Midwives' and Aboriginal and Torres Strait Islander women's experiences with cultural care in the birth suite – an interpretative phenomenological investigation

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Publications arising from the research

The following publications were submitted and accepted by Women and Birth, a peer reviewed Australian Midwifery journal. I am the lead author, with my research supervisors as co-authors. See Appendix nineteen and twenty for copies of the publications.

1. Brown AE, Middleton, PF, Fereday, JA & Pincombe, JI. 2016a 'Cultural safety and midwifery care for Aboriginal women – A phenomenological study'. Women and Birth, vol. 29, no. 2, pp. 196-202.

2. Brown AE, Fereday, JA, Middleton, PF & Pincombe, JI. 2016b 'Aboriginal and Torres Strait Islander women's experiences accessing standard hospital care for birth in South Australia – a phenomenological study.' *Women and Birth* http://dx.doi.org/10.1016/j.wombi.2016.01.004

Glossary of terms

Aboriginal	**In consultation with the Aboriginal Cultural Consultant, I have chosen to use the term Aboriginal to be inclusive of all Aboriginal and Torres Strait Islander peoples within this thesis. I acknowledge and respect the diversity within these communities. The women in the study have used a variety of different terminologies when referring to themselves and other Aboriginal and Torres Strait Islander Australians.**
Aboriginal Liaison Officer (ALO)	The hospital Aboriginal Liaison Officers visit all Aboriginal inpatients. They assist the women by ensuring their medical, practical and cultural needs are met while at the hospital. The Aboriginal Liaison Officers operate out of a unit within the hospital that is open to all Aboriginal people to gather whilst visiting. The officers act as cultural brokers to staff, clients and families. The ALOs are available Monday to Friday from 08.30 – 1630.
Aboriginal Maternal Infant Care Worker (AMIC)	The AMIC worker provides care with a midwife in a continuity program during the antenatal, birth and postnatal period. The AMIC worker is another Aboriginal woman and they provide culturally appropriate care tailored to the women's needs. They work within the Metropolitan Aboriginal Family Birthing Program. The program is a free service offered to some Aboriginal women living in metropolitan Adelaide. Within the program women are cared for by a group of midwives and an AMIC worker. Antenatal care can be provided at any location that is convenient to the woman (e.g. home, hospital or local health service). Women are supported by the AMIC worker when they see other health workers. This care and support continues for the women in their homes (or other convenient location) after the baby is born for up

	to six weeks. The AMIC workers also refer the women to community services that can assist them with their babies (e.g. Mums and Babies groups, playgroups and Child and Family Health Services).
Cardiotocography (CTG)	An electronic method of simultaneously recording fetal heart rate, fetal movements and uterine contractions.
Chorioamnionitis	A bacterial infection of the chorion and amnion and the amniotic fluid.
Cultural safety	The essential components of cultural safety include; • An understanding of one's own culture. • An acknowledgement of difference, and a requirement that caregivers are actively mindful and respectful of difference(s). • It is informed by the theory of power relations - any attempt to depoliticise cultural safety is to miss the point. • An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations People's lives and wellbeing – both in the past and the present. • Its presence or absence is determined by the experience of the recipient of care – it is not defined by the caregiver. (Congress of Aboriginal and Torres Strait Islander Nurses 2013, p.7).
Dasein	Heidegger said it was through language that one's way of being in this world was manifested (Langdridge 2007). Heidegger (1962) used the word Dasein to describe 'being-in-this-world' and it has been described as the fundamental ontological structure characterising humans and the unity of the world and of existence (Sembera 2007).

Dreaming/Dreamtime	For Australian Aboriginal peoples the Dreaming or Dreamtime represents a complex network of knowledge, faith and practices that informs all spiritual and physical aspects of life. These ancestral spirits created the earth and the distinctive natural features of the country (Dunbar & Ford 2011, p.40).
Epistemology	The study of knowledge.
Gravida	The number of times a woman has been pregnant.
Iga Warta	A cultural awareness experience based on the Adnyamathanha Culture with Adnyamathanha People and on Adnyamathanha land in the Flinders Ranges in South Australia.
Midwifery Group Practice	A continuity model of midwifery care where women are cared for by small teams of midwives. They will receive all antenatal care, intrapartum care and postnatal care up to six weeks from their primary midwife and the other team members.
Ngangkari	Aboriginal traditional healers – men and women – from the Pitjantjatjara, Yankunytjatjara, Ngaanyatjarra Aboriginal language groups in Central Australia (Panzironi 2013).
Ontology	The study of the nature of Being.

Parity	The number of children to which a woman has given birth (greater than 20 weeks gestation).
Pre-eclampsia	Pregnancy induced hypertension.
Standard Hospital Care	Standard hospital care in this study refers to the system for women who attend the women's outpatient department for antenatal care. They are attended by a combination of midwives and doctors. A different team of midwives and doctors will assist them with their labour and birth. The baby will be born in the hospital's birth suite. Women who are transferred from rural and remote areas for increased care in their pregnancies also attend the hospital birth suite with an unknown team of midwives and doctors.

List of abbreviations

ACC	Aboriginal Cultural Consultant
AFBP	Aboriginal Family Birthing Program
AHREC	Aboriginal Health Research Ethics Committee
AIM	Assistant in Midwifery
ALO(s)	Aboriginal Liaison Officer(s)
AMIC	Aboriginal and Maternal Infant Care
CALD	Culturally and Linguistically Diverse
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CTG	Cardiotocography
e.g.	For example
PE	Pre-eclampsia
PIS	Participant Information Sheet
PIAS	Pregnancy Induction and Assessment Suite
SHC	Standard hospital care
HCP	Health care provider
HREC	Human Research Ethics Committee
IV	Intravenous
MGP	Midwifery Group Practice
MSL	Meconium Stained Liquor

Abstract and keywords

Background

Aboriginal and Torres Strait islander women face considerable health disparity in relation to their maternity health outcomes when compared to non-Aboriginal women. Culture and culturally appropriate care can contribute to positive health outcomes for Aboriginal women. How midwives provide culturally appropriate care and how the care was experienced by the women was central to this study.

Aim

The research aimed to explore the lived experiences described by Aboriginal women who gave birth in the standard hospital care system. An additional aim included an exploration of the lived experiences described by midwives providing care in the standard hospital care system to Aboriginal women at a large tertiary teaching hospital in South Australia.

Methods

An interpretative Heideggerian hermeneutic phenomenological approach was used. Semi-structured interviews were conducted with fourteen volunteer Aboriginal women and thirteen volunteer midwives. These were transcribed, analysed and presented, informed by an interpretive phenomenological approach. The Aboriginal women were interviewed by Aboriginal interviewers according to the requirements of the Aboriginal Health Research Ethics committee.

Findings

Thematic analysis revealed six main themes for the women: "knowing what is best and wanting the best for my baby", "communicating my way", "how they made me feel", "all of my physical needs were met", "we have resilience and strength despite our hardships" and "recognising my culture". Thematic analysis revealed six main themes for the midwives: “finding ways to connect with the women”, “building support networks – supporting with and through Aboriginal cultural knowledge”, “managing the perceived

barriers to effective care", "perceived equity is treating women the same", "understanding culture" and "assessing cultural needs – urban versus rural/remote Aboriginal women's cultural needs".

Conclusion

Aboriginal women's experiences giving birth in standard care were explored. Some of the women's cultural needs were identified and culturally unsafe practices highlighted. The midwives' data provides insights into midwifery practices for Aboriginal women birthing in standard care at a tertiary hospital. Potential threats to the cultural safety of Aboriginal women are identified. Suggestions aimed to improve the experiences for Aboriginal women are provided. Recommendations that could improve the midwifery understandings of cultural safety and support midwives in their practice are made.

Keywords

Aboriginal and Torres Strait Islander women, Culture, Maternal Health Services, Midwifery, Cultural safety, Phenomenology, Cultural competency.

Declaration

I declare that:

This thesis presents work carried out by myself and does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; to the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.

Angela Brown Date: 6 May 2016

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I would like to acknowledge and thank the women and midwives who agreed to share their stories. I thank the midwives for their honesty and for taking the time to help me achieve a greater understanding of this area of their practice. To the women who also shared their stories, I appreciate you sharing your stories of giving birth in standard care. I hope I have done your accounts justice and other women birthing in standard care might experience a greater understanding of their needs as Aboriginal women.

To Ms. Jessica McKenzie and Ms. Toni-Marie Rowe who worked on the project I wholeheartedly thank you. I truly appreciate that you agreed to help me and thank you for the stories you collected for me.

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time out from my PhD. To George I greatly appreciate your guidance and tolerance whilst I achieved this goal. To Ella thank you for all those times you supported me through editing, listening and attending presentations and your everyday encouragement, you have no idea how much that means to me

Chapter 1 | Introduction

"We have long known that as Aboriginal and Torres Strait Islander people we need to feel connected with our families, communities and cultures to have genuine health and wellbeing."
Pat Anderson (2014)

1.1 Introduction to the study

This is a study of Australian Aboriginal and Torres Strait Islander women's experiences of labour and birth, with a focus on cultural care in the standard hospital care (SHC) system. The study also explores current midwifery practices in the provision of care to Aboriginal women who give birth in the SHC system. Midwives' understandings of Aboriginal cultures, cultural safety and how they provide care that incorporates the women's cultural needs, and how Aboriginal women experience this care, is fundamental to this study. Unlike other investigations that have been conducted in this area (Brown et al. 2015; Fenton & Jones 2015; Williamson & Harrison 2001), my study explores both the experiences of the women and of the midwives during labour and birth. Phenomenological interpretations are made from the interview data that have embodied the experiences of the women and midwives. In this chapter I explore the background and significance of the study, explain how my interest in this area of midwifery practice has developed, outline the research aims and questions, summarise the gaps in the literature, briefly describe the research design and setting, and outline the structure of my thesis.

1.2 Background and significance

Aboriginal and Torres Strait Islander peoples are the original inhabitants of Australia. Australia was colonised by the British in 1788 and following colonisation Aboriginal peoples have suffered trying to protect their land, food and people. They were subjected to massacres and disease, denied access to their traditional foods, and suffered interruption to traditional practices (Sherwood & Geia 2014). Aboriginal peoples' social and emotional welfare was interrupted by colonisation (Hellsten 2014). Colonisation still affects Aboriginal peoples today through the continuing economic, social, political and educational marginalisation it has forced upon them (Sherwood & Geia 2014). The legacy from colonisation and what followed also impacts on Aboriginal peoples' access, uptake and views, and acceptability of the health services today (Taylor & Guerin 2010). Trust by

Aboriginal peoples of health services is another factor that is tied to the historical events of colonisation and what happened to Aboriginal peoples after 1788, and which impacts on the health and welfare of Aboriginal people in mainstream services (Taylor & Guerin 2010).

The concept of cultural safety originated in New Zealand (Papps & Ramsden 1996). In Australia, the provision of midwifery care in a culturally safe manner is an element of mandated midwifery competency (Nursing and Midwifery Board of Australia 2006). The national midwifery competencies represent the minimum requirement for licensure and registration to practice (Pairman & Donnellan-Fernandez 2015). The midwifery competencies provide a guide for the skills, knowledge and attitudes expected of a midwife to work within the midwifery scope of practice (Pairman & Donnellan-Fernandez 2015). Competency 10 of the standards requires that midwives ensure their practice is culturally safe (Nursing and Midwifery Board of Australia 2006). The midwife should plan, implement and evaluate strategies for providing culturally safe care for Aboriginal women (Nursing and Midwifery Board of Australia 2006). The standards also include cues for midwives as an element of the competency, which are:

> Incorporates knowledge of cross cultural and historical factors into practice.
>
> Demonstrates respect for differences in cultural meanings and responses to health and maternity care.
>
> Recognises the specific needs of Aboriginal and Torres Strait Islander women and their communities.
>
> Recognises and respects customary law. (Nursing and Midwifery Board of Australia 2006, p.8)

Although culturally safe care can only be determined by the recipient of the care, there is a requirement for health care providers to examine their own cultural identities, attitudes, beliefs, and the power balance within the health care relationship (Taylor & Guerin 2010). Culturally safe midwifery care can translate to Aboriginal women experiencing less fear accessing maternity health care, which can ultimately improve maternal and infant health care outcomes (Kosiak 2014). Some researchers have argued that it is difficult to measure the efficacy of cultural training for health professionals given the lack of standardised

training curriculums and lack of evidence of the efficacy of the training on improving outcomes for patients (Chun 2010).

Aboriginal peoples have often faced a lack of cultural understanding when accessing health care services through the mainstream system (Durey & Thompson 2012; Taylor & Guerin 2010). Aboriginal community controlled health services have grown over the years, beginning in the 1970s in response to the inability of mainstream services to meet the needs of Aboriginal peoples (Taylor & Guerin 2010). Aboriginal community controlled health services now operate all across Australia (Eckermann et al. 2010; Taylor & Guerin 2010; Ward, Fredericks & Best 2014). For many Aboriginal peoples and communities, these services can be more acceptable than mainstream services (Eckermann et al. 2010; Panaretto et al. 2014; Ward, Fredericks & Best 2014).

Despite these advances, many Aboriginal peoples will still access mainstream health services for many reasons. Some women choose not to access, or are not offered, continuity programs for their midwifery care. Aboriginal women from rural and remote areas who are required to relocate to Adelaide for birth in mainstream care are not currently offered care from an Aboriginal Maternal Infant Care (AMIC) worker or care within a continuity program whilst in Adelaide. Whilst these women will give birth in the standard care system or within the private system, they still have the fundamental right to a culturally responsive health service.

1.3 Development of my interest in Aboriginal cultures and health

I was born in Darwin and my family relocated to Singapore a few days after my birth, where I spent my first three years of life. We eventually settled in Victoria before coming to South Australia when I was about eight years old. We lived in the Adelaide hills and there were Aboriginal families at the school I attended. So although I had some contact with Aboriginal people growing up it was limited. I have always felt strongly about social justice issues, which have fostered my interest in Aboriginal history and cultures.

I have three children and they were all born in different hospitals (one public and two private). The births for my last two children were positive experiences. My first birth was a negative experience where I felt fear and I did not have good midwifery support during

his birth. This led me to explore birth practices and ensure that my next births were nothing like the first. It probably had some influence on me pursuing a midwifery career later on.

I started my career in midwifery after working as a registered nurse, with my last nursing position as an intensive care nurse at a major Adelaide hospital. During that time, I worked with many Aboriginal clients and families, mostly from rural and remote areas who were transferred to Adelaide for a higher level of care. I did have some difficulty connecting with the family members of the Aboriginal clients, although I wondered if this might have been related to the stress of having a loved one critically unwell in an unfamiliar environment. At that stage, I did not have any skills in working with other cultures or skills that would have facilitated an examination of my own position, influence and culture and how that might impact on my health care interactions. I do not recall undertaking any formal training within my nursing education or employment that provided me with any skills to explore my practice for Aboriginal clients.

After becoming a registered midwife, I eventually settled into a permanent clinical midwife position in a birth suite. I still work in that role. Similar to my nursing experiences I was caring for women and families from rural and remote areas, which sparked my interest in improving my clinical practice as a non-Aboriginal midwife. I was particularly interested in the way I connected with the Aboriginal women and families, and the challenges I experienced within those encounters.

I had completed the hospital cultural respect training, which made me consider how theory translated into practice. The training was a one-off mandatory session or split into three sessions. There were three core components: the history of South Australian legislation, impacts of colonisation, and communication with Aboriginal clients. My initial goal was to explore ways to make my care more acceptable to the women and families. I found at that time I was looking for advice or even a checklist for care with Aboriginal families. In doing further research, I came to consider the core concepts behind cultural safety and how these demanded an approach that required me to reflect on my own attitudes, behaviours and culture. Whilst exploring the research interest with my supervisors and Aboriginal Cultural Consultant, I determined that I could explore cultural safety in midwifery practice

in the standard care system. In order to achieve this I needed to also explore the experiences of the women.

1.4 A note of the use of 'Aboriginal' to represent both Aboriginal and Torres Strait Islander peoples within my study

Within the body of this thesis, following consultation with the Aboriginal Cultural Consultant working with me throughout my study, I have chosen to use the term Aboriginal to be inclusive of all Aboriginal and Torres Strait Islander peoples. I acknowledge and respect the autonomy and diversity within these communities. This is an acceptable practice in South Australia (SA Health 2013). The women in the study have used a variety of different terminologies when referring to themselves and to other Aboriginal and Torres Strait Islander Australians.

1.5 Birth and Pregnancy Outcomes

The most recent statistics from the South Australian Pregnancy Outcome Unit have shown that there were 717 Aboriginal women who gave birth, and there were 952 Aboriginal babies born in South Australia in 2013 (Scheil et al. 2015). The Aboriginal women experienced almost twice the rate of preterm birth and low birth weight births in 2013 when compared with non-Aboriginal women (preterm birth rate of 18% compared to 9.5%, and 14.8% low birth weight compared to 6.9%) (Scheil et al. 2015). The perinatal mortality rate for Aboriginal babies in 2013 was 15.1 per 1000 births compared to 8.8 for non-Aboriginal babies (Scheil et al. 2015).

At the time of recruitment (2014 to 2015), there were more Aboriginal women giving birth in the SHC system at the hospital where the study took place. In 2014, 69% (n=132), and in 2015 75% (n=133) of Aboriginal women gave birth in the SHC system. The remaining Aboriginal women gave birth within the continuity model of care.

Health disparity between groups is frequently attributed to socioeconomic factors (Anderson 2004; Donoghue et al. 2013; Helman 2007). However, these are not the only contributing factors, especially for Aboriginal peoples. Culture and cultural needs are also important when considering access, uptake, and service delivery to Aboriginal women and families within a westernised health system.

1.6 Cultural Care and Cultural Safety

Within my study I have used the definition of cultural safety by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2013, pp.8-9); they have outlined the essential components of cultural safety as:

- An understanding of one's own culture.
- An acknowledgement of difference, and a requirement that caregivers are actively mindful and respectful of difference(s).
- It is informed by the theory of power relations - any attempt to depoliticise cultural safety is to miss the point.
- An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on Aboriginal people's lives and wellbeing – both in the past and the present.
- Its presence or absence is determined by the experience of the recipient of care – it is not defined by the caregiver.

Within my research, I wanted to explore how midwives understood culture and how they provided care that they felt was culturally appropriate. This was labelled as 'cultural care', or 'care that incorporated Aboriginal women's cultural needs'. The midwives' understandings of culture are explored in chapter six. The women in the study were asked about their principles and values and/or ways and ceremonies, and how they interpreted their own Aboriginal cultures, and the ways they identified as Aboriginal women. This included their needs as Aboriginal women around birth and is presented in chapter five.

1.7 Research Aims

The overall aim of my study was to develop a deeper understanding of culture and how midwives provided care that incorporated Aboriginal women's cultural needs around birth. I also aimed to explore the lived experiences of Aboriginal women who chose, or who were required to give birth in the standard hospital care system (SHC). I wanted to gain an insight into their cultural needs, and how those needs were responded to during the birth of their babies.

1.8 Research questions

My research project aimed to answer the following questions:

1. What are the cultural expectations of Aboriginal women when accessing midwifery care in the SHC system during birth in a tertiary public maternity hospital in South Australia?
2. How do midwives provide care that they believe is culturally safe to birthing Aboriginal women in the SHC system at a tertiary public maternity hospital in South Australia?
3. What are the similarities and differences with the women's and midwives' experiences?

1.9 Summary of gaps in the literature

Nursing scholars have long identified the importance of being responsive to Aboriginal cultures in health care delivery (Best 2014; Ramsamy 2014; Sherwood & Edwards 2006). Research studies have shown the importance of culturally responsive services operating within diverse areas such as cancer services (Simpson et al. 2011; Thompson et al. 2011), cardiac services (Daws et al. 2014; Taylor et al. 2009), and mental health (Dingwall et al. 2015; Hepworth et al. 2015; Vicary & Bishop 2005).

There are many studies that investigate cultural safety in health care and its importance for Aboriginal peoples accessing health services (Bond & Brough 2007; Downing & Kowal 2011b; Freeman et al. 2014; Liaw et al. 2011). There is also research and discussion that investigates continuity, or targeted programs and culturally safe service delivery both in nursing and in midwifery (Gibbs 2005; Kildea et al. 2012; Parker, McKinnon & Kruske 2014; Phiri, Dietsch & Bonner 2010; Thackrah, Thompson & Durey 2015). It is clear within the health literature that programs that are developed to operate in a culturally sensitive manner are able to meet Aboriginal client's needs better than standard care services.

Midwifery research that specifically investigates Australian Aboriginal cultures and how care is experienced at birth is limited. There has been some work in midwifery that has explored the ways midwives understand culture and the subsequent impact on their practice (Williamson 2008). Investigations into antenatal care experiences have found that women

who access culturally tailored antenatal care programs in South Australia have more positive experiences, which could translate to improved outcomes for Aboriginal women (Brown et al. 2015). My study specifically investigated the lived experiences of birth outside of a continuity model and examined both the experiences of the women and the midwives. Whilst Aboriginal peoples should be offered health services that are designed, delivered, and evaluated by Aboriginal peoples, many are still not receiving care within continuity models or Aboriginal community controlled health services.

Culturally safe care can only be determined by the person accessing care; so the experiences of the women in my study are vital. My research approach has allowed for an exploration of contemporary midwifery practice, and the attitudes and behaviours of the midwives towards Aboriginal cultures and cultural safety in their practice in standard care. My study has also investigated how a small group of Aboriginal women are experiencing their midwifery care at a South Australian maternity teaching hospital. I have been able to develop insights into what was important to this group of women, how their cultures impacted on their experiences of birth, and their expectations for their midwifery care.

1.10 Research design and data collection

A qualitative research design was developed in order to meet the research aims and to explore the lived experiences of both the women accessing care and the midwives providing care in the SHC system. Heidegger's interpretative phenomenology was chosen as the philosophical foundation for my work due to its focus on lived experiences and the telling of narrative stories. An interpretative phenomenological approach can provide researchers with an opportunity to gain an in-depth, woman-centred understanding of a phenomenon (Spencer, Greatrex-White & Fraser 2015). Hermeneutic phenomenology aligns with a number of nursing research studies and offers potential to inform nursing practice (Annells 1996; Cohen 2000; Converse 2012; de Chesnay 2015). Similarly, midwifery research studies grounded in hermeneutic phenomenology can provide an opportunity to explore the lived experiences of midwives and the women who access their care. Phenomenological studies in midwifery offer a path to fully enter into, explore, and understand the relationships between women and their midwives (Berg et al. 1996).

Following ethical approval from the hospital human research ethics committee (HREC), university HREC and the Aboriginal Health Research Ethics Committee, recruitment commenced for volunteer women and midwives. The women and midwives participated in individual interviews, which were transcribed verbatim. I conducted the interviews with the midwives, and the interviews with the women were conducted by two Aboriginal interviewers who were engaged for this purpose. An Aboriginal Cultural Consultant also agreed to assist with all aspects of the study design, delivery and evaluation.

The de-identified interview transcripts were analysed informed by van Manen's (1990) six-step approach for data analysis. Van Manen's six-step method for hermeneutic phenomenological enquiry was used to guide the data analysis because of its foundations in Heidegger's work, and strong focus on narratives and lived experiences. Separate phenomenological interpretations were made from the women's and midwives' data. The philosophical underpinnings used in my study, and the connection with the methods used are explored in detail in chapters three and four.

1.11 Research setting

The research was conducted at a public maternity teaching hospital in South Australia. Several models of maternity care for women were available within the hospital. These included the SHC system, which involved attending a public clinic for antenatal care and giving birth within the hospital's birth suite with an unknown group of midwives and medical team.

Other options included the hospital continuity program, which involved care with a group of known midwives, and for Aboriginal women an AMIC worker. Aboriginal women from metropolitan areas may have been offered this option after their booking visit at the hospital where the study took place. Aboriginal women could also choose to have shared care with their general practitioner or engage a private obstetrician and attend the hospital birth suite for intrapartum care. Women who were transferred later in their pregnancies from rural and remote areas due to medical complications were not offered a place within the continuity program or the opportunity to engage with an AMIC worker.

Given the significant proportion of women choosing or being required to give birth in the SHC system, I found it important to explore the provision of a culturally responsive service for these women.

1.12 Structure of the thesis

I have written this thesis in monograph format. There are eight chapters and I will briefly outline the structure of my thesis in this section. The appendices and reference list are included at the end of my thesis. Two publications based on my research were submitted and accepted by Women and Birth (a peer reviewed journal) and are co-authored by my research supervisors. I have included them in the appendices (appendix nineteen and twenty). Quotes that support both the women's and the midwives' themes are presented in chapters five and six. The participants used Australian slang within their interviews and this has been left as it was said to not detract from the meaning that was implied.

- **Chapter two - Literature review**

  Chapter two provides a comprehensive and critical review of the literature relating to culture and culturally appropriate midwifery care for Aboriginal women. Cultural safety and racism is explored and the deficits in the available research are identified, which support the development of this research study.

- **Chapter three - Philosophical foundations**

  Chapter three identifies the philosophical foundations of my study and how they inform the methods used within this project. Heidegger's and van Manen's work are discussed and connected with the research aims and questions of my project.

- **Chapter four - Methods**

  Within chapter four I outlined the methods used within my study. Sampling, recruitment, interviewing, data management, ethical implications, and van Manen's (1990) six step data analysis technique are outlined. Reflexivity in the research process is discussed and rigour is explored.

- **Chapter five - Phenomenological interpretation for the women**

Chapter five presents the phenomenological interpretations made from the Aboriginal women's data. The six main themes and sub-themes are presented and verbatim quotes from the interviews are provided to support the themes and subthemes.

- **Chapter six - Phenomenological interpretation for the midwives**

  Chapter six presents the phenomenological interpretation that was developed out of the midwives' data. The six main themes and subthemes are presented with verbatim quotes from the midwives' interviews that support the themes.

- **Chapter seven - Discussion**

  Within chapter seven I provide a detailed discussion surrounding the women's and midwives' data. The similarities and differences in the ways culture is understood and considered when accessing or providing care in the SHC system is explored. The similarities and differences in the midwives' and women's experiences are also investigated and critically analysed.

- **Chapter eight - Conclusions and recommendations**

  Within chapter eight I explore how the research study has met the research aims and research questions. I also make recommendations for practice at the hospital where the study took place. I explore the strengths and limitations of the study and conduct an evaluation of the thesis guided by Walsh and Downe's (2006) eight criteria for the evaluation of qualitative studies.

1.13 Summary

In this chapter I have provided the background and significance of my study, shared the development of my interest in this work, identified the research aims and research questions, and outlined the research design and setting. The core concepts of cultural care and cultural safety are provided. A summary of the gap in the literature is provided, and the structure of this thesis outlined. In the next chapter, I will explore the literature surrounding culture and culturally appropriate midwifery care for Aboriginal women in

order to give context to and support for the research aims and questions that guided my study.

Chapter 2 | Literature Review

"We know we cannot live in the past but the past lives in us." Charles Perkins, Aboriginal Activist (cited in Read 1984, p. 3)

2.1 Introduction

Midwives are required, as part of their national competencies, to provide *culturally safe* care to Aboriginal women. What does cultural safety mean? How do the Aboriginal women who access birthing services outside of the culturally tailored programs experience their midwifery care? In this chapter I will explore the literature surrounding culture and cultural safety as it applies to providing midwifery care for Aboriginal women. I will argue that the significance of birth as a transformative event in a woman's life requires an examination of Aboriginal women's birthing needs and experiences. Existing literature will be explored and the confusion around the interpretations of the meaning of culture and the nomenclature relating to cultural training will be outlined and explored.

2.2 Search Strategy

The literature review was conducted using a wide range of sources as outlined in Table 1.

Table 1 - Database and online sources searched

Databases		
CINAHL	RURAL – rural and remote health database	Joanna Briggs Institute
Google Scholar	Indigenous Australia	Medline Plus
Informit Informit Indigenous databases	ATSI health Aboriginal and Torres Strait Islander health bibliography	OVID nursing database
PubMed	iPortal: Indigenous studies portal	Wiley online library
UNISA research archive	ProQuest	TROVE
Health sciences a SAGE full text collection	Health Collection	
Online Sources		
Australian Indigenous Health Bulletin	The Lowitja Institute. http://www.lowitja.org.au/	The Aboriginal health Council of South Australia.

http://healthbulletin.org.au/		http://www.ahcsa.org.au/
The Australian Institute of Health and Welfare. http://www.aihw.gov.au/indigenous-australians/	Australian Indigenous HealthInfoNet. http://www.healthinfonet.ecu.edu.au/	SA Health. http://www.sahealth.sa.gov.au/
The South Australian Pregnancy Outcome Unit. http://www.health.sa.gov/pehs/pregnancyoutcome.html	The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. http://catsinam.org.au/	

The data bases, as outlined in Table 1, were searched using various combinations of the key words as listed in Table 2. For example, midwife* (midwifery, midwives or midwife) was searched with a truncation symbol and connector words (AND, OR) and another key search term e.g. culture* (cultural, culture). This began at the beginning of my candidature and continued throughout my candidature until submission. Various web sources were also checked regularly during my candidature (last searched February 2016) for the latest information, links and research summaries as outlined in Table 1. Many of the web pages of the Aboriginal organisations e.g. http://www.lowitja.org.au/published-research, provide regular updates and summaries of research relating to Aboriginal health. I would then go to the original source to review the literature. Alerts were created which enabled all relevant source information to be explored throughout my candidature.

Although I started the study with a literature review, this mainly explored the concepts around culture, cultural care and how midwives learnt about them. It also explored Aboriginal women's experiences accessing standard care. As the interviewing and analysis stages progressed, issues of interest or relevance were identified. This would subsequently focus my interest and the literature in those areas would be explored. For example, as racism became apparent in the midwives' interviews, it directed a level of enquiry to explore other work relating to this.

Table 2 - Key words for literature searches

Aboriginal*	Aboriginal cultural* awareness training	Aboriginal AND health	Racism*
Indigenous*	Aboriginal AND cultural* safety	Aboriginal AND/ OR birth*	Racism AND/OR health
Torres Strait Islander	Cultural* safety	Aboriginal AND/OR maternal health	Difference blindness
Aboriginal AND women*	Cultural* competency	Phenomenology*	White privilege
Aboriginal AND culture*	Cultural* care/ AND/OR midwife AND/OR Aboriginal	Phenomenology AND Heidegger*	Culture* AND midwife*
Aboriginal AND/OR health AND/OR Culture*	Culture*	Phenomenology AND hermeneutic	Cultural* awareness
Cultural* safety	Equitable* access OR health care outcome	Phenomenology* AND/OR midwifery*	Cultural* safety AND/OR birth AND/OR Aboriginal*

Searching of all the databases originally occurred with a ten-year publication restriction but was expanded to include all time periods due to the dearth of literature relating to the topic. Government websites and SA Health web sites were also explored to gain access to various policies, frameworks and procedures relating to Aboriginal health in South Australia.

2.3 Historical background

Aboriginal Australians have a long history and it is thought that they have populated Australia for as much as 100,000 years (Hampton & Toombs 2013b) and beyond into the Dreaming. When the British colonised the Australian continent in 1788, the common

perception was that the Aboriginal population was a single race, although at that time there were approximately 200 Aboriginal language groups and many more dialects (Hampton & Toombs 2013b). Estimates of the population at that time was approximately between 300,000 and 1,000,000, and the South Australian Aboriginal groups were estimated to be approximately fifty (South Australian Centre for Rural & Remote Health, Spencer Gulf Rural Health School & Adelaide University Rural Clinical School 2001). At colonisation, Aboriginal cultural groups were 'numerous, diverse and dynamic' (Hampton & Toombs 2013b, p.17). Australian Aboriginal cultural identity was:

> …based on language, belief systems, social kinship structure, social behaviours, and links to land. Discrete bands linked with other bands, connected by marriage, language, and country, into broader social structures inextricably connected to country by Dreamings which defined their belief systems (Hampton & Toombs 2013b, p.17).

Following colonisation and continuing to the present day there were many government policies that have contributed negatively to Aboriginal experiences within their communities and with their land (Taylor & Guerin 2010). These included policies of segregation, assimilation, integration, and the forced removal of children from 1910-1970 (Taylor & Guerin 2010). Taylor and Guerin (2010) have said that past welfare policies still influence access to mainstream health services today due to the strong history of oral storytelling within Aboriginal communities. The past has had a major influence on the way Aboriginal peoples now view and interact with health services, and trust is a major barrier to effective interactions. Culturally unsafe encounters that arise from the provision of culturally inappropriate care can have a negative impact and influence the subsequent health care access for an Aboriginal person throughout their life (Blackman 2011).

2.4 What is culture?

Culture is challenging to define, and a number of theorists have provided their definitions. In the Oxford Dictionary (2000) culture is described as a combination of ideas, customs, and social behaviours that shape a people or society. Welsh academic, theorist and critic Williams (1976, p.87) has described culture as one of most complicated words in the English language. Culture is complex, and is expressed in ways that can regulate life through customs, etiquette, taboos, or rituals (Tseng & Streltzer 2008). Culture also manifests itself in the activities of daily life and is reflected in cultural products such as

sayings, legends, drama, art, philosophical thought, religion, and political and legal systems (Tseng & Streltzer 2008). Culture is not static (Bishop 2004; Eckermann et al. 2010; Fredericks 2003), and is a concept that is frequently misused and misunderstood as it is never homogenous. Indeed, it is strongly suggested that making generalisations about people's beliefs and behaviours should always be avoided as this could lead to cultural misunderstandings, prejudices, and discrimination (Helman 2007).

Hampton and Toombs (2013b) have described culture as the learned patterns of thought, action, understanding, and history through which a group of people engage and interact with the world and with others. They have also described culture as a framework for a person to develop an understanding of customary behaviours that are not obvious to outsiders (Hampton & Toombs 2013b). Some scholars have attempted to define Australian Aboriginal cultures, and Gee et al. (2014) have suggested that Aboriginal cultures consist of collectively shared values, principles, practice, customs, and traditions. However, caution is advised as culture is frequently merged with race, ethnicity, or even religion, which fails to capture the diversity in a population (Fung et al. 2012; Thackrah & Thompson 2013a). Other scholars have highlighted how Aboriginal cultures are frequently defined by non-Aboriginal people and almost entirely refer to iconic representations of classical symbols and ceremonies rather than contemporary or traditional customary practices (Cowlishaw 2011).

Williamson and Harrison (2010) have contended that there are two approaches to culture within the nursing and midwifery literature. The first is cognitive, whereby people are grouped together according to their common features (language, beliefs, and traditions) (Williamson & Harrison 2010). The second approach situates culture within a wider framework where social position helps to explain health differences and includes the impact of colonisation for Aboriginal peoples (Williamson & Harrison 2010). Bourque-Bearskin (2011) has suggested that by adopting the second approach it forces the consideration of how culture can be socially constructed from within an historical perspective, which subsequently reflects the values and assumptions from that process. This challenges health care workers to expand their understanding of culture beyond a more simplistic view. Any approach to culture and practice for Aboriginal peoples that includes

the history of colonisation is more meaningful than focusing on traditional beliefs and values (Williamson & Harrison 2010).

Mick Gooda (2011), the Aboriginal Social Justice Commissioner, described Aboriginal cultures at the James Martineau Memorial lecture held in Tasmania in the following way:

> Any understanding of culture therefore, must recognise the diversity within our communities. It is of fundamental importance that this point is grasped – that Aboriginal and Torres Strait Islanders have the right to maintain a cultural identity whilst also participating in the mainstream. The two are not mutually exclusive. We call it walking in two worlds, yet our capacity to do this often eludes the understanding of the wider population. Similarly, the point is not always understood that Aboriginal and Torres Strait Islander ties to community, culture and country are not something an individual can opt to set aside, but are intrinsic elements of their humanity.

Historically, Aboriginal peoples have participated in an ongoing struggle for equality and Aboriginal peoples have retained their cultures which have strengthened in recent times (Dudgeon et al. 2014). They share a continuing legacy of strength, resilience, and determination (National Aboriginal and Torres Strait Islander Health Plan 2013-2023 2013). Various understandings and educational frameworks have evolved to facilitate Aboriginal people's connection to their cultures so that health workers can engage better with Aboriginal peoples. It is important for health workers to explore the way these understandings and frameworks might influence their practice and how they can be used to positively support their engagement with Aboriginal peoples accessing health care.

2.5 Cultural understandings

Scholars have referred to different paradigms when discussing cross-cultural education and understandings. They include (but are not limited to) cultural respect, cultural awareness, cultural safety, cultural competence, cultural competency, and cultural security. These concepts are frequently used interchangeably and understood in slightly different ways within the literature. Taylor and Guerin (2010) have described cultural awareness and cultural respect training as highlighting the issues surrounding Aboriginal people's history, the effects of colonisation on health outcomes, and the diversity of Aboriginal peoples. Their research also determined that there may not be any influence on the subsequent care delivery as the approach did not require the health care providers to make any changes to their practice (Taylor & Guerin 2010).

Downing, Kowal, and Paradies (2011) have criticised cultural awareness models because they have a limited conceptualisation of culture and identity and have focused on teaching 'other cultures' at the expense of an examination of the culture of the health professionals. They also found that cultural awareness models contributed to the essentialism of Aboriginal cultures, or in other words, the idea that Aboriginal culture(s) could be described, taught, and understood (Downing & Kowal 2011a). Fredericks (2003) found that cultural awareness training could raise awareness and improve communication between health care providers and Aboriginal peoples. However, she conceded that it could have little or no impact on some participants and that it could never produce organisational structural change (Fredericks 2003). In contrast, Downing and Kowal (2011a) later found that a shift towards a cultural safety model could provide the opportunity to explore the power differentials between Aboriginal and non-Aboriginal peoples and therefore advance cultural training for health workers.

The concept of cultural safety was initially developed by nurse and scholar Irihapeti Ramsden in New Zealand (Pairman & McAra-Couper 2015). This was in response to the poor health status of the Maori Indigenous people and the negative influence of colonisation on Indigenous health (Durey et al. 2011; Eckermann et al. 2010; Fredericks 2003; Koptie 2009). Coffin (2007) described cultural safety in the context of health care as working with individuals or families and comprising of small actions and gestures that were usually not defined in policy and procedures within the organisation. Other scholars have described cultural safety as the pinnacle of good practice (Eckermann et al. 2010; Kruske, Kildea & Barclay 2006; Phiri, Dietsch & Bonner 2010; Taylor & Guerin 2010), and something that should be aspired to by all health care workers. Cultural safety has the potential to promote a more critical discourse on culture and health inequality that incorporates historical, political, and socioeconomic factors (Gerlach 2012).

Williamson and Harrison (2010) have argued that a cultural safety model has the potential to help health professionals meet the cultural needs of women from culturally and linguistically diverse (CALD) backgrounds, but have acknowledged that health professionals are unclear as to what cultural safety actually means. It is argued that cultural safety is not something that the practitioner, system, organisation, or program can claim to

provide but is something that must be *experienced* by the people who access health care (Walker, Schultz & Sonn 2014).

Midwives who adopt a cultural safety model of practice can help women feel physically, spiritually, socially, and emotionally safe when accessing maternity care (Kruske, Kildea & Barclay 2006). Nurses (and midwives) who do not learn and explore cultural safety may have only their own stereotypes and misleading myths to guide their attitudes towards Aboriginal Australians (Best 2014). The provision of culturally safe maternity care is an element of midwifery competency and will be discussed further in section 2.10. The Congress of Aboriginal and Torres Strait Islander Nurses' and Midwives' (2013) definition includes the practitioner requiring an understanding of their own culture, acknowledgment of difference, is inclusive of power relations, and is the experience of the recipient of care.

Cultural competence is another term used throughout the literature. However, again there is no clear consensus regarding the definition (Brach & Fraser 2000; Stewart 2006). Stewart (2006) argued that the difference between cultural competence and cultural competency training was that the latter was a much narrower term that labelled specific skills that were observable and assessable. Conversely, she described cultural competence as comprising of action, accountability, and reciprocity between a health service provider and a consumer (Stewart 2006). Westwood and Westwood (2010) also used the term cultural competence, but included in that definition not just the individual responses in attitudes and behaviours but the health system as a whole; this has illustrated the merging of the terms competence and competency and the lack of consensus in the literature. Walker, Schultz and Sonn (2014) have described cultural competence as a *dynamic-in-interaction* that demands critical reflection/reflexivity by interrogating and integrating Aboriginal and Western knowledge systems and critically reflective practice at the cultural interface. They have also described the essential elements of cultural competence as inclusive of knowledge, values, skills, and attributes (Walker, Schultz & Sonn 2014).

Research conducted by Downing and Kowal (2011b) consisted of interviews with six nurses in a Northern Territory hospital into how they perceived Aboriginal cultural training and the impact on their professional practice, using a semi-structured interview technique. Thematic analysis revealed that the nurses felt their workplaces were culturally unsafe for

their patients and three of the six participants identified overt and covert racism within their institutions (Downing & Kowal 2011b). The findings from a small participant group cannot be generalised to reflect all cultural training programs for all health workers but can make a contribution to the discussion surrounding cultural education programs for health care workers (Downing & Kowal 2011b).

Chun (2010) has argued that a major weakness of cultural training of medical professionals is the lack of a standardised and validated method to measure its impact. She explained that being culturally competent can be viewed as 'unscientific' because of the lack of standardised definitions and methodology for the curriculum, and because there is minimal evidence of the efficacy of the training (Chun 2010). This is important because there is minimal research to suggest that there is a positive relationship between cultural training for health workers and improved outcomes for the patients (Clifford et al. 2015; Lie et al. 2011). More research needs to be carried out using validated indicators to measure what works in the development of culturally competent health services for Aboriginal peoples (Bainbridge et al. 2015).

Other researchers have stated that the problem lies with the lack of measurement in cultural competency training coupled with the view that 'culture' is a 'confounding variable that white practitioners must deal with' (Kumas-Tan et al. 2007, p.555). Sherwood (2010) argued that health care systems and providers are blaming Aboriginal peoples for their health status by the very nature of the Westernised systems of care that do not contextualise Aboriginal peoples' past history or provide culturally safe care.

Coronado (2013) has identified evaluation of the training as problematic because multi-dimensional constructs are involved. Not only does evaluation need to consider trainee, trainer, and organisational characteristics but outcome variables such as reduced health disparity must also be considered (Coronado 2013). A recent systematic review of interventions designed to improve cultural competency found a lack of evidence from rigorous evaluations on the efficacy of interventions designed to improve cultural competency for Aboriginal peoples (Clifford et al. 2015). The systematic review explored 17 electronic databases and 13 websites from 2002-2013 and identified 16 published evaluations of interventions designed to improve the cultural competency of health care for

Aboriginal peoples (Clifford et al. 2015). Of the evaluations, 11 were for the Aboriginal peoples of America and five for Aboriginal Australians (Clifford et al. 2015). The researchers determined that future evaluations should use more rigorous study designs and measure outcomes relating to the health of Aboriginal peoples (Clifford et al. 2015). Grant, Parry, and Guerin (2013) have suggested that when writing policies in health care it would be useful to actually define the cultural competency terminology within the policy. This would be a beneficial suggestion in order to remove some of the confusion surrounding the nomenclature.

A research study that explored health care providers and Aboriginal renal patients' experiences whilst undergoing haemodialysis found that health care providers (HCPs) needed improvements in their cultural training uptake (Rix et al. 2013). The study involved interviews with 18 Aboriginal patients and 29 HCPs from a rural setting in Australia. The research findings from interviews with both groups called for the development of better relationships with Aboriginal peoples through targeted education within the health care unit itself, and offering sustained relationships with Aboriginal peoples and continuing opportunities to learn (Rix et al. 2013). Although this study was not orientated towards women and birth it does offer some insight into potential opportunities to improve the cultural education for the staff and, in turn, the Aboriginal peoples who access their care.

There is an abundance of literature relating to teaching and learning of cultural skills for health workers both nationally and internationally. The different terms used are frequently used interchangeably, but they are useful when understanding the broader issues that impact on health. Cultural safety, competence, competency, responsiveness, and security usually refer to a more advanced understanding of the social, historical, and political factors that impact on health care. Whether or not they are making a difference to the experiences of Aboriginal Australians can only be answered by exploring the experiences of health care providers and, more importantly, the experiences of the Aboriginal peoples accessing health care.

2.6 Culture and health

Similar to the challenges surrounding the approaches to defining culture and cultural competence, when one seeks to link culture to health, researchers express differing views.

As such it is important that these are explored as the notion of culture and health for Aboriginal Australians is central to this study. Aboriginal peoples' experiences of dispossession, interruption of culture, and intergenerational trauma have significantly impacted on the health and wellbeing of Aboriginal peoples (National Aboriginal and Torres Strait Islander Health Plan 2013-2023 2013). Houston (2009, p.102) argued that the 'right to culture' for Aboriginal peoples must be inclusive of efforts to safeguard against the erosion of Aboriginal cultural patterns and expectations by institutions and services of the dominant society. How Aboriginal peoples view wellness and illness are in part based on cultural beliefs and values (Houston 2009). Houston (2006, p.209) has explained that equity in health care for Aboriginal peoples must be framed with Aboriginal values, contending that:

> Australia has always juxtaposed its objectives for Aboriginal people in terms wrapped in sameness with non-Aboriginal Australians – same education, same housing, same health, same jobs, same values, etc. But Aboriginal people have always framed our future in terms of difference – Aboriginal culture, Aboriginal values, Aboriginal spirit, Aboriginal community control, and Aboriginal self-determination.

Integrating Aboriginal cultural knowledge into health care delivery can contribute to improvements in health service acceptability (Aspin et al. 2012). Some studies have attempted to explore medical professionals' views on culture and health. Rasmussen (2001) reported on focus group findings (seven focus groups with 25 to 30 students per session) with fifth year medical students, and suggested that it was common for the students to hold a binary oppositional view of Aboriginal culture(s), which was defined through and against a western culture. The students saw these cultures pitched against each other, viewing the Aboriginal culture(s) as the 'primitive' culture(s) that was separate from the contemporary status. Rasmussen (2001) also described how the students viewed Aboriginal populations living in urban areas as 'cultureless' and therefore being no different from anyone else, as opposed to the Aboriginal populations from rural and remote areas who were 'real' but located in the past.

Health professionals' assumptions about how an Aboriginal woman might interpret her own 'culture' have contributed to raising barriers to the future access of health care to that woman (Dunbar & Ford 2011). Dunbar and Ford (2011, p.30) have called for maternity

care providers to acknowledge the 'dynamic and evolutionary' nature of culture which will assist the health care provider to develop the capacity to engage with Aboriginal women.

Given the findings of the above studies it is evident that health institutions and health workers must be able to respect and respond to Aboriginal principles and values whilst still understanding the extreme effects of colonisation and its continuing legacy on the health, wellbeing, identity, and culture of Aboriginal peoples (Liaw et al. 2011). A further study consisted of interviews with 12 key informants, eight of whom were Aboriginal health care workers or Aboriginal patients and four were non-Aboriginal health care workers. The interviews formed part of an ethnographic qualitative research study in Queensland aiming to identify cultural barriers to health care for Aboriginal peoples (McBain-Rigg & Veitch 2011).

The researchers found that the cultural barriers were experienced differently by Aboriginal patients and health practitioners (McBain-Rigg & Veitch 2011). For the Aboriginal patients the focus was on interpersonal relationships between themselves and the health care providers, and the creation of comfortable physical environments was seen as a token gesture if it was not coupled with trusting interpersonal relationships (McBain-Rigg & Veitch 2011). The study also discovered that the Aboriginal patients talked about issues tied to people and relationships compared to the health workers, who seemed to identify a more simplistic view with issues such as things people should and should not do when working with Aboriginal patients (McBain-Rigg & Veitch 2011). 'Difference blindness' was identified as an issue with some of the health practitioners being unable to acknowledge that Aboriginal peoples had needs that were specific to their cultural background and historical contact with the Westernised medical model of health care (McBain-Rigg & Veitch 2011).

Achieving cultural safety within health care has the potential to boost positive health outcomes through acceptance of Aboriginal peoples for their differences from mainstream Australians (van den Berg 2010). Cultural safety demands attitudinal changes from health staff; this has the potential to alter the negativity associated with Aboriginal peoples and to recognise their value to Australia's past, present, and future (van den Berg 2010).

It is also important to consider the professional subcultures that exist within the medical and midwifery professions, and how these subcultures also form significance when examining culture in health care. Helman (2007) notes that members of health professions have experienced a process of 'enculturation' over their careers that can contribute negatively to communication and relationships formed with people who access their care. He said that health care professionals slowly acquire the culture of their profession which leads to them developing a different perspective on life from those outside the profession (Helman 2007). The subculture that develops shares concepts and, values, and has its own distinctive features (Helman 2007).

Denial of white privilege is also an issue when considering health care and access for Aboriginal Australians, with Dunn and Nelson's (2011) research illustrating that there is a lack of acknowledgment of cultural privilege amongst many Anglo-Australians. Their research looked at the data from the Challenging Racism Project in 2001-2008, with over 12,000 telephone surveys from all states and territories in Australia (Dunn & Nelson 2011). Anglo-Australian people perceived that whilst racism existed they were unable to see themselves attached to the privilege that flows from the racism (Dunn & Nelson 2011). This is also relevant for maternity care, and for further understanding to be forged it is important to consider the significance of birth and previous experiences of Aboriginal women accessing Westernised health services.

A study, which was part of a larger action research project funded by the South Australian Department of Health, explored 26 health care workers from public South Australian hospitals and their perceptions regarding the implementation of cultural respect policy and attention to health equity for Aboriginal patients from rural and remote areas (Dwyer, Willis & Kelly 2014). Staff that had experience caring for Aboriginal country clients were approached and participated in interviews either individually or in pairs. Open ended questions were used and participants were asked about the provision of care and to identify barriers and their underlying causes, and strategies to address them (Dwyer, Willis & Kelly 2014). The researchers found a systemic misinterpretation of the principle of equal treatment, which acts as a barrier to the development of culturally competent organisations and institutions (Dwyer, Willis & Kelly 2014).

Aboriginal community controlled health services are operating across Australia in many areas. They can be a more acceptable model of care for many Aboriginal peoples (Khoury 2015; Ward, Fredericks & Best 2014). The health services are developed, managed, and controlled by the communities in which they serve (Ward, Fredericks & Best 2014). A qualitative study in Brisbane that explored Aboriginal medical services and Aboriginal community controlled services demonstrated improved health care seeking rates, improved health education, and addressed mental health concerns whilst still operating in a culturally appropriate way (Baba, Brolan & Hill 2014). The study involved focus group meetings with clients of the health services. The participants spoke of fear of mainstream services and the acceptability of services that met their cultural needs (Baba, Brolan & Hill 2014). Although this was a small Brisbane based study, other published research has also supported the acceptability of culturally appropriate health services to Aboriginal peoples (Bertilone & McEvoy 2015; Brown et al. 2015; Homer et al. 2012; Josif et al. 2014; Khoury 2015; Stoneman et al. 2014).

2.7 Aboriginal birthing outcomes and policy interventions

Kingsley et al. (2013) suggested that by understanding the social and cultural determinants of health, the health inequalities between Aboriginal peoples and non-Aboriginal peoples could be reduced. As outlined in chapter one (section 1.5), South Australian Aboriginal women have experienced almost twice the rate of preterm birth and low birth weight births in 2013 when compared with non-Aboriginal women (Scheil et al. 2015). South Australian Aboriginal women in 2013 also experienced higher rates of perinatal and infant mortality when compared with non-Aboriginal women (15.1 compared with 8.8 per 1000 births).

