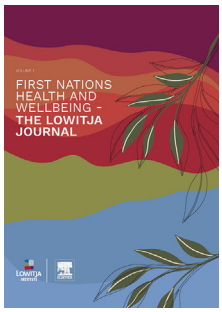

Original Research

‘These people are on your side… this is a safe space.’ Aboriginal women’s stories of having a baby through culturally tailored continuity of midwife care programs in Naarm (Melbourne), Australia

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Abstract

Background Perinatal inequities experienced by Aboriginal and Torres Strait Islander (First Nations) women and newborns are impacted by colonisation. As a redress, government health policies recommend the implementation of evidence-based, co-designed models of care. Maternity services that are committed to meeting the needs of First Nations communities must centre the voices of First Nations women in program planning, implementation, and evaluation. The purpose of the study was to explore the views and experiences of First Nations women who gave birth at one of the health services where new models had been implemented.

Methods The study design was developed with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the partner sites, staff from their respective Aboriginal Health Units and the project Aboriginal Advisory Committee. Using an overall framework underpinned by Critical Race Theory and Indigenous methodologies, a descriptive qualitative design integrated with ‘yarning’ was used. Women were interviewed by a First Nations researcher and data analysed thematically.

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Main findings Ten women participated in an interview. Overall, women reported having very positive experiences of the culturally tailored caseload midwifery models. Key contributing factors were 'relationships' (continuity and accessibility of their known midwife), 'trust' (with their midwife and the program) and 'culture' (acknowledging identity and a safe space). These elements were considered as essential for culturally safe maternity care. Women reported challenges within the broader maternity system if trust, relationships or culture were missing. Women also reported that support and care from First Nations staff was important.

Principal conclusions Women in this study endorsed the implementation of culturally tailored continuity of midwife models of care. Trust, relationships and culture were the trifecta for a safe and positive maternity care experience.

Keywords: First Nations; Cultural Safety; Continuity of midwife care; caseload midwifery; Aboriginal; maternity care

Highlights

- Culturally tailored continuity of midwife care models were successfully implemented in three health services in Naarm, Victoria.
- First Nations women who birthed through the models participated in face-to-face interviews and reported safe and positive maternity care experiences.
- Women reported feeling safer and calmer after having the opportunity to build *relationships* and *trust* with their midwives.
- First Nations midwives and hospital liaison officers were key to integrating *culture* into the program and valued by women.
- Continuation and scale up of the new culturally tailored caseload models has been endorsed by the women.

Introduction

Since European colonisation, Aboriginal and Torres Strait Islander (First Nations) women/birthing people[1] have survived and adapted to what has been a drastic shift in pregnancy and birthing care (Ramsamy, 2021). For > 60,000 years, senior community women provided pregnant women with skilled care on Country (Adams et al., 2018; Chamberlain & Marriott, 2019), before the imposition of a dominant, Euro-centric, largely hospital-based maternity system that has not fully met First Nations women's needs (Hickey et al., 2019). Many First Nations women and newborns experience a healthy pregnancy and birth; however, national data indicate that a disproportionate burden of poor perinatal outcomes are experienced by First Nations women and their newborns (AIHW, 2023). To address this inequity, government health policies state that maternity services need to meet the needs of First Nations women by implementing evidence-

[1]The authors recognise and celebrate that gender diverse people exist and give birth in Aboriginal and Torres Strait Islander communities. Hereafter, we use the terms woman/women, and wish not to undermine the unique, intersecting experiences of First Nations sister girls, brother boys, gender diverse and LGBTQIA people. The research participants referred to themselves as Aboriginal women and are referred to as such.

based, co-designed models of care (Australian Health Minister's Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, 2016; COAG Health Council, 2019; Queensland Health, 2019).

In 2016, La Trobe University, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and four health services in Victoria (three metropolitan and one regional) partnered on a National Health and Medical Research Council (NHMRC) funded partnership project, with the primary aim of implementing and embedding a culturally tailored caseload midwifery model for First Nations women, and women having a First Nations baby (McLachlan et al., 2022). The project was called 'Baggarrook Yurrongi' ('Woman's Journey' in Woi-wurrung language) and 'Nurragh Manma Buliana' ('All of us working together for pregnancy' in Yorta Yorta language). The culturally tailored caseload models include 24/7 access to a known, primary hospital midwife (and one or two back-up midwives) who provides continuity of care across pregnancy, labour and birth, and after the birth. In conjunction with care from the caseload midwives, women also have access to support from Aboriginal Hospital Liaison Officers (AHLOs) and, if desired, can have shared-care with a community-based midwife from an Aboriginal Health Service (McLardie-Hore et al., 2023). The models commenced at three public hospitals, located in Naarm[2], in March 2017 (site one), October 2017 (site two) and April 2018 (site three). The number of First Nations women receiving continuity of midwife care increased exponentially during the study period, from 34 First Nations women ever receiving a continuity of midwife care model at the study sites, to > 700 women having a First Nations baby (McLachlan et al., 2022). The fourth site, located on Yorta Yorta Country (regional Victoria) was unable to implement the model due to ongoing staffing challenges impacting implementation (McLachlan et al., 2022).

This study addressed a key secondary aim of the overarching project, which was to explore women's views and experiences of their maternity care. Genuine involvement of First Nations peoples in the design and evaluation of First Nations specific maternity services increases the likelihood that programs will successfully improve outcomes and meet women's needs (AHRC, 2020). Knowledge exchange in Indigenous cultures has always been based on oral storytelling, which is considered a vital component of Indigenous research (Bull, 2020). The perspectives of Indigenous women through storytelling is of great value in research (Smith, 2012), and birthing stories told by First Nations Australian women have been collected to inform and improve the maternity care that is available (Ireland et al., 2011; Marriott et al., 2019b; Nelson et al., 2021).

