Murdoch University | NGANGK YIRA INSTITUTE FOR CHANGE

Birthing on Noongar Boodjar

Cultural Security & Aboriginal Birthing Women

Project Report

Cultural Security & Aboriginal Birthing Women

Australian Government
National Health and Medical Research Council

Ngala kwop biddi.
Building a brighter future, together.

NHMRC Partnerships Project Grant GNT1076873

Birthing on Noongar Boodjar (BONB) Cultural Security and Aboriginal Birthing Women, 2024

ISBN: 978-1-921877-24-7

Cover design: Murdoch Design

We acknowledge Valerie Ah Chee, Pinjarup/Palyku midwife and artist, as the artist and designer of the Birthing on Noongar Boodjar logo. We thank her for the rights to use this wonderful design within our Project productions.

Ngangk Yira Institute for Change
Murdoch University
90 South Street, Murdoch, 6150
Western Australia

Funded by: The study was funded by the National Health and Medical Research Council (Partnership Grant #1076873) and supplemented by funding and other material support from 13 Partner organisations including Nursing and Midwifery Office and South Metropolitan Area Health Services, WA Department of Health.

Partner Organisations: Women and Newborn Health Service (King Edward Memorial Hospital); Derbarl Yerrigan Aboriginal Health Service; Murdoch University; Nursing and Midwifery Office (WA Department of Health); Aboriginal Health Policy Directorate (WA Department of Health); South Metropolitan Area Health Service; Pindi Pindi Aboriginal Corporation; North Metropolitan Ambulatory Care Health Service; Telethon Kids Institute; St John of God Murdoch (Healthcare); Notre Dame University, Fremantle; University of Kent; and the University of Saskatchewan.

Citation
Marriott, R., Reibel, T., Walker, R., Barrett, T., Kendall, S., Martin, T., Monterosso, L., Kotz, J., Coffin, J., Gliddon, J., Stanley, F. (2025) Birthing on Noongar Boodjar Final Project Report. Ngangk Yira Institute for Change, Murdoch University

Acknowledgment of Country

We acknowledge the Whadjuk people and Binjerab people of the Noongar Nation as the traditional custodians of the land on which both Murdoch University campuses are located.

We acknowledge and pay respect to all Elders past, present, and future and recognise the long history of Aboriginal and Torres Strait Islander peoples on the lands and seas. In doing this, we acknowledge that the past is not just the past but continues to impact on the present and the future.

Through our Birthing on Noongar Boodjar research we have an opportunity to influence the future and we are privileged to have the guidance of our Elders in this task.

Acknowledgment of Community

Many Aboriginal women have been involved in bringing the Birthing on Noongar Boodjar project to completion. To protect research participants' identities, we have not named individual participants in this report. We take this opportunity to thank:

The Aboriginal women and Elders who generously offered their cultural knowledge and expertise to our various governance and project committees and all the Aboriginal women who participated in yarns, yarning circles and community events.

We have aimed to genuinely represent your voices, the concerns you expressed and the strengths and wisdom you have shared with us.

Please note: Aboriginal people should be aware that this publication may contain images in photographs or names of deceased persons in printed material.

Human Resource Ethics Approvals

The project was approved by the following Human Research Ethics Committee (HREC):

Murdoch University Human Research Ethics Committee (2013/027)

The Western Australian Aboriginal Health Ethics Committee (Ref: 444)

The Western Australia Health Department –

- Women and Newborns Health Ethics Committee: RGS-2647 (prev. 2014005-EW).
- WA Health site approval included the following sites: Armadale Health Service, Bentley Health Services, Fiona Stanley Hospital, King Edward Memorial Hospital, Osborne Park Hospital, Perth Children's Hospital, Rockingham General Hospital, Royal Perth Hospital, South Metropolitan Health Service (2015-103) and Sir Charles Gardiner Hospital (2014-095).

Joondalup Health Campus (Project Ref: 1505)

St John of God Health Care (Project Ref: 656)

Contents

Contents

Executive Summary

An Aboriginal woman's pregnancy journey is a significant time that falls within the rich lineage of cultural and family practices. Yet this strength is often minimised by non-Aboriginal health professionals who Aboriginal and Torres Strait Islander women encounter during their pregnancy care. This results from a historical legacy of colonisation, still felt today by Aboriginal and Torres Strait Islander people; a continuing story of dispossession, trauma, and cumulative disadvantage, starkly reflected in inequitable health, and wellbeing outcomes.

It is well established that Aboriginal and Torres Strait Islander people across Australia are subject to unequal life course outcomes. The complex web of social, economic, health and educational influences that Aboriginal people are subjected to, with little influence over, is the environment in which our research has been conducted.

The Cultural security of Aboriginal mothers birthing in an urban maternity facility: Investigating Aboriginal women's cultural needs; and evaluating the cultural competency, workforce and education needs of midwives, renamed as the Birthing on Noongar Boodjar: Cultural Security of Aboriginal Birthing Women Project (BONB Project) is a response to contemporary approaches to maternity care which have not adequately considered what is required to nourish healthy futures for Aboriginal families in urban environments. Put simply, maternity care has not been considered in the right way, or designed by the right people, to provide the best start in life for Aboriginal children. The project considered the needs of the increasing number of Aboriginal families living in urban or large regional areas. We set out to address a knowledge gap between Aboriginal and non-Aboriginal concepts of what maternity care is and how it should be provided by a health system.

Understanding the needs for Aboriginal people in urban areas is particularly relevant for those involved in maternity care to meet the needs of Aboriginal women in a culturally meaningful way. The research was conducted across the Perth metropolitan area, on Noongar Boodjar (Noongar Country), within Western Australia. In this area, approximately 3.9% of the population identify as Aboriginal and/or Torres Strait Islander (ABS, 2016). This mainly consists of Noongar people but is also inclusive of many other Aboriginal cultural groups from across the state and elsewhere.

We worked closely with Aboriginal and non-Aboriginal partners from community-based health and higher education sectors in the collection and interpretation of the evidence. We knew that substantial and informative work was, and continues to be, done by others to improve health service delivery to Aboriginal people. This is crucial work aimed at a more culturally responsive, efficient and effective health care system. Adhering to principles of sustained and high-level engagement with Aboriginal people, the Aboriginal community has been our most significant Birthing on Noongar Boodjar (BONB) partner. Their partnership included joining governance and advisory committees, attending events, and actively contributing ideas about how the WA health system can provide maternity services which Aboriginal women feel safe to use.

We set out to address a knowledge gap between Aboriginal and non-Aboriginal concepts of what maternity care is and how it should be provided by a health system.

Executive Summary continued

This report presents evidence which demonstrates a deep insight into the multiple factors contributing to problems associated with providing culturally secure maternity care for Aboriginal women. Over five years of accumulating evidence, we identified many service gaps, issues and barriers within the Western Australian maternity care system. This included the need to address racism in health settings, strengthen the Aboriginal workforce, and the capability of the whole health system to provide care which supports Aboriginal cultural practices. This evidence has the potential to contribute to multidimensional, dynamic and sustained solutions that recognise the cultural, wellbeing and health needs of Aboriginal people. Expert stakeholders (including community members, researchers, policy makers, clinicians and service providers) have been collaboratively examining the problems and pinpointing the suite of solutions necessary to resolve this fundamental aspect of Indigenous disadvantage. The hope is that the information will influence a more efficient, effective, integrated and culturally secure maternity care system capable of responding to Aboriginal women and their families.

This evidence has the potential to contribute to multidimensional, dynamic and sustained solutions that recognise the cultural, wellbeing and health needs of Aboriginal people.

The strength of the Aboriginal community was continually emphasised in the evidence we collected. This included the importance of family, kinship and hearing the wisdom of the Elders and how these cultural practices have sustained Aboriginal women living on Noongar Boodjar during pregnancy, childbirth and the transition to parenting; described in Noongar as "*wongi mi bardup*", which translates as 'doing it our way'. Aboriginal women also described how women's business and men's business has adapted to take on contemporary practices, such as men being present at childbirth and how midwives could respond to their cultural needs and individual or family requests. The rich detail recounted by Aboriginal women also clearly demonstrated that Aboriginal women have actively resisted attempts to disrupt their knowledge and cultural practices.

From the perspective of midwives involved in interviews and focus groups for the project, it was evident that many were often left wondering how to best support Aboriginal women: *"where do [Aboriginal] women belong in culture? Where do they belong in relation to birthing?"*, or... *"they're coming to us and doing it our way, the way we do things."* One of the obvious gaps was a lack of understanding about Aboriginal culture, a perception that Aboriginal people were always "at-risk", and a tentative uncertainty on how to bridge these differences woven throughout the midwives' data.

The Birthing on Noongar Boodjar research has taken place amidst significant changes occurring across the WA health system. Unfortunately, much of this change has not translated to culturally secure maternity care for Aboriginal women in any significant way. As an investigator group, most of whom have been involved with maternity services or the health system for long periods of time, we have too often witnessed the loss of maternity care services designed for Aboriginal women. The reasons are related to a lack of commitment to evaluation or cost-benefit analyses combined with a lack of forward thinking as to how time-limited program or seed funding will be maintained for enduring service delivery. This outcome of this circumstance is continued disparity between the Aboriginal women and their infants and their non-Aboriginal peers.

Professor Rhonda Marriot AM

Therefore, if we do not listen to the evidence or take the opportunity to provide a place for the knowledge and voices expressed from the BONB project – as a society, we will continue to fail the future health of Aboriginal children in Western Australia.

The overarching message of this research that is communicated throughout this report is that Aboriginal people are strong, resilient and hopeful of changing the future for women and families birthing on Noongar Boodjar. We all know that the earliest years of a child's life shape future life chances and opportunities, and we have research and knowledge to ensure that Aboriginal children are no longer born into an environment that deems them the most disadvantaged people in Australia, from conception until death.

Professor Rhonda Marriot AM
Pro Vice Chancellor of Ngangk Yira Institute for Change

The overarching message of this research that is communicated throughout this report is that Aboriginal people are strong, resilient and hopeful of changing the future for women and families birthing on Noongar Boodjar.

Birthing on Noongar Boodjar Investigators*

Professor Rhonda Marriott^	Pro Vice Chancellor and Centre Director, Yorga Maaman Koolanga Research and Advocacy Centre, Ngangk Yira Institute for Change Murdoch University
Professor Roz Walker	Director, Coolamon Research and Advocacy Centre, Ngangk Yira Institute for Change Murdoch University
Tracy Martin*	Nursing and Midwifery Co Director Surgical & Specialist Care Directorate, Rockingham Peel Group, South Metropolitan Health Service, WA Department of Health Formerly Principal Midwifery Advisor, Nursing and Midwifery Office, Clinical Excellence Division, WA Department of Health
Terri Barrett*	Acting Executive Director, Child and Adolescent Health Service – Community Health, WA Department of Health
Professor Tracy Reibel	Stan Perron Charitable Foundation Chair, Systems and Policy Lead, Ngangk Yira Institute for Change Murdoch University
Professor Fiona Stanley	Founding Director and Patron, formerly Telethon Kids Institute now Kids Institute Australia, University of Western Australia, and, Patron, Ngangk Yira Ngangk Yira Institute for Change, Murdoch University
Professor Juli Coffin^	Ellison Professor Aboriginal Young Peoples Social and Emotional Wellbeing, Centre Director, Yawardani Jan-ga Research and Advocacy Centre, Ngangk Yira Institute for Change Murdoch University
Professor Leanne Monterosso*	Chair of Nursing (Clinical Research) Notre Dame University, Australia, and, St John of God, Murdoch Hospital
Janinne Gliddon^*	Formerly Aboriginal Senior Research Fellow, Ngangk Yira Institute for Change
Denese Griffin^*	Director, Aboriginal Health Strategy, Clinical Services Planning and Population Health, East Metropolitan Health Service, Department of Health+
Professor Dawn Bessarab^*	Director of the Centre for Aboriginal Medical and Dental Health, University of Western Australia
Jade Maddox^	Formerly Research Coordinator, Birthing on Noongar Boodjar Project, and, Cultural Co-Lead, Ngangk Yira Institute for Change, Murdoch University (retired)

Melanie Robinson^*	Director, Aboriginal Health Strategy, Office of the Chief Executive, Child and Adolescent Health Service, WA Department of Health
Jayne Kotz	Formerly, Senior Research Fellow, Ngangk Yira Institute for Change, Murdoch University (retired)
Professor Sally Kendall*	Professor of Community Nursing and Public Health, University of Kent, United Kingdom
Professor Angela Bowen*	Professor, College of Nursing: Associate Member, Psychiatry, College of Medicine, University of Saskatchewan, Canada
Glenn Pearson^*	Research Focus Area Head, Aboriginal Research, Kids Institute Australia, University of Western Australia
Sue Bradshaw*	Formerly, Manager, Midwifery Services, St John of God, Murdoch Hospital (retired)

*Adjunct, Ngangk Yira Research Centre for Aboriginal Health and Social Equity
+Government of Western Australia, Department of Health
^Indicates the named person is Aboriginal

Birthing on Noongar Boodjar Aboriginal Consultative Group

Janinne Gliddon	**Christine Parry**
Isabelle Adams	**Mara West**
Jade Maddox	**Denese Griffin**
Valerie Swift-Otero	**Leslie-Ann Conway**
Nola Naylor	**Marie Taylor**
June Councillor	**Marissa Verma**
Francine Eades	**Alison Bairnsfather-Scott**
Millie Penny	**Rhonda Marriott**

We also acknowledge the following people who contributed to the BONB Project in a variety of roles at various times across the project: Alison Bairnsfather-Scott^, Gail Yarran^, Anne-Marie Eades^, Lesley Nelson^, Millie Penny^, Jenny Dodd, Gabrielle Walker, Yvonne Hauck, Torna Moya, Lisa Morrison^ and Cecilia Strutt.

Terminology, Glossary of Terms and Abbreviations

Terminology

In this report:

Aboriginal is used rather than Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of lands which constitute Western Australia (WA). No disrespect is intended to our Torres Strait Islander colleagues and communities.

Aboriginal and Torres Strait Islander may be used at times in reference to the national context and Indigenous may be used in reference to international contexts, which acknowledges First Nations across the globe.

On Country or Country is a term used by Aboriginal people referring to the land to which they belong and their place of Dreaming.

Elder women are those who have gained recognition within their community as custodians of knowledge and lore, and who have permission to disclose cultural knowledge and beliefs. Recognised Elders are highly respected within Aboriginal communities (Ref: Australian Indigenous Health*Info*Net, Guidelines for Aboriginal and Torres Strait Islander Terminology **https://healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=675466&title=The+Australian+Indigenous+HealthInfoNet+guidelines+for+Aboriginal+and+Torres+Strait+Islander+terminology&contentid=44676_1**

Elder women are acknowledged by their communities as keepers of women's knowledge and 'business' and are respectfully acknowledged as an 'Aunty'.

Senior women are those who are acknowledge by their communities as being a leader and knowledge holders, but have not yet been recognised by their community as an Elder. With colonisation and dislocation of families from ancestral Countries for various reasons, some women who may not have grown up on their ancestral Country/their language group community are recognised for their leadership and standing in the community as senior women.

Glossary of Terms

Noongar terms, some used in this final report and others used by participants in the course of data collection, are translated here, as are frequently used abbreviations across the project.

Noongar Waangkiny (Noongar Terms)	
Term	**Description**
Boodjar	Land, Mother Earth
Boodjari Yorga/s	Pregnant woman/women
Derbarl Yerrigan	The Derbarl Yerrigan is a prominent river in the South West of Western Australia that runs through the metropolitan area of Perth, Western Australia. The river features significantly in Noongar lore and stories and is also known as the Swan River.
Maaman	Father
Maarwit	Baby boy
Mia Mia	Shelters, in this case referring to huts where family lived on Country.
Nbietj	Eldest Son
Ngangk Boodjar	The name given by the Aboriginal Artist Millie Penny to the collaborative mural developed with participants at the Birthing on Noongar Boodjar Symposium (2018). Together the words convey mother, sun, life-giver and boodjar is Country/land/our mother earth.

Term	Description
Ngangk Yira	Ngangk means both 'mother' and 'sun'. Alongside the Noongar word Yira, the meaning expands to: the rising sun (ngangk yira). Together, they have added spiritual meaning for the sun's giving of life to all things in its passage across the sky.
Ngaarnk	Mother
Noongar Boodjar	Noongar Country consists of 14 language groups located in the South West of Western Australia, extending from north of Jurien Bay, inland to north of Moora down to the Southern coast to Bremer Bay and east of Esperance.
Noongar, Nyungar, Nyoongar, Nyoongah	All represent the language and cultural group which occupies Noongar Boodjar. In April 1991, a meeting of Noongar Elders, convened by the Noongar Language and Culture Centre and held in Narrogin, decided the preferred orthography is 'Noongar'.
Wadjela	A term used to describe non-Aboriginal (usually white) people.
Whadjuk or Wadjuck	Both are accepted written representations of the people whose Country occupies the greater metropolitan region of Perth within Noongar Country.
Wongi mi bardup	'*doing it our way*'. A phrase used by a Noongar Elder during round table discussions held at the 2018 three-day BONB symposium. Explained as Aboriginal people be provided with authentic opportunities to participate in the development of, for example, health policy; the phrase emphasises Aboriginal ways of working and a need for Aboriginal people to have access to resources to do things in their own way. The phrase also reflected the general vision of what the project set out to achieve.
Yorga/s	Woman/women

Abbreviations

ACG*	Aboriginal Consultative Group
BONB	The shortform representing *The Cultural security of Aboriginal mothers birthing in an urban maternity facility: Investigating Aboriginal women's cultural needs; and evaluating the cultural competency, workforce and education needs of midwives;* also known as the Birthing on Noongar Boodjar: Cultural Security of Aboriginal Birthing Women Project (BONB Project) or BONB
CIA	Chief Investigator A (also referred to as the Project Lead)
CLB*	Cultural Leadership and Brokerage Group
EDGE*	Evidence Synthesis and Development Guideline Executive Governance Group
M&M*	Methods and Methodology Group
MWE	Midwifery Educator
PSC	Project Steering Committee
P&T*	Policy and Translation Group
RA	Research Assistant
RC	Research Coordinator
RF	Research Fellow
RM	Registered Midwife
SRF	Senior Research Fellow

*These Groups were all part of the overall Governance structure for the BONB Project, detailed on page 16.

Tables and Figures

Table	Name	Section
Table 1	Governance and Research Activity Management	Governance
Table 2	Study Sample	Study Sample
Table 3	All Data Sets Evidence and Data Group Themes	Data Interpretation
Table 4	Aboriginal Birthing Women's Evidence: Primary Themes and Sub-Themes	Aboriginal Birthing Women's Findings
Table 5	Aboriginal Senior Women's Evidence: Primary Themes and Sub-Themes	Aboriginal Senior Women Findings
Table 6	Aboriginal Elder Women's Evidence: Primary Themes and Sub-Themes	Aboriginal Elder Women Findings
Table 7	Midwives Evidence: Primary Themes and Sub-Themes	Midwife Findings
Table 8	Midwifery Focus Group Evidence: Primary Themes and Sub-Themes	Midwifery Focus Group Findings
Table 9	Midwifery Education Evidence: Primary Themes and Sub-Themes	Midwifery Educator Findings
Table 10	Cultural Security Statements	Knowledge of Cultural Security
Table 11	Proportion of Aboriginal and Torres Strait Islander Women in a Service Birthing Off Country	Knowledge of Aboriginal and Torres Strait Islander Women
Table 12	Wellbeing Knowledge Statements	Knowledge of Aboriginal and Torres Strait Islander Women
Table 13	Knowledge of Cultural Security Factors	Knowledge of Aboriginal and Torres Strait Islander Women
Table 14	Confidence in Caring for Aboriginal and/or Torres Strait Islander Mother and Families	Application of Cultural Security Training to Professional Practice
Table 15	Training Impact on Responses and Practice with Aboriginal and/or Torres Strait Islander Mothers and Families	Application of Cultural Security Training to Professional Practice
Table 16	Training Provided Skills to be Reassuring when Aboriginal and/or Torres Strait Islander Mothers in a Service	Application of Cultural Security Training to Professional Practice
Table 17	Training Impact on Understanding Aboriginal and Torres Strait Islander People and their Culture	Application of Cultural Security Training to Professional Practice

Background

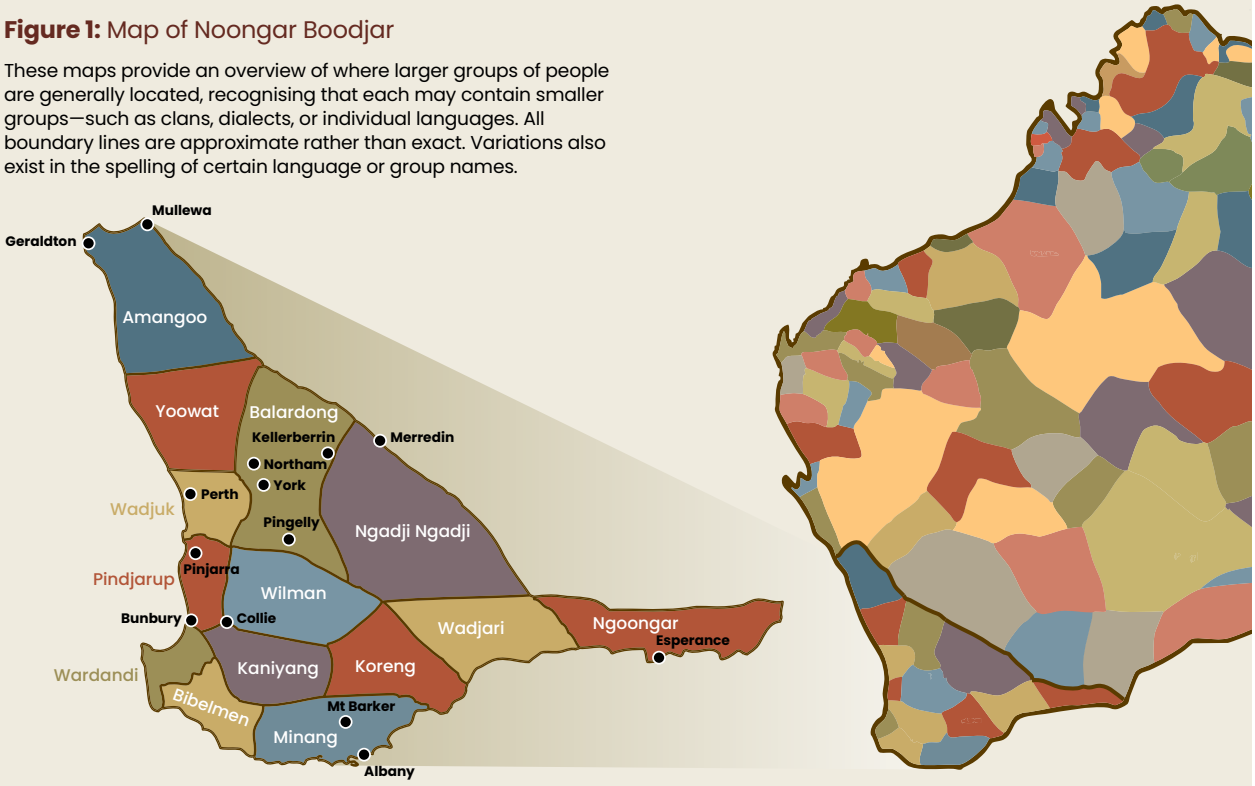
The cultural security of Aboriginal mothers birthing in an urban maternity facility: Investigating Aboriginal women's cultural needs; and evaluating the cultural competency, workforce and education needs of midwives, **renamed Birthing on Noongar Boodjar: Cultural Security of Aboriginal Birthing Women project (BONB), after ethics approvals, commenced data collection in 2015, completing in 2020 with the finalisation of the Recommendations. A central aim was to determine the types of changes required to promote better maternal and infant outcomes for Aboriginal families in Western Australia.**

Birthing on Country for Australian Aboriginal women is an intimate, personal and life-changing experience that requires a woman to make many decisions, including where to give birth and, if they desire to, how to best maintain their cultural and spiritual practices (Kosiak, 2014).

For Aboriginal people, birthing on Country refers to women giving birth on the land of her own birth or that of the father of her child. This is culturally significant for the future of the baby and their belonging to that country (Jones, 2012). For many, birthing on Country ensures a spiritual connection to the land of the mother's (or father's) community for their baby. This desire is rarely understood by non-Aboriginal people to be relevant in urbanised environments, including health professionals involved in maternity care.

Figure 1: Map of Noongar Boodjar

These maps provide an overview of where larger groups of people are generally located, recognising that each may contain smaller groups—such as clans, dialects, or individual languages. All boundary lines are approximate rather than exact. Variations also exist in the spelling of certain language or group names.



By tradition, care and support for mother and child prior to and after the birth is an important component of women's business, intrinsically connected with other Aboriginal Lore, which are inherited through Dreaming. A powerful Lore associated with women's business is Grandmothers' Law (Ramsamy, 2014; Wall, 2010, 2017) which holds much spiritual and cultural significance to Dreaming, Country, community and family. This is one of the reasons why Grandmothers are revered and acknowledged as being the backbone of Aboriginal societies. As such, Senior and Elder Aboriginal women engage in teaching and supporting younger childbearing women within their communities to maintain cultural practices. These *ways of being* assist the functioning, wellbeing, continuance and 'balance' of Aboriginal community life: a constant across time and highly relevant to contemporary models of maternity care available to Aboriginal women, but which are largely missing in maternity care systems.

Cultural security has a central concept in the BONB project for its relevance to designing health services which support Aboriginal people to achieve good outcomes. Coffin (2007, 2018) has described a continuum of change required in health services which starts with cultural awareness and includes ongoing genuine efforts to create culturally safe service delivery, brokered through Aboriginal protocols of engagement and consultation, towards attainment and sustainability of cultural security.

The BONB project focussed on cultural childbirth practices and risks to these in urban settings when culturally safe maternity care may not be available to Aboriginal women. In the broader Australian society generally, including among health service personnel, there are varying understandings of the importance of the social, cultural, and spiritual practices of Aboriginal people. Although the influence of the 'cultural determinants of health' have entered health services dialogue (for example, Western Australia Department of Health, 2015) the precise relationship between cultural practices and health professionals' perceptions of Aboriginality is an understudied phenomenon in Australia (Waterworth et al., 2015; Zubrzycki, Shipp, & Jones, 2017).

By tradition, care and support for mother and child prior to and after the birth is an important component of women's business, intrinsically connected with other Aboriginal Lore, which are inherited through Dreaming.

Background continued

To establish the scope of the BONB project, in consultation with peers, the Project Lead, an Aboriginal nurse/midwife and leading academic in Aboriginal health – Professor Rhonda Marriott AM – initially identified who might be included in an investigation of Aboriginal women and Birthing on Country. As Chief Investigator A (CIA), she focussed on the necessity of investigating the needs of Aboriginal women giving birth in a densely urban Australian context – the Perth metropolitan area of Western Australia, known to the original custodians as Noongar Boodjar, which includes the Whadjuk, Ballardong and Binjarab peoples. While the importance of birthing on Country for Aboriginal women located in rural, regional or remote locations is gaining traction among Aboriginal and non-Aboriginal researchers, there is a scarcity of literature or evidence about women's experiences when their Country has been highly urbanised. Prior to inviting investigators onto the project, Professor Marriott also determined the variety of knowledge and skills that would be required in a project team to ensure the research outcomes would be achieved using culturally secure processes and with a high degree of relevance and translatability to the WA health system.

To this end, Aboriginal and non-Aboriginal experts joined the investigator group of 18 together with 13 partner representatives from the university, Aboriginal community-controlled organisations and public and private health sectors. This resulted in a broad range of skills and knowledge, including cultural expertise, clinical practice, research knowledge, health system knowledge, and diverse work and life experiences.

The central focus of the BONB study was related to Aboriginal women's experiences of maternity care and the types of cultural birthing practices they want to continue and have supported by maternity services.

Collectively, the expertise and reach of the BONB project team enabled communication of the project's progress along the way to the Aboriginal community and partner organisations which, in turn, maintained the cultural integrity required to conduct culturally secure research with Aboriginal people and reach culturally informed project conclusions. This achievement was evident in the culmination of viewpoints brought together at the penultimate BONB project event held in April 2018, referred to throughout this report.

The central focus of the BONB study was related to Aboriginal women's experiences of maternity care and the types of cultural birthing practices they want to continue and have supported by maternity services. As most Aboriginal women access maternity care through public maternity services where they may more frequently encounter midwives or midwife-led maternity models of care, midwives were included in this study as we needed to know what they understood about Aboriginal women's cultural and personal needs during childbearing. The outcomes of both sets of perspectives provided evidence which informed the final project recommendations.

Governance

To maintain cultural integrity and research rigour, a comprehensive governance structure was devised which included:

- Aboriginal protocols framing the project's governance.
- Effective governance and management of the collaboration.
- The purposeful sharing of, and instruction in, Indigenous research methodologies and Indigenist research practice methods.
- Consistent promotion of the project's progress to maintain accountability and relationships with other groups in similar fields of research.
- Effective leadership in all elements of the research process.

The original project proposal had included six streams of governance and research management. In July 2015, these were renamed and realigned to reflect specific elements of the project:

Table 1: Governance and Research Activity Management

Governance and Research Activity Management	
Governance	
Steering Committee	Provide strategic direction of research activities.
Evidence synthesis and Development Guideline Executive (EDGE)	Provide oversight on outcomes of the research aims including the development and implementation of potential cultural security conceptual frameworks from the research findings, the translation to practice and the recommendations for policy changes at State and National Levels.
Aboriginal Consultative Group (ACG)	Provide strong cultural leadership & guidance, advice and scrutiny for the Project Team. Assist in planning and guidance for consultative activities with community.
Cultural Leadership and Brokerage (CLB)	Provide Cultural expertise and guidance to ensure the cultural integrity and security of the project, the analysis and translation.
Methods and Methodology (M&M)	To inform practice, education and service delivery. Contribute to plans for dissemination and policy taking account of cultural implications.
Policy and Translation (P&T)	Refine translation of findings and policy outcomes from the analysis.
Supporting Committee	
Symposium Organising Committee	Event organising and management for a 3-day symposium held in April 2018.
Research operational team at Ngangk Yira Research Centre, Murdoch University Chief Investigator A(CIA); Senior Research Fellow (SRF); Research Fellow (RF); Research Coordinator (RC); and Research Assistants (RA)	Day-to-day research and administrative support including ethical and financial oversight. Management of data collection, transcription, analyses and translation activities (project presentations, publications, newsletters, etc). Three different SRFs were appointed for varying periods across the BONB project.

Methodology and Methods

Aboriginal and Non-Aboriginal Researchers Working Together

The 'how to' of building knowledge and shared understanding of the research questions related to what Aboriginal women and families need during childbearing was premised on the creation of a platform for genuine knowledge exchange. The knowledge from women and midwives could then be used by the investigator group, project team, and Aboriginal Consultative Group to resolve issues identified in the data and formulate consensus driven solutions for translation to maternity care services. This could only occur by working and learning together. As such, it was essential that the Aboriginal and non-Aboriginal investigators and research assistants who made up the project team could work collectively and collaboratively with culturally determined methods of engagement and interpretation and a decolonising process which explicitly applied Aboriginal-led knowledge and privileged Aboriginal worldviews. This required an Indigenous informed research framework complemented by research methods which supported the approach.

Indigenous Research Framework

Indigenous scholarly work framed the methodology with Aboriginal *'ways of doing'* central; while Indigenist research practices directed the study design, data collection, analysis and interpretation. This approach enabled the formation of robust recommendations, which maintained the cultural integrity of the project's aims.

Indigenist research practices decolonise and circumvent Western research practices. When research is led by Aboriginal people, it is reclaimed and framed through Aboriginal knowledge lenses to focus on issues of importance to Aboriginal people (Geia, Hayes, & Usher, 2013; O'Donnell & Kelly, 2011; Saunders, West, & Usher, 2010). Martin and Mirraboopa (2003) summarise Indigenist research practice as occurring 'through centering Aboriginal Ways of Knowing, Ways of Being and Ways of Doing in alignment with aspects of Western qualitative frameworks. This alignment or harmonisation occurs in both the structure of the research and in the research procedures' (p. 211).

The BONB research intentionally practised and prioritised Aboriginal knowledge systems and perspectives. This approach challenged non-Aboriginal investigators to think 'outside their Western paradigms'. Workshops presented by Aboriginal experts early in the project supported the investigator group to explore and focus on the variety of Aboriginal cultural practices and lenses used to 'read', 'see' and 'hear' that which surrounds each of us every day, breaking through dominant research practices to form new, culturally informed perspectives.

The Indigenous research framework promoted capacity building of non-Aboriginal investigators into ways of doing business in Aboriginal contexts; viewing the world through different lenses and ways of thinking that developed their own understanding of Aboriginal ways of knowing, being and doing, reversing dominance of Western research practices. This included learning to be comfortable with being uncomfortable when faced with different ways of thinking (Airhihenbuwa, 2007; Airhihenbuwa & Liburd, 2006). Documenting our approaches to research undertakings was crucial for supporting future collective research on issues of importance to Aboriginal people.

The framework also needed to support intercultural research perspectives and provoke investigators to 'reflexively examine their impact and position within Indigenous research' (Kelly, 2013; Russell-Mundine, 2012). Muller (2012) describes the application of Ganma in research practice as the bringing together of Indigenous and non-Indigenous knowledges in a 'two-way' process. Central to her proposition is that Indigenous knowledge exchange practices have been sustained over millennia and, as such, should not be slotted into or alongside non-Indigenous research practices to justify a research process. Instead, well-articulated and respectful consideration enables the merging of different knowledge systems.

In response, our collective approach privileged Aboriginal voices, resisted 'Western' dominance and maintained cultural integrity. We did this by engaging in deep listening practices (Dadirri) in settings that promoted respectful knowledge exchanges to reach agreed interpretations (Ganma).

Methodology and Methods

Ganma (Knowledge Sharing) and Dadirri (Listening Deeply to One Another)

These two concepts were critical for blending Aboriginal and non-Aboriginal worldviews and knowledges. From the Yolngu people of Arnhem Land, Ganma is explained using the metaphor of fresh and salt water merging. When the waters mix, origins are not forgotten but are merged to create – in our case – shared meanings. Dadirri, from the Ngangiwumirr language group (Northern Territory), is explained as a concept of inner, deep listening. Dadirri requires being quietly aware, listening and watching, with all people recognised as being unique, diverse, complex and interconnected; part of a community where all people matter and all people belong. Accordingly, it is a way of learning and of building knowledge together (Ungunmerr Baumann, 2002).

Both concepts were highly relevant for generating new ways of thinking about, interpreting and expressing the data and its ability to authentically represent Aboriginal experiences. Over time, as the research proceeded, these concepts assisted the investigators to collectively maintain the centrality of Aboriginal worldviews, both when reflecting on our collective processes and progress, particularly when examining the data through an array of interpretive filters.

Western paradigm research techniques compatible with decolonising practice and excellence in research practice were: the worthiness of the topic; ensuring sincere, credible and ethical research rigor; and meaningful coherence which resonates with all those involved (Tracy, 2010). Combining Aboriginal and compatible mainstream methods creates an authentic, culturally secure and meaningful framework from which to undertake the research and provide optimal circumstances for investigating the research questions.

Figure 2 Explanation of Ganma

When two different waters meet to create Ganma, they diffuse into each other, but they do not forget who they are, or where they came from. The metaphor is useful for guiding how people from differing cultures and backgrounds can share deeply, without losing their history or integrity. In this way, Ganma theory explains how Indigenous and non-Indigenous people can negotiate to create new knowledge and understanding by working respectfully together and taking time to listen, and 'see/hear' what is revealed.

(Yunggirringa & Garnggulkpuy, 2007, as cited in Laycock, Walker, Harrison, & Brands, 2011).

Cultural Security

Cultural security was a central principle which the research sought to fully understand in the context of maternity care and also for relevance to conducting culturally secure research. This was particularly important, as the project team of 18 included both Aboriginal and non-Aboriginal experienced and novice researchers. Our understanding of cultural security was guided by the work of Coffin (2007, 2018) who describes cultural security as the 'pinnacle' of achievement in health care, with cultural awareness and cultural safety as steps towards cultural security.

Methodology and Methods

Figure 3 Participants at the 2018 Birthing on Noongar Boodjar Symposium

Critical Reflexivity

Additionally, it was essential that we maintained critical reflexivity in all our processes and that power relations across the whole team were 'neutralised' (Karnieli-Miller, Strier, & Pessach, 2009); requiring investigators to individually interrogate their worldviews and knowledges to ensure these could be effectively and respectfully blended to achieve the project aims. This required intentional and consistent critical thinking and reflexivity on everyone's part as we walked the research journey across the life of the project.

West et al. (2012) noted that critical theories are useful in focussing on issues of power, oppression, inequities and disadvantage, and that a critical lens is able to reveal how gender, class, race and historical factors affect an individual's health. While they also note problems associated with the use of critical theory, in the main they determined it is used by many Indigenous scholars and, in broad terms, is a means of promoting a conscious disruption of a status quo. They also refer to Dadirri as a purposeful plan to act, informed by wisdom and the responsibility that comes with knowledge, extending Ungunmerr Baumann's (2002) description.

