Digging Down to the Deep Story: Understanding the Views and Experiences of Aboriginal and Torres Strait Islander Women who Gave Birth during the Baggarrook Yurrongi Project in Naarm, Victoria.

Submitted by

Pamela (Res) May McCalman

Bachelor of Midwifery

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Judith Lumley Centre

School of Nursing and Midwifery

La Trobe University

Victoria, Australia

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Statement of authorship

Except for where reference is made in the text, no material in this thesis has been published elsewhere, or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. There is no work from any other person that has been used without due acknowledgment in the main text of this thesis. This thesis has not been submitted for the award of any other degree of diploma in any other tertiary institution.

The work in this thesis was undertaken by myself under the guidance of my supervisors:

- Professor Helen McLachlan, Professor of Midwifery, Judtih Lumley Centre and the School or Nursing and Midwifery;

- Professor Della Forster, Professor of Midwifery, Judith Lumley Centre, La Trobe University, and the Royal Women's Hospital;

- Associate Professor Michelle Newton, Judith Lumley Centre and the School of Nursing and Midwifery, La Trobe University.

The thesis contains published work and includes five peer reviewed articles. I am the primary author of four of the papers and fourth author of one. Co-authors, including my three supervisors, have all contributed to the overall study design, intellectual input, drafting and editing of all manuscripts. In relation to the co-authored paper, I made a substantial contribution in my role as a project officer on the Baggarrook Yurrongi project including contribution at regular project governance meetings, management of the project ethics, manuscript drafting and editing, and dissemination of findings. All research procedures reported in this thesis were approved by the relevant Ethics Committees. Details of the published papers in this thesis are as follows:

McCalman, P., McLardie-Hore, F., Newton, M., McLachlan, H. and Forster, D. (2022). Trust, privacy, community, and culture: Important elements of maternity care for Aboriginal and Torres Strait Islander women giving birth in Victoria. *Women and Birth **36***: e150-e160. doi:10.1016/j.wombi.2022.06.001

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Pamela (Res) McCalman 15/07/2024

Abstract

Aboriginal and Torres Strait Islander women have been birthing their babies on the continent of Australia for over 60,000 years, however, colonisation has led to the perinatal inequities experienced by Aboriginal and Torres Strait Islander women and newborns today. Government policies recommend that mainstream maternity systems partner with communities to co-design evidence-based programs. One such strategy is continuity of midwife care, which is supported by evidence as beneficial for women and their newborns. La Trobe University partnered with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) on a National Health and Medical Research Council (NHMRC) funded partnership project to implement culturally tailored continuity of midwife care models in four Victorian partner maternity services (three urban and one regional). This project was named 'Baggarrook Yurrongi; Nurragh Manma Buliana, Woman's Journey.'

This thesis addresses a key outcome of the Baggarrook Yurrongi project, which was to explore the views and experiences of women having an Aboriginal or Torres Strait Islander baby. The methodology of this thesis blends indigenous and Western methods and a mixed-methods design is used. Questionnaires were conducted with a large cohort of women and qualitative interviews were conducted with a smaller sample.

Overall, women having an Aboriginal and/or Torres Strait Islander baby reported high levels of satisfaction with their care. Women reported feeling safe, connected and supported, with 'relationships', 'trust' and 'culture' being key components of culturally appropriate care. Women also reported, however, that the wider maternity system remains complex, fragmented, and unsupportive.

The upscaling and expansion of culturally tailored continuity of midwife care for women having an Aboriginal or Torres Strait Islander baby is recommended. Models should be co-designed with local communities, resourced to provide comprehensive wrap around support, and include an Aboriginal and/or Torres Strait Islander workforce. Greater accountability is required to address the prevalence of behaviour from health professionals that contradict medical and midwifery practice standards or ethical codes of conduct. Finally, the principles of 'Birthing on Country' should be considered in the design of future birthing programs for Aboriginal and Torres Strait Islander women in Victoria.

Abbreviations

AAC – Aboriginal Advisory Committee

ACCHOs – Aboriginal Community Controlled Health Organisations

ACM – Australian College of Midwives

AHS – Aboriginal Health Services

AIHW – AIHW

AHPRA – Australian Health Practitioners Regulation Agency **BoC** – Birthing on Country

CAAC – Central Australian Aboriginal Congress

CATSINAM – Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

CCOPMM – Consultative Council on Obstetric and Paediatric Mortality and Morbidity

COAG – Council of Australian Governments

HCCC – Health Care Complaints Commission

HREOC – Human Rights and Equal Opportunity Commission

KMS – Koori Maternity Services

LGBTIQ – Lesbian Gay Bisexual Transgender Intersex Queer

NAHSWP – National Aboriginal Health Strategy Working Party

NHMRC – The National Health and Medical Research Council

NPDC – National Perinatal Data Collection

PEO – Population, Exposure, Outcome

PMNCH – Partnership for Maternal, Newborn and Child Health

SEIFA – Socio-Economic indexes for Areas

SNAICC – Secretariat of National Aboriginal and Islander Child Care

U.K – The United Kingdom

VAHS – Victorian Aboriginal Health Service

VACCHO – The Victorian Aboriginal Community Controlled Health Organisation

Terminology

- In this thesis I have chosen to mostly use the terms ‘Aboriginal and/or Torres Strait Islander’ to refer to the descendants of the First Peoples of this continent, which is now known as Australia.
- The term ‘Aboriginal’ is used to refer only to the descendants of the First Peoples of the mainland of Australia (including Tasmania) but excluding the Torres Strait Islands.
- At times, ‘First Nations’ will also be used to refer to the descendants of the First Peoples of either the Australian continent, or whichever place is relevant (i.e. First Nations Canadian).
- If referring to a specific person or place, when possible, I have used the name of the traditional Country/clan/custodian/language group.
- I use the term ‘Indigenous’ when referring to the First Peoples of various continents internationally.
- Indigenous with a capital 'I’ is used when referring to humans or as per the author of a particular methodology (i.e. Indigenist research). For all other subject matter that is either conceptual or non-human, lower case ‘i’ is used.
- I recognise and celebrate that that gender diverse people have always existed birthed in Aboriginal and Torres Strait Islander communities. In this thesis, I use the terms woman/women, and I wish not to undermine the unique, intersecting experiences of Aboriginal and Torres Strait Islander sister girls, brother boys, gender diverse and LGBTQIA people.

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Dissemination of thesis findings

TABLE 1 - DISSEMINATION OF THESIS FINDINGS

Presentation	Year	Event	Title
Oral presentation	2017	CATSINaM annual conference, Gold Coast	Partnerships and collaboration: Implementing continuity of midwifery care for Aboriginal women in four Victorian maternity services.
Oral presentation	2017	ACM National Conference, Adelaide	Partnerships and collaboration: Implementing continuity of midwifery care for Aboriginal women in four Victorian maternity services.
Oral presentation	2018	KMS Women's Business forum, Melbourne	Partnerships and collaboration: Implementing continuity of midwifery care for Aboriginal women in four Victorian maternity services.
Oral presentation	2018	ACM maternal wellbeing conference, Melbourne	Partnerships and collaboration: Implementing continuity of midwifery care for Aboriginal women in four Victorian maternity services.
Oral presentation	2018	CATSINaM national conference, Adelaide	"What do our mob think?" Baggarrook Yurrongi, Nurragh Manma Buliana. Improving care for mothers and babies through continuity of midwife care. Oral presentation.
Oral presentation	2018	ACM National Conference, Perth	"What do our mob think?." Baggarrook Yurrongi, Nurragh Manma Buliana. Improving care for mothers and babies through continuity of midwife care.
Television appearance	2018	SBS – The Point	"The women leading the way toward Birthing on Country."
Oral presentation	2019	Koori Maternity Service education forum education day, Melbourne	"What do our mob think?" Baggarrook Yurrongi, Nurragh Manma Buliana. Improving care for mothers and babies through continuity of midwife care.

Presentation	Year	Event	Title
Oral presentation	2021	International Congress of Midwives Triennial Congress (Online)	"What do our mob think?" Exploring the maternity care experiences of Australian Aboriginal and Torres Strait Islander women who were offered continuity of midwife care.
Keynote presentation	2022	ACM national conference, Cairns	Translating evidence into practice: Implementing culturally safe continuity of midwifery care for First Nations women in three maternity services in Victoria, Australia.
Poster presentation	2023	International Congress of Midwives Triennial Congress, Bali	Satisfaction with care of women having an Australian First Nations baby in hospitals offering culturally tailored continuity of midwife care. Findings from the Baggarrook Yurrongi Project.
Radio interview	2023	ABC – Triple J Radio	
Online webinar	2024	Molly Wardaguga Research Centre webinar series	"Baggarrook Yurrongi" Implementing culturally safe continuity of midwifery care for First Nations women in three maternity services in Victoria, Australia.
Oral presentation	2024	ACM National Conference, Melbourne	"Safe connected and supported in a complex system". Exploring the views and experiences of Aboriginal and Torres Strait Islander women at one of three maternity services where culturally tailored continuity of midwife care models were implemented in Victoria.
Podcast	2024	Birth Choices	Care provider choices for First Nations women and babies – an interview with Res McCalman

Preface

I am a Ballardong Noongar woman with Scottish, Irish, and Cornish heritage. My mother is Aboriginal, and my father is white. My white grandmother was heavily involved in my early child-rearing – my Aboriginal grandfather 'Pa' also featured strongly as a constant father figure. My father was orphaned in his teenage years, so Nanna and Pa were the only grandparents I knew.

I was not born on Noongar Boodjar, and neither was my mother. Pa was, but he was a young boy when his family moved to the suburb of Collingwood, in Naarm, on Wurundjeri Country. This was in the 1940s, at a time when A.O Neville, Western Australia's 'chief protector' of 'Aborigines' was stealing a lot of mixed-race kids from their parents. My great-grandfather, Harold Willis Shehan, served in the Royal Australian Air Force during the second world war and so had the means to move away through his employment. We do not know how much, if at all, the decision to move his young family was motivated by the social and political context at the time. If he was haunted by the history of his own grandmother being stolen at four years of age, he never said so.

Her name was Yindolan. After being snatched from her mother Norlap's grip, her name was changed to Annie. 'Annie' was raised by white people and trained as a domestic servant, not far from the town of York, on Ballardong Country. Later, her status in the early Swan River colony evolved to that of the town midwife. The name *'Annie Shehan'* is listed as the accoucheur on many birth certificates from around the general area of York, Western Australia. After the death of Thomas Shehan (Annie's husband of more than 30 years), the name *'Annie Shehan'*, however, was not considered worthy of a mention on her husband's gravestone. Annie was relied upon as a birth keeper for both black and white women in the colony, but for much of her life she was rendered nameless and voiceless. Reflecting on this brings me great sadness, and it speaks to the status of black women in the colony.

I too, am a midwife. So is my mother, Liz Bruhn (nee Shehan). I completed my Bachelor of Midwifery degree in 2014 and then commenced working as a midwife in 2015. At university, I learned about 'woman-centred care' as the philosophy underpinning midwifery practice in Australia. I learned that that continuity of midwife care models

were seen as evidence-based, ‘gold-standard’ models of care. I also studied how ‘cultural safety’ contributes to enhanced wellbeing for Mob[1]. Back then, the day-to-day reality of working as a new midwife did not reflect these learnings. The constraints of working in the system meant a constant struggle to provide care that I considered to be ‘woman-centred’. The continuity of midwife-led care program at my workplace had long waitlists. Only a small group of ‘lucky’ women were able to ‘get in’. The Aboriginal Health Unit was an important place of advocacy and safety, however, there were no culturally tailored maternity programs for Aboriginal and Torres Strait Islander women offered at my place of work.

When I was sent an advertisement for a twelve-month research assistant position working on a project to implement a culturally tailored maternity program for Aboriginal and Torres Strait Islander women in Naarm, I jumped at the opportunity. The National Health and Medical Research Council (NHMRC) funded partnership project between La Trobe University and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) aimed to implement continuity of midwife care for Aboriginal women at the hospital I worked at (and three other hospitals in Victoria). I did not know that it would turn into a seven-year journey through a PhD.

In my research, I have always tried to keep one thing at the core of what I do. That is to elevate the voices of my mob, the deadly women who are birthing and growing the next generation of Aboriginal and Torres Strait Islander kids. I tell a story of their resilience, strength, and tenacity. They are generous, knowledgeable, and staunch. When they are cared for by the maternity system in a good way, they thrive. But they are also discerning. So I also tell a story of ongoing struggle against a system that was not designed by us, or for us. The women have spoken of how things have improved, but also how they could continue to improve.

My hope is that *their voices* are heard.

[1] 'Mob' is a colloquial term used when referring to a group of Aboriginal people either in a general sense or associated with a particular place or Country.

Chapter 1: Introduction

Aboriginal and Torres Strait Islander people are the continuation of the world's oldest living culture (Broome, 2002). Birthing knowledge and practices enacted by skilled, senior, community women sustained Aboriginal and Torres Strait Islander communities for millennia (Adams, Faulkhead et al., 2018; Chamberlain and Marriott, 2019). Colonisation of Australia introduced and imposed a foreign Western maternity system, in which Aboriginal and Torres Strait Islander women in contemporary times have since needed to adapt to (Carter, Hussen et al., 1987). Many Aboriginal and Torres Strait Islander women and newborns enjoy healthy, uncomplicated pregnancies and births. However, perinatal outcome data reports demonstrate that non-Indigenous women experience advantageous perinatal health outcomes when compared to the First Peoples of Australia (AIHW, 2023). As a redress to these inequities, numerous state and government policies recommend implementing evidence-based birthing programs, in partnership with Aboriginal and Torres Strait Islander communities (COAG Health Council, 2019; Department of Health, 2012; Queensland Health, 2019).

In 2015, La Trobe University and VACCHO were successful in receiving an NHMRC partnership grant, together with four mainstream Victorian maternity services. The primary aim was to implement and evaluate a culturally tailored continuity of midwife care model (also referred to as caseload midwifery) for Aboriginal and Torres Strait Islander women birthing at the four services. Three of the services were located on Wurundjeri Country in Naarm (Melbourne) and one regional service was located on Yorta Yorta Country in Kanny-goopna (Shepparton). Continuity of midwife care, also known as 'caseload midwifery' is a maternity care model that is supported by evidence as beneficial for women and newborns (Sandall J, Fernandez Turienzo C et al., 2024). In a caseload midwifery model, the woman has 24/7 access to a known, primary midwife (or one or two back-up midwives). The primary midwife acts as the woman's first point of contact and takes responsibility for the organisation of her care in collaboration with a multidisciplinary team as required. The midwife provides continuity of care over the course of the woman's pregnancy, with on-call support for labour and birth, and in the early postnatal period (AIHW, 2016). An Elder of the Wurundjeri people named the project 'Baggarrook Yurrongi', meaning 'Woman's Journey' in Woi-wurrung language.

An Elder of the Yorta Yorta people named the project 'Nurragh Manma Buliana', meaning 'all of us working together for pregnancy' in Yorta Yorta language.

This thesis is embedded within the larger overarching Baggarrook Yurrongi project.[2] The scope of this thesis is to address one of the key aims of the Baggarrook Yurrongi project, which was to explore the views and experiences of Aboriginal and Torres Strait Islander women, or women having an Aboriginal and Torres Strait Islander baby, who received maternity care at one of the project partner sites. Other secondary aims of the overarching project that are outside the scope of this thesis included reporting on clinical outcome data and exploring the views of key stakeholders.

The thesis addresses an important aim of the Baggarrook Yurrongi project, which was to explore the views and experiences of Aboriginal and Torres Strait Islander women, including women giving birth to Aboriginal and Torres Strait Islander babies. The overall aim of the thesis is to elevate the voices of Aboriginal and Torres Strait Islander women in order to directly inform and improve their maternity care, ultimately to redress the disproportionate burden of perinatal outcome inequities that Aboriginal and Torres Strait Islander women and babies face. The research questions are:

- What are the views and experiences of Aboriginal or Torres Strait Islander women having a baby (or women having an Aboriginal or Torres Strait Islander baby) at one of three maternity services in Naarm, Victoria?
- What are the experiences of Aboriginal women in Naarm, Victoria, who received continuity of midwife care through a culturally tailored continuity of midwife care model?

The objectives are to investigate women's experiences of their maternity care, and to assess the accessibility and acceptability of recently implemented culturally tailored caseload midwifery models at each of the three maternity services located in Naarm, Victoria. As such, women having an Aboriginal or Torres Strait Islander baby were invited to participate in an evaluation of care during the Baggarrook Yurrongi study period. Using a mixed-methods study design, with a blend of Western and indigenous methods, questionnaires were conducted with a large cohort of women. Qualitative interviews guided by indigenous methodologies were also conducted.

[2] Throughout this thesis, reference to the 'Baggarrook Yurrongi, Nurragh Manma Buliana, Woman's Journey Project' will be shortened to the Baggarrook Yurrongi project.

The significance of this thesis is that is represents a broad and deep exploration of the views and experiences of First Nations women in Victora, at a time where a major shift was occurring in how maternity care was being provided in the mainstream maternity system. Aboriginal and Torres Strait Islander women *must* have a say in how maternity programs servicing them are designed, implemented, and evaluated (AHRC, 2020), yet more than twenty years have passed since evidence on the views and experiences of Aboriginal and Torres Strait Islander women in Victoria have been comprehensively reported (Campbell, 2000). Currently, both state and national perinatal outcome data reports demonstrate that poor perinatal outcomes (e.g. pre-term birth, low birthweight, perinatal death) are more commonly experienced by First Nations women (AIHW, 2023). These outcomes are perpetuated by inequitable and culturally unsafe care provision (Hickey, Kildea et al., 2019). The perinatal period is a 'critical time' for women and their babies (Chamberlain, Gee et al., 2019), and it is a 'window of opportunity' for health services to positively engage with Aboriginal and Torres Strait Islander families (Brown, Weetra et al., 2015; Finlay and Kidd, 2021). National, and international evidence supports that where culturally safe maternity care is available, Indigenous women and their babies can thrive, and have better perinatal and psychosocial outcomes that have a positive flow-on effect to the wider community (Kildea, Gao et al., 2021; Van Wagner, Epoo et al., 2007). Additionally, a healthy start to life provides the foundations for a positive health trajectory into early childhood and beyond (Kildea, Gao et al., 2021; March of Dimes, PMNCH et al., 2012).

1.1 Summary

This chapter has provided an overall introduction to the thesis, including research aims. In Chapter two, a comprehensive overview of the historical, social, and political factors that impact on Indigenous women, their births, and their babies is provided. Chapter three reviews the literature in relation to Indigenous women's views and experiences of maternity care. Chapter four details the methodology that underpins this thesis. Chapter five describes the research methods and introduces a cultural metaphor 'digging down to the groundwater (deep knowledge)' to bring the methods and the methodology together. Chapters six to ten present five original research articles that address the thesis aims. In keeping with the cultural metaphor of digging down to the ground water, Chapters seven to ten progressively walk the reader through the results of this thesis, 'digging down' towards the deeper story. The final chapter restates the thesis aims and includes a

discussion of the findings. Recommendations for future directions are made including implications for policy and practise, before a final conclusion about the outcome of this thesis is made.

Chapter 2: Social, historical and political influences on Australian First Nations maternal and newborn outcomes

This chapter describes many of the social, historical, and political factors which impact the health of Aboriginal and Torres Strait Islander people, as well as colonisation and racism as determinants of health. The chapter includes a description of current perinatal outcome data including a discussion of the concept of 'deficit data' and how this can impact on Aboriginal and Torres Strait Islander people. The chapter also includes a review of relevant national health policies and including strategic directions for Australian maternity services.

2.1 Aboriginal and Torres Strait Islander health today

Aboriginal and Torres Strait Islander people are proud to be the people of the continuation of the oldest living and surviving culture on the planet. Archaeological evidence of 120,000 years of inhabitation exists, going back further than any other civilisation on the planet (Broome, 2002). Aboriginal and Torres Strait Islander concepts of health are complex and holistic, having been developed over millennia, encompassing a person's physical, emotional, social, spiritual and cultural wellbeing (AIHW, 2023). Important influences for health include cultural identity, family, access to cultural activities and access to Country[3] (AIHW, 2023).

Different definitions of health from an indigenous perspective are available, but all of them include the holistic underpinnings of health for Aboriginal and Torres Strait Islander people. A common definition first written in the 1989 National Aboriginal Health Working Party (NAHWSP) (NAHSWP, 1989) is still used in the 2021 National Aboriginal and Torres Strait Islander Health Plan (Department of Health, 2021):

> *'Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional, and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.'*

[3] 'Country' is a term used by Aboriginal and Torres Strait Islander peoples when referring to the lands, waters and skies to which they are connected through ancestral ties and family origins.

Many Aboriginal and Torres Strait Islander people enjoy good health. Australia's First Peoples are resilient and strong. However, Aboriginal and Torres Strait Islander people have had to survive and adapt to the colonised society that has been imposed, impacting negatively on health and wellbeing. The arrival of the British in 1788 triggered catastrophic events that resulted in health consequences that continue to impact Aboriginal and Torres Strait Islander people today (Sherwood, 2021).

Overall, non-Indigenous people can expect to live eight to 10 years longer than Aboriginal and Torres Strait Islander people (Commonwealth of Australia, 2023). Health outcome data reports illustrate advantageous health outcomes for non-Indigenous people in social and emotional health and numerous chronic diseases (Commonwealth of Australia, 2023). For Aboriginal and Torres Strait Islander people, the burden of disease, i.e. the impact of disease and injury on the population, is more than double (2.3 times) that of non-Indigenous Australians (AIHW, 2018).

2.1.1 Colonisation

Substantial research confirms the relationship between enduring colonialism and the current health status of Aboriginal and Torres Strait Islander people (Burgess, Johnston et al., 2005; Czyzewski, 2011; Paradies, 2016; Sherwood, 2013). Czyzewski (2011) defines colonialism as "the control or governing influence of a nation over a dependent country, territory, or people; and the system or policy by which a nation maintains or advocates such control or influence" (p.1). The 'health gap' is a direct result of European invasion and colonisation of the continent now known as Australia (Sherwood, 2021). This is not only true for First Nations Australians, but also for other Indigenous groups who live in colonised countries (Czyzewski, 2011; Pulver, Haswell et al., 2010).

Prior to 1788, Aboriginal and Torres Strait Islander people lived sustainable lifestyles by caring for Country, following Lore[4] and law, and maintaining balance between humans and the non-human (Sherwood, 2021). Over 500 language groups lived with established law and family kinship groups (Sherwood, 2021). People lived a life that was semi-nomadic, but agricultural practices also provided a seasonal, variable diet (Gammage, 2012; Pascoe, 2014). Coastal people sourced fish, dugong, turtle and various crustaceans,

[4] 'Lore' refers to traditional knowledges and stories held by particular groups about places and subjects

while in-land people ate kangaroo, emu, reptiles and native bush foods (Lovett and Brinkley, 2021). The generic terms ‘Aboriginal’ or ‘Indigenous’ were used by Europeans and replaced the individual names of language groups that people had for themselves and their Nations (Smith, 2012).

Eighteen years after James Cook claimed the east coast of the Australian continent as British land, the first fleet of convicts and British settlers arrived in New South Wales in 1788, under the command of Captain Arthur Phillip. ‘Terra nullius’ (land belonging to no one) was proclaimed, but Aboriginal and Torres Strait Islander people maintain that sovereignty was never ceded. British invasion triggered years of frontier warfare and violence (Hartz and Sherwood, 2019; Sherwood, 2021). The events of the following decades led to a massive reduction in the Aboriginal population. It is estimated that by the year 1901 the Aboriginal population in the state of Victoria was reduced by 94% (from 15,000 to just 850 people) (Saggers and Gray, 1991).

Early colonial accounts of the health of Aboriginal people are mixed. Lovett and Brinkley (2021) suggest early descriptions such as Aboriginal people being ‘miserable’ could have been attributed to infections such as yaws (skin disease) and trachoma (eye disease), both known to exist pre-colonisation. Other written reports and photographic evidence show Aboriginal people appearing to be strong and healthy (Lovett and Brinkley, 2021; Sherwood, 2021). Foreign introduced diseases which Aboriginal people had never been exposed to, such as pertussis, malaria, diphtheria, and measles caused mass mortality (Lovett and Brinkley, 2021). Sexually transmitted diseases were often passed from white men to Aboriginal women through sexual violence (Lovett and Brinkley, 2021). It is estimated that syphilis and gonorrhoea accounted for half to two-thirds of mortality around the Port Phillip Bay area (Saggers and Gray, 1991). In the 1800s, the expansion of pastoral land meant that if Aboriginal people were not killed, they were moved away from their traditional Country onto fringe camps and reserves. This dispossession of land compounded ill health because semi-nomadic lifestyles ceased, and Aboriginal people were denied access to the usual nutritious diet of native bush foods (Lovett and Brinkley, 2021).

Claims of objection to the treatment of Aboriginal people by colonial governments triggered the emergence of the ‘protection era’ in the early 1800s (Lovett and Brinkley, 2021). When reports of massacres and other atrocities reached Britain, the British

government appointed a Select Committee to inquire into the condition of Aboriginal people (HREOC, 1997). In response, chief 'protectors' were appointed and 'protection' policies were implemented, controlling the lives of Aboriginal people (Lovett and Brinkley, 2021; Sherwood, 2013). Significant breaches of international law followed, most notably the forced removal of Aboriginal children, now known as the 'Stolen Generations' (HREOC, 1997).

2.1.2 The Stolen Generations

Aboriginal children have been systematically removed from their families from the mid-1880s up until the 1970s (Sherwood, 2021). The '*Bringing Them Home'* report estimates that during the twentieth century, 40,000 Aboriginal children were removed from their families (HREOC, 1997). Governments and missionaries targeted Aboriginal children, with the intention of severing familial ties, instilling European values, and training young people to work under colonial employers (Boladeras, 1994). In 1860, Victoria established the first board in Australia to 'watch over the interests of Aborigines'. The board oversaw the formation of new missions (such as Coranderrk and Framlingham) to which Aboriginal people would be confined (HREOC, 1997). The Aborigines Protection Act 1869 authorised the implementation of 'regulations' relating to 'the removal of any Aboriginal child neglected by its parents or left unprotected'. 'Neglected children' were then sought out and brought to reside on the missions. Regulations received less Parliamentary scrutiny than new written legislation, so the consequences of these regulations went largely unnoticed (HREOC, 1997). Instances of child removal did not require justification through the courts. In New South Wales, for example, vague reasons could be given for child removal, including 'being Aboriginal', 'being 14 years', 'at risk of immorality' or 'orphan' (HREOC, 1997).

During the 'protection era', Aboriginal people were seen as a 'dying race', destined to disappear (Sherwood, 2021). When it became clear that the Aboriginal population was not going to 'die out', assimilation policies were then introduced (Lovett and Brinkley, 2021). From the 1930s, forced removal of children continued with a stronger focus on 'breeding out' the black race (Boladeras, 1994). A.O Neville, Western Australia's chief protector of Aborigines, was a strong supporter of 'eugenics', which is defined as a 'scientifically erroneous and immoral theory of racial improvement and planned

breeding' (National Human Genome Research Institute, n.d). In 1938, A.O Neville is recorded to have said:

> *"Are we going to have a population of 100,000 blacks in the Commonwealth, or are we going to merge them into our white community and eventually forget that there ever were any Aborigines in Australia?"* (Bennett, 2013, as cited in (Sherwood, 2021).

Health care institutions, and the nurses and midwives working within them, were instrumental in newborn removals. The Royal Women's Hospital in Naarm, one of Australia's oldest and largest specialist hospitals for women, has publicly apologised for its role in the Stolen Generations (The Women's, 2022). Aboriginal children were confined to 'homes' that have been described as uncaring institutions (Kidd, 1997) and in very recent years, biographies of Victorian Elders who grew up in the 1960s contain personal stories of the abuse and neglect experienced in a system that proclaimed to be 'good' for them (Charles, 2020; Roach, 2020).

Although herein the period of the Stolen Generations is discussed as an historical event, it is important to note that Aboriginal and Torres Strait Islander children are still today overrepresented in 'out of home care' (not living with immediate or extended biological family) (AIHW, 2024). Aboriginal parents are 11 times more likely to have their children taken out of their care, and one in five of these children are less than one year old (AIHW, 2024). Newborns are sometimes removed shortly after birth when notifications to Child Protection Services are initiated during pregnancy (Chamberlain, Gray et al., 2022). Rates of Aboriginal children being removed are increasing (SNAICC, 2023), leading to concerns within the Aboriginal community that the Stolen Generations continue (Sherwood, 2021). Reducing the rates of Aboriginal children in out of home care is a key 'Closing the Gap' target, but current strategies are not working (SNAICC, 2023). Researchers in the field agree that the over-representation of Aboriginal children in out of home care stems from compounded intergenerational trauma and institutional harm, and suggest that culturally safe, trauma-informed maternity care is required to help keep Aboriginal families together (Chamberlain, Gray et al., 2022; Chamberlain, Gray et al., 2022).

2.1.3 The social determinants of health

Much research has also been done to support the understanding that health status is largely socially determined (Wilkinson and Marmot, 2003). Shaped by social and political forces, the social determinants are the 'causes of the causes' (Commission on Social Determinants of Health, 2008). Education, employment, income, housing, racism, and incarceration are all examples of social determinants that impact health (Wilkinson and Marmot, 2003). Communicable and non-communicable diseases are less prevalent among social groups with higher socio-economic status and greater access to economic resources (Wilkinson and Marmot, 2003). The *My Life, My Lead* report (Commonwealth of Australia Department of Health, 2017) attributes over one third (34.4%) of the 'health gap' for Aboriginal and Torres Strait Islander people to the impact of social determinants, but that individual behavioural risk factors, (such as smoking, diet, alcohol consumption) only account for 18.8% of the gap (Commonwealth of Australia Department of Health, 2017). This signals that individual health choices are not the strongest factor in determining health status. There are also social implications for being Aboriginal and of low socioeconomic status, for example, Aboriginal families who are living within the most socially disadvantaged Socio-Economic Index For Areas (SEIFA) quintiles are much more likely than Aboriginal families in the upper three SEIFA quintiles to have children removed from their care (Chamberlain, Gray et al., 2022).

Social disadvantages which stem from colonisation and dispossession are reflected in the social determinants of health (Sherwood, 2013). The assimilation policies introduced during the 1930s did not offer 'full' assimilation. Aboriginal people were relegated to low-paying menial work, such as domestic servitude and farm work, while being denied education opportunities (Boladeras, 1994). Generating wealth was not feasible, as many Aboriginal workers were paid less than Europeans, and access to wages was controlled or even denied by government appointed protection authorities (Kidd, 2000). It would not be until the 1967 referendum that Aboriginal people were counted in the census as part of the human population, so only in recent decades have some Aboriginal people had access to tertiary education (Lovett and Brinkley, 2021). The flow on effects of all of this include entrenched poverty and intergenerational disadvantage within Aboriginal communities (Hartz and Sherwood, 2019).

2.1.4 Racism as a social determinant of health

Wakaya man, Professor Yin Paradies defines racism as "organised systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and

opportunities across racial or ethnic groups. Racism can manifest through beliefs, stereotypes, prejudices or discrimination" (Paradies, Ben et al., 2015) (p.2). The Australian Human Rights Commission (AHRC) found that experiences of racism for Aboriginal and/or Torres Strait Islander people are common, but there is a lack of awareness among the general Australian public about what racism is and how it manifests (AHRC, 2022). Stereotypes based on misinformation and misguided attitudes or beliefs about people who are non-white are most often negative, and are also perpetuated through the media (Sookhoo, 2009). The Wiyi Yani U Thangani report (AHRC, 2020) suggests that the various manifestations of racism in society are normalised due to such a high prevalence. Three different forms of racism are identified and defined in the National Aboriginal and Torres Strait Islander Health Plan:

1) Interpersonal racism, meaning interactions between people that maintain inequities between racial groups;
2) Institutional racism, meaning that it is structural and embedded into institutions, practice, and law and it difficult to identity a single perpetrator; and

3) Unconscious bias, meaning that underlying attitudes towards Aboriginal and Torres Strait Islander people based on stereotypes unintentionally influence understandings and engagement (Department of Health, 2021).

Exposure to racism is recognised as a social determinant of health (Paradies, Ben et al., 2015) and a public health issue (Cobbinah and Lewis, 2018; Gatwiri, Rotumah et al., 2021). Identifying and eliminating racism in the health system is a key priority in national Aboriginal and Torres Strait Islander health policy (Department of Health, 2021)(p. 6). Systemic (or institutional) racism is recognised as a barrier to health system access for Aboriginal and Torres Strait Islander women (Department of Health and Aged Care, 2019).

The link between racism exposure and poor mental health is well established (Awofeso, 2011; Kelaher, Ferdinand et al., 2014; Paradies, 2016; Paradies, Ben et al., 2015). In the Victorian Aboriginal community, experiences of interpersonal racism in mainstream health services has been associated with increased levels of psychological distress (Kelaher, Ferdinand et al., 2014). The relationship between racism exposure and poor physical health is less understood (Paradies, Ben et al., 2015), however, repeated racism

exposure chronically activates physiological stress responses, accelerating premature ageing and increasing susceptibility to chronic disease (Headen, Elovitz et al., 2022). Racism also decreases the likelihood that Aboriginal people will seek healthcare when needed (Artuso, Cargo et al., 2013). Aboriginal people are more likely to leave health services before being discharged (AIHW, 2024), with racist and discriminatory behaviours cited in the literature as reasons for early self-discharge (Askew, Foley et al., 2021). Stereotypes and unconscious biases can also lead to misdiagnoses (Sherwood, 2013). The seriousness of racism and its impact on the lives of Aboriginal women are highlighted when coronial inquests identify unconscious bias and deficient care from institutions like the health system and the legal system, such as in the cases of Aunty Tanya Day (English, 2020) and Ms Dhu (Klippmark and Crawley, 2017), who both died due to injuries sustained while in custody of police[5].

In Australia, midwives and doctors are legally obligated to practice 'cultural safety' (Medical Board, 2020; Nursing and Midwifery Board of Australia, 2018), which is a social theory that seeks to shift the power of defining 'safe' care from health care providers to Indigenous people, though establishing trust and addressing power relationships (Ramsden, 2002). The Australian Health Practitioner Regulation Agency (AHPRA), which protects the public through the regulation of a range of health care professions, lists culturally unsafe practice as an example of unsafe care (AHPRA, 2023). Cultural safety is discussed in virtually every policy, code of ethics, or report regarding quality and safety in healthcare (Australian Commission On Safety And Quality In Health Care, 2021; COAG Health Council, 2019; Medical Board, 2020; Nursing and Midwifery Board of Australia, 2018).Despite cultural safety being legally mandated, racism is felt by Aboriginal and Torres Strait Islander women in the maternity system (Brown, Gartland et al., 2019; Hine, Krakouer et al., 2022; Marriott, Strobel et al., 2019). Again, the significance of this is brought to light in the preventable death of Wiradjuri woman Naomi Williams, who was 27 years old and 22 weeks pregnant. The Coroner's report identified evidence of inadequate clinical care (Grahame, 2019). The septicemia that eventually became fatal went undiagnosed and untreated, despite Naomi presenting to her local hospital multiple times over several days. There was evidence of Naomi being stereotyped as a chronic user of illicit drugs, which influenced her medical management.

[5] It is with the greatest respect and solidarity that this section includes reference to three Aboriginal women who died in preventable circumstances. The families of these women have publicly called for justice and positive change in the name of their mother, sister, aunty, daughter, or friend.

Although the Coroner felt there was insufficient evidence to locate racism as a definite factor in the individual circumstances around Naomi's death, Professor Yin Paradies gave evidence that the circumstances were consistent with patterns in research evidence relating to Aboriginal people's experiences in the health system (Grahame, 2019).

First Nations health scholars have indeed challenged non-Indigenous nurses and midwives to remember that 'black lives matter' (Geia, Baird et al., 2020) and the Australian Racism in Perinatal Practice (AAPP) Alliance has now been established to improve Aboriginal and Torres Strait Islander women's experiences and outcomes of mainstream maternity service provision (Hine, Krakouer et al., 2022). Birthing practices and knowledges held by Aboriginal and Torres Strait Islander women have sustained healthy communities for 60,000 years (Chamberlain and Marriott, 2019), yet the design of the current maternity system has been informed by a Western view of health (Hickey, Kildea et al., 2019). There is little evidence of indigenous knowledges being regarded with equal merit (Adams, Faulkhead et al., 2018). Government aspirations of a health system 'free of racism' have been previously stated (Department of Health, 2015; Department of Health, 2021), however assumptions of Western practices and knowledges as superior is a foundational belief underpinning racism in healthcare (Watego, 2021) (Adebayo, Parcell et al., 2022). As such, it is reasonable to argue that the perpetuation of Western bio-medical dominance, while simultaneously undermining the value of indigenous knowledges, *is* racism.

2.2 The colonisation of birth and Aboriginal women's resistance

2.2.1 Birth in Australia before and after European invasion

It would not be possible for Aboriginal and Torres Strait Islander women to belong to the world's oldest thriving culture (Broome, 2002) without birthing knowledges and practices being sustained over millennia. For more than 60,000 years, senior nominated community women, often Grandmothers, provided pregnant women with skilled care on Country (Adams, Faulkhead et al., 2018; Chamberlain and Marriott, 2019). 'Women's business' was not shared with men, while girls and young women grew up witnessing practices relating to pregnancy and birth, with traditional midwifery knowledge passed from generation to generation (Kosiak, 2021). The 'medicalisation' of birth refers to the progressive dominance of a Western-centric, bio-medical approach to pregnancy and

birth, where sameness and conformity is promoted (Adebayo, Parcell et al., 2022; Sookhoo, 2009).The medicalisation of birth in Indigenous women's lives has also been described as a settler-colonial assimilation policy (Brown, Varcoe et al., 2011; Shaw, 2013; Sheffield and Liddell, 2023; Varcoe, Brown et al., 2013). Written evidence of pre-colonial Aboriginal health practices is scarce (Lovett and Brinkley, 2021), however, some early records indicate that the safety and value of traditional birth care from older Aboriginal women was recognised, with senior Aboriginal women being sought out to assist white women giving birth in early colonies (Adams, Faulkhead et al., 2018; Carter, Hussen et al., 1987). There are historical accounts, for example, of 'unhygienic practices of white male doctors' who 'left placentas in buckets to rot' whereas, Aboriginal women carefully disposed of placentas by burying them (Kosiak, 2021).

Early European accounts describe placental burying, labour pain relief techniques, bush medicine, and healing steams or 'smoking' ceremonies (Kosiak, 2021). Focusing on the south-eastern area of the continent, Adams and colleagues (2018) examined archival evidence of Aboriginal women's birthing practices. The authors concede that most of the available evidence was written by white men, and so there is risk of misinterpretation (Adams, Faulkhead et al., 2018). The researchers note, however, that archival evidence has the potential to uncover evidence of Aboriginal women's agency (Adams, Faulkhead et al., 2018). The authors cite the significance of birthplace, such as the old river red gums on Dja Dja Wurrung Country and birthing caves on Wathaurong Country. There is evidence of using tree branches to facilitate optimal positions for birthing and using fire to warm the sand for the baby (Adams, Faulkhead et al., 2018). Welcome songs were sung as newborns were wrapped in possum skins and rested in warm grass. After birth, women were also well looked after, provided with warmth (from fire and hot stones) and nourishing foods. Men took on the role of providers, bringing supplies such as firewood to the birth camp (Adams, Faulkhead et al., 2018).

Aboriginal women in the area now known as Victoria would continue to take on traditional midwifery roles, even after being moved onto missions such as Coranderrk (Adams, Faulkhead et al., 2018), but colonisation systematically dismantled these knowledge systems (Adams, Faulkhead et al., 2018; Chamberlain and Marriott, 2019). The depletion of knowledge in the south-east area of Australia has been significant due to violence, disease, and government assimilation policies (Adams, Faulkhead et al., 2018). Declining health due to land dispossession would have also introduced risks for Aboriginal women birthing in the bush.

In terms of non-indigenous birth practises, white midwives arrived in the early Australian colonies and established small European style 'lying-in' practices in houses (Fahy, 2007) before the eventual arrival of obstetric practices that resembled early 18th century practices in the UK (such as larger lying-in hospitals and obstetric forceps) (Carter, Hussen et al., 1987). English doctors who were unsuccessful at establishing a general medical practice at home emigrated to Australia where less competition provided greater chances of generating wealth (Fahy, 2007). Midwives, as a cheaper alternative, were still popular until the government introduced financial compensation for medical care in birth in 1912 (but not for Aboriginal women) (Carter, Hussen et al., 1987). After this, midwives attending births became progressively less common (Fahy, 2007).

The major cause of death during the late 1800s and early 1900s was puerperal sepsis, linked to early medical obstetric practices as doctors were not yet being taught hygiene practices such as hand washing (Carter, Hussen et al., 1987; Fahy, 2007). It was not until the 1930s when antibiotics became available (Fahy, 2007). In order to legitimise their involvement in uncomplicated births, however, general practitioners placed the blame for the septic outbreaks on midwives (Carter, Hussen et al., 1987; Fahy, 2007). Even though increased medical involvement in birth did not decrease maternal and perinatal mortality rates, governments attempted to improve things by funding specialist teaching lie-in hospitals, such as the establishment of the Royal Women's Hospital in Naarm (Melbourne) in 1888 (Fahy, 2007). It was around this time that medicine formed an alliance with nursing and legal control of midwifery practice was achieved by legislating who was able to practice midwifery (Fahy, 2007). By the early twentieth century, most births in Australia had been moved into hospitals and the use of anaesthesia and forceps became more and more common (Fahy, 2007). Aboriginal women across the continent, however, were often excluded from birthing in hospitals up until the late twentieth century, and instead birthed outside hospitals or on the verandas (Marriott, Reibel et al., 2019b). Given this, members of the Aboriginal community in Victoria have historically been distrustful of Victorian health services (Campbell, 2000).

2.2.2 The Women's Business Report of the Aboriginal women's task force

Evidence of how Aboriginal women felt about the development and expansion of Western-style health and maternity systems was first collated and presented in a seminal report called the Women's Business Report of the Aboriginal women's task force (Daylight and Johnstone, 1986). Published in 1986, it was the first time that the

government had specifically asked for the views of Aboriginal women in relation to issues that affected them. Emerging leaders such as Marcia Langton, Pat Turner, and Lowitja O'Donoghue were involved in the compilation of the report. The goal of the task force was to make recommendations to the Government after seeking an understanding of women's needs in relation to their human rights, as voiced by the women themselves (Daylight and Johnstone, 1986).

Women described 'going to the doctor' as stressful, particularly if there were no Aboriginal staff, and explained that seeking advice from strangers was in direct contradiction to Aboriginal culture (Daylight and Johnstone, 1986). Pregnant women in Launceston, for example, felt 'looked down upon' and expressed anger at the lack of consent for being observed or practiced on by medical students during intimate procedures (Daylight and Johnstone, 1986). Women from remote locations were dismayed at having no choice but to be sent away to hospital for birth, often with little to no warning of the move, due to non-Indigenous health workers' perceptions of the risk of women absconding into the bush (Daylight and Johnstone, 1986). Important cultural practices were no longer able to be enacted, and feelings of loneliness and alienation were reported (Daylight and Johnstone, 1986). Recommendation 5.9 of the report stated that:

> *"State and territory health authorities give serious consideration to the establishment of culturally appropriate birthing centres in communities with a significant number of Aboriginal patients, and the employment of Aboriginal hospital liaison officers who can also interpret for patients in hospitals with a significant number of Aboriginal patients"* (Daylight and Johnstone, 1986) (p.14).

Key recommendations made to improve maternity care included: more Aboriginal women health workers; more services for women from rural and remote areas; better services for women who are leaving their home community for birth (such as accommodation being provided for family); considering traditional Lore in birth; addressing the issue of non-Aboriginal men being present at birth; increasing opportunities for reproductive health education; and more access to nutrition and supportive programs to address women's social needs (Daylight and Johnstone, 1986).

2.2.3 'Borning Ampe Mbwareke Pmere Alatye' - The Congress Alukura by the Grandmother's Law

Another seminal document was published the following year, called 'Borning Ampe Mbwareke Pmere Alatye - The Congress Alukura by the Grandmother's Law' (the 'Borning report') (Carter, Hussen et al., 1987). This study of the views and experiences of Aboriginal women in central Australia was funded by the Commonwealth Department of Health in response to the perinatal inequities experienced by Aboriginal women. Eighty percent of babies were being born in hospital, yet, the perinatal death rate was quoted to be three to four times higher than non-Aboriginal people (Daylight and Johnstone, 1986).

Women from the areas of central Australia knew that an increase in perinatal mortality was linked to the impacts of colonisation (Carter, Hussen et al., 1987). The report also identified a lack of cultural support and consideration of traditional Lore from mainstream 'whitefella' services as contributing to perinatal mortality rates. Women described distressing experiences with hospital birth in Mparntwe (Alice Springs), such as a loss of baby's identity, feelings of loneliness and homesickness, and white male doctors 'forcing legs apart' which was considered a 'gross cultural shame' (p.50). The views of hospital staff appeared to be in conflict with the views of the women, as one health professional stated: *"despite the cultural points of view, one gets the best clinical results in hospital...they [Aboriginal people] are happy"* (p.57) and one male doctor gave their judgement on the appropriateness of attending Aboriginal women in labour: *"it is not a question of whether you are male or female. Well, acceptance is a matter of confidence, isn't it? The people don't know me yet."* Despite all of this, women also recognised the need for a blend of Western and traditional practices because of the introduced 'whitefella diseases', and antenatal care and access to hospital in emergencies was still seen as beneficial (Carter, Hussen et al., 1987).

The findings of the Borning report led to a submission for funding to support the establishment of a culturally sensitive 'two-way' birthing service at the Central Australian Aboriginal Congress (CAAC). The response was that the Department of Health had helped to reduce perinatal and maternal mortality rates, and that the 'safety' of an Aboriginal birth centre was difficult to assess (Carter, Hussen et al., 1987). One barrier was the growing bio-medical dominance over women and their births in the region, as demonstrated by accounts of Northern Territory Department of Health representatives (Carter, Hussen et al., 1987). One doctor stated *"we have an excellent obstetric unit. A*

specialised unit. Sheer madness not to accept it" (p. 57). Concerned by the proposal for a free-standing birth centre, another senior Obstetrician told 'the Age' newspaper in 1985, "*If you try to give Aboriginal women a choice, it will simply cause troubles in the long run. It is too early to give them a choice"* (Carter, Hussen et al., 1987).

Despite this opposition, long processes of community consultation led to the establishment of the 'Congress Alukura' in 1987 by the CAAC, to provide women with comprehensive antenatal and postnatal care, shared maternity care and women's health services (Carter, Lumley et al., 2004). Evidence of improved antenatal attendance and birthweight were identified in an evaluation, however, the authors recommended further research was needed as data collected from Alukura was limited, and no ethics approval was sought to access medical records (Carter, Lumley et al., 2004). Additionally, the evaluation identified low numbers of women birthing at Alukura, with births ceasing in 1997 (Carter, Lumley et al., 2004). Reasons cited for the low births occurring at Alukura included a lack of resources, hospital birth had become more 'normalised', difficulties with adequate staffing, and difficulties for staff to maintain the skills required (Carter, Lumley et al., 2004). Today, the Congress Alukura still provides antenatal and postnatal care, with recent funding obtained to establish a remote 'Birthing on Country' service to provide women birthing at Alice Springs Hospital with labour and birth care from midwives employed at Alukura (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023).

The Borning report was one of the first reports demonstrating that Aborignal women were concerned with the growing dominance of Western biomedical birthing care (Carter, Hussen et al., 1987). Quite reasonably, women wanted access to Western medical care 'on their own terms', recognising that the answer to the solution was not to solely rely on increased use of technology in hospitals, but that Aboriginal consultation and control would be fundamental for success (Carter, Hussen et al., 1987).

2.2.4 Resistance in more recent years

Well-articulated in these early reports was a concern that women's experiences were being negatively impacted by the undermining of indigenous knowledges and a dominant Western bio-medical approach (Carter, Hussen et al., 1987; Daylight and Johnstone, 1986). Unfortunately, more recent evidence suggests that subsequent generations of Aboriginal and Torres Strait Islander women are reporting similar issues. The midwifery

standards for practice and the code of conduct both state that midwives in Australia have a professional responsibility to take a 'woman-centred' approach and practice 'cultural safety' (discussed in Chapter 4) (Nursing and Midwifery Board of Australia, 2018; Nursing and Midwifery Board of Australia, 2018). Obstetricians and Obstetric trainees must follow the code of conduct for doctors in Australia (RANZCOG, 2023), which outlines standards of practice for 'ethical' medical conduct (Medical Board, 2020). The code addresses doctors' obligation to listen to women, respect women's self-determination, and acknowledge the impacts of racism and colonisation (Medical Board, 2020). Even though these ethical standards are in place, it appears that women's experiences of maternity system are not necessarily positive.

Negative experiences in the mainstream maternity system was a main theme generated from a 2017 meta-synthesis of maternity care for Indigenous women (Corcoran, Catling et al., 2017). Most negative experiences were in the context of no continuity of care/carer or no opportunity to build a relationship with caregivers before the labour and birth (Corcoran, Catling et al., 2017). Women reported feeling mistrusting of unfamiliar caregivers, getting 'lost' in the system, poor communication between hospitals and local services, feeling isolated, separation from support people, and discrimination (Corcoran, Catling et al., 2017). More recent evidence from Boorloo (Perth) (Marriott, Reibel et al., 2019b) and Tarntanya (Adelaide) (Brown, Fereday et al., 2016) further support that these issues remain. Marriot et al (2019b) discuss that negative experiences are often rooted in cultural misunderstandings and inflexible systems.

'Obstetric violence' is defined in the literature as women experiencing mistreatment, disrespect, physical abuse, neglected care, verbal abuse, or non-consented care (Edward and Kibanda, 2023). A recent national survey of over 8,000 Australian women (of whom 3% identified as First Nations) found that more than one in ten women reported experiencing 'obstetric violence' (Keedle, Keedle et al., 2022). This likelihood was increased for First Nations women (Keedle, Keedle et al., 2022). Negative care provider interactions, as well as dysfunction in the Australian maternity system, have each been identified as contributing factors to the rising prevalence of 'birth trauma' (Watson, White et al., 2021), which may or may not involve physical injury but refers to events or care that cause deep distress or prolonged psychological disturbance (Greenfield, Jomeen et al., 2016).

While the recent work of Keedle et al (2022) suggests that many non-First Nations women in Australia are also experiencing great difficulty with the mainstream maternity system, Aboriginal and Torres Strait Islander women carry the colonial load of an imposed, foreign system. Much has been written about the exclusion of indigenous knowledges in perinatal care over the last four decades (Adams, Faulkhead et al., 2018; Adcock, Storey et al., 2019; Aseffa, Mehari et al., 2024; Carter, Hussen et al., 1987; Chamberlain and Marriott, 2019; Hartz and Sherwood, 2019; Hayward and Cidro, 2021; Hickey, Roe et al., 2021; Ireland, Wulili Narjic et al., 2011; Kosiak, 2021; Lawford, Giles et al., 2018; Magick Dennis and Keedle, 2019; O'Driscoll, Payne et al., 2011; Ramsamy, 2021; Sheffield and Liddell, 2023; Van Wagner, Epoo et al., 2007). Critically, this dissonance between Western and indigenous worldviews has been linked to the systemic perpetuation of health (Sherwood and Edwards, 2006) and perinatal inequities (Hickey, Kildea et al., 2019).

Although some cultural practices and knowledges regarding Grandmother's law have been interrupted by colonisation, not all has been lost. The archival research by Adams and colleagues (2018) revived cultural birthing knowledge from the areas of south-east Australia, with the aim addressing the exclusion of First Nations knowledges in a predominantly biomedical maternity system (Adams, Faulkhead et al., 2018). Additionally, Aboriginal people in Australia are still enacting cultural knowledges around the time of birth and reclaiming those practices (Ireland, Wulili Narjic et al., 2011; Magick Dennis and Keedle, 2019; Marriott, Reibel et al., 2019b), as are Indigenous women internationally (Hayward and Cidro, 2021; Lawford, Giles et al., 2018; McKenzie, Varcoe et al., 2022; Sheffield and Liddell, 2023; Van Wagner, Epoo et al., 2007). Both First Nations and non-Indigenous researchers are also using research as a means of activism to decolonise birth care (Hickey, Roe et al., 2021).

2.3 Perinatal statistics - the numbers story

The Australian Department of Health retrieves national perinatal outcome data from the maternity sector through systems of mandatory data reporting (Eddy and Tracy, 2023). Notifications of each birth in Australia (of at least 400 grams or 20 weeks gestation) are completed by midwives or other health professionals, which include demographics characteristics of the birthing woman, as well as information regarding pregnancy, labour, birth and baby outcomes (Eddy and Tracy, 2023) The Australian National Perinatal Data Collection (NPCD) contains data collected from each state and territory (Eddy and Tracy,

2023). The AIHW then releases annual perinatal outcome data reports which provide trends on antenatal, labour and birth, and neonatal outcomes. The reports are based on the data collected during the relevant reporting period from the National Perinatal Data Collection Unit, the National Maternal Mortality Data Collection Unit, and the National Perinatal Mortality Data Collection Unit (AIHW, 2023). This section will refer to three different sources to summarise current perinatal outcomes for Aboriginal and Torres Strait Islander women and newborns.

Firstly, the AIHW's most recent national perinatal outcome data report, called 'Australia's mothers and babies', provides an overview of perinatal outcome data from the year 2021, for the general Australian population (AIHW, 2023). This report does not focus specifically on outcomes for Aboriginal and Torres Strait Islander women but provides a separate statistical profile with the most recent data available for some outcomes, including demographic characteristics, mortality rates and breastfeeding rates among the Aboriginal and/or Torres Strait Islander population at a national level (AIHW, 2023).

Secondly, the AIHW has also released a more detailed publication focusing only on outcomes for Aboriginal and Torres Strait Islander women and newborns, called 'Aboriginal and Torres Strait Islander mothers and babies' (AIHW, 2023). Provided are comprehensive data collected in the year 2020, presented at a national level as well as state/territory/regional outcomes and demographics. This report includes a wider range of pregnancy, intrapartum, and postnatal outcomes based on geographic location, however the data is one year older (AIHW, 2023).

The third source is a report from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) and provides additional perinatal outcome trends specific to the state of Victoria. CCOPMM is an advisory body to the Victorian Minister for Health and releases data outcome report publications that demonstrate trends on births and deaths and provides recommendations to improve quality and safety of Victorian maternity care (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2023). The most recent Victorian perinatal outcome data report released by the CCOPMM was in 2023 (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2023). This report is regarding the general Victorian population but includes a

chapter dedicated to Aboriginal births, mortality, and morbidity (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2023).

2.3.1 How many Aboriginal and/or Torres Strait Islander women give birth each year?

In 2021, Aboriginal and Torres Strait Islander mothers accounted for 5.0% (15,437) of women who gave birth nationally. Babies of First Nations women made up 5.0% of births, and when including First Nations babies of non-Indigenous women, this increased to 6.1% of total births (AIHW, 2023). In 2021, 1,250 Aboriginal and/or Torres Strait Islander women gave birth in Victoria (accounting for 1.6% of all women who gave birth) (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2023). The data suggest that the percentage of indigenous births in Victoria is steadily increasing, from 49.8 per 1000 births in 2005 to 80.8 per 1000 births in 2020, though in the metropolitan area of greater Melbourne, this rate is lower (62.2 per 1,000) (AIHW, 2023).

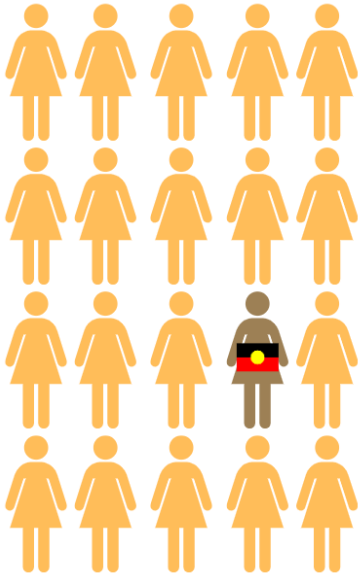


FIGURE 1 - 5 % OF PEOPLE BIRTHING NATIONALLY ARE ABORIGINAL OR TORRES STRAIT ISLANDER (AIHW, 2023).

2.3.2 Where do Aboriginal and/or Torres Strait Islander women live?

In 2020, many Aboriginal and/or Torres Strait Islander women giving birth (36.7%) resided in major cities (AIHW, 2023). Nearly one in five (18.5%) resided in remote or

very remote areas, which is a much higher proportion than non-Indigenous birthing women (1.5% of all non-Indigenous birthing women) (AIHW, 2023).

Of all Aboriginal and/or Torres Strait Islander women giving birth in Australia, 7.2% gave birth in Victoria (3.2% in greater Melbourne/Naarm region, and 4.0% anywhere else in the state of Victoria). For comparison, the region of greater Brisbane/Meanjin (lands of the Turrbal and Jagera people) has the highest indigenous birth rate (10.6% of all Aboriginal/Torres Strait Islander birthing women in Australia). Overall, most Aboriginal and/or Torres Strait Islander women are birthing in the state of New South Wales (32.5%) or the state of Queensland (30.4%) (AIHW, 2023).

2.3.3 Maternal age

In Australia, the mean age of all birthing women is increasing over time (AIHW, 2023). Aboriginal and/or Torres Strait Islander women, on average, are younger than the general population of women giving birth. In 2020, the mean age of Aboriginal and/or Torres Strait Islander mothers was 26.5 years (AIHW, 2023) compared to 31.1 years for non-Indigenous women in 2021 (AIHW, 2023).

