

**RHRU**  
**Rural Health**  
**Research Unit**

**Review of**  
*Literature, evaluations and*  
*research on Australian Indigenous*  
*young parents' programs*

**Final Report**  
**December 2009**

**Literature, evaluations and research on Australian  
Indigenous young parents programs  
A Review**

Project ID 50238

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For consideration by the Maternity, Child Health and Safety Branch

***December 2009***

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## Acronyms

<b>AHW</b>	Aboriginal Health Worker
<b>AMICHW</b>	Aboriginal Maternal Infant Care Health Worker
<b>ACCHS</b>	Aboriginal Community Controlled Health Service
<b>ATSI</b>	Aboriginal and Torres Strait Islander
<b>AMS</b>	Aboriginal Medical Service
<b>CEC</b>	Community Education Counsellor
<b>COAG</b>	Council of Australian Governments
<b>DoHA</b>	Department of Health and Aging
<b>JCU</b>	James Cook University
<b>NACCHO</b>	National Aboriginal Community Controlled Health Organisation
<b>NH&amp;MRC</b>	National Health and Medical Research Council
<b>OATSIH</b>	Office of Aboriginal and Torres Strait Islander Health
<b>QAIHC</b>	Queensland Aboriginal and Islander Health Council
<b>SIDS</b>	Sudden Infant Death Syndrome
<b>SMD</b>	School of Medicine and Dentistry
<b>SNAICC</b>	Secretariat of National Aboriginal and Islander Child Care Inc
<b>STI</b>	Sexually transmitted infection
<b>TTH</b>	The Townsville Hospital

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## **EXECUTIVE SUMMARY**

### **1. Background and aims of the review**

Queensland Health has recognised the strategic importance of providing additional support to young Indigenous parents to optimise outcomes for them and their children. However, limited evidence is available about best practice in providing such support.

This review has two primary aims:

1. To gather evidence from the literature (both published and unpublished), from program evaluations and from primary research with service providers and young parents to identify:

- Key issues impacting on young Indigenous mothers and fathers in Queensland
- Innovation and good practice for delivering young parent programs
- The supports/resources needed by service providers/workers to ensure effective delivery of these types of programs
- Mechanisms for engaging with young Aboriginal and Torres Strait Islander people who are “at risk” of becoming young parents or who are pregnant or already parenting
- Barriers to effective implementation of such programs and strategies to minimize the likelihood of these barriers occurring.

2. To provide advice about how the evidence collected can best be turned into practice in government and non-government provided services.

### **2. Methodology**

The project was conducted by a team of Indigenous and non-Indigenous researchers from the School of Medicine and Dentistry and the School of Indigenous Australian Studies, James Cook University, Townsville. The team is guided by an Indigenous Reference Group, consisting of Indigenous health



care providers, academics and community members with expertise in the area of Indigenous young parent support.

A three part methodology was used to address the aims of the review.

### **2.1. Systematic literature review**

The literature about teenage pregnancy and parenthood for Indigenous women in Australia was reviewed. Literature regarding support for young parents and Indigenous families was also reviewed. Policies, programs and evaluations of their effectiveness were then considered.

Three sources of evidence were searched.

- Published academic literature
- Unpublished literature
- Bibliographic searching of key references and sources known to the project team

After review and scanning for relevance, 310 of the most relevant references were entered into an Endnote library.

### **2.2. Identification of best practice through primary research**

This involved conducting a series of qualitative telephone interviews with service providers, to identify the features of successful programs to support young Indigenous parents, and any additional needs for effective program implementation.

## **3. Findings**

### **3.1. Key issues impacting on young Indigenous parents**

In common with other young parents, young Indigenous parents may come from backgrounds providing few options in terms of education and employment. For many young mothers, pregnancy and parenthood can

become a transformative event, leading them to make a number of positive changes to their lives; however this is contingent on adequate family and professional support.

### ***Poverty, educational disengagement and unemployment***

There is an association between socioeconomic and educational disadvantage and parenting as a teenager, although there is debate about whether these factors are antecedents or consequences of parenting at a young age. Aboriginal and Torres Strait Islander women who are pregnant and parenting often need to contend with ongoing issues related to poverty, lack of employment and access to education. Issues related to poverty have a key impact on young Indigenous parents, particularly through effects on engagement with services. Key issues include:

- Access to stable housing
- Lack of regular transport
- High levels of mobility limiting service engagement
- Lack of affordable childcare.

### ***Social and emotional wellbeing, violence and substance use issues***

Young Aboriginal and Torres Strait Islander parents, like other young parents, may face challenges to their social and emotional wellbeing. Issues frequently reported include the following:

- Postnatal depression
- Stigma and judgement from other people (including service providers)
- Inadequate social support
- Perceived lack of parenting skills
- Family violence
- Substance abuse.

### ***Accessibility and acceptability of services***

Many young Aboriginal and Torres Strait Islander women have had negative experiences when accessing health care, including antenatal services. Frequently reported issues include:

- Trouble accessing services
- Stigma and overt racism from service providers
- Lack of continuity in service providers and long waiting times when attending clinics
- Insufficient Indigenous workers.

### ***Knowledge of and access to contraception***

Indigenous and non-Indigenous young people report similar levels of sexual activity, but studies suggest that Indigenous young people are less likely to use reliable contraception and much less likely to have a termination should a pregnancy occur. Significant gaps have been identified in knowledge about contraception, and access to reliable forms of contraception. These issues are particularly pertinent to hormonal forms of contraception and to Indigenous adolescents in rural areas. Teaching young people the skills to negotiate contraception use and safe sex is another identified issue of importance.

### ***Issues specific to young fathers***

There is a noticeable gap in the literature around young Indigenous fathers and research into best practice protocols for supporting young men in their relationships with the mothers of their children and children would help to address this. Like young mothers, many young Indigenous fathers face issues related to poverty, educational disengagement, unstable housing, substance abuse and stigma.

There is wide variation in the wishes of young parents about the involvement of the father in the family, necessitating flexibility on the part of service providers. Service providers at a local level need to be able to determine whether the needs of young men are best met through inclusion in parenting support programs or via specialised services. Co-location of services for young mothers and young men is one way service providers have balanced these needs. Provision of support to young men needs to be able to be determined by service providers on a case by case basis and flexibly

delivered in recognition of the high rates of violence and unhealthy relationships reported by young people.

There is a broad need for education and programs for young Indigenous men and young Indigenous fathers to support them in their relationships and fathering role, and for more research on the best ways in which this can be achieved.

### **3.2. Innovation and best practice for delivering Indigenous young parent support programs**

Very little published high quality evidence exists to inform best practice in supporting Indigenous young parents, and this is identified as a gap in many reports. Existing programs often operate on short-term funding, and are inadequately evaluated. Findings in this section are divided into best practice for supporting young parents generally, best practice for supporting Indigenous families, and best practice for providing antenatal and sex education services.

#### ***Best practice in supporting young parents***

Some elements of best practice in the provision of young parent support programs include:

- Connecting young parents with local services
- Strengthening the parenting skills of young parents
- Developing social networks for young parents
- Linking young parents with further formal education.

Many successful programs tend to have a primary focus on educational engagement or primary health care services (with links to other services). Some successful programs for young Indigenous parents have a primary social or arts-based focus.

Important factors in the success of young parent programs include the following:

- Involvement of young parents in program design and delivery

- The provision of holistic integrated services;
- Co-location with other services (one-stop shop)
- Use of soft-entry points for engagement
- Committed Indigenous program staff
- Support for young fathers
- Strategies to overcome practical barriers to attendance
- Group activities and peer education components.

### ***Best practice in supporting Indigenous families***

Literature and case studies related to supporting Indigenous families indicate that the following factors are elements of best practice:

- Acknowledgement of broad family responsibility for child rearing and flexibility to address the needs of the extended family
- Groups facilitated by a known local Indigenous community member
- Programs that are informal, holistic and culturally appropriate
- Programs that cover the life course of children, from before birth to adolescence
- An approach that strengthens parenting knowledge and confidence, whilst building on existing cultural and social strengths
- Evaluations that are strengths-based and meaningful, manageable and acceptable to community and funders
- Co-location of programs with services already used by Indigenous parents
- A variety of approaches to enhancing knowledge and skills and supporting Indigenous parents
- Resources that are locally relevant, and use local Indigenous people in their selection and production.

### ***Best practice in providing antenatal and postnatal care for Indigenous women and their babies***

Some key features of best practice in providing maternal and child health programs for Indigenous women include:

- Services designed, staffed and operated by Indigenous women
- Flexible appointment systems

- Continuity of care
- Free transport and childcare
- Aboriginal health workers as key service providers
- Women only clinic days/spaces
- Holistic care provision (whole person care, and care of children, family and community)
- Outreach and home visiting services
- Strong links with Aboriginal and Torres Strait Islander community members.

***Best practice in providing sexual health education and services***

Again, there is limited evidence about best practice in providing sexual health education to Indigenous young people. Elements of best practice in providing sexual health education for Indigenous young people include:

- Cultural sensitivity and discretion (this may involve separate groups for boys and girls)
- Broad-based, sex positive approach (peer education and arts-based approaches are promising)
- Including factual information about puberty, safe sex, contraception and parenting with broader material about negotiation skills and healthy relationships.

Important factors in best practice in providing Indigenous sexual health services include:

- Separate men's and women's health services (facilitated by a service provider of the same sex)
- Integration of sexual health services in a broader raft of men's and women's services
- Health promotion programs with good treatment protocols, recall systems and partner contact and treatment systems.

***Lessons from international reviews***

International reviews and meta-analyses have demonstrated that programs with a focus solely on preventing young pregnancy, especially those based on

abstinence, are ineffective. However, there are promising results from holistic, broadly-based, longitudinal programs designed for Indigenous adolescents deemed “at risk” in Canada, the USA and the UK. These promising programs aim to foster cultural strength, educational engagement and strong networks of social support for participants.

### ***Best practice from case studies***

The team conducted paper reviews of more than thirty Indigenous young parent support programs and telephone interviews with service providers from ten of these. To avoid repetition, interview and paper review findings have been incorporated into the features of best practice and recommendations elsewhere in this summary.

### **3.3. Barriers to successful program implementation**

There is a close relationship between the barriers to effective implementation of support programs for young Indigenous parents, and additional support and resource needs identified by service providers. The main barriers to effective implementation of programs can be summarised as follows.

- Programs are operating in challenging and complex social environments (including high mobility that limits continuity)
- Funding is inadequate in amount or duration
- A lack of basic infrastructure (premises or vehicle)
- Difficulty in attracting and retaining appropriate staff
- Limited appropriate partnerships with community organisations.

### **3.4. Support and resources needed by service providers**

Well trained, reflective and committed program staff, who are accepted by young parents, are vital for the success of Indigenous young parents support programs. However, these service providers and program staff are often

relatively unsupported themselves. The main support and resource needs for service providers from the literature and case studies are as follows:

- Longer term funding for programs, to remove the need for frequent funding applications
- Support in designing and implementing program evaluations (including action research practices)
- Assistance with sourcing or developing appropriate resources.
- Provision of essential infrastructure (including a venue and access to a vehicle)
- Psychological and practical support for program staff (including relief)
- Culturally based peer support for Indigenous workers (eg team work)
- Training and support in cross cultural workplace knowledge and practices
- Capacity-building for service providers (including professional development)

### **3.5. Mechanisms for engaging with young Aboriginal and Torres Strait Islander parents**

In many published reports and articles, Indigenous young people and young parents have been regarded as “hard to reach” populations, yet perhaps it is more helpful to consider many services aimed at meeting their needs as hard to reach. Three key elements have been identified to foster engagement.

#### **1. Location of services**

- School-based services are useful venues for engaging with young people still at school, but there is also a need for outreach services for young people disengaged from school
- Soft entry points for establishing contact with services can improve engagement. Examples of useful soft entry points include child care centres, youth drop-in centres, or youth health services
- Co-location of services whenever possible to form a “one-stop shop”
- Addressing practical issues limiting attendance, such as a lack of transport



## 2. Choice of program staff or service provider

- Indigenous service providers and program staff are important to the success of programs
- Personal qualities of program staff are very important, along with continuity and trust
- Peer-education is a promising option, and involvement of young parents in designing programs is essential
- Flexibility is required to involve family and cultural mentors where appropriate

## 3. Innovative strategies for providing education and support

- SMS reminders of appointments
- Multimedia computer-assisted surveys for collecting and providing information
- Websites and interactive internet booths are useful health promotion tools
- Health promotion through the arts, such as plays demonstrating healthy negotiation around relationships, and through sporting teams and events.

### **3.6. Recommendations for policy and practice**

*The findings of this review of the literature and case studies of best practice lead to the following recommendations for policy and practice in providing support for young Indigenous parents.*

#### **Recommendations for policy**

*Recommendation 1. Policies and programs are designed with extensive Indigenous community consultation. Consultation with Indigenous young people is particularly important.*

*Recommendation 2. There is ongoing funding to improve the delivery of maternal and child health services for young mothers, with a focus on optimising the acceptability and accessibility of these services.*

*Recommendation 3. The evidence-base for best practice in supporting young Indigenous parents is limited, so there is a need to support further research and evaluation of programs in this area.*

*Recommendation 4. Intersectoral collaboration is encouraged at policy design and implementation level, particularly between the health, education and social services sectors.*

*Recommendation 5. Policy focuses on increasing the range of options available for Indigenous young people, and providing support for them should pregnancy occur, rather than on the prevention of teenage pregnancy.*

*Recommendation 6. Policy around the delivery of relationships and safe sex education through schools is broadened and enhanced (ideally as part of a national framework for sex and relationships education for young people).*

*Recommendation 7. Projects are required to demonstrate linkages between services and community groups before funding. This is particularly important when services are to be delivered by organizations without strong links to local Indigenous communities.*

## **Recommendations for programs**

These recommendations for program design and delivery have been grouped into four main domains, underpinned by five generic principles.

The generic principles include the following.

1. Seeking Indigenous input and promoting community ownership at all levels of the program (particularly input from young people and young parents)
2. Respecting Indigenous world-views and incorporating these into program design through employing Indigenous people and

Indigenous research and evidence at all levels of program management and governance

3. Ensuring that a community capacity-building component with early positive action is built into each part of the program
4. Avoiding language or actions that serve to problematise and thus further disadvantage Indigenous young people and young parents
5. Delivering services and programs in a culturally safe environment. This is the responsibility of all services, be they community-controlled organisations, programs or services operated by the state or federal government, or services operated by non-governmental organisations

### **Indigenous young parent support programs**

The literature and case studies suggest that the success of many young parent support programs derives as much from *how* they are delivered as from *what* is actually delivered. The ongoing presence of welcoming and non-judgemental program staff who are passionate about supporting young parents is essential for the success of these programs. There is no generic blueprint for a successful program, with programs focused primarily on education, health, the arts and social support all having a role to play.

*Recommendation 8. Indigenous young parent support programs are designed around strengths-based models that empower and build confidence in young parents.*

*Recommendation 9. Indigenous young parent support programs are delivered in culturally safe environments.*

*Recommendation 10. Programs building on cultural strengths are used as a foundation for providing parenting support (for example through arts based programs).*

*Recommendation 11. Indigenous service providers are recognized as essential to the success of programs. Indigenous service providers receive sufficient training and support to be able to fulfill their roles successfully. Often this may necessitate employing more than one Indigenous worker within an organization.*

*Recommendation 12. Education and information resources are developed locally with local relevance and content, combined where necessary with more generic information.*

*Recommendation 13. Holistic one stop shop programs with intensive case-management and support are fostered and supported. Soft entry points for engagement are important.*

*Recommendation 14. Programs are designed to ensure that practical issues creating barriers to participation for young Indigenous parents are addressed. These practical issues commonly include lack of transport and a lack of childcare.*

*Recommendation 15. Partnerships and collaborations between organisations and services involved with young Indigenous parents are fostered through manageable funding and reporting structures.*

### **Sex and relationship education**

*Recommendation 16. Positive and comprehensive healthy relationships education is included as a mandatory part of the school curriculum. This education includes realistic information about pregnancy, birth and parenting, and is ideally delivered in small single sex groups. School-based nurses are well-placed to provide this education.*

*Recommendation 17. Healthy relationships programs are also needed for young people disengaged from the education system. More work investigating and evaluating novel strategies for delivering these programs is*

*necessary. Programs with a broad, strengths-based approach show the most promise.*

### **Engagement with Indigenous young people**

*Recommendation 18. Innovative approaches for engaging Indigenous young people require further investigation and evaluation. Approaches that show considerable promise include peer education, technology-based delivery and engagement, arts-based programs and outreach services.*

### **Funding and Evaluation**

*Recommendation 19. Acknowledging the time lag between commencing a program and evidence of its effectiveness, program funding should continue beyond the initial year, and be contingent upon adequate evaluation of program success.*

*Recommendation 20. Program facilitators need support with building in evaluation at the planning and early implementation stages. This evaluation must be rigorous, gather information on process and outcomes indicators, and be acceptable to the services and the community.*

## 1. BACKGROUND TO THE PROJECT

Becoming a mother during the teenage years is considerably more common among young Aboriginal and Torres Strait Islander women than in the general community. Little is known about the issues facing pregnant and parenting young Indigenous women, yet 21% of Indigenous births are to teenagers, both nationally and locally. Despite falling teenage birth rates overall, rates are rising in some disadvantaged subgroups (Coory, 2000). Teenage motherhood is generally problematised in the community, although there is debate about whether poorer socioeconomic and educational outcomes are related to the birth itself, or to pre-existing disadvantage (Breheny & Stephens, 2006; Stevens-Simon & Lowy, 1995). Some have suggested that giving birth as a young woman may be an adaptive response to a limited set of circumstances and options (McDermott & Graham, 2005).

For Indigenous young people, issues around young parenting and parenting support must be considered in a broader socio-historical context. Indigenous Australians have historically had a family life structured around complex kinship systems, locating each individual within a clan with clear rights and obligations towards others within the family, clan and language group (S. Atkinson & Swain, 1999). Subsequently, with the colonisation of Australia, assimilation policies damaged families and intergenerational links, and the effects of these policies continue to be manifest in some Indigenous communities today (J. Atkinson, 2002). In particular, several generations of Indigenous young people were raised without the opportunity to experience normal childhood development, family life and bonding with parents and as a result these individuals may have limited skills and confidence in their parenting abilities (S. Atkinson & Swain, 1999).

In Australia, as in other countries, data about Indigenous status is often incompletely collected, limiting the accuracy and completeness of the information available. However, it seems clear that Indigenous teenagers have considerably higher birth rates than other teenagers. In 2007,

Indigenous women had a teenage birth rate of 70 per 1000 per year, compared with an overall teenage birth rate of 16 per 1000 (Australian Bureau of Statistics, 2007). Overall, Indigenous women tend to have more children and at younger ages; in 2007 the total fertility rate for Indigenous women was 2.4, compared with 1.9 for all women, and the median age of Indigenous mothers was 24.7, compared with 30.7 for all women (Australian Bureau of Statistics, 2007). In addition, 21% of births to Indigenous women were to women under 20 years, compared with only 4% of those to all women. Australian Indigenous women had an age specific fertility rate for 15-19 years of 69.2/1000 in 2005, higher than that of Maori women (66.6), or American Indian women (52.5 in 2004; Australian Bureau of Statistics, 2005).

In line with recommendations from the Re-birthing Report (Hirst, 2005), the views of educators (Boulden, 2001) and other Queensland Government reports (Healy 2001), Queensland Health has recognised the strategic importance of providing additional support to young Indigenous parents to optimise outcomes for them and their children. Exploring ways of working with Indigenous young people likely to become parents at a young age is also important. However, little evidence is available about the most effective ways to provide such support.

Early manifestations of this recognition are the recruitment of Indigenous Young Parent Support Officer positions within Queensland Health at two sites. The aim of the Young Indigenous Parents Program is to provide support to Aboriginal and Torres Strait Islander young people during the antenatal, birthing, postnatal and parenting periods and to promote healthy pregnancies and optimal child health and wellbeing. The project will link young people to the health system, encourage school attendance where appropriate, increase access to health education such as preparation for childbirth, improve maternal health and address broader social factors such as access to adequate housing, financial security, alcohol, tobacco and drug issues, family violence, and parenting issues. The parenting program is in response to evidence which recognises that the most direct way of improving outcomes in childhood (and thus providing a positive start to life) is to ensure that all early

caretaking environments are nourishing, stimulating and meet the health and developmental needs of young children (T. Moore, 2006). As part of this commitment to optimising outcomes, Queensland Health has commissioned a body of work to review best practice around support for young Indigenous parents and those likely to become parents young.

### **1.1 Project Components**

There are three components to this project overall:

- a) The evaluation of the Young Indigenous Parent Support Worker Positions in Townsville and Cairns;
- b) A literature review of best practice in the area of providing support to young Indigenous Parents; and
- c) The preparation of a package of materials for the orientation and support of Indigenous health workers appointed to Indigenous Young Parent support roles.

The subject of this report is the literature review and review of best practice in supporting young Indigenous parents (Part B).



## **2. AIMS OF THE REVIEW**

This review has two primary aims:

1. To gather evidence from the literature (both published and unpublished), from program evaluations and from primary research with service providers and young parents to identify:
  - key issues impacting on young Indigenous mothers and fathers in Queensland;
  - innovation and good practice for delivering young parent programs;
  - the supports/resources needed by service providers/workers to ensure effective delivery of these types of programs;
  - mechanisms for engaging with young Aboriginal and Torres Strait Islander people who are at risk of becoming young parents or who are pregnant or already parenting; and
  - barriers to effective implementation of such programs and strategies to minimize the likelihood of these barriers occurring.
  
2. To provide advice about how the evidence collected can best be turned into practice in government and non-government provided services.

### **3. METHODOLOGY**

#### **3.1 Project team**

The project is being led by Professor Sue McGinty from the School of Indigenous Studies, and Dr Sarah Larkins from the School of Medicine and Dentistry, James Cook University, Townsville. A team of Indigenous and non-Indigenous project officers are engaged in conducting the project. Ms Ryl Harrison, Ms Suzanne Smith and Mrs Margaret Spillman are the project officers involved with this part of the project, and there was also input from Ms Gabrielle Schechter, a visiting graduate student from the US.

In addition, all aspects of the work are being guided and informed by an Indigenous Reference Group, consisting of a range of Indigenous health care providers, academics and community members with expertise in the area of Indigenous young parent support. Ethical approval for the project has been granted by the James Cook University Human Research Ethics Committee (and its Indigenous sub-committee; approval number H3454).

#### **3.2 Indigenous Reference Group**

The Indigenous Reference group meets regularly to oversee the methodology and recommendations of all parts of this project. Representation on this group includes the Queensland Aboriginal and Islander Health Council (QAIHC), Apunipima Cape York Health Council, Queensland Health (Community Child Health and Women's and Children's Services), Tropical Medical Training, Education Queensland, James Cook University, and a number of Indigenous community groups. There is representation from Indigenous females and one young Indigenous man on the Reference Group. Full membership of the Group is listed in Appendix 2. These meetings have discussed the methodology for the review, issues arising for young Indigenous parents and ideas about examples of best practice projects. A further meeting has discussed the findings of the literature review and case studies of good practice and agreed on recommendations and priorities for future work.

### **3.3 Systematic literature review**

Initially, the literature about the epidemiology, associations and outcomes of teenage pregnancy in Australia for Indigenous women was reviewed and then the current policy context was assessed. These sections, although broader than the key deliverables, were felt to be important to provide a contextual background to the review. Following this programs to support Indigenous families and young parents and evaluations of their effectiveness were considered. Specific search strategies and inclusion/exclusion criteria for the review were developed to reflect the aims and key deliverables of the review. Recognising that many program evaluations relevant to this topic never appear in the peer-reviewed academic literature a multilevel approach was adopted, with standard database searches expanded through internet searches, scanning of newsletters, journals, reports, bibliographic searches and tracing contacts known to the project team.

Three major sources of evidence were searched:

#### **3.3.1 Published academic literature.**

The databases Pubmed/Medline, CINAHL, Eric, Psychlit, Aboriginal and Torres Strait Islander Online, and Sociological Abstracts Online were searched using the following keywords. :

- (teen\* OR adol\* OR young) AND (pregnan\* OR parent\*) AND program\* (+/- AND Australia\*)
- Instead of program, use (assoc\* OR cause\*), or epidemiol\* or outcome\*
- (Aborigin\* OR Indigen\*)
- In addition, specific bibliographic searches were performed of a number of key journals including the Aboriginal and Islander Health Worker Journal, Rural and Remote Health Online, and the Australian Journal of Rural Health (Table 1).

Systematic searching of the databases listed above using relevant keywords retrieved a total of approximately 610 articles. These were reviewed for relevance, evaluations or other evidence of effectiveness, and as a result of

this process 41 of the most relevant articles were abstracted and entered into an Endnote database. Hand searches of specific journals including Aboriginal and Islander Health Worker Journal, Rural and Remote Health Online and the Australian Journal of Rural Health, yielded another 15 articles. A number of key reviews were also identified and referenced appropriately.

The search range was further broadened to review key articles relating to programs for non-Indigenous Australian young people and reviews from the global literature, particularly in the area of rigorous reviews of program effectiveness where the literature is sparse. In addition, specific searches for material related to engagement with Indigenous young people were carried out.

As predicted, limited relevant articles were found in the published academic literature, with the majority of the articles located relating to the epidemiology, associations and outcomes of teenage pregnancy rather than the views of young parents themselves, or good practice in providing support.

**Table 1 List of database searches**

<b>Databases</b>	<b>Endnote entries</b>
ProQuest	1
Ovid Medline	2
CINAHL	15
ERIC	8
Aboriginal and Torres Strait Islander Health Online via informit	2
Google Scholar	3
PsychArticles	7
PsycINFO	2
Sociological abstracts	1
<b>Specific journals searched by hand</b>	
Aboriginal and Islander Health Worker Journal	6
Australian Journal of Rural Health	3
Rural and Remote Health online	2
First People's Child and Family Review Online Journal	4
<b>Website searches</b>	
Digital theses online	3
National Rural Health Alliance conference presentations	2
Australian Bureau of Statistics	5
Australian Institute of Health and Welfare	3
National Aboriginal Community Controlled Health Organisations	2
Australian Policy Online	1
Cooperative Research Centre for Aboriginal Health	7
First Nations Caring Society	2
Secretariat for National Aboriginal and Islander Child Care	5
Aboriginal Health Infonet	1
Queensland Aboriginal and Islander Health Council	3
Aboriginal Medical Services Alliance Northern Territory	1
Queensland Health	2
Australian Institute of Family Studies	2
Department of Families, Communities and Indigenous Affairs.	2
26 further websites searched for a further 12 articles	

### **3.3.2 Unpublished literature**

This included searching a number of key websites, including the Aboriginal and Torres Strait Islander Health infonet, websites and reports from National Aboriginal Community Controlled Health Organisation (NACCHO) and state-based affiliates, Digital Theses online, Australian Policy online, and also accessing a variety of Queensland Health and other state Health department policy and program reports. Some of these are summarised in Table 1.

### **3.3.3 Bibliographic searching**

Bibliographic searching of identified key references and key works known to the chief investigators was used to widen the field to ensure that all relevant research reports and evaluations were included. The majority of the relevant documents were identified through unpublished literature, bibliographic searching and networks of the chief investigators, rather than from formal database searches. Several key reports were of particular relevance to this review and were utilised extensively.

These included three documents related particularly to Aboriginal and Torres Strait Islander maternal and child health:

- Preventing infant deaths among Aboriginal and teenage women in South Australia (Middleton, 2009);
- Improving health in Aboriginal and Torres Strait Islander mothers, babies and young children: a literature review (Ana Herceg, 2005); and
- Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children (Eades, 2004).

The other three significant documents covered issues related to Indigenous Parenting and family support initiatives. These included:

- The Secretariat for National Aboriginal and Islander Child Care (SNAICC) Indigenous Parenting Program report (Secretariat National Aboriginal and Islander Child Care, 2004);

- Lessons Learnt About Strengthening Indigenous Families report (an evaluation of the Stronger Families and Communities Strategy 2000-2004; Scougall, 2008); and the
- Promising Practice Profiles final report commissioned by the Australian Institute of Family Studies (Soriano, Clark, & Wise, 2008).

Additionally, publications produced by the Australian Association of Women Educators relating to supporting young parents to remain in education were accessed and used as resources (Boulden, 2001).

The completed Endnote library contained 327 of the most relevant articles, web pages and reports abstracted and indexed by keywords.

### **3.4 Identification of best practice and qualitative interviews with program providers**

This phase used published and unpublished literature, the networks of the chief investigators and word-of-mouth recommendation to identify a variety of models and locations of programs demonstrating good practice in providing support for pregnant and parenting Indigenous young people. A range of services provided through Aboriginal Community Controlled Health Services (ACCHS), State Health services, community health services and schools were considered and included where appropriate. Documentary review of 51 of the most relevant programs was carried out, and a brief summary of these is included as Appendix 5.

A subset of these promising programs was selected to be the subject of case studies, based on documentary review, preliminary telephone discussions and the recommendations of the Indigenous Reference Group. After explaining the project and obtaining informed consent, telephone conversations and formal interviews were performed with a number of program providers at these sites, to identify key elements in the success of the programs, and strategies used to engage with Indigenous young people. In addition, the supports needed to assist service providers provide responsive services, and

barriers to implementing such services were explored. These ‘exemplar’ sites are presented in this report as a series of case studies. The number and location of service delivery sites included was determined by a combination of factors, both theoretical (e.g. data saturation, range of services involved) and pragmatic (time and budgetary constraints). Difficulties in establishing contact with key program staff, and in obtaining consent forms in a timely manner through relevant organisational Boards of Management limited involvement of some programs, where published evaluations were not available. Information in the public domain was used to report on additional programs as a documentary review.

