“Got to build that trust”: Aboriginal Health Workers’ perspectives and experiences of maternal oral health

CURRENT STATUS: UNDER REVIEW

International Journal for Equity in Health  ▼ BMC

Ariana C Kong  A.Villarosa@westernsydney.edu.au
Western Sydney University
Corresponding Author
ORCiD: 0000-0002-1384-227X

Mariana S Sousa
University of Technology Sydney

Lucie Ramjan
Western Sydney University

Michelle Dickson
University of Sydney

Joanne Goulding
South Western Sydney Local Health District

Kylie Gwynne
Macquarie University

Folau Talbot
University of Sydney

Nathan Jones
South Western Sydney Local Health District

Ravi Srinivas
South Western Sydney Local Health District

Ajesh George
South Western Sydney Local Health District
| DOI          | 10.21203/rs.2.20092/v1 |
|-------------|------------------------|
| SUBJECT AREAS | Dentistry  | Maternal & Fetal Medicine |
| KEYWORDS     | Aboriginal, dental, pregnancy, qualitative, yarning, model of care |
Abstract

Background Aboriginal Health Workers provide a unique insight into understanding the health needs of the Aboriginal peoples in the community on account of their cultural knowledge, experiences and understanding of the health services. The aim of this study was to explore the perceptions and experiences of Aboriginal Health Workers towards oral health care to inform the development of an oral health care program to better meet the oral health needs of Aboriginal pregnant women and new mothers.

Methods A participatory action research methodology informed the study. Focus groups were conducted with Aboriginal Health Workers at two antenatal health services in Sydney, Australia.

Results A total of 14 people participated in the focus groups. The four themes that emerged from the focus groups provided insight on the importance of trust in the building of empowering relationships with Aboriginal women and highlighted the need for Aboriginal Health Workers to receive additional training to better address the oral health needs of Aboriginal pregnant women and new mothers. However, the Aboriginal Health Workers worked in a system fundamentally driven by the legacy of colonisation and integenerational trauma that has created systemic barriers to access of health services, including dental care. The participants recommended that a priority dental referral pathway, that supported continuity of care, could provide increased accessibility to dental care for Aboriginal pregnant women and new mothers.

Conclusions The oral health of Aboriginal pregnant women and new mothers is supported by Aboriginal Health Workers, who outlined both a systems and an
individual approach in delivery of existing dental care. The Aboriginal Health
Workers provided recommendations to develop a program of dental care that could
break down the systemic factors that create barriers to accessing dental care for
Aboriginal women.

Background

Passing on knowledge verbally through yarning (speaking) is increasingly
recognised among Western research paradigms as a culturally competent
Indigenous research method (see glossary, Appendix 1).[1–4] However, this
research method is not new as it has been practised, in various forms, for thousands
of years by Indigenous peoples (Appendix 1) globally and is central to the exchange
of knowledge among Aboriginal and Torres Strait Islander Australians (hereafter
referred to as Aboriginal Australians, see Appendix 1).[5] Aboriginal ways of
knowing, being and doing takes a strengths-based approach to building
communities by creating a sense of identity, connection, community and kinship,
which are often consolidated by building relationships through yarning.[6]

In stark contrast to Aboriginal peoples’ ways of doing, Western research frameworks
and methods often tell a story about Aboriginal Australians that emphasises poor
health, highlighting inequities in health outcomes with respect to morbidity and
mortality on almost every measure of life.[7] Moreover, these indicators tend to
highlight a more superficial story about the health of Aboriginal peoples. What
Western measures of Aboriginal Australian health and wellbeing typically overlook
are the issues resulting from the cumulative effect of colonisation and
intergenerational trauma associated with policies leading to the Stolen Generation
(Appendix 1), both being key social determinants of health.[8] A step towards
decolonisation (Appendix 1) of this Western paradigm could be achieved by the valuing and engaging with the strength of Aboriginal Australians’ methods of knowledge exchange, such as through oral traditions like yarning.[9] A systematic review undertaken by Kong et al. [10] indicated that a wide range of psychosocial factors, such as education, income, experiences of racism, social support and other priorities, affected the decision of pregnant Indigenous women globally to access the dentist or brush their teeth, which can ultimately affect the mother’s oral health and the wellbeing of the baby. The place of residence and the existence of culturally competent dental services, with coordinated support from a midwife or antenatal care provider, were important contextual factors that seemed to positively influence pregnant Indigenous women’s oral health behaviours.[10] One area for improvement of health outcomes for Aboriginal Australians is oral health, particularly for children.[11] Evidence suggests that the improvement of maternal oral health behaviours plays a key role in reducing the severity and prevalence of early childhood caries and improves the oral health of children.[12-14] Healthcare for Aboriginal Australians is often provided by both Aboriginal community controlled health services (ACCHS) (see glossary, Appendix 1) and mainstream health services.[15] To effectively address the health needs of Aboriginal communities, both mainstream and ACCHS need to build partnerships with communities to ensure that programs are relevant and meet the community’s health needs through the effective implementation of local knowledge.[15, 16] These partnerships should be guided by community needs and share or lead the conception, development, implementation and evaluation of any health program.[17] Many Indigenous Health Workers, commonly known in Australia as Aboriginal Health
Workers (AHWs), already work with mainstream health services and have a long history in bridging the gap between an Aboriginal person and a health service; AHWs often play a major role in facilitating access to services for the local Aboriginal community.\[18\] Although some AHWs provide dental care to children and adults in some remote communities, no specific programs have been developed to build capacity of Indigenous Health Workers globally to promote oral health among Indigenous pregnant women specifically,\[19\] leaving a gap in workforce development. This study aimed to understand the stories, experiences and perceptions of AHWs towards oral health care to inform the development of a program to better meet the oral health needs of Aboriginal pregnant women and new mothers in the community.