Government policies and programs have been developed in order to target the health disparity and achieve equity in health outcomes. These policies include the National *Close the Gap* statement of intent (Indigenous Health Equality Summit 2008), which was signed in 2008. The statement of intent was a commitment for the government to work together with Aboriginal peoples, and was supported by non-Aboriginal peoples and organisations to achieve equity in health outcomes by the year 2030. The statement of intent included a commitment to the provision of *appropriate* health services to Aboriginal peoples. The Australian Government also released the National Aboriginal and Torres Strait Islander

Health Plan 2013-2023, which reflected the partnership between the government, Aboriginal and Torres Strait Islander peoples, and their community organisations. The key priorities within the health plan all centre around culture. Culture within a health context is described as Aboriginal peoples having the right to live a healthy, safe, and empowered life with a healthy, strong connection to culture and country (National Aboriginal and Torres Strait Islander Health Plan 2013-2023 2013). Wellbeing for Aboriginal peoples incorporates the broader issues of social justice, equity, and rights (National Aboriginal and Torres Strait Islander Health Plan 2013-2023 2013) and this is also an important consideration within the delivery and access to health services.

The *Close the Gap* strategy has been criticised by some scholars (Altman 2009; Azzopardi & Gray 2010; Dockery 2010; McMurray 2011; Pholi, Black & Richards 2009; Saggers, Walter & Gray 2011; Sansbury 2012). By reducing the health inequality to statistical indicators of deficit, which are then rectified against government-set targets, power and control over Aboriginal health is reinforced (Pholi, Black & Richards 2009). Altman (2009) described the *Close the Gap* framework as one that measured the socioeconomic disadvantage of a sub-population and that it was not in fact a new approach within Australian political history. Pholi, Black, and Richards (2009) explained that by constructing Aboriginal Australia within statistical disadvantage, the entire approach created a dichotomy that aligned sickness with Aboriginal and health with whiteness, and that the entire approach lacked critical reflection. Dockery (2010) described a tension between maintenance of Aboriginal culture(s) and achievement of socioeconomic equity as 'self-determination' versus 'assimilation'.

South Australian Aboriginal man Tauto Sansbury (2012) has labelled the government's *Close the Gap* initiative as a failure and has called for Aboriginal peoples to lobby the government and take control of their own health. Other academics have encouraged non-Aboriginal people to consider more than the statistics themselves, and to consider where the representations of Aboriginal Australia have been developed, or in other words, to consider that the representations are delivered within a colonising context and are not from Aboriginal peoples themselves (Anderson 2004; Saggers, Walter & Gray 2011).

However, Goold (2010/2011) saw *Close the Gap* as not just as an important means to improve the health statistics but as a framework that demanded active, sustained, and inclusive professional thinking and deeds. Other scholars have seen the *Close the Gap* campaign as an effective means to raise awareness of the health inequality and to also highlight health as a human rights and social justice issue (Laycock et al. 2011). Eckerman et al. (2010) advised caution because they felt that the *Close the Gap* measures must be accompanied with inclusive decision-making processes that support community development and capacity building. Eggington (2012) has described the key to achieving health equity as culture, noting that there is a failure to acknowledge that culture is paramount when considering access or barriers to health care for Aboriginal peoples. He also said that when one is not comfortable in one's own culture, there is a flow-on effect to health, and he has described a day-in and day-out demeaning of Aboriginal culture as leading to the demoralisation of Aboriginal peoples (Eggington 2012).

Much of the health disparity that is experienced by Aboriginal peoples occurs in areas that are considered to be unquestioned rights by all other Australians (Behrendt 2001). A human rights-based approach to policy is vital in order to address disadvantage in Aboriginal and Torres Strait Islander communities (Aboriginal and Torres Strait Islander Social Justice Commissioner 2015).

SA Health has also developed various plans and policies that ultimately have been orientated towards achieving a narrowing or closing of the gap in Aboriginal health outcomes. The South Australian Aboriginal Health Care Plan 2010-2016 (South Australian Department of Health Statewide Service Strategy Division 2010) was designed to specifically target Aboriginal health and wellbeing by achieving a culturally responsive health care system and promoting the health and wellbeing of the Aboriginal population. The health care plan makes frequent references to culturally safe services and culturally responsive services, but lacks any clear definitions of how that translates into clinical settings. The plan did direct that in order to build a culturally responsive health system, clinicians would require cultural competency training (under the cultural respect framework) and the development of a cultural security policy, protocols, and standards in hospitals and health services (South Australian Department of Health Statewide Service

Strategy Division 2010). Russell (2013) calls for an approach to Aboriginal health that is grounded in three principles; shared decision making, addressing the social determinants of health, and addressing the cultural barriers as defined by Aboriginal peoples.

2.8 Aboriginal women and birth

Birth is often described as a significant and transformative event in a woman's life (Dunne, Fraser & Gardner 2014; Jacinto & Buckey 2013; Larkin, Begley & Devane 2009; Overgaard, Fenger-Grøn & Sandall 2012; Parratt 2002; Rice 2011; Sessions 2013). Schneider (2012) described how health care professionals must be able to find a way to help women discover the meanings and transformative qualities of childbirth by creating space for women to explore their birthing context and how that interfaces with their own beliefs. Everything that happens during the birth will affect the mother's memory of the birth of her baby (Eliasson, Kainz & von Post 2008). Providing women with experiences that are respectful, considerate and focused on their individual needs has potential to make the transformative experience a positive one. Notwithstanding this, whilst birth has the potential to be a positive and empowering experience for women (Newman 2009; Parratt 2002; Sessions 2013), some mothers are subordinated and objectified by medical practices (Newman 2009; Sessions 2013). Negative experiences can also contribute to post traumatic stress syndrome, anxiety and depression (Overgaard, Fenger-Grøn & Sandall 2012), which can lead to a number of negative impacts including reduced maternal infant bonding.

Crowther (2013) found that the location of birth can be a source of potential conflict because the place can be exclusionary given its defined boundaries, rules, and systems, which she described as placing birth within an inflexible technocracy. Newman's (2009) qualitative hermeneutic research into the maternity experiences of metropolitan South Australian women (n=38, although not specifically Aboriginal) highlighted women's dissatisfaction with their intrapartum care delivered within the mainstream medical model. The research involved in-depth interviews with participants and thematic data analysis (Newman 2009). She found that the Westernised maternity care services did not meet the needs of a significant number of maternity care consumers (Newman 2009).

Women who accessed care from the Aboriginal Family Birthing Program, both in regional and metropolitan areas in South Australia, were more likely to rate their care favourably

than those attending mainstream services (Brown et al. 2015). The institutional system of maternity care, lack of opportunity for midwives to practice to the full role of midwifery, and the domination of the medical model also act as a barrier for midwives practicing to the full scope and role of midwifery in Australia (Homer et al. 2009).

With respect to birthing Aboriginal women, Bryant (2010) has called for midwives to ensure that all Aboriginal women have their spiritual, cultural, and physical needs cared for whilst giving birth. Given that Aboriginal women still experience a lack of understanding within Westernised health services, it is of no surprise that programs which have handed back birth and birthing to Aboriginal women have been so successful for Aboriginal women. Women birthing within the South Australian system have the option of accessing the Aboriginal Family Birthing Program (AFBP), where their care is provided within a partnership continuity model with an Aboriginal Maternal Infant Care (AMIC) worker and a midwife (Brown et al. 2015). The service is available in rural and metropolitan areas in selected sites and was developed to provide a culturally appropriate service in local and tertiary care centres. Aboriginal women then receive care that lies within a continuity model, that is flexible, and is provided by other Aboriginal women working in partnership with other health care providers (Richards & Foale 2011). The AMIC program facilitates skill sharing and two-way learning between the AMIC workers and the midwives whilst still maintaining cultural safety for the women who access the service (Stamp et al. 2008).

However, the popularity of these programs in reality means that many women wishing to access the models will not be successful due to a lack of availability; some women will not be offered the service and some women will choose not to access these services. It is also important that culturally responsive care in health service delivery is not only operating in targeted programs. For those women that access mainstream services it is argued that the cultural competence of the health workers must be achieved (Clarke & Boyle 2014). Health providers and policy makers should maintain a health sector that is able to respond to the needs of Aboriginal Australians in all areas of service provision (Burchill, Lau & Pyett 2011).

Aboriginal women accessing mainstream services encounter many challenges that are linked to historical factors, family responsibilities and kinship, and the health care system itself (Kosiak 2014). Kosiak (2014) explained that Aboriginal women are linked to their families and their past in many different ways, and family business always takes precedence over the individual woman's needs. This can be at odds with mainstream health services and the care providers (Kosiak 2014).

Continuity of midwifery care programs for Aboriginal women exist across Australia (Bertilone & McEvoy 2015; Brown et al. 2015; Crook et al. 2012; Homer et al. 2012; Josif et al. 2014; Stamp et al. 2008) Culturally safe midwifery care is easier to achieve when there is continuity of care that values the relationship between the woman and her midwife (Phiri, Dietsch & Bonner 2010). Power differentials between the woman and midwife can be reduced with continuity of midwifery care that operates towards a cultural safety model (Kosiak 2014).

A Perth based Aboriginal Maternity Group Practice program was able to demonstrate improved neonatal outcomes for babies born to the mothers who participated in the culturally responsive service (Bertilone & McEvoy 2015). The program employed Aboriginal grandmothers, Aboriginal Health officers, and midwives who worked in partnership to provide antenatal care to Aboriginal women (Bertilone & McEvoy 2015). Babies born to the mothers who participated in the program were at lower risk of adverse health outcome including preterm birth, and the program gave women the opportunity to give birth locally and safely in a culturally safe manner (Bertilone & McEvoy 2015).

Sydney based, Malabar Community Midwifery Link Service was developed to meet the needs of the local Aboriginal community (Homer et al. 2012). It provides a community-based continuity model of care where women access care from a midwife and an Aboriginal Health Education Officer, and the care is provided antenatally, during birth, and postnatally (Homer et al. 2012). An evaluation of the service was able to demonstrate a reduction in the amount of women smoking during their pregnancies and increased satisfaction from the women who accessed the service (Homer et al. 2012). Long-term evaluations of programs such as this one can provide more information as to the success of primary health

care interventions on the outcomes for Aboriginal women and their babies (Homer et al. 2012).

There has been significant research into rural and remote Aboriginal women's birthing experiences, much of which has found negative impacts from forced relocation to tertiary centres (Campbell & Brown 2004; Dietsch et al. 2011; Josif et al. 2014; Kildea 2006; Kildea et al. 2010; Kildea & Wardaguga 2009; Kruske, Kildea & Barclay 2006). Relocation of Aboriginal women contributes to poorer health outcomes and experiences for Aboriginal women (Francis et al. 2012; Hancock 2007; Kildea 2006; Kildea et al. 2010; Kildea & Wardaguga 2009; Kosiak 2014). Dietsch et al. (2011) also recognised the relocation of Aboriginal women as impacting negatively on their experiences because they are denied the opportunity to birth on country and with the support of their families. Kosiak (2014) described this process as contributing to the fracturing of a woman's basic culturally significant learning processes around birth. Some scholars have called for health service delivery that facilitates the possibility for Aboriginal women to have the choice to birth supported on country where possible and if desired (Jones 2011; Kildea & Van Wagner 2012; Kildea & Wardaguga 2009). Birthing on country can provide women the opportunity to have physical, emotional, and spiritual support, and to learn women's ways of birth and birthing in their own communities (Kosiak 2014).

Dietsch et al. (2010) described a qualitative, exploratory study of 42 women, six of whom identified as Aboriginal, who were required to birth outside of their rural and remote areas. They found this to be detrimental to their health and well-being and called for the development of programs that would allow greater choice to women. The women all participated in interviews that were conducted in many rural and remote areas throughout New South Wales, and participants were asked to respond to two prompts about their experiences, which were then explored in detail. Thematic analysis of the transcribed data revealed that four of the women (all of whom had identified as Aboriginal) described experiences with the midwives that they perceived to be oppressive and racist (Dietsch et al. 2010).

Watson et al (2002a) also described a qualitative study of 12 Aboriginal women who birthed at an acute care setting in the Northern Territory. The study involved interviews

(by an Aboriginal Health Worker) with participants that were designed as 'informal chats' and aimed to elicit descriptive, experiential information relating to their hospital experiences. The data were recorded, transcribed, and analysed by the research team. The women all described experiences of miscommunication, lack of empathy, and misunderstanding of their cultural and spiritual beliefs (Watson et al. 2002a). Eleven of the women were living in remote areas and English was not the first language for most of the women; these factors could have influenced the results of this small study.

A survey conducted in an acute care setting in Darwin aimed to explore health care professionals' opinions of Aboriginal women's maternity experiences. They found that the health care workers felt the women often experienced loneliness, fear, and anxiety and whilst they attempted to meet the needs of the women, they felt there were times when they did not (Watson et al. 2002b). The study was stage three of a larger project with an overall goal to gain advice from Aboriginal women about how to gather information from birthing Aboriginal women whilst in hospital. Stage three involved questionnaires that used open and closed ended questions, Likert scales and yes/no responses (based on themes developed from the women's data). The data was collated manually and presented following the questions, which related to women's preparation for birth, general experiences whilst in hospital, being away from home, relationships and communication with Aboriginal women, post-discharge baby care, and neonatal and maternal death. The report findings did not clearly differentiate the participants' occupations as they were collectively referred to as health care professionals. It would have been beneficial to the discussion to have had a breakdown of responses according to occupation.

A study into the role of the support person for the Ngaanyatjarra women from a remote community in Western Australia during pregnancy and birth found that the women should be able to have a support person with them when they are required to access regional birthing services (Simmonds et al. 2012). The women traditionally did not have support persons with them during labour and birth. However, the women did wish to have support for antenatal check-ups and when they were required to travel away from their communities to await birth (Simmonds et al. 2012). The authors also highlighted the importance of not making assumptions about what women want and the importance of input from the women

accessing a service, which then is about providing options and respecting choices (Simmonds et al. 2012).

The study used a participatory research methodology and involved interviews with 36 women who had given birth. Language difficulties were experienced by the research team due to the lack of interpreters and the fact that Ngaanyatjarra use of English is different from mainstream use of English, so misinterpretation of data was possible (Simmonds et al. 2012). The importance of continuous labour support has other positive benefits for birthing women, with research showing that it increased the chance of a spontaneous vaginal birth and increased the level of satisfaction for women (Hodnett et al. 2013).

An ethnographic study into the experiences of women from a remote Northern Territory community who declined relocation to an urban hospital for birth found that women made the decision to remain on country to birth due to their previous experiences of standard care (Ireland et al. 2011). The study involved observation and participation in the community for 24 months, field notes, and the collection of birth histories and narratives from seven Aboriginal women and five family members. The authors described the dislocation of women from their culturally appointed carers and the emotional impact of shame and technological violation during childbirth (Ireland et al. 2011). Although the sample size was small, the data can be used to contribute to the development of services that are acceptable to women.

A Cairns based qualitative study into young Aboriginal women's experiences during pregnancy, birth, and the postpartum period was able to identify barriers within the mainstream service (Minniecon, Parker & Cadet-James 2003). The study involved interviewing women three times during the pregnancy, birth, and postnatal period and the study results highlighted the importance of family to the women within the study (Minniecon, Parker & Cadet-James 2003). The women also felt that rapport with the staff at the hospital overall was good, although one participant made a complaint about a doctor that she felt was asking too many questions and using direct eye contact, which was unacceptable to this woman (Minniecon, Parker & Cadet-James 2003). The study aimed to recruit at least ten women but they were only able to reach half their desired sample size. A higher number of participants may have provided richer information.

A consultation project funded by the Cooperative Research centre for Aboriginal Health in Darwin recruited 136 Aboriginal women living in the Northern Territory to participate in interviews about what constituted good antenatal care for them. The women's data was recorded and transcribed and then analysed inductively to develop unexpected issues and then deductively in order to explore issues that the research team had identified in their literature review (Wilson 2009). Some of the issues identified included how the women were treated by the health service staff including behaviour by nurses and midwives that was found to be offensive because it contravened cultural norms for the women (Wilson 2009). When describing ways for positive interaction with the midwife one participant suggested:

> Have a good chat with them, gain their trust, make 'em feel secure…words, the way you talk to them means a lot…especially young ones, that's what they're looking for. (Wilson 2009, p.47)

A Queensland based qualitative study of women's experiences of maternity care found that Aboriginal women reported high rates of stressful life events during pregnancy, low levels of choice in place of birth and model of care, and limited options to carry out cultural practices (Parker, McKinnon & Kruske 2014). The study involved completion of a culturally-tailored survey by 187 women, either independently or with a trained peer-interviewer. The women had birthed at six areas throughout Queensland and included a combination of urban, regional, and remote dwelling women (Parker, McKinnon & Kruske 2014). Data were analysed using descriptive statistics and thematic analysis. The authors identified a limitation to the study because remuneration for the interviewers was per interview rather than hours worked, and this was reflected in a lack of qualitative data by some interviewers (Parker, McKinnon & Kruske 2014). There is a dearth of qualitative literature relating to contemporary Aboriginal women's experiences when they access mainstream Westernised hospital birthing services in metropolitan areas. Greater exploration of their needs as Aboriginal women would provide caregivers the opportunity to actually fulfil their professional obligations to be able to recognise and respond to their birthing needs.

Williamson (2008), in her Ph.D. thesis, explored how midwives defined culture and how they provided culturally appropriate care to women from culturally and linguistically diverse (CALD) backgrounds. She conducted in-depth interviews with 32 midwives working in various midwifery settings (including urban, rural, and remote). She discovered that midwives used a generic approach when providing care to women from CALD groups and to Aboriginal women (Williamson 2008). She challenged midwives to value the uniqueness of each woman and to consider the broader factors that might influence her life (Williamson 2008). Williamson (2008) also found that the midwives expected all Aboriginal women to follow traditional birthing practices and that if they did not the midwives perceived the women had 'lost their culture'. Urban and rural living Aboriginal Australians suffer from perceptions from non-Aboriginal people that 'real' Aboriginal peoples live in remote areas only, and this is another barrier to celebration and acceptance of Aboriginal cultures (Hampton & Toombs 2013b, p.21).

Fredericks (2013, p.5) in her discussion on the struggles that Aboriginal peoples experience living in urban areas, has said:

> There seems to be a widespread myth that, when Aboriginal people and Torres Strait Islander people enter cities or regional centres, we somehow become less Indigenous. It is almost as if we have to leave our identities at the city limits, jetty or airport. But when Indigenous people live in a city or town, we don't become any less or any more Indigenous.

Family and kinship systems are extremely important to the functioning of traditional and contemporary Aboriginal societies (Gee et al. 2014). Health care providers in Watson et al.'s (2002b) study recognised that for women required to birth outside of their community at tertiary health care centres, the lack of family support contributed negatively to the overall experience. A Western Australian based descriptive qualitative study that investigated young Aboriginal women's voices on pregnancy care and factors that enhanced antenatal engagement, found the important role of female family members in ensuring the young women's ongoing engagement with antenatal care (Reibel et al. 2015). They also found that antenatal services using Aboriginal and non-Aboriginal provider combinations are preferable to mainstream services and more acceptable to young Aboriginal women (Reibel et al. 2015). Their research involved a bi-cultural research

approach and the sample included 28 young women, 36 senior women, and 20 service providers (Reibel et al. 2015). Most of the participants were recruited through the health services and had been engaged with regular antenatal care, which represents a potential bias (Reibel et al. 2015).

Fenton and Jones (2015) carried out an ethnographic qualitative enquiry comprising nine health care workers involved in the provision of Aboriginal maternity services at a rural Victorian location. The project aimed to explore the issues health care providers faced in the provision of support and positive outcomes for the Aboriginal women accessing the service (Fenton & Jones 2015). The study identified the importance of culture and respect for positive communication strategies with the Aboriginal women with cultural safety as a core component (Fenton & Jones 2015). The sample size was small and included administrative staff in the sample; sampling from midwives, Aboriginal health workers, or medical officers only may have provided richer information about the direct provision of maternity care to the women.

The results from the evaluation of the Strong Women, Strong Babies, Strong Culture Program, which operates in the Northern Territory, showed the importance of the inclusion of Aboriginal knowledge and practice to the promotion of maternal and child health (Lowell et al. 2015). They also identified the importance of recognition and respect for Aboriginal knowledge in practice as an important and necessary aspect of health care (Lowell et al. 2015). Community participation and control that is supported by good governance and competence in the collaborative relationships between community-based workers and other staff and organisations has positive effects on the acceptability of services (Lowell et al. 2015).

Treating everyone the same is also said to be detrimental to the health and well-being of Aboriginal peoples (Durey, Thompson & Wood 2012). In McBain-Rigg and Veitchs' (2011, p.73) study into cultural barriers for Aboriginal peoples, an Aboriginal health worker identified how health workers frequently espouse the 'treat them the same' mantra;

> Everyone says: 'We treat everyone the same way, whether they're black or white'. That doesn't help us, because …Aboriginal people have got their own culture that sometimes some people don't take that into consideration…

Culturally safe midwifery care will challenge midwives to explore the inappropriateness of treating all women the same regardless of their cultural needs (Phiri, Dietsch & Bonner 2010). A study that involved interviews with 20 Aboriginal women accessing health services in the Rockhampton area, found that an Aboriginal woman would not use a health service, or access a health worker, if she was made to feel uncomfortable about her culture or if her culture was denied or not considered (Fredericks 2003). Fredericks explained that the only way to improve outcomes for Aboriginal women was to consider practices that "affirmed, acknowledged and valued their cultures" and she suggested anti-racism training for health workers (Fredericks 2003, pp.355-356).

Researchers Kendall and Barnett (2015) used a community-based participatory research approach to explore the reasons why Aboriginal Australians under-utilised mainstream health services. Their work involved three focus groups (21 participants) and interviews (18 participants) with Aboriginal health professionals, leaders, and community members in rural, regional, and urban settings in Queensland (Kendall & Barnett 2015). They determined that there were five factors which influenced utilisation of services: negative historical factors; cultural incompetence; inappropriate communication; a collective approach to health; and a need for a holistic approach to health (Kendall & Barnett 2015). The research was based in Queensland and there was a small sample size. However, other published works have demonstrated the influence of historical factors on health service uptake, cultural incompetence in mainstream services, and inappropriate communication from non-Aboriginal health care workers (Baba, Brolan & Hill 2014; Khoury 2015; Richardson & Williams 2007; Sherwood 2010; Ward & Gorman 2010).

2.9 Racism as a barrier to health care for Aboriginal peoples

Durey (2010) described racism as a fundamental social determinant of health where racist attitudes (both interpersonal and institutional) were embedded in the social, structural, and political systems of health care. Many researchers have determined racism to be a key determinant of mental and physical health and/or health behaviours (Awofeso 2011; Helman 2007, p.5; Henry, Houston & Mooney 2004; Larson et al. 2007; Paradies 2006; Paradies et al. 2015; Paradies & Cunningham 2012; Taylor & Guerin 2010, p.73). A cross-

sectional study of 187 Aboriginal Australians' experiences of racism and the relationship to health found that health inequality cannot be improved without fundamental changes in the way that non-Aboriginal people act towards Aboriginal peoples (Larson et al. 2007). The study also found that whilst there were interventions that have been proven to change racist attitudes of members of dominant groups, there was a paucity of research into how the non-dominant group subsequently *experienced* the changed behaviours (Larson et al. 2007). Frederick's (2008a) research correlated with these findings and she argued that there was a lack of research studies that have explored the way in which Aboriginal women have experienced their encounters with health care providers.

Some researchers have described a new racism in Australia, one that is different from the 'old' racism where hierarchy and separatism occurred (Dunn et al. 2004; Johnstone & Kanitsaki 2009). The new racism is based within the constructs of cultural intolerance and denial of Anglo-privilege or white privilege (Dunn et al. 2004; Nelson 2013). White race privilege has been described as invisible, unearned, denied, systemic, and undesirable, and has conferred dominance (Tannoch-Bland 1998), affording many health care workers a position of institutional privilege. Others have critiqued this approach as focusing on white self-loathing and argued that by focusing on whiteness one risks detracting from the study of the experiences of non-white people and their experiences of racism (Taylor & Guerin 2010).

Mellor (2003) described a study that involved interviewing 34 Aboriginal men and women from the Koori people in Melbourne about how they experienced and responded to racism in their everyday lives. Contrary to contemporary research findings which have focused on the perpetrators of racism, and that have described the new racism as more covert, this study found that Aboriginal peoples experienced racism in complex ways in everyday encounters in all areas of their life (Mellor 2003). However, a recent submission by the Australian Psychological Society to the Attorney General's Department suggested that covert racism was harder to identify and condemn because:

> Statements like 'people are all the same and there shouldn't be special provisions or services for particular groups' sound egalitarian but can be used to deny other people's everyday experiences of difference and discrimination on the basis of race, culture or skin colour. (The Australian Psychological Society 2014, p.10)

An experiential qualitative South Australian study revealed that almost 93% of Aboriginal participants (n=153) had experienced racism and almost two-thirds were experiencing it often (Gallaher et al. 2009). The study involved interviews with participants by an Aboriginal interviewer that ranged in time from 45 minutes to two hours in length. Racism was experienced as verbal and non-verbal, although the report did not provide differentiation between the two. The study was able to illustrate a link between the experiences of racism and adverse physical and mental health outcomes (Gallaher et al. 2009). Although that study was not specific to health care access, a Queensland study into Aboriginal peoples' experiences of racism and access to health care services also found that Aboriginal peoples experienced a high level of racism, discrimination, and prejudice when accessing health care (Ward & Gorman 2010).

Another South Australian study explored the impact of racism and whether it was associated with negative mental health impacts. One hundred and fifty-three Aboriginal peoples participated in face-to-face interviews (Ziersch et al. 2011). Racism was associated with negative mental health impacts that were not mediated by social connections or support (Ziersch et al. 2011). The authors called for a systemic effort to combat racism in all social, institutional, sporting, and work settings in an effort to reduce the impact on Aboriginal people's mental health (Ziersch et al. 2011).

A Victorian cross-sectional survey of Aboriginal peoples' experiences with racism and mental health found that experiencing racism in health settings is associated with increased psychological distress over and above what would be found in other settings (Kelaher, Ferdinand & Paradies 2014). The authors contended that this supports the rationale for improving cultural competency in health organisations and reducing racism as a means to close the health gap between Aboriginal Australians and non-Aboriginal Australians (Kelaher, Ferdinand & Paradies 2014). Within the health settings, participants reported being the target of racist names, jokes, or teasing, and hearing comments that relied on stereotyping of Aboriginal Australians (Kelaher, Ferdinand & Paradies 2014). The study did not assess the characteristics of the perpetrators or assess the type of health settings where the racism occurred (Kelaher, Ferdinand & Paradies 2014).

A recent systematic review and meta-analysis of racism as a determinant of health found that experiencing racism was associated with poorer mental health, which included depression, anxiety, and psychological distress, and was associated with poorer general and physical health (Paradies et al. 2015). This review and meta-analysis was conducted on data from 293 studies reported in 333 articles published between 1983 and 2013 (Paradies et al. 2015). This was not specific to Australian research although nine studies that were based within Australia were included in the review and analysis (Paradies et al. 2015).

Racism is embedded in Australian history; it is endemic in our institutions and policies, our way of life and our psyches (Tannoch-Bland 1998). Rasmussen (2001) outlined the progression of racism within Western medicine and hospitals, and has argued that medical institutions have in fact helped to construct the prevailing negative attitudes towards Aboriginal peoples. The institutionalised racism coupled with individual racism jeopardises Aboriginal peoples' access to, and uptake of, health services (Hampton & Toombs 2013a).

Health services should provide services that are experienced as culturally safe because racism and discrimination experienced by Aboriginal peoples deters them from accessing health care services (Awofeso 2011; Ward & Gorman 2010). Non-Aboriginal Australians must also comprehend and combat institutional and ideological racism, which still define many of our structures and processes (Hollinsworth 2006). Awofeso (2011) suggested adopting a cultural safety model of facilitating cultural competence that focused more on improving the transference of knowledge in social, political, cultural, and historical processes that influence health and health care. He described this as an alternative to cataloguing culture-specific beliefs of the over 200 Aboriginal groups within Australia (Awofeso 2011).

Henry, Houston, and Mooney (2004) have argued that cultural differences and ignorance create racism, and indifference nurtures it. They have suggested a celebration of cultural differences and for non-Aboriginal Australians to recognise Aboriginal cultures and not just their music and dancing (Henry, Houston & Mooney 2004). They have also called for the "unbuilding" of Australia's "divided, divisive, racist and socially unjust society" (Henry, Houston & Mooney 2004, p.519). Aboriginal peoples suffer stereotyping and

discrimination that impacts on their social, physical and mental wellbeing (Bodkin-Andrews et al. 2010).

Institutional racism occurs in health care when hospital systems are based on Western biomedical health models and impose the values and assumptions of the dominant group on those accessing health care (Durey, Thompson & Wood 2012). Often, institutional racism exists covertly and incudes cultural barriers to health; for example, language barriers and the lack of recognition of different constructs of health in mainstream services (Henry, Houston & Mooney 2004).

2.10 How do midwives learn about culture?

Colonised countries from around the world have all faced the task of attempting to improve the health of their Indigenous populations; these include New Zealand, Canada, the United States, and Latin America (Durey & Thompson 2012). Durey and Thompson (2012) have identified through their research that a key element to improving health care is the provision of ethical and respectful care that is *experienced* as culturally safe. This is an important aspect, because while it is easy to espouse notions of cultural safety or culturally competent care, ultimately how Aboriginal peoples experience that care is paramount to improving services. This requires evaluations of care provision by Aboriginal peoples and subsequent feedback to care providers so that clinical practice can be improved. The importance of the birth experience as a transformative event in a woman's life makes this more imperative as a negative birth experience will remain with a woman for the rest of her life.

With the increased understanding of the links between culture, health care access, and wellbeing for Aboriginal peoples, there has also been an increase in the requirement for the health care system to address the health care barriers for Aboriginal peoples (Downing & Kowal 2011b). Various frameworks are in place that have helped to define and address cultural issues within a health care context. The frameworks are useful when understanding the broader issues that impact on health. SA Health has the Aboriginal Cultural Respect Framework (2007) in place which uses the terminology of 'cultural respect' but has many features of a culturally competent service. It includes policy and program development, services reform, workplace development, and monitoring and evaluation.

Competency ten of the national competency standards for the midwife (Nursing and Midwifery Board of Australia 2006) demands that midwives ensure that their practice is 'culturally safe'. The competency standards also require midwives to be able to recognise the specific needs of Aboriginal women and their communities, and show respect for differences in cultural meanings and responses to health and maternity care (Nursing and Midwifery Board of Australia 2006). Midwifery curriculums now include cultural safety training, and it is embedded throughout the training curricula. For the midwives working in the public hospital where this study was based, cultural respect training is a compulsory requirement for employment for all staff. Nurses and midwives who were educated more than ten years ago are unlikely to have had this education embedded within their training (Goold 2010/2011). Goold (2010/2011) has called for all nurses and midwives to understand how their own attitudes and the resulting practice can affect their clients and to strive for the provision of culturally respectful care.

Since the introduction of cultural competency into university curricula for health and the health sciences, there have been limited studies on whether the attitudes are transferred into culturally secure practice in clinical encounters with patients (Thackrah & Thompson 2013b). Thackrah and Thompson (2013b) have suggested that the real challenge is whether or not the learning impacts on their ability to challenge parts of the prevailing culture within the health service that negatively influences the provision of culturally safe care for pregnant and birthing women. An observational study and before and after questionnaires of a Perth-based first-year midwifery student cohort completing a compulsory unit of Aboriginal health and cultures, discovered some students experienced a fear of causing offence to Aboriginal women within their interactions (Thackrah & Thompson 2013b). The study showed that the students were aware of organisational barriers to effective care for Aboriginal women. The unit was able to challenge the students' stereotypes and provided them with experiences of racism delivered from Aboriginal people, which they found challenging and which were unresolved at the completion of the unit (Thackrah & Thompson 2013b).

Midwives working within the SHC system face other barriers to connecting with a woman's needs. Hunter (2004) has described this as a 'with institution' ideology. She said

that within this model there was an emphasis on successful completion of tasks that would ensure the physical safety of the woman and baby (Hunter 2004). The midwives are also governed by institutional demands in an obstetric led model of care. Relationships and communication with the women can be neglected even though quality relationships with caregivers are important to birthing women (Hunter et al. 2008). Power and racism have impacted negatively on the experience of feeling cared for by women in maternity care (Wikberg & Bondas 2010), and the fragmented system that women birth in acts as a barrier to the formation of positive relationships (Hunter et al. 2008).

A Victorian naturalistic inquiry that used data collection and analysis strategies based on qualitative, exploratory, and descriptive research methods explored the understanding of cultural safety in the Australian health care context towards providing and receiving culturally safe care to CALD groups (Johnstone & Kanitsaki 2007). Individual interviews (52 participants) and focus group interviews (28 participants) were conducted with nursing staff (51 participants), patients, families and relatives (8 participants), health interpreters (6 participants), ethnic liaison officers (18 participants), allied health professionals (4 participants), ethnic welfare organisations (11 participants), managers (32 participants) and cultural trainers (15 participants) totalling 145 participants. Data were analysed using content and thematic analysis (Johnstone & Kanitsaki 2007). Findings suggested that few of the health care providers in the study had heard of the term but on the whole when they attempted to define it they referred to it in terms of giving safe physical care and that the patients did not suffer harm because of communication difficulties (Johnstone & Kanitsaki 2007). This limited understanding of the complex meaning of cultural safety is concerning given nurses and midwives must subscribe to the provision of culturally safe care each year in their midwifery competencies. Furthermore, given cultural safety is something that must be *experienced* by a health care user, a greater sample of patients and relatives would have been beneficial in this study to strengthen the findings.

2.11 Summary

It is argued that midwives should be able to recognise their important role in facilitating an Aboriginal woman's appropriate, culturally safe birthing experience. This is imperative not just because of basic human rights and moral and ethical responsibility, but also because it

is an element of midwifery competency. Midwifery care should be *experienced* as encompassing and celebrating a woman's cultures and this should occur regardless of what model of care a woman chooses to engage with. Only when Aboriginal women experience services as culturally safe can inroads into the health disparity occur. Qualitative research data that shares the experiences of both the women and midwives can make a valuable contribution to the experience and understanding of cultural care. Not only can it highlight the experiences of Aboriginal women accessing SHC in a metropolitan health centre, but also provide a means of targeting the educational needs of midwives providing the care. The literature has clearly illustrated confusion with the nomenclature surrounding culture and cultural safety and a closer examination of the terminology or defining the terminology might strengthen the discussion. Chapter three will explore the philosophical foundations and the methods behind the research approach.

Chapter 3 | Philosophical Framework

"Only as phenomenology is ontology possible." Martin Heidegger (1962, p.60)

3.1 Introduction

In chapter two I provided an overview of the literature surrounding Aboriginal health outcomes, government policies, and programs to address health inequalities, and an examination of the meaning of culture and its importance to health care. I have also explored Aboriginal women's experiences accessing traditional westernised health care systems, cultural training for midwives, and racism as a barrier to health care for Aboriginal peoples. The literature review has demonstrated that Aboriginal women can face a lack of cultural understanding when accessing health care within the standard hospital care (SHC) system, and highlighted the importance of health care that incorporates Aboriginal principles and values. Although specialised programs are in place to support Aboriginal women in a more culturally appropriate way, when accessing birthing services in metropolitan South Australia all sectors of service provision should be able to provide for and respond to the cultural needs of Aboriginal women.

In order to understand the individual experiences of midwives when providing culturally appropriate care to Aboriginal women, and the experiences of the women accessing their care, a qualitative research method was used. Qualitative research methods were deemed appropriate for my study as they are concerned with the naturalistic description or interpretation of phenomena (Langdridge 2007). Phenomenology is a philosophical approach that studies and illuminates individual lived experiences (Smith, Larkin & Flowers 2009). In my study, these are the experiences of the Aboriginal women accessing care in the SHC system and those of the birth suite midwives.

3.2 Phenomenology

The word phenomenology originated from the Greek term *phaenesthai* (to appear) and *logos* (reason) (Mohammadi 2008). Vivilaki and Johnson (2008) have described *logos* as an ability that humans have to think and verbalise thoughts in language or their philosophy about life. Sokolowski (2000) and Moran (2000) have described it as giving an account of the way things appear.

3.2.1 Husserl and Heidegger

Mathematician, Edmund Husserl (1859-1938) is often named as the founder of phenomenological philosophy. However, Moran (2000) argued that the term began to appear in philosophical writings in the eighteenth century through the work of philosophers Lambert, Herder, Kant, Fichte, and Hegel. Moran (2000) explained that it was through their work that the works of Brentano and the physicist Mach (who described a general physical phenomenology) developed. Other academics have placed the origins of the phenomenological movement with Husserl, and although Sokolowski (2000) acknowledged that Husserl drew on the works of Brentano, he argued that he greatly exceeded them. Husserl's phenomenology focused on questions of epistemology and the nature of knowledge (Dowling & Cooney 2012). His approach has been developed or re-theorised by other philosophers who have produced slightly different approaches. Notwithstanding this, all phenomenologists reject the subject-object dualism that is central to positivism, where the world as it is and as it appears through perception are separated (Langdridge 2007).

German-born, Martin Heidegger was an assistant and student to Husserl before establishing himself as a leading philosopher (Sloan & Bowe 2014). Heidegger contended that phenomenology should be used to investigate the ontological question; that is, what is the meaning of being? (Bradbury-Jones, Sambrook & Irvine 2009). With respect to this research project, this experiential approach was used to explore the lived experiences of midwives in the provision of culturally appropriate care for Aboriginal women and also to describe and interpret the experiences of the women who access midwifery care.

Vivilaki and Johnson (2008) have described one of the basic components of hermeneutic philosophy as that of a dialogue between the researcher and the text, or between the reader and the interpretations, with each bringing their own preconceptions. This will be further explored in sections 4.8 and 4.11. They also explained that the reader might not share the same interpretation as the author, but that there should be a clear pathway illustrating how the author came to the interpretation (Vivilaki & Johnson 2008).

3.2.2 Heideggerian interpretative hermeneutic phenomenology as a philosophical foundation to the research approach

Unlike Husserl, Heidegger questioned the possibility of any knowledge outside an interpretative position and that knowledge was based in the lived world of things, people, relationships, and language (Smith, Larkin et al. 2009). In contrast, Husserl's phenomenology was more descriptive in nature and the researcher would aim to 'bracket' and separate his/her own presuppositions or preconceived ideas about the subject of investigation (Langdridge 2007, p.17). This would have been a challenging, if not an impossible task for my study as I am very familiar with the work of the sample midwives and have experience providing intrapartum care for Aboriginal women.

Crist and Tanner (2003) have argued that a hermeneutic interpretative approach based on Heideggerian phenomenology is appropriate if the researcher is aiming to uncover meanings within a phenomenon, and when attempting to understand human experiences. As such, I saw interpretative phenomenology, ascribing to the philosophy of Heideggerian phenomenology, as the most appropriate approach to explore the research area, because the approach focused on the meaning of experience and of the shared experience between the researcher and the participant.

Aboriginal Australians have a strong history of oral storytelling, sometimes referred to as *yarning*. Struthers and Peden-McAlpine (2005) have argued that phenomenology is compatible with Aboriginal peoples, and as a research method it has helped Aboriginal peoples to recreate features of the past, present and future through language. They have also argued that the telling of narrative stories has helped reflection on change which can enhance health in a culturally acceptable manner (Struthers & Peden-McAlpine 2005).

3.2.3 Dasein

Langdridge (2007) described how Heidegger felt that it was through discourse that one's way of being in this world was manifested. Heidegger (1962, p.27) used the word *Dasein* to describe 'being-in-this-world' and it has been described as the fundamental ontological structure characterising humans and the unity of the world and of existence (Sembera 2007). *Dasein* is interpretation, and it is through interpretation that the authentic meaning of *being* and the structures of *Dasein* itself are revealed to *Dasein's* understanding of *being* (Nellickappilly 2014). The concept of *Dasein* is pivotal to Heidegger's work (McConnell-

Henry, Chapman & Francis 2009). Through interviews with both midwives and women, the essence of their experiences or their way of being-in-this-world was uncovered.

3.2.4 Heidegger's timeliness and spatiality

Timeliness, or time, is the most fundamental existential-ontological structure of *Dasein*, which is assembled through the past, the present, and the future (Sembera 2007). Spatiality refers to lived space, which van Manen (1990, p.102) called 'felt space'. He described it as difficult to define, given the experience of lived space is pre-verbal and not often reflected upon (van Manen 1990). Timeliness and spatiality are revealed as memories, feelings or awareness, and are attached to culture and history, which in turn have shaped our beliefs (Miles et al. 2013). In the process of discovering the women's and midwives' experiences of *Dasein* or being-in-this-world, it was important to recognise the *context* (time and space) of their experiences. For the Aboriginal women in my study, this included the impact of colonisation, the legacy from the government policies that have oppressed Aboriginal peoples, past experiences with health services, and current contacts with health services. All of these factors are relevant and important in this study.

3.2.5 Heidegger's care

Heidegger referred to *Dasein* as being with things and with others in such a way that the whole existence is structured by care (Moran 2000). Moran (2000) explained that by examining the manner of *Dasein's* being in the world it is, in fact, a disclosing of the world. The notion of *care* aligns well with midwifery as the profession is built on human interaction and relationships. Miles et al. (2013) have argued that the tenets of hermeneutic phenomenology align with those of contemporary midwifery practice. They have suggested that it is a useful methodology for providing insights into midwifery professional issues (Miles et al. 2013). Within my study, the focus is on the experience of cultural care for the women and the midwives.

3.2.6 Heidegger's hermeneutic circle

Heidegger (1962) described the hermeneutic circle where all understanding is connected to fore-structure (prior understanding), and this cannot be ignored. To become aware of the fore-structures that the researcher brings to interpretation is inescapable in the research process. The interpretation occurs through a hermeneutic circle whereby the researcher moves from parts of the experience (interviews and transcribed texts) to the whole

(evolving understanding of the experience) and back and forth again, which helps to increase the depth of engagement with the interviews and texts (Ajjawi & Higgs 2007; Laverty 2008). Heidegger (1962, p.363) said that one must:

> …endeavour to leap into the 'circle', primordially and wholly, so that even at the start of the analysis of Dasein we make sure we have a full view of Dasein's circular being.

Heidegger has seen the circular state of all acts of understanding as an essential feature of the study of being or *Dasein* (Sembera 2007). By engaging the hermeneutic circle in research practices, the researcher is able to read between the lines of a phenomenon through language and uncover the true essence of the experience (McConnell-Henry, Chapman & Francis 2009).

I used a reflective journal within my study as van Manen's (1990) six steps (see section 4.11 and appendices eleven and twelve) were carried out, and this allowed for engagement with the hermeneutic circle; it allowed me to move backwards and forwards between the parts and the whole emerging understanding of the experience. The questions designed by Steeves, Cohen, and Kahn (2000) to assist a researcher engage the hermeneutic circle were adopted in the reflective journal. Heidegger's 'knowing' is developed from interpretation and understanding which reflects his position that there is no difference between epistemology and ontology (McConnell-Henry, Chapman & Francis 2009).

3.2.7 Summary

The philosophical foundations of Heidegger's phenomenology have provided a framework through which I was able to explore the experience of birth with a focus on the cultural aspects of care for the midwives and for the women accessing their care. It was able to support the context for their experiences at this time and place. It was a woman-centred approach for the women in which they could explore their experiences of birthing in the SHC system.

3.3 Max van Manen

Max van Manen was born in the Netherlands and later immigrated to Canada where he had an interest in pedagogy and phenomenology. He is an author and academic, and his book *Researching Lived Experience* has provided an approach for hermeneutic

phenomenological enquiry. Although grounded in pedagogy his approach has also been utilised by researchers in the health sciences (Williamson 2005), and it was chosen to guide the data analysis in this research study due its foundations in Heidegger's work and its strong focus on narratives and lived experiences. His six-step approach was applied to the interview transcripts from both the women and the midwives. Data analysis and interpretation commenced after the first interview and continued whilst the interviews were being conducted. The interviews with the midwives were completed first, and preliminary data analysis had occurred by the time the interviews with the Aboriginal women had commenced. This was due to a delay in securing an interviewer for the women. Van Manen (1990, p.30) argued that hermeneutic phenomenological research is best reflected in a dynamic interplay using his six research activities (or steps), which were used as a framework to conduct the data analysis as outlined below. They will be explored further in chapter four.

- Turning to a phenomenon that seriously interests a person and commits them to the world
- Investigating experience as it is lived rather than how it is conceptualised
- Reflecting on the essential themes that characterise the phenomenon
- Describing the phenomenon through the art of writing and rewriting
- Maintaining a strong and oriented relation to the phenomenon
- Balancing the research context by considering parts and the whole.

3.4 Phenomenology in nursing and midwifery research

Phenomenological research methods have been used by nurses to explore their experiences and to explore the experiences of their clients (Cohen 2000; Converse 2012; Dowling & Cooney 2012; Heinonen 2015; Mackey 2005; Wilson 2014). More specifically, hermeneutic research methods offer the potential to inform nursing practice because of the emphasis on the ontological rather than the epistemological nature of the inquiry (Annells 1996). There have been many hermeneutic nursing studies that have the potential to inform practice. These have included studies into the experiences of nursing practitioners moving from the ward environment to the critical care unit (Gohery & Meaney 2013), and the

experiences of nurses and their clients from different speciality areas, for example cancer (Nasrabadi et al. 2011; Spichiger 2010), intensive care (Everingham, Fawcett & Walsh 2014; Yekefallah et al. 2015), emergency (Cypress 2014; Marynowski-Traczyk & Broadbent 2011) and cardiac (Moore, Kimble & Minick 2010; Schou & Egerod 2008). Patricia Benner is a nurse scholar who contributed to the development of interpretative phenomenological methods for nursing research (Chan et al. 2010). Her seminal work, 'From novice to expert', used a Heideggerian qualitative approach that lay the foundations for understanding nursing expertise and skill acquisition (Altmann 2007). With the work of Patricia Benner and other nurse scholars in developing a research tradition for phenomenology in nursing, came a similar development in midwifery practice.

Phenomenology has allowed midwifery practice to be enhanced by exploring the experiences of midwives and of women and families. Hermeneutic phenomenological enquiry in midwifery has the potential to bring to light the intricacies of the woman and midwife relationship, which can facilitate authentic, therapeutic, caring connections (Miles et al. 2013). There are many hermeneutic studies in midwifery, for example studies into midwives' ways of knowing during childbirth (Hunter 2008), the lived experiences of women who have had an emergency caesarean section (Sullivan 2014), and midwives' first experiences of stillbirth as community midwives (Jones 2012). Hermeneutic phenomenology as a research method aligns with the philosophy behind midwifery practice, which promotes a holistic approach that is woman centred and considers the woman's social, emotional, physical, and cultural needs around birth (Mapp 2008; Miles et al. 2013).

3.5 Phenomenology in nursing and midwifery research – the criticism

Phenomenological research methods grounded in phenomenological philosophy are frequently used for nursing and midwifery research. However, this has not occurred without some critical debate within the academic community. Some of the criticism surrounding the use of Heideggerian philosophy has related to the appropriateness of it as a philosophical foundation, given Heidegger never intended it to be used as a research method (Johnson 2000). Giorgi (2000) argued that if researchers were to follow

phenomenology as Husserl had intended, they would no longer be conducting research but would be practicing philosophy.

Other criticism directed at the use of phenomenology in nursing research has come from Michael Crotty. He described two versions of phenomenology, and the type most commonly used by nurse researchers he labelled as 'new', which he said was not grounded in the European tradition (Crotty 1996). The 'new' phenomenology was described as a North-American hybrid that was considered to be less critical, less descriptive, and subjective (Norlyk & Harder 2010). Crotty (1996) described this new phenomenology as one that embraced and explored culturally derived understandings, whereas traditional phenomenologists have invited us to ignore the culturally derived understandings. Paley (2005) also critiqued nurse researchers and their application of phenomenology. He argued that nurse researchers delivered the correct language within discussions, but in the crucial moments of their research arguments they did not deliver on the philosophical foundations of the approach (Paley 2005). However, Giorgi (2000) argued that scientific phenomenology, as opposed to Crotty's philosophical phenomenology, *is* new because nurses are attempting to carry out scientific caring nursing work, which although new in its application is legitimised by phenomenological philosophers.

Some scholars have argued that midwifery practice and Heideggerian hermeneutic phenomenology are a perfect fit as it has allowed for insights into the humanistic aspects of midwifery practice to be explored (Miles et al. 2013). Wilson (2014) argued that research that is based on Heideggerian philosophy is able to provide a rigourous framework when the researcher has sought to examine the experiences of practitioners. She outlined how the practitioner's experiences of practice are explained by three modes of being; being absorbed in practice, noticing practice, and contemplating practice (Wilson 2014). Within this research project, the midwives were able to explore their practice in a similar way by the application of a Heideggerian philosophical foundation. Sweet (2004) argued that hermeneutics has also offered a means to study the lived experiences of patients (and women) too, and this is of interest and importance to nurses (and midwives).

Another criticism that is sometimes directed towards the use of Heideggerian philosophical frameworks that guide research studies is related to Heidegger's ties to the German

Socialist party. Some academics have argued that this is diametrically opposed to the values and goals of studies developed in nursing and midwifery (Holmes 1996). The use of a Heideggerian philosophical foundation in the study of Aboriginal women's experiences makes this more concerning given the history of colonisation and the experiences of Aboriginal peoples following colonisation. However, Holmes (1996, p.585) has argued that a researcher can choose to align themselves with some aspects of Heidegger's work if they are able to consciously reject the "fascistic, anti-Semitic, and ultra-nationalistic elements of his work". The choice of the philosophical foundations should be determined by the relevance to a study and not by judgements made on the philosopher as a person (McConnell-Henry, Chapman & Francis 2009).

3.6 Conclusion

A hermeneutic phenomenological research design using van Manen's (1990) method and underpinned by Heideggerian philosophy was determined to be the best fit for investigating my research aims. It was seen as an excellent way to explore the experiences of midwives and of women working in and accessing care in a tertiary hospital, with a focus on the cultural aspects of care. It provided an opportunity to uncover the midwives' and women's ways of being-in-this-world and the interconnectedness of their experiences at this time and place. I will explore the research methods employed in the study in the following chapter.

Chapter 4 | Methods

"A good phenomenological description is collected by lived experience and recollects lived experience – is validated by lived experience and it validates lived experience." Max van Manen (1990, p.27)

4.1 Introduction

In this chapter I outline the methods used to explore the women's and midwives' experiences in the standard hospital care (SHC) system. The methods are grounded in Heideggerian phenomenology, as discussed in the previous chapter. I will address the ethical side of the research project and the involvement of, Aboriginal interviewers and an Aboriginal Cultural Consultant. Rigour, quality, and trustworthiness will be explored. Reflexivity and the limitations of the method will be discussed.