In our case, we used reflexive critical thinking and Ganma to explicitly interrogate the unconscious and uncritical ways in which a healthcare system and individual services, and those who work in these, perpetuate ineffective and inappropriate health care for Aboriginal women based on a lack of knowledge of the cultural needs and personal desires of Aboriginal women before, during and after childbirth.

Further, we used Dadirri to purposefully act on the critically reflexive processes of analysis and interpretation through a commitment to act collectively and with cultural integrity when formulating and translating the outcomes of the research.

Yarning

The yarning method is an Indigenist research practice (Bessarab & N'gandu, 2010; Lin, Green & Bessarab, 2016) involving different yarning types (for example, 'social', 'research', 'collaborative', 'therapeutic', 'clinical', 'diagnostic') to collect stories (information) from Aboriginal research participants (or patients in clinical interactions). Storytelling is a well-established practice in many Indigenous cultures, including for Aboriginal people (West et al., 2012). Yarning used in research draws on this established cultural practice in a specific way, with listeners respectfully guiding a storyteller towards the topic of interest or enquiry.

The yarning method was chosen as the most appropriate means through which to undertake data gathering with Aboriginal women participants, as it is considered culturally prescribed and cooperative, and respectfully prioritises Indigenous ways of communicating (Geia et al., 2013; Walker et al., 2014). While data gathering with Aboriginal women was conducted by Aboriginal researchers and research assistants who were known in the community, all project investigators required familiarity with the yarning method as essential background knowledge for data interpretation.

To this end, investigator Dawn Bessarab presented a workshop to investigators and research assistants; introducing fundamentals and how to effectively use yarning to explore research questions with Aboriginal women. In a research process, this starts with 'social yarning', which itself relies on a storyteller and story listener developing a rapport, often based on cultural exchange. For example, sharing details of kinship or commonly held community relationships or stories of Country. Depending on the context and purpose, social yarning is then used alongside other yarning types (research yarning and collaborative yarning), which may involve direct and/or indirect enquiry.

Methodology and Methods Conclusion

Over the course of the project, as learning and knowledge developed across the project team, Aboriginal ways of knowing, being and doing, achieved through the practices of ganma, dadirri and yarning permeated our processes. Having the capacity to critically read our participant data and collectively reach interpretive conclusions validated the theoretical foundations on which we investigated what Birthing on Country means for Aboriginal women and what their experiences of maternity care had been.

As such, BONB was a study which heard through yarning of Aboriginal women's experiences (stories) of childbearing and midwives' experiences of providing care to Aboriginal women. The experiences were subject to rigorous and deep reflection and discussion (using Dadirri) to collectively produce trustworthy and representative knowledge interpretations (using Ganma). That new knowledge formulated sincere and credible representations of women's experiences which, in turn, contributed meaningful coherence in the framing of outcomes through the filter of Aboriginal lenses, leading to ethical formation of recommendations based on the collected evidence. The recommendations held a high truth value and were applicable and relevant to health system policies, clinical practices and service delivery modelling.

1. Conduct of Project

This section describes the study design, study sample, participant data collection and data analysis processes. As the project was conducted using an Indigenous framework developed from the work of Indigenous scholars, and incorporating Indigenist and compatible mainstream qualitative research practices, the detailed conduct of project description supports the outcomes while providing important background for future research projects aimed at addressing questions of significance to Indigenous peoples.

1.1 Study Design

The qualitative study design was purposefully developed using Indigenous theoretical concepts described in the previous section to frame culturally secure research processes. The principled approach to this project drew on methods from Indigenist research practices (e.g. yarning, dadirri and ganma); combining these with compatible mainstream qualitative practices (e.g. establishing topic worthiness, semi-structured interviews and ethical conduct). For example, a core research principle was to always maintain cultural integrity in the conduct of rigorous research. As such, all research methods were chosen for the capacity of these to maintain culturally safe data collection and data analysis, while the project's research framework ensured that Aboriginal cultural knowledges and ways of knowing, being and doing were the primary lenses through which all data would be interpreted.

1.2 Study Sample

Qualitative data was collected from a total of 145 participants, selected through targeted snowballing across community and professional networks. Participants' data were included in one of **six data groups**, shown in Table 2. The **Aboriginal Women data set** (n=74) included three data groups: Birthing women (n=39) representing those with contemporary childbearing experiences (most recent birth <10 years); Senior Women (n=11); and Elder Women (n=24). The **Midwives' data set** (n=71) included those working in clinical roles, university and professional development education, management and some midwifery students (in focus groups), represented in three data groups: individual midwives (n=20); midwifery focus groups (n=41); and midwife educators (n=8). Two midwifery administrators were also interviewed, but their data was not analysed as a part of any midwives' data group. Rather, a summary of their interviews precedes presentation of the midwives' results. Midwife participants ranged from newly graduated (~2 years postgraduate experience) with more experienced participants, some with up to 30 years' experience at the time of interview or focus group participation.

Table 2: Study Sample

Study Sample	
Data Groups	**# of participants**
Aboriginal Birthing Women	39
Aboriginal Senior Women	11
Aboriginal Elder Women	24
Sub total	**74**
Midwife (Individual)	20
Midwife Focus Groups (includes students)	41
Midwifery Educators	8
Midwifery Administrators	2
Sub total	**71**
TOTAL	**145**

1.2.1 National Survey

A national survey undertaken in collaboration with the Australian College of Midwives in the early part of the project resulted in completed surveys from midwives (n=118) and midwifery educators (n=32). The purpose of the surveys was to determine if there was a broader resonance in the midwifery profession nationally with the questions being examined through the qualitative data, as these related to questions of cultural security, cultural competence and delivery of care to Aboriginal women and the extent to which midwifery education varied across jurisdictions. Selected outcomes of these surveys are reported and used to compare some core qualitative outcomes.

1.3 Data Collection

The study included multiple Aboriginal researchers/research assistants undertaking yarning with Aboriginal participants to collect their stories, and Aboriginal and non-Aboriginal researchers undertaking interviews and focus groups with midwives. Data collection commenced in 2015 and was finalised in early 2018. Prior to data collection commencing, training was provided in the yarning method. Yarns, yarning circles, interviews and focus groups were audio recorded, transcribed verbatim and de-identified using a unique identifier for each group or participant (in the case of individual yarns/interviews). With multiple data collectors, yarning and semi-structured interview guides prompted consistent approaches to data collection while at the same time allowing for the yarning method, which draws on strongly held cultural practices associated with knowledge and information exchange to inform all yarns/interviews. Importantly, the yarning method provided a culturally secure way for Aboriginal women to participate in yarns and yarning circles.

1.3.1 Aboriginal Women

In yarns and yarning circles, we were interested in understanding from Aboriginal women what their experiences of maternity care were, what this had meant to them, what cultural practices they had support for, or wanted support for, and what their perspectives were of midwives and health services in general during their maternity care interactions.

In late 2015, a small number of Elder women participated in one-to-one yarns with Aboriginal researchers known to them. Throughout 2016 and 2017, Aboriginal women with recent experiences of childbearing and Senior women were individually invited to 'have a yarn' with an Aboriginal researcher/research assistant. In 2018, two groups of Elder and a few Senior women participated in yarning circles with project investigators at the Ngangk Yira Institute for Change, Murdoch University.

Yarning with Aboriginal women participants (described in data analysis as Birthing Women, Senior Women, and Elder Women) was mostly with an Aboriginal woman researcher or research assistant in a location of each participant's choosing. This provided the right circumstances to allow the women to freely and frankly yarn. However, the yarning circles held in early 2018 brought together Elder and Senior women with project investigators (Aboriginal and non-Aboriginal) for group discussions. These yarning circles were held to collect the women's birth stories for reproduction as posters to be displayed at a three-day project symposium held in April 2018. The yarning circles provided an opportunity to practise Dadirri and Ganma. Directly following each of the yarning circles, the Elder and Senior women paired with an investigator or research assistant to yarn further about their individual birth stories. These individual yarns were transcribed and, in consultation with the women, edited to create their birth story poster content. The yarning circles and individual birth story yarns generated as a result of these enriched the individual Elder yarns recorded in 2015, providing a third robust data group to complete the Aboriginal women's data set.

1.3.2 Midwives

Throughout 2016, semi-structured interviews were conducted with individual midwives and three midwifery educators. In the same year, five focus groups were conducted: three were held with midwives and midwifery students; one with midwifery educators, and one with non-Aboriginal midwives working in an Aboriginal specific maternity group practice.

The approach to the semi-structured interviews with midwives, while not dissimilar in nature to the yarning with Aboriginal participants, were less storytelling oriented and more a question-and-answer style. Most individual interviews were conducted face-to-face, with some telephone interviews, and undertaken by an SRF or one of the Investigators with extensive experience in qualitative data collection. The focus groups were less structured with the facilitator (CIA) posing questions and allowing the discussion to unfold among the focus group participants, with occasional prompts.

All midwife interviews and focus groups explored workplace practices, their experiences of caring for Aboriginal women, their knowledge of Aboriginal birthing practices and how organisations support cultural education and assess cultural competence.

Interviews with midwifery educators employed in both pre and post registration education programs were focussed on how curricular addresses the diversity of cultural needs of Aboriginal women during their maternity care.

1.4 Data Analysis

Data collected from Aboriginal women and midwife participants were iteratively analysed. Iterative analysis in qualitative research uses a reflexive process to provoke insight and develop meaning-making (Srivastava & Hopwood, 2009). As participant data were collected, the process commenced with individual coding of a transcript in a first parse manual coding, undertaken individually by multiple investigators on randomly selected transcripts to establish initial coding profiles. Individual manual coding efforts were combined into detailed coding lists, initially for the Birthing Women and Individual Midwife data groups. These coding lists were a starting point for collective coding discussions, which took place in investigator meetings and analysis workshops when data coding were compared for similarities and differences. The coding lists prompted the process of theme grouping as each layer of review and discussion brought insights to what was being read, how these were being interpreted and what meaning making was emerging. Over time, this iterative practice also enabled identification of thematic groupings in each of the data groups which would make up the Aboriginal women and midwives data sets (Table 3). The cycles of data interpretation enabled investigators to reach collective perspectives of what the data were revealing in relation to the research questions.

To manage the increasingly complex coding pertaining to many participants in each data group, transcripts and coding lists were imported into NVivo (V11 at the time). The use of NVivo enabled systematic management for each **data group** and the two **data sets**. For the Aboriginal women's data set, the groups were finally distinguished as Birthing Women (*data group one,* those with contemporary experiences of pregnancy); Senior Women (*data group two*) and Elder Women (*data group three*) all with past maternity experiences. This grouping differentiated experiential changes Aboriginal women reported across time and generations. The Midwives' data set distinguished individual midwife participants (*data group four*); midwifery focus groups' participants (*data group five*); and Midwifery Educators (*data group six*) comprised university-based educators and those responsible for professional development in hospital settings who were considered separately from midwives in clinical and management roles.

In between investigator meetings and workshops, the Senior Research Fellow continued to further refine coding, themes and sub-themes for each data group in consultation with the Project Lead, with significant analysis milestones reported at Investigator meetings for further discussion and clarification.

The multilayered iterative processes of critical engagement and reflexivity by investigators working individually and in group analysis workshops underpinned the achievement of agreed interpretations and shared understanding of the extent to which, in what ways and why, meanings, understandings and everyday experiences of participants were expressed in the data. This was achieved through multiple layers of data coding and thematic identification, refined over time, as the data were read, discussed and reread against emerging thematic patterns.

The Elder Women's individual and yarning circle data sets coding and analysis was conducted in a similar way; however, coding, analysis and interpretation were undertaken by a small group of Aboriginal investigators in consultation with two Senior Research Fellows responsible for data management, and the CIA.

1.5 Data Interpretation

Over time, guided and informed by our Indigenous research framework, as analysis processes continued, it became apparent that each data group in the two data sets demonstrated distinct cultural norms and beliefs. The Investigator group consolidated this perspective through meta-analysis, triangulating thematic patterns which, from an interpretive perspective, clearly contrasted Aboriginal worldviews and Western worldviews. It was only possible to achieve this perspective through the close working relationship that developed over the course of the project, as the Aboriginal and non-Aboriginal investigators forged strong relationships and built trust with each other.

For example, the Aboriginal investigators undertook a detailed analysis of the Birthing and Senior Women's data groups to settle on a range of themes. These were then considered by all Investigators with a consensus approach to establishing the final thematic set for Aboriginal Birthing Women and Senior Women data groups. This approach ensured that cultural lenses were firstly applied in the interpretation of Aboriginal women's data and the Aboriginal investigators were able to provide nuanced explanations of their thematic rationale, thus maintaining and privileging Aboriginal perspectives. By contrast, as the midwife data was analysed by the whole Investigator team, at times quite different interpretations were evident, requiring these to be deeply considered by all. As non-Aboriginal Investigators explained their thematic rationale, the influence of Aboriginal perspectives derived from close examination of the Aboriginal women's data influenced the interpretation of the midwives' data.

The result of these investigator 'deep dives' into the data, particularly in the Aboriginal Birthing Women and Individual Midwife data groups, resulted in identification of many features being associated with Aboriginal women's experiences of maternity services and how midwives perceived Aboriginal women's experiences. Some features were common to both data groups while showing different viewpoints (Aboriginal and non-Aboriginal) of similar features. Subsequent analysis of the Senior and Elder Women's and Midwives' focus group data sets also confirmed similar themes while adding additional themes, particularly related to how experiences were influenced by health service operations over time.

As such, the final layer of meta-analysis and interpretation of the combined results of all six data groups was the means through which the Investigator team was able to identify the changes required at a health system level to achieve Aboriginal women's cultural security when attending maternity care services. The outcomes achieved in our collective analyses, and how these compared with or were supported by the literature, was detailed in a series of peer reviewed publications (Appendix 1); also referred to in the conclusions to this report.

Analysis of the Elder Women's data towards the end of the project added a further and deeper understanding to the interpretations derived from the outcomes of other data group analyses. Most specifically, the Elder Women's data drew on generational perspectives and clearly demonstrated that while aspects of maternity care experienced by Aboriginal had changed over time, there were issues that continue to vex Aboriginal women across generations, particularly in relation to their interactions with health service personnel. It was the continuing challenges experienced by Aboriginal women, and the frustration expressed by midwives who wanted to see changes in health services and the health system, that represented the impetus for formulating the project recommendations.

At a whole of investigator group analysis workshop held in early 2018, a consensus approach was used to reach final agreement on the themes and sub-themes for each of the data groups. Also discussed were evidence headings, or categories, which encapsulated closely aligned primary and sub-themes, with a preliminary list discussed as a means of synthesising data groups into a summary evidence table.

In consultation with investigators, minor changes to themes, sub-themes and evidence headings/categories continued to be refined up to the finalisation of project outcomes, as categorising the evidence provided a concise means of presenting a meaningful synthesis of the project's thematic outcomes (Table 3).

Table 3: All Data Groups Summary, Evidence, Headings and Themes

All Data Groups *Summary Evidence Headings* and Primary Themes			
ABORIGINAL BIRTHING WOMEN	**Experiences of care** - Pregnancy care - Communication concerns - Traumatic experiences - Adolescent pregnancy	**Reflections on maternity services** - Access to Aboriginal staff - Absence of woman-centred care - Positive care encounters - Experiences of racism and racial assumptions	**Cultural practices supporting cultural security** - Birthing on Country - Intergenerational cultural practices - Cultural security experiences - Family and support networks
ABORIGINAL SENIOR WOMEN	**Perceptions of maternity care and services** - Variable care and birth experiences - Access to Aboriginal staff - Communication to inform and educate - Racism and racial assumptions	**Cultural security and cultural practices** - Intergenerational cultural practices - Family and support networks - Birthing on Country - Promoting cultural security	
ABORIGINAL ELDER WOMEN	**Stories of old ways and across generations** - Birth on Country, belonging and connection - Traditional midwives assisting birth	**My birth, their birth: stories of self, others and changes** - Birth and care experiences - Intergenerational changes - Changing maternity care	**Racism, trauma and segregation** - Racism and trauma - Kept on the verandah
INDIVIDUAL MIDWIVES	**Perceptions of caring for aboriginal women** - Cultural security perceptions - Woman-centred care	**Knowledge of aboriginal culture** - Family support and community - Racism and culturally unsafe practice - Knowledge of culture	**Understanding of systems issues** - Work environment - System not supportive of access and inclusion
MIDWIVES FOCUS GROUPS	**Knowledge And Understanding Of Aboriginal Women's Needs** - Continuity of care - Diversity of Aboriginal women - Engaging and communicating with Aboriginal women - Meeting Aboriginal women's needs	**Professional dimensions of providing care to aboriginal women** - Professional education - Cultural security - Aboriginal staff and services	**Racial assumptions** - Racial assumptions
MIDWIFERY EDUCATORS	**Education and practice** - Organisation commitment to inclusion - Professional education - Individual practice - Work environment	**Cultural safety in education and practice** - Cultural security - Family support and community	**Racial assumptions** - Racial assumptions and stereotyping - Racism and culturally unsafe practice - Recognising racism

2. Results and Discussion

The large and complex **data sets** (Aboriginal women and Midwives), derived from 143 participants, are reported separately as individual **data groups** (three in each data set) with findings detailed in this section. The two Midwifery Administrator interviews precede presentation of the Midwives' findings and are not included in the Midwives' data set analysis. Summary evidence headings and primary themes for each data group shown in Table 3 are re-presented in more detail for each data group, with inclusion of sub-themes for many of the primary themes to demonstrate the detailed coding and analysis described previously. Discussion of findings is intermittently included throughout this section.

2.1 Aboriginal Birthing Women Findings

Aboriginal Birthing Women (Birthing Women) were aged between 18-39 years at the time of participating in yarning with Aboriginal researchers. Women in this cohort reported having recently given birth (most in the previous five years, with a few up to 10 years prior) and most reported being from Noongar Boodjar (Noongar Country). In this cohort, while some women clarified their traditional Country as elsewhere in WA, all women had given birth on Noongar Boodjar.

As a substantial cohort, and with most recent use of maternity services, Birthing Women (n=39) resulted in a detailed set of data from which to identify common thematic elements across their collective experiences. These represent a contemporary perspective of Aboriginal women's experiences of, and reflections on, their maternity care.

Twelve primary themes (eleven with sub-themes) for this data group were allocated to three evidence categories: 1] Experiences of Care; 2] Reflections on Maternity Services; and 3] Cultural Practices Supporting Cultural Security.

Table 4: Aboriginal Birthing Women Themes (and Sub-Themes)

Aboriginal Birthing Women Evidence: Primary and Sub-Themes		
Experiences of Care	**Reflections on Maternity Services**	**Cultural Practices Supporting Cultural Security**
Pregnancy Care *(Access to and choice of care; antenatal classes; continuity of care; no continuity of care; transport; experiences of shame)*	**Access to Aboriginal Staff** *(Aboriginal Liaison staff lacking; Aboriginal Liaison staff vital; Aboriginal Maternity Group Practice; inflexibility of services)*	**Birthing on Country** *(Birthing on Country important)*
Communication Concerns *(Better explanations needed; create relationships; not listening to women)*	**Absence of Woman-Centred Care** *(Negative experiences of maternity care; variable information and education; breastfeeding challenges)*	**Intergenerational Cultural Practices** *(Intergenerational knowledge transfer; traditional co-sleeping practices)*
Traumatic Experiences *(Impact of clinical complications; scary experiences)*	**Positive Care Encounters** *(Breastfeeding support; good environment; woman-centred care)*	**Cultural Security Experiences** *(Family support central; better understanding of Aboriginal families needed)*
Adolescent Pregnancy *(Teen mothers' trauma)*	**Experiences of Racism and Racial Assumptions**	**Family and Support Networks**

The findings incorporate women's voices drawn from the data, clearly underlining thematic veracity, and creating a powerful story of Aboriginal women's recent maternity experiences. This includes the centrality of family during childbearing and how this sits alongside birthing on Country (in this study, Noongar Boodjar) to create the circumstances for being (culturally) secure.

2.1.1 Experiences of Care Evidence

This evidence comprised four themes related to how the women referred to the care they received during pregnancy and at the time of birth. The four themes are: 1. Antenatal care experiences; 2. Communication concerns; 3. Traumatic experiences; and 4. Adolescent pregnancy.

Birthing Women described seeking out health care providers in a range of services across the course of pregnancy and the collective data demonstrated consistent and active engagement in antenatal care, with a typical description in the quote below.

> ***"Right through*** [pregnancy] ***I went to the doctors, started eating healthy, made sure I stayed away from all the stuff I wasn't supposed to eat…all the antenatal clinic sessions that I did were really good."***

The services women recalled using included, for example, ultrasonography, general practitioners, community-based health and support services, Aboriginal health services, hospital antenatal clinics and maternity group practices.[1]

In describing access to antenatal care, many Birthing Women talked about the importance of choice of which service or service provider to attend, including private services, for example, ***"we did ultrasounds through*** [a private hospital]***."*** Other examples included women who chose to attend antenatal classes, while others who preferred one-to-one education during their encounters with midwives in the usual course of care, while others relied on family members for information and education. Attending education classes and antenatal appointments was also often dependent on transport (being picked up and dropped off to/from their home base), for example, ***"they support you right through everything you know. If you can't make it there, they'll come pick you up…they always ask how you are…they take care of you."***

Instances of both continuity of care and no continuity of care were described by women. Continuity of care, evident in the above quote, was mainly associated with being looked after by someone who was 'caring'. Overall, Birthing Women demonstrated ongoing engagement with antenatal care, even when they did not experience continuity of care.

> *"(Did you go to the antenatal clinic?) Yeah, I did go to the antenatal clinics. It was ok, there was a bit of confusion because you go in here and here, and asking you to come back and forth. I mean the doctors were ok."*

> *"I didn't go to ante-natal classes. The midwives there were really nice, they were helpful. Doctor was lovely. She had dealt with a lot of Indigenous patients and she was quite culturally aware and so were the midwives. And then when I did give birth to my son at [the hospital], the midwives were fantastic. They were very helpful. I can't fault them."*

> *"(Could you tell me what it was like when you had your babies?) Oh well the prenatal and the postnatal was really good…like I wasn't there for very long at the hospital. My last bubba, I had a baby before, and then I went* [discharged] *the very next morning… (Did you go and see a local GP?) Yes, at Aboriginal health."*

> *"I started off seeing my GP and then I saw the midwife at* [Aboriginal health service] *who was linked to* [hospital]*. I knew that Aboriginal Health runs Noongar mothers' groups. The GP was good, the midwife…was overworked. It was just her…so it was a bit hard to see her. From there I was meant to go to the birthing centre…but my BMI was too high so I was referred to the* [hospital] *clinic. You would turn up to an 8am appointment because it was before work and you wouldn't get out of there until 9.30 – 10 o'clock, even though you were the first appointment off the bat. And all that waiting would be a 5- or 10-minute appointment."*

1 *Maternity group practices, sometimes referred to as midwifery group practices, usually refer to models of maternity care in which midwives are the lead carers. For Aboriginal women, a maternity group practice may incorporate other roles, such as Aboriginal Health Workers, and/or Aboriginal grandmothers, and/or Maternal and Infant Care Workers.*

For some women, being pregnant was initially associated with a sense of shame, described by one woman when she first realised she was pregnant as: ***"I found out when I was seven weeks pregnant. I was very shame at first. I didn't want to tell no one" and when asked what shame means, said "it's that, you been naughty you know*** [laughing]***…You been naughty…".*** Another woman described shame as associated with not knowing what is happening and being scared to ask questions, but also how 'shame' can be overcome through a relationship which involves communication and support.

> ***"(What does shame mean to you?) Not knowing what's going to happen and you're scared and you don't want to ask too many questions. Yeah, so it's wanting someone to sit down and ask if you need anything and if you are ok, and what they can do to help."***

For Birthing Women who had a first pregnancy in adolescence, their experiences were variable, and for some, traumatically recalled. For one woman who had attended a teenage pregnancy clinic, she described her experience as ***"good there, I liked that"***, while another woman felt alone after the birth of her baby, as her family were not able to stay:

> ***"So, they could have left me in the birthing suite so my family could stay until visiting hours. I was only 17 with a new born baby – I didn't know what to do. So I laid awake that first night staring."***

Yet another woman described the labour care she received as an adolescent as ***"all over the place"*** and being ***"constantly pushed to different people"***, which highlighted both the absence of continuity of care or carers, and the trauma she felt in relation to her birth care and birth experience:

> ***"I had numerous people looking after me and the midwife had never delivered a baby before. This was her first delivery and I had complications with my pregnancy. So, I had about 5 random people constantly in my room and a doctor ended up delivering my baby. At one point, they told me to be quiet, because I was too loud pushing. I didn't react too well to that. I was a bit aggressive…It must have been challenging for the staff, but I was only 15. I wasn't very nice, but being a teenager giving birth is very difficult…it was definitely scary."***

Different experiences of care, such as being young and feeling unsupported were present for some, while for others, unexpected clinical complications were also described. For most of these women, while the complications were associated with trauma, these were described in relation to the pregnancy or birth itself and not usually associated with the care aspect. For example, ***"I had major placenta praevia and I also had pre-eclampsia and I was also a diabetic",*** and ***"I did have complications with the birth…with each contraction his heart rate was dropping so I had to go into an emergency c-section."***

In some cases, a lack of continuity of care (or carer) was evident in Birthing Women's concerns about how communication was managed by health care providers. Many women clearly identified the need for better explanations, for example, ***"then I had the nurse come in and say oh we've got to put a catheter in but not explaining to me what this was"***, and multiple examples were provided of situations in which women did not feel listened to, for example, ***"when I told them about the pain…they didn't really listen", and "they didn't try connecting but they just like told me everything."***

Birthing Women also described the need for relationships to be created between them and those caring for them, as this would improve how communication took place.

> ***"I didn't like when the midwife would just like walk out and come back…in and out, in and out. But like not just in and out within 5 minutes, it was like leave for like an hour and a half… It's probably normal but*** [I] ***just didn't like… I don't think they knew how to communicate well with Noongars. Because like even though I was the only one there, you could tell the difference. It wasn't awkward, but it's just like they were different…in their talk with wadjella[2] women. It just, it seemed put on, you know. But they were nice."***

> ***"I suppose just not talk to them like they're a patient you know, get to know them…build up that trust…like talking, talking more, getting to know them…not treating everyone the same…Like personally asking them what they'd like. And not just telling them these are your options, you know."***

2 *Wadjella is a Noongar word for a 'white (non-Aboriginal) person.'*

2.1.2 Reflections on Maternity Services Evidence

Four themes related to the broader issue of maternity services and how these are provided, are included in this evidence summary: 1. Access to Aboriginal staff; 2. Absence of woman-centred care; 3. Positive care encounters; and 4. Experiences of racism and racial assumptions.

In almost all cases, Birthing Women negatively described some aspects of their pregnancy care and/or birth experiences occurring at some point along the childbearing continuum. The absence of woman- centred care was frequently highlighted in their reflections, as in the following examples:

> ***"No empathy, sympathy that it was my first born, that I was Aboriginal, you know, they just didn't care. Because they see women pregnant every day. That's what they said, because they see women pregnant every day."***

> ***"They said they had no rooms or nothing and I was having contractions like I don't know what? Every five minutes? And I couldn't express myself 'cause there was too many people in and out, in and out. And I thought, I don't want people to watch me scream, go through this, when I should be in my own space."***

Other examples from women included being subject to variable information and education, particularly in connection with breast feeding challenges.

> ***"(Did you get taught about how to properly breast feed when you were in hospital, before you left?) No…basically I just remember the lady just saying okay yep, this is what you do, that was it. It was like a two-minute thing that was all I got. (Did she actually show you?) She didn't actually physically get his head and try and put him on the breast or anything. It was basically okay, yep, hold his head, do this and that was it…I don't think she really had any interest to be honest."***

Even so, except for two women who recounted significant trauma associated with their first pregnancies and births in adolescence, for most of the Birthing Women, negative care and birth experiences were not present across their entire childbearing continuum. The majority also described positive care encounters with individuals at some time during a pregnancy or at the time of childbirth. This included, at least some of the time, instances when woman-centred care was evident in their descriptions of how they were treated by midwives, doctors, and other staff. Other examples included the hospitals in which the women gave birth being described as good environments, ***"the good things were like the actual hospital…how it's all new…well that was the best part"***, and ***"I felt really comfortable there, I really like the atmosphere…the rooms are more nice."***

Positive encounters were also associated with access to Aboriginal staff and involvement in Aboriginal specific services and being supported in breastfeeding. When asked if they saw any Aboriginal staff during their maternity care experiences, most Birthing Women said they had not. However, when Aboriginal staff were present in any role, women said this provided a sense of familiarity for them. Additionally, when an Aboriginal Maternity Group Practice (AMGP)[3] was available, the small number of women in this study who had access to this option recalled much more satisfactory maternity experiences overall than those who had little or no contact with Aboriginal staff, as demonstrated in the following quotes.

> ***"Well I had a lot of support from the*** [name of program] ***at the*** [name of hospital]***. They were very supportive…with the appointments and all that…they were there to support me and when I went into labour one of their midwives was actually there with me."***

> ***"…the ante-natal care was solid…it was a program at [name of hospital] for Aboriginal mothers…I was linked in with them and…they came out and checked on me regularly…how I was going with the pregnancy and how I was feeling about it and what not. A midwife and the Health Workers…instead of messing around going into doctors' clinic all the time… they came out home."***

3 *In Western Australia where this study was conducted, Aboriginal Maternity Group Practices are those which incorporate a Grandmother Liaison role and/or Aboriginal Health Worker and midwife.*

Apart from Birthing Women who had received care through an Aboriginal specific maternity service, most reported not seeing Aboriginal staff either during their pregnancy or at the time of birth, and this concerned them.

> *"That constant Liaison Officer is needed; someone I can build a relationship with. Who understands me and how my family works. So they can cater their advice of how the family functions, and they just lacked that completely. No one took into consideration what the family situation was, it was just always you need to do this; you need to do that. It doesn't really work like that* [for me]*."*

Negative experiences were often associated with the inflexibility of maternity services in meeting women's needs, especially in relation to family members being welcome at the time of birth or during hospital stays following birth. The lack of woman-centred care in these instances also contributed to women negatively describing their experiences, with examples of not always being listened to or having their concerns validated, or general feelings of being unsupported. For example:

> *"The ladies on the actual maternity ward they weren't very nice. My son was turned the wrong way, I was in labour for a week and they didn't know that he was in the wrong position and I was in pain and they sent me home."*

> *"[It was] not that long ago…I know they're busy but someone should still, should be with you at all times, it doesn't matter…and especially for your first baby…you know, just to have that comforting there, and you know not to be just left stranded."*

Also highlighted were experiences of racism or having racial assumptions made about them as people, and women sensing they were being treated differently from non-Aboriginal women.

> *"Like we actually did see out of our own eyes how they spoke to other [non-Aboriginal] girls [compared to] how they spoke to me and my sister. Not only me, my sister sitting there too. They were talking arrogant to her too. And she's just sitting on the side of me, you know, asking what's happening on my behalf…they were just talking down to her too and it's sickening really."*

> *"You know, don't treat them differently to any other coloured person. Just treat them all equal because there is a lot of people out there, and a lot of nursing staff that do discriminate…We are all the same mob, just different colour skin, different colour background, different culture. That's it. All the same."*

> *"And sometimes we might have other beliefs, it's not even about the culture…No-one's ever the same. The thing is, sometimes a white person can give off the signs, even if they're totally a good person, but sometimes it feels as if, we feel undermined and very small…and we pick up on the unspoken and spiteful."*

Also Birthing Women identified instances of care from some health care providers which may not be regarded as overtly racist, but which nonetheless left women feeling excluded.

> *"I think they need to stop like second guessing Aboriginal women…you know most of us are strong and independent and we…are very family orientated, so we've got that close bond with our family. And like they just think that we don't know anything and it's not the case, you know, I've noticed that. You know, don't think 'oh Aboriginal, oh'…We all love our kids no matter, no matter who you are, mother's love their children…I think they need to give more support. If it was a white woman they'd be like more care for that, worry about that, but I reckon they should give more care to Aboriginal women. You know even though we seem like we don't want it…deep down we need it."*

The inflexibility of services to adapt to the needs of Aboriginal families was exacerbated when Aboriginal staff were not available, with women left with feelings of isolation from their surroundings and what they considered their main support, their family. When Aboriginal staff were present, these feelings were less apparent. Nonetheless, their collective reflections strongly indicated a broad absence of woman-centre care, and a distinct absence of Aboriginal staff. This absence was starkly demonstrated in many of the yarns, when women described feeling scared and silenced.

Fear was described by one woman recalling her first birth experience at 24 years of age as:

> ***"It was a new experience for me and I guess the nurses were used to seeing it all before but for me it was like, I thought I was dying. It was a bit scary and I was constantly being told it's not that bad, it's not that bad. But for me it WAS that bad!"***While for another woman, her internalised response to a deep concern about how her baby was being treated was described as follows:

> ***"Well from my experience there was a few times where I wanted to shout and scream at a nurse, well a midwife, 'cause I thought she was being too rough with my child. There's little things like that."***

2.1.3 Cultural Practices Supporting Cultural Security Evidence

The four interconnected themes which comprised this evidence are: 1. Birthing on Country; 2. Intergenerational cultural practices; 3. Cultural security experiences; and 4. Family and support networks.

All Birthing Women were asked a question regarding the importance to them of birthing on Country. Most agreed this was and remains a central cultural practice, as one woman said, ***"it just brings that sense of home…It would be weird to go somewhere else and have a baby",*** while another said her babies need to ***"know where they come from and their culture."***

There were some minor differences in opinion in how Birthing on Country is perceived, with one Birthing Woman describing the connection to where she herself had been born. When asked if she thought that for women of her age it is still important to have their baby on country, she responded:

> ***"Yes and no. It also depends…I have a non-Aboriginal partner, so it wasn't really, you know. I like having my children especially here, where I was born as well. (Do you feel like it gives them a connection to country?) No not really. I think that it's just the connection to their mother."***

Another woman, asked if most women in her family had their babies on Noongar Country and how important this was, responded ***"I think it is quite important. I think when any one has a child it's really comforting to know you're home in your own sort of country…I think it makes a big difference."***

For some women, the concept of birthing on Country was very much associated to literally birthing in close proximity to one's physical home, for example:

> ***"When I was pregnant I didn't go anywhere. Especially close to the time of the births. Like I didn't go on holidays down Busselton or anything. I stayed put at home. So yeah, [my baby] was…always going to be born at Swan Districts, as close to home rather than down in a country town hospital."***

For most women in this cohort though, birthing close to home was associated with ***"that connection with home and your country, it's part of who you are and your kids would have that too."***

The perception of birthing on Country in this data group was very closely associated by them with intergenerational knowledge sharing which took place between grandmothers, mothers and fathers, aunties, cousins and sisters. This knowledge sharing was the main source from which women understood childbearing and cultural practices and contributed to how they maintained their own sense of cultural security.

> ***"I come from a big family. Mum and Dad, especially Mum, she was like my backbone pretty much throughout my pregnancy. And so was my Dad. Mum and Dad took me to appointments before he was born, helping me, like financially buying my baby everything. And my sisters as well. They were always there."***

> ***"For me, my grandmothers are very much my back bones. They're very wise, I think that it's very comforting to have them around. It's quite an honour for them to still be around for most people…I think [when the grandmothers] are spoken about…it should be with the outmost respect."***

Access to intergenerational knowledge included approaches to infant care, such as co-sleeping, as a well-entrenched cultural practice. Women acknowledged co-sleeping as being in direct conflict with education they received from midwives and child health nurses, but keeping their babies close was seen as something that mothers and grandmothers before them had done, and it was their choice to care for their baby in their own way, and as they had been taught by their family.

> ***"With me, I thought the midwives was trying to tell me how to look after my baby. And I was like….well with Noongar ways, in Noongar culture, the Noongar mums always had their babies sleep with them. And like the midwife said well you can't have the baby in the bed with you and I was like, well, 'cause I just usually fall asleep in the bed with baby on my chest. I know that my baby's safe…I explained to the midwife, I said can you let the other ones know that I like to have my baby with me, only when I need my rest you know, I'll put him in the cot and you can have him in the nursery while I have showers and my rest. But my baby sleeps with me!"***

> ***"I know they frown upon co-sleeping but I guess that's how my mum has been with all my siblings and how my grandmother has been, and that's how I am as well. So it just comes from like how other women influence you."***

> ***"Maybe just a bit more accepting of what we would like to do once our child is born. An example is the co-sleeping. Just don't be so 'No you can't do that, it's not safe'. There are pros and cons. But that's just how we've always done it, our ancestors, great-grandmothers, mums and aunties and all that."***

So, while intergenerational knowledge was connected with supporting cultural (and personal) security, in turn, this was also associated with family support and the strength that women drew from knowledge transfer and sharing across family networks, and maintaining the practices of their mothers, grandmothers and great-grandmothers.

> ***"Noongars got the cultural ways of having babies and where they want them to be. With other races, other cultures. But I always have my daughter and my son around Noongar places."***

Family support, particularly in relation to the large numbers of family members who attend the place of birth (usually the hospital) during the labour and once the baby is born, was present in most of the women's stories, as demonstrated in the two extracts below.