Ethical approval was obtained through James Cook University Human Research Ethics Committee for interviews with service providers of support programs for Young Indigenous Parents (H3454). We have identified a large number of funded programs operating in the area of Young Parent Support. A common feature amongst many of these services is short-term funding and a lack of formal or informal program evaluation or reporting.

**Table 2 Contact records for service provider participants (excluding reference group meetings).**

	<b>Government funded program</b>	<b>ACCHS program</b>	<b>Other</b>	<b>Total</b>
Emails sent	49	23	11	83
Informal telephone calls	51	32	15	98
Formal telephone interviews	5	2	1	8
Messages left	29	20	8	57



### **3.5 Synthesis of findings and preparation of a final report and recommendations**

This stage included synthesising the literature and reports gathered, analysing and interpreting the qualitative data collected (with input from the Indigenous Reference Group) and generating this final report, comprising a literature review addressing the aims of the project, a series of case studies, and recommendations in terms of best practice for supporting young Indigenous parents, and engaging with Indigenous young people. These recommendations include practical advice on transforming the evidence as gathered into policy and service provision, through governmental and non-governmental service providers. Suggestions for further work to address evidence gaps are included.

## **4. RESULTS**

Our findings have been separated into seven major sections. Sections one and two set the context for Indigenous young parent support in terms of background on the current Australian and Queensland policy environment and a summary of background literature about the epidemiology, associations and outcomes of teenage pregnancy and parenthood for Aboriginal and Torres Strait Islander Australians.

Sections three to seven integrate findings from the literature (published and unpublished) and findings from our case studies and interviews. Firstly issues for young Indigenous mothers and fathers in Queensland are discussed, then innovation and best practice in providing support and services for young parents or those likely to become parents young are outlined. The last sections focus on barriers to effective implementation of programs, the support needs of workers delivering services for young parents, and strategies for engaging with young Indigenous parents, or those likely to parent early. Recommendations for policy and practice conclude the report.

### **4.1 Policy context**

#### ***4.1.1 Key policy history and background***

Health care policy has an enormous role to play in tackling the poorer health status and access to health care of Aboriginal and Torres Strait Islander Australians. Historical events, political priorities and social forces have all contributed to the current state of affairs with regards to Indigenous health status and health services, and it is imperative that now some of this imbalance is redressed through well-informed and targeted health care policy. This section aims to briefly review some of the relevant Federal and State policy relevant to supporting young Indigenous parents.

#### **4.1.2 Federal, State and Local level policy documents**

The main Federal, State, and Local policy documents setting the framework for this project in terms of service delivery are listed below, followed by the pertinent points of each.

##### **Federal:**

- Aboriginal and Torres Strait Islander Health Performance Framework Report 2006 (OATSIH)
- Overcoming Indigenous Disadvantage: Key Indicators 2007
- National Strategic Framework for Aboriginal and Torres Strait Islander Health. Australian Government Implementation Framework 2007-2013
- Improving Maternity Services in Australia. The Report of the Maternity Services Review 2009
- The Early Years Learning Framework 2009 – Part of the National Quality Agenda for Early Childhood Education and Care
- Indigenous Early Childhood Development National Partnership (Council Of Australian Governments, 2008)
- National Early Childhood Development Strategy- Investing in the early years (Council of Australian Governments, 2009)
- Talking Sexual Health: National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools. Australian Research Centre in Sex, Health and Society 1999

##### **State:**

- Agreement between Queensland Health, Department of Health and Aging and Queensland Aboriginal and Islander Health Council for Aboriginal and Torres Strait Islander health service delivery (Queensland Aboriginal and Torres Strait Islander Health Agreement/ Partnership and The Torres Strait Islands Health Partnership. 2002)
- Queensland Health. Queensland Statewide Health Services Plan 2007-2012

- Partnerships Queensland – Future Directions Framework for Aboriginal and Torres Strait Islander Policy in Queensland 2005-2010 (DATSIP)
- Strategic Policy for Aboriginal and Torres Strait Islander Children’s and Young People’s Health. Queensland Health (2005-2010)
- Re-Birthing: Report of the Review of Maternity Services in Queensland 2005
- Government response to: Re-Birthing: Report of the Review of Maternity Services in Queensland’
- Education Queensland –Advice and Support for Retention of Pregnant and Parenting Students in Education (Queensland Government Department of Education and the Arts, 2005)

The shared focus of these policies is:

- Early intervention for children and families
- Broad primary health care focused interventions for improving health
- Building social capital
- Partnerships and collaboration
- Improving equity in access and outcomes for Indigenous people.

#### **4.1.3 Federal documents**

Many strategic and policy documents with a focus on Aboriginal and Torres Strait Islander health recognize the importance of a healthy start to life in preventing future poor health outcomes (Queensland Health, 2005b; Steering Committee for the Review of Government Service Provision, 2007). Good quality antenatal care is widely recognized as an essential component of comprehensive primary health care. Thus across the country there is a large focus on supporting and funding Indigenous maternal and child health programs, and some of these have demonstrated considerable success. The Healthy for Life program, funded through the Department of Health and Ageing funds primary health care services for Indigenous communities with a

focus on maternal and child health (Commonwealth Department of Health and Ageing, 2008).

### **National Strategic Framework for Aboriginal and Torres Strait Islander Health. Australian Government Implementation Framework 2007- 2013**

This key blueprint, endorsed by Australian and State and territory governments, sets the health policy agenda for Aboriginal peoples and Torres Strait Islanders through to 2013, and suggests areas for health sector investments and development of health policy.

This policy focuses on service improvement through strengthening the provision of comprehensive primary health care using the following principles.

- Service delivery should be flexible and involve partnerships and shared responsibility
- Long term perspective on funding and implementation (and resource needs may be greater)
- Access to services on basis of need and equity with a focus on measurable outcomes
- Coordination of service delivery within and between governments
- Improving community capacity is key in achieving sustainable outcomes
- Improvement of data collection systems

(Department of Health and Ageing, 2007).

### **ATSI Health Performance Framework Report 2006 (OATSIH)**

This Health Performance Framework (HPF) documents the impact of Government policies and strategies on the health of Aboriginal and Torres Strait Islander people and how well the broader health system performs for the Indigenous population. The report covers health, housing and workforce issues, with the following particularly relevant to young Indigenous parents:

- Current health status
- Child and maternal health services
- Strong comprehensive primary health care

(Australian Health Ministers' Advisory Council, 2006).

## **Overcoming Indigenous Disadvantage: Key Indicators 2007**

This reporting framework is based on priority outcomes, reflecting how life should be for Indigenous people, headline indicators, strategic areas for action and strategic change indicators.

Three priority outcomes and seven strategic areas are relevant for improving support for young Indigenous parents:

- Safe, healthy and supportive family environments with strong communities and cultural identity
- Positive child development and prevention of violence, crime and self-harm
- Improved wealth creation and economic sustainability for individuals, families and communities.

Seven strategic areas for action:

- Early child development and growth (prenatal to age 3)
- Early school engagement and performance (preschool to Year 3)
- Positive childhood and transition to adulthood
- Substance use and misuse
- Functional and resilient families and communities
- Effective environmental health systems
- Economic participation and development

(Steering Committee for the Review of Government Service Provision, 2007)

The “Close the Gap” campaign is aiming for health equality within 25 years through non-partisan shared commitments by federal, state and territory leaders, with funding for the following specific measures:

- Improved access to culturally appropriate primary health care at a level commensurate with need
- Increased number of health practitioners working within Aboriginal health settings, and further development and training of the Indigenous health workforce
- Improved responsiveness of mainstream health services and programs to Aboriginal and Torres Strait Islander health needs

- Greater targeting of maternal and child health and greater support for Indigenous-specific population programs for chronic and communicable disease
- Greater funding and support for the building blocks for good health, such as nutrition, physical activity, fresh food, healthy lifestyles and adequate housing
- National targets and benchmarks towards achieving health equality, by which progress can be monitored

(National Aboriginal Community Controlled Health Organisation & Oxfam Australia, 2007).

### **Improving Maternity Services in Australia. The Report of the Maternity Services Review 2009**

This review considered issues relevant to maternity services, including antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the perinatal period.

In considering the inequalities within our current maternity system, the Review focused on the issues of access to maternity services for Indigenous mothers and their babies and for mothers and babies living in rural and remote Australia. Of eighteen recommendations, five are directly related to inequality of access and outcomes for Indigenous mothers and babies

The Review Team concluded that:

- Expanding the range of collaborative care models responsive to local needs will provide greater choice for all women in Australia, including Indigenous women. The expansion of collaborative models of care should take account of the successful models for Indigenous women that have been developed in various rural, remote and urban areas.
- Maternity services should acknowledge— and, where possible, accommodate—the particular cultural beliefs concerning childbirth held by many Indigenous families, including a preference for ‘birthing on country’.

- Maternity care health professionals who work with Indigenous women and their families, including those who work in hospital settings, should have appropriate cultural awareness training  
(Department of Health and Ageing, 2009).

### **Talking Sexual Health: National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools 1999**

This Framework has been developed in response to the need for strategic advice to those involved in the development, implementation and evaluation of school-based policies and education programs about STIs, HIV/AIDS and BBVs. The *Talking Sexual Health* teaching and learning resource has been designed primarily to use with students in years 9 and 10, but it is also suitable to use with students in years 11 and 12. The resource is intended for use by experienced health educators with teaching and learning activities appropriate for year 9 and 10 students. Queensland is the only state that did not adapt and use these resources (Australian Research Centre in Sex Health and Society, 1999).

Skinner and Hickey (2003) review the data in Australia for STI and teenage pregnancies in Australia and conclude that the sexual health needs of teenagers differ from those of adults and these needs are not being met. Skinner argues that:

*“It is imperative that Australia develop a coordinated policy to adequately cater for the reproductive and sexual health needs of adolescents” (Skinner & Hickey, 2003 p.160).*

#### **4.1.4 Queensland Government**

##### **Partnerships Queensland – Future Directions Framework for Aboriginal and Torres Strait Islander Policy in Queensland 2005-2010 (DATSIP)**

The Future Directions Framework has four key goals:

- Strong families, strong cultures
- Safe places
- Health living
- Skilled and prosperous people and communities.



Six priority action areas (each with headline indicator areas and supporting indicator areas) focus on different life stages, and the two of most relevance to supporting young Indigenous parents are:

- Healthy outcomes for babies 0-12 months
- Transition to adulthood 15-24 years

(Department of Communities, 2006).

### **Strategic Policy for Aboriginal and Torres Strait Islander Children's and Young People's Health 2005-2010.**

This policy aims to contribute to outcomes under the four key goals of Partnerships Queensland in terms of improving the health status of Indigenous children and young people through:

- acting on the social and environmental factors affecting health, and
- increasing access to skilled and appropriate health care.

The most pertinent objectives refer to:

- partnerships to address the social, cultural, economic and environmental determinants of health for children and young people
- family and individual service delivery – promotion, prevention, early detection and intervention

(Queensland Health, 2005b).

### **Re-Birthing: Report of the Review of Maternity Services in Queensland 2005**

The Review of Maternity Services was set up in July 2004 by the Queensland Minister for Health to examine services for pregnancy, birth and post-birth care across Queensland and recommend evidence-based, sustainable strategies to enhance choices for women, wherever they live, without compromising safety (Hirst, 2005).

### **Priorities for change**

Three issues have the support of every interest group that the Review was in contact with:

- Poor outcomes among babies of Aboriginal and Torres Strait Islander women and the need to make this the first priority for change
- Care for women in rural and remote areas
- The dearth of post-birth care in the community and the transition from hospital to community care.

The following recommendations from the Re-birthing Report are particularly relevant for this review:

- Maternity care of Indigenous women belongs to Indigenous women
- Culturally-appropriate pregnancy care and education, birth support and post-birth care are a right of all Indigenous women
- Birthing in home communities may not yet be safe as care is not always available in local communities. At the same time birthing on their own lands may be integral to the cultural safety of Indigenous women. Care providers need to work to make community birthing safe. A determined strategy to prepare Indigenous midwives, doctors and health workers who can work in communities must be a priority
- Cultural safety may include changes to birth registration to allow Indigenous people who birth far from home to include their lands or groups on certificates and to provide for cultural adoption

(Hirst, 2005).

### **Government response to: Re-Birthing: Report of the Review of Maternity Services in Queensland**

[http://www.health.qld.gov.au/publications/corporate/maternity\\_report2005/maternity\\_response.pdf](http://www.health.qld.gov.au/publications/corporate/maternity_report2005/maternity_response.pdf)

The Queensland government supported the recommendations of the report and noted that the scope of reform proposed is extensive and complex, requiring sequential implementation strategies. The government appointed a Steering Committee in partnership with key stakeholders to facilitate these strategies. The State Government restated its commitment to working on a partnership approach with *Partnerships Queensland* and the Aboriginal and Torres Strait Islander Health Partnership providing a strong framework. The

government response noted that *Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005-2010* includes relevant strategies and actions (Queensland Health, 2005a).

### **Queensland Education sexual health and relationships education**

<http://education.qld.gov.au/schools/healthy/framework/introduction.html>

The approaches and delivery of sexual health and relationships education within Queensland schools tends to vary and sexual education is taught in a range of subject curricula e.g. science, health and physical education and human relationships. Queensland Health has developed a series of modules for use in Queensland secondary schools for relationships and sex education at different levels. However, in Queensland, School-based Youth Health Nurses frequently use a Family Planning Queensland High Talk package for sex education (Education and Training Department, 2005).

### **School-based Youth Health Nurses**

<http://education.qld.gov.au/student-services/protection/community/nurses.html>

Queensland Health funds a School-Based Youth Health Nurse program in Queensland state schools. From the beginning of 2005 the program was enhanced so that all secondary students in Queensland now have access to a School Based Youth Health Nurse.

These nurses work collaboratively within the school community in a number of ways. Those most relevant to this project include:

- providing support for the school curriculum, teaching and learning activities;
- supporting the planning, implementation and evaluation of health promotion activities;
- advocating on behalf of young people on issues affecting their health and wellbeing; and
- providing individual health consultations for students, parents and members of the school community.

Specific duties of the nurses employed within the program are decided upon by negotiation and monitored by a local consultative team comprised of the principal/s or nominee, the nurse and the designated Health Service District line manager (Education and Training Department, 2006).

In addition, Education Queensland specifies that students should not be discriminated against on the grounds of pregnancy and parenthood, and every effort should be made to enable their continuing engagement with schools (Queensland Government Department of Education and the Arts, 2005).

#### ***4.1.5 Addressing access and equity in health service delivery***

While the well-known high burden of morbidity and mortality suggests that Aboriginal and Torres Strait Island Australians should be accessing more health services, in reality they are accessing all kinds of health services less than other Australians (Grant, Wronski, Couzos, & Murray, 2008). The reasons for this are historical and political, however the result is that Aboriginal and Torres Strait Islander communities have much potential benefit to gain through well targeted programs, health system reforms and interventions (Grant, et al., 2008).

One of the key priorities identified in the COAG Overcoming Disadvantage Report was that of early childhood development and growth (Steering Committee for the Review of Government Service Provision, 2007). This has also been reflected in State Government Documents such as the Partnerships Queensland Framework (Department of Aboriginal and Torres Strait Islander Policy, 2005). There is evidence that integrated community-based maternal and child health services improve maternal and perinatal outcomes (Hunt, 2007; Panaretto, et al., 2007), which could be expected to have flow-on effects in terms of community health and wellbeing, and the prevalence of chronic diseases in future. Less evidence to support policy is available in other areas relevant to this report.

## **4.2 Epidemiology, associations and outcomes of teenage pregnancy and parenthood in Indigenous Australians**

### ***4.2.1 Epidemiology of teenage pregnancy and young parenting: Global, Australian, and Indigenous Australian data***

#### *Defining terminology*

A standardised measure for adolescent pregnancy is teenage fertility rate, which is defined as the number of births per 1,000 among females aged 15-19 years (Australian Bureau of Statistics, 2000). Teenage birth rate is occasionally used; referring to the number of live births among women aged 15-19, and therefore excludes elective terminations and spontaneous miscarriages. While the Australian Bureau of Statistics utilises ages 15 - 19 in its reporting on adolescent fertility, the specific age range that is used to qualify adolescence varies depending on the source and the context, and can include females anywhere from 13 to 24 years of age. In the context of this report, pregnancies among girls aged 13 and 14 are statistically negligible and those up to 24 years extend beyond the scope of this study.

#### *International comparisons of teenage fertility rates*

Australia has the lowest reported teenage fertility rate with 16.0 per 1000 when compared to other similarly developed Western nations (such as the United States, New Zealand, the United Kingdom, and Canada) whereas the U.S. has the highest rate with 43.0 per 1000 (Alan Guttmacher Institute, 2006). The United Kingdom and New Zealand have average teenage fertility rates of about 30 per 1000, and Canada has 20 per 1000 (Australian Bureau of Statistics, 2000). These rates are on the decline globally and within Australia due to a host of factors, including but not limited to, decreasing social and economic inequalities and some development of comprehensive, inclusive sex education supported by governmental policies that promote contraception, rather than abstinence-only agendas. Although Australian rates may be lower than in other developed English-speaking countries, they are much higher than in Western European countries, which uniformly have rates below 10 per 1000 (e.g. 4.1 in the Netherlands), and significantly higher than

Japan which has the lowest reported rate of 3.9 per 1000 (van der Klis, Westenberg, Chan, Dekker, & Keane, 2002).

The global picture of teenage pregnancy and young parenthood is congruent with the Australian scenario where this phenomenon is more commonly distributed among socio-economically and educationally disadvantaged groups. For example, in the United States, teenage fertility rates are higher among African Americans and Latin Americans (66.6 and 83.4 per 1000, respectively), than among White adolescents (39.4 per 1000) (Alan Guttmacher Institute, 2006). Also, in 2006, American Indian women aged 15-19 years had fertility rates of 54.7 per 1000 (Australian Bureau of Statistics, 2007). Similarly, in New Zealand in 2007, the overall teenage fertility rate was reported as 25 per 1000, yet Maori women had rates of 77.7 per 1000, over three times higher than their non-Indigenous counterparts (Australian Bureau of Statistics, 2007).

#### *Australian teenage fertility*

Across Australia, the teenage fertility rate was 16.0 babies per 1000 women in 2007 (Australian Bureau of Statistics, 2007). The rate peaked in 1971 with 55.5 births per 1000 and has declined considerably since then, while elective termination rates have steadily increased over this time, though reporting is inconsistent across the Australian states and territories. The epidemiological picture varies based on geography, rurality, socioeconomic and cultural attitudes regarding voluntary abortion and young parenthood. Discrepancies within Australia highlight the different patterns and trends that exist with respect to this health indicator. Queensland had a teenage fertility rate of 23.0 per 1000 in 2007, a 17.1% increase from the 19.7 teenage fertility rate reported in the previous year. Northern Territory has a substantially higher reported teenage fertility rate than the other states and territories with 58.6 per 1000 in 2007; Victoria has the lowest rate with 10.1 births per 1000 females in this age group (Australian Bureau of Statistics, 2007).

According to a descriptive study using population-based perinatal and abortion data from South Australia, Australian teenage birth and abortion rates

are underestimated, but still higher than in many Western European countries. While high socio-economic regions have the lowest teenage pregnancy rates, these areas also had the highest rates of abortions among teenagers. Adolescents who give birth were more likely than older women to be Australian-born, Aboriginal, and smokers. They also were reported to have attended fewer antenatal visits, and to have delivered small-for-gestational age, preterm, and low birthweight babies (van der Klis, et al., 2002). Similarly, in a Queensland study, Coory (2000) analysed data stratified for geography and economic disadvantage and found that birth rates varied based on both of these factors. Those who live in more affluent, urban areas have lower birth rates whereas those who reside in more rural, economically disadvantaged areas were 10 to 20 times more likely to give birth between the ages of 15-19. This data illustrates major differences based on geography. Rural populations of the Northern Territory experience significantly greater disadvantage, and higher percentage of Indigenous people, than those with comparatively lower rates in Victoria and the Australian Capital Territory.

#### *Indigenous Australian teenage fertility*

Birth registrations classify the newborn as an Aboriginal and/or Torres Strait Islander when at least one parent self-identified as being of Indigenous origin. However, Indigenous births are underreported, as is the case with all data regarding Indigenous people. Underestimates for this particular statistic are due to the fact that the Australian Bureau of Statistics solely refers to births to Indigenous mothers in the Indigenous fertility rate measures. Consequently, the data set excludes babies with Indigenous fathers but non-Indigenous mothers. As a result, this vital minority is underrepresented and understudied in epidemiological profiles of teenage pregnancy and young parenting. Additionally, statistical information varies annually as new reporting measures are adopted. For example, reported numbers of births to Indigenous mothers registered in Queensland have drastically changed, accounting for 57% of the overall increase in births to Indigenous mothers registered in Australia (Australian Bureau of Statistics, 2007).

According to the most recent available data, the teenage fertility rate, or age-specific fertility rate for females 15-19 years of age, of Indigenous women is 70 babies per 1000 women. This number is four times the teenage fertility rate of all Australian women (16 per 1000; Australian Bureau of Statistics, 2007). For Indigenous women, the peak age group for births is 20-24 years and the median age of Indigenous women who registered a birth is 24.7 years (Australian Bureau of Statistics, 2007). However, births to women under 20 (totalling 2000 births in 2007) accounts for 19% of all births to Indigenous women (10,200 births). By comparison, births to teenage women represent only 4% of all Australian births (Australian Bureau of Statistics, 2007). In other words, according to estimates by the Australian Health Ministers Advisory Council (2008), teenagers who give birth in Australia are five times more likely to be Aboriginal and Torres Strait Islander than other women. Also, the report states that Indigenous teenage mothers are most likely to come from remote areas.

Of the 11,200 births registered to teenage women in Australia in 2007, 18% (2000 births) were to teenage Indigenous women (Australian Bureau of Statistics, 2007). In the Northern Territory, specifically, of the 450 registered births to teenage women, 360 (or 81%) were to teenage Indigenous women. This vast majority in the Northern Territory highlights the prevalence of adolescent pregnancy in areas with dense Indigenous populations, and the necessity for supportive services that are tailored to address the structural barriers and concerns of this group. Additionally, the teenage fertility rate of Indigenous women living in the Northern Territory was 111 babies per 1000 women, seven times the rate for all teenage women in Australia. Western Australia also had a high Indigenous teenage fertility rate of 101 per 1000 (Australian Bureau of Statistics, 2007).

Indigenous women tend not only to have children at younger ages, but also have more children throughout their lifetime than non-Indigenous Australians. The total fertility rate for Indigenous women, in 2007, was 2.4 babies per woman, whereas the rate for all women was 1.9 babies (Australian Bureau of Statistics, 2007). This, too, varies by state and/or territory, as Queensland and



Western Australia both have higher than the average Indigenous Australian total fertility rates, 2.7 babies per woman, as compared to New South Wales, which reports 2.0 babies per Indigenous woman.

It is noteworthy that in parts of Australia, some births go unregistered, as customarily birthing on country is an important cultural practice. Many Aboriginal and Torres Strait Islander people, especially those living in remote regions, must travel long distances to get to a mainstream hospital where there are no interpreter services available, and shame can accompany the birthing experience (Kruske, Kildea, & Barclay, 2006). Therefore, some Indigenous families may opt not to officially document the arrival of a newborn child into a system that does not acknowledge culturally significant aspects of birth that are diverge from the Western medical model (Kruske, et al., 2006). As a result, births data is inaccurate as it is limited to those individuals who have been fully registered and legitimized by the state.

In general, obstetric outcomes for births to Indigenous mothers, especially those who are aged 15-19, are worse than Australian mothers overall, particularly in terms of maternal mortality rates, gestational age of the neonate at birth, low birthweight babies, and perinatal mortality (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). These poor outcomes are determined, to a large extent, by low socioeconomic status, generations of social disadvantage, lack of access to care based on place of residence and cultural preferences, and lifestyle factors (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). They are not solely a consequence of young age or Indigenous status.

#### ***4.2.2 Outcomes of young parenting for mother and child***

Deciphering causation from correlation is nearly impossible with respect to teenage pregnancy and young parenting. While assumptions may be made that the poorer educational and economic attainment for an adolescent mother is a consequence of her circumstances, evidence is sparse and data is lacking to prove direct correlation and causation (Geronimus & Korenman, 1993; Hofferth, Reid, & Mott, 2001). Age at motherhood may not be a reliable

determinant of a woman's future life trajectory. Problems with accessing and retaining stable employment, education, and financial independence are found across age groups, though they are prevalent among teenage mothers (Bradbury, 2006a).

#### *Summary of health outcomes*

Health outcomes among Indigenous mothers and children are generally poorer when compared with their non-Indigenous counterparts. When their Indigenous status is combined with young age, there are a multitude of risk factors that potentially result in complications during pregnancy and parturition that negatively impact perinatal and child health outcomes. Though from an evolutionary and physiologic perspective, a woman's body may be capable of conceiving, carrying and bearing a child from menarche up until the perimenopausal period, there are concerns about subsequent social limitations and possible harmful health ramifications that are presumed to follow early pregnancy for both the mother and child. The direst outcome for Indigenous women, specifically those aged 15-19 is maternal mortality. Outcomes are wider ranging for the offspring of young mothers. There is a greater likelihood that they will be born prematurely with low birthweight, having been exposed to toxins in utero and subsequently as an infant (environmental, tobacco, alcohol). Initiation and continuation of breastfeeding is variable.

Quinlivan (2004) found that teenagers who become pregnant were at considerably higher risk than the general population of using substances such as cigarettes, alcohol, and marijuana. However, once pregnant, rates of consumption of their preferred substances were lower than their non-pregnant peers. Reflective personal decision-making, motivation and responsibility are enhanced when a woman is pregnant. This centering and refocusing of energy during pregnancy may benefit the physical and psychological health of teenage women. For Indigenous teenagers, pregnancy, childbirth and the responsibility of raising a family may provide an opportunity for empowerment and motivation to gain control and autonomy in their lives (Quinlivan, 2004).

*The importance of antenatal care for Aboriginal and Torres Strait Islander mothers and babies*

Access to quality antenatal care and maternal-child health outcomes are intertwined worldwide. Aboriginal and Torres Strait Islander women begin receiving antenatal care later and less frequently than other women, only approximately half attend seven or more prenatal visits (Herceg, 2005; Middleton, 2009). Teenage women tend to access antenatal care less often than women who are somewhat older. Results from studies have shown that provision of routine prenatal diagnostic tests, such as ultrasound and screening for gestational diabetes and infections, is limited. Timely referral to appropriate medical services for high-risk pregnancies is also a concern (Middleton, 2009). Foregoing obstetric care during pregnancy is associated with many of the adverse health outcomes in the offspring of Indigenous teenage populations, including perinatal mortality, preterm birth, low birthweight, and small for gestational age (Middleton, 2009). Women may not always make the conscious decision to avoid seeking antenatal care; it may, in fact, be a proxy for a range of socioeconomic and cultural acceptability factors. Aboriginal and Torres Strait Islander women are more likely to attend prenatal visits if the services are community-based or community controlled, if the staff is welcoming, the setting is safe and the scheduling is flexible. Compliance is enhanced if there is an integrated spectrum of services and opportunities for transport, food, and childcare made available to registrants (Middleton, 2009).

*Potential maternal health outcomes of Indigenous teenage childbearing: maternal mortality, prolonged labour, hypertension, anaemia, diabetes, and obesity*

Maternal mortality is higher among Indigenous populations as compared with non-Indigenous. Maternal mortality is defined as the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Maternal mortality is associated with predisposing factors

such as primiparity, poverty, low social status, and lack of access to health services (particularly a skilled birth attendant in the birthplace). Rurality has also been found to impact the rate of maternal mortality (World Health Organisation, 2006). Age may not be the sole contributing factor, although for the small minority of very young Indigenous teenagers who become pregnant, there are physical risks to childbearing if the girl is not fully developed. The most recent available data, from 2000-2002, indicates that the maternal mortality rate for Indigenous families (45.9 per 100,000 females who give birth) was five times the rate for non-Indigenous females (8.7 per 100,000 females who give birth; Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). It is widely recognised that this statistic most likely reflects an under representation of maternal mortality in this group, due to failure to report Indigenous status on death certificates. Prolonged and obstructed labour is more common during first births and can lead to obstetric fistula and/or the death of mother and baby. If such an event occurs, emergency obstetric care and/or Caesarean section may be required to save two lives. Indigenous adolescent mothers in rural or impoverished communities of Australia may lack the economic, cultural, or transport capacities to seek emergency care when it becomes necessary.

Hypertension is the most common complication of pregnancy among women during their first pregnancy and is therefore a frequent burden for adolescent mothers in both the developed and developing world (World Health Organisation, 2006). In the Indigenous Australian context, hypertension is a commonly occurring chronic disease, and gestational hypertension is also prevalent (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Approximately 5% of pregnant Aboriginal and Torres Strait Islander women have high blood pressure. Chronic hypertension and pre-eclampsia are associated with poor birth outcomes. Furthermore, rates of preterm birth and delivery of small-for-gestational age newborns in hypertensive Aboriginal and Torres Strait Islander women are likely to be double the rates of other Australian women (Middleton, 2009). Likewise, anaemia disproportionately affects teenage girls and the Indigenous populations. Nutritional deficiencies in folic acid or iron and infectious

diseases contribute to anaemia. An iron deficient, anaemic adolescent mother is at risk for a variety of morbidities, including preterm birth of a low birthweight baby and postpartum haemorrhage (World Health Organisation, 2006).