4.2 Participants and sampling

I aimed to recruit ten to fifteen volunteer midwives working in the SHC system at a tertiary level public hospital in Adelaide, South Australia. I also aimed to recruit ten to fifteen Aboriginal women who had given birth at the same hospital. The volunteers all participated in an in-depth interview to explore their experiences of birth in the SHC system, either as midwives providing care or having accessed midwifery care with a focus on the cultural aspects of the experience. Phenomenological interviews are important to understand shared meanings by drawing a complex picture of the lived experience that contains rich details and context (Sorrell & Redmond 1995). There were over ninety permanent midwives working within the birthing suite at the time of the recruitment. In 2014, 69% (n=132 of 191), and in 2015 75% (n=133 of 176) of Aboriginal women gave birth in the SHC system. The remaining women gave birth in the hospital continuity of care program.

Purposive sampling was used to ensure the participants had experience with the phenomenon of interest. Creswell (2013) suggested a sample size of five to twenty-five participants in phenomenological research, whilst Morse (1994) suggested at least six participants. An estimate of ten to fifteen was made in order to provide scope for gaining an adequate sample and in order to provide rich texts and descriptions. Saturation techniques were used so that interviewing could cease when the information collected was able to meet the research aims by providing a rich description of cultural care based on lived experience, and where no new themes were developed. Guest, Bunce and Johnson

(2006) have suggested that data saturation can occur in qualitative research as early as six interviews and usually occurs by twelve interviews. Data saturation was reached after fourteen interviews with the women and after thirteen interviews with the midwives.

4.3 Aboriginal Women

4.3.1 Inclusion criteria

All Aboriginal women were eligible for participation provided they were greater or equal to 16 years of age and had birthed in the SHC system within the last six months. Participation was voluntary.

4.3.2 Exclusion criteria

Aboriginal women who had birthed in Midwifery Group Practice (MGP) were not eligible for participation. Aboriginal women who birthed with an Aboriginal Maternal Infant Care Worker (AMIC) worker were also excluded because this was not the focus of the study.

4.3.3 Recruitment

The Aboriginal women were recruited with the assistance of the hospital Aboriginal Liaison Unit, the Aboriginal Research Assistants, and the Aboriginal Cultural Consultant working on the project. Recruitment brochures were provided when they visited women in the postnatal period (see appendix one). Some women were contacted by phone and information given about the study after they had been discharged. If the women expressed an interest or wanted more information it was given to them by the Aboriginal Research Assistants (see 4.4.5). If the women still wished to participate they made arrangements for a mutually convenient time and location.

4.3.4 Demographic data

Table 3 - Provides demographic data for the women in the study

Participant number	Aboriginal or Torres Strait Islander	Age range (years)	Parity	Living in rural/remote or metropolitan area	Location of interview
1	Torres Strait Islander	18-24	First	Rural/remote	Hospital
2	Aboriginal	35-40	Fifth	Rural/remote	Outside the hospital
3	Aboriginal	35-40	First	Rural/remote	Hospital

4	Aboriginal	18-24	Second	Metropolitan	Home
5	Aboriginal	18-24	First	Metropolitan	Phone
6	Aboriginal	30-35	Sixth	Rural/remote	Phone
7	Aboriginal	30-35	Fourth	Metropolitan	Home
8	Aboriginal	30-35	Third	Metropolitan	Hospital
9	Aboriginal	18-24	Fourth	Metropolitan	Hospital
10	Aboriginal	30-35	Seventh	Rural/remote	Hospital
11	Aboriginal	30-35	Eleventh	Rural/remote	Hospital
12	Aboriginal	24-30	Second	Metropolitan	Hospital
13	Aboriginal	18-24	First	Metropolitan	Hospital
14	Aboriginal	18-24	First	Metropolitan	Hospital

Table 3 represents the demographic data for the women in the study. Thirteen of the participants were Aboriginal and one was a Torres Strait Islander woman. Forty-three per cent (n=6) of the sample group lived in rural or remote areas and the following fifty-seven per cent (n=8) were living in metropolitan areas. Most of the women fell into the eighteen to twenty-four years age group (n=6) with the next highest age range being thirty to thirty-five years (n=5). There were two women in the thirty-five to forty age group and one in the twenty-four to thirty years age group. English was not the first language for some of the participants, but none of the participants required a translator.

4.3.5 Interviewers/Research Assistants

Aboriginal interviewers were employed by the University of South Australia for my project. This enabled the women the opportunity to talk freely about their experiences with another Aboriginal woman. This was an important aspect of a culturally appropriate approach for the women. The initial interviewer for the women, Ms. Jessica McKenzie, was approached at the hospital where she was employed as an Assistant in Midwifery (AIM). At the time, she was a third year Bachelor of Midwifery student. She read the research proposal and agreed to become the interviewer for the project. Ms. McKenzie is an Adnyamathanha woman from the Flinders Ranges in South Australia. Ms. McKenzie also assisted in the recruitment of the women in conjunction with the hospital ALOs. She completed four of the interviews before needing to take extended leave from the project

for personal reasons. Ms. McKenzie did come back to the project towards its completion, where she recruited the final participant.

Later on a second interviewer was recruited. Ms. Toni-Marie Rowe is an Aboriginal midwife working at the hospital where the project took place. Ms. Rowe's cultural ties are to the Kulumali and Bidia people from Queensland. She agreed to join the project and ethical clearance was granted for her role. Ms. Rowe completed the remaining ten interviews.

Given Aboriginal women's experiences have often been described as negative within the Westernised health system, it was important that the women should feel able to talk honestly about their experiences. Although I did not conduct the interviews with the women, I talked with Ms. McKenzie or Ms. Rowe after each interview and after transcribing the interviews. Subsequently I was still able to engage Heidegger's hermeneutic circle (see section 3.2.6) whilst reading, transcribing and interpreting the texts, and was still able to discover the essence of the phenomenon as described and experienced by the women (see chapter five).

Using Aboriginal interviewers was very important to the success of the research project for a number of reasons. Firstly, as Kowal, Anderson, and Bailie (2005) have suggested, knowledge possessed by Aboriginal peoples including their beliefs, perceptions, and attitudes, is the best quality knowledge about Aboriginal health. They have suggested that in order to access that knowledge then Aboriginal participation in health research is important; not just at the data collection stage but in the fundamental design too (Kowal, Anderson & Bailie 2005). Engagement with an Aboriginal Cultural Consultant and an Aboriginal Research Proposal assessor was also able to assist with ensuring Aboriginal knowledge was incorporated in all stages of the project.

The tradition of oral storytelling in Aboriginal cultures was incorporated within the interview process. The interviews with the women all commenced with the interviewer asking the women to tell their stories about their birth. This helped to reduce the negativity associated with research conducted on Aboriginal peoples, and the Aboriginal interviewers also assisted with reducing this impact. Geia, Hayes, and Usher (2013) have suggested that

it is important when conducting research involving Aboriginal peoples that the privileging of their voices occurs within that process. They have also suggested that using yarning techniques provides a culturally secure space for participants to tell their stories, and that those stories can change health outcomes for Aboriginal peoples (Geia, Hayes & Usher 2013). Gorman and Toombs (2009, p.4) have suggested that the interface between the researcher and the participant is affected by culture, and 'cultural differences can create serious barriers'. They have also said that when the researcher is collecting information about the subjective experiences of participants the barriers can be more complex (Gorman & Toombs 2009). By engaging Aboriginal interviewers, barriers to effective communication were reduced. It also provided a culturally safe environment for the women to share their stories. The voices of the women will also be heard within this thesis, as their actual words will be used to help illustrate the themes developed (see chapter five).

4.3.6 Data Collection

The recruitment of the women commenced in June, 2014 and was completed in February 2015 with a total of 14 participants. All of the participants were required to read the participant information sheet (PIS) and they had their questions answered prior to signing a consent form (See appendix two, three and four for women less than 18 years). A summary information sheet was developed to assist the interviewer to ensure all aspects of the information sheet were discussed at interview (see appendix five). All participants retained a copy of both the information sheet and the consent form. Semi-structured interviews occurred with the interviewer asking open-ended questions and using prompts in order to elicit as much information as possible about receiving midwifery care in the SHC system (see appendix six for sample questions). Nine of the interviews took place at the hospital, one in the parklands adjacent to the hospital, two in the women's homes, and two by phone. All of the women were offered a fifty-dollar supermarket card for reimbursement of expenses involved in their participation.

4.3.7 Telephone interviews and phenomenology

The decision to include telephone interviews for the women in the study was made because it became apparent that women from rural and remote areas were not being able to participate because they had returned to their homes before we could arrange an interview for them. Following a discussion with the Aboriginal Health Research Ethics Council, a

separate ethics application was made to include telephone interviews for the women from rural and remote areas. Subsequently two of the interviews were conducted by telephone. Telephone conversations often follow an agenda driven format that is similar to semi-structured interviews (Cachia & Millward 2011). In hermeneutic phenomenological research, interviews should resemble conversations; this allows for people to make sense of their experiences by treating them as unfolding narratives (Steeves, Cohen & Kahn 2000). Holt (2010) acknowledged that traditionally face-to-face interviews were the best option when seeking narrative data in research studies. However, she found that the use of telephones should be seriously considered as a preferred alternative to face-to-face interviews for narrative interviews with some groups of participants (Holt 2010). For example, where sensitive information is being shared the telephone gives the participant some control over where and when they participate, and affords them some privacy (Holt 2010).

Sweet (2002) argued that researchers using interpretative phenomenological research methods should not rely exclusively on face-to-face interviews, as telephone interviews can also be a valuable technique especially when participants are geographically distanced or had logistical barriers to attending face-to-face interviews. I was not present at any of the interviews for the women because the Aboriginal interviewers conducted those interviews. The inclusion of telephone interviews in my study has allowed the inclusion of two women who may not have had their stories explored if this was not possible. I was still able to engage the hermeneutic circle through the transcription and analysis of the data and the information gained made a valuable contribution to my study. Body language and non-verbal aspects of the interviews were not accessible to me for any of the women participants, so the inclusion of two phone interviews had little if any impact on the process of interpretation in my study.

4.4 Midwives

4.4.1 Inclusion criteria

All midwives who were working in the birth suite of any experience level who had experience in the provision of labour and birth care to Aboriginal women were eligible for

participation. This included permanent, rotating, and casual staff members. Participation was voluntary.

4.4.2 Exclusion Criteria

Midwives working in other models were excluded from the study because other programs that support Aboriginal women through childbirth, such as the Aboriginal Family Birthing Program (AFBP) were not the focus of my study and are in place within the hospital. Midwives who practised within MGP were not eligible as they often worked with an Aboriginal Maternal Infant Care worker (AMIC), where Aboriginal women had an AMIC worker providing care in partnership with the midwife.

4.4.3 Recruitment

I planned to conduct recruitment sessions within the birth suite education time. Once recruitment commenced a small entry was made in the ward communication book advising midwives that the research project had commenced and that recruitment sessions would be conducted. I included an email address and mobile telephone number so that the participants could confidentially contact me should they be interested in joining the research project. All of the participants contacted me prior to the planned sessions volunteering for the research project, and subsequently the recruitment sessions were cancelled. Eleven of the participants contacted me in person, one sent an expression of interest by way of another participant, and one participant sent a text message and the interview was set up via text message.

4.4.4 Demographic Data

Table 4 - Provides demographic data for the midwives in the study

Participant number	Gender	Age Range (years)	Length of practice (years)	Education
1	Female	≥41	25+	Hospital certificate RN/RM
2	Female	35-40	10-20	Bachelor of Nursing and Midwifery
3	Female	≥41	25+	Hospital certificate RN/RM
4	Female	35-40	10-20	Bachelor of Nursing and Midwifery
5	Female	≥41	20-25	Hospital certificate RN/RM
6	Female	≥41	25+	Hospital certificate RN/RM
7	Female	35-40	10-20	Bachelor of Nursing and Midwifery
8	Female	≥41	25+	Bachelor of Nursing and Midwifery

9	Female	≥41	25+	Hospital certificate RN/RM
10	Female	≥41	25+	Hospital certificate RN/RM and Bachelor of Nursing
11	Female	≥41	25+	Hospital certificate RN/RM
12	Female	≥41	20-25	Hospital certificate RN/RM
13	Female	≥41	25+	Hospital certificate RN/RM

Table 4 represents the demographic data for the midwives. The majority of midwife volunteers had been registered midwives for greater than twenty-five years (n=8). There were three who had ten to twenty years' experience and two within the twenty to twenty-five years' experience range. All of the midwifery participants were aged thirty-five or greater, with the majority aged greater than forty-one years (n=10). All of the participants in the study were female. At the time of the study, there were no male midwives working within the birth suite or rotating through the area.

The midwives who participated in the study all had a variety of educational backgrounds, with most having completed hospital training as registered nurses and as midwives. This is probably because most were within the age groups when nursing and midwifery was not offered in universities when they were commencing their training. The transition of nursing education into universities was occurring during the 1980's and 1990's (Russell 1990). This is important because it is unlikely the midwives who participated in the study had cultural training within their initial midwifery education. Fifty-four per cent (n=7) of participants were hospital trained in nursing and midwifery; thirty-one per cent (n=4) held bachelor of nursing and bachelor of midwifery qualifications; and fifteen per cent (n=2) were hospital trained for nursing and midwifery but also held a bachelor of nursing.

4.4.5 Data Collection

The recruitment commenced in March, 2014 and thirteen interviews were conducted over the next five weeks. All of the participants were required to read the Participant Information Sheet (PIS) and they had their questions answered prior to signing a consent form (see appendix seven and eight). Semi-structured interviews were conducted and I asked open-ended questions, using some prompts in order to elicit as much information as possible about the provision of culturally appropriate midwifery care to Aboriginal women (see appendix nine for sample questions). Interviews were ceased after that time as data

saturation had occurred; however, I still had participants who were interested in conducting an interview. The interviews ranged in time from thirty minutes to one hour with an average interview time of forty minutes. All of the interviews were conducted at the hospital, mostly within the education time available to the midwives. Ten interviews were conducted within the Clinical Practice Development Unit, one in the Pregnancy Induction and Assessment Suite (PIAS), and two in the birth suite. All of the midwives were offered and requested participation certificates (not specifically naming the project) which were provided for their professional portfolios (see sample certificate appendix ten).

4.5 Data Management

All of the interviews were digitally recorded, and I transcribed them verbatim. Within hermeneutic research, it is useful for the researcher to transcribe the data themselves because it enables the researcher to become very familiar with the data in an attuned way (Smythe 2011). Transcribed interviews were de-identified and each transcript was labelled with the participant group identification (e.g. midwife/woman), interview number, and date of interview. Interview transcripts were later assigned a pseudonym which helped facilitate the phenomenological narratives. Digital recordings were stored on a password-protected computer and de-identified printed transcripts were stored in a locked filing cabinet when not in use.

Due to the large volume of data generated, QSR International's NVivo 10 (2012) software management was used in the study. The data for both the women and the midwives were explored through NVivo. Two separate data files were created within NVivo for each participant group. The de-identified word file documents were imported for each interview into the relevant participant group file and they were explored using van Manen's (1990) techniques. Once data saturation was complete all of the interviews were explored again to ensure the meaning clusters and my interpretations had not changed.

Goble et al. (2012) suggested caution when using NVivo or any software management system in a phenomenological study. They have suggested that by using NVivo the phenomenological analysis can be impeded by orientating the researcher's mindset away from the phenomenological stance (Goble et al. 2012). I contend that the software did not impact on the phenomenological process in my study. It was purely a way to manage the

data and conduct the analysis, and helped organise the amount of data that was produced. Van Manen's (1990) steps and the hermeneutic circle can still occur within NVivo, and I saw it merely as a tool not unlike a computer, a word file or the voice recorder used in the study.

4.6 Aboriginal Cultural Consultant

Early on in the research process I was contacted by the then hospital Aboriginal Educator, Ms. Christine Thyer, although she no longer works in that role. She offered her assistance with the project and I commenced regular meetings with her for the duration of my candidature. Ms. Thyer is a Ngarrindjeri woman belonging to the Rigney-Lovegrove family from Raukkan. For many years, she provided Aboriginal Cultural Respect Training and Aboriginal Cultural Consultancy in the Centre of Education and Training at the hospital. She also provided cultural advice on education and training resources within the hospital. Ms. Thyer also sits on various committees and actively participates in community consultation and engagement (Aboriginal Health Consumer Committees and forums).

All aspects of the research design were discussed with her and her advice incorporated within the project. It was important that the project was not an evaluation of the cultural training offered, but an exploration of the experience of cultural care for the women and midwives. Ms. Thyer was very important in facilitating relationships within the hospital and outside the hospital with the relevant Aboriginal staff and organisations. She was also available to provide opinions regarding the interpretations I had made on the women's de-identified transcripts. Ms. Thyer was given a draft of the women's data and her input gathered on the interpretations made from the data. We spent time reading and discussing those interpretations through her cultural lens. We also discussed the publications and the finished phenomenological interpretation for the women, and it was beneficial to understand her perspective on the interpretations. All of her advice was incorporated to ensure cultural competency through this process.

Ms. Thyer and I have met regularly throughout my candidature. She has provided a different way of looking and understanding all aspects related to the research findings. She has also supported me by email, telephone, and by attending my research presentations at the University of South Australia, the South Australian Joint Nurses and Midwives

Research Symposium in 2015, and at all of the presentations I gave at the hospital where the study was based over the duration of my candidature.

4.7 Data Analysis

Within hermeneutic phenomenology guided by van Manen's methodological steps, the data is analysed thematically (Langdridge 2007). Langdridge (2007) has described this as discovering the phenomenological themes as the structures of experience. Van Manen (1990, p.79) described this process as not being a rule-bound process, 'but a free act of seeing meaning'. He also said that in the process of analysing a phenomenon a researcher is attempting to determine the experiential structures that make up the lived experience (van Manen 1990). Although the following stages are represented numerically it was an iterative process. The stages were used as an analytical framework.

4.7.1 Turning to a phenomenon which seriously interests a person and commits them to the world

Phenomenological research represents deep questioning of a concept or thought, of being immersed within it, which is then able to restore a sense of what it is to be a thinker and researcher (van Manen 1990). Van Manen (1990) described how the phenomenological description that follows is always the interpretation of one researcher and will never exclude the possibility of another complementary, richer, or deeper description from another. In my study, the phenomenon of interest was the experiences of midwives in the provision of cultural care to Aboriginal women, and the individual experiences of the Aboriginal women receiving labour and birth care in the SHC system. This began whilst setting up the project and honing in on the research questions and aims. Remaining committed to the focus of the study was important and I did remind myself throughout the process of the aims of this investigation. This stage also involved a level of exploration of my own assumptions and pre-understandings about caring for Aboriginal women as a midwife and through my own culture as a non-Aboriginal woman. I was able to do this through journaling and through exploring the literature.

4.7.2 Investigating experience as it is lived rather than how it is conceptualised

Phenomenological research aims to establish a renewed contact with the original experience (van Manen 1990). The semi-structured interviews with the midwives provided a detailed description of cultural care for Aboriginal women, as perceived by the midwives.

Similarly, the experiences of the women were explored as they lived them, individually, through the use of an Aboriginal interviewer and using semi-structured questions to determine and explore their experiences.

Participants' stories were collected and they were transcribed into word documents. After each interview for the midwives and the subsequent transcription, I was already interpreting the meaning. With the women's interviews, the process started when I first listened to the recording and then throughout the transcription. The process of transcribing was a time-consuming one, but was beneficial to do myself because it forced me to reflect on each word and each sentence many times. Right through this process I was also exploring my own position through the journal and the literature around my topic, which influenced my developing understandings.

4.6.3 Reflecting on the essential themes which characterise the phenomenon.

Each interview with each woman or midwife was reflected upon hermeneutically. Van Manen (1990) described this process as bringing into nearness that which is obscure in order to determine what actually constitutes the nature of the lived experience for each person. Each transcript was read repeatedly as a whole and in parts, and considered in light of the emerging whole understanding.

This stage occurred formally with the assistance of NVivo10 software (2012). However, this was happening at all stages either listening to interviews, transcribing them, journaling, and whilst writing the interpretations of the experiences. I explored each text within NVivo many times because as I read one text it influenced my understandings of the others. Statements were explored and given meaning cluster names. Phrases in the text that illuminated the phenomenon were highlighted and assigned to different cluster groups. This was carried out for every transcript for the interviews with the midwives and the women. The analysis of the data from the midwives and the women occurred separately, with common themes and sub-themes developed for each group. Van Manen (1990) described three approaches towards isolating thematic aspects of a phenomenon; the sententious approach, the highlighted approach, and the detailed line-by-line approach.

The sententious approach involved reading the document as a whole and making sense of the meaning, which leads to the development of an overall meaning. This was occurring through the transcription process. The highlighted approach involved reading the text and highlighting phrases that stood out, and that seemed to be thematic to the experience of the provision of cultural midwifery care or to the experience of the women who receive that care. The detailed line-by-line approach involved reading each sentence or sentence cluster carefully, and then determining what each sentence or sentence cluster revealed about cultural care. All three approaches to the thematic development were used in my study. Figure 1 one illustrates the coding within NVivo 10 software.

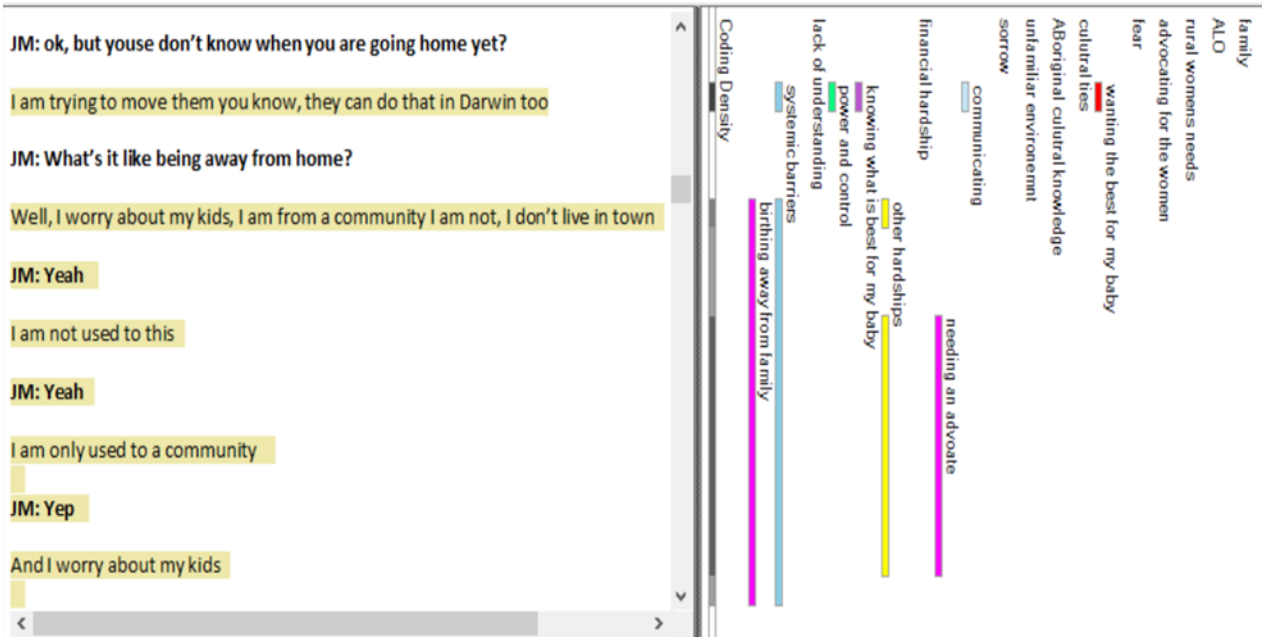
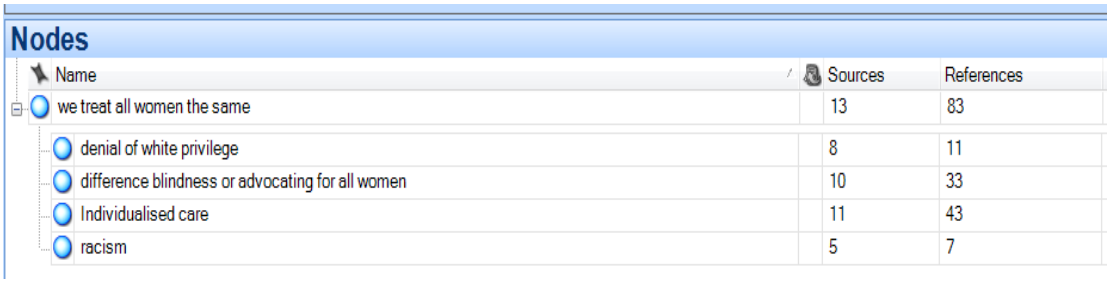


Figure 1 - Coding within one de-identified transcript

Later on, I explored the meaning clusters as a whole and again NVivo 10 was useful to store and search them together. This enabled the main theme areas or areas of understanding of the experience to become tangible.



Nodes

Name	Sources	References
we treat all women the same	13	83
denial of white privilege	8	11
difference blindness or advocating for all women	10	33
Individualised care	11	43
racism	5	7

Figure 2 - Coding within NVivo 10 software

Figure 2 illustrates the meaning cluster 'we treat all women the same' in the midwives' data. Within that cluster I placed denial of white privilege, difference blindness or advocating for all women, individualised care and racism. Within NVivo 10, I was able to group them together and create printouts of the cluster to enable further exploration and interpretation. Text word searches were also made to bring all statements together with a similar meaning. Eventually, these experiences became the theme 'Perceived equity is treating all women the same', with three subthemes (standardised versus individualised care, discrimination – I'm not racist but…, and denial of Aboriginal history and past experiences).

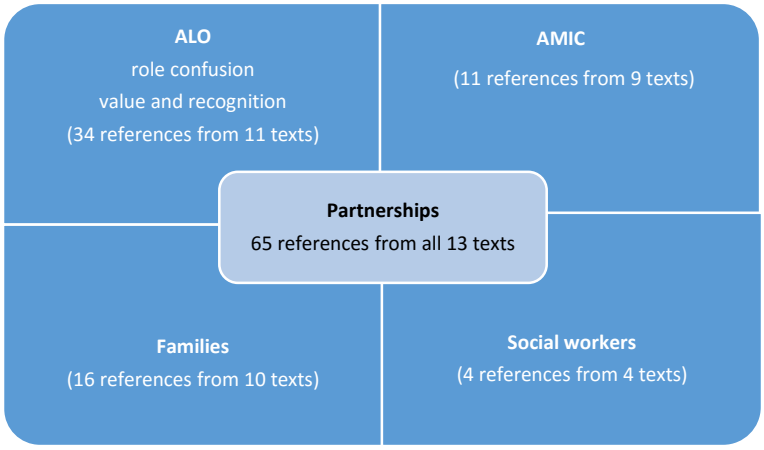


Figure 3 - Coding within NVivo 10 software for one meaning cluster

Figure 3 represents coding within the 'partnership' meaning cluster from the midwives' interviews. There were 65 references within this cluster and they came from every midwifery transcript. This eventually became the theme 'Building support networks –

supporting through and with Aboriginal Cultural knowledge, with three sub-themes (Aboriginal Liaison Officers, Aboriginal Maternal Infant Care workers, and the families).

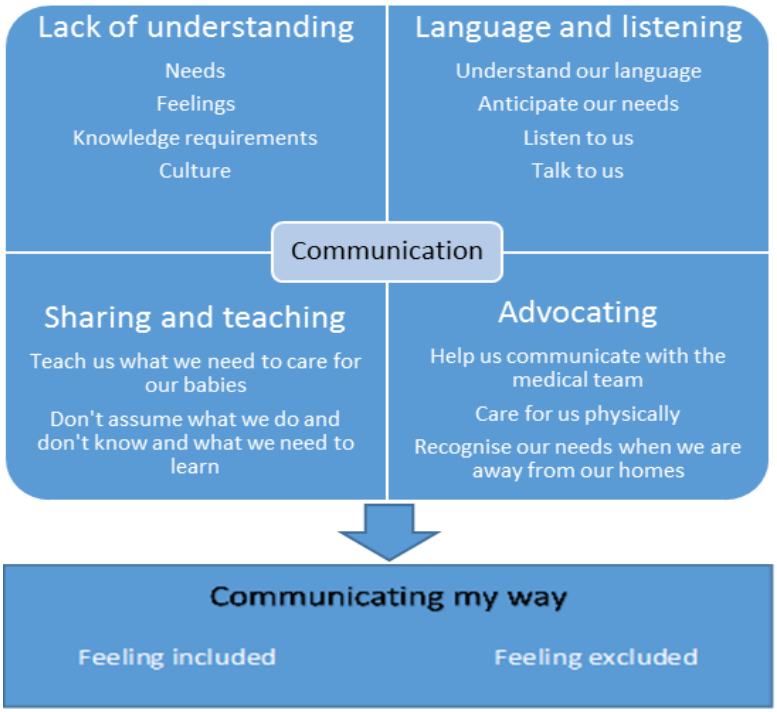


Figure 4 - Representation of the analysis for "communicating my way" in the women's data analysis

Figure 4 represents the development of the theme "Communicating my way" from the women's interviews. In the initial coding stages, statements and phrases that related to the meaning cluster 'women's communication with the health care team' were grouped together and included elements related to understanding, listening, language, sharing, teaching, and advocating. These areas were explored in more detail through van Manen's (1990) analysis and the final theme became 'communicating my way'. I was able to incorporate both the positive and negative aspects of communication described by the women in the study.

For example, in the domain of a lack of understanding, the women talked of the midwives demonstrating a lack of understanding of their needs, feelings, culture, and knowledge requirements. An example of this was when the midwives attempted to provide instruction in breastfeeding techniques to women who had successfully breastfed many children. In the domain of language and listening, they wanted to be spoken to directly and given

information about what was happening with their labours and births. When that occurred they felt less fear and felt included.

4.7.4 Describing the phenomenon through the art of writing and rewriting

Van Manen (1990) described hermeneutic phenomenology as a philosophy of the personal, the individual, which is pursued against a background of an understanding of the character of the other, the whole, the communal, or of the social. Once the interviews were completed, transcribed, de-identified, assigned pseudonyms, and analysed, the essential themes were explored in detail as parts of the whole and reinforced by direct quotes from the midwives and the women. The experiences of the midwives and the women came to the forefront through description and language so that their thoughts and feelings of how they experienced cultural care were revealed. Van Manen (1990) warned of the importance of phenomenological writing as a poetic textual writing practice and the problem when researchers tried to make human science methodologically rigorous in a scientific sense. He said that when the researcher is preoccupied with epistemology and method, the quality of the writing and insights is compromised (van Manen 1990).

I started writing early on even as the interviews were taking place. This enabled a medium for understanding the phenomenon and attempting to develop the essence of the experiences for both groups. The interpretations were edited, rewritten, and reviewed after each interview. Eventually, I came to the final six themes and thirteen subthemes for the midwives. It was through this that the participants' experiences of providing midwifery care to Aboriginal women who gave birth in standard care were revealed. Similarly, I came to the final six themes and seven subthemes for the women, which revealed what it was like to give birth as an Aboriginal woman in standard care. I chose to present the interpretations thematically under the theme clusters and use verbatim quotes to support those interpretations. The quotes within the themes provide the reader the opportunity to judge the strength of interpretation that was made.

There are other ways of presenting phenomenological writing, which include presenting it analytically, exemplificatively, exegetically, existentially, or by inventing an approach (van Manen 1990). An analytical approach would involve writing a reconstructed life story from the data or using incidents described in the interviews to construct fictionalised

accounts that enable contrasting ways of seeing or acting in situations (van Manen 1990). An exemplificative approach involves an initial description that gives the essential structure of the phenomenon, and the writer then continues by systematically varying the examples from the initial structure (van Manen 1990). An exegetical presentation involves a dialogical approach to the writing with the work of a phenomenological author (e.g. Merleau-Ponty), and organises its discussion with the structural themes already identified by that phenomenologist (van Manen 1990). An existential approach is when the writer weaves the interpretation against the existentials of lived time, lived space, lived body, and lived relationships to others (van Manen 1990). The final way of presenting phenomenological writing could be to incorporate a series of the other approaches or to invent a different approach (van Manen 1990). My thematic presentation allowed for the deconstruction of the experience of either being a midwife and providing cultural care, or being an Aboriginal woman giving birth in the SHC system. Each theme was able to represent an aspect of the experience of the participants and it has allowed for a systematic investigation. The women's and the midwives' experiences are presented individually in chapters five and six and discussed collectively in chapter seven.

4.7.5 Maintaining a strong and oriented relation to the phenomenon

Van Manen (1990) said that it is easy to become side-tracked whilst engaged in phenomenological research, and that maintaining a strong orientation to the phenomenon of interest - cultural care for women and for midwives - must be achieved. Van Manen (1990) argued that the researcher cannot adopt a position of scientific disinterestedness as they must be strong in their orientation, and remain animated by it. He found that as a researcher, the text produced must be rich as the epistemological considerations translate into an interest in the story or phenomenological description (van Manen 1990). The use of a reflective journal for the researcher was an important tool and was used throughout the data collection and analysis stages; this was useful to remain grounded and focused on cultural care (see sections 4.8, 4.11 and appendices eleven and twelve).

4.7.6 Balancing the research context by considering parts and the whole

Van Manen (1990) described balancing the research context as being able to continuously measure the overall design of the study or the text under construction as parts of the whole. He advised the researcher to step back and look at the whole and evaluate how the parts

contributed to the whole (van Manen 1990). This approach enabled me to go back to step one to remind myself of the iterative nature of this method as none of these steps were carried out in a linear fashion. As themes and subthemes developed I went back to the beginning and reconsidered my findings in light of the phenomenon of interest. I was able to consider the emerging words and concepts and question whether they were shared and in what ways with the other participants. I would then consider what that meant about cultural care. The phenomenological writing that followed was presented thematically with excerpts from the participants' interviews.

4.8 Reflective Journal

I maintained an electronic reflective journal during the interviewing and interpretation stages of the project. The journal is an essential component of the process of interpretation, used to record the biases and assumptions of the researcher so as to ensure they are embedded within the interpretative processes (Laverty 2008). Steeves, Cohen, and Kahn (2000, p.88) developed guidelines for researchers to address within the journal when undertaking hermeneutic research:

- Focus on the relationship of the researcher and the participants
- How did elements of social attractiveness and mutual trust or mistrust enter into the situation between researcher and participants?
- Consider the interpretations that participants are inevitability making of the researcher and research project and how they might affect the interviews
- How and when did different understandings emerge?
- In what way did the investigator challenge her own understandings of the data and to what extent were preliminary interpretations tested over time?

The questions were used as a guide to help start journaling during the interviewing and interpretation stages of the research project for both the women and the midwives (see appendix eleven and twelve for a sample of journal entries). The journal facilitated the process of interpretation as thoughts and emerging ideas were able to be articulated. This process also allowed for reflexivity during the research process and will be discussed further in sections 4.8, 4.11 and 8.9.6. I was also able to explore my own experiences caring

for Aboriginal women as a midwife, my cultural upbringing, and my understandings of cultural safety and cultural care.

4.9 Ethics

4.9.1 Ethical approvals

Ethical approval from the Hospital Human Research Ethics Committee, University of South Australia's Research Committee, and the Aboriginal Health Research Ethics Committee (AHREC) was gained (see appendix thirteen, fourteen, and fifteen for ethical approval letters). A site-specific assessment was also completed for the hospital as per the requirements of the organisation. The hospital HREC granted approval in December 2013 pending some minor changes to the wording in the information sheets and consent forms. The AHREC did not initially accept the application for approval, requesting that the study be extended to include Aboriginal women younger than 18 years of age. The research team met with a representative from AHREC to determine the best approach to responding to the concerns of the committee. The application was modified guided by their suggestions, and accepted in full at their following meeting. The study was extended to include Aboriginal women aged 16-18 pending parental support.

A later application to grant a modification to the ethics application was made in order to allow Ms. McKenzie to recruit the women. This was approved by all three ethics committees. Further modification requests were made for Ms. Toni-Marie Rowe to recruit and interview women, and to allow telephone interviews for women from rural and remote areas to increase the possibility of their participation in the study.

4.9.2 Aboriginal Ethical Principles

The research project was designed with the values and principles outlined in the National Statement on Ethical Conduct in Human Research (2007). The design specifically considered the six core values identified as being important to Aboriginal and Torres Strait Islander peoples: reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity (National Health and Medical Research Council 2007).

Some of the ways the research project has embraced these principles included a design that allowed the women to tell their stories about what is important to them as Aboriginal

women when they birth. Their voices are heard within this thesis and the results disseminated so that midwives can respond to their experiences. The women were also advised that the research student is not an Aboriginal woman and that an Aboriginal Cultural Consultant might read the de-identified transcripts. The women were also advised that no men would form part of the research team or have access to their information. The women were offered the opportunity to have a summary of the results either in person or by mail at the conclusion of the study; eight of the participants requested a printed summary which was developed with Ms. Thyer.

I presented the literature review internally to the hospital midwives in 2014 and at the Mothers, Babies and Families: Health Research Group and Midwifery Research Symposium. I also presented my research to the academic staff and students at the University of South Australia Research week in 2013, 2014, and 2015 (research proposal and findings). I presented the findings to the 2015 Nursing and Midwifery Research Symposium, which was a joint collaboration with Flinders University, University of South Australia, the University of Adelaide, and the Government of South Australia. I shared the findings with the hospital reconciliation sub-committee in 2015 and with the hospital midwives early in 2016.

By engaging Aboriginal interviewers and partnering with Aboriginal Liaison for recruitment, the women were shown respect and were free to engage in honest representations of their experiences without a colonising context. The partnership with members of the Aboriginal workforce within the hospital and the interviewers was also important for equality, where employment and skill development was also offered to Aboriginal people involved in Aboriginal research. The interviewers were given contracts and employed by the University of South Australia.

4.9.3 Informed Consent

Participation was voluntary and the research participants were informed of their ability to withdraw from the study at any time without prejudice. The participants were all told that non-participation or participation would not affect employment for the midwives, or for women, the care that they would be offered now or in the future. All participants were asked to read the information sheet prior to the commencement of the interview. Interviews

did not start until informed consent was gained and documented, and they all received a copy of the consent form. A separate consent form was designed for women aged sixteen to seventeen years that included parental consent.

All the participants were made aware that the interviews would be digitally recorded and would be transcribed verbatim and then de-identified prior to the interviews starting. All participants were also informed that their actual de-identified words and statements would be used in the final thesis, in journal articles, and at conferences.

4.9.4 Freedom to participate

I did not approach the midwives directly for participation, which helped reduce any obligation that they might feel to participate as I also worked within the birth suite where the participant sample was sought.

In order to reduce the pressure on the women to participate, they were always approached by Aboriginal women in relation to my study. This ensured cultural difference could be respected and the women could feel safer in their decisions to participate or not.

4.9.5 Confidentiality

All participants were advised that their digital interviews would be transcribed into de-identified documents that were accessible to myself and my supervisors. All participants were advised that their information would be stored in a locked filing cabinet when not in use or a password protected computer at the hospital, and a copy of the data also held securely at the School of Nursing and Midwifery at the University of South Australia at the completion of the project for a period of fifteen years. The interviewers were also asked to sign confidentiality agreements prior to commencing the interviews.

Any information that arose within the interviews that could potentially identify the participants was not used within the final thesis or in any subsequent publications or conference presentations arising from the study. Participants were advised that their information would remain confidential except in the case of a legal requirement to pass on personal information to authorised third parties. They were advised that the requirement was standard and applied to information collected both in research and non-research situations. They were also advised that such requests to access information were rare.

4.9.5 Possible risks and benefits

The midwives were informed that they would not benefit directly from their participation and that they might experience emotional distress when discussing aspects of their practice. Referral pathways were developed for the midwives should they need further support (see appendix sixteen). None of the midwives in the study expressed any concerns about their wellbeing during or after the interviews. The midwives understood that the research data might be used to develop and target their educational needs in relation to cultural care.

The women were informed that they would not benefit directly for their participation in the research study. They were also told that sometimes when discussing their births, especially if they had negative experiences, that they might become upset. Referral pathways were developed for women who might become upset when interviewed in hospital and for those who might become upset when interviewed outside the hospital (see appendix seventeen and eighteen). None of the women became distressed during the interviews, but one woman was unhappy about being away from her family and community. She requested her interviewer to come back and see her again the next day. The interviewer did go back and visit with her and offer support. The women were offered $50 supermarket cards for reimbursement of expenses associated with participation.

4.10 Rigour, quality and trustworthiness

Traditionally quantitative research studies have used reliability and validity to establish the credibility of the research process (Noble & Smith 2015). Issues of quality and rigour in qualitative research have generated much debate in academic discussions (Baillie 2015; Rolfe 2006). Three positions have been identified, which include: scholars who believe rigour should be judged in the same way as quantitative research; those who question the use of any set of criteria; and those who believe a different set of criteria are required (Rolfe 2006).

The first position represents those who believe qualitative and quantitative research should be judged in the same way. However, the philosophical assumptions in a positivist study differ considerably from the position adopted in qualitative works. Some academics have argued that the fundamental differences in a qualitative and quantitative study mean they should never be judged against each other, or with the same measures to evaluate them

(Hansen 2006). Validity in a qualitative study has different implications and applications (Holloway & Wheeler 2010) and many qualitative researchers reject reliability and validity as a means to assess quality. Validity is defined as the extent to which an instrument measures what it is supposed to measure (Hansen 2006; Long & Johnson 2000). In a qualitative study, validity relies on description and interpretation by researchers and truth telling by participants (Hansen 2006; Holloway & Wheeler 2010). Reliability refers to the consistency of the research and the extent to which it is repeatable (Holloway & Wheeler 2010). This is a difficult task in a qualitative study as the researcher is the main research instrument unlike in a positivist study (Holloway & Wheeler 2010).

The second position is represented by those who question the use of any set of criteria to judge the quality in a qualitative study. Qualitative studies comprise different approaches with different philosophical assumptions, and scholars have argued about the limitations of attempting to determine rigour within an interpretative phenomenological study. This is because the use of a generic set of criteria for determining rigour is inconsistent with the philosophical underpinning of Heideggerian phenomenology (De Witt & Ploeg 2006). Researchers should clearly outline and provide evidence of the processes involved in the development of the research (De Witt & Ploeg 2006). This is consistent with Whitehead's (2004) recommendations for hermeneutic research where she emphasises the importance of showing and exploring the decision trail to the reader, which reflects the philosophical underpinnings of phenomenology.

In accordance with the underpinning philosophy of interpretative phenomenology, the research data was not provided for validation to the participants. Phenomenological enquiry based on Heideggerian philosophy has sought to elicit pre-reflective accounts of a phenomenon, and returning the transcripts or the interpretations of the phenomenon to the participants interferes with this process. The interaction between the researcher and each participant produced the research texts. Through open-ended questions and the use of probing questions this was achieved. The truth gained from Heideggerian phenomenology is multiple and context-specific (McConnell-Henry, Chapman & Francis 2011) and returning the data to the participants interferes with this process.

Samples of the data analysis were reviewed independently by my supervisors. All three supervisors received a transcript of an entire interview (for a midwife and a woman participant) on which they independently conducted their own data analysis. We met and discussed our interpretations. The interpretation of the women's data was also provided to Ms. Thyer for her consideration around the interpretations that were made. We discussed the data through her cultural lens as an Aboriginal woman. This ensured a level of cultural rigour. The doctoral supervisory process also acted to ensure consistency and adherence to the phenomenological methods used within the study.

The use of verbatim quotations within the study to represent the themes has allowed the reader to determine the credibility of the interpretation (see chapters five and six). Verbatim accounts of data collection contributes to validity in research (Guest, MacQueen & Namey 2012). This also supports an audit trail as the reader can see, judge, and interpret the data analysis interpretations that were made (Guest, MacQueen & Namey 2012). Seers (2012) suggested that quotations are important as they keep the analysis firmly grounded in the participants' experiences. This is vital as the methodology can also serve to direct the level of interpretation undertaken whereby analysis should move beyond description, but interpretation should not move beyond the data and out of the hermeneutic circle (Whitehead 2003).

The third position is represented by those who believe a specific set of criteria can be developed for qualitative works (Rolfe 2006) that parallel traditional quantitative approaches to validation (Creswell 2013). For example, Guba and Lincoln (1994) developed the concepts of trustworthiness and authenticity. They developed them as a parallel concept to validity and reliability from the positivist paradigm as an alternate criteria for judging the quality of a qualitative study (Holloway & Wheeler 2010; Nelms 2015). Whilst the debate continues surrounding the use of criteria to appraise interpretative phenomenological research, many academics have attempted to determine standards or quality indicators for interpretative phenomenological research (De Witt & Ploeg 2006). Some academics have called for paradigm-specific criteria to assess research findings that would ensure greater methodological purity and would hold the research team accountable to the approach selected for the study (Armour, Rivaux & Bell 2009).

Creswell (2013) described five standards to assess the quality of phenomenological research. I will address each of Creswell's (2013, p.260) standards individually:

1. Does the author convey an understanding of the philosophical tenants of phenomenology?

I have provided a thorough outline of the philosophical assumptions of an interpretative phenomenological approach in chapter three. The ontological understandings lend themselves well to understanding the experiences of the women and the midwives. Heidegger's concept of *Dasein* is explored and related to the experience of 'being' for both the women and the midwives. Heidegger's philosophical assumptions are woven throughout the discussion within my thesis.

2. Does the author have a clear phenomenon to study that is articulated in a concise way?

The phenomenon of 'cultural care' is outlined in chapter one. I have explored how the phenomenon relates to both participant groups. Although cultural care is experienced differently by each group, it can still be explored through phenomenology for all of the participants.

3. Does the author use procedures of data analysis in phenomenology, such as the procedures recommended by Moustakas (1994) or van Manen (1990)?

I used van Manen's (1990) data analysis technique because of its foundation in Heidegger's work and its focus on narratives and lived experience. Through adopting his framework, I was able to fully explore both the women's and the midwives' experiences of cultural care in a tertiary hospital. I have outlined the connections between Heidegger and van Manen in chapter three and how they supported the data collection, analysis, and presentation of the results. I conducted much of the analysis within NVivo 10 software, which has enabled an audit trail of the interpretations made and connections with the data and analysis.

4. Does the author convey the overall essence of the experience of the participants? Does this essence include a description of the experience and the context in which it occurred?

Chapter five presents the experience of cultural care by the women in the study. The themes and sub-themes represent how the women experienced their midwifery care with a focus on their cultural needs as Aboriginal women. Chapter six presents the experience for the midwives with the six main themes and sub-themes. The themes provide the structures of the experience of the provision of care that the midwives believed to represent cultural care for Aboriginal women.

5. Is the author reflexive throughout the study?

I have addressed my position throughout this thesis in chapters one, three, four and eight. I also used a reflective journal during data analysis to ensure that I was able to explore my biases and how they could impact on the analysis. As a non-Aboriginal researcher who is also a midwife, this was very important to address throughout this thesis. I was able to explore my own upbringing, culture, births, and experiences caring for Aboriginal people both as a nurse and as a midwife. I was able to deconstruct how those factors influenced my interpretations and how I attempted to minimise their influence.

Despite the debate surrounding the use of generic criteria to evaluate a Heideggerian qualitative study, I conducted an evaluation using Walsh and Downe's (2006) criteria. This was more a way to demonstrate quality within the research process. The scope and purpose, design, sampling strategy, analysis, interpretation, reflexivity, ethical dimensions, relevance, and transferability are all discussed in chapter eight and within this chapter. By engaging in Walsh and Downe's (2006) appraisal method, I was able to demonstrate methodological rigour and support an audit trail.

4.11 Reflexivity

Reflexivity refers to the positioning of the researcher within their writings (Creswell 2013). Creswell (2013) suggested that the author discusses their position in relation to the phenomenon, and discusses how that position might shape the interpretations formed. Some of this occurred during the journaling process of the study and I will address my position and the potential influence in the following section.

As a midwife who has worked for many years in labour and birth care, I had become interested in the ways a person's culture might influence their experience of care. The

hospital where my study was based cares for women from many different cultural backgrounds. I had wondered what that might be like for them on many occasions. The statistics surrounding pre-term births, low birth weight, maternal and neonatal morbidity and mortality for Aboriginal women were personally deeply concerning to me, and I wondered if I was 'doing it right'. Initially, this is what led me to the research aims. I wondered if we, as midwives, had the skills to achieve appropriate care.

I can remember many occasions when I felt that I was not getting it right as I sought to engage with Aboriginal women and families in my care. It was not the midwifery care - I knew I could do that; rather, it was the connections, the communication, and working out their needs. I became interested in the cultural training we received and wondered if we were actually taking home what we needed from that training and implementing it in our practice. This was the initial focus of my doctoral studies; what were we learning? Did we change our practice? I personally felt I needed more help with this part of my midwifery practice. After meeting Ms. Thyer (ACC) and hearing her perspective, and having gained direction from my supervisors, I was able to understand that this was impossible to do without actually hearing from the women.

I have personally learnt so much throughout this Ph.D. in terms of the limitations of my own understandings around Aboriginal health and contact with health services. I was seeking cultural training that would answer all my questions, perhaps with a take-home manual or checklist that could provide the answers for me to provide better care to women and their families. This process has provided me with so many learning opportunities, through the research, through mentoring from Ms Thyer, and having been given the opportunity to ask questions without being judged for my ignorance at times. I have also learnt that it is my responsibility to explore my own culture and history in order to understand Aboriginal peoples' experiences better.

Throughout the process of interviewing I engaged in journaling firstly to aid in data interpretation, but it also served to contribute to reflexivity. I was able to explore how I felt as a midwife hearing some of the statements from my colleagues that at times were quite confronting. What would I say if I was the person being interviewed? Sometimes I felt that they were more open because of the established collegial relationships and because I had

worked with most of them for over ten years. I was well-established in the *culture* of midwifery and felt protective of the profession and of my colleagues. I was very aware how this might negatively influence my interpretations as I sought to protect my profession and my colleagues. On the other hand, it served as a constant reminder not to do that, which made me always try to explore my position in relation to theirs.

As my candidature continued so did my learning and exploration of some of the key issues surrounding Aboriginal health. For example, the concept of reverse discrimination was mentioned often in the midwifery interviews. I am not sure I had previously considered this at all but as I engaged with the academic literature I was able to see that this was an issue of power and reverse discrimination did not exist. However, I continued to hear this term both in the interviews and in my clinical role from the midwives. I was able to determine that it was education that was needed so that the midwives could understand these concepts better.

The journaling was also helpful to explore some of the emotional responses to the women's interviews. Roslyn's entire interview was a very powerful one to hear. I know she would not have spoken to me in the way she did to Ms. McKenzie. The written transcript did not do the interview justice, as hearing Roslyn's experience was so powerful and confronting. Likewise, hearing what Ava experienced and how difficult it was to disclose her marijuana use and subsequent treatment was an interview that was practice-changing for me. I have found that when I care for Aboriginal women now I spend more time trying to determine their needs and respond to them sensitively.

The women in my study did not share their thoughts and feelings with their caregivers, so I find myself now trying to better meet their needs by attempting to identify them. Many of the women in my study wanted to be asked about their cultural needs but were not, so I am now mindful that this is as important as their physical needs and should be explored with every woman.