> ***"Family is very important and they were very very supportive of me. The hospital got packed out, everyone wanted to be there, everyone was there…family from both sides all just come in and waited until baby was born so it was good."***

> ***"They have got to have an understanding that every individual is different, people have different views on things…they also got to consider if the person has got other kids and they have got to adapt to like having a lot of family members in there and they will come after hours and they have to allow that."***

The key factors that Birthing Women identified as sustaining their cultural security were: the support and care that family members provide, which includes the presence of extended family during labour and childbirth; and the intergenerational learning and knowledge sharing that is highly valued by women, particularly when they are young. For example:

> ***"I think they should allow more family in the room to start with. Because you know, I come from a big family…I was only allowed my partner and my mum, that was it. But I mean my sisters were there too you know, and we're a pretty close family…just to have them there with you as a support thing, that would be nice to allow them, to let more people in the room, that would be good."***

The inflexibility of health services, especially in relation to restrictions on the number of support people allowed in a birth (labour) suite or in postnatal rooms, and midwives not always understanding the strength and importance of kinship relationships, were both reported by Birthing Women as having negative impacts on their sense of cultural security. This was described in terms of women believing they have to fit in with the system because the health service has not taken their needs on board.

> "[Hospitals] *don't understand our kinship. The way Aboriginal people work. We don't just want two people in the room whereas they are restricting it to two people in the room. We don't want that; we have large families. We want all our family to be there and everyone that is really close to us and helps us through. There is not just one person that supports us, it is a whole community. And that's something they lack and don't understand. This child will be exposed to hundreds of people after we leave the hospital to take him home. You can't tell us to keep it locked up in a room and only have certain people around us.""I'd like the midwives and doctors to be more aware of family structures and culture because for Black fellas it is important to have your family there but you're not allowed it in the system. The antenatal system and hospital and that – especially when I was so young. That was horrible. But now, I'd be right, but I'd still want my family there. If I had to leave a birthing suite at 4 o clock in the morning again, I would rather stay there until 8am so my family could stay for visiting hours rather than send my family home."*

2.2 Aboriginal Senior Women Findings

Aboriginal Senior Women who participated in yarns (n=11) were 40+ years and five of the eleven women were either working, or had worked, in the health system.

Not all Senior Women identified as Noongar, but all were living on Noongar Boodjar at the time the yarns took place, and most had been for some time. In this cohort the most recent birth experience was approximately 11 years prior to the interview, while for most it was 20 years or more since their last birth experience.

Eight themes, six with associated sub-themes, were arranged in two evidence summaries: 1) Perceptions of care and services; and 2) Cultural security and cultural practices (Table 5).

Table 5: Aboriginal Senior Women Themes (and Sub-Themes)

Aboriginal Senior Women Evidence: Primary themes and Sub-Themes	
Perceptions of Maternity Care and Services	**Cultural Practices and Cultural Security**
Variable Care and Birth Experiences *(negative experiences; positive experiences; traumatic experiences; woman-centred care absent)*	**Intergenerational Cultural Practices** *(impact of stolen generation)*
Access to Aboriginal Staff *(strengthening Aboriginal staff capacity; lack of Aboriginal staff)*	**Family and Support Networks** *(family support central; service flexibility needed; welcome family members during birth)*
Communication to Inform and Educate *(see informed consent)*	**Birthing on Country**
Racism and Racial Assumptions	**Promoting Cultural Security** (understanding the diversity of Aboriginal women)

The Senior Women's evidence was a combination of personal experiences and broader reflective observations developed over time, informed by their connections to their communities and for some, their experiences of working in the health system. As a smaller cohort by comparison to the Birthing Women's data group, less themes and sub-themes were identified during analysis. Even so, the Senior Women's data showed common elements with the Birthing Women's data.

2.2.1 Perceptions of Maternity Care and Services Evidence

This evidence heading comprises four themes: the first refers to the variability of care and birth experiences Senior Women recalled in relation to their own childbearing experiences and which they observed in relation to family members or from their work in health care settings. The second theme included reflections on the importance of Aboriginal staff in health services, and their absence, while also highlighting the need to strengthen the capacity of Aboriginal people to work in the health system. The third theme refers to the need for effective communication which informs and educates women and care providers seeking informed consent from Aboriginal women, while the fourth theme is concerned with racism and racial assumptions.

Senior Women's broader recollections of their maternity care and births were variable and included both negative and positive experiences. Many of the Senior Women had experienced complications in their pregnancies, either for themselves or their infant, often recounted in a matter-of-fact way, such as ***"then I had a third baby which was a spina bifida baby."*** Overall, there was a tendency in the Senior Women's stories to not dwell on complications to any great extent, and to describe positive aspects, as evident in the following quotes.

> ***"Two totally different experiences because having my first child was different to having my second child sort of thing. I didn't know what I was doing sort of thing."***
>
> ***"I actually liked*** [the hospital] ***because it was that old hospital. I did like it. There were some good staff there."***
>
> ***"I just got referred to the hospitals and then I just kept seeing, oh, for the first one, because I was sick all the way through, I just couldn't keep anything down, but the three after that were easier."***

Some Senior Women though recalled what are most accurately described as traumatic experiences, either for themselves, for example, ***"I had an ectopic pregnancy which was a horrible experience",*** or for other women, such as their mothers: ***"she lost her fourth, or second pregnancy out of the four…Mum had haemorrhaging quite bad…she couldn't breast feed us cos we'd be in the baby rooms, and she would be in her bed…cos she would lose quite a lot of blood."***

For one Senior Woman in particular, the details of the circumstances around the birth of her third child were still clearly recalled even with the passing of time. At home and with a sudden onset of heavy bleeding in her eight month of pregnancy and unable to reach any family members, this woman called an ambulance. She was rushed to hospital where an emergency caesarean birth took place. The complication though was not her medical emergency, but what occurred for her infant child, who accompanied her in the ambulance. Before going into surgery for the emergency caesarean, she was advised by hospital staff that her infant would need to be placed in foster care because no family members could be reached to take her into their care. She described her distress:

> ***"I had to have an emergency caesarean section…in that situation I think there should… always be someone…to find your relatives to try and come pick up your child…She had to go into foster care…that night. I tried to get hold of family, I couldn't. So she had to go into foster care while I went into have an emergency caesarean section. And I was heartbroken…I was sobbing. I didn't want her to be taken into foster care. I think I would have felt more comfortable if they would have, if she was with Aboriginal people…it was a very bad experience because I couldn't get hold of anyone, there was no one there for me and my daughter."***

Although there was variability in the experiences recounted by the Senior Women, in their reflections a general absence of woman-centred care was apparent, summed up by one woman's statement: ***"you know we just went to our ante-natal appointments and then just in and out, they didn't really get to know who you were."*** Even though this was evident, most Senior Women also described positive aspects associated with their pregnancies, the care they received or environments in which they found themselves. For example, ***"I had a beautiful pregnancy, everything was healthy",*** or examples of supportive care encounters, such as ***"he gave me a lot of support and he kept telling me what would happen and everything, I found him to be a good doctor."*** Overall, almost equally, positive and negative (or traumatic examples) were provided across this cohort.

It was also notable that Senior Women had used a variety of different services to access their pregnancy care. These had included specialist obstetricians and private hospitals, for example ***"my mum just introduced me to my doctor because he's a specialist"***, while others had attended public hospital antenatal clinics and some referred to care from midwives. No Senior Women though had experienced Aboriginal specific maternity services, "***I hadn't heard of any Aboriginal services or maternity services that could help"***, although some women had used Aboriginal medical services for aspects of their maternity care ***"I did do shared care with Derbarl*** [medical service]***."***

The lack of Aboriginal specific maternity care options during their own pregnancies, while not necessarily explicitly perceived as a negative, was nonetheless noted as not ideal: ***"I was pretty happy with*** [the hospital] ***but would have been nice to be able to have an Aboriginal worker there at the time"***, and "***Aboriginal people, they need Aboriginal people included in that service. So like when they attend their appointments, have an Aboriginal worker on hand."***

One Senior Woman, in relation to her own birth experiences, explained that:

> ***"If there was like an Aboriginal Liaison Officer like at the hospital coming to see you like specifically. That would have made a big difference. Somebody that you can talk to and all that sort of thing… even though I had ticked all the forms that I was Aboriginal. There was no*** [Aboriginal] ***support in the hospitals. I don't know if it's there today because we are talking about 11 years ago. So I don't really know, maybe they have got something set up… Because you do feel alone."***

The importance to Aboriginal women of having access to Aboriginal staff, and an opportunity to have their care in the community, was also referred to by a participant who had knowledge of an Aboriginal specific maternity service:

> ***"I think that's why the Aboriginal maternal group practice is really good because you are taking the services to the women out in their community, you can monitor them in their house, you can do, you know, their antenatal assessments and things like that with the midwife. You are taking it into…their house."***

Also noted, was the need to strengthen Aboriginal staff capacity: ***"I reckon we should get more of our health workers trained up to help support midwives", and "I think it's important language wise, interpreters, bring them down, I mean they have more understanding of their own culture."***

Many of the Senior Women also referred to instances where better communication is required, and that these were opportunities to inform and educate women, for example, ***"I wouldn't complain about [my care] but I think communication is important for these young fellas", or "one thing I always thought…when they talk medical terms…*** [the women] ***are not really understanding what the doctor's talking about or the midwife…talk our kind of English, not the medical English."***

Two Senior Women described occasions when they were subject to procedures without sufficient or any informed consent, for example, ***"I mean they kind of explained but it was while they were doing it, not beforehand***." In other descriptions, a lack of woman-centred care was apparent.

> ***"I had no option to have a vaginal birth after a caesarean… The obstetrician was like, caesarean, that is it. And I didn't have a choice to do a natural birth…So that option wasn't there for me to have a natural birth which I kind of would have wanted to."***

Only two participants described explicit occasions of racism during their yarns. One from a Senior Woman who was working in the health system at the time of the study (first quote below) and demonstrates her role perspective rather than her birth experience, while the second example illustrates the lack of understanding of Aboriginal women or Aboriginal people generally present in many of the Senior Women's stories.

> ***"There's been times here at the hospital where some midwives have over stepped the mark well and truly, especially around comments and stereotyping…'oh, this is your sixth kid and you're married to the same man, you've got all your kids to the same man?'…I think they are getting quite a few complaints coming through. And also from Aboriginal graduate midwives coming through, and health workers that come do their placements here…I think they're finding out that the discrimination is deeper and it's probably still the same as what it was when I first started…a couple of our Aboriginal grad midwives have been very uncomfortable and one resigned, one was going to resign - we need them so badly too - and this hospital doesn't have Aboriginal clinical support. They have normal midwifery support but they don't have Aboriginal people that are in here, that are clinical, that can support the midwives."***

> ***"They don't really understand Aboriginal women, do you know what I mean, sometimes they don't connect…I mean if you know another Aboriginal person that's in there…they know exactly what you feel or what you're going through. A lot of the time you feel really shame… I think it's important for*** [the midwives] ***to be educated culturally…I mean I know sometimes, something maybe silly to them, but for us Aboriginal people, Aboriginal women it's very important."***

2.2.2 Cultural Practices and Cultural Security Evidence

This evidence comprised four themes. The first three themes – intergenerational cultural practices, family and support networks, and birthing on Country – were fundamental to the fourth theme of cultural security and how it is experienced by Aboriginal women. These four themes combined the aspects which comprise the ongoing cultural practices which support cultural security. Central to this are family and the support that family represents, described by the Senior Women as enabling the passing on of knowledge across generations and how for them it provided a sense of (cultural) security that they were being watched over and cared for by their family members.

One Senior Woman, thinking back to her first pregnancy, said that she was in her grandmother's house at the time she went into labour and this was comforting to her: ***"they knew the signs, they watched me all day and they kept saying 'you right, you right' and I was a bit scared but I wasn't hiding anything from them. So they said have a rest you know. They prepared me, 'lay down, just have rest, when you're ready to go, we'll take you to the hospital."***

The comfort drawn from birth knowledge passed down from older women in the example above was also evident in a Senior Woman's description that ***"it's all cultural ways really…if the mother's aren't looking after the kids, then grandparents*** [are there] ***to step in to help, which is our cultural way of doing it."*** This was described as a traditional kinship approach to sharing responsibility for childcare, ***"I mean my three girls work now, their kids are all at school and if I have to help 'em with the babies I do, I usually have about ten on the weekend."***

The birth of a baby was noted as an occasion for Aboriginal families to come together, usually in large numbers, because birth is an event that is celebrated by the extended family. Senior Women noted that hospitals need to be flexible around this: ***"just understanding like… when we're in hospital, we know that we have big families that come in and visit us… being understanding of cultural ways. Like everyone wants to come and see a baby, and sometimes in hospitals they don't understand."*** Another woman said that while she understood that hospitals might in some circumstances need to restrict the number of people some of the time, that they need to also be flexible, because:

> ***"Aboriginal people have huge families, extended families, where it's not only mum and dad and brothers and sisters. Its aunties and uncles, and nannas and pops, the list just goes on, cousins on cousins on cousins, you know. And it's not about cousins, its sister cousins. Like, if you're from up north, then you don't have a cousin, that's your sister, that's your sister cousin."***

Senior Women viewed the presence of family as meaningfully supportive, with women feeling more comfortable and secure with family members in attendance and that hospitals need to be more accommodating in welcoming the whole family because ***"the woman will be more less stressed you know, knowing that their family is with them."***

The other cultural practice that some of the Senior Women referred to is the practice of co-sleeping with babies and children, as explained by one woman:

> ***"I mean for me I had all my children sleep with me, all four of them. They didn't sleep in a cot. I think my fourth child I put in a cot, but he ended up taking seizures. So he was six months old when he took his first seizure…I didn't have him in a cot anymore after that… they may say like, it's not very good for…baby and mother to sleep together, but for me, I wouldn't have it any other way. I would rather my children lay with me, than lay in a cot."***

One Senior Woman who worked in the health system noted that for some young women having babies now, there wasn't always family support available to them and they were missing out on intergenerational knowledge, ***"I see that the young girls here, they don't know much. A lot of them haven't got their mothers around",*** while two of the Senior Women referred to the impact of the Stolen Generations as contributing to a breakdown in intergenerational knowledge transfer, with one woman saying both her mother and grandmother were from the stolen generations, ***"so we grew up a bit, you know, without that proper traditional way."***

Senior Women also discussed the value of birthing on Country, both for themselves, and for the importance of this for other women, especially those who are required to relocate for birth. One Senior Woman, who is Noongar, said in relation to the importance of birthing on Country for her, that ***"it is, of course it is, well most of us don't go anywhere away from here, so it's a good thing, but it is important",*** while another described what this meant to her own children ***"well they always say they Noongars, they're not Yamitji's, they're Noongars they tell me that all the time."*** A further Senior Woman noted the impact on children who are not born on Country as being: ***"very hard for the children themselves as they grow up because…sometimes, they could be bullied by other kids in their community saying…'you're not born in this Country' you know, so it does becomes a problem."***

A Senior Woman acknowledged the ongoing importance place of birth has in maintaining a connection to one's Country, and how women who give birth off Country have adapted, by, for example, retaining placentas to take home. ***"Aboriginal ladies like to take their placenta back home, because if baby's not born on Country…***[they] ***freeze the placenta to bring back home and bury it in their Country. That was something you know, in terms of putting it back in their Country",*** and also noted that when women have to travel to urban areas to have their babies that ***"once they had their babies, all they wanted to do was get home to their Country you know, they just want to go home."***

As a final perspective for this evidence, Senior Women noted the diversity of Aboriginal women and promoting cultural security requires midwives to: ***"be culturally aware…like where* [the women] *come from, like different places, have different traditions, and cultural beliefs."***

As one woman said:

> ***"I think the most important thing for midwives to learn is the culture, a bit about Aboriginal women. Because they have to realise that we're different…We're different in different ways, do you know what I mean. For myself, I would think they need to be educated in cultural awareness because of the fact that I mean, we feel, we see and we do different things to non-Indigenous people…be mindful of that…we don't want to be treated special but we do want you to understand…and consider how we do our things, our culture, how it is to be us."***

2.3 Aboriginal Elder Women Findings

Yarns with some Elder Women about their birth experiences and knowledge occurred in 2015, the first data collected for the project. In 2018 an invitation was circulated for Elder and Senior Women to join one of two 'birth stories' yarning circles. The purpose of these was to provide Noongar Elder Women with an opportunity to reflect on their own birth experiences, their knowledge of past birth practices and observations of changes over time as their daughters, granddaughters and great-granddaughters had experienced pregnancy and childbirth.

In 2015, the Elder Women (n=6) had met with an Aboriginal researcher known to them. These six women were aged between 65-90 years and identified as Noongar. In 2018, the yarning circles were held on two occasions and included Aboriginal and non-Aboriginal project investigators and research assistants participating in the yarning circles. Twenty mainly Elder and some Senior Women attended one of the two yarning circles. While the women were not specifically asked their age, it emerged during yarning that women were aged from in their 50s to in their 80s. They shared many stories in the yarning circles, some happy and some provoking recollections of sadness and loss. Following the yarning circles, each woman paired with a project investigator or research assistant to tell their individual story. These were audio recorded, transcribed and returned to each participant for confirmation of accuracy.

It is noted that the Senior Women attending these yarning circles were not separated from the Elder yarning circle participants, and all who attended to tell their birth stories were included in the Elder Women's data analysis.

The individual yarns and birth stories were initially analysed separately. When these were compared the emerging themes were so closely aligned, the decision was made to merge the data. This resulted in seven themes, all with sub-themes, arranged in three evidence summaries (Table 6): 1) Stories of Old Ways and Across Generations; 2) My Birth, Their Birth: Stories of Self, Others and Changes; and 3) Racism, Trauma and Segregation.

Table 6: Aboriginal Elder Women's Themes (and Sub-Themes)

Aboriginal Elder Women's Evidence: Primary themes and Sub-Themes		
Stories of Old Ways and Across Generations	**My Birth, Their Birth: Stories of Self, Others and Changes**	**Racism, Trauma and Segregation**
Birth on Country, Belonging & Connection *(Being on Country; Survival Grandparents & Grandchildren)*	**Birth and Care Experiences** *(Birth complications; Positive experiences; Negative experiences; Family support)*	**Racism and Trauma** *(Lived trauma; Taking children)*
Traditional Midwives (Bush & Home) *(Elder's wisdom; Birthing Sites; Loss of knowledge)*	**Intergenerational Changes** *(men at births; family size; hospitals have changed)*	**Kept on the Verandah** *(Segregation)*
	Changing Maternity Care *(Aboriginal faces in hospital; Education for health professionals)*	

2.3.1 Stories of Old Ways and Across Generations Evidence

This evidence includes stories from the past, as either directly recounted to Elder Women or which they recalled from family oral histories. The importance of belonging and connection to home, family and Country was strongly present, in accounts of their own experiences as well as in accounts of mothers and grandmothers and younger generations' experiences. Some of the women had given birth or been born on traditional Country, either in sheds used for birthing on Aboriginal missions or reserves, in tents or in *mia mia* (huts). In these stories, the women were always supported by traditional (bush) midwives. These occasions were referred to as special experiences, for example:

> ***"This birthing experience was something I will never forget as it was a special time I had with my grandmother. She was a wonderful old lady and my daughter was one of the last babies born at this place. She delivered two more of my brother's babies but after that she got too old and she couldn't do it anymore."***

The stories Elder Women told about old ways demonstrated the persistence of cultural practices, particularly women supporting each other, and giving birth on Country. Retelling their personal memories led the women to speak of saving this cultural wisdom for the benefit of maintaining cultural birthing practices in the future. For example, the Elder Women described birth on Country as maintaining the sense of ***"where they belong…they got that connection"*** and belonging to Country as being enduring, ***"as a Noongar people…you always have that yearning to go home, wherever home might be."***

The Elder Women were of the view that birth on Country is an aspect of cultural maintenance: ***"when you come from a Country and your mother comes from a Country we should be able to go back and go and visit those places that mean so much to us."*** For one Elder Woman, her perception of birth on Country was literal, and from her perspective not practical in contemporary terms: ***"well, it's not really practical I suppose these days but if you were living down that way and were like used to camping around it would be a natural sort of a thing wouldn't it?"***

Although there were recollections of life being tough in past times, with survival at the forefront, moving around Noongar Country and embracing their culture and ancestors was and continues to be highly valued.

> ***"It's hard to know what happy was. I know there was tough days, yeah. But you know you sort of, Noongars grew up with that expectation of it being tough. A tough life you had in front of you. No one had money. You were lucky if you had a good camp to live in especially in winter time."***
>
> ***"…It's an all embracing culture, and when I go that way, Albany or wherever, I feel blessed to know that my grandparents, my grandmother and my great grandmother came from that side. You know, and it makes me feel good."***

The stories of belonging included grandparents' connection to their grandchildren, and the lasting nature of these relationships:

> ***"When Dad finally did see him, he just cried, that was really something for me to experience. The bond between my dad and son from that day on continued for the rest of their lives, they were inseparable. Mum always said how much dad spoilt him, more in ways of teaching, guiding and nurturing. The outpouring of emotion from*** [my baby's] ***arrival into this world was something I carry with me to this day and gives me great comfort."***
>
> ***"Because of my experience I always wanted to know more about birthing so when my grannies[4] are born, I make sure I'm there and I look on and ask questions. I am still here today looking after great grandkids! In our days a lot of our culture was very close and caring, which is so important."***

4 *"Grannies" is a term used by Aboriginal grandmothers in reference to their grandchildren and great-grandchildren*

The Elder Women had themselves been born in a range of metropolitan and non-metropolitan regions across Noongar Boodjar (Noongar Country) including on Aboriginal missions (or reserves) and retained information about these places. Some Elder Women also retained very detailed knowledge of past practices, passed to them from their own mothers and grandmothers, including knowledge of birth sites. The respect for traditional, or bush, midwives and their wisdom was apparent in the Elder Women's stories.

> *"My Grandmother…was a bush midwife. She delivered 23 babies, even delivering her sister's baby while she was seven months pregnant herself. We've got a little taped interview with someone but it's not very good quality, because Grandmother was speaking very softly, and this person asked her if she enjoyed being a midwife. She said, "Well not really, but there was no one else to do it." But she did it well. It was a tough job, especially when it's for family and friends which it mostly was. It wasn't just any old person; it was always someone in the family or friends."*

> *"That was the main birthing area, because you couldn't build your campsite where the animals went to eat. It had to be away, in the bush. But with the mia mia, the little birth hut, it was the only hut that you could build down by the river, because that was where the old people needed water. The other mias were up on the hill. So once the old women knew that it was time for her baby to come, then they'd go down and build that little mia mia for the mother and look after her."*

> *"Not actually with my own Mum and sisters, but with other Noongar people, you know. Like we had a lady that we called Aunty Eva Roe and we used to go and be in her own little babies' home and* [she] *looked after herself in the bush."*

> *"Two Aboriginal midwives and a mission hospital. Just remember them being there,* [Aboriginal] *midwives delivering the Noongar women's babies on the mission."*

One woman described the high value placed on birth sites and the learning that occurred in relation to these and in relation to child rearing and traditional medicines, with the learning occurring from early childhood.

> *"…there was, you could get water out of it. We used to go and wash our clothes there. But we never used to go and mess around with the spring because Mum said it was taboo, it was for women that had their babies, but we knew where it was."*

> "[My mother] *picked up along the way, probably from her mum, Granny in the bush. She was nine when she was taken from her family so she'd already had all that experience of bush medicine, also your basic child rearing practices and health. There was always something in the cupboard to fix something, even though we were 80 miles from the nearest hospital."*

Another Elder Woman described how her mother and grandmother supported the birth of her daughter; four generations of women continuing cultural practices.

> *"My mother was supported by my grandmother and after the baby was delivered my grandmother cut and tied the umbilical cord and gave it to my mother to bury on Country. So I say to my daughter, you will always be part of that country because your afterbirth was buried there and this is a traditional practice that is done in Aboriginal culture."*

Some Elder Women though told of a sense of loss from not having been supported by traditional midwives during their own births, and some also lamented the loss of cultural practices and the impact of this on young women having babies now.

> *"I really envied all those ones that, where the old midwives birthed them. Especially my husband in particular. I mean I'm really jealous of him* [laughs], *because he had his grandmother there to deliver him, the way that it should've been."*

> *"…that responsibility of looking after our mums and the birthing has been taken from us Noongar people, and we need to take it, we need to reclaim that. 'Cause it's our heritage, it's our cultural heritage, that we have to reclaim and take ownership of and stand up and say 'we don't want our young mums going in there in isolation and having babies'. They need their family around for support."*

"But a lot of people have changed and they don't embrace their cultural beliefs that have been given to them by their families over generations and generations, because it doesn't matter how far you go down the track. All the stories that we get have been passed on from generation to generation to generation and we need to embrace that."

There was also reference to the wisdom of Elder Women before them, who had knowledge of childbirth and provided advice and support to them and other women.

"They had Aboriginal women who helped them through their birthing process and looked after them. So, everything seemed to be fine and if there was an emergency they would take them down to the local hospital."

"I went up to see her and I said to her I am getting pains and I don't know what's happening. And she said come in and stay with me and she was an old woman and… she said 'you sit down and tell me what has happened'. And I said 'I'm losing a lot of mucus and there was a bit of blood in it' and she said 'Do you think you having pains 5 minutes apart or 10 minutes apart?' And I said, 'No it's more like 10 minutes apart'. And she kept me there and then when they got five minutes apart she said to me, 'I'll ring an ambulance for you because no one's home' and she rang an ambulance for me and I went down to the hospital… She was just like my Mum talking to me and I didn't know what to expect. But except for her… I wouldn't know what was going to happen."

2.3.2 My Birth, Their Birth: Stories of Self, Others and Changes Evidence

It was striking in the Elder Women's data that reference to knowledge was mainly in relation to childbirth, with little reference to knowledge of pregnancy itself. Elder Women's recall of their own antenatal care and birth experiences was largely matter of fact, even though many described pregnancy and childbirth complications; for example, breech births, babies admitted to intensive care, miscarriages and severe post-partum haemorrhages.

Even so, Elder Women mainly reported being well treated during their maternity experiences: ***"I couldn't think of anything to complain about."*** However, some women realised this may have been due to limited information being provided about pregnancy and childbirth, while others commented on care and education they received.

"I just went straight down to [the hospital] *and I started my antenatal stuff…it was fully good…but in those days when I had my first baby there was no information about what to expect."*

"They were excellent. We used to go the antenatal clinics and we had [education about] *nutrition and we knew, I knew in those days that nutrition was very important for us, and it was an experience."*

"I mean, as far as how birthing is concerned. It went on and on, like no fuss was made. [You] *would go there and deliver the baby…and go back and…It wasn't any fuss in them days…the doctor would usually come if you needed him."*

One woman reported one of her birth experiences as occurring so quickly, there was no time for the hospital staff to transfer her to a birth suite.

"Nine other women waiting in the delivery ward and they were like, oh we got to do this, we got to take you here, we got to take you there. And I was like, I can't wait for anyone. She was born right there and then. Nine others in front of me! So that was amazing."

Additionally, some Elder Women, reflecting on their own experiences, reported that health professionals, including doctors, were often supportive.

"That's where I was and it was much better we weren't off the sides or anything we were just treated like everybody else."

"But Matron Ross was great, she was a good old darling…you would go to her place. She had a bed there for you and the doctor would come there and deliver the baby."

Even so, negative experiences of care during pregnancy or childbirth were also reported, for example, ***"my experience of childbirth was in hospital - isolated, very scared, very alone",*** and:

> ***"It was not welcoming, it was quite scary, actually. You would see a different midwife each time you went in and they did not actually explain things to you properly, which was confusing because it was my first baby. They just looked at you as if you were just nothing."***

Another woman reported a poor clinical encounter when she presented to a general hospital three times over the course of a weekend during one of her pregnancies. This was eventually resolved when she went to a maternity hospital, with the actual clinical reason for her illness only being identified at that point.

> ***"I had been sick all weekend and so I went to*** [the hospital] ***on the Friday night and went to my local doctor on the Friday night and then I went*** [back to the hospital] ***three times over the weekend…So on the Monday night my mother-in-law came…and said 'is*** [she] ***still sick?' …And I said yes, and so they took me out to*** [maternity hospital] ***and I had tests done on me and I had German measles."***

Having family support and guidance was reported as normal by the Elder Women, as was the support of other Aboriginal women. Typical examples were:

> ***"My birthing experience at that time was a lot different from being in the hospitals because I had my family support, my grandmother, my mother and my sister. My brother and my brother-in law were also standing at the door, they wanted to know what was going on, but they weren't allowed near the birthing."***

> ***"Yeah we would come in*** [to the hospital] ***and I would drag one of them along to support, Yeah, the sisters I would drag in."***

> ***"I was only 16 when I had my first child. A white friend of mine she's said the same thing, and I thought it was just, you know, Aboriginal people, but yeah. But I mean I had my family, like my parents were there for me."***

Mention was also made about the presence of large numbers of extended family members around the time of childbirth:

> ***"I had everything looked after very well. But the main thing*** [the hospital] ***needed to understand is the respect of the Aboriginal people and when, family come to visit regardless of whether it's a good time, happy time, your family's gonna go there and visit, and it's not gonna be one or two it's gonna be big mob."***

With the age differences of the Elder Women, for example, a 25-year gap between the two eldest and two youngest of the Elder Women in the individual yarns with a similar range of ages in the yarning circles, intergenerational differences both between the Elder Women experiences and by comparison to younger women were also evident. For example, two women described in the 1940s being kept on the verandas of hospitals during and after their births. By contrast, in the 1970s, some women had private health cover which gave them a choice of doctor.

> ***"When I had*** [my son] ***I decided to be a private patient, so I came in as a private patient and I had Dr. X to deliver him…the reason why I did that was that it was just so overwhelming having my first baby with all these other mothers around. So being a private patient I only had the one doctor and I was put in a four bed. They only had two private rooms and I was put in a four-bed room which wasn't too bad."***

> ***"I often think goodness me; I was born on the verandah and my kids are being born in this beautiful hospital."***

The other change that Elder Women noted was in relation to young women having babies now compared to when they themselves had commenced families. Even though many of the Elder Women had their first pregnancy at 17 or 18, the Elder Women expressed concern that very young girls were now having babies, and that young women were unable to recognise pregnancy.

"My granddaughter, she was only 13 at the time when she got pregnant with her one, and he was born 4 months premature. Came with a lot of complications. I look after him now because she was young and he was born with all these complications. DCP took him off her, so I look after him. He's 5 now."

"My great granddaughter, she didn't even know she was pregnant…I said, 'you're pregnant!' She said 'what are you saying Nan'…I said 'I can tell, [you're] *having baby'. So I said 'get in the car I'll take you to the doctor'. She was six weeks pregnant…she didn't even know…some of these young girls nowadays, don't even know they're pregnant."*

Other Elder Women reported noticing changes in hospital environments and care arrangements over time and these not always for the better, while some remembered advocating for care that was more suited to Aboriginal women, including highlighting the issue of male health care providers not being acceptable.

"You know, because things have changed over the years it's not like years ago, it is a bit, what's the word, impersonal now. And you can't make contact with somebody or have someone that is there continuously, where you know you can go and talk to that person and remain in that contact all through the pregnancy. It's not like that now."

"Because we used to go to the antenatal clinic but not when I got down [to the youngest children]*…that's when things started to change and it became very impersonal and it was frustrating."*

"We went to the antenatal clinic but we always had somebody different and even in those days, I did not like men coming in and being in the room when I was being examined. And I actually spoke up about that, and they made sure they would always have a nurse and not a man, and so I was happy about that. And I think they used that to, except for the doctor, they kept that for any woman."

"I had the twins at [one metropolitan hospital]*; then my second delivery at* [another hospital]*, my 10/11lb baby…with this one I just walked in, had him and walked out. I liked* [the second hospital]*, it was a familiar area, close to home. You didn't have to book, and you just walked in. I had no ante-natal care with my second one, just doctor's visits. Not all my kid's birthing experience were the same, you don't expect them to be; the births or the babies."*

In terms of men's involvement in birth, it was noted by the Elder Women that this had also changed over time. Some women reported that whereas previously ***"dad stayed home, as men weren't allowed in while you were having a baby",*** others indicated the shift in this practice, for example, ***"my partner was also there for my three little ones."***

The other observation made by Elder Women, was in relation to family size, with one woman reporting coming ***"from a large family. My Mum's first family and second family, and my Dad's first and second family, I'm from the first family, but there's about 16, 17 of us"***, while another said she was ***"from a family of thirteen, five girls and seven boys. I helped my mum look after the family and with the house work so I didn't go to school all the time."*** This was in contrast to another woman, who said ***"my mum only had two, me and my brother, so it was pretty quiet at home"***, while she herself had six children.

The final aspect of this evidence was related to the changes the Elder Women saw as being needed to make contemporary maternity care experiences more culturally secure for Aboriginal women. This was mainly focussed on the need for more Aboriginal staff – ***"it's imperative that Aboriginal people are employed within the hospital system."***

"They seem to do more out in the country [regions]*, especially like with the Aboriginal Health Workers or professionals. They can go out and do needles, they can provide pap smears and things like that, but as soon as they come into a town or to the city they're not allowed to do any of that clinical stuff. You know, and it's really sad because you lose them then as a health worker."*

Also noted, was the need for changes to the way education and training is provided to midwives and medical students, as explained below.

> *"The midwifery programs and even the medical students that do their rounds through all the hospitals. I think they need to reinvent the cultural side of things at the universities… because when they come into the hospital, there really isn't a lot of contact. They have 10 weeks there and then its rush, rush, rush…you do this, you help with this birth…then you're moving on to another hospital."*

One woman recalled her 'luck' at having an Aboriginal midwife for her final birth in hospital, and what this meant to her.

> *"When I had my last one at 31 I didn't have much energy. I was very lucky, I had a nurse from Broome, an Aboriginal midwife. That was the last year that* [hospital] *was open; I was lucky to have her deliver me. Usually you have to be on your own when giving birth because your partner is at home looking after the family. It was good to have her there with me, an Aboriginal lady helping me. It was a lot better. Maybe I could have had someone like her through all my births, it would have been good."*

While the Elder Women recognised that ***"non-Aboriginal people are the majority…so I guess you just gotta do the best you can and work with non-Aboriginal people"***, she also noted that ***"I'd like to see changes where we can have family in with our young girls and we can have our Noongar girls trained as midwives. So, you know, we can have that sharing and caring."*** For one Elder Woman, she explained that ***"Doctors really need to understand Noongar people, their culture ways, because my granddaughter…found out that she was pregnant, she came home, she wanted me to go to the doctors with her. 'Just come with me Nana', you know, I gotta sit with her, you know, when the doctor's talking to her about pregnancy."***

2.3.3 Racism, Trauma and Segregation Evidence

The final Elder Women's evidence emerged from experiences which highlighted the racist treatment and government driven segregation policies that Elder Women, and their families had been subject to, including children being removed and restrictions on where Aboriginal people could be at any given time.

These experiences were sometimes related to childbirth, for example, the practice of excluding Aboriginal women from birthing in the local hospitals, but also the broader implications for Aboriginal people generally. Receiving care on a hospital verandah, for example, rather than allowing the women and men inside hospitals was described as below.

> *"My other two boys was born there too… in the sleep out thing… it wasn't in the proper ward. (Noongar women weren't allowed in the hospital to have their babies?) No, no…took them a long time* [for that to happen]*."*

> *"When my mum's dad died he was in on the back verandah. And he was dying there, on the back verandah. And mum took me with her and I was three she reckons. And I remember the mosquito net they had over the bed there and mum sitting there crying… But they must have let him be on the back verandah. Noongars, we just weren't allowed…"*

> *"They had to stay on the verandah or out on the out-bit thing. The Aboriginal people sat on the verandah and waited* [while] *the doctor finished all the white patients."*

> *"You know so it's just one of those things. And then you tell women now, and they look at you and say "Is this, are you for real? You delivered your babies and you went out on the verandah?"*

> *"I happened to go to Kalgoorlie a month before my son was born and I couldn't get back* [to Noongar Boodjar]*, so my son was born in Kalgoorlie. And they put us out on the verandah, and I said to the nurse "I don't come from this Country, it's not my Country!" you know. And I was really scared."*

> *"When I was born, the hospital made mum and dad build a camp outside the hospital. But Miss Jones, the old mission lady, she came and she argued that no, my mother was to be put in hospital. And so they made a bed out on the verandah, and I was born on the verandah at the hospital."*

The Elder Women described accounts of discrimination and being treated differently to non-Aboriginal people. For one Elder Woman, her experience of pregnancy was remembered as follows:

> *"When I had my son back in 1974, living in Armadale, I had to travel every week to* [the women's] *hospital by train and bus. I wasn't able to have care at my local hospital even though I had a great job and contributed to the community and was studying to get my child care certificate. Being Aboriginal, they said my pregnancy was high risk, even though I was healthy. I would travel for two and half hours, by myself, to get to* [the hospital] *for my appointments."*

Collectively, the Elder Women recalled how their families were treated poorly and unfairly, both by individuals and through the imposition of government policies, such as being forcibly moved around and being segregated from non-Aboriginal people, living on missions and in town camps. The recollections extended to instances of not being able to go into town as children or play games with white children.

> *"Well we got sent to Moore River first when I was seven. And turned eight after we got there and we stayed there for a whole year, and then they sent the whole family away for a year. I mean you wonder what sort of a bloke Mr. Neville was."*

> *"So that, the school* [at the mission] *was good fun but you couldn't go to town. Couldn't go to play their games or anything, you had to play amongst yourselves. Each other you know. You couldn't go and beat those white kids at their own game, unna. You know. But we would have loved to have cleaned them up."*

The impact of racism across the lives of the Elder Women and trauma associated with children being taken – referred to as the stolen generations – had left some of the Elder Women with a deeply felt distrust of white people.

