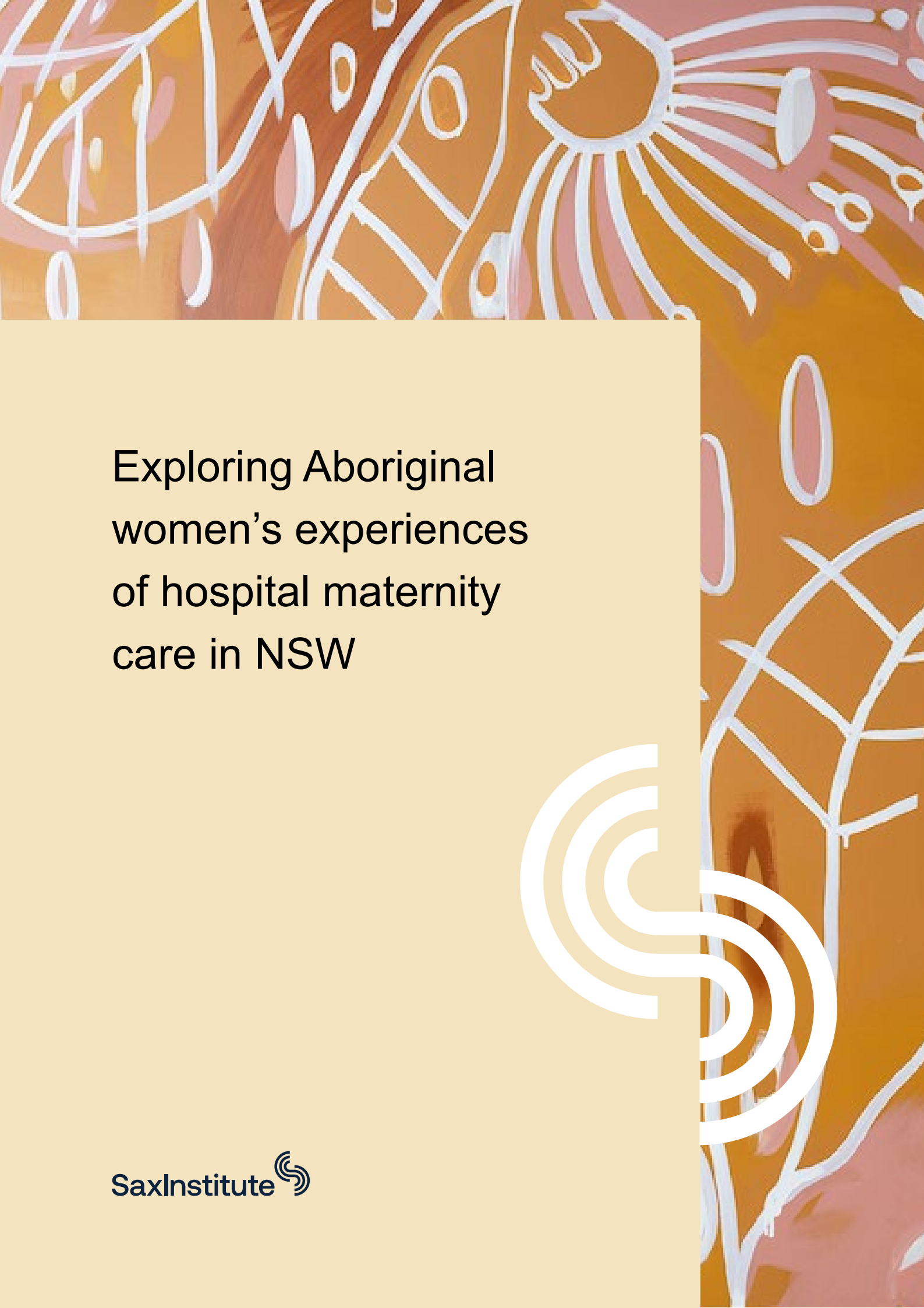

Exploring Aboriginal women's experiences of hospital maternity care in NSW

SaxInstitute

This qualitative study was conducted by the Sax Institute for the NSW Ministry of Health.

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We have used the term Aboriginal in this report to acknowledge Aboriginal and/or Torres Strait Islander peoples. The term is used to acknowledge the traditional custodians of lands in NSW and recognise the numerous nations, language groups and clans now residing in NSW.

Executive Summary

Introduction

Improving patients' experiences of health care is a NSW Health priority. The Bureau of Health Information (BHI) conducted census sampling of Aboriginal people for their Maternity Care Survey in 2019. This state-wide survey found differences in the experiences of hospital care reported by Aboriginal and non-Aboriginal patients, with Aboriginal patients significantly less likely to report being treated with respect and dignity. The Aboriginal Patient Experience Survey Project Advisory Committee subsequently recommended a qualitative study be conducted to further explore Aboriginal people's experiences of care in NSW public hospitals, and specifically the issue of cultural safety.

Purpose of this report

The Sax Institute was engaged by the NSW Ministry of Health to conduct this qualitative study. This report presents the study findings for Aboriginal women receiving hospital maternity care. It includes implications for improving cultural safety and overall patient experience across the care pathway for Aboriginal patients during pregnancy and birth in NSW public hospitals. Findings about Aboriginal patients' experiences of hospital care (excluding maternity care) have been reported elsewhere[1]. The qualitative study findings will be triangulated with the NSW Maternity Care Survey findings to provide a comprehensive story about Aboriginal maternity patients' experiences of hospital care in NSW.

Methods

An advisory committee with Aboriginal majority membership guided all aspects of the study. Three NSW local health districts (LHDs) and 4 Aboriginal Community Controlled Health Services (ACCHSs) participated in this study: Murrumbidgee (MLHD), Illawarra Shoalhaven (ISLHD) and Western Sydney (WSLHD), Riverina Medical and Dental Aboriginal Corporation (Rivmed), Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation (Waminda), Illawarra Aboriginal Medical Service (IAMS) and Greater Western Aboriginal Health Service (GWAHS). Recruitment was coordinated through the LHDs and ACCHSs in each geographical area. The study took a decolonising, Indigenist approach [2], with all interviews and focus groups conducted by a team of experienced Aboriginal researchers, who also played a key role in data analysis, interpretation, and reporting.

Findings

In-depth qualitative interviews were conducted with Aboriginal maternity patients who had given birth in the last 5 years (n=21), LHD staff who worked closely with Aboriginal maternity patients (n=2), and interviews and focus groups with ACCHS staff (n=13). Participants reported a range of experiences throughout the hospital journey, from antenatal care to admission to time on the ward, through to discharge and postnatal care. Many patients reported that they were treated respectfully and in a culturally appropriate way and received appropriate clinical care. Others reported experiencing racism, demonstrated through perceived stereotyping, judgements and biases. Some reported that negative past experiences for themselves or kin with health or other government agencies impacted on their experiences of care, due to anxieties of potential racism. Others reported a more general lack of support or empathy which they attributed to staff being overextended.

Some of the elements that participants reported that contributed to the hospital experience included:

- The ways that staff communicated with patients
- Care delivered by Aboriginal staff
- Welcoming places for patients and visitors

- Continuity of care from antenatal care through birthing and postnatal care.

Recommendations

1. Build cultural capability and safety
2. Address child protection concerns
3. Ensure that cultural models of maternity care are embedded within NSW Health.

1. Build cultural capability and safety

a. Strengthen efforts to address racism and unconscious bias, with a zero-tolerance approach to racism. This may include creating accountability in the system for racism, teaching and celebrating allyship, ensuring cultural safety is built in to how NSW Health does business, and enhancing "respecting the difference" training for NSW Health staff to include cultural immersion programs and decolonisation training to support the delivery of culturally responsive care,
b. Review policies, procedures and systems for measuring, reporting and addressing racism and unconscious basis
c. Develop, implement and monitor policies and environments which enable and support families attending hospitals to receive culturally safe care.
d. Ensure provision of cultural rooms and spaces that are accessible to Aboriginal patients and their visitors, and ensure usage guidelines are adequately communicated to encourage their use.
e. Build on the NSW Health Apology to strengthen efforts to improve trust between Aboriginal families and public maternity services

2. Address child protection concerns

a. Embed systems, policies and protocols to enable appropriate liaison and coordination between NSW Health and NSW Department of Communities and Justice to effectively support families with child protection vulnerabilities at birth
b. Increase maternity staff understanding of the historical and ongoing context of Aboriginal child removal in line with a decolonising approach
c. Ensure systems are in place enabling health staff to seek cultural consultation for child protection matters, to address unconscious bias and ensure any interventions are appropriate

3. **Ensure that cultural models of maternity care are embedded within NSW Health**

a. Increase the availability and strengthen culturally specific maternity models of care (e.g. AMIHS) across the NSW Health system to provide high quality and culturally safe continuity of care for Aboriginal families.
b. Improve Aboriginal women and families' access to support from Aboriginal Health staff, including Aboriginal Liaison Officers, Aboriginal Health Workers, and Aboriginal Midwives
c. Ensure that maternity care pathways address culturally appropriate continuity of care and support early engagement

Background

Patient experience encompasses all aspects of a patient's care and treatment, including how they feel about their experience [3]. Positive patient experiences are associated with better health outcomes, clinical effectiveness, and increased patient safety [3]. There is increasing recognition of the importance of patient perspectives and experiences of their care in informing and improving healthcare [4].Ensuring positive patient experience is a core priority for NSW Health. The first strategic objective in *Future Health,* NSW Health's overarching roadmap, is "*Patients and carers have positive experiences and outcomes that matter*", with key objective 1.2 to "*Bring kindness and compassion into the delivery of personalised and culturally safe care*" [5]. The vision in the *NSW Health Maternity Care Blueprint for Action* is "*that all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes*" [6].

NSW Health has made specific commitments to cultural respect and safety for Aboriginal people by upholding cultural protocols and implementing agreed actions that support the delivery of services and programs to Aboriginal people in NSW [7]. The *NSW Aboriginal Health Plan 2024–2034*, developed in partnership with the Aboriginal Health and Medical Research Council of NSW (AH&MRC) and the *NSW Health Maternity Care Blueprint for Action* also emphasise the importance of culturally safe health service provision [8].

The Bureau of Health Information (BHI) conducted census sampling of Aboriginal people for their Maternity Care Survey in 2019 [9]. Every woman who identified as Aboriginal and gave birth in a NSW public hospital was invited to provide feedback on their experiences. Most Aboriginal women reflected positively on their experiences of receiving maternity care during and after labour and birth, particularly if they had access to support from an Aboriginal Health Worker. However, the survey results highlighted issues worthy of further investigation. For example, Aboriginal women were significantly less likely than non-Aboriginal women to say that they were 'always' treated with respect and dignity, or that their decisions about feeding their baby were 'always' respected. The Aboriginal Patient Experience Survey Project Advisory Committee subsequently recommended a qualitative study be conducted to further explore Aboriginal people's experiences of care in NSW public hospitals, and specifically the issue of cultural safety.

The Aboriginal Maternal and Infant Health Service (AMIHS) is a NSW Health-funded maternity service that provides antenatal and postnatal care up to 8 weeks after birth for Aboriginal families in over 40 sites in NSW, with the aim of improving health outcomes for mothers and babies. A recent evaluation of AMIHS provided further insights into Aboriginal maternity patients' experiences of care in NSW. Participants in all case study sites in the AMIHS evaluation reported racism as an issue for Aboriginal women when accessing inpatient hospital care.[10] The Malabar Community Midwifery Link Service (Malabar Midwifery Service) is an urban Aboriginal maternity care service that integrates multidisciplinary, holistic, wrap-around services, alongside a continuity of midwifery care model and was also evaluated in 2019 [11, 12]. Results found that dedicated integrated continuity of midwifery care with wrap-around services is highly valued and is culturally safe.