Methods

Methodology

Participatory action research (PAR) was used as an overarching framework to explore how best to address the oral health needs of Aboriginal pregnant women and new Aboriginal mothers. In PAR, local people participate in the research process to identify and reflect on existing issues to develop appropriate solutions.\[20\] In the context of Aboriginal Australians, who have traditionally been researched “on” instead of “with”,\[21-23\] PAR methodology ensured the research involved collaboration with AHWs, and therefore, identifies changes that would be acceptable for AHWs within antenatal services.

Conceptualisation of study design

One of the main principles of PAR is to equalise the power relationship between the “researcher” and the “participant”.\[20\] Through yarning with the AHWs we
collectively identified that poor oral health among Aboriginal pregnant women and mothers was an area of need for the community. The AHWs also expressed some desired outcomes of the project (for example, developing an antenatal dental care training program), identified how they wanted to be involved in the project (through a focus group and periodic informal meetings for brainstorming and decision making) and specified that conducting focus groups among the AHWs, followed by interviews with Aboriginal pregnant women, to be the most appropriate methods of data collection for this study. These initial yarns were also important to cultivate trust between the AHWs and the lead author (AK), who identifies as a non-Indigenous woman raised in Australia, and who was the facilitator for the focus groups.

Sampling

Purposive sampling was used to recruit AHWs involved in two different public health programs in Sydney, Australia, that were designed to provide culturally competent antenatal support to Aboriginal pregnant women and new mothers. The public health programs were outreach programs (typically this involved visits to the client’s house instead of having visits at the clinic) where the AHW offered cultural support to Aboriginal women during the antenatal period. These visits were conducted alongside nurses who provided clinical antenatal support.

Participant demographics

A total of 14 people participated in the three focus groups, including 7 AHWs, 2 Aboriginal management staff (who were not AHWs), and 5 Aboriginal Family Partnership Workers. The Family Partnership Workers’ position descriptions were similar to AHWs, in that they raised cultural awareness within their teams to ensure culturally competent service delivery but did not necessarily require the same
qualification. For this paper, Aboriginal Family Partnership Workers will also be referred to as Aboriginal Health Workers. All of the participants were female, and the age of the participants ranged from 22 to 50 years. The highest educational qualification ranged from completion of Year 12 to a university post-graduate qualification. Their years of experience working as an Aboriginal Health Worker ranged from two weeks to ten years.

Ethical Considerations

Ethical approval for this project was granted from the South Western Sydney Local Health District (2019/ETH09963) and the Aboriginal Health & Medical Research Council (1438/18). Reciprocal approval was also granted from Western Sydney University (RH13086).

Data collection

A total of three focus groups were conducted in a private room at a community health centre, where the AHWs were based. Prior to providing consent, the facilitator (AK) reiterated verbally (supported by the participant information sheet) that the participants were in a safe, confidential space to share their experiences; the participants were not obligated to participate, nor were there consequences for non-participation, and they could withdraw their consent at any time. A semi-structured approach to the focus groups was adopted, using five key issues to guide the focus group yarning:

Previous experiences (struggles/successes) caring for Aboriginal and/or Torres Strait Islander pregnant women (tease out the nature of their relationship)
Knowledge about antenatal oral health (problems faced, priorities, practices, trends)
Potential education, assessment and referral (challenges and facilitators)
Education and training (their needs/how they envision it, video resource?)
Other comments/questions

Two focus groups were conducted at the first service to allow all AHWs to attend. A third focus group was conducted at the second service. The first focus group was
facilitated by two of the study authors (AK and LR), where LR also wrote field notes. LR is a qualitative researcher with experience working with vulnerable populations. The subsequent two focus groups were facilitated only by AK, who also wrote field notes after the focus groups. All of the focus groups were audio recorded with consent from all participants. The recordings were transcribed by a professional service and checked for accuracy by AK, who wrote additional memos while listening to the transcripts.

Analysis

An inductive thematic analysis based on the work of Braun et al. [24] was employed. All participants were assigned pseudonyms to ensure confidentiality. AK read and re-read the transcripts and listened to the audio recordings and accompanying field notes and wrote additional memos to ensure adequate immersion in the data. AK initially coded the transcripts inductively using NVivo Software. AK then generated themes by clustering similar codes together. AK revisited these themes a second and third time to better understand the themes from each focus group, and then combined themes across all focus groups. These themes were reviewed by another non-Indigenous researcher with experience in qualitative research (MSS) and by an Aboriginal researcher (FT). After agreement between AK, MSS and FT, AK presented the themes to the AHWs who had agreed to be contacted again. AK yarned about the emerging themes and provided a written copy of the themes, allowing for member checking to confirm the interpretation of the analysis and ensure rigour of the findings.[25] All participants were invited for a follow-up focus group to check interpretation, however only half of the participants (n=7) were available due to unforeseen changes with client scheduling. This discussion refined the concepts underlying each theme and the language used to define the themes.
Results

Four main themes emerged from the focus groups (Table 1) relating to AHW’s perspectives and experiences of maternal oral health care. All findings around the scope and future design of an antenatal oral health program will be published elsewhere.

| Theme                                           | Sub-Theme                                                                 |
|-------------------------------------------------|---------------------------------------------------------------------------|
| Trust builds empowered relationships             | • Building trust                                                          |
|                                                 | • Supporting women to make healthy choices                                 |
| Colonisation and intergenerational trauma:       | • External barriers to accessing dental services                           |
| systemic barriers                                | • Feelings of ‘shame’: fear, anxiety and judgement                        |
| Systems that provide continuity of care          | • Working in two worlds                                                   |
|                                                 | • Need for a priority dental referral pathway                              |
| More knowledge and training to meet              | • Understanding Aboriginal ways of doing                                 |
| communities’ needs                               | • Current oral health training, knowledge and practices                   |

Theme 1: Trust builds empowered relationships

AHWs from all the focus groups identified the need to build trust with their clients to ensure that they could give appropriate support to Aboriginal pregnant women and mothers during the antenatal period.