Diabetes mellitus is considerably more prevalent among Aboriginal and Torres Strait Islander women (Middleton, 2009). Also, Indigenous women are likely to develop diabetes earlier in life. When pregnant, adolescents may develop gestational diabetes, which puts them at considerably higher risk of developing type 2 diabetes at a later stage in their life (Middleton, 2009). Women with gestational diabetes are at higher risk of having co-morbidities such as high blood pressure and pre-eclampsia, preterm labour, caesarean birth and/or birth trauma. There is a paucity of available data regarding obesity in Aboriginal and Torres Strait Islander pregnant women, however, a study from South Australia reported that 20% of women are overweight (body mass index (BMI) 25 to 29.9) and another 20% are obese (BMI 30 and above; Middleton, 2009). Obese women are more likely to develop hypertension and diabetes, with the concomitant risks for poor birth outcomes.

*Potential health outcomes of Indigenous teenage childbearing for the offspring: perinatal mortality, preterm labour, low birthweight, small for gestational age, Sudden Infant Death Syndrome, and birth spacing*

Fortunately, the vast majority of adolescent pregnancies are not high-risk and have good health outcomes. However when complications do occur, consequences can adversely impact both the mother and child. Perinatal deaths are those that occur in utero, foetal deaths (stillbirths), as well as deaths of live born babies within the first 28 days of life. Perinatal mortality is a recognized indicator of the health status of the population as well as access to quality health care. Between 2003-2005 data from Western Australia, South Australia, and Northern Territory reported perinatal deaths at a rate of 15.7 per 1,000 births for Indigenous babies compared with 10.3 per 1,000 births for non-Indigenous babies (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). In recent years, the Indigenous infant mortality rates in most Australian states and territories have improved,

however mortality rates for Indigenous infants in the reporting areas remain two to three times as high as those for the total population of infants (Steering Committee for the Review of Government Service Provision, 2007).

Gestational age is the length of a pregnancy in completed weeks from conception to delivery of the foetus(es). Preterm birth is defined as delivery of a foetus whose gestational age is less than 37 completed weeks and is associated with a host of complications that contribute to morbidity and mortality in neonates. Fourteen percent of all births to Indigenous mothers are preterm, which is double the rate in non-Indigenous mothers (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Compounded with young age, preterm births are even more common among the Indigenous 15-19 year old cohort (Middleton, 2009).

A baby's weight at birth is a key statistic for determining his/her health status. Babies born with a birthweight of less than 2,500 grams are classified as being "low birthweight." This phenomenon often occurs as a consequence of preterm birth and/or intrauterine growth restriction (IUGR). Low birthweight babies are at greater risk for long-term poor health. They frequently require longer periods of hospitalisation after birth and are more likely to develop disabilities (World Health Organisation, 2006). Thirteen percent of live born babies to Indigenous mothers are low birthweight, or 12.1 per 100 live births (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). The birthweight of a baby is a key indicator of its health status; and is influenced by many factors including the mothers smoking and alcohol intake, nutritional status and socioeconomic disadvantage. There were 4,578 low birthweight babies born to Indigenous mothers in the 2001-2004 period, representing 13% of liveborn babies to Indigenous mothers (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Studies have shown that the younger the pregnant woman, the greater the risk of a preterm birth and low birthweight baby (Otterblad, Canattingius, & Haglund, 1999). Stress and lack of social support during pregnancy, common circumstances for pregnant teens, are also associated with preterm labour and delivery.

Sudden Infant Death Syndrome (SIDS) is the leading cause of death among infants between one month and one year of age in the developed world. The Australian SIDS rate was 0.32 per 1000 live births in 2005. This figure marked an 82% drop since risk reduction campaigns began in the 1990s (Middleton, 2009). Comparison data is not current, but it appears clear that infants of Aboriginal and Torres Strait Islander women have a higher incidence of SIDS than do non-Indigenous babies. Statistics from 1993 to 1996 show that the SIDS rate for Aboriginal infants was seven times the rate of non-Indigenous, and that the rate of infants for teenage mothers was three times greater than those of older mothers (Middleton, 2009).

Birth spacing is relevant in the Indigenous Australian context because more than a quarter of women in this group give birth three or more times in their lifetime (Middleton, 2009). Multiparity in this group dramatically increases chances of short intervals between pregnancies. The World Health Organization (2006) recommends an inter-pregnancy interval of at least two years, so that a woman has sufficient time to replenish vital reserves that help to sustain a subsequent pregnancy. If women have consecutive pregnancies, (conceived less than six months after the previous birth), then there is a significantly higher risk of maternal complications such as anaemia and haemorrhage, as well as perinatal complications such as preterm birth, low birthweight, and small for gestational age infants (Middleton, 2009). Shorter interbirth intervals may be linked to lower socioeconomic status, lack of access to health care, reduced use of contraceptives, and inconsistent social support. This has been a recognised area of concern for the young Indigenous parents and those providing services for them (Kirkman, Harrison, Hillier, & Pyett, 2001; Quinlivan, 2004). Efforts have been aimed at reducing repeat pregnancies since multiple, shortly spaced gestations are associated with lower school retention rates for young mothers (Key, Barbosa, & Owens, 2001).

#### *Healthy child development outcomes in Indigenous teenage families*

Healthy child development is acutely impacted by early breastfeeding, diet and nutrition, exposure to passive smoking, and high-risk alcohol use in the

household. Data from the Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008), in addition to studies conducted by Middleton and the University of Adelaide (2009), show that, in terms of all of these factors, there are worse health outcomes among Indigenous teenage families, relative to the general Australian population.

There are well-documented advantages to breastfeeding for the health of both mother and child, and more broadly for ecological systems and economies worldwide. Human milk is much more than sustenance alone. It has been found to have beneficial nutrients and substances that cannot be replicated in infant formula. Exclusive breastfeeding during the first six months of life is universally recommended because of reduced risks for cancers and many childhood illnesses (acute respiratory infections, allergies, SIDS, diarrhoea); immunological and cognitive development benefits; enhanced maternal-child bonding; less waste; less economic burden on health care systems. Australian women, including Aboriginal and Torres Strait Islander mothers, have a 90% breastfeeding initiation rate. Because of the aforementioned benefits, the World Health Organization (2006) recommend that women exclusively breastfeed for the first six months of their child's life and continue with complementary feeding for up to two years. Among the Indigenous teenage cohort by the six-month milestone, breastfeeding rates are at levels below the national average of 50%. Only 3% of Australian women are reported as achieving the target of exclusive breastfeeding for six months. (Middleton, 2009) Indigenous women are less likely to breastfeed for 12 months or more than non-Indigenous women (11% versus 14%; Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). There is a differential across Australia based on socioeconomics and geography. While the lowest socioeconomic quintile has lower than average initiation rates (81%) relative to the highest groups, Indigenous groups living in rural regions have a greater likelihood of breastfeeding at some point in the child's first three years of life than those who live in non-remote settings (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008)



Poor diet and nutritional deficiencies in the early years are known to adversely affect child growth and development, functioning and overall health. Poor nutritional status is a primary basis for numerous health conditions that are common to Aboriginal and Torres Strait Islander people. A diet that is high in carbohydrates and saturated fats is associated with obesity, Type 2 diabetes and renal disease (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Fruit and vegetables may help prevent some illnesses, but in rural and/or poor regions, fresh, affordable food is not readily accessible. Data relevant to the specific cohort is scarce; though it is known that vitamin deficiencies are common and contribute to the high rates of iron deficiency anaemia, stillbirth, small for gestational age, and neural tube defects among pregnant Indigenous women and children (Middleton, 2009). These adverse health outcomes are related to vitamin and mineral consumption preceding and during pregnancy. Good nutrition is fundamental to an individual's general health and well-being, but cost, access and personal food preferences are known barriers for teenage women (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008).

While passive smoke exposure is a significant cause of morbidity and mortality at any age, children are especially vulnerable to its effects. Nearly 60% of Aboriginal and Torres Strait Islander women smoke during pregnancy, which is four times more than other pregnant women. Teen rates are also high, representing one in nine of all pregnant women who smoke in Australia (Middleton, 2009). Smoking during pregnancy causes foetal growth restriction and contributes to all of the adverse health outcomes enumerated previously, notably higher perinatal and infant mortality rates, low birthweight, small for gestational age, and/or preterm birth. Furthermore, the impact of smoking is dose-related. In other words, the greater the amounts of maternal tobacco intake during pregnancy, the worse the birth outcomes are likely to be. Income, less formal education, and unemployment seem to be related to smoking during pregnancy (Middleton, 2009).

Exposure to second hand smoke increases the risk for sudden infant death syndrome as well as a child's risk of ear infections, respiratory diseases, and

asthma. 66% of Indigenous children live with a regular smoker; compared to 35% of non-Indigenous children. 28% of Aboriginal and Torres Strait Islander children live in households with a regular smoker who reported smoking indoors, as compared to 9% of non-Indigenous children (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). Smoking is a particular area of concern for Indigenous Australian populations due to the high proportion of people who continue to abuse tobacco despite long-standing public campaigns about its negative health consequences. Smoking cessation and awareness programs have had variable results with this cohort, as stopping smoking is oftentimes not a high priority in the stressful lives of some young Indigenous women.

The incidence of alcohol use in pregnancy for Aboriginal and Torres Strait Islander teenage women is not well documented. However, social alcohol consumption during pregnancy is similar across ethnicities in Australia. On the other hand, high risk drinking is several times higher in Indigenous as compared to non-Indigenous women (Australian Institute of Health and Welfare, 2009), and as a consequence foetal alcohol syndrome is more common among Indigenous babies. An investigation undertaken by Middleton and researchers at University of Adelaide (Middleton, 2009) concluded that 50% of Australian women drink before pregnancy and between pregnancies; 25% drink during pregnancy and 10% drink at high levels in early pregnancy. In addition to foetal alcohol syndrome, which is not readily diagnosed unless a child exhibits distinctive facial characteristics, moderate to high levels of alcohol use in pregnancy are linked to low birthweight, intrauterine growth restriction, and preterm birth. Foetal alcohol syndrome is a devastating problem resulting in the child exhibiting various degrees of intellectual impairment and a range of behavioural and health issues, which combine to create a lifelong barrier to education. Moreover, a higher percentage of Indigenous children live in households with at least one risky/high risk drinker (15% compared to 11% of non-Indigenous children aged 0-14 years). Rurality does not seem to alter this measure. Programs within Indigenous communities have increased efforts to identify cases and fund prevention strategies for foetal alcohol syndrome since the long-term consequences are

significant (Quinlin, Crawford, & Smith, 2006). Preventive interventions may not be as successful in some teenage populations where pregnancies may not be planned, and when much of the damage from alcohol is in the first months of pregnancy when organogenesis is taking place.

Shaw, Lawlor, & Najman's Australian prospective longitudinal study (2006) reported the outcomes of teenage motherhood on the psychological health, wellbeing and behaviour of their offspring. They concluded that maternal age is not associated with the health outcomes of the children, rather indicators of low socio-economic position and maternal depression are associated with poorer psychological, cognitive and behavioural outcomes in their offspring at 14 years of age. Following this, it follows that interventions aimed at reducing maternal poverty and increasing support among those from the most deprived backgrounds may be more effective ways of improving childhood psychological, cognitive, behavioural and health outcomes than would interventions aimed solely at reducing rates of teenage pregnancy and parenthood (Shaw, et al., 2006). These findings may inform evidence-based policy and are essential for understanding the long-term ramifications of young motherhood in the Australian context. It would seem that generally, though the rates of teenage pregnancy are relatively high in Australia, early parenting does not necessarily negatively impact the overall health of either mother or child.

#### ***4.2.3 Associations with Indigenous young parenthood***

*Disadvantage among Indigenous young parents: poverty, educational attainment, employment, marital status, and place of residence*

The principal association with young parenthood in Indigenous communities is disadvantaged status, including poverty, educational underachievement, and underemployment (Bradbury, 2006a; Herceg, 2005; Titmuss, Harris, & Comino, 2008). Studies have not established causality, presumably because there are many factors that may contribute to social inequities, which are not directly attributable to the age at which a young woman became a mother. Associations, then, are those factors that are commonly seen among Aboriginal and Torres Islander people aged 15-19 before, during, and after a

pregnancy. The World Health Organization and the United Nations Population Fund (2006) label these associations the etiology for a “circle of exclusion.” However, in the Indigenous Australian context, this deficits-based point of view does not constructively target the underlying causes of deprivation. Becoming pregnant during one’s mid to late adolescence, in and of itself, is not inherently the reason for exclusion from the mainstream, as perceived by Western society.

There is an inverse relationship between social class and poverty and the spectrum of adolescent health issues, including early initiation of sexual activity, less reliable contraceptive use, and hence teenage pregnancy (McCullough, 2001). Economic resources may play a role in shaping a young woman’s thoughts about the potential costs and benefits of sexual activity (McCullough, 2001), as do various life experiences associated with living in poverty. Alienation in school, community norms of single parenthood, unemployment, and lack of education opportunities and career prospects may all serve to lower the perceived costs of early motherhood, and increase the perception of limited life choices (Arai, 2003). It is important to note that studies concerning teenage pregnancy, while making evidence-based conclusions about young parenthood, are not uniformly inclusive of the Indigenous Australian context. While socioeconomics certainly colours a woman’s capacities and concerns regarding pregnancy, there are basic cultural determinants that often go unrecognized in the paucity of mainstream published research that has looked at the Indigenous teenaged population. Taking into consideration the Indigenous culture’s point of view regarding this issue is paramount to understanding an adolescent’s decision-making and expectations for what her life will be like (Arabena, 2006; S. Atkinson & Swain, 1999).

Geronimus (2003) argues that limited prospects in the labour market, combined with shorter life expectancy, and opportunities for kin support make childbearing a rational option for minority women in the United States. A comparable, though not identical, scenario exists within the Indigenous context wherein only 23% of the population has attained a Year 12 education

and training opportunities for a marketable trade are limited (Australian Bureau of Statistics: Australian Institute of Health and Welfare, 2008). A life expectancy of 65 years for Indigenous women is drastically lower (by 17 years) than that of non-Indigenous women. Also, extended kinship systems are integral to the perpetuation of Indigenous communities (Cowlshaw, 2004).

The socioeconomic circumstances of women and their families in the years following young motherhood provides an indication of the life-long living standards of these women and a potential sign of the economic conditions under which their children will be raised (Bradbury, 2006a). The statistically significant association that Bradbury (2006a) found does not implicate young motherhood as a causal factor for disadvantage, since an impoverished background also impacts other issues such as age at onset of sexual activity, lack of knowledge about reproductive capacity and contraception, agency and control over relationships, as well as social and economic barriers to accessing an elective abortion.

### *Education*

Educational level correlates with age at first birth in Australia. Almost a quarter of women who were teenage mothers do not complete Year 10, compared to only 2.4% for those whose first birth was in their 30s (Australian Bureau of Statistics, 2000). Correspondingly, only 2.3% of teenage mothers have a high school degree or higher (Bradbury, 2006a, 2006b). However, the correlation with employment status is not as marked (Bradbury, 2006a, 2006b). Though women who delayed childbearing until their 30s had higher educational qualifications, having younger children impacts their employment status after they become a parent.

The landscape and culture of the area of residence within Australia also has an association with teenage childbearing (McCullough, 2001). Rates of teenage pregnancy are higher in economically disadvantaged areas, in both urban and remote regions. Within a given community, there are norms that affect age at onset of sexual activity, acceptability and use of contraception, and attitudes toward early childbearing. In fact, 2/3 of the differences in

pregnancy rates among ethnic groups are related to the standard conditions within the neighbourhood (South & Baumer, 2000). Some studies have found that there were more tolerant attitudes towards young, unmarried parenthood amongst those who reside in deprived communities (South & Baumer, 2000).

The impact and desirability of teenage reproduction rests on socioeconomics in the mainstream Australian framework (Bradbury, 2006a). The extent to which disadvantage occurs as a consequence of early parenthood, as compared to delayed childbearing, is the subject of on-going debate. For example, using Australian data from the Australian Longitudinal Study on Women's Health, Bradbury (2006b) concluded that the association between young motherhood and economic status in subsequent years is related to a range of unobserved variables rather than any direct causal link. However, to be sure, non-Indigenous attitudes toward early parenthood are significantly influenced by lower educational attainment and overall less lucrative employment opportunities for teenage mothers. Moreover, a background of disadvantage is a commonality among young mothers. This evidence should inform the development of policy and identification of families that are in need of appropriate, accessible, and adequate support that maintains cultural security.

#### *Family structure and 'dysfunction' among Indigenous young families*

The associations between family background, dysfunction and teenage childbearing have been studied and described in published literature. Family structure as well as generational trends with respect to early parenthood may influence the initiation of sexual activity, the use of contraception, and the acceptance or termination of pregnancy when it occurs. In particular, there is statistical evidence that early parenthood is more likely to be found among teens who were raised in single parent, mother-headed families (Quinlivan, 2004; Quinlivan, Tan, Steele, & Black, 2004); low parental education levels and resources (Haldre, Rahu, Karro, & Rahu, 2009); large family size (Haldre, et al., 2009); alcohol abuse in the home (Haldre, et al., 2009); and the mother having herself commenced childbearing as a teenager (Shaw, et al., 2006). The extent of family functionality or disruption in a teenager's home is

significantly associated with her likelihood of have an early sexual experience (under 16 years) and her sentiments towards becoming pregnant. A higher occurrence of teenage motherhood has been found among those whose parents were either least strict or most strict. Parents' non-acceptance of their child's sexual activity is associated with teenage pregnancy (Haldre, et al., 2009). In homes where there is limited physical punishment, open communication between parents and their teens, and cohesion in the family, a daughter is less likely to become pregnant. She may feel more supported and valued, since early childbearing is associated with a woman's self-esteem and sense of self-competency (Haldre, et al., 2009).

Indigenous families are dissimilar to most of those that have been studied because, unlike white, Western nuclear units, many are extended kinship systems that cooperatively raise children. In this type of family structure, there may be different cultural norms for sexual behaviour and early childbearing, which may also be mediated by regional standards and socioeconomic disadvantage. According to Kaufman (2007), whose study came out of an American Indigenist framework, "culture" and ethnicity acutely impacts sexual behaviour and decisions regarding pregnancy. If a woman culturally identifies with a community, her life choices are influenced by the extent to which she faces recrimination or support, stigmatization or acceptance for her sexuality and use of contraception, and if her children will be supported or neglected (Kaufman, et al., 2007). They suggest that in some cases, culture may increase feelings of alienation and thereby increase risky behaviour. However, alternatively, culture may strengthen resources which young people use to increase their likelihood of making healthy choices (Kaufman, et al., 2007). In Australia's Aboriginal and Torres Strait Islander populations, the intergenerational trend of early childbearing can influence a woman's decisions insofar as she knows that she will be accepted by her community and her children cared for by many women in her family, i.e. mothers, grandmothers, aunts, sisters, cousins, and friends (S. Atkinson & Swain, 1999; Senior & Chenhall, 2008).

A further aspect of family dysfunction is intimate partner violence, which is a leading contributor to disability and death, among women aged 15-44 years in Australia. While 10% of pregnant Australian women report some form of recent domestic violence, hospitalizations related to this form of abuse are a more common phenomena in Indigenous communities (Berry, Harrison, & Ryan, 2009; Middleton, 2009). Family violence is associated with preterm birth, low birthweight and even perinatal death, especially with increased levels of violence (Panaretto, et al., 2006). Severe and/or repeated instances of physical abuse are associated with neonatal death, while verbal abuse is more often found in cases of low birthweight. Both types of violence are strongly correlated with alcohol and substance abuse (Taft, Watson, & Lee, 2004). In Aboriginal and Torres Strait Islander populations, family violence is attributed to low income, from a history of colonisation, dispossession, family dislocation, and marginalisation, though this may be an oversimplification of a much more complex issue (J. Atkinson, 2002). Programs that have attempted to tackle this issue and the resultant effects on the health and well being of women and children have been largely unsuccessful in Indigenous populations, as they have risen outside the community and have been culturally inappropriate (Saul, Muir, & Oprea, 2009). Steps in the right direction are beginning with the Australian Government's recognition of family and intimate partner violence in a forthcoming plan for reducing abuse of women and children.

#### *Factors specific to Aboriginal and Torres Strait Islander teenagers*

There is a major gap in the literature on associations specific to the Indigenous Australian perspective on sexual behaviour, contraception, and teenage pregnancy. Aboriginal and Torres Strait Islander adolescent women are nearly voiceless and therefore their concerns are largely unknown apart from anecdotal evidence and lessons learned from interventions and support programs for young families. Issues that may exist in the Indigenous teenage female experience have been discussed, namely disadvantage, low school retention and alienation, limited opportunities for employment, family dysfunction, and cultural norms. However, the intergenerational experience of racism, trauma, poverty and a history of dispossession impact the health,



wellbeing, and life course of young women (Arabena, 2006; Australian Institute of Health and Welfare, 2009). It is important to acknowledge that the Indigenous Australian population is highly heterogeneous. There are wide variations in socioeconomic status, education, geography, access to health care and other vital resources, cultural practices, and historical experiences. Therefore, generalisations endanger the cultural security of this disparate people.

Issues of empowerment, stress, and perceived control are integral to good health. The evidence available demonstrates that according to these measures, Indigenous Australians are disadvantaged compared to non-Indigenous people (J. Atkinson, 2002; Tsey, Travers, et al., 2005). Lower incomes, higher rates of unemployment, poorer educational outcomes, lower rates of home ownership, and disadvantage in terms of geography bear a significant burden for young Aboriginal and Torres Strait Islander people (Larkins, 2007). Education seems to be an important avenue for empowering mothers and can be a pathway to improving maternal-child health outcomes (Boulden, 2001). Education is a vital tool insofar as the system is inclusive, and does not reinforce paternalistic ideals of assimilation, which reaffirm the ingrained racism in Australian society.

Research on the experiences of young Australian Indigenous women in pregnancy, childbirth and during the postpartum period is limited. A small qualitative, longitudinal study from Cairns, Queensland found that teenage pregnancy is common and largely accepted, and that pregnancy may be an opportunity for the adolescent to establish autonomy (Minniecon, Parker, & Cadet-James, 2003). Communities and extended kinship systems ensure the care of offspring and often share parenting roles. The major barriers facing women were family responsibilities, shame, and lack of transport. Family support is crucial throughout the entire perinatal period, as well as availability of adequate services, which employ health professionals who have cultural and spiritual understanding and transmit openness and cultural safety to young pregnant mothers (Minniecon, et al., 2003). Similar findings have been

reported in small studies from the Northern Territory (Senior & Chenhall, 2008) and Western Australia (Kite & Lockyer, 2007).

### **4.3 Key issues impacting on young Indigenous mothers and fathers in Queensland**

Although it must be noted that the Indigenous population is highly heterogeneous, it is clear that many young Indigenous parents in Queensland face a variety of issues in establishing their family and day-to-day survival. A combination of historical factors, family disruption, socioeconomic disadvantage and ongoing racism have created problems for some Indigenous communities, with issues of empowerment, stress, and perceived control (J. Atkinson, 2002), especially among teenage populations (Larkins, 2007).

A recent study working with young Indigenous mothers in Townsville found that the main issues confronted included poverty, stigma, issues with transport and housing, depression and mental health problems, violence and access to services and childcare (Larkins, 2007). Likewise, Minniecon et al (2003) found that the major barriers facing Indigenous adolescent pregnant women when it came to accessing services were family responsibilities, shame, and lack of transport. In addition, given the importance of birth spacing to outcomes for young parents, knowledge about and access to a range of contraceptive options is another key issue (Slowinski, 2001).

However, despite (or perhaps because of) all these factors, for many young Indigenous mothers, pregnancy and parenthood is viewed as a transformative experience; a chance to take stock and make positive life-changes in terms of education, employment, relationships and unhelpful behaviours (Larkins, 2007). However, the transformative potential of young parenthood for young Indigenous people is contingent on both adequate family and professional support (Quinlivan, 2004).

This section will initially discuss the related issues of poverty, educational disengagement and unemployment, followed by issues related to social and emotional wellbeing, violence and substance abuse. This will be followed by a discussion about service accessibility, access to contraception for young

parents, and then a section devoted to the relatively sparse literature about the issues confronting young Indigenous fathers.

#### ***4.3.1 Poverty, educational disengagement and unemployment***

Being poor and disadvantaged can be a cause and/or a consequence of pregnancy. Young mothers, and by extension their children, are among the most socioeconomically disadvantaged groups in Australian society (Bradbury, 2006b). Young Aboriginal and Torres Strait Islander women who are pregnant and parenting face potential discrimination (Paradies, 2006) and relegation to continued low socioeconomic status and exclusion from further education (SHine SA, 2007b).

An analysis of births of Indigenous infants at a Sydney hospital found that the rate of negative outcomes (in this case low birthweight) was much higher for Indigenous infants in the lowest quintile for socioeconomic status (SES) compared with those in the other quintiles (16.7% versus 6.3%; Titmuss, et al., 2008). These authors conclude that it is actually maternal socioeconomic disadvantage (including low SES, younger age, smoking status and single parent status), rather than Indigenous status itself that is the major contributor to differences in birth outcomes (Middleton, 2009; Titmuss, et al., 2008).

Although high quality published evidence is sparse in this area, clinical experience, past research and conversations with young parents and service providers teach us that issues related to poverty also have a very significant effect on the wellbeing of Indigenous parents and their infants. For example, access to safe, stable housing is a continual concern (Cortis, Katz, & Patulny, 2009; Larkins, 2007), as is access to transport (essential in turn for accessing services; Cortis, et al., 2009; Saul, et al., 2009). Discrimination from private rental providers and transport providers may exacerbate this problem. It is essential that service provider groups and individuals consider these when planning their services, as continual mobility related to lack of stability in housing has a strong negative effect in terms of engagement with support services (Cortis, et al., 2009). A related issue for some young Indigenous parents is difficulty in accessing high quality, affordable childcare for their

children. This lack of suitable childcare is often cited as an obstacle to resuming education, or gaining employment (Boulden, 2001).

### *Educational disengagement and unemployment*

The cycle of poverty and disadvantage seems to be a common element for many young Australian mothers. Educational attainment and aspirations for academic success and involvement in the labour market perpetuate and reinforce a woman's motivation to delay reproduction. There is limited evidence from Australia as to whether dropping out of school is a consequence of the pregnancy or if leaving school preceded rather than followed a pregnancy (Larkins, 2007). However, international evidence suggests that the former is more commonly the case (Hofferth, et al., 2001). In contemporary Australia, completing high school or attaining a vocational or postgraduate qualification is increasingly necessary for employment that will generate a living wage (Helme, 2005). Consequently, longer periods of education and training generally delay planning to start a family among the middle-class in urban areas. Not surprisingly, these same influences are not noted in Indigenous populations or in remote areas (Arabena, 2006; Senior & Chenhall, 2008). Hence, teenage pregnancy is occurring more often among those young, unmarried women who have fewer prospects of attaining higher education or stable employment for themselves or by their partners (Larkins, 2007).

Teenage fertility impacts on educational attainment and aspirations for academic success and involvement in the labor market. Almost a quarter of mothers who were teenage mothers in Australia have not completed Year 10; whilst only 2.3% have a degree or higher (Boulden, 2001). However, as demonstrated, often it is those with less engagement to education who are more likely to parent early and less likely to have a termination of pregnancy should they become pregnant (Evans, 2004; Senior & Chenhall, 2008).

Teenage mothers have a low employment rate (41.8%) and generally the jobs they hold provide wages that, at best, are middle of the income distribution (Bradbury, 2006a, 2006b). Bradbury (2006a) found that 90% of teenage

mothers are receiving income support at the time of childbearing and 80% continue to receive income support seven years later. These data indicate a lack of economic independence and stability for many young Australian mothers. Furthermore, a key determinant of a living standard for a young mother is the income of other household members, particularly a spouse. Therefore, being a single head of household is an important indicator of disadvantage. Those who were younger at their first birth were also more likely to be single in their early 30s than those who delayed pregnancy (Bradbury, 2006a, 2006b).

#### ***4.3.2 Social and emotional wellbeing, violence and substance use issues***

Young Aboriginal and Torres Strait Islander parents, like other young parents, frequently suffer from issues impacting on their social and emotional wellbeing. Issues frequently identified in previous studies and reports include the following:

- Postnatal depression (Campbell, Hayes, & Buckby, 2008; Slowinski, 2001)
- Stigma and judgement from other people (including service providers; Larkins, 2007; Low, Martin, Sampsel, Guthrie, & Oakley, 2003)
- Inadequate social support (Lee & Gramotnev, 2006; Slowinski, 2001)
- Perceived lack of parenting skills (Bent, Josephson, & Kelly, 2004; Larkins, 2007)
- Family violence (Aboriginal and Torres Strait Islander Women's Task Force on Violence, 2000; Keel, 2004; Middleton, 2009)
- Substance abuse (Kennare, Heard, & Chan, 2005; Larkins, 2007)

Each of these in turn will have a negative impact on the capacity of the young parents to parent effectively and engage meaningfully with support services or further education or training.

In terms of perinatal health, rates of postnatal depression and other psychosocial risk factors identified in Aboriginal and Torres Strait Islander women are similar to those in the wider community (Beyond Blue, 2008).

However, standard scales used widely in Australia, such as the Edinburgh Postnatal Depression Scale, may underestimate the true rate of depression in Indigenous women unless modified for this setting (Campbell, et al., 2008).

A related factor that is not commonly mentioned in service provider evaluations, but is frequently remarked on in narrative studies with young mothers is the stigma felt from society in general, and service providers specifically about being a young parent, and as such perceived as being a “bad parent” (Low, et al., 2003; McDonald, et al., 2009; Wilson & Huntington, 2005). This stigma and perceived judgement can add additional stress to the lives of young people already dealing with complex lives, and can be one of the factors leading to difficulty in continuing with formal education (Boulden, 2001).