Having Aboriginal interviewers was actually beneficial to this process and although at times, listening to the recordings I wanted to ask questions, I still felt engaged in the process of understanding. It felt right that the women could talk to another Aboriginal woman. I

had experience in caring for Aboriginal women in labour that were both positive and negative. It was exciting to wait and wonder about what would come about from their stories of their intrapartum care. As the whole developing understanding of the women's experiences unfolded it was interesting to see how their experiences differed from the interpretation I had made from the midwives' data. Likewise, I started to see the similarities which were grounded in physical care.

4.12 Limitations of the method

It is important to acknowledge that I am a non-Aboriginal midwife and researcher. I have attempted to mitigate that through the use of Aboriginal interviewers and by working closely with Ms Thyer as the ACC throughout the project. I also recognise that I have worked closely with all of the midwifery participants for some time. McEvoy (2001) has said that when interviewing colleagues the shared experience can in fact act as a catalyst, that assists with the development of depth of an enquiry but only if the interviewer is prepared to question the relationship. This was achieved through the journaling process. Other researchers have argued that this might, in fact, be negative as when there is familiarity there is an implicit understanding that might stop the interviewer from seeking more depth or clarity in the process (Seidman 2006). I have chosen to see the relationships that I have had with my colleagues as a benefit to the process because they have spoken very freely with me. I feel that this has enriched the discourse and has been positive to achieving the research aims.

As mentioned in chapter three (section 3.5) Heidegger's links to the German socialist party could be seen as a limitation given Aboriginal peoples' experiences since colonisation. Grounding a research study in the work of a philosopher who was associated with a racist genocidal history could have been seen as a limitation. However, I have chosen to reject his racist beliefs and focus on the philosophy that did fit the research aims of the project.

The study findings are not transferable to other institutions. These were the experiences of one group of midwives and one group of women working in or giving birth at one South Australian public hospital. Although the results are not transferable they do contribute to further knowledge and understanding about Aboriginal cultures in midwifery practice. Some of the attitudes of the midwives towards Aboriginal peoples accessing health care

that are presented here have been found to be similar to the attitudes from health care providers demonstrated in other published works (Best 2014; Henry, Houston & Mooney 2004; Kelaher, Ferdinand & Paradies 2014).

4.13 Summary

Within this chapter, I have explored the methods used in my research project. I have discussed the sampling and recruitment techniques used within the study. The demographic profiles of the participant groups are presented. The data collection techniques through face-to-face interviews and the use of two telephone interviews are explored. I have also outlined the engagement with the Aboriginal Cultural Consultant and the Aboriginal interviewers employed for my project. Issues of reflexivity and rigour are addressed. The women's and the midwives' lived experiences were able to be explored within the research project under the Heideggerian phenomenological framework and using van Manen's (1990) methods for data analysis. I have outlined van Manen's (1990) data analysis technique and how it supported the analysis in this project. In the following chapter, I will present my interpretation of the women's experiences.

Chapter 5 | Women's Experiences

"Our culture is something that has sustained us for thousands and thousands of years and will continue to do so in generations to come." Hetti Perkins (2010)

5.1 Introduction

The interpretative themes from the interviews with the women are presented in this chapter as a phenomenological interpretation of birthing for Aboriginal women, with a focus on the cultural aspects of the experience. They were developed using van Manen's (1990) six steps for thematic development of the fourteen interview transcripts with the women. The themes are supported with the women's actual verbatim words. All of the women were assigned pseudonyms in the study. My interpretations of the women's experiences will be discussed in chapter seven. A paper based on the women's experiences was accepted by the peer reviewed Women and Birth journal (Brown et al 2016b). The midwives' experiences will be explored in chapter six.

Six main themes were developed as illustrated in Table 5.

Table 5 - Themes representing the experience of cultural care for the women

Themes representing the experience of cultural care for the women
1. Knowing what is best and wanting the best for my baby
2. Communicating my way • Feeling included • Feeling excluded
3. How they made me feel • Feeling judged • Feeling supported
4. All my physical needs were met
5. We have resilience and strength despite our hardships
6. Recognising my culture • Being treated differently • Recognition and respect for my culture • Family ties

5.2 Theme 1 – Knowing what is best and wanting the best for my baby

It was clear that all the women wanted the best for their babies. A healthy baby was forefront in their minds and they made sacrifices to ensure that happened. Isabelle explained:

> "…giving birth to her and hearing her cry, because with [other child] we didn't hear him cry and for her to cry I just started to cry myself."

Lucy's focus was on the health of her baby, which was the most important aspect of care. She explained:

> "Just [the baby] being born healthy…just that [the baby] is healthy."

Some of the women relocated from rural and remote areas towards the end of their pregnancies and agreed to be transferred out of their communities and away from their supports. One of the participants, Lucy, had a high-risk pregnancy and came from a rural area. She made a six-hour return bus trip every two weeks to ensure she attended the recommended twice-monthly antenatal appointments. Lucy had five other children and was a carer for her partner.

Some of the women also knew what was best for their children and this was often negated by hospital practices. For example, Stacey discovered that hospital staff had started feeding her baby formula and she told them they had to stop as she wanted her baby exclusively breastfed. Stacey came from a rural area, had a premature baby in the nursery and was not able to find acceptable accommodation at a reasonable price, close to the hospital. She wanted to be close to her baby.

Fiona practised co-sleeping at home and was told by the midwife that she was not able to do that in hospital. She told the midwife that she would prefer the baby to sleep with her but that if she had to she would comply with the hospital practices as she explained in the following excerpt:

> "…we like to keep our children with us in bed, and they sleep with us all the way up until they are old enough to sleep in their own bed, so that's just how we are…we have to leave them in here and we don't like that, we want to grab them and put them in bed with us…and

> I've told her, I said that we prefer them to sleep with us but if we have to we will put them in their cot."

Emily had a premature baby because of medical complications in her pregnancy. She drove herself from a rural area to the hospital to receive care because of her complications. Because of her medical complications she was given a caesarean (after previous normal births). Emily expressed some fear, but her driving focus was on the health of her baby; she explained:

> "I felt a bit scared, but I was just wondering about the baby and what was safer for him."

Roslyn's baby had a medical problem that needed to be investigated after birth. This required her to relocate from her remote community. She was very unhappy about this. She felt that everything was normal with her baby. Being required to have the problem investigated in Adelaide was extremely difficult for her and was contrary to her law in her community. Roslyn explained:

> "Well, in our law, like, when we have a baby we go back to community and we go back to bush medicine, that's what we do at home, it makes them grow strong …bush medicine for flu and all that, for diarrhoea, for everything."

Roslyn felt that she knew the condition was not what the medical staff perceived it to be, but she still came to Adelaide and this was extremely challenging for her. She desperately wanted to be at home and was frustrated by the delays in getting the condition diagnosed and treated. Despite going against her traditional law and customs, she still agreed to come to Adelaide to have her baby in order to secure the best physical health for her child. Roslyn was also told how to care for her baby by the midwives; she did not appreciate the interference given she was an experienced mother. She explained:

> "They was telling me what to do, how to, what to do for my little baby, how to feed my baby and I told them you don't tell me what to do, I already got kids."

5.3 Theme 2 - Communicating my way

There was a strong association within the women's data that showed that when the midwifery and medical staff practised open, inclusive communication with the women, the women's experiences were more positive. When the women felt that they were excluded from care, or not provided with adequate information their level of fear and anxiety would increase which negatively impacted on the experience.

5.3.1 Feeling included

Communicating with the women and keeping them informed about what was happening with their labours and their babies after birth was really vital to positive experiences for the women. When women felt included in what was happening they reported positive experiences. Ella explained:

> "…they were open, they were just, you know, just open and just talking about what is going on and usually sometimes midwives are, sometimes you know they don't say what is going on or what is happening…to be straight out and um, you know, maybe when you are talking about the patient to um, let the patient in instead of being all quiet and talking in the corner which I found was good with the [hospital name] they were open and discussed about, talked about was going on."

Shelley felt that the communication actually helped reduce the fear and anxiety for her. She was feeling confused about what was happening to her and the midwife asked the medical staff to sit down and talk to her about how her labour was progressing. Once she understood what was happening the panic she had been feeling was reduced. She explained:

> "Well, I was a bit worried because doctors were telling me one thing to another, and it was good to be having one doctor come in and clarify what's happening, making sure, like even though they were up in the air, just to double check, and clarify with me, I like that and I didn't expect one of the nurses [midwives] to go out and say 'Oh doctor like, this young lady is confused', cos I was, and cos I didn't have much support, cos
>
> like the further away that my family were, that um, I was just like oh well, I don't know how to take it, like they're telling me one thing and I'm telling my partner and it's like he's panicking and I'm panicking and it's like, it was good to have, like a nurse [midwife] respect me enough to actually go ask the doctor to sit them down and go like we know that you're confused…"

Open communication and feeling that the staff were open to questions helped make Fiona feel better about what was happening and was really important to her experience. Fiona

also felt that when the staff made extra effort to make sure she was comfortable this reduced the fear that she had. Fiona explained:

> "…they helped me really good, they was really nice to me and they wasn't rude or anything, yeah, I, they were really good to me…Yeah, yeah, I felt like, I felt like that was all good. Like I could ask a question and they would help me, answer it and stuff, yeah."

Lucy also felt that having open channels for communication and communicating effectively was associated with her overall satisfaction with the experience, as she stated:

> "I had plenty of time to ask questions and what was going on and I got it all explained properly…they were explaining things as it was going along."

Isla also recognised body language as contributing to open communication:

> "Like, um, some nurse [midwives], like I see, some are really good, like you know when they, in their body language, some nurses [midwives]."

Ella also explained how connections with the midwives were formed with effective communication, and how this helped the women feel comfortable and included. She explained:

> "Just to make sure I was ok, happy, and yeah, cos I was, freaking out, because nothing had happened and they had put me on a drip and, um, they just made sure that I was ok and happy and gave good, just telling stories and that, yeah."

Ella also said how she felt included because the decisions were made around her and with her, and she compared that to her previous experience. She explained:

> "…they talked around the bed. Whereas when I had [other child] up in [different state] they talked like quietly on the side or whatever and my friend who was my midwife, and she had said come and talk to me about what was happening, but yeah it was good. It's a different experience here."

5.3.2 Feeling excluded

Ava shared her thoughts on her experience and how she felt confused about what was happening which made her more fearful; overall she had felt 'out of the picture'. She also

said that she would have liked more communication to have occurred, particularly directly with her as she found out information from her relatives. She explained:

> "It was fearful, I wasn't really sure what was going on at the time…I didn't really get explained what was going on…[I felt] sort of out of the picture…um, yep, it's just like I heard not from the actual doctor or midwife, no one talked to me directly, I just found out stuff from people, like my mother in law, no one looked at me and said 'your baby has passed its bowels' until it had gotten closer to the caesarean and then they said that's why it needed to be done."

Although Ava's experience could have been better, she said that overall it was a good experience because it went smoothly in the end.

Ella also talked about the midwifery staff not asking her wishes when they were planning to do a vaginal examination and asked her support people to leave. She did say that she would not have minded having them there and thought it would have been nice if they asked her what she wanted.

For Roslyn, who was desperately unhappy with being away from her family and community, the lack of communication with her was extremely difficult and contributed to a poor birthing experience. She talked of her frustrations:

> "They gotta let me know soon…I'm getting upset with hospital, I told them I'm not gonna stay in the city, in the ward…they was gonna let me know today but they gonna let me know tomorrow…"

Isabelle had birthed at a different hospital for her first baby, but that experience heavily impacted upon this one. She kept coming back to that experience and the lack of communication with her during the birth. She shared her experience:

> "They just kept me in the dark and didn't tell me anything about it…And then they have turned around and gone 'Do you know?' Like they sat down on the bed and put their hand on my leg and go 'Do you know why, like what's going on here?' And I'm like no, not really and they're like well your baby, do you know the reason why your baby is in the incubator and I'm like no…and they, they just kept trying to skip it and not tell me exactly down to the point of what was wrong and then they were, like, just left me and they were like figure it out for yourself."

Isabelle explained that while she was happy with this experience of birth overall, she did have one occasion where the midwife would not allow her partner to enter the room because a vaginal examination was taking place:

> "…she was rude to my partner when they were like, checking how dilated I was because I was having pains and stuff. Um, and they were like 'you can't go in there' and he was like 'but I'm her partner' and they were like, 'nup, you still can't go in'."

5.4 Theme 3 - How they made me feel

For some of the women, a sense of feeling judged, which was often linked to their Aboriginality, also contributed to negative experiences. However, there were also births for the women where they felt supported in their care. How the women felt, either supported or judged, was important to their overall experience of birth and for them was often tied to their Aboriginality.

5.4.1 Feeling judged

Rose talked of her experience with this birth. Like many of the other women who had other children, their past experiences with birth were frequently mentioned in relation to the current birth. It was important to her to not feel judged. She explained:

> "Just to feel welcome, and not judged, that's my main, last time when I had my son I just felt like I was, I think there were a lot of emotions too, but I just felt like a little bit judged. If I'd go outside for a smoke or if I needed to put her in the nursery for five minutes, I would just feel like there was pressure on me to be that extra bit more perfect because of my culture. But this time I haven't even felt that at all. Everyone has just been awesome…and to, to not feel like we are being judged because we are black."

Ava also felt judged as a person and she felt that it was because she was Aboriginal. She talked about disclosing to the doctors and midwives the fact that she had smoked marijuana in her pregnancy. This had been extremely difficult for her, but she did disclose her marijuana use because she wanted the best health care for her baby. The medical staff did not believe that she had only smoked marijuana and questioned her on multiple occasions. She shared her experience in the following excerpt:

> "And in hospital about three or four times, um, I was questioned as to whether I did something else. And I whole heartily told the truth, like I smoked marijuana and I even got taken out of my room and into another room and sat down with a doctor who said 'you can

> tell me no one is here'…I cried, I was very, very upset, I felt like they were judging me…it meant a lot to me tell the truth, it meant a lot to me to say yeah I smoked marijuana, it makes you feel bad that I did drugs when I was pregnant, marijuana, um, to do the drugs and it's a bad thing to do and it took a lot for me to say that and apparently they told me that her conditions or the side effects was like amphetamines or heroin. And um, it really, really upset me. Um, but they ended up letting me go home, like um, and they said it about three or four times, and the last time they said it, like they even said it in front of my partner at one stage and he told me the next time they say it just to say um, if you're not going to take my word for it just test her, do a blood test do whatever you have to do, but, um they didn't end up saying it again, because I burst out into tears in front of them the last time they said it and said 'get out of the room and don't question me like that' and they said 'no one is here, young mums have a tendency not to tell the truth' and stuff like that and I just burst out crying, I felt, um, judged, really judged."

Ava was made to feel that she might not be able to leave with her baby. She recognised that her marijuana use was bad for her baby but acknowledged and reported it to the health care team so that her baby would get the best care. Ava discussed her thoughts:

> "I don't think like, marijuana is only something small and I really didn't think that they were going to let me go home with her because they thought that I was this huge horrible person or that I had done this huge bad thing. But I think that there was just a mix-up with her scores or something that's all."

5.4.2 Feeling supported

Stacey felt supported by the midwives for her birth. She also described how she was attended in labour by midwives who were not actually assigned to her care. Because they answered her call bell and stayed with her she felt supported and cared for. Stacey shared her experience:

> "…when I went into labour and I was screaming and some people didn't, the nurses [midwives] who weren't meant to be checking on me, they'd come in and check on me and stayed with me and they were really good."

Rose felt that the experience of labour support and good communication led to a positive experience for her:

> "I had the smoothest experience with my second, um, yeah, I think, I don't know how to put it, like, they were really, um, like, really supportive and just helped me cope…I felt really, um, just like, everything just went right, I didn't have any worries or stresses, they were very good with the coaching, helping me breathe and stuff like that."

Rose also described how she felt that she was not alone due to the midwifery support in labour despite the fact she only had her sister there for the birth and had planned to have more people. She shared her thoughts:

> "Considering I had no, only my sister around me, it felt like I wasn't alone anyway, I just felt, yeah, it was the best birth."

Shelley was really happy with her birth, she felt comfortable and supported and described really positive communications with her midwives:

> "It was excellent, um, some of the other staff, um, they're, they're so nice, the care, the staff here are lovely, um, the, yeah, um, yeah I am a talking person and so I always like to chat to everybody, so I am just chatty jabber jaws, besides that the staffing was excellent they answered all the questions and they didn't look at me like I was stupid and, um sometimes, like, cos I had my son young, the first one, um, they used to go 'Oh her again' you know what I mean? This was absolutely excellent compared to my previous, um, children, the [hospital name] are excellent, the staffing didn't make me feel any, they made me feel comfortable, they didn't make me feel out of place, it was excellent…"

Shelley also described how feeling supported and comfortable helped reduce the fear for her. Shelley shared her thoughts in the following excerpt:

> "I was panicking cos when I got transferred here they made me think that I was going for a c-section, my, I was failing, my kidneys were failing, like, um, and I didn't know what was happening. So it was really, really, scary until I come here the staffing made me feel comfortable and I wasn't really scared and I was just scared because I was by myself."

Fiona explained how she felt supported through the birth and that led to her positive association with the experience:

> "Today, I like [hospital name]. I think they were really nice, you know they, they support you in a really good way. I have had all my, my four children, here, so this morning, it happened, it all happened really quick, and everyone was really nice to me and helped me really…they helped me really good, they was really nice to me and they wasn't rude or anything, yeah, I, they were really good to me…Um, yeah, like all of it did, yeah they helped me really good they was really nice. Um."

Rachel, too, felt supported by all of the hospital staff. She said:

> "Yeah, um, there is nothing really to say like for a first-time experience everything went well, you know, like, I am looked after, the midwives, nurses, doctors everybody here is you know, all supportive."

5.5 Theme 4 – All my physical needs were met

The women frequently expressed satisfaction with the midwifery care provided to them. The midwifery care was often measured in terms of physical care. Physical care related to medications, analgesia, birth coaching, getting them to theatre, performing observations, or getting them something to eat. It was less related to the emotional or cultural aspects of caregiving. Ella explained:

> "No, they did a good job and they just come in and take the observations and, um, they said if I needed anything to press the buzzer."

Rose felt that the coaching to get her through the physical act of birth contributed to the positive experience of midwifery care:

> "Yeah, yeah, I was, I felt really, um, just like, everything went right, I didn't have any worries or stresses, they were very good with the coaching, helping me breathe and stuff like that."

Ella also associated a satisfying experience with the fact the midwives got her something to eat while she was waiting for her induction to start in the birth suite:

> "Yep no it was like because we were waiting around for so long I was getting hungry and one of the midwives said you can have a snack but don't eat too much in case you have to go into the surgery…they got me a big feed later."

Like Ella, Ava correlated good midwifery care with ensuring that she was helped with the baby and fed well. She explored her experience:

> "Um, I did have a midwife, like I wasn't eating and stuff cos I had a caesarean, um, emergency caesarean and like that was the worst outcome, was a caesarean, and I was worried like if I vomit for some reason my stomach was really tense and cos I wasn't eating I wasn't breastfeeding and my midwife, she would come in and say like 'get off your phone' and 'go to sleep' or 'make sure you eat' and like she was really nice to me and um, yeah it was good like the midwives were good it was mainly the doctor who was pretty mean…so just like helping me with the baby and passing it to me, like giving me hints and

> tips on breastfeeding and stuff cos it really wasn't working at first. Um, settling and stuff like that. They were just helpful."

Brooke was focused on the management of her mental health condition and this was the most important part for her entire birth experience. Brooke felt her needs were met from the midwives because they ensured her medications were given on time. She explained:

> "…like having a mental illness, you know I had to make sure that my medication was there for me to take daily because I could relapse, um so they made sure that I was comfortable, um you know, taking my medication, and that you know if I was in pain that it was dealt with instead of, you know, just mucking around."

Lucy said the midwives were great because they were efficient and got her to theatre on time:

> "Really good. They were real supportive, yeah. They dun what they had to do to get me to theatre in time."

Fiona described how she liked the way the midwives handled the babies and helped her with caring for her new baby. The good care provision was tied to the physical aspects of birth and parenting. She explained:

> "Um, I just don't know, just everything is all good, I like how they handle the babies and deal with me as well, like help me as well here. So yeah, I don't think there is like, yeah, everything is all good here I like this hospital and I wouldn't go to any other hospital if I had to."

Fiona also saw the midwifery role as that of teaching her how to parent. She discussed her thoughts:

> "Yeah, they taught me really well here when I had my first daughter here. My first child…I didn't know what I was doing and they helped me and now I know how to do everything like that, yeah, breastfeeding. It's all good, yeah."

The focus for the women was the physical side of labour and birth which included pain management and the physical experience of birth and postnatal care. The expectation that

the midwives were responsible for the physical aspects of care delivery may have contributed to evidence in the data that showed that women were having negative experiences, but still saying everything went well. This is reflected by Shelley's experience, as her birth was straightforward. However, she asked the midwives to call her partner when she went into labour because he was staying a reasonable distance from the hospital. The midwives declined to do this for her as they thought it was not necessary, which subsequently saw the partner missing the birth of their baby. This was really disappointing for her, but this negative experience was masked by the birth going well physically, and the joy of a new baby seemed to dilute any dissatisfaction with her partner missing the birth. She explained:

> "Straight away I wanted my partner to be called and I don't, and they were like 'no we just want to clarify just to double check', that, um, 'you're', um, that I am 'not dilating or not'…And my partner missed it so he was a bit disappointed, like he was 'Oh I missed it' and I was scared because like my partn [sic], I live, a little bit way out and it takes forty minutes to get here and he was, and I wanted him here and the nursing [midwifery] staff were just like [woman's name], like 'please sit back' and, um, 'we need to think about you and your baby', not, like I was just panicking about not, about being by myself…just to listen, like I don't know…yeah, so yeah I just wished they, like I was even telling them 'Just get my partner on the phone' because I knew it wasn't normal."

Shelley continued to talk about how satisfied she was with the hospital and her physical care:

> "The nursing [midwifery] staff are lovely. Like I will still look back and go yep like I would um, rec, highly recommend the nursing [midwifery] staff here…and the staff especially in this, like, department, they're excellent, and they're easy to answer like this is a place where babies are always born every single day, like I mean, so yeah, um, yeah, um, I am happy about that."

Rachel, like many of the other women, was satisfied with her care in the standard system. She felt that the physical aspect of birth and the process of being born went well and that is where the role of the midwife was situated. She explained:

> "…the midwife was just there, there was four of them in the room they were good, really helpful and they started, oh they told me to push at, at I think it was seven thirty, eight o'clock, no it would have been about eight o'clock because I had her at eight thirty…you know it's just a really, um, memorable experience…just watching her pop out and start crying, you know, everything."

Rachel saw the midwives as teachers of things related to babies and childcare and grounded in the physical parts of birth. When she was asked about what she could teach the midwives about her needs as an Aboriginal woman she stated that the midwives were there to teach her and not the other way around.

Ava had significant worries and concerns with her treatment whilst at the hospital, which ended with her in tears and feeling fearful that she would not be able to take her baby home. However, she was happy with the overall experience, possibly because the birth of her child was able to override all of the negative aspects of the experience. She also recognised the physical aspect of caregiving and the help she received in caring for her baby whilst in the hospital. She said:

> "Everyone's support and everyone helping me and it was a lot better than when I came home. I would say that I preferred it in the hospital."

5.6 Theme 5 - We have resilience and strength despite our hardships

The women in my study all faced significant hardships and barriers to attending the hospital. These included being required to relocate from rural and remote areas in order to access the care they needed or that was recommended for them. Those women also faced the associated isolation that comes with being separated from family. They had financial hardships, prematurity, babies in the intensive or special care nursery, unemployment, mental health issues, drug use, complicating medical conditions, and one woman's partner was incarcerated. The women were very positive and did not complain about the barriers and hardships they faced. They all remained focused on the health care of their babies. They were strong and tolerated difficult and challenging situations. Quite often they did not share how they were feeling with their caregivers.

Lucy had a high-risk pregnancy and was required to come to Adelaide every two weeks for antenatal care. This involved a six-hour return bus trip. She also had other children at home and was a carer for her partner.

Brooke had a mental health condition and she was really happy with her care because of the way that it was managed. She had been an inpatient prior to the birth on the antenatal ward, and had contact with the hospital psychiatry team and had a firm mental health plan that ensured the best experience for her. She was grateful and happy with the management of her psychological health. For her, feeling in control of her birth and care was important in order to achieve a good experience.

On the contrary, Roslyn had been transferred from a remote community and she was distraught at being separated from her family, her friends, and her children. She actually described her stay as being like she was in prison. Roslyn explained:

> "And I am frightened here, you know, I am not used to the city and when I see the sunset it's making me lonely and I want to cry, worry…I'm getting homesick, I'm lonely…When I get homesick and lonely I get sick, you know…every time when I sit here I see the planes come past it makes me sad…every time I sit here there are tears, I sit here, I just go back and forwards, inside, outside, I come out, one o'clock, two o'clock…It's like being in a prison, I don't sleep, when I get up at one o'clock and two o'clock I stay awake…today I don't sleep, every time I see the sunset."

Roslyn also felt that staying in Adelaide was making her sick and she experienced a lack of understanding of her needs. She explained:

> "You get sick, we are hurting yourself, when we worry too much for our kids, we cry, they don't know how we feel, the suffering…"

Roslyn's pain was evident throughout her interview and was predominantly related to the isolation from her family and supports.

Like Roslyn, Stacey came from a rural or remote area and found it challenging to have a premature baby in the nursery and being required to leave the hospital. She did not have any acceptable close-by accommodation to allow her to be near her baby. She explained:

> "…so I could stay here instead of being discharged, [baby's name] has to stay here because she is prem and I have to leave today so…"

When she was asked about how she would manage the situation she described that there was not acceptable, affordable accommodation that was close to her baby. Stacey explained that she would have to stay with her aunties:

> "Um, my aunties by the looks of it because all the other places sound pretty dodgy or really expensive so…I was just seeing someone before about it but they all sound a bit, not exactly places you'd want to stay especially after giving birth but um yeah and the other places that are good are all booked out and are the other ones are too expensive so…so by the looks of it my best option is to stay with my auntie."

Isla recognised moving forward from the birth and letting go of any negative aspects; she explained:

> "The thing is, that especially when you want to get away, like, you know, if you got new life looking forward, like, you leave the bad things behind you and you move on to new life."

Overall the women demonstrated positivity and strength in managing their complex lives and social situations.

5.7 Theme 7 – Recognising my culture

The women in the study had differing views of Aboriginal cultures, which reflects the diversity in the sample. The women were born and raised in different areas all over Australia. There was a mix of women who were living in metropolitan, rural, and remote areas. The data revealed a strong sense of family with all of the women. For some of the women, a demonstrated recognition and respect of their cultures would have made a significant difference to their experience, but for others it was not paramount. In the same way, some of the women wanted to be treated the same as everybody else but others wanted to be treated differently and in respect of their cultures.

5.7.1 Recognition and respect for my culture

Many of the women were not asked about their cultural needs around birth by their midwives. For some of them this did not appear to matter, but for others it would have meant a lot to have the question asked. Most of those women would not have said anything in particular but thought it would have been nice to have been asked the question. Lucy explained:

> "…that would have been good…it would have been good to have been asked."

Ava also would have liked to have been asked. She explained how she did not have any particular needs but would have liked to have been asked the question:

> "Nothing really, I just would have liked to have been asked."

Shelley was asked and she expressed how that made her feel good:

> "…the first person that has ever, um, asked about respecting the wishes of my Indigenous, and I was, I was shocked about it and I was, I was amazed and that was a good feeling."

Shelley also explained how when she was asked about her needs as an Aboriginal woman it made her feel respected as a person:

> "Well, I liked it, I was like wow, like out of all my care in any hospital, like, and me working in an Indigenous centre for the nursing [midwifery] staff especially to say that I was like, like wow, I was. I think that it's good, but I think that maybe even a translator, I don't know if you have translators here? Because, um, I know that I, working in, like I said, working in an Indigenous centre was shocked, and I was like wow and I felt so good and it's good to know that somebody is respecting you in that way and if, especially if you're like a native woman, for you know, but it's just understanding."

Stacey felt that her needs may have better been met had her midwife asked about her cultural needs around birth. Isla also was not asked but thought recognition of her culture would have been nice. She explained:

> "…like if they want to ask me, like my culture or my language, like where are you from?"

Ella felt that it was more important to ask the women from rural and remote areas about their cultural needs because she perceived their needs to be greater. She explained:

> "I don't mind, I don't know maybe it would be different for the girls coming in from out bush than, um, because I have been in, because I have grown up in the cities and all that sort of stuff. So yeah it would be different for those."

Rose had a positive experience and she acknowledged that the midwife who had cared for her in labour had worked within Aboriginal communities in the past and she recognised that it positively contributed to her overall experience, she explained:

> "My midwife yesterday, she's worked in communities, she was telling me she has worked in communities and stuff like that so we had a bit of common ground there and she was more, a bit more in tune with the cultural side of things."

Like Rose, Ella also was able to connect with her midwife because of the midwife's previous experience in working in a community. She explained:

> "…the lady who was my midwife, she used to work up at, um, [place] and she knows my cousin and all that sort of stuff, so having her there was cool and we could just talk about stuff, um, Aboriginal stuff, issues, whatever and it was good to have her there and it was also good to, um, talk to the other midwives about, um, birthing and all that sort of stuff."

5.7.2 Being treated differently

For some of the women, they did not want to be treated differently to anyone else. Ava felt like she was treated differently because she was Aboriginal, she explained:

> "But if I was a white person I don't think they would have looked at me like that I guess like I feel like they were looking at me like a druggy or a bad person."

Ava did not want to be treated differently because of her Aboriginality. She explained:

> "Just not to look at me as a different kind of person. Like, I am normal."

For Ava having an Aboriginal midwife or Aboriginal health worker would have made her feel more comfortable. She explained:

> "I'd say that I would have felt more comfortable…I think she would have looked at me more or less just as me."

Shelley felt that being treated differently might sometimes make you feel out of place or singled out. She also acknowledged that on the other hand it made her feel good to have

her Aboriginality recognised. She also felt that for women coming from rural and remote areas there was a stronger need for different care:

> "I'm not the type of person who will always ask questions, whenever I asked questions they have been nicely answered, and like I said they don't make me feel like I was different…I am a bit tanned, not that looking much Aboriginal, but they're like what culture yeah, the staffing are lovely, like they're, yeah, sometimes getting treated different might feel like you're a bit out of place but like especially when with rural, that, that, it's good they get that, like, but yeah, there are some things that they have to, like I said, like women's business and especially like no male doctors. I don't think they would like they should try and avoid because, like I said, like women's business is women's business and men's business is men's business."

Rachel felt happy with her care but also that she was not treated differently because she was Aboriginal. She explained:

> "Everything, like everything, went perfectly here at the [hospital name] there is nothing wrong that youse are doing. I can't see anything wrong, like I do hear other like Aboriginal girls that have had their babies here…say that they don't want to come back here and I don't know why, you know, but I can't see anything wrong with this hospital. Everyone is perfectly fine, and the way that you do things, you know like, you aren't treating any other, like cultures different, you know."

Rachel also discussed the standard care system and having been offered AMIC care at the start of her pregnancy. She felt that she would possibly connect better with an Aboriginal caregiver because of their mutual ties but decided against the program because of concerns for her confidentiality. She shared her thoughts:

> "Um, I don't know, like, that would be weird, you know like, I'd get along with, I probably get along with her, like you know, the connection, would probably be a bit more stronger if we were both Aboriginal…Um, but, it would just depend you know, like, if I knew her, or you know like, I don't know. It would just have to be, you know like…If she knew me, and if there was something really confidential I wouldn't like, I wouldn't know if she would be able to keep that."

Fiona also expressed her opinion about having an Aboriginal midwife:

> "I would prefer to, like Aboriginal people we all know each other. Basically no, if I don't know that person in person, that person will know my family and stuff like that so I would rather be with a non-Aboriginal midwife…I wouldn't want to be with an Aboriginal midwife that know my family and stuff, yeah…yeah cos everyone knows everybody."

Brooke had limited contact with the hospital ALO staff during her visit and she felt that it might have been good for her to have their support. She explained:

> "I didn't get really, much visits, or much contact with the, um, Aboriginal Liaison Officers but I, yeah I, more visits from the psychologist, um, yeah just to make sure I was comfortable or if I had any problems, um so that was good…I would have, like especially not being from Adelaide, and, um, the fact that, um, my family were transported down to Adelaide to be with me, um, which was my partner and my two daughters, um, so it would have been nice to get a bit more help from the Aboriginal Liaison Officers themselves in regards to, you know, um, my treatment at [hospital name] and also you know, um, some of the help, you know, some help for my family as we weren't from that area…after dealing with the Aboriginal Liaison Officers, yes, I, me and my partner sometimes wish we had been transported to [different hospital] but um, you know, the midwives on the antenatal ward were more helpful, the psychologists were more helpful to me and my family than what the Aboriginal Liaison Officers were."

Lucy identified that having an Aboriginal midwife or Aboriginal health worker would be a good experience. She said it would be different to a non-Aboriginal midwife or carer but thought the care would be the same. She explained:

> "Yes, it would be a different experience compared to a normal one [non-Aboriginal midwife or health worker]…it [the care] would be the same. I reckon it would be the same."

Roslyn felt that her needs coming from a remote community were not met. That included things like her physical comforts, financial needs, and assisting her communicate with the hospital staff. She talked of wanting someone to act as an intermediary between her and the midwives and doctors:

> "They don't know how we feel…So we need a person like you [Aboriginal interviewer] to sit and talk and explain to the doctor and nurse [midwife]…I'm not used to the city, sometimes when you got a nurse [midwife] back at Katherine, they know how it feels."

5.7.3 Family ties

Many of the women identified the importance of their families in birth or in the customs around birth. Rose explained her feelings on family and birth:

> "Just having family, having family around is the most important thing to me, yeah…She was meant to be in the room, if mum was here I would have had the whole tribe in the room…Before all the gory stuff happens we just have all the family come in and out and

> stuff, whoever wants to, but once the gory, everything starts happening, the men go…a lot of my family and stuff will have the whole mob there."

Rose also found the hospital practice of limiting visitors between certain times as negatively impacting on her needs as an Aboriginal woman. She explained:

> "We have to have our family around us a lot, like, I found the visiting hours really hard because I have to wait for my mum until one o'clock in the afternoon when she could be here, like, you know, that's the hardest thing for me, waiting all day for my family. That's probably the most important thing to us, family."

Rose also recounted her previous birth where the midwife tried to limit the family members from attending:

> "And yeah, we had a bit of a words, with the midwife to start with because she told us there was only two people allowed in the room and my mum said well that's not going to happen because in our culture we, we like, it's a family thing…and we like all the women to support each other and stuff like that."

Isla's family connections required her to take her baby back to her community (which was not where she was currently living) for a smoking ceremony. She explained:

> "And when they have baby, they like, go back to their communities and like grandparents, like they will decide to smoke the baby, like the next day, like the next day after…Like, me thinking, like if I go back from here, not go back, just go back to visit family, show the baby to my family and the baby can be smoked there…Yeah, it is hard, like sometimes it like, your family needs you back there with them, you can still go back, like when your family die or pass away, you still have respects, and still have to go back to the law to finish off, yeah, especially the Aboriginal peoples, they got their culture more strong, yeah."

Isabelle wanted to have her family members present and felt really happy that the midwife said she could have more than two people in the room for the birth. She explained:

> "…the midwife that I had, she let, well you are only meant to have two people in the room and she let my Aunty, she let my step-mum, my step-sister, my partner, my Dad all in the room and that was fine…we even, what you call it, a referral? To the midwife saying that she was a really good midwife and we were proud of her."

Rachel talked of the importance of family for Aboriginal women. She talked of how there were always people around and they were connected even if they were not together:

> "Um, that's probably the thing, you know like being Aboriginal you, you do get all that family support and you know, like, everyone being there, so you're never ending lonely. I mean…Sometimes like and it has been a little bit you, you know like especially when you want to sleep and get rest and you just get like, like someone knocking on the door and just visitors after visitors after visitors…And so, it, you know that's probably, and you, just like, you just, even throughout the pregnancy, you know, like you just, you know, always getting reminded that you are pregnant and people are always there…Sometimes you do feel like you are really lonely though and like because like me being away from my family in [rural area]. It does feel like, you know, like, I don't have anyone there but, like I do, like there is always a phone that's ringing and text messages."

Shelley talked more generally about cultural needs for Aboriginal women:

> "…but sometimes they needs their family in here to do the little talks in their language and stuff like that and so, um, yeah you have to let them do that, I'm not, I understand about obs [observations] and stuff but you have to, sometimes when you interfere with them, um like the chants or anything like that it stops the cycle of going around, so yeah, like just to respect, like give them time, like."

Roslyn's disconnection from her family was really difficult for her. Her entire experience was overshadowed by a deep despair and longing to be back near her home and with her family and children. She shared her thoughts:

> "Well, I worry about my kids, I am from a community, I am not, I don't live in town…I am not used to this…I am only used to community…and I worry about my kids…Yeah, we haven't got no family, we got nobody."

5.8 Summary

In this chapter I have presented my interpretation of this group of Aboriginal women's experiences whilst giving birth in standard care. The six main themes and subthemes have allowed me to deconstruct and share their experiences through language. In the following chapter, I will share the midwives' experiences.

Chapter 6 | Midwives' Experiences

"Maternity care and midwifery services must be viewed through a lens of cultural safety."
Machellee Kosiak (2014, p.141)

6.1 Introduction

The interpretative themes from the interviews with the midwives are explored in this chapter as a phenomenological description and interpretation of cultural care in the birth suite for the midwives. They were developed using van Manen's (1990) six steps to thematic development of the thirteen transcripts of interviews with the midwives. The themes are supported by the midwives' verbatim words. Six main themes were developed as shown in Table 6. They are presented as experiential structures of the experiences of cultural care. All of the midwives were assigned pseudonyms in the study. A paper based on the midwives' experiences was accepted and published by the peer reviewed Women and Birth journal (Brown et al. 2016a).

Table 6 - Themes representing the experience of cultural care for the midwives

Themes representing the experience of cultural care for the midwives
1. **Finding ways to connect with the women** • Connecting through a woman's supports • Connecting without words • Connecting through language
2. **Building support networks - supporting with and through Aboriginal cultural knowledge** • Aboriginal Liaison Officers ➢ Value and Recognition ➢ Role confusion • Aboriginal Maternal Infant Care Workers • Families
3. **Managing the perceived barriers to effective care**
4. **Perceived equity is treating women the same** • Standardised versus individualised care • Discrimination – I'm not racist but… • Denial of Aboriginal history and past experiences
5. **Understanding culture** • Differentiating physical needs from cultural needs • Cultural understandings and misunderstandings
6. **Assessing cultural needs – urban versus rural/remote Aboriginal cultural needs** • Belief that women from urban areas have lesser cultural needs • Familiarity with environments and systems impacts on cultural needs

6.2 Theme 1 – Finding ways to connect with the women

Finding ways to connect with the women was an important aspect of care for the midwives. Establishing rapport and communicating with the women was seen as central to this process, and the midwives would seek out ways to facilitate communication in a way that was acceptable to the women. They recognised different communication styles and they valued the importance of the families and support people to assist them to engage and communicate with the women. They were also able to recognise situations where communication breakdowns had negative impacts on the delivery of care for the women. They talked of frustrations when they were unable to communicate with the women because of language barriers or lack of interpreters, or women who appeared to not want to engage with them. They were able to adapt their communication styles depending on the individual woman's needs.

Fran talked about the importance of communication in connecting with women, and she felt frustrated in attempting to meet a woman's needs and establish trust if the woman was not able to communicate with her, as demonstrated in the following extract:

> "I still think one of the biggest obstacles is actually one-to-one communication with a shy Aboriginal woman and how do we get around that? How do we make them trust us? How do we make them open up to us and talk to us? I mean, that's what I would like to do, it is very hard talking to a woman who is sitting under the bed sheets, who hides her face and won't look at you, I mean I don't have to look at her in the eye. I can be at the other side of the room if she'll talk to me, I don't care. Um, but how can I, um, help her, if she won't talk to me so I'd like to know, I'd really like to know how to communicate better with Aboriginal people, I don't, I don't know, I think, that would be the, one of the most important things is better communication."

Some midwives accepted that the women did not want to talk much or engage in conversations; they labelled this as a 'cultural' issue and as such accepted it. They also labelled specific actions that they felt assisted appropriate care. Beverley explained:

> "They [Aboriginal women] don't really say much, they just keep to themselves and they just talk to each other. And they don't communicate as openly as other people might…and we are not meant to give eye contact and talk to them slowly and softly and what not and I don't know you just do it."

Some of the midwives described the differing communication styles and they frequently used words such as 'shy' in those conversations. Fran described her perception of Aboriginal women:

> "I have seen hundreds of the Aboriginal women who have been fine, they don't want to talk to you, I respect that, they don't look at you, I respect that, all they want to do is to come in have their baby and go and they are very shy…"

Differing communication styles were acknowledged and accepted by the midwives. Kate described a situation when she cared for a woman who had been transferred for care from a remote location. She said that when given time the relationship developed and trust was established; this improved the communication and assisted in care provision. Kate explained:

> "I just remember, you know, the more time you spent with her and she was used to the same person and you didn't try to push the fact or try and really get her to talk, you just would, I would actually say to her, look I do need a response, I only want a response to a couple of things about your clinical situation and she was ok after a while but usually just, um, just try to respect her needs, I know they are very shy, very quiet. She was one person because she actually started to open up the more she knew you, just trying to gain her trust a little bit…"

Jean described the importance of communication and how she thought that the lack of communication at times meant she could not really know if she had provided satisfactory care as she was only meeting the woman's physical needs. She explained:

> "…often they are so shy and you know, with, not withdrawn, but you know, um, not interact, not interacting that you can only really work out what their physical needs are, often not what their emotional needs are, so I've felt like, I've never, you know, done a really good job when I have cared for an Aboriginal woman…"

Connecting with Aboriginal women for the midwives was primarily considered successful if it was coupled with good communication and rapport. Although the midwives recognised that the women might not want to engage with the midwife, they did not consider why they might not want to engage. Iris described how she would listen to their needs but that it was up to the women to communicate their wishes:

> "…listening to their needs, they are often withdrawn so it's hard to really know…I'd say it's more them communicating their needs."

6.2.1 Connecting through the woman's supports

The midwives were able to recognise the importance of the support people and families in the provision of effective care for the women. They frequently talked of partnering with the women, their families, and the Aboriginal workforce within the hospital in their attempts to provide care and communicate with the women. Sophia talked of a case when she provided care for a woman who did not speak English, but her mother did. She said that the mother acted as an interpreter for her daughter and because her mother trusted Sophia, the woman did too. Sophia indicated that this was vital in this case for her role in delivering acceptable care and facilitating effective communication with the woman. Sophia explained:

> "…we couldn't have gotten an official interpreter for that language and it really made the situation for that young girl having the baby so much better because, you know, she trusts her mother to look after her and in that respect because the mother trusted us, she trusted us as well."

Georgina described looking after a young woman from a remote area and the importance of the support provided by her family to help combat the fear the woman had. In that situation, the woman was not going to have a live baby and was very scared and Georgina described how having support around was so important for that woman. Georgina reflected on her memories of the support they were able to provide as a team surrounding and supporting the woman.

Not all of the interactions with the families and support people described were positive. Jean described a situation when she was trying to provide care for a woman. The pregnant woman was leaving the hospital frequently and had a complex medical history that the medical staff wanted to monitor closely. In this situation, the communication breakdown was quite serious and the outcome for the woman was the loss of her baby. Jean described how she perceived the family and support people to be negative towards the hospital staff, and how she felt frustrated about her fear of causing offense to them. The loss of the baby

caused great distress to Jean and she spent time worrying about what they could have done differently in order to prevent that outcome. Jean explained:

> "…and then her family coming in and there were some Elders that came in also to see her and, um, said that we hadn't made enough of an effort to go and bring her back and that if that had been a whitey we would have made more effort to get her back. And, um, that we should have got in the car and gone looking for her, and I said well the only option for us would have been, obviously that's not an option for us, that we could have asked the police to engage with us, 'yeah well that would be your first option wouldn't it? Of course you'd think of the police' and you think no matter what you do, you know, it's going to be offensive and in the end there were, you know when she was here, which wasn't a lot of the time, you know sometimes she'd allow us to do observations, sometimes she wouldn't and but she had lots of Elders sitting on the floor, there were lots of people coming and going…And so in the end she stayed out for several days, had chorioamnionitis, had no fetal heart, the baby died and then it was our fault so that was one of those kind of no-win situations and when I, and that was very, you know, a very emotional thing for me, thinking well what could we have done differently, you know, the, every single thing we tried to do was difficult… it was really quite distressing..."

Kate also described a situation where effective communication was lacking. She was working as the shift coordinator at the time and after the woman had her baby a family member asked her to call someone to take the woman's grandmother home. Kate felt that the relative was demanding her to do something that she did not feel she was necessarily required to do. She said:

> "Well, I just looked at her, and she said 'you've gotta do this'. She was quite rude and there was no reason for her to be, we just knew that they had to go and said 'Well she's going upstairs and you can't go, you need to go', and they said 'you need to do this for my grandmother' and I said, 'Oh, do I? How did you get her here? Can't you take her home?' As you would with anybody else and I was…so in the end I just rang up whatever number they told me to, or they did, can't remember which one and they came and got their grandmother and took her home."

Lana described a situation when she was caring for a woman in labour and the woman asked Lana if some of the support people could be asked to leave. The woman's Auntie was upset at this and told Lana that in Aboriginal culture having lots of support around was necessary. Lana had to explain to the Auntie that it was actually the woman's request to have less support people in the room. The Auntie accepted the request when it was explained to her. This was another situation where the midwife was able to identify a

communication breakdown and the importance of connections with the support team as well as the women. Lana explained:

> "I remember looking after one Aboriginal lady going back, again, and um, it was her, well I don't know, cos everyone's Auntie or cousin, there was a relative in the room with this young girl and, um, the young girl didn't want everybody in the room so I asked if some could leave and this Auntie said 'It's our culture', so I got quite, here we go, then I had to take Auntie and say 'look, so and so, doesn't want anyone in the room and it's not due to her culture, it's her request. Is it ok if you get some people to leave?' And then she was fine…"

6.2.3 Connecting without words

Some of the midwives talked of non-verbal communication, which at times was enough to know that they were connecting with the women. Sophia described a woman who she had cared for where there had been little verbal communication. However, Sophia had treated her respectfully and asked for consent before checking her vital signs despite the limited verbal communication. She explained that when the medical officers came into this woman's room and wanted to do an ultrasound scan, the woman held onto Sophia's hand and that was enough for her to know that the interaction was positive and that they were communicating. She explained:

> "In that situation I remember this one girl who, um, she, who I had been looking after her, caring for a few hours and then the doctors wanted to come in and do a scan and up until then she had sort of shied away from me and you know I had always got consent if, you know, is it alright if I take your blood pressure and listen to your baby? And she had just nodded and hadn't been very verbal at all she had said yes or no but not a lot of things, it's quite difficult, but when the doctors came in to do her scan she was holding onto my hand, so it was like, I know that I can trust, that you are going to look after me and not let anything happen to me because so far that is what you have done so I think things like that…"

Other midwives talked of non-verbal aspects that they should or should not do when caring for Aboriginal women. Beverley explained that she tries not to look at the Aboriginal women or give them eye contact especially when they were not from metropolitan areas:

> "I just specifically remember eye contact and after looking after people I have noticed that they never look at me and so I try and remember not to do that either cos that is a big part of my personality…"

Cassie felt that midwives, in general, were adept at reading body language and that was an important part of connecting with the women. She explained:

> "Um, I am pretty sensitive to what it is they may or may not need, um, ah, a lot of midwives can be really good at reading body language, even when you don't get a direct response, you can assume from the body language or prompt and say 'does that mean that you would prefer to not have a procedure done or to have an epidural or not have an epidural, or, um, you know, or are there your clothes that you want put on your baby?'"

Jean talked about the differences in communication between non-Aboriginal Australians and Aboriginal Australians. She said that Aboriginal cultures differed in that eye contact was important as a sign of respect for non-Aboriginal Australians whereas body language was important for Aboriginal Australians, but she also recognised that each woman was different. She explained:

> "Respect is respect, that, you know, someone in, in an Australian culture, if someone doesn't look you in the eye when they are talking to you, then they are not respecting you and it's a sign that you know, um, that they're not wanting to have communication, but with Aboriginal people it's just used for body language, it's more about the body language than the words and to position yourself alongside the woman, instead of in front of her and, you know, it's about engaging in, in persevering to see what you can do to make that, um, the care, appropriate. Cos it's not, there's not one fit for Aboriginal in the Aboriginal culture."

Iris identified compassion as an important aspect of making connections with women. She also said showing interest in the women's lives and where they are from helped with establishing those connections:

> "Well, I think you have got to be compassionate for a start, if you don't, that's number one really, if you are not compassionate well then you're not going to get past base one really. Are you? Um having an interest in where they are from, you know, looking up on maps where they are from, you know, just say how far, you know, just get the conversation going, where, how far from…"

6.2.4 Connecting through language

Language was seen as a barrier at times to connecting with women despite the fact that the midwives would attempt to partner with families, interpreters, or with the use of non-verbal communication. Beverley said that when she could not communicate with language she attempted to connect by doing little gestures to make the woman feel safer:

> "…language is obviously important if you can't speak the language then it is confusing and what not. There is obviously different dialects of Aboriginal culture, of language, so it's not always easy to get, sometimes you can't get interpreters…like you can't change that they don't speak English, and so, we can only do the little things to make them feel safer and that they are somewhere where they can feel culturally safe."

The midwives also made adjustments in the language they used depending on the women's needs. For example, Cassie said that depending on the woman, she would adjust her communication style by perhaps asking questions that only required a yes or no answer rather than open-ended questions. She also said that if the woman had limited English then she would use the simplest words in order to facilitate some communication.

When the midwives were asked to describe positive experiences with Aboriginal women, they frequently talked of building a rapport, of chatting with the women, and they saw these experiences as positive. Georgina said that if the woman chats freely to her, is comfortable around her, then she saw that as validation that she had provided good midwifery care for the woman. She said:

> "But if you are looking after someone in labour and then at the end of the shift they are quite comfortable, like whether they have pain relief or not, whether their labour is progressing or they are able to sit there and chat to you or whatever and feeling quite comfortable around you, I think that's always a reassuring thing for me, I like to think, like you know, if you start the shift and someone is not very chatty but then you leave at the end of the day and you have sort of, over the space of the time, have been able to build that rapport, I think that sort of shows that the level of care you have done has been good because they have been able to relax and become comfortable around you, and then, so have a bit more of a relationship."

6.3 Theme 2 – Building support networks – supporting through and with Aboriginal cultural knowledge

Building support networks with other Aboriginal health care providers was recognised as important for the midwives in care delivery for Aboriginal women. The midwives talked of partnering with the families, the Aboriginal Maternal Infant Care (AMIC) workers, and the hospital Aboriginal Liaison Officers (ALOs). Generally, the partnership with the ALOs was positive but some role confusion and fears around those interactions were also identified. The midwives also talked of building support networks with the family members

that came with the birthing Aboriginal women, and incorporating their cultural knowledge into care delivery.