Building trust

Trust was discussed as an imperative to understand their clients’ needs and priorities. Trust was something that required both time and empathy to build through yarning, with some AHWs drawing on their personal experiences and cultural knowledge to cultivate this trust.

Trust. Got to build that trust. (Melissa, AHW)

It’s totally up to them and what they want. We tend to find that if we just sit there and have a yarn with them rather than push them. We find a lot of services do try and push, you known like, to tell the girls what to do. We don’t do that: and we find we get better outcomes when we don’t do that. (Karina, AHW)
But it's also too with that rapport building is that those yarns that you're having with your clients aren't about this is what you're doing, it's about you giving them your experience as well. So, you know, it's like, I've done this too. (Tess, AHW)

Due to the trust developed with AHWs, Aboriginal pregnant women and mothers tended to be more receptive towards AHWs compared with other health professionals.

Often, at times, when they're in crisis and they don't answer the phone calls to the nurses, all it takes is one phone call from us and then we're back on board with them...when we contact them they're usually pretty honest with us about what's going on with them. (Sarah, AHW)

We basically just support the nurses. Already questions that the client might have. Sometimes they ...direct the questions at us rather than the nurse. We just bounce off one and another and just support, you know, what we're delivering (Karina, AHW)

Supporting women to make healthy choices

The role the AHWs had in building trust was essential in developing an understanding of what support a pregnant woman needed to make healthy choices during their pregnancy. Regardless of whether this support was socioemotional, practical or both, the participants spoke about how such support gave power back to the mother.

Yes, and I actually just tend to ask, do you have somebody you can go with or do you feel okay doing this, um, or are you all right to make the call? Or if you haven't got credit, do you need to use my work phone or do you want to wait until you've got credit? So always giving options or if they've got ideas, well what do you think? So they'll let us know if they can't do that. (Louise, AHW)

it depends on where the mum is at, I guess. I'll say it that way... Yeah, their ability
to access, whether they're comfortable calling, because I'll call for some clients...

We do provide transport if we need to as well. (Emily, AHW)

When asked a question about the nature of the relationships the AHWs had with their clients, some of the participants described themselves as being the connectors, interpreters and the first point of contact for many clients. I guess we're that connector, we're the connecter with a system that is different traditionally to what some of our systems would be or would look like. So we help break down the barriers of, um, an institution which has historically been, um, one that's had a negative attachment to it from past policies and history. (Louise, AHW)

So it's kind of like - I think of us as...friendly - not a friend. Um, we look after their cultural stuff, you know, to help support them with culture? Um, we're the link between mainstream and Aboriginal people and Aboriginal culture stuff. We're kind of like interpreters as well? Because a lot of clinical stuff is a lot of jargon, so we, um, will explain it in a different way. We advocate - [emphasised] a lot. (Emily, AHW)

Theme 2: Colonisation & intergenerational trauma: systemic barriers

The long-term effects of colonisation and intergenerational trauma, which affected their clients’ desire and ability to engage with services and institutions, were discussed by all focus groups. The AHWs identified that the cost of private dental appointments, issues with transport, long-waiting time for a dental appointment, dentists refusing to treat pregnant women, ineligibility to access public dental services or ACCHS dental services and systemic racism as external barriers to Aboriginal women accessing dental services. Additionally, the AHWs discussed that ‘shame’, alongside feelings of fear, anxiety and being judged during a dental appointment, were interpersonal factors that could affect an Aboriginal woman’s
desire to visit the dentist.

**External barriers to accessing dental services**

In response to a question about how many Aboriginal pregnant women (out of ten) had dental problems, one participant said “I’ve had two” (Melissa, AHW), whereas others agreed that the number was closer to “six to eight” (Rachel, AHW) out of ten. However, another two participants agreed that about only “one to two” (Melody, AHW) actually end up attending a dental appointment.

Cost, transport, long-waiting lists and dentists who refused to treat pregnant women were cited as some reasons for poor uptake of dental services. However, the AHWs also attributed a number of policy-related barriers arising from colonisation and intergenerational trauma. The participants reiterated the barriers to accessing both mainstream public dental services and ACCHS. In mainstream dental services, a Health Care Card (concession card) is required to access public dental services; however, not all Aboriginal women qualified for this card if they were on a higher income. Furthermore, for Aboriginal pregnant women and mothers who were on a higher income, money was prioritised elsewhere.

Because I earn over the threshold, you don't get the free dental. (Emily, AHW)

the Health Care card is the biggest issue. If they're still working while they're antenatal - they can't go and access [the public dental service] because they're still getting paid...They just can't financially afford to go to a dentist, but then on a higher income - because of choices of buying a home which is what we want to do...

(Louise, AHW)

Accessing mainstream dental services were also problematic because of the systemic racism within institutions that manifested in difficulties engaging with institutions.
That [institutions] goes hand in hand. [with racism] (Sally, AHW)

There are so many complexities sometimes that it's really difficult for families to engage with Centrelink to chase that. They might have previous debt. They might have a child that's come, that's left their care, and they're backwards and forwards and it's all too hard to go into Centrelink and negotiate in that space. So that whole fear of institutional contact is...So it’s the fear of going in and having to deal with that entity, that institution, that’s why Aboriginal families prefer that outreach contact. (Jennifer, management staff)

Some of the AHWs’ clients preferred to see a dentist from an ACCHS due to a fear associated with mainstream institutions. However, five participants explained that since ACCHSs provide free dental services for Aboriginal Australians, some non-Aboriginal peoples try to identify as being Aboriginal to access these services; as such, some ACCHSs require ‘confirmation papers’ (Confirmation of Aboriginality) (see glossary, Appendix 1). However, participants identified confirmation papers as a barrier for many of their clients, especially if their clients were affected by the policies leading to the Stolen Generations that meant facing removal or disconnection from their families.