The findings of a survey exploring satisfaction of care among women who birthed a First Nations baby at one of the three study sites have previously been reported. Overall, 213 women reported being very satisfied with their care: they felt informed, that they had an active say in decisions and that their concerns were taken seriously (McCalman et al., 2023). A subsequent analysis of women's free-text survey responses provided context and further explanation of the high ratings of care. Women reported receiving high-quality clinical care, and that having a known midwife enabled self-determination and gave emotional safety, so that they felt safe, connected and supported (McCalman et al., 2024). Women also identified that service provision from the wider maternity system was

[2]Naarm is the Woi-wurrung word for the lands and waters of what is also now known as Melbourne, in Victoria.

complex, fragmented and unsupportive at times (McCalman et al., 2024). A small number of other studies also reported that First Nations women value access to culturally tailored midwife continuity models (Homer et al., 2012; Marriott et al., 2019b), and that the likelihood of a negative experience decreases with the availability of such models (Corcoran et al., 2017).

Several recent reviews have recommended ongoing research to explore First Nations women's maternity care experiences (Marriott et al., 2019; Simpson et al., 2020; Sivertsen et al., 2020), including enabling factors for positive engagement with antenatal care (Simpson et al., 2020) and focusing on women who live in urban settings (Sivertsen et al., 2020). Overall, limited access to continuity models for pregnant First Nations women has been reported, although where models do exist, First Nations women value having known care providers with strong community links and care through Aboriginal community-controlled health organisations (Sivertsen et al., 2020). Marriot and colleagues (2019) also discuss that as First Nations-specific maternity models expand, there is scope to further explore how this contributes to women's experiences of cultural security in urban settings.

This paper aimed to describe the views and experiences of First Nations women who had given birth and received care from a known midwife through a recently implemented culturally tailored caseload midwifery program in three health services in Naarm, Victoria.

Design/methodology

The overarching Baggarrook Yurrongi project was co-developed in partnership with VACCHO, the partner sites and staff from their respective Aboriginal health units. The multidisciplinary research team included both First Nations and non-First Nations researchers.

An Aboriginal advisory committee (AAC) was established and included community Elders, First Nations members of the research team, Aboriginal health unit staff from each of the study sites, a First Nations woman who had recently given birth, and a VACCHO representative. The AAC provided advice on Indigenous methodologies, as well as input into decisions relating to community engagement, research dissemination and design of the data collection tools.

The design of the Baggarrook Yurrongi study was informed by an Indigenous research paradigm and recognised the voices of First Nations women as integral to the research process. A descriptive qualitative design with semi-structured interviews was used. Inviting First Nations women to participate in semi-structured interviews about their experience was viewed as an opportunity for positive community engagement in the research process, and as a culturally appropriate tool to support relationship building, relationality (Wilson, 2008) and 'yarning' (Bessarab & Ng'andu, 2010). Indigenous scholars have critiqued the use of Western research methods 'on' First Nations peoples as both inadequate and unethical, noting the potential for harmful undermining of Indigenous worldviews (Martin & Mirraboopa, 2003; Sherwood, 2010; Smith, 2012), although it is also accepted by Indigenous scholars that Western methods can facilitate Indigenous research, as long as Indigenous worldviews are central to the research process (Martin & Mirraboopa, 2003; West et al., 2012).

Reflexivity (Creswell & Miller, 2000; West et al., 2012) was practiced through transparency, reflection and journalling during the study design, data collection and data analysis phases. Importantly, the first author of this paper positions herself as a Noongar woman and a

midwife. Rigney (1999) names the process of Indigenous researchers gathering knowledge from Indigenous informants as 'Indigenist research'. An Indigenist research paradigm locates colonial oppression as the social structure from which emancipation is predominantly called for, while privileging the voices of Indigenous peoples and maintaining political integrity throughout the research process (Rigney, 1999). 'Critical race theory' is the conceptual framework used for this study (West et al., 2012). Conceptual frameworks provide an argument for why a research topic is important (Ravitch, 2012). Like an Indigenist research paradigm, critical race theory challenges dominant discourses constructed by the privileged in society by elevating accounts of the racially marginalised (Creswell & Poth, 2018). Critical race theory has previously been used by First Nations researchers exploring First Nations women's experiences relating to childbearing (Fergie, 2015; Kelly et al., 2014).

Study sample

First Nations women who consented to further contact after completing a follow-up telephone questionnaire at 3 months postpartum (McCalman et al., 2024; McCalman et al., 2023) were invited to participate in a face-to-face interview. The eligibility criteria were developed following discussions between the research team and the AAC. Eligible women had received care though the new culturally tailored caseload midwifery models and had met their midwife on at least three occasions prior to giving birth, as the aim of the study was to explore women's experiences of continuity of care with their midwife. It was decided by the AAC and the research team not to include non-First Nations women having a First Nations baby, as the aim of the interviews was to specifically explore the views of First Nations women. Other inclusion criteria were having a live baby. Women were excluded from the study if they had experienced perinatal loss (i.e. women *not* discharged from hospital with a live baby were ineligible). Sampling was both purposive (Creswell, 2013) and random, with the aim of including at least one woman from each study site and a mix of primiparous women (first baby) and multiparous women (not first baby). To minimise the risk of possible recall bias, women who were 3–9 months postpartum were eligible (Brown & Lumley, 1997; Waldenström, 2004).