6.3.1 Aboriginal Liaison Officers

Most of the midwives talked about paging Aboriginal Liaison for the women they cared for and partnering with them in the delivery of care for the women. Some of the midwives talked about not understanding what the ALOs' roles were in the care of women and feeling frustrated at their inability to contact them at all hours.

6.3.1.1 Value and recognition

The ALOs were identified as a starting point to the provision of care often in combination with other services such as social work. The midwives recognised the importance of the cultural knowledge that the ALO team had and how that was a positive thing for the women in their care. Fran described a situation when she was attempting to provide care for a woman from Alice Springs, who was pregnant and suffered many other health problems requiring medical care, and the difficulty in trying to provide midwifery care to her. Fran really valued the role of the ALOs in attempting to meet that woman's needs and saw them as an important link between the medical/midwifery care and the woman's needs as an Aboriginal woman, who was isolated from her social and emotional supports:

> "Aboriginal Liaison were very good, they found a lady who was from her area who was at the [hospital name] and she came to visit her."

Fran described the ALOs as a connection that was really important in balancing fear for the women and delivering safe care. She said:

> "Because I do think when they [ALOs] come, I do think that they have provided a very good service and that bridge between both of us…you have got to try and find that link, otherwise she's going to lie in that bed terrified, um, and it doesn't matter how much explaining, she's not listening to me, you know, so I've got to, I've got to find that link to provide her care so that I don't terrorise her with what I am going to do with her. Because it would be frightening to her, especially if she's very young, a lot of young girls come through, so um, you know, I think it's quite important that we do try and communicate but not push it so far that they get pushed the other way."

Beverley explained how she thought the women appreciated the opportunity to see the ALOs as she thought that it contributed to cultural security and that they were better at understanding the women's needs. She said:

> "…and they always appreciate seeing the ALO girls and I guess it makes them feel more secure and that there are people that are more understanding of their needs…"

6.3.1.2 Role confusion

Some of the midwives expressed frustration and had a lack of understanding of what the role of the ALOs actually was. Sophia explained:

> "…there is a degree of frustration in how the ALOs interact with, um, staff and how urgent that they think things could be. But then maybe I have a skewed view of what their role is."

The midwives all worked on a rotating twenty-four hour roster and some of them expressed frustration with not having the ALOs available to consult at all hours. The ALOs work on a Monday to Friday schedule and this was seen as limiting to some midwives, as they frequently needed the ALOs outside of normal hours. Sophia continued to explain that she felt that the ALOs job was to offer cultural support and assist the women with accommodation for their support people:

> "Well I think their role is to actually support Aboriginal women in, when they are requested to, um, so I would always offer to the patient 'would you like me to get an Aboriginal Liaison Officer?' And if they say yes then I believe that it is within their role to come in and support the woman. Not to suggest what sort of care she has but to support her culturally and in that way to support the staff in getting accommodation for the, um, for the partner or the support person or facilitating that to happen in the hospital."

Jean talked of her anxiety when interacting with Aboriginal Liaison as she felt that no matter what she did it would be considered as offensive to Aboriginal people, despite her efforts to protect the woman's needs. She described a situation when she was caring for a woman and Aboriginal Liaison came into the room and she asked them to wait for a minute so she could cover the woman. This led to a verbal confrontation between the midwife and

the ALO. Jean also felt that because she was a very 'white Australian' that Aboriginal people assumed that she was not supportive or caring. Jean explained:

> "…you can't get them when you need them so and I have actually been, I feel, you know, anxious if I have to deal with Aboriginal Liaison because there have been a couple of times when you think you have been doing a really good job and they've come in, I can give you an example of giving care to a young woman…who came with ruptured membranes and had her cousin there and I felt we had a really good rapport going and she ruptured her membranes and you know she was going to go to theatre, so I said 'do you want to have a quick shower, if you can stand over there', the bed was absolutely soaked, frothy, you know, liquor, the fetal heart was ok and she was going to have a section and I was trying to, you know, quickly get her ready for theatre, inform her, get her cousin to come through with me because she spoke good English but the girl didn't, and um, then having Aboriginal Liaison come and burst in on me and I said 'could you just hold on for a minute? She's just uncovered, standing out of bed', and being told that I was racist and discriminating…and I actually said to the cousin I don't know what I did there, she said don't worry about it, let's get on with it and go to theatre and the Aboriginal Liaison person was going to put in a complaint about me, and I just feel like no matter what you do, you can't get it right with Aboriginal people because somebody will say it's offensive…I had this fear that someone was always going to say you're a racist and that's, that's happened to me on lots of occasions and I think that's because of my appearance. Someone's going to assume because, you know, I'm a very white Australian that I'm not going to be supportive or caring or you know, um, responsive to what their needs are whereas that's actually not, not true."

6.3.2 Aboriginal Maternal Infant Care Workers (AMIC)

The AMIC workers, although they were not providing care in the SHC system, were often seen as support people for the midwives and were consulted for advice at times. The midwives in the study were all practicing outside of the continuity models but were still able to recognise that there was support or a resource that could be utilised within the hospital. Sophia explained:

> "I actually went to MGP [Midwifery Group Practice] and there was an AMIC worker there and so I asked her if she wouldn't mind coming and seeing the lady and she did and she was really helpful…whilst it was a little more reassuring that she could see another Aboriginal woman who was within the system and who could anticipate things. She was very helpful…"

In this instance Sophia found the AMIC worker's assistance valuable to the care she was able to provide to the woman, and she felt that for some women being able to see another Aboriginal woman was important.

Donna described a birth in which she went in to assist, and was very positive about the role of the AMIC workers for the woman because of the communication and support provided for the woman:

> "…the AMIC worker was sitting with her just supporting her, there was lots of family around, um, that came and went, um, and there was lots of communication going on, I wasn't in the room for very long admittedly, um, it was a very open environment, they were talking pain relief and what could we do for her. Um, so I think just that little snapshot of that room while I was in there was very positive, um, the AMIC worker was there helping and rubbing her back and doing all the bits and, um, there were little kids and, um, other adults in and out of the room while she was in labour…"

Many of the midwives recognised the importance of AMIC workers to women and talked about increasing the Aboriginal workforce as a beneficial thing for birthing Aboriginal women. They talked of increasing the numbers of Aboriginal doctors, Aboriginal midwives, and AMIC workers.

6.3.3 Families and support people

Building support networks for the women was really important to the midwives in the study. The midwives identified working with families and support people as an important aspect of this. When asked what constituted culturally safe care for Aboriginal women, Edwina identified that it was having their families present:

> "…that would be things like having all the family the aunts, the uncles, all the friends that they want in there, that's sort of part of what they like to have if that's what they want…"

The midwives identified families as a crucial aspect to aid in communication with the women. They were seen in a partnership, almost a bridging role between the midwives and the women similar to the role that the midwives saw the ALOs occupy. When Jean was asked to share a positive birthing experience for an Aboriginal woman she identified the importance of the family to the delivery of midwifery care to that particular woman:

> "…because of continuity and because of, you know, her cousin being there and who could explain to me what was culturally appropriate, there was kind of a middle person there who helped me with planning her care and you know good documentation about what she wanted, you know what was appropriate and not having the rush I think, you know I think it's important that if you're not being dragged in ten directions when someone identifies that they have got a little bit more of a need than somebody else has."

Maddie talked about the major influence of families when developing care plans with the women. She said that family members could be persuasive in assisting to negotiate acceptable care with the women:

> "By, again bringing in the Aboriginal Liaison if need be or other family members, I mean sometimes other family members can be quite persuasive perhaps towards the way they behave in hospital."

Edwina also felt that family support was a good way to reduce fear for those Aboriginal women who were quite fearful of the hospital processes. She explained how it was important to have family support and that she tried to always facilitate that:

> "Well, it would depend if she had lots of support people. I guess if, I would refer, or make sure that she had those people around her and help them be involved with her care."

6.4 Theme 3 – Managing the perceived barriers to effective care

Some midwives were able to identify some barriers within the hospital system that impacted negatively on their ability to provide care for women. Sophia explained her frustration and a sense of letting the women down with the systemic barriers that working in a large institution created for her when trying to deliver woman-centred care. She also explained that those things that might just appear as little things to others were, in fact, more important than the physical environment that the women birthed in. Sophia described that not being able to facilitate supportive family relationships would shadow the memories the women might have of the birth experience irrespective of comfortable birthing environments:

> "…most frustrating thing with the, um, Aboriginal people in particular or people that have specific cultural requirements is the inability to actually fulfil those needs when it seems that it's such a simple thing to do but for instance there is no facility to, for the Aunty or the mum or the sister to room in with the woman, you know, it's just a fold out bed and it's just, and to me that's what it is, a fold out bed, put the sheets on the bed and the woman or the person can stay, but you know we are governed by rules and regulations…that is her right to do that and you do feel like you are not abandoning them, but you are letting them down because you are not able to provide some really small thing that would actually make a whole world of difference to them because they're not going to remember having their baby in a beautiful environment, you know, with everybody around them they are going to

> remember that they left me, they left me alone and that's the same with anybody, the bad thing or the thing that bothers you the most no matter how little it might seem to somebody else is the thing that is going to shadow everything else."

Sophia judged the overall experience for the woman as positive if she was able to facilitate her wishes within the organisational constraints.

Cassie saw the birthing time as an opportunity to attempt to meet the woman's birthing educational needs but which was limited by the time constraints and the fragmented system in which she worked:

> "…and in most of the models of care we have it's segmented and so then they will move to another area after birthing and another group of midwives will look after them on postnatal."

Some of the midwives also identified that the system whereby women are required to relocate from rural and remote areas to birth is a barrier to care provision. They could identify with how difficult it might be for a woman to be taken from her home to an unfamiliar environment without her supports. Fran described how she would feel in the same situation:

> "…they would be flown in from about 36 weeks of their pregnancy which I also found quite disturbing because if someone told me that I had to go somewhere else at 36 weeks of my pregnancy I wouldn't be happy and leave my family, my friends, my partner…"

Some of the midwives identified the unfamiliarity of some of the technology and systems that occur in a large tertiary hospital as a barrier. Cassie explained that for those women who attended the hospital for the first time as a transfer, they might have had no preparation. She used the example of when a woman might present in labour with meconium-stained liquor (MSL) with no prior understanding of the policies and procedures around fetal monitoring for MSL. She said it was easier if some of those things were talked about prior to the woman's presentation:

> "…or the Aboriginal woman who we have had the opportunity to orientate to the area, to prepare for labour, to explain that in order to watch your baby we are going to have to have a CTG [Cardiotocography] on, managing that type of situation is always easier if there has

> been an opportunity to do some of that explanation first. Or, if they have arrived in the city knowing that that is what is going to happen, you know it happened to their cousin, or it happened to their sister but the woman who might come in full blown labour who doesn't understand what meconium stained liquor is, to restrain her to a CTG machine is perhaps one instance which is particularly difficult if that's something she is not expecting…"

For the women who were required to relocate from regional and remote areas to birth, the midwives attempted to do little things that they thought might help the women within the hospital system. Donna and Maddie identified making phone calls for the women to their family members; although they were little things they felt they were important to help the women with loneliness and the disconnection from family and friends. Donna and Georgina talked of getting the women basic necessities such as shampoo, combs, and conditioner and they described this as trying to make the women's lives easier. Georgina said little things like helping to get the television connected was important in an attempt to reach out and support the women. Donna explained:

> "I have had people come in from the country that have been high dependency, um, for extended periods of time, um, they are often here by themselves, and you've, I have rung home for them and made sure that they have had, you know just essentials…"

The policies and procedures that midwives are expected to follow were also seen as a barrier to facilitating woman-centred care at times. Lana described how the policies and procedures often led to the midwives having to make compromises with the woman in order to satisfy the institutional requirements and the needs of the woman:

> "…because we're very guided by policies and protocols and guidelines and we have to work within them as well, so if somebody has a specific need in their birth or that I'm not comfortable with then, I would look elsewhere to see what we could do to facilitate that, maybe not that, but something else…"

Fran saw the institutional policies and procedures as restricting her ability to provide care for the woman as they created a dichotomy for her between protecting herself professionally and providing the woman with what she wanted or needed for her birth:

> "That's a bit tricky because I think that, um, the trouble is when you work within a hospital you have to work within a hospital's guidelines and policies, I mean you are restricted by

> it, um, so it's very hard when you work within a hospital system, it really is very, very hard because you are restricted yourself, you are restricted, um, you know, if an Aboriginal lady said I want to deliver over in the parklands, I wouldn't be able to do it, do you know what I mean? Um, so, or any patient, you really are very restricted because you have to work within the hospital guidelines, but that is there to protect me as much as it is to protect them. So, um, I don't know."

Time was also identified as a factor that placed pressure on the midwives and their ability to provide woman-centred care. Andrea correlated good experiences with Aboriginal women as including the opportunity to provide the time needed at birth rather than meeting the institutional requirements. Jean talked of the length of time a woman is in hospital now and how it can be difficult to meet her needs within a shortened time frame:

> "…in maternity, how quickly women transition through the service. So there's no opportunity to get it right tomorrow, you've got to get it right today because she's gonna have a baby. You can't stop it, she's gonna have her emergency section cos there's a problem right now, so you often don't have the time to engage with the people who might be able to give you the information…but it's actually the timeframe we have to work with, because by the time I get the Aboriginal Liaison officer in two days' time the woman's already gone and she won't be happy with the care I've given her. So, you know, it's actually having those resources available twenty-four hours a day to help me plan an appropriate service for that individual woman because I know she might be different from the other Indigenous woman I've looked after."

6.5 Theme 4 – Treating all women the same

All of the midwives talked of treating all women the same. They also identified that they did not do anything different for Aboriginal women, that they treated all women the same regardless. Sophia explained:

> "So I suppose when I look at, or when you ask me specifically about Aboriginal women I suppose I just see women…"

All of the participants were unable to recognise any specific needs for Aboriginal women. All of the midwives frequently grouped the Aboriginal women with other minority groups and talked of Asian, Vietnamese, Sudanese, African, and Indian women when asked about Aboriginal women. Beverley explained how she treated all women the same:

> "Depending on what their race or ethnicity was I would provide the same care and I am not specifically more culturally sensitive to Aboriginals [sic] than I am to any other person, white, black, yellow or green."

Kate explained that she did nothing different for Aboriginal women and that she did not even think of Aboriginal women as Aboriginal as she provided the same care to all women:

> "I just treat women pretty much the same, no matter what culture they are from…it's just, I don't think of Aboriginal women as Aborigines [sic]. I actually think of people that I care for and just try and give the same care. That's why I find it really hard to answer these questions because I don't think 'Oh God she's Aboriginal, I've got to do this'. I just introduce myself, work out their situation and go from there, that's all I do for everybody. And to have to actually think about their culture, of which, of course, I'm always aware of, oh, well deep down you're always aware. It's not foremost in my mind. Don't know if that's a good thing or a bad thing, that's just the way I am, that's the way I do it."

Whilst all of the midwives made mention of treating all women the same, they always seemed to counter that with assertions of asking women what they wanted and attempting to fulfil her individual needs. None of the midwives recognised that the women might not communicate their needs in the context of the discussion about what they did differently for Aboriginal women.

6.5.1 Individualised care for all women

The midwives talked at length about individualising the care for all women. They grouped the women together with other cultures and made comments about how the other cultural groups had needs that they perceived to be just as great as the Aboriginal women. There was a resentment present that the other cultural groups were missed in favour of the Aboriginal women. Jean talked of achieving equity of care for all women and Georgina talked at length about how she thought that providing services to Aboriginal women that were culturally sensitive excluded other cultures and she labelled it as favouritism. Georgina talked about providing the 'same' care to all women; she felt very strongly that equal money should be spent on all women. She tied those statements with talk of one culture not being 'supreme' over another and that by focussing on Aboriginal cultures it detracted from other cultures. She labelled that as favouritism, which she saw as creating inter-cultural rifts:

> "Can I say though that I don't think, I do think that if we do make allowances on Delivery Suite for Aboriginal women, I do believe then that we do need to have allowances for every other cultural woman. Like, I don't think Aboriginal women should get any specialised treatment because we get Aboriginal women as much as we get Indian women and Chinese women, from all different cultural backgrounds and I think that if we are going to do something specifically for Aboriginal women then theoretically and to be culturally sensitive to everybody then we are going to have to do the same thing for all the women as well which means that you could have a never ending sort of need to be doing something specific. You know, if we spend money doing this for Aboriginal women then why aren't we spending the money doing that for Indian women or doing that for Vietnamese women because they're just as important, I don't, I don't look at it and see one type of culture as supreme, I see everybody as even and so like Aboriginal women, I would care for exactly the same as I would care for the other women because I don't think that they get any specialised treatment because at the end of the day all of those sort of women have come, whether it be them themselves or from, you know from a background that has been out of Australia and so they are all, um, foreign in a sense to Australia and they all might not have their comforts and their family around them or anything like that and I think that we all need to be able to be caring for those women exactly the same way, we need to not show any favouritism and treat everybody the same and I think that's going to be a thing that's going to be good as well, it's just not showing favouritism because otherwise that's where rifts and everything start because you are being specialised to someone and not to someone else."

Lana described how she thought that culture was focused on too much. She said that women were all the same and although she recognised Aboriginal people might want to be treated differently she did not because she thought all women were the same. Lana could not see how the cultural needs and the experiences of labour and birth were tied:

> "I think sometimes culture comes into it a bit too much I think, these are women who are in labour, we're all the same and, um, yes, I understand that is important to you and we will do that, but I'm not going to treat you any differently to anybody else and I think sometimes I've heard certain Aboriginal people, that I've heard talk, expect them to be treated differently, well I'm not going to treat you any differently. I'm just gonna facilitate what you need and that's what I'm going to do, but I'm not going to treat you any differently than anyone else because you're not different. Your culture's different, but you're not different. You know, does that make sense?"

Overall the midwives believed that they were providing equal care, which they thought was important and that they were advocating for all women by individualising the care.

The midwives also linked the idea of individualised care to providing culturally safe care. Donna explained her focus on individualised midwifery care for every woman:

> "I think I like to treat everybody as an individual and so I generally ask everybody what they need and can I do anything to make this birth better for you, is there anything in your background that you need me to do? Um, to be honest, I don't know if I do anything a lot more different for Aboriginal women than I do for any other person, once I have asked them what they want, then that tells me what they need or what's going to make it a positive experience in terms of their birth. I don't really think I do anything particular for any one particular group of people whether it be Aboriginal or Indian or what."

Sophia saw her ability to adapt her practice according to a woman's needs as important. Sophia explained the linkage between individualised care and culturally safe care:

> "I do provide a culturally safe service because I individualise the care. I think that you can, you can really make a mess of things if you just assume things about people…I think that the women here are getting culturally safe care because you are individualising the care to their requests and so some of the requests may be cultural and some may be that they do want to birth on all fours and that's not a cultural thing, that's what they want to do."

Lana said that by treating everybody with dignity and respect and by providing them with individualised care according to their wishes that the service to the women was appropriate and culturally safe.

6.5.2 Discrimination - I'm not racist but…

Discrimination was woven through the interview transcripts. Although the midwives talked of treating all women the same there was an undertone of racist attitudes and views. It was mostly in relation to the sorts of lifestyles some of the midwives assumed the Aboriginal women had. They also made assumptions about the women and their ability as mothers. Maddie linked a lack of compliance to medical treatments by Aboriginal women as being linked with negative activities that the woman might want to participate in rather than protecting her baby:

> "…you know there might be a good party going on, a drinking session, who knows. Um, yeah, outside activities that they want to participate in rather than protecting themselves and their baby."

Hallie described Aboriginal women as having a welfare ethos. She said that although she thought many Aboriginal women breastfed their babies, for those who did not, she felt that they came to the hospital and expected to be given what they needed. She said:

> "…getting back to the breastfeeding like a high percentage of women have to breastfeed and of those that aren't, if their plan is to artificially feed, lots of them have a welfare ethos, and they don't bring any formula in. They just expect us to supply that."

Beverley linked Aboriginal women to a lower socio-economic position and in turn linked them to being 'not as nice to look after' on that basis. She went on to state that she was not racist but acknowledged that she made assumptions about people prior to actually meeting them based on their culture. She explained:

> "I would like to think that I am not racist, but I guess we do see more, like if you have got an urban Aboriginal [sic] then they are generally from a lower socioeconomic, um, and perhaps, and um, you know that they might not be as nice as other people that you look after…But, um, I am not racist but you just know that people from different areas, and probably make a few assumptions before you meet them which sometimes isn't very professional."

Fran attributed aggression and bad language to the Aboriginal community:

> "Like you don't want to be derogatory towards anybody but I do find culturally that they can be quite aggressive towards us and I don't mean physically and sometimes they are but verbally aggressive and sometimes having, I can't, I find it quite hard to agree with some habits that they might have like spitting tobacco at me and things like that. Um, language, I find um, I find it very difficult with people that are quite verbally abusive towards me and, unfortunately, I do find that a lot of that language is within that community."

6.5.1 Denial of Aboriginal history

Some midwives talked about the historical events (stolen generation, colonisation) and downplayed what happened to Aboriginal people. Sophia explained her thoughts after attending Iga Warta, an Aboriginal cultural awareness camp:

> "And you know it's awful, it's an awful thing, but it is reflective in every society. So you know what Iga Warta gave me was a snapshot of things that happened to Aboriginal, or those people, but I have the feeling that they think that they were alone in that and they actually weren't."

Sophia found it difficult to see the position of privilege she was in as a member of the dominant culture and health care provider, and she talked of wanting Aboriginal people to understand her better:

> "…sometimes I feel that it is not very two-way. So you know when you go and want to learn about anything about culture but what we really want to do is interact on an equal level so that you can, because I feel like you can't, I can't go into a relationship with an Aboriginal person and it be one way so they need to know a little bit about me as well."

Jean talked about some of the fears and anxieties she had about caring for Aboriginal women from her experiences as a nurse working in a country hospital, and she described experiencing reverse discrimination that she thought occurred because of the way she looked:

> "…and experiencing discrimination, reverse discrimination from, um, Aboriginal people towards myself. I suppose, because I look quite different to an Aboriginal person, and it does attract attention to those people, and, um, yeah. I suppose I already have some fears."

6.6 Theme 5 – Navigating culture

The midwives were required to navigate their own understandings of culture when providing care for Aboriginal women. They seemed to experience difficulty in differentiating between the physical aspects of care provision with determining the woman's cultural needs. Cultural safety for the midwives was also often considered in terms of a physically safe birth. The midwives did often consider cultural safety in terms of individualised care but still located the individualised care within physical safety. For some of the midwives, cultural safety was tied with supporting the family groups in delivering care.

6.6.1 Differentiating physical needs from cultural needs

The midwives frequently talked about the ease that they had in providing physical care to the women. However, it became more difficult for the midwives when they attempted to offer support to the women outside of their physical requirements. Sophia described how she attempted to anticipate their needs but that she thought that what those women really needed was something that she would never be able to provide. She said:

> "…you don't know where to start with them because you look at them and you know they are just so fearful and they are very, very shy. You encourage them to ask for things, but it's not in their nature so they, you are trying to anticipate what they might need. Um, and actually what they need is actually something you can't provide…"

Sophia also explained how she could provide them with material things, such as shampoo, but that she often sensed loneliness when they were isolated from their support people. She also felt that it was not midwifery care that they needed; they needed the emotional support of another Aboriginal woman. She explained:

> "So, even material wise, they don't have pads or toiletries or you know, I mean we can provide them with a gown or shampoo or things like that but you know they often need a bit of cash or, but they just, or they don't know how to ask because they are not used to that. Yeah it's just those girls seem so lonely and so isolated and it's not in fact midwifery care that they need immediately. It's just personal care, they just need someone to look after them…you think what this woman needs is another Aboriginal woman and there is nothing, there is nobody here."

When the midwives were asked about what they did differently for Aboriginal women in relation to their cultural needs they felt, from a midwifery perspective, that they did not do anything differently because when they talked of caring for Aboriginal women they talked of physical care. Sophia explained:

> "But I didn't prepare the room any differently than I ordinarily would have because her pressing need was, in fact, the fact that she had been bleeding so she had lost some blood. She would need some fluid replacement so I suppose you go into midwifery and nursing mode and everybody's body is the same, so if they are hypovolaemic, they are hypovolaemic whether they are Aboriginal or, you know, English."

When asked what was the most important aspect of providing culturally safe care for Aboriginal women, many of the midwives talked of the physical aspects of care as they seemed to find it difficult to differentiate between the physical and the cultural aspects. Maddie explained:

> "OK, well I want a healthy outcome for mother and baby and that's my priority, that's what I think a midwife's role is."

The midwives expressed empathy for the women, particularly those from rural and remote areas, who they frequently described as scared and shy. They described feeling sadness for those women. Donna explained how she felt for the women coming from the lands:

> "I do feel sorry, I feel bad for people when they come down from the lands and they don't have anybody with them. Or there's um, yeah their support people aren't here for them and so it's really hard for them and I feel bad."

Sophia expressed her sadness for the women from who are required to be relocated to tertiary centres to birth. She said:

> "I feel sad that they become unwell in their pregnancy or there is something wrong with their baby or they are put on transport and they are brought down here and sometimes unfortunately they don't come with anybody."

Despite the concern expressed for the women, the midwives still seemed to focus on what they could do for the women physically in order to provide physical safety when considering culture.

6.6.2 Cultural understandings and misunderstandings

Within the interviews, all of the midwives were asked about their understandings of culture and how they would define cultural safety. Culture as a concept was most often referred to in terms of the way someone was raised and was associated with beliefs and traditions. Iris explained:

> "…I suppose I believe culture is, well I believe it to mean, it's what you're, what you as a community believe in, live, the way you live your life, the way you live as a community, whether that be within food or religion or behaviour."

Donna, Sophia, Iris and Georgina all linked cultural safety to the provision of individualised care. The midwives felt that by providing care that was centred on the woman's wishes cultural safety was able to be achieved. Donna explained:

> "Culturally safe? When I look after women I get, it's all about treating them as their own individual so when I ask them what they need and want and is there anything that I can do for them, I think that that then provides for them a culturally safe environment because I have asked them individually what they need and I would hope that they would tell me what they, what they want or require. Um, so that I can respect their beliefs and what they want."

Kate and Maddie linked cultural safety to showing respect to the women and Hallie and Beverley talked about gestures, such as having Aboriginal flags in the room, that they felt made the women feel more comfortable. Beverley said:

> "Um so I don't know I think or I assume that we provide a culturally safe, we have got flags everywhere…"

Cultural safety was also described in terms of physical safety for the mother and the baby. Fran described how she interpreted cultural safety in the physical sense but also discussed how the women were frequently not compliant with the provision of what she thought was culturally safe midwifery care:

> "…we want to provide safety for them to have a safe baby and delivery, safe mother, safe practice, but that doesn't mean to say that the person who is receiving, or is being protected is going to be compliant with that…"

Fran recognised that the situation was something that might cause fear for the woman, but with her focus angled directly on the woman's physical safety, the woman's perceived lack of compliance was seen as a cultural issue; but again cultural safety was located firmly within physical safety:

> "…whether it was because she was frightened or, she probably was a bit frightened because she felt alone, um, really, really scared and also very unwell so that was making things harder anyway, and pregnant so she actually ran away. And so even though she was on sliding scale insulin and she was really verbally abusive to me and in the end the physician said she could go outside for an hour. She never came back, she did not take her insulin with her, she went away with an IV [intravenous access cannula] in, so even though we tried to provide good education, get support people in to help her, she would not comply at all…So, I think providing a safe environment is really important for these people, I mean they must be terrified if they if they have lived out in the bush and I have been out to some of those communities and then you come into somewhere like Adelaide which to me is like a big country town but to someone who has come from a different environment it must be very scary."

Lana explained her own interpretation of cultural safety and she saw it being linked with physical safety:

> "I think that it, well to me, means that I am aware of the needs of that specific woman, not necessarily related to whether she's Aboriginal or Sudanese or whatever. I think to me it's

> what is safe for that woman at that point in time in her labour, her birth or whatever and I would endeavour to assist and provide the care that she, she wants."

Hallie, Edwina and Cassie also linked the acceptance by the midwives of the large family support groups that often accompany Aboriginal women as being important to ensuring cultural safety. Edwina explained:

> "Well that would be things like having all the family the aunts, the uncles, all the friends that they want in there, that's sort of part of what they like to have, if that's what they want, I mean some of them don't, but other people like to have lots of friends in there, they, um, they don't, for example, might not name the baby cos it has to be an aunty who has to say what the baby is going to be called or who is going to be at the birth, that sort of thing I guess I would be thinking of."

6.7 Theme 6 – Assessing cultural needs

The midwives in the study made assessments about the women in their care and they tended to link their cultural needs to where they came from. Sometimes this was linked to the familiarity of the hospital environment for the women, and at other times it was linked to the perceived notion that a woman who represented the traditional stereotypical image of an Aboriginal woman was somehow more authentic in her ties to her culture.

6.7.1 Belief that women from urban areas have lesser cultural needs

Twelve of the midwives expressed views that women from rural and remote areas had differing cultural needs to the women from urban areas. They felt that women who came from rural and remote areas had stronger ties with their cultural heritage, compared to Aboriginal women living in urban areas, who four of the midwives said had in fact *lost their culture*. Kate explained that women from metropolitan areas were far more Westernised in their cultural needs and that they had higher expectations of services. She said:

> "Well, ones from the metropolitan, are far more Westernised I should say, or 'whitenised', whatever you like to say…I think a lot of people from the metropolitan Aboriginals [sic], the expectations are extremely high of what they expect when they come to us whereas I don't think remotely they do, as in the services you need to provide – free services you provide."

The midwives talked of the women from rural and remote areas being fearful in a foreign hospital environment and the disconnection they had from their families when required to relocate for birth. Many of those differences identified were due to the familiarity of the hospital environment and the disconnection from their families and communities.

Lana explained that she thought women living in metropolitan areas had lost their cultural connections to their Elders and their cultural heritage. Lana said:

> "Um, I think to me when I look after an Aboriginal woman from here, um, I certainly, the ones I've looked after I think that a lot of their culture has basically been lost. Um, that they're not in tune with the older people, you know, older Aboriginal people, yeah I dunno. I suppose it's like any integration with people, eventually the generations lose that connection, don't they? And that's what I find, most have lost that connection."

Hallie explained that she thought that when Aboriginal people lived in city areas, as more generations passed, the less connection they had to their cultural heritage. She described it as becoming Westernised:

> "…depending on how many generations have been in the city a lot of them have lost contact with that cultural, um, bond, and are very sort of westernised if you like in their ideas. And, um, you know, and I think it's probably worth asking them for how many generations they have lived in the city, what was the norm for their mums? Like the same as if we ask them did your mother have PE [Pre-eclampsia]? Um, um, you know it's probably a really important practice to just see what their background is and you know, not ever presume that one cultural norm or something that is culturally, um, you know, expected or complementary is going to be what they feel is being respectful to them, culturally."

Fran described how the women from metropolitan areas lost the influences from their communities and this also affected birthing customs. She also attributed increasing education to the loss of customs. Fran explained:

> "…they think differently, maybe because they have had some education, um, you know, they have also lost a lot of their customs. So with the birthing process I think their customs have been lost."

Georgina explained how she believed the women from rural and remote areas had stronger connections to their Elders and communities. She felt that when living in urbanised areas the women had greater western influences, which almost negated their cultural heritage and

connections. She said that you might have to look back further in the generations to see those connections.

Only one of the midwives expressed the opinion that the cultural needs for women from metropolitan areas were the same. Maddie explained that the women's cultural needs did not depend on where they lived but on their families, backgrounds, and closeness to their roots:

> "Their cultural needs, um, I would say that's it probably the same regardless of where they live, their cultural needs depend on their family and their background and how close they are to that family…"

6.7.2 Familiarity with environments and systems impacts on cultural needs

The midwives felt that the familiarity of the environment also contributed to the differing cultural needs of women from rural and remote areas. Those women had disconnection from their families, communities, and languages, and they were faced with unfamiliar environments, schedules, people, communication styles, and technology. The midwives felt that those things affected the women's experiences and cultural needs around birth. They also identified fear and loneliness in those women.

Technology was thought to be quite intimidating for the women by some of the midwives. They expressed the view that the preparation for what to expect was sometimes lacking and that coming into an unfamiliar environment with many inflexible rules, schedules, and requirements was something that was quite confronting for the women from rural and remote areas. However, the midwives thought that the women living in urban areas were used to Western customs and, therefore, were easier in a sense to care for and some midwives said those women were just like anybody else. Donna explained:

> "I think that they do have quite a different need because people who live within the city are much more used to how, how I think things, um, they are just more used to being in an environment with lots of white people. They are used to being, um, used to technology, I suppose, a bit more, um, they are generally people who have got family around them so it's quite different to someone who lives on a remote station out in the middle of nowhere, you know with hardly any electricity, they have probably got generators, they have their whole community around them, they may not even speak the language. Most people who live in the city would speak English. Um, they would be able to read English, that may not be the case for people from the country. Um, so they would also be quite intimidated I think having the bustle around of people if they are not used to that sort of thing if they are from

> the country. So I think just with communication as well I think people in the city have mobile phones, they are aware of more access to different things. So I think if you are looking at cultural, you know needs of women in the city and you know there can be isolated people that live in the city as well but my general thought is that they would have quite different needs from someone who comes from an isolated station."

When discussing women from rural and remote areas the midwives thought the women were often scared, and they said that they thought the women experienced fear and loneliness. This was not the case for the discussions around the women living in urbanised areas. Beverley explained how she recognised that the women from rural and remote areas were fearful:

> "…like they are probably a bit scared as well when they come here from, when they have been transferred from a smaller town to Adelaide – the big smoke and they are usually here because they are sick, or they have a sick baby or the pregnancy isn't doing very well so there is that element that would, um, make them more reserved and shy because they are scared."

Fran explained a case where a woman had come from Alice Springs at thirty-two weeks gestation with medical complications of pregnancy. The woman had been transferred and was alone and eventually left the hospital against medical advice. Fran was quite upset and she identified fear and lack of community support as a major factor for this woman. She explained:

> "She really did not want us to do that and I don't know why she didn't want to, whether it was because she was frightened or, she probably was a bit frightened because she felt alone, um, really, really scared and also very unwell so that was making things harder anyway, and pregnant so she actually ran away."

Maddie linked the concept of non-compliance to fear as she thought that was the reason many Aboriginal women were not accepting of some of the medical interventions in their pregnancies:

> "Just being non-compliant for whatever reason it is that they are non-compliant which is maybe the fear."

6.8 Summary

I have presented the midwives' experiences of cultural care for Aboriginal women who give birth in the SHC system. The six main themes and the subthemes have demonstrated the essence of the experience for the midwives. The midwives words have supported my interpretations. In the following chapter, I will critically analyse the interpretations and explore the similarities and differences within those experiences.

Chapter 7 | Discussion

"I know the importance of getting people to see beyond the "issue" and to understand the lived experiences." Graeme Innes (2011), Race Discrimination Commissioner

7.1 Introduction

In chapters five and six I have presented the phenomenological interpretations for both the women and the midwives, focusing on the cultural aspects of care during labour and birth in the standard hospital care system. In this chapter, I will synthesise those experiences and explore the cultural relationships as experienced by both the women and the midwives during birth.

7.2 Midwives and women building connections

In the following section, I will explore what constitutes successful connections between the midwives and the women. I will also examine the aspects of practice that midwives found to be beneficial to enable them to facilitate what they believed to be positive interactions with the women. Midwifery care grounded in a philosophy of caring and the women's sense of 'feeling supported' will also be discussed.

The findings from the phenomenological explorations suggested that successful connections were made between the midwives and the women when communication was open and rapport was established. Sharing the same language was important for positive connections for the midwives. The positive women's experiences were centred on a sense of feeling supported by the midwife and feeling included in the care provided. The interactions for the midwives were most often positive if they were able to establish a good rapport and the midwives were supported in their practice by either family support or support from other Aboriginal health workers.

Rapport and relationships with midwives have been found to be important for birthing women (Clark, Beatty & Reibel 2015), and often women are more concerned with relationships with caregivers than the physical places or spaces that they birth in (Jenkins et al. 2014). For the Aboriginal women in my study, the positive experiences have involved good communication, rapport, and engagement with caregivers which have contributed to a sense of feeling supported through birth. The women wanted to know what was

happening during their labours, and births and they wanted information to be provided directly to them.

Caring is a fundamental element of midwifery practice. Birthing women want to be cared for and they want effective communication with their caregivers (Homer 2006). A caring presence during birth involves creating an environment of trust and security within the midwife/woman relationship (Pembroke & Pembroke 2008).

Communicating with the women was an important aspect leading to positive birthing experiences. When midwives talked to the women it helped form connections and allowed the women to feel less afraid of what was happening. The midwives identified the importance of the support from Aboriginal people, either the families or hospital staff members, to be important in building and sustaining a relationship with the women. Sophia described this aspect as contributing to the development of trust because when the women's support people trusted the midwife, quite often the woman would too.

The women who described positive experiences during their births also talked about feeling involved and included in their care delivery. Taylor and Guerin (2010) found that engaging in dialogue is very important for health care professionals working with Aboriginal peoples. They also contended that appearing to be under time constraints when engaging with Aboriginal clients and not allowing Aboriginal people to have sufficient time to consider responses was detrimental to the relationship (Taylor & Guerin 2010). This is often at odds with the busy schedules in maternity units, but was important to the women in my study in order to build relationships with the midwives. When the women were included in their care they felt empowered and in control and at times grateful that they had been considered.

The midwives also identified the limitations placed on their practice in attempting to achieve optimal care within the time pressures of a large organisation. Jean acknowledged that she felt the importance of immediately attempting to meet the women's needs. She was frustrated when she was unable to organise appropriate services for the women and they had already been discharged home. Jean felt that the women would then not be happy

with the care they had received and that she was not facilitating the standard of care she hoped to achieve.

Establishing culturally appropriate relationships with Aboriginal women is an important element of cultural safety in midwifery practice. Those relationships would consist of a space where the women felt that they were respected and where their cultural needs (as Aboriginal women) were facilitated. The women who participated in the study wanted effective communication and involvement in the decision-making before, during, and after the birth of their babies. The midwives also valued connections with women and those connections were more often positive if rapport and relationships could be formed. The midwives did rely on verbal communication in order to achieve the connections but did attempt other means of communication, like touch or through the family members, if the woman did not speak English. The midwives also suggested that by asking women about their needs they were then able to facilitate them and that was a culturally safe service. However, with the midwives' focus directed at the physical components of birth, often the women's cultural needs had not been identified and responded to.

7.3 Women and midwives - differing perspectives

An important aspect of my study was the relationships between the women and their midwives. This section will explore the differences in their world-views, stereotyping, judgments, and compliance as they related to the woman/midwife relationship.

When the women felt excluded from the discussions about their care, the experiences were not positive. This led to disempowerment and a lack of cultural safety for the women. Culturally unsafe experiences can prevent Aboriginal peoples from wishing to engage with the service in the future (Blackman 2011; Kendall & Barnett 2015). They might also share their experiences with others discouraging them from utilising the service themselves (Kendall & Barnett 2015). Rachel had heard word-of-mouth experiences that were negative prior to her birth in standard care. Fortunately, she did not choose to birth elsewhere and had an overall positive experience. Aboriginal peoples prioritise relationships so the development of positive relationships between clients and the health service is extremely important (Kosiak 2014).

In the study by Durey et al. (2011), a collaborative model was developed that aimed to improve health service delivery for Aboriginal peoples. Midwives are well positioned within this model to enact change at personal, interpersonal, and family-centred levels (Durey et al. 2011). The proposed model can be used to strengthen midwives' capacity to reduce racism by employing a critical self-reflexive lens to their practice (Durey et al. 2011). This is important in midwifery practice where the significance of birth in a woman's life makes change extremely important for better outcomes. The midwives in my study valued the relationships they were able to establish and the input of Aboriginal knowledge into making those relationships successful with the women in their care.

Feeling safe when giving birth and how women are welcomed and treated at hospitals are important social determinants of maternal newborn and child health outcomes (Buckskin et al. 2013). Some of the women in the study shared experiences of feeling judged, and others of feeling supported in their birth experiences. Many Aboriginal peoples will not use mainstream health services because of the way they are made to feel in them (Kendall & Barnett 2015; O'Donoghue 2007). Many of the women described experiences from the current birth or previous births at different hospitals that were negative, and they believed that this was related to their cultures.

Sherwood and Geia (2014) have described how nurses (and midwives) make value judgements about their patients, either intentionally or not and that those judgements can influence the subsequent care provision. This was evident in the women's data. Ava's experience is a good example where she disclosed her marijuana use and subsequently the health care team made assumptions about her using other drugs. This extended to her being fearful that they would not let her take her baby home because she thought that they thought she was a 'horrible person'. This is extremely concerning because they also questioned her on numerous occasions and told her that young mothers like her were prone to being dishonest. Sherwood and Geia (2014) have outlined how the ways in which nurses (and midwives) think, talk about, and deliver care to Aboriginal peoples will be formulated around the narrative being played in their heads. For example, the midwives who looked after Ava had negative narratives and it impacted on Ava's care and treatment.

Many of the midwifery participants talked about their negative stereotypes within their interviews. They tended to associate bad behaviour, drug use, lower socioeconomic position, and poor parenting with Aboriginal women. Beverly acknowledged that she made assumptions about Aboriginal women prior to meeting them and that she thought caring for them was 'not as nice as other women' because they often came from lower socioeconomic areas. Maddie described how she felt that Aboriginal women did not engage in medical treatments and advice because they would rather attend a party or go drinking than protect their babies and themselves. This was a concerning finding in the midwives' data as it illustrates how damaging those assumptions can be to the women in their care, and where the midwives' understandings are limited particularly in relation to compliance to medical treatment.

Compliance or lack of compliance that some midwives identified in Aboriginal women is associated with communication breakdowns. The communication responsibility lies with the health service and the midwives providing care. Aboriginal patients are frequently labelled as non-compliant, non-communicative, or even not interested in their own health and health care (Taylor & Guerin 2010). By labelling the patients as non-compliant, it places the responsibility on the patient rather than the health service (Taylor & Guerin 2010). Sherwood (2010) argued that health care providers label Aboriginal peoples as non-compliant which does not acknowledge the culturally unsafe care that they receive in mainstream services.

The midwives in my study identified a lack of compliance but did not explore any further into the reasons behind this and their own responsibility for it. Compliance is not the problem itself but a measure of the problem that surfaces when there are differences in cultures and world-views (McConnel 2003). A cultural safety model of care could provide an opportunity for midwives to better understand compliance as differences in world views rather than perceived poor choices by Aboriginal women. It would also assist in recognising the power issues at play within the relationships rather than poor choices.

7.4 Perceived barriers to effective relationships and experiences

The women in my study experienced some barriers within the organisation that negatively impacted on their experiences as Aboriginal women. The midwives also identified some

aspects of practice that they felt negatively impacted on their ability to care for women in the way that they should. They will now be explored.

The midwives were able to identify barriers to care provision that included time constraints, inflexible policies, procedures, rules, and regulations. They also argued that relocation from rural and remote areas, the speed at which women transitioned through the service, the fragmented systems of care, and language barriers all impacted negatively on care delivery for Aboriginal women. The hospital's inflexible rules and regulations were also perceived as negatively impacting on some of the women's birthing experiences. They included the visiting hours, inability to take their babies outside, relocation for birth, and the signs on the birthing room doors.

Some of the barriers that the midwives identified have also been recognised in other studies, and they include the institutional system of maternity care that has prevented midwives working to the full scope and role of midwifery practice (Homer et al. 2009). Maternity care that is grounded in the biomedical model is completely opposed to the traditional ways of Aboriginal birthing and healing (Kosiak 2014). Institutional systems of care, coupled with a grounding in the biomedical model, requires midwives to consider and integrate flexibility into the delivery of services to Aboriginal women. This is demanded from a cultural safety perspective.

The midwives were able to recognise barriers to the provision of care to Aboriginal women. Culturally unsafe practices are those that diminish, demean, or disempower the cultural identity and wellbeing of an individual (Nursing Council of New Zealand 2005). The practice of relocating women from rural and remote areas is an example of a culturally unsafe practice. Roslyn's experience is a good example and the subsequent impact on her cultural, social, and emotional health was evident. Had the midwives recognised the barriers as direct threats to the cultural safety of the women in their care, they might have recognised the need to take action.

The midwives acknowledged that they lacked the capacity to facilitate the family interactions for Aboriginal women within the organisation. The rules and regulations prevented them from achieving this for women. Sophia described how she felt she was

letting the women down as she was obligated to adhere to the strict organisational policies that limited her ability to have support people stay with the women overnight. This was frustrating to her and other midwives, and was also identified by some of the women in the study. Rose talked about her frustrations after the baby was born with the very strict visiting hours that excluded her mother from being with her all of the time. For Rose, having other Aboriginal women around was extremely important for her birth experience and was expected in her culture. Other women also identified the signs on the birthing room doors that expressed a maximum of two support people at any time as limiting.

Midwives are in a position of influence in the woman/midwife relationship. Effective midwifery care involves reciprocity and power sharing with the women through the sharing of information and involvement in her own labour (Pembroke & Pembroke 2008). The women in the study placed a significant amount of value in being in control of the birthing process. As the literature has contended, midwives must both recognise and acknowledge their position of power in the birthing process. Failure to do this risks the real potential for midwives to subordinate and control women (Anderson 2000). A culturally safe service demands an examination of the power imbalances that can be negotiated and changed to provide equitable, acceptable care that minimises risk to the person accessing health services (Durie 1994).

Communication breakdowns with Aboriginal peoples accessing health care have been identified as a major stressor for staff, who experience a sense of hopelessness (Taylor & Guerin 2010). The midwives in my study expressed similar frustrations at trying to meet women's needs when they were unable to communicate with them. Jean's experience is able to demonstrate this. She described a situation where she was unable to successfully engage with either the woman or her family members. Jean experienced fear of causing offence within these interactions. This culminated in the woman losing her baby. As a result, she worried about what she could have done differently in order to have prevented the outcome for this woman. This is a situation where urgent assistance was required from Aboriginal Liaison or an Aboriginal Maternal Infant Care worker (AMIC) to attempt to bridge the gap between the midwives and the woman and her family. Women who birth within the Metropolitan Aboriginal Family Birthing Program would have had access to an

AMIC worker. Women birthing in the standard system do not currently have the ability to access that support.

Fear of causing offence by doing or saying the wrong thing was identified in the midwives' interviews. If the midwives had a successful relationship with an Aboriginal health worker this may have been avoided. Having a safe space between two health professionals to talk about what is and is not appropriate could have assisted in this situation.

The women in my study articulated the importance of close family ties in many ways. Family is important in Aboriginal cultures and is pivotal in determining appropriate behaviours and cultural identity (Colquhoun & Dockery 2012). Health for Aboriginal peoples involves an interconnected joining of individuals, families, and community cultures, which demands a similar response from health organisations (Wood et al. 2011). The midwives in the study also recognised the importance of families for Aboriginal women. Isabelle judged her midwifery care as good because she was *allowed* to have all of her support people attend her birth. This was despite the signs on the birthing rooms doors that instructed a limit of two people in the room. Rose found the practice of allowing visitors only in the afternoon whilst she was in the postnatal ward as a negative aspect of her experience. The birth room door signs and visiting hours can be seen as a direct threat to the cultural safety for the women in this study.

7.5 Equal care, equitable care and cultural safety

In this section, I will explore the concepts of equal care and equitable care which were misunderstood within the midwives' data. They will then be linked to the understandings of cultural safety within the interviews. The concept of difference and how it was understood by both the midwives and the women will be examined.

A strong theme in the midwives' data was that they felt that treating all women the same was important for equity of services and equity of care for all women. They felt that by individualising the care to each woman her individual needs would always be accommodated. The approach they used with each woman was the same: 'ask her what she needs and attempt to provide it', which was to the midwives equity of care. Midwives were of the strong opinion that this was the most appropriate approach in order to provide equity

of care. Donna explained that she asked the woman if she had anything that she needed her to do for her to make her birth better, and that she would then facilitate it. She went on to specify that her approach was equitable as it was the approach she used for every woman whether she was Aboriginal or not.

Phillips (2014) identified a series of identifiable responses that are frequently given when discussions about race and racism arise in colonised countries. They include: denial and disbelief, minimisation, justifications of being colour blind or treating everybody the same, and that reverse racism is as prevalent as racism (Phillips 2014). All of these responses were present in the midwifery data. The response heard most prevalently was that the midwives treated everyone the same.

Midwives were so determined to provide what they felt was equal care that they felt that Aboriginal women should not get any 'extra' services above and beyond any other cultures. They saw equity of care as being the 'same' care. They did not explore or understand that in order to provide equitable care a more targeted approach was required. Some of the midwives did acknowledge the disparate health outcomes experienced by Aboriginal women, but could not link those outcomes to the need for acceptable culturally appropriate services. Marshall (2014) described the concept of 'proportionate universalism' in maternity services, where the service is available to all but greater intensity provided to those with greater social and economic disadvantage. Women will always require greater health services due to the nature of their reproductive roles than men, and equitable health care should provide greater health services to those with a greater need (Thomsen et al. 2011).

The midwives' views of equal care and equitable care require a closer examination. It is good practice for midwives not to apply a generic approach to all Aboriginal women (Williamson & Harrison 2010). The midwives' attempts at meeting the women's individual needs illustrate a broader understanding of culture. Culture is much more complex, is never static, and it evolves over time (Eckermann et al. 2010; Fredericks 2003). Whilst traditional cultural education provided itemised aspects of a patient's culture for the health care provider to cover and attempt to achieve in an interaction (Richardson & Williams 2007), modern training requires an examination of self and an acknowledgement of difference

between the health care provider and the person presenting for care. However, for this group of midwives it was the development of their thoughts about difference that was lacking with notions that appeared to be grounded in the physical. Lana talked about difference and linked her understanding to the physical body with her statements about every 'body' being the same. Sophia also talked about everybody's body being the same if they were bleeding. The midwives had real difficulty with thinking outside of the physical aspects of midwifery care.

Whilst individualising care to each woman is a good practice, the midwife needs to understand the principles of cultural safety first to ensure that the individualised care is not only based in physical care like analgesia and other intrapartum choices. Every woman in Australia should be individually assessed to identify her cultural needs and ensure they are met (Phiri, Dietsch & Bonner 2010). The midwives should think outside of midwifery practices and specifically help the women achieve birth experiences that reflect their lives as Aboriginal women. This could be their ties to their families, traditions, customs, ways, ceremonies, principles and values, or their worldviews. For the women in my study, it was related to their autonomy, having the support of their families, knowing what was best and wanting the best for their babies, and acknowledging and respecting their cultures.

Cultural safety in practice should involve providing care that is regardful of culture or that values difference (Taylor & Guerin 2010). For the midwives in the study, the idea of treating all women the same does not necessarily value their differences. Midwifery care that is based in equitable care should also seek to gain equitable outcomes as experienced by Aboriginal women. This certainly fits with care that places cultural safety as core and is in line with the Australian national midwifery competency standards (Nursing and Midwifery Board of Australia 2006). Health services must be able to better respond to the needs of Aboriginal women, and a greater understanding of Aboriginal needs is warranted that must be informed by Aboriginal principles and values rather than mainstream values. Cultural responsiveness should occur within mainstream services.