Dental’s one of them. That's why they're [people who didn’t identify previously] identifying, so they can get free access to it. (Karina, AHW)

That's why it's harder to get the confirmation now, because people were just going and using names and getting their confirmation, where now you need to go to these meetings and it is harder... But then it's harder for people that are from Stolen Generations and don't have - and are disconnected with their family. It's just so - it's just all a big mess. (Ellie, AHW)

There's a number of NGOs [non-government organisations] that also don't require
confirmation papers, but there are some services, like the Aboriginal Community Controlled organisations that do health and dental, that do require those confirmation papers. (Jennifer, management staff)

The participants described the process of acquiring Confirmation of Aboriginality to be a long process. In the AHWs’ experience, after applying for the Confirmation, some Aboriginal applicants would be interviewed in front of a community board which could comprise members of the Aboriginal Land Council or another Aboriginal organisation responsible for issuing the confirmation paperwork.

That is pretty much - there's nearly a 12-month waiting list. So you fill in your application form, hand that in, then ... once it's your turn they'll send you a letter and say this is the day and time that you need to present in front of the board - um, the board will ask you a couple of questions, and then it goes from there. So whether they accept it or not... More information, exactly. Come back or go back to where your family is known. (Melody, AHW)

Feelings of ‘shame’: fear, anxiety and judgement

The AHWs extensively discussed the shame (see glossary, Appendix 1), anxiety and fear associated with oral health and accessing dental services within the community. Despite knowing the importance of having healthy teeth, the participants spoke about anxiety and fear arising from personal experiences or from experiencing discomfort within the dental environment. They also spoke about the stories their clients had heard within the community, from past dental care experiences of older Aboriginal Australians.

My dad’s tooth just fell out...like the whole thing. He put it in the bin. I said, why did you do that? [Unclear]. I said, why didn't you take it to the dentist, and they can put it back in? He's like, nup. My nan yells at him every day, like rips him up. She says,
you can't get jobs with teeth like that you need to go and fix your teeth. (Ellie, AHW)

There's also just dental in general, the horror stories...and shame (Rachel, AHW)

Sometimes it's the elders, they instil the fear, I've got to say, because my grandmother wouldn't go into hospital. Never went to a hospital. Some of my immediate relatives could be in there dying, she won't go to a hospital. She wouldn't go and see a doctor. She wouldn't go to a dentist. God, no, she never went to a dentist. Even though my nan had false teeth, she never went to a dentist in her life. (Jennifer, management staff)

The participants also discussed that feelings of shame in the community arose from being embarrassed about their oral health. They also spoke about the fear of being judged by dental services.

Some people that we spoke to did this. [covers mouth with hand] Covered their mouth when they were talking to us. (Jennifer, management staff)

But also, I wouldn't initiate this story about how my parents didn't give me a toothbrush or do that, because I wouldn't want people to judge my parents. I'm sharing because it's safe. (Sharon, management staff)

I've got false teeth. Mine are through domestic violence. You know I mean? You've got to be careful on 'em lines too. Like, I don't mind talking about it. I'm strong enough to talk about it. But there's some that don't - you know what I mean, admit to that. (Karina, AHW)

The AHWs discussed the effect of past government policies of assimilation that allowed for the removal of children, enforced English as the only language that
could be spoken, and policed cultural acts or changes. Some participants mentioned that as a result, knowledge, language and culture were not passed down to younger generations, including the passing down of traditional dietary and dental health knowledge and practices.

Back in the day you weren’t allowed to [talk to anyone]... Doesn’t matter if you were Stolen or not. Yeah, you just weren’t allowed to. It was part of the white law at the moment. You know what I mean? (Karina, AHW)

There's certain stuff, yeah, that they chew on and stuff like that, but no ones ever really passed that down. (Karina, AHW)

Just living on bush tucker and nothing out there to hurt your teeth. (Melody, AHW)

Yeah, and this is how it went off-track and the introduction of a Western diet, and when you think about why people choose the bottle over the breast and, you know, what they put in, it's because of what's going on...and you need to capture that from Aboriginal people. Um, some of that you can see how some people do know here, and how it's okay to regain that knowledge, because the same way why other knowledge hasn't been passed down, this is, you know, the same reason. So that, I think, is really important. (Sharon, management staff)

Theme 3: Systems that provide continuity of care

Working in two worlds

The participants discussed how they found themselves balancing their professional roles while also maintaining their cultural responsibilities within the community. The AHWs spoke about having a role in both ‘worlds’, suggesting that the services’ policies were not always culturally safe.

Like, um, we obviously work under policies and guidelines, um - we're always
competing with - what is culturally safe and appropriate versus policies that we've got [to] work under. So we're always adapting to make it work in regards to what we're allowed and what we know within ourselves as Aboriginal people what is actually appropriate to do within the homes. (Louise, AHW)

One AHW shared an example where the existing workplace policies meant that Aboriginal clients had no option to access culturally competent and affordable dental services:

Well, I have a client that's just relocated from Melbourne. She's Aboriginal, no confirmation papers, she's not on the pension card, Health Care card, and her teeth are pretty much not there. What access does she have? Any kind of money that she has - she's got five - six children now. Very young mum, 23.... It’s a brick wall.

That’s just an example. (Sally, AHW)

Need for a priority dental referral pathway

All focus groups stressed the need for a priority dental referral pathway that would provide a free dental check-up for all Aboriginal pregnant women and for women who were pregnant with an Aboriginal child. This was considered an important preventative initiative for the community.