#### *Inadequate social support and perceived parenting skills*

Coping in early parenthood is often impacted on by the degree of community and family support received by a young parent (Larkins, 2007; Secretariat National Aboriginal and Islander Child Care, 2004). Young parents with inadequate social support may experience a negative impact on their relationships with their children, and ultimately child development may be affected (Clemmens, 2001). Recognition of this in the design and implementation of programs is important, such that programs build on and involve social support and networks that are already in existence (Slowinski, 2001). Depending on the circumstances this may mean involving extended family members, peers or other relevant supports. For example, narrative research in Victoria has demonstrated ongoing strong networks of mothering support amongst Koorie women that could be utilised more fully in supporting young mothers (S. Atkinson & Swain, 1999).

A related issue is the lack of confidence that a number of young Indigenous parents feel about their parenting skills and capacity to parent successfully (Stephen. R. Zubrick, et al., 2008). This is likely to be so particularly for young people who have come from dysfunctional families themselves. Specific, culturally appropriate parenting education and advice is frequently articulated

as a support need by young Indigenous parents (Allwood, Rogers, & Hume, 2001).

### *Family violence*

Family violence is a significant problem for some pregnant Aboriginal and Torres Strait Islander women, with one Queensland study finding a prevalence of 16% (69/387) in an antenatal population (of whom approximately 1/5 were teenagers; Panaretto, et al., 2006). The reasons for this are multifactorial, but relate to colonization and dispossession, as well as ongoing experiences of marginalisation. Intimate partner violence has been linked with preterm birth, and other adverse outcomes for the child, as well as the mother (Taft & Watson, 2007). Family violence is associated with alcohol abuse, depression, low socioeconomic status and higher rates of sexually transmitted infections and unintended pregnancies (Middleton, 2009; Quinlivan, et al., 2004). It is important that this is raised as an issue, and that service providers are trained to ask about family/domestic violence in a sensitive and culturally-appropriate manner. Victoria is currently implementing an Indigenous Family Violence Strategy (Victorian Department of Human Services, 2008), but initiatives such as this are lacking elsewhere. However, there are still large gaps in the literature in terms of how family violence is experienced by young Indigenous women and parents, and in particular what strategies for responding to family violence are most effective in Indigenous settings (Middleton, 2009).

### *Substance abuse*

In a large South Australian audit, 115/2151 (5.3%) of Aboriginal mothers self-reported substance use in pregnancy (including risky alcohol use and illicit drugs, but excluding nicotine; Kennare, et al., 2005). Likewise, a study in Townsville found that in a cohort of 456 pregnant Indigenous women, 64% were smokers, 27% used alcohol (15.8% at harmful or hazardous levels), and 13.8% used recreational drugs, mostly cannabis (Panaretto, et al., 2006). However, a study of pregnant teenagers found that most of the Indigenous pregnant women (76%) did not use any drugs during their pregnancy, with 18% using marijuana only, and 6% using marijuana and other drugs



(Quinlivan & Evans, 2004). Substance use during pregnancy is significantly associated with adverse perinatal outcomes, including preterm birth, low birthweight, and stillbirth (Kennare, et al., 2005; Middleton, 2009).

A recent review concludes that, overall, substance using mothers were more likely to be young and Indigenous than non-substance using mothers, and they often have a raft of other social issues to deal with including poverty, unemployment and mental illness (Middleton, 2009). Very little work has been done on how best to provide drug and alcohol services to young Indigenous people in general, or young parents, and this is an area needing further work (Rio Tinto Child Health Partnership, 2006). However, once again, there is agreement that models that consider whole families or communities, rather than solely individuals, may have more success in Indigenous settings (Middleton, 2009).

#### ***4.3.3 Accessibility and acceptability of services***

Many Aboriginal and Torres Strait Islander women have fairly negative experiences of accessing health care, including antenatal services. A doctoral study by Hunt (2006) found the following factors common to women's experiences:

- Long waiting time, short consultations and lack of continuity of care in outpatient clinics;
  - Limited access to interpreter services;
  - Understaffing;
  - Lack of Aboriginal and Torres Strait Islander staff and lack of Aboriginal Health Workers;
  - Skills of midwives not being acknowledged or used;
  - Problems with information exchange with community providers;
  - Explicitly racist attitudes and behaviours in mainstream settings
- (Hunt, 2006).

Most other studies have been restricted to quantitative obstetric outcomes, but there have been several small qualitative investigations of Indigenous

women's experiences of the perinatal period. A longitudinal study of 5 Indigenous women in Cairns found that there were some problems with accessing mainstream antenatal and postnatal services, with major barriers being family responsibilities, shame, and lack of transport. This group identified the importance of family support for the whole perinatal period (Minniecon, et al., 2003). These findings have been replicated by a body of work from the Northern Territory (Kruske, et al., 2006). Other consistent themes include inadequate services, miscommunication and a lack of cultural and spiritual understanding by health professionals, and inadequate preparation for birth in a hospital setting (Kruske, et al., 2006; Lockyer & Kite, 2007; Watson, Hodson, Johnson, & Kemp, 2002). However, considerable promising practices have also been developed in the area of maternal and child health services for Indigenous women. These will be discussed in Section 4.4.

#### ***4.3.4 Knowledge of and access to contraception***

In terms of the decision-making path to teenage pregnancy, the first decision is to have sexual intercourse, and the second is the use or non-use of contraception. To effectively use contraception a young person must have adequate knowledge about contraceptive methods and their correct use, access to contraceptive methods at reasonable costs, and attitudes supportive of contraceptive use (i.e. that the benefits of contraceptive use outweigh the disadvantages). In addition, the young woman must possess adequate confidence and negotiation skills to allow discussion of contraceptive use with a partner in the context of unequal power distributions within relationships, and a society that puts a moral double bind on women who think ahead with regard to contraception (Larkins, et al., 2007; Skinner & Hickey, 2003).

Limited information is available about the sexual behaviour of Indigenous young people. The Youth Self Report section of the large Western Australian Aboriginal Child Health Survey (WAACHS; 1073 young people aged 12 to 17 years old; Stephen R Zubrick, et al., 2005) found that 74.5% of Aboriginal 17-year-olds reported having had sexual intercourse and for 48.6% this occurred

before the age of 16 years. For Aboriginal young people 33.4% of 15-year-olds, and 43.9% of 16-year-olds had had sex (comparable 1993 estimates for non-Aboriginal youth were 16.0% and 23.5% respectively). Apart from age, independent associations with having had sex were having left school, drinking alcohol and using marijuana (Stephen R Zubrick, et al., 2005).

Just over 70% of the sexually active students in the WAACHS study relied on condoms for contraception, and this percentage declined with age, and was lower (59%) in females. Over 33% of 17-year-old girls reported having been pregnant (Stephen R Zubrick, et al., 2005). It is interesting to note that in the Aboriginal study condom use was found to decrease with age, while in largely non-Indigenous studies the tendency was for condom use to increase with age. Other work indicates that condom use tended to increase with age, especially for condom use at first sexual intercourse, however many factors other than age impact on condom use in a given situation (Larkins, 2007; Larkins, et al., 2007), and on occasion they may be viewed as a hassle by young women (Skinner, et al., 2009).

#### *Knowledge about contraception*

The international literature suggests that a lack of knowledge about the contraceptive options available is not the primary cause of non-use (Arai, 2003). However, a lack of knowledge about contraception and effective contraceptive use is common amongst the youngest teenagers having sex (American Academy of Pediatrics Committee on Adolescence, 1999; Grunseit, 2004). Around half of all initial premarital pregnancies occur in the first 6 months of sexual activity (American Academy of Pediatrics Committee on Adolescence, 1999), mostly because the younger women are much less likely to use contraception. Emergency contraception is one area where knowledge about the method, its correct use and availability appears to be lacking (Free, Lee, & Ogden, 2002; Pearson, Owen, Phillips, Pereira Gray, & Marshall, 1995). Although joint use of condoms and a hormonal method of contraception are the recommended gold standard for safe sexual behaviour (Ott, Adler et al. 2002; Brady 2003), few adolescents in Africa (MacPhail, Pettifor, Pascoe, & Rees, 2007) or Australia (Agius, Pitts, Dyson, Mitchell, &

Smith, 2006) use this combination. A lack of communication skills is thought to be the most common limiting factor. Overall, Australian research shows that around 60% of sexually active adolescents are consistent users of condoms (Agius, et al., 2006).

In Australia, school is the preferred site for the provision of sex education (Smith, Agius, Dyson, Mitchell, & Pitts, 2002), although as has been discussed a strong national policy framework is lacking. Young women are often dissatisfied with the provision of sex education at school, in terms of quantity, quality and timing (Jewell, Tacchi, & Donovan, 2000; Milburn, 2006), but it has been shown that this can be improved with attention to the process (Graham, Moore, Sharp, & Diamond, 2002; Milburn, 2006). In particular, there appears to be an association between pragmatic and sex positive government policies for school sex education and better sexual health indicators in young people (Weaver, Smith, & Kippax, 2005). Overall, as Stevens-Simon and her group (1998) have concluded, there is evidence suggesting that knowledge-based sex education and vocational programs help motivated teenagers avoid childbearing. However, these strategies are not effective with those who do not already feel that the benefits of contraceptive use outweigh the risks of conception, not to mention those who are disengaged from school. This international work needs confirmation in the Indigenous Australian setting.

#### *Attitudes towards contraception*

How a young woman feels about contraception, termination of pregnancy, having a child, and indeed herself as a sexually active human being will have major consequences in terms of teenage pregnancy and childbearing rates. Using a racially-diverse sample of 200 pregnant teenagers, Stevens-Simon, Kelly et al (1996) found that the most frequently mentioned reasons for not using contraception were: "didn't mind getting pregnant" (20%); "wanted to get pregnant" (17.5%); "contraception didn't work/broke" (12%); "thought couldn't get pregnant" (9%); and "just didn't get around to it" (9%). They concluded that the absence of negative attitudes towards having babies was more important than negative attitudes to contraception in terms of reducing

contraceptive use (Stevens-Simon, et al., 1996). Ambivalence towards pregnancy was confirmed as a predictor of inconsistent contraceptive use in a more recent prospective analysis of non-pregnant African American adolescents (Crosby, DiClemente, Wingood, Davies, & Harrington, 2002), along with the attitudes of males to using condoms (Sonenstein, Ku, Duberstein Lindberg, Turner, & Pleck, 1998). This is consistent with some evidence from Aboriginal and Torres Strait Islander young people (Larkins, et al., 2007).

Women in less stable relationships, those having sex infrequently, and women who have recently had non-voluntary sex for the first time are more likely to have a high risk contraceptive pattern (Glei, 1999). For some young women, the desire to establish a relationship based on trust, and an age-appropriate belief in lack of vulnerability to pregnancy and sexually transmitted infections, may inhibit safer sexual practices (Lear, 1995; Milne-Home, Power, & Dennis, 1996).

#### *Termination of pregnancy*

Once a teenage pregnancy is confirmed, options for the adolescent include having a termination of pregnancy or carrying the pregnancy to term, and then either having the baby adopted, raising it herself, or sharing child-care responsibilities with others (usually family members). Formal adoption is now a strategy very uncommonly chosen by teenagers (or older mothers), apart from the process of Torres Strait Islander traditional adoption (Ban, Mam, Elu, Trevallion, & Reid, 1993), so will not be further considered here. Studies have shown that pregnant teenagers who opt for a termination tend to be more educated, from more advantaged backgrounds, from smaller families, and have more educational and vocational aspirations when compared with those who continue with the pregnancy (Dickson, Sporle et al. 2000; Singh and Darroch 2000; van der Klis, Westenberget al. 2002). They are also less likely to have mothers who gave birth as a teenager (Evans, 2001). For many adolescents, especially those from lower socioeconomic backgrounds, termination of pregnancy is seen as a morally unacceptable option (Turner, 2004). Adolescents often tend to delay the confirmation of a pregnancy, thus

eliminating the option of a termination, and there continue to be problems with access to and affordability of termination services, especially for Indigenous adolescents in remote areas (Arabena, 2006).

Evans (2001) studied the outcomes of over 1300 Australian teenage pregnancies and found that young Indigenous women had a much lower likelihood of having a termination (Odds Ratio (OR) 0.2) as did young women whose mother had had a child as a teenager (OR 0.4; Evans, 2001). A UK study found that high teenage birth rates in students from lower socioeconomic backgrounds were not due to differences in sexual behaviour or to the students regarding young motherhood as beneficial, but rather that they were more likely to reject abortion and see fewer negative implications (in terms of aspirations and reactions from others) of becoming a mother young (Turner, 2004).

Cultural beliefs, norms and coming-of-age scripts can influence behaviour around sex, contraception and parenting (Batrouney & Soriano, 2001; Burbank & Chisholm, 1998; Lesko, 2001). For example, a Victorian study amongst Koorie mothers shows that traditional patterns of multiple mothering, providing a network of support for children and mothers in a hostile society, have endured despite the history of assimilation policies (S. Atkinson & Swain, 1999). Similar attitudes persist in other Indigenous Australian populations, and have been demonstrated in the Northern Territory (Kruske, et al., 2006) and Queensland (Minniecon, et al., 2003).

#### *Access to contraception*

Access to contraception involves clear and reliable information, access to appropriate health services and affordable contraceptive methods. In a broad discussion about adolescent sexuality, Brown (2000) discussed the key factors involved in successful adolescent contraceptive use as: confidentiality; effective education; follow-up; methods separated from the act of intercourse; interpersonal negotiation and communication skills; and education of clinicians.

Several UK studies have found that a lack of access to contraceptive advice is not a major issue for pregnant young people (Churchill, et al., 2000). Furthermore, increasing access to family planning clinics over time had no effect on teenage pregnancy rates in the UK (Paton, 2006), leading the author to conclude, rather controversially, that teenage sexual activity is the result of a random decision-making process rather than a rational process.

In Australia, a study of family planning clinics showed that these were well used by young women, especially for emergency contraception and STI screening and counselling. However, it was recognised that these services may not be meeting the needs of young Indigenous women, or those who spoke English as a second language (Mirza, Kovacs, & McDonald, 1998). Studies about access to contraception for young Indigenous people through mainstream general practice are lacking.

#### *Barriers to contraceptive use*

Thus barriers to contraceptive use can be conceptualised on several levels. Firstly inadequate knowledge about contraceptive types and availability, related to poor communication at home, or poor sex education at school (Kippax & Stephenson, 2005). Secondly, lack of access to contraceptive knowledge or methods, or having attitudes not conducive to contraceptive use. Thirdly, developmental factors in the adolescents themselves; concrete thought, present orientation and propensity to risk taking are all age-related and related to adolescent sexual risk taking. In addition, factors pertaining to the relationship, such as attitudes of boyfriends to contraception, unequal power relationships and coercion, and self-esteem and communication issues may all be relevant (K. A. Moore, Nord, & Peterson, 1989; Taylor, 1995). Broader contextual factors in the constitution of sexual practices within a particular locality and time are likely to be important, but understudied, and a history of sexual abuse may reduce contraceptive self-efficacy, and make adolescents more vulnerable to pregnancy and sexually transmitted diseases (L. K. Brown, Lourie, Zlotnick, & Cohn, 2000). There is certainly a need to reconsider the way relationships and sex education is delivered through

Australian schools (Kippax & Stephenson, 2005; Skinner & Hickey, 2003), and this will be discussed further in Section 4.4.

#### ***4.3.5 Issues specific to young fathers***

There is a noticeable gap in the literature around young Indigenous fathers, and earlier programs evaluations and research have tended to ignore the role of Indigenous young fathers (Ball, 2008). This may be an unintended consequence of the worldwide focus (from the United Nations down) on maternal and child health, due to demonstrated outcomes of low cost primary health care interventions in this area. Further work investigating best practice protocols for supporting young men in their relationships with the mothers of their children and children is necessary (Hammond, 2009b).

That said there is wide variation in the wishes of young parents about the involvement of the father in the family, necessitating flexibility on the part of service providers. Service providers at a local level need to be able to determine whether the needs of young men are best met through inclusion in parenting support programs or via specialised services. Co-location of services for young mothers and young men is one way service providers have balanced these needs. Provision of support to young men needs to be determined by service providers on a case by case basis and flexibly delivered in recognition of the high rates of violence and unhealthy relationships reported by young people.

There is a broad need for education and programs for young Indigenous men, including young fathers, to support them in their relationships. Young Indigenous men may lack knowledge and understanding of what it means to be a father and what that role actually necessitates. Programs such as Core of Life are useful in raising awareness in young men in schools about what parenthood involves. Contact with positive male role models, through programs which ensure a sharing of knowledge and understanding of the parenting process, and programs which build self esteem are valuable (Berlyn, Wise, & Soriano, 2009). Jia defines the parenting role as one of nurturing and caring (Jia, 2000). There is clear evidence that traditional



Indigenous cultures involved examples of intimate, caring , involved father roles (Hammond, Fletcher, Lester, & Pascoe, 2008).

With the colonisation process and subsequent discriminatory policies, the reality for many Aboriginal families has been a break down of their communities, their kinship networks and consequently family structures. This has further impacted on the fathers' role within the parenting experience, through a loss of country, loss of culture and loss of identity. Structural inequalities on the macro and micro level have produced situations of consistent and significant systemic violence towards Indigenous Australians (J. Atkinson, 2002). Structural inequalities continue to impact families by causing severe stress and potentially familial dysfunction. Consequently, many Aboriginal fathers have experienced violence at the hands of their own fathers, uncles or grandfathers leading to intergenerational trauma and a lack of positive male role models (J. Atkinson, 2002).

In addition, compounding this are issues of unemployment, and an inability to provide for their family, often resulting in low self esteem. Jia (2000) states 'respect and self esteem are essential ingredients to prevent physical, sexual and emotional abuse' (p.19). Clearly, unemployment is a major barrier to paternal participation as young males who are unable to provide for their families potentially turn to substance abuse as a perceived viable economic option (Schoppe-Sullivan, Brown, Cannon, Mangelsdorf, & Sokolowski, 2008)

Many men's programs aim to rebuild positive role models and to encourage family values. This requires building respect for themselves as males and as fathers whilst also reaffirming the importance of spending time with their children (Jia, 2000). The literature reveals there is a need to challenge young Indigenous fathers' negative perception of themselves (Berlyn, et al., 2009) as well as acknowledge the negative stereotypes attached to Aboriginal and Torres Strait Island men with respect to child health and wellbeing (National Rural Health Alliance, 2008, p. 6)

#### **4.4 Innovation and best practice for delivering young parent programs**

There is limited evidence about what constitutes innovation and best practice for delivering young parent support programs for Aboriginal and Torres Strait Islander young parents. As discussed earlier, many programs operate for a short time and are inadequately evaluated.

However, there is a growing evidence base (although still fairly marginal) about what constitutes best practice for delivering care for Aboriginal and Torres Strait Islander women during pregnancies and the postnatal period, and for young parents generally. Some caution is required, as there are considerable differences between different Indigenous communities, and thus we cannot regard Aboriginal and Torres Strait Islander young parents as a homogenous group. In addition, programs and reports tend to focus on either antenatal care programs, or parenting programs, or sexual education but no rigorous reports have arisen from programs with a focus on providing holistic longitudinal care for young Indigenous parents.

Findings in this section are based on an understanding, also cited in previous work that:

- Positive interventions in early years around parenting are likely to provide better outcomes for children in the long term;
- There are many social, cultural and historical factors affecting the ability to parent effectively in some Indigenous communities; and
- Programs for Indigenous families should use a strengths based approach which builds on existing skills and respects Indigenous cultures and values (Secretariat National Aboriginal and Islander Child Care, 2004, p. 12).

This chapter will have two major sections. Firstly, findings from the literature about what constitutes best practice in providing care and parenting support to young Indigenous parents will be discussed, and then case studies illustrating best practice in one area or another will be outlined.

#### ***4.4.3 Findings from the literature***

As described, the literature about good practice in providing support for young Indigenous parents is very limited. This section, therefore, discusses examples of good practice from the grey and white literature under the headings of:

- Indigenous parenting and family-based programs
- maternal and child health care programs
- sexual health services and school-based sex education programs
- evidence from international programs about young parent support
- Australian young parent specific services.

##### *Indigenous parenting and family-based programs*

The Secretariat of National Aboriginal and Islander Child Care produced a comprehensive report entitled *Indigenous Parenting Project* in 2004 (Secretariat National Aboriginal and Islander Child Care, 2004). This report made a number of recommendations about how programs and services should be delivered, but throughout the report and the consultations informing it, services for Indigenous young parents and young people were acknowledged as gaps and limitations.

The central recommendations about parenting programs from this report include the need for a framework linked to funding and including guidelines and benchmarks for culturally appropriate practices for mainstream and Indigenous program providers (Secretariat National Aboriginal and Islander Child Care, 2004). Other recommendations around parenting programs for Indigenous families included the following.

- Programs need to acknowledge broad family responsibility for child rearing and flexibility to address the extended family's needs in relation to child raising
- Groups should be facilitated by known local Indigenous community member
- Programs should be informal, flexible, holistic, long term and culturally appropriate

- Programs need to cover life course of children, from before birth to adolescence
- Approach should strengthen parenting and cultural knowledge and use group problem solving approach
- Evaluations should be strengths based and be meaningful, manageable and acceptable to community and funders
- SNAICC and relevant Government departments should develop a range of evaluation tools and evaluation outcomes should be made publicly available
- Providers should be assisted with evaluation processes at the time of first submitting funding applications
- Existing services used by Indigenous parents should be prioritised as sites for programs
- Multi-faceted approaches to parent support and skills enhancement are best practice

(Secretariat National Aboriginal and Islander Child Care, 2004).

This report also made some recommendations about resources, suggesting that they need to be locally relevant. This involves using local Indigenous people and local scenes in their selection and production. Resources should also be highly visual and useful in facilitating group work, (for example posters in preference to brochures). Resources should use 'family stories' and promote local and cultural knowledge about parenting practices. Resources should be centrally collated and promoted from a clearinghouse to enable other services to have access (Secretariat National Aboriginal and Islander Child Care, 2004). In response to this the SNAICC Resource Service was set up in 2006 as a clearinghouse for Indigenous parenting resources (<http://srs.snaicc.asn.au/resourcing/>).

The need for parenting support programs to operate on a strengths-based approach is echoed by Jewell and Blackmore (2004), in their manual of facilitating parenting programs with diverse groups of parents. The location of services for parenting programs is also very important, with various reports

commenting on the importance of so-called “soft-entry points”, so locating services and programs at locations already frequented by Indigenous parents, such as playgroups, health centres or other services (Secretariat National Aboriginal and Islander Child Care, 2004; Soriano, Clark, & Wise, 2008).

Home visiting is another strategy that is frequently used in programs aimed at supporting young Indigenous parents (Office for Aboriginal and Torres Strait Islander Health, 2009; Slowinski, 2001), and will be discussed later in the maternal and child health section. Home visiting has advantages around appointments actually happening, solves transport issues and can be informal. However, it also has challenges around privacy, and a potential to reduce young women’s control over their interaction with professional support (Middleton, 2009).

Services aimed at young children are also important, and one program that has been enjoying some success in Western Australia is the Jalaris ‘Kids Futures Club’ and the Health Outreach Service, Western Australia, auspiced by the local Jalaris Aboriginal Corporation (Australian Medical Association, 2008). Jalaris adopts a holistic and child-centred approach to health and well-being based on early intervention and the health education of families, including awareness of nutrition and preventable illnesses. These services provide after-school health and cultural activities for Aboriginal children at risk of truanting (involving semi-structured literacy and numeracy support activities), and outreach health support and information to families of children involved in the program, including a nutrition project and the Building Stronger Families project. Evaluation indicates that the Jalaris programs have promoted positive changes in health and increased interactions with mainstream health services by children and their families. The rate of engagement in the Kids Futures Club is increasing, and it is anticipated there will be a 30% increase in educational engagement by participants (Australian Medical Association, 2008).

The Family Wellbeing initiative is a social and emotional wellbeing and empowerment program that addresses the physical, mental, emotional and spiritual issues that impact on an individual's wellbeing, family unity, and community harmony (Australian Indigenous Health Infonet, 2009). Stage 1 of the four-stage program was piloted and evaluated in North Queensland and confirmed earlier findings regarding the Family Wellbeing Program's potential to engage and equip people with greater analytical and problem solving skills and abilities (Travers, Gibson, Tsey, Bombie, & Mclvor, 2004). The program has since been successful in obtaining research funding over a number of years, and is involved in ongoing work evaluating and assessing its long term outcomes and impacts. This program is underpinned by joint philosophies: recognition of the impact of past government policies and the denial of basic human rights and needs to generations of Indigenous people and their communities; and a strengths-based perspective recognising the experiences of many Indigenous peoples (Tsey, Travers, et al., 2005; Tsey, Whiteside, et al., 2005; Tsey, et al., 2009). Related initiatives that have been particularly successful in empowering men in North Queensland communities involve participatory men's groups, originally set up as suicide prevention initiatives (Tsey, et al., 2003), and the work has been recently extended to have a special focus on young people.

Another program designed and implemented by Indigenous people and taking a broad view of improving the health of particular groups through understanding of the past and a healing process is the Red Dust Healing Program (Ross & Powell, 2008). This project has been successfully implemented in New South Wales, showing particular success with Indigenous young people, and is now being explored as a healing program for use on Palm Island, amongst other places.

#### *Indigenous maternal and child health programs*

As mentioned earlier, the area of best practice in providing maternal and child health programs for Indigenous women has the strongest evidence base to support it. In terms of maternal and child health care programs designed to

cater for Indigenous women, some of the key features important for best practice include:

- Services designed, staffed, operated and managed by Indigenous women
- Flexible appointment systems
- Continuity of care
- Free transport and childcare
- Aboriginal health workers as key service providers
- Women only clinic days/spaces
- Holistic care provision (whole person care, and care of children, family and community)
- Outreach and home visiting services
- Strong links with Aboriginal and Torres Strait Islander community members (Eades, 2004; Herceg, 2005).

In addition, some reports stress the importance of a role in advocacy and policy development for these services (Australian Indigenous Doctors' Association, 2008; Hunt, 2006).

There have been several successful Indigenous women's health programs that are widely reported in reviews and evaluations in this area. They are described briefly in this section, however have not been selected as in depth case studies as they are well known already in the field, and their current level of functioning is questionable.

The Townsville Aboriginal and Islander Health Services Mums and Babies Program was set up as a collaboration between the health service, Queensland Health (Community Child Health and Townsville Hospital midwives and obstetricians), and the Aboriginal and Torres Strait Islander Health Program, in response to poor antenatal attendance figures and outcomes. Over a period of 5 or 6 years, the Mums and Babies program was able to demonstrate high patient satisfaction, much improved antenatal attendance rates and process indicators of best practice antenatal care, and significant improvements in perinatal mortality prematurity (K. S. Panaretto, et al., 2005a; K. S. Panaretto, et al., 2007). For example, when comparing 456

women who attended TAIHS Mums and Babies for antenatal care between 2000 and 2003 with historical controls, the median number of antenatal visits per pregnancy increased significantly from 3 to 7, there were significant improvements in quality of care measures, and a significant reduction in preterm births (8.7% vs 14.3%;  $p < 0.01$ ; Panaretto, et al., 2005). A continuation of this study to 2005 demonstrated a significant reduction in perinatal mortality (14 vs 60 per 1000;  $p = 0.014$ ; Panaretto, et al., 2007).

Factors important to the success of this program were identified as:

- Location at an ACCHS but separated from other clinic services
- Integration of services by different providers with AHW led team approach
- Pregnancy register (monthly recalls)
- Daily walk-in clinics
- Family orientation (playground, educational toys, weekly playgroup)
- Care plans emphasising essential elements of care
- Transport service
- Brief intervention for risk factors

(Panaretto, et al., 2005).

Many of these factors had been identified in an earlier systematic review of Aboriginal-specific programs relating to the care of pregnant women and young children (Herceg, 2005).

Other well-known successful programs include the Strong Women, Strong Babies, Strong Culture program in the Northern Territory, the Daruk AMS antenatal program, and the Alukura Women's Business service of the Central Australian Aboriginal Congress (Appendix 5). The Strong Women, Strong Babies, Strong Culture Program, established in 1992, involves Aboriginal women in three pilot communities working with pregnant women in a program that emphasises both western medicine and traditional practices. An evaluation identified significant increases in mean birth weight, reduction in low birth weight (LBW), from 15 per cent to 11 per cent in original intervention group, and an increase in antenatal clinic attendances (D'Espaignet, Measey,



Carnegie, & Mackerras, 2003). This outcome was more pronounced among young mothers, women having their first baby and older multiparous women.

Congress Alukura is another successful Aboriginal womens' health and birthing service located in Alice Springs, Northern Territory. Services are run through a midwife-led maternity service and women's health clinic. The program was developed in 1984 through a process of community consultation and was guided by the Grandmother's Law (Carter, Lumley, Wilson, & Bell, 2004). Interventions and services provided include antenatal and postnatal care, gynaecological services, adult and youth health education, transportation, health worker training, bush mobile clinic, visiting specialists, home visiting and hospital/specialist liaison. The program also provides a comprehensive breastfeeding and nutrition intervention. Another unique feature of the program is the availability of a culturally-appropriate women's only space that has been used to identify other undiagnosed health problems. A 2003 evaluation of this program identified an increase in antenatal clinic visits increased by 42 per cent (2,130 in 1995-96 to 3,016 in 1997-98) and an increase of 100g in mean birth weights of babies born to urban Aboriginal mothers. In addition, the proportion of women having a first trimester antenatal visit increased from 23 per cent (1986-88) to 33 per cent (1993-95; Carter, et al., 2004).