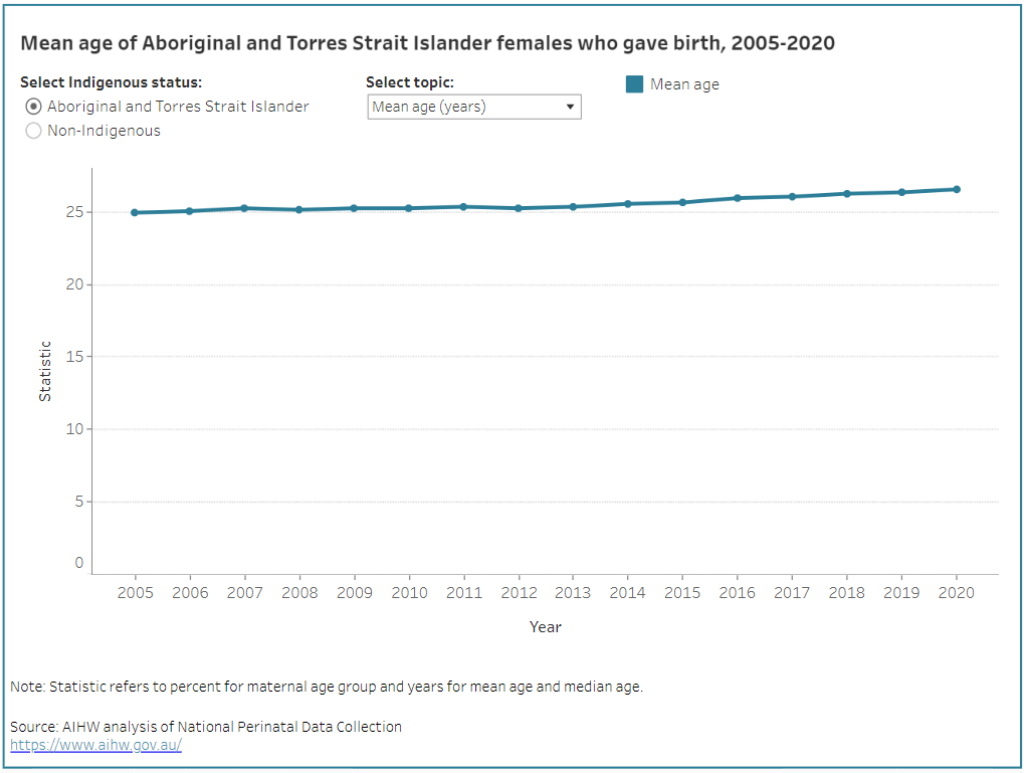


FIGURE 2 - MEAN AGE OF ABORIGINAL AND TORRES STRAIT ISLANDER BIRTHING WOMEN OVER TIME (AIHW, 2023).

In Victoria, Aboriginal and Torres Strait Islander women most commonly give birth between the ages of 25-29 years (30.3%), which is similar to national data which reports that 29.8% of all birthing Aboriginal and Torres Strait Islander women are in this age group. The proportion of birthing women under the age of 20 in Victoria was 8.9%, which is lower than national proportion of 11.2% (AIHW, 2023).

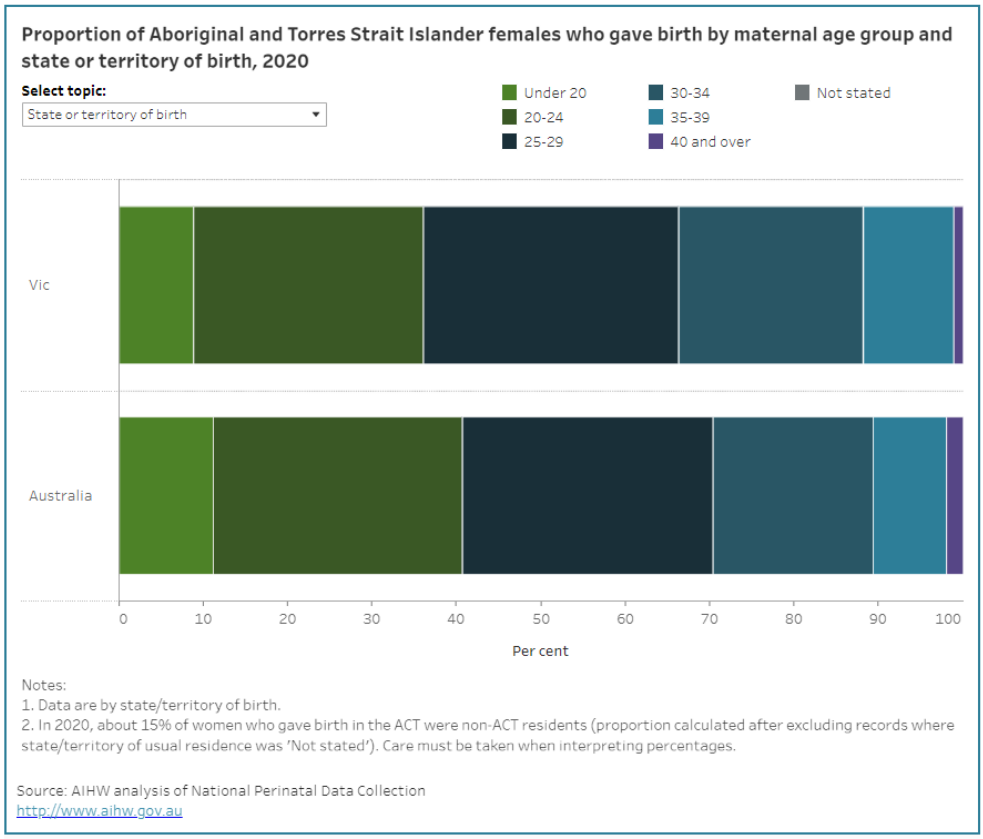


FIGURE 3 - PROPORTION OF ABORIGINAL AND TORRES STRAIT ISLANDER BIRTHING WOMEN BY AGE GROUP (AIHW, 2023)

2.3.4 Antenatal attendance

The Australian Pregnancy Care Guidelines recommend that a woman has her first antenatal visit within the first 10 weeks of pregnancy (Department of Health and Aged Care, 2020). National trends show that Aboriginal and Torres Strait Islander women are more often attending an early antenatal visit in the first trimester (72% in 2021, up from 50% in 2011) (AIHW, 2023) and are also more often attending the recommended minimum of five (or more) antenatal visits across pregnancy (up from 85% in 2012 to 88% in 2021) (AIHW, 2023). In Victoria, 72% of Aboriginal and/or Torres Strait Islander women attended their first antenatal visit when they were less than 14 weeks, 12.9% attending for the first time between 14-19 weeks, and 12.2% attending at 20 weeks or more. Only 1.7% of Aboriginal and Torres Strait Islander women were recorded as receiving no antenatal care (AIHW, 2023).

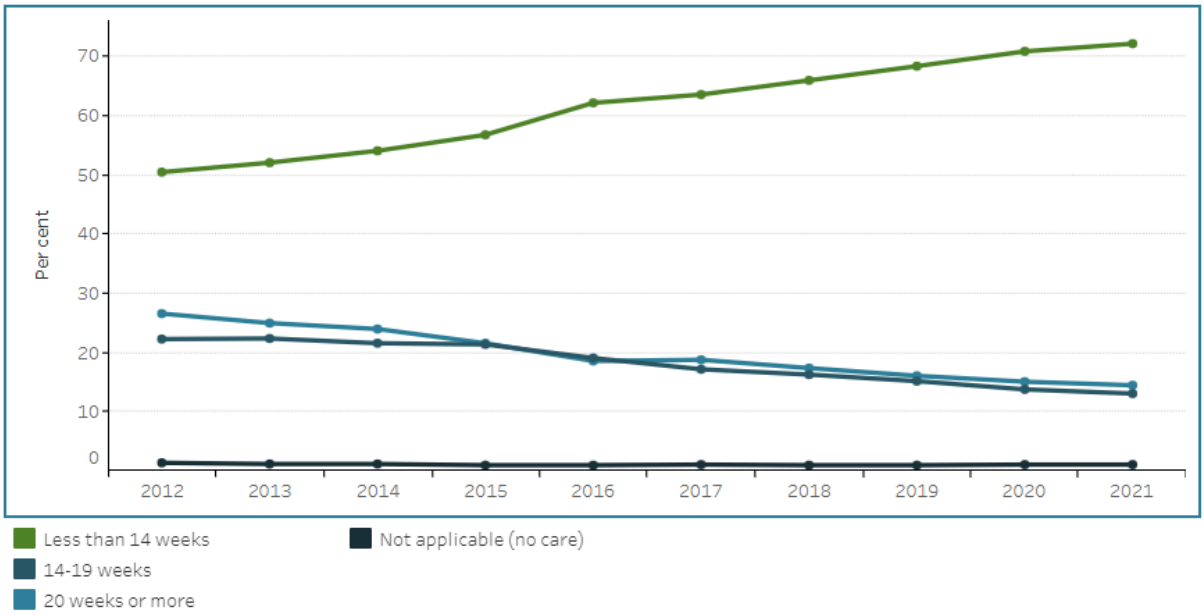


FIGURE 4 - NATIONAL PROPORTIONS OF GESTATIONAL AGES AT FIRST PREGNANCY VISIT FOR ABORIGINAL AND/OR TORRES STRAIT ISLANDER WOMEN (AIHW, 2023)

2.3.4 Smoking

The percentage of Aboriginal and/or Torres Strait Islander women who report tobacco smoking at any time during pregnancy is decreasing (from 50% in 2011 down to 42% in 2021) (AIHW, 2023).

2.3.5 Gestational age

Gestational age is defined as the duration of pregnancy in completed weeks (AIHW, 2023). A 'pre-term' birth is a birth occurring at less than 37 weeks gestation, birth at term is from 37 weeks until 41 completed weeks, and birth from 42 weeks onwards is considered to be post-term (AIHW, 2023). Gestational age is an important perinatal outcome, as being born prematurely is linked to ongoing negative health sequalae across the life span (March of Dimes, PMNCH et al., 2012).

In 2021, most babies of Aboriginal and Torres Strait Islander mothers[6] (85.6%) were born at a healthy gestational age or at 'term' (this increases to 87% for all Aboriginal/Torres

[6] In this section 'Aboriginal and/or Torres Strait Islander babies' refers to all Aboriginal and Torres Strait Islander babies. Phrases such 'babies of' or 'babies born to' Aboriginal and/or Torres Strait Islander women refer specifically to babies whose mother is also Aboriginal and/or Torres Strait Islander.

Strait Islander babies) (AIHW, 2023). The national pre-term birth rate for babies of Aboriginal and Torres Strait Islander women was 14.1% (AIHW, 2023), equal to the rate for babies born in Victoria to Aboriginal and Torres Strait Islander women in the year prior (2020) (AIHW, 2023). Non-Indigenous babies are more likely to be born at term, with a national pre-term birth rate (7.9%) which is almost half the national rate for Aboriginal and/or Torres Strait Islander babies (AIHW, 2023).

According to the AIHW (AIHW, 2023), Aboriginal and/or Torres Strait Islander babies are more likely to be born at term if:

- mothers live in the least socioeconomically disadvantaged areas (90%, compared with 85% for the most disadvantaged areas)
- mothers live in major cities or inner regional areas (both 87%, compared with 83% for remote areas and very remote areas)
- born to mothers who did not smoke (89%, compared with 83% of those born to mothers who smoked).

In 2021, babies of Aboriginal and/or Torres Strait Islander women in the greater Melbourne/Naarm region were more likely to be born at term (414 [81%] of 470 babies born), compared to those born in regional Victoria (498 [84.6%] of 589 babies born) (AIHW, 2023).

2.3.6 Birthweight

Birthweight is defined as the first weight after birth and 'healthy' birthweight is considered to be between 2,500 and 4,499 grams for a term infant (AIHW, 2023). Being born outside of a healthy birthweight is linked to perinatal mortality and chronic illness in childhood and later in life (AIHW, 2023).

In 2021, most babies (86.9%) born to Aboriginal and/or Torres Strait Islander women were born with a healthy birthweight (increasing to 88% for all Aboriginal/Torres Strait Islander babies) (AIHW, 2023). However, the proportion of low birthweight babies born to non-Indigenous women is half that compared with babies of Aboriginal and/or Torres Strait Islander women (6% vs 11.8%) (AIHW, 2023).

In Victoria, non-Indigenous babies are also more likely to be born at a healthy birthweight. Overall, six percent of all babies born in Victoria were low birthweight (AIHW, 2023), however, data from 2021 shows 10.9% of babies born in Victoria to

Aboriginal and/or Torres Strait Islander women had a low birthweight (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2023)Increasing the proportion of Aboriginal and/or Torres Strait Islander babies with a healthy birthweight to 91% by 2031, is one of the targets in the national Closing the Gap agreement (Commonwealth of Australia, 2023).

2.3.7 Perinatal mortality rate

Perinatal mortality is defined as all stillbirths (after 20 weeks gestation and all babies weighing 400 grams), intrapartum death, and neonatal deaths up to 28 days of age (AIHW, 2023). Being born of low birthweight, very pre-term, or being born to mothers who are underweight, living in very remote areas, or have pre-existing diabetes are factors that are associated with perinatal death (AIHW, 2023).

Non-indigenous babies are currently more likely to survive the perinatal period. Since the year 2007, national perinatal mortality rates have decreased slightly for babies of Aboriginal and/or Torres Strait Islander s mothers. While there has been some fluctuation over the last decade, the rate has decreased from 20 deaths/1000 births in 2007 to 17/1000 births in 2020 (AIHW, 2023).

Down from 13.6 deaths/1000 births for the years 2013-2015, the perinatal mortality rate for Aboriginal babies in Victoria during the 2014-2016 triennium was at its lowest in 16 years (9 deaths/1000 births), which was almost on par with babies from non-Indigenous women (The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2016). However, during the next reporting period (2017-2019) the perinatal mortality rate increased again to 12.6 deaths/1000 births, compared to 8.7 deaths per 1000 births for babies of non-Indigenous women (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2019). As the perinatal mortality rate for non-Indigenous babies also decreased, the ‘gap’ between non-Indigenous and Aboriginal and Torres Strait Islander babies in Victoria actually widened (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2019).

2.3.8 Maternal mortality

Maternal mortality is the death of a woman while pregnant, or within 42 days postnatal, regardless of the duration and outcome of the pregnancy, and from any cause related to or aggravated by the pregnancy or its management. (AIHW, 2023).

Data from 2012-2021 show that non-Indigenous women have consistently been more likely to survive the perinatal period. Currently, non-Indigenous women are three times less likely to die during the perinatal period (AIHW, 2023). The maternal mortality ratio is 5.3/100,000 pregnancies for non-Indigenous women and it is 16.8/100, 000 pregnancies for Aboriginal and Torres Strait Islander women (AIHW, 2023) Of the 54 deaths between 2012 and 2021, 21 (11.3%) women were Aboriginal (AIHW, 2023) despite Aboriginal/Torres Strait Islander women making up only 5% of birthing women.

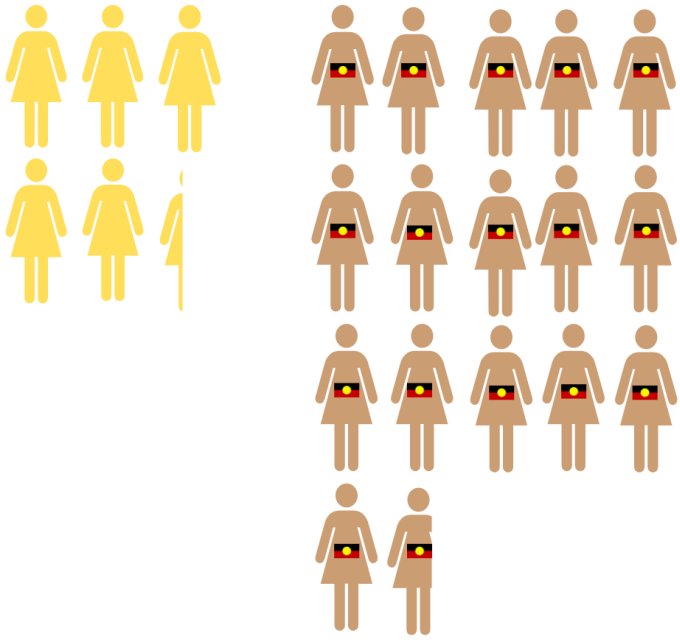


FIGURE 5 - 2021 MATERNAL MORTALITY RATES 5.3/100,000 FOR NON-INDIGENOUS WOMEN AND 16.8/100,000 FOR FIRST NATIONS WOMEN (AIHW, 2024)

2.3.9 Socioeconomic status

Outcomes such as premature birth, low birthweight, and perinatal mortality are on a social gradient. They are more prevalent among Aboriginal and/or Torres Strait Islander women who live in the most disadvantaged areas (SEIFA quintile) compared to Aboriginal and/or Torres Strait Islander women who live in the least disadvantaged areas (AIHW, 2023). In Victoria, Aboriginal and/or Torres Strait Islander women giving birth are twice as likely to living in the most disadvantaged quintile (43.5% vs 18.2% non-Indigenous birthing women in Victoria) (AIHW, 2023). Also, only 3.9% of Aboriginal and/or Torres Strait

Islander birthing women are living in the most advantaged areas, compared with 18.1% of non-Indigenous birthing women (AIHW, 2023).

2.4 The problem with statistics

> "*We are unknown as living, healthy, or as well. We are instead known via our premature deaths, via illness and ailments, the cause of which can be explained through a knowing of us as a people who don't know what's good for us...*" *(Watego et al., 2021, p. 35).*

Statistics about Aboriginal and Torres Strait Islander people may be useful in highlighting disadvantage (Fogarty, Bulloch et al., 2018; Watego, Singh et al., 2021), however, some Indigenous scholars challenge the statistical reporting of big, open access data, such as from the AIHW, in its ability to improve outcomes for Indigenous people (in Chapter four, this will be discussed further in relation to Western approaches to research). It is not the intention of this section to argue that the use of statistics is never appropriate and can never be beneficial. In Indigenous women's health research, it is not necessarily the use of quantitative statistics that is the problem per se, but rather the lack of a critical lens applied to the collection, construction, and interpretation of the data (McGuire-Adams, Gaudet et al., 2023). This thesis connects perinatal statistical outcome data to the context of colonisation and its impacts, which contribute to inequitable health outcomes but often are omitted from medical research (Sherwood, 2013). Highlighted in this section are some important considerations for the collection and reporting of statistical data, such as the generation of deficit discourse, narratives positioning Aboriginal and Torres Strait Islander people as 'the problem', and the production of negative racial stereotypes (Fogarty, Bulloch et al., 2018; Walter and Anderson, 2016; Walter, Lovett et al., 2021; Watego, Singh et al., 2021). Alternative approaches to data that have been applied in this thesis, and principles that I will continue to adopt, will then be discussed in the section that follows.

Most data about Indigenous peoples are in the numeric form, referred to as statistics or quantitative data (Walter and Anderson, 2016). In Australia, statistics about Aboriginal and Torres Strait Islander people are collected by national government statistical agencies such as the Australian Bureau of Statistics (ABS), and the AIHW (Walter and Anderson, 2016). First Nations scholars have observed that statistical summaries of Aboriginal lives

are often ‘deficit’ based, leading to deficit discourse (Fforde, Bamblett et al., 2013; Fogarty, Bulloch et al., 2018; Walter and Anderson, 2016; Walter, Lovett et al., 2021; Watego, Singh et al., 2021). ‘Deficit discourse’ is language that represents Aboriginal and Torres Strait Islander people in a narrative of negativity, deficiency, and failure (Fforde, Bamblett et al., 2013). How poorly Aboriginal and Torres Strait Islander populations compare with non-Indigenous populations in areas such as health, education, economic wealth, and other socio-economic aspects is the focus (Walter, Lovett et al., 2021). Open access Government data almost always reports in this way (Maiam nayri Wingara Indigenous Data Sovereignty Collective, 2024). Reporting on what Aboriginal and Torres Strait Islander people lack compared to ‘a utopian non-Indigenous ideal’ (Fogarty, Bulloch et al., 2018) (p.1) positions non-Indigenous people as ‘normal’ and Aboriginal/Torres Strait Islander people as the ‘other’ or the ‘problem’ to be fixed (Fogarty, Bulloch et al., 2018; Maiam nayri Wingara Indigenous Data Sovereignty Collective, 2024 ; Watego, Singh et al., 2021). This is done by documenting difference *without* providing an explanation of how or why these differences exist (Fogarty, Bulloch et al., 2018; Sherwood, 2013; Watego, Singh et al., 2021). Usually not discussed is how racial harm is created by social systems, or if governments have failed to meet the needs of Aboriginal and Torres Strait Islander people (Fogarty, Bulloch et al., 2018; Watego, Singh et al., 2021). Trawlwoolway Palawa woman and Professor Maggie Walter and colleagues (2021) summarise these issues using a framework called ‘BADDR’.

TABLE 2 - 'BADDR' DATA

Blaming data	Too much Indigenous versus non-Indigenous data. Comparing the ‘troubled’ Aboriginal person again the non-Indigenous ‘normal’ person.
Aggregated data	Too much national/state level data, implying that Aboriginal people are all the same.
De-contextualised data	Data is too simple, focusing on individual persons outside of their social and cultural context.
Deficit data	Too much ‘5D’ data – disadvantage, disparity, dysfunction, difference, deficit.
Restricted access data	Too much data published about Aboriginal people but access for Aboriginal communities is blocked

Adapted from Walter, et al. (2021).

Quantifying Aboriginal and Torres Strait Islander health outcomes often aims to demonstrate that a real, measurable 'problem' exists and requires action (Watego, Singh et al., 2021). One example of how this kind of data has failed to improve outcomes as was intended is the 'Closing the Gap' strategy (Fogarty, Bulloch et al., 2018), which has been criticised as a medical solution to what is largely a social and political issue (Bond and Singh, 2020). The Closing the Gap targets outlined in the strategy (including but not limited to; closing the life expectancy gap within a generation and halving the gap in mortality rates for Indigenous children under five) were developed by the Council of Australian Governments (COAG), a Government body, and Aboriginal people themselves did not hold ultimate decision-making power in how the targets were constructed (Lovett, Jones et al., 2020). Data presented annually has compared Aboriginal and Torres Strait Islander people to non-Indigenous people in relation to the pre-determined targets which mostly had not been achieved (Fogarty, Bulloch et al., 2018). An example of what can happen when deficit data is politicised through the media is the Howard government's 'intervention' (Fogarty, Bulloch et al., 2018; Sherwood, 2013; Walter, 2010). Public accusations of serious child sexual abuse in Aboriginal communities led to a Northern Territory government commissioned report titled 'Little children are sacred' (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, 2007). The public release of the report was a catalyst for national debate and gained the attention of the media. Rather than implementing the recommendations made by Aboriginal leaders in the report, the federal government's political response was an immediate takeover of 73 Aboriginal communities in the Northern Territory without warning or consultation. Punitive and non-evidence-based policies were enforced, which Aboriginal communities state did more harm than good (Fogarty, Bulloch et al., 2018; Sherwood, 2013; Walter, 2010).

Deficit data runs the risk of reproducing negative racial stereotypes (Watego, Singh et al., 2021). Statistical data made openly accessible for the general public acts as a prism through which the broader Australian society comes to 'know' about us (Russo Carroll and Walter, 2020; Walter, Lovett et al., 2021). The discourse that flows from the statistics also impacts how Aboriginal and Torres Strait Islander people are treated within the health system (Sherwood, 2013). Health care professionals too can hold racist beliefs that poor health status is a result of Indigenous peoples' personal failures (Sherwood, 2021;

Watego, Singh et al., 2021). On the other hand, Aboriginal women have questioned being labelled 'high risk' in pregnancy, purely because they are Aboriginal (Nelson, Marriot et al., 2021). The perception of Aboriginal women generally being 'high-risk' has been criticised as limiting women's choices in Canada (Brown, Varcoe et al., 2011). The same goes for Black women in the United States (Adebayo, Parcell et al., 2022). On occasions I have personally challenged non-Indigenous doctors, nurses, midwives, or academics, who through access to statistical 'fact' have come to 'know' that 'Aboriginality' is a risk factor for a myriad of poor social or biophysical outcomes. Ultimately, deficit data does not allow Aboriginal and Torres Strait Islander people to determine their own futures (Walter, Lovett et al., 2021) and may not represent how Aboriginal and Torres Strait Islander people see themselves (Fogarty, Bulloch et al., 2018).

2.4.1 Indigenous data needs

> *"What is needed is an appreciation of Indigenous well-being, as perceived by the Indigenous population itself. With a clearer understanding of Indigenous well-being and its determinants, more appropriate policy, and ultimately better outcomes, will be able to be achieved for this population—with the mantra of data by us, for us." (Lovett, 2020, p. 4)*

Walter and colleagues (2021) suggest that the future success of the now reformed Closing the Gap strategy, or any other initiative aiming to improve outcomes for Indigenous people, should rely on data that is high quality, relevant, disaggregated, and reflects the perspectives and priorities of Aboriginal and Torres Strait Islander people. By providing disaggregated, nuanced and contextualised data that focuses on the priorities and resilience of Aboriginal and Torres Strait Islander women, the approach to the data in this thesis avoids BADDR data (Walter, Lovett et al., 2021) and is more aligned with the principles of 'indigenous data needs'(Walter, Lovett et al., 2021), which are summarised below in Table 3.

Also guiding the construction, analysis and interpretation of the data in this thesis are the principles of an indigenous quantitative methodology called 'nayri kati' (meaning 'good numbers' in Pakana language) (Moreton-Robinson and Walter, 2010). Nayri kati reframes quantitative research discourse by positioning Indigenous researchers as the decision makers regarding research questions and agendas. I have engaged with this thesis through the prism of my lived experience as an Aboriginal woman who was born and raised in

Naarm, where the study has taken place. In nayri kati methodology, the analyses and interpretation of the data is framed by an indigenous lens (Moreton-Robinson and Walter, 2010). The application of nayri kati in this thesis will be discussed in more detail in section 5.1.1.

TABLE 3 - INDIGENOUS DATA NEEDS

Lifeworld data	We need data to inform a comprehensive, nuanced narrative of who we are as peoples, of our culture, our communities, of our resilience, our goals and our successes
Disaggregated data	We need data that recognise our cultural and geographical diversity and can provide evidence for community-level planning and delivery
Contextualised data	We need data that are inclusive of the wider social structural complexities in which Indigenous disadvantage occurs
Indigenous priority data	We need data that measure not just our problems but data that addresses our priorities and agendas
Available, amendable data	We need data that are accessible and amendable to our requirements

Adapted from Walter et al (2021).

2.5 Health and maternity service policy today

As a redress for the current burden of inequitable perinatal outcomes experienced by Aboriginal and Torres Strait Islander women and newborns (AIHW, 2023; AIHW, 2023), numerous policies recommend the implementation of evidence-based programs to improve maternity service provision for Aboriginal and Torres Strait Islander women. Additionally, maternity service provision that is equitable and First Nations-led has been called for by peak Aboriginal and Torres Strait Islander health bodies such as the Lowitja Institute (Dudgeon, Bray et al., 2020) and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) (ACM, CATSINaM et al., 2017)

In summary, current Australian federal and state Government health and maternity service policies recommend addressing perinatal health inequities by: improving access to

pregnancy care and continuity of carer, partnering with First Nations communities, implementing 'Birthing on Country' services, ensuring workforce cultural competence, and growing the Aboriginal and Torres Strait Islander maternity workforce (COAG Health Council, 2019 {Department of Health, 2012 #144; Department of Health, 2021) (AHRC, 2020; Department of Health and Aged Care, 2019; Queensland Health, 2019).

The current overarching national strategy for Australian maternity services 'Woman-centred care: Strategic Directions for Australian maternity services framework' (COAG Health Council, 2019) recommends implementing culturally safe models of care for Aboriginal and Torres Strait Islander communities that align with the principles of *Birthing on Country* (to be defined and discussed later in this chapter). The strategy also lists a number of enablers that largely refer to recommendations made in other documents, such as the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017) and the Culturally Competent Maternity Care for Aboriginal and Torres Strait Islander Women Report (Kruske, 2012). Access to maternity service provision that is both safe and culturally appropriate is as a key evaluation indicator of the strategy (COAG Health Council, 2019).

A 'life course approach' to health equity is taken in national Aboriginal and Torres Strait Islander health policy, which harbours a focus on maternal and newborn health (Department of Health, 2021). Additionally, the National Women's Health Strategy 2020-2030, which aims to address gender inequities in health, recognises that the lives of First Nations women and girls are different to those of other women in Australia. As such, Aboriginal and Torres Strait Islander women and girls are listed as a priority population, and the report adds that as various aspects of a person's identity (gender, race, sexuality, etc.) can intersect, there is a need for multi-sectoral approaches and partnerships with women to deliver improved outcomes and effective services (Department of Health and Aged Care, 2019). The compounding impacts of intersectionality on Aboriginal and Torres Strait Islander women's wellbeing was also raised in the Wiyi Yani U Thangani (Women's Voices) report, which states that political erasure of the multiple oppressions that go beyond gender equality, for Aboriginal women, often results in failure of policy and legislation (AHRC, 2020). Represented in this report are the voices of many Aboriginal and Torres Strait Islander women and girls, who call for culturally appropriate service delivery models. Support for maternal and infant health is emphasised specifically (AHRC, 2020). The report discusses the value of traditional knowledges of birthing,

maternal health and parenting and the need for improved programs in both mainstream and ACCHO sectors (AHRC, 2020).

Queensland is the only state or territory that has developed an Aboriginal and Torres Strait Islander health strategy dedicated to maternity care, called the Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Servies Strategy 2019-2025 (Queensland Health, 2019). The strategy is informed by recent evidence and includes co-designing and delivering services in partnership with Aboriginal and Torres Strait Islander communities; access to comprehensive, woman-centred, continuity of midwife care for all women pregnant with an Aboriginal and/or Torres Strait Islander baby, and a culturally capable workforce with more Aboriginal and Torres Strait Islander people working in maternity care (Queensland Health, 2019).

2.5.1 Victorian context

Victorian Aboriginal health policy also recognises maternal and newborn health as important areas, but there is no current maternity-specific strategic direction policy available. The now-expired Koolin Balit (2012-2022) named ‘high quality and accessible antenatal care’ as a key priority for improving Aboriginal maternal and birthing outcomes, but the policy stated that ways to improve access to quality maternity care were still being reviewed (Department of Health, 2012). Targets towards a ‘healthy start to life’ as dedicated priority were however included, such as more Aboriginal mothers receiving early antenatal care; positive lifestyle behaviour support programs; and enhanced links between programs and initiatives across different departments (Department of Health, 2012). The current strategic plan for Aboriginal health in Victoria for 2017-2027, Korin Korin Balit-Djak,(Department of Health and Human Services, 2017) no longer includes a dedicated maternal and newborn health strategy, instead encompassing a broader focus on better access to culturally responsive early-years services. The policy does, however, support the expansion of the Koori Maternity Service (KMS) program, which was established in 2000 as a culturally tailored maternity service for Aboriginal women in Victoria (see section 2.5.3) (Department of Health and Human Services, 2017).

2.5.2 Partnering with First Nations communities

Each of the policies cited in the previous section recognise that improvements to maternity care and outcomes for women and babies can only be achieved through

partnering with Aboriginal and Torres Strait Islander communities. Partnerships between ACCHOs and mainstream or government organisations are critical to improving health outcomes (Haynes, Taylor et al., 2014). Formal partnerships and shared decision making have been listed as priority reform number one in the 2023 Close the Gap report (National Indigenous Australians Agency, 2024). For effective models of maternity care, the evidence iterates that input from Indigenous women is foundational (Corcoran, Catling et al., 2017).

Although partnerships between government services and the ACCHO sector are crucial in addressing service gaps and improving care, they can also be complex due to power differentials, colonial practices, funding and outcome pressures, and confusion over where responsibility lies (Haynes, Taylor et al., 2014; Taylor and Thompson, 2011; Tsou, Haynes et al., 2015). Gaining community perspectives is essential for effective service planning (Palmer, Weavell et al., 2019), yet Aboriginal and Torres Strait Islander women have often been excluded from how services for them are designed and delivered (Kildea, Lockey et al., 2016). A number of Australian maternity programs have reported success with engaging local communities (Bertilone and McEvoy, 2015; Kildea, Gao et al., 2021; Middleton, Bubner et al., 2017; Murphy and Best, 2012; Yu, Gold et al., 2014), yet how mainstream maternity services and ACCHOs could link together to provide culturally appropriate birthing services in urban and regional areas remains understudied (Sivertsen, Anikeeva et al., 2020).

The history of the Closing the Gap campaign is one example of how a lack of partnerships can weaken efforts to improve outcomes. It was not until December 2019,16 years after the ‘Closing the Gap’ targets were originally agreed upon (by COAG), that a genuine partnership was formalised with the Coalition of Aboriginal and Torres Strait Islander Peaks Organisations (the Coalition of Peaks) (Lovett, Jones et al., 2020). The ineffectiveness of the Closing the Gap campaign was established when only two of the seven targets were ‘on track’ in 2020 (Commonwealth of Australia, 2020). Some First Nations scholars have critiqued Closing the Gap as failing to improve outcomes and generating deficit discourse by positioning Aboriginal people as the problem (Bond and Singh, 2020; Lovett, Jones et al., 2020). Referring to a Closing the Gap refresh in the form of 16 new targets, Former Prime Minister Scott Morrison announced that for the ‘first time’ Closing the Gap would commit to ‘Indigenous Australians having a ‘real say’ (Commonwealth of Australia, 2020). The Lowitja Institute has since led the reporting on the progress of Closing the Gap, which addresses the upstream factors impacting on the

health of Aboriginal and Torres Strait Islander people (such as climate change) and maintains a strengths-based key message that First Nations communities have the solutions to their own health and wellbeing (Lowitja Institute, 2022).

The National Aboriginal and Torres Strait Islander Health plan advises that true partnership prioritises self-determination and recognises the unique needs of Aboriginal and Torres Strait Islander people, facilitates Aboriginal and Torres Strait Islander leadership, and maintains genuine shared decision making (Department of Health, 2021). Principles of successful ACCHO-mainstream partnerships include long-term relationships based on trust; respect for cultural knowledge; commitment to self-determination; shared responsibility and accountability; redressing unequal power differentials; and an openness to working differently (Burton, 2012). Importantly, the plan makes an important distinction between 'consultation' and 'self-determination'. Consultation alone may not equate to autonomy in decision making or control over processes and outcomes (Department of Health, 2021). The Wiyi Yani U Thangani report (AHRC, 2020) discusses that communities have lost faith in 'consultation' due to feeling unheard and recommends that partnerships should instead focus on 'co-design' as a more appropriate way to engage:

> *"The traditional government approach to community engagement involves 'consultation'. This approach is rigid, has proven to fail over decades of continued disadvantage and over-representation … In contrast with 'consultation', co-design involves service providers and communities working together from the outset to develop new approaches that are genuinely informed by clients. By working directly with Aboriginal and Torres Strait Islander men, women and children on every aspect of program design and evaluation, communities will ensure that programs are designed to be safe, accessible and culturally and locally relevant."* (AHRC, 2020) (p. 84).

For maternity services to meet the needs of Aboriginal and Torres Strait Islander women, Aboriginal and Torres Strait Islander women must be positioned as decision makers in relation to the development, delivery and evaluation of such programs (AHRC, 2020).

2.5.3 The Koori Maternity Service (KMS) in Victoria

The Victorian KMS program was established in 2000 in partnership between the Department of Health and VACCHO as a strategy to provide culturally appropriate maternity care for Aboriginal women by (Campbell, 2000). Community consultation involved talking to over 230 Aboriginal women about their experiences with antenatal care and care in hospitals and led to the development of a report called 'From her to Maternity' (Campbell, 2000). The report aimed to identify the maternity services available to Victorian Aboriginal communities, while gathering evidence to inform the implementation a new program (Campbell, 2000). The report concluded there were significant gaps in service provision, no community in Victoria was resourced to offer culturally appropriate and complete maternity care, and choices for Aboriginal women were virtually non-existent (Campbell, 2000). Mainstream maternity facilities were described as incompatible for use by Aboriginal people (Campbell, 2000). However, the report did however highlight Rumbalara (established in 1996 in Kanny-goopna/Shepparton) and the Victorian Aborignal Health Service (VAHS) (established in 1996 in Naarm/Melbourne) as two examples of successful maternity programs offered in partnership between mainstream maternity services and ACCHOs (Campbell, 2000). Recommendations from the report included collaborative partnerships between mainstream hospitals and ACCHOs through Memorandums of Understanding and shared clinical practice partnerships between midwives and Aboriginal Health Workers (Campbell, 2000).

There are now 14 KMS sites across Victoria, three of which are embedded within public maternity hospitals (Department of Health and Human Services, 2017). VACCHO stated in the most recent evaluation of KMS , dated back to 2007, that a strong focus of KMS is facilitating effective partnerships with mainstream birthing services and increasing Aboriginal women's access to services early in their pregnancy (VACCHO and Cooperative Research Centre for Aboriginal Health, 2007). This evaluation found that access to antenatal care was increased through shared care partnership agreements at VAHS. The evaluation also stated there was evidence of increased average birthweights, though there was no data demonstrating trends over time available in the report (VACCHO and Cooperative Research Centre for Aboriginal Health, 2007). Additionally, the evaluation discusses that the KMS program focuses on antenatal and postnatal care only and does not formally address in-hospital components of care, particularly for labour and birth (VACCHO and Cooperative Research Centre for Aboriginal Health, 2007).

2.5.4 Continuity of midwife care (caseload midwifery)

Access to continuity of midwifery care is recommended in policy (COAG Health Council, 2019; Department of Health, 2012; Queensland Health, 2019). The overarching Baggarrook Yurrongi project aimed to implement, embed, and sustain, caseload midwifery models of care for women having an Aboriginal or Torres Strait Islander baby across pregnancy, labour and birth and in the postnatal period. Caseload midwifery is a type of maternity care where a pregnant woman has 24/7 access to a 'known' midwife (and one or two backup midwives) throughout her pregnancy. The midwife (or the back up midwives) care for the woman during labour, birth, and during the early postnatal weeks (AIHW, 2016). High-level Australian evidence not focusing on Aboriginal and Torres Strait Islander women shows that continuity of midwife care (and carer) provides benefits for women and newborns including less pre-term births, less perinatal deaths, less admissions to the Neonatal Intensive Care Unit, less need for surgical births (McLachlan, Forster et al., 2012; Tracy, Hartz et al., 2013) and also that women benefit psycho-socially with increased feelings of satisfaction with care (Allen, Kildea et al., 2017; Forster, McLachlan et al., 2016). The most recent Cochrane review found women reported more positive experiences during pregnancy, labour, and postpartum, with less need for medical intervention and cost savings in the antenatal and intrapartum period (Sandall J, Fernandez Turienzo C et al., 2024). A recent scoping review including 59 studies relating to women's views of their maternity care needs in Australia found that having continuity of carer (most often continuity of midwife care) is highly desirable among Australian women (Faktor, Small et al., 2024). This was apparent in the literature overall, but also in the ten studies included in the review that specifically related to Aboriginal and Torres Strait Islander women (Faktor, Small et al., 2024).

For Aboriginal and Torres Strait Islander women and babies, the literature supports that caseload midwifery models are safe and are associated with improved perinatal outcomes, as demonstrated in a prospective, non-randomised, interventional trial conducted in Meanjin/Brisbane, QLD (Kildea, Gao et al., 2021). The trial found that compared with standard hospital care, outcomes were improved for women who received a 'Birthing in Our Community Service', described as a holistic, wrap around service with an Aboriginal workforce and continuity of midwifery carer (Kildea, Gao et al., 2021). The improved outcomes included a decreased pre-term birth rate, higher rates of exclusive breastfeeding, and more regular antenatal care visits (Kildea, Gao et al., 2021) Other

evidence has highlighted decreased levels of tobacco use, and increased feelings of trust and safety among Aboriginal women who have access to a known midwife (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Kildea, Stapleton et al., 2012). Overall, caseload midwifery appears to enhance the ability of the system to meet the needs of women, and is valued by Indigenous women (Corcoran, Catling et al., 2017).

Access to a known midwife is recognised as a strategy to improving the maternity care that is available for Aboriginal and Torres Strait Islander women (Queensland Health, 2019) and is an important aspect of culturally competent maternity care (Kruske, 2012). Despite the known benefits, approximately 15% of women in Australia have access to a caseload midwife through a continuity of midwife care program (AIHW, 2023), with data from three tertiary hospitals in Naarm suggesting that prior to the commencement of the Baggarrook Yurrongi project, Aboriginal and Torres Strait Islander women in Victoria have been less likely to have access (McLachlan, Newton et al., 2022).

2.5.5 Birthing on Country

In 2011, the now expired National Maternity Service Plan 2010-2015 (Commonwealth of Australia, 2011) set out three strategic directions which were to 1) increase the cultural competence of the maternity system 2) support the First Nations workforce and 3) establish *'Birthing on Country'* (BoC) models of care.

As a key deliverable of this plan, the first ever Australian BoC workshop was hosted in 2012, located in Mparntwe (Alice Springs) (Kildea, Magick Dennis et al., 2012). Researchers, Elders, community members, and key stakeholders met to discuss BoC. The objectives were to establish Australia's commitment to BoC, create community representative steering groups, develop an implementation framework, and identify possible BoC pilot sites across different geographical contexts (Kildea, Magick Dennis et al., 2012).

The workshop built on international evidence showing that the Inuulitsivik midwifery service, located in a remote area of the Inuit region in Quebec, Canada, established a community-based birth service with improved outcomes for women and babies (Van Wagner, Epoo et al., 2007; Van Wagner, Osepchook et al., 2012).

At the workshop, it was decided that BoC should be understood as

> *"a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families because it provides an integrated, holistic and culturally appropriate model of care; not only bio-physical outcomes ... it's much, much broader than just the labour and delivery ... (it) deals with socio-cultural and spiritual risk that is not dealt with in the current systems. It is important that the Birthing on Country project moves from being aspirational to actual. The Birthing on Country agenda relates to system-wide reform and is perceived as an important opportunity in 'closing the gap' between Indigenous and non-Indigenous health and quality of life outcomes."* (Kildea, Magick Dennis et al., 2012) (p.25).

Since this initial workshop, evidence has been emerging. BoC is described as a 'metaphor', a model of care (Kildea, Lockey et al., 2016) and an international social justice movement to return birthing services back to First Nations communities (Ireland, Maypilama et al., 2021). This movement has been endorsed by key First Nations academics in field of midwifery (Chamberlain and Marriott, 2019).

The principles of a BoC model of care are as follows:

- community-based and governed;
- allow for incorporation of traditional practice;
- involve a connection with land and country;
- incorporate a holistic definition of health;
- value Indigenous and non-Indigenous ways of knowing and learning;
- culturally competent risk assessment and service delivery; and
- developed by, or with, Indigenous people (Kildea, Lockey et al., 2016).

The physical act of giving birth 'on Country' may or may not be relevant or possible, depending on the woman's context. Models of maternity care, however, should be guided by these 'Birthing on Country' principles (Kildea, Lockey et al., 2016) with features embedded to facilitate connection to Country for any First Nations woman, in whichever context she is birthing in. Important to note, is that continuity of midwife care has also been identified as a key feature of BoC models of care (Kildea, Lockey et al., 2016).

A framework for implementing BoC models of care in Australian maternity services, called the RISE framework, has also been developed (Kildea, Hickey et al., 2019.) As mentioned in the previous section, the 'Birthing in Our Community' service, which included continuity of midwife care, was underpinned by BoC principles (Kildea, Hickey

et al., 2017). The success of this model included increased rates of antenatal attendance, breastfeeding, and a 38% reduction in pre-term births (Kildea, Gao et al., 2021). The cultural needs of women who are birthing in urban settings must continue to be investigated, as Marriot and colleagues (2019) discuss that BoC models of care cited in the literature often relate to rural and remote contexts, though a significant proportion of Aboriginal and/or Torres Strait Islander women either live in urban areas or relocate to an urban setting for birth.

Despite the demonstrated benefits of BoC services, lack of support from government funders has meant that progress has been slow (Hickey, Roe et al., 2021 {Central Australian Aboriginal Congress, 2023 #303). As a response, an international collaboration of Indigenous and non-Indigenous researchers published an urgent call to action, arguing for adequate funding for Indigenous-led solutions (Hickey, Roe et al., 2021). Leading researchers in the field urged for ongoing scale-up and subsequent evaluation of these evidence-based programs across diverse Australian contexts (Kildea, Gao et al., 2021; McLachlan, Newton et al., 2023). A rural BoC site was established on the lands of the Yuin Nation (Nowra, NSW). This ACCHO, known as Waminda, aims to reclaim birth and facilitate birthing on Country, with funding secured by the Government of New South Wales to support the first Aboriginal owned and operated birth centre to be built and on this continent (Haora, Roe et al., 2023). At the time of this thesis publication, the birth centre has not yet been built. Other BoC trial sites have been selected such as a remote site at Congress Alukura in Mparntwe (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023) and a very remote site in Galiwinku, Northeast Arnhem Land (Ireland, Maypilama et al., 2021). Research is underway to implement and evaluate programs in these locations.

A large gain for the BoC movement is that the establishment of BoC services is now recommended in government strategic directions for maternity services (COAG Health Council, 2019). Investing in BoC Services was also listed as a strategy in the 2023 Closing the Gap report (Commonwealth of Australia, 2023). However, is has been noted that confusion regarding terminology of what ‘Birthing on Country’ means resulted in national debate, and other structural barriers have been identified that have slowed the progression of rolling out BoC services (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023).

Ten years after the initial BoC gathering in 2012, a second national gathering in Mparntwe was held for women to gather with stakeholders and industry leaders progress the BoC movement (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023). Other objectives of the second national gathering was to consult on the continued use of the term 'Birthing on Country' and to initiate the co-design of a ten-year national roadmap so that the vision of a 'best start to life' for First Nations families can be realised (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023). To date this roadmap has not yet been published, however, preliminary themes include that governments resolve barriers to ACCHOs in delivering local, holistic, BoC services with relationship-based care from a Aboriginal and/or Torres Strait Islander workforce (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023).

In summary, this chapter has discussed historical, social and political issues impacting on the health of Aboriginal and Torres Strait Islander People. A review of the health and maternity care policies illustrated that evidence-based programs should be implemented in partnership with Aboriginal and Torres Strait Islander communities. The evidence for continuity of midwife care as a strategy for improving the maternity care available to Aboriginal and Torres Strait Islander women was reviewed, before finally defining and discussing 'Birthing on Country' services.

Chapter 3: Review of the literature

This chapter reports on a systematic search of the literature on Indigenous women's experiences of their maternity care. A description of each step of the search strategy is included, and then the findings discussed and critiqued.

3.1 Search strategy

Step 1: Identify research question and search terms

The research question for this search of the literature was 'what are the maternity care experiences of Indigenous women?'. Key points and concepts were extracted from the research question using a 'Population Exposure Outcome' (PEO) template (Bettany-Saltikov and McSherry, 2016).

The population of interest was 'Indigenous women'. The exposure was 'maternity care' and the outcome of interest was 'experiences'. For the purpose of the search, 'Indigenous' meant women who identified as belonging to a non-dominant cultural group recognised as the First Peoples who occupied a geographical area before the arrival of people from other cultures or ethnic origins (United Nations, n.d).

The context of this thesis is Aboriginal and/or Torres Strait Islander women accessing maternity care and birthing in an urban setting. For the purpose of this search, 'maternity care' refers specifically to care from a formal health service (i.e. antenatal clinic, ACCHO, or maternity unit in a hospital) or care from a formal health provider (i.e midwives, Aboriginal health workers, obstetricians, or general practitioners). Research relating only to the perspectives of the care providers were not included. Articles relating to maternal or maternity care from conception up to one year old were included, as per a previous scoping review on a similar topic (Marriott, Strobel et al., 2019). Original research articles only were included.

In terms of geographical location, papers were included from other high-income colonised countries with recognised Indigenous Peoples, from either rural, remote, regional, or urban contexts. The rationale for excluding papers from low-middle income countries was due to vastly different historical, political, economic, and geographical contexts compared with Australia. Further, the United States, Australia, New Zealand, and Canada are often considered as comparable contexts when exploring First Nations

wellbeing (Cooke, Mitrou et al., 2007). Additionally, First Nations Canadians, Australian Aboriginal and Torres Strait Islanders Peoples, Māori, First Americans, and Alaska Natives have a shared history of assimilation, protectionism, and dispossession from former or existing British colonies (Cooke, Mitrou et al., 2007).

Step 2: Identify synonyms and alternative phrases

The population search terms were chosen to include groups specific to high income countries with recognised indigenous populations (Cooke, Mitrou et al., 2007). 'Maternity care' was expanded to cover various aspects of perinatal care from pregnancy, birth, and the postnatal period up to one year, as well as 'midwifery' and 'obstetric' to cover maternity providers including midwives, obstetricians, obstetric nurses and/or perinatal nurses. Quotation marks to indicate a phrase such as 'maternity care' or 'First Nations'. A thesaurus was used for the keyword 'experiences' (Bernard, 2007)

TABLE 4 - SEARCH TERMS USED IN A REVIEW OF THE LITERATURE

	Population	**Exposure**	**Outcomes**
	OR ↓	**OR ↓**	**OR ↓**
AND →	Aboriginal	Maternity care	Experiences
	Indigenous	Pregnancy care	Views
	Torres Strait Islander	Birth	Perceptions
	"First Nations"	Obstetric	Satisfaction
	Native	Midwifery	Feelings
	Māori	Antenatal	Stories
	"First American"	Maternity	Perspectives
	Sámi	Perinatal	Outcome
	Inuit	Postnatal	Evaluation

Step 3: Abbreviations and truncations

Any abbreviations and truncations were identified. The appropriate symbols and formatting was as below:

Wom* (women, woman, women's), Midwi* (midwife, midwifery, midwives , Obstet*(Obstetrics, Obstetric), Birth* (birth, birthing, births, birthed), Experience* (experience, experiences), View* (view, views), Perception* (perception, perceptions), Feeling* (feeling, feelings); Stor* (story, stories, storytelling), Perspective* (perspective, perspectives) and Outcome* (Outcomes).

Step 4: Choosing a database

CINAHL and PubMed were the databases used for the search. CINAHL is a leading nursing and midwifery focused database (Aveyard, 2014; Wishart, 2012) and PubMed is also a leading database in health sciences more broadly (White, 2020).

Step 5: Combining the key words

The key words in the PEO table were used to develop a search strategy string. The words were individually typed and linked, using the words "OR". The separate concepts were then linked using the word "AND". This is known as Boolean logic (Oliver, 2012).

Step 6: Determine filters

The same filters were applied for both searches and were as follows: 'English language' and 'female'. No publication year limit was set.

Step 7: CINAHL search

The most recent search using these terms in CINAHL was undertaken on the 6th of March, 2024.

A total of 1381 results between the years 1979 to 2024 were yielded. Many articles were identified as irrelevant by reading the titles. Abstracts were also scanned if it was not clear from the title if the article should be included. Articles related to the Baggarrook Project were excluded.

Step 8: PubMed search

The most recent search using these terms in PubMed was undertaken on the 8th of March, 2024.

((Aboriginal OR Indigenous OR "Torres Strait Islander" OR "First Nations" OR Native OR Maori OR "First American" OR Inuit OR sami [MeSH Terms]) AND ('Maternity care' OR 'Pregnancy care' OR Birth* OR Obstetric* OR midwi* OR antenatal OR maternity OR perinatal OR postnatal[MeSH Terms])) AND (Experience* OR view* OR perception* OR satisfaction OR feeling* OR Stor* OR perspective* OR outcome* OR evaluation[MeSH Terms])

This search yielded 3,638 results. It appeared that the term 'outcome' included many papers that were focused on biomedical risk factors for specific perinatal outcomes or diseases and were not relevant to the research topic. As such, the term 'outcome' was removed from the PubMed search. This narrowed the search down to 1,920 results from

the years 1971 to 2024. Titles and abstracts in the results of the data base searches were then scanned. Duplicates from the CINAHL search were not included.

Step 9: Assess papers for full examination

Scanning of titles and abstracts in the databases led to a total of 54 papers (45 from CINAHL and an additional nine from PubMed) being identified and included for further examination. Of these, nine articles were removed after it became apparent from reading the manuscripts that they did not provide evidence relevant to the research question.

Step 10: Read included articles

A total of 46 articles were included and read in full.

Step 11: Hand search

Reference lists of included articles were 'hand searched', which involved a manual page by page examination of the text to identify additional literature that was not found in the electronic search (Armstrong, Jackson et al., 2005). One additional article which met the inclusion criteria was included and added to the literature.

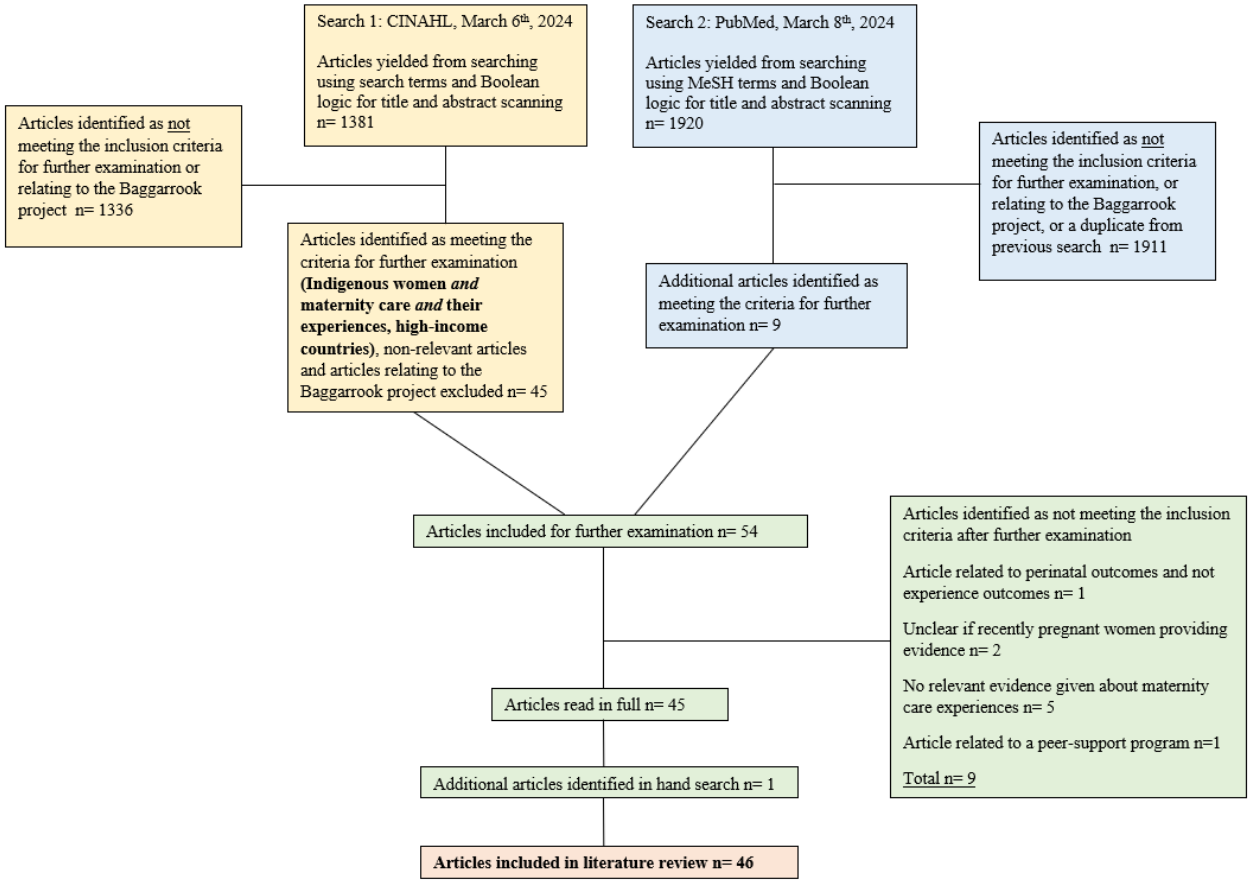


FIGURE 6 - LITERATURE REVIEW SEARCH FLOWCHART

3.2 Critique of the evidence

Forty-six research articles were identified that provided evidence of Indigenous women's views and experiences of their maternity care (Figure 6). Only evidence from counties with a colonial history comparable to Australia were included (New Zealand, the United States and Canada). Below an overall critique of the evidence is provided, before discussing the findings of the evidence in more detail.

3.2.1 Study designs

Most identified papers (n = 32) were of a qualitative design with interviews or focus groups and included a sample size ranging from seven to 20 participants. A few studies used larger sample sizes (ranging from 30 to over 100 participants) (see Table 5). Some studies used Participatory Action Research (PAR) with focus groups and so included larger samples (Brown, Varcoe et al., 2011; Varcoe, Brown et al., 2013). PAR is seen as

an appropriate methodology that facilitates genuine partnerships with Aboriginal and Torres Strait Islander communities in research, due to the minimised power differentials and the ability of research participants to also act as co-investigators (Dudgeon, Bray et al., 2020). In a study that explored the birthing experiences of rural Aboriginal women, Brown et al (2011) discussed that the sample size was decided by the community. Other studies, however, did not provide a clear rationale for including a larger sample size (Hanson, 2012; Kirkham, King et al., 2021; Makowharemahihi, Lawton et al., 2014; Marriott, Reibel et al., 2019b; Reibel, Morrison et al., 2015; Sheffield and Liddell, 2023). On the other hand, authors of some studies with sample sizes of three to five women did recognise a possible limitation in representing women's views (Burns, Whitty-Rogers et al., 2019; Dietsch, Martin et al., 2011; Silver, Tukalak et al., 2023), while others did not discuss this (Buchner, Pearson et al., 2022; Hanson, 2012; Kelly, West et al., 2014; Seear, Spry et al., 2021).