...in an ideal scenario we can get them in and get them streamlined to have that check-up then as a preventative measure for when, as you just said, pregnancy and everything. (Sarah, AHW)

Maybe that could be something, an escalated pathway so people in the program can make sure that within that - we get them checked within a... (Sharon, management staff)...Certain timeframe, like a KPI [key performance indicator] (Jennifer, management staff)

But if we offered it as something that was offered to everyone across the board, it
wouldn't be so confronting... You know, so if it was something that was offered to everyone [all pregnant women with Aboriginal babies] (Sally, AHW)

Some AHWs suggested that there should be an initial dental appointment available to clients to raise awareness about existing oral health problems and subsequently discuss their potential risk.

Because then you go to a dentist and you find out. Because I wouldn't go unless I had an issue; then I would go (Ellie, AHW)

So I don't know how that would fit but in my ideal world once she's pregnant I think she should be able to receive some treatment, whether that be an examination and fillings or what not, what they can do during the pregnancy (Sharon, management staff)

One of the management staff recommended that Aboriginal pregnant women, mothers, and women with Aboriginal babies needed pathways to a range of public and private services, including ACCHSs.

So I think if you attach the model to your program, that could have several pathways. One into the AMS [Aboriginal medical service], because we do outreach there and we do different pathways and, you know, there's no wait for any Aboriginal child, so why can't we have that for our unborn child and mothers? And then you've got the voucher system, where if you're needing services [the AMS] can't provide, you can get a voucher...into private dental. (Sharon, management staff)

It was important that non-Aboriginal mothers of Aboriginal babies could also access culturally competent services because they were still considered part of the community.

So when we look at a holistic thing so that non-Aboriginal mum that's pregnant
within our Aboriginal community, even though she's not seen as Aboriginal she's still seen as a part of our community... everyone has a place in their community, in their family structures (Louise, AHW)

Another suggestion was issuing all women with a concession card during their pregnancy to ensure that dental services were accessible to all women regardless of culture. Some participants were cautious about the potential for further discrimination if only Aboriginal women received a priority referral.

It could work from once - like from my perspective then all - well not just Aboriginal women, all women who are pregnant, there's a guideline that they have to book in before 20 weeks gestation. So, everyone is under that umbrella, who knows whether they've been booked in or not, and that's including Centrelink and everyone else... so every antenatal mum who has booked in why can't they be issued with a healthcare card for the duration for when she's pregnant? Why can't that be an open healthcare card that's given to all regardless of how much you earn and things like that? (Tess, AHW)

But how that's rolled out, there needs to be some sort of consultation around it to be mindful about stigma that's already attached, you know, prejudice that’s already attached...my worry would be how it's done, done in the best way (Louise, AHW)

Theme 4: More knowledge and training to meet communities’ needs

The AHWs recognised the importance of oral health during pregnancy for the future of healthy families and agreed that they could provide oral health education to pregnant Aboriginal women and mothers as part of their role. The AHWs discussed appropriate Aboriginal ways of ‘doing’ in health services and highlighted the need for training in antenatal oral health. The participants also commented on their own existing oral health knowledge, practices and training received.
Understanding Aboriginal ways of doing health service provision

Participants identified that any oral health training should be integrated into an existing antenatal program. Two of the AHWs identified a potential role for Elders (see glossary, Appendix 1) to be involved to pass on knowledge about healthy oral health practices in families.

I think you could build it into the [antenatal] program, though. (Sharon, management staff)

I think, um, culturally we always go to our Elders for guidance so I think for the Elders to, um, have an opportunity to filter down ideas, guidance, support - that's an appropriate way for us. So I guess keeping in with that, um, you know, speak... and having that yarn and consultation with them. This is what we're thinking or what ideas do you have, can you guide us as to what will work best because the two communities are different here (Louise, AHW)

If we say something, then their grandma says something, they're not going to go say what we say - they’re going to listen to their [Elders] (Teigan, AHW)

Current oral health training, knowledge and practices

Only one AHW had acquired oral health knowledge through formal training, with the others identifying the need for a formal training program in antenatal oral health.

I think I’ve just learnt it [oral health] over the training that I’ve done, like Certificate III and IV in Aboriginal and Torres Strait Islander Primary Health Care... then over my lifetime...I know I’ve got a thing about teeth. (Melissa, AHW)

Yeah, I think informal as well. I mean, we did do little in-services. We do do in-services on dental, so it could be some formal as well...I would be up for it [formal training] (Emily, AHW)
Several AHWs already had some knowledge of the effect of pregnancy on a woman’s oral health and vice-versa and understood the importance of a healthy diet for the mother’s and baby’s teeth. Several participants already encouraged women to see the dentist. In one of the services, the AHWs also handed out dental products to families.

So I know that during pregnancy, women's oral health can be exasperated from pregnancy. You know, that can cause wobbly teeth, it can cause decay to happen quicker, so it exasperates all of the symptoms, so I do know that. Um, it can cause headaches. It can cause other health concerns. It can stop them eating. It can give them anxiety. All kinds of different things (Emily, AHW)

If the client hasn't seen a dentist in a while, we usually ask them when was their last dental check-up. (Melissa, AHW)

So when we're talking about any good foods, we talk about the type of food you do that are better for your teeth rather than the sugary ones and the soft drinks and all that. The mums and dads are hearing that as well so we do access some other pregnant ones and we talk to them about that because it becomes a part of nutrition as well when they're pregnant. About if you're having a lot of soft drinks which are high caffeine and high sugar that's going through to bub. (Louise, AHW)

I know with some of our clients, that we've gone out and some of the content we've - it's touched on the oral health, we've given, like in the gift packs, we've given out the toothpaste and toothbrush. (Melissa, AHW)

Discussion

This study sought to understand the perspectives and experiences of AHWs related to the oral health needs of Aboriginal pregnant women and new mothers within the
community. The AHWs provided insight into the roles and relationships between AHWs and Aboriginal pregnant women, existing issues facing Aboriginal pregnant women within their local communities and identified the potential for AHWs to be trained to promote oral care among Aboriginal pregnant women.