Quinlivan (2003) has demonstrated that intensive home visiting may be an effective way of optimising social support and parenting information for young mothers in general. A program called Nurse-Family Partnerships has demonstrated considerable success in working with young mothers in North America (Olds, Sadler, & Kitzman, 2007). As a result, as part of the Stronger Families strategy, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) is sponsoring a trial of the Australian Nurse Family Partnerships in providing support through intensive home-visiting and case management with first-time Aboriginal mothers. This trial is currently underway in Cairns (Wuchopperen Health Service), Central Australian Aboriginal Congress and Victorian Aboriginal Health Service, however no evaluation results are

available to date (Office for Aboriginal and Torres Strait Islander Health, 2009).

Many Aboriginal women, despite attending the majority of their antenatal care in their community are forced to leave home at 36 or 37 weeks gestation, to stay “in town” and deliver in a larger regional hospital. Diverse groups of Aboriginal women have expressed negative views about public hospital care for delivery, sometimes finding both staff and institutions hostile (Kruske, et al., 2006; Minniecon, et al., 2003). In addition, there is a major disruption to the family in this temporary dislocation, and a major cultural burden for some women in babies being born “off-country” (Hunt, 2007). All of these factors need to be considered by those planning, implementing and evaluating antenatal and postnatal care services with Indigenous communities.

#### *Sexual health services and school sex education programs*

One of the earliest and most effective sexual health programs was the Nganampa Health Council’s STI and blood borne viruses (BBV) screening program (Huang, Depraetere, Scales, & Hateley, 2006). This program maintains data on testing, treatment and contact tracing of STIs including chlamydia, gonorrhoea, syphilis, HIV and trichomonas for all the communities on the Anangu Pitjantjatjara lands in remote northern SA. This provides the basis for evaluating the effectiveness of interventions, and of case management of STIs. Free condom distribution has, over many years, been facilitated through condom after-hours dispensers located in both large and smaller communities across the APY Lands. Provision of appropriate equipment to prevent blood-borne virus transmission occurs in the ceremonial season through Anangu Ceremonial Workers as part of the Safe Ceremonies Strategy (Nganampa Health Council, 2008).

The Women’s Health and Male Health Programs co-ordinate an increasing number of sessions of school-based health education on the APY Lands with a strong focus on age-appropriate sexual health education. Through these programs the Port Augusta educational prison visits also continue, as well as education delivered to girls attending Wiltja Residential College in Adelaide

(Nganampa Health Council, 2008). Queensland Aboriginal and Islander Health Council also employs a central STI/BBV resource officer. His role is to support male and female Indigenous Sexual Health Workers at various ACCHS settings to provide sexual health services, surveillance and treatment (Queensland Aboriginal and Islander Health Council, 2008).

Another innovative sexual health education program aimed at Indigenous young people is the Mooditj (“solid”) program, developed by the Family Planning Association of Western Australia (FPWA) in consultation with more than 200 community members from all over WA. Delivered over ten sessions, Mooditj uses art, puppets, role-plays and informal discussions to explore a wide range of 'sensitive' topics, from self-identity, emotions and positive relationships through to sexual issues and rights, through fun activities that get the young people laughing and talking. It has been piloted in 10 rural and metropolitan communities, involving over 150 young people, with considerable success. Training local community members as facilitators is an important factor in the program's success and builds local community capacity (Australians for Native Title and Reconciliation (ANTaR), 2008).

The Core of Life Program is a midwife-led education program, designed to provide realistic information about pregnancy, birthing and parenting to adolescents aged 14 to 17 through schools or other venues (Core of Life, 2004; Core Of Life Organisation, 2009). It is designed to build confidence and community strength, together with realistic attitudes. This program has been very widely adopted, and more recently adapted for use with Indigenous young people in schools and other settings. To date it has been delivered to 35,000 Indigenous young people (Patrick & Smith, 2007), although rigorous evaluation and outcome data is not yet available.

Overall, the important key features appear to be cultural sensitivity and discretion, separate men's and women's health services (facilitated by a preferably Indigenous service provider of the same sex), integration of sexual health services in a broader raft of men's and women's services, and good treatment protocols, recall systems and partner contact and treatment

systems. Opportunistic sexual health screening must be offered where possible, along with targeted health promotion and education programs directed at high risk groups in the community.

*Evidence from the international literature about programs to support young parents*

Many programs from both the USA and the UK have had pregnancy prevention in teenage women as their primary focus. Randomised control trials of these interventions have largely been disappointing (DiCenso, Guyatt, Willan, & Griffith, 2002), apart from some effectiveness of very comprehensive programs to promote school engagement and social capital in the USA (Kirby, 2002). More recently, a systematic literature review from the UK combining controlled trials and qualitative studies has concluded that comprehensive early childhood interventions and youth development programs may have some effect on reducing unintended teenage pregnancies (Harden, Brunton, Fletcher, & Oakley, 2009). However, these authors also caution that these programs should exist as alongside (not instead of) comprehensive sex education programs for young people and support for young parents.

Issues of lack of comprehensive support for very young parents have also been identified from Canada and the UK, and similar recommendations about ways to engage with and support young people have been made (Middleton, 2009). In particular, as in Australia, pregnant women in rural Canada often have to relocate away from friends and family to give birth, and programs allowing women with low-risk pregnancies to stay and access culturally appropriate antenatal services in their home settings have shown promising results (Middleton, 2009). This is particularly pertinent given the importance of connection to land and country for the health of Indigenous peoples in Australia (Ganesharajah, 2009) and internationally (Mowbray, 2007). In developing countries worldwide, there is recognition that comprehensive but low cost primary health care interventions have the capacity to improve the health of all mothers and their infants and children, including adolescent mothers (Ekman, Pathmanathan, & Liljestrand, 2008).

Canada in particular is providing leadership in strengths-based programs to support “at-risk” Canadian Aboriginal youth, often with very promising results in the areas of educational engagement and progress, employment and general health and wellbeing (McCluskey, O'Hagan, Baker, & Richard, 2000). Projects for young Indigenous Canadian parents that incorporate cultural strengths building activities have demonstrated a stronger cultural identity, and stronger global self-worth as a result of the program (Bent, et al., 2004). Linked programs include the Resources for Adolescent Parents (RAP) programs run by the non-governmental organization New Directions in Canada. These programs attempt to support parents under 18 by linking them into educational and vocational pathways and increasing self-worth and self-esteem. Again, they credit much of their success to the Indigenous cultural strengths component of their programs (Bent, et al., 2004).

#### *Australian young parent specific services*

Many small, short timeframe programs are operating in the field of supporting young parents (especially young mothers) in Australia. There is a dearth of programs with a focus on providing support and links to other services for young fathers (Indigenous or otherwise). Two of the largest and most well-known of the programs designed to support young parents are Talking Realities and Shine SA (SHine SA, 2007a). Talking Realities (Johns & Lawless, 2009; Kovatseff & Power, 2005) is an Australian program developed in South Australia providing peer education and support and links to vocational education pathways in conjunction with a raft of other services. Attempts to initiate this program in other locations have demonstrated the importance of a ground-up approach and local networks in the success of programs. This will be discussed further as a case study in the following section. The SHine SA project aimed to improve the educational, social and physical health and wellbeing outcomes for teenage mothers and their infants through increasing school retention and social inclusion. The project had six distinctive aims: 1. research 2. identifying inter-agency pathways 3. documenting curriculum pathway options 4. developing a resource for pregnant teenagers 5. developing a resource for agencies 6. developing a whole of school package (SHine SA, 2007a). Most of these aims were

achieved, although again evidence of better outcomes for young women is lacking.

Another important group of services to support young parents that have demonstrated some success and generated publicity in Australia include services based in schools, and having a primary focus on keeping young parents engaged with education and vocational pathways (Boulden, 2001). These are reviewed in publications by the Association of Women Educators, and case studies of best practice are highlighted. The common factors in best practice appear to be: flexibility in the way educational and support services are delivered; availability of childcare; and committed program staff with an element of continuity, providing pastoral and educational support and linking young parents in to other services. Well known successful examples of these programs highlighted in the report are those operating out of Plumpton High School in Sydney, Para West Adult Re-entry College in Adelaide and the Brisbane School of Distance Education (Boulden, 2001). In Queensland, the Edmund Rice Flexi-learning Centres aim to connect disadvantaged young people back into formal education, through flexible learning programs, a strengths-based approach to the individual, and building social connectedness. There is a network of five of these flexi-learning centres in Queensland, each with a base campus and various outreach locations. A considerable proportion of their clientele are young parents (Edmund Rice Education Australia, 2009).

Overall, there seems to be some consensus that best practice in this area seems to involve fulfilling five key functions:

- Expand service provision for young parents
- Connect young parents with local services
- Strengthen the parenting skills of young parents
- Develop social networks for young parents
- Link young parents into further education

(Young, Taylor, & Clarke, 2009).

#### **4.4.2 Best practice case studies.**

Many programs were identified operating in the area of supporting young Aboriginal and Torres Strait Islander parents, or young parents more generally, and the best of these have been tabulated in Appendix 7.5.

The process of selecting a number of these to be used as case studies was somewhat eclectic, but was based on an assessment of what material was available in the public domain about the program and recommendations by Indigenous Reference group members, supplemented by an initial informal telephone contact or email with a key service provider.

Programs were loosely evaluated against six assessment criteria that have been developed by the Australian Institute of Family Studies National Evaluation Consortium as part of their assessment of “Promising Practice Profiles” for supporting disadvantaged families (Soriano, et al., 2008).

To be included as a case study we needed to feel satisfied that the program:

- is effective;
- draws on the evidence base;
- contributes to the existing evidence base;
- is replicable;
- is innovative; and
- is sustainable

(Soriano, et al., 2008, p. 8).

In practice, the most difficult of these was the third criteria of contributing to the existing evidence base, as several of the programs had not been instigated with evaluation in mind, and had not been formally evaluated. Despite this, many program providers were happy to share information about operational aspects of their program.

A word of caution, pertinent to this review, is clearly articulated by Scougall (2008) in his review of effectiveness of programs strengthening Indigenous

families. Scougall stresses that best practice and outcomes data about strengthening Indigenous families and communities is scarce, few programs have run long enough for reliable outcome data, and that contextual differences mean that strategies that work well in one setting may not be transferable to another (Scougall, 2008).

A number of potential case study programs were identified, yet were not included as case studies due to lack of formal permission from local governance organisations (such as Boards of Management) within the time frames of the project or where published evaluations were not available.

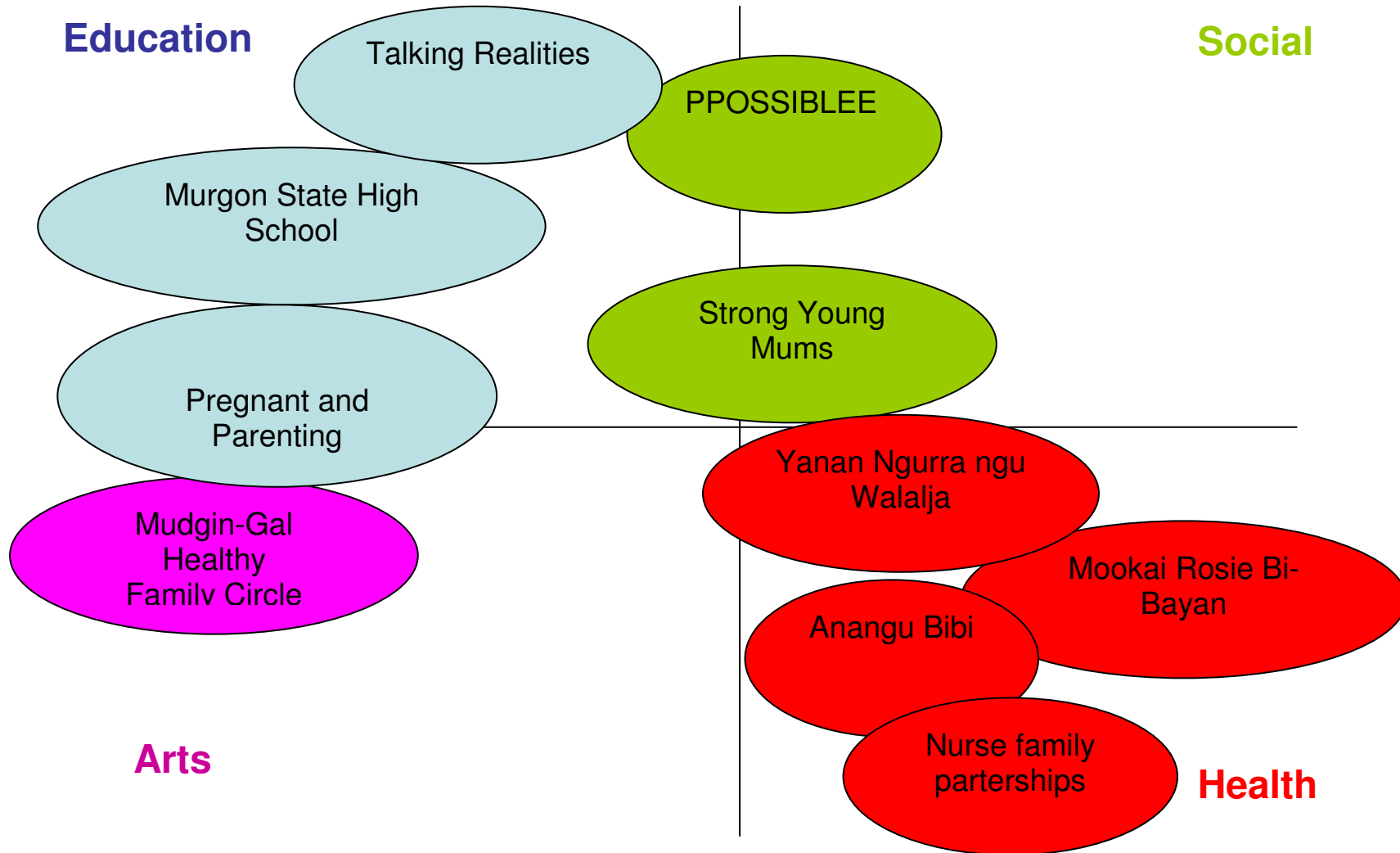
All programs are designed to support young parents (although not all of them focus especially on Indigenous young parents), with each having their own strengths and weaknesses, and many operating over a range of domains. However, for the purposes of this discussion; the programs have been split into the areas of major focus. We have divided the programs into those primarily focused on linking young parents back into education systems, those with a social basis, those delivered through primary health care systems and those with an arts focus. Programs targeting young people likely to become parents at a young age are discussed in the following section covering strategies for engagement with disadvantaged young people.



**Table 3 Programs selected as final case studies**

<b>Title of Program</b>	<b>Location</b>	<b>Funded by</b>	<b>Focus of service</b>
<b>Strong Young Mums</b>	Centacare Wilcannia-Forbes, Bourke, NSW	Communities for Children: Local Answers. Relies on 20% from other sources	Education and Social
<b>Talking Realities - Young Parenting Program</b>	North Adelaide, South Australia	Different government depts. - Multiple source funding	Education – disadvantaged young parents
<b>Yanan Ngurra ngu Walalja - Curtin Community Mothers Program</b>	Halls Creek, Western Australia	Collaboration KAMSC and WADoH	Education and Health – Indigenous mothers
<b>Mookai Rosie Bi-Bayan</b>	Cairns, North Queensland	Department of Health and Ageing	Young Mums and children -Health – Indigenous women and children from Cape and Gulf communities
<b>Mudgin-Gal Healthy Family Circle</b>	Redfern Sydney, New South Wales	State and Federal funding	Education and Arts
<b>Anangu Bibi</b>	Whyalla, South Australia	State Government	Health
<b>Murgon State High School – Young Mothers Program</b>	Wide Bay Area, Queensland	DETA	Young mothers (students) Education
<b>PPOSSIBLEE Project – Queensland Youth Services</b>	Townsville, North Queensland	Communities for Children: Local Answers	Education and Social
<b>Pregnant and Parenting Students Program – Moreton Region</b>	Moreton Region, Queensland	Education Queensland	Young mums and dads(students) - Education

Figure 1 Main focus areas of case studies



## **Strong Young Mums**

### **Centacare Wilcannia-Forbes, Bourke, NSW**

The Strong Young Mums program was developed by Centacare Director Margaret Flynn who identified a large number of teenage mothers who had dropped out of school. Centacare works holistically with young families. This program is designed to work with young mothers who are disengaged from education. A crucial component of the Strong Young Mums program is assisting young women in their relationships with other services providers, acting as “the glue that holds everything together” in an intensive case management approach. The program has had significant input from Indigenous organisations, including the Aboriginal Medical Service and Aboriginal Preschool and Family Support. The Bourke Aboriginal Working Party (a multi sectoral group) has also endorsed this program.

#### **Aims**

- To re-engage and support young mothers in education
- To help young women participate confidently in community activities
- To assist young women access existing services and networks
- Assist young women to gain parenting skills and knowledge about child development needs, and to identify what quality of life means for them
- To establish social support networks
- Improve health practices and take action against violence in relationships
- To promote and support Aboriginal culture

#### **Innovation**

- Provides an over-arching intensive support to young mothers
- Provides an integrated, no-wrong-door interface for young women and their community

- Co-location of programs, which provides many advantages for young women

### **Good practice**

- Education is a key component of Strong Young Mums
- Works with an average of 20 – 25 young women per year
- Assist young women in their multiple relationships with other services providers – acting as “the glue that holds everything together”
- Programs based on the key practice of establishing trust
- Relationships are developed, nurtured and valued at all levels, between young mums, between workers and mums, and between services providers
- A supportive organisational culture - relationships are cared for through formal structures (for example interagency meetings) and informal networking
- Indigenous cultural safety is fundamental to practice
- Inclusive practice - Young women are continually included in decision making around the program
- Strong Young Mums provide a number of activities which are family based and involve young fathers
- Good ties with other members of community
- The program has resulted in a high level of participants re-engaging with education and learning
- All young women reported they spent more quality time with their children and had gained confidence as parents
- All young women reported the program had connected them to other services, including health services
- Centacare employs a male Aboriginal Family Health worker to deliver early intervention strategies with young men under a different program – co-location of services

## **Supports**

- All activities are organised by two support workers (one Aboriginal, one Non-Indigenous) who provide continuous intensive support
- Staff are organisationally well supported and attend professional development and training out of the agency to facilitate strong peer and professional networks

## **Engagement practices**

- Women are informally approached by the workers and invited to join Strong Young Mums, or introduced by peers
- Intensive support
- Home visits – weekly visits to brief women on the activities in the coming week and to organise any arrangements for childcare or TAFE attendance
- Casual social groups with a recreational or art focus. Art is used as a key engagement tool.
- Invite guest speakers from other services to come to talk to the young women
- Accompany the women when first accessing these services
- A fortnightly supported playgroup is run with transport provided
- Transport is provided to all Strong Young Mums activities, including to TAFE. Transport ensures that appointments can be met and raises the importance of the event
- Short intensive training courses enable completion when young women are highly mobile

## **Barriers/Challenges**

- Insecure and limited funding
- Meeting reporting requirements for funding is time intensive and can take between four and eight weeks of full time work per annum
- High mobility of young women

## **Funding**

- Funded under Communities for Children: Local Answers - short term funding and requires programs to be self sufficient after three years
- 20% of funding from other sources: Mary Ward International Australia and the Loreto Toorak Past Pupils Association

## **Evaluation**

This program has been internally evaluated. Funding has been received for formal evaluation but this has not occurred yet.

(Aboriginal and Torres Strait Islander Social Justice Commissioner, 2009; Australian Institute of Family Studies, 2009a; Soriano, et al., 2008)

## **Talking Realities**

### **North Adelaide, South Australia**

Talking Realities was developed in Adelaide and has since been licensed and adopted (in various forms) in six other locations in South Australia, Western Australia, Victoria and Queensland. The program was originally designed as a peer educational tool. Talking Realities is a multi-levelled, holistic program providing parenting support, educational and vocational pathways in response to the needs of the young mother peer educators.

### **Aims**

- To improve social, health and education outcomes of young mothers and their children.
- To increase capacity of young people in high school and at youth services to make informed choices around young parenting

### **Innovation**

- Development of strong service provider networks has been a key to this program

### **Good practice**

- High level community ownership
- Client centred, client led, holistic program based on mutual respect
- Priorities are identified in response to the needs of the young women taking part
- Long term staff commitment
- Services and resources are developed within funding constraints
- Talking Realities has produced an educational DVD about teen fathers' perspectives: "What's Life Like Now? Young Dads Share their Experiences"

- Talking Realities has developed ten workshops on ‘Safe and Happy Relationships’ in response to young women’s concerns about domestic violence and safety within their relationships and families
- Key staff members have driven the process

### **Engagement practices**

- Offers multiple entry points for engagement; referral, playgroup, workshops and fun group. Informal group settings (drop in, Baby & Mother clubs) are promoted, rather than ‘advice centres’.
- In Adelaide, the support playgroup ‘Little Engines’ is now co-located with the Parks Children Centre which provides services such as allied health and child care. This has been beneficial in building relationships between the young women and service providers.
- Transport, childcare and intensive support have been important to the success of the program
- Advocacy, peer support and mentoring have been important to retain young women in school

### **Barriers/Challenges**

- Evaluations have shown that when staffing is not stable or team-based there has been difficulty in recruiting and supporting young women
- Funding is a key barrier, and may limit sustainability of the program
- Can be difficult to source education service providers: to link with secondary schools and other Registered Training Organisations to deliver flexible education
- Important that organisations who implement the program have strong community networks and access to the young mothers
- Experiences in replicating the program in new locations prove that the program does not work if it is not embedded in the community
- Teacher attitude plays a large part in young women’s decisions around continuing education



## **Recommendations**

- The inclusion of Aboriginal parenting practices within the Program's Early Child Development model is recommended as an area for development
- The recruitment of Aboriginal peer educators is seen as important to engage other young Aboriginal women
- Aboriginal specific activities would develop in line with the client led, client focussed value of the program
- Relationship building and collaborative practice frameworks are integral to the program; the implementation in new locations takes time and resources to develop credibility

## **Funding**

Funding is provided by different government departments and organisations. It is estimated \$240,000 is required per site, per year to run all components of Talking Realities and to support 40 – 50 young families (Johns & Lawless, 2009).

## **Evaluation**

The program has been evaluated extensively.

(Australian Institute of Family Studies, 2009b; Johns & Lawless, 2009; Jolley & Masters, 2004; Kovatseff & Power, 2005; Montague, 2008; Parks Primary Health Care Service, 2009)

## **Yanan Ngurra ngu Walalja - Community Mothers' Program**

### **Halls Creek, WA**

Yanan Ngurra ngu Walalja is based on the Community Mothers' Program and is an early parenting support program. Yanan Ngurra ngu Walalja incorporates a developmental health focus to address factors in the early years which potentially impact on a child's health and well being. The program is a "comprehensive home visiting strategy with a focus on the family's child rearing environment in holistic terms" (Tammy. Wayne-Elliot, 2009). The program originated with an invitation from the older mothers within the community, and this local ownership enables the older women to provide emotional support for young families. The program is delivered through collaboration between the Western Australian Department of Health and Curtin University.

### **Aims**

- To foster empowerment through support and encouragement to take positive control over their own lives and those of their children
- To foster the strengthening of community partnerships and development within local communities
- To encourage peer support and links with parental expertise from within the community
- To focus on enhancing the confidence of young parents

### **Innovation**

- The program involves home visits with young Indigenous parents

### **Good practice**

- Ailsa Munns is the coordinator of the program. There are four other trainers who are Community Health nurses with Child and Adolescent Community Health.

- The Central Project Officer is an Aboriginal Health Worker who chose six workers from the community specifically by language groups
- The Central Project Officer is fully supported by Halls Creek Community Health Services. She has extensive involvement with the community, health and social projects and domestic violence
- Program consists of six Community Care Workers altogether, including two men
- Success of the program lies in the initiative of building from a base of language and culture
- Community Care Workers match language group
- Build self esteem and assist in empowering young parents to find their own parenting solutions
- Highlight strengths each parent has to offer

### **Supports**

- The Community Care Workers participate in face to face training and regular video conferencing with the Coordinator
- The Coordinator (Ailsa Munns) flies to Halls Creek for education and training sessions for support workers. This is done on a regular basis – visits last five days (including travel)

### **Engagement practices**

- Soft entry points - proactive interview, community kept informed, information to schools, talks about culture and law.
- Within the team women target women, for informal talking
- Aim to engage fathers in culturally appropriate activities where men's roles in parenting can be explored
- Cultural trips to bush to fish, build relationships, target men talking to men, to help build strong families

### **Barriers/Challenges**

Funding is needed to make it sustainable.

## **Recommendations from program staff**

- The support is requested by the local people
- The model is adapted to suit local needs
- The model is developed in partnership between the supporting agency and the local people
- Local people take the lead so they assume ownership of the program from the beginning
- Local people working in the program are respected for their cultural lore and language
- Local people working in the program have (or are trained in) the skills of active listening, empathy, ability to work in partnership with the client families and confidentiality

## **Funding**

- Originated from Commonwealth funded Australian Better Health Initiative
- The ABHI funding was sourced from the DOHA Office of Aboriginal Affairs then to the Kimberley Aboriginal Medical Service Council

## **Evaluation**

External evaluation of this program by the Telethon Institute for Child Health Research is due to be completed in 2010. It is anticipated that will shortly be self sustaining by the local Community Care Workers.

## **Mookai Rosie Bi-Bayan**

### **Cairns, North Queensland**

Mookai Rosie Bi-Bayan provides accommodation and support services for Aboriginal and Torres Strait Islander women who are travelling from Cape York for medical treatment in Cairns. The majority of women who stay at Mookai Rosie are pregnant women awaiting the birth of their babies. The organisation started in 1983 when Mrs Rose Richards, an Aboriginal Welfare Officer at Cairns Base Hospital recognised the need to support women and children travelling for medical reasons.

There are no birthing facilities in Remote Cape York and Western Queensland so pregnant women must come to Cairns around four to six weeks before the birth of their baby (Mookai Rosie Bi-Bayan, 2009). Mookai Rosie Bi-Bayan is able to have a major and critical influence on the health of Aboriginal and Torres Strait Islander people through providing pre and postnatal care and support, nutrition education and parenting education and support. It is a residential service, and currently has accommodation for twelve women and their children. The Board of Management and committed staff strive to provide a place of care for Aboriginal and Torres Strait Islander women and children.

### **Aims**

To provide a culturally sensitive service that helps to improve the health status and well-being of Aboriginal and Torres Strait Islander people, particularly that of women and children.

### **Innovation**

- All meals and transportation to and from medical appointments and leisure activities is provided
- A staff member is on duty twenty-four hours a day and available for emergencies at all times
- Accepts clients referred by Community Clinics in conjunction with RFDS

- Clients can stay from one night to six weeks
- Staff give assistance about mothercraft, nutrition, health education, welfare issues and minor ailments
- Playgroup support
- A safe and comfortable home-away-from-home is offered to all mothers and children who choose to come and stay at Mookai Rosie

### **Good practice**

- Indigenous community-controlled organisation
- Specialises in Maternal and Child Health Care and has provided services to the Far North Queensland region for almost 25 years
- Long term commitment of the Board of Directors and staff
- Health Worker and Education Promotion Officer provide individualised support and information on maternal health services
- Modification of Information and education resources are made to ensure clients can easily learn in a relaxed and comfortable environment to suit Indigenous clients from Cape York and Gulf areas
- Staff are supported in providing information to clients and further support is available from other organisations and networks
- Staff and clients are supported to access the most up to date health information

### **Support**

- Staff are provided with education and training sessions for new programs and on health related subjects
- Service is promoted to other services providers to facilitate information sharing and partnerships to improve client outcomes

### **Barriers/Challenges**

Funding for additional Health Worker positions would enable the provision of further resources

## **Funding**

- Australian Government Department of Health and Ageing
- Support from individuals, corporate and philanthropic organisations
- The Hunt Foundation
- The Body Shop

(Mookai Rosie Bi-Bayan, 2009)

## **Mudgin-Gal - Healthy Family Circle**

### **Redfern Sydney, NSW**

Mudgin-Gal is an Aboriginal Women's organisation and operates as a drop-in centre and source of leadership and positive cultural and social networking. Healthy Family Circle has operated out of Mudgin-Gal and was developed in partnership with Relationships Australia, Sydney Children's Services and Connect Redfern.

#### **Aims**

- To provide mothers (including very young mothers) with training in parenting and early childhood development
- To enable these mothers to provide leadership in these areas in their community

#### **Innovation**

- Programs run in a variety of areas: in home support, referral for accommodation, legal, medical, court support and post-release service
- Courses include Training for Employment and Better Parenting

#### **Good practice**

- Young women empowered to assist others in linking into services in the community
- Provide opportunities for younger and older women to act as mentors, and supports this through leadership training, education and networking
- Caters for very young mothers with accessible training in parenting and early childhood development
- Young women are able to promote and model the skills, understanding and positive behaviour they have learnt in their own families and community



- The program has been successful in skilling young women with many going on to employment
- The impact of Healthy Family Circle has been wide reaching with many participants gaining confidence in setting goals and following new opportunities. For example, some participants have progressed to serve on the Board of Management of Mudgin-Gal
- Many participants have developed cultural strengths and have been supported in their desire to learn about their families and family connections
- Young women gain TAFE certification by participating in the Playgroup Facilitators Training Course
- Healthy Family Circle incorporates 'Knitted Together', an art based mentoring project where older and younger women join together to knit with a view to travelling to the Beanie Festival in Alice Springs
- 'Not Just Another Yarn' is a resource to help women deal with childhood sexual abuse and 'Yarning Circle' is a twice yearly event to highlight and destigmatise the problem of sexual abuse.

