparisons to be undertaken of satisfaction levels between the women from each group.

Conclusion

Continuity of midwife care throughout pregnancy, birth and the postpartum period is recommended in Australian national policy as a strategy towards improving outcomes for First Nations women and newborns [3]. Additionally, 'Birthing on Country' models of care require First Nations women to have access to a known midwife across the continuum, as one of the key principles [17]. Evidence demonstrates both physical and psychosocial benefits for women and babies generally, [6] and culturally specific models that include continuity of midwife care have improved outcomes for First Nations women newborns [7,8]. As a means of quality assessment and accountability, targeted maternity programs for First Nations women require community-led approaches in service planning, delivery, and evaluation [3,24]. The Baggarrook Yurrongi partnership project led to an exponential increase in the number of First Nations women having access to a known-midwife within three major tertiary centres located in Naarm (Melbourne) [18], and exploring women's views and satisfaction of their maternity care was an important outcome of the project. Overall, this large cohort of First Nations women (and women having a First Nations baby) reported high levels of satisfaction with their care within the three sites during the study period, particularly during pregnancy, labour and birth, and postnatal care in the home. It is recommended that further up-scale and implementation of First Nations community-led, culturally specific maternity models of care is prioritised, with ongoing evaluation of such models across the country [7,18].

Conflict of Interest

None declared.

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