> *"I used to hate white people, I still hate them now and* [my daughter] *says 'oh Mum, don't be silly'. But you know, when you read about all the things they used to do to Noongars, you know, like shocking stuff. It's like women have no feelings, they take kids away….*[like] *they don't feel anything, you know. That you didn't have that feeling of love for your kid, that they thought you didn't have it. What horrible people."*

> *"I don't know who are the most civilised, the whitefellas or the blackfellas because they had no idea. How to treat people. They had no heart. I still hold it against people, you know, good people now, but still."*

> *"So the impact of Stolen Gen on people…it's the fact that the missionaries, even preached 'you don't have anything and you should share'. They didn't actually do it themselves. And there was abuse in the mission with the* [religious] *fathers and all those things and it wasn't brought out and it wasn't dealt with."*

> *"See it takes you back really to like, and we lived on reserves and that, we never, you know, really had nothing, yeah. But our old people used to say, well I know my old fellas or rellies used to say: to survive in this world you gotta learn the white man's way. And you gotta live with these people, you know."*

This issue of survival in the face of racism was strongly present in the Elder Women's efforts in continuing to provide love and care to grandchildren, in some cases great-grandchildren, who would otherwise be taken into care by child protection agencies.

"I think it's just got to a point now where these girls are getting so defensive it doesn't matter who it is, whether you say it out of love or not, they feel like they're being judged, and they are scared, so instead of embracing their Nana's information and that they're frightened, because so many Nanas have had to take kids and look after them…[because] *they need that."*

Some of the women shared deeply personal experiences of their own trauma that included losing children and making their way through life without their families.

> *"No mum and dad to support, mum died when I was 13 a very sad time in my life. Dad died when my first born was 8-9 months. No one to help. I had to learn it all myself, do it all myself. No one to guide me and add all the medical stuff on top. It was tough."*

Others talked about the strength of their families in the face of child removal policies.

> *"Cause in our little town…we were really blessed. I s'pose because, you know how the police were, the native protectors, well, when the welfare did come and you know like our mob would recognise the tracks/trucks. Or my grandfather would be straight on the doorstep of the local police. And he'd say, you know, 'You better get this mob out of town' he said, 'because they're not taking any of my family!' So, the only way they ended up getting our family that we're aware of was, that my grandfather's old brother was placed in hospital and they put the kids down in Carrolup mission. But the old uncles went down there and stole all the kids and brought them back."*

Despite the experiences of racism and the indifference of others encountered across the life course, the significance of the opportunity to share their birth stories in the yarning circles was captured in these two Elder Women's comments recorded on the day:

> *"I'm just overjoyed to be here, to share this. I think it's just been special so far, listening to everyone tell their stories, and I'm glad that you are doing this research. I think it's long overdue."*

> *"As Noongar women it's been really hard for us, having our babies. But it's been a wonderful day to sit here and listen to each other, talk to each other about our experiences and hopefully learning about our culture will strengthen us, heal our hearts, slow our tears and make us stronger to go forward."*

2.4 Discussion of Aboriginal Women's Data Set

2.4.1 Aboriginal Birthing Women

While there were similarities between the evidence categories *experiences of care* and *reflections on maternity services* in this data group, the themes and sub-themes also highlighted differences between these. For example, when asked questions in relation to their experiences of care, Birthing Women's responses were mainly drawn from their deeply held memories and recollections which they described in relation to how they were personally treated during encounters with care providers, how this made them feel and/or what this meant to them. These recollections were sometimes positive, but often negatively described, often influenced by the age at which women had their first baby. If they had been cared for in Aboriginal specific models of care, they were more likely to recall positive experiences, whereas maternity care that did not incorporate any contact with Aboriginal staff (the majority of women in this data group) or any continuity of care or carer resulted in more negatively recalled experiences. Adolescent pregnancy tended not to be associated with satisfying memories; and for two women, was traumatic to recall. Even so, these women were insistent their experiences were included in the data collection.

When referring to maternity services more generally, the women tended to be more outward looking at what they and their families had encountered in hospitals and, as such, included examples which reflected on what they identified as requiring change to make maternity services more acceptable to Aboriginal women, as evidenced in the theme *cultural practices supporting cultural security*. The combined Birthing Women's evidence therefore provides the basis for identifying elements able to be incorporated into maternity services to improve the cultural safety of Aboriginal women and improve their care and birth experiences. This includes: greater attention to providing the circumstances for more continuous relationships between women and care providers, which in turn would support better and more consistent two-way communication; more Aboriginal staff; more education for non-Aboriginal staff about Aboriginal people, including about their family relationships; and more flexibility in service delivery. The availability of these elements in woman-centred and continuity of care (and carer) service delivery models would likely address the concerns that were expressed and improve health service personnel's understanding of the cultural needs of Aboriginal families.

The women also described family and extended family networks and shared knowledge as central to their childbearing experiences, as these represented to women a cultural strength from which they drew to maintain their cultural security. When women had access to Aboriginal specific services, a minority of this cohort, this greatly improved their opportunity for a satisfactory and culturally safe experience, during which women did not need to explain themselves or their requirements, and which resulted in them feeling supported and cared for.

In terms of birthing on Country, while a few women did not express strong feelings associated with the question of how important it is to have their baby on the Country of their ancestors, most of the Birthing Women strongly agreed this was an important aspect of their childbearing journey. This was primarily expressed by the women as representing connection to Country and providing their babies/children with an identity of belonging to place, Country, family and culture.

Overall, the Birthing Women's stories held strong common threads across the collective experiences of pregnancy and childbirth with Aboriginal women encountering a maternity care system which did not consistently respond to their cultural needs, frequently or not at all, which ultimately translated to unsatisfactory recall of their encounters with the maternity care system.

2.4.2 Aboriginal Senior Women

The two evidence categories - *perceptions of maternity care and services and cultural practices and cultural security* for the Senior Women data group were closely aligned with the Birthing Women's data. Senior Women also described family and the support provided by extended family particularly at the time of birth and immediately following as central to their own, and other Aboriginal women's sense of cultural security. The presence of family members at the time of birth to welcome a baby into the family and community was strongly articulated as an important cultural practice, as was intergenerational knowledge sharing across the course of pregnancy and in preparation for childbirth and parenting.

It was also evident in the Senior Women's data that access to Aboriginal staff promotes cultural security for Aboriginal women. It was explained that when Aboriginal staff are available in caring and/or support roles, women feel more comfortable being in a hospital environment. When Aboriginal staff were consistently available, this was perceived as promoting continuity for women, as well as being highly desirable; and had the ability to enhance women's experiences of care.

While most Senior Women recalled positive encounters in at least some aspects of their own maternity care. Most also recalled specific events or people which had left them with negative memories of their experiences. Some women described the undercurrent of racial assumptions made about them which had framed those experiences, leaving them with negative perceptions of maternity services.

The Senior Women's data demonstrates a convergence of evidence identified in the Aboriginal Birthing Women findings. While the Senior Women in this cohort were less likely to have lived permanently on Noongar Boodjar, they emphasised the cultural practice of Birthing on Country as important to all women, including those in urban environments.

Senior Women were more likely to note the changes which had occurred over time in health systems and the impact of these changes on Aboriginal women generally. Just under half of the Senior Women in this data group had previously or were at the time of data collection, working in the health system, and as such, they had insight into the influence of the health system on women's experiences of maternity care. The Senior Women's data also provides further evidence of the elements noted in the Birthing Women's discussion as relevant to the delivery of better and more culturally safe maternity care for Aboriginal women, to increase their cultural security when attending maternity services.

2.4.3 Aboriginal Elder Women

When considered alongside the Birthing Women and Senior Women data groups, the Elder Women's yarns about their own births and those of their daughters and granddaughters and their stories of their mothers' and grandmothers' old ways clearly demonstrated that access to culturally secure maternity care, as the Elder Women know it to have been in the past, is observed as lacking for Aboriginal women across multiple generations. It is evident that while Aboriginal women may no longer be overtly segregated on verandahs during childbirth or postnatal hospital stays, neither did they feel fully welcome in the maternity services which took the place of cultural care by traditional midwives. The Elder Women's data confirms an absence of cultural support in the health care system over a long period of time. This was contrasted in the Elder Women's stories by the love and care they recalled as present when traditional (bush) midwives were the care providers, even though those births took place in tents or mission 'hospitals' which were, in reality, tin sheds. The Elder Women noted there were non-Aboriginal advocates in small towns who spoke up on their behalf, with doctors and matrons particularly noted, but these people were few. Overall, it was evident that Aboriginal people, including those giving birth, were excluded from usual services, and subject to discriminatory care. Further, the Elder Women's accounts of accessing care suited to their needs largely replicates those given by the Birthing Women and Senior Women. References to access to transport, proximity of services, the absence of Aboriginal staff, and being assumed to be high risk simply due to being Aboriginal were noted in this data group.

Changes in maternity care across time and generations was a theme woven throughout the Elder Women's data. Strong sentiments were expressed of the importance of sharing passed down intergenerational knowledge, to maintain cultural practices and knowledge for future generations. Recollections of intergenerational changes, from perspectives of personal circumstances and in relation to observations of daughters' and granddaughters' experiences of pregnancy and childbirth were made. One Elder Woman had seen this as an opportunity to improve her own knowledge. This perspective highlighted that some Elder Women had relatively little knowledge about what pregnancy involved (other than just being a fact) even though they felt well supported by older Women in their community during their own pregnancies, and especially at the time of childbirth. As such, most of their recollections of cultural practices across time were focussed on childbirth itself, and how traditional midwives had provided culturally secure care.

Observations of change were also associated with differences in hospital environments now by comparison to their own experiences. These were generally not considered by many of the Elder Women to be for the better. For example, one Elder Woman noted changes between her first children, when she had continuity of carer, while for her later children she did not. Additionally, having been involved with their own daughters and granddaughters during childbearing, the Elder Women strongly advocated for a culturally secure health care system for younger Aboriginal women. They believed the healthcare system can do a better job to include Aboriginal people in their vision of the future. It is evident the women want to see more Aboriginal faces in hospitals. However, there was also awareness that enabling choices for Aboriginal people was not purely the domain of Aboriginal people. The Elder Women's stories made it clear that it was important that non-Aboriginal health care professionals do not offload the responsibility for cultural security to Aboriginal staff or outside Aboriginal organisations.

The Elder Women's yarning and stories provided rich detail, which included recollections of their own experiences, and those of their mothers and other older women. Elder Women also shared their knowledge of traditional midwives and birthing sites located on Noongar Boodjar. Historically, the Elder Women's recollections spanned four generations, including daughters and granddaughters even great-granddaughters experiences. The Elder Women also reported details of their broader life experiences, including life on missions and in the country towns where they were born and/or lived and had their own children, which included being segregated from non-Aboriginal people, and being treated or cared for on the verandahs of hospitals, rather than within these services. These recollections had shaped their life experiences, including childbearing, and their feelings towards non-Aboriginal people. Due to these experiences, some of the Elder Women retained a deeply held distrust, and dislike, of non-Aboriginal people.

The Elder Women's data contributes important context to many of the issues that Aboriginal people faced and continue to face when interacting with mainstream health services, and the enduring impact of Government policies they were subject too, still resonating in their everyday lives.

2.5 Summary Discussion – Aboriginal Women's Data Set

Overall, the Aboriginal women's data set represents a detailed multi-generational perspective of the experiences, perceptions, perspectives and reflections of how birth has been experienced across their childbearing years. Women across this data set frequently referred to themselves, and Aboriginal people, as being different from non-Aboriginal people 'in different ways'. They sought acknowledgement of this, stating it was not about receiving 'special treatment', rather that they have different requirements, most strongly associated with their cultural needs.

The Aboriginal women's data set demonstrates deeply embedded cultural practices passed down through grandmothers for those still connected to their families – reliance on family, on the wisdom of Elders and grandmothers, and on birth as a collective kinship event. Also present, were strong recollections of birthing before inclusion in health services. This included in tin sheds which acted as hospitals on missions, tents, mia mia, in private homes and on hospital verandahs. Following increased access to health care, women's past experiences through to current and contemporary experiences demonstrated that Aboriginal women felt, and continue to feel, health services do not know or understand much, if anything, about their needs and they feel excluded when accessing care. By contrast, the few women who had experienced maternity care through an Aboriginal specific service, such as an Aboriginal Maternity Group Practice, positively reflected on their experiences. While other women had some positive encounters, generally, across all the data groups, most recounted negative care experiences in the hospitals they attended. One of the Senior Women recollected being attended by an Aboriginal midwife for her final birth and said this was the best experience she had over her childbearing years.

At a minimum, women in all data groups referred to the need for access to other Aboriginal women in either support (Aboriginal Health Workers [AHWs]) or primary care roles (midwives), or at the very least for an Aboriginal Liaison Officer (ALO) available during their time in hospital. The lack of Aboriginal 'faces' in hospitals was seen as a system deficit and added to women's feelings of not being cared for appropriately., While Aboriginal people are employed in the health system and acknowledged for their contribution to Aboriginal patients cultural security, there are too few, including in maternity care. In some services there may not be any Aboriginal health care providers or supporting roles such as Aboriginal Liaison Officers or Aboriginal Health Workers. Further, in recognition that the majority of health care providers are non-Aboriginal, and this will remain the case, the women also spoke about the need for non-Aboriginal health care professionals to have a much better understanding of Aboriginal people and culture and how to provide culturally safe care as an essential requirement for working in the health system.

There were many features associated with Aboriginal women's experiences of maternity care and maternity services which are more fully understood alongside women's descriptions of cultural practices and concepts with supported them to feel safe (and culturally secure). Intergenerational knowledge sharing and family support were at the heart of their perceptions of what provides them with cultural security. From the Aboriginal birthing women through to the Elder women with – collectively representing a period of around 70 years – maternity services still fail to accommodate extended family members attending a hospital to support birthing women as a strong cultural practice. From a broader perspective, the need for more Aboriginal people working in the health system, and more non-Aboriginal people with knowledge and understanding of Aboriginal people, their history and cultural practices, would go a long way towards addressing the racism that was persistently expressed by Aboriginal women participating in this study as ever present.

2.6 Midwives Results and Discussion

This section reports the findings from the Midwives data set, inclusive of Individual Midwife (n=20), Midwifery Focus Group (n=41) and Midwifery Educator (n=8) data groups. The Individual Midwife and Midwifery Focus Group data are reported separately and then discussed as a whole. The Midwifery Educator findings are then reported followed by a brief discussion of the findings related to how midwives are educated. This is followed by a final discussion related to the Midwives data set (n=69).

Prior to reporting the Midwives' data set results, key aspects of interviews (n=2) undertaken with Midwifery Administrators before Midwives data collection commenced are summarised below to set the scene for presentation of the findings. To provide context for readers of the Midwives' data set results we have also prefaced the Midwifery Results Section with extracts from the Council of Australian Government (COAG) Health Council published, *Woman-centred care; Strategic directions for Australian maternity services* (August 2019).

2.6.1 Midwifery Administrators

Two (non-Aboriginal) senior midwives working in the Western Australian Department of Health at the time were identified as health system midwifery experts. Both had lengthy experience in policy, clinical management and other aspects of providing midwifery services to the women of Western Australia.

The information derived from these two interviews provide a snapshot in time (2016), close to the start of data collection for the BONB project, of the delivery of care for Aboriginal women by the WA health system. The interviews were conducted by the Project Lead. Topics covered included cultural security, cultural competence, and how the health system supports Aboriginal women. These participants were also asked for their thoughts about what Aboriginal women need during childbearing and what health systems changes may make a difference for them. The following summarises the two interviews, identifying service and policy contexts.

2.6.1.1 Cultural Security is Not Theoretical

Cultural security was viewed by these midwifery administrators as understanding from Aboriginal people, as experts in their own needs, what they require in care environments, noting that:

> ***"Cultural security, it's around respecting an individual's beliefs, laws, family, community… looking at the person as a whole…you*** [can't] ***separate the spiritual and cultural from the psychological, physical, emotional because it's all embedded."***

It was noted that the cultural competence of practitioners directly connects to the creation of cultural security, which may look different to different Aboriginal people:

> ***"Cultural security…is so different for different people…you only learn that when you talk to people to find out what it is that you might need to make people feel welcome."***

Further, ***"an Aboriginal painting on a wall is not cultural security"*** and that acknowledgements of country and flying the (Aboriginal) flag is only superficial if it does not come together with meaning making and understanding how the delivery of culturally safe care to individual Aboriginal women might be achieved.

It was noted that new graduate midwives tend to *"get it"* (cultural competence) more than some midwives who have worked in the system for a long time. Of 'learning' cultural competence, it was noted that:

> ***"You do learn it in your undergrad, you do go through all that and as a nurse and a midwife, you do understand the holistic nature of it. Once you then get into that system you're never afforded the time to do any of that…the pressures on the system then result in those things not being addressed."***

Both administrators said there are no midwifery cultural competence measures in the health system and it is not assessed. Once learned in the undergraduate setting, there is no further reference to or requirement for further learning to enable practitioners to demonstrate their cultural competence.

With respect to cultural education, which may contribute to better cultural competence, it was noted that culturally responsive practice is a continual and ongoing process, should not be a

'tick a box' exercise, and that understanding of such practice needs to be purposefully applied to be effective.

> ***"We are here for the women not the other way round. The women are not here for us, we are here for them…so we are here to meet their needs and to ensure that they get the best care possible."***

2.6.1.2 Making a Difference to Aboriginal Women

With respect to what would make a difference in maternal health care service delivery, the administrators referred to how midwives need to 'be with' Aboriginal women, including working in partnership and actively engaging in two-way learning, while being aware that Aboriginal women come from a completely different world view of what care should include:

"Being self-aware is really important particularly when dealing with Aboriginal people because how you come across, if you have no insight and you're not aware of your own biases, your own values and your own judgements, how can you possibly provide care to an Aboriginal woman."

These administrators perceived that Aboriginal women want midwives to be open and display really good skills of being welcoming, treating each woman as an individual, and taking the time to build rapport and trusting relationships, noting that this approach *"takes time, it won't happen instantly"* and that midwives should *"not give up on it."* Further, that the health system needs to ensure that continuity of carer is available to Aboriginal women, so that relationships between midwives and the Aboriginal women they care for can be fostered and supported across the childbearing continuum.

2.6.1.3 Changes Within the Health System

The midwifery administrators referred to the maternal health care system as not 'seeing' women's individual needs, and as such isn't flexible or responsive to Aboriginal women's expectations that the care offered will meet their needs. Both highlighted similar principles required in the health system, such as:

- treating the whole person with respect and non-judgemental care as routine practice;
- that Reconciliation Action Plans are developed and communicated to all staff;
- that senior people within maternal health care services role-model and 'walk the talk';
- that non-Aboriginal people within the health system become champions for change; and,
- that more opportunities are created for Aboriginal people in all roles of service provision.

The bolded points in the content extracted from the COAG Health Council Woman-Centred Care strategic directions (2019) below are included to highlight the Midwifery Administrators data collected in 2016 demonstrated understanding of the changes required to better support Aboriginal women's maternity care; and the alignment of data interpretations in the BONB analysis with high level change actions that were being determined at the same time. This is relevant to contextualising the data analysis and interpretations presented in this section.

A. Respectful, holistic care (p. 13)

Principle: ***Women are treated with dignity and respect throughout maternity care. Maternity care is holistic, encompassing a woman's physical, emotional, psychosocial, spiritual and cultural needs.***

Strategic direction: Respect women's choices, experiences and outcomes and use woman-reported data to inform quality improvement in maternity care.

Rationale:

- Women need and deserve respectful care and protection of their autonomy and right to self-determination; this includes individualised care for marginalised women and women vulnerable to poor outcomes and to safeguard maternal and infant health.
- Disrespect and abuse during maternity care are a violation of women's basic human rights.
- Women want their experiences and outcomes to be collected, responded to and made publicly available.

Enablers:

- Maternity care providers commit to the Respectful maternity charter: the universal rights of childbearing women.
- Woman-reported outcomes, wellbeing and experiences are collected (e.g. using patient-reported experience and outcome measures) and reported as a core part of quality assessment of maternity services.
- A core set of questions is collected to enable national comparability.
- Women are included in maternity service planning and monitoring committees.

B. Collaboration among health professionals (p. 13)

Principle: ***Women's safety and experience of maternity care is underpinned by respectful communication and collaboration among health professionals.***

Strategic direction: Promote a positive maternity workforce culture based on interdisciplinary collaboration and communication.

Rationale:

- Women expect all members of the health care team to work collaboratively to support integrated care and care transitions.
- Collaboration among all maternity providers improves communication and outcomes and is essential to continuity of care and continuity of carer.
- **The regulatory framework and service leaders have a role to play in setting standards and role-modelling appropriate behaviour.**
- Respectful interaction between health professionals is highlighted in the codes of ethical practice for doctors and midwives.

Enablers:

- Professional colleges and associations for health professionals involved in maternity care endorse this Strategy.
- The roll out of digital patient health records effectively crosses and integrates the maternity services sector.
- Investment occurs in systems to support team-based leadership and interprofessional and interprofessional cooperation, including interdisciplinary team-based training.

C. Cultural safety (p. 10)

Principle: ***Women have access to individualised culturally safe and responsive maternity care, in their preferred language.***

Strategic direction: Develop and implement culturally safe, evidence-based models of care in partnership with Aboriginal and Torres Strait Islander people and communities.

Rationale:

- In 2016, 4.4% of women who gave birth in Australia identified as being Aboriginal and/or Torres Strait Islander. These 13,608 women gave birth to 13,794 babies. Around 1 in 19 (5.2% or 16,479) of all babies born were Aboriginal and/or Torres Strait Islander (based on the Indigenous status of the baby, i.e. where the baby's father was Aboriginal and/or Torres Strait Islander and the mother was non-Indigenous).
- Evaluated state-based initiatives have found improved outcomes associated with maternity care models that are culturally safe and responsive, provide continuity of care and involve partnerships with Aboriginal and Torres Strait Islander health staff and services.
- Women from remote communities frequently give birth in larger centres away from their communities.
- In Australia in 2017, 0.4% of employed medical practitioners and 1.1% of employed nurses and midwives identified as being Australian born Aboriginal and/or Torres Strait Islander.

Enablers:

- **Uptake of the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women report 2012 is supported.**
- Strategies relevant to maternity care in the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 and the associated Implementation Plan are implemented. Aboriginal and Torres Strait Islander women can access care utilising The 'Birthing on Country' Service Model and Evaluation Framework.
- **Existing maternity care providers have been educated in and practice cultural safety.**
- Individualised support is provided to women who have to spend time away from their communities during the perinatal period.
- Language services, bilingual workers and Aboriginal maternity liaison officers are accessible.
- Language-specific antenatal clinics that provide antenatal classes and translated information are available
- Strategies in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 are implemented.

Presentation of findings from the Midwives data set now follows.

2.7 Individual Midwife Findings

Midwives working in clinical roles (n=20) participated in individual semi-structured interviews. Participants reported having been in midwifery practice for between 2-35 years. While not asked a specific question regarding country of birth or cultural identification, some participants identified as being other than born in Australia (e.g. Scottish, Malay/Indonesian), while one midwife identified as Aboriginal and a second as Torres Strait Islander.

Seven primary themes, six with sub-themes, were grouped in three evidence summaries: 1] perceptions of caring for Aboriginal women; 2] knowledge of Aboriginal culture; and 3] understanding of health system issues (Table 7).

Table 7: Midwives Themes (and Sub-Themes)

Midwives Evidence: Primary Themes and Sub-Themes		
Perceptions of caring for Aboriginal women	**Knowledge of Aboriginal Culture**	**Understanding of health systems issues**
Cultural Security Perceptions *(advocating for women; applying knowledge learned to practice; midwives understanding women's isolation when away from Country; partnership and engagement; respect and kindness; supportive communication; ways of working with Aboriginal women)*	**Family Support and Community** *(midwives' perceptions of birth planning; women's business and intergenerational learning)*	**Work Environment** *(Aboriginal workforce; cultural education opportunities; knowledge of available resources; pathways to supportive care; sharing knowledge with colleagues; the value of Aboriginal colleagues)*
Woman-Centred Care *(lack of woman-centred care; providing an interface between woman and system)*	**Racism and Culturally Unsafe Practice (CuSP)** *(challenging CuSP; racial and cultural stereotyping)*	**System not Supportive of Equity, Access and Inclusion** *(hierarchy of professional relationships; system changes which would promote access and inclusion)*
	Knowledge of Culture	

2.7.1 Perceptions of Caring for Aboriginal Women Evidence

All participants were asked a question about their understanding of cultural security and how this relates to Aboriginal women. While most were unable to define cultural security or cultural safety, elements were identified as likely associated with assisting Aboriginal women to feel safe. This included, for example, acknowledging that health professionals require knowledge of Aboriginal cultural practices if they are to contribute to providing culturally safe maternity services and how history has impacted on the health needs of Aboriginal people. The following response is illustrative:

> ***"Cultural security always confuses me a little bit, in that there are other terms like cultural competence and cultural safety. But I would describe cultural security…*** [as] ***providing health care in a safe and secure way that respects the culture of your client. (Interviewer: and how does that particularly relate to Aboriginal women say?) I guess having understanding about their law and history and how that's impacted on their health needs and their health situation at this point in time, taking all that into consideration and having an awareness of that. And practising…with that in mind."***

The cultural security question prompted many participants to identify factors such as embarking on a partnership with Aboriginal women to enable both engagement with women and in order to advocate on their behalf. For example, ***"I guess trying to be a liaison between her and the health care system if you…are lucky enough to become a person that she trusts in that relationship and being able to in some ways to buffer or protect her."***

Achieving a woman/midwife partnership was acknowledged as requiring the use of supportive communication, practicing kindness and respect, and midwives learning ways of working effectively with Aboriginal women. For example, in response to a question about what the participant thought Aboriginal women expect from a health service to achieve a culturally secure birth, the response was ***"to be treated the same and fairly and not be judged",*** while another said ***"I think they would expect respect and kindness…like any woman." I***n reference to applying knowledge learned to midwifery practice, a participant said:

> ***"So for example in town here you may be able to make contact by actually phoning them on the mobile you might have phone reception and you might be able to put a letter in the post box. But you're probably always better off if you can go and visit them. Don't just put three reminders in the post and expect that they will get them and turn up at that newly scheduled appointment. Or, if it's not through you, being resourceful and using an Aboriginal Health Worker or Liaison Officer."***

Midwives in this data group also demonstrated understanding of women's isolation when away from Country, ***"I think we've got an awareness that people landing in Perth, are really on their own, a lot of the time. So*** [asking] ***'have you got any family in Perth or you got any one that you know, have you got somewhere for your partner to stay, how you getting around?"***, and from another participant ***"just to consider that they may not have…been to a city before. How frightening that is. I know myself coming from a different country how scary it is when you don't know people, you don't know how it works."***

In response to a question of experience working with Aboriginal women, one participant was very positive that there are ways of working with Aboriginal women that acknowledges their difference and needs, while at the same time experiencing their individuality: ***"Aboriginal women generally have a quirky sense of humour and bring with them… a fairly relaxed nature about child birth…every woman brings a different experience to child birth but generally they seem fairly relaxed…They usually have a reasonable amount of support, so often an aunt or a cousin or a sister, or all of them, and they all seem very upbeat and positive about birth."***

For some participants, providing a culturally secure birthing experience for Aboriginal women means applying the principles of woman centre care, particularly when their knowledge of Aboriginal women's cultural and personal requirements is limited.

The concept of woman-centred care was often linked by participants with a continuity of care model, which was considered as the means through which trusting woman/midwife relationships are developed. Continuity of care was presented as notional rather than necessarily reflecting current practice in health services, as indicated in this example: ***"I imagine that continuity of care would be important because you would develop a relationship with that woman and you would develop that trust."*** As such, an ideal approach to providing culturally safe maternity care to Aboriginal women is articulated in this participant's response:

> ***"I think*** [midwives] ***really need to have that cultural awareness, obviously, and probably understand not all Aboriginal people are from the same cultural background…a continuity of care model is probably the best…especially if*** [the midwife] ***has got that empathy and cultural awareness…and trust and respect are some things that are really important. Changing care provider all the time…***[Aboriginal women] ***don't really build up that respect and security. I think cultural awareness training and a continuity of care model including an Aboriginal caregiver of some description…is a really good way to go."***

In practice terms, for some midwife participants, meeting Aboriginal women's needs through a women-centred approach meant 'breaking the rules' to allow, for example, Aboriginal Elders to visit out of hours, or for more than two support people to be present in a birth room: **"I've looked after a woman, a young girl who was having her baby and there must have been like ten people in the room…and really it's against the hospital policy to allow so many people into the birth suite"** and ***"postnatally, we had Elders visiting and…as a coordinator I'd say, 'Look, you know, they've come all the way…to visit the baby'…so we had to break the rules to let them come in."***

In this respect, midwives sometimes perceived themselves as having a responsibility to be an interface between women and the *'health system'*, to *'protect'* women. Some midwives were aware that Aboriginal women's lives are often complex and that women are diverse and have different ways of articulating and managing their own sense of security, each of which requires an individualised approach to care. For example, one midwife said:

> ***"One mum I can think of particularly, who really had a concern over that she didn't want the baby she was carrying and she was living with the partner and had three other children and she was very anxious. She was actually really well informed. She had done quite a bit of reading herself and…we knew where she was, so that was an easier one. But she was very concerned, so we basically just set up a plan for her, postnatally, antenatally, so she felt really secure."***

2.7.2 Knowledge of Aboriginal Culture Evidence

Midwives in this data group often referred to their knowledge of Aboriginal birthing culture as being mostly associated with a woman's family, with mothers, grandmothers and aunties responsible for intergenerational teaching and maintaining *'women's business'*. Further, some understood that family are often central in the birth process as family are ***"fairly close and obviously they are there for support, so that is their main role, to be supportive in the labour process"***, and that ***"family is really important to everyone, particularly Aboriginal woman, if they have family with them they often feel a lot more secure."*** The importance of family was explained by one midwife:

> ***"The family, inter-family relationships and how that impacts on them socially…how respect is really important in their culture…if you recognise what their model of respect in the family is, then…you can incorporate that into your practice. Say if there was an Elder that visits…that you do allow the time for them to visit and…create that space for them."***

About birth planning, a participant said ***"nobody really comes in with a birthing plan. But I think it's in their head. They have listened to their mothers or their aunties and they are very aware that they know this process is going to happen and that's normal and they have got to deal with that…There's no written birthing plan but they tend to have a bit of a plan in their head, of what they are going to do."*** General perceptions in this data group however were that if Aboriginal women have a birth plan, it is not likely to be communicated to midwives.

In relation to maintaining a culturally safe space for Aboriginal women, when midwives were asked what they would do if they observed culturally unsafe practices, responses were variable. This was sometimes framed in terms of being a 'minimal' issue, for example, ***"I don't see discriminatory behaviour from any of the doctors or the midwives you know specifically to Indigenous people"***, and ***"I have not come across it very often, I feel my colleagues are very culturally aware of what the Aborigine community expect, so I have not really come across somebody that's been inappropriate in that sense."***

Other midwives saw that professional experience or age hierarchies in health services may prevent them from responding to an unacceptable or racist situation, as explained by a midwife in response to the question about culturally unsafe practice:

> ***"That's a bit difficult because I am only two years on*** [from graduation] ***and it depends. If the colleague…if she's younger than me I would take her aside and 'oh, you know, there could be something you could do better, or do you think you are doing things appropriately?' But, if someone who is like, you know, has thirty years of experience, I probably would talk to my coordinator and say 'oh look I see this person and she's not doing so great with the Aboriginal girl, maybe we should swap people'…I wouldn't talk to her myself. I would ask my coordinator to talk to her."***

Another midwife, in response to a similar question said: ***"I think I would be probably at the stage of my life where I could say something directly to them…I would have a discussion with them. Not in front of the client but, perhaps how they could have approached that situation, how they could have been more respectful."*** For some midwives, racism they observed in the health care system seemed to overwhelm their perceived individual capacity to respond:

> ***"I find it quite a tricky one, it's not that I don't want to be an advocate, it's just that it can be very difficult, and in the whole manic phase of where we work, sometimes I don't think it's necessarily addressed well…I feel so overwhelmed with the whole thing…as far as blatant racism is concerned I would be the first person to step up and go 'no no, that really is not called for'. However, when you're trying to, it's not that it becomes too hard, it is quite overwhelming."***

Questions of racism and culturally unsafe practice were highlighted in instances of racial and cultural stereotyping expressed by some participants in this data group; for example, ***"it depends what Aboriginal we are talking about because the tribal woman are just quite happy to go along with whatever you say aren't they. But the city Aboriginals can be very demanding and expect a lot for nothing"***, and ***"I haven't come across an Aboriginal midwife yet, which is very telling isn't it."***

In relation to the broader issue of knowledge of Aboriginal culture, the prevailing perception across this data group was that, as health professionals, any knowledge or understanding they have of cultural birth practices may or may not be taken account of in the everyday practice of providing maternity care to Aboriginal women.

> ***"I don't think I can completely understand their culture because I am not part of it. But that I can be respectful and that they can feel comfortable talking about their culture and feel that when they rock up, that they can, that their cultural needs are understood and*** [emphasis added] ***perhaps…we may incorporate that into our practice."***

2.7.3 Understanding of Health Systems Issues Evidence

In the individual midwife data group were multiple examples of how midwife capacity to respond to Aboriginal women's needs, either culturally or more broadly through a woman-centred, continuity of care approach, was impacted by the health services, and health system, in which they worked.

In terms of the work environment, one participant reported having first received cultural awareness education some 18 years previously and nothing since that time. Others could only give minimal information related to cultural training or education they had participated in. It was evident in the data that access to cultural learning and education is ad hoc, not systematically reviewed or assessed as a professional competency and many participants expressed wanting more help with understanding the needs of Aboriginal women.

> *"I would like to see a…little bit more help with the Indigenous aspect…because I don't know what Indigenous women want really. I mean you can say that to a migrant or a refugee but Indigenous women are Australian women and I am an Australian woman…I just think we…can learn more about our own women…there are hundreds of different countries that come into Australia and we can't possibly learn about each one to the same degree* [but] *I just think we should look after Indigenous women the best we can and find out what they want."*

Many participants in this data group also articulated the important role and value of Aboriginal colleagues, as well as the need for more Aboriginal midwives and Aboriginal people in other roles. For example, in relation to AHWs or ALOs, midwives reported that these colleagues were not consistently available; and that positions within the health system had come and gone over time. It was acknowledged also that many demands are placed on Aboriginal Liaison or Health Worker positions within a service, for example:

> *"The last place I worked…the lady there was actually quite good but she's only one person – it was only contracted and part time. So, she can't be there – you know what I mean – for everybody."*

Similar situations were reported as a source of frustration by many in this data group, as was a lack of knowledge of resources available to midwives, which hindered supportive care for Aboriginal women, particularly when women are transferred from locations outside the metropolitan area.

Some participants wanted help from Aboriginal staff to educate Aboriginal women about the health service. More broadly though, better access for women to Aboriginal Liaison, Health Worker or support staff was viewed as needed, and the people in these roles might help midwives to learn and develop better understanding of how they can support Aboriginal women during pregnancy and childbirth.

> *"I don't feel like I have had a lot of training to help me work with Aboriginal women. But we do have an Aboriginal Liaison Officer who works at my hospital and I do, you know, ask her things and get her to see my Aboriginal women and if there is anything that she can deal with to understand our* [health service] *culture more. And we used to have two Aboriginal Health Workers as well that I found really helpful…but I do feel like we need a bit more training into the cultures of these women and how we can actually help with the care that we give to them here."*

It was also evident in responses from some participants experienced in providing care to Aboriginal women, that the health system as a whole is not supportive of equitable care or access for Aboriginal women during childbearing and does not enable midwives to provide culturally safe maternity care. This was expressed in terms of both a lack of personal knowledge of caring for Aboriginal women and a lack of formal support in establishing what is available within services to assist in the care of Aboriginal women. For example, one respondent noted that generally, midwives are left to their own devices: ***"I think I just kind of learnt myself really by just asking…I don't particularly remember going to an in-service or anything like that, I kind of picked it up as I went along"***, while others said ***"there's a big lack of cultural awareness",*** and ***"the hospital policies are the same for everyone"***, implying the approach does not acknowledge cultural diversity or promote inclusion.

The elements that midwifery participants identified as having potential to promote access and inclusion included: having Aboriginal women give presentations to staff about ***"what we've done well or stuff that we did badly"***; women being offered the option of birthing on Country ***"I don't know if it's to do with funding but women who are from Country, rural, remote, whatever, if that's where they want to be then they should be able to birth on their Country";*** and more Aboriginal midwives ***"I'd like to see more Aboriginal midwives. They have some familiarity and it's culturally safe and all that sort of stuff. We just need more."***

Additionally, more support staff are required, ***"I think it's just someone to talk to…because sometimes, as midwives, you don't have time to sit down and ask them about their family and ask them how they are doing. I mean you ask them how they are doing of course, but we don't ask them more than from our medical point of view."*** Other aspects referred to were: better understanding of supporting Aboriginal women's support people, particularly when both the birthing woman and support people were leaving home communities to travel to regional centres or the metropolitan area; more flexible policies within health services to accommodate the cultural needs of Aboriginal women, including the presence of large numbers of family members at the time of or after birth; and assistance with practical everyday necessities, such as housing, food and transport.