Most of the qualitative studies applied Western interpretive designs such as ethnography (Brown, Varcoe et al., 2011; Ireland, Wulili Narjic et al., 2011; Varcoe, Brown et al., 2013), phenomenology (Brown, Fereday et al., 2016; Kirkham, King et al., 2021; Whitty-Rogers, Caine et al., 2016) or content analysis (Hanson, 2012; Seear, Spry et al., 2021; Spangaro, Herring et al., 2016; Spangaro, Herring et al., 2019). These designs do not necessarily account for issues of power differentials in research (Chilisa, 2012). Some authors did however describe community collaboration though PAR principles (Brown, Varcoe et al., 2011; Varcoe, Brown et al., 2013; Whitty-Rogers, Caine et al., 2016). Others that did not use PAR still provided details of community collaboration throughout the research process (Hanson, 2012; Kornelsen, Kotaska et al., 2010).

What is striking about the qualitative literature is the lack of discussion relating to theoretical frameworks underpinning the research and the reflexivity of the researcher (see Table 5). This brings ambiguity to qualitative researchers' application of social theory or awareness of the assumptions that have informed their research (Creswell and Poth, 2018; Willis, Daly et al., 2007). Some of the articles discussed this, but with varying levels of detail (Buchner, Pearson et al., 2022; Churchill, Smylie et al., 2020; Ireland, Wulili Narjic et al., 2011; Lawford, Giles et al., 2018; Makowharemahihi, Lawton et al., 2014; Massi, Hickey et al., 2023). Using Western methodologies to interpret and explain Indigenous women's views and experiences, without naming a theoretical or conceptual framework as the lens through which the research was constructed, or the importance of reflexivity, potentially undermines the strength of the research findings. Table 5

demonstrates that this is a common occurrence in research relating to Indigenous women's views and experiences of their maternity care. Further, some authors discuss using indigenous methodologies, but do not discuss their own reflexivity, which is an important practice in the use of indigenous methodologies (West, Stewart et al., 2012).

Indigenous methodologies, which are recommended in researching Indigenous women's health (Marriott, Strobel et al., 2019; McGuire-Adams, Gaudet et al., 2023), were not used in most of the articles (indigenous methodologies will be discussed in detail in Chapters four and five). Many of the papers did not clearly name a First Nations researcher as the lead author. Indigenous methodologies were used in 14 studies, mostly by researchers in Australia (n= 10), though there were varying levels of discussion or clarity around how they were applied. Originating from Critical Theory (see Chapter four), indigenous methodologies are concerned with relationality, sovereignty, power relations, privileging indigenous worldviews, and are emancipatory (Martin and Mirraboopa, 2003; Moreton-Robinson, 2017; Moreton-Robinson and Walter, 2010; Rigney, 1999; West, Stewart et al., 2012). Only three articles connected the use of indigenous research methodologies to a critical lens (Churchill, Smylie et al., 2020; Kelly, West et al., 2014; Massi, Hickey et al., 2023). Some researchers did discuss issues of positionality and the lens applied to the interpretation of the research data (Austin, 2023; Bowden, Toombs et al., 2023; Marriott, Reibel et al., 2019b), but most often this was not discussed. Only one study from Australia discussed the issue of sovereignty as a critical tenet of indigenous methodologies. The non-Indigenous first author also discussed that issues of sovereignty are likely to be best conveyed by Aboriginal and Torres Strait Islander researchers themselves (Austin, 2023).

In the Australian literature, 'Yarning' as a method was used by nine qualitative studies (Austin, 2023; Bovill, Gruppetta et al., 2018; Bowden, Toombs et al., 2023; Carlin, Atkinson et al., 2019; Chan, Reid et al., 2022; Kelly, West et al., 2014; Lyall, Egert et al., 2023; Lyall, Guy et al., 2020; Massi, Hickey et al., 2023) ('Yarning' will be discussed further in Chapter five). Information provided about how 'Yarning' was applied as a research method varied, and whether or not the research is written by Aboriginal or Torres Strait Islander people is not always clear. One research paper, for example, does discuss that the first author is not Indigenous, and states they were not comfortable using 'Yarning' so instead used the 'spirit of yarning', though it is not clear how this this was enacted (Bowden, Toombs et al., 2023). The increasing number of research articles citing

‘Yarning’ as a method and the need for authors to ensure transparency and clarity in the use of ‘Yarning’ has previously been raised (Kennedy, Maddox et al., 2022).

Ten studies used a mixed-methods design with interviews and structured surveys. Some authors stated that ‘triangulation’, which refers to using different data sources to explore a single topic (Creswell and Miller, 2000), strengthened the findings (Glover, Waldon et al., 2009; Kildea, Stapleton et al., 2012). However, only three out of the 10 mixed-methods studies included data relating to women’s views or experiences in both the quantitative and qualitative components. Five instead used quantitative data to present clinical outcomes (see Table 5). Other mixed-methods studies did not present or clearly discuss the quantitative data (see Table 5). Additionally, the authors of a study which used a population-based survey to describe the maternity care experiences of Aboriginal and/or Torres Strait Islander women in Queensland discussed acquiring low levels of qualitative data due to less participant responsiveness to the open-ended free text questions (Parker, McKinnon et al., 2014). This study still provides substantial contribution to the body of evidence with a large sample size of 187 women, which the authors discussed was representative of the wider Aboriginal and Torres Strait Islander birthing population in the state at that time. Recommendations for policy and practice were provided, including cultural competence, increasing continuity of carer, and engaging women in the design of services (Parker, McKinnon et al., 2014).

Three articles were a quantitative design, two of which report on data from one single cohort of women having an Aboriginal and/or Torres Strait Islander baby (n=344) residing in either remote, regional or urban settings in South Australia (Brown, Gartland et al., 2019; Brown, Weetra et al., 2015). The authors discussed that the sample was representative of the Aboriginal birthing population in South Australia, and that the inclusion of 12 Aboriginal community members as part of the research team facilitated the recruitment of such a large number of women from different geographical locations. A population-based survey compared women’s experiences of mainstream care or experiences of care from the Aboriginal Families Birthing Program (AFBP), which aimed to provide culturally appropriate primary health care for pregnant Aboriginal women and their families (Brown, Weetra et al., 2015). The authors state that the use of structured booklets was based on advice given during consultation with the community (Brown, Weetra et al., 2015). As women who attended the AFBP were more likely to report positive experiences of care, this study provides important evidence of the benefit of

culturally specific birthing programs. Women's views and experiences of their labour, birth and postpartum care, however, are not addressed. For the second study, the authors discuss that this was the first study in Australia to link experiences of discrimination with birth outcomes, and that the study was conducted in partnership with the relevant AHSs with an Aboriginal Advisory Group and community consultation (Brown, Gartland et al., 2019). The authors did however discuss the lack of a standardised tool to measure experiences of racism in the perinatal sector, and that the study could not address impacts of everyday experiences of racism or systemic or structural racism on perinatal outcomes (Brown, Gartland et al., 2019).

The other quantitative study was conducted in the year 2004, and evaluated the Women's Business Service, located at the Mildura Aboriginal health service, a rural town in the far northwest of Victora (Campbell and Brown, 2004). Structured interviews were conducted with a small sample of 25 women who accessed the service, though the authors state that sample size was restricted due to small numbers of women attending the service (40 to 50 women per year). The service was described as a community-controlled primary health service that aimed to provide holistic antenatal and postnatal care to Aboriginal women in Mildura from a midwife and an Aboriginal maternal health worker. On-call support for labour and birth was available but it is not clear if the midwife acted as the woman's primary intrapartum carer (Campbell and Brown, 2004). Compared with other rural women who completed a similar state-wide maternity service evaluation survey, women participating in the Women's Business Service evaluation were significantly more positive about many aspects of their care in pregnancy and postnatally (Campbell and Brown, 2004). The study concluded that collaborative care between ACCHOs and mainstream health services is beneficial and ACCHOs are well-placed to provide accessible maternity care (Campbell and Brown, 2004). As this study is from the year 2004 the findings could potentially be outdated, and the small sample size could limit the relevance of the findings to the wider Victorian Aboriginal community.

3.2.2 Evaluations of culturally specific birthing programs for Indigenous women

In terms of evaluations of culturally specific birthing programs for Indigenous women, there appears to be a gap in the international literature. Much of the international literature discusses women's experience of 'status-quo' and changes that women would like to see,

rather than evaluating programs that have been implemented. This is except for an evaluation of an urban-based Indigenous focused midwifery program in Canada (Churchill, Smylie et al., 2020) and an evaluation of a recently implemented hospital-based Indigenous birth support program in Canada, which explored the views of program clients (Pandey, Smith et al., 2023). There is also a lack of midwifery research in the international evidence, possibly due to differences in how maternity care systems are delivered in other countries (Kennedy, Balaam et al., 2020). Community-based nursing, maternity nursing, or physician care is sometimes discussed instead (Brown, Varcoe et al., 2011; Burns, Whitty-Rogers et al., 2019; Hanson, 2012; Whitty-Rogers, Caine et al., 2016). Aside from Churchill et al. (Churchill, Smylie et al., 2020), other authors in Canada do discuss that First Nations Canadian communities are reviving community-based midwifery, though these authors focused on areas where no midwifery or birthing services were available (Kornelsen, Kotaska et al., 2010; Lawford, Giles et al., 2018).

The body of Australian evidence was larger, and differences in locations and context are important to consider due to the diversity of Aboriginal and Torres Strait Islander communities. Like Canada, it appears that the experiences of rural and remote women is an area of research interest in Australia. Six articles focused on this context (Campbell and Brown, 2004; Carlin, Atkinson et al., 2019; Dietsch, Martin et al., 2011; Ireland, Wulili Narjic et al., 2011; Josif, Barclay et al., 2014; Seear, Spry et al., 2021) and eight others were not specific to remote areas, but rural and remote living women who had relocated for birth were included in the sample of participants (Brown, Fereday et al., 2016; Brown, Gartland et al., 2019; Brown, Weetra et al., 2015; Kirkham, King et al., 2021; Middleton, Bubner et al., 2017; Parker, McKinnon et al., 2014; Reibel, Morrison et al., 2015; Watson, Hodson et al., 2002). Of these, four studies evaluated culturally specific birthing programs for Aboriginal or Torres Strait Islander women (Brown, Weetra et al., 2015; Campbell and Brown, 2004; Josif, Barclay et al., 2014; Middleton, Bubner et al., 2017).

Of the 11 articles focusing on women who live in urban areas, four evaluated culturally specific midwifery programs for Aboriginal and Torres Strait islander women (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Jan, Conaty et al., 2004; Kildea, Stapleton et al., 2012). There was also one article evaluating a culturally specific, non-clinical parenting support home visiting program (Massi, Hickey et al., 2023). Two explored women's experiences of their maternity care in a general sense (Bowden, Toombs et al.,

2023; Marriott, Reibel et al., 2019b). The other four articles focused more on women's views and experiences of specific clinical or public health interventions (Chan, Reid et al., 2022; Lyall, Egert et al., 2023; Lyall, Guy et al., 2020; Rahman, Weatherall et al., 2023).

2.2.3 Studies from the state of Victoria

Only two studies were from the state of Victoria, where the research in this thesis took place. Additionally, neither were focused on women who live in an urban context. The first article by Campbell et al (2004) was discussed previously as a small quantitative study which evaluated the Women's Business Service, located at the Mildura Aboriginal health service, a rural town in the far northwest of Victoria. This study is the only study identified that evaluated a midwifery service for Aboriginal women in the state of Victoria, and at the time of writing this thesis, was published 20 years ago. The Victorian article relates to maternal and child health services, which are community-based, state government funded primary health services for women in the early postnatal period and for children from birth up to five years (Austin, 2023). Qualitative interviews with 35 Aboriginal mothers who resided in the region of the Glenelg shire in the southwest of the state, and who had children aged birth to five years were conducted. The study aimed to explore factors which enabled access and engagement with maternal child health services from Aboriginal women. Not addressed in this study are any aspects of pregnancy, labour, birth, or in-hospital postnatal care.

3.3 Findings

Below, I provide an overview of the findings in international literature, before specifically focusing on the findings from Australian evidence.

3.3.1 International evidence – overview of the findings

Fifteen articles were identified that explored the views and experiences of Indigenous women from New Zealand (n=2), the United States (n=2) and Canada (n=11). Much of the Canadian literature related to women who lived in rural/remote locations, where local birthing services were not available (Brown, Varcoe et al., 2011; Burns, Whitty-Rogers et al., 2019; Kornelsen, Kotaska et al., 2010; Lawford, Giles et al., 2018; Silver, Tukalak et

al., 2023; Varcoe, Brown et al., 2013). As such, women's experiences in the context of travelling away from home was often the focus.

One article did however evaluate experiences of cultural safety for clients of an urban-based culturally specific indigenous midwifery service in Toronto, Canada (Churchill, Smylie et al., 2020). Indigenous clients of the service conceptualised cultural safety as feeling respected, having a continuous relationship with a known midwife, the inclusion of cultural ceremony, and having an Aboriginal midwife (Churchill, Smylie et al., 2020). This study describes heavy involvement of Indigenous midwives in the research process and used indigenous methodologies with a decolonising lens and appears to contribute important evidence in relation to cultural safety for Indigenous women (Churchill, Smylie et al., 2020).

Another article from the Saskatchewan province of Canada evaluated a recently implemented hospital-based indigenous birth support worker program and explored the views of program clients (Pandey, Smith et al., 2023). The involvement of an Indigenous midwife and Indigenous nurses in program implementation was discussed, and the authors determined that the program provided culturally safe care with increased continuity of carer for Indigenous women. In critiquing this article, there were however some aspects of the study methodology that may have introduced bias into the data. Some of the participants were interviewed by the manager of the program, signalling that not all efforts were made to minimise the power imbalance inherently held by the researcher. Additionally, undertaking interviews in the days after birth does not allow enough time for the possible euphoric effects of labour and birth (known as the 'halo effect') to wear off, nor are women afforded time to properly reflect on their experience (Brown and Lumley, 1997; Waldenström, 2004). Further, difficulties may arise for women in responding truthfully during interviews, if still receiving care as an in-patient, so it may have been more appropriate to delay the timing of interviews until after discharge from hospital.

Overall, family and social supports were reported to be valuable resources for women's wellbeing and disconnection from family or other social supports should be avoided (Burns, Whitty-Rogers et al., 2019; Kornelsen, Kotaska et al., 2010; Makowharemahihi, Lawton et al., 2014; Silver, Tukalak et al., 2023; Varcoe, Brown et al., 2013). Birthing close to home was also viewed as important and described as a 'human right' (Brown, Varcoe et al., 2011; Kornelsen, Kotaska et al., 2010). A number of international studies

suggested that women may feel safer with midwives or other carers who are also Indigenous (Churchill, Smylie et al., 2020; Lawford, Giles et al., 2018; Pandey, Smith et al., 2023; Silver, Tukalak et al., 2023) and that cultural activities are important (Burns, Whitty-Rogers et al., 2019; Churchill, Smylie et al., 2020; Pandey, Smith et al., 2023; Silver, Tukalak et al., 2023). Findings, especially from Canada, were that positive maternity care experiences were associated with high level interpersonal skills, with positive communication and by communicating positively and understanding (Burns, Whitty-Rogers et al., 2019; Whitty-Rogers, Caine et al., 2016), and when the system accommodated cultural needs (Burns, Whitty-Rogers et al., 2019 Churchill, 2020 #661).

International evidence included in this review was that overall, the maternity system is often a challenging space for Indigenous women. Challenges included racism (Buchner, Pearson et al., 2022; Silver, Tukalak et al., 2023; Varcoe, Brown et al., 2013) and care that felt culturally inappropriate (Buchner, Pearson et al., 2022; Hanson, 2012; Sheffield and Liddell, 2023; Sokoloski, 1995; Varcoe, Brown et al., 2013). Overall, there were few opportunities to develop trusting relationships with care providers (Brown, Varcoe et al., 2011; Buchner, Pearson et al., 2022; Hanson, 2012), and overall lack of support from the health system or health care professionals (Buchner, Pearson et al.; Glover, Waldon et al., 2009; Hanson, 2012; Lawford, Giles et al., 2018; Makowharemahihi, Lawton et al., 2014). A lack of choices around who will provide care and/or decision making in care was also highlighted (Brown, Varcoe et al., 2011; Buchner, Pearson et al., 2022; Lawford, Giles et al., 2018; Sheffield and Liddell, 2023; Varcoe, Brown et al., 2013; Whitty-Rogers, Caine et al., 2016), particularly for women living in rural and remote areas where maternity service have closed (Kornelsen, Kotaska et al., 2010; Varcoe, Brown et al., 2013).

Care has been described as impersonal (Hanson, 2012) and inaccessible (Burns, Whitty-Rogers et al., 2019; Hanson, 2012; Whitty-Rogers, Caine et al., 2016) with poor communication from health care professionals (Buchner, Pearson et al., 2022; Hanson, 2012; Silver, Tukalak et al., 2023). Women reported not being listened to (Hanson, 2012; Pandey, Smith et al., 2023; Whitty-Rogers, Caine et al., 2016) and receiving non-consensual procedures (Sheffield and Liddell, 2023; Varcoe, Brown et al., 2013).

A summary of key recommendations from the international publications were increasing continuity of care/carer (Brown, Varcoe et al., 2011; Churchill, Smylie et al., 2020; Hanson, 2012), establishing Indigenous-led birthing services (Churchill, Smylie et al., 2020; Silver, Tukalak et al., 2023), choice and control for Indigenous women (Pandey,

Smith et al., 2023; Sheffield and Liddell, 2023; Silver, Tukalak et al., 2023; Varcoe, Brown et al., 2013), expanding the Indigenous maternity workforce (Churchill, Smylie et al., 2020Glover, 2009 #527; Pandey, Smith et al., 2023; Silver, Tukalak et al., 2023; Varcoe, Brown et al., 2013), and listening to Indigenous women about how to provide the best models of care for them (Sheffield and Liddell, 2023).

3.3.2 Australian evidence – overview of the findings

The body of evidence from Australia was much larger, with 31 articles included (see Table 5). Similar to the international evidence, the recommendations in the literature include that Indigenous women need services close to home; increased access to continuity of care/carer models is needed; expanding the Indigenous maternity care workforce is important; care should include culture; links to community are important; women's choices and control should be increased; and that family support is valuable and should be accommodated. As the body of Australian evidence is larger, and this thesis relates to Aboriginal and Torres Strait Islander women in Australia, the findings have been organised under the following headings:

- Evidence of what women value in their maternity care;
- Experiences of mainstream/standard maternity care;
- Experiences of care that is different to mainstream/standard maternity care; and
- Evidence of women's views and experiences of specific clinical or public health interventions.

Summary of the evidence of what women value

Consistent with the international evidence is the value women place on family or kinship support (Bowden, Toombs et al., 2023; Brown, Fereday et al., 2016; Dietsch, Martin et al., 2011; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Marriott, Reibel et al., 2019b; Reibel, Morrison et al., 2015). The literature strongly highlights the value placed on continuity of carer (Austin, 2023; Bowden, Toombs et al., 2023; Homer, Foureur et al., 2012; Jan, Conaty et al., 2004; Josif, Barclay et al., 2014; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Marriott, Reibel et al., 2019b; Reibel, Morrison et al., 2015; Seear, Spry et al., 2021) and relationship building (Homer, Foureur et al., 2012; Kelly, West et al., 2014; Massi, Hickey et al., 2023; Reibel, Morrison et al., 2015; Seear, Spry et al., 2021). A known

midwife in labour and birth was identified as valuable (Homer, Foureur et al., 2012; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019), as was the presence of Aboriginal or Torres Strait Islander staff, and connection to community or culture (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Marriott, Reibel et al., 2019b). Women also value clear communication from health care professionals who possess positive interpersonal skills (Brown, Fereday et al., 2016; Kildea, Stapleton et al., 2012; Seear, Spry et al., 2021). All of these values align with the recommendations summarised in the international literature. Additional information in the Australian evidence is that women value community-based care (Hartz, Blain et al., 2019; Reibel, Morrison et al., 2015), and privacy and confidentiality was highlighted as very important among younger women (Reibel, Morrison et al., 2015).

Summary of the evidence of women's experiences of mainstream/standard maternity care

Negative experiences in the Australian mainstream maternity system ('the system') are discussed more often than positive experiences. A number of studies described the system as 'inflexible' (Austin, 2023; Brown, Fereday et al., 2016; Kelly, West et al., 2014; Marriott, Reibel et al., 2019b), 'impersonal' (Jan, Conaty et al., 2004; Parker, McKinnon et al., 2014) or culturally inappropriate (Austin, 2023; Dietsch, Martin et al., 2011; Ireland, Wulili Narjic et al., 2011). Issues reported by women included poor communication from health staff (Brown, Fereday et al., 2016; Jan, Conaty et al., 2004; Seear, Spry et al., 2021; Watson, Hodson et al., 2002), racism (Brown, Fereday et al., 2016; Brown, Gartland et al., 2019; Dietsch, Martin et al., 2011; Jan, Conaty et al., 2004; Marriott, Reibel et al., 2019b) and a dearth of Aboriginal staff (Austin, 2023; Marriott, Reibel et al., 2019b; Watson, Hodson et al., 2002). The system was sometimes approached with suspicion due to the Stolen Generations, knowledge of mandatory reporting to child protection, or anticipating pressure to be evacuated from rural areas to urban hospitals (Austin, 2023; Dietsch, Martin et al., 2011; Ireland, Wulili Narjic et al., 2011). As such, women reported at times feeling judged and cautious (Austin, 2023; Brown, Fereday et al., 2016; Watson, Hodson et al., 2002).

A lack of relationships with care providers featured strongly as an area of concern (Austin, 2023; Bowden, Toombs et al., 2023; Ireland, Wulili Narjic et al., 2011; Josif, Barclay et al., 2014; Marriott, Reibel et al., 2019b; Parker, McKinnon et al., 2014). There was also evidence of lack of informed consent (Marriott, Reibel et al., 2019b; Watson, Hodson et al., 2002) and lack of choice of care provider (Parker, McKinnon et al., 2014). The Australian evidence demonstrates that women are often dealing with life stressors (Brown, Fereday et al., 2016; Brown, Gartland et al., 2019; Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Parker, McKinnon et al., 2014), yet feel generally unsupported by the system (Ireland, Wulili Narjic et al., 2011; Josif, Barclay et al., 2014; Kelly, West et al., 2014; Parker, McKinnon et al., 2014). This includes a lack of financial and structural support in terms of transport or facilitating family presence when travelling long distances for care (Jan, Conaty et al., 2004; Kelly, West et al., 2014; Seear, Spry et al., 2021), and women report feeling 'lonely' or isolated (Dietsch, Martin et al., 2011; Ireland, Wulili Narjic et al., 2011; Josif, Barclay et al., 2014; Marriott, Reibel et al., 2019b; Watson, Hodson et al., 2002).

Overall, evidence of high levels of satisfaction or positive experiences in the mainstream maternity setting appears to be less robust. There was some evidence suggesting that some women, particularly young women, may choose mainstream maternity care rather than a program connected to the Aboriginal community, if seeking privacy and confidentiality (Brown, Fereday et al., 2016; Reibel, Morrison et al., 2015). Evidence of health care providers asking about women's cultural needs for pregnancy and birth is very scant (Parker, McKinnon et al., 2014), however, one woman expressed great satisfaction with being asked about this by a midwife in a mainstream hospital (Brown, Fereday et al., 2016). Varcoe et al (2013) observes some of the positive feedback from Indigenous women regarding mainstream care such as 'they were nice' or 'they brought me juice' (p. 5) is rudimentary, and should just be standard procedure. This type of feedback is also reported in Brown et al (2016) such as 'all my physical needs were met' (p.354). Additionally, issues of timing and location of interviews that were apparent in Pandey et al (2023) (on the hospital ward in the days after birth) are also evident in this Brown et al (2016). Moreover, it is not clear if any of the authors are Aboriginal and as such, the meaning of the data may have been interpreted solely through a non-Indigenous lens.

Another study reported positive experiences of midwifery care on the labour ward in the Northern Territory (Bowden, Toombs et al., 2023). Bowden et al (Bowden, Toombs et al., 2023) reported that women placed high importance on continuity of midwife care during

pregnancy, but less so during labour and birth. The authors, however, do not discuss that this contradicts other evidence suggesting that building a relationship with a midwife before labour and birth is important (Corcoran, Catling et al., 2017; Homer, Foureur et al., 2012; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019). When reviewing the Australian literature, evidence of negative experiences with mainstream, standard hospital care appear to feature more strongly than evidence of positive experiences.

Women's experiences of care that is different to mainstream standard maternity care

Fourteen articles provided evidence of women's experiences receiving care in models that were alternatives to standard mainstream maternity care. This included culturally specific midwife continuity models through mainstream services (Josif, Barclay et al., 2014; Kildea, Stapleton et al., 2012; Middleton, Bubner et al., 2017), continuity of midwife care through a mainstream community-based organisation (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012) and maternity care through ACCHOs, with varying levels of continuity of care or carer (Bowden, Toombs et al., 2023; Campbell and Brown, 2004; Jan, Conaty et al., 2004; Reibel, Morrison et al., 2015; Seear, Spry et al., 2021). One other article focused on women's experiences of receiving continuous support across the childbearing continuum from Aboriginal midwifery students who were completing follow through experiences as part of their midwifery training (Kelly, West et al., 2014). Other articles explored the experiences of women who organised their own maternity care on Country, after negative experiences in the mainstream system (Ireland, Wulili Narjic et al., 2011; Magick Dennis and Keedle, 2019). Another paper evaluated women's experiences of a nurse home visiting parenting program (Massi, Hickey et al., 2023).

Overall, the evidence suggests that women's experiences are more positive in models or programs that were alternatives to standard mainstream maternity care. A number of these programs have been set up and aim to increase continuity of care/carer (Bowden, Toombs et al., 2023; Campbell and Brown, 2004; Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Jan, Conaty et al., 2004; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Massi, Hickey et al., 2023; Middleton, Bubner et al., 2017). Relational care with a known midwife removes the need to repeat personal histories multiple times, which is valuable to women (Bowden, Toombs et al., 2023;

Homer, Foureur et al., 2012; Josif, Barclay et al., 2014; Kildea, Stapleton et al., 2012; Seear, Spry et al., 2021). Many papers included evidence of women experiencing trusting relationships with care providers (Homer, Foureur et al., 2012; Jan, Conaty et al., 2004; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Massi, Hickey et al., 2023) and feeling supported (Homer, Foureur et al., 2012; Kelly, West et al., 2014; Magick Dennis and Keedle, 2019; Massi, Hickey et al., 2023). The literature suggests that women value care that is connected to their culture in some way (Brown, Weetra et al., 2015; Hartz, Blain et al., 2019; Kelly, West et al., 2014; Magick Dennis and Keedle, 2019; Massi, Hickey et al., 2023). Women also reported accessibility (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Jan, Conaty et al., 2004) and flexibility with care (Jan, Conaty et al., 2004). Quantitative or mixed-methods studies suggest higher ratings of satisfaction with care in culturally targeted models compared with standard mainstream care (Brown, Weetra et al., 2015; Campbell and Brown, 2004; Kildea, Stapleton et al., 2012).

Summary of the evidence relating to specific clinical or public health care interventions

Some studies focused on women's views and experiences with specific clinical or public health interventions offered during the perinatal period (Bovill, Gruppetta et al., 2018; Carlin, Atkinson et al., 2019; Chan, Reid et al., 2022; Kirkham, King et al., 2021; Lyall, Egert et al., 2023; Lyall, Guy et al., 2020; Rahman, Weatherall et al., 2023; Spangaro, Herring et al., 2016; Spangaro, Herring et al., 2019). These initiatives are aimed at improving perinatal outcomes and were often embedded into antenatal care, such as smoking cessation initiatives, hyperglycaemia management, fetal alcohol syndrome prevention strategies, or screening for intimate partner violence and perinatal mental health.

These studies identified that Aboriginal and Torres Strait Islander women in Australia view health care professionals and services as having a role in providing information and support around sensitive health issues. Some women identified fragmented information and inconsistent support (Bovill, Gruppetta et al., 2018; Rahman, Weatherall et al., 2023), however, these studies did not identify if women had access to a known care provider. This literature suggests that Aboriginal and/or Torres Strait Islander women evaluate primary health programs as most effective if they are connected to the community,

involve First Nations staff, and provide opportunities for continuity of carer and trusting relationships (Carlin, Atkinson et al., 2019; Chan, Reid et al., 2022; Kirkham, King et al., 2021; Lyall, Egert et al., 2023; Lyall, Guy et al., 2020; Spangaro, Herring et al., 2016; Spangaro, Herring et al., 2019).

3.4 Positioning this thesis

This thesis contributes to the clear gap in the evidence of women's experiences of urban-based maternity care and the dearth of evidence evaluating culturally specific birthing or maternity programs from the perspectives of Indigenous women themselves. Though there are a small number of studies from Canada and Australia that do this, no recent evidence in the Australian state of Victoria has evaluated any kind of midwifery or birthing service for Aboriginal women who live in an urban setting. This thesis is the first to explore the views and experiences of Aboriginal and Torres Strait Islander women residing in the state of Victoria, in relation to their urban-based maternity care, including continuity of midwife care.

It is one of the few mixed-methods studies which addresses women's experiences of their pregnancy, labour and birth, and postnatal care in both the qualitative and quantitative components of the research. The inclusion of indigenous methodologies and a clear declaration of a chosen theoretical framework is often missing in much of the available evidence. As an Aboriginal researcher, I have intended to provide clarity and transparency in the use of indigenous methodologies in my research, and I have chosen appropriate theoretical frameworks (Critical Race Theory and Indigenous woman's standpoint) to underpin my thesis.

TABLE 5 - SYSTEMATIC SEARCH OF THE LITERATURE - INCLUDED ARTICLES

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
International evidence										
Brown, et al.	2011	The Birthing Experiences of Rural Aboriginal Women in Context: Implications for Nursing	CAN	Rural	Qualitative	66 mothers and 1 father individual interviews, 36 mothers and 2 fathers focus groups, separate groups with 5 youths and 11 Elders, and 4 health providers.	N	N	Y	
Buchner, et al.	2022	Indigenous Women's Experiences with Child Protection at Their Child's Birth	CAN	Not clearly stated	Qualitative	5 Indigenous women in Northern British Columbia	N	Y	N	
Burns, et al.	2019	Understanding Mi'kmaq Women's Experiences Accessing Prenatal Care in Rural Nova Scotia	CAN	Rural	Qualitative	4 Mi'kmaq women living in Mi'kmaq nations, Nova Scotia, who received prenatal care in the last 5 years	N	N	Y	
Churchill, et al	2020	Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: qualitative interviews with indigenous and non-Indigenous clients	CAN	Urban	Qualitative	9 Indigenous participants, 11 non-Indigenous participants	Y	N	Y	*An evaluation of an Indigenous-focused midwifery program
Glover, et al.	2009	Barriers to Best Outcomes in Breastfeeding for Māori: Mothers' Perceptions, Whānau Perceptions, and Services.	NZ	Urban	Mixed methods	59 Māori women, who had given birth in the previous 3 years, and 27 whanau members	N	N	N	*Quantitative component is related to women's views or experiences
Hanson, J. D.	2012	Understanding Prenatal Health Care for American Indian Women in a Northern Plains Tribe	USA	Not clearly stated	Mixed methods	58 American Indian women from one tribe in the Northern Plains	N	N	N	*Quantitative data is not presented
Kornelson, et al.	2010	The geography of belonging: The experience of birthing at	CAN	Remote	Mixed methods	12 interviews and 55 surveys with Aborignal	N	N	N	*Quantitative component is related to

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
		home for First Nations women				women from a remote BC community				women's views or experiences
Lawford, et al.	2018	Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance	CAN	Rural/remote	Qualitative	7 women and 5 community members (four females, one male)	Y	Y	N	*Urban centre, women evacuated for birth
Makowharemahihi, et al.	2014	Initiation of maternity care for young Māori women under 20 years of age	NZ	Mixed	Qualitative	44 pregnant or recently pregnant Māori women under 20 years old	Y	Y	Y	
Pandey, et al.	2023	Indigenous birth support worker (IBSW) program evaluation: a Qualitative analysis of program workers and clients' perspectives	CAN	Urban	Qualitative	10 clients of the service	N	N	N	*Evaluation of an Indigenous Birth Support Worker Program
Sheffield, et al.	2023	"If I Had a Choice, I'd Do It Natural": Gulf South Indigenous Women's Preferences and Experiences in Childbirth	USA	Not clearly stated	Qualitative	31 women-identifying, self-identified members of a specific state-recognized Indigenous tribe in the Gulf Coast region of the United States	N	N	N	
Silver, et al.	2023	Giving birth in a good way when it must take place away from home: Participatory research into visions of Inuit families and their Montreal-based medical providers	CAN	Remote	Qualitative	4 Inuit women and their medical escorts	N	N	N	*Urban centre, women evacuated for birth
Sokoloski, E.	1995	Canadian First Nations Women's Beliefs About Pregnancy and Prenatal Care	CAN	Urban	Qualitative	7 informants, representing 3 First Nations tribes	N	N	N	
Varcoe, et al.	2013	Help Bring Back the Celebration of Life: A Community-Based Participatory Study of Rural Aboriginal Women's Maternity Experiences and Outcomes.	CAN	Rural	Qualitative	100 Aboriginal women from the Nuxálk, Haida and Namgis First Nations and additional community members	N	N	N	

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
Whitty-Rogers, et al.	2016	Aboriginal Women's Experiences With Gestational Diabetes Mellitus	CAN	Not clearly stated	Qualitative	9 Mi'kmaq women who experienced gestational diabetes mellitus	N	N	N	
Australian evidence										
Austin, C.	2023	The impact of social determinants of health of Australian Indigenous women on access and engagement in maternal child health services	AUS	Regional	Qualitative	35 Aboriginal mothers wit h children aged birth to 5 years in regional Victoria	N	N	Y	*Relates to maternal child health services (from birth to 5 years) – pregnancy and birth not included
Bovill, et al.	2018	Wula (Voices) of Aboriginal women on barriers to accepting smoking cessation support during pregnancy: Findings from a Qualitative study	AUS	Regional	Qualitative	20 Aboriginal women between who were pregnant or recently given birth, living in the Hunter New England (HNE) area, NSW.	N	Y	Y	
Bowden, et al.	2023	Listening to First Nations women's voices, hearing requests for continuity of carer, trusted knowledge and family involvement: A Qualitative study in urban Darwin	AUS	Urban	Qualitative	10 Aboriginal women in the first 12 months postpartum in Darwin, Northern Territory	N	N	Y	
Brown, et al.	2016	Aboriginal and Torres Strait Islander women's experiences accessing standard hospital care for birth in South Australia – A phenomenological study	AUS	Mixed	Qualitative	14 Indigenous women accessing labour and birth care in a standard hospital in South Australia	N	N	N	*Urban centre, some women relocated for birth
Brown, et al.	2019	Health care experiences and birth outcomes: Results of an Aboriginal birth cohort	AUS	Mixed	Quantitative	344 women who had an Aborignal baby in South Australia	-	-	N	
Brown, et al.	2015	Improving Aboriginal Women's Experiences of Antenatal Care: Findings	AUS	Mixed	Quantitative	344 women who had an Aboriginal or Torres Strait Islander baby in South Australia	-	-	N	

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
		from the Aboriginal Families Study in South Australia								
Campbell, et al.	2004	Maternity care with the Women's Business Service at the Mildura Aboriginal Health Service	AUS	Regional	Quantitative	25 clients of the Women's Business Service in rural Victoria	-	-	N	
Carlin, et al.	2019	'Having a Quiet Word': Yarning with Aboriginal Women in the Pilbara Region of Western Australia about Mental Health and Mental Health Screening during the Perinatal Period	AUS	Remote	Qualitative	15 Aboriginal women in the Pilbara	N	N	Y	
Chan, et al.	2022	Experiences of using the Edinburgh Postnatal Depression Scale in the context of antenatal care for Aboriginal mothers: Women and midwives' perspective	AUS	Urban	Mixed - methods	13 Aboriginal women seeking antenatal care in Western Australia, 10 non-Aborignal midwives	N	N	Y	*Quantitative data is not presented
Dietsch, et al.	2011	Australian Aboriginal kinship: A means to enhance maternal well-being	AUS	Rural/remote	Qualitative	Focus group with 3 Aborignal women and one male partner	N	N	N	*Urban centre, women evacuated for birth
Hartz, et al.	2019	Evaluation of an Australian Aboriginal model of maternity care: The Malabar Community Midwifery Link Service	AUS	Urban	Mixed-methods	9 women who used the Malabar service (8 out of 9 were Aboriginal) in New South Wales	N	N	N	*Quantitative component not related to women's views or experiences
Homer, et al.	2012	'It's more than just having a baby' women's experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families	AUS	Urban	Mixed-methods	For Qualitative component, 7 Aborignal and/or Torres Strait Islander women in New South Wales	N	N	N	*Quantitative component not related to women's views or experiences
Ireland, et al.	2011	Niyith Nniyith Watmam (the quiet story): Exploring the experiences of Aboriginal	AUS	Remote	Qualitative	7 Aboriginal women and 5 family members	Y	N	N	

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
		women who give birth in their remote community								
Jan, et al.	2004	An holistic economic evaluation of an Aboriginal community-controlled midwifery programme in Western Sydney	AUS	Urban	Mixed-methods	6 focus groups with 10 and 15 Aboriginal women each who used the Daruk antenatal programme	N	N	N	*Quantitative component not related to women's views or experiences
Josif, et al.	2014	'No more strangers': Investigating the experiences of women, midwives and others during the establishment of a new model of maternity care for remote dwelling Aboriginal women in northern Australia	AUS	Remote	Qualitative	12 Aboriginal women who used the service, and midwives	N	N	N	*Urban centre, women evacuated for birth
Kelly, et al.	2014	'She knows how we feel': Australian Aboriginal and Torres Strait Islander childbearing women's experience of Continuity of Care with an Australian Aboriginal and Torres Strait Islander midwifery student	AUS	Unclear	Qualitative	4 Aborignal and/or Torres Strait Islander women who received care from an Aboriginal or Torres Strait Islander midwifery students though Continuity of Care Journeys	Y	N	Unclear	
Kildea, et al.	2012	The Murri clinic: a comparative retrospective study of an antenatal clinic developed for Aboriginal and Torres Strait Islander women	AUS	Urban	Mixed-methods	38 surveys and 8 interviews with services users of the Murri clinic, health professionals also included	N	N	N	*Quantitative component is related to women's views or experiences
Kirkham, et al.	2021	'No sugar', 'no junk food', 'do more exercise' – moving beyond simple messages to improve the health of Aboriginal women with Hyperglycaemia in Pregnancy in the Northern Territory – A phenomenological study	AUS	Unclear	Qualitative	35 Aboriginal women who needed management for gestational diabetes, health professionals also included	Y	N	N	

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
Lyall, et al.	2023	"Our Mothers Have Handed That to Us. Her Mother Has Handed That to Her": Urban Aboriginal and Torres Strait Islander Yarning about Community Wellbeing, Healthy Pregnancies, and the Prevention of Fetal Alcohol Spectrum Disorder	AUS	Urban	Qualitative	8 female and 2 male community members	N	Y	Y	
Lyall, et al.	2020	"They Were Willing to Work with Me and Not Pressure Me": A Qualitative Investigation into the Features of Value of a Smoking Cessation in Pregnancy Program for Aboriginal and Torres Strait Islander Women	AUS	Urban	Qualitative	7 pregnant women, 6 family members, 3 case managers, 4 health professionals	N	Y	Y	
Magick-Dennis, et al.	2019	Birthing As Country	AUS	Regional	Case study	1 Wiradjuri & Ngemba-Wayilwan woman	-	-	N	
Marriott, et al.	2019	"Our culture, how it is to be us" — Listening to Aboriginal women about on Country urban birthing	AUS	Urban	Qualitative	A total of 74 Aboriginal women. Aboriginal birthing women = 39 Senior women = 11 Elder women = 24	Y	N	Y	
Massi, et al.	2023	“This has changed me to be a better mum”: A Qualitative study exploring how the Australian Nurse-Family Partnership Program contributes to the development of First Nations women’s self-efficacy	AUS	Urban	Qualitative	29 participants in total. 26 First-time mothers having a First Nations baby who had accessed the program (n = 26), 1 family member, and First Nations Elders (n = 2)	Y	Y	Y	* A non-clinical intensive nurse home visiting support program
Middleton, et al.	2017	'Partnerships are crucial': an evaluation of the Aboriginal Family Birthing Program in South Australia	AUS	Mixed	Mixed-methods	20 Aboriginal Family Birthing Program clients, 107 health professionals	N	N	N	*Quantitative component not related to women’s views or experiences

Authors	Year	Title	Country	Context	Design	Sample	Theoretical /conceptual framework discussed (if qualitative)	Reflexivity discussed (if qualitative)	Authors state indigenous methodologies/ methods applied	Comments
Parker, et al.	2014	'Choice, culture and confidence': key findings from the 2012 having a baby in Queensland Aboriginal and Torres Strait Islander survey	AUS	Mixed	Mixed-methods	187 Aboriginal and/or Torres Strait Islander women living in Queensland	-	-	N	*Quantitative component is related to women's views or experiences
Rahman, et al.	2023	My quitting stories: A Qualitative study exploring Aboriginal women's experiences of smoking cessation and preventing relapse in the context of pregnancy	AUS	Urban	Qualitative	12 Aboriginal women who either smoked tobacco or quit smoking and had been pregnant in the last five years, living in NSW	N	Y	N	
Reibel, et al.	2015	Young Aboriginal women's voices on pregnancy care: factors encouraging antenatal engagement	AUS	Mixed	Qualitative	28 young women and 56 senior women, and service providers	N	N	N	
Seear, et al.	2021	Aboriginal women's experiences of strengths and challenges of antenatal care in the Kimberley: A Qualitative study	AUS	Remote	Qualitative	124 Aboriginal women who had accessed antenatal care	N	N	N	
Spangaro, et al.	2016	'They aren't really black fellas but they are easy to talk to': Factors which influence Australian Aboriginal women's decision to disclose intimate partner violence during pregnancy	AUS	Mixed	Qualitative	12 Indigenous women 28+ weeks pregnant attending antenatal care	Y	N	N	
Spangaro, et al.	2019	'Yarn about it': Aboriginal Australian women's perceptions of the impact of routine enquiry for intimate partner violence	AUS	Mixed	Qualitative	12 Aboriginal Australian women	N	N	N	
Watson, et al.	2002	The maternity experiences of indigenous women admitted to an acute care setting	AUS	Mixed	Qualitative	12 Aborignal women who were admitted to acute care during or after birth	N	N	N	

Chapter 4: Methodology

This chapter discusses the methodology and relevant social theories that underpin this research. Separate disciplines define 'methodology' differently. In this thesis, I use a definition of methodology that is used by Goenpul woman of the Quandamooka people and Distinguished professor Aileen Moreton Robinson.

According to Professor Moreton-Robinson (personal communication, Feb 29, 2024), a research methodology is comprised of three parts**: 1)** a conceptual framework, **2)** a standpoint positioning, and **3)** the methods used in the research process.

- Methodology part 1 - The conceptual framework. Definitions of a conceptual framework vary, and the terms 'conceptual framework' and 'theoretical framework' are often used interchangeably (Crawford, 2019). A conceptual framework can be defined as "an argument about why the topic one wishes to study matters, and why the means proposed to study it are appropriate and rigorous" (Ravitch, 2012) (p. 5). Like Crawford (2019), I have also chosen this definition, because Ravitch and Riggin (2012) distinguish conceptual frameworks from theoretical frameworks, stating that the latter should be embedded within the former (Crawford, 2019).

- Methodology part 2 - The standpoint. 'Standpoint' as a theory was a term coined by feminist scholar Sandra Harding (1992). Standpoint theory regards all knowledge as being situated within the social context, where people who are (or have been) historically oppressed have access to knowledge that dominant groups in society do not (Harding, 1992)

- Methodology part 3 - The methods. Methods are the techniques or strategies used in the research process to acquire data and knowledge (Liamputtong, 2019).

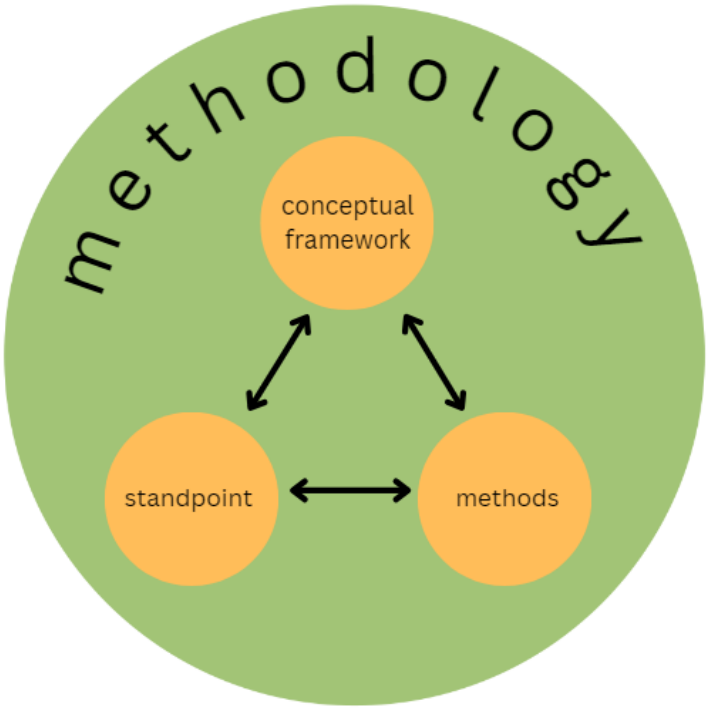


FIGURE 7 - MORETON-ROBINSON'S (2024) COMPONENTS OF A RESEARCH METHODOLOGY

'Methodology' in research is shaped by assumptions about the nature of reality, knowledge, and values (Creswell, 2013). The methodology applied in this thesis is comprised of Critical Race Theory as a conceptual framework, Indigenous woman's standpoint theory as a standpoint, and mixed-methods is the approach used to acquire data and knowledge.

There are other important concepts and terminology related to discussing methodology that need to be defined. Ontological, epistemological, and axiological positionings differ between researchers and/or disciplines. Creswell and Poth (2018) define theses terms and explain that in research, a researcher's belief about the nature of reality (ontology), how to know what is reality (epistemology), and their values or ethical approaches to reality (axiology) are applied through a set of beliefs that guide actions (paradigm) and theories (what the literature says about possible research outcomes). These all underpin how the research is conceptualised and conducted (the research methodology) (Creswell and Poth, 2018). The first time I felt I had begun to grasp how ontology, epistemology, axiology inform and influence research methodology, in the context of an Aboriginal person doing research, was while reading the work of Opaskwayak Cree scholar Shawn Wilson (Wilson, 2001). Wilson's (2001) explanation of these concepts resonated with me and

gave me the confidence to build on my knowledge, and so this work will be referred to throughout this chapter.

This chapter will first address Western and indigenous knowledges. The differences and similarities between indigenous methodologies and Western methodologies will be outlined and why indigenous methodologies are needed to advance the wellbeing of First Nations people. The chapter will also describe how both indigenous and Western methods can be used together in research and how this has been applied throughout this thesis.

This chapter will then evaluate the relevance of social theory in research, before covering the origins of Critical Theory and then discussing Critical Race Theory as the chosen conceptual framework (part 1) for my methodology. For part 2 of my methodology (my standpoint), I will discuss the origins of Feminist standpoint theory, the critiques of Feminism, and Indigenous women's standpoint theory as the standpoint from which I position myself. The methods (part 3) will then be discussed in Chapter five.

4.1 Different ways of knowing

4.1.1 Western knowledges

To understand and contextualise indigenous methodologies, an understanding of Western methodologies and how they differ is required (Chilisa, 2012; Moreton-Robinson and Walter, 2010). Western methodologies originate from the European period of 'Enlightenment' during sixteenth and seventeenth centuries. The scientific revolution meant that the church was losing traction as the dominant source of knowledge, as society was shifting to become more secular, with an academic focus on medicine and philosophy (Moreton-Robinson and Walter, 2010). The epistemology of early Western scientific methodologies is predicated on 'objectivity' and 'reason', where the ways to know about reality are value-neutral, separate from history, and acultural (Crotty, 1998). Western positivist thought is about *disconnection* between the mind, the body, and the earth and the knower is 'disembodied' (Moreton-Robinson, 2017). Facts and data are conceptualised into abstract information that is analysed to produce non-personalised knowledge (Bartlett, Iwasaki et al., 2007). This is the underpinning epistemology of positivist scientists who have supported this theory since the 'Enlightenment' (Bartlett, Iwasaki et al., 2007). Western philosophers such as Aristotle (383-348 BC), followed by

Francis Bacon (1561-1626) and John Locke (1632-1704) contributed to positivism through their beliefs that fixed natural laws create reality which are independent of human thinking, and scientific methods reveal the truth about what is happening in reality through measurable, observable information (Chilisa, 2012).

Wilson (2001) provides an overview of the dominant Western research paradigms and reminds us that positivist and post positivist science is in pursuit of the 'one single truth' or it attempts to get as close to this single truth as possible. In other words, the true world is 'out there' to be discovered regardless of what we think about it. Positivism claims that what is truth must be able to be observed using our senses in a neutral and detached manner (Dyson and Brown, 2006). Wilson (2001) demonstrates how the epistemology of a research paradigm determines the methodology, by explaining that the structured, numerical, experimental *methodology* of positivist research is tied to its *ontological epistemological* beliefs, being that there is only one reality to interpret (ontology) and it should be done as objectively as possible (epistemology).

My belief is that some things that are 'known' in the natural world cannot always be measured within the positivist stricture. In saying that, though, my own research includes a quantitative component, where steps were taken to produce statistical outcomes that were as accurate as possible, and this is possibly where the positivist paradigm is relevant to my research. However, I do not think I can say, as a positivist would, that there is 'one true reality'. Also excluding this thesis from a positivist paradigm is that I, as the researcher, am not value free nor am I detached from the research, and I do not claim to be.

Not all Western paradigms are positivist. Anti-positivist critiques that emerged during the post-modern era that challenged researchers as objective and impartial were discussed earlier in this section. A postmodernist approach, for example, emphasises reflexivity and seeks to demonstrate how the thinking behind the research influences construction of the data (Dyson and Brown, 2006). Postmodernism is said to be a paradigm that is emancipatory by placing the voices of marginalised people at the forefront (Guba and Lincoln, 2005). Koori Professor Dennis Foley observes that postmodern scholarship is still dominated by white male voices and does not account for an Indigenous standpoint (Foley, 2003). In the same vein, interpretive Western paradigms such as phenomenological and ethnographic designs do accommodate multiple subjective realities that are mind-dependant and constructed socially (Creswell, 2013), but Chilisa

(2012) argues that these interpretive frameworks do not account for collective realities common to indigenous societies, and power imbalances between the outside researcher positioned as 'educated knower' and the colonised insider positioned as study 'subject' are not addressed.

4.1.2 Indigenous methodologies

Moreton-Robinson and Walter(2010) define Indigenous methodologies as:

> "a vigorous and active field of knowledge production involving Indigenous peoples from around the world, including Australia, applying their own lenses, perspectives and understandings to social research and methodologies" (p.2).

Indigenous researchers applying indigenous methodologies enables new ways of knowing, promoting the protection of knowledge so that the benefits flow to Indigenous people themselves (Rigney, 2006). Only in recent decades have Indigenous people had opportunities to engage in academia as bona fide scholars, and subsequently, indigenous critique of Western methods has sparked interest in the development of Indigenous research frameworks (Martin and Mirraboopa, 2003; Rigney, 2006). Disseminating knowledge in ways that are irrelevant to the original knowledge holders (Keane, Khupe et al., 2017) is replaced by research outcomes that are "disseminated back to the people in culturally appropriate ways and in a language that can be understood" (Smith, 2012).

Indigenous notions of interconnectedness contradict Western colonial paradigms (Rowe S. and Dowse, 2023). The Western mind-body split was originally theorised by French philosopher Desecrates (1596-1650) who argued that the mind and body are separate and independent of one another (Skirry, 2005). Even emancipatory Western paradigms that see the knower as embodied (such as Feminist research) are still human-centric, where the body and mind are separate from the earth. Ecofeminism, for example, connects the oppressive treatment of nature to the oppressive treatment of women, but still it keeps women and nature as separate entities (Plumwood, 1986). Walter and Moreton-Robinson (2010) provide a summary of indigenous methodologies adjacent to a summary of Western methodologies. A table below is provided to highlight the connected, metaphysical, relational nature of Indigenous methodologies.

In direct opposition to positivist science, indigenous science has always accounted for the inclusion of concepts that are metaphysical, or in other words, things that are unobservable to the human senses (Smith, 2012). In critiquing Western hegemony,

Moreton-Robinson (2017) suggests that if Western knowledge systems do not address the metaphysical roots of its claim of human disconnectedness (Skirry, 2005), it is just as valid for indigenous knowledges to claim, metaphysically, that the mind body and natural world are interconnected.

TABLE 6 - COMPARISON OF INDIGENOUS AND WESTERN METHODOLOGIES.

Indigenous	**Western**
Epistemology – 'our way of knowing'	**Epistemology – 'theories of knowledge'**
• Legitimacy is based on connection. • Connectivity is integral to knowledge production. • Connection is knowing, knowing is embodied and connected to Country. • Knowledge is revealed and belongs to a group. • Social relations and bloodline to Country determine who can be a knower. • Knower status is specific to context, place and relationships. • Knower status is earned through the life cycle.	• Legitimacy based on objectivity and rationality. • Reason is the apex of knowledge production hierarchy. • A person of reason is disembodied, not connected to land or place. • Knowledge is discovered and owned by individual knower. • Knowledge status is for the educated and elite. Institutional knowledge is of the highest status. • Status of knower is earned though formal process.
Axiology – our way of doing, embedded in Indigenous value systems	**Axiology - Theory of values, extrinsic and intrinsic**
• Indigenous knowledge values are based on observation from being in the world. Knowledge is tested and verified. • Valued knowledge is communicated, generated and re-generated. • Value of Indigenous knowledge is providing connection to the world. • Valued knowledge comes from many sources including dreams, the ancestors, stories, and experience, and is embedded in the land. • Knowledge is produced through connection.	• Western knowledge values rigour established via measurement, explanation, causality, classification and differentiation. • Knowers of valued knowledge are 'experts' and knowledge is owned. • Knowledge is valued for itself. • Valued knowledge comes from disembodied theories that are considered rationally. • Knowledge is produced through study of the object/subject.
Ontology - Our way of being and belonging	**Ontology - theories related to the nature of being**
• Ontological framework based on connectiveness to Country. • Knowledges and realities exist beyond us as humans. Both men and women are knowledge holders. • Realities are predicated on being embodied and connected. Reality is not immutable, and there are different layers of reality that are contextual and related to being a knowledge holder.	• Western ontological framework is hierarchical and provides for understanding of what constitutes reality. • Ontology predicated on a hierarchical gendered and racial dichotomy of the mind–body split. White men are the disembodied creators of culture and knowledge; others are governed by their emotions and their bodies.

Adapted from Walter and Moreton-Robinson (2010).

4.1.3 Relationality

Wilson (2001) provides an overview of four dominant Western paradigms (positivism, post-positivism, critical theory and constructivist) and explains that one of the main ways that indigenous methodologies differ is that in Western paradigms, knowledge is thought of as an individual affair, and in indigenous methodologies knowledge is *relational* (Wilson, 2001). Morton Robinson (2017) explains:

> "Relationality is an inextricable part of our sovereign knowledges, informing our scholarship to produce innovative social research. As a presupposition it shapes ways of knowing, being and doing. To be connected is to know, and knowing is embodied in social relations and bloodline to country, determined by ancestors and creator beings, that guide who can be a knower and of what knowledges."

The contributions of Indigenous scholars such as Wilson (2008) Martin (2003) and Moreton-Robinson (2017) in developing and describing indigenous research paradigms underpinned by interconnections and relatedness remind us that relationships and connection are of upmost importance.

Indigenous ontology (ways of knowing) is driven by ways of being in reciprocal, relational connection with all 'Entities' that determine our rights and responsibilities to Country, self and others (Martin and Mirraboopa, 2003). In indigenous epistemology, our relationship with something is more important than the thing itself (Wilson, 2008). The axiology (way of doing) and methodology of an indigenous paradigm is occupied with maintaining accountability to relationships (Wilson, 2008). This indigenous relational accountability is discussed as being composed of four principles (sometimes referred to as the four Rs) (Chilisa, 2012). They are: accountable responsibility, respectful representation, reciprocal appropriation, and rights and regulations (Wilson, 2008). According to Wilson (2008), Western value judgements such as validity and statistical significance are not as important as relational accountability, because the main concern of Indigenous researchers should be that their methodology is respectful, that integrity and reciprocity is maintained, and that the research outcomes can be of use to the community.

In section 5.1.1, how relationality can be applied as a key principle in a quantitative indigenous methodology (nayri kati) will be discussed (Moreton-Robinson and Walter, 2010). Relationality is inherent in story telling (Drawson, Toombs et al., 2017). In chapter

five, section 5.2.4, I demonstrate how through ‘Yarning’, relationality has underpinned the qualitative component of this research. In chapter five, section 5.1.5, I briefly share how relationality has informed how I have constructed the cultural metaphor that I use to make sense of my research design.

4.1.4 Indigenist research

Narungga, Kaurna and Ngarrindjeri man and Professor Lester-Irrabina Rigney (Rigney, 1999) coined the term ‘Indigenist research’ to name a research framework that is compatible with indigenous worldviews. Rigney explains that aspects of Feminist theory (as the theory of women’s oppression by the patriarchy) were borrowed to craft a framework that aligns with an indigenous research agenda. Like Critical Race Theory, Indigenist research strives for social justice, locating colonial oppression as the social structure from which emancipation for Indigenous people is predominantly called for (Rigney, 1999). According to Rigney (2006) (1999), three fundamental principles of Indigenist research are:

1. ‘Resistance as emancipatory’- the struggle for the recognition of the rights to self-determination is addressed. Ongoing oppression is uncovered and resisted, and issues that stem from colonisation are engaged with. Indigenous survival is celebrated, and power and control exerted by traditional research methodologies are challenged.
2. ‘Political Integrity’- political integrity is maintained by research that is undertaken by the communities themselves, who decide research priorities and agendas.
3. ‘Privileging Indigenous voices’- Indigenist researchers are accountable to the community. The experiences of communities both lived and historical are the focus. Ideas, aspirations, traditions and struggles of Indigenous people are privileged (Rigney, 2006; Rigney, 1999).