Recruitment

A database of Baggarrook Yurrongi participants was managed by the research team in a password secured research data management software program 'Research Electronic Data Capture' (REDCap) (Harris et al., 2009). REDCap was used to generate a list of names of women who had consented to further contact and met the eligibility criteria. The first author (PMc) then contacted the women via telephone in the order that they appeared on the list and invited them to participate. If the woman agreed, a meeting time and place of the woman's choosing was arranged. Due to COVID-19 restrictions, some interviews took place via a video call, using video conference technology. A plain language consent form was either read out to the woman and signed in person before the interview commenced or was electronically signed and emailed back to the researcher before a video conference interview. Data collection was between January and September 2020.

Data collection

The first author (PMc) conducted the interviews, with training and mentorship in conducting semi-structured interviews from co-author MN. A pre-determined study interview guide was used with questions relating to the research topic (Whitehead & Whitehead, 2018). The AAC provided advice and input

into the design of the interview guide. Four questions were asked and related to i) the woman's experience in the culturally tailored caseload midwife program, ii) views regarding the relationship with her midwife, iii) experiences of service provision outside the model, and iv) views and experiences of cultural safety. The interview guide ensured that the research topic was addressed, but the semi-structured interviews still allowed for a flexible approach to the questions and the ability to follow any additional topics of interest (Nagy et al., 2010; Serry, 2016).

Indigenous methodologies were integrated with PMc receiving additional guidance and mentorship from a community Elder and member of the AAC on the inclusion of 'social yarning' and 'research yarning' (Bessarab & Ng'andu, 2010). Bessarab and Ng'andu (2010) originally described the integration of 'yarning' into a semi-structured interview framework as discussion covering relevant areas of a research topic in an informal manner to gather knowledge from informants, but to also develop a relationship of accountability and reciprocity between the researcher and informant. Relationships between PMc and each of the participants were developed through initial 'social yarning', where two-way storytelling and information exchange occurred (Bessarab & Ng'andu, 2010). PMc understood that her accountability to each research participant was a responsibility to accurately capture each story, and to disseminate these stories with the shared goal of improving birthing services for other First Nations women. As a gesture of reciprocity, gift vouchers were offered to women at the completion of each interview, which all the women accepted.

Data management and analysis

The interviews were voice recorded and transcribed verbatim by PMc. The transcripts were then sent to each woman for verification and approval, a process referred to as member checking (Carlson, 2010), before being de-identified. Then, a four-step process of data immersion, coding, categorisation and identification of themes followed, as described by Green et al. (2007), where the researchers (PMc and HMc) moved back and forth along the steps as data analysis progressed and understanding of the data developed. PMc and HMc completed the initial steps of data immersion and coding the text separately, before comparing interpretations together and engaging in regular meetings to address any questions relating to the data. As has been described by Marriott et al. (2019a), researchers PMc (First Nations) and HMc (non-Indigenous) engaged in dialogue that privileged Aboriginal worldviews around any discrepancies about the research data, until consensus was reached (Marriott et al., 2019a).

Ethical approval

Multisite ethics approval was provided by St Vincent's Hospital HREC reference number HREC-16\SVHM\223, followed by approval from La Trobe University (HREC 195/16) and all partner organisations. The study was conducted in accordance with National Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research (National Health and Medical Research Council, 2018).

Results

Twenty-eight women were identified as eligible during the period of recruitment. Of those, 10 accepted, three declined (citing a lack of time) and eight were unable to be contacted. The remaining seven women were not contacted, as data saturation had been reached (Serry, 2016).

Women were an average age of 29.9 years and 6.3 months postpartum when interviewed. The sample

included three primiparous women (first baby) and seven multiparous women (not first baby), with at least one woman from each of the three study sites (Table 1). Three overall themes were identified: 'relationships', 'trust' and 'culture'. Quotes are provided with an alias to maintain anonymity, and names have been removed from quotes.

Theme 1: Relationships

The theme of 'relationships' featured strongly in the data. Being able to see the same midwife was viewed very positively by women. Most women, even if this was not their first baby, had never heard of being able to have a 'known' midwife.

> *I hadn't kind of thought much about what model of care I was interested in, um, because it's my first baby and I didn't really understand how the hospital system would work... when I kind of learnt that there were different types of care... caseload care, or what the [caseload] program was, really appealed to me. Like, knowing who I was seeing and actually having a midwife that was sort of my midwife to go and talk to... I was really excited about that* (Jade, first baby).

Women spoke positively about their relationship with their midwife. Many women described feeling genuinely cared for, with some women using the word 'friendship'. For most, this was developed through regular visits that felt personal and relaxed.

> *...rather than just getting straight to the point of my pregnancy... she wanted to get to know me... she wanted to get to know... [my older child]... so that was how that, the relationship really evolved* (Amber, not first baby).
>
> *I actually felt like a real human being. Like, she knew my name, it wasn't, you know, 'Oh hi I'm your midwife for this five minutes of your day, what's your name, what's your story?'...it was more a friendship at the end, more than anything* (Violet, not first baby).

Establishing a relationship with one midwife (and/or the back-up midwife) appeared to make it easier for women to access pregnancy care in a practical sense. Women explained that the midwife knew about their life and was flexible.