As such individual midwife participants demonstrated awareness of systems issues which prevent access and inclusion by Aboriginal women to maternity care and provided concrete suggestions as to how this may be overcome. This included suggestions such as providing continuity of care and carer wherever possible, more Aboriginal specific programs or continuity models of care which include a midwife, Aboriginal grandmother, and AHWs providing team care.

> ***"I suppose like the ultimate model I think that works, that I've seen work…would be to have an Aboriginal midwife, or a grandmother or even an Aboriginal Liaison Officer or someone that is Aboriginal…that identifies as Aboriginal as part of the team…*** [and] ***midwives at every Aboriginal medical service, that could be, you know like eligible midwives or whatever, provide that whole care for them."***

2.8 Midwifery Focus Group Findings

Focus groups were conducted with midwives in two locations: three groups at one hospital on three separate occasions; and a fourth focus group with midwives at a different hospital. The four focus groups comprised a total of (n=41) participants. A fifth focus group was held with midwifery educators with that data group analysed independently from the general focus groups and reported further on in this section of the report.

In the midwifery focus groups, between eight and 15 participants attended each group and included midwives working in different roles: as clinical preceptors providing professional staff development; clinical midwives; newly graduated and student midwives; and in one focus group, non-Aboriginal clinical midwives working exclusively in an AMGP. As group discussions, a diversity of views, opinions and knowledge were presented.

The midwifery focus group data generated eight themes, all but one with sub-themes, described in three evidence summaries: 1] professional dimensions of providing care to Aboriginal women; 2] knowledge and understanding of Aboriginal women's needs; and 3] racial assumptions, as shown in Table 8.

Table 8: Midwifery Focus Group Themes (and Sub-Themes)

Midwifery Focus Group Evidence: Primary Themes and Sub-Themes		
Knowledge and understanding of Aboriginal women's needs	**Professional dimensions of providing care to Aboriginal women**	**Racial Assumptions**
Continuity of Care *(availability of woman-centred care; complexity of need)*	**Professional Education** *(cultural competence; staff development)*	**Racial Assumptions** *(Western perspectives different to Aboriginal perspectives)*
Diversity of Aboriginal Women *(birth planning)*	**Cultural Security**	
Engaging and Communicating with Aboriginal Women *(family involvement; educating and informing feedback)*	**Aboriginal Staff and Services** *(Aboriginal specific services)*	
Meeting Aboriginal Women's Needs *(women's isolation when transferred)*		

2.8.1 Knowledge and Understanding of Aboriginal Women's Needs Evidence

This evidence summary encompassed themes such as continuity of care, the diversity of Aboriginal women, how midwives meet women's needs, and engagement and communication as important aspects of providing care.

Continuity of care was often cited as the best way to care for women, but participants frequently responded this is not available, for example, ***"I think a key word*** [is] ***continuous. That's where we fall down. That's the way the system works…we don't have continuity with them and that's a big problem."*** It was acknowledged that in the absence of continuity of care models, midwives build on previous care encounters with Aboriginal women as they moved through the maternity care system to establish rapport, and therefore engagement, as demonstrated in this extract from a focus group.

> [Speaker 1]: ***"I think there is quite a bit of a rotating, like you might see*** [the women] ***in clinic, and then it's rotating again and then you see them in postnates. So, some of them you are lucky, you seem to catch them on the way through."*** [Speaker 2]: ***"And they seem to respond to that."*** [Speaker 1]: ***"Yeah, they do, actually."*** [Speaker 2]: ***"If they remember your face they are more willing to engage with you. But it is hard when you do have to hand over because you feel almost like you are betraying them when you leave."***

In acknowledging the lack of availability of continuity of care and carer, focus group participants frequently referred to woman-centred care as substituting for continuity when meeting Aboriginal women's needs. For example, ***"I think we just tailor it, like we would with anybody, tailor it to the unique situation at the time. To what that family wants, to facilitate the best outcome…as far as, if they do have extra family, to try and negotiate to keep people in the room or you know if they need other services…You know I think we are pretty good at individualising the way that we actually approach everybody."*** Another participant said: ***"it's women's centred care isn't it, so it's always centred around the women and her needs regardless of her culture. So, having our limited awareness of their Aboriginal culture, it works together."***

For the AMGP focus group participants, in addition to noting that Aboriginal women are diverse, and different Aboriginal women have different needs, there was more nuanced awareness that continuity and woman-centred care also requires a careful approach, as noted in the extract below:

> ***"We have to be careful as we are offering the service to these women, that we are offering transport and that sort of thing. We have to offer the opportunity that they…determine their own care and*** [are] ***responsible for their own care. And that can sometimes be, that line can sometimes be blurred. We are all guilty, we all do it because we want to get them in for their appointment so we might just keep…you know constantly chasing, chasing, chasing and some of the girls it has the opposite effect, it pushes them away. So, we have to be really careful and that's something that's an ongoing thing that we….you can't have a policy for that. It's something that you just have to use to your own discretion because some women do require more follow up and some don't. So you can't have a one thing fits all. You have to be able to customise it and be flexible."***

By contrast, a midwife said in response to working around the lack of continuity said: ***"Well, we try. We'll get them to see the same doctor again. It won't always be the same midwife, but often the same doctor. And that's for every patient. If it's appropriate."***

Notably, Aboriginal women's diversity seemed to cause confusion for midwife participants about how to approach and manage care for their Aboriginal patients. For example, a participant's response to a question regarding caring for Aboriginal women and their families and how a midwife might meet cultural needs, provoked the following response:

> ***"It's important not to presume*** [when] ***you are looking at Aboriginal women who are birthing in Perth, and a lot of people who might be birthing on Country…it's quite complex. An Aboriginal girl comes from Perth…she might be traditional but she might not be. It's much easier to connect with girls who are obviously from a*** [remote] ***community. You make presumptions and you work much more quickly, I think, but sometimes it can be quite confusing with an Aboriginal person from Perth."***

Another participant reported her own increased awareness of how to work with Aboriginal women, when working alongside a more experienced midwife in a remote community:

> ***"One thing I find very hard is silence. Because I am not a very silent person as you can tell. And one thing I picked up with the midwife I was with out in the Lands, was sometimes you just sit and have a cup of tea and you just don't talk…I find it really hard just sitting and saying nothing and just being quiet. But then we found the amazing bits of information would come from these girls just from sitting quietly…it took just a while of having a cup of tea and just sitting down and it would be almost an hour later when we thought they were coming in for one thing, they were actually coming in for something completely different. And it was sitting there and actually not saying anything."***

Generally, participants in the focus groups noted that engaging and communicating with Aboriginal women was key to establishing a connection, with one noting: ***"sometimes they're more engaged, and it might not be the first visit, it might be the second or the third visit… they've obviously got to sort of trust. Whereas we assume that we will get on with people the first time we meet them. They might want to wait to see, 'well she was okay this time but will she be alright next time', or, you know, 'who am I gonna see next time'."***

Additionally, some focus group participants were aware of the importance of family involvement in Aboriginal women's maternity care, ***"they quite often come here with quite a lot of people which is fine, they can just wait in the waiting room. So…you know they come with family, which is, I mean nice."*** For other participants family presence or involvement during childbirth was viewed as being problematic: ***"they sometimes bring probably up to 20 people with them. We are only allowed to have two support people in the labour wards. Only because we have a lot of emergencies and a lot of things going on, so we can't have a room full of people. So, I think that's one of the biggest issues, that they get a little bit upset sometimes when they can only have two support people."***

Opposing views about Aboriginal women and their cultural and personal needs during childbearing were present in different focus groups. For example, in one, with regards to birth plans or women's other cultural requirements, one participant said ***"the main thing I've found is just that they don't want to breast feed. Most of them won't breast feed and I haven't really had a woman with a firm idea of what she really wants, just she is having a baby and that's it."*** By contrast, a participant in another focus group said ***"if I was to make a broad sweeping generalisation, like a lot of the Indigenous girls, they don't want the epidural. Or they talk to you about having morphine or something and walking around…but they think they're just going to come and have a baby generally. Culturally it's the normal thing to do. And generally, they're going to breastfeed."***

In relation to meeting Aboriginal women's needs, participants noted ways in which this might occur, which often included linking with Aboriginal Liaison staff or Aboriginal medical services, for example:

> ***"There is definitely an Aboriginal Liaison Officer, yeah. And they have a lot of the girls' appointments through AMS as well, so they have got linked into AMS service, the metro, they bring them in. Actually, I was just speaking to someone at Narrogin, at the AMS, who is bringing someone up, so these are quite good services to get them, you know, attached to."***

It was noted in one focus group that student midwives are now expected to provide continuity of care to women and a participant said in relation to Aboriginal student midwives:

> ***"The Aboriginal students we've had do tend to engage mostly with Aboriginal women… one student…the majority of her continuity of care women have been Aboriginal.*** [She] ***has also expressed a desire to not…only be seen as suitable, or appropriate for Aboriginal women. She is equally interested in knowing a little bit more of the experience of women who are not Aboriginal. So, I think we have to be careful that we do not make those assumptions that everyone's going to want the same thing."***

The focus group participants working in an AMGP noted that they are contacted by Aboriginal women from outside the metropolitan area from as far north as Broome, as well as further south from Narrogin and Katanning, and by hospital staff: ***"remember that time that girl came down from Halls Creek or somewhere and she was in labour? And got all of us, so if it was an Aboriginal girl birthing they would call us, for one of us to look after her."*** It was noted in another focus group, that Aboriginal women arriving from outside the metropolitan area need access to an Aboriginal person: ***"the out of town girls…we usually always try and make sure they have got access to the Aboriginal Liaison worker because they are often more isolated and often don't have family and often turn up off the plane with nothing so usually there will be…those people who organise that."***

The AMGP participants also noted that even in adverse circumstances, for example, when a woman's baby was being removed by the Department for Child Protection following the birth, that the relationship the midwives are able to initiate with a woman helps with providing pathways for her to maintain a link with her baby.

> ***"Even in really tough situations, like babies being removed…just recently we've had one come through. And she still felt really well supported…Like we tried to support her as much as possible, in accessing care and getting to any meetings as well because we can liaise with the social worker…and all those things that they need to attend. And even in the process of the actual baby being taken from the hospital. We still were that presence…and I really think that is important in those situations that…we are consistent. This lady actually came back and expressed milk postnatally after that baby was born in the hospital…that was really good that she still felt she could ask to do that."***

When midwives in the AMGP focus group were asked what the elements are that assist with providing Aboriginal women with care that meets their needs, participants identified a number of things. These included: ***"trust", "building relationships with the community", "consistency",*** taking things slowly, creating a comfortable environment***, "flexibility",*** non-judgemental care***, "accepting people as they are, rather than trying to fit in with the health care", "providing a one-stop-shop"*** (a dedicated site which provides for antenatal, labour/birth and postnatal care and ongoing breastfeeding assistance, and other family services, such as children's immunisations and other women's health care such as pap smears).

Some of these elements were also identified by participants in other focus groups, demonstrating a broader awareness among some focus group participants that Aboriginal women may respond to different approaches more suited to their needs. For example, one participant said ***"we're not in their community…they're coming to us and doing it our way, the way we do things rather than you know like having maybe community clinics or something, we could go out to them and make life a little bit easier."***

2.8.2 Professional Dimensions of Providing Care to Aboriginal Women Evidence

Professional dimensions of providing care to Aboriginal women included themes associated with professional education, cultural security and Aboriginal staff and services. In response to a question posed in all focus groups regarding the extent of education received which was specific to Aboriginal people in general and/or Aboriginal women's needs during childbearing, participants broadly recalled that professional education on these topics was variable and not consistently available.

In one focus group, two responses related to cultural education were ***"nothing"*** and ***"16 years ago, with nothing since"***, whereas a newly graduated midwife in the same focus group said ***"I just graduated this year, so we did a unit purely on cultural Aboriginal health which was really good."*** In another focus group, several participants referred to a presentation to them by an Aboriginal person on the topic of health promotion. There was no other specific recollection in that group of cultural awareness training or cultural education focussed on Aboriginal health they had recently attended. It was indicated across all focus groups that limited education is available which is specifically related to Aboriginal women's needs during childbearing. At least one participant in each focus group referred to online cultural training available across the health system, but that this was not pregnancy specific, although was noted as ***"mandatory now…online and also face-to-face…".***

Participants in some of the focus groups referred to experiences of working with Aboriginal women and learning from peers along the way as increasing their knowledge. For example, working in different settings and applying that experience to a current role, ***"it was a big benefit for me in working out in the country…in the Aboriginal communities in Balgo and Mullen and Halls Creek and Derby…I think just knowing the vastness and challenges*** [the women] ***face. Being out there enables you to assist women coming in to the service".*** In relation to improving cultural competence, other participants referred to study days, for example, ***"there has been some study days linked to Aboriginal culture and needs. I couldn't tell you how recent…there is the online one and there seems to be other ones that you can access"***, implying these as optional rather than a requirement. Other participants referred to an annual Aboriginal Health conference and undertaking an 'Aboriginal' placement (in an Aboriginal community) as ways to improve personal knowledge of caring for Aboriginal women. These were generally framed as being ad hoc and required midwives to take responsibility for finding out and organising their own attendance.

For the participants in the AMGP focus group, the prevailing view was that midwives learned from the women by working with them and developing understanding of the challenges the women face on a day-to-day basis. One participant in this focus group highlighted the knowledge and understanding that comes from working in a continuity of carer model, and how student midwives might benefit from being assigned to an AMGP. The participant described the difference from being with an Aboriginal woman on an eight-hour shift as opposed to working in an AMGP and providing continuity of care and how perceptions of student midwives might change with more sustained contact.

> ***"For a student midwife to come and work with us or any other group similar to us where you are going out on a regular basis, visiting the home, getting to know the women. Getting to know the issues. Even if you have had any training, even if you have picked up a text book on the history of colonisation or anything like that, you would still get far more of an understanding of what it would be like to work with Aboriginal people than it would be doing your job and coming and going for eight-hour shifts…student midwives they should…not just be*** [in a position of] ***'I allocate you an Aboriginal person and that's your exposure to culturally learning'. It should be…mandatory really, that they have to go and spend time with people who actually go and work on a much sort of deeper level with Aboriginal women."***

In other focus groups, cultural education was mainly referred to as being associated with student midwives, rather than being considered as an ongoing requirement for experienced midwives. When midwives were asked about cultural security and what this meant and how their cultural competence is assessed within maternity care settings, or what staff development occurs in relation to understanding Aboriginal women's needs, the most common response was that cultural competence is not assessed, and when it is referred to, is not specific to Aboriginal women. The following quote summarises the informal nature of professional practice education reported by participants across the focus groups in relation to how midwives learn about the needs of Aboriginal women during childbirth.

> ***"I came from*** [a private hospital] ***six years ago, so when I was working there for eleven years as a midwife we didn't have any Aboriginal women. No, one, actually. One person presenting in eleven years. So, I hadn't had a lot to do with the Aboriginal cultures and I came here and I started working with a lot of Aboriginal women. I found that quite different. But I talked to other staff members or they would talk to me and say that usually…*** [the women] ***might have a lot of visitors, so you need to do this, this and this. People just gave you advice and I suppose education and tips on how best to care for these women, and what are the common sort of themes of what they like and don't like in labour. Just other peers educating you, which I would do with the students as well."***

In relation to a specific question of what is meant by cultural security and cultural safety, responses were variable, ranging from ***"ensuring their integrity and identity and the fact that they are recognised as individuals within our society"***, to ***"feeling their cultural needs are being respected during the child birth process"*** and ***"being respectful of other cultures, particularly when they are different, and factoring that into the care that you do provide."*** One participant said in relation to making maternity care culturally safe: ***"we have to offer the opportunity that*** [Aboriginal women] ***are able to self-determine. Like determine their own care and be able to be responsible for their own care."***

Within the context of what is associated with providing care to Aboriginal women, focus group participants broadly agreed that Aboriginal staff and support services are important. In response to whether ALOs are available, a participant in one focus group said, ***"yes, and they will come and usually before we've contacted them, they've already seen people in the system…so they're pretty good at linking*** [with Aboriginal patients]***."***

It was noted that Aboriginal staff positions are not constant, and funding or programs for the positions had come and gone over time, which was viewed as frustrating. For example, ***"those girls we've had working here, the support girls…they were great. I mean they were seriously of good use and it's a shame the program finished."*** It was noted in another group, ***"Aboriginal Health Workers here were part of a study, a trial that despite the success of the trial, and I think this has been one of the features of working with a range of services over the years, is that despite being successful, when the initial funding appears to run out, there is no continued planning."*** Another response was related to Aboriginal grandmothers who work in multidisciplinary teams: ***"they have the Aboriginal grandmothers come postnatally now. I saw them at the diabetes service bringing women in for appointments, with one of the Aboriginal grandmothers from those areas. But I haven't seen anybody come in for a while."***

In terms of Aboriginal specific maternity care programs, it was noted that for one such program available at the time the focus groups were taking place: ***"if that closes, it's like we have an amazing relationship with them and I refer every Aboriginal woman that lives in*** [that area] ***and if they close, you know there's all our shared care models, for these women gone. So, it's a bit scary in the end"***. The need for both specific programs of care and Aboriginal Liaison and Health Worker positions for mainstream services was summed up by one participant: ***"so there's probably a need for more Aboriginal Liaison, or Aboriginal Health Workers."***

Targeted questions about access to Aboriginal midwives showed that very few of the overall focus group participants recollected contact with Aboriginal midwifery colleagues, with one participant saying, ***"we've got a few, but not many…but it depends on how they identify obviously."*** Another participant response indicated little knowledge of Aboriginal midwifery colleagues or their aspirations.

> ***"We have got a number, or have had a number, of Aboriginal students and new midwives. Some of them have specifically decided, I think, to complete midwifery because they really want to work with the community. And some of them are not in a position to go back to perhaps, their country towns which is perhaps where they have come from."***

This and other comments in the focus groups highlighted some of the assumptions made about Aboriginal women as patients as well as Aboriginal women as midwives, health workers and liaison officers. This was frequently framed in terms of Aboriginal women not participating in decisions about their care, and Aboriginal staff roles as 'coming and going'.

Focus group participants conceded that Aboriginal women would likely generally prefer Aboriginal specific services and/or Aboriginal midwives and other Aboriginal personnel involved in their maternity care. Participants also reported that Aboriginal specific programs and roles were negatively impacted by cessation of funding or, when studies were successfully completed, the care models tested were not made permanent, emphasising the marginalisation of these roles within health services.

2.8.3 Racial Assumptions Evidence

The final noteworthy aspect of midwives' focus group data was persistent evidence of racial assumptions made by some participants about Aboriginal women (also evident in the knowledge and understanding of Aboriginal women's needs theme above) both as childbearing women and as members of the maternity care workforce, in addition to perceptions of Aboriginal men and children.

The examples noted were couched in terms of Aboriginal people being 'other' or behaving differently from what is perceived as usual, or 'like us'. For example, a comment from a participant made in relation to the role of men during childbirth, ***"these*** [Aboriginal] ***girls they don't seem to have expectations of a bloke in the same way, so that's a bit tricky for me sometimes"*** while another participant commented ***"I have to just ask the Aboriginal guys to take the kids down to the park. They're really active Aboriginal kids; they climb and I find*** [the men] ***don't play with them in the way that we would."***

In relation to questions of what Aboriginal women want in terms of birth care or specific cultural requirements, some focus group participants regarded their inability to determine individual needs as a lack on the women's part. For example, ***"sometimes I don't know what they want really…because sometimes they don't maybe want to communicate with us and if they have got support people in the room, you know, they will talk amongst themselves more than to us."***

In contrast, another participant owned her own inadequacy in being able to communicate effectively with Aboriginal women, ***"I feel…communication isn't as free flowing as it could be. And it does impact…I mean they may have a birth plan and whether…I'm not asking in the right way, it's difficult to know sometimes even after doing all the cultural competencies and things."***

In one focus group, a participant noted that ***"I think they would like Aboriginal midwives"*** with some participants responding about why this may not be achievable as demonstrated by the following examples, which again highlighted the 'lack' in Aboriginal people, rather than considering the potential issues that may be barriers to Aboriginal people's participation in the health workforce.

> ***"The Aboriginal girls that have got cadetships and scholarships and things…***[but] ***how long do they stay in the field? Because that's the thing, you can train as many people as you want. But if they*** [only] ***stay for a year, you haven't got that workforce."***
>
> ***"We haven't got enough*** [Aboriginal people] ***graduating, people who graduate from high school for minimum…so it's hard to retain them to get them through to that point for staffing…*** [perhaps] ***due to a traumatic background…that's dragging the whole system down, so how do you get those girls?"***

Responses such as these were not linked by the participants to the potential barriers Aboriginal people may experience to participate in midwifery education, or how workforce issues, services and the health systems which are organised from mainstream perspectives may negatively influence the participation of Aboriginal people in staff roles.

As such, participants' perceptions of what is required to promote cultural security in maternity care services (more Aboriginal staff) were not connected by the participants to how systemic stereotyping of Aboriginal health, culture and people across the health system contributes to culturally unsafe environments, for both Aboriginal staff and Aboriginal people attending services for health care.

2.9 Discussion of Midwife and Midwifery Focus Group Findings

There were consistent similarities between the individual midwife and midwifery focus group data groups (n=61) to make summary observations on the findings from these. For example, while several participants in both data groups articulated that Aboriginal women are diverse and have cultural birth practices requiring supportive environments, these were exceptions. Many midwifery participants struggled to articulate their perceptions/knowledge of cultural security as a concept or how it applies to Aboriginal women. Even so, many participants also understood that family support is strongly associated with Aboriginal women attending hospital to give birth; and there is ongoing intergenerational knowledge sharing between women.

It was implied by some participants in both data groups that Aboriginal women need to more fully understand how maternity care is provided. This was conveyed along the lines that 'if Aboriginal women knew more about maternity care services, and what is required of them as patients, they may be able to more fully participate in their care planning'. These types of views deflect responsibility from midwives to learn about and understand the individual and cultural needs of Aboriginal women.

Perspectives such as these do not support a woman-centred care approach, cited by many as a solution for providing (culturally) safe care. For example, some midwives, trying to create a better environment for Aboriginal women, referred to as 'breaking the rules' to, for example allow more than two support people in a labour room, implying they actively work around individual health service requirements. Further, it seemed to be a generalised understanding promoted within health services that it is convenient to restrict the number of support people, with an example given that this is in case emergencies arise. However, there is no Department of Health policy requiring restrictions on the number of support people able to be present during a woman's labour and birth. As such, there is a contradiction in the findings for these data groups that is directly at odds with the concept of woman-centred care or of providing a culturally safe environment, as it ignores the knowledge also articulated in these two data groups that Aboriginal women rely on family support at the time of birth.

Several midwife participants reported that health services, and the health system in general, is not flexible and imposes unrealistic policies and clinical practice standards which do not account for Aboriginal women's needs. So, while woman-centred care was perceived as an optimal approach by many, there was little critical reflection by participants in this study as to how woman-centred care can be achieved, or how woman-centred care might support Aboriginal women to be culturally secure. The exception to this was from participants who had worked in continuity of carer models and, as such, had observed the positive impact of woman-centred care on those Aboriginal women they had cared for. Generally, however, midwives in this study did not express their capacity to challenge the service they worked within to change how care is managed.

In the absence of health system/service flexibility in the way care is provided, combined with the distinct lack of continuity of carer models or in the capacity of midwives to work in more autonomous ways, Aboriginal women would find it challenging to access support for their cultural needs or to avoid the racial assumptions directed at them when they are forced to interact with a diversity of health professionals across the continuum of their care. It was clear from the data collected from participants in these two data groups that the system does not support equity and the inclusion of Aboriginal women in accessing the care they need and inhibits midwives from providing more culturally responsive care. Further, professional hierarchies prevent midwives from effectively challenging any culturally unsafe care they observe, or to challenge instances of racial and cultural stereotyping.

This study also demonstrated that too many midwifery participants apply unconscious bias when discussing Aboriginal women and their care needs. Also of note was the, at times, blatant racism articulated by a few participants in relation to Aboriginal women, families and communities; going unchallenged by other participants in the focus groups in which this occurred, and in the presence of the Aboriginal person facilitating the focus group discussions. Further, while some participants described feeling overwhelmed by having to witness racism in the clinical environment, others denied that racism or racial stereotyping was a problem.

Even so, a good proportion of midwife participants reported the value of working with Aboriginal staff members, particularly Aboriginal Liaison and Health Workers. These roles were seen as effective in supporting Aboriginal women, and therefore their cultural safety, and providing a knowledgeable colleague for midwives to call on as required. Very few midwives were aware of Aboriginal midwifery colleagues or had worked with Aboriginal midwives, although most participants agreed that more Aboriginal midwives are required if meaningful changes in maternity care is to occur to better meet the needs of Aboriginal women. There were few instances across these two data groups of midwives taking responsibility for their own professional development and seeking out learning opportunities about the cultural birth practices and needs of Aboriginal women.

Concrete suggestions were provided by individual participants about the types of changes that need to take place. These included wider availability of continuity of carer models, more Aboriginal staff employed in health settings, and better education available in the health system for midwives to learn about Aboriginal women's needs and cultural birth practices. It was implied that the health system needs to rise to the challenge of creating more culturally safe environments for Aboriginal women; with no generalised sense that individual midwives can make a difference through enhancing their own knowledge and understanding of Aboriginal women, their birthing practices and what makes Aboriginal women feel safe when using maternity care services. Some participants noted that the way in which care is provided is unsatisfactory and unfair and undermines the self determination of Aboriginal women to control their maternity care in their own way.

2.10 Midwifery Educator Findings

Midwifery Educator (MWE) participants included three individual interviews and a focus group held with 5 participants (n=8): the individual interview participants held joint educator/clinical roles in hospital settings, and responsibility for staff development, and the focus group comprised academic midwife educators from three universities providing midwifery post-graduate midwifery courses. In WA, midwifery registration is attained via a graduate degree in nursing and a post-graduate midwifery qualification. Even so, direct entry midwives are employed in the WA health system, although direct entry undergraduate midwifery is no longer offered by any WA university.

This data group included the least number of participants of the three midwifery data groups. While the midwifery educator data group resulted in a similar range of themes to those noted from the individual midwife and focus group data thematic analysis, nuanced perspectives in the educators' data was evident. This was likely due to the educators being asked questions related to their responsibilities educating future midwives and/or providing continuing professional development opportunities for already qualified midwives.

Seven themes, four with sub-themes, were grouped into three evidence summaries: 1] education and practice, 2] cultural safety in education and practice, and 3] racial assumptions, shown in Table 9.

Table 9: Midwifery Educator Themes (and Sub-Themes)

Midwifery Education Evidence: Primary Themes and Sub-Themes		
Education and Practice	**Cultural Safety in Education and Practice**	**Racial Assumptions**
Professional Education *(Aboriginal midwifery students; educating the educators; teaching and assessing cultural competence)*	**Cultural Security**	**Racial Assumptions and Stereotyping** *(Racism and culturally unsafe practice; racism and culturally practice; recognising racism)*
Organisational Commitment to Inclusion *(cultural responsiveness)*	**Family Support and Community** *(Community and Aboriginal informed practice; cultural birth practices; diversity of Aboriginal women)*	
Individual Practice		
Work Environment		

The purpose of meeting with midwifery educators separately was to determine how curriculum or professional development topics are delivered to support teaching Aboriginal culture, history and social determinants; the type of content about Aboriginal culture and history; what cultural competency standards are used with students, how these are assessed and what occurs if a student is regarded as not being culturally competent; how educators themselves have learned about cultural security; and, what professional development opportunities are available to them as educators.

2.10.1 Education and Practice Evidence

This evidence category included themes related to professional education, organisational commitments to inclusion, individual practice and the work environment. Combined, these themes highlighted the influence of individual experiences and practice on educators' approaches to teaching midwifery. It also incorporated how they drew on their experiences of working with Aboriginal women to inform their teaching roles, for example, ***"I guess it's just over time when I've cared for Aboriginal women …I've learned a few things along the way…*** [and] ***when Aboriginal Liaison Officers come and talk about the culture."***

Some educator participants spoke of difficulties in bridging the gap between teaching students about caring for Aboriginal women during pregnancy, labour and birth and being able to facilitate opportunities for students to apply their learning to practice. One midwifery educator said, "my challenge specifically is to actually then directly access learning opportunities for those students to actually put into practice what they are learning from an Indigenous perspective." The educators also referred to the role of reflection in informing their practice, and understanding how cultural biases impact on the work environment, as described in the following example:

> ***"How your individual practice can influence the women that you care for and the people that you work with too…you have to also consider that there are some pretty engrained biases out there in the workplace and I think it's really important [to] reflect on our practices…as an individual…you reflect on how your interacting with others and the cultural biases you may have."***

Another educator also referred to the need to understand different cultural practices and how these might differ from a 'white European background' and as midwives and educators it is important ***"to reflect, that that's our culture…and it's different from theirs and it's not that theirs is wrong, it's just different."*** The same educator noted her role is to bridge the theory-practice gap when working with students in clinical settings, and that in terms of working with Aboriginal women, she imparted information and understanding ***"learned over the years"*** to students. It was further noted that the teaching and assessing of students' cultural competence, a national midwifery standard, was not specifically directed at Aboriginal women – ***"as a midwife one of your competency standards is about culture – it doesn't specifically talk about Aboriginal culture"*** and, as such, tended to be more generically considered by both students and experienced midwives with a range of cultures. For example, another educator noted ***"that particular competency will encompass all the various cultures…a lot of us tend to fall back on examples of where we worked with a Muslim family."***

In this focus group, educators noted a range of ways that students demonstrate their knowledge about Aboriginal and Torres Strait Islander women during pregnancy and childbirth. One participant noted that a student can nominate to go out to a remote community for a placement, while another noted that ***"students have assessments…in the care of Aboriginal women…***[and] ***choose their own assessments to look at Aboriginal issues as well."*** Another referred to assessments of assignment related to inequalities in health. It was also noted in this discussion that accreditation standards had changed for university courses, with requirements for "a discreet unit on Aboriginal health, culture, wellness and history and that's just a discreet unit and then a discussion around issues surrounding women, birthing women."

In terms of midwifery practice generally, and educator perspectives of this, reference was made to organisations' clinical assessment approaches to reducing risks in maternity care as interrupting capacity to support Aboriginal women's inclusion in maternity care, with one participant concerned that services prioritise medical risks, undermining a balanced approach to meeting women's other needs. ***"I understand some of the parameters with safety and birthing and everything. But I felt that outweighed the ability to provide that social support. And that mental health and wellbeing and social support is just as important as well as the physical, and sometimes that gets out of balance."***

Nonetheless, cultural responsiveness towards Aboriginal women was considered by one educator in terms of ***"we need to try and direct services that meet that need…it's very important."*** Another participant suggested that having ***"Aboriginal people come and speak to us and tell us what they want"*** was one approach to being more culturally responsive, while another educator described the need to look at what is being done well to meet the cultural needs of Aboriginal women. For example:

> ***"Trying to find…dynamic ways that we can actually care for these women and their families. Without displacing them too much*** [from] ***where they are comfortable, where they are from, where their support is, the land that gives them meaning is really important. But I don't think anyone has really got that right yet. I think there has been pockets of brilliance looking from the outside, doing really good things. And communities making changes; communities, individuals within a community."***

In relation to professional development education in the clinical workplace, an educator noted that ***"we've done a lot of Aboriginal cultural awareness study days, we've had speakers, we've done cultural packages – but I still don't think we've got what we need to help Aboriginal women"***, suggesting that further work is required to make professional development education more available to influence more culturally responsive maternity care practice. Further, more education is required for the educators themselves so they can effectively educate others. For example, in terms of access to cultural awareness training, some of the educators noted that these primarily tend to focus on Aboriginal history, health and culture, and that there is very little education available that targets Aboriginal women's cultural birth practices or maternity care needs.

In relation to educating both midwifery post-graduate students and the professional development of already practising midwives, the midwifery educators also referred to a range of ways to improve overall workforce capacity. These included: supporting Aboriginal midwifery students and drawing on their cultural expertise to peer teach other students; as educators, maintaining their own knowledge of Aboriginal culture and health practices, including undertaking consistent learning experiences; and, in teaching cultural competence, finding ways to effectively assess this aspect of midwifery practice. A university-based educator noted that:

> ***"Midwifery students are prepared through a double degree so they have some midwifery only units, some nursing only units and some shared units. So one of the shared units is Aboriginal and Torres Strait Islander competency unit so they have a very intensive focus sort of looking at those issues in relation to a health context, early in their course."***

2.10.2 Cultural Safety in Education and Practice Evidence

This evidence category had two themes associated with 1] cultural security; and 2] family support and community. Educator participants framed cultural security as mainly associated with creating a safe space for all women. In relation to Aboriginal women, this was qualified by one educator as ***"depending on where they come from and where they've been, because we have quite a few Aboriginal women who come from up north"***, while another said cultural security meant ***"having all staff to have an understanding of different factors of what it means to be/identify as being Aboriginal, what their values are and practicing in a way that isn't going to directly…cause conflict with those values that the Aboriginal holds."*** The same participant also noted that ***"I don't think we have particularly done cultural safety or cultural security or whatever term, I don't think we have done it particularly well."***

Another educator referred to woman-centred care as the means through which to provide cultural security:

> ***"I think as part of being a midwife…if you have a passion for midwifery you have a passion for women-centred care…I keep that at the core of my practice then all I add to that are things that are important, depending on where someone is from or what they've identified as a need or what our service has identified as a need for them. So, I think as I have grown as a midwife I have developed more knowledge and I have developed more skills at looking after women from many different places with many different backgrounds and religions…*** [so] ***being culturally aware is really important…*** [and] ***keeping the woman at the centre."***

In the educator focus group, one participant referred to cultural security and safety being ***"visited throughout every unit in the undergraduate midwifery units"*** while another noted that ***"we generally talk about…maternity care*** [requiring] ***humility and respect for all women, but they have that particular knowledge about Aboriginal women's historical background which means that they must pay particular attention to those challenges that those women bring to the maternity service, and those sensitivities that we must display."***

In relation to Aboriginal women, educator participants also referred to family and community informed practice as being related to cultural safety or security. This was associated with awareness of the importance of family support and drawing on Aboriginal community members to inform practice, with one example given of educators arranging to take ***"the students out to a birthing site*** [where] ***they meet women who have birthed or have family who have birthed on Country."*** Another example demonstrated how removing Aboriginal women from their family support was detrimental, with the educator saying:

"I looked after a young woman and I felt very sad about the situation…her and her partner, [were] *both employed, working, lovely to talk to, educated, everything. They were from* [regional WA] *but just because her BMI was too high they made her come down to Perth and totally removed her from all her social support. She said, 'you know, I have a huge family, you know my Aunties are having babies, lots of family support'. They both come down here, it's cold, they have got no friends that they know."*

Another educator said that enabling a support person to be with a woman transferring from outside the metropolitan area was another way to support women's cultural security: "[bring] Aunty/sister whoever down with them and [emphasis added] we make an allowance and let them stay with the patient…as part of our cultural security we do acknowledge that it is a big thing for them to be here in the city and being in a building with elevators and lots of white people, so they need that person."

A further perspective in relation to the diverse needs of Aboriginal women was described as: "they are all very different. And what their cultural needs are or might be are very different. Then they are all individuals, so you have to ask – except when you ask – asking may not give you answer."

The following extract clearly indicates the need for educators to have more knowledge of Aboriginal birth practices and Aboriginal women's needs while developing a deeper understanding of not only the diversity of Aboriginal women, which may be mediated by their location, but also how family relationships are framed, and how these impact on women's expectations of the care they receive:

"Even if you had an historical concept of 'okay this is the role of women…they were the hunters and the gatherers'…I know all that, but specifically, contemporarily now. Where do Aboriginal women sit now. You know, they say strong women, strong communities… but that's the same for all cultures…So, if you could have something about: where do [Aboriginal] women belong? Where do they belong in culture, where do they belong in relation to birthing? I know there are some great birthing practices. I know we can't smoke the baby, is there anything [else] we could do…Is there some way [birth] could be symbolised for them? If there was some way of doing it. It's about symbolism isn't it? About the connection of being, and country, and birth, and all that sort of stuff…and their role in the family. So if they have a partner, what does that sort of look like…where do the children fit in the family? Because I know a lot of the babies are looked after by their grandmother, or their aunt. Is that done all the time? Or is it only if the mother is not well, or is it if she's well. Where does that all fit in? Does everyone take a role depending on how connected they are with the family? … Or do you only take a role if they're not well, not coping? Or is that just normal? … So, there's a lot of stuff you need to know about. For us, we need to know about [Aboriginal] women."

Conversely, another participant referred to cultural training which was informative, but didn't address what she needed when working with Aboriginal women, and there was frustration evident with the lack of specific knowledge.

"We also did the old [cultural training] *and it was talking about the history of the Aboriginal culture what's happened to them since the white man has arrived – about the legislation in the past. What happened to their culture, what happened in communities – but there wasn't a great deal about how the communities work. It had a really good DVD in it about a man who was drawing in a community and crossing the river, and how hard it is to be in the community and cross the river and come into the white culture, and you take a bit of that away…But I still don't think it gave us the basis for how to help women! Yes, it helps us understand the culture and know the history, but nothing concrete to hold onto. And that's what we need, something concrete to hang on to."*

2.10.3 Racial Assumptions Evidence

The final evidence category in the midwifery educator findings relates to racial assumptions, which included highlighting to students the need for them to be aware of stereotyping Aboriginal people and how racism and culturally unsafe practice are handled in an education context. Educators reported that racism occurs in practice settings, but without explicitly drawing a link to what this means to Aboriginal women as birthing women or Aboriginal colleagues in health settings.