Nonnuccal woman Karen Martin (2003) expands on Rigney’s work toward a definition of Indigenist research. Martin wishes not to position herself in one of reactive ‘resistance’ to oppressive colonial hegemony, but rather she orientates herself toward a position of strength in being Aboriginal and so perceiving anything Western as 'other' (Martin and Mirraboopa, 2003). As such, adapted versions of the principles of Indigenist research, according to Martin (Martin and Mirraboopa, 2003), include:

1. Recognition of our world views, our knowledges and our realities as distinctive and vital to our existence and survival;
2. Honouring our social mores as essential processes through which we live, learn and situate ourselves as Aboriginal people in our own lands and when in the lands of other Aboriginal people;
3. Emphasis of social, historical and political contexts which shape our experiences, lives, positions and futures; and
4. Privileging the voices, experiences and lives of Aboriginal people and Aboriginal lands.

4.1.5 The need for Indigenous methodologies

"The word itself, 'research' is probably one of the dirtiest words in the indigenous world's vocabulary" - Linda Tuhiwai Smith (2012) (p.1)

Indigenous scholars have pointed out that Aboriginal and Torres Strait Islander communities, and other indigenous communities, are over-researched (Moreton-Robinson and Walter, 2010; Smith, 2012). Aboriginal ways of knowing being and doing are also seldom prioritised in academic scholarship (Drawson, Toombs et al., 2017; Rigney, 1999; Smith, 2012). Indigenous people have historically been placed as the object of study, rather than as co-researchers or collaborators (Drawson, Toombs et al., 2017) (Rigney, 2006). Researching racialised groups as 'other' through Eurocentric paradigms has actually been used as a powerful tool in positioning Indigenous and other colonised people as subordinate, and the 'knowledge' produced used as justification for white possession of land, people, and power (Smith, 2012; Watego, Singh et al., 2021). Distinguished Professor and Māori scholar Linda Tuhawei Smith (2012) shows how through white Western epistemology Indigenous people have been constructed and represented by Western researchers through a discourse dominated by 'problems' taken as 'truth'. Colonial power is then legitimised and reinforced (Finlay and Kidd, 2021).

For research with First Nations people, Indigenous scholars have critiqued the sole use of Western research methods 'on' First Nations people as inadequate and ethically risky (Martin and Mirraboopa, 2003; Sherwood, 2010; Smith, 2012). The 'research gaze' is

aimed at Indigenous peoples cultures and lives, usually through a lens informed by Western traditions, and then interpreted by non-Indigenous researchers (Moreton-Robinson and Walter, 2010) (p. 1). Indigenous realities are then at risk of being distorted by the bias of the non-Indigenous interpreter (Rigney, 2006). Racist and colonial narratives can be perpetuated, while indigenous worldviews are undermined (Martin and Mirraboopa, 2003; Sherwood, 2010; Smith, 2012). As such, First Nations leaders in academia have highlighted that to improve First People's wellbeing, the repression of indigenous ways of knowing and doing must be undone (Martin and Mirraboopa, 2003; Moreton-Robinson, 2000; Rigney, 1999; Sherwood, 2010; Wilson, 2008).

A scoping review of Indigenous women's health literature revealed that two-thirds of the included articles used mainstream approaches (qualitative and quantitative) with quantitative research ranking within the top three most commonly used method (McGuire-Adams, Gaudet et al., 2023). The authors conclude that Western methodologies are predominantly being used to study Indigenous women and their health (McGuire-Adams, Gaudet et al., 2023). Wiradjuri woman and Professor, Juanita Sherwood's doctoral thesis provides a comprehensive analysis and critique of Western dominance in knowledge production, putting forward the case that decolonisation of Aboriginal health research is required (Sherwood, 2010). As an example, Finlay (Finlay and Kidd, 2021) discusses that in the National Aboriginal Health Plan 2013-2023 (Department of Health, 2021), Western knowledge is presented as 'clinical' and 'evidence-based' and given priority over Aboriginal cultural knowledge (Finlay and Kidd, 2021). The impact of Western dominance in ways of knowing and doing in maternity system on Aboriginal and Torres Strait Islander women and babies has also been discussed extensively in the literature (Adams, Faulkhead et al., 2018; Carter, Hussen et al., 1987; Hickey, Kildea et al., 2019) (this was also discussed in Chapter two).

4.1.6 Can we have both?

One argument for using purely indigenous paradigms is that a Western theoretical lens creates the conditions for the ongoing exclusion of indigenous ways of knowing, and the subordination of indigenous sovereignties (Cox, FireMoon et al., 2021; Moreton-Robinson, 2013). Another concern is that if the academy 'allows' for indigenous methodologies, it is still doing so on Western terms (Botha, 2011). Wilson (2001) interprets using indigenous perspectives in combination with dominant Western paradigms as incommensurable with research that can be useful for Indigenous people,

and that a paradigm that is inherently indigenous must be followed. Wilson (2001) recommends that:

> "Indigenous methodologies move beyond an Indigenous perspective within a Western paradigm and work from an indigenous paradigm." (p.176).

Reading this made me nervous, as I had planned to incorporate indigenous methodologies into my research, rather than seeing my research as embodying indigenous methodologies. I began to wonder if this plan was appropriate. Nakata (2007) encountered a similar conundrum when wrestling with the notion that the only way to have his worldview received as legitimate might be to express it within the constraints of the dominant paradigms.

First Nations scholars have, however, discussed the potential for Western research methods to be of use in facilitating indigenous research, so long as indigenous worldviews are central (Martin and Mirraboopa, 2003; Nakata, 2007; West, Stewart et al., 2012). As Rigney (2006) points out, Indigenist research is not a complete boycott of the English language or of the dominant culture and should not be understood as 'methodological separatism' (p.42), but rather explores how a theoretical framework can facilitate intellectual, social, and political emancipation for Indigenous people. Sherwood (2010) discusses that indigenous philosophy can accommodate co-existence of Western knowledge systems through balance and survival as core to indigenous philosophies. West and colleagues (2012) agree, stating the Critical Theory can be an appropriate framework for research with Indigenous people, adding however, that it must be grounded in reflexivity, and connected to community customs, traditions and meanings specific to the setting the research is situated within. West and colleagues (2012) also support that Western research methods can be complementary to indigenous methodologies, if core research principles of emancipation, liberation and self-determination, as described by Rigney (1999), have been upheld.

Analogies for two knowledge systems

Drawing upon the works of other First Nations women in my research area, I was reassured that there are examples of how the incorporation of indigenous knowledges and Western knowledges has been achieved. For example, the Caring for Mum on Country project (Ireland, Maypilama et al., 2021) is underpinned by the Yolŋu concept of

'Ganma', a metaphor for when the fresh and salty water (indigenous and Western knowledges) meet to create foam (new knowledge) (Laycock, Walker et al., 2011). It is through my personal relations with Yolŋu, and spending time doing research with Yolŋu on Yolŋu Country that I have witnessed the Yolŋu way of working with non-Indigenous (or non-Yolŋu) people through the concept of Ganma.

Similar to the concept of Ganma, Aboriginal and Torres Strait Islander Elder, Aunty Dr Doseena Fergie theorised the 'two-river analogy', where the Darling river (Aboriginal knowledges) and Murray river (Euro-centric knowledges) meet like the merging of the two worldviews (Fergie, 2015). Aunty Dr Fergie used this analogy to explain the design of her research in her doctoral thesis, which explored Aboriginal women's experiences of postnatal depression (Fergie, 2015).



FIGURE 8 - 'GANMA'. (LAYCOCK, ET AL., 2021).



Figure 5:

The Junction of the Murray – Darling Rivers

(D. Fergie Collection 2012)

FIGURE 9 - TWO-RIVER SYSTEM ANALOGY (FERGIE, D., 2015).

4.2 Why theory?

Theory presents us with assumptions that have been made about reality (Willis, Daly et al., 2007). They are tools to be used for explaining reality and making sense of the world around us (Miller and Bear, 2019). Theories generate theoretical concepts, which are organised into more comprehensive theoretical frameworks (Willis, Daly et al., 2007). Social theories emphasise the social context of human behaviour, reasoning that actions and beliefs are at least partially produced by the social structures around us (Willis, Daly et al., 2007).

Social theory and the social sciences have been very important in unpacking fundamental questions about the meanings of knowledge and power (Smith, 2012). Foucault's thinking on 'truth' is that whatever is accepted as established truth is actually a reflection of the social groups that have historically emerged as 'winners'. These 'winners' have the discourse that is dominant, or in other words, the way of seeing the world. This suggests that other discourses do exist, but have been suppressed (Foucalt, 1979). Dyson and Brown (2006) further explain that Foucauldian thought is not that things 'just are', but rather that established truth has to do with power, and that power produces knowledge. Power is not automatically oppressive, but it is within power relationships that the production of knowledge occurs (Foucault, 1979 as cited in (Dyson and Brown, 2006) page 56). Foucault applied this relationship between knowledge and power to the formation of institutions such as hospitals, prisons, and psychiatric facilities (Dyson and Brown, 2006; Fahy, 2007).

Truth, knowledge, and discourse as a product of power is illustrated in the high court decision declaring *'terra nullius'* (land belonging to no one) as fiction in Mabo vs Queensland 1992. There remains a "deafening silence in the legal literature about the non-legitimacy of Crown sovereignty…and the status of Aboriginal and Torres Strait Islander sovereignties" (Ardill, 2013) (p.315). The establishment and legitimisation of a colony on the continent now thought of as Australia, and its continued existence, is the manifestation of the dominant discourse of the historical 'winners'.

Social theory is relevant in both qualitative and quantitative research. Qualitative researchers should be able to articulate an understanding of the theories and philosophical assumptions that inform their research (Creswell and Poth, 2018). To produce qualitative research that is high quality, Willis and colleagues (2007) say that knowledge of social

theory in qualitative research is equal to the importance of statistical knowledge in epidemiology. Choosing a social theory depends on the research question (Willis, Daly et al., 2007). Social theories are useful in constructing a research framework most suitable to address the research question (Willis, Daly et al., 2007). This is done by providing a lens through which we can develop an understanding of relevant issues (Forster, Newton et al., 2011). Knowledge of theory enables the researcher to analyse and articulate the philosophical assumptions brought to the research, brings awareness to these assumptions (known as reflexivity), and of how they influence the construction of the research project (Creswell and Poth, 2018). Even though being able to generalise qualitative findings is not the main aim of qualitative research (Creswell and Poth, 2018), a theoretically informed analysis also assists researchers to justify the application of findings to the broader context beyond the study (Willis, Daly et al., 2007). In quantitative social research, theoretical frameworks obtained from existing literature can be useful to mitigate the complexity of human behavior when exploring possible causal relationships between variables (attributes of difference) and outcomes (Jirojwong and Pepper, 2011).

Two social theories that are relevant to this research topic are the theory of midwifery partnership (Miller and Bear, 2019) and the 'cultural safety' framework, which was theorised by Māori woman and nurse Irihapeti Ramsden (Ramsden, 2002). Both theoretical frameworks were developed in Aotearoa (New Zealand) but have relevance and importance for the practice of midwifery in Australia (Miller and Bear, 2019). Each of these frameworks seek to address power differentials, so that women and midwives can negotiate partnerships, and both are politically motivated. The former seeks to challenge the medicalisation of women's bodies and birth (Miller and Bear, 2019), and the latter seeks to shift the power of defining 'safe' care from health care providers to Indigenous people, though establishing trust and analysis of power relationships (Ramsden, 2002). Power differentials and political motivation for change as fundamental aspects of a critical research agenda will be discussed in the next section of this chapter.

Social theories also oppose the belief that individual health status is separate from the wider social and political context, and so are useful in informing how to approach complex situations in health care research (Haynes, Taylor et al., 2014). For example, Haynes and colleagues (2014) examine how theoretical approaches derived from social theory can enhance understandings of intercultural partnerships between mainstream health systems and Aboriginal and Torres Strait Islander partners and people, which are often challenging to navigate but critical to improving health outcomes. Social theory was

also used by Forster and colleagues (2011) to inform the implementation of the first continuity of midwife care models (for women from the general population with uncomplicated pregnancies) at a hospital in Naarm (Melbourne), years before the Baggarrook Yurrongi project was conceived. The authors discuss that successful implementation of a new model of care into a complex health service relies on multiple factors that go beyond evidence of benefit for women and midwives, and that application of a theoretical model enables deeper understanding of the factors that facilitate change (Forster, Newton et al., 2011).

4.3 Critical theory

Critical Race Theory was selected as the conceptual framework underpinning my methodology, as a lens though which to approach and interpret this research. Before I address Critical Race Theory in the next section, in this section I will first discuss the origins, aims and scope of Critical Theory.

4.3.1 Marxism

The roots of Critical Theory are founded within Marxism (Karl Marx 1818-1838) (Antonio, 1983; Crotty, 1998). Karl Marx was concerned primarily with the conflict between capital and labour, class struggles between the bourgeoisie the proletariat, and the development of a feudal society derived from historical exploitation of enslaved people (Crotty, 1998). Marx envisioned a socialist, classless society through an emancipatory process where true freedom could be experienced by all (Crotty, 1998). After Karl Marx' death, 'Marxism' was further developed by Friedrich Engels and others, where emphasis was placed on distinguishing culture from economics (Crotty, 1998). Although Marxist and Critical thought are related, Antonio (1983) points out that Critical Theory, unlike Marxism, imagines that liberation and emancipation can occur within the context of existing capitalist and social conditions in society (Antonio, 1983).

4.3.2 The Frankfurt school

Critical Theory originated at the Frankfurt school, which was established within the Institute for social research in the 1920s by Marxist professor Carl Grünberg. Many of the leading Jewish scholars from the Frankfurt school (Max Horkheimer (1895–1973); Theodor Adorno (1903 –1969) and Herbert Marcuse (1898–1979) lived in American exile

due to the nazi takeover in Germany (Antonio, 1983). With the rise of Nazism and social consequences for Jewish people in Europe between post World War I Germany, and leading up to the Second World War, questions were being asked both from within the academy, and externally through social movements, about fundamental issues relating to knowledge and power (Smith, 2012; West, Stewart et al., 2012). The Frankfurt scholars were the leading 'anti-positivist'[7] thinkers of that time, and had been influenced heavily influenced by Karl Marx (1818-1883) and other German anti-positivist philosophers such as Immanuel Kant (1724-1804), Friedrich Hegel (1770–1831), Karl Weber (1864–1920) (Crotty, 1998).

The work of the Frankfurt school aligned with the objectives of Critical Theory from the outset, but the philosophical stance of the Frankfurt school was not named 'Critical Theory' until the 1950s (Crotty, 1998). Habermas became known as one of the most well-known critical theorists of the late twentieth century, whose ontological orientation was toward understanding truth through freedom and justice (Antonio, 1983). Habermas (1978) as cited in Dyson and Brown (2006) argued that communication about organising society (including healthcare) could not be a fair or equal debate between social groups with unequal power relationships (i.e. women and men, employers and employees, black people or white people). Haberman calls this a *'distorted speech community'* because marginalised social groups avoid upsetting those in power, particularly when dependent on those in power for resources (Dyson and Brown, 2006). Habermas believed science could serve to achieve equal status and eradicate distorted communication between social groups (Dyson and Brown, 2006). Inspired by the Frankfurt thinkers, Paolo Freire (1921-1971) articulated a kind of psychological oppression that comes through connecting power, cultural domination, and research. Freire (1996) called this the 'pedagogy of the oppressed', where the oppressed internalise how they are viewed by the oppressors and begin to think of themselves in the same way. The dominant culture is perpetuated, benefitting the oppressor (Freire, 1996). Sherwood (2010) scrutinises research on Aboriginal health research as a perpetuation of this kind of oppression, noting that the dominant cultural view of the 'Aboriginal problem' is evident, even in Aboriginal health strategy.

[7] Positivism stems from European positivist science dating back to the Enlightenment period. It takes the position that there is one 'true reality' that can be measured through a value-free, objective, unattached approach to the research (Bartlett et al, 2007). Both Western and indigenous scholarly critique of positivism is drawn upon throughout this thesis.

4.3.3 Emerging paradigms

Several paradigms emerged from the 1960s onwards including post-colonialism, which is concerned with critiquing the legacy of Euro-Western languages in constructing new knowledge (Chilisa, 2012), and post-modernism, which seeks to challenge essentialist claims about the meanings of history, culture, art and philosophy (Creswell, 2013). Anti-positivist critics of the post-modern era, such as Foucault, began to assert that scientists should be required to have their perceptions tested (Dyson and Brown, 2006). Postmodernist thought, in direct opposition to positivism, maintains that all knowledge is political and can only ever be partial (Ardill, 2013). The researcher is positioned as the creator of the data and from a certain cultural vantage point (Dyson and Brown, 2006). These emerging paradigms were considered breakthroughs in critical thought about Eurocentric[8] knowledges, giving way to Critical Theories (Battiste, 2000; Crotty, 1998). The common goal shared by all Critical Theories is the aim of emancipation (Antonio, 1983; Crotty, 1998; Rigney, 1999; Smith, 2012), and the drive to transform society through empowering individuals (Kinchelow, McLaren et al., 2011).

4.3.4 Power relations

Critical Theorists are primarily concerned with power relations (Dunbar, 2014; Kinchelow, McLaren et al., 2011), recognising that power relationships influence the execution and interpretation of research (Dunbar, 2014). Antonio (1983) explains that both scholarship in sociology and Critical Theory require analytical processes which lead to empirical understanding of a phenomenon. Social research is universally guided by orientations toward certain values, but choice of 'value' is left to the individual sociologist, bringing diverse value orientations to research in sociology. Conversely, Critical Theory is charactered by a fixed orientation toward emancipation and a specific set of issues that determine the scope of Critical Theory research (Antonio, 1983).

Critical Theory views advantaged social groups as seeking to protect their privilege by maintaining the status quo (Kinchelow and McLaren, 2002), perpetuated through mainstream research either consciously or unconsciously (Kinchelow, McLaren et al., 2011). Critical Theory rejects the neutrality and objectivity traditionally claimed in

[8] Oxford Dictionary of English (2010) defines Eurocentric as: "focusing on European culture or history to the exclusion of a wider view of the world; implicitly regarding European culture as pre-eminent."

scholarly research (Dunbar, 2014) arguing that it is not possible to fully separate 'fact' from 'value' (Kinchelow, McLaren et al., 2011). Critical Theory is inherently political, motivated by bringing awareness to social injustices (West, Stewart et al., 2012). Critical Theories are frequently used to explore health care issues that relate to race, culture, race, ethnicity and socioeconomic status (Anderson, 2006; McGuire-Adams, Gaudet et al., 2023). Applying a critical lens is useful in uncovering how race, class, gender and sexuality influence the health of the individual (Maureen O'Mahony and Truong Donnelly, 2010; Spurlin, 2019). The political, community driven, social-justice nature of Critical Theory makes it compatible with indigenous methodologies, and as such, it has been named as one of the preferred methodologies of First Nations people (West, Stewart et al., 2012).

4.4 Conceptual framework - Critical Race Theory

The conceptual framework applied to this research is Critical Race Theory. This section will review the origins, characteristics, and aims of Critical Race Theory, and discusses the viability of Critical Race Theory in research in the Australian context with First Nations women.

Critical Race Theory is a framework grounded in Critical Theory and so takes the assumption that reality is shaped by identity and power struggles (ontological belief), reality is known through studying social and societal structures (epistemological beliefs), and social change can be achieved through research (axiological belief) (Creswell and Poth, 2018). As is the case with all Critical Theories, Critical Race Theory rejects that scholarship can or should be objective and neutral (Dunbar, 2014).

The writings of many legal scholars in the 1970s led to the development of Critical Race Theory (Watego, Singh et al., 2021), including Derrick Bell (1930-2011), Kimberle Crenshaw (b. 1959) , Richard Delgado (b. 1939) and Mari Matsuda (b. 1956) (Delgado and Stefancic, 1998). Through legal academia, social justice scholars were searching for new ways to progress the social gains made by black activists during the civil rights movement of the 1950s and 60s (Delgado and Stefancic, 1998). Crenshaw et al (1995) challenged the neutrality of legal scholarship in America, arguing that writings about race could not be separated the social and political environment, because there is no scholarly platform from which to observe and analyse these dynamics from a distance. The early

works of these Critical Race Theorists focused on the power of the elite to control the destinies of black people and from the 1990s onwards, Critical Race Theory has evolved to address how identity categories contribute to the allocation (or hoarding) or power (intersectionality and anti-essentialism), storytelling and narrative, and how race is constructed (Delgado and Stefancic, 1998; Parker and Lynn, 2002).

Moving to the twenty-first century, Parker and Lynn (2002) have identified three main goals of Critical Race Theory. The first is to advance accounts of discrimination from people of colour (Parker and Lynn, 2002). Qualitative interviews with marginalised groups, for example, can provide counter narratives to dominant discourse and disrupt white complacency (Creswell and Poth, 2018). The second goal is to put an end to racial subjugation, while mutually recognising that race is a social construct (Parker and Lynn, 2002). To show how race can be constructed in the Australian legal context, Delgado and Stefancic (1998) provide a hypothetical example of a commissioner deciding there is no tradition of women's business practiced by Aboriginal women, when granting permission to build a highway through a women's sacred site. But this is not a hypothetical example, because Djab Wurrung people, who belong to Country located some 200 kilometres west of Naarm, continue a long-running fight against legislative heritage frameworks to protect 800-year-old scared birthing trees from being cut down for a highway upgrade (Cunningham, 2019; Hinkson, 2020). Thirdly, Critical Race Theory addresses the intersection of race and other aspects of identity, such as sex, gender, socioeconomic status and so on (Parker and Lynn, 2002), making it suitable to be used in conjunction with other theoretical frameworks (West, Stewart et al., 2012). Aboriginal and Torres Strait Islander women from diverse communities across the Australian continent have voiced how various identity markers (such as gender, culture, community, sexuality or disability) contribute to their experiences of 'intersectional discrimination'[9](AHRC, 2020) (p.72).

4.4.1 Critical Race Theory in indigenous research

Critical Race Theory has been named as an appropriate theoretical framework for Aboriginal and/or Torres Strait Islander research in Australia (West, Stewart et al., 2012).

[9] Crenshaw (1989) first coined the term 'intersectionality' when critiquing the exclusion of Black women's experiences has described intersectionality as "a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LGBTIQ problem there. Many times that framework erases what happens to people who are subject to all of these things." (p.73).

It is an approach to studying the nexus between race, racism and power (Watego, Singh et al., 2021). Researchers start with assumptions of power and identity struggles, and aim to document these and call for action and positive change through research (Creswell, 2013). There is a social justice orientation towards emancipation of racial minority groups from oppression stemming from racism and colonialism (Crenshaw, Gotanda et al., 1995; Martin, 2010; Parker and Lynn, 2002). A scoping review exploring research approaches used in Indigenous women's health research found that, though still dominated by general quantitative and qualitative approaches, the application of Critical Theories is growing (McGuire-Adams, Gaudet et al., 2023).

U.K born race scholar, David Singh (2020) evaluates the ability of a Critical Race Theory lens alone to fully address health inequities for First Nations people in Australia, because Critical Race Theory emerged from a context of African American oppression. Singh (2020) points out that for Critical Race Theory to be useful, additional considerations such as indigeneity and sovereignty in a settler-colonial context should be included. First Nations scholars though, have highlighted the similarities and compatibilities between Critical Race Theory and indigenous methodologies, through storytelling, the rejection of there being only 'one truth' and political motivation for social justice (Dunbar, 2014; West, Stewart et al., 2012).

Prior to the conceptualisation of this research project, Critical Race Theory had been chosen previously by First Nations scholars before me, who also had research interests in the areas of pregnancy, birth, early parenting, and models of care (Fergie, 2015; Kelly, West et al., 2014).

4.5 Feminism

As a woman who is doing research that relates to the experiences of birthing women, it seems that a feminist framework in some way would be relevant to this research. As A. Moreton-Robinson (personal communication, Feb 29, 2024) reflected: "Feminism brings the 'body' into theory. Feminism *is* embodiment within scholarship".

This section is divided in two parts. Part one will discuss the origins and aims of Western feminism as a key social theory in the development of other social theories. Part two will explore the critiques of a Western feminist lens from black and Indigenous writers. I will then introduce Indigenous women's standpoint theory (Moreton-Robinson, 2013) and

discuss the rationale for choosing this theory, rather than feminism, as the standpoint and lens through which to interpret my research.

4.5.1 Western feminism

Feminism has played an important role in critical theory and the social sciences (Smith, 2012). Feminism critiqued objective and detached knowledge production about women's bodies, challenging positivist claims of truth (Crotty, 1998; Squires, 2009). Western feminism strives for emancipation from patriarchal oppression by demanding that women's experiences and knowledge be placed at the core of research in women's studies (Sherwood, 2010). Feminist theory also provided the foundation for indigenous standpoints and theoretical frameworks (Foley, 2003; Rigney, 1999).

There are many categories of Western feminist thought and so a possible definition to the complex concept of feminism is as follows:

> "at the very least a feminist is someone who holds that women suffer discrimination because of their sex that they have specific needs which remain negated and unsatisfied and that satisfaction of these needs would require a radical change (some would say a revolution even) in the social economic and political order." Delmar (1986), as cited by (Squires, 2009)).

Radical feminism emerged in the 1960s and 1970s, asserting that women are dominated by men through the patriarchy in many areas of life, including within the family structure, marriage, other relationships, domestic labour, sexuality, and birth (Squires, 2009). At that time, women were also opposing an increase in technocratic approaches to childbirth (Laverick, 1997; McCool and McCool, 1989). Feminist writers including Mitchell (1974), Delphi (1984) and Walby (1990) contributed to the theorisation of the patriarchy as a concept, through analysing how 'feminine' was constructed as subordinate though gender socialisation. Unpaid domestic labour in the home and taking on the role of motherhood was seen as the inevitable, overarching role for women (Squires, 2009). For midwives and birthing women, the patriarchy can be used to as a tool to analyse poor experiences of women, due to patriarchal views of the male body as the 'standard norm' and the female body as unreliable and flawed (Jenkinson, Kruske et al., 2017; Squires, 2009).

Other schools of feminist thought include 'liberal feminism' which focuses on equal opportunities for women and Marxist feminism, which builds on the writings of Marx in

an attempt to explain women's oppression (Squires, 2009). Marxist feminism links the capitalist system and the exploitation of female labour. Women generally take on most of the childcare and housework, have careers that are interrupted, or work only part-time, or in lower status role, and there is a general gendered pay gap. How these circumstances increase women's dependence within the family household unit has been used to analyse ways that the state maintains and reinforces power relations (Squires, 2009)

In this chapter, I discuss Indigenous women's standpoint theory. In section 4.1.4, I discussed that Rigney (1999) borrowed elements of feminist theory (i.e. women's liberation from the patriarchy) to construct an approach to research he calls 'Indigenist' research.

4.5.2 Black feminism

Though feminism has contributed greatly to the exploration of power and knowledge through the social sciences, one of its greatest critiques comes from women of colour (Smith, 2012). As most categories of Western feminism view class and gender as primary forces of women's oppression, black and Indigenous scholars and writers have highlighted a 'silence' on issues of race (Aziz, 1997; Crenshaw, 1989; Moreton-Robinson, 2000; Sabbioni, 1996). Although postmodern feminism promotes a more comprehensive understanding of how race, gender, and class interact by accepting that theory is limited in being able to capture absolute representations of complex realities, Black feminism asserts that the experiences of black women have been rendered invisible and legitimate difference unacknowledged (Squires, 2009). Doyal (1995) suggests that rejecting all theoretical generalisations could be counterproductive, as fear of being labeled 'racist' might lead to the needs of women of colour being ignored completely. According to Doyal (1995) a more appropriate approach to constructing feminist theories might be to centre the common experiences of all women, such as for example, the experience of women being seen as inferior in society. But the position of Black feminism is that there is no common experience of oppression for 'all women' (Smith, 2012), and Aziz (1997) discusses that women who have been exploited by racism, colonialism, or imperialism have interests that align them closely with men in their community, while Western feminism is rooted in advocating for the direct opposite.

4.5.3 Indigenous feminism

Indigenous feminism is inseparable from experiences of, connection to, and dispossession of land and the experiences of colonialism (Green, 2017). Although colonialism affects both Indigenous men and women, Indigenous women have been impacted uniquely because settler colonialism was and still is a gendered process (Green, 2017). The subjugation and objectification of Indigenous women, by white men, over the last two or three hundred years (depending on the continent) formed stereotypes relating to the sexuality of Indigenous women that have left a legacy of marginalisation of Indigenous women in both Indigenous and white societies (Green, 2017). It is also true that white women in Australia have contributed to, and have benefitted from, the colonial positioning of Aboriginal women as subordinate (Fredericks, 2010; Moreton-Robinson, 2000; Sabbioni, 1996; Watego, 2021).

Moreton-Robinson (2000) asserts that Indigenous women's involvement in the Australian feminist movement will remain limited, unless white feminists redistribute some power and give the priorities of Indigenous women some traction. Advocating that Indigenous feminism is for everyone, Denetdale (2021) proposes that Indigenous feminists commit to land rights and reviving cultural practices that have been repressed by colonisation. Tokenism occurs if Aboriginal women are celebrated by, or invited to speak at, feminist events, but the white feminists remain either unaware of, unmotivated by, or in direct opposition to, the priorities of Aboriginal women (Fredericks, 2010). Aboriginal scholars do reflect that when they dissent or challenge white women, they often have been positioned as 'angry' and the white woman's feelings are the focal point (Fredericks, 2010; Watego, 2021). Smith (2012) provides an example of Māori feminism by first considering the historical othering of Indigenous women, and colonial interpretations of women and men in society (i.e. sovereignty being for men). This meant that rangatiratanga (chieftainship) status of Māori women was ignored by white men in treaty of Waitangi negotiations. This Māori feminist issue has been brought before the Waitangi Tribunal by respected Māori women, who have always been rangatira (chiefs) as much as Māori men (Smith, 2012). The point being highlighted here is that feminism does not specifically account for engagement with Indigenous sovereignties (Ardill, 2013), but sovereignty for Aboriginal women has been a common thread between how our identities are reclaimed, reconstructed and "reempowered" (Fredericks, 2010; Moreton-Robinson, 2000).

4.6 Standpoint - Indigenous women's standpoint theory

If we consider the arguments of both black and Indigenous feminist writers, (Aziz, 1997; Crenshaw, 1989; Fredericks, 2010; Moreton-Robinson, 2000; Smith, 2012) in that **a)** the intersections of race, class and gender means there is no there is no common experience of oppression for 'all women', and **b)** feminism does not account for the priorities of black and Indigenous women and **c)** Indigenous women's sovereignties are not addressed, then it is reasonable to conclude that a Western feminist framework is not appropriate to apply to this research. Using Indigenous women's standpoint theory (Moreton-Robinson, 2000) would be a more suitable lens to interpret the research through.

Professor Moreton-Robinson has theorised and articulated Indigenous women's standpoint within the realms of both feminism and Critical Race Theory (Moreton-Robinson, 2000). Indigenous women's standpoint theory has been informed by feminist theory, but it differs in that the lived experience of being an Indigenous woman is intertwined with reality and worldview (Moreton-Robinson and Walter, 2010). Moreton-Robinson discusses how Indigenous women present to the world is rooted in a history different to that of the white feminist position. White feminist anthropological representations of Indigenous women omitted the subjectiveness of individual Indigenous women (our personal opinions or beliefs about things), but Indigenous women can challenge white hegemony through how we present ourselves (Moreton-Robinson, 2000).

An Indigenous woman's standpoint is constructed by the common experience of being inextricably connected to land with a legacy of dispossession, being exposed to racism and sexism, and continuing activism all while resisting disparaging images and negotiating sexual politics (Moreton-Robinson, 2000). Moreton-Robinson (2010) explains further that the epistemology of an Indigenous woman's standpoint theory is underpinned by these experiences, as well as the experience of being mothers, sisters, daughters, aunties, grandmothers, and leaders within our communities, all while having our sovereignty denied and continuously negotiating non-indigenous spaces. Indigenous woman's standpoint theory harbors a political commitment to examining and challenging Western ways of knowing us, as we struggle for epistemic authority within the academy (Moreton-Robinson and Walter, 2010)

A scoping review by McGuire-Adams et al (2023) suggests there is currently a gap in the use of Indigenous feminism in health research. Applying the logic of Indigenous women's

standpoint theory would suggest that the experiences of white women birthing in the current mainstream maternity system cannot be applied to Indigenous women and vice versa. It is true, however, that a smaller proportion of research participants in some aspects of this study were non-Indigenous, however, the majority of the women who participated in this research are Aboriginal, and this research seeks to privilege the voices of First Nations women.

4.7 Reflexive statement

Reflexivity means that researchers position themselves within their research, making known their cultural and professional backgrounds, articulate how these things influence their interpretation of their research, and state what they as the researcher might gain from conducting the study in the first place (Creswell, 2013). As a researcher, inevitably I bring my personal bias and worldview into my research process. It is necessary to engage in reflexive research practice, where I give continuous consideration of how this influences the research process and my interpretation of the data (Creswell and Miller, 2000).

I am a Ballardong-Noongar woman, who was born and raised on an Aboriginal Country that is not my own. As a family with Stolen Generation heritage, connections to our Ballardong roots have been interrupted, however, this does not mean it is not a very important and positive aspect of my identity. My Aboriginality has meant that in my life I have often been blessed to have been surrounded by other Mob, and for Elders to call me 'bub'. My Aboriginality, and its historical, cultural and social significance, shape the way I see the world. Indigenous methodologies view the Indigenous researcher's bias and positionality as a potential strength, rather than a potential risk (Wilson, 2008). Still, the need for reflexivity in qualitative research practice crosses into the realms of both Indigenous (West, Stewart et al., 2012) and Western methodologies (Creswell, 2013).

In my life so far, I haven't connected strongly with my Irish, Scottish or Cornish heritage. I am yet to visit these Ancestral places, and I know less about those Ancestors. Yet I was still raised in a predominantly white suburb, and I was educated through the Western system. As Rigney (1999) points out, Indigenous academics are not immune to 'colonial hegemony' (p.187). I know this to be true about myself, and I am on an ongoing journey of reflection about the influence of my Western upbringing on how I make sense of things.

As a young person, being the daughter of a teacher and a nurse/midwife meant two things: a middle-class upbringing where I was privileged to have shelter and nourishment, and that gaining an education was talked about as a virtuous route to success. In an attempt to enhance my chances at academic success, my parents forked out the modest but notable fees required to enrol their surly and rebellious fifteen-year-old into an all-girls Catholic high school. It is these kinds of privileges that boosted my ability to reach my goals, and I must acknowledge that my experience of the world is also shaped by the privileges I have had.

I acknowledge that my professional background as a midwife strongly influences my approach and interpretation of my research. I am influenced by my discipline because in order to obtain my midwifery qualification at university, I needed to do what the academy asked of me. During my Bachelor of Midwifery studies, I was taught that the underpinning philosophy of midwifery is 'woman-centred' (Pairman, Tracy et al., 2018). Woman-centred practice is founded on principles of respecting women and enhancing women's' status in society. It promotes normal physiological birth, and upholds women's self-determination, focusing on the health needs of the woman and her family (Pairman and Gray, 2018). I am frustrated to disclose that once I graduated from university, I found the constraints of working in a 'system' diminished my ability to practise in a way that I consider to be woman-centred, nor did I witness woman-centred care as being standard practice. This strongly colours the lens through which I view my research.

As researchers, it is always important to think carefully about what we are doing and why. There is a history of mistreatment of First Nations people by Western researchers, even if the intention was to do good. My Aboriginality, however, does not mean that I cannot cause harm. Cultural misunderstandings and miscommunication in research that are seemingly innocuous have led to retraumatising of participants. As a result, there is a reluctance from the First Nations community to trust researchers. As Linda Tuhiwai-Smith so bluntly states, 'research', for First Nations people, is a "dirty" word (Smith, 2012) (p.1). Remembering that indigenous systems of knowledge are built on relationships – with people, objects, the cosmos, ideas, and concepts, and knowing that indigenous methodologies are all about relational accountability, these are things that I have kept in my mind to guide all my decisions. As Wilson (2001) says, instead of putting all the focus onto the constructs of validity and reliability, I can ask myself, "how am I fulfilling my relationship? Am I truth-telling?". To remember that I am not discovering anything new because the knowledge of my research topic already exists. Dominant

Western paradigms say that knowledge is individual or something that the researcher has gained, where, rather, in an indigenous paradigm, knowledge is relational. I thought to myself, “whichever way I go, as long as I remember these things, I will be okay”.

I have practiced reflexivity through being transparent about my perceived strengths and my short-comings. I have journaled throughout my research journey and have reflected deeply throughout the process of study design, data collection and data analysis. Journeying back to Country, as I was writing my thesis was a profoundly reflexive exercise. It was here, that I connected with Country, Ancestors and community, telling the story of my research journey as I passed through. Without this experience, I wouldn’t have been able to feel secure that I was on the right path. As Martin (2003) states:

> “Reflexivity is a process that allows us to work from Aboriginal centres and ensure we work with relatedness of self and Entities. Reflexivity challenges us to claim our shortcomings, misunderstandings, oversights and mistakes, to re-claim our lives and make strong changes to our current realities. Being reflexive ensures we do not compromise our identity whilst undertaking research.” (p.212)

Chapter 5: Research design and research methods.

This chapter discusses the research design and methods used in this thesis. Liamputtong (2016) defines research methods as “the strategies and techniques that researchers use to acquire knowledge and collect data” (p.519). As per Moreton-Robinson (Personal communication, Feb 29, 2024) the methods used are the third and final part of a research methodology, along with the conceptual framework and the standpoint that have been described in Chapter four.

In terms of indigenous research methods, Drawson and colleagues (2017) conducted a systematic review of indigenous research methods in peer-reviewed literature and found that indigenous research methods are diverse and are difficult to define generically. They also found that in the 64 articles included, that ‘method’ was used to either refer to the specific research procedures, or the research framework. They were, however, able to organise the methods into five categories: General Indigenous Frameworks; Western Methods in an Indigenous Context; Community-Based Participatory Action Research; Story Telling; and Culture-Specific methods (Drawson, Toombs et al., 2017). The authors determined that diverse indigenous research methods all share the following:

- Reflection of context – the researchers situate themselves and the Indigenous Peoples who are collaborating in the research process;
- Indigenous people are included in the research process in a way that is respectful; reciprocal, decolonising, and preserves self-determination; and
- Indigenous ways of knowing are prioritised (Drawson, Toombs et al., 2017).

This thesis is one component of the overarching Baggarrook Yurrongi project, which was a prospective, non-randomised translational study. The Baggarrook Yurrongi project was co-developed in partnership with VACCHO, each of the partner sites (three metropolitan tertiary maternity hospitals, and one regional hospital), staff from their respective Aboriginal Health Units (AHUs), and an Aboriginal Advisory Committee (AAC). The research team was comprised of a multidisciplinary team of both First Nations and non-First Nations researchers. The AAC was comprised of two community Elders, First Nations staff from the partner sites, a First Nations woman who had recently given birth, and First Nations members of the research team. The AAC provided input into decisions relating to aspects of the research such as eligibility criteria, the design of the data collection tools, and offered advice on community engagement.

This thesis addresses one of the secondary aims of the overarching project, which was to explore the views and experiences of women having an Aboriginal or Torres Strait Islander baby at the study sites.

The design of this thesis is mixed methods, with indigenous and Western methodologies incorporated. This chapter will present the rationale for use of both quantitative and qualitative methods in social science, and the benefits of using both in a single research study (mixed-methods), and also, how indigenous methodologies have been incorporated into the methods.

5.1 Research Design

5.1.1 Quantitative methods in social research

Quantitative research is known as the science of numbers and "relies on quantification in collecting and analysing data and uses statistical analyses" (Patton 2015 as cited in (Liamputtong, 2016) (p. 4). Rigorous quantitative research designs follows a clear set of rules to carefully control the environment, optimising both internal validity (research that measures what it says it measures) and external validity (results can be generalised

beyond the study setting) in the findings, historically being the preferred approach within the health sciences (Liamputtong, 2016). Quantitative research seeks to 'generalise' findings (meaning to apply trends identified in the sample to a wider population) by checking that steps taken such as sampling, measurement, and statistical analysis are concise and logical (Jirojwong and Pepper, 2011). Additionally, the traditional ontology of quantitative research is that there is a single objective reality to be discovered (Liamputtong, 2016). Researchers usually maintain an objective attitude and keep any value judgements separate, so that bias does not impact results and reduce the validity of results (Jirojwong and Pepper, 2011; Liamputtong, 2016). In evaluating health care, systematic reviews followed by randomised-controlled-trials are generally considered to be well-designed and are highest in the 'hierarchy of evidence', which is an evidence ranking system based on the research design (Liamputtong, 2016; Nagy, Mills et al., 2010). Quantitative research has been viewed as 'hard science', producing findings that are more empirical and valid when compared to subjective qualitative approaches (Liamputtong, 2016). According to Buettner and colleagues, (2011) statistics assist in knowledge acquisition in a way that is 'universally accepted' among health care professionals. The political, social and cultural power that statistical data holds has been also recognised by Aboriginal researchers (Moreton-Robinson and Walter, 2010). Quantitative research methods are also efficient and cost-effective in obtaining data to build evidence (Liamputtong, 2016).

This thesis includes quantitative analysis of closed-ended questionnaire responses. The aim was to invite as many Aboriginal and/or Torres Strait Islander women (or women having an Aboriginal and/or Torres Strait Islander baby) as possible to share their views, making surveys an appropriate method of data collection. Conducting surveys with women meant that questions about their views and experiences of care were able to be quantified and statistically analysed (Schofield and Forrester-Knauss, 2017). Compared to a qualitative study design, collecting quantitative data on women's views using structured surveys allowed the inclusion of a much larger number of women (n=343). The perspectives of many women have been included, giving strength to the findings (Schofield and Forrester-Knauss, 2017). Additionally, a larger cohort increases the chance that the findings may be applicable to the wider population of Aboriginal and Torres Strait Islander women in Naarm (Schofield and Forrester-Knauss, 2017). Some of the research findings may also be transferrable to other Aboriginal and/or Torres Strait Islander communities, but given the diversity between communities, it is recommended

that policy makers should seek the views and opinions of women who are representative of the area relevant to the service (Palmer, Weavell et al., 2019).

Nayri kati – An indigenous quantitative methodology

As has been discussed earlier in the chapter, quantitative research methods 'on' Aboriginal and Torres Strait Islander (and other Indigenous) communities can be problematic because Indigenous people may be 'othered', statistical portraits of deficit are often produced, indigenous worldviews possibly undermined, and the full story of how Indigenous lives may not be represented (Moreton-Robinson and Walter, 2010; Watego, Singh et al., 2021). It is therefore important for me to reflect on the use of quantitative research methods here.

Using numbers, percentages and statistics is a very Western way of trying to understand reality. To increase the usefulness of quantitative research for First Nations communities, Professor Maggie Walter has identified that applying an indigenous research framework to quantitative research methodology is possible. The name given to this indigenous quantitative methodology is called 'nayri kati' (meaning 'good numbers' in Pakana language) (Moreton-Robinson and Walter, 2010). Nayri kati reframes the discourse that flows from quantitative research practices by positioning Indigenous researchers as the decision makers regarding research questions and research agendas. An indigenous lens frames, analyses and interprets the data (Moreton-Robinson and Walter, 2010).

As discussed in Chapter four, indigenous knowledge is relational, and so this is the epistemology of nayri kati. The principles of nayri kati are: that knowledge cannot be 'discovered', only revealed and then shared; the Indigenous person as the observer; and indigenous worldviews are the lens through which knowledge is revealed (Moreton-Robinson and Walter, 2010). The axiology (value framework) of nayri kati is that indigenous views of reality are privileged and that reflexivity is central (Moreton-Robinson and Walter, 2010).

By positioning myself as an Aboriginal woman and using this positionality as the lens through which I predominantly view this research, as well as asking myself reflexive questions such as why have I chosen this topic, why am I focusing on this aspect, and where my interest comes from (Moreton-Robinson and Walter, 2010), I have applied the principles of an indigenous quantitative methodology, or nayri kati, in my research.

5.1.2 Qualitative methods in social research

Qualitative research is the "science of words" (Liamputtong, 2016) (p.16). Unlike quantitative data, which is numerical, qualitative data are presented as diagrams, words or drawings (Liamputtong, 2016). Because of the diversity in approaches and methods that fall under the category of qualitative research, providing a generic definition is difficult (Denzin and Lincoln, 2011). Creswell's (2013) chosen definition does however describe qualitative research in a concise manner

> "Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study or research topics, addressing the meaning individuals or groups ascribe to a social or human issue. To study this topic, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns of themes. The final written report or presentation includes voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change." (p.44).

Qualitative research designs range from phenomenology (lived experience of a phenomena) to ethnography (study of groups) or as is in the case of this thesis, to Critical Theory (Creswell, 2013). Each shares the key principles of qualitative research, in that multiple realities are accepted and accounted for, the reflexive researcher is a key instrument, the study is conducted in a natural setting, and the perspectives of research participants in their context are the focus (Creswell, 2013; Welch, 2011).

Qualitative inquiry is useful to understand complex issues that require exploration with depth through talking to people directly (Creswell, 2013). The aim of qualitative research is to understand how people construct and make sense of the world and their experiences (Welch, 2011). Qualitative research is interpretive, and the researcher attempts to interpret the meanings that people apply to a certain phenomenon (Denzin and Lincoln, 2011). A focus on lived experiences in context gives 'richness' to the data, enabling the revelation of underlying complexities in any given issue (Liamputtong, 2016; Miles, Huberman et al., 2020; Willis, Daly et al., 2007).

Criticisms of the dominance of positivism in Western paradigms were discussed in Chapter four. However, since positivist science has been referred to by some as the "crowning achievement of western civilisation" (Denzin and Lincoln, 2011; Liamputtong, 2016), friction exists between quantitative and qualitative disciplines. Qualitative

researchers such as Denzin and Lincoln (Denzin and Lincoln, 2011) lament that quantitative evidence as 'hard science' may be more acceptable and influential to decision makers, and qualitative opponents have claimed there is no criteria for verifying truth and rigour in qualitative research (Denzin and Lincoln, 2011). Liamputtong (Liamputtong), however, demonstrates that qualitative rigour is assessed through concepts of 'credibility' 'transferability' 'dependability' and 'confirmability'. Qualitative research sits lower on the 'hierarchy of evidence', though the limitations of this hierarchy as the sole benchmark for evidence-based practice, particularly for vulnerable populations, have also been raised (Liamputtong, 2016). This was the case for the Baggarrook Yurrongi study, as the co-design approach to the Baggarrook Yurrongi project resulted in agreement that a randomised-controlled-trial design did not align with the priorities of the community. Other issues identified with quantitative research includes that less attention is placed on the social and cultural determinants of health, known to strongly influence an individual's health status (Rogers, 2004). Additionally, the position of some researchers is that quantitative methods striving for unbiased, value free, objective results potentially 'silences' too many voices (Liamputtong, 2016). Even if quantitative researchers and decision makers have critiqued the interpretive nature of qualitative research methods as being of low value in 'scientific' knowledge (Denzin and Lincoln, 2011; Liamputtong, 2016), qualitative research is increasingly contributing to the evidence base in health care research (Liamputtong, 2016).

Qualitative research is valuable in empowering individuals to share their stories, have their voices heard, and can minimise power differentials between the researcher and the researched (Creswell, 2013). Some advantages of using qualitative approaches in healthcare research is that the specific needs of people can be identified; the most acceptable intervention can be developed; and the effect of a new treatment or model of care can be understood from the perspective of the recipient of care, in their own social or cultural context (Liamputtong, 2016). Because it provides evidence an in-depth understanding on the human experience, which may otherwise not be obtainable in quantitative research, it contributes greatly to the issue of 'appropriateness' of care (Liamputtong, 2016). Qualitative research is a legitimate research approach on its own (Denzin and Lincoln, 2011), but it is also very useful for the illumination or supplementation of quantitative data (Miles, Huberman et al., 2020).

The qualitative component of this thesis involved semi-structured interviews with Aboriginal women, guided by both Western and indigenous methodologies. I first learned

about the practical skills needed to do research interviews (or semi-structured interviews) from a Western perspective (how and when to ask questions, bring a tape recorder, listen to and transcribe your recordings) and then I learned about incorporating indigenous methodologies into the interviews. The semi-structured interviews provided an opportunity for positive engagement between myself as the researcher, and the women participating in the research with me, and provided rich data of their experience (Willis, Daly et al., 2007). Oral story telling is one of the foundations of Aboriginal culture. It is how we traditionally came to understand the world around us, and therefore qualitative methods are often chosen by First Nations researchers (Bull, 2020; Drawson, Toombs et al., 2017; Marriott, Reibel et al., 2019; Nelson, Marriot et al., 2021; Rigney, 1999). I approached my interviews with the aim of providing a safe and empowering space for women to do 'truth-telling' (Wilson, 2001), where myself, as another Aboriginal woman, was the only person present (Rigney, 1999). In section 5.2.4, I will discuss how 'Yarning' was applied (Bessarab and Ng'andu, 2010).

5.1.3 Mixed-methods research

Selecting a research design is about judging the most appropriate way to answer the research question (Liamputtong, 2016). Sometimes a researcher will decide the questions cannot be answered completely if using only one of either approaches (qualitative or quantitative) and so a mixed-methods design is used (Liamputtong, 2016). From a Western perspective, mixed-methods research is "a research design that combines research methods from qualitative and/or quantitative research approaches within a single research study." (Taket, 2010) (p.332).

The research questions asked in this thesis are:

1. What are the views and experiences of Aboriginal or Torres Strait Islander women having a baby (or women having an Aboriginal or Torres Strait Islander baby) at one of three maternity services in Naarm, Victoria?
2. What are the experiences of Aboriginal women in Naarm, Victoria, who received continuity of midwife care through a culturally tailored continuity of midwife care model?

The design of this thesis is mixed-methods, as quantitative analyses of questionnaire responses were accompanied by qualitative analyses of free-text survey responses, as well as qualitative semi-structured interviews. Mixed-methods research aims to provide

answers to complex research questions by merging two sets of results so that different aspects of a research question can be elaborated on or clarified (Gbrich, 2010; Taket, 2010).

An advantage of using mixed-methods research is that both 'breadth' and 'depth' can be achieved in a single study (Meixner and Hathcoat, 2019). Mixed-methods research also offers more flexibility in an approach to answering complex research questions, because the experiences behind the statistics can be explored, which provides greater insight into results (Gbrich, 2010; Nagy, Mills et al., 2010). There has been a steady rise in mixed-methods research since the 1990s (Nagy, Mills et al., 2010; Thierbach, 2020) as health care researchers are becoming increasingly aware that using multiple methods is potentially very effective as an approach to understanding best practice (Nagy, Mills et al., 2010). Mixed-methods is useful in health care evaluations as qualitative methods used with quantitative outcome measures can assist in deepening understanding about what parts of a new program or intervention were important in influencing the outcome (Taket, 2010).

Methodological critique of mixed-methods research designs is usually related to whether or not it is possible to combine two research methods that are derived from contradictory paradigms (quantitative being objective and the research is uninvolved, and qualitative being subjective, researcher is a key instrument) (Nagy, Mills et al., 2010; Taket, 2010; Thierbach, 2020). Disadvantages to consider in doing mixed-methods research are that the process can be resource intensive in terms of time taken and potentially needing more people to cover the relevant skill sets required to carry out each component (Gbrich, 2010; Nagy, Mills et al., 2010; Taket, 2010). I recognise that because this thesis is nested within a larger overarching project, the required resources to undertake a mixed-methods design were available. To recruit 343 women from across three study sites, and then to follow the women up postnatally was a team effort. It would not have been possible for me to do this alone.

One thing that is agreed upon in the literature is that a mixed-methods design allows for the 'triangulation' of results (Creswell and Miller, 2000; Gbrich, 2010; Liamputtong, 2016; Thierbach, 2020). Triangulation refers to the merging of qualitative and quantitative research results (Liamputtong, 2016), and if there is consensus between the different data sets, validity (the integrity of the findings) and credibility (how believable

are the findings) is increased (Curtin and Fossey, 2007; Schofield and Forrester-Knauss, 2017).

5.1.4 Indigenous mixed-methods research

Botha (2011) interprets indigenous mixed-methods research as fusing the conventional qualitative approaches that are typically used with Indigenous people, with methods or ways of knowing that are unique to Indigenous people (such as local practises, cultural relationships or altered states of consciousness). Botha's process does not consider any inclusion of quantitative methods, however, Chilisa and Tsheko (2014) provide a definition of indigenous mixed-methods that could be applied to research that includes a quantitative and qualitative mixed methods design:

> "A mixed methods approach that uses an indigenous research paradigm seeks to integrate multiple ways of knowing and seeing the world, multiple standpoints, and multiple values. It promotes a multidirectional lending and borrowing of knowledge systems between dominant and marginalized cultures. The indigenous mixed methods approach thus starts with a change of mindset that problematizes, critiques, and challenges the marginalization and exclusion of the ways of knowing and seeing the world of marginalized communities. The mixing can take the process of the indigenization process where researchers invoke indigenous knowledge to inform ways in which concepts and new theoretical frameworks for research studies are defined, new tools of collecting data developed, and the literature base broadened, so that we do not only depend on written texts but also on the largely unwritten texts of the formerly colonized and historically disadvantaged people. The indigenous mixed methods from this view point are about inviting different voices to participate in a dialogue that embraces all cultures and promotes the social validity of research studies. From this perspective, there cannot be an indigenous research without mixed methods. Both quantitative and qualitative approaches are indigenized."

In a study with adolescents in Botswana that explored beliefs about HIV, Chilisa and Tsheko (2014) combined both Western and indigenous qualitative methods that were relevant to the cultural context. The authors then included quantitative questionnaires that were analysed using Western quantitative methods with indigenous quantitative methods used in the final phase of the research. They say that their decolonised, indigenous research approach of relationship building and inclusion of cultural knowledge allowed for the integration of marginalised knowledge systems with dominant knowledge systems (Chilisa and Tsheko, 2014). This is similar to a process used by Hill et al. (2010) where qualitative and quantitative methods were incorporated with an indigenous methodology

in a study that aimed to assess the cultural validity of using the Minnesota Multiphasic Personality Inventory (MMPI)-2 with Indigenous people. The indigenous methodology was prioritising and centring the values of the Eastern Woodland Oklahoma Elders who were involved (Hill, Pace et al., 2010).

Important to consider is 'why' and 'when' do mixed-methods become a sensible or preferable choice, and for what purpose are methods mixed (Thierbach, 2020). Elston et al. (2013) contended that their mixed-method approach successfully built capacity and increased involvement of Indigenous people in health research. Likewise, we aimed to offer the opportunity to participate in the research and provide feedback to as many women having an Aboriginal and/or Torres Strait Islander baby as possible. As qualitative research is limited to a smaller sample, a survey was deemed the most appropriate way to reach as many women as possible during the data collection phase. However, it was also recognised that qualitative in-depth interviews would address the complexity of the research question and also align with the cultural value of oral story-telling in Aboriginal communities. Thus, with the availability of the resources required, using mixed-methods was seen as the best way to answer the research questions.

5.1.5 Digging down to the groundwater analogy

When thinking about the process of my research journey, I have borrowed the idea from my Yolŋu friends and also from Aunty Doseena Fergie that *water represents knowledge* (see section 4.1.6). Indigenous ways of knowing, being and doing are based primarily on our relationships. It is my relationship to Noongar Boodjar, intertwined with my relations with the women who participated in this research, my relations with Yolŋu, Aunty Doseena, my research team, and the time spent in those relationships that have allowed this analogy to take form. I am grateful for all of it.

I use the analogy of 'digging down to the groundwater' to describe the design of my thesis, which is a mixed-methods study using both indigenous and Western and methodologies. Noongar women traditionally used 'warnna' (digging sticks) to unearth food. Many other communities, particularly those further in-land, used digging sticks to find freshwater. There are examples of artwork and rock art representing knowledge directions to locate water (Moggridge, 2020). For Ballardong, a significant song line theme is about the sharing of water.



FIGURE 10 - WARNNA (WOMAN'S DIGGING STICK).

Photo taken by P.McCalman, Northam, 2022.

In Western research methodology, quantitative methods provide 'breadth' and qualitative methods provide 'depth'. Mixed-methods research provides both 'breadth' and 'depth' in the findings (Meixner and Hathcoat, 2019). I also use this diagram to demonstrate that I have undergone a process of 'triangulation', which Creswell and Miller (2000) describe as gathering and analysing data in more than one way, then linking the findings together to increase the trustworthiness of the findings. Similarly, Curtin and Fossey (2007) discuss one example of triangulation as using quantitative and qualitative research to explore the same topic. I see my thesis as a process of moving from the topsoil layer (surface knowledge) and sometimes using my warnna (indigenous knowledge), or sometimes my shovel (Western knowledge), to dig down to the ground water – the deep knowledge.