> *I knew all of the midwives by first name... she made sure that every visit, that my little boy was able to come along to them... that the appointments were made on the days when I wasn't working. And also, she made sure that they accommodated [my older child]'s nap times. So that just made it much easier... they also made sure that there were things that [my older child] could, could do, so that he was occupied. So they could,*

Study ID	Pseudonym	First Nations status	First baby	Study site	Interview method	Age (years)	Months postnatal
1152	Amber	Aboriginal	No	Site 1	Video call	35	4
3043	Violet	Aboriginal	No	Site 3	Video call	27	6
3053	Coral	Aboriginal	No	Site 3	In person	27	5
1145	Hazel	Aboriginal	Yes	Site 1	Video call	27	5
1104	Jade	Aboriginal	Yes	Site 1	In person	35	9
1106	Mauve	Aboriginal	No	Site 1	In person	38	9
2041	Olive	Aboriginal	Yes	Site 2	In person	23	8
3031	Rose	Aboriginal	No	Site 3	In person	31	4
3049	Ruby	Aboriginal	No	Site 3	Video call	24	7
3078	Indigo	Aboriginal	No	Site 3	Video call	32	6

Table 1: Participant characteristics

could talk to me and ask me questions about how I was going and the pregnancy (Amber, not first baby).

Many emphasised that not having to repeat personal stories several times was important. For Rose, it removed some of the barriers to accessing care that she overcame during her first pregnancy:

...seeing a new person every time, it would be a whole week before, a whole day leading up, just worried about, you know, what's this person gonna ask me, what I'm gonna have to tell them. What I'm gonna have to go over again, and with [my midwife] and [my back-up midwife] it was just none of that (Rose, not first baby).

Women described how it was easy to contact their midwife if they were going into labour or if they were concerned. Having direct 24/7 telephone access to their midwife or back-up midwife was very important.

...if I had any concerns whatsoever, unusual pain that I've never experienced, I could call her on her pager and she would get back to me in like two seconds, five minutes. So I liked that, that we had that communication... she ah, delivered bubs and... yeah, she was, she was nice... I really liked it. We, we got along really good (Mauve, not first baby).

Olive reflected that if it wasn't for those relationships, she may not have sought much needed care in time:

...if I didn't have them to kind of call, I would have been like, 'maybe I am just over thinking, maybe I won't go in'... where, that could have been, like, bad for him [baby] in the end, 'cos obviously he had the cord around his neck so many times and there's like, reduced movements... (Olive, first baby).

Amber explained that during her first pregnancy appointments felt 'rushed', but with the program for her second pregnancy, she was more comfortable to ask questions:

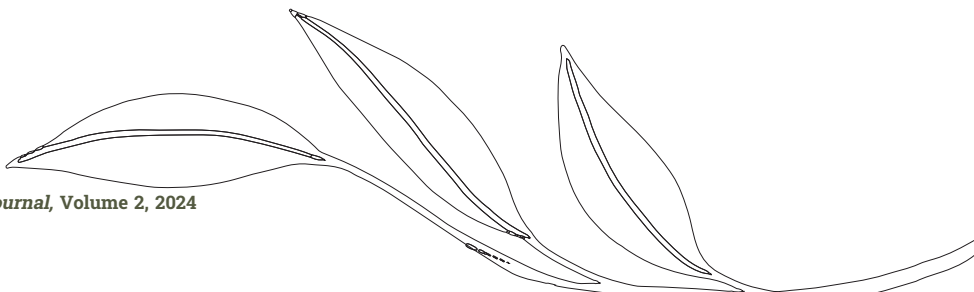
...they were just 'ticking the box'... reading from a script... in some cases I just felt like it was really, really rushed, like, because they've got lots of people to see... I maybe probably didn't feel comfortable asking questions, or, you know, raising issues... when you've got that kind of one-on-one relationship and that continuity of care, I, I just personally felt like, I could ask them anything and I could raise any issues (Amber, not first baby).

Many of the women also talked about how the relationships between the midwife and their partners or family members made a big difference to their experience:

...she'd built a relationship as well, with my partner and so he felt really comfortable with her. And he hates hospitals, like gets bad anxiety when he goes there... So having her for like, all of us... my son was familiar with her... I don't know if it would have been the same if it was just any random midwife that he didn't have a relationship with... made the difference as well, like, when we came home... asking her any of those silly questions all of us being comfortable... 'Cos his like, normal response is to just be quiet. And then like, Google later (Coral, not first baby).

The significance of having the opportunity to develop relationships was highlighted by Indigo's experience, which differed to the other women. Indigo viewed her interactions with her midwife positively, but as a long-term inpatient with a complex pregnancy, she described feelings of disappointment and isolation. Hoping for a closer relationship, Indigo perceived that her midwife was too busy:

...when someone says they're gonna come every week, you kind of expect them to be there every week... it's not a reflection on [my midwife] at all. She was a beautiful person. I just feel like maybe she had too much on her plate, yeah... it was very isolating... I think I would have



built more of a relationship, um, in a way that made me feel comfortable, because… they would say things like, 'oh, you know, please call me if you need anything'. I'm the kind of person that I don't tend to, I don't wanna bother anyone, um, but if you're in front of me, I'll tell you (Indigo, not first baby).

Theme 2: Trust

The importance of trust was talked about extensively. Most women described feeling very trusting of their midwives and the program, stating that they would like the program to continue, or that they would like to come through the program with their next baby, or that they would like other Aboriginal women to also have this care.