Culturally safe care demands that midwives are able to recognise and respect differences in each individual presenting for care (Papps & Ramsden 1996). Many of the women in the study articulated that they wanted to be treated the same as everyone else. This may

have been related to the fact that on the whole the women evaluated their care on the physical aspects (their physical needs and comforts). It may also be grounded in a notion where the women felt that by getting the same care as everyone else they would get better care than they might otherwise achieve, as illustrated by Ava's experience.

For Ava, there was a sense of different care and being treated differently which for her was negative. She felt that she was perceived to be a bad person and this was because she was Aboriginal. She stated that she did not want to be treated as a different person and also acknowledged that had she had an Aboriginal caregiver she would not have been perceived in that way. When midwives do not adopt a cultural safety model, the potential exists that the care provided could become culturally unsafe, which has some potential major ramifications for the women. Stereotyping can lead to false assumptions that can affect care delivery (Walton & Marriott 2008). Ava felt she was stereotyped by the staff after disclosing her marijuana use and assumptions were made about her that were extremely damaging to her psychological wellbeing.

Shelley explored the notion of difference in her interview and acknowledged a sense that at times being treated differently made her feel singled out; but the acknowledgment and respect for her culture made her feel safe within the service. She was happy to have her needs outside of the physical acknowledged and her Aboriginality celebrated. Ava's and Shelley's experiences are underpinned by the ability of the staff to engage well in cross-cultural practices, their understandings of cultural safety, their understandings of their own cultures, and their abilities to implement the Aboriginal health organisational policies and procedures. Health policies need to clearly define pathways for staff to follow to ensure that culturally unsafe practices are eliminated (Grant, Parry & Guerin 2013). Practitioners need to also be able to recognise where the mainstream systems and practices (designed to produce uniform service provisions and best practice) undermine the cultural safety of clients by diminishing the importance of difference (Walker, Schultz & Sonn 2014).

Cultural safety in midwifery practice includes optimal communication, building relationships, and acknowledging women's cultural preferences (Phiri, Dietsch & Bonner 2010). Within my study, most of the women were not asked about their cultural needs around birth. For some of the women, it did not appear to matter, perhaps because the

expectations from many of the women was for physical care only. For the women who wanted to have been asked about their cultural needs, this was really important. For Shelley (who was asked) it was significant and she felt shocked and amazed, and it made her feel good. A culturally safe service at a minimum should involve recognition, questioning, and supporting of cultural needs and the fact that she was shocked illustrates that it is not something that is generally happening in mainstream services.

Australian midwives should identify and acknowledge the presence of cultural differences (Phiri, Dietsch & Bonner 2010); this would contribute to achieving cultural safety for Aboriginal women birthing in standard care. Health workers must be able to recognise how the impact of their own cultural, ethnic, gender, and religious backgrounds influences their perceptions and understandings of the people they care for (Fredericks & Thompson 2010). Difference blindness or treating everyone the same fails to allow the health worker to appreciate and acknowledge the needs and concerns of Aboriginal peoples and of the historical encounter with standard health care services (McBain-Rigg & Veitch 2011).

It is evident that the midwives were confused about the notion of culture and they frequently conflated culture with the physical body and act of birth. Some of the midwives held the impression that Aboriginal women living in urban areas had lost their culture. Their understandings were based either in the physical body or in traditional understandings of culture as static and unchanging. Aboriginal peoples do not become non-Aboriginal or lacking in culture when they are not seen as 'traditional' by a non-Aboriginal person (Morrissey et al. 2007).

7.6 Racism

I will explore racism and institutional racism in this section. Stereotyping of Aboriginal women, which was prevalent within the midwives' data, will also be examined and related to culturally safe practice.

The four principal processes of racism include categorisation, stereotyping, evaluation and behaviour (Hampton & Toombs 2013a). Categorisation occurs with difference in physical features and appearance, and stereotyping occurs when individuals are assigned cultural characteristics based on their genetic background (Hampton & Toombs 2013a). Health care

providers then evaluate and assign stereotypes to all members of the group that are grounded in their beliefs involving discrimination against members of the group (Hampton & Toombs 2013a). Some of the midwives recognised the categorisation and stereotyping that was occurring but did not see how that might negatively influence their interactions with the women in their care.

Racism was present in the midwifery data and some of the women felt that they were treated negatively in some instances because they were Aboriginal. Institutional racism occurs when the organisational policies and procedures reflect the cultural assumptions of the dominant group (Morrissey et al. 2007). Some of the midwives identified the hospital's inflexible policies and procedures and their own inability to challenge them. The policies and procedures that were in place certainly reinforced the dominance of Westernised cultures within the system.

Fear of appearing racist or doing or saying the wrong thing was apparent in the midwives' data. Many white people minimise difference in an attempt to appear non-racist (Sue 2013). Coupled with the fear of appearing racist lies a greater fear that they might have biased and prejudicial attitudes (Sue 2013). The midwives in my study did appear to minimise difference, which could have been associated with attempting to appear non-racist. However, the strong undertones of dissatisfaction with what some of the midwives perceived as preferential treatment for Aboriginal women suggests a stronger grounding in a misunderstanding of equitable care.

Ava's negative feelings of being treated differently because she was Aboriginal portrays the racial discrimination inherent within the system. Many of the midwives expressed their negative stereotypes about Aboriginal women and families. Ava 'experienced' her treatment as racism and race-related, and this must be acknowledged because cultural safety is grounded in the experience of the client or patient.

Nelson (2015) identified language as being imperative to addressing racism, and she said using the words 'racism and anti-racism' ensures the existence of racism is acknowledged. A statement that was heard throughout some of the midwifery interviews was 'I'm not racist but…'. Most of the time that statement is a precursor to a racist comment (Innes

2011). Acknowledgement of racist views, judgments, and stereotypes as racism would enable those midwives to work through their beliefs and the impact they have on the women they care for.

Negative experiences of racism are transformed across generations for the people who experience it, and this is reinforced with their own experiences of racism in health care (Kendall & Barnett 2015). In order to stop the continuance of racism in health care, it must be named as such. Statements such as 'I am not racist but…' must be named as racism because the denial of racism is just a form of racism itself (Innes 2011). Furthermore, espousals of 'reverse racism' minimise the power of racism (Cabrera 2012) and they were heard within the midwifery interviews.

Anti-racism training challenges practitioners to acknowledge and address white race privilege, which would better position them to acknowledge and address the marginalisation and disempowerment of Aboriginal peoples (Fredericks 2008b). Working through these issues in workshops could help the midwives re-examine their own positions, acknowledge their white race privilege (for most of them), and explore how to provide a better service to the women in their care.

Providing additional training in cultural safety might equip the midwives to better understand their professional requirements, recognise their privilege, and respond better to Aboriginal women. Health care professionals need to critically analyse their own attitudes and practices towards Aboriginal clients and work hard at institutional change that will improve the experiences of those accessing health care (Durey, Thompson & Wood 2012). Failure to recognise Aboriginal Australians' different constructs of health is also an example of institutional racism in Australia (Henry, Houston & Mooney 2004).

7.7 Breaking stereotypes

Many of the midwives shared their stereotypes about Aboriginal women, which included a perceived indifference and of not placing their babies' needs above their own. The women's interviews challenged the midwives' stereotypes as all of the women placed their babies as their primary concern. They made sacrifices for their babies and they wanted the best for them. I will explore the extent of those sacrifices in this section.

Aboriginal knowledge is not incorporated well into large institutions with a standardised health service focus, despite some strong policies and procedures at management level. This group of women all birthed in standard care without access to Aboriginal health workers. Some of the women wanted some practices within their hospital stays that could not be provided or that were not facilitated in the model of care provided to them. They included things like Roslyn wanting to take her baby outside, women wanting continuity of care and not being offered it, or wanting an Aboriginal midwife or carer. Many of the women were not asked about their cultural needs, and they would like to have been asked.

Equitable care demands consideration of the whole worldview of health for Aboriginal peoples. Health includes family, community, land, ties with the past and a vision of the future, hope, dignity, freedom from anxiety, the right to self-determination, economic security, and absence of abuse (Eckermann et al. 2010). Health care grounded in the biomedical model often neglects the whole world view of health for Aboriginal peoples.

Women coming from remote communities should receive special consideration of their needs. Roslyn felt that being in Adelaide was making her and her baby sick and she *wanted* bush medicine for her baby. She likened her hospital stay with prison. Her distress was very strong having been separated from her way of life to be in a different state and without her supports. This is a situation where a traditional healer could have been appropriate to work with the hospital midwives and doctors. Many Aboriginal peoples have traditional healers as their primary health care provider (Taylor & Guerin 2010). This would have provided a more holistic approach, which would have considered her world view and would have provided better care to her and her baby.

The use of traditional medical practitioners, either alone or working with Westernised health practitioners, is occurring throughout Australia mainly at the primary health care level (Oliver 2013). Some large institutions have introduced traditional healers, and in-patients at one major Adelaide adult hospital have been found to be more at ease after visits from the Ngangkari and after special ‘cleansing’ ceremonies (Willis et al. 2010). Culturally appropriate care for Roslyn should have provided this option, which may have improved her experience. In her situation, it would have been beneficial to have also had her children relocated to Adelaide as well as her partner as she was missing them. Her treatment should

have been fast-tracked, and lengthy delays in diagnosis and management avoided, for her psychological health and in respect of her cultural traditions and needs as an Aboriginal woman.

At the midwifery level, some consideration around Roslyn's needs, especially around her desire to be outside with her baby, would have been warranted to improve her experience. The midwives, possibly without even being aware, were enforcing their own principles and values by exerting the hospital rules and regulations. They denied Roslyn the opportunity to take her child outside where she felt more comfortable. In doing so, they were exerting power and control over Roslyn and adding to her distress. If the midwives had a more advanced understanding of cultural safety they could have critically examined the care they were providing and possibly the outcomes could have been different for Roslyn. If an Aboriginal health worker had been involved in her care the issues may have been identified earlier and the lack of cultural responsiveness in the service identified.

Roslyn asked her interviewer to come back in another day to advocate for her, which she did. She also asked the ACC, who recruited her, to assist her with the birth registration and Medicare paperwork and again an Aboriginal health worker would have been ideal in this situation. Some urgency in the management of her care would have ensured a shortened length of stay and separation from her way of life. The re-establishment of birthing services in rural and remote areas should also be considered as a matter of urgency (Dietsch et al. 2011). Obstetric and medical risk must be balanced with the social and spiritual risk in Aboriginal maternity care (Fenton & Jones 2015). The midwives needed to explore the other aspects of Roslyn's health including the social, emotional, spiritual, and cultural components.

Elkin (2011) described an independent program operating in Western Australia that involved advocacy and listening to Aboriginal consumer experiences about accessing health care. She said that many Aboriginal consumers felt they had been negatively discriminated against when accessing mainstream services, and that this frequently led to them not feeling able to raise their concerns in person (Kildea, Kruske & Sherwood 2015). Roslyn needed an advocate and her interviewer attempted to assist her. However, this was

a service that should have been provided by the hospital and could have made a real difference to her experience.

Ava also felt she had been negatively discriminated against and some advocacy for her at the time she was being interrogated may have assisted in resolving the issue promptly before it escalated into her crying and becoming distressed. If Ava or Roslyn had birthed in the MGP continuity program with an AMIC worker, their experiences may have been better because continuity of care assists in the provision of culturally safe midwifery services (Phiri, Dietsch & Bonner 2010).

There can be a systemic misinterpretation of the principle of equal treatment when policies for cultural respect and health equity are implemented in the care of Aboriginal peoples (Morrissey et al. 2007). This requires a need for clarification around equal care and equitable care within institutions (Morrissey et al. 2007). The notion of equal care was important to the midwives, but they did not see that equal care was not the 'same care' and that for equitable care a more targeted approach is demanded. Institutions can challenge these notions with organisational policies, procedures, and practices, which could go a long way to lifting the cultural competency of organisations (Morrissey et al. 2007). Although the hospital did have the policies and procedures in place they did not always translate into practice at the point of care. The medical and midwifery staff needed a better understanding of equitable care. Health care should also be provided that incorporates the values and beliefs of the women presenting for birth, which will require some flexibility around the way care is delivered.

Fiona's story of wanting to co-sleep with her baby clearly illustrated the power relations between the midwife and the woman. Hospital protocols were enforced on Fiona and she accepted them despite not being happy about it. Kosiak (2014) explained that for many Aboriginal women, power is connected to 'whiteness' because people in a position of power are often non-Aboriginal. Midwives need to recognise their positions of power in order to combat the negative effects subsequently placed on the women. In Fiona's situation, a discussion, perhaps with the ALOs present or an Aboriginal health worker, around the reasons for the policy, the legal requirements of the hospital, and Fiona's

individual needs was warranted. Although the hospital had a legal requirement to ensure safe sleeping standards were met, this was not explained to Fiona.

Considering the experiences of some of the women birthing in standard care an examination of culturally appropriate birthing services for Aboriginal women is required. The Aboriginal Family Birthing Program (AFBP) is currently operating in South Australia in both regional and metropolitan areas. The program offers women a culturally appropriate service that includes AMIC workers involved in delivering care to the women (Brown et al. 2015). Culturally safe midwifery care can be achieved for women birthing in continuity or caseload models of care with a known midwife (Phiri, Dietsch & Bonner 2010).

The women in the study had mixed feelings about continuity models of care. Some had not been offered the AFBP program but would have liked to have been. Some had been offered the program but declined because a known midwife was not something they wanted and they did not wish to have an AMIC worker involved in their care. Rachel and Fiona identified privacy as an issue, as although they felt they would have a stronger connection with an Aboriginal carer, they wanted their privacy respected and felt that 'everybody knows everybody' in the Aboriginal community. This could have been an opportunity to share with them the professional obligations, which included confidentiality, and which may have reassured them and given them the chance to birth in a continuity program with an AMIC worker.

The women in my study made significant sacrifices to ensure that they gained the best health care for their babies. This was sometimes at odds with the way they practised health and health care and with their worldviews of health. Hospitals can better meet the needs of Aboriginal women by working together with Aboriginal peoples to incorporate a more holistic approach to maternity care that considers her needs outside of the physical aspects of care.

The strength of the women participants was remarkable. They tolerated adversity and demonstrated positive attitudes towards their situations. The women in my study faced many challenges either in their personal lives and situations, with accessing care, in their treatments within the organisation, and with their physical health. They showed an ability

to move on and look forward with positivity despite their personal situations and experiences in the hospital.

7.8 Physical care versus cultural care

There was a strong focus on the physical aspects of birth within the data. The midwives found it difficult to navigate both culture and the physical process of giving birth. For the Aboriginal women, the expectation from their caregivers was most often related to the physical aspects of birth even when encouraged to consider culture as it relates to birth. Those concepts will be explored in this section.

Respecting, acknowledging, and recognising Aboriginal cultures at the point of care is essential to working to the full scope of midwifery practice. Many of the women in the study did not have an expectation of anything other than the physical aspects of midwifery care. The midwives were also comfortable with the physical side of midwifery care for Aboriginal women, but felt ill-equipped when they practised outside physical care. Being fully present with labouring women involves challenging the status quo in institutions that privilege physical checks over relationships with women (Hunter 2015).

The women's data clearly demonstrated that the midwives were meeting the physical needs of the women around labour and birth. The Australian National Midwifery competencies for practice, competency ten (Nursing and Midwifery Board of Australia 2006), requires that midwives provide culturally safe care that includes the ability to recognise and respond to the specific needs of Aboriginal women. The competency standards direct midwives to move beyond physical care and to examine the needs of Aboriginal women, which includes respect for differences in cultural meanings to health and maternity care.

Do the midwives feel equipped to meet those needs? Does the institution support the midwives working in standard care to achieve competency? I would argue that the institution does not support midwives in that aspect of care. The time constraints placed on midwives to meet women's needs often means that the physical aspects of care is the only part that is able to be achieved. Furthermore, midwives working in standard care do not have the benefit of AMIC workers in delivering care to Aboriginal women. Aboriginal health organisational policies are not currently translated into clinical practice in any way,

which would assist midwives in delivering optimal services at the point of care in the SHC system. A recent scoping review that examined the organisational culture in maternity care also found that midwives perceived organisational barriers, such as time constraints, procedural imperatives, and professional conflicts, as negatively affecting their ability to provide good maternity care to women (Frith et al. 2014).

It is evident that Aboriginal health workers working in standard care or being on call for standard care could have facilitated holistic care for the women, and assisted the midwives to practice outside of the physical aspects of care. Workplace partnerships between Aboriginal health workers and other staff are able to help build practical knowledge about the provision of culturally safe care, which have been found to be more effective than formal training (Taylor et al. 2009). Attitudinal change is needed for some of the midwives; this could be addressed through formal anti-racism training provided by the organisation.

The women in my study identified a lack of information and communication as being vital to them, and when the midwives did not communicate well with them or involve them in decision-making this led to fear. Although the midwives recognised the importance of positive communication they also talked about technology in the institution as contributing to fear for the women, especially for the women from rural and remote areas. Technology for the midwives included the cardiotocography machines, intravenous pumps, computer systems, and other technology that is prevalent in a large health care organisation. Biomedical obstetric practices are grounded in science and technology and constitute the patient as object, and contribute to the alienation of practitioner from patient; they are authoritarian and have a mind and body separation (Davis-Floyd 2001). For the women in my study technology was not seen as contributing to fear as they valued the relationships with caregivers foremost, and could achieve positive experiences with positive, inclusive interactions with their midwives.

7.9 Summary

I have explored the midwives and women's findings within this chapter. This has facilitated an examination of the differences and similarities in the way culture is understood and considered when accessing care or providing care in the SHC system. In the following chapter, I will explore the research aims and research questions and demonstrate how they

were met within my project. I will also share some recommendations arising from my research. A summary of the findings, implications for practice, and the strengths and limitations will also be shared. Finally, I will conclude with an evaluation of the thesis using Walsh and Downe's (2006) eight essential criteria.

Chapter 8 | Conclusions and recommendations

"Culturally safe practice in health service delivery is embedded in the notion that it is the confident culture of the person and the institutional philosophy delivering the service which, by its very nature, creates service barriers." Irihapeti Ramsden (2002, pp.179-180)

8.1 Introduction

I have explored the experiences of fourteen Aboriginal women birthing in the standard hospital care (SHC) system at a public teaching hospital in Adelaide within my study. The focus was on the cultural aspects of their birth experience and care by midwives. I have also explored the practices of thirteen midwives working in the SHC system at the same hospital, focusing on the cultural care for Aboriginal women in labour.

My research has shared insights into their experiences and has revealed that there are some similarities with the midwives' and the women's experiences. Those similarities are centred in positive relationships requiring good communication and the establishment of rapport. Both the midwives and the women were able to identify barriers to the provision of culturally appropriate care. The midwives felt comfortable in the provision of the physical aspects of midwifery care and less comfortable with the cultural aspects. The women tended to only express an expectation for the physical aspects of care from the midwives.

The midwives valued and needed support from the Aboriginal health workers within the hospital or the woman's support people. The women valued the role their families and friends played in supporting them through birth.

Women from rural and remote areas suffered from isolation and loneliness when they were disconnected from their supports to birth. The women in my study were strong and positive and tolerated their situations because they all wanted the best for their babies. Some of the women felt judged by their caregivers and this was related to their Aboriginality.

The midwives demonstrated a lack of understanding of equitable care for Aboriginal women. They also demonstrated racism and stereotyping, and made negative assumptions about Aboriginal women. The midwives' understandings of culture tended to be based in

a static 'traditional' view of what they thought Aboriginal cultures should be. The midwives falsely identified women from urban areas as having lesser cultural needs.

Interpretative phenomenology using van Manen's data analysis has allowed an examination of this group of midwives' and women's lived experiences. The phenomenological interpretations have shared the women's and midwives' voices, and a greater understanding of the impact of culture on the work of midwives and the experiences of women birthing in standard care has emerged.

In this chapter, I will explore the research aims and research questions and how they have been achieved within the study. I will also present some recommendations arising from the work and outline and discuss the strengths and limitations of the study. I will summarise the work, determine the implications, and conduct an evaluation of the thesis as outlined in chapter four.

8.2 Meeting the research aims and questions

I will explore the research aims of the project in the following section and how they were achieved within the study. I will then revisit the research questions and determine how they were met within the research outcomes.

8.2.1 Research Aims

My study aimed to describe and interpret the experiences of Aboriginal women birthing their babies in the SHC system. It also aimed to describe and interpret the experiences of midwives in the provision of intrapartum care in the SHC system, with the overarching aim of developing further understanding of cultural care based on lived experience.

My study has described and interpreted the experiences of twenty-seven women and midwives giving birth or working in the SHC system, focusing on the cultural aspects of care. The experiences were shared in chapters five and six, and chapter seven explored how those experiences have contributed to new knowledge on cultural care for women and midwives giving birth and working in the SHC system at a tertiary hospital in South Australia.

8.2.2 Research Questions

In the following section, I will explore the research questions and how they were answered within my study. The phenomenological approach used has provided rich accounts of the women's and the midwives' lived experiences either birthing in or accessing midwifery care in the SHC system at one South Australian teaching hospital.

Research Question One

What are the cultural expectations of Aboriginal women when accessing midwifery care in the SHC system during birth in a tertiary hospital?

The Aboriginal women wanted the best health care for their babies; they placed their babies' needs above their own and they made significant personal sacrifices to ensure their babies' needs were accommodated. Relocation from rural and remote areas was a significant stressor for Aboriginal women. This was related to the disconnection from their families, other children, communities, friends, and way of life.

The women valued having their families around them before, during, and after their births. Some of the strict rules and regulations within the institution did negatively impact on those relationships.

The Aboriginal women in my study had expectations that were predominately grounded in the physical aspects of midwifery care. This included birth coaching, giving information about the process, getting them medications, analgesia, getting them something to eat, or getting them to theatre on time.

The Aboriginal women wanted to feel supported in their care, which was quite often related to the birth process. Positive relationships with their caregivers were able to contribute to less fear for the women. They wanted not to feel judged by their caregivers when they disclosed information. Some of the women wanted their Aboriginality celebrated, and simply asking them if they had any cultural needs was able to achieve that.

Positive experiences occurred when the relationships between the women and the midwives were based on mutual respect, sharing of information and feeling included in the decisions about their babies. When the women felt judged and excluded their experiences were negatively affected.

Research Question Two

How do midwives provide care that they believe is culturally safe to birthing Aboriginal women in the SHC system at a tertiary public maternity hospital in South Australia?

The midwives in the study used the same approach to each woman in their care. They asked her what her individual needs were and attempted to facilitate those needs within the boundaries of the institution.

The midwives valued and recognised the role of the women's support people, families, friends, and the Aboriginal health workers within the institution. They saw them as partners in delivering acceptable, appropriate care to the women.

The midwives felt comfortable with the physical facets of the provision of midwifery care, but felt less comfortable with the social, cultural, spiritual, and emotional aspects of their roles. The midwives wanted more support in the delivery of care and they wanted that support to come from Aboriginal health workers like the AMIC workers, or a greater level of support from the Aboriginal Liaison teams.

The midwives lacked a deep understanding of the concepts of cultural safety and this was reflected in some of their practices. They did not explore their own positions of power as caregivers, and they held negative assumptions about Aboriginal women. The midwives' understanding of culture, which was grounded in a static, unchanging traditional sense, led to the misunderstanding that women from urban areas had lesser cultural needs than women from rural and remote areas.

Research Question Three

What are the similarities and differences with the women's and midwives' experiences?

The lived experiences of this group of women and midwives did share some similarities and some differences. The midwives identified that the place of birth itself induced fear in some women, particularly those from rural and remote areas, and that was most often related to the technology. This was not the case in the women's stories, where fear was almost always related to the information and involvement with the hospital caregivers. The women valued the relationships with their caregivers, and if they were involved in the

decision making and given enough information then those experiences tended to be more positive.

Physical care was an aspect that the midwives felt confident about providing to the women. The women in the study usually expected only physical care from their midwives and those expectations were met.

Some of the assumptions and stereotypes that the midwives had about Aboriginal women were completely disproven within my study. All of the Aboriginal women wanted the best for their babies and they prioritised their babies' needs above their own. This was contrary to some of the midwives' statements that implied the women put their own needs above their babies.

The cultural needs of the women from urban, rural and remote areas did not differ. This was contrary to the thoughts of most of the midwives in the study. Cultural needs were in no way affected by the place of residence of the participants.

8.3 Personal thoughts on the research findings and process

On a personal level, as a midwife, this research experience has had a significant effect on my clinical practice. Listening to the accounts that the women shared was an extremely moving process. It has challenged me personally to not take at face value what a woman might express to me and to seek to explore her needs on a deeper level. I do that now by taking some time with the women despite the other workplace demands. I sit and talk to them about where they come from, about their languages, their family life, and their communities. The women really did not complain about the things that happened to them at the hospital, and they did not express how they felt. Understanding that influences my practice as I try harder to meet the needs of Aboriginal women and their families in my care.

The power at play within the health care relationship is something I also seek to explore in every encounter with every woman. Hearing the Aboriginal women speak of being told how to breastfeed (having successfully breastfed their other children) has made me take more time to identify the women's educational needs rather than enforcing needs that I might perceive them to have.

I also feel more empowered to challenge staff who espouse the hospital rules and regulations and seek to control women with them. I feel privileged to have been given the opportunity to be mentored particularly by Ms Thyer throughout this process, as I have learnt so much about looking at things from a difference perspective; this positively impacts on my midwifery practice. On a personal level she has challenged me every step of this process to look at things in different ways and I value that on many levels.

8.4 Recommendations for practice

Some recommendations can be made for the maternity hospital. These include three main areas: workforce and models of care, education and training, and changes to improve the women's experiences. The recommendations will be explored below.

8.4.1 Workforce/models of care

1. **AMIC workers for women from rural and remote areas.** Currently, women from rural and remote areas are not provided with an opportunity to engage with an AMIC worker as they are usually transferred on an emergency basis. They should be given the opportunity to have a designated AMIC worker manage their transition through the service. This would ensure their needs are better met and help limit the time the women are required to be away from their supports.
2. **AMIC workers on call to assist the women and midwives**. Midwives identified the need for support in caring for women at all hours of the day and night in the SHC system. AMIC workers on call would assist the midwives in the provision of appropriate care and contribute to better experiences for the women. On call AMIC workers for all Aboriginal women could provide an opportunity for each woman to have her needs addressed, which values every single birth experience. Having access to AMIC workers in standard care does not diminish the importance of continuity programs, but values each woman's experience and right to appropriate care with whatever health care model she engages with.
3. **Increased education, employment, and retention of Aboriginal midwives.** Increased education, employment, and retention of Aboriginal midwives will ensure greater incorporation of Aboriginal principles and values into health care delivery and ultimately benefit the women. This would require collaboration with the South Australian universities and SA Health. Retention of midwives could be

improved with a greater understanding of the challenges they face in the workplace and strategies could be developed to meet their needs within the profession. Career progression and the opportunity for them to shape and develop Aboriginal birthing services should be provided.

4. **Investigation into the organisational culture and its effects on the midwives' ability to provide optimal care.** Future research into the organisational culture, and nature and transference of organisational policies and procedures, is required in order to ensure that they are appropriate and that they support clinicians in providing care.
5. **Changes to birthing services in rural and remote areas for Aboriginal women so the women may not have to relocate for birth.** Culturally safe midwifery care ultimately could be provided if women were not having to relocate from their homes to birth. A commitment to provide these services might make a more significant positive impact on the health outcomes for Aboriginal women and babies.

8.4.2 Education and training

6. **Cultural safety workshops.** Facilitating cultural safety workshops with Aboriginal staff, midwives, cultural trainers, and even consumer representations could all build positive and mutually beneficial relationships. The sessions could be facilitated by a non-Aboriginal and Aboriginal trainer working together. This would assist in breaking down stereotypes, exploring midwifery and medical cultures, individual cultures, and professional responsibility. Some stories from women either in person or recorded would benefit midwifery practice. Development and training in skills of critical reflexivity would also benefit culturally safe midwifery practice.
7. **Anti-racism training**. Anti-racism training is needed. This could consist of workshops run by Aboriginal and non-Aboriginal facilitators. The workshops should explore white race privilege, unpack racism, and examine the everyday experiences of racism for Aboriginal peoples. Stereotyping, institutional racism, and tools to challenge and address racism would also be facilitated within these sessions.

8. **Annual assessable cultural training.** Annual cultural safety training would highlight the importance of the sessions and should include an assessable component. This may help develop the understanding of the key concepts of cultural safety.

8.4.3 Changes to improve the women's experiences

9. **Extension of the current care planners to include cultural needs and requests or a stand-alone planner.** It is important that the women are asked about their cultural needs. It could be incorporated into current care plans or as a stand-alone planner that is used when a woman identifies as Aboriginal. Given so many midwives did not ask the women about their cultural needs in the study, a planner that reminds the midwife to ask would ensure that no woman is missed. The planner would then provide an opportunity to clearly specify each woman's cultural needs, and could be seen and responded to by staff members as the woman transitions through the service. The planner would also legitimise the importance of a woman's cultural needs around birth, and assist in ensuring midwives are cognisant of their professional obligations. This is something that could also be addressed and recorded antenatally or as an aspect of the pregnancy handheld record.
10. **Voluntary mentorship partnerships.** Interested Aboriginal and non-Aboriginal staff members could participate in mentorship programs, which would help build positive relationships between Aboriginal and non-Aboriginal staff members.
11. **Increased review into women's experiences.** Cultural safety demands consumer feedback, and by better understanding the experiences of women accessing care a greater understanding of their needs could be developed. This could then be used to ensure optimal experiences for all Aboriginal women. Consumer feedback should also be sought from women from rural and remote areas (preferably in their own communities where they feel safe).
12. **Removal of the signs on the door restricting visitors in the birth suite.** The signs on the door restricting visitors in the birth suite should be removed for all women. The restrictions can be experienced as a barrier to Aboriginal women's practices around birth. I acknowledge that some women may express a desire for less people

to be present at the birth. The midwife does have the capacity to advocate for the woman and is in a position to ask visitors to leave if that is what a woman wants.

13. **Flexibility in the application of hospital rules and regulations for Aboriginal women.** The midwives should receive institutional support in order to facilitate women's wishes. For example, if the woman expresses a desire to take her baby outside, wishes to have a family member stay overnight, wishes to have a smoking ceremony, or wishes to engage with a traditional healer, the midwives should be assisted to meet her needs. Flexible visiting hours should also be considered for Aboriginal women. The midwives should understand that they are supported to achieve women's wishes where appropriate. If not appropriate, or if the midwife is unsure, AMIC workers or Aboriginal health workers should be consulted for clarification and/or alternatives. If the midwife is unable to facilitate a woman's wishes even after consultation with Aboriginal health workers, it is important that this is discussed with the woman, preferably with an Aboriginal health worker present.
14. **Building relationships with midwives and Aboriginal health workforce.** In order to bring midwives and the Aboriginal Liaison Officers (ALOs) together to provide better care as a team, some sessions that would allow friendships and relationships to develop outside of clinical encounters could assist in building positive relationships. This may help the midwives in their fear of causing offence, help them to better understand the ALOs' workloads, and break down barriers between the two groups to the benefit of the women.

8.5 Summary of findings

Culture and culturally appropriate midwifery care are important aspects of holistic midwifery practice. There is a lack of research that specifically explores midwifery practice at birth for Aboriginal and Torres Strait Islander women birthing in standard care. My research has enabled an understanding of midwives' practices, understandings, and misunderstandings around cultural care. It has highlighted the barriers the midwives feel they face when attempting to provide care within a large institution. It has also explored their understandings of equal care and equitable care, and illustrated a way forward for addressing the gap in knowledge. Racism and stereotyping was identified in the midwives'

data, which enables a pathway to education. A cultural safety model with elements of antiracism training could address this.

This research has also enabled an exploration of the experiences of Aboriginal women birthing in standard care, focusing on their cultural needs and contacts with their midwives. This has shown that women value communication and being fully involved in the decision-making around birth. Some of the women described how they felt negatively judged and this was related to their Aboriginality. It has also demonstrated that these Aboriginal women usually had an expectation of physical care only from their midwives, and those expectations were generally met. Other aspects of the birth experience such as the social, emotional, and cultural were achieved through their relationships with their families, friends, and support people. It also revealed that the women were strong, positive, and wanted the best care for their babies. Almost all of the women birthing in standard care were not asked about their cultural needs around birth. Some of the women indicated this was not important, which was probably related to their expectations of physical care only from their midwives. For the others it would have made a significant difference to have their cultures acknowledged. Families were important to the women in the study, and disconnection either through relocation to birth or restrictions on visitors caused the women distress.

Overall my study has demonstrated some significant areas that could be addressed in order to improve experiences both for the women and the midwives at the maternity hospital. Culture is important, and work needs to be done to ensure responsiveness to the women's cultural needs in the standard hospital care system.

8.6 Implications for practice

Understanding this group of twenty-seven women's and midwives' experiences has provided a glimpse into midwifery practices and birthing women's lives. It has provided an opportunity to attempt to address the limitations of the SHC system at this hospital. Whilst culturally appropriate continuity models of care are the ideal for Aboriginal women, women who are required or who choose to birth in SHC should not be forgotten. The recommendations made in section 8.4 provide suggestions for improving services at this

hospital by challenging the current cultural training, and its efficacy in practice. Suggestions grounded in optimal services in SHC for women are also presented.

8.7 Strengths and limitations of the study

I believe my study contributes to new knowledge about midwifery practices and Aboriginal women's cultural needs birthing in standard care. However, some strengths and limitations have been identified and will be discussed in the following sections.

8.7.1 Strengths of the study

The use of Aboriginal interviewers was a significant strength in the study and was important in order to conduct an ethical standard of research with Aboriginal peoples. This allowed for a safe space for the women to share and tell their stories with another Aboriginal woman. The engagement with the Aboriginal Cultural Consultant (ACC) across the entire length of the study, including data analysis and interpretation, was a strength given I was a non-Aboriginal researcher. Her knowledge as an Aboriginal cultural educator was invaluable at all stages during the study and ensured every action was mutually considered and appropriate. The process of achieving ethical clearance with the Aboriginal Health Research Council is also a strength in my study. Whilst addressing the requirements for ethical research involving Aboriginal peoples, I was able to incorporate the core values that guide ethical research with Aboriginal communities. This has contributed positively to the overall project.

I see the relationship that I have with my colleagues as a strength in my study. I have known them all for many years and they came to their interviews and shared openly, honestly, and freely their thoughts and feelings. Some of those thoughts and experiences they may not have shared with an outsider.

The women's voices and experiences are a strength in the study and are demanded from a cultural safety standpoint. Having their words within the thesis adds insight into their lived experiences and assists in validation of the thematic interpretations. Overall my use of interpretative phenomenology was a strength within my study because I was able to gain rich texts of the experience of culture and its influence on midwifery practice and women's experiences. Those texts are important to inform ethical midwifery practice for Aboriginal women at the hospital.

8.7.2 Limitations of the study

This study was based at one South Australian hospital and the data is not transferrable to other institutions. The midwifery participants in the study were all female, senior midwives with significant clinical experience. It would have been useful to explore the experiences of some of the younger midwives who had been educated over the last few years. This is important as Aboriginal cultural training is now embedded within most contemporary midwifery curricula. The research study was open to all midwives of any experience level, but there were no volunteers from the midwives with less experience and there were no male midwives working or rotating through the area. The midwives all came from one metroplitan hospital and it might have been interesting to have explored the experiences of midwives working in different hospitals, but still within the standard care system.

My study did not explore institutional performance or influences over practice, which could be examined in a future investigation. The interpretations I have made are all through my lens (as a non-Aboriginal midwife), and although I have attempted to mitigate that with the Aboriginal interviewers and the ACC it should be acknowledged as a limitation. Both of the Aboriginal interviewers were midwives and a potential power imbalance exists within those relationships.

For the six women who came from rural/remote areas interviews conducted within their communities may have provided an increased opportunity for them to share more of their experiences away from the hospital environment. Women who were living in metropolitan areas were afforded the option of where they would like to have their interviews conducted.

Heidegger's links to the Nazi party could be seen as a limitation. However, I have chosen to reject his racist views and ground my work in his philosophy, which does align with the research aims of the project.

It is not possible to make generalisations from the data given the sample size. Although this was the experience of a small group of women and midwives working in and birthing in a public hospital, their experiences can add to the discussion about cultural safety within health institutions. Other published works have also discovered similar attitudes towards Aboriginal peoples accessing health care as the ones presented here (Best 2014; Henry,

Houston & Mooney 2004; Kelaher, Ferdinand & Paradies 2014). A larger investigation would provide greater information about culture and midwifery practice and birthing Aboriginal women's experiences in mainstream services.

8.8 Heidegger's phenomenology and this study

The use of a hermeneutic research design based on Heidegger's work was appropriate to explore the women's and midwives' experiences of *Dasein*, or being in this world. To consider what it is like to experience care (or even to provide care) and wholeness we cannot ignore the lives outside of the caring encounter (Wojnar & Swanson 2007). For the participants, their experience of care and health is always in the context of family traditions, community values, and the broader socio-political contexts (Wojnar & Swanson 2007). Heidegger's time and place helps to situate the participants within a particular time and place (Wojnar & Swanson 2007) and with all the influences that come with that. Heidegger believed that the experience of Being was inextricably tied to and constituted by time, of which history was a part (Nelms 2015). For the women, there is still a potential distrust of health services because of the many government policies that have hurt Aboriginal peoples since colonisation (Kosiak 2014). Aboriginal people still experience racism and poor treatment accessing health care in mainstream services (Hampton & Toombs 2013a). The midwives in the study also are influenced by their family traditions, values, and the socio-political contexts, which include those exerted from the institution and from the culture of midwifery.

8.9 Evaluation of the thesis

Eight criteria for appraising the quality of qualitative research studies will be addressed in this section and are taken from Walsh and Downe's (2006) work. The criteria are: scope and purpose; design; sampling strategy; analysis; interpretation; reflexivity; ethical dimensions; and relevance and transferability (Walsh & Downe 2006).

8.9.1 – Scope and Purpose

This criterion calls for a clear statement of, and rationale for, the research question and aims, and that the study is contextualised by existing literature (Walsh & Downe 2006). In chapter one, I have explicated the research aims and questions. My research aims were to describe and interpret the lived experiences of midwives working in and Aboriginal women

giving birth in the SHC system, with a focus on the cultural aspects of care. Chapters five, six, and seven have addressed these aims. The study has been contextualised through the extensive literature review in chapter two.

8.9.2 – Design

Essential criteria for appraising qualitative research include a clear outline of the methods and research design, with clear data collection strategies relevant to the design chosen (Walsh & Downe 2006). Heideggerian phenomenology was chosen to guide the research project because of its strong focus on lived experiences and narratives. This was achievable through van Manen's (1990) research approach, which again provided a clear pathway to follow to achieve the research aims. Chapters three and four attest to the relevance of the project design and how the data collection techniques were applicable to the project. Individual semi-structured interviews with each participant allowed for the richness of their experiences to be explored.

8.9.3 – Sampling Strategy

Another essential criterion for appraisal of a research study is the sample and sampling methods (Walsh & Downe 2006). In order to provide in-depth experiences from participants in phenomenological studies, the participants must have experience with the phenomenon of interest (Creswell 2013). In my case, it was midwives working in the SHC system and Aboriginal women birthing in the SHC system. A purposeful sampling strategy was required in order to achieve the research aims. The sampling strategy and relevance to the research design was explored in chapter four. The phenomenological interpretations from chapters five and six have achieved the desired outcomes and have provided rich details of the experiences of the women and the midwives.

8.9.4 – Analysis

The analytic approach should be appropriate for the research design chosen (Walsh & Downe 2006). The data analysis techniques that I used in the study were grounded in van Manen's (1990) work. His approach is appropriate for use in an interpretative hermeneutic research study (Creswell 2013; Steeves, Cohen & Kahn 2000). Van Manen's (1990) six steps to data analysis allowed for engagement with the hermeneutic circle. NVivo 10 software was used within the project and was necessary to manage the large amount of data produced by the twenty-seven interviews. I have outlined in chapter four the development

of the themes through the analytical process of van Manen's method and provided examples. Each theme is supported with the actual words of the participants, which provides the reader an opportunity to determine where the interpretation arose from. The ACC was also involved in this process in relation to the women's data, and this was important to ensure cultural credibility.

8.9.5 – Interpretation

Essential criteria for the evaluation of the interpretation includes a description of the context, a clear audit trail, and the use of data to support the interpretation (Walsh & Downe 2006). The process of the interpretation has been outlined within chapter four. Van Manen's (1990) six steps have allowed for a lengthy process of 'dwelling within the data' for each and every transcript. The data was always considered individually and as a part of the whole emerging experience for each participant group. NVivo 10 software made it easier to explore and code the emerging themes. Chapter four, section 4.7, explains the coding process with examples so that the reader can understand how that interpretation occurred. My research supervisors conducted their own independent analysis of a complete transcript from one participant from each group (women and midwives). This facilitated discussions around the direction of the interpretations. The ACC was also involved in the interpretation of the women's data. She was able to provide her opinion on some of the areas as they were developed within the women's interpretations. The journal that I used throughout this process also allowed for exploration of alternative areas or directions that could have arisen within the interviews. An example of a journal entry for both the women and midwives' data is also included in the appendices to give the reader the opportunity to judge (appendix eleven and twelve). The phenomenological interpretations presented in chapters five and six are supported with the participants' actual words in verbatim quotes, which support the themes. Quotes facilitate critical evaluation by others of my interpretations, and Guest, MacQueen, and Namey (2012) have said that they are the foundation upon which good qualitative data analysis is based.

8.9.6 – Reflexivity

Reflexivity was achieved through the journaling process. I was able to explore my assumptions and beliefs, and my own previous experiences whilst working as a midwife and providing care to Aboriginal women, within the journal. After each interview was

transcribed and coded I was able to reflect on my own thoughts about what was emerging. This allowed for critical reflection and assisted in the application of van Manen's (1990) six steps. My relationships with the participants were also explored during this process. I was also able to examine the influences from hearing the women's stories on my own clinical practice. This process was shared within appendix eleven with the sample from a section of the journal. I have also addressed reflexivity in more detail within chapter four.

8.9.7 – Ethical Dimensions

Demonstration of sensitivity to ethical concerns is an essential criterion for appraising the quality of qualitative research (Walsh & Downe 2006). The research project achieved ethical clearance from three ethics committees, including the hospital committee, the University of South Australia's committee, and the Aboriginal Health Research ethics committee. Evidence of the approvals is included within Appendix thirteen, fourteen, and fifteen. Ethical issues were also addressed in detail within chapter four. The six values that are important when conducting research with Aboriginal peoples were responded to in chapter four, section 4.9.2. Informed consent, freedom to participate, confidentiality, and possible risks and benefits of the research were all addressed individually within chapter four, section 4.9.

8.9.8 – Relevance and transferability

Relevance and transferability of the study are essential within a qualitative research study (Walsh & Downe 2006). I have identified the strengths and limitations of the study in section 8.7. I have also outlined the directions for further research, and addressed the research aims and how they were fulfilled within my study. The experiences of the midwives and the women have contributed to a greater understanding of cultural care within midwifery practice.

8.10 Summary and conclusions

Within this chapter, I have presented a summary of the research findings and demonstrated the similarities and differences between the women's and midwives' experiences. I have also explored the research aims and questions, and how they were achieved within my study. I have made some recommendations aimed at improving the experiences for the women and supporting midwives in their practice. I have identified the strengths and

limitations of my study and conducted an evaluation of the thesis based on Walsh and Downe's (2006) eight criteria for qualitative research.

Heideggerian phenomenology has allowed a deep investigation into the lived experiences of the women and the midwives. Aboriginal women's cultural needs and expectations around birth have been explored and a new understanding of birth in the SHC system has emerged. Midwifery practice for Aboriginal women has been explored and this research has demonstrated that culture is misunderstood and not well responded to in standard care. Midwives are confident and competent in the provision of physical care for the women. In order to achieve optimal experiences for the women the research has illustrated opportunities where the midwives can make improvements to their practice and develop their understandings of Aboriginal cultures.

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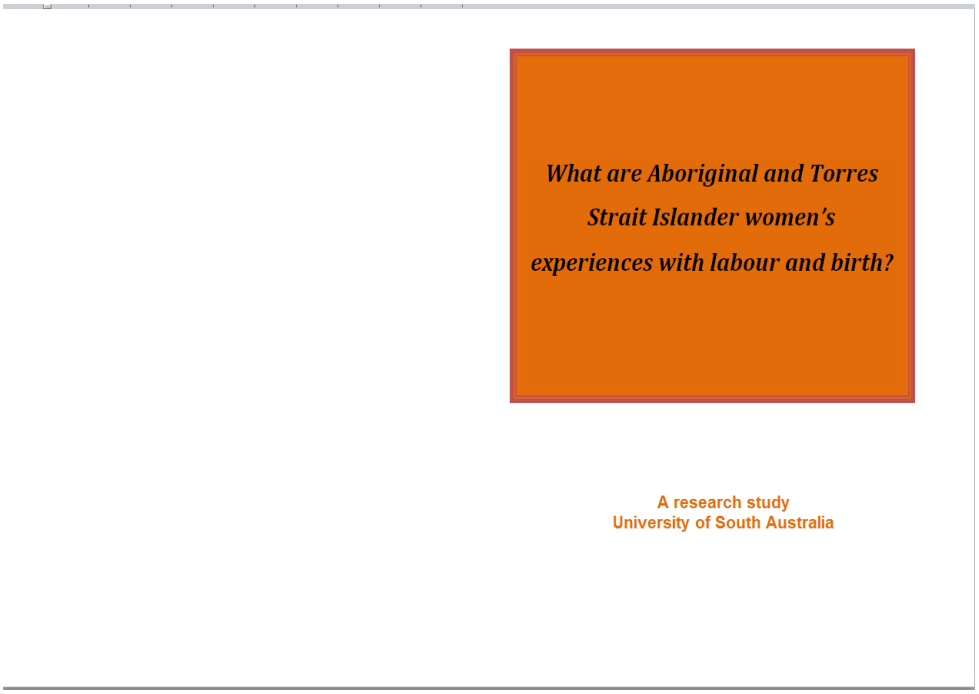
Appendices

Appendix One – Women's recruitment brochure



What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

A research study
University of South Australia

- We are looking for volunteer Aboriginal or Torres Strait Islander women who have had a baby in the standard hospital care system
- After you have your baby you might be invited to join in the study by the hospital Aboriginal Liaison Officers or you can ask your midwife to page the Aboriginal Liaison Officers to tell them you would like to join in
- You do not have to take part
- We want to know what your birth experience was like with your midwife

What is the study about?

We are looking at the experiences of Aboriginal and Torres Strait Islander women when they have had a baby. We will also talk to the midwives to see what their experiences are like in providing care.

What would I have to do if I joined in?

If you want to join in you can tell the Aboriginal Liaison Officer after you have your baby. You would then be contacted by phone or in person by an Aboriginal interviewer. She can answer your questions. If you want to join in she will ask you where you would like to have your interview.

Your interview will last about an hour and you will be asked to describe your experience when you gave birth. We would like to know in particular how you felt you were treated with regard to your individual needs as an Aboriginal woman. You are encouraged to have your baby with you.

What is in it for me?

You will not benefit directly from the study but the results may help midwives provide better care to other Aboriginal or Torres Strait Islander women in the future when they have a baby in the standard hospital care system. You will be given a $50 Woolworths Essentials Card for reimbursement of any costs associated with your participation at your interview.

Appendix Two – Women's Information sheet

Women's Information Sheet

What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

What is this all about?

We are interested in talking to you because we are looking at how midwives provide care for Aboriginal and Torres Strait Islander women when they give birth to their babies. We want to know what your experience was like with your midwife when you had your baby.

Why am I being invited to join in?

You have been invited to take part because you have had a baby at the hospital in the standard care system. We are looking for women who are at least 16 and who haven't had an Aboriginal Maternal Infant Care Worker involved in their care.

What is in it for me?

You will not benefit directly from the study, but the results may improve care for other Aboriginal or Torres Strait Islander women when they have a baby in the standard hospital care system. You will get a $50 Woolworths Essential Card to cover your expenses.

Do I have to take part?

No, you do not have to join in – you can change your mind at any time and if you do not join in you will not be treated any differently.

If I want to take part, what will I need to do?

You can tell the Aboriginal Liaison Officers if you would like to join in. Then your Aboriginal interviewer will phone you while you are still in the hospital to organise a time and place for your interview. Your interview will take about an hour. You will be asked to sign a consent form and you will keep a copy of both the consent form and this information sheet. You can decide where you would like to meet the interviewer, for example at the hospital, in your home or somewhere else that you decide. The interviewer will be an Aboriginal woman and if you decide that you would like a different interviewer then you have the option to change too.

You will be asked to describe your experience when you had your baby and in particular how you felt you were treated and cared for during the birth with regard to your needs

as an Aboriginal woman. If you do not want to answer a question then you can say no. Your interview will be taped with your permission.

If talking about your experience makes you feel sad or upset then your interviewer will listen to you and help you get more support.

What happens to my information?

Your voice recorded interview will not be played to anyone else except the research student (who is a non-Aboriginal woman) who will type up the interview herself and your name will not be included on the typed document. All your information will be stored in a locked filing cabinet or a computer at the hospital and a copy of the data also held safely at the University of South Australia. No men will be a part of the research team or analyse the data.

The information will be collected (without your name) and compared to other women's information to find aspects that are similar. This will be written up in the student's thesis, sometimes with direct quotes from you (however your name will not be used, contact details or identifying information will not be included). If you decide you would like a copy of the final report then you can have one on request. An Aboriginal Cultural Consultant might be asked for an opinion about the information collected from you in the typed document (without your name). The results may be presented in research journals or conferences and again your name will not be used.

Your information will remain confidential except in the case of a legal requirement to pass on personal information to authorised third parties. This requirement is standard and applies to information collected both in research and non-research situations. Such requests to access information don't happen very often, but we have to tell you of this possibility.

Further Information

If you would like further information about the interviews or the project or you have any questions or complaints please contact:

Researcher: Angela Brown [redacted] or [redacted] [redacted]

Adjunct Professor Jan Pincombe	**Philippa Middleton**
University of South Australia	Executive Director ARCH
Division of Health Sciences	

School of Nursing and Midwifery GPO Box 2471 Adelaide SA 5001 Australia Tel: 8302 1832 Email: Jan.Pincombe@unisa.edu.au **Dr Jenny Fereday** [redacted]	(Australian Research Centre for Health of Women and Babies) The Robinson Institute The University of Adelaide Level 1, Queen Victoria Building Women's and Children's Hospital 72 King William Road North Adelaide 5006 Phone: +61 8 81617612 Email: philippa.middleton@adelaide.edu.au

Ethical Concerns

This study has been given approval by the [redacted] If you would like further information contact the Executive Officer of the HREC – [redacted]

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: Vicki.Allen@unisa.edu.au.

This study has been approved by the Aboriginal Health Research Ethics Committee (AHREC) a subcommittee of the Aboriginal Health Council of South Australia. If you require further information please contact the executive officer, Aboriginal Health Council Ethics Committee on 08 83126700.