A small number of qualitative studies have documented Aboriginal women's experiences of cultural safety in maternity care settings [13-15]. Undertaken in the Northern Territory and South Australia, these studies covered issues such as preparation for hospital and for birth, travel, accommodation, family support, experiences while in hospital, and being away from home. Watson et al found that miscommunication and lack of cultural and spiritual understanding by health care professionals were consistently reported by participants, while Brown et al highlighted the importance of communication, not feeling judged and recognition of culture. Qualitative studies exploring the experiences of Aboriginal women using the NSW public hospital system are few. However, some studies about

remote and regional birthing experiences which included Aboriginal participants have been published [16]. Research has also been conducted to determine what Aboriginal women would like to have available to them for birthing, which included some experiences of birthing in NSW hospitals [17]. Both studies reported experiences of racism, further suggesting the need for broader investigation. Several strategies to improve hospital experiences for Aboriginal people have been identified in the literature, including providing flexible family-focused care, assisting in managing fear of mainstream services, cultural training, and reflection for hospital staff, providing a service shaped by Aboriginal culture [18, 19].

This qualitative study has been conducted to improve understandings of Aboriginal maternity patient perspectives and experiences of care in public hospitals in urban and rural parts of NSW. The experiences of Aboriginal patients in general hospital settings were also explored through this study and are described in a separate report [20].

Study aim

The study aim was to develop a detailed understanding of Aboriginal peoples' experiences and perceptions of maternity care in NSW public hospitals.

Objectives

To explore in the context of hospital-based maternity care:

I. Aboriginal patients' experiences of, and views about, the quality and safety of their care
II. Aboriginal patients' experiences of feeling culturally safe (or culturally unsafe) while receiving care[1]
III. What a culturally safe service looks like to Aboriginal patients and health staff
IV. How the quality and cultural safety of care influences the health of Aboriginal patients, including their help-seeking and self-management behaviours
V. Aboriginal patients' experiences of reporting incidents of discrimination in a service and of receiving support following such incidents, as well as their views about actions taken by the facility to address the problem
VI. Aboriginal patients and health staff suggestions for improving care for Aboriginal people in NSW

Research team, ethics and governance

An advisory committee was established and guided all aspects of the study and were instrumental in co-designing the recommendations. The committee was chaired by the Executive Director of the NSW Health Centre for Aboriginal Health and included senior Aboriginal academics, the Directors of Aboriginal Health of participating local health districts (LHDs), CEOs of participating Aboriginal Community Controlled Health Services (ACCHS), representatives of relevant branches of the NSW Ministry of Health, and the Aboriginal Health and Medical Research Council of NSW (AH&MRC). A smaller project management team consisting of key staff of the Centre for Epidemiology and Evidence, Centre for Aboriginal Health and Health and Social Policy Branch at the Ministry was developed to support the study and facilitate input from the advisory committee.

The Aboriginal Health Division at the Sax Institute was engaged to conduct the study. All interviews were conducted by Aboriginal researchers (CC, JN, SS and MC) and the team was led by Senior

Aboriginal Advisor, SB. DK was responsible for the project management of the study and jointly developed the themes with CC.

Ethics approval for this study was provided by the AH&MRC of NSW Ethics Committee (1836/21). The research was carried out in accordance with the AH&MRC of NSW Ethics Committee guidelines for research with Aboriginal peoples. Ethical approval was also provided by the Joint University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (2021/ETH10941). Site Specific Approvals were also obtained from each participating LHD.

Methods

Qualitative research methodology was used to gather rich data about Aboriginal people's experiences of hospital care in NSW. Interviews and focus groups were conducted with Aboriginal hospital maternity patients, LHD staff and ACCHS staff to understand Aboriginal people's experiences of maternity care in NSW. The interviews and focus groups were semi-structured and incorporated elements of yarning methodology [21].

Aboriginal researchers were involved throughout the process, including data collection, analysis and interpretation of findings.

This research also drew on the following aspects of Indigenous standpoint theory:

- Having Aboriginal researchers doing the 'researching' with Aboriginal people and involved throughout study design, conduct, analysis and reporting [22, 23]
- Privileging Indigenous voices [24].

Setting

Three NSW LHDs were chosen for this study: Murrumbidgee (MLHD), Illawarra Shoalhaven (ISLHD) and Western Sydney (WSLHD). These LHDs were chosen with consideration of the size of their Aboriginal populations, the geographical spread of metropolitan, regional and rural areas. In each LHD a hospital was nominated, through which data collection was coordinated: Wagga Wagga Base Hospital (MLHD), Wollongong Hospital (ISLHD) and Westmead Hospital (WSLHD). Other patients who attended other hospitals within each LHD were also invited for interview. Four ACCHSs located within the geographical boundaries of these three LHDs were key partners in the research: Riverina Medical and Dental Aboriginal Corporation (RivMed); Illawarra Aboriginal Medical Service (IAMS); Waminda South Coast Women's Health and Welfare Aboriginal Corporation (Waminda); and Greater Western Aboriginal Health Service (GWAHS).

Inclusion/ exclusion criteria

Maternity patients

Inclusion criteria: Patients who were Aboriginal and/or Torres Strait Islander, were aged 18 years and above, who had recently given birth in a NSW hospital (preferably in the last 12 months, but any time up to 5 years post-birth), were able to speak English, were mentally and physically able to participate, and were able to provide informed consent. Where the participant was unable to read English, family members could provide support by reading the consent and participant information sheet to the participant. Patients who were discharged against medical advice were also eligible to be part of the study.

Staff - ACCHS and LHDs

ACCHS staff inclusion criteria: Staff who were aged 18 years and above, had worked at the participating ACCHS for at least 3 months, and had a role where they provide health or social services to Aboriginal community members. Staff were not required to have maternity care experience.

LHD inclusion criteria: The Aboriginal Hospital Liaison Officers (AHLO), Aboriginal Health Workers (AHWs) and affiliated staff (e.g., midwives in the AMIHS program) who work closely with Aboriginal maternity patients in the public hospital system in each participating LHD.

Participant recruitment

Maternity patients

Purposive maximum variation sampling was used to identify Aboriginal community members who had recently given birth in an NSW public hospital (up to 5 years post-birth). In the ACCHS setting, ACCHS staff with good knowledge of their community invited community members who they felt would be willing and able to talk about their recent hospital experience of maternity care. In the LHD setting, recruitment was conducted with the assistance of either the Director, Aboriginal Health; Nurse Unit Manager (AMIHS); or an Aboriginal Health Worker (AHW) who supported Aboriginal maternity patients at each hospital, utilising their existing relationships with patients to identify eligible patients. The ACCHS/LHD staff contacted each identified eligible patient, explained the purpose of the study, and invited the patient to participate. If the participant gave informed consent, the ACCHS/LHD staff either scheduled a time for the patient to be interviewed by the Sax Institute Aboriginal research team, or their details were passed to the Sax Institute Aboriginal research team to schedule the interview. Five patients either declined to participate or did not respond to the invite when contacted by the Sax Institute team. No participants withdrew consent. ACCHS/LHD staff aimed to recruit patients with varied characteristics (e.g., age, number of births, experience during their hospital stay – negative/positive). Approximately 60% of maternity admitted patients were recruited via the ACCHSs and 40% via LHD recruitment. Preliminary analysis was conducted once 50% of data collection was completed, which informed case selection and further exploration of emerging themes for the remaining 50% of data collection.

Staff ACCHS and LHD

ACCHS CEOs (or delegated staff member with good knowledge of ACCHS staff) identified and invited staff members who were most appropriate to be involved in a focus group to discuss Aboriginal community members' experiences in hospital and maternity settings. Again, it was requested that the staff have varied demographic characteristics (e.g., age, sex) where possible. In each LHD, staff were invited for interview by the Sax Institute Aboriginal researchers, following consultation with the Director, Aboriginal Health. There were 2 maternity staff who declined to be a participant and 1 was not contactable.

Data collection

Maternity patient interviews

Interviews and focus groups were conducted by experienced Aboriginal researchers who followed the key domains of semi-structured interview guides (Appendix 2). Participants provided voluntary informed consent prior to the interviews. Interviews were primarily conducted face to face, except where participants requested interview via telephone. Participants recruited via the ACCHS attended either the ACCHS for interview or participated in the interview at their home or via phone. Patients recruited through the LHD were interviewed in the Aboriginal cultural room, a local health service or community area, at the interviewee's home or via phone. Family members who were present during the hospital stay were able to be part of the interview, following consent from the patient themselves, and the family member. Most patient interviews were conducted one-on-one, with one interview held

with two people. All patient participants received a $50 gift card intended to acknowledge their time, specialist knowledge and contribute to costs incurred through their participation in the research. One or two experienced Aboriginal interviewers conducted each interview. Where requested by the patient, an AHLO, AHW or ACCHS staff member was present during the interview. Interviews were audio-recorded with the participants' consent.

LHD staff interviews

Voluntary informed consent to take part in the interviews was sought from LHD staff by the interview team prior to the commencement of each focus group interview. Interviews were held in a meeting room at the hospital where the staff member was employed, or via Teams. Two experienced Aboriginal researchers conducted the interviews at each LHD. Interviews were audio-recorded with the participants' consent.

ACCHS staff focus groups

Voluntary informed consent to take part in the focus groups was sought from ACCHS staff by the interview team before each focus group began. Focus groups were held at each of the four participating ACCHSs (RivMed, Waminda, IAMS and GWAHS). Two experienced Aboriginal interviewers conducted the focus group/interviews at each ACCHS, with the focus groups ranging from 2-4 participants. Focus groups were audio-recorded with the participants' consent. Focus groups covered both general and maternity patient care and data has been included in this report where it relates to maternity experiences.

Data analysis

All focus groups and interviews were audio-recorded, transcribed by a professional transcriber, and checked by the interviewer for errors. Confidentiality of collected information was strictly maintained. All records were saved using a unique study code. Raw data was saved on a secure drive, re-identifiable by the research team only. Identifiers were saved on a separate secure drive from the data itself to maintain data security. Data collected for the study will be destroyed 5 years post-publication.

A proportion of early transcripts were coded independently by two researchers (one Aboriginal). Emerging themes were shared with the wider group which included Aboriginal researchers, to compare their preliminary coding and agree on a coding frame that captures the breadth of views and experiences in the data. Using NVivo, this coding frame was applied to further transcripts and revised iteratively in response to further data. The Aboriginal advisory committee reviewed early findings after 50% of data collection was complete.

Analysis and write-up followed the qualitative description approach [25, 26] which aims to represent data in a way that most stakeholders (participants, community members, clinicians and any others who understand the phenomenon) would agree is accurate, i.e. descriptively valid, staying close to participants' direct experiences and summarise the data in participants' everyday language with minimal interpretation [25]. This method is considered especially appropriate for research with priority groups where findings will be used to address healthcare barriers [27].

Findings

A total of 36 people were interviewed, comprised of 21 Aboriginal women who were recent maternity patients and 15 staff (13 ACCHS staff and 2 LHD staff). A combination of 3 focus groups and 2 interviews were conducted, the majority being face to face. A level of flexibility and pragmatism was required to facilitate patient engagement, particularly for new mothers; hence telephone interviews were used where requested by the participant. Participant characteristics are described in Table 1

(Appendix 1). All patients were female, aged between 21 to 40 years. The interviews and focus groups were held between April 2022 and July 2023, and the average duration of interviews was 41 mins, and for focus group the average duration was 75 mins. Additional illustrative quotes are presented in Appendix 2. Patients and participants are used interchangeably throughout the report.

Participants spoke of their most recent hospital stay, but also often gave recounts of previous hospital stays which fell inside the study period of up to five years post-admission. In some cases, participants had been admitted to hospital in more than one of our study locations during that 5-year period. Patients received care from one or more of the following hospitals within one or more hospitals within the participating LHDs. Patients spoke of their hospital journeys in their entirety: from their antenatal care through to birth and postnatal care. They also gave recounts of previous maternity care and birth experiences which fell inside the study period of up to five years post-admission.

In this study we probed on what elements of care made Aboriginal patients feel *comfortable* and *respected* in hospital. From the data we learnt that, as well as feeling comfortable and respected, it is also critical that patients feel *welcome* and *supported* during their hospital stay and that these elements lead to positive, *culturally safe*, hospital experiences that leaves the patient *empowered* to manage their health into the future. The perceived quality of clinical care the patient receives also plays a significant role in overall hospital experiences.