When I heard about the caseload program… a big part of it was knowing that it was trusted, from other mob. Like other blackfullas saying, like, 'this is good, you'll be looked after' (Jade, first baby).

Women often linked trust to the relationship with their midwife that had developed over time. Women described feeling comfortable to be 'honest', that they could openly share their thoughts and emotions, and just 'be themselves'.

She's very easy to kinda, open up to I guess. Um, she doesn't pry too much, like, she lets you slowly open up to her (Hazel, first baby).

…I trusted her… and I'd be more honest about, like, what I'm eating, or, you know?… 'Cos I had that relationship with her, I guess… there's been times where, like in my first pregnancy, I had like a nurse say to me, so I'd cut down to three cigarettes and she was like 'you shouldn't be doing anything at all' and I was like, 'shut your, shut your face'… so it was really good, and I felt really comfortable being able to talk to her. And then, being able to be honest about my health (Coral, not first baby).

I felt that I could say whatever I wanted… that led me to trust her, and for us to, for us to develop a relationship… (Jade, first baby).

Rose explained that she didn't need to 'filter' anything. Instead, she was able to express herself, using humour without fear of stigma or having a 'red flag' marked against her name:

…you also don't have to be real formal. You don't have to watch your language. You don't have to… [sighs] you don't have to filter anything. You can walk in and say 'I've had a fuckin' shit day, took me ages to get here, I'm sick of everything…' and they're like, 'yeah cool'… I know they're not gonna do that to me?… other doctors they're… processing things… the way they do things… whether they will put a big red flag on your file and be like 'this person needs serious help'… but even just havin' a laugh. Going in there and being able to talk shit. And, and yes, I've had an awful day, but we can have a laugh about it (Rose, not first baby).

Some women talked about feeling the need to 'censor' themselves while interacting with hospital staff. Mauve wanted to do what was best for her baby, but she felt judged during her previous experiences and so she did not trust the hospital:

I was scared because I thought… well, if the hospital have to report everything to DHS [Department of Human Services] well, they're going to… so I literally watched everything, my Ps my Qs… it takes a long, a while for me to trust and yeah, I didn't trust the hospital but end of the day I had no choice, it was either have her at a hospital where she would be safe, or have her on the street in a motel… Well end of the day it was all for her… (Mauve, not first baby).

Amber felt that the program could help women to talk about difficult or personal issues and more easily seek support:

> *...if there are significant issues, if they don't have that continuity of care, um, often some women may not raise those issues and that's just really, I guess, made me more aware of just, why it is important that Aboriginal women, in particular, have that sort of care...* (Amber, not first baby).

Women also raised how trust impacted their birth experiences. There was a sense of assurance that their midwife would respect them, helping them to feel calmer and more confident to birth:

> *...I think the biggest thing was trusting their decision... I got to know my midwife, really well. I had complete faith in her... and that she would respect the way that I wanted to, you know, approach my birth, and that she would listen to me... I think that's so different, having her in the room, who I had become friends with, versus like, some random midwife, random doctor, telling me like, 'okay, you need to get up now'. I don't know that I would have liked that, if it was a complete stranger, just kind of telling me what to do. Whereas with my midwife, it felt very, um, like a two-way communication and it had all the trust from previous weeks behind it* (Jade, first baby).

> *...like the whole birth was just so calm. It was so relaxed. Just because I trusted my midwife. We'd already had a chat about what I wanted, what I didn't want, if it was safe, what my birth plan was. If it wasn't safe, what we do, I found I didn't worry about what she was doing... I wasn't worried because I knew that she would respect what we'd spoken about* (Violet, not first baby).

Most women said that if their primary midwife was not available for the labour or birth, they felt comfortable with their 'back-up' midwife because they had met them before, or because they knew that their midwifery philosophy would be the same:

> *Even though [my midwife] wasn't there, um, I just felt really comfortable knowing that ah, [my back-up midwife], the midwife who delivered [my baby], I had met her and that, you know... she just had the same sort of approach that [my midwife] had...* (Amber, not first baby).

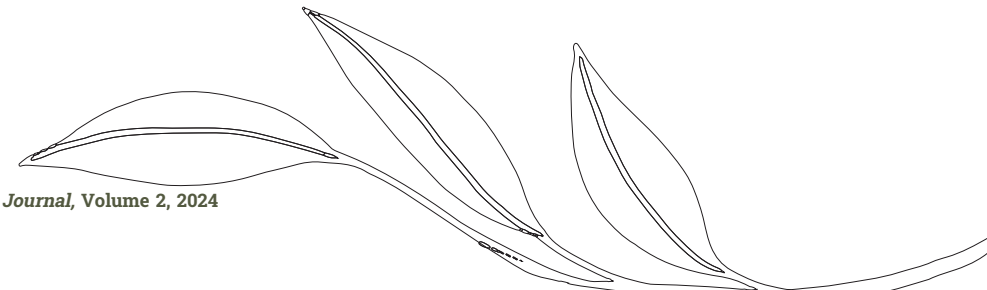
Overall, most women agreed that having a known, trusted midwife, who respected their individual needs had a very positive effect on their birth experience. Ruby explained that she had previously experienced trauma, but described her birth as 'healing':

> *Unfortunately both of my kids were conceived out of sexual assault... I didn't want any males in the room whatsoever... I didn't have to remind them... that made me feel a lot better that they remembered that, because at that time I was just exhausted and I wouldn't have even been able to say anything... Reflecting back on the hospital experience... I had to remind myself that it was real... I questioned a lot of the time, like, 'is this too good to be true?'... I said to [my midwife] halfway through the pregnancy that this time 'I just want a healing experience'... I just wanted a healing experience... like yeah it just was that healing birth... the birth that I needed* (Ruby, not first baby).