Appendix Three – Women's consent form 18 years and over

CONSENT FORM

What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

I, _____

agree to my involvement in the research project called:

What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

1. I understand what this project is about and I agree to take part.
2. I have volunteered to participate in an interview.
3. I know I can pull out at any time without getting in trouble with the researcher or anyone else.
4. I understand that I will not benefit directly from joining in.
5. I understand that I will not be paid for joining in but that I will be offered a $50 Woolworths Essentials Card.
6. I understand that I have had the chance to discuss taking part with a family member or friend and have been given the chance to have them present when the project was explained to me.
7. I understand that I should keep a copy of the information sheet and consent form.
8. I understand that while the information collected during the study might be published I won't be personally identified.
9. I understand that some of my actual words will be used, but I will be given a fake name.
10. I understand that my interview tapes will be kept on a password protected computer and the copies without my name will be stored in a locked filing cabinet when not in use.
11. I understand that a copy of my interview will be stored securely at the University of South Australia for 15 years after the project has finished.
12. I understand that my information will be kept a secret as explained in the information sheet except where there is a legal requirement by law for it to be shared.

Signed: .....

Full name of participant: .....

Dated:.....

I have explained the study to the participant and consider that she understands what is involved.

Signed: ..... Title: .....

Dated: .....

Appendix Four – Women's consent form 18 years and under

CONSENT FORM

What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

I, _____

agree to my involvement in the research project called:

What are Aboriginal and Torres Strait Islander women's experiences with labour and birth?

13. I understand what this project is about and I agree to take part.
14. I have volunteered to participate in an interview.
15. I know I can pull out at any time without getting in trouble with the researcher or anyone else.
16. I understand that I will not benefit directly from joining in.
17. I understand that I will not be paid for joining in but that I will be offered a $50 Woolworths Essentials Card.
18. I understand that I have had the chance to discuss taking part with a family member or friend and have been given the chance to have them present when the project was explained to me.
19. I understand that I should keep a copy of the information sheet and consent form.
20. I understand that while the information collected during the study might be published I won't be personally identified.
21. I understand that some of my actual words will be used, but I will be given a fake name.
22. I understand that my interview tapes will be kept on a password protected computer and the copies without my name will be stored in a locked filing cabinet when not in use.
23. I understand that a copy of my interview will be stored securely at the University of South Australia for 15 years after the project has finished.
24. I understand that my information will be kept a secret as explained in the information sheet except where there is a legal requirement by law for it to be shared.

Signed: .....

Full name of participant: .....

Dated:.....

I (Parent's or guardian's name (please print):.....

am aware that.....

is participating in this study and I support her decision to do so.

Parent's or guardian's signature: .....

I have explained the study to the participant and consider that she understands what is involved.

Signed: ..... Title: .....

Dated: .....

Appendix Five – Summary Information sheet (for use by Aboriginal interviewers)

Summary information sheet to be used by the interviewer as a discussion guide prior to interviews in conjunction with the women's information sheet

- Discuss with the woman the nature of the study – interested in women's experiences when accessing the standard health care system and, in particular, their experiences with birth and the relationship with their midwife – is the midwifery care appropriate and acceptable to the woman?
- There is NO obligation to participate
- No direct benefits to the women for participation but the study might help midwives provide better care in the future to other women
- A reimbursement of expenses voucher ($50 Woolworths Essentials Card) will be offered to the participants
- The interviews will take approximately an hour
- The participants will decide where and when the interview will take place
- The participants will be asked to tell the interviewer about her birth experience and how her needs were met or not met as an Aboriginal woman
- The interview will be audiotaped with permission
- The audiotapes will only be played to the research student and then the words typed up into written form and the participant's name will not be on the typed document and identifying information will be removed from typed documents. The audiotapes will be stored on a password-protected computer and the typed document in a locked filing cabinet when not in use
- The information will be used to find aspects that are similar and will be written up in the student's thesis and in research journals or presented at a conference
- If the woman feels upset about talking about their birth experience, the interviewer will help her contact support services

Appendix Six – Women's question guide

We are seeking to explore the birthing experience for you as an Aboriginal woman. This could be your principles and values and/or your ways and ceremonies. We would like to know how your birth experience was as an Aboriginal woman at the [redacted] Hospital. We want to hear your stories both good and bad about what your experience was like. If it is easier you can start by just telling us about the birth of your baby.

Can you tell me about your experience with your midwife and the birth of your baby in delivery suite?

Can you tell me about anything which is important to you as an Aboriginal woman that relates to the birth experience? Possible prompts – Can you tell me about it? Can you give me an example?

Do you feel that your needs as an Aboriginal woman were looked after by your midwife when you had your baby?

Possible prompts – Can you give me an example (for yes or no)

Can you tell me anything that is important to you about your experience with the hospital when you had your baby?

Possible Prompts – Can you tell me about it?

When you think back on your birth experience what will you remember the most about your care at the hospital?

If you could make the experience with your midwife better what do you think could be done to make it better?

If you could teach the midwife about your needs as an Aboriginal woman to help her look after you – what is the most important thing/things you would teach her?

Is there anything else about your experience having a baby that you would like to talk about?

Appendix Seven – Midwives Information Sheet

Midwives Information Sheet

What are the experiences of women and midwives in receiving and providing 'cultural' midwifery care?

Exploring midwives' and Aboriginal and Torres Strait Islander women's experiences with 'cultural' care in delivery suite at a tertiary hospital - An interpretative phenomenological investigation

Who is conducting the study?

My name is Angela Brown; I am a midwife and a PhD student at the University of South Australia. My supervisors are Adjunct Professor Jan Pincombe, Dr Jenny Fereday and Philippa Middleton.

Why is this study important?

Culturally appropriate midwifery care can improve the experiences for Aboriginal women giving birth; programs which support Aboriginal women include these aspects and have shown improved outcomes for the mothers and babies. This study aims to describe and interpret the experiences of Aboriginal women birthing their babies in the standard hospital care system. It also aims to describe and interpret the experiences of midwives in the provision of labour care in the standard hospital care system with the overarching aim of developing further understanding of cultural care based on lived experience.

What will participation involve for you?

If you choose to participate in this study you will be asked to sign a consent form and you will be asked to participate in an individual in-depth interview which will last approximately one hour. You will be asked to describe your experiences in the provision of midwifery care to Aboriginal women. You will be able to nominate a location for your interview and you will be able to participate in the interview within your education time at work (off the ward so your participation remains confidential) and if you wish you will be provided with a certificate (not specifically naming the project) for use in your professional portfolio. You can also nominate another location for your interview if you wish.

The interview will be audiotape recorded and the researcher will transcribe the data into a document without your name. Later your data will be assigned a pseudonym to facilitate

the writing up of the thesis. Your participation will be completely confidential and voluntary and you will not be identified in the study. The digital recordings will be stored on a password protected computer and transcripts (without your name) kept in a locked filing cabinet or password protected computer when not in use. The University of South Australia will be provided with an electronic copy of the original interviews and transcribed data to be stored securely in the School of Nursing and Midwifery as per the requirements of the organisation. The audiotapes of your data will be retained for fifteen years post publication of the thesis. Your data (without your name) will be accessed by the researcher and her supervisors. Your information will remain confidential except in the case of a legal requirement to pass on personal information to authorised third parties. This requirement is standard and applies to information collected both in research and non-research situations. Such requests to access information are rare; however we have an obligation to inform you of this possibility.

If you do not wish to participate in the project this will not affect your employment at the hospital in any way and you can decide at any time to withdraw your consent, even after the interviews. Your participation is completely voluntary.

The results of the study may form the basis of research papers, journal publications and conference presentations. You or your individual participation will not be identified if this occurs.

You will not receive any payment for your participation in the study. You will be provided with an electronic copy of the completed thesis on request.

Participants are reminded that discussing aspects of their clinical practice can sometimes be distressing and are reminded of the availability of staff counselling within the organisation. Confidential staff counselling can be accessed on: [redacted].

What will the study provide?

You may not benefit directly from your involvement in this study. The information you provide will be analysed and themes established for the midwives and the women. These will be explored and some of your direct quotes will be used in the final thesis however you will not be identified. The research aims to gain further understanding of cultural care based on lived experience.

Who am I looking for?

I am seeking midwives who have provided midwifery care to Aboriginal and Torres Strait Islander women within delivery suite. Midwives of any experience level are invited to

participate. You are not required to be a permanent delivery suite team member – ***all*** midwives are welcome to become involved, provided you have practiced within the standard hospital care system within delivery suite. I am not seeking midwives who are working within midwifery group practice as these midwives often work with the Aboriginal Maternal and Infant Care workers and this is not the focus of my study

Looking for more information or wanting to participate?

I can be contacted by phone on [redacted] or [redacted] or via email [redacted] or angela.brown@mymail.unisa.edu.au

My supervisors can also be contacted for further information;

Adjunct Professor Jan Pincombe University of South Australia Division of Health Sciences School of Nursing and Midwifery GPO Box 2471 Adelaide SA 5001 Australia Tel: 8302 1832 Email: Jan.Pincombe@unisa.edu.au	**Philippa Middleton** Executive Director ARCH Australian Research Centre for Health of Women ad Babies The Robinson Institute Discipline of Obstetrics and Gynaecology School of Paediatrics and Reproductive Health The University of Adelaide Level 1, Queen Victoria Building Women's and Children's Hospital 72 King William Road North Adelaide 5006 Phone: +61 8 81617612 Email: philippa.middleton@adelaide.edu.au
Dr Jenny Fereday [redacted]	

[redacted]	

This study has been given approval by the [redacted] If you would like further information contact the Executive Officer of the [redacted] Human Research Ethics Committee – [redacted]

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: Vicki.Allen@unisa.edu.au

This study has been approved by the Aboriginal Health Research Ethics Committee (AHREC) a sub-committee of the Aboriginal Health Council of South Australia. If you require further information please contact the executive officer, Aboriginal Health Council Ethics Committee on 08 83126700.

Appendix Eight – Midwives Consent Form

CONSENT FORM

What are the experiences of women and midwives in receiving and providing 'cultural' midwifery care?

Exploring midwives' and Aboriginal and Torres Strait Islander women's experiences with 'cultural' care in delivery suite at a tertiary hospital - An interpretative phenomenological investigation

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I hereby consent to my involvement in the research project entitled:

_____

1. The nature and purpose of the research project described on the attached Information Sheet has been explained to me. I understand it and agree to take part.

2. I understand that I may not directly benefit by taking part in this study.

3. I acknowledge the possible inconveniences as outlined in the Information Sheet have been explained to me.

4. I understand that I can withdraw from the study at any stage and that this will not affect my employment with the hospital now or in the future.

5. I understand that there will be no payment to me for taking part in this study.

6. I have had the opportunity to discuss taking part in this research project with a family member or friend, and/or have had the opportunity to have a family member or friend present whilst the research project was being explained by the researcher.

7. I am aware that I should retain a copy of the Consent Form, when completed, and the Participant Information Sheet.

8. I understand that while the information gained during the study might be published, I will not be personally identified.

9. I understand that my direct quotes may be used within the study and that my data will be assigned a pseudonym.

10. I understand that my interview will be audiotape recorded and the digital recordings kept on a password protected computer and the transcripts (without my name) will be stored in a locked filing cabinet or a password protected computer when not in use.

11. I understand that the researcher's supervisors will also have access to the transcripts of my interviews (without my name).

12. I understand that a digital copy of the tape recorded interview and transcript of my interview (without my name) will be stored securely for fifteen years at the School of Nursing and Midwifery at the University of South Australia at the completion of the research project and publication of the final thesis. I understand that all data associated with my interview will be destroyed after fifteen years.

13. I understand that my information will be kept confidential as explained in the information sheet except where there is a requirement by law for it to be divulged.

Signed: .....

Full name of participant: .....

Dated:.....

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: ..... Title: .....

Dated: .....

Appendix Nine – Midwives Question Guide

How did you learn about the cultural needs of birthing Aboriginal women?

What did you learn?

What does culture mean to you?

What does cultural safety mean to you?

Can you tell me about your experiences in caring for Aboriginal women in labour?

Can you give me some examples of times when you think it went well?

Why do you think it went well?

Can you think of a time when you think you could have done things better?

Why?

Can you tell me what you do differently when providing care for Aboriginal women?

Why?

How do assess the care that you provide to Aboriginal women?

Possible prompts – Why? How?

If you could receive more education in the provision of cultural midwifery care to Aboriginal women – what would it be centred on?

Possible prompts – If yes can you tell me what might help you? If no – can you explain further?

Do you think you have the necessary skills to meet Aboriginal women's birthing needs?

Appendix Ten – Sample midwives certificate of participation

Research Project Participation

This is to certify that

Participant Name

Made a contribution to

Midwifery Research

March, 2014

Angela Brown PhD Candidate

University of South Australia

Appendix Eleven – Sample journal entry (women's data)

Interview Five

- The relationship of the researcher with the participants gender difference social attractiveness, mutual trust or mistrust
- The relationship of the researcher with the data
- Interpretations the participants are making of the researcher and the project
- Recognise the circularity of the hermeneutic process and how and when did different understandings emerge
- How did the researcher challenge her understanding of the data
- To what extent were preliminary interpretations tested over the course of the study

I started the data analysis again today for interview transcript 5. This was very interesting given this woman had what I would call a horrifying experience. She felt judged, the staff made her cry, she felt she was treated negatively because of her culture yet overall the experience was a good one. I am beginning to wonder if the extreme joy of a new baby is able to overshadow the myriad of things that are not acceptable in the experience. It is really strongly coming through that these women all want the best for their babies, that they face quite a bit of adversity in their lives that I am not sure I could manage yet they are still strong and positive. They are inspirational in many ways. There is poverty, mental health issues, medical issues, birthing away from family, being treated badly, contact with the judicial system (partners in jail) yet they are still positive and trying to do their best.

because I burst out into tears in front of them the last time they said it and said get out of the room and don't question me like that and they said no one is here, young mums have a tendency not to tell the truth and stuff like that and I just burst out crying, I felt, um, judged, really judged (interview 5)

The other aspect is that of the women wanting to be asked about their needs as Aboriginal women – they don't necessarily have any which they want to share, but they want to be asked! This is such a simple thing to do – we could start implementing that immediately and it would make a difference to these women.

I also feel that the women are having experiences whereby they feel misunderstood and judged and it is related to their culture. What is interesting is the midwives didn't consider it in their interviews. It is also interesting to watch the interface between the two data sets emerge.

I feel the language the women use was interesting too – in this interview it's very 'they will "let" me go home, she had fear that they might not, and it's really disturbing to hear. I also wonder about their expectations, maybe they aren't very high, how can this be a good experience and how could she ever want to come back? Makes me think it would be good for other midwives to hear the stories from the women (obviously not these ones) but it can be really moving to hear them and I think it could change practice.

I talked through the issues of being treated the same with Chris and it was so interesting – she helped me see that some of the women want the same care BECAUSE they perceive that their

current care is not as good. I like having Chris's perspective on the women's words. She helps me understand them differently.

Initially, I felt that the birth of the baby and associated happiness was able to override anything negative about the birth. My views on that are changing as I spend more time in the data. I now believe that the expectations from the women are low – they don't expect much from the system and they see the midwife as the provider of physical care. So the midwife doesn't appear to have an important role in terms of their social, emotional or spiritual needs. Having said that if the midwife was Aboriginal she would be able to better meet their needs as they would have higher expectations of her. I can see how culturally appropriate services would better meet the women's needs and can also see a really important role for Aboriginal midwives and AMIC workers for women in standard care.

Appendix Twelve – Sample journal entry (midwives data)

Interview Two

- The relationship of the researcher with the participants gender difference social attractiveness, mutual trust or mistrust
- The relationship of the researcher with the data
- Interpretations the participants are making of the researcher and the project
- Recognise the circularity of the hermeneutic process and how and when did different understandings emerge
- How did the researcher challenge her understanding of the data
- To what extent were preliminary interpretations tested over the course of the study

17/4/14

My second interview was a challenging one in many ways. I feel on reflection that she doesn't value what I am trying to achieve in my project and there were several negative comments during the interview (not recorded) about why anyone would want to study this. During the course of the interview, I was able to see her move from a position of feeling she was a fabulous midwife to all women, to recognising that perhaps she hadn't really challenged what she does and why in her practice before. In some ways her adjustments to practice were superficial – 'I don't look at Aboriginal women or talk too loud', but she had failed to consider the other issues that affect these women. This was the first text that the issue of overt racism came up which I found challenging. I read and reread that section many times because despite the midwife's espousal of I am not racist – racism was clearly embedded in those words. This was the point that I had to challenge my personal acquaintance with the midwife and recognise what she was saying and the meaning behind it which was difficult.

I would like to think that I am not racist, but I guess we do see more like if you have got an urban Aboriginal then they are generally from a lower socioeconomic um and perhaps and um you know that they might not be as nice as other people that you look after. (Interview 2)

Prior to the interviews, I felt that maybe the midwives would say that they treated everybody the same, probably because of the comments I have heard around the ward about compulsory ACRT (Aboriginal cultural respect training). I also expected some negativity towards the hospital's adoption of tokens (like the Aboriginal flags in the rooms) and programs to improve the experiences for this group because of the things I had heard. I think over the course of the year I have changed too as I have come to understand the needs, challenges and barriers to effective health care for Aboriginal women. I feel with this interview I have understood that maybe the problem is also what midwives are taking away from their ACRT training – are they really implicitly made aware of Aboriginal women's health outcomes and the challenges they face in a western system? What about cultural safety and acknowledgement of our own positions?

Appendix Thirteen – Ethics approval letter Aboriginal Health Research Ethics Committee

17 February 2014

Angela Brown
[redacted]

RE: Exploring midwives and Aboriginal and Torres Strait Islander women's experiences with labour and birth in delivery suite
REFERENCE NO: 04-13-535

Dear Angela

Thank you for submitting your research project *Exploring midwives' and Aboriginal and Torres Strait Islander women's experiences with labour and birth in delivery suite* on the 6 February 2014 for ethical consideration.

I am pleased to inform you that this proposal has met with support and that the committee appreciated the comprehensive response to their concerns and have decided that your application be recommended for approval. The duration of approval is from 6 February 2014 until the expected completion date of your project indicated as 31 December 2015.

In accordance with the NHMRC guidelines, *National Statement on Ethical Conduct in Human Research* (2007), we require at regular periods, at least annually, reports from principal researcher(s). An 'Annual Progress or Final Report' template is available at: http://www.ahcsa.org.au/research-ethics/

If you require any further information please do not hesitate to contact the Executive Officer or myself. We wish you well with the project and look forward to receiving a copy of your report.

Sincerely yours

MS LUCY EVANS
CHAIRPERSON
Ref: Proposal/Approval 6 February 2014

AHREC is a sub-committee of AHCSA
9 King William Road Unley SA 5061 PO Box 981 Unley SA 5061
Tel: (08) 8273 7200 Fax: (08) 8273 7299 Email: ahcsa@ahcsa.org.au Website: www.ahcsa.org.au

Appendix Fourteen – Ethics approval letter for the hospital human research

[redacted]

18th December 2013

[redacted]

Dear Angela

Re: Exploring midwives' and Aboriginal and Torres Strait Islander women's experiences with 'cultural' care in delivery suite at a tertiary hospital: an interpretive phenomenological investigation. [redacted]
Ethics expiry date: 31/12/16

[redacted]

I refer to your letter dated 12th December 2013 in which you responded to matters raised by the [redacted] Human Research Ethics Committee at its December 2013 meeting. I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research*.

Specifically, the following documents have been noted/approved:

Document	*Version*	*Date*
Interview Schedules / Topic Guides: Women's Interview Guides		11 November 2013
Interview Schedules / Topic Guides: Midwives Question Guides		11 November 2013
Women's Recruitment Brochure		11 November 2013
Summary Question Guide for the Aboriginal Interviewer(s)		11 November 2013
Referral Pathways - midwives and women		11 November 2013
Peer Review Submission: Research Proposal Assessment Dr Lois McKellor		11 November 2013
Protocol: Research Proposal		12 November 2013
Peer Review Submission: Donna Weetra Review		12 November 2013
Letter of support from Chris Rigney-Thyer - written for the Aboriginal Health Research Ethics Committee		14 November 2013
Application		
Women's Consent Form		
Women's Information Sheet		
Midwives Consent Form		
Midwives Information Sheet		

As previously advised, in keeping with section 4.7 of the *National Statement,* the approval of the Aboriginal Health Research Ethics Committee must be obtained before you proceed with the study and a copy of the approval letter provided to the [redacted] for its records.

[redacted]

I remind you approval is given subject to:
•immediate notification of any serious or unexpected adverse events to subjects;

[redacted]

•immediate notification of any unforeseen events that might affect continued ethical acceptability of the project;
•submission of any proposed changes to the original protocol. Changes must be approved by the Committee before they are implemented;
•immediate advice, giving reasons, if the protocol is discontinued before its completion;
•submission of an annual report on the progress of the study, and a final report when it is completed. It is your responsibility to provide these reports – without reminder from the Ethics Committee.

Approval is given for three years only. If the study is more prolonged than this, an extension request should be submitted unless there are significant modifications, in which case a new submission may be required. Please note the expiry date in the title above and include it in any future communications.

If University of Adelaide personnel are involved in this project, you, as chief investigator must submit a Human Research Approval notification form online at http://www.adelaide.edu.au/ethics/human/guidelines/ within 14 days of receiving this ethical clearance to ensure compliance with University requirements and appropriate indemnification.

Appendix Fifteen – Ethics approval from the University of South Australia

Human Ethics: Application approved

no_reply@unisa.edu.au

Fri 21/02/2014 12:22 PM

Inbox

To: Brown, Angela Elisabeth - broae001 <angela.brown@mymail.unisa.edu.au>; Jan Pincombe <Jan.Pincombe@unisa.edu.au>; ethics@unisa.edu.au <ethics@unisa.edu.au>;

Dear Applicant

Re: Ethics protocol "Exploring midwives and Aboriginal and Torres Strait Islander women's experiences with labour and birth in delivery suite" (Application ID: 0000032635)

Thank you for submitting your ethics protocol for consideration. Your protocol has been considered by the E1 Committee Review Group.

I am pleased to advise that your protocol has been granted ethics approval and meets the requirements of the National Statement on Ethical Conduct in Human Research. Please note that the E1 Committee Review Group's decision will be reported to the next meeting of the Human Research Ethics Committee for endorsement.

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed at http://www.unisa.edu.au/res/forms/docs/humanresearchethics_conditions.doc; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/default.asp

Please note, if your project is a clinical trial you are required to register it in a publicly accessible trials registry prior to enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry http://www.anzctr.org.au/) as a condition of ethics approval.

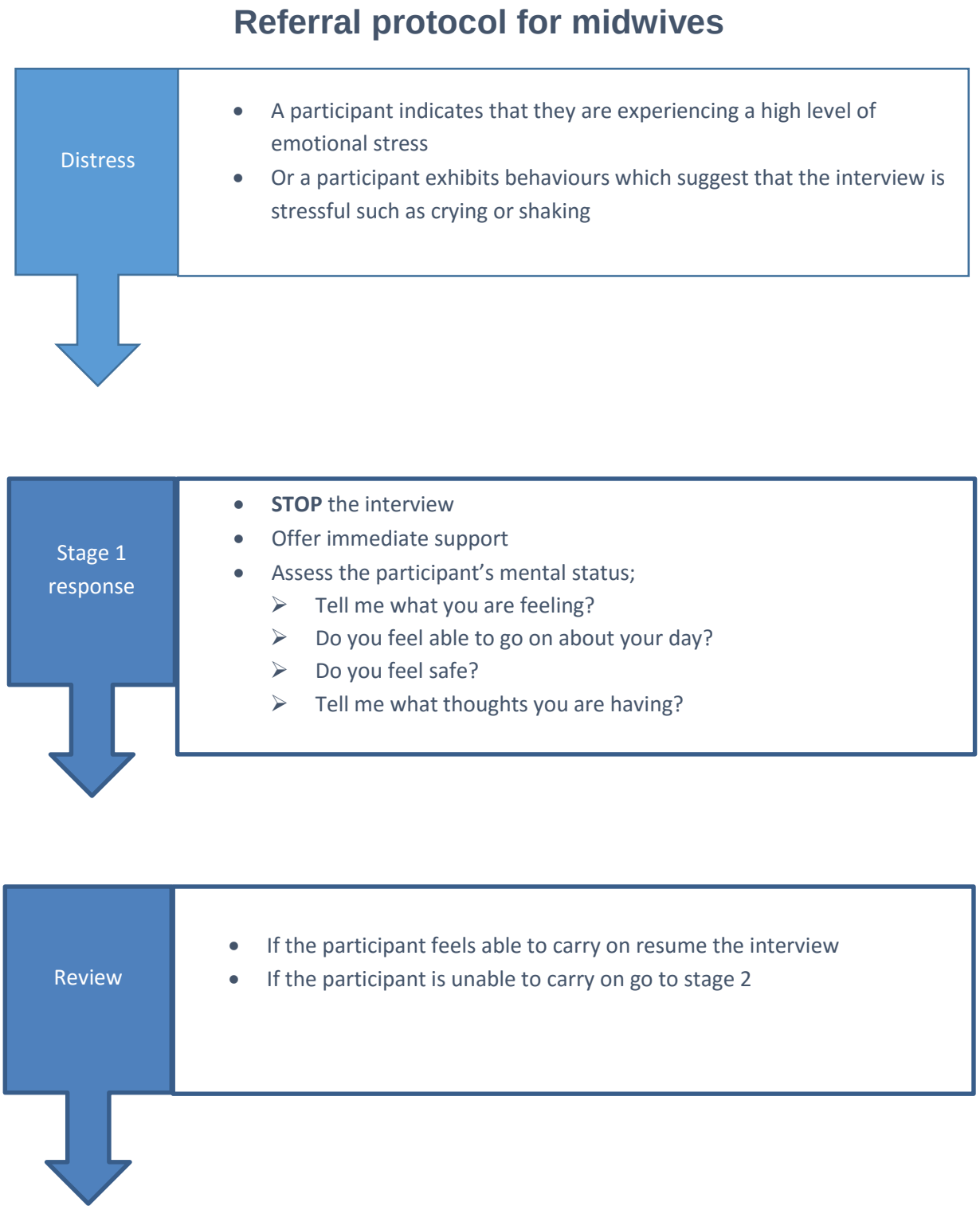
Best wishes for your research.

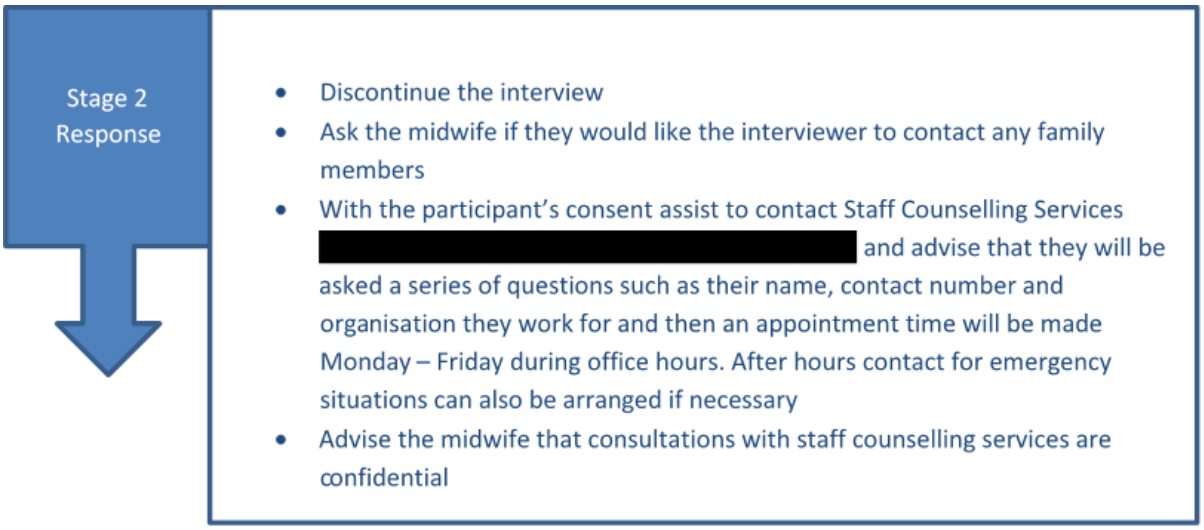
Executive Officer
UniSA's Human Research Ethics Committee
CRICOS provider number 00121B

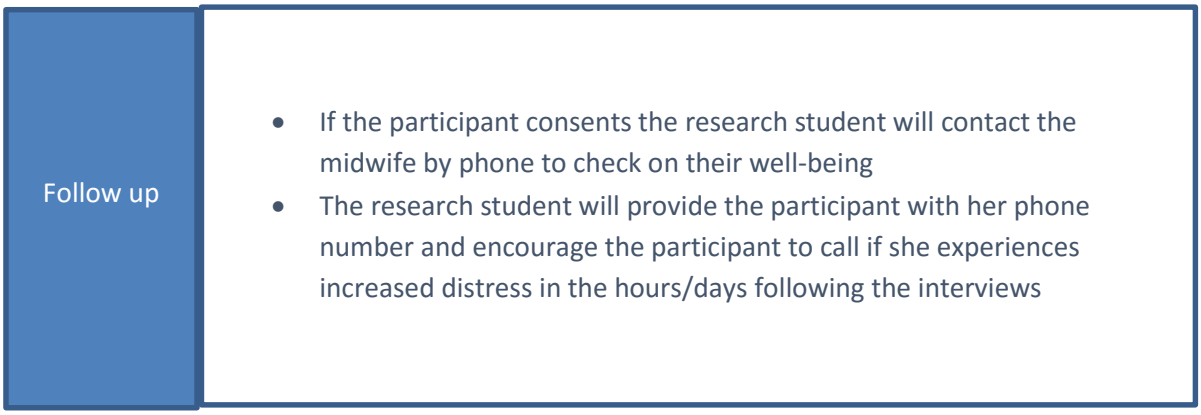
This is an automated email and cannot be replied to. Please direct your query to ethics@unisa.edu.au.

Appendix Sixteen – Referral protocol for midwives

The participant referrals were developed based on the work of Professor Carol Haigh and Gary Witham from the department of Nursing at the Manchester Metropolitan University (Distress protocol for qualitative data collection).




Stage 2 Response
Discontinue the interview
Ask the midwife if they would like the interviewer to contact any family members
With the participant's consent assist to contact Staff Counselling Services [redacted] and advise that they will be asked a series of questions such as their name, contact number and organisation they work for and then an appointment time will be made Monday – Friday during office hours. After hours contact for emergency situations can also be arranged if necessary
Advise the midwife that consultations with staff counselling services are confidential


Follow up
If the participant consents the research student will contact the midwife by phone to check on their well-being
The research student will provide the participant with her phone number and encourage the participant to call if she experiences increased distress in the hours/days following the interviews

Appendix Seventeen – Referral protocol for women who are interviewed at the hospital

The participant referrals were developed based on the work of Professor Carol Haigh and Gary Witham from the department of Nursing at the Manchester Metropolitan University (Distress protocol for qualitative data collection).

Referral protocol for women 1

Protocol for women who have interviews within the [redacted]

Distress

- A participant indicates that they are experiencing a high level of emotional stress
- Or a participant exhibits behaviours which suggest that the interview is stressful such as crying or shaking

Stage 1 response

- **STOP** the interview
- Offer immediate support
- Assess the participant's mental status;
  - Tell me what you are feeling?
  - Do you feel able to go on about your day?
  - Do you feel safe?
  - Tell me what thoughts you are having?

Review

- If the participant feels able to carry on resume the interview
- If the participant is unable to carry on go to stage 2
- Notify the research student

Stage 2 Response	• Discontinue the interview • Ask the woman if the participant would like the interviewer to contact any family members • Ask the women if the interviewer can contact the Aboriginal Liaison Officer for support • With participant consent contact a member of the health care team treating them for further advice/support

Follow up	• If the participant consents, the Aboriginal interviewer will contact the participant with a courtesy call to check on their well-being • Provide the woman with the interviewer's phone number and encourage the participant to call if she experiences increased distress in the hours/days following the interview • Notify the research student

Possible support services

[redacted]	Aboriginal Liaison Officer [redacted] ***The Aboriginal Liaison Officers are able to refer the women for long-term counselling and support***	[redacted]

[redacted]	Aboriginal Liaison Officer [redacted] ***The Aboriginal Liaison Officers are able to refer the women for long-term counselling and support***	[redacted]
Contact the research student who will assist in paging the medical team caring for the woman depending on her hospital clinic	Angela Brown	[redacted]

Appendix Eighteen – Referral pathways for women interviewed outside of the hospital

The participant referrals were developed based on the work of Professor Carol Haigh and Gary Witham from the department of Nursing at the Manchester Metropolitan University (Distress protocol for qualitative data collection).

Referral protocol for women 2

Protocol for women who have interviews outside of [redacted] Hospital

Distress

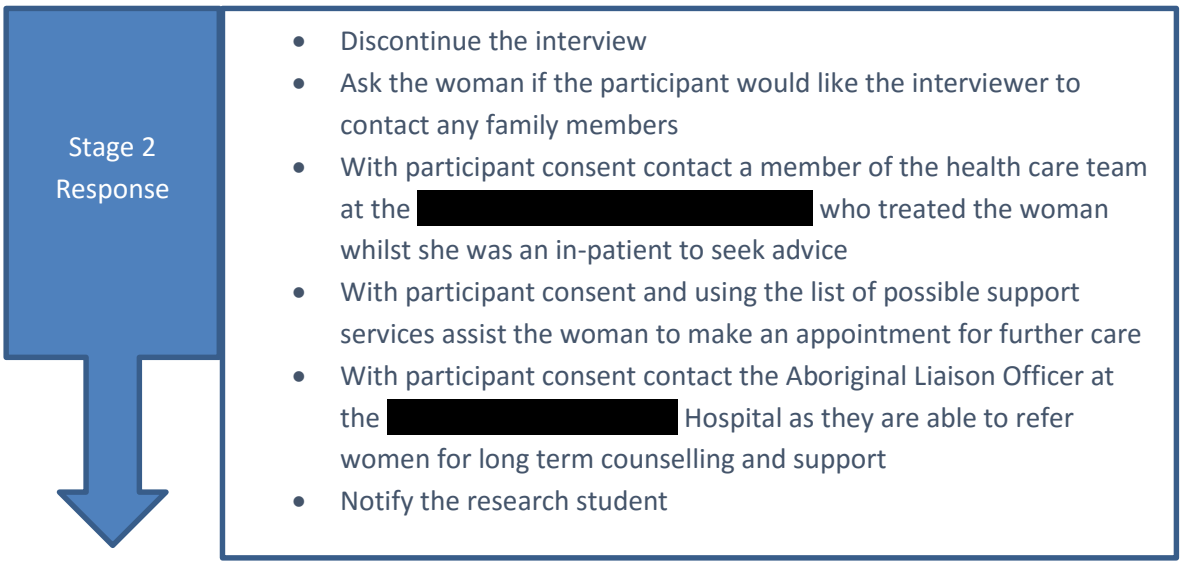
- A participant indicates that they are experiencing a high level of emotional stress
- Or a participant exhibits behaviours which suggest that the interview is stressful such as crying or shaking

Stage 1 response

- **STOP** the interview
- Offer immediate support
- Assess the participant's mental status;
  - Tell me what you are feeling?
  - Do you feel able to go on about your day?
  - Do you feel safe?
  - Tell me what thoughts you are having?

Review

- If the participant feels able to carry on resume the interview
- If the participant is unable to carry on go to stage 2
- Notify the research student



Possible support services

[redacted]	[redacted] Open 24 hours a day seven days a week
Nunkuwarrin Yunti Clinic	Ask for an appointment with an Aboriginal health Worker 182-190 Wakefield Street Adelaide Phone: 08 82235011 Hours: Monday 09.00 – 11.30 am Tuesday to Friday – 09.00 – 11.30 am; 1.30 – 3.30 pm 28-30 Brady Street Elizabeth Downs Phone: 08 8254 5300

	Hours: Tuesday to Friday 0900 – 11.00 am; 1.30 – 3.30 pm
Beyond Blue	24-hour phone service 1300 22 4636
Emergency Care GP Connect Crisis Care	 Phone: 08 8310 3333 Phone: 131 611
Mental Health Emergency	Phone: 13 14 65 For assistance in a mental health emergency, contact the mental health triage service - telephone 13 14 65 available 24 hours, seven days a week.
GP Plus Aldinga GP Plus Health Centre Elizabeth GP Plus Health Centre Marion GP Plus Health Care Centre	Bulk bill for Medicare card holders; Phone: During opening hours: (08) 8557 9500 After hours appointments: (08) 8557 9555 Location: Pridham Boulevard Aldinga Beach South Australia Phone: (08) 7485 4000 Location: 16 Playford Boulevard Elizabeth South Australia Telephone: (08) 7425 8200 Location: 10 Milham Street Oaklands Park South Australia

Modbury GP Plus Health Care Centre	Telephone: (08) 7425 8990 Street Address: Gilles Crescent Hillcrest South Australia 5086
Morphett Vale GP Plus Health Care Centre	Telephone: (08) 8325 8100 Location: 211 Main South Road Morphett Vale South Australia
Noarlunga GP Plus Health Care Centre	Aboriginal Health Services/Family Clinic Telephone: (08) 8384 9577
Woodville GP Plus Health Care Centre	For all general services: (08) 8300 5300 After hours medical service: (08) 8244 0800

Advise the research student - Angela Brown after the interview on [redacted]

Appendix Nineteen – Publication (women's experiences)

G Model
WOMBI-506; No. of Pages 9
ARTICLE IN PRESS
Women and Birth xxx (2016) xxx–xxx
Contents lists available at ScienceDirect
Women and Birth
journal homepage: www.elsevier.com/locate/wombi

ORIGINAL RESEARCH – QUALITATIVE

Aboriginal and Torres Strait Islander women's experiences accessing standard hospital care for birth in South Australia – A phenomenological study

Angela E. Brown [a,*], Jennifer A. Fereday [a], Philippa F. Middleton [b], Jan I. Pincombe [a]

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ABSTRACT

Background: Aboriginal and Torres Strait Islander women, hereafter called Indigenous women, can experience a lack of understanding of their cultural needs when accessing maternity care in the standard hospital care system.
Aim: To explore the lived experiences described by Indigenous women accessing labour and birth care in the standard hospital care system at a tertiary public hospital in South Australia.
Methods: An interpretive Heideggerian phenomenological approach was used. Indigenous women who accessed standard care voluntarily agreed to participate in semi-structured interviews with Indigenous interviewers. The interviews were transcribed and analysed informed by van Manen's approach.
Findings: Thematic analysis revealed six main themes: "knowing what is best and wanting the best for my baby", "communicating my way", "how they made me feel", "all of my physical needs were met", "we have resilience and strength despite our hardships" and "recognising my culture".
Conclusion: Indigenous women in this study expressed and shared some of their cultural needs, identifying culturally unsafe practices. Recommendations to address these include the extension of current care planners to include cultural needs; Aboriginal Maternal Infant Care (AMIC) workers for women from rural and remote areas; AMIC workers on call to assist the women and midwives; increased education, employment and retention of Indigenous midwives; increased review into the women's experiences; removal of signs on the door restricting visitors in the birth suite; flexibility in the application of hospital rules and regulations; and changes to birthing services in rural and remote areas so women may not have to relocate for birth.

Summary of Relevance:

Issue

- Indigenous women can experience a lack of cultural understanding when they give birth in mainstream services.

What is already known?

- Culturally safe midwifery care can positively impact on the birth experience for the women but can be neglected in mainstream services.

What this paper adds

- Fourteen Indigenous women from one South Australian maternity hospital have shared their stories after giving birth in the standard hospital care system. The women's experiences of giving birth provide an insight into their cultural needs around birth and demonstrated strong connections to

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E-mail address: angela.brown@mymail.unisa.edu.au (A.E. Brown).

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1871-5192/

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their families. They usually expected only physical care from their midwives. Some of the women felt judged and misunderstood, which related to their Indigeneity. Recommendations are made for improving the women's experiences by recognising and incorporating their cultural needs into their care.

1. Background

Following European colonisation, and continuing to the present day, many government policies have contributed negatively to Indigenous people's experiences within their communities and with their connections to their land.[1] These include policies of segregation, assimilation, integration and the forced removal of children, particularly from 1910 to 1970.[1] Policies of the past continue to influence the way Indigenous people view and interact with health services, and lack of trust of health services is a major barrier to effective interactions.[1]

Indigenous women who give birth in South Australia have higher rates of perinatal mortality, preterm births and low birth weight babies compared to non-Indigenous women.[2] While the health disparity is frequently linked to socioeconomic factors, culturally appropriate care can have a positive impact on access, uptake and acceptability of health services for Indigenous women.

The concept of cultural safety originated in New Zealand as a way to address the need for culturally appropriate care for Maori people accessing healthcare.[3] In Australia, the provision of care in a culturally safe manner is an element of mandated midwifery competency.[4] Culturally safe care can be defined as something which can only be determined by the recipient of the care, and which requires health care providers to examine their own cultural identities, attitudes, beliefs and the power balance within the health care relationship.[1] Culturally safe midwifery care may help Indigenous women experience less fear and anxiety when accessing maternity health care, and thus may ultimately improve maternal and infant health care outcomes.[5]

Culturally safe maternity care aims to ensure every woman feels physically, spiritually, socially and emotionally safe.[6] If women do not deem the service as culturally safe, they will not attend for their care.[7] Continuity of carer enhances trust within the relationship and this trust helps women and their midwives develop positive relationships.[8] Enquiring if a woman has any cultural needs which will make her feel safer or has any needs for birthing is something that midwives should do to help build the relationship.[8]

A cultural safety approach challenges midwives to explore the power imbalances and the way they impact on the health care relationship.[9] Minimising the power imbalance can be easier when care is provided within a continuity of care midwifery model.[5]

In South Australia, the Aboriginal Family Birthing Program offers culturally appropriate maternity care to Indigenous women. Women in six regional areas of South Australia and in most metropolitan areas can access care from a group of midwives and an Aboriginal Maternal Infant Care (AMIC) Worker.[10] However, many mainstream health services across Australia do not provide culturally safe maternity services (both at the practitioner and the institutional level), necessary for supporting Indigenous women.[6]

Mainstream health services are founded in the biomedical model, with birth in hospitals attended by teams of midwifery and medical staff who are often not known to the women.[5] The biomedical model can be at odds with traditional Indigenous ways of giving birth.[5] Birth is an important and transformative event in a woman's life.[11] It can be a positive and empowering experience, but women can also be subordinated and objectified by medically dominated systems of care.[12] Attending a mainstream hospital to give birth can be a frightening and alienating experience for some Indigenous women.[5]

Women who participated in this study accessed care in the standard hospital care (SHC) system underpinned by a biomedical model of care. The SHC system involves attending a public clinic for antenatal care and giving birth within the hospital's birth suite with an unknown group of midwives and medical team. Women who relocated to Adelaide for birth due to complications in their pregnancies also attended the SHC system.

This qualitative study aimed to explore the experiences of Indigenous women who gave birth in standard care and to answer the following question: what are the cultural expectations of Indigenous women when accessing midwifery care in the SHC system during birth in a tertiary public maternity hospital in South Australia? As part of a larger study, the research also explored midwifery practices and understanding around the provision of culturally safe midwifery care to Indigenous women.[13] However, this paper explores the women's experiences only.

2. Methods

2.1. Phenomenology

We chose a philosophical framework grounded in Heideggerian phenomenology as this enabled us to explore the accounts of the individual experiences of the women. An interpretative approach can provide researchers with an opportunity to gain an in-depth, woman-centred understanding of a phenomenon.[14] Heidegger felt that through discourse a person's way of being in this world was manifested[15] and Heidegger[16] used the word Dasein to describe 'being in this world'. Pivotal to Heidegger's work,[17] Dasein has been described as the fundamental ontological structure characterising humans and the unity of the world and of existence.[18] The structures of Dasein are revealed to the understanding of being through interpretation.[19]

According to Heidegger,[16] all understanding is connected to fore-structure (prior understanding) and this cannot be set aside. It is through the interpretation that the researcher can go beyond the participant's words and explore the fore-structures and thematic meanings held in the data.[20] Such interpretation occurs through a hermeneutic circle whereby the researcher moves from parts of the experience (interviews and transcribed texts) to the whole (evolving understanding of the experience) and back and forth again.[21] This helps to increase the depth of engagement with the interviews and texts.[21] Heidegger described the circular state of all acts of understanding as an essential feature of the study of being or Dasein.[18] By engaging the hermeneutic circle in research practices, the researcher is able to read between the lines of a phenomenon through language and theoretically uncover the true essence of the experience.[22]

Indigenous Australians have a strong history of oral storytelling, sometimes referred to as 'yarning'.[23] Yarning facilitates the sharing of information through narrative storytelling and it is a culturally safe method for conducting research with Indigenous people.[23] Phenomenology is compatible with Indigenous peoples as a research method because it provides a link between Indigenous people and their cultures by incorporating the methods of oral tradition, narratives and stories.[24] While the method is compatible with yarning, it is dependent on what the women chose and felt safe to reveal about their experiences at the hospital.

Please cite this article in press as: Brown AE, et al. Aboriginal and Torres Strait Islander women's experiences accessing standard hospital care for birth in South Australia – A phenomenological study. *Women Birth* (2016), http://dx.doi.org/10.1016/j.wombi.2016.01.004

2.2. Participants

Indigenous women who accessed standard care voluntarily agreed to participate in semi-structured interviews with Indigenous interviewers. The women had all given birth at a large tertiary maternity teaching hospital in South Australia. Fourteen women were recruited via the hospital Aboriginal Liaison Unit and/or the Aboriginal Cultural Consultant or Indigenous interviewers employed on the project. Thirteen of the women identified as Aboriginal and there was one Torres Strait Islander woman in the study. English was not the first language for some of the participants, but none of the participants required a translator. Forty-three percent ($n = 6$) of the sample group were living in rural or remote areas and the other 57 percent ($n = 8$) were living in metropolitan areas at the time of their interviews. Demographic details for the participants are provided in Table 1.

2.3. Data collection

Women were interviewed by one of two female Indigenous interviewers employed on the project. The interviewers were both midwives who were working at the hospital where the study took place. Women who met the inclusion criteria were able to nominate a time and location for their individual, semi-structured interview. Nine of the interviews occurred at the hospital where the women birthed, one in the parklands adjacent to the hospital, two in the women's homes and two by phone. The interviews ranged in time from thirty minutes to one hour. Interviews were digitally recorded and subsequently transcribed into de-identified Microsoft word documents.

Prior to the interviews, the women were required to read or have read to them an information sheet and give consent for their interview. The women understood that their stories would be read by other non-Indigenous women. They also understood their de-identified stories would form the basis of a thesis and would be published and presented in midwifery. At the conclusion of the study, women will receive a summary of the results, developed by the Aboriginal Cultural Consultant and principal researcher. The interviews took place from June 2014 to February 2015. Recruitment ceased when data saturation was reached (information collected was able to meet the research aims and no further themes needed to be developed).

The women's interviews commenced with the following question: "We are seeking to explore the birthing experience for you as an Indigenous woman. This could be your principles and values and/or your ways and ceremonies. We would like to know how your birth experience was as an Indigenous woman at the hospital. We want to hear your stories both good and bad about what your experience was like. If it is easier you can start by just telling us about the birth of your baby."

Once the birth stories were explored the interviewers asked other questions that related to midwifery practices, for example: "Do you feel that your needs as an Indigenous woman were looked after by your midwife when you had your baby?" Prompts were used by the interviewers, which included asking the women for examples that represented their answers.

2.4. Data analysis

The transcribed, de-identified Microsoft word documents were imported into QSR International's NVivo 10 software.[25] NVivo software was used as a data management technique as there were significant amounts of data produced from the interviews. Van Manen's[26] six-step method for hermeneutic phenomenological enquiry was used to guide the data analysis because of its philosophical foundations in Heidegger's work and strong focus on narratives and lived experiences. Within the analysis of a phenomenon, the researcher aims to determine the experiential structures that make up the lived experience.[26] Although van Manen's data analysis steps are represented numerically, it was an iterative process.

The collection of the women's stories provided a way to explore the experiences as they were lived, and the initial interpretations were being made during the transcription process. The analysis involved a detailed reading and re-reading of the interview transcripts to facilitate immersion in the data. Sentences and phrases that represented the women's experiences with their cultures were highlighted and grouped together into clusters that shared similar meanings. The phrases and sentences were then considered collectively, which came to form the theme clusters for the women's data.

The theme "Communicating my way" was developed because when transcribing, reading and re-reading the transcripts, communication issues clearly emerged. In the initial coding stages, statements and phrases that related to the meaning cluster "women's communication with the healthcare team" were grouped together. Statements and phrases were taken from every transcript and they were explored in more detail through van Manen's[26] analysis.

The analysis involved considering the significant statements and what they revealed about the women's cultural needs at birth. These essential structures were highlighted and the statements were read again, line by line to reveal the essence of culture at birth, to reveal women's needs relating to communication.

For example: within the theme "communicating my way" there were four main domains which were understanding, advocating,

Table 1
Demographic details for the participants.

Participant	Aboriginal or Torres Strait Islander	Age range (years)	Baby number	Living in rural/remote or metropolitan area	Location of interview
One	Torres Strait Islander	18–24	First	Rural/remote	Hospital
Two	Aboriginal	35–40	Fifth	Rural/remote	Outside the hospital
Three	Aboriginal	35–40	First	Rural/remote	Hospital
Four	Aboriginal	18–24	Second	Metropolitan	Home
Five	Aboriginal	18–24	First	Metropolitan	Phone
Six	Aboriginal	30–35	Sixth	Rural/remote	Phone
Seven	Aboriginal	30–35	Fourth	Metropolitan	Home
Eight	Aboriginal	30–35	Third	Metropolitan	Hospital
Nine	Aboriginal	18–24	Fourth	Metropolitan	Hospital
Ten	Aboriginal	30–35	Seventh	Rural/remote	Hospital
Eleven	Aboriginal	30–35	Eleventh	Rural/remote	Hospital
Twelve	Aboriginal	24–30	Second	Metropolitan	Hospital
Thirteen	Aboriginal	18–24	First	Metropolitan	Hospital
Fourteen	Aboriginal	18–24	First	Metropolitan	Hospital

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sharing and teaching and language and listening. They all were coded to the 'women's communication with the healthcare team' cluster. In the domain of 'understanding,' the women talked of the midwives demonstrating a lack of understanding of their needs, feelings, culture and knowledge requirements e.g. midwives attempting to provide instruction in breastfeeding techniques to women who had successfully breastfed many children. In the domain of language and listening the women wanted to be spoken to directly and given information about what was happening within their labours. When that occurred they felt less fear and felt included.

The theme "communicating my way" represented the different communication styles and needs of the women in the study and incorporated both the positive and negative aspects of communication as described by the women.

This process continued from the interviewing and transcription until the development of the phenomenological writing about the women's experiences evolved. The principal researcher had also met with the interviewers after each interview to gain insight into their views of the experiences. The development of the interpretations and the de-identified transcripts were also shared and discussed with the Aboriginal Cultural Consultant who participated in the project. She was able to provide cultural insights that could be misinterpreted by the non-Indigenous members of the research team.

The principal researcher, a midwife with many years' experience in labour and birth care, is not an Indigenous woman. She used a reflective journal during the data interpretation stage to explore the researcher's position, which helped examine the influence of the researcher's position in relation to the participants and the views of the interviewers and cultural consultant. The journal was also able to assist in engagement with the hermeneutic circle through the interpretative stages for the principal researcher. The three other authors conducted their own independent data analysis for an entire transcript. These interpretations were reviewed and discussed by the research team.