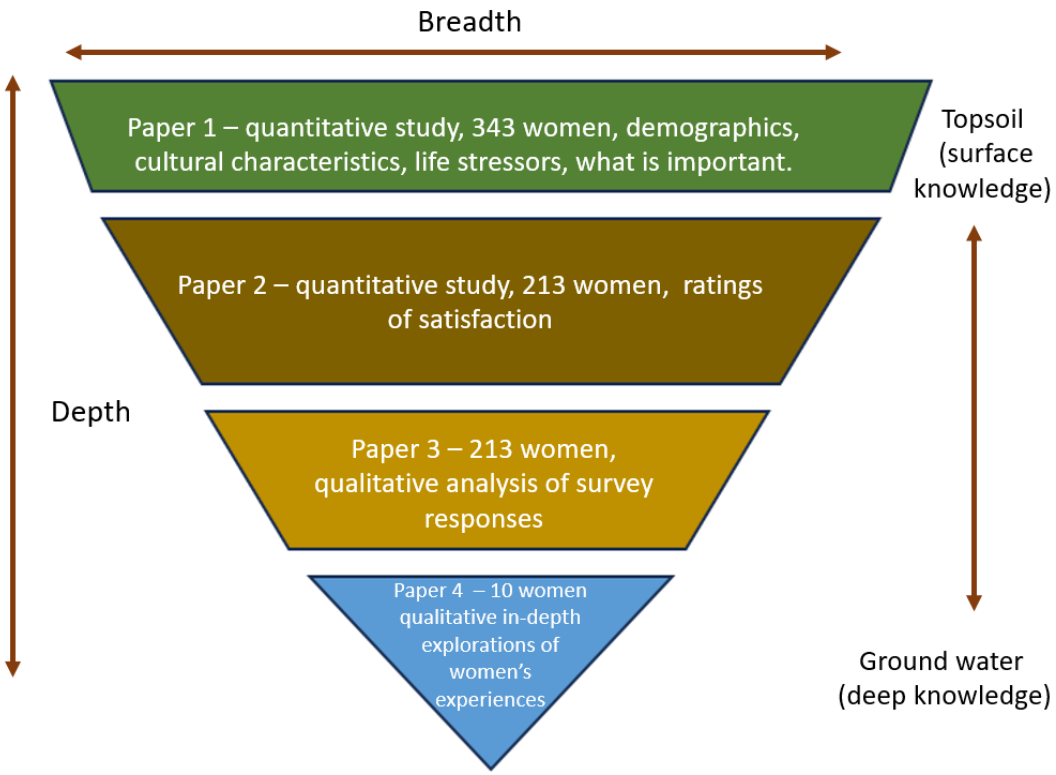


FIGURE 11 - DIGGING DOWN TO THE GROUNDWATER (DEEP KNOWLEDGE) ANALOGY

5.2 Research methods

The following chapter provides an overview of the research methods used in this thesis. Additional detail specific the methods used for each paper are presented in Chapters six though to ten.

5.2.1 The questionnaires (part 1)

Using questionnaires to measure satisfaction and experiences with maternity care

Evaluating experiences of maternity care through surveys as a measure of quality is common, and results from routine or large-scale surveys have informed changes in policy and practice (Beecher, Greene et al., 2021). An example of this is the Victorian survey of recent mothers, which had a broad statewide focus and has been used to inform the development, implementation and evaluation of government policies and service development at the hospital level (Brown and Lumley, 1997).

There is however complexity and inconsistency with measuring women's satisfaction with maternity care and as such, the Cochrane review on continuity of midwife care models discussed the subject of maternal satisfaction narratively (Sandall J, Fernandez Turienzo C et al., 2024). 'Satisfaction', 'experiences' and 'perceptions' mean different things in the literature, but are sometimes used interchangeably (Haines, Hildingsson et al., 2013). Adding to this complexity is the subjective nature of satisfaction. How someone might evaluate their care is often influenced by their background and individual circumstances, and pre-held expectations can also influence subsequent levels of satisfaction (Crow, Gage et al., 2002). Whether or not pre-held expectations are met is an important determinant of subsequent satisfaction with maternity care (Galle, Roelens et al., 2015). These pre-held expectations can also more strongly influence experience of satisfaction, than the quality of the service per se (Haines, Hildingsson et al., 2013; Hayman, 2009).

Despite the current lack of a standardised tool to measure women's satisfaction with their maternity care (Perriman and Davis, 2016), seeking valid and reliable feedback from women about their experiences of satisfaction is an important measure of quality in a service (Perriman and Davis, 2016). As such, our approach to using questionnaires was to collaborate with researchers who had conducted similar studies with Aboriginal and/or Torres Strait Islander women, obtain feedback from the AAC about the questionnaire design, and to test and pilot the questionnaires before use with participants (detail discussed above).

In health care research, using questionnaires and surveys is generally considered effective for collecting information about opinions, expectations, and satisfaction (Schofield and Forrester-Knauss, 2017). Valid (whether the questionnaire measures what it aims to) and reliable (the questionnaire facilitates consistent responses) questionnaires in midwifery can assist research and inform clinical practice or service development (Perriman and Davis, 2016). Questionnaires are also useful in collecting data about the characteristics of the people who are participating in the research (Schofield and Forrester-Knauss, 2017).

Two structured questionnaires were used in this thesis. The first was a 'recruitment' questionnaire which was usually completed by women during pregnancy (or less frequently on the postnatal ward before discharge from hospital). The second questionnaire was the 'follow up' questionnaire which was completed between three and six months postpartum. The data collection tools were based on items used previously by

the senior members of the Baggarrook Yurrongi research team, in a randomised-controlled-trial evaluating the effect of caseload midwifery for women of low obstetric risk in Naarm (Forster, McLachlan et al., 2016). Permission was also granted from Baggarrook Yurrongi co-investigator Professor Sue Kildea to include items used in data collection tools from a previous study, comparing different models of care for women having Aboriginal and Torres Strait Islander babies in Meanjin/Brisbane (Hickey, Roe et al., 2018). Additional items were used from another study exploring the experiences of Aboriginal families accessing maternity care in South Australia (Brown, Weetra et al., 2015) with permission.

Draft versions of the recruitment questionnaire and the follow up questionnaire were reviewed first by the AAC, and revisions were made accordingly. Feedback from the AAC was that the follow up questionnaire was too long, and there were also some items that were more relevant to a rural and remote context, rather than an urban context. Adjustments were made accordingly and then questionnaires were piloted with three First Nations women, who were midwives, but who were not involved in the project directly. This ensured questions were logical and were culturally appropriate (Schofield and Forrester-Knauss, 2017). Feedback from the piloting was that no further adjustments were required.

Questionnaire 1: Recruitment questionnaire

The recruitment questionnaire collected data on maternal socio-demographic characteristics, such as Aboriginal or Torres Strait Islander status, age, education level, place of residence, and socioeconomic status (see Appendix D). Socioeconomic status was explored by proxy questions, such as health care card concession holder status, private insurance versus Medicare only, and whether the household received a government benefit as the main source of income. Data were also collected on social and emotional factors that may be associated with negative perinatal health outcomes, such as exposure to stressful life events, current worries, and tobacco use (Brown, Yelland et al., 2011). To measure psychological distress, a 9-item tool was used which was originally developed and validated for use in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)(AIHW, 2009). Women were also asked to rate the importance of certain factors relating to antenatal, birth and postnatal care, using Likert type scale questions, rating on a scale of 1 to 5. Questions explored factors such as ‘Having culturally appropriate posters, brochures, artwork and Aboriginal/Torres Strait Islander

flags visible', 'Having female caregivers for labour and birth', 'Feeling I can trust the health care staff' and 'Being cared for by Aboriginal/Torres Strait Islander staff'. These questions were based on those used in the Indigenous Birthing in an Urban Setting (IBUS) study (Hickey, Roe et al., 2018), which were originally based on a maternity-specific cultural competence tool (Kruske, 2012). Women also were given the option to respond to free-text questions such as 'Which Aboriginal language group or community do your people come from?'.

Recruitment questionnaire items

- Demographic and personal information including:
- Maternal age
- Education level
- Aboriginal or Torres Strait Islander language group
- Smoking status
- Current gestation
- Parity
- Current life stressors
- Modified K-10 anxiety scale (Kessler, Andrews et al., 2002)

Questionnaire 2: Follow up questionnaire

The follow-up questionnaire (see Appendix E) explored which model of maternity care that woman received (i.e. culturally tailored caseload model, standard hospital care, etc.). The questionnaire also included questions on women's levels of satisfaction with their pregnancy, labour and birth, and postnatal care. Ordinal data were collected in questions where women were asked to answer, for example, 'Always' 'Mostly' 'Sometimes' 'Occasionally' or 'Never', in relation to their interactions with midwives, as well as in 7-point Likert-type scales where women could rate each aspect of care from '1' (Very poor) up to '7' (Very good). Free text, open-ended questions were also included, relating to women's views about their care.

Other questions asked about maternal and newborn health since birth, infant feeding practices, social and emotional health, and service usage. Free text, open-ended questions were also included, where women were given an opportunity to comment further on questions. Free-text open-ended questions included: 'Was there anything about your

pregnancy care that you were particularly happy with?', 'Was there anything about your pregnancy care that you were particularly unhappy with?', 'Was there anything in particular with your labour and birth care that you were particularly happy with?', 'Was there anything in particular with your labour and birth care that you were particularly unhappy with?' and 'Is there anything else you would like to tell me about your care in hospital after the birth?' Responses to open-ended questions were transcribed verbatim by the researcher, and then re-read out to the participant to for confirmation.

Follow up questionnaire items

Including but not limited to:

- The model of care received
- The level of continuity in that model of care (i.e. how many times did you see a midwife you knew)
- Infant date of birth
- Mode of birth (normal vaginal birth, instrumental vaginal birth, caesarean)
- Infant admission to Special care/ Neonatal intensive care
- Satisfaction with care in each area of hospital (pregnancy clinic, birth suite, postnatal ward, domiciliary)
- Level of engagement with community services
- Cultural safety questions
- Health outcomes for mother and baby
- Infant feeding practises
- Current life stressors
- Modified K-10 anxiety scale (Kessler, Andrews et al., 2002)

5.2.2 Questionnaire Data collection

Participants

We aimed to offer all eligible women during the recruitment period the opportunity to take part in the research, and women were invited to participate regardless of what model of care they had chosen or were able to access; that is whether or not they received a culturally specific caseload midwifery model of care. Eligible women **a)** were booked for antenatal care under the public system at one of the study sites, **b)** were over the age of

16, **c)** spoke English confidently (defined as not requiring an English translator), and **d)** identified either themselves or their baby as Aboriginal or Torres Strait Islander. The research team aimed to approach women to invite them to participate in an evaluation of care only after they had already attended an initial antenatal booking visit and then a subsequent antenatal visit. This ensured there were no issues that would preclude an approach for the purpose of the research, for example, if the woman was not expecting a live baby, or if the clinical team had reason to advise the woman should not be approached to participate in the research (for example, if a woman was experiencing severe medical or social complexity).

Recruitment procedure

Research midwives, who were employed at each of the three study Sites, aimed to approach all eligible women during the recruitment period and invite them to participate in an evaluation of care comprised of two questionnaires; an initial questionnaire at recruitment, and then a second questionnaire completed at three months postpartum by telephone. Women were approached in the antenatal clinic area, in the antenatal inpatient ward, or in the postnatal ward after birth (some women transferred care to the study site late in pregnancy or were not identified as eligible until after birth). Recruitment at Sites 2 and 3 was impacted by the COVID-19 pandemic, and face-to-face recruitment had to cease due to contact restrictions within those health services. During this time, women were contacted and invited to participate by telephone.

The research midwives explained the project and provided the women with plain language written information (see Appendix D). Women were able to discuss participation in the evaluation with their partner, family, or members of their community, or with the Aboriginal Hospital Liaison Officer [AHLO]. Women were informed that participating in the evaluation was voluntary and were reassured that if they did not wish to participate they would receive the best care possible and would not be contacted again by the research team. If the woman agreed to participate in the evaluation, a participant information and consent form (PICF) (see Appendix D) was signed.

Questionnaire 1: Recruitment questionnaire data collection

The recruitment questionnaire came in the form of a hard copy and was usually completed by the research midwife in person, after the woman provided written consent

to participate. The recruitment questionnaire was filled out by the woman, or if she preferred, the research midwife read out the questions and wrote down the woman's responses. A small number of women elected to take the questionnaire home and were provided with a self-addressed, postage-paid envelope to return by mail. During COVID-19 pandemic restrictions, women were mailed the recruitment questionnaire with an addressed postage-paid envelope.

Questionnaire 2: Follow up questionnaire data collection

Three months after the recorded birth date of their baby/ies, women were followed up by telephone. Members of the research team were notified when women were due to be contacted via a computer-generated list on REDCap (Research Electronic Data Capture) (Harris, Taylor et al., 2009). During the phone call the researcher would reconfirm consent with the woman, and then read out the questions and document the responses on a hardcopy questionnaire. A standardised contact protocol was followed which guided the team on how often to attempt to contact women. If women reached six months postpartum and were not able to be contacted, they were then considered 'lost to follow up'. Although uncommon, some women elected to opt-out of the 3 month follow up. These women were removed from the list, and no further contact was made.

5.2.3 Questionnaire data analysis

Quantitative data

As soon as possible after the questionnaires were completed, data were entered by members of the research team from the hard copy questionnaires onto REDCap (Harris, Taylor et al., 2009) a secure password protected data management software. Data were then imported into Stata 17 (Stata Corp and 2021) for cleaning and analysis. Prior to analysis, data were 'cleaned', which is a process that aims to identify and correct errors and to minimise the impact of data entry errors on study results (Van den Broeck, Cunningham et al., 2005) (see Appendix H). Data cleaning involved using Stata 17 to run range and logic check reports, checking missing data fields, and cross checking the hard copy questionnaires that were stored in locked filing cabinets. Nominal and ordinal categorical data (Pierson, 2016) were summarised using frequencies and percentages, and

continuous variables summarised using mean and standard deviation (or median and range for non-normally distributed data) (Buettner, Muller et al., 2011).

These data contribute to papers in Chapters seven and eight.

Content analysis

Included in the recruitment questionnaire was one free-text question 'Which Aboriginal language group or community do your people come from?'. Content analysis (Asheim, 1952) was used to analyse responses. Content analysis can be either quantitative or qualitative, and it is considered to be appropriate for open-ended questionnaire responses (Bengtsson, 2016). A quantitative content analysis presents the number of categories in the data as frequencies (Bengtsson, 2016). It involves coding and counting how many times a certain word or subject appears in the text (Nagy, Mills et al., 2010). Responses to this question were exported onto an Excel spread sheet and then individual answers were sorted into categories (in this case, the names of language or custodian groups). The number of different language or custodian groups were then counted. This process is named in the literature as a 'manifest' content analysis, as little interpretation is involved. The researcher picks words that people have actually said, uses those specific words and stays very close to the text (Bengtsson, 2016). I then presented the data visually as a 'wordle'. Some custodian/language groups had much stronger representation than others, however, to maintain confidentiality all groups were 'weighted' equally in the wordle. Words such as 'sad' and 'researching' were included to acknowledge the responses from women who reported not knowing which custodian or language group they came from. Results from this analysis contribute to the paper presented in Chapter seven.

Open-ended free text follow up questionnaire responses

Two members of the research team (PMc and HMc) undertook a process of thematic analysis of the open-ended free-text questions from the follow up questionnaire. Braun and Clarke (2006) define thematic analysis as a 'method of identifying, analysing and reporting patterns or themes within data' that seeks to provide a 'rich description of the data set.' (p.79)

A six-step process of thematic analysis as described by Attride-Stirling (2001) was used. Processes of thematic analysis should be transparent (Braun and Clarke, 2006) and so provided below is a detailed account of the steps taken.

Qualitative data from each of the free-text open-ended questions were exported from Stata 17 onto Excel Spread sheets. One Excel spreadsheet was created per question. Each questionnaire response was linked to the de-identified unique study identification number of the participant. The following free-text open-ended questions were analysed:

- 'Was there anything about your pregnancy care that you were particularly happy with?'
- 'Was there anything about your pregnancy care that you were particularly unhappy with?'
- 'Was there anything in particular with your labour and birth care that you were particularly happy with?'
- 'Was there anything in particular with your labour and birth care that you were particularly unhappy with?'
- 'Is there anything else you would like to tell me about your care in hospital after the birth?'

As per Attride-Stirling (2001), the first step of analysis **(step 1)** was to reduce the data into simple statements that were relevant to the question that was asked, and any other recurrent issues in the text. Qualitative researchers refer to this as 'open coding', where the aim is to gain initial familiarisation of the data, and to organise data prior to further analysis (Liamputtong and Serry, 2010; Miles, Huberman et al., 2020). The next step **(step 2)** was to re-read the coded text, and identity themes based on salient themes and patterns identified, (Creswell and Poth, 2018) and as Attride-Stirling (2001) recommends, the themes were then refined to ensure a non-repetitive and succinct summary of the text. For coding reliability, the two researchers completed steps one and two separately, and then met to compare, discuss, and reach consensus on any differences in codes or meaning of codes identified (Green, Willis et al., 2007). The third step **(step 3)** was to create the thematic networks, which are web-like visual representations of the data, used as a tool for analysis (Attride-Stirling, 2001). To construct the thematic networks, the researchers organised and managed the themes by grouping themes that were interrelated based on their content. Attride-Stirling (2001) categorises themes as 'Basic' (simple statements or low-order premises in the text); 'Organising' (an abstract summary of clustered basic themes) and 'Global' (a concluding statement or metaphor about the text as a whole). Once the thematic map was illustrated and organised with basic themes

working inwards to a global theme, the thematic map was verified against the text, to ensure that the data is accurately reflected.

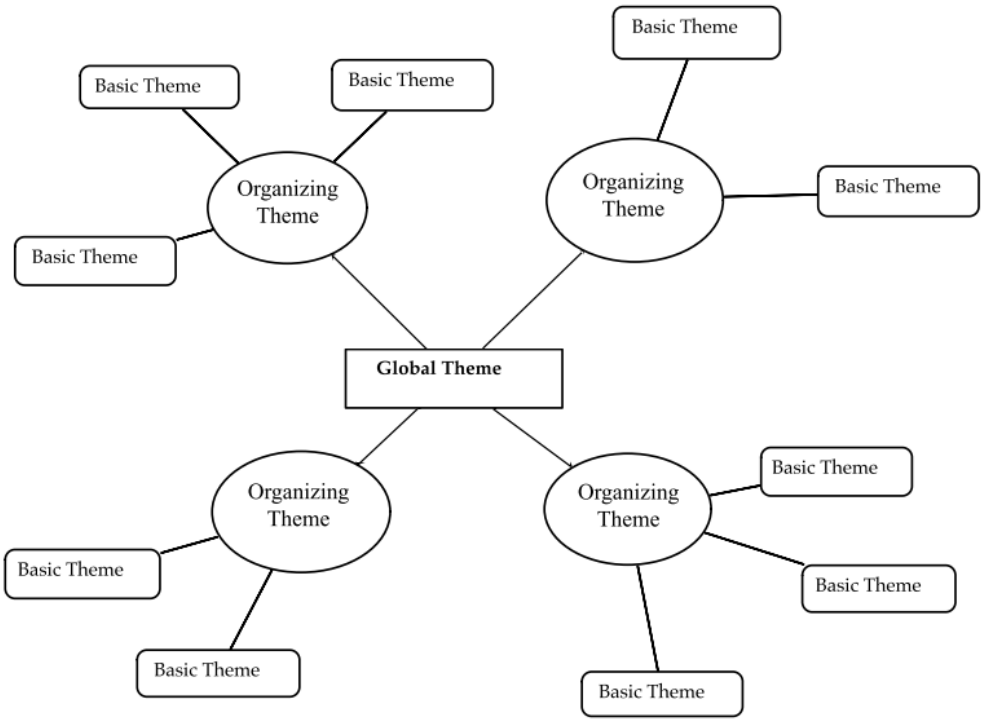


FIGURE 12 - EXAMPLE OF A THEMATIC NETWORK (ATTRIDE-STIRLING, 2001).

As indigenous methodologies promote indigenous ways of knowing, being and doing, (Martin and Mirraboopa, 2003) my supervisor, who is white, and I discussed our interpretations of the data at length, ensuring Aboriginal worldviews were privileged. This process was similar to a method of cross-cultural qualitative analysis described previously by Marriot and colleagues (2019a), and it could not have been achieved without a trusting relationship that could withstand the level of discomfort required to meet each other in the cultural interface (Nakata, 2007). The analytical process was underpinned by initial assumptions of possible systemic oppression stemming from colonial practices, as theorised in Critical Race Theory (Parker and Lynn, 2002). Additionally, my standpoint (Indigenous woman's standpoint) (Moreton-Robinson, 2000) specifically considered issues of sovereignty, community, historical societal depreciation, dispossession, Indigenous women's negotiation of private and public spaces, and a political commitment to challenging Western ways of knowing us.

An iterative process of moving back and forth along steps 1-3 took place, as the researchers met regularly over a period of six months to ensure a solid sense of the data was gained, as steps 1-3 (Attride-Stirling, 2001) were repeated several times. We initially planned to construct thematic networks illustrating positive and negative feedback from antenatal, labour and birth, and postnatal care (see Figure 13). However, after initial stages of coding, identification of themes and construction of the thematic networks, it became apparent that the positive and negative themes generated in those discrete thematic networks were very similar across antenatal, labour and birth, and postnatal areas. The thematic networks illustrating women's positive feedback were repetitious, as were the thematic networks illustrating women's negative feedback. Therefore, we decided to combine women's positive feedback from the antenatal, labour and birth, and postnatal episodes for one single analysis. The same was done for women's negative feedback. The outcome was two thematic networks being produced (one for what women liked about their care, and one for what women did not like about their care). The two final thematic networks are presented in Chapter nine.

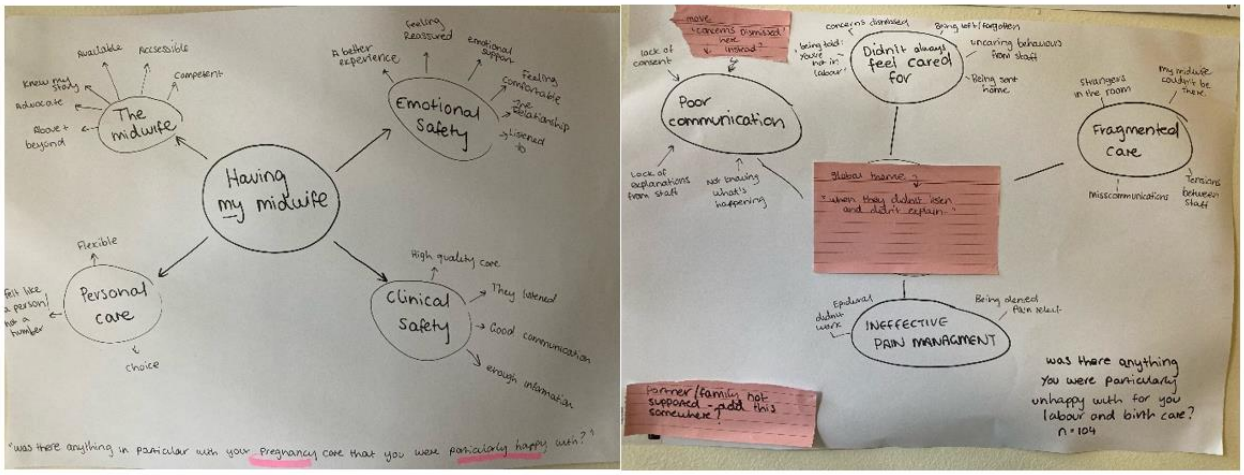


FIGURE 13 - EARLY ITERATIONS OF MY THEMATIC MAPS

Attride-Stirling (2001) explains that during steps 4-6 are where the deeper meaning of the text is explored. As thematic networks are used as a tool for the analytic process, rather than epitomising the analysis itself, **step four** involved re-reading the data, but rather than in a linear fashion, the data were read and interpreted through the Global, Organising and Basic themes. A full exploration and description of the thematic networks followed,

where the content of the thematic networks were described with supporting quotes from the text. The completion of steps five and six were carried out during the write-up phase of the findings. On completion of step four, a succinct summary of the principal themes and patterns was then prepared for an audience **(step 5),** in the form of a journal article. The journal article included an interpretation of the patterns and deductions, in the context of the original research question and the chosen social theory (Critical Race Theory) **(step 6).**

Results from this analysis contribute to the paper presented in Chapter nine.

5.2.4 Semi-structured interviews (part 2)

The research design also included conducting qualitative semi-structured interviews with a smaller sample of women (see Appendix F). Liamputtong and Serry (2016) describe engaging in semi-structured interviews as a 'partnership' (p.68). The nature of in-depth interviews have been described as 'conversational', (Whitehead and Whitehead, 2018) but a conversation requiring skill and preparation, because in-depth interviews are more than asking questions and talking with people (Serry, 2016).

Semi-structured interviews feature a pre-determined study guide with a set of open-ended questions that are intended to address the research topic, though they differ from structured interviews, as semi-structed interviews offer flexibility in terms of how the questions are asked and in what order (Nagy, Mills et al., 2010; Whitehead and Whitehead, 2018). The level of structure applied to in-depth interviews is on a spectrum from minimal structure (informal conversational interview) to maximum structure (standardised open-ended interview), and semi-structured interviews are situated in the middle (Serry, 2016).

Semi-structured interviews allow for spontaneity and the researcher has the freedom to explore additional topics of interest that emerge with the research participant (Liamputtong, 2016). The use of open-ended questions allows the participant to talk about their lived experience without enforcing binary options onto the participant (Serry, 2016). The data is not 'found' but it is generated from interactions between the researcher and the participants (Nagy, Mills et al., 2010). Effort was made to minimise the risk of introducing bias by asking questions in a way that allowed the women to explore their

own reasonings for issues raised, and asking any questions that could influence the responses given was avoided.

The interpretive methodology that frames a research project determines how important it is to include interviews (Nagy, Mills et al., 2010). As such, the inclusion of semi-structured interviews in this research process was viewed as an opportunity for positive community engagement, as well as a culturally appropriate tool for supporting indigenous methodologies such as relationship building, relationality (Wilson, 2008) and 'Yarning' (Bessarab and Ng'andu, 2010). Methods for the semi-structured, in-depth interviews were co-developed by the research team and the AAC and are detailed below.

Eligibility criteria for semi-structured interviews

On completion of the postnatal follow up telephone questionnaire, all women were asked if they would be interested in possible further contact relating to the project. The details of women who gave consent for further contact were then tracked on a computer-generated list, using REDCap (Harris, Taylor et al., 2009), with their details allowing me to then purposefully select women for the interviews based on the eligibility criteria. These criteria were based on discussions between the research team and the AAC about the specific aims and scope of the qualitative component of the study. Close mentorship and guidance was provided by two senior First Nations AAC members, both with professional backgrounds in midwifery and academia.

To be eligible for a semi-structured interview, women needed to **a)** have received the newly implemented culturally tailored caseload midwifery model, **b)** identify as Aboriginal or Torres Strait Islander, **c)** have met their midwife on at least three occasions prior to giving birth, **d)** be discharged home after birth with a live baby, and **e)** be between 3-9 months postpartum at the time of the interview. The rationale for only including women who received the newly implemented culturally tailored caseload midwifery model was that the aim of the semi-structured interviews was to explore women's views and experiences of care, specifically when they had a 'known' midwife through a culturally tailored caseload midwifery model.

It was also decided that eligible research participants needed to self-identify as either Aboriginal and/or Torres Strait Islander, whereas eligibility to participate in the survey component of the study included non-First Nations women having a First Nations baby.

This was based on discussion between the AAC and research team about the aim of the semi-structured interviews, where it was agreed that the aim was to understand women's views and experiences of having a known midwife, in the context of their lived experience as First Nations women. It was acknowledged that although indigenous knowledges highly value kinship structures and the importance of extended family members in relation to the birth of a new baby, Indigenist research involves First Nations researchers gathering knowledge from First Nations people (Rigney, 1999) and the value this opportunity was recognised by the research team and the AAC.

The number of times a woman had met with her primary midwife prior to birth (on three occasions as a minimum) was considered important because one aim of the interviews was to explore women's experiences of care when there was adequate opportunity to build a relationship with their midwife. The rationale for a minimum of three meetings was based on findings from a randomised-controlled-trial previously conducted by the research team that evaluated the effect of caseload midwifery on satisfaction of care for women of low obstetric risk (Forster, McLachlan et al., 2016). The findings suggested that the more times women met the midwife providing care for labour and birth during pregnancy, the higher overall ratings of care. This 'dose' of midwife continuity of care appeared to affect overall satisfaction, up until four or more antenatal visits. After this point, there did not appear to be incremental increases in overall satisfaction. The authors stated, however, that the study was not statistically powered to reach a conclusion on this (Forster, McLachlan et al., 2016).

The decision not to include women who were not discharged home with a live baby was not made lightly. It was recognised, however, that the experiences of women who have experienced perinatal loss is a separate and distinct issue, which requires specific attention that was not within the scope of this component of the study. Lastly, the issue of timing of interviews was discussed. In an attempt to minimise the potential impact of the postnatal 'halo effect' (the euphoric effects of labour and birth) and postnatal recall bias, interviews were conducted only with women who were between three-nine months postpartum at the time of data collection, in order to allow for the halo effect to wear off and not too far postnatally that recall was inaccurate (Brown and Lumley, 1997; Waldenström, 2004). Recent studies that have sought to confirm the validity of birth outcome data collected via questionnaires completed by women postnatally have shown that maternal recall is very accurate at four months postpartum, (Bat-Erdene, Metcalfe et al., 2013) but even years after the birth (Skulstad, Igland et al., 2017).

Sampling and sample size estimate

Purposeful sampling was used, which involves sampling a group of individuals who are best placed to inform the researcher of the specific research topic (Creswell and Poth, 2018). The aim was to include women who met the eligibility criteria, including at least one woman from each of the three study sites, and a mix of both primiparous and multiparous women of varying ages. Sampling was both purposive (Creswell, 2013) and random purposive, which refers to randomly selecting a sub-set of women from the larger pool of identified eligible women, ending with a smaller, more manageable sample (Johnson and Chang, 2011).

As the intent of qualitative research is not to generalise findings (Creswell and Poth, 2018), preliminary decisions about sample size are not required (Carpenter, 2016; Whitehead and Whitehead, 2018). The literature stipulates that the number of participants needed for any given qualitative study is variable with no set formula (Creswell and Poth, 2018; Isaacs, 2014; Liamputtong and Serry, 2010). Somewhere between 8-20 participants has been recommended by qualitative researchers (Creswell, 2013; Isaacs, 2014; Whitehead and Whitehead, 2018) and Creswell and Poth (2018) articulate that appropriate sample size depends on the chosen methodology. Qualitative researchers discuss though, that qualitative research is about 'quality, not quantity'(Liamputtong and Serry, 2010) (p.23). More important than large numbers is richness of the data (Whitehead and Whitehead, 2018) and whether the sample size is appropriate to address the research question thoroughly (Mason, 2002). Based on this information, an initial estimate of 10-20 women as an appropriate sample size was made.

Data collection tool

An interview guide (see Appendix F) was developed as a tool to ensure the research topic was addressed. The tool was broadly based on previous research conducted by the research team that related to women's experiences of continuity of midwife care (Forster, McLachlan et al., 2016) and adapted to explore the woman's experience of care within a culturally tailored continuity model. The AAC then provided input into the study interview guide. Four questions were asked relating 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 of the model, and **iv)** views and experiences of cultural safety.

An opening question was asked first to allow the women to talk about the topic at length, followed by questions which moved the interview along from one theme to the next, after it was apparent that topic of the previous question had been adequately explored (Serry, 2016). Listed on the study guide were also a range of potential sub-topics that could be raised by women, which were used as prompts if a 'probing' question was needed for further clarification on the subject (Serry, 2016; Whitehead and Whitehead, 2018). The interview guide ensured the research topic was addressed, and the semi-structured interviews still allowed for a flexible approach to the questions and the ability to follow any additional topics of interest (Nagy, Mills et al., 2010; Serry, 2016).

Data collection

Participant consent was gained (see Appendix F), and interviews were recorded using an audio recorder. The interviews took place at a time and place nominated by the woman (which was usually in her home), until COVID-19 restrictions precluded face to face meetings and video technology was used.

'Yarning' – 'Tell them who your mother is!'

'Yarning' was chosen as a culturally appropriate method of gathering information in the research process (Bessarab and Ng'andu, 2010). Yarning is a word commonly used in modern Aboriginal culture and refers to a culture-specific kind of conversation (Bronwyn, Karen et al., 2011). Yarning is used in this way in the contemporary Noongar culture of my people and is commonly used in this way across many Aboriginal communities including in Victoria, where this study took place. As a research method, Yarning is a useful strategy in decolonising the research process by centring indigenous knowledge systems, values and perspectives (Walker, Fredericks et al., 2014). It also helps to decolonise the research process by removing power imbalances between the researcher and the participant (Geia, Hayes et al., 2013).

As a legitimate research method in its own right, Yarning can be used in combination with Western research methods (Bessarab and Ng'andu, 2010; Walker, Fredericks et al., 2014). The importance of using Yarning rigorously and reporting the process accurately was highlighted by the authors of a review of qualitative studies that reported to have used Yarning as a research method (Kennedy, Maddox et al., 2022). The authors found

inconsistencies in the level of detail reported by researchers regarding how Yarning was applied and the level of inclusion of First Nations people or Advisory groups (Kennedy, Maddox et al., 2022). As such, my process will be outlined in detail below.

I received close mentorship and training from a community Elder, who was a member of the project AAC and has experience in using Yarning as a method in her own research. During the early days of the research journey, we spoke on the telephone many times before I was ready to begin my interviews with women. This Elder assisted me to incorporate Yarning into my study interview guide. She challenged me to keep true to my Aboriginality during the research interview process, and I still remember her strong voice saying, *'Tell them who your mother is!*'

The study interview guide included four types of 'yarns', as originally described by Bessarb and N'gandu (Bessarab and Ng'andu, 2010).

1) Social yarning (first establishing a connection)

In social yarning, I would introduce myself to the woman. I did not know any of the women personally, and so I would tell them who I was, where my Country was, where I was born, who my mother is, who my Ancestors were. Connections were made about lived experiences, community people whom we both knew (if any), and family histories. I would also tell them about my work as a midwife, and what led me to do research.

2) Research Topic Yarning (gathering information about the research topic in a relaxed semi-structured interview format)

When research yarning began, the audio tape recorder would be switched on and we both knew we were in the 'formal' part of the interview. But it was not very formal. Often this was done sitting on the loungeroom floor with a cup of tea, or on the floor playing with bub. I would start asking the questions that were on the study interview guide.

3) Collaborative Yarning (information sharing, explaining new ideas, uncovering new understanding)

In collaborative yarning, we would explore the things that the women had shared. We would yarn about any new revelations about her experience, and then I faciliated the woman's yarn to come to its own natural conclusion about the research topic.

4) Therapeutic Yarning (researcher listens attentively and affirmatively when traumatic of emotional issues are disclosed by the informant) (Bessarab and Ng'andu, 2010; Marriott, Reibel et al., 2019a)

Therapeutic yarning occurred if and when it needed to. It happened when women became upset or emotional during the research yarn. In the therapeutic yarn, I paused from gathering information from the woman and changed my communication to a position of deep listening and validation of whatever she was feeling at the time. In therapeutic yarning, it did not matter if the topic had moved far away from the research topic yarn. When the woman was ready, the therapeutic yarn could be moved back to a research topic yarn.

Similar to a study conducted by Marriot and colleagues (2019a), I used social yarning at the beginning of each interview to build rapport and facilitate relationality with the participants by sharing information about my identity, Country, and family history. It made both myself and the participant feel relaxed, particularly if shared understandings of lived experiences were evident. When the social yarn came to its natural conclusion, it was at this point that the tape recorded was introduced and the research topic yarn began. Research topic yarning is mostly led by the participants, however, the semi-structured interview process involves the asking of some direct questions. I used the questions on the study guide to ensure that the research topic was addressed, but the strength of using yarning techniques is that women are more likely to feel comfortable to speak freely and truthfully, as yarning is a familiar method of communication (Walker, Fredericks et al., 2014). Two-way collaborative yarning occurred when new understandings about the research topic were reached as a result of the information exchange that had occurred between myself and the participant. When a participant disclosed something traumatic or emotional, I temporarily moved away from research topic yarning, and listened intently to validate the participant's experience without judgement until the participant was ready to move forward with the yarn (Bessarab and Ng'andu, 2010).

Yarning techniques place emphasis on the concepts of accountability and relationality that are fundamental to indigenous methodologies.(Walker, Fredericks et al., 2014). During my yarns with the participants, I came to understand my accountability to each as a responsibility to accurately record their stories and disseminate them with the shared goal of improving the maternity care that is available for other First Nations women.

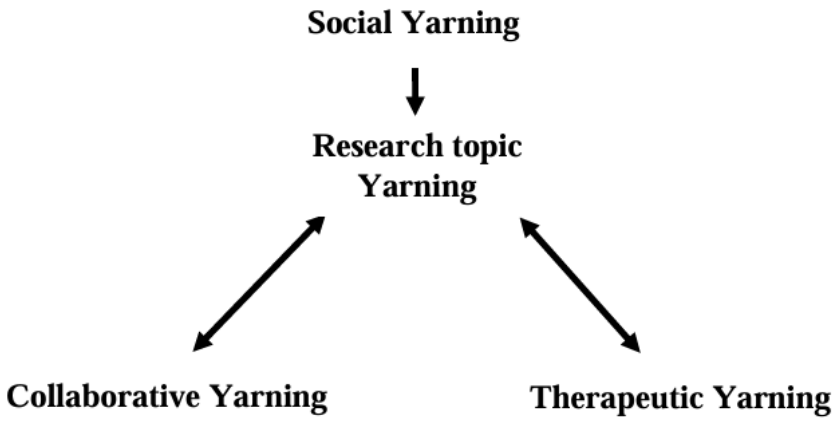


FIGURE 14 - THE YARNING RESEARCH PROCESS (BESSARB & NG'ANDU, 2010).

The recordings were transcribed verbatim, allowing me to immerse myself in the data (Liamputtong and Serry, 2010). Transcribing the data contemporaneously provided an initial awareness of the data, that then assists the researcher to judge when data saturation has been achieved (Liamputtong and Serry, 2010). The transcriptions were returned back to the participants as soon as possible for negotiation and confirmation, adding validity to the analysis (Creswell and Miller, 2000). The transcripts were then de-identified with pseudonyms and places names omitted from the text and stored in a password protected shared drive.

The final sample size

With keeping the estimated sample size of 10-20 women in mind, data collection was to cease when 'data saturation' had been achieved. Data saturation is said to have been reached when little new information or insight is being obtained from the data being generated (Liamputtong, 2016). Saturation of data is a concept associated with grounded theory research (Wong, Liamputtong et al., 2016), but it is also used in other qualitative studies as a means to justify sample size (Liamputtong and Serry, 2010). Determining whether or not data saturation has occurred however can be challenging (Carpenter,

2016), so much so that data saturation as a concept is an area of research on its own (Hennink and Kaiser, 2022). Additionally, the reality of time constraints within a research training program is taken account in the literature, where it is recognised that realistically, true data saturation may not always be able to be achieved (Carpenter, 2016). By the tenth interview, important key messages from the women about the research question had been achieved and new insights were limited. One or two women had reported experiences that deviated from the dominant narrative, however, the conditions under which these exceptions occurred were able to be explained (Green, Willis et al., 2007). After the tenth interview, a decision was made to cease data collection.

Data analysis

Thematic analysis was undertaken by two researchers using the four-step process previously described by Green and colleagues (2007). Similar to our process with the open-ended free-text questionnaire responses, we began a process of 'open coding' (Liamputtong and Serry, 2010; Miles, Huberman et al., 2020). This involved reading each interview transcript several times, helping to develop early ideas about the analysis. The second step was to commence coding the data manually, where simple notes about statements of interest in the text were added to the margins of the transcript. The first two steps were conducted separately before meeting to compare codes discuss meaning and reach a consensus about the data. As was the case with our previous analysis of the free-text questionnaire responses, the same consideration of indigenous methodologies, Critical Race Theory, and Indigenous woman's standpoint (described in Chapter four) was applied to this analytical process to reach consensus. The third step was to create categories which involved sorting related codes into groups and generating an explanation of their shared meaning.

This time it was not necessary to produce different 'thematic maps' (Attride-Stirling, 2001) because we were not analysing responses to separate, discrete questionnaire items. Instead, a table and a mind map were used as visual tools, as suggested by Braun and Clarke (2006) to assist in exploring relationships between the codes. The final step involved identifying themes to provide an interpretation of the specific issue being explored. Thematic analysis does not mean the researcher moves neatly from one step to the next, nor is it a linear process. (Braun and Clarke, 2006). This iterative research

process moved ‘back and forth’ (Green, Willis et al., 2007) along these steps over a period of ten months, as our understanding of the data developed.

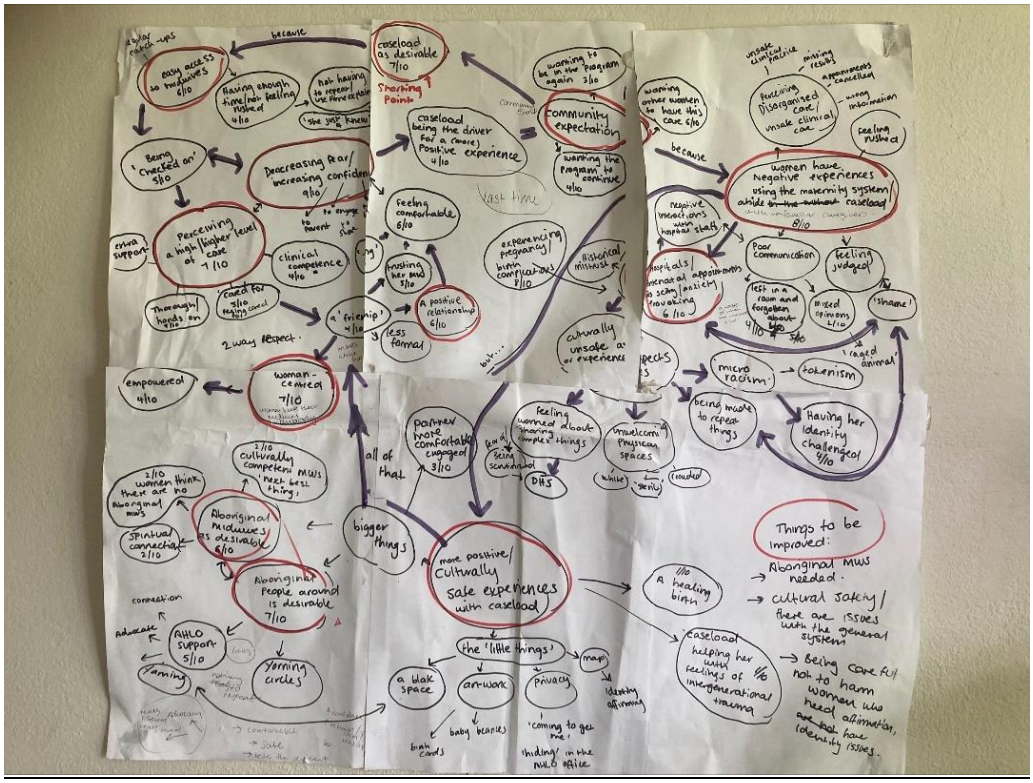


FIGURE 15 – A ‘MIND MAP’ USED IN THE EARLY STAGES OF THEMATIC ANALYSIS

5.3 Ethical considerations

Ethical statement:

Multisite Ethics approval has been provided by St Vincent’s hospital HREC reference number HREC-16\SVHM\223, La Trobe University (HREC 195/16) and all partner organisations.

Ethics approval was successfully received from all partner organisations, via St Vincent’s Hospital HREC multi-site ethics application process, and site-specific applications. The NHMRC (2018) National Statement on Ethical Conduct in Human Research was referred to, maintaining accordance with Chapter 4.7: Aboriginal and Torres Strait Islander Peoples (National Health and Medical Research Council, 2018). The Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS] (2012) Guidelines for Ethical Research in Australian Indigenous Studies was also be referred to for guidance in practise

(Australian Institute of Aboriginal and Torres Strait Islander Studies, 2012). Western research activities have historically been used as exploitive tools of imperialism and colonialism, causing great harm to First Nations people (Laycock, Walker et al., 2011). It is therefore recommended that research activities focusing on the health of Aboriginal people are led by Aboriginal people, or are undertaken in partnership with Aboriginal communities (Lowitja Institute, 2022). For all aspects of the research process, extensive community consultation with the AAC, VACCHO and the Aboriginal health units within the partner sites occurred. Steps that were taken to dismantle the inherent power imbalance that can exist between the researchers and First Nations women are discussed throughout this chapter (Smith, 2012).

Part of the research process is assessing how to 'give back' to participants for their time to ensure reciprocity (Creswell and Poth, 2018). The women were informed that no direct benefit was guaranteed from participating in the evaluation of care, however, collective participation would contribute to improving the provision of maternity services available for Aboriginal and Torres Strait Islander women and families in the future. For the ten women who participated in the semi-structured interviews, a gift voucher was provided at the end of the meeting, as a gesture of reciprocity, which all of the women accepted.

It was not anticipated that participating in the study would pose any serious risks for the women or their babies. However, the survey or interview questions included sensitive health questions, which although not highly likely, may cause psychological harm. As per the National Statement for Ethical Conduct in Human Research, psychological harm includes 'feelings of worthlessness, distress, guilt, anger or fear related, for example, to disclosure of sensitive or embarrassing information' (NHMRC, et al., 2018 p. 13). At a lesser severity, discomfort or inconvenience to the participants was also a possibility. All researchers engaging in data collection received specific training on responding to any distress experienced by the participant, including appropriate referral pathways for additional support.

Participation was voluntary, and individual consent was sought to obtain women's views for both for surveys and interviews (see Appendices D and F). Renegotiation of consent took place at frequent intervals during the research process, providing women with ample opportunities to withdraw from the study if this is their wish. Women also had the option of discussing the study with their family, community or the AHLO before deciding to participate. Women were provided with written information about the project, including

information on risks and benefits, privacy and confidentiality, possible uses for the data collected, how to withdraw from the study, and various contacts for more information or how to make a complaint (see Appendices D and F).
All data were stored securely. Electronic data were stored securely in password protected databases, and all hard-copy data were stored in a locked filing cabinet, in a locked office.

5.4 Conclusion

This chapter has defined and described key characteristics of quantitative, qualitative, and mixed-method research. Advantages and critiques of each design were discussed as supported by the literature and the rationale for the selection of the chosen methods. A large number of women were able to be invited to participate in an evaluation of care, where they were able share their views through questionnaires that were distributed, which then enabled exploration of the deeper meaning and the 'what' and the 'why' behind the quantitative results through qualitative inquiry.

This research study was situated within the larger Baggarrook Yurrongi project. As such, a team of people contributed to participant recruitment, survey data collection, and assisted with the different methods of data analysis. If the resources required to conduct mixed-method research were not available, I believe that the nature of qualitative research allows for culturally appropriate research methods and could address the complexity of the research topic. I am, however, not convinced that distribution of surveys in a purely quantitative design would be able fully answer the question. As such, I think that a qualitative research design, rather than mixed-methods could be an appropriate alternative research design if less resources were available.

Chapter five through to ten present the findings in this thesis. Chapter six will now present the primary outcome paper of the Baggarrook Yurrongi Project. Then presented in Chapter seven through to Chapter nine are the findings of the questionnaires, and the findings of the semi-structured qualitative 'Yarning' interviews are then presented in Chapter ten.

Chapter 6: Primary outcome paper: Baggarrook Yurrongi; Nurragh Manma Buliana (Woman's Journey).

The first paper included in this thesis is the primary outcome paper of the Baggarrook Yurrongi project. It is included here as part of the results as it provides critical context for the subsequent papers. The overarching study underpins the subsequent studies explored in this thesis – they would not exist without the main study. As detailed more below, I made a substantial contribution throughout the study and to this paper. The women included in the subsequent studies described in Chapter five and then presented in Chapters six to eleven, were all connected to this overarching study.

The primary aim of the Baggarrook Yurrongi project was to assess the organisational capacity of four maternity services to implement, embed, and sustain culturally tailored continuity of midwife care models for Aboriginal and/or Torres Strait Islander women, or women having an Aboriginal or Torres Strait Islander baby, with all eligible women offered the newly implemented models of care at the sites during the project study period. Between the years 2017 and 2020, 1040 women having a First Nations baby were identified at the study sites. Of these, 844 women (81.2%) were offered referral into the model, 758 (89.8%) accepted the referral, and by the end of data collection, 675 women (89%) had either received the culturally tailored model or were waiting for their first appointment. During the study period, there was a 21-fold increase in the number of First Nations women having access to a continuity of midwife care model across the study sites.

Three of the study sites (tertiary metropolitan maternity services in Naarm) were able to successfully implement a new, culturally tailored caseload midwifery models for women having a First Nations baby, and the models were embedded and sustained throughout the study period.

Enablers of this outcome included co-design of the study with Aboriginal and Torres Strait Islander people, cultural competency training of staff, improved processes for the identification of Aboriginal or Torres Strait Islander women and babies, engagement between hospital caseload midwives, Aboriginal health units, and a local AMS. Recommendations for further work include addressing barriers to implementing culturally tailored caseload midwifery models in regional areas. In regional Victoria, acute and

ongoing staffing shortages impacted on the ability of the fourth site to implement the model.

The primary paper on model implementation below helps inform the key secondary aim addressed by this thesis, to explore women's views and experiences of care (the focus of this thesis).

Citation:

McLachlan, H. L., Newton, M., McLardie-Hore, F. E., **McCalman, P**., Jackomos, M., Bundle, G., Kildea, S., Chamberlain, C., Browne, J., Ryan, J., Freemantle, J., Shafiei, T., Jacobs, S. E., Oats, J., Blow, N., Ferguson, K., Gold, L., Watkins, J., Dell, M., Read, K., Hyde, R., Matthews, R. and Forster, D. A. (2022). Translating evidence into practice: Implementing culturally safe continuity of midwifery care for First Nations women in three maternity services in Victoria, Australia. The Lancet, *eClinicalMedicine **47***. doi.10.1016/j.eclinm.2022.101415

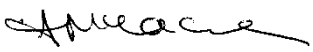
Contribution to the paper:

I declare that I have made a substantial contribution to this paper. I was employed as a project officer on the Baggarrook Yurrongi project from February 2017 until the completing of the project in December 2021 (the project study period was extended an additional 12 months due to the impact of COVID-19). I attended regular project governance meetings with the working and steering groups at each of the study sites. I assisted in the management of the project ethics requirements, including applications and modifications. I was directly involved in liaising with VACCHO and key stakeholders at VAHS. I assisted with running staff education sessions at the study sites. I have also contributed to the dissemination of the findings of this paper at conferences. I was involved in the editing and review of the manuscript. The co-authors all contributed to the overall project design, intellectual input and editing of the manuscript.



P. McCalman

I declare that Res McCalman made a substantial contribution to this paper. She contributed to many different aspects of the Baggarrook Yurrongi project, model implementation at the study sites, and edited and reviewed the paper.



H. McLachlan

Translating evidence into practice: Implementing culturally safe continuity of midwifery care for First Nations women in three maternity services in Victoria, Australia

Helen L. McLachlan,[a,b]* Michelle Newton,[a,b] Fiona E. McLardie-Hore,[a,c] Pamela McCalman,[a,c] Marika Jackomos,[i] Gina Bundle,[c] Sue Kildea,[d] Catherine Chamberlain,[a,e,m,n] Jennifer Browne,[h,o] Jenny Ryan,[c] Jane Freemantle,[e,k] Touran Shafiei,[a] Susan E. Jacobs,[c,f,g] Jeremy Oats,[e] Ngaree Blow,[e] Karyn Ferguson,[k] Lisa Gold,[h] Jacqueline Watkins,[j] Maree Dell,[j] Kim Read,[l] Rebecca Hyde,[a,b,c] Robyn Matthews,[a,c] and Della A. Forster[a,c]

[a]Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086 Australia
[b]School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086, Australia
[c]The Royal Women's Hospital, Parkville, Victoria 3052, Australia
[d]Molly Wardaguga Research Centre, School of Nursing and Midwifery, Charles Darwin University, Alice Springs 0870, Australia
[e]Melbourne School of Population and Global Health, The University of Melbourne, Parkville, Victoria 3053, Australia
[f]Murdoch Children's Research Institute, University of Melbourne, Parkville, Victoria 3052, Australia
[g]Department of Obstetrics and Gynaecology, University of Melbourne, Parkville, Victoria 3052, Australia
[h]Deakin University Institute for Health Transformation, Geelong, Victoria 3220, Australia
[i]Mercy Hospital for Women, Heidelberg, Victoria 3084, Australia
[j]Joan Kirner Hospital, Western Health St Albans, Victoria 3021, Australia
[k]Rural Health Academic Centre, The University of Melbourne, Shepparton, Victoria 3630, Australia
[l]Goulburn Valley Health, Shepparton, Victoria 3644, Australia
[m]Ngangk Yira: Murdoch University Research Centre for Aboriginal Health and Social Equity, Murdoch, Western Australia 6150, Australia
[n]The Lowitja Institute, Carlton, Victoria 3053, Australia
[o]Victorian Aboriginal Community Controlled Health Organisation, Collingwood, Victoria 3066, Australia

Summary

Background Strategies to improve outcomes for Australian First Nations mothers and babies are urgently needed. Caseload midwifery, where women have midwife-led continuity throughout pregnancy, labour, birth and the early postnatal period, is associated with substantially better perinatal health outcomes, but few First Nations women receive it. We assessed the capacity of four maternity services in Victoria, Australia, to implement, embed, and sustain a culturally responsive caseload midwifery service.

Methods A prospective, non-randomised research translational study design was used. Site specific culturally responsive caseload models were developed by site working groups in partnership with their First Nations health units and the Victorian Aboriginal Community Controlled Health Organisation. The primary outcome was to increase the proportion of women having a First Nations baby proactively offered and receiving caseload midwifery as measured before and after programme implementation. The study was conducted in Melbourne, Australia. Data collection commenced at the Royal Women's Hospital on 06/03/2017, Joan Kirner Women's and Children's Hospital 01/10/2017 and Mercy Hospital for Women 16/04/2018, with data collection completed at all sites on 31/12/2020.

Findings The model was successfully implemented in three major metropolitan maternity services between 2017 and 2020. Prior to this, over a similar timeframe, only 5.8% of First Nations women ($n = 34$) had ever received caseload midwifery at the three sites combined. Of 844 women offered the model, 90% ($n = 758$) accepted it, of whom 89% ($n = 663$) received it. Another 40 women received standard caseload. Factors including ongoing staffing crises, prevented the fourth site, in regional Victoria, implementing the model.

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*Corresponding author at: Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086 Australia.
E-mail address: H.McLachlan@latrobe.edu.au (H.L. McLachlan).

Interpretation Key enablers included co-design of the study and programme implementation with First Nations people, staff cultural competency training, identification of First Nations women (and babies), and regular engagement between caseload midwives and First Nations hospital and community teams. Further work should include a focus on addressing cultural and workforce barriers to implementation of culturally responsive caseload midwifery in regional areas.

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Keywords: First nations; Implementation science; Midwifery

Research in context

Evidence before this study

In Australia, numerous government reports and enquiries state that strategies to improve health outcomes for Aboriginal and Torres Strait Islander (hereafter called First Nations) mothers and babies are urgently needed. A Cochrane review found that women who had midwife-led continuity of care (compared with standard maternity care) were less likely to experience preterm birth or fetal loss prior to 24 weeks' gestation, yet the availability of these models for First Nations women is limited, and little is known about the capacity of large maternity services to implement culturally-specific models for First Nations women. Since project commencement, we have had an ongoing search alert for relevant Medical Subject Headings (MeSH) search terms and actively monitored publications, therefore no additional specific literature search was conducted for this study.

Added value of this study

This research translation study demonstrated the ability of three major metropolitan health services in Melbourne, Australia to successfully implement and sustain a culturally responsive model of maternity care for women having a First Nations baby. The model, developed in partnership with the Victorian Aboriginal Community Controlled Health Organisation, along with participating sites and their First Nations health units, provided women with continuity of care during pregnancy, labour, birth and the early postnatal period from the same known midwife (with one or two back-up midwives) – caseload midwifery – a model associated with substantially better perinatal health outcomes for non-First Nations women. We demonstrated a 21-fold increase in access to the model for First Nations women with high uptake (90%), demonstrating feasibility and acceptability. We did not achieve translation in the regional setting.

Implications of all the available evidence

Our successful research translation study demonstrated the ability of three major, metropolitan maternity services to implement a new, culturally responsive, caseload midwifery model that was embedded and sustained throughout the study period. Further scale-up of this model should be prioritised, with further research focused on understanding key features of implementing and sustaining the model (including in regional settings) and continuing to build the partnership between First Nations and hospital maternity services.

Introduction

In Australia, numerous government reports have recommended the urgent need for strategies that improve health outcomes for Aboriginal and Torres Strait Islander (hereafter called First Nations) mothers and babies.[1,2] Perinatal mortality for First Nations babies is substantially higher than non-First Nations babies (14.8 vs 9.6 deaths/1000 births) and the maternal mortality ratio is more than three times higher for First Nations women (17.5 vs 5.5 deaths/100,000 births).[3] Preterm birth (birth before 37 completed gestational weeks) and being low birthweight (< 2500 g) are both substantially higher for First Nations babies, and associated with significant morbidity and mortality.[3] Perinatal factors such as preterm birth are responsible for 85% of deaths occurring in the first 18 months of life.[2]

Poor quality antenatal care can contribute to poorer pregnancy outcomes for First Nations women.[4] The National Aboriginal and Torres Strait Islander Health Plan (2013–2023) highlights the need for improved quality and accessibility of routine antenatal care; evidence-based strategies to reduce maternal stress and smoking, improve nutrition in pregnancy, and increase breastfeeding; and better monitoring of maternal and fetal health.[1] More recently, the National Strategic Directions for Australian Maternity Services report[5] and Victorian Government strategic plans emphasise the need for services to provide appropriately developed, culturally safe and accessible perinatal care for First Nations women.[6,7] The caseload midwifery model may

be an important strategy to address these requirements.[8–13]

In the caseload midwifery model, women receive continuity in pregnancy, labour, birth and the early postnatal period from the same known midwife (and one or two 'back-up' midwives). Our team conducted the world's largest randomised controlled trial (RCT) of caseload midwifery (the COSMOS trial, n = 2314 low-risk women),[14] and found that compared with standard maternity care, babies of women allocated to caseload care were less likely to be low birthweight or admitted to neonatal special or intensive care units. Women were more likely to report being satisfied with their care, and to feel safe, informed, supported emotionally, and that their concerns were taken seriously.[15] The model was further tested with women of any obstetric risk in another Australian RCT, the M@NGO trial (n = 1748 women), and was found to be safe and cost effective.[16]

The Cochrane review of midwife-led care (n = 15 RCTs (including COSMOS and M@NGO) and 17,674 women), found that women who had midwife-led continuity of care (compared with other models of maternity care) were less likely to experience preterm birth or fetal loss prior to 24 weeks', and less likely to have interventions such as instrumental birth and episiotomy.[17] Women were more satisfied with care, and there was some evidence of reduced costs. The review concluded that most women should be offered midwife-led care, but that caution be exercised in applying this to women at substantial risk of obstetric or medical complications.