## **Supports**

Operates on minimum paid staffing and a volunteer network. Relationships Australia works in partnership with Mudgin-Gal in managing funding and in providing some of the training.

## **Engagement practices**

- Mentors recruited through flyers and playgroups and Mudgin-Gal's drop-in centre
- Women often become involved after being introduced to the Healthy Family Circle co-ordinator

## **Barriers/Challenges**

- Meeting reporting requirements has required a significant investment of time and resources
- Reporting has been done through Relationships Australia
- Six-monthly reports can take up to four weeks to produce

- Relationships Australia have worked to find effective ways to collect data, produce reports and keep the needs of Indigenous participants as a central focus
- Relationships Australia consider another key learning for their organisation has been the development of cultural awareness and insight into Indigenous experiences
- Working in partnership requires an investment of significant amounts of time
- Funding is the key barrier

### **Funding**

- Programs run from the Centre are all individually funded by state and federal government
- Current funding for the Healthy Family Circle program will not continue in 2010

### **Evaluation**

The program has not been externally evaluated (Mudgin-Gal Aboriginal Corporation, ND)

## **Regional Birthing Program - Anangu Bibi**

### **Whyalla, South Australia**

Anangu Bibi is available to Aboriginal women of all ages and non-Aboriginal teenage women in Whyalla. It is part of a wider regional birthing program that also operates in Port Augusta and is being expanded to Ceduna and Murray Bridge. The program in each location has its own name, artwork and resources.

The program consists of midwives and Aboriginal Maternal Infant Care (AMIC) workers who visit mothers for health checks and facilitate women's access to mainstream services such as clinics and hospital, providing transport if required. An aim and outcome is to have mainstream services practice in culturally appropriate ways to meet Indigenous women's needs.

#### **Aims**

- To provide holistic primary health care for Aboriginal women
- To provide continuity of care, consideration of physical, spiritual, emotional and social aspects
- To facilitate skills exchange between Aboriginal Health Workers and Midwives

#### **Innovation**

- The program was designed to be Aboriginal led, through the Aboriginal Maternal and Infant Care workers, this philosophical focus has now grown to a partnership and collaboration model
- Aboriginal Women's Advocacy group made up of elders and senior women provides expert advice to the program on cultural issues
- Regional Management Group of key stakeholders and staff meet regularly to build relationships and to develop the direction, co-ordination and sustainability of the program

- Women who do not speak English or have English as a second language are supported and workers advocate for young women in hospital settings where they may not feel confident to approach non-Aboriginal staff
- Transport is provided as needed
- Location specific names, artwork and resources

### **Barriers/Challenges**

- Supporting the Aboriginal Women's Advocacy Group in their contributions in a sustainable way
- Finding ways to ensure Aboriginal Maternal Infant Care Workers can access peer support, for example, working in teams

### **Support**

- Evaluations highlight that AMIC workers need to be adequately supported in terms of hours employed, support given and training and development in order to be most effective. Working in a team (enabling peer support) was also identified as being crucial for AMIC workers in terms of workforce support
- A Workforce Development Officer delivers cross-cultural training to non-Indigenous staff and supports AMIC workers in gaining qualifications in Aboriginal Maternal and Infant Care including the newly developed Certificate 4.

### **Funding**

The Anangu Bibi program was established under the auspices of the South Australian, Northern and Far Western Regional Health Service in 2004.

### **Evaluation**

The program has been externally evaluated, and has resulted in women having more antenatal care visits. In the first fifty births under the program, less than 16% of Aboriginal women had less than seven antenatal visits in comparison to 39% of Aboriginal Women statewide (Stamp, et al., 2006).

## **Murgon State High School – Young Mothers Program**

### **Wide Bay Area, Queensland**

Located in the Education District of Wide Bay, Murgon State High School services the communities of Murgon, Wondai, Cherbourg, Goomeri and Proston. Murgon State High School opened in 1945 and is currently a band 9 school.

#### **Aims**

To enable young women to access education in a flexible way

#### **Innovation**

Emphasis on re-engaging young women with education

#### **Good practice**

- Young Mothers' Program runs over three days
- One day is conducted at Cherbourg and covers nutrition and health checks
- Second day is located at the school and is focussed on coursework for Diploma or Certificate studies. Young women are able to take their babies to this class and it is run separately to the regular school classes.
- Third day enables young women to receive one-on-one support
- Training is delivered through a partnership with the Community Training Centre which enables young women to gain qualifications such as a Diploma or Certificate in Childcare or Hospitality

#### **Supports**

The Co-ordinator position for this program has been undertaken by a number of different people. Having the Coordinator position filled by an Indigenous worker has been highly beneficial.

## **Engagement practices**

Identified need for onsite childcare that increases participation

## **Barriers/Challenges**

- Initially targeted fifteen to seventeen year old women however it has been found that younger mums are not ready to engage in education when babies are still very young
- Older young women at eighteen and nineteen years have been very ready to commit; at this stage their children are a little older and they are more confident to have their children cared for in childcare

## **Funding**

Department of Education and Training

## **PPOSSIBLEE Project – Queensland Youth Services**

### **Townsville, North Queensland**

PPOSSIBLEE (Providing Parents with Opportunities for Support & Self Sufficiency in Building Links to Employment and Education) targets young mothers who are socio-economically disadvantaged, and also supports young people who are homeless, or at risk of homelessness. Queensland Youth Services (QYS) has been operating in Townsville since 1978. QYS auspices a Young Parents Program and a Playgroup (Munchkins) which is delivered through PPOSSIBLEE Project. Forty young people are involved at any given time, currently including three young fathers, and around 125 families per year pass through the program.

#### **Aims**

- To run Munchkins Playgroup
- To support the Young Parents' Group, assist young parents to attend workshops put on by other service providers, and provide referrals to other services
- Case management, assistance with housing, and other needs
- Assistance in accessing TAFE through 'A New Day' at the Townsville Community Centre

#### **Good practice**

- Project workers organise childcare and transport for women to attend TAFE and workshops
- Facilitates informal communication time between women and workers
- Non-judgemental
- Ensures young people know their rights
- Respect for confidentiality (particularly if concerned about Child Safety)
- Involves young women planning process – local ownership/empowerment

- Offers choices within set boundaries on activities and services. This directive and supportive framework provides some necessary structure
- Consultative rather than collaborative focus is considered most effective
- Facilitates peer support
- An Indigenous support worker ensures higher participation by Indigenous mums

### **Supports**

- Organisation embedded within the community and has strong local networks
- Networks are informally cultivated through staff relationships

### **Engagement practices**

- Soft entry point through the Munchkins Playgroup and word of mouth
- Referrals from Government Departments and Service Providers (Child Safety, Queensland Health Young Parents Project, Centacare, Playgroups)
- Food supplied which alleviates financial stress
- Onsite childcare increases participation
- Advantaged young mothers who have support and resources in place also use the service for assistance with education and training
- Potential to include young Indigenous women's sisters, friends, aunts and mothers in activities to encourage mother's participation: "Come on, let's go". Wider inclusion would recognise that the growing up of children belongs with significant others apart from the mother. Inclusion of sisters and others in the program helps to create a culturally safe place for the mother and child and recognises that mainstream programs can be sites of racism and exclusion.



- Transport a key enabler for participation. Staff will collect young parents from their homes and go to neutral places to meet; this is seen as less threatening than home visiting.

### **Barriers/Challenges**

- Funding limitations – Co-ordinators facing limited resources prioritise disadvantaged young women rather than investing on-going support for young women who were doing well or younger fathers.

### **Recommendations**

- High Schools in Townsville to implement support programs for pregnant and parenting students
- Onsite childcare is seen as important
- Support to attend school
- Older young parents supported to access adult learning opportunities
- Timing of groups is important for participation - groups held on Mondays or in the mornings may be poorly attended by Indigenous parents, however funding constraints have limited afternoon groups

### **Funding**

The program has been funded through Local Answers Funding.

### **Evaluation**

The program has not been externally evaluated, however has met significant funding reporting requirements. These requirements have recently been reduced to bi-annually, a very welcome reduction in service resources where reporting takes significant and precious resource time.

## **Pregnant and Parenting Students Program**

### **Moreton Region**

The Pregnant and Parenting Program was established in 2004 and services up to 18 high schools in the Moreton educational area. This program helps young people who are pregnant or have parenting responsibilities to complete their education, and recognises that pregnant and parenting students have a need for security, consistency, inclusion, social recognition and a sense of belonging (Gude & Harper, 2008). In 2008, the Pregnant and Parenting Program won the Queensland University of Technology Showcase Award for Excellence in Leadership.

### **Aims**

- Increase participation rates of pregnant and parenting students in education, training or work
- Support pregnant and parenting students to complete education to senior level/Certificate 2 or successful transition to work, university or TAFE
- Establish whole-of-district support systems to address the needs of students who are pregnant and parenting
- Improve service delivery and support for pregnant and parenting students
- Improve students' parenting skills and their ability to balance family and education
- Promote educational settings that welcome and support pregnant and parenting students

### **Innovation**

- Sustainable program, based on quantitative evaluation
- Provide training in skills for life – 8 week program

## **Good practice**

- Supports up to 40 students (male and female) each year, helping them to plan their education and training
- 15-20 Indigenous students over 5 years who are not reliant on day-care for infants as they have family support
- Links students with agencies providing assistance with accommodation, legal advice and domestic violence issues
- Encourages and supports pregnant or parenting adolescents to remain in an educational setting of their choice to complete their education
- Assists young people who have left school to re-engage in the education system
- The number of students participating in the program has increased by 86 percent since 2003, with an approximately 300-percent increase in participation and retention rates in the schools covered by the program
- Provides a range of flexible pathways and alternatives for learning designed to support the individual needs and achievements of students
- Student's timetable may range from attending school for six hours a week studying Literacy and Numeracy or full-time, depending on the needs and circumstances of the student
- 5-6 young dads – over time have had 30 dads and encourage their involvement
- Link into community resources

## **Supports**

- Government car for transporting students when necessary
- Support of school Principal

## **Engagement practices**

- Access years 10/11/12 – early prevention strategy
- Supportive welcoming environment

- Gatherings led by the Pregnant & Parenting Program District Officers provide referral opportunities and are an ideal way of encouraging and reinforcing student organisational skills and networking opportunities
- Guest speakers for students covering a range of important issues
- Soft entry points – newsletters, media releases, annual mailouts to principals, Guidance Officers, School Based Youth Health Nurses, government and community organisations

### **Barriers/Challenges**

- Transport
- Without support from family students will drop out
- Bullying (tends to occur in the early stages of parenting)
- Once mothers are 'showing' they stay home – often drop out of school
- Need flexible timetables

### **Funding**

- State - Education and Training Reforms for the Future (\$60,000 per year over 3 years)
- Financial support through various non-governmental organisations and community support

**Table 4 Elements of best practice in case study programs**

Elements of best practice	Case Study Title								
	Strong Young Mums	Talking Realities	Yanan Ngurra ngu Walalja	Mookai Rosie Bi-Bayan	Mudjin-Gal Healthy Family Circle	Anangu Bibi	Murgon High Young Mothers Program	PPOSSIBLEE	Pregnant and Parenting Moreton Region
Young mums involved in design	√	√	√		√	√		√	
Holistic integrated services	√	√	√	√	√	√		√	√
Colocation with other services	√	√	√	√	√	√	√		√
Soft-entry points for engagement	√	√	√	√	√	√	√	√	√
Committed Indigenous program staff	√		√	√	√	√	√	√	
Transport provided	√	√	√	√		√	√	√	√
Childcare provided		√					√	√	
Support for young fathers	√	√	√					√	√

#### **4.4 Barriers to effective implementation of support programs**

There is a close relationship between the barriers to effective implementation of support programs for young Indigenous parents, and additional support and resources identified by service providers involved in providing this support. This section of the report summarises the main barriers to effective implementation of programs, and the following section identifies support needs as articulated by service providers (in interviews and previous evaluations). Strategies for minimising the effect of these barriers, and optimising support for service providers are then included in Section 6: Recommendations for policy and practice.

##### ***4.4.1 Programs operating in difficult social environments***

Given the pre-existing disadvantage of many young Indigenous parents, the majority of programs operate in difficult and unsupportive social environments that are not conducive to smooth project implementation. Although clearly resulting from a history of colonisation and dispossession, reports from some programs and service providers highlight the degree to which poor health and difficult social circumstances restrict the capacity to participate and the life choices of many Indigenous families and communities (Larkins, 2007). As Scougall (2008) reports when referring to programs involving young people, sometimes the peer pressure that is so influential in shaping high risk behaviours (such as gang culture, unsafe sexual practices, binge drinking and smoking) tends to overwhelm the best efforts of project staff to change dysfunctional patterns of behaviour through awareness raising.

An additional and related factor is the high level of mobility experienced by young Indigenous parents, both antenatally and postnatally (Larkins, 2007). This often results from housing insecurity, poverty or family violence, but contributes to difficulties in engaging and forming trusting relationships with young parents and providing service continuity. The Strong Young Mums program (case study) provides adaptive short term, intensive training and support opportunities to facilitate completion amongst highly mobile young people in an attempt to try to counter the issue of mobility.

#### ***4.4.2 Funding inadequate in amount or duration***

Many program providers commented that funding was their biggest limitation in terms of providing more comprehensive services for young mothers and fathers. Most programs reported that they needed funding and other support to continue beyond the expiration of their initial seeding fund (usually gained from various community/state government grants), and there was little evidence that many programs had planned for this transition. Limited partnerships had been built between programs supporting Young Indigenous Parents and mainstream business and philanthropic bodies, although where these partnerships existed the programs appeared to be more sustainable (for example, Strong Young Mums and Curtin Community Mothers). Not surprisingly, there was virtually no evidence of self-funding of activities. This is understandable given that there is virtually no private sector in remote regions and most Indigenous communities are impoverished.

Furthermore, program staff request and value external assistance in areas such as project planning, preparing funding applications and budgets, evaluation and building partnerships in the community sector. There are few staff available with the skills and attributes to be effective Young Parent Support Workers who also have high-level project management or grant-writing skills. Some projects also needed intensive after-care during the implementation phase (Scougall, 2008) and may need assistance in developing evaluation plans that will contribute to the evidence base about best practice in this area. The Healthy Family Circle program (case study) delivered by Mudgin-Gal is an example of an Indigenous organisation developing a skill-sharing partnership with a mainstream organisation (Relationships Australia) in order to secure and acquire funding. It is important that programs be rigorously evaluated, but that this does not impact too negatively on service providers in terms of time and resources. Several program staff commented on the time commitment required to meeting reporting requirements for funding, and felt that current funding structures prevent smaller organisations from being competitive in acquiring these funds.

#### **4.4.3 Lack of basic infrastructure**

In some communities, programs are limited by a lack of basic infrastructure, such as appropriate venues to conduct project activities, availability of office accommodation and access to suitable vehicles. These factors can be key contributors to high staff turnover, feelings of burnout and other human resource issues (Scougall, 2008). Furthermore, lack of access to these basic resources will limit program effectiveness, and can often have a negative effect in terms of engagement of young families (Secretariat National Aboriginal and Islander Child Care, 2004).

Factors that were frequently remarked upon in our interviews and case studies included access to suitable transport (appropriate vehicle, with child safety restraints, and organisational approval to transport both young parents and their children). Additionally, a venue that was culturally safe and welcoming that allowed the young mothers to meet socially and have private conversations with program staff was often lacking. The majority of program providers felt that it was important to provide food at young parents' activities, as a social lubricant, and as a nutritional and educational intervention. Almost all of the successful programs presented in this report have taken concrete steps to deal with these practical issues, and identify them as important components of their success.

#### **4.4.4 Issues with attracting and retaining appropriate staff**

Recruiting and retaining quality staff is a critical issue for Indigenous projects, especially in rural and remote areas. Qualities commonly reported as being important for program staff include:

- Personal qualities, particularly being trustworthy, warm, non-judgemental
- Personal background, good links and understanding of local Indigenous community
- Professional background, relevant knowledge of health and child development
- Networks and linkages with other services



(Secretariat National Aboriginal and Islander Child Care, 2004; Soriano, et al., 2008).

One issue that is commonly reported when discussing local Indigenous program workers is that on occasion there may be perceptions of a lack of confidentiality within the community, and that this needs to be actively addressed and countered (Secretariat National Aboriginal and Islander Child Care, 2004).

Anecdotal reports from a number of programs based in mainstream services report a very high turnover of Indigenous program staff, and our interviews with such workers suggest that a sense of social and professional isolation contributes to this high movement. Interview data identified staff support as being crucial to retention (Crawley, 2009). Opportunities to attend professional training away from the workplace are valued because they enable workers to form supportive networks with workers from other organisations and locations who are facing similar challenges. Isolation is key problem for Indigenous workers in mainstream organisations. Service providers identified the importance of providing peer support for Indigenous workers; this was primarily achieved by enabling team work and having more than one Indigenous worker (Crawley, 2009).

#### ***4.4.5 Lack of appropriate local partnerships with community organisations and young parents***

A recurring theme in terms of program effectiveness is the need for linked up services, so that for an individual young parent, services can be provided through a central venue using a case-management approach. Although robust data are lacking, this approach intuitively will lead to effective and efficient outcomes. The corollary of this is that where services are provided in a range of service silos, the possibilities for integrated service delivery are very limited.

For Indigenous organisations, such as Aboriginal and Islander Community Controlled Health Services it may be important to initiate and nurture links with mainstream service providers for example Queensland Health services, early childhood services, and Centrelink services. Strategic links are necessary, but where possible the Indigenous organisation as the safe and acceptable venue should be the linking site for service delivery. Townsville Aboriginal and Islander Health Service (TAIHS) Mums and Babies program provided a very good example of this in operation; (Panaretto, et al., 2005). Programs can also benefit from the support of an auspicing organisation with strengths in the areas of administrative capacity, relevant previous project experience and established links with Indigenous people. Examples of this are seen through the Strong Young Mums and Mudgin-Gal Healthy Family Circle Programs.

Where the administering body is a non-Indigenous body without existing relationships with the Indigenous community, difficulties are likely to be experienced in developing relationships within the limited lifespan of the project. Such organisations need to invest heavily in building trust with participants and with Indigenous community members. Bamblett and Lewisa (2007) refer to the problem of transplantation of mainstream programs (often superficially indigenised) to Indigenous populations. These are unlikely to respond adequately to local community needs or be successful. They argue a better approach is local development of programs based on local needs, with local resources and using cultural strengths as the foundation of the program (Bamblett & Lewisa, 2007). In a similar vein, programs that are extended from a site where they have been successful, to a new site may fail to deliver if they do not have adequate community networks. An example of this is the Talking Realities program, with demonstrated effectiveness in southern states, yet not effective when delivered by a 'training provider' in Townsville without established networks with young parents (Johns & Lawless, 2009).

There is an opportunity for projects to learn from each other's experience by fostering dialogue about issues such as effective strategies of participation in Indigenous contexts. Some Indigenous projects appear to be isolated from

other projects with a similar focus (Scougall, 2008). There is an opportunity to support greater networking between similar initiatives. One option is to establish linkages between projects and organisations that are considered leaders in their field, for example, between Indigenous specific antenatal services in terms of services provided for young parents.

There appear to be efficiencies of scale and certain other advantages where the auspice is a regional organisation with strong local links. Again Strong Young Mums, Anangu Bibi and Curtin Community Mothers programs are examples of this in action. Small scale and fledgling community organisations sometimes struggled to adequately fulfil the role.

#### ***4.4.6 Lack of support for cross-sectoral involvement***

This related barrier concerns administrative and governance barriers to linking services across sectors through one program. For example, there are some barriers to gaining funding and reporting against programs that cross over the health and education sector (Tammy Wayne-Elliot, 2009). Some initiatives, such as Queensland Health School Based Nurses, attempt to bridge this divide, but a more explicit approach to this in terms of supporting Young Indigenous Parents particularly would be beneficial. Federal COAG policies are beginning to address these issues in their reporting frameworks, but these policies are not yet reflected in ground-level service implementation (Steering Committee for the Review of Government Service Provision, 2007).

#### **4.5 Support and resources needed by service providers**

An additional aim for this review was to identify support and resources needed by service providers involved in providing services to pregnant and parenting Indigenous young people, or to those likely to become young parents. As we have seen, well trained, acceptable, reflective and committed program staff are essential to the success of programs supporting young Indigenous parents. However, these service providers and program staff are often relatively unsupported themselves, thus there is considerable need for support and capacity-building for program staff (Scougall, 2008; Soriano, et al., 2008)

Here the findings from the literature and from interviews with service providers have been integrated, and seven key areas for additional support and resources have been identified. Each of these will be discussed below in turn.

##### ***4.5.1 Ongoing funding for programs***

The literature and previous reviews of programs and their effectiveness, and interviews with service providers are quite consistent about the negative impacts of recurrent short term funding rounds and the need for constantly reapplying for funds on the security of programs, and the effectiveness of the services they deliver (Johns & Lawless, 2009; Soriano, et al., 2008). Service providers discussed with some passion their need for assistance in obtaining grants, and the positive effect of longer term funding on their ability to deliver successful programs and build up trust with the communities with which they work. Unfortunately, all too often the story is of promising programs that start to become effective towards the end of the first year of funding, but then peter out due to lack of ongoing funds. In fact, at least three of the case study programs were at immediate risk of ceasing operations due to a lack of confirmed funding for 2010. Issues with funding had flow-on effects in terms of staff retention and security, and staff time commitments to meet funding application and reporting requirements. This negatively impacted on staff capacity to engage effectively in program delivery.

#### ***4.5.2 Support in evaluating projects***

A related need articulated by service delivery staff is to receive assistance and support in designing and implementing evaluation processes for their programs (Secretariat National Aboriginal and Islander Child Care, 2004). This is essential to continually improve the program, demonstrate its effectiveness in terms of both process and outcomes, and thus secure further funding. However, this element of program design and implementation is often neglected or added on as an after-thought. A related issue is the need for sharing evaluation findings between programs operating in similar environments, and the training and use of action learning cycles to optimize improvement of the program.

In addition to formal evaluation processes, the evidence suggests that many programs can benefit from engagement in action learning processes, which involve: experience and critical reflection on that experience; group discussion; trial and error; discovery; and learning from one another. Programs can apply the action research cycle (action, observation, reflection and planning) to ensure continual improvement in program/service delivery and that these remain relevant to key stakeholders. These processes have the potential to contribute to our understanding of what works, under what conditions, and why it works in particular communities (Scougall, 2008).

#### ***4.5.3 Staffing issues***

Projects aimed at supporting Indigenous families need the support of competent and committed staff with close relationships with the local community, cultural competence, and relevant subject matter expertise. In most cases this means a team comprised of both Indigenous and non-Indigenous project staff with complementary capacities (Scougall, 2008). Building teamwork and partnerships based on mutual respect and recognition of complementary skill sets is essential in this regard.

Service providers involved with supporting young Indigenous parents, or disadvantaged young people likely to parent early, face a demanding role, with close, trusting relationships being a key factor in the success of

programs, and one of the factors most valued by young parents. This creates a risk of burnout for service providers/support workers, who require a combination of psychological and practical support from other members of their team. Recruiting and retaining quality staff is a critical issue for Indigenous projects, especially in rural and remote areas (Australian Institute of Family Studies, 2009a; Scougall, 2008). Support manuals for Indigenous Health Workers may be useful, however there is a danger that they may individualise broad structural problems.

An additional element of cultural safety and support for staff, particularly for services and programs delivered outside the Indigenous community-controlled sector, is the need for a “critical mass” of staff members. Conversations with service providers describe experiences of professional and social isolation when placed as the sole Indigenous worker in a mainstream organization. Thus, it seems optimal to have at least two Indigenous workers in programs operating out of mainstream services to optimize sustainability (Australian Institute of Family Studies, 2009a).

#### ***4.5.4 Practical support and infrastructure***

In order to be successful, Indigenous Young Parent support programs need to pay attention to the basics of practical support, as these are factors that loom large in the lives of young parents. Basic infrastructure support, such as a suitable venue (that is friendly, culturally safe and non-stigmatising) is important, and as discussed in an earlier section, colocation with other services can be an advantage in terms of attractiveness and accessibility of the service, as well as providing administrative support and efficiencies.

The other issue frequently raised by service providers is the need for access to a vehicle (with child and infant car restraints) as this is essential in carrying out their roles. As identified in section 4.3.1, young Indigenous parents very rarely have access to reliable transport, thus service providers need to be able to visit the young parents in the community and/or transport them to centralized or group activities.

#### **4.5.5 Capacity building for service providers**

When investing in Indigenous capacity building, a key issue is finding the appropriate balance between upstream institutional capacity building (building the capacity of organisations to plan and implement programs) and downstream capacity building with families and communities (enhancing the self-reliance of families and communities; Scougall, 2008). Unfortunately, often the process of building capacity in service providers themselves is neglected. Service providers frequently commented on the need for training and support in proposal writing, grant writing, project management and evaluation skills (Scougall, 2008; Secretariat National Aboriginal and Islander Child Care, 2004; Soriano, et al., 2008). In some cases, workers themselves wanted additional information about antenatal and child development, local service availability, child health and nutrition, and group facilitation and counselling skills. In addition, particularly in rural and remote areas, it was particularly important for support workers to be able to leave their service (with backfill where necessary) to attend group-based professional development activities in a regional centre. This serves two main functions, upskilling and professional development, but also ameliorating the social and professional isolation felt on occasion by sole workers in remote programs (exemplified by Strong Young Mum's Program in Bourke).

In terms of support and training for service providers, most reports and interviews suggested that a combination of training and orientation prior to starting the position, with on-the-job mentoring and capacity-building was the optimal way of receiving job-related professional development (Soriano, et al., 2008). Mentoring, role modelling, providing home-based services and using a buddy system have all been popular and successful strategies used to achieve training outcomes (Scougall, 2008). These are demonstrated in some of our case studies, often based on Indigenous understandings, where skills and initiative have been fostered on the job through practical hands-on involvement.

#### **4.5.6 Assistance with sourcing or developing appropriate resources**

The SNAICC report recommends the development of Indigenous specific parenting information for Indigenous communities, and that this should combine local content with information that is more broadly applicable and drawn from the evidence base on child and adolescent development (Secretariat National Aboriginal and Islander Child Care, 2004). Overwhelmingly, we also heard from service providers about the importance of developing local resources for young Indigenous parents and their families, and that these resources should be culturally relevant, designed and delivered by local Indigenous people. In many cases, family stories could be developed as locally relevant resources. This is equally true for young Indigenous parenting resources, where appropriate localized content may include:

- Reference to local role models and mentors
- Recognition of family/kinship networks
- Local language and artwork
- Local service and support contacts
- Local cultural traditions and norms

(Secretariat National Aboriginal and Islander Child Care, 2004 p 97).

In many cases local service providers may need assistance in developing locally relevant and applicable information and resources, and there is also a need to link service providers with applicable resources that might be able to be locally adapted, having been developed at local, regional or statewide levels. Examples of these include The National Association for Prevention of Child Abuse and Neglect (NAPCAN) Indigenous resources, and University of Newcastle, Family Action Centre Indigenous video. The SNAICC Resource Service is a valuable clearinghouse where resources are collected to enable sharing of resources and ideas. In particular, the evidence suggests that funding should support the development of highly visual Indigenous parenting information resources, designed for use in facilitated group settings, in both plain English and language where appropriate. Audiovisual materials may also be appropriate.



#### **4.6 Mechanisms for engaging with young Aboriginal and Torres Strait Islander parents or those likely to parent as teenagers**

There is much literature to support the belief, sometimes articulated by mainstream services, that young parents are difficult to engage. This is often attributed to social exclusion, which in turn arises from factors such as early school leaving, housing issues, poverty and other factors that reduce their access to services (Boulden, 2001; Social Exclusion Unit, 1999). Perhaps a more constructive approach is to consider that it is the services, rather than the young people themselves, that are hard to reach.

A separate aim of this review was to investigate strategies for optimizing engagement of service providers with young Aboriginal and Torres Strait Islander parents, and those likely to parent as teenagers. This section will be divided into sections discussing where engagement can best be fostered, who should provide or lead such services, and what services should be delivered. A further section relates particularly to the issues surrounding engagement of young fathers.

##### ***4.6.1 Where can engagement be fostered***

Services designed to engage young people who are pregnant or parenting, or at likely to become parents young can be delivered through a range of locations. The logical first entry points for such services are schools and primary health care centres. School is a good way to engage the majority of young people in health promotion and educational interventions, and a great example of this is the Core of Life program providing realistic education about pregnancy, giving birth, parenting a newborn and healthy decision making (Core of Life, 2004). Healthy sexuality programs are also well delivered through schools, although a national implementation framework is lacking and these are currently of variable quality (Dyson & Mitchell, 2005). It is important to employing Indigenous staff within the school as an Indigenous presence within the school increases attendance rates of children, and engagement of young people in relevant education processes (Helme, 2005).

Young teenage parents encounter numerous barriers within the school environment. Some of the key issues which emerge are bullying by other students, a lack of support from teachers, homelessness and lack of childcare (Boulden, 2001). Furthermore, many young parents outside of the school environment lack the parental support to continue their education (TFLC, 2007).

Many young teenage parents experience limited post compulsory school options, with fewer career pathways and less opportunities. Critically, Indigenous young people may experience disadvantage in terms of participation in education, attainment of education qualifications and participation in the labour market (Buckskin, 2001). In an attempt to address this, O'Callaghan (2005) recommends: building relationships with students and communities; training that is responsive rather than 'supply driven'; increase Indigenous staff; flexible funding; and support through mentoring and literacy and numeracy programs (O'Callaghan, 2005).