While stereotyping of Aboriginal people was addressed by educator participants as a topic covered within midwifery curricula, for example, ***"in one of my modules I talk about stereotypes because we talk drugs and alcohol in a certain area so we have a big issue about stereotyping…and that's a good time when you can actually discuss things like that",*** there were some examples of stereotyping from the educator participants themselves. For example, ***"you know there is also a lot of dysfunctionality in the community, I think, the Indigenous community"***, and ***"it's probably a bit harder with Aboriginal women because they often don't tell you what it is that either upsets them or what they actually want, or what they need."*** The latter comment though was not followed by any reflection on why that circumstance might be the case, while another educator noted that ***"look I think it's really hard for them but it's also hard for us knowing what's appropriate – what's not appropriate."***

While the educator focus group participants were unable to identify instances where a student was considered to be culturally unsafe, based on the belief that as midwives ***"we are a caring profession and you would hope that the people attracted to this profession would be the kind of people who would be open to looking after everyone",*** these educators also noted that white privilege is a topic that is covered in the education setting. As the discussion on this aspect of midwifery education progressed, another focus group educator noted that ***"actually thinking about that, I know we have all challenged statements that students have made on occasion about someone being non-compliant."***

These educators also feel obliged to alert student midwives to what they may encounter from midwifery colleagues when they are doing practicums, with the following example given.

> ***"I think we have probably all in practice, and in education worked with, I'm going to say 'old midwives', and when I say old midwives, midwives that have been around for a long time in the system and perhaps worked in one area…that don't have such a balanced view, and that is difficult. And I probably think we all, well I do, we all talk to the students when they come across that and how they are going to deal with that kind of thing and it wouldn't just be Aboriginal women."***

Reflecting one's own privilege, and making others aware of inequity, was also raised by another educator, in relation to life and educational opportunities:

> ***"I've had, you know, a good education. I've had the ability to make some choices. I've had the ability to earn some money to enable me to do that. A 19-year-old Indigenous young girl having a second child, she's much more limited…But I just think I constantly reflect all the time and I think if we can encourage everyone to do that*** [we]***…could remove some of those biases out of their thinking and their practice. I think that's really important. There is a hell of a lot of people out there that still have some negative view points towards Indigenous people. And that does carry through into their attitudes at work and that's just really out of order. It shouldn't be happening."***

Educator participants therefore were aware of the need to alert midwifery students and their colleagues that Aboriginal women do have specific cultural needs while balancing this against making generalised assumptions about Aboriginal women (and people), for example, ***"you've got people who come from, who live in the metropolitan area, people…who live in the country, people who live remotely – they are all very different. And what their cultural needs are or might be, are very different."*** It was evident too, that educators discuss racism and culturally unsafe practice with midwifery students and attempt to provide them with skills to use when the students are confronted with colleagues who are racist or providing culturally inappropriate care.

Educators noted though that addressing racism in the workplace can be very difficult, particularly when it is subtle rather than overt, and this perspective was also evident in educator reflections on addressing culturally unsafe colleagues and what they would do in a circumstance where a colleague was making racist comments or practising in a discriminatory way towards an Aboriginal woman.

In response to a question posed to an educator about how to address a situation where a colleague was observed to not be culturally appropriate, the response indicated there are limited avenues to address identification of discriminatory behaviours in the health care workplace setting.

"Well you'd have to, you have to sit them down with the manager or whoever it was and say well look you know, this is what I saw, this is my understanding. Please explain what your understanding is. OK, so maybe you need to think about your communication – maybe you need to go and do a communication course. [But] *I don't think there is any communication course, culturally to do."*

2.11 Discussion of Midwifery Educator Findings

It was evident from analysis of this groups' data that some changes have occurred over time to the way in which the midwifery curriculum is provided, and that accreditation standards have promoted this change. This is a positive outcome. The foundational education that students of midwifery receive will underpin how they respond in future interactions with a diversity of people.

For example, with specific regard to the teaching of Aboriginal health and Aboriginal women's birthing needs, midwifery educators particularly in the focus group described that there is now much more attention to this aspect of midwifery education and that reference to Aboriginal women is woven across all the curricula. This goes some way to addressing the concerns expressed in this and the two other midwifery data groups about not really knowing what Aboriginal women want in terms of maternal health care and needing more knowledge about cultural practices associated with pregnancy and childbirth, which is the purpose of developing the cultural competence of health professionals as a component of accreditation standards. Midwifery educators expressed frustration that they don't know enough themselves, and more input is needed to develop a strong sense of what Aboriginal women require during their maternity care and which of their cultural birthing practices they need supported by health professionals. From educators' perspectives, this includes requiring more knowledge about kinship and community structures and how/whether these impact Aboriginal women in respect of their engagement with health care services.

In relation to a specific question of assessing midwifery students' or registered midwives' cultural competence, there was no clarity as to how to do this, or what to assess. As with the two other midwifery data groups, it was again confirmed that cultural competence taught in university midwifery education was taught in relation to other than Australian cultures – which by implication are non-Western cultures. In addition, the cultural competence of midwives is not assessed pre or post registration for any cultures, including Aboriginal and Torres Strait Islander peoples.

Deficits were also noted in the continuing professional development sphere, with many participants noting that education on Aboriginal women's cultural needs during maternity care was lacking, but with no clear suggestions as to how this might be addressed. As cultural competence is specifically referred to in both education and practice standards, a measure is likely needed to ensure this is incorporated into both undergraduate education and professional practice reviews. Such a measure should include specific reference to the cultural needs of Aboriginal women during pregnancy and childbirth.

It was noted by educator participants that contemporary midwifery students are more open to more knowledge of women across a broad spectrum of contexts, including wanting to be informed about the cultural needs of Aboriginal women.

Midwifery educators also noted that they were mindful to alert midwifery students to the possibility that older more experienced midwives may have perspectives of Aboriginal women that are racist or stereotypical, and the need to provide students with the skills they need to manage such situations when these arise.

The information derived from the midwifery educator data group contributes to future thinking about the structure and content of midwifery education at an undergraduate level, whether there is sufficient focus on Aboriginal women and families during undergraduate learning, and, in the absence of any formal ongoing assessment of cultural competence, how students can be critically reflective in their practice.

Further, when reflecting on the midwives' data set as a whole, it is clear that far more robust continuing professional development which educates practising midwives about working with and caring for Aboriginal women is needed to respond to as unmet need expressed both by midwifery educators and by midwives who participated in individual interviews and focus groups.

2.12 Discussion of Midwives Data Set Findings

From the midwives' data set as a whole, it is apparent that individual midwives' knowledge of Aboriginal culture is variable. Some expressed quite well-developed knowledge of both the history and contemporary circumstances, a larger number understood some fundamentals, such as the importance of family support and the role of grandmothers, aunties and sisters, and many openly stated their knowledge is limited. The small number of midwives across the individual and focus group data groups who had worked in a variety of locations, including outside the metropolitan area or in an Aboriginal specific model of care, were those more likely to have better knowledge of the variety and diversity of Aboriginal women's cultural needs than those midwives who had only worked in metropolitan hospitals. This small number of participants had learned more about the needs of Aboriginal women during pregnancy and childbirth through experience of working with Aboriginal women during pregnancy and childbirth. Further, the midwifery administrators and educators demonstrated a more nuanced understanding of Aboriginal women's needs and what is needed to educate the next generations of midwives with the knowledge they require to be effective care providers to Aboriginal women. It was also made apparent by participants across the data set that the health system is failing to adequately respond to their professional need for more knowledge, with ongoing professional development education which highlights Aboriginal women's cultural birthing practices and how to meet the women's cultural and individual needs.

As one of the key aspects of this project was to investigate the experiences of Aboriginal women birthing in urban environments and the midwives who support them to do so, it is significant that only one participant acknowledged that Aboriginal women in the metropolitan area are 'birthing on Country'. In the other few mentions of birth on Country, this was mostly in the context of Aboriginal women who live outside the metropolitan area. Some midwives did describe a difference between city based Aboriginal women and "traditional Aboriginals" (frequently described as being from "up North"), and was usually in the context of different practices between different Aboriginal language groups. Most noted by midwife participants was Aboriginal women having large numbers of family members visiting either at the time of birth or immediately after and a number of midwives viewed this as problematic for clinical staff. Only a few midwife participants acknowledged this is a common cultural practice.

Despite shortcomings in knowledge about Aboriginal women and their needs, clearly evident from the midwives' data set findings, is that most midwives want to know more and be better at supporting Aboriginal women. The health system, and health service issues, were most often noted as preventing culturally responsive care due to inadequate/inappropriate policies, guidelines and clinical requirements, persistently reported as inflexible, and which prevent midwives from practising women-centred care. A few midwives across the data set referred to 'breaking the rules' to meet the needs of Aboriginal women, but for the most part, midwives did not report challenging the health services they worked in to make changes. From this, it is possible to infer that midwives feel disempowered in their roles as autonomous practitioners of maternity care, with a scope of practice that enables them to provide continuity of care and carer. This was highlighted further by an educator who noted a disconnect with how student midwives are educated to care for Aboriginal women and how their opportunity to apply this knowledge in their clinical practice placements is not aligned with existing health system/health service policies or models of care.

When it came to addressing questions of racism in health care, some midwives indicated they are overwhelmed at having to address racism in the workplace when this is directed at Aboriginal birthing women. No mention was made by any participant as to how racism may affect Aboriginal people working in the health system, or indeed the impact on Aboriginal women's experiences of maternity care.

It is reasonable to conclude from the range of evidence that access to cultural learning and education is ad hoc, and midwives would need to make concerted efforts to identify appropriate education. Further, the capability of midwives to provide culturally safe care to Aboriginal women is not a system requirement and cultural competency is not assessed as a professional competency after graduation. Cultural competency was most often reported as applying to all women, rather than explicitly Aboriginal women, which leads to a question of the relevance of cultural competence as a practice standard if applied to improving the cultural security of Aboriginal women during childbearing.

While the roles of AHWs and/or ALOs have been in the health system for decades, and intermittently in maternity services, these colleagues were described by midwives as highly valued and having positive influence on Aboriginal women as patients. However, it was also noted they are not always

being easy to access, that these roles 'come and go' and funding seems to have a significant impact on whether these colleagues are consistently available. Further, midwives agreed that more Aboriginal midwives working in health services is important. However, there was little confidence expressed by some participants in Aboriginal women being able to reach the goal of graduating and working in the field of midwifery. Most midwives were unable to identify if they had worked with an Aboriginal midwife. Given the relatively small number of Aboriginal midwives by comparison to the whole midwifery workforce in the WA health workforce, this is not an unexpected outcome.

The focus group data provided additional perspectives to themes/sub-themes identified in the individual midwives' data group. At the same time, these perspectives were less nuanced, probably a result of group discussion. It is particularly noted that some participants in focus groups were not concerned, or did not consider, they were expressing explicitly racist viewpoints, and such viewpoints were not challenged by other participants in the focus groups. When asked specific questions about racism directed at Aboriginal women in the maternity care workplace, some participants described feeling overwhelmed with how to address the problem. The midwifery educator findings showed that understanding the impacts of racism is now included in midwifery education, and that students are provided with ways to deal with racism if they encounter culturally unsafe colleagues when on clinical placement. However, midwives already working in the health system reported their inability to effectively address instances of racism by colleagues. The overall lack of critical insight in relation to racism in health care was compounded by some participants not acknowledging that the problem exists. Further, there was strong evidence across all midwifery data groups that the unconscious stereotyping of Aboriginal people persists. The issue of unconscious bias, and white privilege, was referred to by only a few of the overall 71 midwifery participants.

Across all data groups in the midwives' findings, it is evident that the majority of midwife participants are not able to clearly articulate what cultural security or cultural safety means in the context of providing culturally responsive maternity care to Aboriginal women. Further, the cultural competence aspect of maintaining professional practice standards was only vaguely described. Length of time working as a midwife seemed to be an indicator of how extensively midwives remembered the extent of receiving information and/or education about Aboriginal health in general. For example, midwives who had graduated more recently recalled receiving reasonably comprehensive education and instruction directly from Aboriginal people as educators, whereas midwives who had been practising for many years recalled little to nothing in the way of professional development education related to Aboriginal women since graduation. Nonetheless, some midwives noted their best education in providing responsive care came from actively working with Aboriginal women, learning about their needs, practising kindness and respect and working on developing trust, which was noted as easier to do when midwives are able to provide continuity of care(r).

It was noted by some participants in focus groups and individual interviews that family members being present during childbirth is important in terms of providing comfort and security to Aboriginal women. Some reported ensuring that more than two support people were able to present during birth. While this observation might be described as promoting cultural security, it was evident from the data that the focus group participants did not necessarily equate these aspects of care to sustaining cultural safety in maternity services; rather it was an attempt to provide woman-centred care. There were many comments made about not knowing or understanding what cultural birth practices are, or what Aboriginal women want from their maternity care.

In terms of continuity of care, this was mostly referred to by participants as being provided within the restrictions of what is achievable in a hospital setting where the principles of continuity of care and women-centred care are secondary to the medical complexity of women's circumstances or by health services who do not provide models of care which promote continuity of carer.

It is also evident from the findings that there needs to be co-design within the midwifery education sphere to promote better and more appropriate education specifically related to the birthing practices and needs of Aboriginal women, preferably delivered by Aboriginal people, if future generations of midwives are to graduate as culturally responsive practitioners. A validated means of measuring the cultural competence, or more specifically the cultural safety of midwifery practice is urgently needed.

Overall, the midwives' data set demonstrates a consistency of themes and sub-themes, producing strong outcomes of relevance to the midwifery profession. Encouragingly, the insights of midwifery administrators and midwifery educators demonstrates a will to provoke change in the maternity care system for Aboriginal women.

3. National Midwifery Surveys

To extend opportunity for midwifery input and supplement qualitative data collection being undertaken in WA, a survey was developed to be distributed nationally to midwives and midwifery educators. The Australian College of Midwives, a peak professional body, hosted the survey link on the organisations website and invited members to participate in circulated newsletters, with a result of (n=118) general surveys and (n=32) midwifery educator surveys. The survey returns represent only a fraction of registered midwives nationally, and a specific sub-set of midwifery members of a professional body.

If reported as unrelated results, there would be significant limitations in interpreting the survey findings. In this study, survey results were to be used to determine resonance with the qualitative outcomes, for example, where results aligned with, or deviated from, qualitative outcomes. At the same time, survey results might provide a broader snapshot of survey respondents' perceptions and knowledge of key research questions. The surveys focussed on midwives' knowledge of and access to cultural security training; knowledge of Aboriginal and Torres Strait Islander women who use maternity services; and, how midwives apply their cultural security training to their professional practice. Both surveys were similar with the midwifery educator survey questions including questions relevant to curriculum content and professional development education (Appendix 5).

Statistical analyses of the two surveys were undertaken by two HDR students, although the analysis reported here was not associated with their HDR work. Selected results are described separately from each of the two surveys.

3.1 General Midwife Survey Results

The general midwifery survey comprised 26 questions: seven requesting demographic information; four referring to workplace policies; eight related to cultural security training; four about providing care to Aboriginal women, two of which had multiple (5 and 11) sub-questions; and three supplementary questions (results not reported) about professional association membership, hearing about the survey, and any additional comments.

The general midwife survey cohort (n=118) were all female, mostly comprised midwives (n=98) with a small number of participants (n=20) nominating roles such as Remote Area Nurse, Mental Health Nurse, Social Worker or AHW or ALO. All survey participants were engaged in providing care to pregnant Aboriginal women. Cross tabulation showed only minor differences when excluding roles other than a midwife, therefore all responses were retained for analysis. Most states/territories were represented, except Victoria and the Northern Territory.

One third of participants were from New South Wales, one quarter from Western Australia, and the remainder from Queensland (13%), Tasmania (10%), South Australia (9%) and the ACT (7%). Most participants were non-Indigenous (89%). Just over half worked in a public maternity unit (55%) or private maternity unit (7%); 34% worked in either an Aboriginal program in a mainstream service, an Aboriginal Health Service, or an AMGP Aboriginal; 14% in a community midwifery program; and 2% in general practice.

The outcomes of the general midwifery survey results are reported for relevance to: midwives' [1] knowledge of cultural security; [2] knowledge of Aboriginal and Torres Strait Islander women who use maternity services; and [3] how cultural security training is applied to professional practice.

The results are discussed in relation to the extent to which survey analysis reflected qualitative data outcomes.

3.1.1 Knowledge of Cultural Security

Exposure to cultural security training is considered a minimum in health services to highlight the aspects of health care delivery that may make it easier for health professionals to provide care to Aboriginal and Torres Strait Islander people. 81% of participants indicated their organisation provides cultural security training about how to work with Aboriginal and Torres Strait Islander clients.

To ascertain how cultural security training impacts the care midwives provide to Aboriginal and Torres Strait Islander people, four statements required selecting responses that the statements did or did not apply to the organisation they work in. Percentage responses are set out in Table 10.

Table 10: Cultural Security Statements

Cultural Security Statements		
	Does not apply to my organisation	**Applies to my organisation**
There are organisational or professional barriers that limit how I can respond to the needs of Aboriginal birthing women and their families	54.2%	45.8%
There are audit tools available to measure characteristics of culturally competent maternity care and I am encouraged to use these to reflect on my practice	88.1%	11.9%
The cultural security training that is recommended by the organisation does not reflect the issues I confront in the everyday work experience	64.4%	35.6%
The organisation has structures and policies in place that support my cultural security training and enables me to implement what I learn	62.7%	37.3%

Taken as a whole, the four statements about how organisations support the application of cultural security training in practice (learning to practise) from respondent perspectives shows that while cultural security training is compulsory, the vast majority indicated that cultural competence is not audited by organisations, while around two thirds of respondents perceived that the cultural security training undertaken did not reflect everyday work experiences, or that structures and polices are in place to enable implementation of what has been learned in the training. Just under half of survey respondents experience organisational barriers in responding to the needs of Aboriginal women.

3.1.2 Knowledge of Aboriginal and Torres Strait Islander Women

We were interested to know about midwives' knowledge of Aboriginal and Torres Strait Islander women who attended the service where they work, including their knowledge and perceptions of factors which may be important to Aboriginal and Torres Strait Islander women when they are receiving maternity care.

When asked to estimate the proportion of Aboriginal women receiving maternity care at their service who are birthing off their own Country, almost one-third of participants did not know (31%) while slight less than one third (28%) responded less than 10%. Other responses are shown in Table 11.

Table 11: Proportion of Aboriginal and Torres Strait Islander Women in a Service Birthing Off Country

Proportion of Aboriginal and Torres Strait Islander Women in a Service Birthing Off Country			
		Frequency	**Percent**
Valid	I don't know	37	31.4
	Less than 10 percent	33	28.0
	10 - 15 percent	6	5.1
	15 - 20 percent	3	2.5
	20 - 30 percent	8	6.8
	30 - 40 percent	1	0.8
	40 - 50 percent	4	3.4
	50 - 60 percent	3	2.5
	70 - 80 percent	3	2.5
	80 - 90 percent	5	4.2
	90 - 100 percent	14	11.9
	Total	117	99.2
Missing	System	1	0.8
Total		**118**	**100.0**

A series of five statements related to the wellbeing of Aboriginal and/or Torres Strait Islander mothers in their care required respondents to rate the importance of each statement. Rating options were essential, very important, important, or not important in the role of each statement for its impact on wellbeing. We combined Essential/Very Important responses (Table 12) and described these as follows.

Respondents demonstrated in majority the essential/very important nature of all five statements. At 96% (82% essential and 14% very important) the most highly rated statement was staff being knowledgeable about grief and loss issues and knowing how to respond to those mothers who experience a stillbirth or miscarriage (96%). The least highly rated, although still high at 88% (58% essential and 30% very important), was staff being knowledgeable about

their own culture, while being knowledgeable about Aboriginal people and their culture was highly rated at 94% (78% essential and 17% very important). When asked the importance of staff reflecting on how their own culture shapes decisions they make or views they have about birthing, 90% of respondents perceived this as essential (67%) or very important (23%).

If these knowledge aspects are not seen as essential or very important, approaches to care may be sub-optimal if based on personal perceptions about how birthing should occur. What the results above show is that respondents understand the essential/very important nature of the statements. Respondents also highly valued, at 91% (69% essential and 22% very important), that an organisation has policies and procedures in place that inform and guide staff.

When considered in the context of responses to a statement about organisational barriers that limit responses to Aboriginal women's needs (Table 10), just under half of respondents selected 'applies to my organisation' while one third selected 'does not apply to my organisation' as to whether structures and policies are in place to support learning from cultural security training. This demonstrates that individuals may be hampered in their ability to use cultural security training knowledge in their practice when they are not supported by organisational policies and procedures to offer culturally safe care.

Table 12: Wellbeing Knowledge Statements

Table 12: Wellbeing Knowledge Statements

	Essential/ Very Important	Important	Not Important
Staff being knowledgeable about grief and loss issues for Aboriginal or Torres Strait Islander mothers and knowing how to respond to those mothers who experience a still birth or miscarriage	82% / 14% **(96%)**	4%	
Staff being knowledgeable about Aboriginal people and their culture	78% / 17% **(94%)**	5%	
The organisation has policies and procedures in place that inform and guide staff about how to work in culturally secure ways	69% / 22% **(91%)**	9%	
Staff reflecting on how their own culture shapes decisions they make or views they hold about birthing	67% / 23% **(90%)**	7%	3%
Staff being knowledgeable about their own culture	58% / 30% **(88%)**	11%	1%

Participants were also surveyed about the availability or otherwise of cultural security factors which may influence or impact Aboriginal and Torres Strait Islander birthing women's experiences. Respondent selections of the essential/very important nature of these factors demonstrate high sensitivity to Aboriginal women feeling safe when having their babies; as well as other factors such as cultural traditions around birthing, the role of grandmothers, kinship ties, good relations with family and connection to land/Country.

The full range of factors presented to survey participants are shown in descending order of respondents' combined choices, with essential/very important combined, as shown in Table 13. These outcomes show that respondents are sensitive to cultural security factors. However, they may be limited in their responses to Aboriginal and Torres Strait Islander women during pregnancy care or birth because of inadequate organisational policies and procedures to inform and guide staff to provide culturally secure environments. These are combined with barriers to implementing what is learned in cultural security training, and potentially, that cultural security training has not sufficiently reflected the importance of understanding the range of Aboriginal and Torres Strait Islander women's cultural birthing practices.

Table 13: Knowledge of Cultural Security Factors

Knowledge of Cultural Security Factors			
	Essential/ Very Important	**Important**	**Not Important**
Mother feeling safe when they are having their baby	85.6% / 12.7% **(98.3%)**	0.8	0.8
Mother's own cultural traditions around birthing	66.1% / 28% **(94.1%)**	5.9	nil
The role of grandmothers	65.3% / 28% **(93.3%)**	0.8	0.8
Mother' kinship ties	63.6% / 28.8% **(92.4%)**	7.6	nil
Mothers' family passing on traditional values and customs to the mother and her children	59.3% / 33.1% **(92.4%)**	6.8	0.8
Mother's good relations with her family	61.9% / 29.7% **(91.6%)**	7.6	0.8
Mother's connection to Land/Country	57.6% / 33.1% **(90.7%)**	8.5	0.8
Mother has stable and appropriate housing	65.3% / 25.4% **(90.7%)**	9.3	
Traditional heath practices and knowledge	50% / 36.4% **(86.4%)**	12.7	0.8
Mother has access to Aboriginal and/or Torres Strait Islander staff while being cared for at the service	59.3% / 27.1% **(86.4%)**	11.9	1.7
Mother has stable and peaceful family life	54.2% / 31.4% **(85.6%)**	14.4	nil

3.1.3 Application of Cultural Security Training to Professional Practice

Participants were asked to rate how their cultural security training had increased and informed their own professional care and practice when supporting their Aboriginal and/or Torres Strait Islander clients. Fourteen participants (12%) did not respond to this question. There was no option to skip/indicate training had not been completed, as such, it has been assumed that this small proportion of survey respondents did or had not completed cultural security training at the time of answering the survey. The percentage breakdowns in the results presented in this section are based on the 88% of the total survey responders who had completed some form of cultural security training.

Overall, most participants felt that their training had increased their understanding of Aboriginal and Torres Strait Islander people and culture *Most of the time*, if not *All of the time* (40% and 39% respectively); 14% found training increased their understanding only *A little of the time*, while 7% responded *Not at all* to this question.

To a question if cultural security training had provided participants with the skills to be reassuring when Aboriginal and/or Torres Strait Islander mothers present at their service, 32% responded this was the case *All of the time* and 40% *Most of the time*. 17% responded *A little of the time* and 11% that training had *Not at all* provided them with skills to be reassuring to Aboriginal and Torres Strait Islander mothers at their service.

With respect to if cultural security training had changed their responses and practice with Aboriginal and/or Torres Strait Islander mothers and their families, 39% chose *All of the time* and 26% *Most of the time*. The remaining one-third of participants responded A little of the time (20%) or *Not at all* (14%).

Finally, in relation to confidence in caring appropriately for Aboriginal and/or Torres Strait Islander mothers and their families, 38% of participants responded that training had helped them feel more confident *All of the time*, with a further 41% *Most of the time*. 13% of participants only felt more confident *A little of them time*, while 9% did not feel more confident at all.

When examining how midwives self-reported the application of their cultural security training to their professional practice, it was also interesting to compare differences between midwives who were recent graduates (0-3 years in current professional role) to those who had worked as a midwife/related role for a more established and substantial period (4+ years in current role).

Using Fisher's Exact Test, the variables of midwives' time in practice (post-graduation, either 0-3 years or 4+ years) were tested in relation to four general survey questions related to cultural security training.

To the question of midwives' confidence in caring for Aboriginal and/or Torres Strait Islander mothers and families, **a significant difference** (p = .02) was noted between the length of time midwives had been in their professional role and how cultural security training had influenced their confidence, with more recent graduates (0-3 years) feeling more confident all of the time, as shown in Table 14.

Table 14: Confidence in Caring for Aboriginal and/or Torres Strait Islander Mother and Families

Confidence in Caring for Aboriginal and/or Torres Strait Islander Mother and Families							
I feel more confident that I can care appropriately for Aboriginal and/or Torres Strait Islander mother and their families			**All of the time**	**Most of the time**	**A little of the time**	**Not at all**	**Total**
Length of time in years in current role - 2 groups	0 - 3 years	Count	17	7	2	4	**30**
		% within Length of time in years in current role - 2 groups	56.7%	23.3%	6.7%	13.3%	**100.0%**
	4+ years	Count	22	35	11	4	**72**
		% within Length of time in years in current role - 2 groups	30.6%	48.6%	15.3%	5.6%	**100.0%**
Total		Count	**39**	**42**	**13**	**8**	**102**
		% within Length of time in years in current role - 2 groups	**38.2%**	**41.2%**	**12.7%**	**7.8%**	**100.0%**

A significant association (*p* = .03) was also found between time in profession and if midwives felt their cultural security training changed their responses/practice with Aboriginal and/or Torres Strait Islander mothers and families (Table 15), again showing more recent graduates more positively associated the training all of the time.

Table 15: Training Impact on Responses and Practice with Aboriginal and/or Torres Strait Islander Mothers and Families

Training Impact on Responses and Practice with Aboriginal and/or Torres Strait Islander Mothers and Families							
The training has changed my responses and practice with Aboriginal and/or Torres Strait Islander mothers and families			**All of the time**	**Most of the time**	**A little of the time**	**Not at all**	**Total**
Length of time in years in current role - 2 groups	0 - 3 years	Count	18	3	5	4	**30**
		% within Length of time in years in current role - 2 groups	60.0%	10.0%	16.7%	13.3%	**100.0%**
	4+ years	Count	23	24	15	10	**72**
		% within Length of time in years in current role - 2 groups	31.9%	33.3%	20.8%	13.9%	**100.0%**
Total		Count	41	27	20	14	**102**
		% within Length of time in years in current role - 2 groups	**40.2%**	**26.5%**	**19.6%**	**13.7%**	**100.0%**

Similarly, **a significant difference** (p = .01) was also noted between time in role and whether cultural security training provided the skills to be reassuring when Aboriginal and/or Torres Strait Islander mothers present at a service (Table 16), with more recent graduates being positive in relation to this factor all of the time.

Table 16: Training Provided Skills to be Reassuring when Aboriginal and/or Torres Strait Islander Mothers in a Service

Training Provided Skills to be Reassuring when Aboriginal and/or Torres Strait Islander Mothers in a Service							
The training has provided me with the skills to be reassuring when Aboriginal and/or Torres Strait Islander mothers present at our service			**All of the time**	**Most of the time**	**A little of the time**	**Not at all**	**Total**
Length of time in years in current role - 2 groups	0 - 3 years	Count	16	7	3	4	**30**
		% within Length of time in years in current role - 2 groups	53.3%	23.3%	10.0%	13.3%	**100.0%**
	4+ years	Count	17	35	14	6	**72**
		% within Length of time in years in current role - 2 groups	23.6%	48.6%	19.4%	8.3%	**100.0%**
Total		Count	33	42	17	10	**102**
		% within Length of time in years in current role - 2 groups	**41.2%**	**39.2%**	**14.7%**	**4.9%**	**100.0%**

Finally, to the question of whether cultural security training increased understanding of Aboriginal and Torres Strait Islander people and their cultures, **no significant association** was found between recent graduates (0-3 years) and 4+ year midwives (Table 17). Even so, the vast majority of respondents (80%) selected all/most of the time that the training had impact on understanding of Aboriginal and Torres Strait Islander people and their culture. This finding supports the ongoing delivery of cultural security training to health professionals in an effort to increase knowledge of these cultures.

Table 17: Training Impact on Understanding Aboriginal and Torres Strait Islander People and their Culture

Training Impact on Understanding Aboriginal and Torres Strait Islander People and their Culture							
The training has increased my understanding of Aboriginal and Torres Strait Islander people and their culture			**All of the time**	**Most of the time**	**A little of the time**	**Not at all**	**Total**
Length of time in years in current role - 2 groups	0 - 3 years	Count	17	7	4	2	30
		% within Length of time in years in current role - 2 groups	56.7%	23.3%	13.3%	6.7%	100.0%
	4+ years	Count	25	33	11	3	72
		% within Length of time in years in current role - 2 groups	34.7%	45.8%	15.3%	4.2%	100.0%
Total		Count	42	40	15	5	102
		% within Length of time in years in current role - 2 groups	**41.2%**	**39.2%**	**14.7%**	**4.9%**	**100.0%**

3.2 Discussion of General Midwifery Survey and Individual Midwife and Midwifery Focus Group Data

Analysis of the general midwifery survey indicated that there are organisational audit tools to measure cultural competence, but it is not known if these tools are available nationally or in some states/territories only. We know from the Individual Midwife and Midwifery Focus Group data that cultural competence is not measured in the WA government health system. Further, while survey respondents acknowledged that organisations do have support structures and policies in place to enable cultural security training, of concern was that close to half (46%) of respondents identified organisational or professional barriers limiting how they respond to the needs of Aboriginal birthing women and their families. The midwives' qualitative data demonstrated that, in WA, midwives feel constrained to provide care that meets the needs of Aboriginal women, often referring to inflexible policies and procedures.

In relation to participation in cultural security training provided by an organisation, 81% of survey respondents had participated in such training, 74% indicated the training as compulsory, and 61% that the cultural security training was presented by an Aboriginal and/or Torres Strait Islander person. This latter point was at odds with the midwives' qualitative data which indicated that little culturally security training had been presented by an Aboriginal person or people.

One third of survey respondents selected that the cultural security training offered by their organisation did not address the everyday issues they encounter when supporting Aboriginal and Torres Strait Islander women. Even so, most respondents considered the cultural security training had improved their capacity to respond to the needs of Aboriginal women. The survey data also demonstrated that organisations do not have sufficient organisational policies and procedures to support what is learned in cultural security training.

A vast majority of respondents indicated the essential/very important nature of a range of cultural factors that may impact the wellbeing of Aboriginal and Torres Strait Islander women (for example, kinship ties, connection to Country, feeling safe when having their baby, role of grandmothers, cultural traditions around birthing, good relationships with family and access to Aboriginal and/or Torres Strait Islander staff). This outcome aligns to some extent with the midwives' qualitative data.

When considering questions as to whether cultural security training positively influenced confidence and skills to be reassuring when caring for Aboriginal and Torres Strait Islander women, a significant difference was found between new graduates (0-3 years) and more experienced midwives (4+ years); and a significant association was found between these same groups on the question of improvements in responses and practice to Aboriginal and Torres Strait Islander women following cultural security training.

Most respondents rated 'staff being knowledgeable about Aboriginal people and their culture' and 'staff reflecting on how their own culture shapes decisions they make or views they hold about birthing' as essential/very important, strongly indicating that midwives understand there may be an association between the knowledge of Aboriginal and Torres Strait Islander cultural approaches and their own cultural approach to birthing as having an impact on their decisions making when caring for Aboriginal and Torres Strait Islander women. Additionally, a question related to an organisation having policies and procedures in place that inform and guide staff about how to work in culturally secure ways was regarded by all respondents as required. As noted above, however, while these are viewed as required by respondents, it was also strongly indicated these elements are not always in place within the organisational structure of health services.

Comparisons on some key questions in relation to cultural security training completed by newer graduates (0-3 years) or those more established in their role (4+ years), showed that overall, new graduates selected greater confidence and skills when working with Aboriginal and Torres Strait Islander women, as well as in their responses and practice resulting from their participation in cultural security training, compared with their more experienced colleagues.

In the midwives' qualitative data set, participants noted a compulsory online cultural training module is available in the WA government health system, focussed on history and its impacts on Aboriginal people. However, very few participants had undertaken any other additional training related to working with Aboriginal women, and some indicated they had cultural training as long ago as 16-18 years, with nothing since. The newer graduates in the midwives' data set were more likely to have undertaken a comprehensive unit on Aboriginal and Torres Strait Islander people/history/health needs in their undergraduate or post graduate degree. The midwives' qualitative data also clearly indicated that midwives want far more information, professional development and education on how to effectively care for and meet the needs of Aboriginal women.

Overall, when taking account of both the qualitative data and the survey data, it can be inferred that cultural security training is required by organisations. However, the training does not always meet the needs of midwives providing care to Aboriginal and Torres Strait Islander women in respect of relevance to midwifery practice. Further, there are organisational barriers to fully implementing what is learned in cultural security training, noted in the midwives' qualitative data set as inflexible policies, and in the survey data as having insufficient supportive policies and procedures.

Encouragingly though, survey respondents were positive in identifying that cultural security training does improve midwife confidence, skills, response and practice when caring for Aboriginal and Torres Strait Islander women, at least from a midwifery perspective.

From the evidence, it seems reasonable to conclude that cultural security training has benefits and potentially improves the way in which midwives approach care practices with Aboriginal and Torres Strait Islander women. Equally reasonable to conclude, is that changes are needed; both in refining cultural security training to ensure the training is relevant to midwives and others providing care during pregnancy and birth, and, that policies and procedures in organisations are either improved or made more explicit to ensure the application of cultural security learning into maternity care practice. Finally, that further investigations are undertaken to identify the barriers midwives perceive as preventing them from applying what they have learned in cultural security training into their everyday practice.

It is crucial that organisations enable midwives to be culturally safe and culturally responsive in all care interactions involving Aboriginal and Torres Strait Islander women during the significant life event of childbearing. This can be achieved through meaningful policy and procedure development, consistent cultural security training which enhances clinical practice, and targeted professional education to reinforce the ways in which the cultural security of Aboriginal and Torres Strait Island women during pregnancy and childbirth can be supported in maternity care services.

3.3 Midwifery Educator Survey Results

The midwifery educator surveys comprised 28 questions: seven requesting demographic information; six referring to workplace policies and cultural security training; seven concerned with curriculum content; seven questions about content development and delivery, terminology, assessment and Aboriginal childbearing women's needs; and a final question for any additional comments.

The midwifery educator survey cohort (n=32) were all female, all were midwives and participants represented all states/territories. Most participants were non-Indigenous (84%) with 9% identifying as Aboriginal or Torres Strait Islander, and two participants did not respond to this question. All were educators in university courses. Most had been in their role as a university educator in a Midwifery Program for four or more years, while three participants had between one to three years' experience in their role, and one less than one year. Thirty participants had been registered midwives for more than 10 years.

The findings from the quantitative analysis completed for questions related to cultural security training and the content and teaching of midwifery curriculum are included below.

3.3.1 Cultural Security

We were interested to know how many educators working in university-based midwifery education had completed cultural security training.

When asked to indicate if cultural security training had been completed, 25/32 (78%) chose yes while 7/32 chose no.

Asked to select yes/no/I don't know to other statements about the organisation resulted in: 28/32 respondents (87.5%) selecting yes to 'does your organisation have an Aboriginal employment strategy'; 18/32 (56%) yes to the organisation having a Reconciliation Action Plan (RAP); and, 26/32 (81%) yes to the organisation having a cultural competence policy that encourages staff to actively resist racism and discrimination.