From the analysis of the interview data, the following five themes emerged:

1. **Pre-existing views about hospital**– experiences shaped by colonisation, past and ongoing practices, culture, family and friends, and previous health care.
2. **People** – what, who and how matters – engagement with staff and the key role of Aboriginal staff and communication in providing welcoming, supportive and respectful, culturally safe care.
3. **Processes, practices and policies** – how hospital systems contribute to Aboriginal patients feeling comfortable, supported, and empowered and the perception of the quality of clinical care provided.
4. **Places** – elements of the physical spaces in the hospital can impact how comfortable and supported Aboriginal patients and their families feel during their stay.
5. **Pathways**- the extent to which maternity patients experience continuity of care throughout their antenatal care, stay for birthing, and post-natal care including complications, and how this affects their overall experience.

Pre-existing view about hospital

Several study participants noted feeling fear and mistrust of hospital coming into their stay for birthing. Among both patients and staff, **a fear of Department of Communities and Justice (DCJ)** (often referred to by the former organisational names, Family and Community Services (FACS) and Department of Community Services (DOCS)) **involvement and child removal** was frequently mentioned. Many participants had had previous experience with at least one of these organisations, and others had heard accounts of child removal through friends, family, or community members.

> *Back in 2019 they [DOCS] did steal my other children and when I say they did steal them, I've got proof on that. I went to the Ombudsman and it's clearly shown. They had to apologise for the way that they removed my children. They took them from my parents while I was seeking medical treatment because I was pregnant, and they placed them in the care of my ex-partner that has got a history of domestic violence that is still continuing.*
>
> *Maternity patient, LHD*

It's DCJ involvement… It's like every mother - every Indigenous mother, basically, gets a DCJ report. That's how it feels.

Staff, LHD

Some first-time mothers mentioned a **fear of the unknown** (childbirth and child rearing), unfamiliar or unsafe environments, made worse by feeling they may not be listened to by health professionals during the birth.

I was already concerned about going into [de-identified hospital], people having bad experiences there, so that stressed me out a little. I guess it's just that most people's [general fear], because they're the professionals, and it's like, oh, we know better, like, we can tell you what's going on. But we're the ones feeling it, so, sometimes they might put their professional opinion over ours.

Maternity patient, LHD

Some patients mentioned **previous negative birth experiences**, including stillbirths, and experiences of not being listened to, which contributed to **fear and anxiety**, that they may not receive the care they need or their requests will be ignored:

That's what I hated the most coming back with [de-identified]. Is because I'm like, if I get that midwife again. Now I know my rights or my options, but are you even going to give it to me? Like even though I'm going to voice them.

Maternity patient, LHD

However, some second-time mothers also noted feeling more confident coming into the birth, because they had built skills and knowledge throughout the process of the first birth and early child rearing.

Because this was my second child, I felt like I knew a bit more what I was doing and could read my baby and things like that.

Maternity patient, LHD

Several patients highlighted that birthing is sacred Women's Business and has an important role in Aboriginal culture. Participants emphasised that Aboriginal women have been birthing according to long-standing cultural birthing practices for tens of thousands of years and would like to see Aboriginal culture placed at the forefront of maternity care.

It's having an understanding of our culture and how we do things. Like, how important it is and that it is Women's Business. Just take it into consideration how we've done things for thousands of years, you know what I mean? We've had so much of a loss of our culture. We want to try and hold onto a little bit of it.

Maternity patient, LHD

Staff also noted that where previous experiences with hospitals have been poor, women are hesitant to engage with the hospital system. AMIHS staff noted being cognisant of this and work hard to build back trust in the system, by supporting women in a way that empowers them to be in control of their own health:

You can definitely tell the ones that have had a good experience are more than happy to come back and engage and stuff like that. Whereas others that have had a negative experience, they are really hesitant to engage in that initial appointment and their updates are really difficult. I feel like I'm always chasing them which I don't want to be in that position to be chasing them because I want them to understand this is about them and their health. It's not about me taking

control and making orders. At the end of the day it's about them taking the control over their own health and their own body.

Staff, LHD

People – what, how and who matters

While experiences of racism and discrimination were often raised, a more general lack of support or empathy was attributed to staff being overextended. It was also reported that some staff were uncaring and disrespectful towards all patients regardless of race. Inconsistency and variability of interactions with staff across the maternity care pathway was frequently discussed. Consistent access to Aboriginal staff was particularly valued, as they played a critical role in offering culturally sensitive support and ensuring Aboriginal patients feel respected and understood.

What - racism and unconscious bias exists

Experiences of racism and unconscious bias continue to be experienced by Aboriginal patients while in hospital. Patients described being made to **feel inferior or judged,** with **assumptions** being made regarding the **use of drugs or alcohol**, or domestic violence. Some participants felt that previous DCJ involvement resulted in them being treated differently by staff in the hospital.

The vibe in the room, the way that they approach questions about your personal life, the way that they approach questions about your family life. They instantly assume there's addiction in the family. They instantly assume there's trauma and mental health issues and potential AVOs, DVOs. You get it. You just get stereotyped.

Maternity patient, LHD

The person was very …rude, because she knew I had DCJ involvement. I feel because of that, some people treated me differently, even without knowing the reason why DCJ was involved. Most people see DCJ involvement - you get treated differently. I wasn't happy about that.

Maternity patient, LHD

Others described a lack of respect, not being listened to, or having **threats of DCJ involvement** made to get the patient to comply with directions.

[deidentified hospital] threatened me with FACS so many times and that honestly probably does have the Indigenous link. They knew that my [relatives] were a ward of the state so actually maybe that was linked there because they brought that up all the time. If I didn't do it, then FACS would be called. That's how they got me to comply with them, [hospital]. I was [young] and constantly being threatened with FACS, constantly... So, it was a lot. [Cries]

Maternity patient, LHD

Some participants were **undecided** as to whether the perceived negative treatment they received was **racially based** or poor patient treatment overall.

I don't know whether some of the nurses are against Aboriginal people…. Sometimes they talk to you rough and this, that and the other, and you don't know whether they've just got the shits for the day or it's just happening and everything's getting on top of them, and they haven't got the right amount of staff to help them. But I think the main ingredient with it is staff. I think they've got to teach the staff there's no discrimination between any race, no matter who you are or what you are. That's the way I look at it.

Maternity patient, LHD

Other patients felt **singled out** once they **identified as Aboriginal** and reported tactless delivery of information and processes relating to their care, based on their culture.

> *I was asked [whether I identified as Aboriginal] in my first antenatal appointment. I was then asked that when I went in to get induced. Both times they said… that changes everything and walked out, come back in, and proceeded to give me a domestic violence pamphlet. In my delivery…I just said to her, I feel like you're only looking at me as a statistic based on my culture.*
>
> *Maternity patient, LHD*

Where such **experiences of racism or unconscious bias** occurred, it significantly impacted the patient's overall stay in hospital and in some cases and had **negative effects on their mental health**.

> *I struggled a lot with postpartum depression and anxiety. I think a lot of it was around how incompetent I was made to feel as well and how often they threatened me with FACS.*
>
> *Maternity patient, LHD*

Most commonly, patients reported an **unwillingness to return** to the particular hospital where the incident occurred, even if they needed further support with breastfeeding for example. This resulted in the patient seeking care at other health providers or going to a hospital further away to avoid the hospital where the incident occurred.

> *You don't want to talk about it because you think oh, you know, move forward in life, but it – those types of things stop us from going up to the hospital to get the type of treatment that we need.*
>
> *Maternity patient, LHD*

Staff reiterated that racism and unconscious bias in the hospital usually took place in the form of **stereotyping, judgements and biases**, giving examples of how judgement and stereotyping could **impact patients' willingness to seek care while in the hospital, as well as preventing them from seeking support with breastfeeding**.

> *It starts with the nurses and midwives that are already in there. They're not culturally appropriate. They frown on Aboriginal women and their children. If they come in – if mum's had the fifth or sixth child, well then, oh, why haven't they got a TV at home? You know? Oh, they must need more money. Oh, they don't want to work. Because the more children you have, you don't have to go to work. They're just so insulting and so un-culturally appropriate.*
>
> *Staff, ACCHS*

One staff member told of a **lack of support** when trying to address issues of racism with other staff.

> *It's a lot of just stereotypes and judgement. There's a lot of non-Indigenous people that feel as though, you know Aboriginal people get handouts and things like that without actually realising the damage that was caused by past governments and why these things are in place. I think it's definitely a lot of judgement, a lot of bias, looking at if they've got a drug and alcohol background, DCJ background, things like that. I have even worked with nurses and midwives before that have refused to care for Aboriginal women because of their own issues. People say that racism is not as bad as what it used to be and it's just bullshit, sorry [laughs] to say. But for those of us that are there and – that's another thing too, if you bring it up then you're the problem by bringing up racism and trying to address it.*
>
> *Staff, ACCHS*

Some staff also noted that while there have been improvements over time, **some individual staff members in the hospitals continued to be racist**. It was also mentioned that staff generally behaved better towards Aboriginal patients around the AHLOs nearby, and that most instances of racism and unconscious bias occur when an Aboriginal staff member is not present. Staff also highlighted that Aboriginal mothers' often felt like they are being **watched and judged**, which also heightened **anxiety** in the hospital environment, particularly in the context of child removals.

> *It's little things like, say if they're in special care nursery, they don't explain to the mums that all the babies that stay in special care, they have the mums stay in overnight. That's the normal process. So, a lot of mums feel like, is she coming in to watch me be a mother? What if she picks up on how I'm making the bottle? They feel like they're being judged. Even us upstairs, we have our little desks - we're right in the corner, so we can see everybody. We don't like eyes on us though. It's that old saying - what a lot of the Elders would say - whatever you do, don't have your back to the door because that's when they take you away.*
>
> *Staff, LHD*

Staff described strategies that were underway in their respective hospitals to improve cultural safety. They felt that there was a need for training to **educate non-Aboriginal hospital staff to address unconscious and even conscious biases.** This was seen as important to ensure that staff were cognisant of the **past trauma and complex** lives of Aboriginal patients, and could provide care with more **understanding and compassion**.

> *The problem with our Indigenous women and young girls that are pregnant, ones that have had lots of trauma in their life and hard upbringings and that has resulted in substance use, drugs, alcohol, and then mental health illnesses, but if they actually took the time to read their full history and background to see what these women have gone through and how traumatic their lives and upbringings have probably been, they'd probably have a bit more of an understanding I think.*
>
> *Staff, ACCHS*

How – the way staff communicate with Aboriginal patients matters.

Participants explained that the manner of communication by hospital staff affected their hospital experiences. Where staff communicated in a manner that was seen to be **kind, friendly and caring**, where staff took time to 'get to know you', patients reported positive experiences, including feeling **welcomed, respected, and comfortable**. A key element of communication mentioned by participants was staff **demeanour**.

> *They were respectful towards me, they were caring, they were serious about their job, so they wanted to get their jobs done and make sure everyone was comfortable and okay.*
>
> *Maternity patient, LHD*

> *I was too scared to ask for help, but like, I'm just I'm really quiet and I did get worried about asking. The nurse ended up coming in and checking on me, and she pretty much stayed with me the whole night to help get her to breastfeed, latch on the boob and stuff. Yeah, that was good.*
>
> *Maternity patient, LHD*

> *But there is one good doctor at [de-identified] Hospital. I don't know her name but every time I've gone there, she is very caring. Yeah, and she had done everything to support us. So I'm really happy when she's on shift. She has even stayed back after her shift to make sure that everything is covered, that one doctor.*

Maternity patient, LHD

Being **consulted** on decisions relating to the birth was highly **valued** by many participants. Where patients were consulted with and **listened to**, they felt respected and empowered in their maternity and birth journey.

> *Making you feel culturally safe, by just talking more and explaining stuff and giving you options. Instead of just making you do what they think's right for you. Having a voice is the most important thing and when you get shut down, and when they try and override how you feel or what you say, that's – that breaks the system down there.*

Maternity patient, LHD

Similarly, participants reported feeling more confident and prepared for discharge when staff took time to explain things clearly, avoided medical jargon, and provided options in a way that allowed informed decision-making.

Some patients described how valuable it was when staff took the time to **get to know them** and encourage them through the birth. This assisted them to feel **comfortable** and **supported** during their hospital stay.