The problem, however is that many young people (especially Indigenous young people) likely to become pregnant at a young age have already disengaged from the formal educational system, and will not be engaged by school-based programs (Hill, Dawes, Boon, & Hillman, 2005). Thus a more creative approach is needed, involving outreach to places where young people might congregate, such as youth shelters or youth services. Furthermore, primary health care services that are both culturally safe and accessible and "adolescent friendly" in their atmosphere, can be great venues for engaging adolescents in opportunistic education and health promotion activities.

Many programs have found engaging young parents problematic. Particular subgroups of young people can be particularly difficult to engage with, especially homeless young people and those involved in substance abuse or suffering from mental illness. High levels of mobility of disadvantaged young people, particularly those who are homeless exacerbates this issue (Cortis, et al., 2009). Increasingly, there is recognition of the effectiveness of using so

called “soft entry” points for engaging young parents and other Indigenous young people in support programs. Soft entry points for engagement may include:

- Supported playgroups. Mothers engage via playgroup and in turn this empowers the young mums. The young mums take ownership and become the driving force for the program (e.g. POSSIBLEE program)
- Childcare services
- Primary health care services, particularly those providing child health checks and immunizations in a culturally safe manner (Mums and Babies, TAIHS)
- Youth drop-in centres

In addition, for young parents and young people, the provision of co-located services through a “one-stop shop” is very effective and attractive. Headspace youth mental health services are provided using this model (Headspace, 2009), as are a number of the effective Young Parent Support Programs identified (Cortis, et al., 2009).

#### ***4.6.2 Who should engage with young parents***

The first key principle here is the importance of Indigenous program staff (both male and female) in engaging with Indigenous young parents and those likely to become parents young (Cortis, et al., 2009; Saul, et al., 2009).

The second key principle is the importance of involving young parents and young people in the design and implementation of any programs and interventions. Many of the successful programs employ versions of peer-education and mentoring, which provide positive role-models and empathetic support for the young people participating, as well as further training, confidence and capacity-building in the young parents trained as peer educators or facilitators (Cortis, et al., 2009; Katz, La Placa, & Hunter, 2007; Mohajer, Bessarab, & Earnest, 2009).

Mentoring as an engagement strategy has surfaced consistently during interviews with service providers and through the literature and as such must be prioritised (Johns & Lawless, 2009). Informal interviews with program coordinators identified several key strategies essential for engaging young Indigenous and non Indigenous parents: the employment of male and female Indigenous staff; community ownership; the building and maintenance of mutual relationships of trust and respect; and the importance of creating separate spaces specific to the needs of young Indigenous parents. Indigenous ownership increases community capacity and is paramount to the success of any Indigenous parenting program. Therefore engaging Indigenous parents with the planning, recruitment and promotion of programs is fundamental.

#### ***4.6.3 What strategies can be used to optimize engagement of Indigenous young people and young parents***

Key strategies for engaging Indigenous and non-Indigenous young parents may include: recruiting service partners and community elders; including young parents in the planning process; engaging those in attendance to recruit and promote the program; building on existing relationships; and establishing trust and rapport. Ethical issues in recruiting and engaging young parents in programs are also important (Alderman, Balla, Blackstock, & Khanna, 2006).

In addition, practical issues, such a lack of transport, lack of childcare, homelessness and poverty are all very real issues for young parents, so designing programs to remove these practical issues as barriers to attendance is imperative. This might involve pick-up service for meetings, child-friendly meetings or the provision of childcare, and the provision of a meal or healthy snack together with the meeting or training session. Baydar, Reid & Webster-Statton (2003, p. 43) showed that when logistical barriers such as childcare, food and transportation were addressed engagement was high. Practical assistance in solving some of these issues (including homelessness) in an ongoing manner through advocacy and service linkage

is also appreciated, and may help to optimise engagement of young people in programs (Cortis, et al., 2009).

It is important that all engagement and support strategies for young parents or other Indigenous young people focus on empowerment and a strengths-based model, rather than a deficit-based model. Indigenous young people, and particularly indigenous young parents are constantly confronted by negative perceptions and discrimination, thus it is essential that programs do not contribute further to their marginalization, but rather build strength and capacity in the young people involved to respond positively to the challenges they face. Successful examples of programs that engage using these principles are arts and cultural strengths based models (Mikhailovich & Arabena, 2005), such as Mudgin-Gal Family Circle, and the Curtin Young Mothers programs, and broader social and emotional wellbeing programs such as Red Dust Healing (Ross & Powell, 2008). In addition, there have been a small number of studies that use sporting clubs and activities as venues and strategies for engagement with young people. Up until now, this has been so particularly for health promotion and health screening activities (Gold, Hocking, & Hellard, 2007), but there is the potential to embed broader programs in sporting activities (Mohajer, et al., 2009).

There are many new technologies that show considerable promise in engaging and providing health information to disadvantaged young people. On the whole, testing and evaluation of the effectiveness of these approaches in affecting outcomes is still in progress, but they are almost universally popular and acceptable to young people, and thus are worth consideration for the future. Examples of these technologies currently in use in various settings include:

- The use of SMS reminders for appointments, or for notification of positive STI results (Gude & Harper, 2008)
- Internet booths for health promotion information (for example HITnet booths in wide use in Cape York communities; Travers, Hunter, Gibson, & Campion, 2004)

- Multimedia computer-assisted self–interview (M-CASI) technology for the provision of health promotion information and the collection of health, knowledge and attitudinal data (Larkins, et al., 2007)
- Audiovisual dissemination of health promotion messages, for example through DVDs or community radio.

It is important to note that there may be some significant barriers concerning cultural restraints and difficulties with communication especially internet and online access, particularly in remote areas.

#### ***4.6.4 Particular issues for engaging with young fathers***

An essential aspect of any program is the inclusion of Indigenous staff , and this applies particularly in terms of employing male Indigenous staff to facilitate father’s programs. While female staff are able to engage well with fathers, it is often argued that the best way to engage fathers is through providing male workers, or through mentor learning where groups are facilitated by men who share common experiences (King, Sweeney, & Fletcher, 2004). There remains an extensive gap in building relationships and subsequently in maintaining ongoing contact with fathers. Fathers need places where they feel comfortable, welcome and able to relate to other fathers, to build trusting relationships with other fathers, male health workers and male practitioners.

Fathers have been identified as a group who have traditionally experienced difficulty accessing mainstream services due to physical barriers such as time constraints and socio-cultural barriers due to a perceived irrelevance of the service to men’s needs and ambivalence about services ran for women by women (Katz, et al., 2007).

Engaging fathers has important implications for service delivery, particularly when considering the context of teen parenting and childhood development. Increasing recognition is being given to the importance of fathering in society (National Evaluation Consortium, 2008).

One Australian study sought to identify ways in which fathers engaged with child and family services and the barriers to engagement. Barriers included a highly structured program format, times and locations unsuitable to working fathers and female staff. Conversely, the enablers for participation of fathers included male staff, informal peer discussions and formal “hands on” program activities (Berlyn, et al., 2009; National Evaluation Consortium, 2008). In addition, in providing services for young Indigenous fathers, it is important to have some understanding of the cultural ways men may seek support and advice, and build on these as strengths in designing the program (Hammond, 2009a; Jia, 2000).

## 5.0 SUMMARY AND CONCLUSIONS

This report demonstrates that although there is considerable evidence, especially internationally, about the epidemiology, association and outcomes of parenthood in the teenage years, there is very little work into the effectiveness of programs to support young parents. Most notably, there is very little participatory work with young parents themselves concerning their experiences, or what support and services would be of most value to them. This is particularly true of Aboriginal and Torres Strait Islander young parents.

The evidence suggests that with high quality acceptable primary health care services, and integrated educational and support programs for young parents, that the outcomes for both mother and child can be positive. Flexibility is needed for service providers in terms of provision of education and the inclusion of young fathers, according to the wishes of the family. More work is needed into the best ways of providing support for young Indigenous fathers.

Many small-scale programs are operating on short-term seeding funding, and have not been adequately evaluated. Program staff request support and assistance in developing and implementing meaningful evaluation frameworks to contribute to the evidence base.

However, there is enough agreement in grey literature reports, websites and from program providers to be able to make suggestions and recommendations about what constitutes best practice in supporting young Indigenous parents. It is important that whilst gathering more robust data about the effectiveness of various programs and interventions we do not stand back from working with Indigenous young people and service providers to develop, implement and evaluate holistic strengths-based services to support young parents. It is important that these balance general principles with flexibility for local implementation. The following section outlines a series of recommendations or suggestions for policy and best practice on which to base ongoing program delivery in the meantime



## 6.0 RECOMMENDATIONS FOR POLICY AND BEST PRACTICE

The findings of this review of the literature and case studies of best practice lead to the following recommendations for policy and practice in providing support for young Indigenous parents.

### 6.1 Recommendations for policy

*Recommendation 1. Policies and programs are designed with extensive Indigenous community consultation. Consultation with Indigenous young people is particularly important.*

It is recognized that Indigenous communities are heterogeneous, however it is important to have Indigenous representation at the policy design and implementation stage, to ensure that the policy recognizes some of the specific issues relevant to Aboriginal and Torres Strait Islander young people and parents. Very often a community development (or “bottom-up” approach), designing policy to respond to community needs and preferences, may produce the most sustainable outcomes.

*Recommendation 2. There is ongoing funding to improve the delivery of maternal and child health services for young mothers, with a focus on optimizing the acceptability and accessibility of these services.*

There is considerable evidence that strengthening Indigenous families and communities requires sustained, long-term outcomes to achieve measurable outcomes. There is reasonable evidence that comprehensive antenatal and postnatal programs can improve attendance at services and improve perinatal outcomes for young Indigenous mothers and their babies. These services and programs need to be supported to demonstrate their effectiveness, and be freed from the burden of short-term funding cycles that distract them from the process of clinical care provision. Ongoing funding streams (such as those provided through Healthy for Life and Best Start programs), are important to facilitate this. Additionally, it is important that these services are explicitly welcoming to young parents.

*Recommendation 3. The evidence-base for best practice in supporting young Indigenous parents is limited, so there is a need to support further research and evaluation of programs in this area.*

There is still a lack of evidence for interventions in many areas of support for Indigenous young parents. These include social and emotional wellbeing, substance use in pregnancy, and mental health, and the effectiveness of various forms of intervention and support. What evidence that does exist is patchy and of low quality, and needs to be tested in a variety of different settings. In addition, there is still inadequate data in Australia about the effectiveness of various strategies for engaging with disadvantaged young people, particularly those who are disengaged from formal education. As a result of the lack of good quality evidence, national and international evidence does need to be used as a basis for planning programs, however these studies then need to be trialled and evaluated in local Indigenous communities. Participatory action approaches working with local Indigenous communities to design, implement and evaluate support programs are most likely to generate meaningful data in this respect.

There is an opportunity for projects to learn from each other's experience by fostering dialogue about issues such as effective strategies of participation in Indigenous contexts. Some Indigenous projects appear to be isolated from other projects with a similar focus. There is an opportunity to support greater networking between similar initiatives. One option is to establish linkages between projects and organisations that are considered leaders in their field, for example, leadership development projects and the Australian Indigenous Leadership Centre (Scougall, 2008).

*Recommendation 4. Intersectoral collaboration is encouraged at policy design and implementation level, particularly between the health, education and social services sectors.*

As highlighted in a variety of national and state policy documents, there is a need for integrated policy that allows for the possibility of developing holistic programs linking services across the education, health and social service sectors. Some positive steps in this direction have occurred, but further

simplification would still be beneficial in terms of service provision. Greater collaboration between agencies could influence the socioeconomic, environmental and socio-cultural factors that affect the health of young Aboriginal and Torres Strait Islander mothers and their children.

*Recommendation 5. Policy focuses on increasing the range of options available for Indigenous young people, and providing support for them should pregnancy occur, rather than on the prevention of teenage pregnancy.*

Many young parents come from very disadvantaged backgrounds, where they have few options or aspirations for the future. Pregnancy and parenthood in this setting can be a transformative event, provided adequate support and assistance is provided. Pregnancy prevention programs (in addition to being largely ineffective) can serve to further stigmatise disadvantaged young people and the emphasis should be on information, empowerment and support, rather than prevention. Examples of programs that may be useful in this regard include vocational information and linkage, links with further education options, and programs building social capital, cultural identity and self-esteem.

*Recommendation 6. Policy around the delivery of relationships and safe sex education through schools is broadened and enhanced (ideally as part of a national framework for sex and relationships education for young people).*

Education Queensland has very limited policy and guidance about what is covered in school sex education and the way in which it is delivered, and many students miss it altogether due to absenteeism, scheduling issues and “shame” about the way in which it is conducted. It is imperative that all students receive a broad raft of healthy relationships education, delivered by a staff member comfortable with the content. This should include communication and negotiation skills, and attempt to challenge some of the prevailing norms about male and female sexual roles. For many Indigenous young people, sex education in small single-sex groups led by a peer educator would be the best way of reducing the shame of this type of discussion. Policy also needs to support the delivery of similar education to

young people disengaged from formal education, through innovative means, where necessary.

*Recommendation 7. Projects are required to demonstrate linkages between services and community groups before funding. This is particularly important when services are to be delivered by organizations without strong links to local Indigenous communities.*

The evidence that does exist suggests that strong community engagement and support is vital to the success of Indigenous young parent support programs. Ground-up design as a collaborative process between community members and local service providers is optimal, however if an existing program is to be brought into a community, appropriate consultation with relevant community members and groups should occur before funding and implementation.

## **6.2 Recommendations for programs**

These recommendations for program design and delivery have been grouped into four main domains, underpinned by five generic principles.

The generic principles include the following.

1. Seeking Indigenous input and promoting community ownership at all levels of the program (particularly input from young people and young parents)
2. Respecting Indigenous world-views and incorporating these into program design through employing Indigenous people and Indigenous research and evidence at all levels of program management and governance
3. Ensuring that a community capacity-building component with early positive action is build into each part of the program
4. Avoiding language or actions that serve to problematize and thus further disadvantage Indigenous young people and young parents
5. Delivering services and programs in a culturally safe environment. This is the responsibility of all services, be they community-controlled organisations, programs or services operated by the

state or federal government, or services operated by non-governmental organisations

### ***Indigenous young parent support programs***

The literature and case studies suggest that the success of many young parent support programs derives as much from *how* they are delivered as from *what* is actually delivered. The ongoing presence of welcoming and non-judgemental program staff who are passionate about supporting young parents is essential for the success of these programs. There is no generic blueprint for a successful program, with programs focused primarily on education, health, the arts and social support all having a role to play.

*Recommendation 8. Indigenous young parent support programs are designed around strengths-based models that empower and build confidence in young parents.*

A variety of research identifies stigma from the public and from service providers as one of the issues faced by young parents. Thus it is important that services and programs to support young parents operate from a strengths-based model, building on the strengths in the particular young parents and their surroundings, whilst realistically acknowledging the difficulties they face. This involves focusing on the capacities young parents possess already (ie. knowledge, interests, understandings and so on), rather than focusing on their limitations in terms of poverty or education, which may erode confidence and self-belief.

Participatory approaches facilitating ownership and shaping of the program by young parents themselves are very important to the success of programs, both through making the programs relevant and acceptable to the potential participants, and through building capacity and skills in those involved in the planning process. This can be achieved through peer education, leadership and peer support roles, and opportunities for young mothers to develop community engagement/participation and employment skills.

*Recommendation 9. Indigenous young parent support programs are delivered in culturally safe environments.*

It is important that services for young Indigenous parents are delivered in an environment of cultural safety. In many cases this may be an Indigenous community controlled health service or organization, although other community spaces that are utilized by Aboriginal and Torres Strait Islander young people and are seen as non-stigmatizing may also be appropriate. Many Indigenous people choose not to access (or do not have the option to access) Indigenous specific services, thus it is essential that mainstream services also share the responsibility to deliver culturally appropriate services. Cultural safety may include (but is not limited to) having Aboriginal and Torres Strait Islander staff members, having inclusive educational and promotional materials (preferably locally developed), and providing a warm and welcoming environment. Service providers require flexibility in the inclusion of young fathers in support programs, according to the wishes of the young parents. Separate programs providing support for young Indigenous fathers are likely to be important.

*Recommendation 10. Programs building on cultural strengths are used as a foundation for providing parenting support (for example through arts based programs).*

Several reports and reviews of Indigenous parenting support have remarked on the need to utilize cultural strengths within the Aboriginal and Torres Strait Islander community to support parenting programs. Examples of this include strong family kinship networks and the importance of extended family, respect and knowledge of cultural elders and strengths in music and dance. Engaging local community Elders to participate in programs to support young Indigenous parents, through sharing stories, parenting journeys and strengthening cultural identity may assist in developing resilience and self-esteem. Programs based around arts activities or participation in sport may also have a role to play.

*Recommendation 11. Indigenous service providers are recognized as essential to the success of programs. Indigenous service providers receive sufficient training and support to be able to fulfill their roles successfully.*

The presence of dedicated and committed staff was often highlighted as an important factor in program success. It was recognized that local Indigenous women were most suitable for providing support services for young Indigenous parents, and personal factors such as warmth, non-judgemental attitude and understanding were also frequently mentioned. A background in primary health care or education, some formal training for the role and workplace coaching can all be used to support the role. When based in a mainstream department, there may be a need for a critical mass of two Indigenous program staff, to support one another in the role. Programs to support young fathers will require the employment of an Indigenous male service provider.

*Recommendation 12. Education and information resources are developed locally with local relevance and content, combined where necessary with more generic information.*

Service providers require assistance in working with local communities to develop health promotion and educational resources for young Indigenous parents. In some cases, existing resources can be adapted to include local content. Very visual materials such as posters and electronic media are important for providing information to Indigenous young parents.

*Recommendation 13. Holistic one stop shop programs with intensive case-management and support are fostered and supported. Soft entry points for engagement are important.*

Programs that have shown most promise in terms of supporting Indigenous young parents operate holistically, ideally combining a variety of services at a single location in order to minimize barriers to engagement. Soft-entry points to facilitate entry into these services is important, and building trusting relationships with workers that can help guide the young parent through available services can be very useful.

*Recommendation 14. Programs are designed to ensure that practical issues creating barriers to participation for young Indigenous parents are addressed. These practical issues commonly include lack of transport and a lack of childcare.*

Practical issues related to poverty, including lack of transport, homelessness, lack of childcare and high levels of mobility may limit the engagement of young Indigenous parents with services. Addressing these factors in program design (for example, through providing transport, food and childcare and advocating for stable housing) can have a strong positive effect on engagement and retention of young parents in programs. Other strategies currently being used and requiring further evaluation are home visiting programs, and programs specifically addressing the needs of young fathers.

*Recommendation 15. Partnerships and collaborations between organizations and services involved with young Indigenous parents are fostered through funding and reporting structures.*

Single service silos are confusing and alienating for young parents, and will have a negative effect on engagement and uptake of services. Encouraging collaboration (and ideally co-location) of services in a one-stop-shop approach simplifies the process of accessing services. This may involve government services being delivered through community organizations, to ensure the cultural safety of the service location. This process of collaboration and partnership can be facilitated through funding and reporting structures.

### ***Sex and relationship education***

*Recommendation 16. Positive and comprehensive healthy relationships education is included as a mandatory part of the school curriculum. This education includes realistic information about pregnancy, birth and parenting, and is ideally delivered in small single sex groups. School-based nurses are well-placed to provide this education.*

Whilst it is important to avoid a focus purely on preventing teenage pregnancy, which may serve to further stigmatize young parents, it would be remiss to not address the need for appropriate education for Indigenous young people, aimed at providing skills and attitudes conducive to healthy



relationships, knowledge about safe sex, contraception and sexually transmitted infections, and information about the realities of pregnancy, childbirth and parenting. This again should be positive and strengths-based.

This education should include communication and negotiation skills, and attempt to challenge some of the prevailing norms about male and female sexual roles. For many Indigenous young people, sex education in small single-sex groups led by a peer educator would be the best way of reducing the shame of this type of discussion.

*Recommendation 17. Healthy relationships programs are also needed for young people disengaged from the education system. More work investigating and evaluating novel strategies for delivering these programs is necessary. Programs with a broad, strengths-based approach show the most promise.*

Many young people likely to become parents early have already disengaged from formal education. Thus there is a need for programs to reach young people disengaged from education, using some of the creative strategies for engagement outlined below.

### ***Engagement with Indigenous young people***

*Recommendation 18. Innovative approaches for engaging Indigenous young people require further investigation and evaluation. Approaches that show considerable promise include peer education, technology-based delivery and engagement, arts-based programs and engagement through sports.*

To engage Indigenous young parents and those likely to become parents in services, a range of strategies may be required. Practical issues, high levels of mobility and stigma or exclusion can limit engagement in mainstream services. To optimize engagement it is important that programs are designed with input from Indigenous young people, and peer education and mentoring have shown promising results. Engagement through information technology, art-based activities and sporting activities may all play a role, but these strategies need further evaluation.

### ***Funding and Evaluation***

*Recommendation 19. Acknowledging the time lag between commencing a program and evidence of its effectiveness, program funding should continue beyond the initial year, and be contingent upon adequate evaluation of program success.*

Building strong programs in an atmosphere of trust and as a cooperative venture between Indigenous communities and service providers takes some time. Demonstrating effectiveness of the program in terms of outcomes takes even longer. It is important that sufficient start-up funding (in amount and duration) is provided to enable a realistic establishment and trial of the project. However, service providers should be assisted to develop an evaluation framework at the planning stages of the project, to assist with decisions about further funding.

*Recommendation 20. Program facilitators need support with building in evaluation at the planning and early implementation stages. This evaluation must be rigorous, gather information on process and outcomes indicators, and be acceptable to the services and the community.*

Providing culturally-appropriate support to young Indigenous parents, and designing and implementing a rigorous program evaluation are two very different skill-sets, and it is rare to find a service provider who is well qualified for both. Program staff request assistance in designing and implementing program evaluations at the early planning stages of programs. In most cases this is probably best done through partnerships between organizations. It is important that the evaluation is rigorous and comprehensive, that it collects meaningful data, and is acceptable to both service providers and the community.

## **APPENDICES**

### **APPENDIX 1 - Project team**

#### ***Dr Sarah Larkins***

Sarah is a general practitioner with 10 years experience working in Indigenous maternal and child health care delivery. She currently works as a Senior Lecturer in the School of Medicine and Dentistry at James Cook University, having completed a PhD studying the attitudes and behaviours of young Indigenous women in Townsville to pregnancy and parenthood, involving a variety of participatory approaches for working with young Indigenous parents.

#### ***Prof Sue McGinty***

Sue is an experienced educator and academic who is currently Associate Dean, Research for the Faculty of Arts, Education and Social Sciences, and Deputy Head, School of Indigenous Australian Studies. She has written extensively about factors influencing resilience in disadvantaged young people, and improving educational outcomes for these young people.

#### ***Ms Ryl Harrison***

Ryl has completed a B Arts (Hons) Political Science and currently works with the School of Social Work and Community Welfare tutoring in Human Rights and Social Issues and Research Methodologies. She also tutors with the School of Veterinary Sciences in their personal and professional development stream.

#### ***Ms Suzanne Smith***

Suzanne has completed a B Social Science and is presently completing honours in Anthropology. She has worked extensively in Early Childhood Education, completed a project within the Indigenous Health Unit at James Cook University and is currently working for School of Indigenous Australian Studies as a Project Officer.

***Mrs Margaret Spillman***

Margaret has been involved in university-based research for several years. She has extensive experience in both quantitative and qualitative research and evaluation methodologies. Margaret has been involved with several general practice-based research projects in her time at the Rural Health Research Unit.

***Ms Gabrielle Schechter***

Gabrielle is completing a Bachelor of Science in International Health, with a minor in Women's Studies, at Georgetown University's School of Nursing and Health Studies in Washington, DC, USA. She spent July-October 2009 collaborating with research at James Cook University. She focuses her academic pursuits on health disparities that impact maternal-child and sexual health issues.

## APPENDIX 2 - Indigenous community reference group membership

Reference group members Indigenous Young Parents Support Program			
Name	Job title	Organisation	Clinical background
Priscilla Page	Indigenous Health Training Officer	Tropical Medical Training	Aboriginal Health Worker (AHW)
Valerie Alberts	Lecturer, Indigenous Health	JCU, School of Medicine and Dentistry (SMD)	Education
Peter Malouf	Lecturer, Indigenous Health	JCU, SMD	Indigenous health policy
Catrina Felton-Busch	Project officer, MICCRH Indigenous young parents support worker	JCU, MICRRH	Masters of Public Health, Indigenous researcher
Melvina Mitchell		QH, Child Health, Kirwan Queensland Aboriginal and Islander Health Council (QAIHC)	EN/AHW
Lynette Anderson	Health worker		AHW/EN
Joanne Bourne	Health worker	QAIHC	AHW
Katie Panaretto	Public Health Medical Officer	QAIHC	Doctor/Public Health
Carol Fyfe	Maternal and child Health Worker	Apunipima Health Services Council	AHW
Fiona Millard	Support worker	Mookai Rosie Indigenous support centre	
Heather Lee	Indigenous child health coordinator Indigenous HW Mothers and Babies	The Townsville Hospital (TTH)	AHW
Athena Tamwoy	Indigenous HW Mothers and Babies	TTH	AHW
Narelle Draper	Babies	TTH	AHW
Dorothy Savage	Social work	JCU, Social Work	Education/social work
Jeanette Wyles	Regional CEC	Education Queensland	Education
Daphne Tapim	Youth transitional house worker	Youth Transitional House (NGO)	Social work

### **APPENDIX 3 - Interview framework for case studies**

1. Tell us about the program to support young parents that you are involved with.

Prompts:

- target group for support eg women/men; Indigenous; pregnant/parenting
- services/linkages provided
- service delivery organization eg govt/NGO/AICCHS etc
- staffing
- funding

2. What are some of the factors that you consider contribute to the success of your program?

3. What are some factors limiting the success of your program?

Prompts:

- staffing
- funding
- additional support needs of service providers

4. What do you do to support your staff/service providers in their work supporting young parents?

Prompts:

- orientation
- support packages
- links with other workers

5. What are the main issues confronting the young people with whom you work?

- young mothers
- young fathers
- How could they be dealt with?

6.. What are some of the ways in which you engage with young Aboriginal and Torres Strait Islander parents and those likely to become parents young?

Prompts:

- in schools
- out of school

7. Anything you would like to add about programs and support for Indigenous young parents?

8. Any other program you are aware of that we should include in our study?

## APPENDIX 4 - Interview consent form and information sheet



**JAMES COOK UNIVERSITY**  
TOWNSVILLE Queensland 4811 Australia Telephone: (07) 4781 4811

### INFORMED CONSENT FORM

<b>PRINCIPAL INVESTIGATOR</b>	<b>Dr. Sarah Larkins and Prof. Sue McGinty</b>
<b>PROJECT TITLE:</b>	<b>Review of Evidence Associated with Indigenous Young Parents Programs</b>
<b>SCHOOL</b>	<b>School of Indigenous Australian Studies</b>

I understand the aim of this research study is to gather evidence from the literature and service provider case studies to identify models of best practice in providing support for Indigenous young people who are pregnant or parenting, or for young Indigenous people likely to experience early pregnancy. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written information sheet to keep.

I understand that my participation will involve a telephone interview and I agree that the researcher may use the results as described in the information sheet.

I acknowledge that:

- any risks and possible effects of participating in the interview been explained to my satisfaction;
- taking part in this study is voluntary and I am aware that I can stop taking part in it at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
- that any information I give will be kept strictly confidential and that no names will be used to identify me with this study without my approval.

*(Please tick to indicate consent)*

**I consent to be interviewed by telephone**

<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
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**I consent for the interview to be audio taped**

<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
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<b>Name:</b> <i>(printed)</i>	
<b>Signature:</b>	<b>Date:</b>



## INFORMATION SHEET

### **Review of Evidence Associated with Indigenous Young Parents Programs: Systematic Literature Review & Identification of Best Practice and Qualitative Interviews with Program Providers**

You are invited to take part in a review of the evidence on Indigenous young parents support programs. The study will include a literature review to identify best practice and case studies. These case studies of exemplar programs will involve paper review and interviews with service providers modelling best practice in providing support for Indigenous young people who are pregnant or parenting, or for young Indigenous people likely to experience early pregnancy. The study is being conducted by Dr. Sarah Larkins and Prof. Sue McGinty and will contribute to the *Review of Evidence Associated with Indigenous Young Parents Programs* in the School of Indigenous Australian Studies at James Cook University for Queensland Health. The overall aim of the project is to increase the assistance available for young Indigenous parents through supporting the rollout of Indigenous Young Parent Support Worker positions across the state, with appropriate orientation and resources..

If you agree to be involved in the study, you will be interviewed at a time convenient to you. The interview, with your consent, will be audio-taped, and should take no more than 1 hour of your time. The interview will be conducted via telephone, or face-to-face where feasible.

Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation. You may also withdraw any unprocessed data from the study.

If you know of other excellent programs providing support to young Indigenous parents , can you please pass on this information sheet to them so they may contact Dr. Larkins or Prof. McGinty to volunteer for the study.

Your responses and contact details will be strictly confidential. The data from the study will be used in reports to Queensland Health and possibly in academic publications. You will not be identified in any way in these publications.

If you have any questions about the study, please contact Dr. Sarah Larkins or Prof. Sue McGinty.