The responses indicate that midwifery educators in the main have undertaken cultural security training, have knowledge of an organisational Aboriginal employment strategy and a cultural competence policy that actively resists racism and discrimination in the organisation. However, 14/32 (44%) were not aware if their organisation has a RAP in place. Not knowing if a RAP exists implies the universities are either not promoting RAP plans, or do not have a RAP plan, which is unlikely. If midwifery educators are not aware of RAP plans, they may also not know if their university has strategies promoting inclusion of Aboriginal and Torres Strait Islander people in the organisation. That a third of survey respondents did not know the proportion of Aboriginal or Torres Strait Islander staff in their organisation supports this assertion.

Figure 4 Cultural Security Training Factors

If you have completed Cultural Security training about Aboriginal people please tick as many of the factors below that apply to you (filtered)

Of the 25/32 respondents who had completed cultural security, 23/25 provided responses to a series of statements related to the impact of the training on their practice. All 23 respondents to the series of questions (Figure 4) indicated a positive impact of training on their increased understanding of Aboriginal people/s and their culture/s and increased confidence about educating midwifery students to care appropriately for Aboriginal women.

With respect to training impact on learning something about Aboriginal people/s and their culture/s, 15 of the 23 respondents wanted more education. All 23 respondents indicated the cultural security training was delivered by an Aboriginal person.

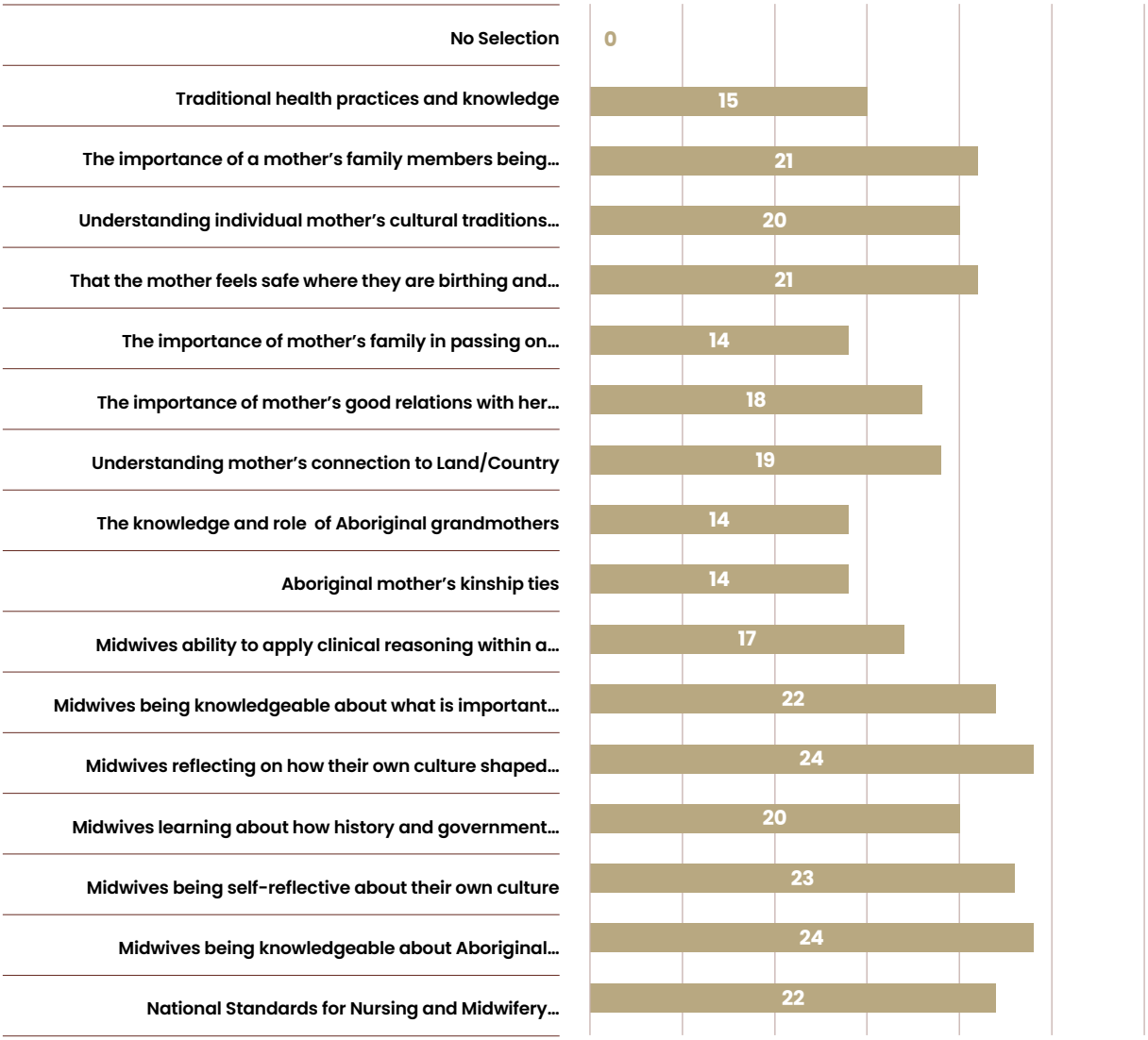
3.3.2 Curriculum

A series of statements required respondents to select as many as applicable from a list of curriculum content points covered in the course they teach. From the educator survey cohort, 24/32 respondents chose to make selections from the list provided.

To summarise, from the statement selections relevant to midwifery curriculum content taught, around half of respondents selected inclusion of: traditional practices and knowledge, the importance of mother's family in passing on traditional values and customs, the knowledge and role of Aboriginal grandmothers, and Aboriginal mothers' kinship ties.

Figure 5 Curriculum Content

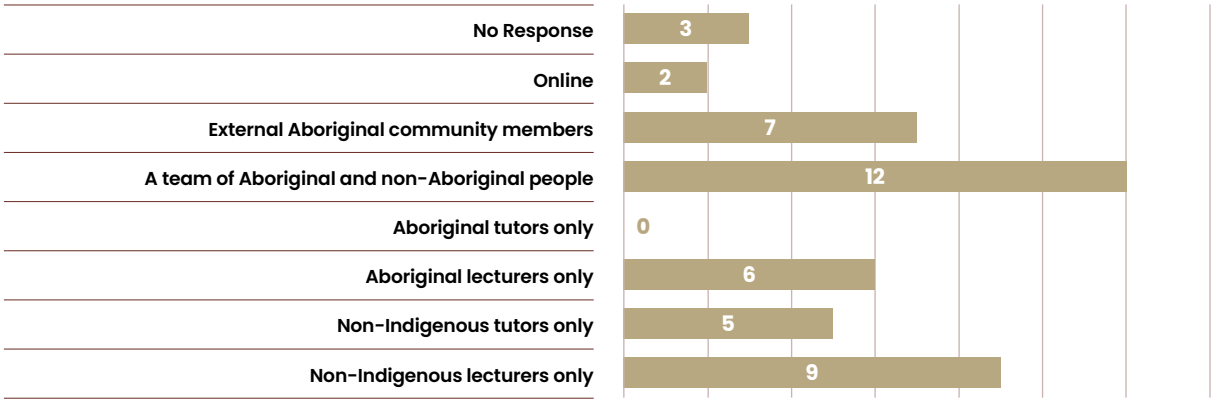
How many of the following content points are covered in the curriculum of the midwifery course/s you offer or teach? (filtered)



For the remaining curriculum content statements, 70% or more respondents selected inclusion of the points above, in addition to: the importance of a mother's family members being present at birth; understanding individual mother's cultural traditions around having a baby; the mother feels safe where they are birthing and are able to articulate their needs; the importance of mother's good relations with her family; understanding mother's connection to Land/Country; midwives being knowledgeable about what is important for Aboriginal birthing women; midwives reflecting on how their own culture shaped decisions they make or views they hold about birthing; midwives learning about how history and government policy has affected Aboriginal people/s; midwives being self-reflective about their own culture; midwives being knowledgeable about Aboriginal people/s and their culture/s; midwives ability to apply clinical reasoning within a cultural framework; and, national standards for nursing and midwifery competencies relating to Aboriginal and Torres Strait Islander culture. Further, participants were asked if the curriculum was taught across multiple campuses in different locations with half of respondents choosing yes and half choosing no. To a further question related to if the content was taught in different campus whether the Aboriginal content varied, the answer was no. In terms of who teaches the Aboriginal content in the course, Figure 6 below shows the variety of responses. From these results, it is evident that the inclusion of Aboriginal people in the delivery of Aboriginal content occurs, at least in some locations.

Figure 6 Content Providers

Q21 - Who teaches the Aboriginal content in the course you offer or teach?



When asked to estimate the proportion of the course devoted specifically to being about Aboriginal people and about Aboriginal people who live in the local region, response rates were: specific Aboriginal content, 59% of participants estimated less than 10 percent of content, 22% estimated between 10-20 percent, and 6% estimated 20-30 percent, while four participants did not respond. For content that is specific to local Aboriginal people, 65% estimated less than 10 percent of content, 12% estimated 1-20 percent, and 3% 20-30 percent, and six participants did not respond.

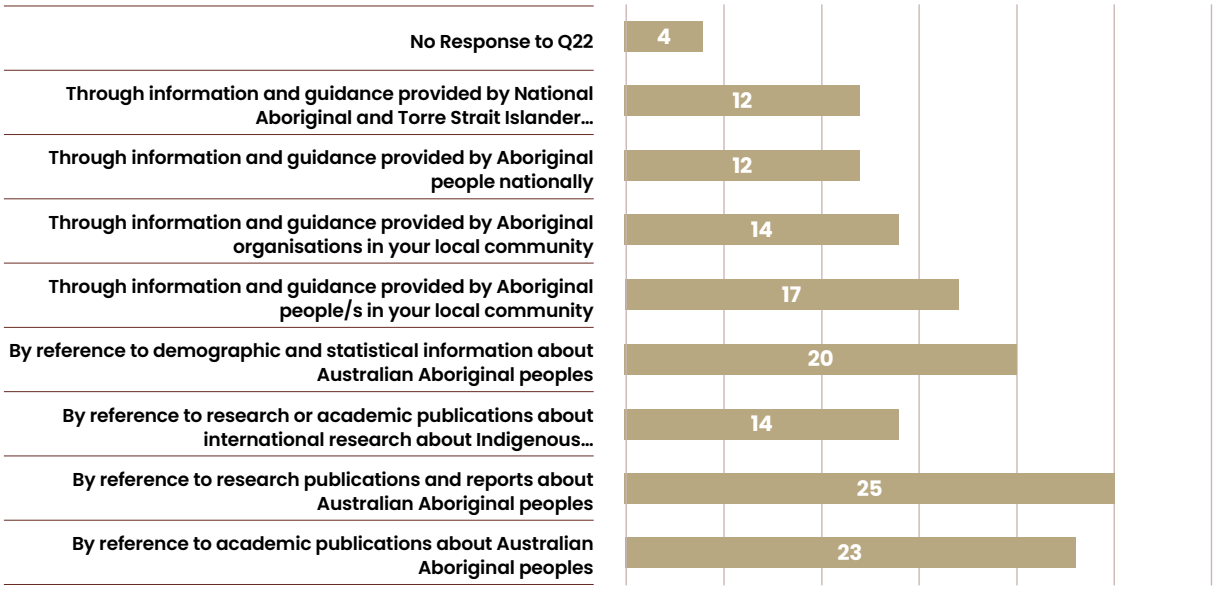
Overall, outcomes from these questions suggest a variety of approaches to the teaching of content focussed on Aboriginal and Torres Strait Islander women in midwifery curriculum, and that the content is generalised rather than specific to local Aboriginal people, with 59% estimating curriculum content was less than 10 percent, while 22% estimated 10-20% and 6% estimated 20-30%.

In terms of Aboriginal content developed for the course taught, Figure 7 shows that most information is derived from (in descending number of responses): research publications, reports and academic publications about Australian Aboriginal people, demographic and statistical information about Aboriginal people and information and guidance provided by Aboriginal people/s in the local community. The latter point suggests efforts in some locations to consult with and be guided by Aboriginal people.

Of lesser influence is international research about Indigenous people or Aboriginal people nationally or National Aboriginal and Torres Strait Islander organisations.

Figure 7 Aboriginal Course Content

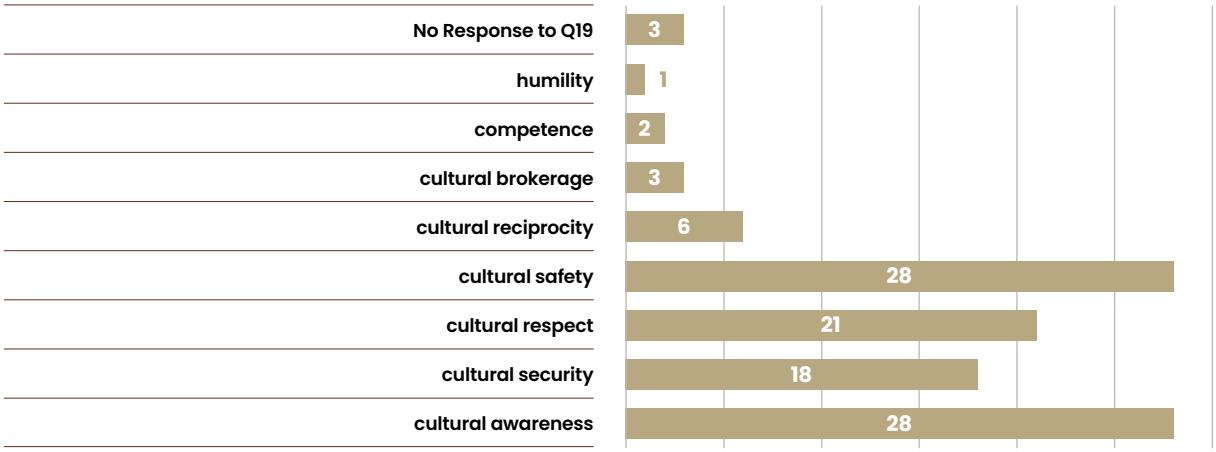
Q22 - How is the Aboriginal content in your course developed?



Finally, to gauge the extent to which terms strongly associated with either interacting with or providing care to Aboriginal and Torres Strait Islander people are defined, described and used in midwifery education, responses are shown in Figure 8.

Figure 8 Terms Defined in Content

Q19 - Which of the following terms are defined, described and used in your course?



3.4 Discussion of Midwifery Educator Survey and Focus Group Data

The midwifery educator surveys, in the main, reflected findings made in analysis of the Midwifery Educator qualitative results, and reinforce the need for more consultation with Aboriginal people in the updating of curricula content so that, as is now the case in WA universities, that there is more focussed attention to the needs of Aboriginal and Torres Strait Islander women and supporting their cultural birthing practices.

Conclusion

From the outset, the Birthing on Noongar Boodjar (BONB) project was focussed on the cultural security of Aboriginal mothers when they give birth in urban located maternity services.

At the commencement of BONB, the *Cultural Security in the perinatal period for Indigenous women in urban areas: a scoping review* (Marriott et al., 2019) summarised the available evidence at the time as it related to the cultural needs of childbearing Indigenous women who relocate to an urban location to give birth or are usually located on urbanised ancestral lands (in Aboriginal contexts, Country). The paper concluded the experiences of Indigenous women are both positive and negative but crucially provided an understanding of care that is delivered well and where improvements need to be made. The review provided an evidence base for future interpretation of the collected data, enhanced through the publication of other papers which also drew on published literature to inform project findings.

Firstly though, to achieve the project outcomes, and because our Investigator team comprised Aboriginal and non-Aboriginal people with a diversity of expertise, an Aboriginal Consultative Group including Elders and partners from across the health system, we needed to ensure that strong cultural protocols and governance structures were in place to guide the research and ensure we maintained cultural security for all Aboriginal people in all aspects of the conduct of the research.

That we consulted widely and appropriately; and, that we were open and transparent in how our research was planned, carried out and reported was reinforced by the number of delegates who attended the penultimate BONB event, a three-day symposium held in 2018, during which results were presented for the Aboriginal women's and Midwives' data sets. The 300+ delegates included Aboriginal community members, Elders and Senior Women, health service representatives from across the WA health system and Australia, primarily including midwives and other working in maternity care. In addition to the presentation of results and acknowledging the diversity of expertise 'in the room' for the symposium, we held two round table discussions on days two and three. For the first round table on day one, facilitated small groups discussed questions about cultural security, what this means and how it applies to health services. On day three, the same format was used for the second round table and focussed on the health workforce. For both round tables, each group presented key points, and this was followed by a whole of meeting discussion to reach consensus on the key concepts related to the two topics. The round table outcomes became an additional source of data, and confirmation for the iterative analysis and interpretation that had been done, while also informing the finalisation of the project recommendations.

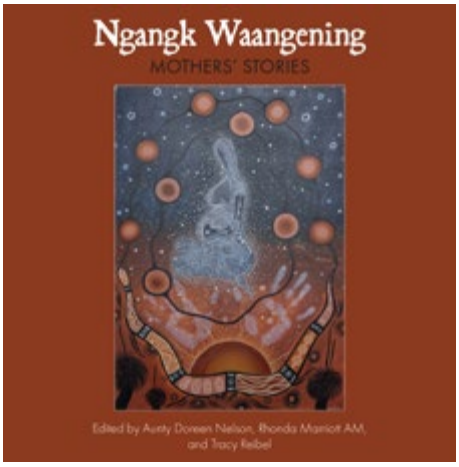
Across the three days, we also held cultural activities, including inviting a Noongar Elder artist-in-residence, who guided Aboriginal and non-Aboriginal participants to create individual paintings. Participants could donate their individual efforts to the project, and these smaller paintings became part of a large mural created by Aunty Millie Penny, entitled Ngangk Boodjar. Displayed in the Ngangk Yira Institute for Change, Ngangk Boodjar acts as a creative legacy demonstrating how Aboriginal and non-Aboriginal people working together find ways to generate Ganma, the mixing of ideas towards a mutually satisfactory conclusion.

Another highlight of the BONB symposium was the presentation of Elders Birthing Story posters. On the second day of the symposium, the 18 women who had elected to display their posters were overwhelmed with the interest and respect shown to them by delegates who practised Dadirri (deep listening). Originally scheduled for presentation across the lunchtime break, there were so many questions and further exchanges of information between the Elders and the delegates, that the session time was extended.

Ngangk Boodjar acts as a creative legacy demonstrating how Aboriginal and non-Aboriginal people working together find ways to generate Ganma, the mixing of ideas towards a mutually satisfactory conclusion

Ngangk Boodjar mural created by Aunty Millie Penny

The success of this aspect of the symposium led to another Elder, Aunty Doreen Nelson, requesting that the stories be published. In 2021, Ngangk Yira and 12 Elder and Senior women were immensely proud to launch their published collection of stories entitled *Ngangk Waangening: Mothers Stories*, with Aunty Doreen, one of the editors, at an event in the same venue used for the BONB three-day symposium. Importantly, Ngangk Waangening has become an important teaching tool for student and graduate midwives; primarily informed by the knowledge of a long time AHW who has supported the development and sustainability of an AMGP located in a suburban hospital. At the conclusion of the BONB project, this AMGP had been serving Aboriginal women for more than 15 years and continues to this day.



Ngangk Waangening: Mothers Stories

Our research approaches which led to these outcomes were outlined in two papers, *Wongi mi bardup (doing it our way): methodologies promoting Aboriginal knowledges and cultural practices for Birthing on Noongar Boodjar* (Marriott et al., 2019) and *Aboriginal research methods and researcher reflections on working two-ways to investigate culturally secure birthing for Aboriginal women* (Marriott et al., 2020). These papers detailed the Indigenous Research Framework and Indigenist research practices which underpinned the research process, alongside compatible mainstream research practices, and how cultural lenses and diverse expertise were used to translate our collected data into culturally meaningful outcomes. In turn, these and all project outcomes informed the development of three key recommendations (detailed further along in this report), presented directly to the WA Government Minister for Health in 2021. The recommendations addressed the health system changes required and highlighted to the midwifery profession the changes required in professional practice, professional development and midwifery education. The result of presenting the recommendations to the Minister led to his office organising a Round Table comprising the Chief Executive of all metropolitan health services and the WA Country Health service and other high level health system decision makers. Professor Rhonda Marriott, as Chief Investigator A and Project Lead for BONB, presented a findings summary and the rationale for the three recommendations.

Conclusion

Developing meaningful recommendations which engaged the Minister for Health, and those charged with both developing and administering the health system and health services on his behalf, we were cognisant of having rigorous research evidence. It was with great pride in the BONB outcomes that the project team established three recommendations and that the health system took action to implement all of these. Firstly, through announcement of the appointment of a Principal Aboriginal Nursing and Midwifery Advisor to be located in the WA Department of Health Nursing and Midwifery Office. Secondly, through funding support from the WA Health Nursing and Midwifery Office and the Aboriginal Health Policy Directorate to enable publication of Ngangk Waangening. Finally, announcing the establishment of an Aboriginal Maternity Group Practice at the State's tertiary woman's hospital.

Through BONB, we had set out first and foremost to ascertain Aboriginal women's cultural needs. Our qualitative outcomes resulted from the input of 74 Aboriginal women. Through the stories they told, we identified comprehensive evidence that Aboriginal women want and need acknowledgement of their culture and cultural practices, in addition to respect, kindness, and understanding of their differences from all who they encounter in the maternity care system. The women emphasised they were not seeking special treatment, but they do have cultural requirements and expectations that health services would do their best to support these. Instead, they reported too often encountering racism and a lack of empathy for their requirements.

The majority of Aboriginal women who participated in the BONB project are Noongar, and, as such, had birthed their babies on their Country – Noongar Boodjar. The stories they told reflected the lack of acknowledgement received that they are Birthing on the Country of their Ancestors, which remains a culturally significant consideration for Aboriginal women, and there remains a lack of support for family members to be present during the culturally significant event of welcoming a new member into the kinship family.

The Aboriginal women's data set results were published as *"Our culture, how it is to be us" – Listening to Aboriginal women about on Country urban birthing* (Marriott et al., 2019). It demonstrated women's consistent reporting of ongoing cultural practices associated with childbirth, including knowledge sharing across generations and family support, observance of extended family present at the time of for shortly after birth and how their cultural security is improved when Aboriginal staff are present. The women also noted the inflexibility of health services to meet their needs and midwives' lack of cultural awareness and understanding of the importance of Aboriginal kinship. The Aboriginal women's data set represented four generations of women's stories, experiences and expressions of childbearing. Collectively, the women expressed a strong desire to maintain their cultural practices, including birthing close to home (on Country);

having family acknowledged and included; and having access to Aboriginal midwives, nurses, doctors, and other health care workers to support their cultural security.

We also wanted to know more about midwives' knowledge of the Aboriginal women they care for during pregnancy and childbirth, and their understanding of cultural security, cultural safety, and cultural competency. We also wanted to hear about midwives' experiences working in the health system and their views and opinions of cultural security training and professional development needs. Finally, we also wanted to develop an understanding of how midwifery educators deliver education to midwifery students.

The Midwives' data set comprised 71 midwives. This included two highly experienced midwifery administrators who participated in one-on-one interviews with CIA at the beginning of the BONB data collection process. Analysis of those interviews set the scene for the presentation of the Midwives data set results. Detailed in the paper *Midwifery knowledge of equitable and culturally safe maternity care for Aboriginal women* (Marriott et al., 2020), we reported on the outcomes from the Individual Midwife and Midwifery Focus Group data groups (n=61). We found that midwives demonstrated limited knowledge of Aboriginal women's cultural childbearing requirements, reported inadequate access to cultural education that met their needs to understand more about what Aboriginal women need during childbearing, substituted references to women-centred care in the absence of culturally relevant knowledge and, from some participants, consistently expressed racialised assumptions.

Factors identified by midwives as likely to influence the midwifery workforce to enable it to provide culturally safe care for Aboriginal women included more professional development focussed on improving understanding of cultural birth practices, and health system changes to create culturally safer maternal health care environments for Aboriginal women. This included the development of more continuity of carer models, more Aboriginal people encouraged into midwifery and other Aboriginal specific roles within maternity services.

We concluded from the Midwives' data set that individual, workforce and health systems issues impact midwives' capability to meet Aboriginal women's cultural needs.

The Midwifery Educator data group added to the findings from the two other groups in the Midwives' data set. We learned that educators of the next generation of midwives are alert to the need to provide good education about how to provide culturally safe care to Aboriginal women, provide opportunities for student midwives to translate their education into clinical practice when on placements, and highlight that Aboriginal women do have distinct cultural practices associated with childbirth in particular and ways to support this in a system that is very risk oriented.

In combination, the results from the Aboriginal and Midwives' data sets provided a culturally informed and robust body of evidence that had translatability to health services and the health system.

It was with great pride in the BONB outcomes that the project team established three recommendations and that the health system took action to implement all of these.

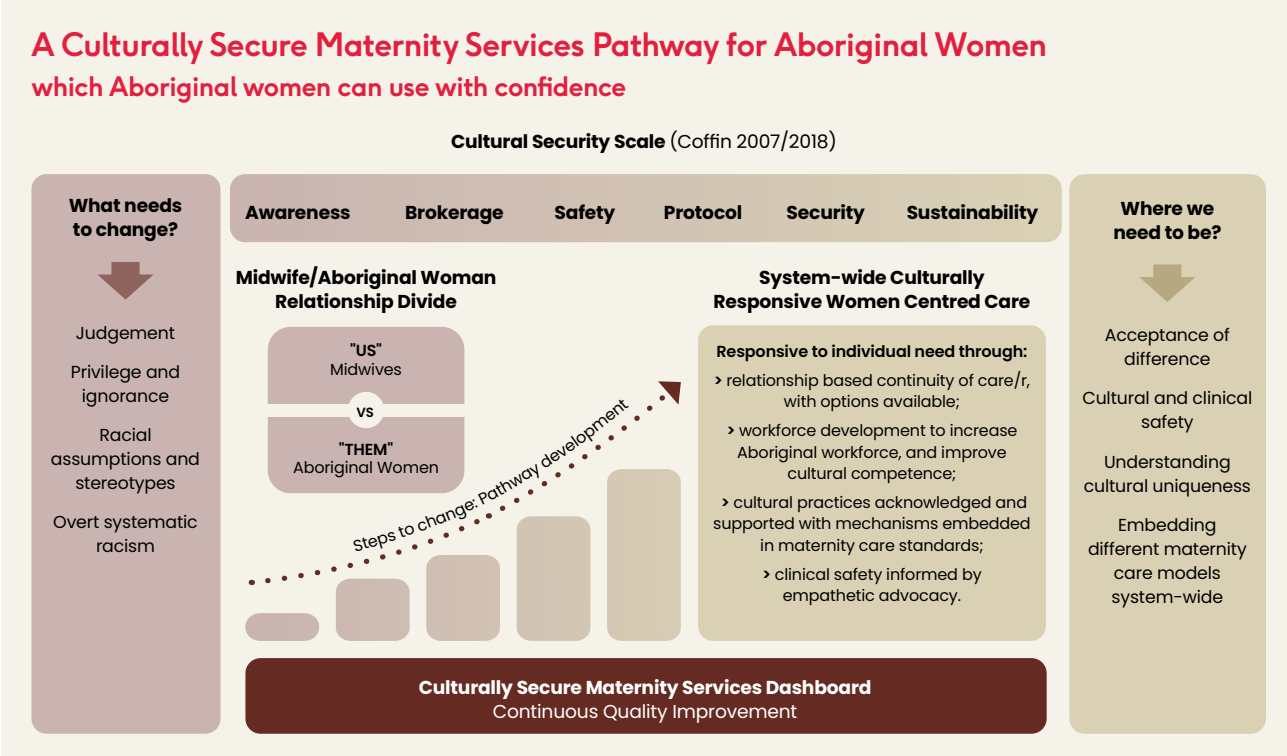
Conceptual Model and Recommendations

The Birthing on Noongar Boodjar Project findings advocate a set of principle driven recommendations which are founded on the proposition that:

Aboriginal women require equitable access to widely available culturally secure models of maternity care provided by culturally competent health professionals through a culturally competent health system. This care should hold as its focus woman-centred principles that include continuity of care and carer, commitment to the employment of Aboriginal personnel in a range of health practitioner, diagnostic, support and administrative roles and be integrated with culturally safe mainstream services.

Figure 9 shows a conceptual model developed from the evidence describing the 'steps to change' required to achieve cultural security in maternity care for Aboriginal women. A larger scale of the model is in Appendix 6.

Figure 9 A Culturally Secure Maternity Services Pathway for Aboriginal Women



The recommendations developed from the Birthing on Noongar Boodjar evidence are detailed below and draw on the Culturally Secure Maternity Services Pathway for Aboriginal Women conceptual model, which, in itself, is a Continuous Quality Improvement guide for the development of culturally responsive and appropriate woman-centred models of care co-designed by and for Aboriginal women.

Further, changes to the provision of culturally secure maternity services require that co-design is central and involves all relevant stakeholders and aims for sustainable, consistent, evidence based, culturally informed and responsive maternity care tailored for local conditions. The Pathway model sits alongside the development of health system data collection methods to secure collection of culturally meaningful longitudinal data able to demonstrate the association of culturally safe maternity care with maternal and infant health outcomes. The Pathway should also incorporate economic modelling to measure the cost benefit of targeted maternity care.

WA is in a position to provide leadership to other Australian States and Territories and demonstrate that closing the gap in Aboriginal maternal and child health outcomes is within reach when commitments are made to long term, ongoing, evidence-based planning and care provision; and this can be achieved within existing health budgets when a different ethos drives the process.

Conceptual Model and Recommendations

The Birthing on Noongar Boodjar Project Recommendations are aimed at changing the ethos of:

1. Government approaches to maternity care
2. The WA maternity health workforce
3. Education pathways supporting maternity care in WA

Birthing on Noongar Boodjar Project recommendations draw on/refer to documents with a direct influence on addressing the delivery of maternity care. These are set out in the Guiding Documents reference table below which shows the document reference number (Doc Ref #); Document Title (colour coded to assist easy identification); and Recommendation Reference number (Ref #).

Doc Ref #	Document title	Recommendation Ref #		
		1	2	3
A.	WA Aboriginal Health and Wellbeing Framework and Implementation Guide 2015-2030	*	*	
B.	WA Health Aboriginal Workforce Strategy 2014-2024	*	*	*
C.	National Aboriginal and Torres Strait Islander Health Pathway 2013-2023	*		
D.	National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023	*		*
E.	National Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander People	*		
F.	National Health and Safety Quality Standards User Guide for Aboriginal and Torres Strait Islander Health (2017)	*		
G.	Sustainable Health Review Interim Report (2018)	*		
H.	Nursing and Midwifery Board of Australia Code of Conduct for Midwives (2018)	*	*	*
I.	Nursing and Midwifery Board of Australia Professional Standards: Midwife Standards for Practice (2018)	*	*	*
J.	Culturally Competent Maternity Care for Aboriginal and Torres Strait Islander Women (2012)	*		
K.	National Maternity Services Capability Framework (2012)	*		
L.	Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework (2016)	*		

Guiding Documents Reference Key

A	B	C	D	E	F	G	H	i	J	K	L

Each Birthing on Noongar Boodjar Project Recommendation is set out as:

Recommendation Title

The Problem

Refers to an existing problem for which a change in thinking is required to identify solutions.

Relevant Birthing on Noongar Boodjar Evidence Summaries

Names the evidence summaries (which act as the summary descriptors for each primary theme) for each of the Birthing on Noongar Boodjar data groups, described as: Aboriginal Birthing Women; Aboriginal Senior Women; Aboriginal Elder Women; Midwives Individual; Midwives Focus Groups; Midwifery Educators.

Attachment A incorporates a Summary of Findings detailing the overall evidence, summarised for each data group. This includes an Evidence Summary Table which shows the data groups and associated evidence summaries descriptors, and the primary themes included in each evidence summary.

The Solutions

Frames the solutions which address the problem and incorporates a colour coded key to indicate which of the listed documents guide the solutions.

Recommendation

The recommended action to drive change.

Recommendation 1:

Changing the Ethos of Government Approaches to Maternity Care

The Problem

A history of culturally incompetent maternity services, fragmented care and inconsistent service delivery, resulting from time limited program funding, in conjunction with inadequate consultation with Aboriginal women, families and communities, has resulted in broad disengagement by Aboriginal women from mainstream maternity care.

This long history has reinforced a deeply embedded perception held by Aboriginal people that health services are not culturally safe to access and when access occurs, do not meet their needs.

A lack of cultural security and cultural competence is demonstrated at individual, organisational and systems levels across the majority of maternity services in WA. Additionally, there are limited examples of evidence based, culturally secure maternity care for Aboriginal women being implemented, measured, reported on or sustained.

Relevant Birthing on Noongar Boodjar Evidence descriptors (see Attachment A for detail)

Aboriginal Birthing Women: Experiences of Care, Perceptions of Maternity Services, Cultural Practices and Concepts which Inform Cultural Security

Aboriginal Senior Women: Perceptions of Care Experiences, Perceptions of Maternity Services, Cultural Security and Cultural Practices

Aboriginal Elder Women: Stories of Old Ways, Stories of Self and Changes, Racism and Segregation

Midwives – Individual: Midwives Perceptions of Caring for Aboriginal Women, Midwives Knowledge of Aboriginal Culture, Midwives Understanding of Systems Issues

Midwives Focus Groups: Professional Dimensions of Providing Care to Aboriginal Women, Knowledge and Understanding of Aboriginal Women's Needs, Racial Assumptions

Midwifery Educators: Education and Practice, Racial Assumptions, Cultural Security in Education and Practice

The Solutions

A Culturally Secure Maternity Services Pathway for Aboriginal women incorporated into the State's health system planning will provide a clearly articulated long term direction for the delivery of maternity services. This approach will be integrated with all relevant services and agencies, including the Aboriginal Community Controlled Health Sector. The Pathway requires the Premier and Minister for Health of the Government of WA to include the Pathway in forward estimates; and the Health System Manager to fully integrate the Pathway across the health sector, via Health Service Provider Boards.

Actions and strategies which embed a range of mechanisms into the health system designed to support more effective health care for Aboriginal people generally are clearly articulated in many existing planning and framework documents. Collectively, these emphasise that culturally secure health service delivery begins with the Cultural Determinants of Health and includes: cultural safety; cultural competence; cultural governance; and culturally informed professionals. These elements are essential to the effective delivery of maternity services.

We acknowledge that work has commenced to embed the WA Aboriginal Health and Wellbeing Framework across the WA health system using the directions documented in the Implementation Guide. We endorse this as an important initiative to improve the cultural competency of the health system as a whole. Using these substantial documents will also be highly beneficial to focussing on the changes required to improve the delivery of maternity services to Aboriginal women.

Guiding document reference key for Recommendation 1

Recommendation 1

A commitment by the Government of Western Australia to support the development of a Culturally Secure Maternity Services Pathway for Aboriginal Women co-designed with key relevant stakeholders and Aboriginal community experts.

"No empathy, sympathy that it was my first born, that I was Aboriginal, you know, they just didn't care. Because they see women pregnant every day. That's what they said, because they see women pregnant every day."

- Aboriginal Birthing Woman

"A couple of our Aboriginal grad midwives have been very uncomfortable and one resigned. One was going to resign, we need them so badly too, and this hospital doesn't have Aboriginal clinical support. They have normal midwifery support but they don't have Aboriginal people that are in here that are clinical, that can support the midwives."

- Aboriginal Senior Woman

"That constant liaison officer is needed, someone I can build a relationship with. Who understands me and how my family works. So they can cater their advice of how the family functions and they just lacked that completely. No one took into consideration what the family situation was, it was just always you need to do this; you need to do that. It doesn't really work like that [for me]."

- Aboriginal Birthing Woman

Recommendation 2:

Changing the Ethos of the WA Maternity Health Workforce

The Problem

A lack of Aboriginal people in all roles across all maternity services impacts on Aboriginal women's confidence to access maternity care. When available, there is a heavy reliance on the small number of Aboriginal staff already working in maternity services to 'do the cultural work'. This removes responsibility from non-Aboriginal personnel to be culturally informed and culturally competent in their clinical and caring interactions with Aboriginal women and their families.

There are limited cultural safety education learning opportunities that promote culturally secure maternity care or which challenge non-Aboriginal personnel to improve their knowledge of Aboriginal people and cultural practices. This situation leads to culturally unsafe environments and often contributes to poor service engagement by Aboriginal women.

Those working in direct contact with pregnant Aboriginal women and their families need have a commitment to know and understand how to effectively work with Aboriginal women and their families.

The presence of discriminatory care is exacerbated by a scarcity of health professionals capable of providing culturally secure care, and short-term program funding leading to cessation of services when further funding is not available. This cycle has led to fragmented service delivery and disillusioned health professionals, resulting in Aboriginal women being reluctant to seek antenatal care.

The multiple lost opportunities to sustainably integrate maternity care with other health and support services results in Aboriginal women, their families, and communities not trusting the capacity of health services to meet their maternity care needs which, in turn, contributes to the health gap and inequities in Aboriginal maternal and infant health outcomes.