Many hospital-based caseload models have restrictive inclusion criteria related to medical and obstetric risk factors, thus often exclude First Nations women. An Australian national survey found 16 services specifically offered caseload midwifery care to First Nations women, but actual numbers of First Nations women receiving caseload was low.[18] However, where First Nations women accessed caseload care, they reported it to be very positive, and valued having a known care provider.[10,11,13,19] A recent large prospective, non-randomised intervention study (n = 766 intervention group; n = 656 control) conducted in Queensland, Australia, evaluated a midwifery group practice (caseload) continuity of care model for First Nations women. The study found that women in the intervention group were more likely to access early antenatal care and have five or more antenatal visits, with significantly reduced preterm births, neonatal nursery admissions, planned caesareans, and epidural pain relief, and increased exclusive breastfeeding on discharge from hospital.[10] Other studies have found increased antenatal engagement,[8] increased pregnancy visits, and more antenatal screening[13] and a recent review concluded that there is an urgent need to extend continuity of care for First Nations women in order to improve outcomes.[20] However, implementation of culturally appropriate caseload midwifery care models requires local leadership, specific funding and strong partnerships.[21–23]

The caseload midwifery model offers a collaborative and coordinated approach, providing First Nations women the opportunity to have a known midwife who has appropriate cultural training to help them navigate their journey through the maternity care system, while maintaining their community and family supports. Given how few First Nations women in Australia currently have access to this model of care, we aimed to assess the capacity of four Victorian maternity services (including a regional hospital), to implement, embed and sustain a culturally responsive caseload midwifery model for First Nations women. This paper reports on the outcomes of the primary aim of the study – to increase the proportion of First Nations women and non-First Nations women having a First Nations baby, (hereafter referred to as women having a First Nations baby) proactively offered and receiving caseload midwifery.

Methods

Study design

This study was co-designed in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), the peak body for First Nations health in Victoria, along with participating health services and their First Nations health units. The project was developed with a focus on evidence translation – offering First Nations women access to caseload midwifery care given the known beneficial outcomes, both clinical and psychosocial.[17] An RCT was considered, but the group's view was that implementing the model and offering it to all First Nations women at the study sites was the most appropriate design. We therefore developed a prospective non-randomised implementation study, using before and after outcome measures. The study was conducted in Melbourne, Australia with data collection commencing at the Women's on 06/03/2017, Joan Kirner 01/10/2017 and the Mercy 16/04/2018. Data collection was completed at all sites on 31/12/2020.

This paper includes among its authors members of the study's First Nations Advisory Committee (comprising all First Nations project investigators, two Elders, a recent new mother from the First Nations community, and representatives from VACCHO), the research team, and key stakeholders from partner organisations, both First Nations and non-First Nations. The Advisory Committee provided cultural guidance and oversight to the research team regarding methods, community engagement, discussion of findings, and knowledge translation. Participating health services each established a steering committee of key staff responsible for model implementation.

Study aims

The overall study aimed to explore (1) model implementation (2) women's views, experiences and outcomes (clinical and psychosocial, including infant outcomes), and (3) potential for sustainability of the model in the organisations (staff views, workforce capacity building cultural safety, costs etc.). This paper reports on Aim 1 (model implementation). Aims 2 and 3 will be reported elsewhere. Specific aims related to model implementation were:

(a) *Develop and implement* culturally appropriate caseload midwifery care for First Nations women at the study sites;
(b) *Increase the proportion* of First Nations women booking for maternity care at the study sites who are i. identified and ii. offered caseload midwifery care; and
(c) *Measure the uptake* of caseload midwifery care by First Nations women booking for maternity care at the study sites.

Participants

Four health services in Victoria, Australia, were partners in the project, along with VACCHO and La Trobe University. The sites were specifically chosen for having an established functioning caseload midwifery model, and a relatively large number of First Nations babies born at the site. Prior to study commencement there were approximately 250 First Nations women per year birthing across the four sites. Table 1 describes the sites. Many women accessing maternity care at the Women's and the Mercy hospital are referred from the Victorian Aboriginal Health Service (VAHS), a number of whom chose maternity care shared between VAHS and the health service (for women attending Joan Kirner, VAHS was not 'local', thus this was not the case).

Description of the caseload midwifery model implemented for First Nations women

In the *standard* caseload model, women receive antenatal, intrapartum and postpartum care from a caseload midwife with one or two antenatal visits conducted by a 'back-up' midwife (so they are also 'known'), with midwives taking a caseload of approximately 40 to 45 women per Equivalent Full-time (EFT) per year (varies by site and by the risk profile of the caseload). The primary midwife is on-call for a woman's labour and birth and for other telephone contact except in designated circumstances such as annual leave, sick leave, having already worked >12 h in a 24 h period, having more than one woman in labour, or being off duty, when care is provided by the back-up midwife, or on occasion, by core staff.[14] Collaboration with obstetricians and other health professionals is as needed.

In *this study*, caseload care was provided in conjunction with existing supports provided through community- and hospital-based First Nations health services and tailored at each site and for individual women. All women having a First Nations baby were eligible to be offered the model, regardless of risk factors. *The model was designed to enhance, not replace, existing systems,* to further close care gaps. The aim was that no matter where a woman chose to have most of her pregnancy care, she was linked with, and had 24/7 phone access to, a known caseload midwife who was her primary care provider for the hospital components of her care. Care could be solely hospital-based, with all care by the caseload midwife, or shared care between the caseload midwife and other specialised hospital service, e.g. maternal fetal medicine unit, obstetric team etc. Care could also be caseload care shared with a community-based provider e.g. a local Aboriginal Health Service or General Practitioner. It was expected that the caseload for each midwife would be slightly less than standard caseload if/where women had more complex needs.

All caseload midwives, managers, and some obstetric staff working within the model of care participated in-house cultural training as well as cultural safety training in First Nations health conducted by VACCHO, including face-to-face and online. The aim of the training was to assist staff to understand the impact of colonial history on First Nations people and the context of women's lives and to explore how to work effectively with First Nations people and their communities. It included information on working with the Victorian First Nations community health sector, and on closing the health gap between First Nations and non-First Nations people. During the project the caseload midwives liaised regularly with the Aboriginal Hospital Liaison Officers (AHLOs) to facilitate the best outcomes for women.

Operationalising the model at the study sites

Each participating health service had a steering committee to oversee project implementation and provide governance, and a smaller working group to develop and implement the model. Steering committees met four to five times each year on average, and included key hospital staff such as maternity managers, manager of Aboriginal programs, Koori Maternity Service (KMS) staff, and social work representation, along with some of the project investigators, a First Nations research midwife, hospital research midwives and the project co-ordinator. Working groups included staff relevant to implementation, e.g. caseload manager, clinic manager, research midwives.

Sample size considerations. There was no sample size calculation for this aspect of the overall study. This population-based study aimed to see if the sites could implement the model as planned and offer it to all women having a First Nations baby.

Site	Location, classification	Births per year (≈)	Caseload places per year (% of total births)	Women who identified as First Nations who received caseload care prior to project [#]	Cultural support unit and staff positions	Aboriginal Community Controlled Health Organisation (ACCHO) 'partner'
Royal Women's Hospital*	Metropolitan, tertiary	≈ 7500	500 women / year (8% of births)	2011–2014: 6 women (0.3% of 2093 caseload places)	Badjurr-Bulok Wilam 1.5 Aboriginal Hospital Liaison Officers (AHLO) positions	Victorian Aboriginal Health Service (VAHS) offers shared care model
Joan Kirner Women's and Children's Hospital	Metropolitan, tertiary	≈ 5500	1100 women / year (20% of total births)	2012–2013: 24 women (0.9% of 2744 caseload places)	Wilim Berrbang 2 AHLOs** 1 Koori Maternity Services worker	Not located near an ACCHO
Mercy Hospital for Women	Metropolitan, tertiary	≈ 6000	650 women / year (9% of total births)	2014: 4 women (1.0% of 398 caseload places)	Nangnak Baban Murrup 2 AHLOs 2 Nangnak Wan Myeek: postnatal support workers	VAHS offers shared care model
Goulburn Valley Health	Regional	≈ 1200	130 (11% total births)	2011–2014: 15 women (3.0% of 514 caseload places)	2 AHLOs	Rumbalara offers shared care, with midwife and obstetric antenatal care available from GVH

Table 1: **Site descriptions.**

[#] Data are provided for different years due to what was available from the sites.

* Model commenced as part of COSMOS trial in 2008.

** including a dedicated Aboriginal Hospital Liaison Officer whose role is to work with midwives to support First Nations women and their families throughout pregnancy, birth and up to eight weeks postpartum.

Outcome measures. Number and percentage of women having a First Nations baby who:

- Were identified, then offered caseload midwifery care at the hospital booking visit or later in pregnancy;
- Enrolled in the model;
- Received caseload midwife care during pregnancy and remained in the model for labour, birth and postnatal care.

All women having a First Nations baby were eligible. There were no exclusion criteria.

Data collection. Research midwives at each site educated staff about the study and reinforced the importance of identification of First Nations women and babies (with site AHLOs), collected data to meet the study aims, and recruited women to the embedded evaluation of women's views and experiences (study Aim 2, reported elsewhere). Data collection forms were developed to record the number of eligible women identified, then, of those, the number that were (a) offered the caseload model; (b) enrolled in the model; and (c) received it. These data are not routinely collected. Data were collected from clinic booking schedules, routine data sets, the caseload midwives' records etc.

Statistical analysis

Data were recorded on Excel spreadsheets, then data cleaning and analysis were undertaken in STATA 17. Data cleaning included range, logic and missing data checks. Analysis was first by site, then combined, with site identifiers included. Quantitative data were summarised using frequencies and percentages for categorical data and means and standard deviations calculated for continuous data.

Ethics

Ethics approval was granted by St Vincent's Hospital (16\SVHM\233), La Trobe University (HREC 195/16) and all partner organisations. Multi-institutional agreements were signed by each partner organisation and the study conducted in accordance with National Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research.[24]

Role of the funding source

The funders of the study had no role in study design, collection, analysis, and interpretation of data nor any role in the writing of this paper. All authors had full access to the data, and contributed to data interpretation. FMc, HMc, DF and TS prepared the data and did the statistical analysis. All authors contributed to manuscript revisions and accept responsibility to submit for publication.

Results

Caseload implementation and uptake

Three of the four partner sites successfully implemented the new, culturally specific caseload models during the study implementation period, which commenced in March 2017 (Figure 1), and all three sites

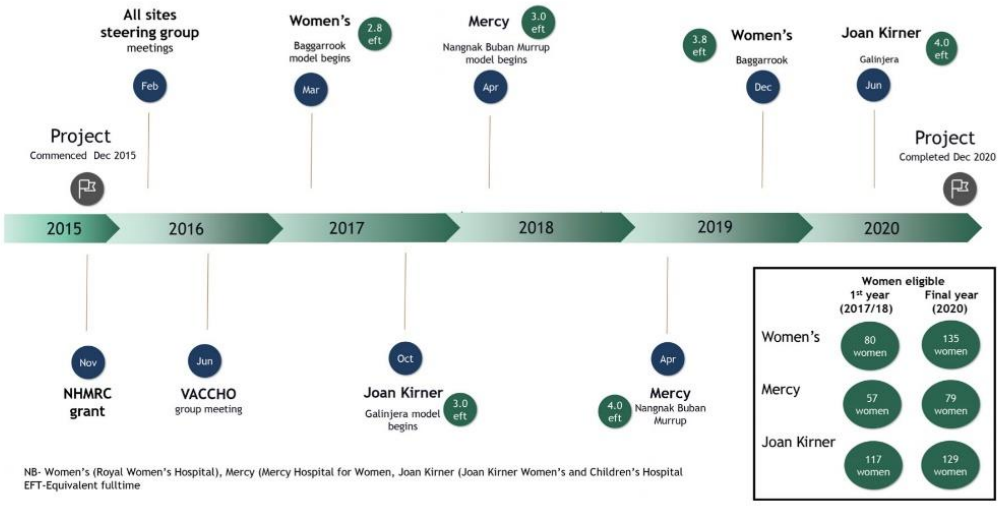


Figure 1. Baggarrook Yurrongi project timeline.
NB- Women's (Royal Women's Hospital), Mercy (Mercy Hospital for Women, Joan Kirner (Joan Kirner Women's and Children's Hospital. EFT-Equivalent fulltime.

sustained and continued the caseload model to the completion of data collection in December 2020. Table 2 shows model implementation by site, including midwife EFT and staff turnover, along with caseload size, and Figure 1 shows the implementation timeline.

Goulburn Valley Health (GVH) was committed to offering all First Nations women culturally specific caseload care, and met with the investigator team many times over the study period with meetings at the hospital and Rumbalara, the local Aboriginal Community Controlled Health Organisation (ACCHO). A steering group with broad key stakeholder representation was formed early in the study period, which included the Divisional Operational Director of Women's and Children's Services, the Maternity Services Director, the hospital AHLOs, Aboriginal health staff from Rumbalara, two local Chief Investigators and other members of the research team. Despite this, and the comprehensive preparation for model implementation (such as obtaining site specific ethics approval, ongoing site and key personnel meetings with Rumbalara, and appointment of a research midwife), ongoing acute and chronic staffing crises in maternity services at the hospital precluded model implementation. The data below therefore do not include GVH.

At the three implementation sites, all midwives appointed to the roles received cultural competency training, and all sites implemented education for staff more broadly regarding internal referral pathways, identification processes and data integrity i.e., the importance of accurately documenting the First Nations status of mothers and babies. There was regular engagement between the caseload midwives and all the relevant internal and external key stakeholders, e.g., the First Nations teams in the hospitals, and external midwives and other health care professionals. Midwives and managers from the Women's and Mercy regularly met with staff from VAHS to build on the relationship and enhance communication, with the caseload midwives being the hospital point of contact for the VAHS staff. Approximately 10% of women were directly referred into the model from their local ACCHO.

First nations women and babies who received caseload care

During the program implementation period (March 2017 to December 2020), 1040 women having a First Nations baby) were identified at the three sites (Figure 2, Tables 3 and 4). Approximately 70% of mothers identified as Aboriginal and/or Torres Strait Islander, the majority as Aboriginal (Table 4). Of the two sites which documented the father's First Nation status, 39.1% identified as Aboriginal and/or Torres Strait Islander, with >90% of these being Aboriginal. At the Women's the baby (not the father's) First Nations status was recorded during the antenatal period.

A small number of women transferred to another hospital before being allocated to a model of care (n = 12), and some were not documented as First Nations until after birth (n = 52) (Table 2, Figure 2). Of the 976 remaining women, 86.5% (844/976) were offered care in the model. Some women were not offered the model or referred by hospital staff (9.7%, 95/976) and in a few cases (2.2%, 21/976) there were no places available in the model. Almost all women who were offered the culturally specific model accepted it (758/844; 90%), with the remainder choosing other models of care (Figure 2). Of the 758 women who accepted the model, 87.5% (663/758) received it. The most frequent reason for not receiving the model (after accepting it) was that there were no places available i.e. the midwives' caseloads were full for the month (n = 83), although 18 of these women were subsequently offered midwifery caseload care in the standard hospital caseload program. For the remaining women (n = 65), most received standard hospital care including specialist obstetric or perinatal care (n = 47), standard midwife care (n = 6), care in the drug and alcohol unit (n = 7), or had their care transferred elsewhere (n = 5).

In total, 663 of 1040 women (63.8%) having a First Nations baby received the culturally specific caseload model and another 40 women received standard caseload, therefore 67.6% of all the identified women received caseload care (703/1040). Excluding those women who transferred to another hospital before the model could be offered, or who were not identified until after birth, 67.9% (663/976) received the culturally specific caseload model and 72.0% received any caseload care (703/976).

For women who received the culturally specific caseload model, care was exclusively within the model, or shared with other hospital and community-based models. Approximately half of the women (49%) had caseload care solely with their primary or back up midwife in the culturally specific models - Nangnak Buban Murrup (Mercy Hospital), Galinjera (Joan Kirner Hospital), or Baggarrook (the Women's) with no scheduled shared care with another provider. A further 41.9% (n = 605 women) had hospital-based collaborative care, i.e., caseload care shared with another specialist team at the respective hospital, including obstetrics, perinatal medicine, drug and alcohol, endocrinology, young women's clinic, and a clinic for women with a disability (Table 2). A small percentage of women (n = 58/663, 8.7%) had community-based shared care, and their caseload midwife was their primary hospital-based care provider, with the number of each varying by individual need and choice). Of these, 57 women had shared care with VAHS (on site, and midwife-led) and one woman with her GP. The VAHS midwife aimed to visit women in hospital, after the birth, to help with the transition back to VAHS care. Where women needed transport to attend pregnancy appointments VAHS was often able

	Mercy n=242		Joan Kirner n=387		Women's n=411		Total n=1040	
	n	%	n	%	n	%	n	%
First Nations women^ offered culturally specific model	211	87.2	304	78.6	329	80.0	844	81.2
Accepted	198	93.8	258	85.0	302	91.8	758	89.8
Accepted & awaiting first appointment (as at end of data collection period)	*2/198*	*1.0*	*10/258*	*3.8*	*0*	*0*	*12/758*	*1.6*
Accepted & received (n=196, n=248, n=302, total n=746)	*192/196*	*98.0*	*191/248*	*77.0*	*280/302*	*92.7*	*663/746*	*88.9*
Transferred care to other hospital before accepting/declining	0	0	2	0.65	0	0	2	0.2
Declined	13	6.2	44	14.5	27	8.2	84	10.0
First Nations women^ NOT offered culturally specific model	31	12.8	83	21.4	82	20.0	196	18.8
Family identified but model not offered by staff	12	5.0	53	13.7	30	7.3	95	9.1
Not documented as First Nations until after birth	17	7.0	7	1.8	28	6.8	52	5.0
Booked or /transferred from other hospital later in pregnancy, unable to access model	1	0.4	3	0.8	17	4.1	21	2.0
Transferred care out, prior to model offered	1	0.4	7	1.8	4	1.0	12	1.2
Other (e.g. pregnancy loss)	0	0	13	3.4	3	0.7	16	1.5
Total First Nations women^ receiving culturally specific model	**192**	**79.3**	**191**	**49.4**	**280**	**68.2**	**663**	**63.8**
Nangnak/Galinjera/Baggarrook ^^caseload midwife only care	**127/192**	**66.1**	**89/191**	**46.6**	**111/280**	**39.6**	**327/663**	**49.3**
Nangnak/Galinjera/Baggarrook shared care with hospital team^^^ (total)	**35/192**	**18.2**	**102/191**	**53.4**	**141/280**	**50.4**	**278/663**	**41.9**
General obstetrics	*15/192*	*7.8*	*65/191*	*34.0*	*12/280*	*4.3*	*92/663*	*13.9*
Perinatal medicine	*16/192*	*8.3*	*17/191*	*8.9*	*56/280*	*20.0*	*89/663*	*13.4*
Drug and alcohol service	*4/192*	*2.1*	*0*	*0*	*36/280*	*12.9*	*40/663*	*6.0*
Endocrinology	*0*	*0*	*20/191*	*10.5*	*14/280*	*5.0*	*34/663*	*5.1*
Young Women's clinic	*0*	*0*	*NA*	*NA*	*14/280*	*5.0*	*14/663*	*2.1*
Women with individual needs	*NA*	*NA*	*NA*	*NA*	*9/280*	*3.2*	*9/663*	*1.4*
Nangnak/Galinjera/Baggarrook shared care in community	30/192	15.6	0	0	28/280	10.0	58/663	8.7
Shared care model with Victorian Aboriginal Health Service (VAHS)	*29/192*	*15.1*	*NA*	*NA*	*28/280*	*10.0*	*57/663*	*8.6*
Shared care model with General Practitioner	*1/192*	*0.5*	*0*	*0*	*0*	*0*	*1/663*	*0.2*
Total First Nations women^ receiving other caseload care (i.e., not culturally specific model)	**3**	**1.3**	**32**	**8.4**	**5**	**1.2**	**40**	**3.9**
Total First Nations women receiving any caseload model of care	**195**	**80.6**	**223**	**57.6**	**285**	**69.3**	**703**	**67.6**
Model of care received if not in Nangnak/Galinjera/Baggarrook or standard caseload model	45	18.6	154	39.8	126	30.7	325	31.3
General obstetric care	23	9.6	86	22.2	0	0	109	10.5
Perinatal medicine/ Fetal Management Unit	8	3.3	25	6.5	40	9.7	73	7.0
Standard hospital care (mostly midwife care if medically low risk)	2	0.8	8	4.0	60	14.6	70	6.7
Drug and alcohol service	9	3.8	NA	NA	15	3.6	24	2.3
Shared care with General Practitioner	0	0	2	0.5	6	1.5	8	0.8
Young Women's clinic	2	0.8	NA	NA	4	1.0	6	0.6
Hospital community/satellite clinic	0	0	2	0.5	1	0.2	3	0.3
Incarcerated^^^^	NA	NA	20	5.2	NA	NA	20	1.9
Transferred care prior to model allocation	1	0.4	11	2.8	0	0	12	1.2
Other pregnancy booking information								
Direct referral from a local Aboriginal Community Controlled Organisation	33	13.6	0	0	67	16.3	100	9.6
Gestation at booking visit, weeks (mean, sd, (range)) (n=240, n=387, n=409, total n=1036)	17.5	5.7 (6.5, 37)	18.9	6.8 (8.5,39.7)	20.5	6.9 (6.8,39.8)	19.2	6.7 (6.5,39.8)
Booking appointment by midwife from Nangnak/Galinjera/Baggarrook	82	34.0	25	6.5	63	15.3	170	16.4

***Table 2*: Pregnancy models of care**

^ Includes women having a First Nations baby.

^^ Site names for culturally specific models Nangnak/Galinjera/Baggarrook.

^^^ as main speciality team, care may have involved more than one team.

^^^^ Care provided by visiting midwife (caseload not available), NA=Not Applicable.

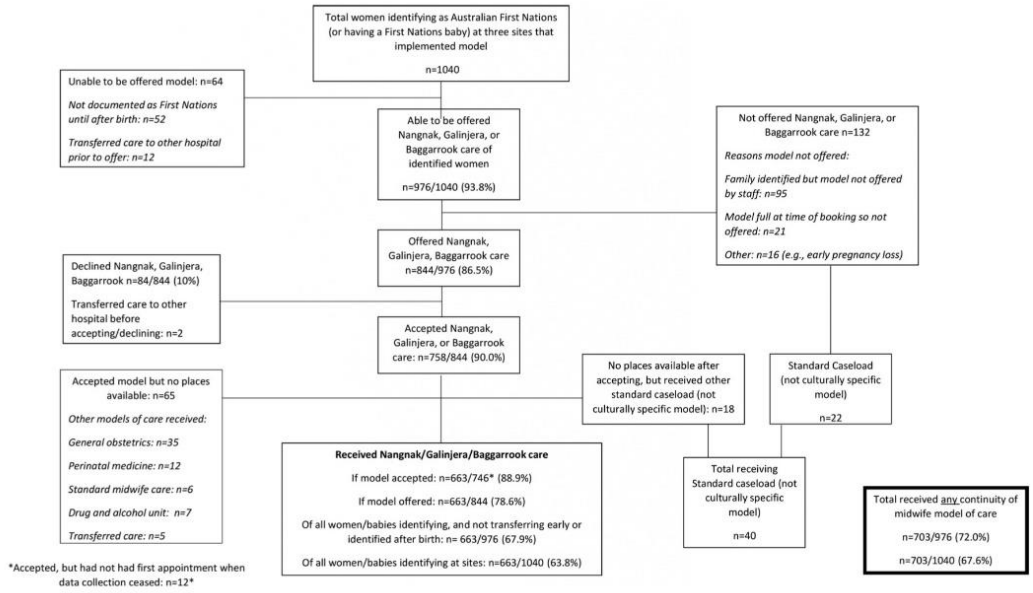


Figure 2. Pregnancy care pathway for women having a First Nations baby.
*Accepted, but had not had first appointment when data collection ceased: *n* = 12.*

to organise and provide transport (for VAHS, Mercy or Women's), and alternatively, when needed, all sites provided support to access transport, e.g., cab vouchers, parking vouchers, public transport cards. At two hospitals there were dedicated social workers linked to the new model. One hospital ran a 'Yarning Circle' facilitated by the AHLO and the caseload midwives, where mothers could meet to 'yarn' (informally discuss/chat) about pregnancy, birth and parenting while doing craft and artwork.

At the completion of data collection (December 31st 2020) 32/663 (4.8%) women who had pregnancy care in the culturally specific caseload model gave birth elsewhere, 48/663 (7.2%) had not yet given birth, and 2/663 (0.3%) had opted to leave the model. All other women allocated to the model had pregnancy care, gave birth and had postnatal care in the model, with a varying number of pregnancy visits with their caseload midwife depending on gestation at booking and amount of collaborative care required.

Figure 3 shows the number of First Nations women receiving caseload care before and at the end of the project at the implementation sites.

Discussion

This implementation study demonstrated how three metropolitan tertiary maternity services in Melbourne, Australia, successfully translated gold standard evidence into practice on a large scale. Working collaboratively with all study partners, the sites successfully implemented a culturally responsive caseload midwifery model for women having a First Nations baby resulting in a 21-fold increase in access to this model for First Nations women from March 2017 to December 2020. In total, 703 women received caseload midwifery care during project implementation (663 in culturally specific caseload, and 40 in standard caseload) compared to only 34 First Nations women ever receiving caseload midwifery at the three sites previously.

Successful and timely translation of evidence into practice is rare and there is an urgent need to translate knowledge produced. For First Nations communities, this is even more so; uptake of western research evidence is limited due to factors such as lack of involvement of First Nations communities, lack of trust, and limited relevance for First Nations communities.[24] This study was able to overcome these challenges in three of the four sites.

Despite many attempts to implement the model in the regional hospital, this was not achieved. Contributing factors in research translation failure include poor communication; lack of stakeholder engagement, funding, and technical expertise; resistance to change; and a lack of planning and effort in relation to evidence scale-up.[25,26] In this case, the reasons for non-implementation were likely multifactorial. Arguably there was adequate technical expertise to achieve the outcome (the caseload model was already operational at the health services), there was planning, local leadership and a

Site	Date commenced	Name of model	Midwife EFT 1st year	Mothers eligible for model 1st year	Midwife EFT end final year(2020)	Mothers eligible for model final year (2020)	Caseload of women per year	Staff exiting model[d]
Women's	March 2017	Baggarrook - 'Woman' in Woiwurrung language	2.8 EFT[a] (3 mws)	80	3.8 EFT (4 mws)	135	1.0 EFT- 40 0.8 EFT- 35	4 (1 retired)
Joan Kirner	October 2017	Galinjera - 'To come together and connect and love' in Wemba language	3.0 EFT[b]	117	4.0 EFT	129	1.0 EFT - 35	5
Mercy	April 2018	Nangnak Babun Murrup - 'Nurturing Mother's Spirit' in Woiwurrung language	3.0 EFT[c]	57	4.0 EFT	79	1.0 EFT 40–45 (including leave relief)	1 (maternity leave)

***Table 3*: Model implementation by site.**
[a] 2.8 Equivalent fulltime (EFT) = 3 midwives, one of the four pre-existing caseload groups adapted; b: used EFT from an existing caseload group (2 EFT initially, another EFT added within two months due to high demand); c: newly configured group reallocated from of existing caseload EFT; d: Women's – one midwife stayed all through project and another stayed from when she joined the model until the end, Joan Kirner had 100% midwife turnover, Mercy – all three midwives who commenced stayed in model (one had maternity leave – and her replacement did not leave the model).

	Mercy *n* = 242		Joan Kirner *n* = 387		Women's *n* = 411		Total *n* = 1040	
MOTHER	*n*	%	*n*	%	*n*	%	*n*	%
Mother identifies as either Aboriginal and/or Torres Strait Islander	184	76.0	249	64.3	298	72.5	731	70.2
Mother Aboriginal	169/184	91.8	227/249	91.2	274/298	91.9	670/731	91.7
Mother Torres Strait Islander	5/184	2.7	9/249	3.6	10/298	3.6	24/731	2.3
Mother both Aboriginal and Torres Strait Islander	10/184	5.4	13/249	5.2	14/298	4.7	37/731	3.6
Mother identifies as neither Aboriginal nor Torres Strait Islander	58	24.0	138	35.7	113	27.5	309	29.8
FATHER								
Father identifies as either Aboriginal and/or Torres Strait Islander	87	36.0	159	41.1	**	**	246	39.1
Father Aboriginal	83/87	95.4	141/159	88.7	**	**	224	91.1
Father Torres Strait Islander	0	0	92/159	5.7	**	**	9	3.7
Father both Aboriginal and Torres Strait Islander	4/87	4.6	9/159	5.7	**	**	13	5.3
Father identifies as neither Aboriginal nor Torres Strait Islander	122	50.4	128	33.1	**	**	250	39.8
Father's status not documented	33	13.6	100	25.8	**	**	133	21.3

***Table 4*: Identification of First Nations mothers and fathers, as documented in maternal medical record.**
** At the Women's the baby's and not the baby's father's identification information is routinely collected.

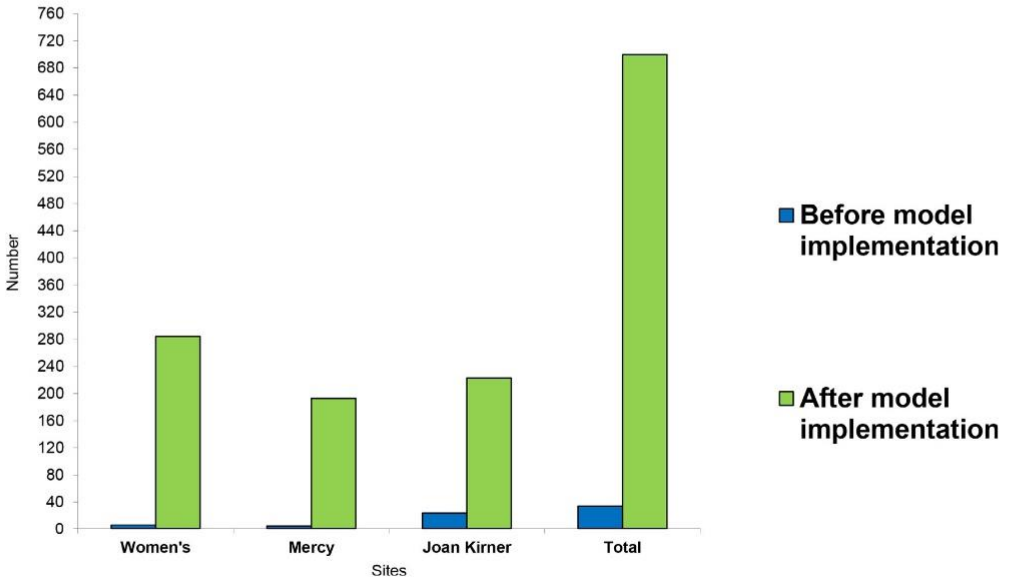


Figure 3. Number of women having a First Nations baby who received caseload (before and after program implementation). Before program implementation – blue; after program implementation – green.

governance structure set up for the project, including a steering committee that met regularly. Analysis of project meeting minutes demonstrates this ongoing commitment to program implementation, however the hospital had ongoing major staffing issues that are not unusual for regional and rural maternity services.[27] It is also possible that the smaller size of the unit made a difference and especially given the often poorer resourcing of rural health services.[28] There may also have been other unseen and unspecified barriers that will be further elucidated following analyses of key stakeholder interview data (to be reported elsewhere).

Key contributors to the successful model implementation at the other three sites include being a First Nations' community-driven and endorsed, collaborative project that included significant input and commitment from each partner organisation, having a research team with significant technical expertise in implementing caseload models, and funding to support the process. Engagement with all key stakeholders was critical. The partnership with VACCHO was a key driver (the project was initiated following an approach from VACCHO to partner on the initiative), and ensured high level input in the development and implementation of the work. There was First Nations community leadership on the investigator team, and an Aboriginal Advisory Committee to provide cultural guidance and oversight, and to promote community engagement. Steering committee members from the participating health services, along with senior project investigators, met regularly throughout the project to monitor program implementation. Engagement with VAHS and KMS was critical as they are key providers of maternity care, and in this instance continued to provide shared care for 8.6% of women in the caseload model. This adaptation of the caseload model to enable shared care with the ACCHO sector enabled effective integration of the hospital- and community-based services without significant duplication of services, and decreased the chance of women 'falling through the cracks', as the model enhanced communication and co-ordination between hospital and community services. This type of partnership approach has long been advocated by both government and the First Nations community-controlled sector, and is considered to be a fundamental component of any strategy for improving health outcomes for First Nations people.[21,29] Similar to our study, a recent study that explored stakeholder experiences in establishing an Aboriginal-Mainstream partnership in Queensland found that key factors for success were trusting relationships, maintaining flexibility in service provision and planning, clear expectations and distinction of staff roles and responsibilities, a shared vision, committed leadership, and engaging all staff in the process.[29]

The successful implementation of the culturally responsive program is consistent with the 2019 Australian National Strategic Directions for Australian Maternity Services that recommends the development and implementation of culturally safe, evidence-based models of care in partnership with First Nations people and communities,[30] enabled through utilisation of a 'Birthing on Country Service Model and Evaluation

Framework' which includes engagement and governance as being important in model design, services co-designed with community, including continuity of midwifery care, First Nations workforce inclusion, partnerships with primary and tertiary services, and cultural strengthening programs. Given the challenges of implementation of complex interventions such as 'Birthing on Country' services, Kildea and colleagues have developed a framework to guide implementation of models of care like that implemented in this study. It allows for customisation of the model to the local community context through a participatory action process, enabled by strong partnerships and leadership from First Nations people and ACCHOs.[22]

The three sites that implemented the model, all reallocated resources (EFT) from existing caseload models, and it may be that this ability does make it easier to implement such a model. It follows that this reallocation of resources potentially reduces the caseload places available for non-First Nations women, and moves the benefits of the model to those First Nations families who access it. In this study we do not know if the non-First Nations women who missed out were equally 'at risk', such as other socially vulnerable groups, but it is our view that the caseload model needs to be scaled up more broadly, and available to all women. While the proportion of women having a First Nations baby increased over the study period (254 women identified in the first 12 months for combined sites compared to 343 in final 12 months, a 35% increase) we cannot determine if this simply reflects more close attention to identification – all sites had research midwives employed to coordinate the study on site, and education and follow-up regarding identification was a major aspect of the role.

In Australia, there has been a lack of access to, and availability of, culturally responsive maternity services for First Nations women and babies and to caseload midwifery. This study has demonstrated the ability of three large, metropolitan maternity services to implement caseload midwifery for First Nations women, with cultural competency training for all participating midwives, and services sustained and popular over three to four years. Ninety percent model uptake meant an exponential (21-fold) increase in the number of First Nations women receiving caseload midwifery at the three sites during the study period. Early and ongoing consultation, collaboration and engagement with key First Nations community stakeholders was crucial to the success of the programs. The model has enabled First Nations women to have a *known* midwife in the hospital system, who is there for them for all parts of their maternity care – a model that has built on existing initiatives in a responsive and individualised way. The findings support government policies that have recommended the development and implementation of culturally safe, evidence-based models of care that have been developed in partnership with First Nations communities and underpinned by 'Birthing on Country' principles. The expansion of this model should be prioritised, with further research focused on understanding key features of sustaining the model and continuing to bridge the partnership between First Nations and mainstream health services.

Contributors

HMc and DF conceived the project. All authors contributed to study design. HMc, DF, RH and RM undertook the literature review. HMc, DF, SK, CC, MJ, JB, JR, JF, JO, SJ, NB, KF, LG, JW and MN all contributed to writing the initial funding application. FMc, HMc, DF and TS prepared and verified the data and did the statistical analysis. All authors had full access to the data, and contributed to data interpretation. HMc and DF wrote the first draft of the manuscript. All authors contributed to manuscript revisions and accept responsibility to submit for publication.

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Data sharing

Data collected for the study that contributed to this paper, including de-identified individual data and a data dictionary defining each field in the set, will be made available to others after publication of the paper for use by other researchers for further analysis unspecified in the Baggarrook Yurrongi publication plan, with investigator support, after ethical approval including scientific review of a proposal, and with a signed data access agreement.

Declaration of interests

We declare there are no competing interests.

Acknowledgments

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Chapter 7: Important elements of maternity care for Aboriginal and Torres Strait Islander women giving birth in Victoria

This paper reports on data collected during the initial recruitment questionnaire, which uses a cross-sectional survey design (see sections 5.2.1 and 5.2.2). Reported on are participant socio-demographic characteristics, prevalence of life stressors, worries, and depressive symptoms, and ratings of women is important to women for their maternity care.

The aim of the paper is to directly inform the design and planning of maternity care that is available for First Nations women in urban Victoria, while brining to the forefront social and cultural determinants that need to be considered in programme planning. Participation involved the completion of two questionnaires. The initial recruitment questionnaire was usually completed face to face during pregnancy (occasionally women were approached on the postnatal ward after birth if they had not yet been invited to participate). This paper concludes that health services should partner with First Nations communities to deliver well informed, evidence-based, culturally secure maternity services. Highlighted is the geographical and cultural diversity of women birthing in urban Victoria, as well as the need for services that account for the social complexity of women's lives. Participants reported that trust, privacy, community and culture are important elements of maternity care. Combined with the principles of Birthing on Country services, these findings provide important information to inform the future development of evidence-based, community-led maternity programmes in Victoria.

Citation:

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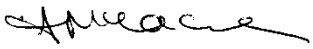
Contribution to the paper:

I declare that I have made a substantial contribution to this paper, of which I am the lead author. This includes leading conceptualisation of the paper, contributing to the design of data collection tools, conducting data collection. I personally undertook majority of the data cleaning processes. I undertook data management, and conducted data analysis (under supervision), and drafted the manuscript. The co-authors contributed to supervision of the data cleaning, data analysis, and editing of the manuscript.



P.McCalman

I declare that Res McCalman made a substantial contribution to this paper. She contributed to many different aspects of the Baggarrook Yurrongi project, model implementation at the study sites, and edited and reviewed the paper.



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Trust, privacy, community, and culture: Important elements of maternity care for Aboriginal and Torres Strait Islander women giving birth in Victoria.

P. McCalman [a,b,*], F. McLardie-Hore [a,c], M. Newton [a,b], H. McLachlan [a,b], D. Forster [a,c]

[a] Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086 Australia
[b] School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3052 Australia
[c] The Royal Women's Hospital, Parkville, Victoria 3052 Australia

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ABSTRACT

Background: The Australian maternity system must enhance its capacity to meet the needs of Aboriginal and Torres Strait Islander (First Nations) mothers and babies, however evidence regarding what is important to women is limited.
Aims: The aim of this study was to explore what women having a First Nations baby rate as important for their maternity care as well as what life stressors they may be experiencing.
Methods: Women having a First Nations baby who booked for care at one of three urban Victorian maternity services were invited to complete a questionnaire.
Results: 343 women from 76 different language groups across Australia. Almost one third of women reported high levels of psychological distress, mental illness and/or were dealing with serious illness or death of relatives or friends. Almost one quarter reported three or more coinciding life stressors. Factors rated as most important were privacy and confidentiality (98 %), feeling that staff were trustworthy (97 %), unrestricted access to support people during pregnancy appointments, (87 %) birth (66 %) and postnatally (75 %), midwife home visits (78 %), female carers (66 %), culturally appropriate artwork, brochures (68 %) and access to Elders (65 %).
Conclusions: This study provides important information about what matters to women who are having a First Nations baby in Victoria, Australia, bringing to the forefront social and cultural complexities experienced by many women that need to be considered in programme planning. It is paramount that maternity services partner with First Nations communities to implement culturally secure programmes that respond to the needs of local communities.

* Corresponding author at: Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086 Australia.
E-mail address: P.McCalman@latrobe.edu.au (P. McCalman).

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Statement of significance

Issue

In order to improve maternity care provision for First Nations women, more evidence is needed on what women having a First Nations baby rate as important for their maternity care.

What is known?

Maternity service provision should be underpinned by partnerships and engagement with First Nations communities.

What this paper adds

Factors rated as most important were privacy and confidentiality, trust, and access to support people. This is particularly important given the high rates of psychological distress and life stressors the women reported. Understanding women's views and the context of their lives is critical in planning appropriate care and to inform policy.

1. Introduction

On the continent now commonly referred to as Australia, Aboriginal and Torres Strait Islander (First Nations)[1] women have been giving birth for millennia. First Nations knowledges around pregnancy and birthing were interrupted by colonial practices [1,2], and current perinatal outcome data reports show that First Nations women and newborns face an excessive burden of inequitable perinatal outcomes [3,4]. To redress this, maternity providers should partner with First Nations communities to implement evidence-based, culturally appropriate models of maternity care, as recommended by numerous state and federal government reports [5–7]. Currently, First Nations women are less likely to attend early antenatal care (within the first 14 weeks of pregnancy) and are less likely to have the recommended five or more antenatal visits [3]. Receiving the recommended minimum number of antenatal visits is associated with improved perinatal outcomes [3], which positively influences a newborn's health trajectory across the lifespan [8,9]. As a policy response, the Victorian government outlined in a key strategic priority called 'Koolin Balit' [6], to improve maternal and infant outcomes by providing high quality, accessible antenatal care. Critical to implementing this policy is ensuring that it is accompanied by strategies to strengthen engagement between First Nations women and the mainstream maternity system.

A lack of culturally appropriate maternity care being available for First Nations women has been identified as a barrier to access [10–12], such that women may feel reluctant to seek or receive care. This potential lack of engagement with mainstream maternity services is likely to perpetuate inequitable perinatal outcomes [10]. Instead of continuing this cycle, mainstream maternity services should employ a culturally secure approach, which is associated with improved perinatal outcomes [13]. Cultural security involves embedding First Nations cultural values into service policy, design and delivery, so that First Nations women's cultural needs are treated as legitimate and valuable [14]. Although these policies are designed to facilitate 'immediate' feelings of safety for First Nations women and families, cultural security also relies on staff being able to link these practical and philosophical understandings to their own practice [13]. The literature [12,13,15] cites cultural security as being linked to the concept of 'Birthing on Country', where maternity models are designed and aligned with First Nations' worldviews [16], providing the 'best start in life' (pp.8) for First Nations newborns [17].

[1] The terms 'Aboriginal and Torres Strait Islander' and 'First Nations' are used interchangeably and refer to the original inhabitants of the Australian continent, unless stated otherwise.

First Nations women have often been excluded from how services set up for them are designed and delivered [16], yet input from First Nations women themselves is needed for effective models of maternity care [10]. Recent studies have illustrated this, where models underpinned by First Nations community engagement have been implemented and evaluated across the country, reporting improved perinatal outcomes [8,18–20] and increased antenatal attendance [8,19]. Researchers have long acknowledged that gaining community perspectives on service planning is essential [21], and engaging with the local community is also strongly recommended in First Nations health policy [6,7,22]. Currently however, there is little evidence on the views and preferences of First Nations women in an urban Victorian context, in relation to their maternity care. More evidence is also needed in relation to factors which may facilitate antenatal engagement for First Nations women [23]. Overarching frameworks for quality maternity care provision are well documented [5,24,25], recommending that for the general population, antenatal care should be culturally appropriate, accessible, woman-centred, and evidence-based [26]. Effective communication that addresses physiological, biomedical, behavioural, and sociocultural issues is considered fundamental to good antenatal care [25]. When specifically advising on maternity care provision for First Nations women, the frameworks focus on facilitating cultural safety and partnering with First Nations communities, Aboriginal Community Controlled Health Organisations (ACCHOs) and the First Nations health workforce [5,24]. Additionally, antenatal care should be culturally appropriate and relevant to the local community, with a focus on underlying social and economic determinants [27]. Although evidence is building, researchers in the field urge for ongoing scale up and subsequent evaluation of evidence-based programmes, across diverse Australian First Nations contexts [8].

Perinatal outcomes for First Nations women and their babies are impacted by social determinants of health and inequitable access to care, leading to disparities [10,22]. The legacy of colonisation and dispossession has led to a cycle of social disadvantage which impacts negatively on First Nations peoples' health status [7], and First Nations communities have expressed that all health programme planning must consider the cultural and social determinants of health [22]. Certain levels of maternal exposure to social stressors are also associated with less positive perinatal outcomes [28], so it has been recommended that maternity service planning and resource allocation for First Nations programmes should account for this. Antenatal care has been described as a 'window of opportunity' [28] (pp. 36) to engage women and families coping with social stressors, and for maternity services to prioritise the issues that women from the local community are commonly experiencing [29].

The aim of this paper is to directly inform and improve the maternity care that is available to First Nations women and newborns by describing what childbearing First Nations women (and non-First Nations women having a First Nations baby) in urban Victoria rate as important for their maternity care. This will include bringing to the forefront the social and cultural determinants that need to be considered in the planning and delivery of maternity services [7].

2. Methods

This study was embedded in a larger National Health and Medical Research Council (NHMRC) funded partnership project: "Baggarrook Yurrongi" (meaning "Woman's Journey" in Woi-wurrung language) and "Nurragh Manma Buliana" (meaning "All of us working together for pregnancy" in Yorta Yorta language). La Trobe University, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and four Victorian maternity services (three urban and one regional) partnered together to implement and evaluate a culturally specific caseload midwifery model of care for First Nations women, or women having a First Nations baby, who were birthing at the four services (reported in detail elsewhere). Secondary aims included exploring the views and

experiences of the women in relation to their maternity care, to collect and report on clinical outcomes, and to understand key stakeholder views.

The overarching study was co-developed in partnership with VACCHO, along with the partner sites and staff from their respective Aboriginal Health Units (AHUs). The multidisciplinary research team included both First Nations and non-First Nations researchers. An Aboriginal Advisory Committee (AAC) was established in 2017, comprised of community Elders, members of the research team who identify as Aboriginal or First Nations, First Nations staff from the AHUs at the study sites, a First Nations woman who had recently given birth, and a representative from VACCHO, to work in partnership with the research team. The AAC provided input into decisions relating to aspects of the research such as eligibility criteria, the design of the data collection tools, and offered advice on community engagement.

Model implementation commenced at three public hospitals located in Naarm (the Woiwurrung word for the lands and waters of Melbourne) from March 2017 (site one), with site two starting October 2017, and site three in April 2018. At the time of writing this paper, the model is continuing at all three sites, although data collection related to the overarching Baggarrook Yurrongi - Nurragh Manma Buliana project was completed at the end of December 2020. Site four, the regional site, while committed to implementing the model, was unable to do so due to ongoing acute and chronic staffing crises in maternity services.

This paper reports on data collected from a descriptive cross-sectional questionnaire completed by First Nations women and non-First nations women having a First Nations baby, who agreed to participate in a study exploring their views, experiences, and expectations of care.

2.1. Participants

We aimed to offer all First Nations women attending the sites during the study period the opportunity to take part in the questionnaire being reported here, as well as to be contacted again three months after their baby was born to talk more about their views, outcomes, and experiences (findings from the second questionnaire will be reported elsewhere). Women were invited to participate regardless of what model of care they had chosen or were able to access; that is whether (or not) they received the culturally specific caseload model, as we wanted this opportunity to be inclusive. To be eligible women needed to be booked for antenatal care as a public patient at one of the study sites, over the age of 16, speak English well (i.e., not requiring a translator), and identify either themselves or their baby as First Nations Australian. There were no explicit exclusion criteria, but we aimed not to approach women until after they had already attended the booking visit and a subsequent visit, to make sure there were no issues that would preclude approaching them, for example if they did not have a live baby, or if the clinical team had reason to advise the woman should not be approached. We also wanted to make sure women clearly understood that allocation to the model was not dependent upon participation in the evaluation.

2.2. Recruitment

Research midwives, who were employed at each site, aimed to approach all eligible women during the recruitment period (Fig. 1) and invite them to participate. Women were approached in the antenatal clinic area, in the antenatal inpatient ward, or in the postnatal ward after birth (where the women had transferred in for care late in pregnancy or were not identified as eligible until after birth). Later recruitment at Sites 2 and 3 was impacted by the COVID-19 pandemic, and face-to-face recruitment ceased, so women were called by telephone and asked if they would like to participate. Only a small number of women (n = 25) were able to be recruited during the pandemic. The research midwives explained the project and provided women with plain language written information. Women were able to discuss participation in the evaluation with their partner, family, or members of their community, or with the Aboriginal Hospital Liaison Officer [AHLO]. Women were informed that participating in the evaluation was voluntary. If the woman agreed to participate in the evaluation, a participant information and consent form was signed and the paper-based questionnaire was completed, either by the woman, or if she preferred, the research midwife read out the questions and wrote the woman's responses. The latter was more commonly the preferred option.

2.3. Data collection tools

The questionnaire was designed specifically for the study, based on data collection tools previously used by the research team [30], and tools used in a similar South Australian study [31], and in a Queensland study which was conducted by a member of our broader study chief investigator team [32]. Maternal socio-demographic characteristics such as First Nations status, age, education level, place of residence and socioeconomic status were collected. Items used to describe socioeconomic status included health care card concession card holder status, health insurance status versus public health care only, and whether the household received a government benefit as the main source of income. Data were also collected on social and emotional factors that may be associated with negative perinatal health outcomes, such as exposure to stressful life events and tobacco use [28].

To measure psychological distress, a 9-item tool that was developed and validated for use in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) [33] was used. The tool was based on the Kessler-10 (K-10) scale, which is an effective measure of non-specific psychological distress within the general population [34], however it was not validated for use with First Nations people [33]. The 9-item tool is comprised of a shorter 5-item (K-5) psychological distress scale and includes 4 additional positive wellbeing questions. The 9 items are a combination of positively phrased (e.g., "During the last 4 weeks, how often have you been a happy person?"), and negatively phrased items (e.g., "During the last 4 weeks, how often have you felt nervous?").

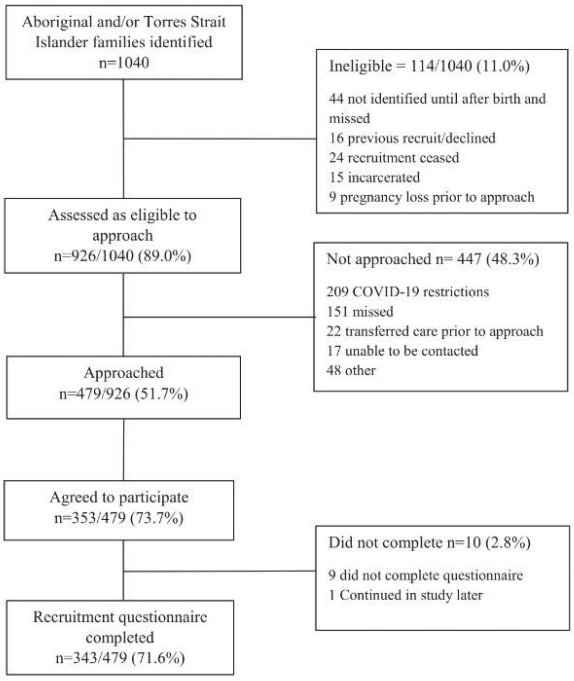


Fig. 1. Participant flow chart.

Response options for each item are: 'None of the time', 'A little of the time', 'Some of the time', 'Most of the time' and 'All of the time'. The K-5 score ranges from 5 to 25, with a score of equal to or greater than 12 indicating 'high' or 'very high' psychological distress. Research midwives received training and guidelines for responding to women who disclosed high levels of psychological distress or who reported significant exposure to stressful life events at the time of the questionnaire.

Women were asked about the importance of cultural factors relating to their antenatal, birth and postnatal care using Likert scale type questions using a scale of 1–5 ('1'= Not at all important, '5'= Very important). Questions explored factors such as "Having culturally appropriate posters, brochures, artwork and Aboriginal/Torres Strait Islander flags visible", "Having female caregivers for labour and birth", "Feeling I can trust the health care staff" and "Being cared for by Aboriginal/Torres Strait Islander staff". The questions were based on those used in the Indigenous Birthing in an Urban Setting study [32], which was originally based on a maternity specific cultural competence tool [35]. Women were given the option to free-text response for questions such as "Which Aboriginal language group or community do your people come from?".

The questionnaire was drafted, then reviewed by the AAC. Revisions were made accordingly, then the questionnaire was piloted by a First Nations researcher with three First Nations women, who were midwives, but who were not involved in the project directly. This ensured questions were logical and were culturally appropriate.

2.4. Data management and analysis

Data were entered by members of the research team onto a secure, password protected data management software, REDCap (Research Electronic Data Capture), then imported into Stata 17 [36] for data cleaning and analysis. Data cleaning included range and logic checks as well as checking missing data fields and cross checking the hard copy questionnaires. Quantitative categorical data were summarised using frequencies and percentages, and continuous variable summarises using mean and standard deviation (or median and range for non-normally distributed data). Content analysis [37] was conducted for the free-text response question "Which Aboriginal language group or community do your people come from?" where qualitative data were presented as a list, revealing the most common words. Word frequency and location were used to generate taxonomies which have been presented as a Wordle.

2.5. Ethics

Multisite ethics approval was provided by St Vincent's hospital HREC reference number HREC-16\SVHM\223, 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.

2.6. Findings

Women were recruited to the evaluation between May 2017 and November 2020. During this period, across the three sites, a total of 1040 women who were expecting a First Nations baby were identified (Fig. 1), of whom 926 (89.0 %) were considered eligible. Of these, 479 (51.7 %) women were approached by the research midwives and invited to participate. Of women approached, 73.7 % (353/479) agreed to participate, and 71.6 % (343/479) completed the questionnaires. Details of eligible women who were not approached are shown in Fig. 1.

2.7. Participant characteristics

Participant characteristics are reported in Table 1. Site one had the longest period of recruitment and therefore had the highest number of participants. Most women were recruited in pregnancy (n = 282/343 83 %), at a mean gestation of 30.2 weeks, with the remaining women recruited after birth in the postnatal ward (58/343 16.9 %). On average women were 28 years old and living in urban areas of Victoria (87.6 %). Almost half of the women were primiparous and the majority of the participants reported stable accommodation in the form of owning a house, paying a mortgage, or renting a house or an apartment (74.3 %). One quarter (24.4 %) of women reported tobacco smoking during their pregnancy, which was an overall reduction when compared to tobacco

Table 1
Women's characteristics.

	n (n = 343)	%
Study site (n=343)		
Site 1	154	44.9
Site 2	84	24.5
Site 3	105	30.6
Age at recruitment (years) (n=336)		
Mean (SD), range	28 (5.4), 16–44	
<21	24	7.1
21–25	92	27.4
26–30	107	31.9
31–35	78	23.2
36–40	31	9.2
>40	4	1.2
Parity		
Primiparous	158	46.1
Usual residence (n=336)		
Urban metropolitan	296	87.6
Regional/Rural Victoria	35	10.4
Interstate	5	1.5
In a relationship (n=340)		
Yes	296	87.1
Type of relationship (n=340)		
Married	80	23.5
De facto	192	56.5
Have partner, living separate	24	7.1
Separated/divorced	17	5.0
Single	27	7.9
Highest Education level (n=339)		
Year 10 or less	63	18.6
Year 11 or 12	114	33.6
Cert 3 & 4 or Diploma	96	28.3
Degree	66	19.5
Studying at pregnancy confirmation (n=339)		
Yes	66	19.5
Employment at pregnancy confirmation (n=339)		
Unemployed	124	36.6
Part time	81	23.9
Full time	134	39.5
Pension/government benefit main source of income (n=339)		
Yes	101	29.8
Health care concession card holder (n=339)		
Yes	155	45.7
Private health insurance (n=337)		
Yes	55	16.3
Accommodation (n=334)		
Own house/paying off mortgage	66	19.8
Renting flat/apartment	75	22.5
Renting house	107	32.0
Living with family/friends	60	18.0
Temporary accommodation	9	2.7
Other	17	5.1
Number of cigarettes per day pre pregnancy (n=338)		
None	195	57.7
1–9	58	17.2
10–19	55	16.3
20+	30	8.9
Number of cigarettes per day at recruitment (n=336)		
None	254	75.6
1–9	57	17.0
10–19	23	6.8
20+	2	0.6
Others smoking at home (n=334)		
Yes	100	30.9

smoking rates pre-pregnancy (42.3 %).

The majority of the women were either married or in a de facto relationship (80.0%), and almost half of the cohort had qualifications after high school (47.8 %). A significant proportion of women were not in paid employment (36.6 %) and one-fifth (19.5 %) were studying when their pregnancy was confirmed. Further examining socio-economic status indicators, just under half of the women were health care concession card holders (45.7 %) and just under one-third were relying on a government pension as their main source of income (29.8 %).

2.8. Cultural characteristics

Most of the women identified as First Nations (Table 2). The remainder of the women (23.5 %) identified their baby as First Nations. Women identified with 76 First Nations communities (Fig. 2) from locations across Queensland, Tasmania, Western Australia, the Northern Territory, South Australia, and the Torres Strait. The majority (55.8 %) identified themselves belonging to communities either within Victoria or New South Wales, or those crossing over the Victorian/New South Wales borders (55.8 %) (e.g., Wemba-Wemba Country). A majority of the women (84 %) had knowledge of which custodian group they were connected to (Table 2). Partners/fathers of babies identified with 54 different communities, with representation from Victoria, New South Wales, South Australia, Western Australia, Queensland, and the Torres Strait.