**Principal Investigator:**  
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**Co-Investigator:**  
**Professor Sue McGinty**  
School of Indigenous Australian Studies  
James Cook University  
Townsville QLD 4811  
Phone: (07) 4781 4642  
Email: sue.mcginity@jcu.edu.au

*If you have any concerns regarding the ethical conduct of the study, please contact Tina Langford, Ethics Officer, Research Office, James Cook University, Townsville, Qld, 4811. Phone: 4781 4342, [Tina.Langford@jcu.edu.au](mailto:Tina.Langford@jcu.edu.au)*

## APPENDIX 5 - List of programs for parenting support identified

### Australia

Name and duration	Details	Target Group	Location	Reference
Core of Life 1999 ongoing	Trained facilitators deliver localised /custom information re: realities of parenting / breastfeeding through schools/groups	Indigenous teen  Also Mainstream  Parenting skills based program	Australia  ICC centres VACCHO NSW Remote Health Cairns Yarra Ranges Mildura Echuca	(Core of Life, 2004; Middleton, 2009; Patrick & Smith, 2007)
Healthy for Life 2005 ongoing	Capacity building program for Aboriginal Primary Health Care Services	Indigenous  Primary Health Care Program	Australia Over 50 sites	(Middleton, 2009; Office for Aboriginal and Torres Strait Islander Health, 2007)
Talking Realities Commenced 1995 - ongoing	Multi-level collaborative approach.  Community Development model.  Peer education model  Delivered in schools by young mothers who are trained.	Mainstream – teen  Education based program	SA WA VIC NSW QLD  Riverland Whyalla Adelaide Perth Melbourne	(Johns & Lawless, 2009; Kovatseff & Power, 2005; Middleton, 2009)

## Queensland

Name and duration	Details	Target Group	Location	Reference
Mums and Babies Program at the TAIHS  2000 – 2007 and ongoing a little	<p>Delivered through daily maternal and child health clinics. Integrated team approach with each woman seen by:</p> <ul style="list-style-type: none"> <li>• Aboriginal health workers</li> <li>• Midwives/child health nurses</li> <li>• TAIHS female doctors</li> <li>• Obstetric team</li> <li>• Indigenous outreach health worker</li> <li>• Pregnancy register (monthly recalls)</li> <li>• Daily walk-in clinics</li> <li>• Family orientation (playground, educational toys, weekly playgroup)</li> <li>• Care plans emphasising essential elements of care)</li> <li>• Ultrasound dating</li> <li>• PCR testing for STIs</li> <li>• Lower vaginal swab for group B streptococcal infection</li> <li>• Transport service</li> <li>• Brief intervention for risk factors</li> </ul> <p>Improved access to quality antenatal care and significantly improved preterm birth rates which later translated into a significantly reduced perinatal death rate.</p>	<p>Indigenous women</p> <p>Primary Health Care Program</p>	<p>Queensland</p> <p>Townsville</p>	<p>(Middleton, 2009; Panaretto, et al., 2005; Panaretto, et al., 2007) (Eades, 2004)</p>
<p>Ngua Gundi</p> <p>Mother / child project</p> <p>1993</p>	<p>Community Midwifery program</p> <p>Full time midwife and health worker and part time driver. Group or one-one-one antenatal education. (including locally produced resource books)</p> <p>Maternal &amp; child health services (including breastfeeding promotion and the child nutrition education)</p> <p>Mothers Group (meets weekly, decides own activities)</p> <p>The program provides a holistic approach to health care. Transport to clinic is provided &amp; home visiting.</p> <p>High level of acceptance.</p>	<p>Indigenous Women - set up primarily for young women.</p> <p>Ngua Gundi cared for 21% of women birthing at Rockhampton hospital</p> <p>Provided services to 50% of Aboriginal children born in Rockhampton</p> <p>Parenting skills based program</p>	<p>Queensland</p> <p>Woorabinda</p>	<p>(Middleton, 2009) (Secretariat National Aboriginal and Islander Child Care, 2004)</p>

Name and duration	Details	Target Group	Location	Reference
The Young Mums Program	<p>Joint initiative of Murgon State High School &amp; Community training Centre (and other community groups)</p> <p>8 Young mums are enrolled in TAFE course – doing childcare program.</p> <p>Outcome of program is diploma course and jobs, but it responds to a need in community – A holistic approach to community health issues.</p>	<p>Indigenous Young Mums</p> <p>Education based program</p>	Cherbourg	National Indigenous Times 24 Jan (2008)
<p>Wuchopperen Mums &amp; Bubs Program</p> <p>Started 7 August 2009</p>	<p>Home visiting</p> <p>(part of Australian Nurse-Family Partnership Program (ANFP) Pilot</p> <p>For pregnant first time mums.</p> <p>Nurse led with Indigenous Family Partnership worker. (Current 4 IFPW)</p> <p>From early pregnancy until 2 years old.</p> <p>Modelled on US – Nurse –Family Partnership</p>	<p>Indigenous first time mothers</p> <p>Parenting skills based program</p>	<p>Cairns</p> <p>But ANFP is also being piloted at Melbourne – Victorian Aboriginal Health Service and Alice Springs’ Central Australian Aboriginal Congress.</p>	<p>(Office for Aboriginal and Torres Strait Islander Health, 2009)</p> <p>CRAH newsletter Aug 09</p> <p>Refer: <a href="http://www.anfpp.com.au/anfp-services/anfp-program-centre-cairns">http://www.anfpp.com.au/anfp-services/anfp-program-centre-cairns</a></p>
Yapatjarra 2002	<p>A weekly antenatal clinic established at Yapatjarra Medical Centre with shared-care policy for all doctors in region</p> <p>Problems identified in existing services were:</p> <ul style="list-style-type: none"> <li>• Culturally inappropriate waiting rooms &amp; spaces</li> <li>• Lengthy waiting times</li> <li>• Not continuity of care</li> <li>• No transport</li> <li>• No sharing of medical history between providers.</li> </ul> <p>Good results for health care.</p>	<p>All Indigenous women</p> <p>Primary Health Care Program</p>	<p>Queensland</p> <p>Mount Isa</p>	(Middleton, 2009)
<p>Young Parents Group</p> <p>Brisbane School of</p>	Queensland – web based school program	<p>Young mothers – all</p> <p>Education based program</p>	Queensland	<p>Refer: <a href="http://www.brisbanesde.eq.edu.au/?studentservices/">http://www.brisbanesde.eq.edu.au/?studentservices/</a></p>

## New South Wales

Name and duration	Details	Target Group	Location	Reference
Daruk	Midwifery program from Daruk Aboriginal Medical Service. Direct Service / Brokerage with mainstream services (hospital)	All Indigenous women	Western Sydney – urban	(Middleton, 2009) (Eades, 2004)
1990	Aboriginal Health Worker / non-Aboriginal midwife, and female GP <ul style="list-style-type: none"> <li>• Antenatal check up</li> <li>• Hospital liaison</li> <li>• Transport</li> <li>• Home/ hospital visits</li> <li>• Labour support</li> <li>• Coordinating high risk pregnancy</li> <li>• Feeding</li> <li>• Provides cultural awareness services with local hospital</li> </ul>	Primary Health Care Program		
Djuli Galban	Part of Durri Aboriginal Medical Service	Indigenous Women	NSW – regional/rural	(Middleton, 2009)
1992 pilot	<ul style="list-style-type: none"> <li>• Community based cultural sensitive outreach during pregnancy &amp; after birth.</li> <li>• Fulltime midwife and Aboriginal Health Worker team</li> </ul>	Parenting skills based program	Macleay Valley Kempsey	
Ongoing	<ul style="list-style-type: none"> <li>• Weekly antenatal</li> <li>• Transport</li> <li>• Advocacy &amp; transport to access hospital &amp; mainstream services</li> <li>• Home visits / clinic visits up to 8 weeks postnatal.</li> <li>• Parenting support.</li> <li>• Immunization clinics</li> </ul>		75% of Aboriginal women in area used the service.  26% of women were aged 19 or under.	
Djuli Galban Project	Wellbeing program for women and children during pregnancy & early years	Parenting skills based program	Kempsey, NSW	(Secretariat National Aboriginal and Islander Child Care, 2004)
From 1992 - Ongoing	Aims to increase breastfeeding and nutrition, attendance at antenatal clinic and women's health screening programs and immunization.			

The success of the service relies heavily on the work of the Aboriginal health workers. Their knowledge of local conditions and of culturally correct protocol is a key factor in the success of the service.

Name and duration	Details	Target Group	Location	Reference
Gudaga "Healthy Baby" 2000 – pilot	Aboriginal Home Visiting Program by Project Officers (filled by local Aboriginal Mothers)  Culturally appropriate outreach service after leaving hospital.  3 x ½ hour home visits over 12 months. Health issues checkup – and goodies (magnets, t-shirts)	All mothers of Indigenous babies (40% have non-indigenous mothers)  Parenting skills based program	Urban New South Wales  Campbellton	(Middleton, 2009)
NSW Aboriginal Maternal and Infant Health Strategy 2001	Community midwife and an Aboriginal Health Worker provide community based services and brokerage to existing mainstream services. Midwives received cultural awareness training, Transport is provided as being essential for access.  Full time consultant support person to these workers who provides resources and organises annual conferences & quarterly tele-meetings	All Indigenous women  (1 in 4 under 20)  Primary Health Care Program	NSW  Across 26 sites	(Middleton, 2009)
Parenting Our Way Ongoing	Parenting issues have been identified as a major cause of stress and distress for parents attending the service.  Culturally appropriate resources and support for families; information, groups.  Mums' programs and dads' programs and grandparents or other carers are invited to be part of the program.	Parenting skills based program	Ainslie, ACT  Winnunga Nimmityjah Aboriginal Health Service.	(Secretariat National Aboriginal and Islander Child Care, 2004)
Strong Young Mums Project 2008 (Centacare)	The program in response to the large number of teenage mothers in the community who had dropped out of school. Positive outcomes for almost 50 young mothers and their children.  TAFE training, play groups, guest speaker sessions and home visiting, Home visiting, individual support, art, advocacy with other services, childcare, transport, establish trust through continuity and consistency, engagement of women through consultative process, cultural awareness	Parenting skills based program	Bourke  Lake Cargelligo  Narromine as In 2009, Centacare hopes to extend the program to new	(Australian Institute of Family Studies, 2009a; <b>Soriano</b> , et al., 2008)

Two family workers meet regularly with the women on an individual basis, Government & Private funding.

locations in NSW including Cowra and Brewarrina.

Name and duration	Details	Target Group	Location	Reference
Young Parents Early Intervention Parenting Program	Parents 14 – 24 yrs. 4 components:	Mainstream (but likely to have Indigenous parents participating?)	NSW Shoalhaven region	Youth Action and Policy Association NSW (YAPA) website.
YPEIPP	Triple P training for GPS and Service providers  Young Parents Network linking 30 agencies in region to meet 2 – 3 times a year.  Parenting workshops (delivered by Triple P trained GPs) 2 x 3 hrs  Parenting 1 on one support (6 hours of face to face or phone support working on specific behaviour issues with an early childhood teacher with Triple P training)  Provide transport, childcare, free resources.	Parenting skills based program		

## Victoria

Name and duration	Details	Target Group	Location	Reference
Best Start and Aboriginal Best Start 2002	21 mainstream and 6 Aboriginal programs  Universally available and targeting 'at risk'  Focuses on 0 – 8 years old  Facilitating better access to child and family support, health & early education.  Increase capacity and confidence of parents to enjoy parenting and improving capacity to care  Helping communities become more child friendly	Indigenous women  Parenting skills based program	Victoria  Aboriginal programs Horsham, Morwell, Geelong, Bairnsdale, Echucu Dendanongy/Casey.	(Middleton, 2009; Victorian Aboriginal Community Services Association Incorporated., Victorian Aboriginal Community Controlled Health Organisation., Victorian Aboriginal Child Association., & Incorporated., 2004)
Boorai Bumps 2009	Brings together hospital, Aboriginal health service – antenatal, ongoing support and pathways into services (through Connecting Young Parents – above)	Indigenous young parents  Parenting skills based program	Victoria Albury Wodonga	(Young, et al., 2009)
Connecting Young Parents Program 2009	20 participants – 12 months –  Aims to provide young parents aged 16 – 24 who have not completed education to re-engage with education, training & Employment	All young parents  Parenting skills based program	Victoria Alburby Wodonga	Link Employment: <a href="http://Linkemploy.org.au">Linkemploy.org.au</a>
Frankston North Community Renew project 12 Month program	Not health focused  Childcare provided. Training component is 5 weeks; two weeks of life skills; three weeks of employment skills			Promising Practice Profile (Young, et al., 2009)



Name and duration	Details	Target Group	Location	Reference
In Home Support	<p>Model allows flexibility for local Aboriginal organizations to meet local needs.</p> <p>Aimed for health/development/learning and wellbeing Aboriginal children from birth – 3 Strengthen, support and improve parent &amp; family capacity in culturally respectful way Promote social connections and links with services.</p> <p>Individual support (one on one – coaching and modeling) Group / Social connection Linking families with communities</p> <p>Qualified Aboriginal staff experience with working with vulnerable and complex families, modeling rather than expert approach. Strength approach.</p> <p>Sites required establishing Indigenous Working group.</p>	<p>Indigenous women</p> <p>Parenting skills based program</p>	<p>Victoria</p> <p>4 Koori maternity sites have implemented in home support program</p> <p>Mildura Aboriginal cooperative, Rumbalara Aboriginal cooperative Gillpsland and East Gippsland Aboriginal Cooperative and Victorian Aboriginal Health Services.</p>	(Middleton, 2009)
Koori Maternity Services Strategy	<p>AHW and midwives employed through Aboriginal Community Controlled Health organisations.</p> <p>Two models:</p> <ul style="list-style-type: none"> <li>• Midwife and Aboriginal maternity health worker provide clinical-linkage-advocacy –health promotion services, focused on outreach.</li> <li>• Aboriginal Health worker employed at local cooperative and/or hospital.</li> </ul> <p>Ante and postnatal care - breastfeeding support), education, birthing support and child health service. Transport is provided.</p> <p>Strengths are cultural appropriateness, flexibility, reliability, confidentiality, community based, Social networking, access to mainstream services</p>	<p>All Indigenous Women</p> <p>Primary Health Care Program</p>	<p>Victoria</p> <p>Across 12 sites</p> <p>Hume region moving to more integrated childhood service system for Aboriginal Community in Shepparton including Gana n burri (Aboriginal birthing suite and support for new parents), in home services, and Lidje Batdja children's services hub.</p>	<p>(Middleton, 2009)</p> <p>(Secretariat National Aboriginal and Islander Child Care, 2004)</p>

Name and duration	Details	Target Group	Location	Reference
Mums & Bubs Training  Certificate IV in Mothers & Babies  VACCHO Education and Training Unit	Support for young Indigenous mothers to gain a Cert IV in Mothers and Babies	Indigenous young mums  Education based program	Victoria	VACCHO Newsletter May 2009 Vol 2 Iss 7
Wajana Lidj  ongoing	Parenting course for Indigenous families adapted from the mainstream Parenting Australia course.  Group sets its own topics. An Aboriginal venue is used. Food and transportation for families living in outlying areas is provided. Children are present.  The parenting course is built around supporting parents to communicate with their children and to learn to set appropriate boundaries. The course builds on parent's existing strengths and uses the group's experience to help find solutions to improving communication in families.  Families have continued social contact after the course.  Fathers and grandparents are regular attendees. A spin off from the group has been gaining funding under the Indigenous Parenting Program to help prevent teenage pregnancy.	Indigenous  Parenting skills based program	Morwell, Victoria	(Secretariat National Aboriginal and Islander Child Care, 2004)
Women's Business Service  2000	WBS is a community controlled primary health care run from Mildura Aboriginal Health Service.  Registered midwife & Aboriginal Maternal Health Worker provide personalized service on 24 hr basis.  <ul style="list-style-type: none"> <li>• Antenatal / postnatal care</li> <li>• Health education</li> <li>• Support for clients during labour and birth.</li> </ul>	40 – 50 women use WBS a year, 75% are Aboriginal  Parenting skills based program	Victoria regional/rural  Mildura	(Middleton, 2009)

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Home visits/transport/ nurturing continuity of care

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## South Australia

Name and duration	Details	Target Group	Location	Reference
Anangu Bibi 2004 Ongoing	Aboriginal Family Birthing Program  Dedicated service  <ul style="list-style-type: none"> <li>• 5 part time midwives</li> <li>• 5 part time AMIC workers (advocacy &amp; brokerage)</li> <li>• Casework : until 8 weeks after birth (recommended to extend)</li> <li>• Clinic and home visiting</li> <li>• Grandmothers' roles &amp; traditional ways important.</li> <li>• Aboriginal Women's Advocacy Group</li> </ul>	Indigenous  Mothers & teen focus  Parenting skills based program	Regional SA  Port Augusta Whyalla	(Middleton, 2009; Stamp, et al., 2006)
Country Health SA is expanding program across rural SA  Funded through COAG				
Nganampa Health Council  1991 - ongoing  Remote	Antenatal care/birth Dedicated service  (YAWEP – Young Anangu Women's Education Program. Six sessions developed by Health Council – delivered in schools or clinics: key message is for young women to make pregnancy a conscious decisions – and to discuss spacing of children)	Indigenous teen  Education based program	SA  APY lands, remote	(Eades, 2004; Middleton, 2009; Nganampa Health Council, 2008)
Ngangkitta Ngartodli Karpandi (Supporting mums and babies)  2006 pilot project	Project Officer employed in Brokerage model access to mainstream  Integrated maternity care service.	Indigenous all  Primary Health Care Program	SA  Adelaide	(Middleton, 2009)

Name and duration	Details	Target Group	Location	Reference
Northern Women's Community Midwifery Program	<p>One stop shop.</p> <ul style="list-style-type: none"> <li>• NWCMP midwives</li> <li>• Hospital midwives</li> <li>• Aboriginal Health Workers</li> <li>• Aboriginal Young Mothers Worker</li> <li>• Mothercarers – home visiting by trained peers.</li> </ul>	<p>Indigenous – teen</p> <p>Parenting skills based program</p>	<p>Northern Metropolitan SA</p> <p>At Muna Paendi Indigenous Community Health Centre</p>	(Middleton, 2009)
Nunga Young Mums	<p>Parenting program, at Para West Adult Campus receive qualifications</p> <p>Based on the Incredible Years in US.</p>	<p>Indigenous young mums</p> <p>Education based program</p>	<p>SA</p> <p>Para West, Port Adelaide?</p>	AHCSA News Dec 2008
SA Healthy Ways 2001- ongoing	<p>Community Development Model – Health &amp; Wellbeing</p> <ul style="list-style-type: none"> <li>• Mums to be</li> <li>• Growing little kids up</li> <li>• Kids and young mums learning</li> <li>• School building bridges</li> </ul> <p>(around tobacco; nutrition; leadership; training)</p> <p>Whyalla – Indigenous Antenatal program for teenage mums</p>	<p>Indigenous- teen</p> <p>Parenting skills based program</p>	<p>Rural &amp; Remote SA</p> <p>Cooper Pedy Oodnadatta Marree Whyalla Yalata APY Lands Oak Valley</p>	(Middleton, 2009)
Young Mums Program 2003 pilot – ongoing	<p>School based program</p> <p>John Eyre School</p> <p>Student designed Integrated services</p>	<p>Teens</p> <p>Education based program</p>	<p>Whyalla</p> <p>Highest teen pregnancy rate in SA</p>	(Middleton, 2009)

## Northern Territory

Name and duration	Details	Target Group	Location	Reference
Congress Alukura 1991	<p>Indigenous Women's Health Service – primary care with traditional grandmother knowledge</p> <ul style="list-style-type: none"> <li>• Antenatal/postnatal</li> <li>• Gynaecological</li> <li>• Sexual assault/dv</li> <li>• Health ed</li> <li>• Transport</li> <li>• Health care worker training</li> <li>• Bush mobile</li> <li>• Clinic birthing centre.</li> </ul>	<p>All Indigenous women</p> <p>Parenting skills based program</p>	<p>NT</p> <p>98% of urban women from Alice Springs</p> <p>18% Rural women from area.</p>	<p>(Carter, et al., 2004; Middleton, 2009)</p> <p>Refer: <a href="http://www.crcah.org.au/research/alukura_antenatal.html">www.crcah.org.au/research/alukura_antenatal.html</a></p>
Gumileybirra Women's Health Service 1994 ongoing	<p>Women's Health Service</p> <p>Started Mums &amp; Bubs group in 2008</p> <p>Health education, health promotion, advocacy and co-ordination of care delivered by Indigenous staff.</p>	<p>All Indigenous women</p> <p>Education based program</p>	<p>Darwin, NT</p>	<p>(Middleton, 2009)</p>
Strong Women, Strong Babies, Strong Culture Program 1993 started as pilot. 1998 funded to expand to 14 communities.	<p>Strong Women Workers employed to support pregnant women to access care, eat properly and have infections treated, promote health care for children and others.</p> <p>Community development focus.</p> <p>Program depends on traditional authority of older women.</p> <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Dangers</li> <li>• Protection &amp; prevention – culture</li> <li>• Sharing</li> <li>• Caring – nurturing young women</li> </ul> <p>Culture and traditional women's ceremonies revived and practiced.</p>	<p>All Indigenous Women</p> <p>Education based program</p>	<p>NT</p> <p>14 communities</p> <p>Pilbara / Gasgoyne Health region</p>	<p>(Middleton, 2009)</p> <p>(Eades, 2004) (Secretariat National Aboriginal and Islander Child Care, 2004)</p>

## Western Australia

Name and duration	Details	Target Group	Location	Reference
Building Strong and Healthy Families in Derby	<p>Jalaris acts as resource and drop in centre for children 0 – 12 and young mothers.</p> <p>Supports engagement to other agencies.</p> <p>Child nutrition, school attendance, parenting skills, poverty, budgeting, substance abuse, violence, self esteem, child health &amp; development.</p>	<p>Indigenous</p> <p>Parenting skills based program</p>	<p>Derby – West Kimberley</p> <p>Jalaris Aboriginal Corporation</p>	(Secretariat National Aboriginal and Islander Child Care, 2004)
<p>Strong Women, Strong Babies, Strong Culture Program WA</p> <p>Based on NT Model</p>	<p>Two qualified Aboriginal Health Workers work with communities (strong focus on bush medicine and bush food).</p> <ul style="list-style-type: none"> <li>• Cooking classes</li> <li>• Direct contact with antenatal care in 1<sup>st</sup> trimester</li> <li>• Increase in fathers involved in birthing process</li> <li>• Increase in pap smears.</li> <li>• A Baby festival.</li> <li>• Storybook</li> </ul>	<p>All Aboriginal women</p> <p>(SNAICC report details Jalaris Aboriginal Corporation which acts as a resource centre and has established a drop in centre for children 0 – 12 years and for young mothers).</p> <p>Education based program</p>	<p>Western Australia</p> <p>3 communities in Kimberley 2 in Pilbara</p> <p>Communities were small 200 – 600 residents and between 30 – 160km to town with hospitals.</p>	<p>(Middleton, 2009)</p> <p>(Secretariat National Aboriginal and Islander Child Care, 2004)</p>

## International examples

Name and duration	Details	Target Group	Location	Reference
Aboriginal Head Start Initiative Quebec	<p>The program aims to help enhance child development and school readiness of the Algonquin, Cree and Attikamek First Nations.</p> <p>The programs are run by locally managed Aboriginal non-profit organisations and active parental and community involvement is a key aspect of the program.</p>	First Nations	Val d'Or and Seneterre, Quebec Canada	(Ball, 2008; Secretariat National Aboriginal and Islander Child Care, 2004)
Aboriginal Family Support Program	The program provides support to children and their families through culturally appropriate holistic, healing and preventative services. These services address child development from the pre-conception stage, and offer support and parental skills training.	Parents and youth in urban Aboriginal communities	Ottawa Canada	(Secretariat National Aboriginal and Islander Child Care, 2004)
Inuulitsivik Midwifery Services and Education Program  1986 ongoing	<p>The centre employs midwives to provide:</p> <ul style="list-style-type: none"> <li>antenatal and postnatal support</li> <li>staff the maternity ward at Puvirnituq in Nunavik.</li> </ul> <p>Aims to return childbirth to the remote Hudson coast communities of Nunavik, and to reconcile traditional practices with modern medical services.</p> <p>The midwifery services cover seven Nunavik communities with a total population of about 5500. Half the residents are &lt; 20; with a birth rate twice the Canadian average.</p>	Inuit people, Inuit region of Quebec	Nunavik Canada	(Middleton, 2009)
Parents as Teachers	This is an international early childhood parent education and family support program serving families throughout pregnancy until their child enters kindergarten, usually aged 5. It is designed to enhance child development and school achievement through parent education accessible to all families. It is a national model but a local program.	Early childhood parent education and family support	Ottawa Canada	(Secretariat National Aboriginal and Islander Child Care, 2004)



Name and duration	Details	Target Group	Location	Reference
Program for Early Parenting Support PEPS	<p>Sessions organised by Odawa native Friendship Centre take place once a week between 5-7.30pm. There is time for parents to share concerns and events, take part in activities with their babies and/or toddlers, enjoy a family snack together and participate in parenting-related discussion.</p> <p>The timing allows for working parents to take part. The program has become a weekly social event for families.</p>	Parents and families	Ottawa Canada	(Secretariat National Aboriginal and Islander Child Care, 2004)
Roots of Empathy	<p>This is a classroom program that aims to reduce aggression and bullying in children. It does so by adding 'emotional literacy' to the range of literacies incorporated into the curriculum. The program introduces babies into the classroom.</p> <p>Research results indicate significant reduction of aggression and increase in pro-social behaviour. Observations of a loving child relationship also gives children a model of competent parenting.</p>	Students School based program	Toronto Canada	(Secretariat National Aboriginal and Islander Child Care, 2004)
Vancouver Native Health Society (VNHS)	<p>Urban Aboriginal Health Centres are controlled and administered by a qualified team of Aboriginal people and recruit Aboriginal health professionals. A holistic philosophy of care blends traditional Aboriginal healing and Western medicine.</p> <p>The VNHS Walk-In Medical Clinic provides free, non-judgmental primary care and health promotion to all Vancouver's Downtown Eastside (DTES), residents.</p> <p>Aboriginal clientele of VNHS is now 40%, with a minority of the staff having an Aboriginal background.</p>	Urban Aboriginal women	Vancouver Canada	(Middleton, 2009)
Atawhaingia Te Pa Harakeke "Nurture the Family"	<p>This is a training and support programme that delivers to up to 90 Maori and Iwi providers. It is aimed at the safety and on-going wellbeing of Maori children. It helps children who have been affected by domestic violence and neglect.</p>	Community	Whangarei, Kainga New Zealand	(Secretariat National Aboriginal and Islander Child Care, 2004)
Sure Start	<p>Sure Start differs from most other early childhood interventions in two ways:</p> <ul style="list-style-type: none"> <li>• It is area-based rather than being targeted at specific groups of parents and children; this broadens access and avoid potential problems of stigma</li> <li>• Local programs have been given considerable autonomy</li> </ul> <p>Sure Start Children's Centres provide parenting support, health advice and support</p>	Disadvantaged families with children under 4	United Kingdom	(Middleton, 2009) (Secretariat National Aboriginal and Islander Child

for parents moving into employment.

Care, 2004)

Name and duration	Details	Target Group	Location	Reference
Baby Fast	<p>Families and Schools Together (FAST) and baby fast is a collaborative prevention and parenting involvement program. It is a research based, family support and prevention program for infants (0-3), their mother and the new mother's natural supports. It is a multi-family group process that brings together families of high school teenagers to build and enhance the relationships of young new parents.</p> <p>The program is structured around social activities for parents and families.</p>	Young new parents	Wisconsin USA	(Secretariat National Aboriginal and Islander Child Care, 2004)
Centering Pregnancy	<p>CenteringPregnancy provides antenatal care to groups of 8 to 12 women of similar gestational age over ten visits, with the group staying together for the duration of the pregnancy. In USA this is mostly African-American women.</p> <p>Women are examined in the group setting, clinicians can arrange individual follow up and group discussion follows.</p>	Antenatal care	USA (and Australia from 2008)	(Middleton, 2009)
<p>Early Head Start</p> <p>Established in 1994 as an extension to Head Start (commenced 1965)</p>	<p>Early Head Start is a federally funded program targeting children aged 0-3 from low income homes.</p> <p>Early Head Start was established in 1994 as an extension to Head Start, in response to the growing body of evidence about the critical nature of the period from birth to 3 for later development.</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>• early education (at home or at a centre)</li> <li>• home visits</li> <li>• parent education and health services, both antenatal and postnatal</li> <li>• case management and home support.</li> </ul> <p>Early Head Start has significant positive impacts on key developmental indicators and on parents.</p>	Low-income families with young children	USA	(Middleton, 2009) (Eades, 2004)
The Carolina Abercaderian Project	<p>The project was a carefully controlled scientific study of the potential benefits of early childhood education for poor children.</p> <p>Children from low-income families received full time, high quality educational intervention in a childcare setting from infancy through to age 5.</p> <p>Each child had an individualised prescription of education activities and consisted of</p>	Children from low income families	North Carolina USA	(Secretariat National Aboriginal and Islander Child Care, 2004)

“games” incorporated into the child’s day. The findings of the project underscore the importance of child development during the first five years of life.

Name and duration	Details	Target Group	Location	Reference
The Even Start Program	<p>The program provides literacy programs for families and children under 7 years who are classed as disadvantaged. The aim of the program is to break the cycle of poverty.</p> <p>The early childhood and adult education programs and the parenting programs are integrated into a unified literacy program.</p> <p>Parents and their children learn together. This builds support for parents to succeed with their educational and employment goals, and develop habits of life-long learning for their children.</p>	Disadvantaged families	San Diego California USA	(Secretariat National Aboriginal and Islander Child Care, 2004)

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