Relevant Birthing on Noongar Boodjar Evidence descriptors (see Attachment A for detail)

Aboriginal Birthing Women: Experiences of Care, Perceptions of Maternity Services

Aboriginal Senior Women: Perceptions of Care Experiences, Perceptions of Maternity Services

Aboriginal Elder Women: Stories of Old Ways, Stories of Self and Changes, Experiences of Racism

Midwives Individual: Midwives' Perceptions of Caring for Aboriginal Women, Midwives' Understanding of System Issues

Midwives Focus Groups: Professional Dimensions of Providing Care to Aboriginal Women, Knowledge and Understanding of Aboriginal Women's Needs, Racial Assumptions

Midwifery Educators: Cultural Security in Education and Practice

"Like we actually did see out of our own eyes how they spoke to other girls, [compared to] how they spoke to me and my sister. Not only me, my sister sitting there too. They were talking arrogant to her too. And she's just sitting on the side of me, you know, asking what's happening on my behalf… they were just talking down to her too, and it's sickening really."

- Aboriginal Birthing Woman

"I suppose like the ultimate model I think that works, that I've seen work…would be to have an Aboriginal midwife, or a grandmother or even an Aboriginal liaison officer or someone that is Aboriginal…that identifies as Aboriginal part of the team…[and] midwives at every Aboriginal medical service, that could be, you know like eligible midwives or whatever, provide that whole care for them."

- Midwife

The Solutions

In addition to improving the overall number of Aboriginal people in the maternity care workforce, in all roles, Birthing on Noongar Boodjar has identified an urgent need to improve the cultural competence of non-Aboriginal people providing care to pregnant Aboriginal women.

Existing mandatory online training is an entry point to commence cultural awareness. The next step for personnel providing services to pregnant Aboriginal women is face-to-face cultural learning opportunities. These should be provided by Aboriginal staff to improve knowledge and understanding of Aboriginal women's individual needs and cultural practices, particularly in relation to the centrality of family being present during childbirth.

A range of consistently available professional development opportunities are needed, including user friendly tools which promote the development of good carer/patient relationships and culturally safe environments. One best practice example is the development of the Cultural Champions program at Fiona Stanley Hospital. The Director, Aboriginal Health Strategy, Clinical Service Planning & Population Health created the program using existing resources. It provides intensive cultural training to senior non-Aboriginal people who themselves demonstrate culturally secure clinical and patient practices, and advocate these to other staff. In this way Cultural Champions provide leadership and promote maintenance of a culturally respectful environment, in which Aboriginal patients are welcomed and supported. Initiatives like these are being developed in other HSPs by Directors of Aboriginal Health.

Another tool and systems integrated platform of engagement for perinatal mental health assessment is being developed through the Baby Coming - You Ready (BCYR) Project at the Ngangk Yira Institute for Change. Commencing in pregnancy, BCYR aims to promote holistic approaches to culturally secure relationships between practitioners, Aboriginal women and their partners.

BCYR has been co-designed with Aboriginal Elders, community members, health care practitioners and researchers. It is a highly innovate social and emotional wellbeing screening tool, digitised to seamlessly and securely integrate with WA health information systems. BCYR is designed as an interactive, web-based rubric that encourages Aboriginal mothers' ownership over their birthing journey and both mothers' and fathers' transition to parenting.

Both the Cultural Champions and BCYR rubric complement the WA Aboriginal Health and Wellbeing Framework, specifically Strategic Direction 3 of the Implementation Guide, which calls for a culturally respectful and non-discriminatory health system, improved access to cultural education and training for non-Aboriginal staff and opportunities for ongoing professional development.

Guiding document reference key for Recommendation 2

A	B	C	D	E	F	G	H	i	J	K	L

Recommendation 2

The Department of Health maintain and further develop mandatory Aboriginal cultural eLearning programs for the health system. Health Service Providers be required to deliver complementary face-to-face cultural safety education training programs at the local level for all staff involved with service delivery to Aboriginal women and families during their maternity journey.

Recommendation 3:

Changing the Ethos of Education Relevant to Maternity Care in Western Australia

The Problem

Whether a maternity care service is culturally safe is obvious to an Aboriginal woman when she first seeks maternity care: from when she enters the facility's main entrance, through to encounters in antenatal clinics, labour and post-natal wards and child health clinics. The first encounter an Aboriginal woman has with a health professional (midwife, doctor, nurse) may be the prism through which she experiences the rest of her maternity care. Not seeing other Aboriginal people working in a range of roles within health services is a further barrier to accessing maternity care.

There are currently limited opportunities for Aboriginal people to engage in post-secondary and tertiary educational skills attainment relevant to maternity care or undertake incremental pathways from certificate based (e.g., maternal and infant care), through diploma (e.g., enrolled nursing) to undergraduate and graduate qualifications (e.g., midwifery, nursing, medicine, pathology, radiology).

A lack of educational pathways to support the entry of Aboriginal people into a culturally secure maternity care environment negatively impacts on participation in the workforce.

Relevant Birthing on Noongar Boodjar Evidence descriptors (see Attachment A for detail)

Aboriginal Birthing Women: Perceptions of Maternity Services

Aboriginal Senior Women: Cultural Security and Cultural Practices

Midwives Individual: Midwives' Knowledge of Aboriginal Culture

Midwives Focus Groups: Professional Dimensions of Providing Care to Aboriginal Women

Midwifery Educators: Education and Practice

The Solutions

To improve the cultural security of maternity services requires an inclusive workforce with more Aboriginal people working in all roles in all health services. Aboriginal people require opportunities to step into a range of educational pathways and step out to culturally secure maternity care working environments.

This includes staged learning opportunities, commencing with certificate or diploma education (for example, Aboriginal Maternal and Infant Care workers) before proceeding to undergraduate and postgraduate education. Education pathways which transition, for example, Aboriginal Health Workers to skill specific Aboriginal Maternal Infant Care Health Workers (via on-the-job training) and then potentially to midwifery (with supported study leave options), is one solution. An overall maternity workforce strategy requires a collaborative approach developed by education institutions (i.e., TAFE, universities, registered training organisations) including the resumption of a WA undergraduate midwifery education pathway and development of a certificate/diploma based Aboriginal Maternal and Infant Carer qualification.

Guiding document reference key for Recommendation 3

Recommendation 3

The Department of Health establish a Principal Aboriginal Nurse and Midwifery Advisor position to provide leadership in growing the Aboriginal nursing and midwifery workforce including the Aboriginal maternity health care workforce.

"I think they should allow more family in the room to start with. Because you know, I come from a big family…I was only allowed my partner and my mum, that was it. But I mean my sisters were there too you know, and we're a pretty close family… just to have them there with you as a support thing, that would be nice to allow them, to let more people in the room, that would be good."

- Aboriginal Birthing Woman

"My other two boys was born there too…(So that was the hospital) Yep the sleep out thing. (You had to sleep outside?) Yep it wasn't in the proper ward. (Noongar women weren't allowed in the hospital to have their babies?) No, no…took them a long time."

- Elder Woman

"I don't feel like I have had a lot of training to help me work with Aboriginal women but we do have an Aboriginal Liaison Officer who works at my hospital and I do, you know, ask her things and get her to see my Aboriginal women and if there is anything that she can deal with to understand our culture more. And we used to have two Aboriginal health workers as well that I found really helpful…but I do feel like we need a bit more training into the cultures of these women and how we can actually help with the care that we give to them here."

- Midwife

References

Airhihenbuwa, C. O. (2007). On being comfortable with being uncomfortable: Centering an Africanist vision in our gateway to global health. Health Education & Behavior, 34(1), 31– 42.

Airhihenbuwa, C. O., & Liburd, L. (2006). Eliminating health disparities in the African American population: The interface of culture, gender, and power. Health Education & Behavior, 33(4), 488–501.

Angen, M.J. (2000). Evaluating Interpretive Inquiry: Reviewing the Validity Debate and Opening the Dialogue. Qualitative Health Research 10(3): 378-395. DOI: **10.1177/104973230001000308**

Australian Bureau of Statistics. (2016). Estimates of Aboriginal and Torres Strait Islander Australians, June 2016. (cat no. 3238.0.55.001). Retrieved from: **https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001**

Bessarab D., & Ng'andu B. (2010). Yarning about yarning as a legitimate method in Indigenous research. International Journal of Critical Indigenous Studies, 3(1), 37–50.

COAG Health Council (2019) Woman-centred care: strategic directions for Australian maternity services **https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf**

Coffin, J. (2007). Rising to the challenge in Aboriginal health by creating cultural security. Aboriginal and Islander Health Worker Journal, 31(3), 22–24.

Coffin, J. (2018, April). Birthing on Noongar Boodjar with cultural security. Keynote address presented at the Birthing on Noongar Boodjar Symposium, Perth, Western Australia.

Department of Health, Western Australia. (2015). WA Aboriginal Health and Wellbeing Framework 2015–2030. Perth, Australia: Aboriginal Health Directorate, Department of Health, Western Australia.

Derbarl Yerrigan Health Service Aboriginal Corporation. (2019). A brief history of Derbarl Yerrigan Health Service Aboriginal Corporation. Retrieved from: **https://www.dyhs.org.au/index.php/about-us**.

Fredericks, B. L., Adams, K., Finlay, S. M., Fletcher, G., Andy, S., Briggs, L., Briggs, L., & Hall, R. (2011). Engaging the practice of yarning in Action Research. Action Learning and Action Research Journal, 17(2), 7–19.

Geia, L. K., Hayes, B., & Usher, K. (2013). Yarning/Aboriginal storytelling: Towards an understanding of an Indigenous perspective and its implications for research practice. Contemporary Nurse, 46(1), 13–17.

Jones, J. N. (2012). Birthing: Aboriginal women. Journal of Indigenous Policy, (13), 103– 109. Karnieli-Miller, O., Strier, R., & Pessach, L. (2009). Power relations in qualitative research. Qualitative Health Research, 19(2), 279–289. doi:10.1177/1049732308329306

Kelly, J. (2013). Decolonizing sexual health nursing with Aboriginal women. Canadian Journal of Nursing Research, 45(3), 50–65.

Kosiak, M. (2014). Midwifery practices and Aboriginal and Torres Strait Islander women: Urban and regional perspectives. In O. Best & B. Fredericks (Eds.), Yatdjuligin: Aboriginal and Torres Strait Islander nursing & midwifery care (pp. 120–144). Melbourne, Australia: Cambridge University Press.

Laycock, A., with Walker, D., Harrison, N., & Brands, J. (2011). Researching Indigenous health: A practical guide for researchers. Melbourne, Australia: The Lowitja Institute.

Marriott, R., Reibel, T., Strobel, N., Kendall, S., Bowen, A., Eades, A.-M., Landes, J., & Adams, C. (2019). Cultural security in the perinatal period for Indigenous women in urban areas: a scoping review. Women and Birth, 32(5), 412-426. **https://doi.org/10.1016/j.wombi.2019.06.012**

Marriott, R., Reibel, T., Coffin J., Gliddon, J., Griffin, D., Robinson, M., Eades A.-M., & Maddox, J. (2019). "Our culture, how it is to be us" — Listening to Aboriginal women about on Country urban birthing. Women and Birth, 32(5), 391-403. **https://doi.org/10.1016/j.wombi.2019.06.017**

Marriott, R., Reibel, T., Coffin, J., Barrett, T.-L., Gliddon, J., Robinson, M., Griffin, D., & Walker, R. (2019). Wongi mi bardup (doing it our way): methodologies promoting Aboriginal knowledges and cultural practices for Birthing on Noongar Boodjar. International Journal of Critical Indigenous Studies, 12(1), 15-28. **https://doi.org/10.5204/ijcis.v12i1.1102**

Marriott, R., Reibel, T., Gliddon, J., Griffin, D., Coffin, J., Eades, A.-M., Robinson, M., Bowen, A., Kendall, S., Martin, T., Monterosso, L., Stanley, F., & Walker, R. (2020). Aboriginal research methods and researcher reflections on working two-ways to investigate culturally secure birthing for Aboriginal women. Australian Aboriginal Studies, 1, 36-53.

Marriott, R., Reibel, T., Barrett, T.-L., Bowen, A., Bradshaw, S., Kendall, S., Kotz, J., Martin, T., Monterosso, L., & Robinson, M. (2020). Midwifery knowledge of equitable and culturally safe maternity care for Aboriginal women. Birth, 48(1), 132-138. **https://doi.org/10.1111/birt.12525**

Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for indigenous and Indigenist re-search. Journal of Australian Studies, 27, 203–214.

Muller, S. (2012). 'Two Ways': Bringing Indigenous and Non-Indigenous knowledges together. In J. L. Weir (Ed.), Country, native title and ecology (pp. 59–79). Canberra, Australia: ANU Press. **http://press.anu.edu.au?p=175041**

O'Donnell, K., & Kelly, J. (2011). Using Ganma knowledge sharing as a decolonising approach to conference planning and facilitation. ALAR Journal, 17(2), 137–156.

Oxenham, D. (1999). Aboriginal terms of reference: The concept at the Centre for Aboriginal Studies. Perth, Australia: Curtin Indigenous Research Centre.

Ramsamy, N. (2014). Indigenous birthing in remote locations: Grandmothers' Law and government medicine. In O. Best & B. Fredericks (Eds.), Yatdjuligin: Aboriginal and Torres Strait Islander nursing & midwifery care (pp. 102–119). Melbourne, Australia: Cambridge University Press.

Reibel, T., & Walker, R. (2010). Antenatal Services for Aboriginal women: The relevance of cultural competence. Quality in Primary Care, 18(1), 65–74.

Rigney, L.-I. (1997). Internationalisation of an Indigenous anti-colonial cultural critique of research methodologies: A guide to Indigenist research methodology and its principles. Journal for Native American Studies, 14(2), 109–121.

Rigne, L.-I. (2006). Indigenist research and Aboriginal Australia. In J. Kunnie & N. Goduka (Eds.), Indigenous peoples' wisdoms and power: Affirming our knowledges through narrative (pp. 32–50). London, UK: Ashgate Publishing.

Russell-Mundine, G. (2012). Reflexivity in Indigenous research: Reframing and decolonising research? Journal of Hospitality and Tourism Management, 19(1), 85–90. doi:10.1017/jht.2012.8

Saunders, V., West, R., & Usher, K. (2010). Applying Indigenist research methodologies in health research: Experiences in the Borderlands. The Australian Journal of Indigenous Education, 39(S1), 1–7. **https://doi.org/10.1375/S1326011100001071**

Smith, L. T. (1999/2012). Decolonising methodologies: Research and Indigenous people (2nd ed.). London, UK: Zed Books.

Tracy, S.J. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research, Qualitative Inquiry 16(10);837-851 **https://doi.org/10.1177/1077800410383121**

Ungunmerr-Baumann, M.-R. (2002). Dadirri—A reflection by Miriam-Rose Ungunmerr-Baumann. Emmaus Productions. Retrieved August 31, 2018, from **http://nextwave.org.au/wp-content/uploads/Dadirri-Inner-Deep-Listening-M-R-UngunmerrBauman-Refl.pdf**

Walker, M., Fredericks, B., Mills, K., & Anderson, D. (2014). 'Yarning' as a method for community-based health research with Indigenous women: The Indigenous Women's Wellness Research Program. Health Care for Women International, 35(10), 1216–1226. doi:10.1080/07399332.2013.815754

Walker, R., Schultz, C., & Sonn, C. (2014). Cultural competence – Transforming policy, services, programs and practice. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (2nd ed., pp. 195–220). Canberra, Australia: Australian Government Department of the Prime Minister and Cabinet.

Wall, C. (2010). Law and story strings, Queensland historical atlas. Retrieved August 31, 2018, from **http://www.qhatlas.com.au/content/law-and-story-strings**

Wall, C. (2017). Aboriginal Grandmothers Law. Aboriginal Institute of Aboriginal and Torres Strait Islander Studies. Retrieved August 31, 2018, from **https://aiatsis.gov.au/publications/presentations/aboriginal-grandmothers-law**

Waterworth, P., Pescud, M., Braham, R., Dimmock, J., & Rosenberg, M. (2015). Factors Influencing the health behaviour of Indigenous Australians: Perspectives from support people. PLoS ONE, 10(11), e0142323. doi:10.1371/journal.pone.0142323

West, R., Steward, L., Foster, K., & Usher, K. (2012). Through a critical lens: Indigenist research and the Dadirri method. Qualitative Health Research, 22(11), 1582–1590.

Yunggirringa, D., & Garnggulkpuy, J. (2007). Yolnu participatory action research. Paper presented at the Action Learning Action Research Association conference, 'Moving Forward Together', Tauondi College, Adelaide, Australia.

Zubrzycki, J., Shipp, R., & Jones, V. (2017). Knowing, being and doing: Aboriginal and non-Aboriginal collaboration in cancer services. Qualitative Health Research, 27(9), 1316– 1329.

Appendices

Appendix 1: Publications

Article 1

Marriott, R., Reibel, T., Strobel, N., Kendall, S., Bowen, A., Eades, A.-M., Landes, J., & Adams, C. (2019). Cultural security in the perinatal period for Indigenous women in urban areas: a scoping review. Women and Birth, 32(5), 412-426. **https://doi.org/10.1016/j.wombi.2019.06.012**

Background: Culturally secure care is considered foundational for good perinatal outcomes for Indigenous women. It is unknown what literature reports on whether Indigenous women giving birth in urban areas receives appropriate cultural care. The aim of this scoping review was to examine and summarise relevant evidence which reports on culturally secure care for Indigenous women using urban maternity services at any time during the perinatal period. ***Methods:*** Ten journal databases plus grey literature and theses databases were searched for relevant material dated 1986-2018. Articles were included if they were about Indigenous women from Australia, New Zealand, Canada or the USA; care was provided anytime during the perinatal period, in an urban area; and cultural security (or variations of this term) were used. ***Results:*** 6856 titles and abstracts were screened, of these: 25 studies, 15 grey literature documents and 9 theses matched the search criteria. Studies were mostly qualitative (13/25) and from Australia (18/25). Studies showed women's access to and experiences of culturally secure maternity care in urban areas as variable. The grey literature originated from Australia (8/15); New Zealand (4/15); and Canada (3/15); while theses were from Canada (7/9) and Australia (2/9). ***Conclusion:*** The scoping review results showed substantial qualitative evidence on Indigenous women's experience during the perinatal period in urban areas. In-depth analysis of these studies is required to inform future practice and policy on what works and what needs improvement. Culturally secure midwifery care shows promising results.

Article 2

Marriott, R., Reibel, T., Coffin J., Gliddon, J., Griffin, D., Robinson, M., Eades A.-M., & Maddox, J. (2019). "Our culture, how it is to be us" — Listening to Aboriginal women about on Country urban birthing. Women and Birth, 32(5), 391-403. **https://doi.org/10.1016/j.wombi.2019.06.017**

Background: Birth on Country is often assumed as relevant to Aboriginal women in rural/remote locations and not usually associated with urban environments. In Western Australia, one third of the Aboriginal population live in the greater metropolitan area. We wanted to know Aboriginal women's experiences of on Country urban births. ***Methods:*** Indigenous qualitative data collection and analysis methods were used to learn about Aboriginal women's stories of contemporary and past experiences of maternity care and cultural practices associated with Birth on Country. ***Results:*** Aboriginal Birthing, Senior and Elder women consistently reported ongoing cultural practices associated with childbirth including knowledge sharing across generations and family support, observance of extended family present at the time of or shortly after birth, and how their cultural security was improved when Aboriginal staff were present. Also noted, were the inflexibility of health systems to meet their needs and midwives lack of cultural awareness and understanding of the importance of Aboriginal kinship. ***Conclusion:*** The Birthing on Noongar Boodjar project Aboriginal women's data represents four generations of women's stories, experiences and expressions of childbearing, which highlighted that maternity care changes across time have failed to acknowledge and support Aboriginal women's cultural needs during childbearing. In terms of on Country urban birth, the women collectively expressed a strong desire to maintain cultural practices associated with childbirth, including birthing close to home (on Country); having family acknowledged and included throughout the perinatal period; and, having access to Aboriginal midwives, nurses, doctors, and other health care workers to support their cultural security.

Article 3

Marriott, R., Reibel, T., Coffin, J., Barrett, T.-L., Gliddon, J., Robinson, M., Griffin, D., & Walker, R. (2019). Wongi mi bardup (doing it our way): methodologies promoting Aboriginal knowledges and cultural practices for Birthing on Noongar Boodjar. International Journal of Critical Indigenous Studies, 12(1), 15-28. **https://doi.org/10.5204/ijcis.v12i1.1102**

The Birthing on Noongar Boodjar project investigated the cultural birthing practices of Aboriginal women living *on country* (Noongar Boodjar) in an urbanised environment; and their experiences of interactions with maternal health care providers (especially midwives). The evidence from the five year study identified changes required in health systems to adequately support Aboriginal women and their families during the significant cultural and life event of childbearing. This paper sets out the methodological and theoretical considerations which framed how the Birthing on Noongar Boodjar project was conducted by the Aboriginal and non-Aboriginal investigators. We provide a brief project background before describing the Indigenous research methodologies and practices crucial to exploring the research questions, collecting data in culturally secure ways and using cultural lenses to analyse and interpret the data. The study design and results are reported in other publications.

Article 4

Marriott, R., Reibel, T., Gliddon, J., Griffin, D., Coffin, J., Eades, A.-M., Robinson, M., Bowen, A., Kendall, S., Martin, T., Monterosso, L., Stanley, F., & Walker, R. (2020). Aboriginal research methods and researcher reflections on working two-ways to investigate culturally secure birthing for Aboriginal women. Australian Aboriginal Studies, 1, 36-53.

This five-year study investigated the cultural birthing practices, needs and requirements of Aboriginal women giving birth in urban settings, and their experiences of maternity care and views of birthing on Country. It also investigated how midwives perceive and support cultural security. The paper highlights the selection of research methods that complemented the project's Indigenous methodological framework. Cultural lenses and diverse expertise translated the outcomes to recommendations about a culturally meaningful health system and professional practice and education aimed at supporting Aboriginal women's birthing expectations in the future. Our tailored research practices privileged culturally secure approaches to push back against Western knowledge paradigms that have dominated qualitative research undertaken with Aboriginal people. This paper describes the research methods chosen to manage complex data collection and analysis, and how we blended Indigenous-specific methods with compatible standard methods to support Indigenist and decolonising research practices. We include Aboriginal researcher reflections to highlight the importance of culturally determined research processes that result in high-quality, culturally meaningful research.

Article 5

Marriott, R., Reibel, T., Barrett, T.-L., Bowen, A., Bradshaw, S., Kendall, S., Kotz, J., Martin, T., Monterosso, L., & Robinson, M. (2020). Midwifery knowledge of equitable and culturally safe maternity care for Aboriginal women. Birth, 48(1), 132-138. **https://doi.org/10.1111/birt.12525**

***Background*:** The Birthing on Noongar Boodjar project (NHMRC Partnership Project #GNT1076873) investigated Australian Aboriginal women and midwives' views of culturally safe care during childbearing. This paper reports on midwifery knowledge of Aboriginal women's cultural needs, their perceptions of health systems issues, and their ability to provide equitable and culturally safe care. ***Method*:** A qualitative study framed by an Indigenous methodology and methods which supported inductive, multilayered analyses and consensus-driven interpretations for two clinical midwife data groups (n=61) drawn from a larger project data set (n=145) comprising Aboriginal women and midwives. ***Findings*:** Midwives demonstrated limited knowledge of Aboriginal women's cultural childbearing requirements, reported inadequate access to cultural education, substituted references to women-centred care in the absence of culturally relevant knowledge and consistently expressed racialised assumptions. Factors identified by midwives as likely to influence the midwifery workforce enabling them to provide culturally safe care for Aboriginal women included more professional development focused on improving understandings of cultural birth practices and health system changes which create safer maternal health care environments for Aboriginal women. ***Conclusion*:** Individual, workforce, and health systems issues impact midwives' capability to meet Aboriginal women's cultural needs. An imperative exists for effective cultural education and improved professional accountability regarding Aboriginal women's perinatal requirements and significant changes in health systems to embed culturally safe woman-centred care models as a means of addressing racism in health care.

Appendices

Appendix 2: Communication and Engagement Plan: Birthing on Noongar Boodjar

A brief background to your project:

Birthing on Country speaks to a spiritual connection for the mother and her baby that is not only little understood by health professionals, if undervalued creates a perceptual separation between social, cultural and spiritual risk and western medical biophysical risk. This meaning of *Birthing on Country* in urban maternity facilities needs to be investigated and better understood before policies can be changed to ensure Aboriginal women at time of birthing are afforded the respectful care required to preserve their cultural safety whether that involves them *Birthing on their own Country or the Country of another*.

The cultural competence of maternity hospital services and staff is "critical to the willingness of Aboriginal women to access services and to ensuring a culturally secure experience and positive outcome for both mother and baby". To do this, maternity services must ensure a culturally secure environment with culturally competent staff safeguarding the birthing woman's cultural rights, values and expectations; and respecting her right to feel culturally safe.

The project will **investigate** the best possible contemporary, culturally secure maternity care for Aboriginal women birthing in an urban health setting; **evaluate** principles and models for culturally secure maternity services and cultural competence development of midwives through education; **advise** policy change to promote cultural security in maternity services; **inform** national accreditation education requirements and policies to ensure a culturally competent midwifery workforce; **inform** the theoretical literature on cultural competence and cultural security through comparative conceptualisation of these cultural markers for individuals and organisations; and facilitate the **translation** of outcomes into policy and practice to mandate culturally secure maternity services for a culturally safe experience for birthing Aboriginal women and their families.

What is the Stakeholder Engagement Objective of this project?

To disseminate the findings of the project and socialise the recommendations and actions.

Why engage? Why is engagement important for this project?

The stakeholder community of this project has a unique and evolving set of cultures, expectations and perceptions. To effectively engage with and influence this diverse community, the traditional approach to project communications of regular reports and other 'one size fits all' strategies need to be replaced by a methodology that considers the complexities of the people and the information that is of interest to them.

What outputs are you expecting?

A set of essential criteria, which are measurable, achievable and reportable.

What outcome are you hoping to achieve?

A report card to act as a mechanism to assist in driving tangible change in the delivery of maternity services.

Identifying appropriate stakeholders (internal, government, community, industry, media)

Internal WA Health: HSP Boards, Senior Nursing and Midwifery Leaders, Aboriginal Health Policy Directorate, Nursing and Midwifery Office, Office of Safety and Quality, AMGPs such as Moort Boodjari Mia and Boodjari Yorgas, Strategic Aboriginal Health Group

External to WA Health: Aboriginal Consultative Committee, AHCWA, Aboriginal Medical Services, Aboriginal Community Controlled Health Services, Universities, Private Hospitals, Australian College of Midwives, Australian Nursing and Midwifery Accreditation Council, Medical Peak Bodies such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian Indigenous Doctors Association, Congress of Aboriginal & Torres Strait Islander Nurses & Midwives, Aboriginal women and families, Aboriginal Communities, Aboriginal Elders, Aboriginal Midwives, Australian College of Nursing, Australian Indigenous Psychology Association, Australian Indigenous Allied Health Association

Stakeholder Environment

Involve / consult	Proposed method of engagement
• Australian College of Midwives • Australian Nursing and Midwifery Accreditation Council • Medical Peak Bodies such as Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), RACGP, ACRRM • Australian Indigenous Doctors Association • Congress of Aboriginal & Torres Strait Islander Nurses & Midwives • Strategic Aboriginal Health Group	**Involve** *Stakeholder engagement goal: To work directly with stakeholders throughout the process to ensure that their concerns and needs are consistently understood and considered.* • Forums • Action research • Advisory committees
Collaborate / empower	**Proposed method of engagement**
• Aboriginal women and families • Aboriginal Communities • Aboriginal Maternity Group Practices • Aboriginal Midwives	**Collaborate** *Stakeholder engagement goal: To partner with the stakeholder including the development of alternatives, making decisions and the identification of preferred solutions.* • Participating (writing documents) • Health Service Provider Collaborative **Empower** *Stakeholder engagement goal: To place final decision-making in the hands of the stakeholder.* • Facilitation of direct dialogue between stakeholders and decision-makers
Consult	**Proposed method of engagement**
• Aboriginal Community & Elders • Aboriginal women who have given birth	*Stakeholder engagement goal: To obtain feedback from stakeholders on analysis, alternatives and/ or outcomes.* • Meetings, • Workshops • Targeted invitation to stakeholders
Inform	**Proposed method of engagement**
• The Health Service Provider Boards • Non-government health providers • Aboriginal Community Controlled Health Services • External stakeholders delivering services to Aboriginal women and families	*Stakeholder engagement goal: To provide balanced, objective, accurate and consistent information to assist stakeholders to understand the problem, alternatives, opportunities and/or solutions.* • Annual Reports • Regular updates through newsletters, radio, and online mediums • Presenting the findings at conferences, publications and key strategic meetings • Symposium

Appendices

Appendix 2 continued

Logistics (timing, resourcing, responsibilities)

Policy and Translation Stream

Communicating the message:

Identify and manage risk

Research findings are not translated into actions

Lack support from Public Health Service Providers

Creating a report that does not get actioned – include measures & accountability

Evaluating the process

Round table review 12 months after Symposium

Now you have considered all of the above, the following will assist you identify your engagement and communication priorities for each stakeholder group:

Who	How					Other	
Stakeholders	**Specific audience**	**Level of engagement**	**Method, tools and activities**	**Frequency & Logistics**	**Purpose**	**Risks**	**Evaluation**
Internal	Policy and service providers	Collaborate	Presentations	Monthly	Influence	Lack of engagement	
Government	Director General; Health Service Providers and maternity services	Inform	Briefing notes, presentations and regular updates	Twice a year	Influence/ seek feedback	Lack of engagement	
Community	Non-government services being delivered to Aboriginal women and families Consumers and health users including the women and their families	Collaborate	Presentations	Monthly	Influence	Lack of engagement	
Industry	Senior Executives for Nursing & Midwifery Midwifery Service Providers Educators	Collaborate/ inform	Presentations	Monthly	Influence/ seek feedback	Lack of engagement	
Media	Aboriginal radio and programs Stories in Health Point (global intranet for public health employees) Sunday Times Stories contact Regina Titelius phone: 9482 9270 or email: **regina.titelius@wanews.com.au**	Inform	Presentations	Twice a year	Inform	Lack of engagement	

Appendix 3: Community Engagement Activities

Facilitated by the Aboriginal Consultative Group and Cultural Leadership and Brokerage (2014 – 2018)

Date	Event	Place	Numbers	Response
11 June 2015	Elders 1st Consultation	Derbarl Yerrigan East Perth	Approx. 20	Approval for project Broad discussions regarding culture & birth
12 Dec 2016	Elders 2nd Consultation	Derbarl Yerrigan East Perth	Approx. 25	Update on how project was developing Sharing of stories
19 Sept 2017	Community Consultation	Champion Centre, Armadale	11	Overview of project with interest in project outcomes; discussion related to themes emerging from interviews
9 November 2017	Community Consultation	Moorditj Koort, Medina	10	Overview of project with interest in project outcomes, including discussions around educational materials. Suggestion by Elders regarding an app with culturally themed pregnancy education. Outcome: Website design with app access in planning stages
24 January 2018	Community Consultation	Midland Women's Health Space	2	Community and service providers invited. Overview of project shared with discussion related to themes and possible outcomes
6th February 2018	Elders share their birthing stories	Ngangk Yira Centre for Health and Social Equity Research	6 Elders 8 Project members	Elders birthing stories shared with the project team moving including descriptions of cultural birthing practices and personal experiences in the bush and at home
13th February 2018	Elders share their birthing stories	Ngangk Yira Centre for Health and Social Equity Research	5 Elders 11 Project members	Second session of Elders Birthing stories, shared with the project team, including moving descriptions of cultural birthing practices and personal experiences in the bush and at home
21st February 2018	Elder shares birthing story	Ngangk Yira Centre for Health and Social Equity Research	1 Elder	One on one interview detailing births of an Elder's 9 children (who was unable to attend above sessions)
14th March 2018	Elders Birthing Poster meeting	Ngangk Yira Centre for Health and Social Equity Research	13 Elders 10 Facilitators 8 Family	Overview and editing of stories for Elder's permission to transpose the content to posters, for presentation and public viewing at the BONB Symposium in April 2018
11th July 2018	NAIDOC morning tea "Because of Her we can" Honouring the Elders who shared their birthing stories	Ngangk Yira Centre for Health and Social Equity Research	38 guests including Elders, family & friends	Aboriginal Elders and their families, community, Murdoch staff & students and health service providers came together to graciously commend and deeply thank the Elders who created posters for the symposium. Music from the Moody sisters filled the air and traditional dancers performed.

Appendices

Appendix 4: Yarning Questions with Aboriginal Women

The following questions guided the yarns with women participating in the study. All research assistants undertaking the yarns were Aboriginal.

1. Describe how you feel about your perinatal and birthing experiences?
2. What cultural or language group do you identify with?
3. Where is your family's Country? If it is not here, how did you come to be giving birth in Wadjuk Noongar Country?
4. Did you have a choice about where you had your baby? Would you have preferred to give birth closer to home and family? Did you feel any anxiety about how and where you gave birth?
5. What does *Birthing on Country* mean for you (as an Aboriginal woman)?
6. Would a *Birthing on Country* birth plan improve culturally safe birthing of your baby? (Such as Grandmothers Law)?
7. What are the cultural risks to you, as an Aboriginal woman, and your baby if your cultural birth requirements are not met?
8. As an Aboriginal woman, what do you want and expect from your health service in relation to your needs for the culturally safe birthing of your baby?
9. As an Aboriginal woman, what do you think could improve the *cultural competence* of midwives and doctors who assisted in the birthing of your baby/your *Birthing on Country* needs?

Appendix 5: Semi-Structured Interview Questions with Midwives

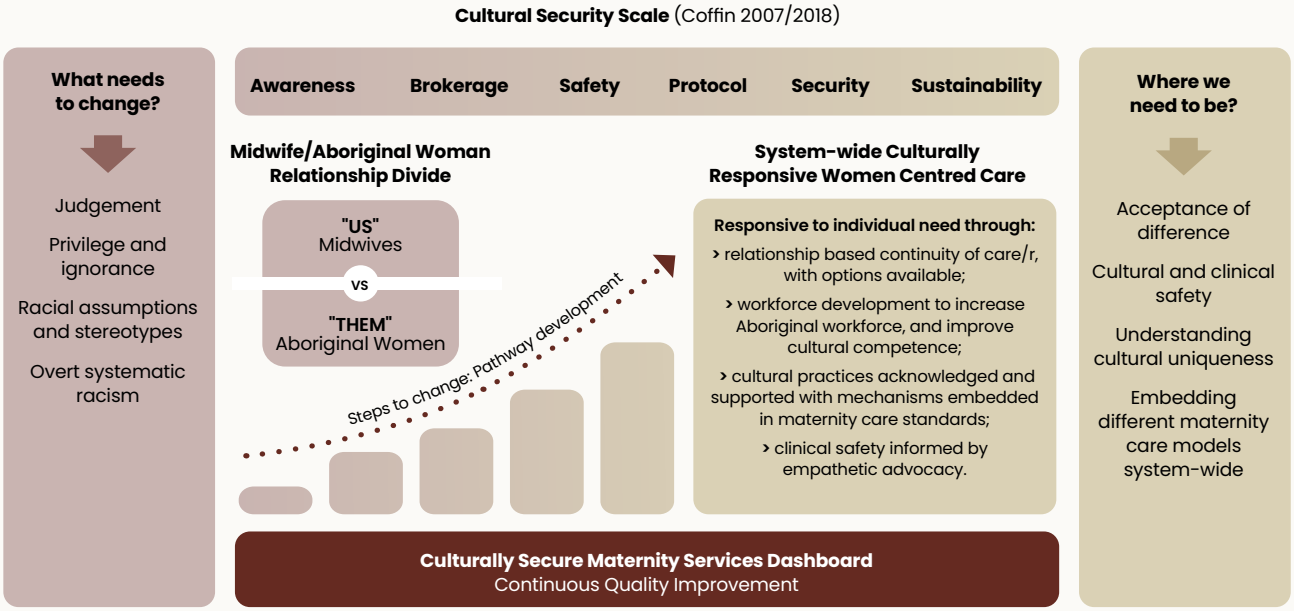
The following questions guided the semi-structured interviews with Midwives participating in the study.

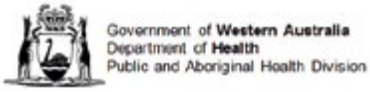
1. What do you think is the meaning of *Birthing on Country* for an Aboriginal woman?
2. What do think would need to be included in a culturally safe birth plan/*Birthing on Country* birth plan that would facilitate cultural security and meaning for an Aboriginal woman?
3. Have you heard of *Grandmothers' Law*? What do you think it means?
4. Are there any cultural risks to an Aboriginal woman and her baby if her cultural birth requirements or specific *Birthing on Country* needs are not met?
5. What do you think Aboriginal women expect from this health service in relation to a culturally safe birthing/*Birthing on Country* maternity model?
6. What do you consider that *cultural competence* of midwives and doctors would look and feel like in relation to an Aboriginal woman's culturally safe birthing/*Birthing on Country* needs?
7. What education was provided in your midwifery pre-registration programs in order for you to be prepared for the cultural birthing needs of Aboriginal women?
8. What culturally appropriate education continuing education programs are available to you as a midwife to increase your cultural competence for the cultural birthing needs of Aboriginal women

Appendix 6: A Culturally Secure Maternity Services Pathway for Aboriginal Women

A Culturally Secure Maternity Services Pathway for Aboriginal Women

which Aboriginal women can use with confidence





CRICOS Provider Code 00125J | TEQSA Provider ID: PRV12163 (Australian University) CASE0220799 11/25