2.5. Ethics

The project was designed to incorporate the six values that guide ethical research for Indigenous peoples and that are outlined in the National Statement on Ethical Conduct in Human Research.[27] These principles are responsibility, reciprocity, survival and protection, equality, respect, and spirit and integrity.[28] The use of the Indigenous interviewers gave the women the opportunity to share their stories with another Indigenous woman. The women's voices are also heard with the use of verbatim quotes.

The study was conducted with advice from an Aboriginal Cultural Consultant who has worked throughout the design, implementation and data analysis stages. Advice was sought from the South Australian Aboriginal Health Research Ethics Committee and incorporated into the design. Distress protocols were developed to ensure that culturally sensitive follow-up could be achieved for the women should they become distressed. None of the women required follow-up, but one woman asked her interviewer to visit her again to support her in her interactions with the healthcare team.

The research study was approved by the hospital human research ethics committee, the South Australian Aboriginal Health Research Ethics Committee, and the University of South Australia's human research ethics committee.

3. Findings

Six main themes were developed from the women's accounts, and they are presented as an interpretation of the lived experiences of this group of Indigenous women birthing in standard care at an Adelaide hospital. The themes are: "knowing what is best and wanting the best for my baby"; "communicating my way"; "how they made me feel"; "all of my physical needs were met"; "we have resilience and strength despite our hardships" and "recognising my culture". The themes are supported by the women's actual words. All of the women were given pseudonyms within this study.

3.1. "Knowing what is best and wanting the best for my baby"

The women in the study all wanted the best for their babies and expressed knowledge of best practice for their babies such as breastfeeding. A healthy baby was foremost in their minds. The women made sacrifices to ensure that they received the care that was recommended to them. Some of the women relocated from rural and remote areas towards the end of their pregnancies. Lucy made a six-hour return bus trip every two weeks to achieve the recommended antenatal care in her pregnancy. She had other young children and was a carer for her partner. Her sacrifice for her baby's care was significant.

Emily had medical complications with her pregnancy and it was subsequently recommended that she have a caesarean. Emily had previous vaginal births and she experienced some fear, but her driving focus was on the health of her baby. Emily explained:

> *"I felt a bit scared, but I was just wondering about the baby and what was safer for him."*

Roslyn agreed to be transferred from her remote community for care despite the fact that this was contrary to the laws in her community. Roslyn explained:

> *"Well, in our law, like, when we have a baby we go back to bush medicine, that's what we do at home, it makes them grow strong…bush medicine for flu and all that, for diarrhoea, for everything."*

3.2. "Communicating my way"

There was a strong association within the women's data that showed that when the midwifery and medical staff practised open, inclusive communication with the women, the women's experiences were more positive. When the women felt that they were excluded from care or not provided with adequate information then their level of fear and anxiety would increase, which negatively impacted on their experiences.

Communicating with the women and keeping them informed about what was happening with their labours, and with their babies after the birth was vital to the positive experiences. When women felt included in what was happening, they reported positive experiences. Ella explained:

> *"…they were open, they were just, you know, just open and just talking about what is going on and usually sometimes midwives are, sometimes you know they don't say what is going on or what is happening…to be straight out and um, you know, maybe when you are talking about the patient to um, let the patient in instead of being all quiet and talking in the corner which I found was good with the [hospital name] they were open and discussed about, talked about was going on."*

Shelley explained how the communication with her assisted in reducing her fear and anxiety. She felt that having events explained to her demonstrated respect and was able to reduce the panic she was feeling. She explained:

> *"Well, I was a bit worried because doctors were telling me one thing to another, and it was good to be having one doctor come in and clarify what's happening…and clarify with me, I like that and I*

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didn't expect one of the nurses [midwives] to go out and say 'Oh doctor like, this young lady is confused', coz I was, and coz I didn't have much support, coz like the further away that my family were, that um, I was just like oh well, I don't know how to take it, like they're telling me one thing and I'm telling my partner and it's like he's panicking and I'm panicking and it's like, it was good to have, like a nurse [midwife] respect me enough to actually go ask the doctor to sit them down and go like 'we know that you're confused'…"

For some of the women, their experiences were negatively affected when they felt excluded from what was happening and they were not provided with enough information. Ava explained:

"I was fearful, I wasn't really sure what was going on at the time…I didn't really get explained what was going on…[I felt] sort of out of the picture…um, yep, it's just like I heard not from the actual doctor or midwife, no one talked to me directly, I just found out stuff from people, like my mother-in-law, no one looked at me and said 'your baby has passed its bowels' until it had gotten closer to the caesarean and then they said that's why it needed to be done."

3.3. "How they made me feel"

Some of the women in the study experienced a sense of feeling judged by their midwives, and this was linked to their cultures. However, there were also births where the women felt supported in their care. How the women felt, either supported or judged, was important to their overall experience of birth.

Rose talked of her experience with this birth. Like many of the other women who had other children, her past experiences with birth were frequently mentioned in relation to the current birth. It was important to Rose to not feel judged by her carers, as she explained:

"Just to feel welcome, and not judged, that's my main, last time when I had my son I just felt like I was, I think there were a lot of emotions too, but I just felt like a little bit judged. If I'd go outside for a smoke or if I needed to put her in the nursery for five minutes, I would just feel like there was pressure on me to be that extra bit more perfect because of my culture. But this time I haven't even felt that at all. Everyone has just been awesome…and to, to not feel like we are being judged because we are black."

Ava also felt judged and she felt that it was because she was Indigenous. She talked about disclosing to the doctors and midwives the fact that she had smoked marijuana in her pregnancy. This had been extremely difficult for her, but she did disclose her marijuana use because she wanted the best health care for her baby. The staff did not believe that she had only smoked marijuana and questioned her on multiple occasions. She shared her experience in the following excerpt:

"And in hospital about three or four times, um, I was questioned as to whether I did something else. And I whole heartily told the truth, like I smoked marijuana and I even got taken out of my room and into another room and sat down with a doctor who said 'you can tell me no one is here'…I cried, I was very, very upset, I felt like they were judging me…it meant a lot to me to tell the truth, it meant a lot to me to say yeah I smoked marijuana…And um, it really, really upset me…because I burst out into tears in front of them the last time they said it and said get out of the room and don't question me like that and they said 'no one is here, young mums have a tendency not to tell the truth' and stuff like that and I just burst out crying, I felt, um, judged, really judged."

When the women felt supported they had more positive experiences of their births. Stacey felt supported by her midwives for her birth. She also described how midwives who were not assigned to her care answered her call bell and provided support to her, and this made her feel cared for. She explained:

"…when I went into labour and I was screaming and some people didn't, the nurses [midwives] who weren't meant to be checking on me, they'd come in and check on me and stayed with me and they were really good."

3.4. "All of my physical needs were met"

The women frequently expressed satisfaction with the midwifery care provided to them. The midwifery care was often measured in terms of physical care. Physical care related to medications, analgesia, birth coaching, getting them to theatre, performing observations or getting them something to eat. It was less related to the emotional or cultural aspects of caregiving.

Brooke was focused on the management of her mental health condition and this was the most important part for her entire birth experience. Brooke felt her needs were met by the midwives because they ensured her medications were given on time. She explained:

"…like having a mental illness, you know I had to make sure that my medication was there for me to take daily because I could relapse, um, so they made sure that I was comfortable, um, you know, taking my medication, and that you know if I was in pain that it was dealt with instead of, you know, just mucking around."

The focus for the women was the physical side of labour and birth, which included pain management and the physical experience of birth and postnatal care. Although the women were having negative experiences (not related to the physical side of birth) they were still saying that everything went well. This appeared to be associated with the expectation for physical care from the midwives. This is reflected by Shelley's experience as her birth was straightforward. However, she asked the midwives to call her partner when she went into labour because he was staying a reasonable distance from the hospital. The midwives declined to do this for her as they thought it wasn't necessary, which subsequently saw her partner missing the birth of their baby. This was really disappointing for her, but this negative experience was masked by her physical needs being met, and the joy of a new baby seemed to override any dissatisfaction with her partner missing the birth. She explained:

"Straight away I wanted my partner to be called and I don't, and they were like no we just want to clarify just to double check, that, um, you're, um, that I am not dilating or not…and I was scared because like my partner, I live a little bit way out and it takes forty minutes to get here and he was, and I wanted him here and the nursing [midwifery] staff were just like [woman's name], like please sit back and, um, we need to think about you and your baby, not, like I was just panicking about not, about being by myself…just to listen, like I don't know…yeah, so yeah I just wished they, like I was even telling them 'Just get my partner on the phone' because I knew it wasn't normal."

Shelley went on to express her satisfaction with her midwifery care overall:

"The nursing [midwifery] staff are lovely. Like I will still look back and go yep like I would um, rec, highly recommend the nursing [midwifery] staff here…and the staff especially in this, like, department, they're excellent, and they're easy to answer like this is a place where babies are always born every single day like I mean, so yeah, um, yeah, um, I am happy about that."

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3.5. "We have resilience and strength despite our hardships"

The women in the study all faced significant hardships and barriers to attending the hospital. These included being required to relocate from rural and remote areas in order to access the care they needed or that was recommended for them. Those women also faced the associated isolation that comes with being separated from family. They had financial hardships, prematurity, babies in the intensive or special care nursery, unemployment, mental health issues, drug use, complicating medical conditions and one woman's partner was incarcerated. The women were very positive and did not complain about the barriers and hardships they faced. They all remained focused on the healthcare of their babies. They were strong and tolerated difficult and challenging circumstances. Quite often they did not share how they were feeling with their caregivers. Stacey explained the difficulties she faced because she was required to relocate from her community to birth:

> *"Yes, I would change a bit, like, now it's like, it's really hard when you're living out in the bush rather than the big city like this, it's really hard, yeah."*

3.6. "Recognising my culture"

The women in the study had differing views of Indigenous cultures, which reflects the diversity in the sample. The women were born and raised in different areas from all over Australia. There was a mix of women who were currently living in metropolitan areas and women living in rural and remote areas. The women's accounts revealed a strong sense of family for all of the women. For some of the women, a demonstrated recognition and respect of their cultures would have made a significant difference to their experience, but for others it was not paramount. In the same way, some of the women wanted to be treated the same as everybody else but others wanted to be treated differently and in respect of their cultures.

Many of the women were not asked by their midwives about their cultural needs around birth. Shelley was asked and she described how this made her feel respected as a person:

> *"…the first person that has ever, um, asked about respecting the wishes of my Aboriginal, and I was, I was shocked about it and I was, I was amazed and that was a good feeling…Well, I liked it, I was like wow, like out of all my care in any hospital…I was like, like wow, I was…like I said, working in an Aboriginal centre was shocked, and I was like, wow and I felt so good and it's good to know that somebody is respecting you in that way and if, especially if you're like a native woman, for you know, but it's just understanding."*

Some of the women didn't want to be treated any differently to anyone else. Ava felt she was treated differently in a negative sense because she was Indigenous. Ava explained:

> *"But if I was a white person I don't think they would have looked at me like that I guess, like I feel like they were looking at me like a druggy or a bad person."*

Rachel described how she felt she was treated the same as everyone else:

> *"Everything, like everything, went perfectly here at the [hospital name] there is nothing wrong that youse are doing. I can't see anything wrong, like I do hear other like Aboriginal girls that have had their babies here…say that they don't want to come back here and I don't know why, you know, but I can't see anything wrong with this hospital. Everyone is perfectly fine, and the way that you do things, you know like, you aren't treating any other, like cultures different, you know."*

Ava felt that having an Indigenous health worker would have made her feel more comfortable and better understood:

> *"I'd say that I would have felt more comfortable…I think she would have looked at me more or less just as me."*

Rachel discussed the SHC system and identified that she had been offered AMIC care at the start of her pregnancy. She felt that although she would possibly connect better with an Indigenous carer she declined the programme due to fears around confidentiality. Fiona also identified confidentiality as the reason she chose not to have continuity of care with an AMIC worker. Lucy felt that having an Indigenous health worker would be a good experience although she was not offered care in the AMIC program.

Many of the women identified the importance of their families in birth or in the customs around birth. They talked about having their families present for the births and expressed frustrations with some of the institutional policies that restricted visiting hours and numbers of visitors. Isabelle judged her care as good because the midwives said she could have many family members present. This was despite the signs on the birth room doors which restricted the numbers of visitors. Rose also found the practice of restricting visitor numbers on the postnatal ward as limiting as she wanted to have her mother around all the time.

Isla talked about her responsibilities to take her baby back to her community (where she was not currently living) after the birth for a smoking ceremony. She explained:

> *"And when they have baby, they like, go back to their communities and like grandparents, like they will decide to smoke the baby, like the next day, like the next day after…Like, me thinking, like if I go back from here…show the baby to my family and the baby can be smoked there…Yeah, it is hard, like sometimes it like, your family needs you back there with them, you can still go back, like when your family die or pass away, you still have respects, and still have to go back to the law to finish off, yeah, especially the Aboriginal peoples, they got their culture more strong, yeah."*

Roslyn wanted to take her baby outside, but the midwives prevented her from doing so. Her disconnection from her family was extremely difficult. Her entire experience was overshadowed by a deep despair and longing to be back in her community with her family and children. She explained:

> *"And I am frightened here, you know, I am not used to the city and when I see the sunset it's making me lonely and I want to cry, worry…I'm getting homesick, I'm lonely…When I get homesick and lonely I get sick, you know…every time when I sit here I see the planes come past it makes me sad…every time I sit here there are tears, I sit here, I just go back and forwards, inside, outside, I come out, one o'clock, two o'clock…It's like being in a prison, I don't sleep, when I get up at one o'clock and two o'clock I stay awake…today I don't sleep, every time I see the sunset."*

4. Discussion

Cultural safety can only be determined by the recipients of care.[29] The women sharing their experiences accessing mainstream services demonstrated a commitment to the best health care for their babies which was foremost in their minds. Their stories have illustrated that women want information, support and want to be fully included in their care planning and delivery. They also have expectations of physical care only from their midwives. They have shown strong ties to their families and communities and

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shared stories of feeling judged and stories of the difficulties they face as Indigenous women accessing mainstream services.

Rapport and relationships with midwives have been found to be important for birthing women.[30] For the women in this study, the positive experiences have involved good communication, rapport and engagement with their caregivers, which have contributed to a sense of feeling supported through birth. The women who described positive experiences during their births also talked about feeling involved and included in their care delivery. Engaging in dialogue is very important for health care professionals working with Indigenous people.[1] Appearing to be under time constraints and not allowing Indigenous people to have sufficient time to consider responses can be detrimental to the relationships.[1] This is often at odds with the busy schedules in maternity units but time to consider was important to the women in this study and was necessary to help build relationships with their midwives. When the women felt excluded from the discussions about their care, the experiences were not positive. This led to disempowerment and a real lack of cultural safety for the women.

Since Indigenous people prioritise relationships, development of positive relationships between clients and the health service is extremely important.[5] Miscommunication can lead to potential negative flow on effects with a client not returning to a service in the future.[31] They might also share their experiences and discourage others from using the service themselves.[31] Rachel had heard negative word-of-mouth accounts prior to her birth in standard care. Fortunately, she didn't choose to birth elsewhere and had an overall positive experience.

How safe women feel presenting at hospitals to birth, how they and their families are welcomed, and what happens to them when they stay in hospitals are important social determinants of maternal newborn and child health outcomes.[32] Some of the women in the study shared experiences of feeling judged. Many Indigenous people will not use mainstream health services because of the way they are made to feel when accessing them.[33] Many of the women described experiences from the current birth or previous births at different hospitals that were negative, and they believed that this was related to their cultures.

The hospital's inflexible rules and regulations were also perceived as negatively impacting on some of the women's birthing experiences. They included the visiting hours, inability to take their babies outside, relocation for birth and the signs on the birthing room doors limiting the number of visitors. Isabelle judged her midwifery care as good because she could have all of her support people attend her birth. This was despite the signs on the birthing rooms doors which instructed a limit of two people in the room. Rose found the practice of allowing visitors only in the afternoon whilst she was in the postnatal ward as a negative aspect of her experience. The signs and visiting hours can be seen as a direct threat to the cultural safety for the Indigenous women in this study.

Culturally safe care demands that midwives are able to recognise and respect differences in each individual presenting for care.[3] Many of the women in the study articulated that they wanted to be treated the same as everyone else. This may have been related to the fact that on the whole the women evaluated their care on the physical aspects (their physical needs and comforts). It may also be grounded in a notion where the women felt that by getting the same care as everyone else they would get better care than they might otherwise achieve.

This is illustrated in Ava's experience where she had a sense of different care and being treated differently, which for her was negative. She felt that she was perceived to be a bad person and this was because she was Indigenous. She stated that she didn't want to be treated as a different person and also acknowledged that had she had an Indigenous caregiver she would not have been perceived in that way. When midwives do not adopt a cultural safety model of care there can be negative experiences for the women accessing care. Stereotyping can lead to false assumptions and can affect care delivery.[34] Ava felt she was being stereotyped by the staff after disclosing her marijuana use, and assumptions were made about her that were extremely damaging to her psychological wellbeing. Many of the women, when defining 'same care' did not want to be singled out as the 'other'. This was not mutually exclusive from receiving individually tailored care, which could acknowledge and incorporate their cultures.

Shelley also explored the notion of difference in her interview. She acknowledged that while being treated differently can make you feel singled out, the acknowledgement and respect for her culture made her feel safe within the service. She was truly delighted to have her needs outside of the physical recognised and her culture acknowledged.

Ava and Shelley's experiences were influenced by staff engaging in cross-cultural practices, their understandings of cultural safety, their understandings of their own cultures, and their abilities to implement the Indigenous health policies and procedures. Health policies need to clearly define pathways for staff to follow to ensure that culturally unsafe practices are eliminated.[35] Practitioners also need to be able to recognise where the mainstream systems and practices (designed to produce uniform service provisions and best practice) undermine the cultural safety of clients by diminishing the importance of difference.[36]

Cultural safety in midwifery practice includes optimal communication, building relationships and acknowledging women's cultural preferences.[8] Within this study, most of the women were not asked about their cultural needs around birth. For some of the women, it did not appear to matter, perhaps because the expectations from many of the women were for physical care only. It was very important for women who wished to be asked about their cultural needs, for this to happen. Shelley (who was asked) felt surprised and amazed, and it made her feel good. Shelley's surprise illustrates that recognition, questioning and supporting of cultural needs is not generally happening in mainstream services.

This group of women all birthed in standard care without access to Indigenous health workers. Some of the women wanted practices within their hospital stays that could not be provided or that were not facilitated in the model of care provided to them. These included aspects like Roslyn wanting to take her baby outside, women wanting continuity of care and not being offered it or wanting an Indigenous midwife or health care worker. Equitable care demands consideration of the whole world view of health for Indigenous peoples, encompassing family, community, land, ties with the past and a vision of the future, hope, dignity, freedom from anxiety, the right to self-determination, economic security, and absence of abuse.[37] Healthcare grounded in the biomedical model often neglects the whole world-view of health for Indigenous peoples.

Women coming from remote communities could benefit from special consideration of their needs. Roslyn felt that being in Adelaide was making her and her baby sick and she wanted bush medicine for her baby. She described her hospital stay as being like a prison. Her distress was very strong, having been separated from her way of life, in a different state and without her supports. This is a situation where a traditional healer may have been appropriate to work with the hospital midwives and doctors. Many Indigenous people have traditional healers as their primary health care provider.[1] This may have been a more holistic approach which could have considered her world-view and possibly provide better care to her and her baby.

The women in the study had mixed feelings about continuity models of care. Some had not been offered a continuity model of

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care but would have liked the option. Some had been offered the programme but declined because a known midwife was not something they wanted, and they did not wish to have an AMIC worker involved in their care. Rachel and Fiona identified privacy as an issue because although they felt they would have a stronger connection with an Indigenous caregiver, they wanted their privacy respected and felt that 'everybody knows everybody' in the Indigenous community. This may have been an opportunity to share with them health workers' professional obligations that include confidentiality, which may have reassured them and given them the chance to birth in a continuity programme with an AMIC worker.

The women in the study made significant sacrifices to ensure that they gained the best health care for their babies. This was sometimes at odds with the way they practiced health and healthcare and with their world-views of health. Hospitals can better meet the needs of Indigenous women by working together with Indigenous people to incorporate a more holistic approach to maternity care that considers women's needs apart from just the physical aspects of care.

Overall, the strength of the women in the study was evident. They faced many challenges either in their personal lives and situations, accessing care, in their treatments within the organisation and with their physical health. They showed an ability to move on and look forward with great positivity despite their personal situations and experiences in the hospital.

5. Study limitations

All of the women birthed at one South Australian public hospital and though the data are not transferable to other institutions, it does provide an insight into what is required to place Indigenous women's experiences as central to midwifery care. For the six women who came from rural/remote areas, interviews conducted within their communities may have provided an increased opportunity for them to share more of their experiences away from the hospital environment. Women who were living in urban areas were afforded the option of where they would like to have their interviews conducted. The Indigenous interviewers employed in the study were both midwives and a potential power imbalance did exist in those relationships.

6. Conclusions

This paper has presented part of a research project where Indigenous women's lived experiences accessing midwifery care in the standard hospital care system were explored. The focus of the study was on the cultural aspects of their experiences. Midwifery practices around the provision of care to Indigenous women at birth were also explored and are reported separately.[13]

Indigenous women can experience a lack of cultural understanding in mainstream services. Culturally safe midwifery care places the focus on the women's experiences, and this approach can positively impact on the birth experience. This research has enabled an exploration of the experiences described by Indigenous women birthing in standard care, focusing on their cultural needs and contacts with their midwives. The study has shown that women value communication and being fully involved in the decision-making around birth. Some of the women described how they felt judged and misunderstood and this was related to their cultures. It has also demonstrated that these women had an expectation of physical care only from their midwives and that these expectations were generally met. The study also revealed that the women were strong, positive and wanted the best care for their babies.

Other aspects of the birth experience such as the social, emotional and cultural support were achieved through their relationships with their families, friends and support people. Almost all of the women birthing in standard care were not asked about their cultural needs around birth. Some of the women indicated this was not important, which was probably related to their expectations of physical care only from their midwives. For the others, it would have made a significant difference to have their cultures acknowledged. Families were important to the women in the study, and disconnection either through relocation to birth or restrictions on visitors caused the women distress.

Recommendations related to the maternity hospital arising from this research study include the development of an extension to the current care plans to include cultural planning which can ensure women are asked about their cultural needs; Aboriginal Maternal Infant Care (AMIC) workers for women from rural and remote areas; AMIC workers on call to assist the women and midwives in standard care; cultural safety workshops for the midwives; annual assessable cultural safety training for the midwives; increased review of women's experiences; increased education, employment and retention of Indigenous midwives; removal of the signs on the door restricting visitors in the birth suite; flexibility in the application of hospital rules and regulations for Indigenous women; and changes to birthing services in rural and remote areas so women may not have to relocate for birth.

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Appendix Twenty – Publication (midwives' experiences)

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ORIGINAL RESEARCH – QUALITATIVE

Cultural safety and midwifery care for Aboriginal women – A phenomenological study

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ABSTRACT

Background: Aboriginal and Torres Strait islander[1] women face considerable health disparity in relation to their maternity health outcomes when compared to non-Aboriginal women. Culture and culturally appropriate care can contribute to positive health outcomes for Aboriginal women. How midwives provide culturally appropriate care and how the care is experienced by the women is central to this study.

Aim: To explore the lived experiences of midwives providing care in the standard hospital care system to Aboriginal women at a large tertiary teaching hospital.

Methods: An interpretive Heideggerian phenomenological approach was used. Semi-structured interviews were conducted with thirteen volunteer midwives which were transcribed, analysed and presented informed by van Manen's approach.

Findings: Thematic analysis revealed six main themes: "Finding ways to connect with the women", "building support networks – supporting with and through Aboriginal cultural knowledge", "managing the perceived barriers to effective care", "perceived equity is treating women the same", "understanding culture" and "assessing cultural needs – urban versus rural/remote Aboriginal cultural needs".

Conclusion: The midwives in this study have shared their stories of caring for Aboriginal women. They have identified communication and building support with Aboriginal health workers and families as important. They have identified perceived barriers to the provision of care, and misunderstanding around the interpretation of cultural safety in practice was found. Suggestions are made to support midwives in their practice and improve the experiences for Aboriginal women.

1. Background

Cultural safety is a term that originated in New Zealand in response to the poor health status of the Maori Indigenous people.[1] The definition of cultural safety is contested with some scholars defining it in terms of small actions which were usually not defined in policy and procedures within the organisation.[2] Other scholars have defined cultural safety as the standard to which nurses and midwives should seek to aspire.[3–6] The Congress of Aboriginal and Torres Strait Islander nurses have outlined the essential features of cultural safety as[7]:

- An understanding of one's own culture;
- An acknowledgement of difference and a requirement that caregivers are actively mindful and respectful of differences;
- Is informed by the theory of power relations;
- Is the experience of the recipient of care;
- Is not defined by the caregiver.

Historically Australian Aboriginal people have experienced a lack of cultural understanding within the delivery of health services which continues to the present day.[6] Culture and culturally appropriate health care is important and can improve the experiences for Aboriginal people accessing mainstream health services. Whilst culturally appropriate services designed and delivered by Aboriginal people to Aboriginal people are a more acceptable and appropriate option,[8] all sectors of health service delivery should be able to respond to the cultural needs of Aboriginal people.

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[1] The term Aboriginal is inclusive of both Aboriginal and Torres Strait Islander peoples in this study.

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Competency ten of the Australian National Competency Standards for the midwife requires that midwives ensure their practice is culturally safe.[9] The standards also require midwives to be able to recognise the specific needs of Aboriginal women and their communities, demonstrate respect for differences in cultural meanings and responses to health and maternity care.[9]

Giving birth is a significant event in a woman's life,[10,11] and negative experiences can contribute to post traumatic stress syndrome, anxiety and depression.[12] It is important for a woman's health and wellbeing that midwives ensure that all Aboriginal women have their spiritual, cultural and physical needs cared for whilst birthing.[13] For many Aboriginal women attending hospital to birth can be a frightening and alienating experience.[14] For some Aboriginal women who believe that their connection to country can be particularly strong during birth, giving birth in a hospital where they do not feel culturally safe is detrimental to their well-being.[14]

Whilst there is significant research surrounding the experiences of women and midwives working in and receiving care in culturally tailored programs, there remains a dearth of literature examining the experiences of midwives as care providers and their understandings of cultural safety in practice within the standard hospital care (SHC) system. Williamson[15] explored how midwives defined culture and how they provided culturally appropriate care to women from culturally and linguistically diverse backgrounds (CALD). She found that midwives applied a generic approach to all women which failed to consider other factors that might impact on an individual woman.[15]

Obstetric led models of care and the institutional systems of care can act as a barrier to midwives achieving the full spectrum of midwifery practice.[16] Relationships and communication with the women can be impacted by these barriers. Quality relationships with caregivers are important to birthing women.[17] Power and racism have also impacted negatively on the experiences of birthing women[18] and the fragmented system that women birth in acts as a barrier to the formation of positive relationships.[17]

Research conducted into the understanding of cultural safety in the Australian health care context discovered that healthcare providers had little or no understanding of the meaning of cultural safety.[19] The findings suggested that when the healthcare providers attempted to define it, they did so in terms of providing safe care.[19]

In order to explore the midwives' lived experiences of the provision of care to Aboriginal women a phenomenological approach was employed. The aim is to present their experiences of cultural care for Aboriginal women and understandings of cultural safety in their practice. Culturally safe care is an outcome that can only be determined by the recipients of care.[7]

2. Participants

Midwifery volunteer participants were sought from a large tertiary teaching hospital in South Australia. A brief entry was made in the birth suite communication book advising them that the research study had commenced and of upcoming information sessions. A mobile number and for the principal researcher was also included. All of the participants contacted the principal researcher prior to the planned sessions and subsequently the information sessions were cancelled.

The midwives were required to be working within the standard hospital care (SHC) system and to have provided intrapartum care to birthing Aboriginal women. Midwives could have any level of experience and they were not required to be permanent staff members in the birthing unit. Thirteen midwives were interviewed by the first author and a data saturation approach was taken. The interviews took place through March and April, 2014. Participants chose to be interviewed at the hospital in which they worked.

The majority of the midwifery participants had been registered midwives for greater than 25 years ($n = 10$). There were two who had 10–20 years' experience and one who fell within the 20–25 years' experience range. All of the midwives were aged thirty-five or greater with the majority aged over 41 years ($n = 10$). All of the participants in the study were female and at the time of the study there were no male midwives working within the birthing unit or rotating through the area. Fifty-four percent ($n = 7$) of participants were hospital trained in nursing and midwifery, 31% ($n = 4$) held Bachelor of Nursing and Bachelor of Midwifery qualifications and 15% ($n = 2$) were hospital trained in nursing and midwifery but also held a Bachelor of Nursing.

3. Ethics

The research study was approved by the hospital human research ethics committee, the South Australian Aboriginal Health Research Ethics Committee and the University of South Australia's human research ethics committee in late 2013 and early 2014.

4. Methods

4.1. Phenomenology

Interpretive Heideggerian phenomenology was chosen as the philosophical foundation guiding the research study. Heidegger questioned the possibility of any knowledge outside an interpretive position and that knowledge was based in the lived world of things, people, relationships and language.[20] Heidegger's interpretive approach is an appropriate foundation when a researcher wants to uncover meanings within a phenomenon and when attempting to understand human experiences.[21] Heidegger[22] used the word *Dasein* to describe *being in this world* and it has been described as the fundamental ontological structure characterising humans and the unity of the world and existence.[23]

Heidegger[22] described how all understanding is connected to fore-structure, and this cannot be set aside. The process of interpretation allows the researcher to look beyond the participants' words and explore the fore-structures and thematic meanings held in the data.[24] Heidegger described a hermeneutic circle as facilitating the circular process of understanding and as essential to the understanding of *Dasein*.[23] The midwives' experiences of *Dasein* in care provision for Aboriginal women were explored using a Heideggerian approach.

4.2. Data collection

Midwives who met the inclusion criteria nominated a time and location for their face-to-face, individual, semi-structured interview which was digitally recorded and transcribed verbatim into de-identified Microsoft word documents.

Prior to the interviews, the participants were required to read the information sheet and sign a consent form. Interviews ranged in time from 30 min to 1 h with an average length of 40 min.

Open ended questions were asked and some prompts used to elicit as much information as possible about the provision of culturally appropriate care for Aboriginal women. The interviews started with asking the midwives to share their experiences in caring for Aboriginal women. Prompts were used which included asking the midwives to share examples. All of the interviews took place at the hospital were the midwives worked.

4.3. Data analysis

van Manen's[25] six step method for hermeneutic phenomenological enquiry was used for data analysis because of its

foundations in Heidegger's work and strong focus on narratives and lived experiences. The transcribed de-identified interview transcripts had van Manen's[25] steps applied individually and although his steps are presented numerically, it was an iterative process. NVivo10 software was also used to manage the large amount of data produced. The analysis included reading and re-reading of the interview transcripts. Sentences and phrases which represented cultural care within the transcripts were grouped together into clusters that shared similar meanings. The sentences and phrases were then considered collectively, which came to form the theme clusters.

The principal researcher, a midwife with many years' experience in labour and birth care, used a reflective journal during the data collection and interpretation stages. This enabled an exploration of the researcher's position and the impact on the interpretations. She was not an Aboriginal woman. The journal enabled a pathway to explore the researcher's position in relation to the participants and the emerging interpretations. It also facilitated engagement with Heidegger's hermeneutic circle. An Aboriginal Cultural Consultant also participated in the project, and the journal facilitated an exploration of her views on the emerging themes.

5. Findings

Six main themes emerged from the data. The experiential themes are presented as a representation of the experience of *cultural care* for the midwives in the study. The themes are: "Finding ways to connect with the women"; "building support networks – supporting with and through Aboriginal cultural knowledge"; "managing the perceived barriers to effective care"; "perceived equity is treating women the same"; "understanding culture" and "assessing cultural needs – urban versus rural/remote Aboriginal cultural needs". The themes are supported with the midwives' actual words. The midwives were all given pseudonyms within the study.

5.1. Finding ways to connect with the women

Establishing rapport and communicating with the women was seen as central to midwifery care. The midwives would seek out ways to facilitate communication in a way that they felt was acceptable to the women. They recognised different communication styles that some women used. They valued the importance of the families and support people to assist them engage with and communicate with the women. They were also able to recognise situations where communication breakdowns had negative impacts on the delivery of care for the women. They talked of frustrations when they were unable to communicate with the women because of language barriers or lack of interpreters or women who appeared to not want to engage with them. They felt able to adapt their communication styles depending on how they perceived the individual woman's needs.

The midwives talked about connecting through non-verbal communication and through language. Language and the ability to establish rapport through discourse was most often associated with positive interactions with the women. Beverley explained:

> "...language is obviously important if you can't speak the language then it is confusing and what not. There is obviously different dialects of Aboriginal culture, of language, so it's not always easy to get, sometimes you can't get interpreters...like you can't change that they don't speak English, and so, we can only do the little things to make them feel safer and that they are somewhere where they can feel culturally safe".

Georgina described how if the woman talked to her freely and seemed comfortable then it provided her with validation that her midwifery care was acceptable for the woman. Georgina explained:

> "But if you are looking after someone in labour and then at the end of the shift they are quite comfortable, like whether they have pain relief or not, whether their labour is progressing or they are able to sit there and chat to you or whatever and feeling quite comfortable around you, I think that's always a reassuring thing for me, I like to think, like you know, if you start the shift and someone is not very chatty but then you leave at the end of the day and you have sort of, over the space of the time, have been able to build that rapport, I think that sort of shows that the level of care you have done has been good because they have been able to relax and become comfortable around you, and then, so have a bit more of a relationship."

The midwives also talked about connecting with the women through support from the Aboriginal staff members and from the women's families and friends. Sophia described caring for a woman who did not speak English so the woman's mother acted as an interpreter for her daughter. Sophia felt that because the woman's mother trusted her, then the woman did too, despite the fact that they were unable to verbally communicate with each other. The woman's mother was vital to providing acceptable care and in connecting with the woman. Sophia explained:

> "...we couldn't have gotten an official interpreter for that language and it really made the situation for that young girl having the baby so much better because, you know, she trusts her mother to look after her and in that respect because the mother trusted us, she trusted us as well."

5.2. Building support networks – supporting through and with Aboriginal cultural knowledge

Building support networks with other Aboriginal health care providers and with the women's families was recognised as important for the midwives in care delivery for Aboriginal women. The midwives talked of partnering with the families, the Aboriginal Maternal Infant Care (AMIC) workers and the hospital Aboriginal Liaison Officers (ALOs). Generally, the partnership with the ALOs was positive but some role confusion around those interactions were also identified. The midwives also talked of building support networks with the family members who came with the birthing Aboriginal women and incorporating their cultural knowledge into care delivery.

Fran described the ALOs as providing a connection which was really important in balancing fear for the woman and providing safe care:

> "Because I do think when they [ALOs] come, I do think that they have provided a very good service and that bridge between both of us...you have got to try and find that link, otherwise she's going to lie in that bed terrified, um, and it doesn't matter how much explaining, she's not listening to me, you know, so I've got to, I've got to find that link to provide her care..."

The availability of support from the ALO team was also identified as limiting for the midwives as they frequently needed their support outside of business hours. There were also some fears identified for some of the midwives when interacting with the ALOs. This tended to be grounded in a fear of being labelled racist, Jean explained:

> "I just feel like no matter what you do, you can't get it right with Aboriginal people because somebody will say it's offensive...I had this fear that someone was always going to say you're a racist and that's, that's happened to me on lots of occasions".

The AMIC workers were not practicing within the SHC system but were still sought out and seen as a resource for Aboriginal cultural knowledge. The midwives also identified the family members and the woman's support people as playing an important role in providing culturally appropriate care as they were able to advocate for women's needs around birth. The families and support people were seen in a partnership, almost bridging role between the midwives and the women.

5.3. Managing the perceived barriers to effective care

Some midwives were able to identify barriers within the standard hospital system that they perceived negatively impacted on their ability to provide care for women. Those barriers included the time restraints placed on the work of midwives within a large organisation, the fragmented systems of care (lack of continuity of care), the lack of 24 h a day support from the Aboriginal workforce and the inflexible policies and procedures of the maternity hospital. They also identified the system whereby women were required to relocate from rural and remote areas to birth as being a barrier to facilitating woman centred care. Lana described how the policies and procedures often led to the midwives having to make compromises with the woman in order to satisfy the institutional requirements and the needs of the woman:

> "…because we're very guided by policies and protocols and guidelines and we have to work within them as well, so if somebody has a specific need in their birth or that I'm not comfortable with then, I would look elsewhere to see what we could do to facilitate that, maybe not that, but something else…"

Sophia judged the overall experience for the woman as positive, if she was able to facilitate her wishes within the organisational constraints. Sophia explained:

> "…most frustrating thing with the, um, Aboriginal people in particular or people that have specific cultural requirements is the inability to actually fulfil those needs when it seems that it's such a simple thing to do, but, for instance there is no facility to, for the Aunty or the mum or the sister to room in with the woman, you know, it's just a fold out bed and it's just, and to me that's what it is, a fold out bed, put the sheets on the bed and the woman or the person can stay, but you know we are governed by rules and regulations…that is her right to do that and you do feel like you are not abandoning them, but you are letting them down because you are not able to provide some really small thing that would actually make a whole world of difference to them…"

5.4. Perceived equity is treating all women the same

The midwives frequently grouped the Aboriginal women with other groups and talked of Asian, Vietnamese, Sudanese, African and Indian women when asked about Aboriginal women. Beverley explained how she treated all women the same:

> "Depending on what their race or ethnicity was I would provide the same care and I am not specifically more culturally sensitive to Aboriginals [sic] than I am to any other person, white, black, yellow or green."

All of the midwives said that they did not do anything different for Aboriginal women, that they treated all women the same regardless. Sophia explained:

> "So I suppose when I look at, or when you ask me specifically about Aboriginal women I suppose I just see women…"

Kate explained in her interview that she did nothing different for Aboriginal women and that she did not even think of Aboriginal women as Aboriginal as she provided the same care to all women:

> "I just treat women pretty much the same, no matter what culture they are from…it's just, I don't think of Aboriginal women as Aborigines [sic]. I actually think of people that I care for and just try and give the same care. That's why I find it really hard to answer these questions because I don't think 'Oh God she's Aboriginal, I've got to do this'. I just introduce myself, work out their situation and go from there, that's all I do for everybody. And to have to actually think about their culture, of which of course I'm always aware of, oh, well deep down you're always aware. It's not foremost in my mind. Don't know if that's a good thing or a bad thing, that's just the way I am, that's the way I do it."

The midwives grouped the women together with other cultures and made comments about how the other cultural groups had needs which they perceived to be just as great as the Aboriginal women. The midwives expressed some resentment as they felt that other cultural groups were missed in favour of the Aboriginal women.

Lana described how she thought that culture was focused on too much. She said that women were all the same and although she recognised Aboriginal people might want to be treated differently she did not because she thought all women were the same. She explained:

> "I think sometimes culture comes into it a bit too much I think, these are women who are in labour, we're all the same and, um, yes, I understand that is important to you and we will do that, but I'm not going to treat you any differently to anybody else and I think sometimes I've heard certain Aboriginal people, that I've heard talk, expect them to be treated differently, well I'm not going to treat you any differently. I'm just gonna [sic] facilitate what you need and that's what I'm going to do, but I'm not going to treat you any differently than anyone else because you're not different. Your culture's different but you're not different. You know, does that make sense?"

The midwives talked at length about individualising the care for all women. This was how they approached any woman in their care. They would meet the woman, attempt to determine her needs (by asking her) and then facilitate her wishes as best they could within the institutional constraints. To the midwives this was the 'same care' for every woman. Equity of care was also important to the midwives. They felt that every woman was entitled to the same care which was individualised.

Discrimination was woven through the interview transcripts. Although the midwives talked of treating all women the same there was an undertone of both overt and covert racist views. It was mostly in relation to stereotyping and in the formation of assumptions about Aboriginal women. The assumptions were negative and were founded in their ability as mothers based on their cultures and on the sorts of lifestyles they assumed the women led.

5.5. Understanding culture

The midwives were required to navigate their own understandings of culture when providing care for Aboriginal women. They seemed to experience difficulty in differentiating between the physical aspects of care provision with determining the woman's cultural needs. Cultural safety for the midwives was also often considered in terms of a physically safe birth. The midwives did consider cultural safety in terms of individualised care but still located the individualised care within physical safety. For some of

the midwives cultural safety was also tied with supporting the family groups in delivering care.

The midwives frequently talked about the ease that they had in providing physical care to the women. However, it became more difficult for the midwives when they attempted to offer support to the women outside of their physical requirements. Maddie felt her role as a midwife was for the physical safety of the mother and baby. She explained:

> "Ok, well I want a healthy outcome for mother and baby and that's my priority, that's what I think a midwife's role is."

When the midwives were asked about what they did differently for Aboriginal women they felt that they did not do anything differently because when they talked of caring for Aboriginal women they talked of physical care. Sophia explained:

> "But I didn't prepare the room any differently than I ordinarily would have because her pressing need was in fact the fact that she had been bleeding so she had lost some blood. She would need some fluid replacement so I suppose you go into midwifery and nursing mode and everybody's body is the same, so if they are hypovolaemic, they are hypovolaemic whether they are Aboriginal or, you know, English."

Cultural safety was often defined in terms of physical safety for the mother and the baby. Lana explained her own interpretation of cultural safety and she saw it being linked with physical safety:

> "I think that it, well to me, means that I am aware of the needs of that specific woman, not necessarily related to whether she's Aboriginal or Sudanese or whatever. I think to me it's what is safe for that woman at that point in time in her labour, her birth or whatever and I would endeavour to assist and provide the care that she, she wants".

5.6. *Assessing cultural needs – urban versus rural/remote Aboriginal cultural needs*

The midwives in the study made assessments about the women in their care and they tended to link their cultural needs to where they came from. Sometimes this was linked to the familiarity of the hospital environment for the women. At other times it was linked to the perceived notion that a woman who represented the traditional stereotypical image of an Aboriginal woman was somehow more authentic in her ties to her culture.

Twelve of the midwives expressed views that women who were living in rural and remote areas had differing cultural needs from the women living in urban areas. They felt that women who came from rural and remote areas had stronger ties with their cultural heritage, compared to Aboriginal women living in metropolitan areas who four of the midwives said had in fact 'lost their culture'. Kate explained that women from metropolitan areas were far more 'westernised' in their cultural needs:

> "Well, ones from the metropolitan are far more westernised I should say, or 'whitenised', whatever you like to say…I think a lot of people from the metropolitan Aboriginals [sic], the expectations are extremely high of what they expect when they come to us whereas I don't think remotely they do, as in the services you need to provide."

The midwives felt that the familiarity of the environment also contributed to the differing cultural needs of women from rural and remote areas. Those women were geographically disconnected from their families, communities, languages and they were faced with unfamiliar environments, schedules, people, communication styles and technology. The midwives felt that those things affected the women's experiences and cultural needs around birth. They also identified fear and loneliness in those women.

6. Discussion

Cultural safety should guide Australian midwifery practice, it is a requirement of midwifery competency[9] and it can only be determined by the recipients of care.[3] The midwives' experiences of *cultural care* have demonstrated that there is some way to go to achieving appropriate care for Aboriginal women birthing in standard care.

When considering the definition provided by the Congress of Aboriginal and Torres Strait Islander nurses[7] for cultural safety, there is an evident clear shortfall in the midwives' understandings. None of the midwives recognised the position of power they were afforded as caregivers, there was no clear respect for difference or even an understanding of their own cultures and the impact that might have on the women they cared for. These factors all impact on the care which is received by the Aboriginal women birthing in the SHC system.

The midwives were able to recognise barriers to the provision of care in the SHC system but were not able to analyse those barriers as potential threats to the cultural safety of the women in their care. Culturally unsafe practices are those which diminish, demean or disempower the cultural identity and well-being of an individual.[26] The hospital regulations which limit or deny family members from staying with the women are a good example of an unsafe cultural practice. For women who are required to travel from rural or remote areas to birth their babies is another example of an unsafe cultural practice whereby these women are isolated from their cultural, social and emotional supports. New Zealand medical practitioners can be de-registered for culturally unsafe practices.[6] Although the midwives were able to recognise them as barriers some further consideration around them from a cultural safety perspective may have demanded the midwives take some action.

Most of the midwives had either not heard of cultural safety or when they did try to define it placed cultural safety within the domain of physical safety. All of the midwives in the study trained when the principles of cultural safety were not embedded within midwifery curricula but they had all completed the mandatory cultural awareness training required by the organisation. Some of the midwives had also participated in an Aboriginal cultural training weekend in the Flinders Ranges exploring the Adnyamathanha people's culture.

The midwives felt comfortable with the physical aspects of care, they were inventive and they found ways to communicate with the women in their care. Communication was important to the midwives and the positive relationships were always tied to the women with whom they were able to establish effective verbal communication. If the women could not verbally communicate with them they still attempted to develop relationships through other means. They were comfortable with the physical side of midwifery practice.

The women's needs outside of the physical were foreign to the midwives; they relied on others for support for this aspect of care. This is where the midwives valued the role of the Aboriginal workforce and of the women's families and support people. The recognition of the importance of Aboriginal cultural knowledge in the role of birth for women shows that the midwives have some knowledge about what might be important for Aboriginal birthing women.

"Treating all women the same" was tied to equity and equal care for the midwives. There was a strong undertone of dissatisfaction within the midwifery data that lay in the sense that equal care for all women was the *same* care. They were unable

to see that equitable care would demand a different approach although some of the midwives did recognise the disparate health outcomes for Aboriginal Australians.

Midwives practicing with a focus on cultural safety need to be able to recognise and respect difference.[27] This is at odds with the midwives' experiences of "treating all women the same". However, the midwives felt strongly that by individualising care for each woman they were providing appropriate care and providing equitable care. Training in the development of reflexivity may help the midwives explore how their understanding of the norm and their assumptions and values might impact on the women in their care.

Houston[28] argued that in order to achieve equity in health care for Aboriginal Australians, health care must be framed with Aboriginal principles and values. The dichotomy occurs as health care in the standard care system is provided with the principles and values of western health care delivery and explains to some extent where the midwives' position of 'same care' originates.

There was recognition of the diversity of Aboriginal Australians with several of the midwives. Those midwives felt that individualised care to each unique woman would ensure her cultural needs were met. Given that so many of the midwives went on to define cultural safety in a physical sense it becomes difficult to reconcile that argument.

Most of the midwives in the study did not consider their own cultures or the culture of midwifery in general when considering the experience of culturally appropriate care. The power over birthing women as healthcare providers and as members of the dominant culture was not considered. The midwives did feel empathy for the women and did seek ways to improve the experiences for the women. Generally they felt powerless to change the situations the women faced. They went out of their way to do little things for the women. One of the midwives paid for television connection, others sought to get things like soaps and shampoos for the women to make the physical aspects easier for the women.

There was a strong sense that they felt unable to enact change for the women due to fear of doing or saying the wrong thing, not knowing what they could do and the barriers exerted from the institutional policies. For example, the hospital policy that limited the capacity of the midwives to allow the woman's family members to stay overnight. When coupled with their westernised understandings of health and healthcare and limited understanding of cultural safety the midwives were not in a position to challenge this policy and enact change. Working on their educational needs and developing their understandings from an Aboriginal perspective would equip them to better manage their requirements as midwives and to help them better support the women.

The notion that women from rural or remote areas had stronger ties to country and culture was a concerning finding. Most of the midwives ($n = 12$) determined that those women had greater cultural needs. Although the needs may have been perceived as greater, they recognised familiarity with the environment as an aspect of that. This shows evidence of confusion around what culture and cultural needs are rather than a true representation of what the cultural differences were. Williamson[15] also found that midwives expected women to follow their traditional birth practices and perceived them to have lost their culture if they did not. Aboriginal people do not become less Aboriginal when they live in cities or towns.[29]

Racism was evident throughout the data. Frequently this involved some level of stereotyping of Aboriginal women. Current cultural respect training should be enhanced to name and address racism to ensure that participants can develop an understanding of Aboriginal people's everyday experiences when accessing healthcare.[30] Moving towards cultural safety training embedded with anti-racism training would be beneficial to address this. Anti-racism frameworks in cultural training would require the health care provider to address their own position in health care delivery and would also contribute to stopping the marginalisation and disempowerment of Aboriginal peoples.[31]

This paper has presented the findings of a qualitative research study where midwifery practices around cultural care for Aboriginal women have been explored. The study also explored the women's experiences of intrapartum care in the standard hospital care system, focusing on their cultural needs as Aboriginal women. The women's data will be reported separately.

7. Study limitations

The use of Heideggerian phenomenology as a philosophical foundation has been criticised because Heidegger never intended it to be used to guide research.[32] Heidegger's personal links to the Nazi socialist party could be seen as a limitation within this study especially given Aboriginal Australian's experiences since colonisation. However, his ontological philosophy does align with the research aims of the project.

The research included a small proportion of midwives, however, other published work has demonstrated similar attitudes from health care providers towards Aboriginal people accessing healthcare.[33–35] These attitudes impact on the health and wellbeing of Aboriginal Australians.[36] Expanding this project to investigate the attitudes, practices and experiences of larger groups of midwives from different institutions would be beneficial for exploring the way forward for cultural safety training for midwives. This would ensure that midwives are aligning their practice to the requirements of the Australian National Competency standards.

The midwives in the study were already qualified when cultural safety was embedded within nursing and midwifery curricula. A study sample with representations from the younger cohorts of midwives would have provided some opportunity to explore their understandings of cultural safety and if these differed from the findings presented here.

8. Conclusion

This study has shown that midwives value effective communication with the women they care for. They attempt to build support networks around Aboriginal women with assistance from the Aboriginal workforce and the women's support people. The midwives identified perceived barriers within mainstream services which included the time constraints in a busy hospital; lack of flexibility in the hospital protocols and polices; the system whereby women were required to relocate to birth; lack of continuity of care; lack of support 24 h a day from the Aboriginal workforce and the speed at which women transitioned through the service.

The midwives had some difficulty differentiating the women's physical needs from their cultural needs. The concept of cultural safety was not well understood. The midwives also determined that women who were living in metropolitan areas had lesser cultural needs than the women who were living in rural and remote areas. Stereotyping and racism was also identified within the study.

Considering the findings from a cultural safety perspective can place the women as central to midwifery practice. It is also able to highlight shortfalls both in midwifery care, in the systems of care delivery and most importantly the threats to the cultural safety of birthing Aboriginal women.

A way forward for standard hospital care could see a strengthening of the partnerships between the Aboriginal workforce, the women and the midwives. Focusing on the development of respectful, positive relationships should be a priority. Consumer feedback would be beneficial to midwifery practice and is required from a cultural safety perspective. Strengthening training with cultural safety as a core concept would align better with the Australian National Competency Standards. Ensuring cultural training was an assessable component of practice and recognition that it is as important as the physical aspects of care for the women would be a positive approach for improving the experiences of the women and supporting midwives in practice.

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