Table 2
Cultural characteristics.

	n (n = 343)	%
Aboriginal/Torres Strait Islander Status		
Aboriginal	243	71.0
Torres Strait Islander	9	2.5
Both Aboriginal & Torres Strait Islander	10	3.0
Not Aboriginal or Torres Strait Islander	81	23.5
Partner's Indigenous Status		
Aboriginal	136	39.7
Torres Strait Islander	4	1.2
Both Aboriginal & Torres Strait Islander	5	1.5
Not Aboriginal or Torres Strait Islander	194	56.6
Unsure	4	1.2
Language spoken at home		
English	330	96.2
Other	13	3.8
Aboriginal or Torres Strait Islander language is spoken (n=342)		
Yes	46	13.5
Knows who their language group are *(n=243)*		
Yes	204	84.0

Fig. 2 is a visual representation (a 'wordle') of all the custodian/language groups named by the women, illustrating the diversity of the women in this study. Some custodian/language groups had much stronger representation than others, however, to maintain confidentiality all have been 'weighted' equally in this wordle. Words such as 'sad' and 'researching' have been included to acknowledge the responses from women who reported not knowing which custodian or language group they came from.

2.8.1. Life stressors, depressive symptoms, and worries

The survey included questions on the stress in women's lives and explored women's reported exposure to life stressors in the previous 12 months and level of psychological distress using the Kessler 5 (K5) tool. Almost one third (30.7 %) of women scored equal to or greater than 12 on the K-5, indicating 'high' or 'very high' levels of psychological distress. A considerable proportion of women reported that they were dealing with a serious illness of a relative or close friend (35.3 %) or the death of a relative of close friend (36.9 %) and approximately one third (32.5 %) reported dealing with a mental illness (Table 3). Almost one quarter (22.4 %) of women reported three or more coinciding life stressors. When asked about current 'worries' during pregnancy, the most common worries that women reported experiencing were worries that something could be wrong with the baby (61.7 %), worries about the birth (60.2 %), and money worries (55.2 %).

2.8.2. What women rated as important for their maternity care

We asked women what they rated as important for their maternity care (Fig. 3). The aspects of care that were most often rated as important ('4' or '5' on a scale where '1' is "Not important" and '5' is "Very

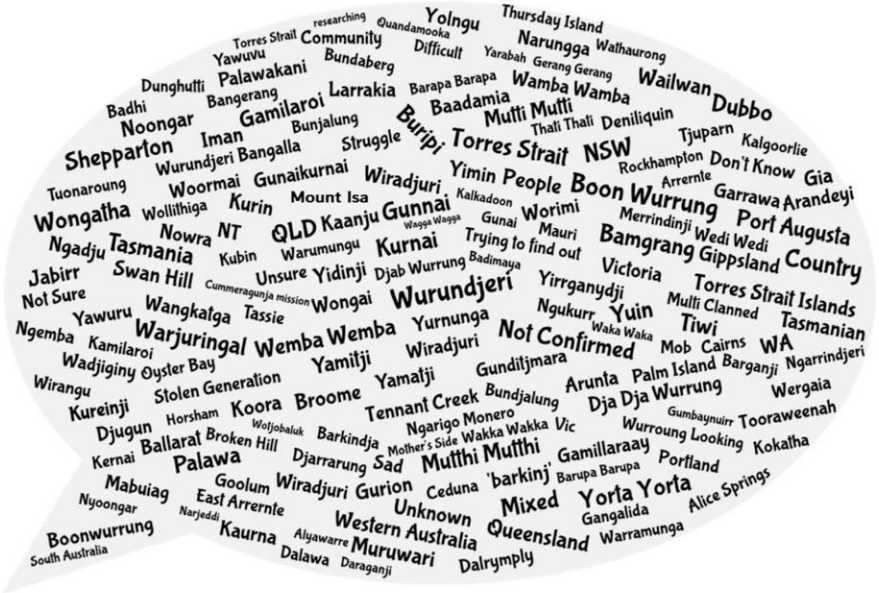


Fig. 2. Visual representation of "Which Aboriginal language group or community do your people come from?".

important") were "Respecting my privacy and confidentiality" (98 %) and "Feeling I can trust the health staff" (97 %). Items relating to the unrestricted presence of chosen support people across the continuum were also commonly reported as important. Eighty-seven percent of women rated this as important during antenatal appointments, 66 % for the birthing environment and 75 % for on the postnatal ward. The vast majority of women rated home visiting from a midwife during pregnancy as important (78 %), however it was less frequently rated as important that there is an Aboriginal/Torres Strait Islander worker present during home visits (51 %). Sixty-six percent of women consider being attended by females as important, and just over half (52 %) placed the same importance on being looked after by First Nations staff. Two thirds of women considered access to Elders for education on both birthing (64 %) and parenting (65 %) as important. Similarly, 68 % of women rated culturally appropriate artwork, posters, and brochures within the hospital as important. Meeting other Aboriginal and Torres Strait Islander women who were also pregnant, having transport available for appointments and having most care at an Aboriginal Community-Controlled Health Service yielded mixed responses. Given that First Nations women may have responded to the questions differently to non-First Nations women, a secondary analysis was conducted to compare responses of First Nations women and non-First Nations women. Overall responses were very similar so are not reported here separately.

3. Discussion

This study describes what First Nations women, and non-First Nations women having a First Nations baby, reported as important to them when seeking maternity care in urban Victoria. Also described are women's exposures to stressful life events and levels of psychological distress, which need to be considered in the planning and delivery of maternity services. This discussion will contextualise these findings in light of the current literature, identifying key recommendations for future maternity service design and delivery.

Provided in this paper is a 'snapshot' of elements that women rate as important for their maternity care. Embedding the priorities of First Nations women into policies and procedures at an organisational level is essential for creating a culturally secure maternity service. A culturally secure approach creates an environment that is highly likely to facilitate feelings of safety for First Nations people at the initial point of contact [14]. It also requires midwives and health care providers to practice with adequate knowledge and skills to work safely with First Nations women, and to link these understandings to their practice [13,14].

Table 3
Life stressors, depressive symptoms, and worries.

	n	%
Psychological distress (n=313)		
K5 5–7.9 (low)	74	23.6
K5 8–11.9 (moderate)	143	45.7
K5 12–14.9 (high)	51	16.3
K5 15–25 (very high)	45	14.4
Responded yes to the following life stressors (within last 12 months) (n=339)		
Death of a family member or close friend	125	36.9
Serious illness of a family member or close friend	119	35.3
Mental illness	110	32.5
Overcrowding at home	57	16.8
Serious illness	43	12.7
Divorce or separation	33	9.7
Getting back together with a partner	25	7.4
Serious accident	14	4.1
Serious disability	13	3.8
Worries during current pregnancy (yes/no) (n=337)		
Worries something could be wrong with baby	209	61.7
Worries about the birth	204	60.2
Money worries	188	55.2
Health worries	139	41.0
Worries about adult members of the family	105	31.0
Worries about my partner	105	31.0
Worries about my kids	102	30.1
Worries at work	87	25.7
Other worries	82	24.2
Worries about problems at home	74	21.8

This research found "Feeling that I can trust the health staff" was almost unanimously rated as important to women, and therefore maternity services should implement evidence-based strategies that enable the development of a trusting relationship between First Nations women and their health care providers. Continuity of midwife care, where women have an opportunity to develop a relationship with a midwife over several meetings prior to the birth, increases First Nations women's feelings of trust and safety [10]. Being attended by known caregivers during pregnancy, labour and birth also aligns with Aboriginal and Torres Strait Islander culture [1,12]. Numerous benefits for women and babies have been demonstrated for women and newborns generally [38], and access for women is recommended in national strategic directions for maternity care [5]. Evidence also supports that continuity of midwife care models are safe for First Nations women [39], and are associated with improved perinatal outcomes [8]. The findings of this study affirms the importance that First Nations women place on having a trusting relationship with caregivers, which may be enhanced by access to continuity of midwife care models.

Almost all of the women also placed high importance on having their privacy and confidentiality respected, which has been recognised as a key principle of respectful maternity care [40]. A report on characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women [35] recommends that extra consideration should be given to the physical environment to enable privacy and confidentiality. This report has also been endorsed in national policy [5] and advises that strategies that should be embedded within health services include drop-in clinics, designated areas for First Nations families to receive care as well as having home visiting services as a means to facilitate privacy [35]. The possibility of home visiting services was popular amongst this cohort of women. This may be linked to privacy and confidentiality being of great importance, although we did not ask about this. Further, over just over half the women in this study reported that transport assistance to check-ups was important to them, indicating that challenges with physically accessing hospital-based care may not just be an issue for women living in rural and remote areas [15].

Mixed responses from women in relation to items such as "Having most of my care at an Aboriginal Community Controlled Health Organisation", "Having the opportunity to meet other Aboriginal and Torres Strait Islander families who are also having a baby", or "Having an Aboriginal/Torres Strait Islander worker on home visits" indicate that midwives and health care professionals must take due care to engage in respectful dialogue with women to ascertain their unique needs and preferences, without making assumptions. A significant proportion of women did consider these elements of care were important, so these opportunities should be available to the women who do view these aspects of care as beneficial. Similar to these issues is the availability of First Nations staff to care for First Nations families. Existing evidence suggests that First Nations women gain psychosocial benefits from having access to First Nations midwives [41], and that the presence of First Nations staff during pregnancy and birth creates a culturally secure environment [12,20]. Beyond the Australian context, an evaluation of First Nations midwives caring for First Nations women from the Nunavik region of Quebec, Canada, reported positive outcomes for women and positive flow on effects to the community [42]. Just over half the women in this study felt that it was important to be cared for by Aboriginal or Torres Strait Islander staff. This presents a challenge for the Australian maternity system, given there are many more First Nations women birthing then there are First Nations midwives to care for them [43], so there is an urgent need to increase the number of First Nations midwives [15]. Maternity services should ensure equitable pathways into

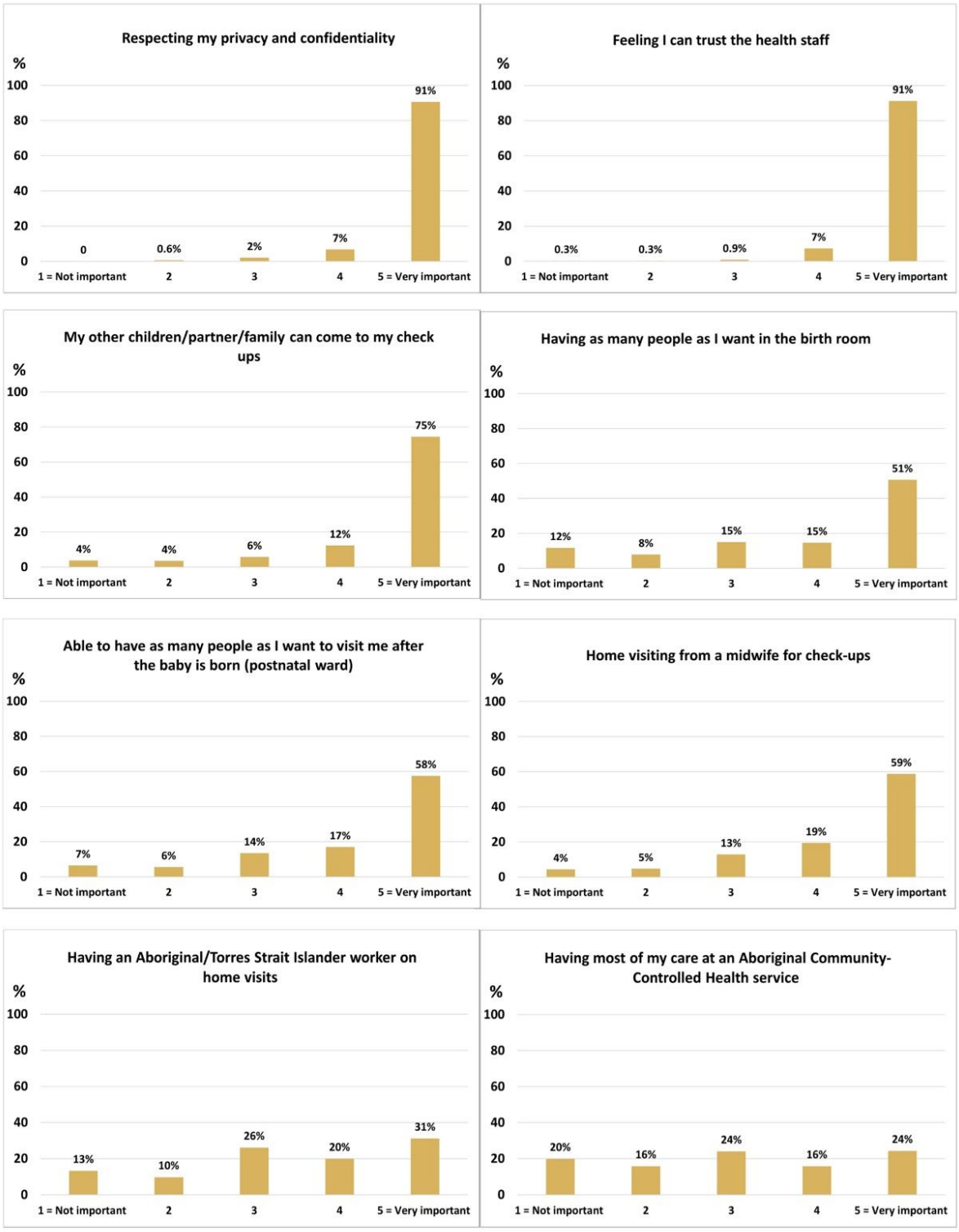


Fig. 3. What women rated as important for their maternity care.

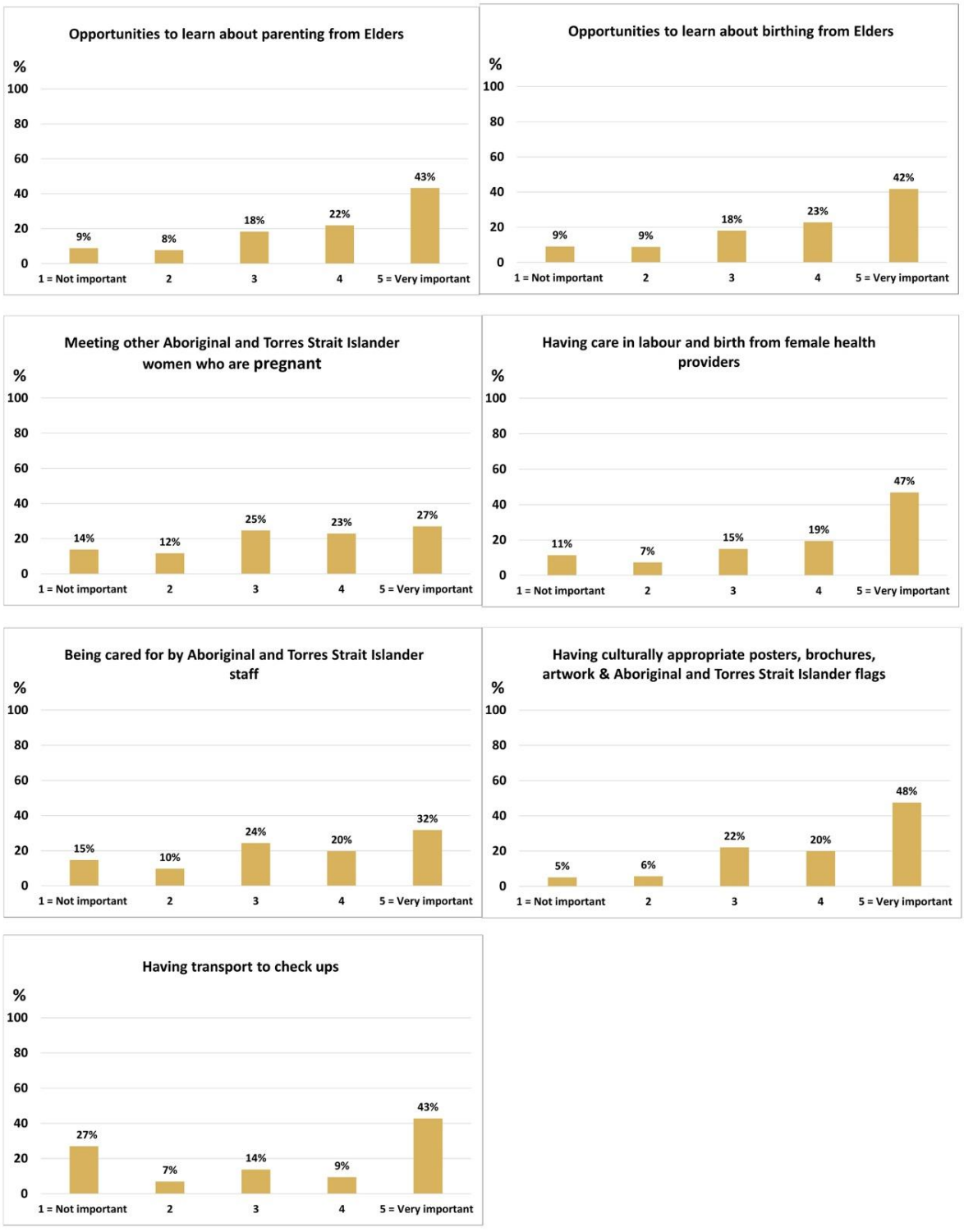


Fig. 3. (*continued*).

employment for First Nations midwives and allied health staff, and in particular into First Nations specific models of care [5,7].

The majority of women placed high importance on learning from Elders about birthing (64 %) and parenting (65 %). In other areas of Australia, senior women referred to as 'Grandmothers' have been employed to provide antenatal and postnatal support and education [18]. Learning from Elders is also a cultural method of knowledge sharing. This ties into other aspects of culture that women rated as important, such as being cared for by only females, and having culturally appropriate flags, artwork, and brochures visible within the service.

What is clear from women's responses in this study is the importance which women place on having access to their support people and family. This is central to First Nations culture, and high importance was placed on unrestricted access during pregnancy, birth and on the postnatal ward. The presence or absence of institutional policies which restrict First Nations women's access to family and other support people makes a difference to whether they perceive their experience as positive or negative [11,12]. Mainstream maternity services should consider the benefits versus risks of enforcing such policies, which appear to strongly contradict the cultural needs and preferences of First Nations women in Victoria. Women having a First Nations baby in Victoria place value on these elements of care, and mainstream maternity services should ensure that targeted First Nations programmes encompass each of the various elements, with scope to tailor care based on women's individual preferences.

The need to address the social determinants of health that influence maternal and neonatal outcomes was also evident. The majority of women reported experiencing at least one stressful life event within the 12 months prior to the questionnaire, and one in five reported experiencing three or more coinciding life stressors. The significance of this is that having multiple life stressors is associated with higher levels of psychological distress [29] and less positive perinatal outcomes [28]. The findings of this study reveal that as women are planning for a new baby, grief, loss, dealing with a mental illness, or having a very sick family member or close friend is a common experience. The proportion of women with a K-5 score indicative of high/very high levels of psychological distress was slightly more common in our study than in a similar cohort of Australian First Nations women (30.7 % vs 24.7 %) [29], and much higher than non-First Nations women of similar ages [44]. First Nations communities have recommended that health systems must consider the cultural and social determinants in programme planning [22], as they are major influences on the health of First Nations people [7]. It is important that care providers pay attention to social, emotional, and cultural aspects of women's lives and not only their physical needs [22]. A holistic approach such as this aligns with a First Nations approach to health [7], and the findings from this study can be used to help inform the planning and allocation of resources for First Nations specific maternity programmes [29].

The dissonance that exists between a First Nations approach to health and the bio-medical model is linked to systemic perpetuation of health inequities [45]. The impacts of a dominant bio-medical approach to pregnancy and birth for First Nations women in Australia were documented in a seminal report that is decades old: Borning: Pmere Laltyeke Anwerne Ampe Mpwaretyeke; Congress Alukura by the Grandmother's law [46]. How this tension continues to contribute to perinatal inequity is also discussed in recent literature [47], signalling that effective integration of First Nations knowledges into the current maternity system is yet to be achieved. Australian First Nations women belong to the world's oldest thriving culture, which has been contingent on the execution of capable and skilful birthing practices that sustained communities for millennia. As a result of colonisation and dispossession, contemporary women have needed to adapt to birthing within systems that have been designed and informed by a contrasting Western worldview. In Victoria, for example, the dispossession of knowledge was significant due to serious violence, disease, and government assimilation policies, but this knowledge has not been lost. Cultural birthing knowledge has been recently revived as a means to address the exclusion of First Nations knowledges within the predominantly biomedical maternity system [1].

Despite the historical challenges, connection to Country remains a strong protective influence on health for contemporary First Nations women and babies [2]. The 2019 National Strategic Directions for Australian maternity services [5] recommends that models of care are based on the principles of 'Birthing on Country', which should be seen as "a metaphor for the best start in life for Aboriginal and Torres Strait Islander families" (p.8) [17]. Birthing on Country models of care are First-Nations led, strengths-based, multi-faceted and place women at the centre of care [16]. Importantly, the physical act of giving birth on Country may or may not be relevant or possible, depending on the woman's context. Models of maternity care, however, should be guided by 'Birthing on Country' principles [16], with features embedded to facilitate connection to Country for any First Nations woman, in whichever context she is birthing in. There is much cultural and geographical diversity between First Nations women who are birthing in urban Victoria and this is demonstrated by the 76 different language groups named by the women in this study, also suggesting that a significant proportion of women in urban Victoria are not birthing on their traditional ancestral Country. Some women reported not knowing which language group they come from, with the Stolen Generations being one example of a reason that was given for this, and other women reported that they were still trying to find this information out.

This research addresses a gap in the literature around birthing in an urban context. A significant proportion of First Nations people either reside in urban areas, or relocate to an urban setting for birth, and so evidence around the cultural needs and expectations of First Nations women birthing on urbanised Country is required [13]. The recommendations made in this study, such as enabling trusting relationships via continuity of midwife care models, and adopting a holistic approach to care, align with the principles of Birthing on Country [16]. As Birthing on Country models are designed in partnership with local communities and are underpinned by First Nations world views, the data collected for this research can be used as a 'first step' framework, informing further community-led development of a Birthing on Country model that is relevant to the needs and preferences of First Nations women in an urban Victorian context.

3.1. Strengths and limitations

The strengths of this study include the size of the cohort of women (343), making this the largest study to explore First Nations women's views in urban Victoria to our knowledge. Some of the research findings may also be transferrable to other communities, yet due to the diversity of First Nations communities, policy makers should seek the views and opinions of local First Nations women located in the area relevant to the service. There are some limitations of this study. It includes only the views of women who were seeking care at one of the three study sites, none of which were regional or rural. The views of women who did not consent to participate are not reflected, nor are the views of women who were identified and not approached. Although care was taken to dismantle the inherent power imbalance that can exist between the researchers and women [48], the fact that data collection took place in a clinical environment, where care was still being received, may have impacted on some women's inclination to respond freely. Also, it is not the intention of this paper to deeply address cultural safety [49]. Cultural safety is considered to be essential for the actualisation of equitable health outcomes for First Nations people, and so should be prioritised accordingly [50]. Cultural safety, however, is a complex concept involving decolonising practice, dismantling of power imbalances and the presence or absence of cultural safety in a particular episode of care can only be defined by the woman [49]. The scope of this paper is to provide an overarching view of what women rate as important for their maternity care, as well as to describe some aspects of the social and

cultural context of women's lives, in order to inform maternity care that is available for First Nations families, and to advocate for widespread application of culturally secure models of care in Victoria.

3.2. Conclusion

Enhancing the capacity of the maternity system to meet the needs of First Nations women is likely to help address the inequitable perinatal outcomes. One solution is that maternity services partner with First Nations communities to implement well-informed, evidence-based, culturally secure models of maternity care. For this to be done well, the voices of First Nations people must be placed at the centre of service design and delivery, rather than maternity services deciding how care will be provided for them. This study was an outcome of collaboration between local First Nations women, who were generous enough to share their views, a local Aboriginal Health service, the state ACCHO, and three local maternity services. Participants reported trust, privacy, community, and culture as important elements of maternity care, while also highlighting geographical and cultural diversity, exposure to life stressors, and psychological distress. Together with the Birthing on Country principles [16], these findings provide important information to inform the future development and evaluation of evidence-based, community-led maternity programmes in Victoria.

Author Contributions

P. McCalman – conceptualisation, methodology, formal analysis, investigation, data curation, writing - original draft, visualisation. F. McLardie-Hore – investigation, writing - review & editing, project co-ordination. M. Newton – conceptualisation, writing - review and editing, writing, supervision. H. McLachlan – conceptualisation, methodology, writing - review and editing, supervision, funding acquisition. D. Forster – conceptualisation, methodology, writing - review and editing, supervision, data curation, funding acquisition.

Ethical statement

Multisite ethics approval was provided by St Vincent's hospital HREC reference number HREC-16\SVHM\223, 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.

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Conflict of interest

None declared.

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Chapter 8: Exploring women's satisfaction with care

This chapter focuses on levels of satisfaction among women having a First Nations baby who received care at one of the three Baggarrook Yurrongi study sites where the culturally tailored caseload midwifery models had been implemented. Reported on are women's ratings of satisfaction with their maternity care across pregnancy, labour and birth, and during the early postnatal period.

Women who were identified as having a First Nations baby at the study sites were invited to participate in an evaluation of their care, which involved the completion of two separate questionnaires. This paper reports on data collected during the follow up questionnaires, which were conducted via telephone between 3-6 months postpartum. A cross-sectional survey design was used (see sections 5.2.1 and 5.2.2) .

Two-hundred and thirteen women completed a follow up questionnaire, 186 of whom received continuity of midwife care. Eighty percent of women rated their pregnancy care highly (defined as either '6' or '7' on a scale of 1-7, where '1' was 'very poor' and '7' was 'very good'), which was similar to labour and birth care (81% of women rated this episode of care highly). High ratings of in-patient postnatal care were 62%, and then 87% for postnatal care in the home (domiciliary care). Given the high levels of satisfaction with care reported at the services where culturally tailored caseload midwifery models were implemented, this paper recommends that the programs should be upscaled, implemented and sustained.

Citation:

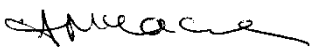
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Contribution to the paper:

I declare that I have made a substantial contribution to this paper, of which I am the lead author. This includes leading the conceptualisation of the paper and contributing to the design of data collection tools. Under supervision, I took on majority of the responsibility in the collection, cleaning and analysis of the data. I then drafter the paper. The co-authors contributed to supervision of the data cleaning, data analysis, and editing of the manuscript.



I declare that Res McCalman made a substantial contribution to this paper. She contributed to many different aspects of the Baggarrook Yurrongi project, model implementation at the study sites, and edited and reviewed the paper.



H. McLachlan

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Exploring satisfaction among women having a First Nations baby at one of three maternity hospitals offering culturally specific continuity of midwife care in Victoria, Australia: A cross-sectional survey

P. McCalman [a,b,*], D. Forster [a,c], T. Springall [a], M. Newton [a,b], F. McLardie-Hore [a,c], H. McLachlan [a,b]

[a] Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086, Australia
[b] School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3052, Australia
[c] The Royal Women's Hospital, Parkville, Victoria 3052, Australia

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ABSTRACT

Background: Continuity of midwife care is recommended to redress the inequitable perinatal outcomes experienced by Aboriginal and Torres Strait Islander (First Nations) mothers and babies, however more evidence is needed about First Nations women's views and experiences of their care.
Aims: This study aimed to explore levels of satisfaction among women having a First Nations baby, who received maternity care at one of three maternity services, where new culturally specific midwife continuity models had been recently implemented.
Methods: Women having a First Nations baby who were booked for care at one of three study sites in Naarm (Melbourne), Victoria, were invited to complete one questionnaire during pregnancy and then a follow up questionnaire, 3 months after the birth.
Results: Follow up questionnaires were completed by 213 women, of whom 186 had received continuity of midwife care. Most women rated their pregnancy (80 %) and labour and birth care (81 %) highly ('6 or '7' on a scale of 1–7). Women felt informed, that they had an active say in decisions, that their concerns were taken seriously, and that the midwives were kind, understanding and there when needed. Ratings of inpatient postnatal care were lower (62 %), than care at home (87 %).
Conclusions: Women having a First Nations baby at one of three maternity services, where culturally specific, continuity of midwife care models were implemented reported high levels of satisfaction with care. It is recommended that these programs are upscaled, implemented and sustained.

Issue

Due to the known benefits, continuity of midwife-led care models for First Nations women are recommended in maternity policy.

What is already known

Targeted maternity programs for First Nations women require community-led approaches in service planning, delivery, and evaluation.

What this paper adds

This paper adds to the gap in the literature in terms of understanding the views of First Nations women who received continuity of midwife care in an urban setting.

Introduction

In Australia, Aboriginal and Torres Strait Islander (First Nations) women and newborns continue to experience inequitable perinatal outcomes [1,2]. Numerous government policies recommend that the mainstream maternity system must improve its capacity to meet the needs of First Nations women by partnering with communities to implement and sustain evidence-based programs [3,4]. Continuity of midwife-led care throughout pregnancy, birth and the postpartum period is one such strategy [3]. Caseload midwifery is a type of midwife-led continuity where a woman has 24/7 telephone access to a primary caseload midwife (and one or two backup midwives) who

* Corresponding author at: Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086, Australia.
E-mail address: P.McCalman@latrobe.edu.au (P. McCalman).

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provides care throughout pregnancy, labour and birth, and in the early postnatal weeks.

The benefits of caseload midwifery have been well documented [5,6], and for First Nations women, continuity of midwife care has been associated with fewer preterm births, more frequent antenatal care, higher rates of exclusive breastfeeding at discharge [7], decreased levels of tobacco use, and increased feelings of trust and safety [8]. These are important findings, as numerous studies have reported that First Nations women can experience challenges within the maternity system, such as culturally unsafe practices inhibiting access to appropriate care [9–11] and experiences of racism contributing to inequitable outcomes [12,13]. In Australia it is recommended that caseload midwifery models are expanded [3], given that only approximately 15 % of women can receive caseload midwifery care [14]. First Nations women are even less likely to have access, due to factors such as models being available to women with 'low-risk' pregnancies only and lack of culturally specific programs [11]. At the national level, it is recommended that Birthing on Country (BoC) models of care are implemented [3]. These are community-led, holistic, comprehensive, strengths-based maternity care models for First Nations women, providing First Nations babies with 'the best possible start in life' [15]. Evidence-based frameworks, such as the RISE framework, have been developed to guide the implementation of BoC models in Australia [16]. Continuity of carer is one of the principles that underpins BoC [17], and BoC services featuring continuity of midwife care have demonstrated benefits for First Nations women and newborns [7].

The Baggarrook Yurrongi project was a translational partnership project between La Trobe University, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and three major tertiary centres located in Naarm (Melbourne), Victoria. The overarching aim was to implement and sustain midwife continuity models for First Nations women, and women expecting a First Nations baby. The new models commenced in 2017 and led to a 21-fold increase in the number of women having a First Nations baby receiving caseload midwifery care [18]. Only 34 First Nations women had ever received caseload midwifery at any of the three sites previously, increasing to 703 First Nations families during the study period [18]. Exploring the views and experiences of women having a First Nations baby was a key aim of the project.

Seeking valid and reliable feedback from women about their satisfaction with care is an important measure of quality [19]. Collating the views of women offers opportunities for future improvement, [20–22] and the Australian National Safety and Quality Health Service Standards emphasise the importance of partnering with consumers for service evaluation [23]. For targeted First Nations women's health programs, it is essential that local First Nations women are involved in monitoring and evaluation, for assurance of quality and tracking of progress [24]. Engaging local First Nations women in the design, implementation, and evaluation of targeted models of care is also recommended in national maternity service policy, which recognises that women-reported well-being and experience outcome data is a key enabler of the woman-centred care strategic framework [3].

Recent evaluations of First Nations specific maternity programs that include continuity of midwife care provide evidence of successful implementation [7,8,18], with recommendations to scale-up these programs [7,18]. However, a systematic review has identified a shortage of evidence in relation to midwife continuity models for First Nations women in urban contexts [25], and more evidence is needed in relation to First Nations women's cultural needs when birthing in an urban setting [26]. A cross-sectional study, which used a culturally tailored survey explored satisfaction among First Nations women having a baby in Queensland, recommended enabling more choice for women by increasing access to strength-based, continuity of care programs [27]. Other studies that have explored First Nations women's views have not specifically included satisfaction as an outcome measure, with variations in methods, terminology and measurement tools used [8,28–31]. All the identified studies reported that First Nations women responded positively to models aiming to increase continuity of midwife care [8,27–31]. A 2017 meta-synthesis found that overall, continuity of midwife care enhances the ability of the system to meet the needs of First Nations women [11].

In Victoria, there is limited evidence regarding the views and experiences of First Nations women regarding their maternity care. One study evaluated the Women's Business Service (WBS), a community-controlled maternity program in rural Victoria that included antenatal and postnatal continuity of midwife care, with the possibility of non-clinical support provided by the WBS midwife or maternal infant health worker during labour and birth at the hospital [29]. Women who attended the WBS reported higher levels of satisfaction, compared with other women who were not specifically First Nations but were living in rural Victoria and receiving public maternity care in a similar period [29]. There have been no studies specifically exploring the experiences of First Nations women accessing maternity care in an urban Victorian context to the knowledge of the authors. This paper explores the views of women having a First Nations baby in one of three hospitals that implemented a new culturally specific caseload midwifery model in Naarm (Melbourne), Victoria, with a focus on satisfaction with care.

Methods

A descriptive design [32] was used for this study. The study was co-designed with VACCHO and an Aboriginal Advisory Committee (AAC) [18]. The AAC included First Nations members of the research team, community Elders, First Nations staff from the Aboriginal Health Units at the study sites, a recent First Nations mother, and a representative from VACCHO. The AAC provided input into the study design, eligibility criteria, data collection processes and tools, and community engagement.

Participants

First Nations women and women having a First Nations baby, who were booked for care at one of the study sites during the study period were approached and offered the opportunity to participate. Women were invited to participate regardless of what model of care they had chosen or were able to access; that is whether or not they received the culturally specific caseload midwifery model. Eligible women were booked for antenatal care as a public patient at one of the three study sites, were over the age of 16, spoke English well enough to not require an English translator, and identified either themselves or their baby as First Nations. We aimed to offer all eligible women during the recruitment period the opportunity to participate, however women were not approached if they did not have a live baby, or if the clinical team had reason to advise the woman should not be approached (e.g. acute psychiatric illness or being very unwell).

Participation involved completing two questionnaires – one at recruitment, and a follow up questionnaire between three and six months postpartum.

Recruitment

Research midwives aimed to approach all eligible women (Fig. 1). Recruitment to the study commenced concurrently with the commencement of the new models at each study site. As each site was ready to commence at different time points, recruitment began in March 2017 at site one, October 2017 at site two, and in April 2018 at site three. Most women were approached during a routine antenatal visit. Some women were approached on the antenatal inpatient ward, or on the postnatal ward after birth (if a woman had transferred in for care late in pregnancy or had not been identified as eligible until after birth). The research midwives explained the project and provided women with written information. Women were able to discuss participation in the

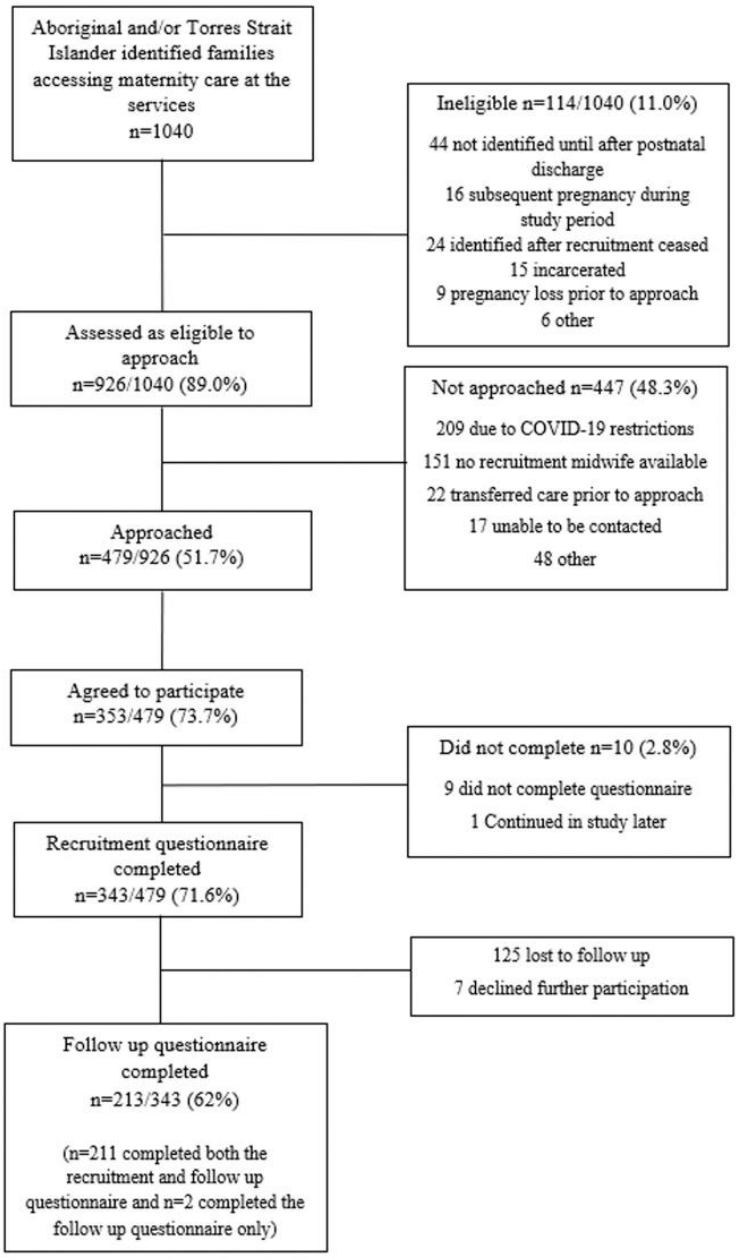


Fig. 1. Participant flow chart.

evaluation with their partner, family, or members of their community, or with the Aboriginal Hospital Liaison Officer (AHLO). Women were informed that participating in the evaluation was voluntary. If a woman agreed to take part, she signed a consent form. In 2020, face-to-face recruitment was impacted by the COVID-19 pandemic, therefore some women were invited to participate by telephone. In this instance, consent was provided using an online link via REDCap (Research Electronic Data Capture), a secure, password protected data management software program [33].

Data collection

The initial questionnaire was completed face-to-face following consent, except where recruitment was by telephone, in which case the researcher would read out the questions to the woman and then document her answers onto the hardcopy questionnaire.

The follow up questionnaire was completed via telephone. When women reached three months postpartum, the research assistants/midwives called women to complete the questionnaire. Telephone calls were conducted by First Nations researchers where possible. If no First Nations research assistant/midwife was available, then a non-First

Table 1
Participant characteristics.

	Recruitment questionnaire		Follow up questionnaire	
	n (n = 343)	%	n (n = 213)	%
Study site				
Site 1	154	44.9	98	46.0
Site 2	84	24.5	54	25.4
Site 3	105	30.6	61	28.6
Age at recruitment (years)				
Mean (SD), range	28 (5.4) 16–44		29 (5.8) 18–44	
< 21	24	7.0	10	4.7
21–25	92	26.8	50	23.5
26–30	109	31.8	74	34.7
31–35	83	24.2	57	26.8
36–40	31	9.0	19	8.9
> 40	4	1.2	3	1.4
First Baby (n = 343/211)				
Yes	158	46.1	102	48.3
Age of baby at follow-up (weeks)				
Mean (SD), range			17 (4.2) 12–39	
Mode of birth (n = 343/211)				
Spontaneous vaginal	-	-	121	57.4
Forceps	-	-	8	3.8
Vacuum	-	-	13	6.2
Caesarean section (planned)	-	-	27	12.8
Caesarean section (unplanned)	-	-	42	19.9
Received caseload				
Yes	-	-	186	87.3
Aboriginal/Torres Strait Islander status (n = 343/211)				
Aboriginal	243	71.0	146	69.2
Torres Strait Islander	9	2.5	7	3.3
Both	10	3.0	9	4.3
Neither	81	23.5	49	23.2
Partnered (n = 340/209)				
Yes	296	87.1	192	91.9
Partner's Aboriginal/Torres Strait Islander status (n = 343/211)				
Aboriginal	136	39.7	77	36.5
Torres Strait Islander	4	1.2	3	1.4
Both	5	1.5	3	1.4
Neither	194	56.6	125	59.2
Unsure	4	1.2	3	1.4
Language spoken at home (n = 343/211)				
English	330	96.2	203	96.2
Aboriginal or Torres Strait Islander language is spoken (n = 342/211)				
Yes	46	13.5	25	11.9
Education (n = 339/209)				
Year 10 or less	63	18.6	31	14.8
Year 11 or 12	114	33.6	58	27.8
Cert 3 & 4 or Diploma	96	28.3	64	30.6
Degree	66	19.5	56	26.8
Studying at pregnancy confirmation (n = 339/209)				
Yes	66	19.5	40	19.1
Was employed at pregnancy confirmation (n = 339/209)				
Yes	215	63.4	149	71.3
Pension/government benefit main source of income (n = 339/207)				
Yes	101	29.8	44	21.3
Health care concession card holder (n = 339/209)				
Yes	155	45.7	79	37.8
Private health insurance (n=337/209)				
Yes	55	16.3	46	22.1
Accommodation (n = 334/204)				
Homeowner/paying off mortgage	66	19.8	48	23.5
Renting	182	54.5	113	55.5
Living with family/friends	60	18.0	35	17.2
Temporary accommodation	9	2.7	3	1.5
Other	17	5.1	5	2.5
Smoking pre-pregnancy (n = 338/208)				
Yes	143	42.4	74	33.6
Smoking at time of survey (n = 336/142)				
Yes	82	24.4	50	35.5
Others smoking at home (n= 334/198)				
Yes	100	30.9	18	9.1

nations researcher would conduct the telephone interview, with the woman's agreement. For all calls the researcher re-confirmed consent with the woman and checked she was in a safe and private space to complete the questionnaire. Women were reminded that the questionnaire included sensitive health questions, and of the option to pause or end the session at any point. The researcher then read out the questions to the woman and documented her responses on a hardcopy questionnaire.

A standardised contact protocol was used for women who requested a call back at a later time, or if women were not able to be contacted in the first instance. If a woman reached six months postpartum and was not able to be contacted, they were then considered 'lost to follow up' and contact attempts were ceased. If a woman contacted the research team to complete the questionnaire after this, they were still able to participate, with a cut-off date set at nine months postpartum. A protocol was also in place in the event that a woman required referral to a particular service for further support. The researchers also were able to provide contact information for each of the AHLOs from the study sites, if a woman wanted to provide feedback to the hospital directly.

Data collection tools

The questionnaires were based on data collection tools previously used by the research team [34] and tools used in similar studies [28,35]. The AAC provided feedback to ensure the questions asked were relevant and culturally appropriate. The initial questionnaire collected information on sociodemographic characteristics including First Nations status, age, education level, place of residence and socioeconomic status i.e. health care card concession holder status, and whether the household received a government benefit as the main source of income [36].

The follow up questionnaire included questions on the model of care women received, (i.e. caseload midwifery, standard care, or the culturally specific Baggarrook Yurrongi caseload midwifery model). The questionnaire also included questions on women's levels of satisfaction with their pregnancy, labour and birth, and postnatal care [34]. Ordinal data were collected in questions where women were asked to answer, for example, 'Always' 'Mostly' 'Sometimes' 'Occasionally' or 'Never', in relation to their interactions with midwives, as well as in 7-point Likert-type scales where women could rate each aspect of care from '1' (Very poor) up to '7' (Very good).

Data management and analysis

Data were entered into REDCap [33] and then imported into Stata 17 [37] for cleaning and analysis. Data cleaning included range and logic checks as well as checking missing data fields and cross checking the hard copy questionnaires. Quantitative data were summarised using frequencies and percentages.

Ethics

Multi-site Ethics approval was received from St Vincent's hospital HREC (reference number HREC-16\SVHM\223), and La Trobe University (HREC 195/16) and all three health services provided site specific

approval. The study was conducted in accordance with National Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research [38].

Results

Data collection was from March 2017 until August 2021, during which time 1040 Aboriginal and/or Torres Strait Islander families were identified and booked for care across the three study sites. Of those, there were 479/926 (51.7 %) of the eligible women that were approached to participate in the evaluation (Fig. 1).

Participant characteristics

Table 1 shows the characteristics of women recruited to the study, and of the women who responded to the follow up questionnaire [36]. Characteristics were similar with the exception of women who participated in the follow up questionnaire being more likely to live in regional/rural areas of Victoria, more likely to have a university degree, less likely to be unemployed, less likely to be a healthcare concession card holder. Just over half the women had a spontaneous vaginal birth (57 %), and most had a partner (87 %), spoke English at home (96 %), were employed (71 %) and had completed some form of tertiary education (57 %). Most women (87 %) had received caseload midwifery care (site 1: 88 %, site 2: 82 %, and site 3: 92 %).

Satisfaction with care

Pregnancy care

Figs. 2 and 5 shows women's overall ratings of their pregnancy care where '1′ was 'Very poor', and '7′ which was 'Very good'. The majority of women (80 %) rated their pregnancy care positively (either '6′ or '7′). Similarly, most women who received a caseload model rated their pregnancy care as either '6′ or '7′ (81 %), with 70 % of the women who did not receive a caseload model rating their care as '6′ or '7′.

We also asked women a number of questions about a range of aspects of their pregnancy care (Table 2). Overall, levels of satisfaction with care were high, with most women 'Agreeing' or 'Strongly agreeing' that they had a say in decisions (87 %), that the midwives kept them informed (93 %), took their concerns seriously (95 %), and asked if they had any questions whilst at check-ups (97 %). Women were happy with their physical and emotional care, and overall there was a pattern of higher levels of satisfaction with caseload care and care provided by midwives, compared with doctors. Women were satisfied overall with the level of information they received about a range of topics during pregnancy (Table 2).

Labour and birth care

Overall, levels of satisfaction with labour and birth care were high. Most women (81 %) rated their care during labour and birth positively ('6′ or '7′) (see Figs. 2 and 5). The percentages of women who rated their

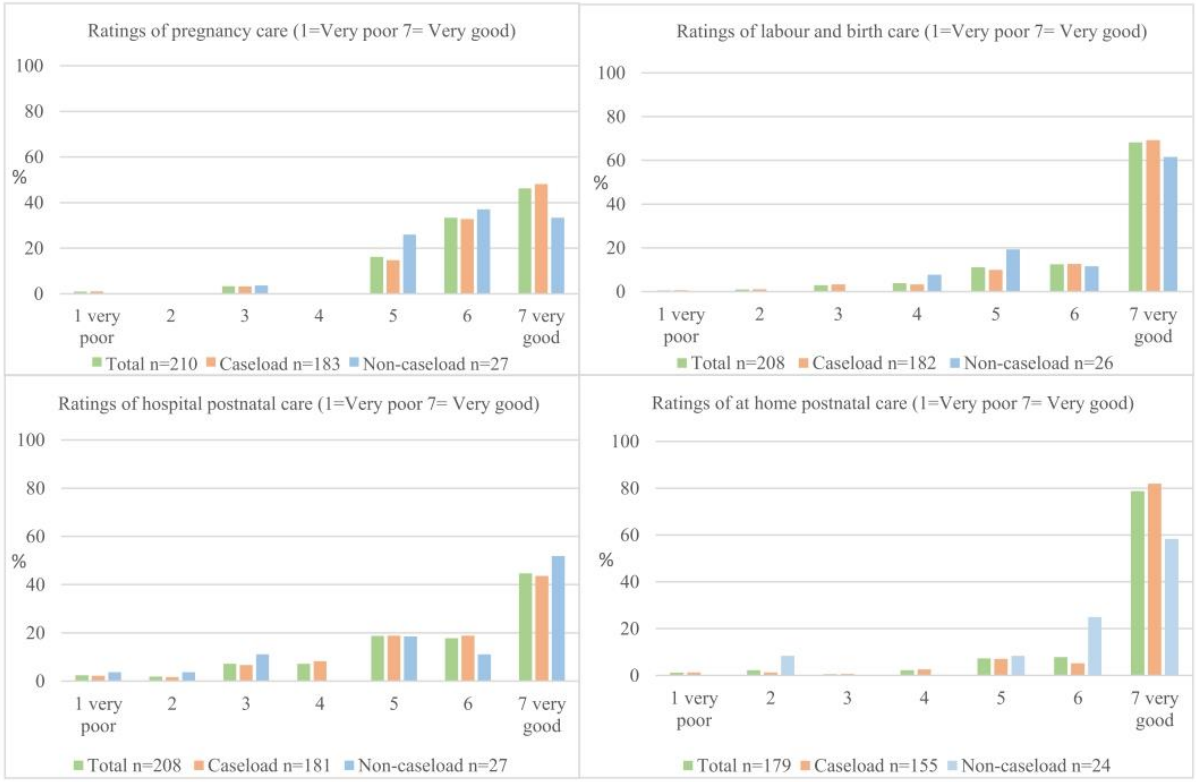


Fig. 2. Overall ratings of care across all 3 study sites.

Table 2
Satisfaction with pregnancy care.

Satisfaction scores (%)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
At my check-ups I was always asked whether I had any questions					
All women n = 213	0.5	0.5	1.9	11.3	85.9
Caseload n = 186	0.5	0.5	1.6	10.8	86.6
Non-caseload n = 27	-	3.7	-	14.8	81.5
The midwives kept me informed					
All women n = 204	1.0	2.5	3.4	17.7	75.5
Caseload n = 182	1.1	2.2	3.9	16.5	76.4
Non-caseload n = 22	-	4.6	-	27.3	68.2
The doctors kept me informed					
All women n = 213	3.1	4.9	13.6	26.5	51.9
Caseload n = 162	2.7	4.3	11.8	23.1	45.2
Non-caseload n = 24	4.2	-	20.8	33.3	41.7
I was given an active say in decisions about my care					
All women n = 212	1.4	3.3	8.0	19.8	67.5
Caseload n = 185	1.6	3.2	8.1	17.8	69.2
Non-caseload n = 27	-	3.7	7.4	33.3	55.6
My worries, anxieties, and concerns about my pregnancy and the baby were taken seriously by the midwives					
All women n = 203	1.0	2.9	1.0	15.8	79.3
Caseload n = 182	1.1	3.3	0.6	15.4	79.8
Non-caseload n = 21	-	-	4.8	19.0	76.2
My worries, anxieties, and concerns about my pregnancy and the baby were taken seriously by the doctors					
All women n = 184	2.2	7.6	10.3	20.1	59.8
Caseload n = 159	2.5	7.6	10.1	20.8	59.1
Non-caseload n = 25	-	8.0	12.0	16.0	64.0
The midwives provided reassurance when I needed it					
All women n = 204	1.0	1.0	4.4	13.2	80.4
Caseload n = 183	0.6	1.1	4.4	12.6	81.4
Non-caseload n = 21	4.8	-	4.8	19.1	71.4
The doctors provided reassurance when I needed it					
All women n = 184	1.1	4.3	12.5	25.5	56.52
Caseload n = 159	1.26	5.0	12.0	23.9	57.9
Non-caseload n = 25	-	-	16.0	36.0	48.0
The midwives seemed rushed					
All women n = 202	51.0	25.3	2.1	13.9	6.9
Caseload n = 181	51.9	24.3	3.3	14.4	6.1
Non-caseload n = 21	42.9	33.3	-	9.5	14.3
The doctors seemed rushed					
All women n = 182	33.0	20.3	14.3	19.2	13.19
Caseload n = 157	31.9	21.7	16.6	17.2	12.7
Non-caseload n = 25	40.0	12.0	-	32.0	16.0
My care was provided in a competent way					
All women n = 212	-	2.4	3.3	23.1	71.2
Caseload n = 185	-	2.2	3.2	20.5	74.1
Non-caseload n = 27	-	3.7	3.7	40.7	51.6
I was happy with the physical care I received from midwives					
All women n = 202	2.0	1.5	0.5	17.8	78.2
Caseload n = 181	2.2	1.1	0.6	17.1	79.0
Non-caseload n = 21	-	4.8	-	23.8	71.4
I was happy with the physical care I received from doctors					
All women n = 180	1.7	2.8	10.0	25.6	60.0
Caseload n = 155	1.9	3.2	8.4	23.2	63.2
Non-caseload n = 25	-	-	20.0	40.0	40.0
I was happy with the emotional support I received from midwives					
All women n = 202	2.5	1.5	3.0	15.8	77.2
Caseload n = 181	2.2	1.7	3.3	14.4	78.5
Non-caseload n = 21	4.8	-	-	28.6	66.7
I was happy with the emotional support I received from doctors					
All women n = 178	2.3	6.7	18.0	25.8	47.2
Caseload n = 152	2.6	6.7	19.1	23.0	48.7
Non-caseload n = 26	-	7.7	11.5	42.3	38.5
I was happy with the cultural support I received in pregnancy					
All women n = 208	5.7	5.3	10.6	24.5	53.8
Caseload n = 181	5.0	3.9	11.1	23.8	56.4
Non-caseload n = 27	11.1	14.8	7.4	29.6	37.0
I received adequate information about caring for my baby					
All women n = 209	0.5	9.6	8.6	21.0	60.2
Caseload n = 183	0.5	9.8	8.7	21.3	59.6
Non-caseload n = 26	-	7.7	7.7	19.2	65.4
I received adequate information about breastfeeding					
All women n = 203	3.9	12.3	13.8	18.7	51.2
Caseload n = 177	4.0	12.4	12.4	19.2	52.0
Non-caseload n = 226	3.9	11.5	23.1	15.4	46.2
I received adequate information about caring for myself after the birth					
All women n = 209	4.8	12.0	13.8	25.8	43.5
Caseload n = 185	4.9	12.4	13.0	24.3	43.8
Non-caseload n = 27	3.7	7.4	18.5	33.3	37.0
I received adequate information about labour and birth					
All women n = 205	2.9	5.4	10.2	25.4	56.1
Caseload n = 182	2.2	5.0	9.5	25.7	57.5
Non-caseload n = 26	7.7	7.7	15.4	23.1	46.2
I received adequate information about services available to me in the community					
All women n = 211	6.6	14.2	20.4	22.8	36.0
Caseload n = 182	6.6	12.0	22.3	24.5	35.9
Non-caseload n = 27	14.8	29.6	7.4	11.1	37.0
I received adequate information about how long I would stay in hospital					
All women n = 208	7.2	8.2	7.2	24.5	52.8
Caseload n = 182	6.6	7.7	7.7	25.3	52.8
Non-caseload n = 26	11.5	11.5	3.9	19.2	53.9

care positively in each group were 82 % for the women who received a caseload model, and 74 % of women who did not receive caseload.

Other questions related to how women perceived interactions with their midwife/midwives during labour and birth, with positive responses from most women (Fig. 3). Most reported that the midwives were 'Always' kind and understanding (90 %), there when needed (84 %), and used words that women could understand (86 %), but less reported 'Always' having a say about decisions about their care (72 %) or receiving explanations about what was happening (67 %).

Postnatal care

Women's ratings of in-patient postnatal care were less positive than for other components of care, however most women (62 %) rated their care positively as either '6' or '7'. This increased to 87 % once women were receiving postnatal care at home (Figs. 2 and 5). Fig. 4 shows that on the postnatal ward, less than half of the women 'Strongly agreed' that they received enough advice about looking after their baby (43 %) or their own health (46 %). Just over half (53 %) of women 'Strongly agreed' that they received enough information about breastfeeding or that the midwives were encouraging (57 %).

Satisfaction ratings across the continuum

Fig. 5 shows the proportions of women who rated their care positively ('6' or '7) across the continuum. Overall women were highly satisfied with pregnancy (80 %), labour and birth (81 %), and domiciliary care (87 %). Women were most critical of their in-patient postnatal care, with 62 % of women rating their care positively.