> *They walked around with a smile and actually would say, hey, how are you going? What's been happening? They took the time to actually know you, more as an individual rather than just a patient.*

Maternity patient, LHD

> *She was very - not pushy with it, but she was just very supportive. She just made sure I was relaxed. I think she could identify things that I was feeling without me having to say it. She was just really good at making me relaxed and got me water and fanning me, because I was sweating profusely and she was fanning me. She was just encouraging. She made it nice. She got me through.*

Maternity patient, LHD

A few patients highlighted the importance of **good communication with their partners** and family members as well as with the mothers themselves:

> *With my partner, he had a lot of questions. He wanted reassurance. Sometimes, he didn't receive that, so I guess that's when your emotions start to heighten if you're unsure of something or they don't explain something to you in a specific way, you're just a bit unsure and yeah, you don't feel safe I guess.*

Maternity patient, LHD

Where patients received communication that was **rushed, dismissive and not explained well,** patients felt like a 'hassle'. This often **prevented them from asking questions,** even when they were unsure about an aspect of their care or care for the baby**, including not asking for support with breastfeeding.** As one participant noted '*when people seem like they're really busy, then it makes you feel like you're putting people out, which actually makes you feel a bit uncomfortable about it [asking questions]*' *Maternity patient, LHD*.

> *I think like just the way they respond to any questions, it makes you feel like you can't actually ask again. Like, it's just fine and you're like, oh, now I feel like an idiot. And then you actually have to keep asking. So I feel like for someone that's probably like a bit shy, they wouldn't ask and then there could be, I guess, heaps of extra issues.*

Maternity patient, LHD

Many participants noted that when they were younger or first-time mothers, they **did not feel empowered to ask questions.**

> *I couldn't pinpoint it at the time - you look back on it and you think oh, maybe I should have just spoken up and said hang on a minute, can you please come and help me or get me a lactation consultant, but I didn't know at the time. I just thought oh, okay, I'm struggling. She is busy, I'll just see how I go.*
>
> *Maternity patient, LHD*

Several patients described aspects of communication where they **were not listened to and not consulted,** and their patient experiences were compromised:

> *I found her very hostile. I just wanted to clarify that I was doing the right thing with my breastfeeding I didn't even tell her that my nipples were hurting. It was just that I winced when my baby was feeding. She made the comment, well if you're in too much pain we might just have to give you formula, which I thought was pretty out of place for someone who is actively seeking advice and help on breastfeeding. I then let her know I had spoken with the lactation specialist the night before and this is the goal that we were doing. She said, while I'm on the floor and I'm your nurse, you can count me as your lactation specialist, I thought no, it's very different. I didn't feel like she was listening to what I was saying, she was either finding a reason not to do what I was asking or belittling me.*
>
> *Maternity patient, LHD*

Some participants described communication with staff which they felt were **uncaring and without tact,** including instances where patients were forced to re-tell traumatic stories:

> *You go in there and you see a different person every single time and you're expected to go over your history every single time you go in there. Then you get asked so many questions. I would get asked all the time, so why did you have a stillborn? What happened? What did you do? What made you have a stillborn? You constantly have to go over the same thing every week. That was really in the antenatal area. I don't know if it's because they're understaffed or they're so under pressure but just their attitudes… They don't feel compassion about any of the patients in there. I didn't see a single person go out of their way to help anyone the whole time I was there, and I was in there for weekly appointments.*
>
> *Maternity patient, LHD*

Staff demeanour was widely noted as impacting patient experience; unfriendly or indifferent attitudes left patients feeling unwelcomed and unsupported.

> *It was more so the [one midwife]. Just the tone in her voice and just the way that she spoke. She just seemed like she was in a bit of a shitty mood if I'm honest. I'd asked if I could go down there and they said yes, and then she was whinging that I was going down there. It was just her tone of voice.*
>
> *Maternity patient, LHD*

> *The other thing is the ward clerks aren't as approachable as what the nurses are. They're the first face. So you get put off straight away as soon as you walk in there. Well, who are you here to see? Well who else is with you? All those kind of questions and you're like already put on the back foot.*
>
> *Maternity patient, LHD*

Inconsistent, incomplete or contradictory information contributed to some patients feeling confused, anxious, and even inadequate.

> *I don't feel like things were explained to me to a level that I understood it comfortably. I feel like because they get so used to - it's second nature to them. They do it every day. I think they just need to also remember that we're first-time mums. All of it's new to us. Even though you've been in nursing and midwifery for 22 years and you're used to it, I'm not. It's scary for me.*
>
> *Maternity patient, LHD*

Some people were asked if they identified as Aboriginal and some thought that hospital staff just assumed that they were, so ticked the box. Patients and staff participants noted that **some hospital staff don't know what is available for Aboriginal patients** and therefore weren't able to properly explain what is available to patients.

> *It just felt like as well, you're Aboriginal, we're just letting you know. It was process. As soon as we hear that you're Aboriginal, we have to tell you this room exists. It would have been nice for them to take us there, show us the place, introduce us to people in there, say how it came about. What was the idea behind it? What's it for?*
>
> *Maternity patient, LHD*

Some patients and staff described how **poor communication** and treatment during birth can **damage patients' willingness to seek care**, particularly during subsequent pregnancies.

> *I had one particular lady who had a really traumatic birth and was treated really awfully by the midwives during the birth and she fell pregnant and she didn't actually even tell us until she was 30 weeks. So we then had to call up and speak on her behalf because she was so - just anxiety ridden. So we went to the Doctor's appointments with her, ended up booking her in for a caesarean section because she had a really awful tear the first time but, yeah, just even, even just signing baby up for Medicare because she was worried about flagging baby because of the – she got to that point of, well I haven't done anything about it now, if I tell anyone I'm going to get - they'll take my baby off me. So yeah, it definitely has huge impacts and if it wasn't for our service, I don't know what would have happened really. She would have maybe given birth at home or, I don't know. So yeah, definitely lasting effects.*
>
> *Staff, ACCHS*

Several participants reported **mixed experiences** during and across their hospital stay/s and maternity care, perceiving that some staff communicated with them poorly, and others were caring and helpful.

> *It's like, when I was screaming cause I didn't know where the button was, I feel like they literally just took their time to come back out, they were like we thought you were like pushing and I was like, I don't know what I'm doing, you're the nurse. But after that, because he [baby] was restless. So that nurse was really good. She, like, come in and like, took him out and stuff.*
>
> *Maternity patient, LHD*

> *But there was one that I wasn't happy with. She came in. It was like a tick-a-box kind of thing. Came in as quick as she could, asked as little as she could, looked at as little as she could and got in and out. But there was one that came that was absolutely amazing. She went above and beyond.*
>
> *Maternity patient, LHD*

Who – Aboriginal staff are key to cultural safety

Participants considered having **Aboriginal staff** throughout the antenatal and postnatal care, and at the hospitals for birthing to be the **most important factor in ensuring cultural safety**. All participants, whether they had a good, average or poor experience reported that Aboriginal staff were key to a culturally safe hospital experience.

In the maternity context Aboriginal staff were largely based at the local ACCHS, AMIHS or sometimes employed at the hospital. In some cases, the AMIHS midwife was not Aboriginal, however where the midwife worked closely with the AHW this was also highly valued. Patients gave several reasons why having Aboriginal staff in the hospital provided them with a positive, culturally safe experience. Participants described feeling comfortable asking questions, and confident that they were being listened to and receiving non-judgmental advice and support when Aboriginal staff were involved in their care. This highlighted the importance that Aboriginal health is everyone's business and shouldn't just be the burden placed on Aboriginal staff. Culturally safe practices and trauma informed care is therefore an important approach for all staff.

> *They listen to you. With some midwives, they can just not listen to you, not take your voice. Where with the AMIHS, they make sure they listen to you. They get your input. They don't do anything that you don't want to do. So you feel very supported.*
>
> *Maternity patient, LHD*

> *They've [the AMIHS staff] just got a positive outlook on everything. They're heaps more positive. They take the time to sit there and actually make sure that you understand everything that they've spoken about, and if you have any questions about absolutely anything. No question is a dumb question basically. Not only that, if you speak to them about any concerns, they do make sure that they actually go and follow it up. You don't get told that they're going to do something about it and then they don't. They actually do what they say they're going do.*
>
> *Maternity patient, LHD*

> *We talk about the impacts of colonisation and invasion as a past, and it's still happening now. Our kids are still being stolen. There's some horrific trauma. That's what we carry. That's why there is a mistrust with government and hospital's a part of that system, that's what we're talking about.*
>
> *Staff, ACCHS*

Other participants reported that Aboriginal staff just 'get it'. They **understand** about **Aboriginal culture, including the importance of family and kin relationships**, which in the maternity context provided invaluable **support** to new mothers.

> *They get it. You don't have to worry about anything.*
>
> *Maternity patient, LHD*

Some patients reported **waiting to address specific questions to the AMIHS or AMS staff** supporting their care, feeling more comfortable with the model of culturally safe care provided by staff from these organisations. This included care provided by Aboriginal staff, and non-Aboriginal staff who worked closely with Aboriginal staff.

> *[AMIHS midwife] is absolutely beautiful, but she doesn't have an Aboriginal background. But [Aboriginal liaison officer] was at almost every single appointment I had, and she would always have like a yarn with me before we started. And that, just like immediately like, relaxes you because they are asking like super personal questions half the time. When I ended up going up*

to the hospital, when I had my little bit of a scare, … [Aboriginal liaison officer] was double checking on me.

Maternity patient, LHD

They [the hospital] are …super understaffed. So that did stop me from asking a lot of things, but I wrote them down and then because I knew [AMIHS midwife] was coming to check up on me, I was asking her. So my direct midwives, I would say no. But again, I was way more comfortable with my AMIHS midwife. She knew me because I'd seen her like almost half my pregnancy, so I felt way more comfortable with her as well.

Maternity patient, LHD

Most participants suggested that the best way to improve cultural safety and hospital experiences for Aboriginal patients was to **increase the number of Aboriginal staff** at each of the hospital.

Having more Aboriginal people at the hospital for them, because I find that some Aboriginal people don't do well with having – not having the Aboriginal support there.

Maternity patient, LHD

There just needs to be more Aboriginal health workers. This is where the system is failing. There's not enough Aboriginal support in the hospitals. It's just really letting us down.

Maternity patient, LHD

The need for **more resources for the AMIHS program** was expressed, as the team was unable to service all the Aboriginal clients that would like to receive care via that program under current funding arrangements. ACCHS based care was also seen as highly valuable for providing cultural safety.

That was hard, that was really - because there were really women there that could have benefitted from our service but we just could not take on any more. We were so overworked.

Staff, LHD

… I feel like they need a lot more staff too because there is a lot more families that want to engage.

Maternity patient, LHD

Processes, practices and policies

This section describes the clinical care practices, staffing arrangements, transfer policies, visitor policies and discharge processes that participants described as impacting their experiences of care.

Clinical care practices

Several participants in this study experienced an **intervention** during birth. In the majority of these cases the patient was induced, or caesarean section was undertaken due to health concerns for the mother or baby. However, in most of these instances the mother felt that the induction was **forced or unnecessary**. In subsequent pregnancies these mothers reported feeling more confident to decline suggested interventions. In some cases, patients experienced ongoing health concerns, which they attributed to the intervention.

With my second, they were talking induction as early as 30, 32 weeks because they were saying there were growth issues but I went for second opinions and the scans came back completely normal. So, they were going to induce off scans that weren't done properly or

something… There was no tearing, no intervention at all. Which was amazing for me because it healed a lot of my birth trauma from my first [induced] birth.

Maternity patient, LHD

They put me in a week before to be induced, and now that I think about it, I was so healthy, I don't understand that. But their reasoning was because I had the [type of] surgery, but I was healthy. Looking at it now, I probably could've went full-term, but that was a decision that the doctor made. I should've questioned the doctor more about inducing me. Instead, being a first-time mum, I just thought, well, if that's what the doctor says, then maybe that's a good thing.

Maternity patient, LHD

Some patients described being offered what they perceived to be **too little or too much pain relief**; felt pressure to use pain relief; or the rationale for the prescribed pain relief was not explained.

I was in a lot of pain and I find with all the hospitals that I've been with, with pain management they need to be on top of it for mums. It was very hard. They said, we can give you Panadol. We've got to wait. We've got to go and get the liquid Panadol. Then I was always asking, can I have something stronger? I'm still in pain. Voltaren or something. I just felt like - I was even saying to [de-identified], I might need you to go to the chemist and get me something because they're not on top of my pain.