The findings from this study emphasised that building trust with the clients was a priority for the AHWs as they provided support for clients to make informed decisions about their health. Although the AHWs had cultural expertise and knowledge, trust still took time to build with clients. As discussed by Karina and Tess, trust was built through yarning and sharing experiences, a traditional method of passing down information in Aboriginal cultures.[9] The AHWs’ priority to build trust highlighted a dynamic in the health provider-client relationship that is comparable to a partnership. Similar to previous studies, the AHWs identified themselves and their services as the link that some Aboriginal women used to access health services during the antenatal period.[18, 19, 26] The importance of social support was also an important factor identified by Kong et al. [10] in determining whether Indigenous women engaged with oral hygiene. Increased trust with health providers among vulnerable populations is associated with regular routine check-ups and improved mental and physical wellbeing.[27, 28] However, the participants acknowledged that trusting relationships with clients did not always result in clients trusting the health system.

The AHWs drew attention to two main factors that have led to an increased distrust in health systems among Aboriginal peoples, the long-term effects of colonisation and intergenerational trauma. The AHWs disclosed the fear of institutions by some Aboriginal people in the community who refused to access mainstream health institutions, even if a relative was hospitalised or if it potentially affected the
person’s prospects for employment. The AHWs described shame in the context of individuals and the wider community. Participants explained that some Aboriginal women would fear being judged for not being able to afford dental care, or fear for being judged about having poor oral health. The fear of being judged by health providers has been reported previously among Aboriginal peoples.[29, 30] The participants’ discussion around both the fear of institutions and fear of judgement highlight perceptions and experiences that some health care providers and health services do not deliver culturally safe or competent care for Aboriginal Australian peoples. Experiences of poor cultural competence has been reported among people from other ethnic groups receiving health care,[31] suggesting the need for further development in cultural competence across the health systems.[32] External barriers also led to increased difficulty for Aboriginal pregnant women and mothers to acquire correct documentation to access dental care in mainstream institutions and ACCHSs. While confirmation papers are issued to ensure that only people who are of Aboriginal and or Torres Strait Islander descent can access the service, some Aboriginal women experienced increased difficulty obtaining confirmation of Aboriginality if they had relocated from where they were known by community or could not trace their ancestry. Some ACCHSs requiring confirmation papers highlight the cycle created by historical colonising policies, which initially excluded Aboriginal peoples from receiving appropriate health care and continue to exclude Aboriginal peoples from culturally-specific health care services. As discussed by AHWs including Karina and Ellie, since some non-Aboriginal people claimed to be Aboriginal in order to access affordable health services, this highlights issues with the cost of existing health services for women more broadly. The difficulties acquiring correct documentation to access affordable dental care,
fear of judgement and fear of institutions demonstrate the need to shift towards systems of healthcare that aim to provide continuity of care that is culturally competent, safe and inclusive. While continuity of care includes having an ongoing, trusting relationship with a health provider, it also refers to receiving accessible, continuity of care that is individualised to the person’s needs across a range of services.[33, 34] In Australia, healthcare services (particularly dental health services) are typically siloed, with each service having its own eligibility requirements and pathways for accessibility.[35] The AHWs and management staff identified that a range of referral pathways into public, private and Aboriginal community controlled dental services needed to be created for all women pregnant with Aboriginal babies, irrespective of Aboriginal status. In the UK, the National Health Service offers free dental treatment to women during pregnancy and up to 12 months after delivery.[36] The participants related the need for a freely available initial dental check-up at least to improve awareness of the importance of oral health among pregnant women. Although part of the participants’ role was to provide culturally competent continuity of care for clients, balancing between working as a health service employee alongside the AHWs’ cultural responsibilities to the community required some skill. Some of the AHWs reported that the antenatal services sometimes needed to be adapted to make it culturally competent, indicating that perhaps the health system needs to focus on continuity of care. AHWs in other health disciplines have also shared stories depicting the difficulties working with their kinship communities while providing care consistent with Aboriginal ways of doing within a non-Indigenous organisation, and navigating the intersect between professional and interpersonal cultural relationships.[37, 38]
To provide enhanced care for communities, the AHWs identified the need for formal training to provide evidence-based oral care advice and referrals for Aboriginal pregnant women and new mothers. Although some AHWs had knowledge about maternal oral health, this was learned informally and did not provide the AHWs a formal qualification to enhance existing skill sets. This was not surprising as a recent review Villarosa et al. [19] found that no antenatal oral health training programs have been developed and evaluated for AHWs globally. However, it was important that this training program was developed with community, including the Elders, to ensure that the program would meet the needs of Aboriginal pregnant women and new mothers. Some studies with Australian Aboriginal communities revealed that the effectiveness of a health program is linked to how well the program adopts the community’s cultural practices, knowledge, and involves community members to participate and lead the program,[39–42] highlighting the importance of AHWs direct involvement in the development of the training program.

Lastly, the AHWs in this study drew attention to a number of recommendations and gaps relating to Aboriginal pregnant women and new mothers receiving dental care. Although building trusting and empowering relationships with clients were a necessity among the AHWs, the dental and broader health systems the AHWs navigated had both historical and existing barriers that prevented engagement for some Aboriginal women. On a systems level, dental services need to provide increased accessibility and continuity of care for Aboriginal women.

Despite the strengths, there were some limitations in this study. The AHWs involved in this study worked in an urban area therefore the challenges and perspectives of AHWs working in regional or remote areas were not identified. Moreover, as every Aboriginal community is distinct and diverse, the perspectives of the AHWs from
this study are not intended to be representative of other AHWs.

