*Summary of a research project:*
*Preconception Care in a Remote Aboriginal Community Context: What, When and by Whom?*

# Preconception care delivery from an Aboriginal Community Controlled Health Service perspective

Aboriginal people face well documented inequalities in health outcomes, including reproductive health. Access to both acceptable, safe and reliable contraception for women who don't want to be pregnant and preconception care for women who might become pregnant (whether planned or not) is an important reproductive health right. Previously we described high uptake and continuation of Long-Acting Reversible Contraception (LARC) (etonogestrel implant, or Implanon) and talked to women about their experiences accessing contraception and other reproductive health care. Preconception care (PCC) is a priority for Aboriginal and Torres Strait Islander populations due to higher rates of pregnancy risk factors and adverse perinatal outcomes. It aims to improve the health of prospective parents by screening for and modifying risk factors that contribute to poor maternal and child health outcomes. This study aimed to explore the provision of PCC in participating communities.

### We aimed to find out:

- What preconception care is being delivered?
- Who is providing preconception care, and in what context?
- Are there any factors that predict whether women received preconception care?
- Are there any opportunities to increase the availability of preconception care for women?

### How was this study done?

We completed a retrospective audit of service delivery for PCC prior to 177 pregnancies in 127 women who resided in participating communities during their preconception period. We used guidelines from the Royal Australian College of General Practitioners (RACGP) to define key components of PCC and a search strategy of the electronic medical record system (MMEx) to record how often they were provided.

### What did we find?

Of 177 confirmed pregnancies, 121 had received PCC prior to the pregnancy. Sexually transmissible infection screening (71%) was the most common care delivered, followed by folic acid prescription (57%) and smoking cessation support (43%). Younger women received PCC less often, particularly screening for modifiable pregnancy risk factors (e.g. pre-diabetes/diabetes, albuminuria, overweight/obesity and smoking). These risk factors were common amongst those who did get screened (48-60%). Women who got PCC usually requested it themselves. Overall, PCC increased over time. Presentation for antenatal care in the first trimester of pregnancy was high at 73%.

### What happens now?

In parallel with this study, a regional Preconception Care Protocol has been developed through the Kimberley Aboriginal Health Planning Forum (KAHPF). Opportunities to increase PCC delivery include integration with routine health checks, pregnancy tests and chronic disease programs. PCC programs co-designed with young people are also recommended. All primary care providers should be supported and assisted to provide opportunistic PCC and health promotion. Clinic checklists to support increased preconception care delivery are in draft and will be further developed with clinics and the KAHPF Maternal, Child, Youth and Family Health Subcommittee. We will continue consultation to identify strategies to integrate PCC into existing models of care, to address an important need for women residing in remote communities.

***We would like to thank all the women in the participating communities for their contributions over several years, for which we are deeply grateful.***

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