Maternity patient, LHD

The thing that I felt conflicted the most was that I didn't want to have any gas in labour and when the nurse asked me, I said, no, I really don't want to, I want to hold off. Then she went and got another nurse and the nurse come in and goes, I think you need to try the gas because this is only just the start. Like, I was three centimetres dilated and I said, no, I want to try and go without. They're like, we need you to try it, it will be okay. So, I felt like that was a bit pressured into me and that was the one thing that I didn't really want to have… I just wish that it would've been one of the last options instead of saying, you're only this far, you need to take it. I just felt like when the nurse went and got another nurse and brought them in, I thought, you're undermining what I want.

Maternity patient, LHD

Participants described perceived **mistakes and misdiagnoses** that occurred during and post-birth.

I've got permanent damage from that birth; I have a prolapse that no one's looked after. I had an IUD put in after that birth by [de-identified] Hospital, which snapped and no one would take it out for me for six months being snapped. Yeah, it was a lot of yuck after yuck with a lot of negligence there.

Maternity patient, LHD

Patients provided mixed responses regarding **breastfeeding support**, some described good support, with staff **taking time to work through breastfeeding issues** with the mother and baby and giving different options. Others felt assistance with breastfeeding was inadequate, for example being **dismissed, ignored or denigrated**.

Overall, like after I had him, it was good. Like everyone was pretty good. They helped out when he was unsettled. Like with the breastfeeding and stuff I felt like I got someone to help us out. Because I think that was my main thing because he wasn't like latching for ages. Yeah. And then even when I went home, it was still the same. So it was that nurse that was at the hospital,

she was the one that come around. It was good because she showed like different ways to breastfeed and stuff.

Maternity patient, LHD

[De-identified] ended up on formula. No one supported me in breastfeeding at all until I got home, which was six days in. It was rough. I bled on the chair, she screamed and yelled at me for putting blood on the chair, it was disgusting. I was like, I don't know what I'm doing.

Maternity patient, LHD

So just after having my son, I was struggling to latch him on, so breastfeeding. I said I really want to try give that a go. I tried and I tried and I had a female midwife come in and she just goes oh, I can see you're struggling and she walked out. I felt really left alone and unsupported.

Maternity patient, LHD

A few patients mentioned the importance of caring for **mother's health** as well as the baby's:

Focusing on mum's follow-up care...because ultimately the health of the mother impacts the bub. If she's not well, bub's not going to be cared for right. Just genuine mutual care for me and bub.

Maternity patient, LHD

Staffing arrangements

Patients described feeling that the staff in the hospital were under-resourced, and felt that staff appeared **stretched**, citing **long waits for assistance** whilst in the hospital. This was seen as potentially harmful, particularly for first time mothers.

It's not the staff's fault. They're just under the pump. They were busy at times and tired. The patients notice the exhaustion of the staff. You feel sorry for them. You empathise a little bit. But you're also in a bad way, so it's hard… You can just physically see it. I just feel like perhaps maybe they weren't as on the ball as what they would have been at the beginning of their shift as - just because they've been smashed for the day, which I get it.

Maternity patient, LHD

A few times I asked for things that I needed, probably three or four times before I actually got them. Having him being in the NICU I had to wait a few hours before they had somebody who could take me down to see him, because of the C-section I couldn't walk down there to see him but it took them quite a while to get a ward clerk to come and take me down to see him, which really upset me, because I just had him, had seen him for two minutes and I had to give him away… I felt that should be a bit more important.

Maternity patient, LHD

Some staff perceived that **time limits** on antenatal care appointments at the hospital made it difficult to disseminate all the required information, in a way that was thorough and understandable for patients.

The time limits that the midwives have there to actually give the information, it's usually quick... So many of the times I will see clients and say oh, so you know, you're having your GTT test, so do you know what the process? And they're like, no, I just have an appointment here for this time. So then I go into all of that education and get them prepared for it. A lot of the time they get referrals and they're kind of just left to figure it out themselves.

Staff, ACCHS

Staff reported that under the current system AMIHS and ACCHS midwives generally aren't available or able to birth the babies for women that they have provided antenatal care for. However, some AMIHS and ACCHS midwives also have midwifery roles at the hospital and try to take the Aboriginal patients on if they come in for birthing while they are on shift. Further, Waminda staff described their 'Birthing on Country' model which includes working towards a Waminda midwife having rights to be at the hospital for birthing[2].

> *If I'm working on the wards but I knew that there was an Aboriginal client coming in to labour I would say oh, can I take her as one of my patients today? Just because I know it's going to be better outcomes and they will probably - hopefully have a better experience.*
>
> *Staff, LHD*

> *It's getting better. Because they know that we've got Aboriginal midwives here, Aboriginal nurses here within this service, and know that a couple of our midwives, we work up in hospital a couple of days a week. We're just trying to break down those barriers of allowing us. They don't like to share that hospital, in a sense of – [ACCHS Midwife] was given the award of the year, the best midwife of Australia. But they still refuse to let her in that door to service our clients that are coming through having their babies…that's part of Birthing on Country project, that's part of the lobbying we've done,*
>
> *Staff, ACCHS*

There was a suggestion that having doctors travel out to AMIHS sites would provide more accessible antenatal care for Aboriginal clients.

> *I had to go and see the doctor at the hospital and I used to just not want to go because I know what their waiting times are like. It's just a lot of people are in the same situation… I feel that the doctors need to travel to [health service]. There needs to be some sort of system there. I find that to do the antenatal appointments they're on time... They're on top of everything.*
>
> *Maternity patient, LHD*

Some patients highlighted that in Aboriginal culture birthing is **women's business**, and how male presence in the process can leave Aboriginal women feeling uncomfortable.

> *I was laying there naked and I remember after I had the baby, I was having a shower to wash the blood off me and the door was left wide open and I still remember it - a male doctor or like a student or whatever was - walked past and stood there and he was like oh, are you okay? That memory has stuck with me, I just really wasn't comfortable.*
>
> *Maternity patient, LHD*

Some Aboriginal staff reported feeling **unsupported** in the hospital system:

> *There's not really cultural support for Aboriginal staff, so you kind of just get thrown in there and you find your own support. So for me, I - somehow we find each other, but all the Aboriginal staff, we just found each other and we made our own little groups and we'd meet up. We created that ourselves, but in terms of with New South Wales Health, I don't think that there's enough initiatives that support Aboriginal staff either.*
>
> *Staff, ACCHS*

[2] In order to work in a hospital birthing suite, midwives need to be endorsed privately practising midwives with an access agreement with the hospital

Transfer policies

Some patients reported being transferred from regional hospitals to a maternity hospital in Sydney, due to complications during pregnancy that could not be managed locally. The Sydney-based hospitals were outside of our study locations; however, the participants often noted missing home, especially their families, but also contrasted the care that they received at the varying locations and spoke of the experience of being far from family during this time.

> *I was not offered a single support service in [local de-identified hospital]. In Sydney, I was offered several supports and I had several social workers and support workers and that come and speak to me. In [de-identified hospital], I didn't experience that.*
>
> *Maternity patient, LHD*

Visitor policies

Some participants relayed stories of **isolation and missing family** and the support they provide during their hospital stays due to visitor policies that were restricted during 2020-21 to control the spread of COVID. While some liked the time alone to bond with their baby, many felt unsupported without family members being able to be present, often their mother.

> *It was really traumatising, the whole situation I was in with the hospital, not being able to see [my partner] for so long, being stuck in hospital for three weeks, especially after we got isolated because they sent me to the emergency room, we were stuck in a…room for two weeks, me and my baby, we couldn't leave… his dad and his brothers didn't get to meet him until he was three weeks old.*
>
> *Maternity patient, LHD*

> *Definitely disconnected, was my experience, because in the midst of COVID we had restrictions. Family weren't allowed in or it was capped two at a time. So I had a lot of family looking through the window, ringing and having those conversations through a glass window. You don't realise the impact that it has on you and the distress because birthing is special, it's a new life, you want family around you.*
>
> *Maternity patient, LHD*

*A*s well as COVID restrictions, participants discussed the usual **visitor policies**. Many participants noted having large families and the importance of **kinship relations** in Aboriginal culture and communities, with some highlighting instances where they felt **staff were uninviting** to their family who were visiting. Other patients told of how their partners were not allowed to stay overnight, and how they struggled with this loss of support while in hospital.

> *With my previous birth ... I'm from a big family, so lots of cousins, sisters, whatever, so obviously when I had my babies, it's not just two people coming in. I've got like five… as much as possible would come in and the amount of times the midwives - and I know there's other people in there, they were quite rude to my family and the kids and stuff like that.*
>
> *Maternity patient, LHD*

> *[De-identified] was born; he was taken to NICU. They kicked dad out of the hospital. I don't even know what that was, visiting hours were over, I think, but we had a baby in NICU so he should have been allowed in there.*
>
> *Maternity patient, LHD*

The baby's father had to leave by a certain time, so pretty much eight o'clock every night. So he couldn't stay with me. But it was weird because there was another lady next to her partner got to stay with her overnight. So how does that work? I understand when you're in shared rooms and you can't. But another lady had their partner stay overnight. And so, yeah, I thought that's a bit unfair in that partner with me and all struggling and I was scared to ask for help, you know?

Maternity patient, LHD

While patients valued accommodation being provided while babies in NICU, some noted feeling uncomfortable being located with patients who were pregnant or already had their babies with them and would have preferred being in an area with other mothers whose babies were also in NICU.

They need to find a way to put NICU mums in a room together. Putting me in a room for three days with everybody with babies and my baby is in another room and they wouldn't let me hold him for more than 20 minutes in that three-hour block and I think that was really hard.

Maternity patient, LHD

Discharge processes

Many patients felt they were **ready to leave** when they were discharged, as one mother noted: '*I was pushing to leave more than anything because I wanted to be with my family and they were all waiting at home', Maternity patient, LHD.*

I was booked in for an extended stay, but I raised it with the nurse practitioner down in NICU or something - I raised to them about potentially being discharged from upstairs if they need the bed. They were like, don't worry. If they discharge you, we have a bed here that you can stay in. We'll make sure that is put aside for you. It was good, I didn't feel rushed out. They allowed you to take your time, which was good.

Maternity patient, LHD

Others described feeling **rushed** out or pressured to leave before they felt ready, with some not feeling confident to care for a newborn at home.

…my baby had to be in special care, because he was born early, and regardless of how I felt they were just wanted to discharge – like, they were persistent. They needed that bed. So, I was discharged, and he was kept there…That was a whole eight-day journey of back and forth.

Maternity patient, LHD

I felt like I got rushed out. I don't know if I even had an option. I was just following the hospital process. I thought that I was at the end of my journey and time to go home. But I wasn't confident. I had no idea what to do with breastfeeding.

Maternity patient, LHD

Some patients felt that while it was their choice to only have a short stay in hospital**, on reflection thought they should have stayed longer** or been checked more thoroughly before discharge. This was particularly to establish breastfeeding or where complications arose once home.

I think that I rushed myself out of there… He had really bad jaundice too, and two days later and they wouldn't take him up [to the maternity ward] because he was discharged for 24 hours already and they wanted him in emergency with a huge COVID outbreak. But I was discharged within 10 hours of giving birth to him. At the time, I thought it was great but I think no one looked at my mental health; no one looked at anything. No one looked at the baby, he wasn't even in there for the 24, 48-hour bloods. I think looking back now, maybe someone should have checked it a little bit more.

Maternity patient, LHD

A few patients noted **long delays in discharge processes.**

> *I waited over 24 hours for a doctor to come round and see me so I could leave. I ended up saying to the head midwife that was on shift, do you have any concerns of my baby or any concerns of me? She said, no. She was like, I'm so sorry. We've just got to wait for a doctor to come round. I ended up saying, if you've got no concerns then I'm leaving even if you just don't want me to, and I just left.*

Maternity patient, LHD

Some patients felt that they were provided with **adequate information** upon discharge, leading them to -feel confident in their ability to care for their child at home.

> *With my daughter, the doctors explained everything that needed to happen for her to be discharged from NICU, and made sure I was all over everything.*

Maternity patient, LHD

Some patients felt that more information could have assisted them including a contact number to get assistance post-birth.