Conclusions
The AHWs from this study provided insight on the complexities and factors that influence the oral health needs of Aboriginal pregnant women and new mothers in light of developing a program of care. From the findings of this study, it was clear that the AHWs wanted to be formally trained to provide maternal oral health education and referrals for Aboriginal women during the antenatal period. Alongside this training program, the AHWs identified the need for a dental referral pathway that facilitated continuity of care to be implemented which would offer affordable dental care for their clients. Future research and development of a training program and referral pathway for AHWs should be developed with the AHWs to ensure the program is culturally competent and addresses the maternal oral health needs of Aboriginal women.

Abbreviations
AHWs: Aboriginal Health Workers; ACCHSs: Aboriginal community controlled health services; AMS: Aboriginal medical service; PAR: Participatory Action Research

Declarations
Ethics approval and consent to participate
Ethical approval was obtained from the South Western Sydney Local Health District Human Research Ethics Committee (2019/ETH09963) and the Aboriginal Health & Medical Research Council (1438/18). Reciprocal approval was also granted from Western Sydney University (RH13086). Written informed consent was obtained from
all participants.

Consent for publication

Not applicable.

Availability of data and materials

The data used and/or analysed for this study are available from the corresponding author on reasonable request.

Competing interests

The authors declare no competing interests.

Funding

Grant funding for this study was received from the South Western Sydney Local Health District and Maridulu Budyari Gumal. The South Western Sydney Local Health District provided some contribution to the study design and supported data collection. The funding organisations were not involved in the analysis and interpretation of the findings.

Authors’ contributions

AK, MSS, LR, JG, KG, NJ, RS and AG were involved in the conceptualisation of the study and the design of the study. JG supported participant recruitment. AK and LR were involved in the acquisition of the study findings whereas AK, FT and MSS were involved in the analysis of the study findings. AK, MSS, LR, MD, JG, KG, FT and AG all contributed to the interpretation of the findings. AK completed the first draft of the manuscript. MSS, LR, JG, KG, MD and AG provided substantial revisions to the manuscript. All authors have read and approved the submitted manuscript.

Acknowledgements

We would like to thank the Aboriginal Health Workers who have generously participated in this research. We would also like to thank Mr Boe Rambaldini who
contributed to the conceptualisation of the study.

Authors' information (optional)

1 Centre for Oral Health Outcomes and Research Translation (COHORT), School of Nursing and Midwifery, Western Sydney University/South Western Sydney Local Health District / Ingham Institute for Applied Medical Research, Liverpool, NSW, Australia

2 IMPACCT (Improving Palliative, Aged and Chronic Care through Clinical Research and Translation), Faculty of Health, University of Technology Sydney, Sydney, Australia /

3 Translational Health Research Institute, Campbelltown, NSW, Australia / Faculty of Dentistry, University of Sydney, Camperdown 2050, Australia

4 Faculty of Medicine and Health, University of Sydney, Camperdown 2050, Australia

5 Primary and Community Services, South Western Sydney Local Health District, NSW, Australia

6 Faculty of Medicine and Health Sciences, Macquarie University, Macquarie Park, NSW, Australia

7 Aboriginal Health Unit, South Western Sydney Local Health District, NSW, Australia

8 Oral Health Services, South Western Sydney Local Health District

9 Faculty of Dentistry, University of Sydney, Camperdown 2050, Australia

Reference List

1. Bessarab D, Ng’andu B. Yarning about yarning as a legitimate method in Indigenous research. International Journal of Critical Indigenous Studies. 2010;3(1):37-50.
2. Geia LK, Hayes B, Usher K. Yarning/Aboriginal storytelling: towards an understanding of an Indigenous perspective and its implications for research practice. Contemp Nurse. 2013;46(1):13-7.

3. Kovach M. Indigenous methodologies: Characteristics, conversations, and contexts: University of Toronto Press; 2010.

4. Rigney L-I. A first perspective of Indigenous Australian participation in science: framing Indigenous research towards Indigenous Australian intellectual sovereignty. Second National Indigenous Researchers Forum; 1997; Adelaide: Aboriginal Research Institute, University of South Australia.

5. Christensen J. Telling stories: exploring research storytelling as a meaningful approach to knowledge mobilization with Indigenous research collaborators and diverse audiences in community-based participatory research. Can Geogr. 2012;56(2):231-42.

6. Zubrzycki J, Shipp R, Jones V. Knowing, being, and doing: Aboriginal and non-Aboriginal collaboration in cancer services. Qual Health Res. 2017;27(9):1316-29.

7. Australian Institute of Health and Welfare. The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples 2015. 2015. Available at: https://www.aihw.gov.au/getmedia/584073f7-041e-4818-9419-39f5a060b1aa/18175.pdf.aspx?inline=true. Accessed 25 Nov 2019.

8. Czyzewski K. Colonialism as a broader social determinant of health. Int Indig Policy J. 2011;2(1).

9. Prior D. Decolonising research: a shift toward reconciliation. Nurs Inq. 2007;14(2):162-8.

10. Kong AC, Ramjan L, Sousa MS, Gwynne K, Goulding J, Jones N, et al. The oral
health of Indigenous pregnant women: A mixed-methods systematic review. 
Women Birth. 2019.

11. Jamieson LM, Armfield J, Roberts-Thomson K. Oral health of Aboriginal and Torres Strait Islander children. 2007. Available at: https://www.aihw.gov.au/reports/dental-oral-health/oral-health-indigenous-children/contents/table-of-contents. Accessed 25 Nov 2019.

12. Kim Seow W. Environmental, maternal, and child factors which contribute to early childhood caries: A unifying conceptual model. Int J Paediatr Dent. 2012;22(3):157-68.

13. Mitchell SC, Ruby JD, Moser S, Momeni S, Smith A, Osgood R, et al. Maternal transmission of mutans streptococci in severe-early childhood caries. Pediatr Dent. 2009;31(3):193-201.

14. Yost J, Li Y. Promoting oral health from birth through childhood: prevention of early childhood caries. MCN Am J Matern Child Nurs. 2008;33(1):17-23.