But for Olive, who experienced a distressing caesarean birth, there was a question of whether the decreased familiarity with her back-up midwife, who did not know her as well as her primary midwife, meant that she was unable to be as strongly advocated for during her birth:

> *...she [the back-up midwife] was tryin' to say what's going on in the theatre wasn't right... she's like... obviously standing back all soaped up ready for the baby. So she couldn't do much... if it was my own midwife, they would have known... I have like a really high pain tolerance and stuff* (Olive, first baby).

Olive experienced postnatal complications and described her overall experience in the hospital after



the birth as disorganised and unsupportive. She explained that, without her caseload midwife, she would have 'gone crazy' as she had otherwise lost trust in the system:

> *[my midwife] was checkin' up on me and like, I could text them... if I didn't have that, I would have... like gone a bit crazy... like in the end, I didn't really trust [the other staff... my partner said, he's like, 'you were kind of like a caged animal in the end... everyone was coming in and out... but you didn't trust anyone'.*
> *I can't be bothered fighting the hospital... But I was like, in the end, I'm just not gonna go back there* (Olive, first baby).

Trust was seen as essential for care to feel safe. Some of the women recognised that for other women in community, trust may not always be automatically experienced. Rose, who did trust her midwives, still felt it was important to raise that a midwife-woman relationship without trust was potentially unsafe:

> *Vulnerable. It is vulnerability... if I didn't have people that I trusted, or, cared about and felt comfortable with, how are those things going to be managed? Like, how am I going to be protected and how am I gonna be kept safe, if my midwife is not somebody who is on my side?* (Rose, not first baby).

Coral reflected that while she had a positive experience, she could see how other women in community might need additional support, commenting on the challenges with the 'system'.

> *...for our women that are going into the hospital, there can be a lot going on... just because my, my experience like has been... has been good with the midwives... doesn't necessarily mean everyone... is feeling as supported... as safe, like, it's a lot harder if you've got a drug issue or got DHS involvement... they probably do need like a lot, a lot more support and to feel a lot more safe... it might not be enough and navigating all of that... with everything else that's going, you know? So how to expand on, expand on that safe space... make it better for everyone... I guess, the most vulnerable in our community... So, I think the importance of the health, the health of our women and their babies is, so you know, like so how do we make that system better?* (Coral, not first baby).

Culture

Indigenous culture and cultural identity was talked about by many of the women. Women talked about the 'little things' as being important, with examples such as being gifted Indigenous birth cards, or hand-knitted Aboriginal flag beanies as 'keepsakes'.

> *It's just all about incorporating our culture into the birth. 'Cos I know this may sound a bit silly, but, when you do look around, you know, the room... there isn't really a presence of our culture there...* (Amber, not first baby).

Women talked about how 'a space for mob' creates a sense of safety, privacy and familiarity with the hospital. Women also spoke of seeing artwork, flags and culturally appropriate pamphlets and other resources, and being able to sit in the Aboriginal Health Unit space, rather than the mainstream antenatal clinic:

> *...that little segue between 'not comfortable'... you know, big room, lots of people... no familiarity. Going into, you know, this little room where you see pictures of people that you know... books that you've read and... the Koori flag and it's all of those little things... you know you're safe... these people are on your side... this is a safe space and I don't have to be somebody else, or I don't have to pretend to be... something different...* (Rose, not first baby).

The general hospital environment was described by some as 'white', 'sterile' and 'uncomfortable'. Coral

considered that having artwork and a small Aboriginal health unit may not be enough for all women to feel safe, and suggested a larger space for Aboriginal women to receive care from Aboriginal staff might be preferable:

> *…the artwork around the hospital we put that in every space, don't we? Like, any politically correct institution has some artwork. It's part of their RAP plan, I don't know [laughter]… doesn't necessarily feel culturally safe. It's just whatever, it is what it is, it's a hospital… it might not be enough just having that little Koori room, with two Aboriginal workers… I think if we could just like, have our, like a whole, our own space, that'd be so awesome. You know, black social workers, black midwives! [laughter]…* (Coral, not first baby).

A feeling of belonging in the program was also identified as important. Some women mentioned 'yarning circles', aimed at connecting Aboriginal families going through the program. Others felt that the program fostered a 'sense of community':

> *I feel like they definitely try to keep that sense of community, as much as possible. So you do feel like you're kind of wrapped in a warm blanket* (Hazel, first baby).

The women described how the program needed to foster a sense of belonging in order to feel culturally safe. Amber gave an example of using pins on a map to represent the Country of her Ancestors:

> *…being part of the [caseload] program, I'd felt, definitely culturally safe… there were lots of things that made me feel like that, not just safe, but culturally comfortable… they have a beautiful, um, language map… they asked me to put a pin in where my mob's from… it was amazing to see where other mob, other babies were from… my mob's from the Northern Territory… seeing that there were so many other babies and mums from other language groups that weren't just Victoria… I didn't feel like… I shouldn't be here* (Amber, not first baby).