> *It would help like if they gave out other support numbers. Especially cause you've just left and if anything happens you don't want to head straight back there, you'd have to ring over to the hospital. I guess that's why it would be good to have more information about after, like where you can access other programs. Yeah, that would be good because you know for a while after he was really unsettled and you know it was really hard. So it was hard to know where to look for help. Like to know where to get it.*

Maternity patient, LHD

Staff noted a need for a **consistent discharge process** to ensure new mothers were getting the information they need to care for baby once they are home.

> *I think the discharge process for anyone is very dysfunctional as it is. I've worked in other public health systems too and that's across the board and I've said that to management here saying there needs to be a formal process for discharge because I think a lot of people go home and are like… What just happened? [I felt] pushed out of the door and I don't know what I'm doing, that anxiety spiral going home with a newborn baby. But I think that's everyone not just Aboriginal clients.*

Staff, LHD

Feedback processes

Where patients had experienced perceived poor treatment or care in their hospital stay, many had **made complaints through varied mechanisms**, from face to face, to hard copy written letters of complaint, and the use of online complaints processes. Several patients noted feeling comfortable using online complaint processes and reported prompt responses from the hospital.

> *I searched it on Google and put a complaint in. I put the complaint in that same day, and they contacted me via email. Obviously, they wanted to meet with me beforehand, but I didn't get back to them straightaway. I wanted to settle in at home and everything. Then she apologised and everything. She's like, I don't appreciate that my staff made you feel that way. I'm going to take it further… She said they would bring it up to everyone and be like, this is how someone has been made to feel [so I'm not identified], and that way it doesn't happen again. So, she's going to do that and get back to me.*

Maternity patient, LHD

So they [the other nurses on the ward] brought me a pen and paper. They said no one should be treated that way and we're so, so sorry that you had to go through that. Then they said, if you would like to make a complaint, you pass it on to this person and they're going to follow up with it. So I felt very supported in that sense because I don't think I would have made a complaint. I would have just been really unhappy with that woman. Unless they had said no, you should make a complaint. That's not okay.

Maternity patient, LHD

Some patients reported unfamiliarity with the feedback processes or lack of confidence in feedback being actioned.

I don't really know what their complaint process is or how you can do that. They don't really say much on how you can do that, but I did speak about it to the higher up doctors when they did come around and when I did get a chance, yeah… All they really did was apologise. I don't think it ever went any further. That was really it, just apologised on behalf and that was kind of it. Just tick a box, that's all it is.

Maternity patient, LHD

Places

Maternity patients valued spaces that were **visually light**, **warm rather than clinical**, and included **cultural aspects created a sense of wellbeing and welcome.** While there was some Aboriginal artwork on display in the hospitals, having Aboriginal artwork in the maternity wards, as well as other elements that bring warmth to the space, resonates culturally and aesthetically.

It was good. It was brand new. It was light and airy. It wasn't that dark and dungy looking thing. I had like natural light in the room.

Maternity patient, LHD

Just making the rooms more friendly like, there was nothing. There was like nothing on the walls, like I've seen birth suites, I don't know on Facebook or whatever, of hospitals trying to make it more friendly with like even just a nice blanket in there, but a pillow in the corner, at least just something. But yeah, that's probably the only thing it just was so clean. Like, there wasn't even a painting on the wall or anything. I wouldn't walk in there and go, oh, this is a safe place for us.

Maternity patient, LHD

I know [another hospital], they have a beautiful room with beautiful Aboriginal paintings and it was very culturally appropriate. I would have liked to see something like that.

Maternity patient, LHD

Aboriginal cultural rooms were considered important, but patients reported that there needed to be **better communication** to let people know about access. While a cultural room often existed in the hospital more broadly, there was desire for a **culturally safe space on the maternity ward for Aboriginal clients** and bigger rooms to accommodate visiting family members.

Towards the end of it, they let me know that there was a room in the hospital for Aboriginal women. But I didn't know until the end. It would have been nice to have been told that when I first got there, that if I wanted to go to that safe space up there that is just for Aboriginal women that I could have gone there if I needed to. Other than that room, I don't feel any Aboriginal cultural connection in that hospital. It's a very sterile, government, horrible building.

Maternity patient, LHD

Even I think with the planning of services that we already have at the hospital it wasn't even thought about that AMIHS might need a culturally safe area for our clients. Because they say, oh you're community-based service but it's not always applicable for us to go into women's homes or meet out in the community due to various reasons.

Staff, LHD

I'm from a big family, so lots of cousins, sisters, whatever, so obviously when I had my babies, it's not just two people coming in. I've got like five…Maybe have bigger rooms or something.

Maternity patient, LHD

Staff from Waminda told of their 'Birthing on Country' program that they were implementing, based on Aboriginal culture and traditions, reconnecting with Aboriginal ways of knowing, being and doing. Staff, who had also recently given birth in the hospital setting, described the Birthing on Country program as both a celebration of new life and an enduring cultural practice.

My grandchildren will be born there, and it won't be a controlled birth. It will be wrapped around with their Aunties, their family and the space for the men to be there, to celebrate life. That's what it's going to be – I hate hearing comments, like oh, yeah well, I don't know if we will be able to do this. We've done it forever.

Staff, ACCHS

Pathways: Continuity of care was highly valued

Many patients observed that the maternity care system was complex, noting multiple care types during their care pathway. Patients appreciated the opportunity to **develop relationships** with staff throughout the care pathway, who were then able to provide **continuity of care** during the antenatal period, postnatally, and in some cases at birth. This continuity of care antenatally and postnatally was often provided **by the local AMIHS or ACCHS**, which patients felt had the added benefit of cultural safety. In some cases, the AMIHS or ACCHS midwife was able to provide care during the birth, as they also held a position at the hospital.

At one site **an Aboriginal Caseload Midwifery Program** was used by some patients. Care was delivered by a consistent midwife from antenatal care, birth and postnatal care, and this model of care was also highly valued. Continuity of care by consistent health staff helped mothers particularly around **communication** and helped patients **overcome previously held fears of birthing or hospitals**, as **trust** had been built throughout the antenatal care provision. Patients also noted feeling more comfortable with staff they had developed relationships with, which meant they more readily asked question and sought assistance from them when needed.

[AMIHS midwife] didn't have to stay involved when I was admitted there, because the doctors there and everything make the plans, because I'm admitted into hospital. But she still checked up on my notes, came and saw me regularly, which was good to have that. Certain midwives don't explain things as well as the midwife that you know, so it was good - any questions I had - I messaged her daily. She came and saw me weekly, which was good.

Maternity patient, LHD

I know she's not Aboriginal, but the AMIHS midwife at the hospital, she does the midwife stuff. Yeah, she actually come and seen me before she started her shift, and then while she was in

the middle of it. She actually come and seen me. So it was really good because, I already knew her.

Maternity patient, LHD

The trust that's formed. They've been sitting there, going through it with you this whole time, and for them to see you make it right to the end, it's a little bit more special, for both end, that [she bring] do it from start to finish.

Maternity patient, LHD

Where there was **little consistency** and multiple staff coming in and out of the maternity care and birthing, patients reported feeling **disconnected, stressed and uncomfortable.** This was particularly true for first-time mothers who didn't feel empowered to push back.

I'm going through the busiest time in my life right here, and I've got seven different doctors, so I'm extra stressed, it makes it hard to focus, as well, like through breathing through the contractions and all the difficult stuff that can arise during birth. It makes it hard, when you've constantly got different people coming in and out.

Maternity patient, LHD

Especially when I was younger, I agreed to things that I didn't really feel comfortable to. I think some other people may experience this when they ask you permission and for other medical students and staff to come in and I remember when I had my first bub, I was only like 20, so - and I had - I felt like I had so many people in the room and I really didn't feel comfortable.

Maternity patient, LHD

The **in-home postnatal care** provided by the community nurse or AMIHS staff member was highly valued by several participants, as it provided reassurance around feeding and baby's growth as well as detecting any issues once home. However, where the community nurse was not known to the patient, some patients reported feeling less comfortable.

They had the midwife that go out to your house. She come like a day later so that was really good. Perfect really. [De-identified] had jaundice, they were all over it.

Maternity patient, LHD

I can't fault the care with bub after she was born. That was amazing. The community midwives came out probably I think four or five times, only because she was a small bub.

Maternity patient, LHD

I didn't hear anything from that midwife [community nurse] ever again. I've never seen her. Yeah, so that disconnection and that kind of bit of a barrier there, that was what I experienced. Hopefully, we can break down that so we can have our [ACCHS] midwives throughout the whole journey.

Maternity patient, LHD

At one AMIHS site staff noted a desire for increased capacity to do more postnatal visits, particularly to support breastfeeding.

So yeah, we've been told even though I feel passionate about going into the home and doing these postnatal services, I've just been told oh only just do a couple of visits. Then phone calls and just discharge them is the impression that I get… But one of our KPIs is making sure that they have support in breastfeeding so that they're breastfeeding at six weeks postnatal but we just don't have the resources to be able to do that.

Staff, LHD

There was also desire for ACCHS and AMIHS midwives to provide support and care during birthing. However current systems generally do not allow for this, except for those midwives who worked at both the ACCHS and the hospital.

> *Just having that empowerment like the choice of the midwives linking them in and utilising them throughout your whole journey, not just say okay, well, now they're labour, we'll take it from here and then have that follow-up care. So probably see it streamlined a bit more… I would want her [ACCHS midwife] to support and actually be able to assist and deliver.*

Maternity patient, LHD

Staff from ACCHSs highlighted that **information sharing** across the care pathway between the ACCHS and hospital could be improved with strengthened relationships between these organisations, which could help **support seamless care** for Aboriginal patients:

> *We have the Aboriginal Medical Service looking at offering an antenatal, postnatal clinic because Aboriginal people are more likely to come to Aboriginal Medical Services and get their care. So I think it would be really beneficial as well, is strengthening those relationships, obviously between the AMS and the hospital as well to be able to offer the wrap-around service. Because obviously we can't do birthing at the AMS but if we can offer links with known and respected people within the community at the hospital, then that would make things a lot easier. But yeah, basically continuity of care and culturally safe models of care.*

Staff, ACCHS

> *There's also a disconnection with them, so if women are going to get most of their care with their GP, if it's an Aboriginal Medical Service, there's no crossover of information. So women are presenting at the hospital and then they're getting reports put on them for being - having no antenatal care when in actual fact they have, but there's been no discussion. Then DCJ are involved.*

Staff, ACCHS

Looking to the future, several maternity patients desired a **consistent midwife or midwifery care team** from antenatal care through to birthing and post-natal care, to build rapport and trust, walking through the journey together in a seamless manner.

> *I wish I had the same midwife from the first appointment the whole way through, because it also disrupted my relationship and my comfort level with the person. I would have built rapport. I would have built a relationship. I would have felt comfortable. Even if it wasn't the first visit but maybe by the third visit, I would have addressed the things I wouldn't have been comfortable to address back then. I think that that's why my care suffered, because no one knew what the other person had been doing.*

Maternity patient, LHD

> *I know it's hard with resources and stuff with - but is it possible to allocate the same midwife during your antenatal process to be with you when you give birth? Because that would be amazing. She's been on the journey the whole way. She knows your ups and downs. She knows what you've been through. You've built that relationship. It's like what you see on the movies when they're going in to give birth. They ring their doctor. They ring their midwife and they meet them there. We don't have that here. I know. It's just because of resources, which can't be helped. But it would be lovely in an ideal world.*

Maternity patient, LHD

Discussion

Overall, most Aboriginal maternity patients in this study reported that their clinical care is good, consistent with the 2019 Maternity Care Survey (MCS) which reported that 69% of Aboriginal women surveyed said the care during labour and birth was 'very good' (BHI, 2020). However, discussions with Aboriginal women of their experiences of maternity care illuminated several areas where improvements to cultural safety and overall care are needed.