15. Taylor KP, Thompson SC. Closing the (service) gap: exploring partnerships between Aboriginal and mainstream health services. Aust Health Rev. 2011;35(3):297-308.

16. Durey A, McEvoy S, Swift-Otero V, Taylor K, Katzenellenbogen J, Bessarab D. Improving healthcare for Aboriginal Australians through effective engagement between community and health services. BMC Health Serv Res. 2016;16(1):224.

17. Street J, Baum F, Anderson I. Developing a collaborative research system for Aboriginal health. Aust N Z J Public Health. 2007;31(4):372-8.

18. Taylor KP, Thompson SC, Smith JS, Dimer L, Ali M, Wood MM. Exploring the impact of an Aboriginal health worker on hospitalised Aboriginal experiences:
lessons from cardiology. Aust Health Rev. 2009;33(4):549-57.

19. Villarosa AC, Villarosa AR, Salamonson Y, Ramjan LM, Sousa MS, Srinivas R, et al. The role of Indigenous health workers in promoting oral health during pregnancy: a scoping review. BMC Public Health. 2018;18(381):1-15.

20. Baum F, MacDougall C, Smith D. Glossary: participatory action research. J Epidemiol Community Health. 2006;60(10):854-7.

21. Penman R. Aboriginal and Torres Strait Islander views on research in their communities. Department of Families, Community Services and Indigenous Affairs. 2006. Available at: https://www.dss.gov.au/sites/default/files/documents/05_2012/op16.pdf. Accessed 30 Oct 2019.

22. Steinhauer E. Thoughts on an indigenous research methodology. Canadian Journal of Native Education. 2002;26(2):69-81,201.

23. Wilson S. Progressing toward an Indigenous research paradigm in Canada and Australia. Canadian Journal of Native Education. 2003;27(2):161-78.

24. Braun V, Clarke V, Hayfield N, Terry G. Thematic analysis. Handbook of Research Methods in Health Social Sciences. 2019:843-60.

25. Lincoln YS, Guba EG. Naturalistic inquiry. Newberry Park, CA: Sage; 1985.

26. Abbott P, Gordon E, Davison J. Expanding roles of Aboriginal health workers in the primary care setting: seeking recognition. Contemp Nurse. 2008;27(2):157-64.

27. Musa D, Schulz R, Harris R, Silverman M, Thomas SB. Trust in the health care system and the use of preventive health services by older black and white adults. Am J Public Health. 2009;99(7):1293-9.

28. Whetten K, Whetten R, Leserman J, Ostermann J, Thielman N, Swartz M, et al.
Exploring lack of trust in care providers and the government as a barrier to health service use. Am J Public Health. 2006;96(4):716-21.

29. Goodman A, Fleming K, Markwick N, Morrison T, Lagimodiere L, Kerr T, et al. "They treated me like crap and I know it was because I was Native": the healthcare experiences of Aboriginal peoples living in Vancouver's inner city. Soc Sci Med. 2017;178:87-94.

30. Browne AJ, Fiske J-A. First Nations women’s encounters with mainstream health care services. West J Nurs Res. 2001;23(2):126-47.

31. Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. J Gen Intern Med. 2004;19(2):101-10.

32. Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. J Transcult Nurs. 2002;13(3):181-4.

33. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ. 2003;327(7425):1219-21.

34. Waibel S, Henao D, Aller M-B, Vargas I, Vázquez M-L. What do we know about patients' perceptions of continuity of care? a meta-synthesis of qualitative studies. Int J Qual Health Care. 2011;24(1):39-48.

35. Department of Health. The Australian health system: Department of Health; 2019. Available from: https://www.health.gov.au/about-us/the-australian-health-system.

36. National Health Service. Are pregnant women entitled to free NHS dental treatment? : NHS; 2019. Available from: https://www.nhs.uk/common-health-questions/pregnancy/are-pregnant-women-entitled-to-free-nhs-dental-treatment/.
37. Bennett B, Zubrzycki J. Hearing the stories of Australian Aboriginal and Torres Strait Islander social workers: challenging and educating the system. Australian Social Work. 2003;56(1):61-70.

38. Roche AM, Duraisingam V, Trifonoff A, Battams S, Freeman T, Tovell A, et al. Sharing stories: Indigenous alcohol and other drug workers' well-being, stress and burnout. Drug Alcohol Rev. 2013;32(5):527-35.

39. Dimitropoulos Y, Gunasekera H, Blinkhorn A, Byun R, Binge N, Gwynne K, et al. A collaboration with local Aboriginal communities in rural New South Wales, Australia to determine the oral health needs of their children and develop a community-owned oral health promotion program. Rural Remote Health. 2018;18(2):4453.

40. Dimitropoulos Y, Holden A, Gwynne K, Irving M, Binge N, Blinkhorn A. An assessment of strategies to control dental caries in Aboriginal children living in rural and remote communities in New South Wales, Australia. BMC Oral Health. 2018;18(1):177.

41. Irving M, Gwynne K, Angell B, Tennant M, Blinkhorn A. Client perspectives on an Aboriginal community led oral health service in rural Australia. Aust J Rural Health. 2017;25(3):163-8.

42. Barnett L, Kendall E. Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. Health Promot J Austr. 2011;22(1):27-32.

43. Australian Institute of Family Studies. Theme 3: elderly family members are important to family functioning: AIFS; 2014. Available from: https://aifs.gov.au/cfca/publications/strengths-australian-aboriginal-cultural-practices-fam/theme-3-elderly-family-members.
44. Menzies P, Bodnar A, Harper V. The role of the elder within a mainstream addiction and mental health hospital: developing an integrated paradigm. Native Social Work Journal. 2010;7:87-107.

Supplementary Files

This is a list of supplementary files associated with the primary manuscript. Click to download.

AHWPaper3_Appendix1.docx