On the other hand, Indigo's midwife did not contact her as often as promised during her long-term stay on the antenatal ward, leaving her expressing feelings of isolation (as previously stated). Indigo described how alienation from the program triggered very difficult feelings relating to past experiences of racism and disconnection from community. Indigo's story highlights the risks to women's wellbeing if a sense of belonging in the program is lacking:

> *…it made it feel like it was because I don't 'fit' there anyway… like I don't fit in my culture, so… why would they care… it did make me think, well, maybe… I shouldn't put my name down on stuff… it seems stupid, but… it hit me in the identity, um, side of things as well… you hear a lot as you as you're growing up, like, 'oh, you're not even that Aboriginal, so what does this matter', like, oh, you know… like, you think you're part of the program… then to not feel like you're important in that way, it's just a little bit heartbreaking in a way, yeah* (Indigo, not first baby).

Women also spoke of the need for their cultural identity to be seen as unique to them and something that shouldn't be challenged. It was very positive for women if they felt that in their sense of identity was accepted. As Rose explained:

> *… in the safe space… you know people aren't gonna ask you stupid questions. You know people aren't gonna… all of the things that, happen sometimes… when you are in a space that isn't necessarily safe, for you culturally, like just being questioned… identity wise. It's the last thing you need, you going for a check-up, or something… every now and again you do have somebody who's like 'oh, where are you from?' or, you*

know, challenge that, if you tell them… but if you say you're black, you're black! (Rose, not first baby).

Violet liked that the AHLO contacted her directly and made no assumptions, raising the importance of non-judgemental dialogue around women's individual needs when it comes to culture:

…right from the start they kind of like scaled it right back, asked you know like, how cultural was I? What my expectations would be, what I needed from them, what I wanted them to do… I do identify but I don't have huge rich heritage ties… I found that really nice 'cos I find a lot of times if you tick that box you're just put into a category… that was really nice, that, it wasn't just an umbrella category… it's not a category, it is what is it for everyone (Violet, not first baby).

Women talked about the important role of the AHLOs along their journey, for advocacy and for someone to 'yarn with'. Some of the women talked about being 'treated normally' when other Aboriginal people were around, as Ruby explained:

…having someone who you feel you can relate to and speak about things… the Aboriginal Liaison Officers, they played a big part in all of this as well… I didn't even know having Indigenous people was a thing, because my last experience I didn't have that… I'm glad that I did, because they really did, like 'oh yeah, Indigenous people in pregnancy overall have high risk for things', they didn't make it seem like a bad thing, like, they didn't, um, make it sound like a drama. Whereas the last pregnancy, 'obviously you're Aboriginal, you're most likely going to get this, you're most likely gonna get this'… it felt like I was being treated normally, which was nice (Ruby, not first baby).

In the context of missing her mother, who had recently passed away, Rose expressed a deep sense of connection and 'feeling at home' while spending time at the hospital with the AHLOs and her midwives:

…it felt like… how it would have if she was here… yeah… havin' a laugh and all that. That's the sort of stuff I did with my mum when I was pregnant with [my older child]… that little bit of like, feeling like I'm at home, you know? (Rose, not first baby).

Overall, the women agreed that it was very positive if their midwives were culturally sensitive, but many women also explored the idea of being cared for by Aboriginal midwives. Some women felt 'shocked' or 'surprised' if they saw no Aboriginal midwives. Other women said that they didn't know if there were many Aboriginal midwives 'out there' and you would have to be 'lucky' to have one.

…knowing that the staff have cultural awareness about Indigenous women… our own kind of cultural expectations about how birth should be handled. Um, that stuff is really, really, obviously really important. And I felt… my midwives, were fairly good at that… I do think it's odd to have an Indigenous program that's all white women. Um… I remember kind of thinking that it would be Indigenous midwives when I heard about the program. And then, yeah being a little bit shocked that there weren't any… (Jade, first baby).

…to find out that the midwife I had was actually not Aboriginal was kind of disappointing for me. But she was lovely. She was she was… yeah… she was alright, but, yeah, I was hoping for an Elder or someone from our mob. I wasn't expecting just some other person who's not. 'Cos it's my culture, our culture is very important to me and my kids… (Mauve, not first baby).

In contrast, Amber was cared for during her labour and birth by her back-up midwife who is an Aboriginal woman. She described a 'spiritual connection':

I was really quite lucky actually because I believe she's the only Aboriginal midwife... so just having her there, I just felt like really safe. And I just felt like this connection to her, because, you know, she's Aboriginal as well... her and I were sharing stories. Our stories. And you know, we just had this connection... that familiarity of you know, family and mob. You know, we just really, really bonded... it does really make a difference, I think it does really make women just feel more kind of... special in some ways... you can have that spiritual connection... (Amber, not first baby).

Discussion

This study explored the views and experiences of Aboriginal women who received maternity care in a culturally tailored caseload midwifery model that had been implemented in three metropolitan hospitals in Naarm. This study addressed a gap in the literature in relation to Aboriginal women's experiences of continuity of midwife care and considerations for the design of such programs in urban settings (Marriott et al., 2019), providing important information for future programs and maternity service policy. This study included an Indigenist research paradigm and First Nations research capacity building, which are important for producing meaningful contributions to this body of evidence (Marriott et al., 2019; Simpson et al., 2020). The strong message from the women was to have a safe and positive experience, with 'relationships', 'trust' and 'culture' as the trifecta. The findings in this study support other evidence that culturally tailored continuity of care models improve First Nations women's maternity care experiences, with similar factors being key to a positive experience (i.e. relationship building, trust and a connection with culture) (Homer et al., 2012; Josif et al., 2014; Kelly et al., 2014).