Participants told of pre-existing fears of hospitals, often based on a fear of children being removed. This fear of children being removed at birth by government departments was also reported by Aboriginal mothers in two NSW- based studies [16, 17]. Staff also reported that DCJ involvement around Aboriginal births was common. Some mothers also noted fear of birthing for the first time; or during subsequent pregnancies, felt anxiety linked to previous negative birth experiences, highlighting the importance of supporting first time mothers well. Participants conveyed how birthing has a central role in Aboriginal culture and is considered important Women's Business, acknowledging the need to ensure that **cultural practices are understood and supported within hospitals.**

Consistent with other recent studies in Australia, this study found that some individuals in the hospital system continue to behave in a way which is racist or discriminatory towards Aboriginal maternity patients, primarily in the form of 'covert racism' consisting of judgement, stereotyping and assumptions around drugs, alcohol, and domestic violence [14, 16, 17, 28]. Experiences of racism or unconscious bias were reported to impact patients' mental health, and health-seeking behaviour in particular seeking support for breastfeeding or not wanting to return to a particular hospital. Staff also reported barriers to calling out racism. **There is a need for more training so staff are cognisant of what racism looks like, and past trauma that can affect the lives of Aboriginal patients, as well as improved channels for staff to report racism in hospitals.** Furthermore, measures that report on institutional racism within the health system and measure access by First Nations people to culturally safe health services to align with the 2024 Closing the Gap implementation plan. [29]

Participants noted that negative experiences with a minority of staff were common, [28] good communication reduced fear and anxiety among Aboriginal women, and that when women felt included in what was happening, they reported positive experiences [14].

Where communication is rushed or dismissive, patients are hesitant to ask questions, especially during first pregnancies and births, with similar experiences shared in earlier work by Watson whose participants reported that the nurses often 'looked busy' and were non-communicative [13]. Communication that is perceived as uncaring, rude or lacking in compassion, can understandably result in patients feeling upset and less willing to engage with those health providers. As also reported in Dietsch and Brown, non-consultation was seen as particularly damaging to Aboriginal mother's experiences of hospital stays for birthing and maternity care [14, 16]. In contrast to building trusting relationships, some patients felt 'like a tick box' or that they were being treated as a number rather than a person, which is contradictory to holistic health and wellbeing notions that are encompassed in Aboriginal culture. Where there is too much use of jargon, inadequate or conflicting information, patients felt less confident to ask questions or to manage their care; this finding was also expressed in Brown et al who reported that when women felt that they were not provided with adequate information then their level of fear and anxiety would increase [14].

Provision of care by Aboriginal staff throughout the antenatal and postnatal care, and at the hospitals for birthing was considered the most important factor in ensuring cultural safety. Patients felt more listened to, more supported, and that clearer explanations were given. Participants felt Aboriginal staff were always happy to see them, took the time to build relationships, and perceived the care they provided to be less rushed, which resulted in patients feeling more comfortable, and more willing to

ask questions. Aboriginal staff were noted to have a shared understanding of Aboriginal culture, including the importance of family and kin relationships. Similar findings arose in previous studies which found that Aboriginal women are more likely to communicate openly with Aboriginal staff in hospital [13, 17]. It was felt strongly that more Aboriginal staff in hospitals would improve overall care for Aboriginal women, both in terms of cultural safety and health outcomes. At the time of the study, it was noted by participants that some AMIHS services couldn't meet the demand of those wanting to use the service. The 2019 MCS study reported only 52% of Aboriginal patients were offered support from an Aboriginal Health Worker while they were in hospital [9], suggesting that further expansion of Aboriginal-led programs and the Aboriginal maternity care workforce would be advantageous.

Most patients reported an intervention during their birth, and several felt that the intervention was forced or unnecessary, and some had concerns regarding their pain relief. This finding is consistent with state and national data which shows the rates of interventions during pregnancy increasing across all populations [30], suggesting that further exploration into whether the increased interventions are indeed improving health outcomes for babies and mothers. Recent evidence shows that Aboriginal women using Birthing on Country services required less epidural pain relief in the first stage of labour, and had fewer planned caesarean sections, and were less like to have a pre-term birth [31].

Patients' experiences of breastfeeding support were mixed, with some sharing positive experiences and others felt left to work it out on their own. Inadequate breastfeeding support has been previously reported [16], and in this study some patients discussed how a lack breastfeeding support had resulted in them starting the baby on formula, even if this was not what they had planned. Data from other studies shows that rates of breastfeeding are low in Aboriginal populations, suggesting that is should be focus for hospital/hospital staff [32].

Women in this study described instances which were perceived as under resourcing where staff were thought to be stretched, citing long waits for assistance whilst in the hospital which was seen as particularly problematic for first time mothers needing post-natal support. This is supported by data from the MCS which reported that 56% of Aboriginal women said they 'always' got assistance or advice when they needed it [9], and highlights the need for sufficient staff resourcing in the hospital.

As has been found in other studies, participants emphasised the importance of kinship relations in Aboriginal culture and valued family support around birthing [17], suggesting a need for hospital policies that allow partners to stay overnight; and are supportive and accommodating of larger family groups.

Maternity care models which provide continuity of care with the same midwife or healthcare worker across the antenatal and postnatal pathway were highly valued as they allowed for relationships to be developed, trust to be built and supported improved communication. This work suggests that models which provide continuity of care antenatally and such as AMIHS or the local ACCHS, which have the added benefit of cultural safety, or caseload midwifery programs (potentially also Aboriginal-specific) should be continued, and potentially expanded, into the future.

Patients noted the desire for birthing spaces with more warmth and less clinical feeling to the rooms, with natural light and Aboriginal paintings. Cultural rooms were seen as important and were available in the hospitals in the three areas the study was conducted in, however communication with patients around what culturally safe spaces on the maternity ward were available and how to access these could be increased.

Study strengths

The study has several strengths; it adopted an Indigenist research approach, was led and conducted by Aboriginal researchers, used culturally appropriate yarning methodology, was guided by an advisory committee with strong representation from senior Aboriginal stakeholders, and privileged

Aboriginal voices throughout. An Indigenist research approach can improve both the quality of data collected and the relevance and utility of its findings [33]. Rigorous research methods were used; interviews were recorded and transcribed verbatim, data were analysed systematically using an appropriate approach, and findings were reported transparently, with extensive inclusion of quote data to substantiate thematic findings. Maximum variation sampling ensured the experiences of people from a range of geographic locations, ages, and perspectives were heard, and enabled the documentation of negative experiences of care, while also providing examples of what good practice looks like.

Study Limitations

While the purpose of qualitative research is not to answer questions of prevalence or generalisability, the BHI state-wide NSW Patient Survey Program has established significant quantitative differences in the experiences of public hospital care for Aboriginal and non-Aboriginal patients [34], The findings in the current qualitative study complement and contextualise these findings and hold learnings to inform improvement. There were also 2 LHD staff interviewed for the study meaning only there was one LHD which wasn't represented in the study. While the study may be key informants, the small number of LHD participating provides a limited number of perspectives.

Recommendations

The draft recommendations have been prepared in consultation with the NSW Ministry of Health and Aboriginal advisory committee and are organised into three categories.

1. Build cultural capability and safety
2. Address child protection concerns
3. Ensure that cultural models of maternity care are embedded within NSW Health.

1. Build cultural capability and safety

a. Strengthen efforts to address racism and unconscious bias, with a zero-tolerance approach to racism. This may include creating accountability in the system for racism, teaching and celebrating allyship, ensuring cultural safety is built in to how NSW Health does business and enhancing "respecting the difference" training for NSW Health staff to include cultural immersion programs and decolonisation training to support the delivery of culturally responsive care
b. Review policies, procedures and systems for measuring, reporting and addressing racism and unconscious basis
c. Develop, implement and monitor policies and environments which enable and support families attending hospitals to receive culturally safe care.
d. Ensure provision of cultural rooms and spaces that are accessible to Aboriginal patients and their visitors, and ensure usage guidelines are adequately communicated to encourage their use.
e. Build on the NSW Health Apology to strengthen efforts to improve trust between Aboriginal families and public maternity services

2. Address child protection concerns

a. Embed systems, policies and protocols to enable appropriate liaison and coordination between NSW Health and NSW Department of Communities and Justice to effectively support families with child protection vulnerabilities at birth
b. Increase maternity staff understanding of the historical and ongoing context of Aboriginal child removal in line with a decolonising approach

c. Ensure systems are in place enabling health staff to seek cultural consultation for child protection matters, to address unconscious bias and ensure any interventions are appropriate

3. **Ensure that cultural models of maternity care are embedded within NSW Health**
   a. Increase the availability and strengthen culturally specific maternity models of care (e.g. AMIHS) across the NSW Health system to provide high quality and culturally safe continuity of care for Aboriginal families.
   b. Improve Aboriginal women and families' access to support from Aboriginal Health staff, including Aboriginal Liaison Officers, Aboriginal Health Workers, and Aboriginal Midwives
   c. Ensure that maternity care pathways address culturally appropriate continuity of care and support early engagement

Conclusion

Findings from this study suggest that while Aboriginal mother's experiences of hospital care are generally positive, some Aboriginal mothers admitted in NSW hospitals reported negative experiences including that of racism and unconscious bias. Further, there are ongoing concerns around the systematic removal of Aboriginal children from their mothers which urgently require addressing. Three categories with 11 recommendations are proposed to improve the experience of culturally safe care for Aboriginal mothers in NSW hospitals centring around efforts to improve the cultural safety of staff and hospital environments, addressing child protection concerns, and strengthening and increasing cultural models of maternity care for Aboriginal mothers and their babies. Implementing these recommendations and improving the experience of Aboriginal mothers and their babies in NSW hospitals is vital to ensure enduring improved outcomes across generations for Aboriginal communities of NSW.

Appendix 1 – Demographics

Table 1: Participant characteristics

Characteristics (maternity patient)	*n*	%
Gender		
Male	0	0%
Female	21	100%
TOTAL	21	
Age (years)		
18-24	9	43%
25 to 34	11	52%
35-44	1	5%
Recruitment sites		
Murrumbidgee LHD (RivMed and MLHD)	8	38%
Illawarra-Shoalhaven LHD (IAMS, Waminda and ISLHD)	6	29%
Western Sydney LHD (GWAHS and WSLHD)	7	33%
Most recent admission date		
Last 6 months	11	52%
6-12 months	1	5%
1-2 years	8	38%
2-5 years	1	5%

Table 2: Staff Characteristics

Characteristics (staff)	*n*	%
Gender		
Male	2	13%
Female	13	87%
TOTAL	15	
Age (years)		
18-24	0	0%
25 to 34	4	27%
35-44	10	67%
45-54	0	0%
55-66	1	7%
Recruitment sites		
Murrumbidgee LHD (RivMed and MLHD)	6	40%
Illawarra-Shoalhaven LHD (IAMS, Waminda and ISLHD)	8	53%
Western Sydney LHD (GWAHS and WSLHD)	1	7%
Participant type		
ACCHS staff	13	87%
LHD Staff -maternity	2	13%

Appendix 2: Interview guides

Exploring experiences of maternity care among Aboriginal people: a qualitative study

Interview guide – Maternity patient

Introduction

Hi, my name is _____ from the Sax Institute.

Firstly, thank you for speaking with us today. We want to talk to you about your recent experience of maternity care including when you were in hospital for the birth of your baby.

The Sax Institute is conducting a study on behalf of NSW Health, who will use the information to improve services for Aboriginal people. The study wants to hear about women's experiences of their maternity care, particularly if they received good care, felt safe, well supported and listened to as an Aboriginal person during their maternity care and hospital care, with a focus on cultural safety. We expect the interview will take approximately 60 minutes.

We want to be clear that the information that you tell us today will be kept secure and will not be given to any other person or organisation. Your information will be included with information from other participants. Your name will not be used and you will not be able to be identified in any way. If in your consent you have agreed that your information can be used, we will contact you again with the information we would like to use.

This study is voluntary. You can choose to end the interview at any time.

If you agree, we would like to record the meeting. Is that ok with you? Do you have any questions about the interview before we start?

Your hospital experience

1. **Perhaps we could start with you telling us about your hospital stay for birthing and what it was like, and then we'll ask some more detailed questions.**

Prompts:

- What was your initial impression of the hospital?
- What was it like to be in hospital?
- What words would you use to describe how you felt in hospital?

Thank you for that. We'll go some more specific questions now. You've already talked about some of the issues we want to know about, but we'll ask those questions anyway in case there's anything more you would like to add. Please let us know if at any time you feel upset or distressed during the interview, we can take a break or stop the interview.