Relationships between birthing women and caregivers are integral to Indigenous birth practices (Hartz & Sherwood, 2019). Pregnancy and birth practices traditionally have been provided by skilled, senior community women, who were often grandmothers. These practices (sometimes referred to as Grandmother's law) (Carter et al., 1987; Ramsamy, 2021) have supported thriving communities for millennia (Adams et al., 2018; Chamberlain & Marriott, 2019; Nelson et al., 2021). Documented evidence of First Nations women's resistance to the dominance of non-relationship based, biomedical care, as a stark contrast to Aboriginal culture, can be traced back almost four decades (Carter et al., 1987; Daylight & Johnstone, 1986). More recent evidence of First Nations women dealing with feeling judged, poor communication, racism and impersonal care in the mainstream maternity system (Josif et al., 2014; Marriott et al., 2019b; Marriott et al., 2019) signals that the next generation of women continue to face similar challenges. Culturally appropriate relationship-based care, lobbied for by First Nations women over several decades, is unavailable for the vast majority. However, for First Nations women who have received continuity of midwife care, relationships have appeared to be the driver of a safer, more positive experience, with improvements in continuity of care also benefitting non-Indigenous midwives by strengthening communication abilities and elevating cultural competence (Marriott et al., 2019). However, one participant (Rose) did allude to the potential risks of midwife-woman relationships that are not positive and suggested that First Nations women should be in control and able to exit a relationship that feels unsafe.

Trust was a key component of the positive relationships between the women and their midwives, demonstrating that positive relationships must be based on trust. Trust and relationships were linked

together in a previous study conducted in Sydney, where First Nations women described feeling trusting of their midwives, more trusting of the hospital system and of their own abilities to birth (Homer et al., 2012). In this study, the program was viewed by the women as a positive and important service for the Aboriginal community, and some suggested expanding the scope of the program to ensure that the needs of the most vulnerable women are met. Given that the mainstream maternity system is implicated in the Stolen Generations and the intergenerational trauma that followed, trust is not unconditional and is something earned over time. Considering the evidence of culturally unsafe maternity care practices (Marriott et al., 2019), racism (Brown et al., 2019) and high rates of First Nations infant removals (Chamberlain et al. (2022), women's endorsement of the program and the need for the continuation and scale up of this program is a significant finding.

The importance of Indigenous culture was also raised by the women. As First Nations women birthing in Naarm are not a culturally homogenous group (McCalman et al., 2022), it is unsurprising that the women in this study had varying degrees of connection to culture and community, with differing views and experiences of culture. Yet, the significance of cultural care, or at least having the option to incorporate culture into care, was also raised by women in this study. Receiving support from Aboriginal staff was highlighted by women as a key factor in care that felt culturally appropriate. One participant (Amber) recalled an added sense of familiarity, connection and safety in her relationship with her First Nations midwife. A review by Marriott et al. (2019) included some evidence demonstrating the importance of First Nations midwives for First Nations women, citing a study that highlighted the beneficial relationship and shared understanding of lived experiences between First Nations midwifery students and women (Kelly et al., 2014). In addition to a workforce that is culturally competent, strategic directions for Australian maternity services also include growing the First Nations maternity workforce by implementing recommendations as per the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017, as cited in COAG Health Council, 2019). At the time of this study being published, 12 midwives are now providing culturally tailored caseload care across the three sites, and the number of First Nations midwives working in the model has grown to four.

Women also described the importance of physically appropriate spaces to facilitate engagement in cultural activities with Aboriginal staff. It appeared that a safe care experience required women's unique cultural identities to be affirmed, rather than challenged. Additionally, a sense of belonging within the program was deeply valued. Many First Nations women in Naarm are not physically birthing on their ancestral Country (McCalman et al., 2022); however, connection to Country is still significant for First Nations women who either live on, or relocate to, Country which has been urbanised for birth (Marriott et al., 2019b). Demonstrating this was an example given by one participant (Amber), who felt a strong sense of cultural safety when placing her pin on a map representing the cultural and ancestral ties of the women and babies in the program. Enabling connection to Country is a key component of 'Birthing on Country' services (Kildea et al., 2016), which have been described as holistic community-driven maternity services for First Nations women (Kildea et al., 2021) and are recommended in national maternity service policy (COAG Health Council, 2019).

Conclusion

Maternity services that are committed to meeting the needs of First Nations communities must ensure that the voices of First Nations women are central to program planning, design, implementation and evaluation (AHRC, 2020). The Baggarrook Yurrongi project led to three tertiary hospitals successfully implementing and sustaining culturally tailored caseload midwife models for First Nations women in Naarm, Victoria. Overall, women were very positive about their experience of care and have previously reported high ratings of satisfaction with care. 'Relationships', 'trust' and 'culture' were key factors that explained the high ratings of care. The culturally tailored model was endorsed by the First Nations women in this study. Given the findings of this study, along with other evidence of benefit, it is important that culturally tailored continuity of care is scaled up and made available to more First Nations women.

Author contributions

PMc conceptualised and designed the study, provided acquisition of data, analysis and interpretation of data; drafted the article or critically revised for important intellectual content; gave final approval of the version to be submitted.

HMc conceptualised and designed the study; drafted the article or critically revised it for important intellectual content; gave final approval of the version to be submitted.

MN conceptualised and designed the study; drafted the article or critically revised it for important intellectual content; gave final approval of the version to be submitted.

FM-H conceptualised and designed the study; drafted the article or critically revised it for important intellectual content; gave final approval of the version to be submitted.

DF conceptualised and designed the study; drafted the article or critically revised it for important intellectual content; gave final approval of the version to be submitted.

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