Quality and appropriateness

2. How did you find the communication with the hospital staff? (*Explore why/why not? Ask for further explanation or specific example)*

- How well was everything explained? Was everything clear to you?
- Did you feel that you could ask questions, or check back on anything?
- If you asked a question, or other comments, were you listened to?
- Were the staff respectful? If no, which staff member was not respectful (Doctor, Midwife, cleaning staff?)

3. What did you think of the care you received at the hospital? *(Explore why/why not? Ask for further explanation or specific example)*

- Were you asked whether you are Aboriginal and/or Torres Strait Islander?
- Did you feel that you could you ask about your needs and the needs of the baby?
- Were your needs met?
- Could you access staff to help you when you needed assistance?
- Did you feel comfortable in the location/setting where care was provided? How did you find the visiting hours and conditions?
- Did you trust the staff?
- Were you able to access an Aboriginal Health Worker/Liaison Officer? Can you describe what impact this had on your experience?

4. What was the discharge process like? *(Explore why/why not? Ask for further explanation or specific example)*

- Did you feel well enough to leave hospital?
- Did you feel confident about what to do once you were home?
- Were you able to get assistance with transport home from hospital?
- Did the hospital communicate with your family/friends to support your discharge?

If the participant reports discharging themselves early, explore why they left, and prompt how they felt.

3. Overall, how would you rate quality of the hospital care you received when you were having your baby?

1. Very poor
2. Poor
3. Fair
4. Good
5. Very good
6. Excellent

Why?

Experiences and perceptions of feeling culturally safe (or culturally unsafe)):

4. **When accessing health care what kinds of things help make you feel comfortable and respected as an Aboriginal person**?

5. Can you describe any aspects of your maternity care that you particularly valued?

6. When you were receiving your maternity care (both during in pregnancy care and in the hospital), did you feel you feel comfortable and respected as an Aboriginal person? Can you describe anything that made you feel uncomfortable?

7. Is there anything else that you think is important to ensure Aboriginal people feel comfortable and respected in hospital?

Experiences and perceptions of any incidents of discrimination:

8. Did you experience any discrimination or racism during your maternity care?

- If so, can you tell me about your experience? Did you or anyone report the incident/s?
- If yes, did you feel supported? Was it followed up?
- If yes - were you satisfied? Why/Why not? If it wasn't followed up, what would you like to have seen done?
- If you didn't report, was there a reason why? What could be done to support people to report such instances?
- Do you want to talk to someone about your care or submit a formal complaint? We can provide you with some information if you wish to do so (see distress protocol).

Perceived impacts from maternity care and/or hospital stay:

9. Has your hospital stay impacted on your health in other ways (positive or negative)? Can you describe these impacts?

Prompts:

Has it affected your:

- willingness or ability to seek help for health concerns?
- self-management of any health conditions?
- social and emotional wellbeing?
- decisions on how you access health services?

Suggestions for improvement

10. Are there any things that could have improved your experience during your maternity care or hospital stay? How?

Exploring experiences of maternity care among Aboriginal people: a qualitative study

Interview - Aboriginal Health Worker – Maternity

Introduction

Hi, my name is _____ from the Sax Institute.

We are here to speak with you today about your experiences working in an NSW public hospital and your views of the care Aboriginal patients receive in these hospitals, with a focus on cultural safety. We expect the interview will take approximately 45 minutes to 1 hour to complete.

The Sax Institute is implementing this study on behalf of NSW Health, who will use the information to inform how to best provide hospital services for Aboriginal people.

We want to emphasise that the information that you provide will be kept secure and will not be passed onto any other person or organisation. This information will be combined with information from other participants and you will not be named or identifiable in anyway. If in your consent you have agreed that your information can be used, we will contact you again with the information we would like to use.

As we noted in the consent form that you signed earlier, this study is voluntary. You can choose to leave the discussion at any time.

With your permission we would like to record the meeting. Is that ok with you? Do you have any questions about the interview before we start?

Your experiences working in a NSW public hospital or in a public maternity service

1. **We are interested in what it is like for you working at this hospital/public maternity service:**
   - How would you describe the culture?
   - What are your interactions with other staff like?
   - Do you feel the communication is respectful?
2. **Do you think Aboriginal staff feel comfortable and respected working at this hospital/public maternity service? What sorts of things contribute to this?**
3. **Is there anything else that you think is important to ensure Aboriginal staff to feel comfortable and respected in the hospital/public maternity service?**

Perceptions of the care Aboriginal patients receive at local hospitals (maternity)

Quality and appropriateness

4. **How do you think Aboriginal patients find giving birth in NSW public hospitals?**
5. **How do you think Aboriginal patients find communication by hospital staff? (for the sub questions – prompt why/why not and ask for further explanation or specific examples)**

- Do you think everything is explained properly (in a way the patient can understand)?
- Do you think Aboriginal patients feel like they can ask questions?
- When they ask questions, or other comments, do you think they feel listened to?
  Do you think hospital staff are respectful to Aboriginal patients?

6. **What do you think of the healthcare and support Aboriginal patients receive when giving birth in a NSW public hospital? (for the sub questions – prompt why/why not and ask for further explanation or specific examples)**

- Do you think Aboriginal patients feel comfortable to ask about their needs? Are they encouraged to ask any questions they may have?
- Do you think their needs, particularly any cultural needs are met?
- Do you think Aboriginal patients can easily access staff to help when they need assistance?
- Do you think Aboriginal patients feel respected?
- Do you think Aboriginal patients trust the staff at the hospital?
- Do you feel that hospital staff are consistent and respectful when asking patients about their Aboriginal status?

7. **What about leaving hospital? What are your views on the discharge processes?**

- Do you think Aboriginal new mothers leave the hospital feeling confident about what to do once they are home? Can you explain?
- Are Aboriginal patients able to get assistance with transport home from hospital?
- Does the hospital communicate with family members to support discharge and caring for the baby at home?
- Do you have any suggestions on whether, and how the discharge process could be improved?

Experiences and perceptions of feeling culturally safe (or culturally unsafe)):

8. **When accessing health care what kinds of things do you think help make Aboriginal people feel comfortable and respected? Can you think of any specific examples?**
9. **Can you think of any aspects of hospital care that are particularly valued by Aboriginal patients? Can you think of any specific examples?**
10. **Do you think Aboriginal patients feel comfortable and respected at the hospital where you work? What sorts of things contribute to this? Can you think of any specific examples?**
11. **Is there anything else that you think is important to ensure Aboriginal patients to feel comfortable and respected while in hospital?**

Experiences and perceptions of any incidents of discrimination:

12. **Can you please describe any experiences of discrimination/racism that have happened to Aboriginal patients at the hospital where you are employed?**

Prompt: Does it seem like assumptions are made about Aboriginal patients' behaviours? Can you describe some of the assumptions that are made?

Do you know if anyone reported these incident/s?

- If yes, did the patient feel supported? Was it followed up? If it wasn't followed up, what would you like to have seen done?
- If no, was there a reason it was not reported? What could be done to support people to report such instances?

Perceived impacts on health after the stay in hospital:

- Do you think Aboriginal patients' experiences in hospital impact their health in broader (negative and positive) ways?

Prompts are there any changes, positive or negative in patients

- willingness or ability to seek help for health concerns
- self-management of any health conditions
- social and emotional wellbeing their decision on how they access health services.
- Misdiagnosis or mismanagement of a health issue – are there any examples of this and what impact did it have for the patient?

Suggestions for improvement

13. **Do you have any suggestions for things that NSW public hospitals could do to improve maternity patient experiences for Aboriginal people?**

Exploring experiences of hospital and maternity care among Aboriginal people: an qualitative study

Focus group guide – ACCHS staff

Introduction

We are here to speak with you today about your views of the care Aboriginal patients receive in NSW public hospitals and your experiences of working with local public hospitals (in your role in the ACCHS) and with a focus on cultural safety. We expect the focus group will take approximately 60-90 minutes to complete.

The Sax Institute is implementing this study on behalf of NSW Health, who will use the information to inform how to best provide hospital services for Aboriginal people.

We want to emphasise that the information that you provide will be kept secure and will not be passed onto any other person or organisation. This information will be combined with information from other participants and you will not be named or identifiable in anyway.

As we noted in the consent form that you signed earlier, this study is voluntary, and you can choose to leave the discussion at any time. With your permission we would like to record the meeting. Is that ok with you? Do you have any questions about the interview before we start?

Thank you for meeting with us today. There are two main areas we would like to explore in this focus group:
1 - your experiences working with local hospitals (during your role at the ACCHS)
2 – your perceptions of Aboriginal patient experiences at the hospitals (main focus)

Your experiences working with local public hospitals

1. **In your role at the ACCHS, can you tell us about your interactions with hospital staff?**
   (for the sub-questions – prompt why/why not and ask for further explanation or specific examples)
   - Do you feel everything you need to know is explained clearly?
   - Do you feel the communication with you, as an Aboriginal health worker is respectful?
   - How do your interactions with hospital staff influence the quality and continuity of care that you are able to provide to your patients?
   - How do you feel when you enter a local hospital or public maternity service? What are your first impressions?

1. **Do you have any suggestions for things the local public hospitals could do to improve the way they work with local ACCHS?**

Perceptions of the care Aboriginal patients receive at local hospitals (general and maternity)

Quality and appropriateness

2.	**Can you tell us about the experiences of Aboriginal patients/clients that have been admitted to hospital?**
	How do you think Aboriginal patients find the communication by hospital staff? Do you have any examples that you can share? *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)* • Do you think everything is fully explained, in a way the patient can understand? • Do you think Aboriginal patients feel comfortable to ask questions? • When they ask questions, or make comments, do you think they feel listened to? Do you think hospital staff are respectful to Aboriginal patients?
	What do you think of the healthcare Aboriginal patients receive? If you have any examples that you can share, that would be great. *(for the sub-questions – prompt why/why not and ask for further explanation or specific examples)* • Do you think the patients feel comfortable asking about their needs? • Do you think they feel that their needs are met? • Do you think Aboriginal patients can easily access staff to help them when they need assistance? • Do you think Aboriginal patients trust the staff at the hospital? • Have you heard if hospital staff are consistent and respectful when asking patients about their Aboriginal status?
3.	**What about leaving hospital? What are your views on the discharge processes?** *(for the sub-questions – prompt why/why not?)* • Do you think Aboriginal patients feel confident about what to do once they are home? • Are Aboriginal patients able to get assistance with transport home from hospital? • Does the hospital generally communicate with family members to support the Aboriginal patients' discharge? **Do you hear reports of patients discharging themselves early? If yes, why do you think they discharge early?**

Experiences and perceptions of feeling culturally safe (or culturally unsafe)):

4.	**When accessing health care what kinds of things do you think help make Aboriginal people feel comfortable and respected? Can you think of any specific examples?**
5.	**Can you think of any aspects of hospital care that are particularly valued by Aboriginal patients? Are there any specific examples you can share with us?**
6.	**Do you think Aboriginal patients feel comfortable and respected at the local hospitals? What sorts of things contribute to this? Can you think of any specific examples?**
7.	**Is there anything else that you think is important to ensure Aboriginal patients feel comfortable and respected while in hospital?**

Experiences and perceptions of any incidents of discrimination:

8. **Have any of your patients experienced any discrimination or racism during their hospital stay? If so, can you tell me about their experience?**

Prompt: Does it seem like assumptions are made about Aboriginal patients' behaviours? Can you describe some of the assumptions that are made?

Do you know if anyone reported these incident/s?

- If yes, was the patient supported? Was it followed up? If it wasn't followed up, what would you like to have seen done?
- If no, was there a reason it was not reported? What could be done to support people to report such instances?

Perceived impacts on health after the stay in hospital:

9. **Do you think Aboriginal patients' experiences in hospital impact their health in broader (negative and positive) ways?**

Prompts

Are there any changes, positive or negative in patients:

- willingness or ability to seek help for health concerns?
- self-management of any health conditions?
- social and emotional wellbeing?
- decisions on how they access health services in the future?
- Misdiagnosis or mismanagement of a health issue – are there any examples of this and what impact did it have for the patient?

Suggestions for improvement

10. **Do you have any suggestions for things the local hospitals could do to improve patient experiences for Aboriginal people in your community?**

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