Discussion

This study explored levels of satisfaction among women having a First Nations baby, who received maternity care at one of three Victorian

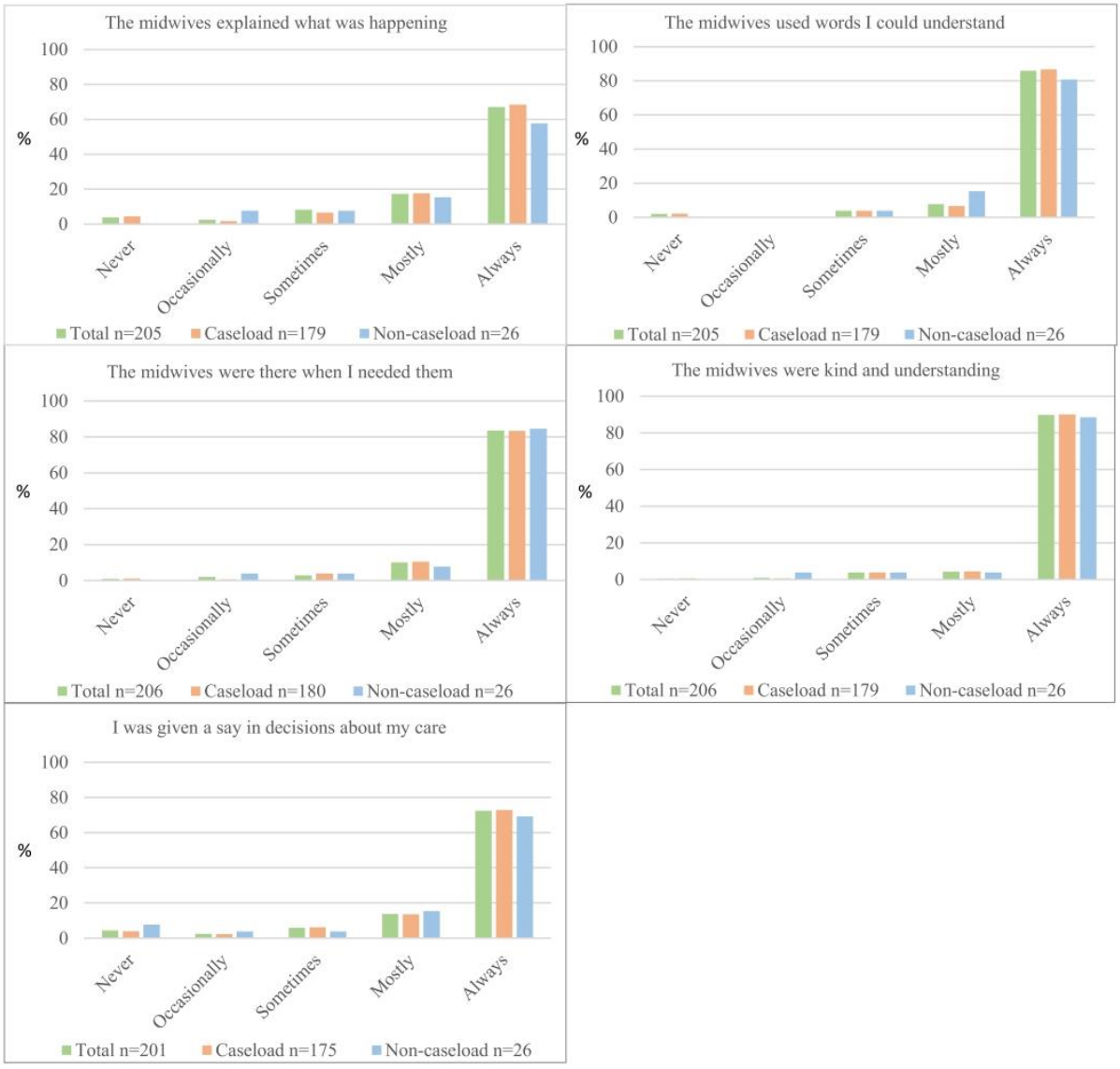


Fig. 3. Ratings of labour and birth care.

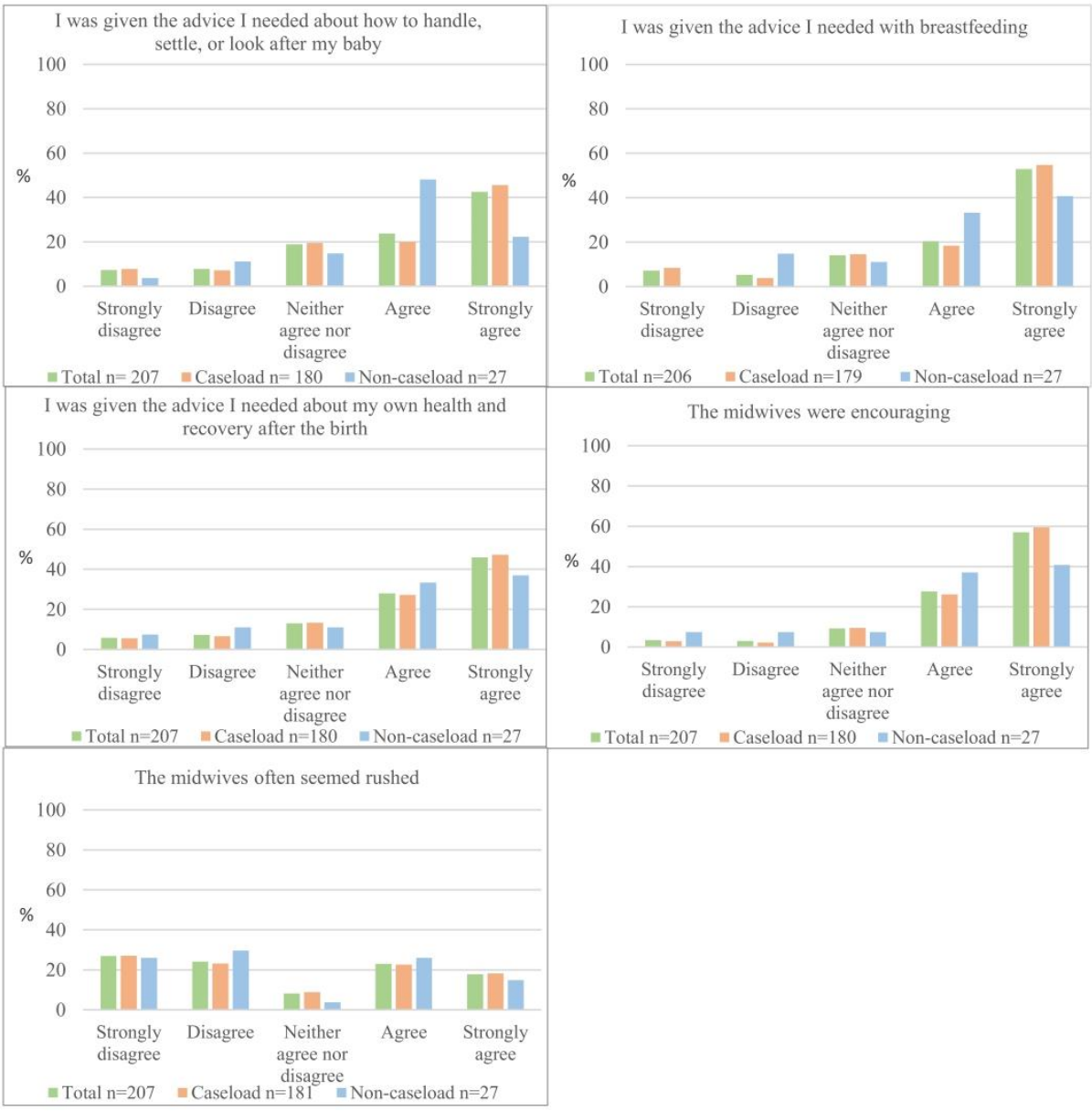


Fig. 4. Ratings of in-patient postnatal care.

tertiary services where new culturally specific caseload midwifery models were implemented on a large scale. We have presented women's views overall, as well as presenting them based on whether they received a caseload midwifery model (n = 186) or if they did not (n = 27). Given that First Nations women and newborns face an excessive burden of inequitable outcomes [1,2], and due to the well researched benefits of continuity of midwife models for women and newborns [6], both national [3] and state [39] policies recommend that First Nations women have greater access to these models. However, there is a lack of data about women's experiences of these models, particularly in urban settings and in Victoria.

Overall, women in this study have reported high levels of satisfaction with their maternity care, echoing findings from previous studies that have compared caseload midwifery versus standard care [34,40,41] and also with previous studies of continuity of care for First Nations women [8,11,27–31]. Antenatal and intrapartum care were rated highly by the large majority of women. Satisfaction declined during inpatient postnatal care, then increased again once the women were at home. Overall, a pattern of lower levels of satisfaction in the non-caseload midwifery group was identified in the data, however, due to the small number of women who did not receive caseload, the sample size was inadequate to provide sufficient statistical power for comparisons. We were also interested if the site where the woman was receiving care, or the woman's Indigenous status impacted on satisfaction. When comparing percentages between the different study sites and women's First Nations status, there were no differences identified. However, the numbers were

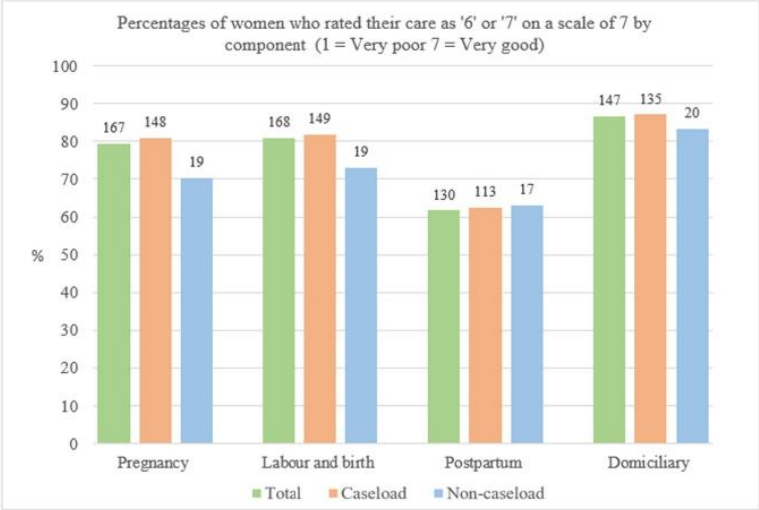


Fig. 5. Ratings across the continuum.

too small within the groups to undertake statistical comparisons.

Collecting satisfaction outcome data from birthing women is recommended in policy as an important means of quality control, [3] as this provides opportunity for health services to understand how care is being perceived by care recipients, as well as any areas for improvement [19]. Nationwide consultation aiming to elevate the voices of First Nations women and girls resulted in the recent Wiyi Yani U Thangani report, which supports that for targeted First Nations birthing programs, community involvement in the design, delivery and evaluation is considered essential for success [24]. The report argues that, while these programs are needed, they will be more likely to meet the needs of First Nations women if a role is maintained for First Nations women in monitoring and evaluating them [24]. The goal of this study has been to provide an opportunity for First Nations women to provide feedback about their care, to directly inform and improve the maternity services that are available.

This study has also presented data on various aspects of care within each phase of the childbearing continuum that contributes to maternal satisfaction overall [34,42]. The psychosocial aspects of pregnancy care have been recognised as critical to satisfaction [43], and women in this study mostly felt that the midwives took their worries seriously, kept them informed, asked if they had any questions, and provided good emotional support. This is likely to be correlated with women's high levels of satisfaction with pregnancy care overall. Patterns of lower satisfaction levels with medical care could be related to women more often reporting that the doctors seemed 'rushed'. Women in this study reported during labour and birth, the midwives kept them informed, they were given a say in decisions, and that the midwives were encouraging. This has also been reported by women who received caseload midwifery in previous studies [34,40,41]. As has been identified in this study, a previous study found that women experienced lower levels of satisfaction with care once on the postnatal ward [44]. Similar to some women reporting that medical staff appeared rushed during their pregnancy care, this was also the case for the midwives on the postnatal ward. Staffing issues and a busy environment on the postnatal ward have previously been recognised as a barrier for midwives to meet the needs of women [45], however, evidence shows that continuity of midwife care can improve women's satisfaction with their in-patient postnatal care, compared with standard care [34,40,41].

Models of care aiming to meet the needs of First Nations women and newborns should be designed with consideration that First Nations approaches to health are holistic and are underpinned by culture [46]. Importantly, the majority of the women in this study reported that during their pregnancy, they were happy with the cultural support they received. The opportunity to establish a trusting relationship with a known caregiver aligns with First Nations culture [47,48], and maternity services need to ensure adequate resource allocation to allow for care to include First Nations ways of knowing, being and doing. This includes ensuring women have access to care that is holistic, with enough time to build relationships [49], which are core aspects of Birthing on Country models [17]. Previous studies have reported a lack of cultural safety within the maternity system [9,10], which perpetuates inequitable health outcomes for First Nations women and newborns [12]. Corcoran et al. identified that negative experiences often occur where care is fragmented, bearing little opportunity to build a trusting relationship with caregivers [11], and previous findings from the Baggarrook Yurrongi project have highlighted the importance that First Nations women place on trust [36]. Therefore, it is important to recognise the success of Birthing on Country programs that have reported positive outcomes for women [7]. In this study women have been very positive about the care they received in hospitals that had introduced a culturally specific, continuity of midwife care model, and this was particularly so for women who received the new model. Considering this, as well as all the known benefits of caseload midwifery, it is recommended that these programs are upscaled, implemented and sustained in areas of Australia where First Nations women do not have access to a known midwife.

Strengths and limitations

To our knowledge, this is the largest study to date exploring satisfaction with care among women having a First Nations baby in Australia where the majority of the women received culturally specific model of caseload midwifery. This study also adds to the gap in the literature in terms of understanding the views of First Nations urban women [25,26]. Another strength of this study was the co-design approach with First Nations people, including input from the AAC. Given the existing high-level evidence of the benefits of continuity of midwife care for women, consultation with First Nations community members resulted in a decision that this should be a translational, implementation study

design (as opposed to a randomised controlled trial). One limitation of this study is that due to the low numbers of First Nations women who did not receive a caseload midwifery model, this study was not powered for statistical comparisons to be undertaken of satisfaction levels between the women from each group.

Conclusion

Continuity of midwife care throughout pregnancy, birth and the postpartum period is recommended in Australian national policy as a strategy towards improving outcomes for First Nations women and newborns [3]. Additionally, 'Birthing on Country' models of care require First Nations women to have access to a known midwife across the continuum, as one of the key principles [17]. Evidence demonstrates both physical and psychosocial benefits for women and babies generally, [6] and culturally specific models that include continuity of midwife care have improved outcomes for First Nations women newborns [7,8]. As a means of quality assessment and accountability, targeted maternity programs for First Nations women require community-led approaches in service planning, delivery, and evaluation [3,24]. The Baggarrook Yurrongi partnership project led to an exponential increase in the number of First Nations women having access to a known-midwife within three major tertiary centres located in Naarm (Melbourne) [18], and exploring women's views and satisfaction of their maternity care was an important outcome of the project. Overall, this large cohort of First Nations women (and women having a First Nations baby) reported high levels of satisfaction with their care within the three sites during the study period, particularly during pregnancy, labour and birth, and postnatal care in the home. It is recommended that further up-scale and implementation of First Nations community-led, culturally specific maternity models of care is prioritised, with ongoing evaluation of such models across the country [7,18].

Conflict of Interest

None declared.

Acknowledgements

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Chapter 9: Exploring women's views and experiences of their care

Chapter nine includes a paper that presents qualitative data from responses to free-text, opened ended questions that were included in the follow up questionnaire which was completed between 3-6 months after birth (see section 5.2.3). Provided is an exploration of women's views and experiences of their pregnancy, labour and birth, early postnatal care.

Two-hundred and thirteen women completed the follow up questionnaire, 186 of whom received continuity of midwife care at one of the three maternity services. Thematic analysis was used for the analysis. The global theme for what women liked about their care was feeling 'safe, supported and connected'. The global theme for what women did not like about their care was a 'complex, fragmented and unsupportive system'.

This paper concludes that the culturally tailored caseload midwifery models appeared to make care feel safer for women having a First Nations baby, however the wider mainstream maternity system remained challenging for some women. Recommended is the implementation of these models for First Nations women with the use of evidence-based frameworks to facilitate organisational change.

Citation:

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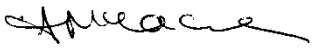
Contribution to the paper:

I declare that I have made a substantial contribution to this paper, of which I am the lead author. This includes leading the conceptualisation of the paper and contributing to the design of data collection tools. Under supervision, I took on majority of the responsibility in the collection, cleaning and analysis of the data. I then drafter the paper. The co-

authors contributed to supervision of the data cleaning, data analysis, and editing of the manuscript.



I declare that Res McCalman made a substantial contribution to this paper. She contributed to many different aspects of the Baggarrook Yurrongi project, model implementation at the study sites, and edited and reviewed the paper.



H. McLachlan

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Original Research

"Safe, connected, supported in a complex system." Exploring the views of women who had a First Nations baby at one of three maternity services offering culturally tailored continuity of midwife care in Victoria, Australia. A qualitative analysis of free-text survey responses

P. McCalman [a,b,*], D. Forster [a,c], M. Newton [a,b], F. McLardie-Hore [a,c], H. McLachlan [a,b]

[a] Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086, Australia
[b] School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3052, Australia
[c] The Royal Women's Hospital, Parkville, Victoria 3052, Australia

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ABSTRACT

Background: In Australia, continuity of midwife care is recommended for First Nations women to address the burden of inequitable perinatal outcomes experienced by First Nations women and newborns.
Aims: This study aimed to explore the experiences of women having a First Nations baby who received care at one of three maternity services in Naarm (Melbourne), Victoria, where culturally tailored midwife continuity models had been implemented.
Methods: Women having a First Nations baby who were booked for care at one of three study sites were invited to participate in an evaluation of care. Thematic analysis was used to analyse qualitative data from responses to free-text, open ended questions that were included in a follow-up questionnaire at 3–6 months after the birth.
Results: In total, 213 women (of whom 186 had continuity of midwife care) participated. The global theme for what women liked about their care was 'Safe, connected, supported' including emotional and clinical safety, having a known midwife and being supported 'my way'. The global theme for what women did not like about their care was 'A complex, fragmented and unsupportive system' including not being listened to, things not being explained, and a lack of cultural safety.
Conclusions: Culturally tailored caseload midwifery models appear to make maternity care feel safer for women having a First Nations baby, however, the mainstream maternity care system remained challenging for some. These models should be implemented for First Nations women, and evidence-based frameworks, such as the RISE framework, should be used to facilitate change.

Statement of significance

Issue:

Continuity of midwife-led care for First Nations women is recommended in maternity policy. For targeted First Nations programs to be effective, the perspectives of First Nations women should be included in service planning, delivery, and evaluation.

What is known:

First Nations women (and women having a First Nations baby) reported high levels of satisfaction with culturally tailored midwife continuity models implemented at one of three tertiary maternity services in Melbourne, Australia.

What this paper adds:

This paper provides an in-depth understanding of the elements of care which women found supportive and those that were negative/challenging. Women reported feeling safe and supported in the culturally tailored model, in what can be a complex, fragmented and unsupportive system.

* Corresponding author at: Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria 3086, Australia.
E-mail address: P.McCalman@latrobe.edu.au (P. McCalman).

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Introduction

Aboriginal and Torres Strait Islander (First Nations) women and newborns experience inequitable perinatal outcomes. [1,2] Government policy and First Nations health strategies recommend improving maternity service provision by partnering with First Nations communities to implement evidence-based programs. [3,4,5] One such program called Baggarrook Yurrongi ("Woman's Journey" in Woi-wurrung language) was a partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and three metropolitan Victorian maternity services that explored the capacity of the services to implement culturally tailored caseload midwifery for First Nations women (and non-First Nations women having a First Nations baby). [6] The program was successfully implemented in three services in Naarm (Melbourne), with an exponential increase in the number of First Nations women having access to a caseload midwife. [6].

Across all three sites, the culturally tailored models included proactively offering continuity of care from a known hospital-based midwife, in conjunction with additional specialist teams as needed. The hospital-based midwives received cultural safety training provided by VACCHO, who was a project partner organisation and is the state peak body for Aboriginal health. The culturally tailored model included the option for women to have all hospital-based care, or to have the continuity model of care in conjunction with community Aboriginal health services (including a community-based midwife) via a shared care arrangement. [7] The midwives also worked with Aboriginal Hospital Liaison Officers (AHLOs) from the Aboriginal Health Units at the sites. The culturally tailored model aimed to enhance, rather than replace existing Aboriginal health services. Engagement between the AHLOs and the midwives, and women's access to cultural activities was site specific. For example, AHLOs at one of the sites coordinated regular 'Yarning Circles' for women and the caseload midwives, and another site had an established 'Koori Maternity Service (KMS) program'.[1]

Listening to the voices of First Nations women is critical for the success of First Nations maternity programs. [3] A key aim of the Baggarrook Yurrongi project was to explore women's satisfaction, experiences, and views of their care, adding to the small number of studies exploring the impact of continuity of care models for Aboriginal families living and birthing in urban settings. [8] One previous study conducted in regional Victoria compared the experiences of 25 First Nations women who received continuity of care within an Aboriginal Community Controlled Health Organisation (ACCHO) with other rural women who gave birth in Victoria and participated in a state-wide survey. [9] ACCHOs are primary healthcare services that are established and governed by Aboriginal community members and are founded on social models of health, providing culturally appropriate and holistic health services that address the social determinants of health. [10] First Nations women in the ACCHO continuity model were more likely to say they were kept informed, the midwives were not rushed, and they were satisfied with their care compared to the other women. [9] More recent evidence found First Nations women who accessed a midwife continuity program in Sydney NSW experienced accessibility, preparedness for birth, and feelings of trust. [11] A systematic review that included studies from Australia and Canada reported that continuity of midwife care is valued by First Nations women, and negative experiences are more likely to occur when there is lack of access to culturally tailored services and continuity of care. [12] Only one study in the review included the views of urban First Nations women who accessed continuity of midwife care. [13].

We have previously reported that women having a First Nations baby at one of the three metropolitan services that implemented culturally tailored continuity of care in the Baggarrook Yurrongi study reported high satisfaction with their maternity care. [14] Two hundred and thirteen women from the study participated in a telephone survey between three and six months after the birth, and the vast majority felt informed, that they were actively included in decision making, that their concerns were taken seriously, and that midwives were kind, understanding and readily available. [14].

In the Baggarrook Yurrongi telephone survey we also asked a number of open-ended questions in order to further explore and understand women's responses to questions about their care. Analysis of open-ended questions is important to help explain women's responses, [15,16] and to provide context and depth of understanding, [16] which is particularly important for populations that may be marginalised. [17] Qualitative data from free-text survey comments are recognised as an important data source for interpreting complexities in women's health care experiences, because participants are enabled to address relevant issues. [15].

This aim of this paper was to conduct a more in-depth exploration of the views and experiences of First Nations women (and women having a First Nations baby) receiving maternity care at one of three urban tertiary maternity services where culturally tailored, continuity of midwife care programs had been recently implemented in Naarm, Victoria, Australia, using qualitative, free text data.

Participants, methods, ethics

The study was co-developed in partnership with VACCHO and the Baggarrook Yurrongi Aboriginal Advisory Committee (AAC). The AAC included a representative from VACCHO, community Elders, a recent First Nations mother, First Nations research team members, and staff from each study site's Aboriginal Health Units. The AAC provided advice relating to community engagement, eligibility criteria, the design of the data collection tools, and provided feedback on research dissemination.

The methodological lens used to frame this research is Critical Race Theory (CRT). Used in other studies relating to First Nations women and birth, [18,19] a CRT lens attempts to contribute to the emancipation of groups where oppression relating to race and racism stem from imposed colonial practices and policies. [20,21] CRT is political, in that it attempts to produce social change by examining power imbalances and social injustices. [22] For First Nations women, birth has been impacted by colonial government policies including land dispossession, restriction of cultural practices, [23] women being excluded from birthing in hospitals, [24] forced removal of children and infants, and ongoing institutional racism. [23,25] Further, the context of this research is that the first author (PMc) positions herself as an Aboriginal woman and midwife, gathering knowledge from predominantly First Nations informants. Rigney [26] names this as Indigenist research. Aspects of feminist research are borrowed, (i.e. women's liberation from the patriarchy) but Indigenist research harbours a specific focus on colonialism as the systemic oppression. [26].

A descriptive exploratory method was used and included analysis of free-text responses collected by telephone interview as part of a survey when women were between three and six months postpartum. We aimed to approach all eligible women having a First Nations baby, who were booked for care at one of the three study sites (hereafter called site 1, 2, and 3 respectively) during the study period, to participate in an evaluation of their care. To be eligible, women had to be expecting a First Nations baby and booked for care at one of the three study sites. Further detail of eligibility and the proportion of women approached and agreeing to participate is published elsewhere. [14].

Research midwives approached eligible women and invited them to participate. Plain language information was provided about the project and the voluntary nature of participation explained. The option to first discuss participation with their partner, family, or members of their community, or with the AHLO was offered. If a woman agreed to participate, a participant information and consent form was signed.

[1] The Koori Maternity Service (KMS) program is a state-wide program provided across 14 sites that provides culturally safe maternity care for Aboriginal and Torres Strait Islander women and their families during pregnancy.

Women were mostly approached in the antenatal clinic area, or less often in the antenatal inpatient ward, or the postnatal ward after birth (for women transferred in for care late in pregnancy or were not identified as eligible until after birth). Where face-to-face recruitment was precluded due to the COVID-19 pandemic, women were called by telephone and offered participation. Demographic data were collected via a short survey at the time of recruitment, then women were contacted by telephone from three months after the birth.

The questionnaires were based on those previously used by the research team [27] along with data items from similar studies used with permission of the respective authors. [28,29] Structured questions included an exploration of women's satisfaction with and experiences of care (reported in detail elsewhere [14]), and questions on individual characteristics such as age and the specific First Nations language group women identified with (collected at recruitment, when women completed a brief questionnaire [30]). Open-ended questions (from the follow-up questionnaire) analysed and reported in this paper are:

> "Was there anything about your pregnancy care that you were particularly happy/unhappy with?"
>
> "Was there anything in particular with your labour and birth care that you were particularly happy/unhappy with?"
>
> "Is there anything else you would like to tell me about your care in hospital after the birth?"

Data were collected from three months after the baby's birth by a team of First Nations and non-First Nations researchers. The option to speak to a First Nations researcher was offered if the initial call was by a non-First Nations researcher. The researcher re-confirmed consent and then read the questions out to the woman, documenting her responses on a hardcopy questionnaire. Responses to open-ended questions were transcribed verbatim, and the researchers were able to confirm with women that their responses were recorded accurately. If no contact was established by six months postpartum, women were considered 'lost to follow up' and contact attempts ceased. In a few cases where a woman contacted the research team to complete the follow up survey after six-months, the survey was completed and included.

Data were entered onto a secure, password protected data management software, REDCap [31] then imported into Stata 16 for cleaning and analysis. Data cleaning included range and logic checks and checking missing data fields. Data were summarised using frequencies and percentages. For this analysis, two authors (PMc and HMc) completed the initial steps of data immersion and coding of the text separately. Women's responses for each component of care were analysed separately, but initial coding showed that positive and negative themes were similar across care episodes, so responses were reanalysed with all care components combined. A process described by Attride-Stirling [32] was followed, where basic themes (generated from reoccurring codes from the text) and organising themes (middle-tier themes) were compared and agreed upon. [32] Based on the basic and organising themes, and the researcher's positionality and methodological lens, the global themes (overarching statements) were chosen. [32] Ongoing two-way discussion and regular meetings between the First Nations researcher (PMc) and the non-First Nations researcher (HMc) ensured Indigenous worldviews were privileged and a sound consensus was reached. [33] The visual thematic networks produced were verified and refined, as the researchers re-read the text to determine that the map accurately represented the text (see Fig. 1 and Fig. 2). To visually illustrate the themes that were generated in the analysis, Fig. 1 was developed as a Birthing Tree, with the intention of representing the voices of First Nations women, while giving reference to First Nations birthing culture. Birthing trees are strongly associated with First Nations birthing and have connected mothers, babies and communities for thousands of years. [23].

Quotes are provided throughout the text, identified with a unique study identification number, model of care received, and the women's parity. Additional illustrative quotes are also provided in Tables 2 and 3, where we have aimed to include as many First Nations voices as possible.

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.

Results

Recruitment to the study through to final data collection was from March 2017 to August 2021, with 479 eligible women offered participation. Of those, 343 (71.6%) agreed to participate and completed the recruitment questionnaire, with 213 women (62%) completing the three-month follow-up questionnaire. Table 1 shows the demographic characteristics of the women at recruitment (n = 343) and of those who participated in the follow-up questionnaire (n = 213). Participants identified with 60 First Nations communities from across the Australian continent, and most (87%) who took part in the survey received the continuity of care model (site 1: 88%, site 2: 82%, and site 3: 92%).

Results of the analyses of women's positive and then negative feedback are presented below. First the global theme is provided, then a description of the four organising themes that emerged from the basic themes.

Table 1
Women's characteristics.

	Recruitment		Postnatal follow up	
	n = 343	%	n = 213	%
Study site				
Site 1	154	44.9	98	46.0
Site 2	84	24.5	54	25.4
Site 3	105	30.6	61	28.6
Age at recruitment (years)				
Mean (SD, *range*)	28.3 (5.4, *16-44*)		28.8 (5.8, *18-44*)	
First Baby			*(n = 211)*	
Yes	158	46.1	102	48.3
Weeks postnatal at follow up				
Mean (SD, *range*)	-	-	16.8 (4.2, *12-39*)	
Received caseload				
Yes	-	-	186	87.3
No	-	-	27	12.7
Aboriginal/Torres Strait Islander Status			*(n = 211)*	
Aboriginal	243	71.0	146	69.2
Torres Strait Islander	9	2.5	7	3.3
Both Aboriginal & Torres Strait Islander	10	3.0	9	4.3
Not Aboriginal or Torres Strait Islander	81	23.5	49	23.2
Partnered	*(n = 340)*		*(n = 209)*	
Yes	296	87.1	192	91.9
Language spoken at home			*(n = 211)*	
English	330	96.2	203	96.2
Other	13	3.8	8	3.8
Aboriginal or Torres Strait Islander language spoken	*(n = 342)*		*(n = 211)*	
Yes	46	13.5	25	11.9
Education	*(n = 339)*		*(n = 209)*	
Year 10 or less	63	18.6	31	14.8
Year 11 or 12	114	33.6	58	27.8
Cert 3 & 4 or Diploma	96	28.3	64	30.6
Degree	66	19.5	56	26.8
Employed at pregnancy confirmation	*(n = 339)*		*(n = 209)*	
Yes	215	63.4	149	71.3
Pension/government benefit main source of income	*(n = 339)*		*(n = 207)*	
Yes	101	29.8	44	21.3
Health care concession card holder	*(n = 339)*		*(n = 209)*	
Yes	155	45.7	79	37.8

Global theme for what women were particularly happy with: 'Safe, connected, supported'

Women were asked about aspects of their care that they were particularly happy with. Most of the women received continuity of midwife care, either as part of a First Nations specific caseload model (FNCL) or a standard continuity model. The overall global theme was that women felt 'Safe, connected and supported'. This global theme included four organising themes which were 'Having *my* midwife', 'Emotional safety', 'High quality clinical care' and 'Being supported *my* way'.

Having my midwife

A factor that clearly contributed to women's satisfaction with care was being able to see the same midwife/midwives throughout their maternity care experience. Women often commented that they 'liked' their midwife, describing them as experienced, knowledgeable, or kind. Women liked that midwives knew them more on a personal level, and they didn't have to retell their stories several times. Women valued the availability and accessibility of their midwife and appreciated being able to call or text their named midwife (or a backup midwife) 24/7, which was highly satisfying and reduced levels of stress and anxiety. Women also commented that being able to communicate with their midwives to arrange or reschedule appointments directly worked well.

> *"…it was more the fact that I had my own personal midwives. Like, so if I'm at home I thought there was something wrong I could call them because you get their work mobile and they call you back that day or send you a text. Even on weekends I messaged them and they'd get back to me straight away and I think that's what us Aboriginal women need, do you know what I mean?"* ID 2019, multiparous, First Nations Caseload (First Nations Caseload [FNCL])

Women felt positive about knowing who was going to be supporting them throughout their birth journey and then at home afterwards. Many women described how having their caseload midwife with them during labour or birth made them feel calmer, and more trusting:

> *"… because I knew her quite well, I felt comfortable and trusted everything she was saying. At the end of the day it was my decision, but I trusted what she said."* ID 3043, multiparous, FNCL

Some women who had previous experiences with mainstream care without continuity reported that they had a more positive experience compared with their past experience:

> *"I really loved the fact that 9 times out of 10 I seen the same one. So, I knew her on a personal level. Because when I had my son it was completely different, and I made the effort to tell them that I loved how they're doing things now."* ID 3044, multiparous, FNCL

Emotional safety

'Emotional safety' was another theme. Women talked about how the relationship with their midwife/midwives developed over time and contributed to them feeling emotionally safe. Many talked about midwives supporting them and reducing their stress when they were dealing with things such as pregnancy complications, external life stressors or having a history of perinatal loss. Women talked about things like a 'sense of ease' with their care, describing feelings of comfort, familiarity, and reassurance. The words 'connection' and 'family' (see Table 2) were sometimes used to describe their experience.

Table 2
What women liked about their care – illustrative quotes.

Having my midwife	*"It's the obvious stuff, it's really nice to consistently have the same person and know who you will have for the birth and visiting you at home. I really really liked my midwife. The back up one was good too."* ID 3045, multiparous, FNCL
	"I loved seeing the one midwife, it made a huge difference. [My midwife] always knew where we were up to which meant I could bring questions in rather than wasting time on updating a midwife. Being able to call [my midwife] at any time was amazing." ID 1026, multiparous, FNCL
	"This was my 2nd pregnancy at [name of hospital]. This time was a lot better having one midwife all the way through. Having a different midwife means they don't know you and you are thrown around." ID 3045, multiparous, FNCL
Emotional safety	*"…the midwives were there all the time and they listened to you… She makes you feel welcome you know, like she's not a midwife or medical staff, she makes you feel like she's family, like it was someone I've known for many years like I could open up to her and tell her what was going on in my life."* ID 2019, multiparous, FNCL
	"I was most happy with the support, the emotional support I got from the [caseload] midwives, each and every one of them. From when I went in early and then when I had the baby and afterwards." ID 1028, primiparous, FNCL
	"…she always made me feel at ease and you can imagine that that is just such an important thing. And I had a few miscarriages before and the stress of that you know that always plays on your mind…so she just made me feel so relaxed." ID 2043, multiparous, Standard Caseload
	"…the level of emotional support especially because I basically went through a breakup…[my baby] was sick and I was sick and they were caring and reassuring in that way, and that was just the midwives, the doctors were like robots you couldn't get anything out of them. Even the midwives on the ward, they were pretty decent even though I didn't have as strong connection with them like the [caseload] midwives." ID 1055, multiparous, FNCL
High quality clinical care	*"…I feel like they followed up pretty well on anything they were looking out for… I always got lots of information as well…I thought the midwives were really good. They were really attentive and helpful."* ID 2072, multiparous, FNCL
	"I just feel like I had the best care like they were so caring and they were listening to me when I was concerned about something they would answer for me or if they didn't know how to answer it they would get a senior." ID 1096, multiparous, FNCL
	"There were complications so our little man needed assistance breathing. The staff were absolutely amazing and kept reassuring me and my husband and kept an open line of communication. One, in particular, I think it was the anaesthetist, he was fantastic. He stood next to my husband and helped settled his nerves." ID 2069, primiparous, Standard maternity care
	"I really loved it, I tell everyone about it! The midwives always made time for me I never felt like I was a chore. I had a high risk pregnancy and whenever I needed an appointment with a doctor or monitoring or a scan it wasn't a problem, it happened quickly." ID 3014, multiparous, FNCL
	"I was really happy that the doctors and midwives agreed with my decision to have a C-section. It alleviated my doubts." ID 1026, multiparous, FNCL
	"My first pregnancy was purely perinatal, and I didn't have anything to do with the midwives, other than a couple of appointments. To have midwives for my second pregnancy, it was like chalk and cheese. They have a different way of thinking." ID 3090, multiparous, FNCL
Being supported 'my way'	*"I was really happy that [my midwife] was flexible. When I asked if we could just do a phone appointment instead of me coming in and she was totally fine with that, as long as I had no concerns, and also on the other end of that, like, when I was worried at the very end of my pregnancy, she was like 'yeah, come in straight away' and she made time to check me out. So yeah, I think like, being flexible and being available to see me when I needed was really awesome."* ID 3095, multiparous, FNCL
	"…I didn't want to be induced. I was happy that one of the many doctors did listen and I was monitored closely in that term. I was happy with the monitoring they were doing. That was quite helpful anxiety-wise and knowing that I had the control." ID 2070, primiparous, Standard maternity care
	"Um just yeah that I was able to be in control and my midwife really stuck to my birth plan and I was adamant that I didn't want any needles…and even when I was like, 'I need something!' she helped me get through it without anything." ID 1115, primiparous, FNCL
	"I did go into it saying, 'no I'm not having pain relief'. They were understanding when I got the pain, they were quick to change the plan and work with me." 3010, primiparous, FNCL

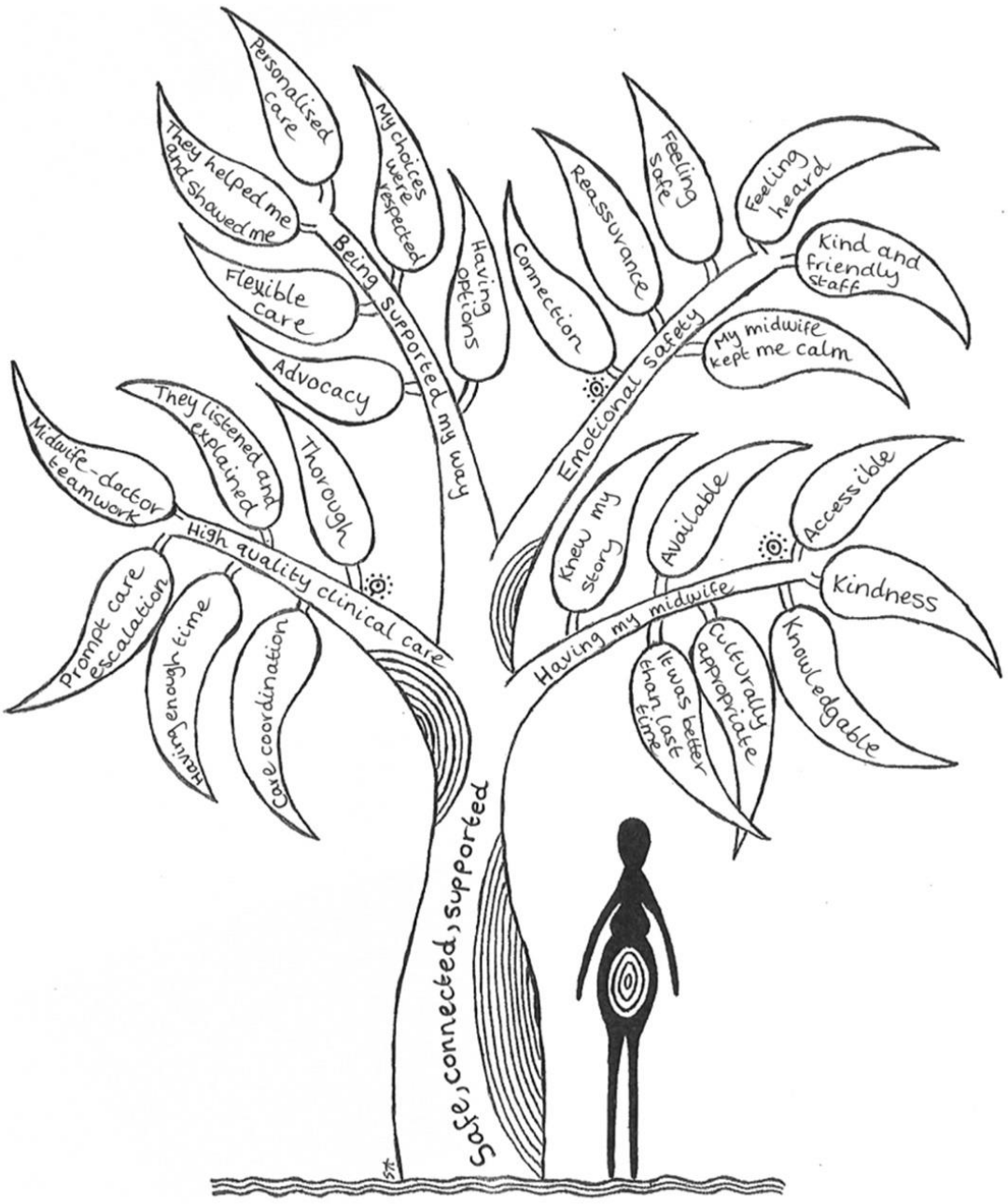


Fig. 1. Thematic analysis visual map of what women liked about their care. Artwork: "Birthing Tree 2" by Shawana Andrews.

"I think the program's great where women have got the midwives to connect with. Having that connection with the workers is important. I think it's really beautiful and you just get to trust that person. It makes mums feel special." ID 3061, multiparous, FNCL

"Once I got to know them [the midwives], it was just comfortable. That was probably the best part of it, you know just feeling comfortable, you know safe…in that relationship…because when you're getting care you don't usually get to have that personal relationship, especially in pregnancy. Yeah, that was nice." ID 3031, multiparous, FNCL

Women also talked about the encouragement they received during labour and birth, with continuous support, the inclusion of their partner or family members, and debriefing after the birth (see Table 2).

"…[the midwife] was amazing [and] stood by myself the whole time … pretty much held my hand, not even gonna sugar coat it…and they just reassured me that they were gonna look after me. I had every single doctor and midwife in there encouraging me, every time I felt sick they just fixed it and they listened to me. Every time I looked at my midwife [they] just said to me 'you are doing amazing, you've got this'." ID 2048, multiparous, FNCL

High quality clinical care

High quality, co-ordinated care that women believed was safe for themselves and their babies was another theme. Women valued clinicians really listening to their concerns and clear communication. Some women talked about 'knowing something was not right', and that health staff took them seriously, acted quickly, or promptly escalated their care. Advocacy from their caseload midwives, and sometimes from other midwives and doctors, was frequently mentioned. Women also described instances where they felt that they were given information that they needed, understood all of their options, and were able to provide truly informed consent (see Table 2).

> *"….my [caseload midwives] always took me seriously when I said there was a problem or there was something wrong and they stood up for me … and with my history, I have complications and I lost my previous baby…so it was really good to have someone in my corner speaking up for me, it was very important to me. To me, that advocacy on my behalf was the most important thing about having the [caseload midwives]. Even if the midwives or doctors on the ward weren't listening, I could call the midwife on the ward and say 'This is happening…help!'"* ID 1070, multiparous, FNCL

The quote below is an example of care co-ordination and collaboration provided in the new model and how it was valued:

> *"I had Gestational Diabetes. It complicated the situation but they worked the system so that I could also continue having the midwives. My midwife was able to bring everything together from the obstetrician side, gestational diabetes side, and midwifery side."* ID 3017, multiparous, FNCL

Effective pain management (non-pharmacological techniques or otherwise) during labour and birth also emerged as a theme under high quality clinical care.

> *"Options of pain relief. I was very happy with that. If I was uncomfortable they had options for me. I got that one that feels like bee stings in your back…they made me as comfortable as I could be in other ways, like getting in the shower or turning the lights down. I really appreciated being comfortable and safe in that space."* ID 1153, primiparous, FNCL

> *"I was very happy that the midwife supported me to get the epidural, I had no pain for the birth and the midwife guided me well for pushing."* ID 2080, primiparous, FNCL

Being supported 'my way'

Another key factor in women's satisfaction was feeling that the care they received was individualised and personalised. They valued flexible care, such as midwives helping to schedule appointments at times that accommodated childcare or long-distance travel, telephone appointments or last minute 'drop in' appointments. One woman explained that she felt like she was she was not 'just another patient' but was treated as an individual and felt genuinely cared for:

> *"Ah it was just, the midwives didn't make it about, how do you explain it…like they made it about me and the baby, it was, it actually felt like you were an individual. I don't know how to explain it, it was like they gave you more time, they actually cared about you and the baby, they didn't make it out like you were just another patient like they can just shove you on your way…and I have had that before."* ID 3012, multiparous, FNCL

Women appreciated being given options, and that their choices were respected. This included things like their planned place of birth, mode of birth, what level of medical intervention they were comfortable with and being 'in control' (see Table 2). The quote below is from a woman whose baby was expected to die shortly after birth due to a congenital anomaly. She described the difference it made that her caseload midwife and birth team were able to support her, *her* way:

> *"I talked through my birth plan with [my midwife]. Back on Country the tradition is that no male person is to touch the cord while it is still attached. So I asked [my midwife] if in the worst case she could cut it, in case my sister couldn't. And we spoke a lot. Then when [my baby] was born, they intubated her at the end of the bed which was just so special. I asked if she could have delayed cord clamping and the paediatrician had every reason to say no, but he didn't. And because of all this I was able to hold her…and if they didn't I wouldn't ever have been able to hold her alive. And there were so many members of my family there, five to six, and they were able to stay. It was so special."* ID 1014, primiparous, FNCL

Global theme for what women were particularly unhappy with: 'A complex, fragmented and unsupportive system'

Women were asked to describe aspects of their care that they were unhappy with. The global theme was 'A complex, fragmented and unsupportive system'. For women who received caseload midwifery care, negative experiences mostly occurred during interactions with staff who were not working in these models. The four organising themes were: 'A lack of 'cultural safety'', [34] 'Fragmented care', 'They didn't listen/didn't explain' and 'Unsupportive'.

A lack of cultural safety

There were some examples of culturally unsafe interactions with staff who were not working in the culturally tailored caseload models. Some women felt stereotyped, for example staff assuming that they were using illicit drugs during their pregnancy, and wondered if it was linked to their Aboriginality. Other women perceived a pressure to explain themselves due to an obvious lack of knowledge from staff, particularly around skin colour.

> *"The doctor asked if 'ATSI' was a disease. He had no idea what it meant. He was trying hard to be respectful but was ignorant. Continued to ask questions and his preconceived ideas were bizarre. I didn't enjoy the scan, I felt uncomfortable and had to give a history lesson and explain myself."* ID 1094, primiparous, FNCL

> *"…they accused me of being a drug user. The midwife just casually said it…I don't know if it was because I had Aboriginal next to my name or the way I look. If [my caseload midwife] wasn't there, it was a totally different attitude."* ID 3081, multiparous, FNCL

Some women commented that hospital processes were not culturally appropriate. A small number of women commented on feeling worried about the Department of Human Services (DHS), linking this worry to their Aboriginality (see Table 3). Some women expressed that cultural safety may also be improved with greater access to Aboriginal midwives and Aboriginal Hospital Liaison Officers, while also recognising the need for ongoing cultural support for non-Indigenous staff.

> *"…I was surprised that there was no Aboriginal midwife providing care. Having Aboriginal staff working in this model would be the most appropriate and if this can't happen, non-Aboriginal staff need continuous*

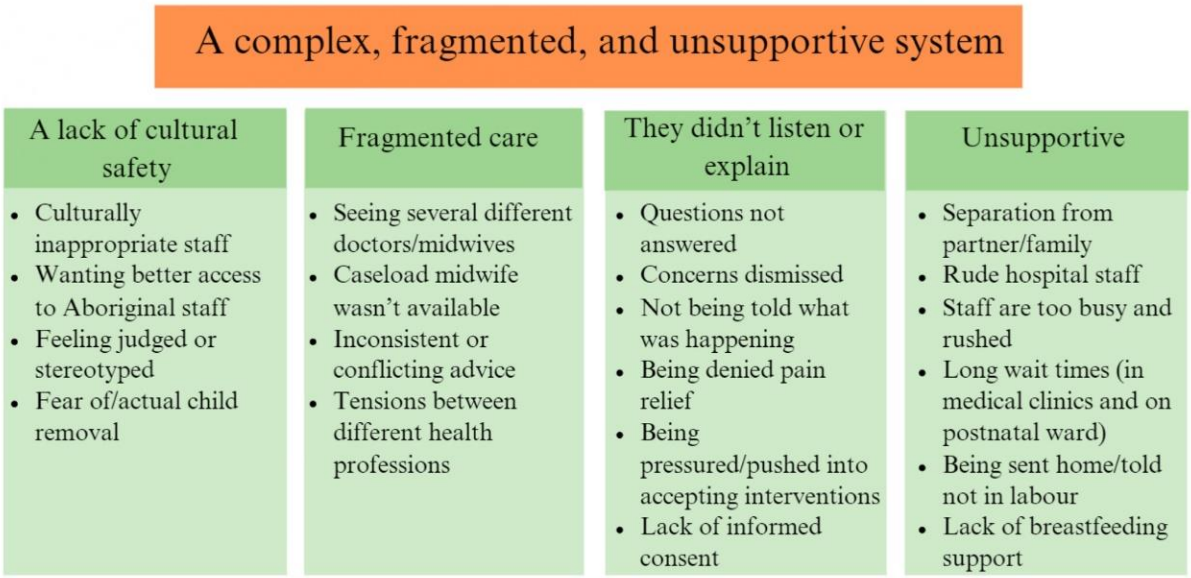


Fig. 2. Global, organising, and basic themes for what women did not like about their care:.

cultural support, as the learning never stops." ID 1023, multiparous, FNCL

Fragmented care

A factor associated with dissatisfaction was when there was a lack of continuity of care. This could be if a woman's caseload midwife was unavailable or if they saw many different midwives or medical staff. Women talked about a lack of consistent advice, which reduced confidence in the clinical care (Table 3).

"…in the later stages my midwife wasn't sort of available, and it went from 1, to 2, and then possible 4 people could have been delivering my baby. I was really annoyed, and anxious and upset, because then it was like, the purpose of the caseload was gone." ID 2007, multiparous, FNCL

"I didn't like that every time I saw a doctor it was someone different. It took up most of the time explaining yourself. Sometimes it felt like you waited 2–3 hours to see the doctor and then were rushed through your appointment and sent back out again." ID 1113, primiparous, Standard caseload (SC)

They didn't listen or didn't explain

Another key factor associated with dissatisfaction was staff not listening or explaining things. For women who received caseload midwifery, these experiences occurred mostly when interacting with health staff other than their caseload midwife/midwives. Sometimes concerns were dismissed, women didn't know what was happening, or didn't know why certain procedures were performed.

"…one of the biggest concerns was the doctors…I lost my previous baby to a placental abruption at 34 weeks…I had another placental abruption … So with my history it's really difficult when I feel like nobody listened to me and people were saying I was fine but I knew I wasn't…I think that everyone who has a complicated history needs a known midwife, like someone who knows your history." ID 1070, multiparous, FNCL

Women recounted situations where informed consent was not obtained. Some felt rushed or pressured into consenting to procedures.

"They were rough and pushy, tried to do an episiotomy without consent, they lacked the personal care side of stuff. They had the scissors and I was saying 'don't cut me, don't cut me, please please'…My partner had to intervene and say, 'don't cut her'." ID 3013, multiparous, FNCL

Women sometimes negatively commented on being told they were not in labour by staff. This sometimes meant being sent home or being denied pain relief. Other women recalled feeling pain during perineal suturing, but not feeling listened to.

"I kept asking for the epidural and they kept saying "no, you can do it"… She waited until I was 8 cm dilated and I was asking before then…I told them before the birth that if I asked for one, they should listen to me." ID 2081, primiparous, FNCL

Unsupportive

The theme 'unsupportive' included a range of factors mostly related to both the system and the behaviours of some staff. System issues included long wait times with women feeling 'left alone' and 'forgotten about'.

"When I went in with worries and complications at 16 weeks, I waited 6 hours all by myself. I thought I was losing the baby." ID 2080, primiparous, FNCL

"During fetal monitoring, after I had been there for 5 hours I was completely forgotten about. When I asked if I could go home I could hear the staff complaining about me. This happened twice." ID 1142, multiparous, FNCL

Women also talked about experiencing unsupportive behaviours from staff outside the caseload model. Words like 'rude', 'dismissive' or 'abrupt' were used. This was particularly the case in the postnatal ward. Some women commented that because it was not their first baby, midwives on the ward assumed they needed minimal support and subsequently did not make themselves available. Participants recalled a lack of support with breastfeeding, caring for their babies, and that the physical environment was not supportive for rest or sleep after the birth. Other women commented that being at home would have been preferable, since their partner wasn't allowed to stay and support in the

Table 3
What women did not like about their care – illustrative quotes.

A lack of cultural safety	*"I had a weird encounter with a receptionist. She asked whether I had trouble getting a certificate for my Aboriginality as my skin is pale. I don't think she meant this in a negative way but it showed her lack of knowledge and someone else may have been very offended."* 1104, primiparous, FNCL
	"My initial appointment with the hospital midwife I felt she was judgmental. There was judgment over us not having a plan. This woman made off hand comments about [my partner] being Aboriginal." ID 2002, primiparous, FNCL
	"So my first midwife got the social worker involved and the social worker actually ended up contacting DHS on me… apparently my history and my age is a worry for me having a child and I call bullshit on that…The DHS case got closed 2 weeks after her was born, that's how ridiculous it was… one appointment I had with the social worker was when she said 'don't stress, this isn't a cultural thing' and I was like, 'what do you mean by that?'" ID 3080, primiparous, FNCL
Fragmented care	*"…. There were strong differences in opinion between shifts. There was not a lot of continuity of care. At one point we were told off for doing something that the midwife in the previous shift had told us to do. Our baby was born small and some midwives told us we should be topping up with formula and others thought not."* ID 2052, multiparous, FNCL
	"When I was in the pushing stage there were two midwives in the room. There were two doctors outside wanting to come in and intervene. I felt the midwives thought everything was fine but that the doctors wanted things to happen faster. There was tension between them and I felt unsure as to how I should feel or what should happen." ID 1126, primiparous, GP Shared care
	"The induction. I just wish there was more awareness of what was going on. It felt like there was a bit of miscommunication. I'd talked about the induction with my midwives in the lead up. Why we might do this or that. I found when it came to that, the doctors were very much like 'this is the way it's going to be, what you've discussed is not an option'. It felt like a big disconnect between what the midwives thought were ok, and the doctors." ID 3090, multiparous, FNCL
They didn't listen or didn't explain	*"…no one explained what happened during surgery, which is really bad care, you should be telling people during their stay and it shouldn't be up to me to chase it up. If you're touching someone's human body and providing care they should give you a summary of what they did to you."* 2083, multiparous, FNCL
	"I felt semi-coerced into agreeing to treatment that I wasn't provided enough information with.They wanted me to sign off on it then and there. I felt as though I didn't know enough about it but they said 'sign now' and I could 'decline later'. I was losing sleep over it. When I walked out I heard her say to her colleague 'oh, that's all done' like it was ticked off. That was the disrespectful part for me." ID 3059, multiparous, Standard maternity care
Unsupportive	*"Sometimes I would wait for 4 hours and then have to leave to pick up my daughter. Also, the inconsistency of people. I'd see a different doctor every time and I'd have to re-explain everything all over again and then I wouldn't have time to discuss what happened between appointments. They were so rushed."* ID 3081, multiparous, FNCL
	"One of the midwives was abrupt and dismissive to my support team immediately after the birth. This made me feel disrespected, and unsafe. My main midwife knew what I wanted and my preferences, then this midwife who didn't know me, was potentially judgmental and belittled the atmosphere in the room. She was very clinical." ID 1023, multiparous, FNCL
	"…some [midwives] were very rude and rushed and it's like they had other things to be doing…like you can't just throw a breast pump and tell me to keep feeding her…I had one midwife stay with me for half an hour to calm me down because the midwife before just didn't care…just told me she was too busy, that was the response I got." ID 3044, multiparous, FNCL

hospital was lacking:

> *"[My baby] wouldn't stop crying and she wouldn't settle and nobody would help me…and I begged the midwife to take her for like ten minutes so I could sleep and they were just like 'oh I'll just come back after my rounds' or 'I'll be there in a minute' but never came back… so I slept with her in the bed and then someone would come in and be like 'oh you can't do that'. So I just cried for most of the night…just no one would help me. I knew if I went home there would be help for me there, like my partner would be there…I was just so tempted to walk out and go home."* ID 2022, multiparous, FNCL

Discussion

We have analysed women's open-ended responses to questions about satisfaction with care in three hospitals where First Nations specific continuity of midwife care models were implemented in Naarm, Victoria. Elevating the voices of First Nations women to move forward and improve birthing services is best practice [35] and is required for the Australian government to enact national maternity service policy. [3] Applying a CRT approach to this research [36] suggests the broader issue to be addressed is that the maternity system needs to enhance its capacity to meet the needs of First Nations women, as a redress of the negative impacts on health outcomes that stem from colonisation. [37] The strong message from women in this study is that the opportunity for a trusting relationship with a known midwife through a culturally tailored continuity of care model facilitated feelings of safety, connectedness, and support. Overall, for women who had previously birthed in the system without a caseload midwife, the newly implemented model was a much more positive and satisfying experience.

The findings of this study echo the voices of First Nations women in other areas of Australia who also received care though a caseload model. A study conducted in the Northern Territory of Australia reported that First Nations women placed strong emphasis on the benefits of having 'their' midwife, who knew their story. [38] Additionally, women who accessed an urban-based program for First Nations women in Sydney reported feeling supported, relaxed, trusting of their midwives, and more than 'just a number'. [13] Other evidence not focused on First Nations women also shows that women are more satisfied with caseload midwifery, [39] and like this study, women feel safe, trusting, and supported by their caseload midwives. [40] Analysis of these qualitative data provides a deeper understanding of the quantitative data obtained in this study, further explaining the high satisfaction rates. Many comments from women suggested that a respectful relationship with a midwife that was based on trust allowed for genuine shared decision making. This is in line with 'woman-centred care', the principle which underpins midwifery practice in Australia. [41] Respectful relationships and genuine shared decision making help to dismantle the power imbalance that traditionally favours health professionals, and care is more likely to be experienced as culturally safe. [34].

Despite women reporting very positive experiences, it was evident that the broader maternity system remained a challenging space for some women. Outside the caseload model there were many instances where women described not feeling listened to, having concerns dismissed, or experiences of racism. These issues have also been reported by other First Nations women in a qualitative study conducted on Noongar Boodjar (Perth, Western Australia). [24] It has been previously identified that if First Nations women face negative experiences in the maternity care system, it is usually in the context where women have no continuity of care, and no access to culturally tailored programs. [12] In this study, most of the negative experiences reported by women related to service provision that occurred peripherally to, or outside the caseload model. Structural or systemic issues remained, such as care that was at times fragmented and unsupportive, and cultural safety within the broader health service was not guaranteed. Issues raised by some women that were directly related to the culturally tailored midwifery

models were if their primary midwife changed during pregnancy or wasn't available as expected, and some mentioned that they would have liked access to more First Nations staff. Government data shows a shortage of First Nations midwives in Australia, [42] and implementing strategies to increase the First Nations maternity workforce is recommended. [3].

The findings of this study, along with the other evidence of benefit of culturally tailored midwife continuity models suggest that the model should be implemented more widely. To assist with this process, an evidence-based framework, known as the 'RISE framework', has been developed to guide implementation of 'Birthing on Country' services, which include midwife continuity models, across various settings. [43] Rooted in a social justice approach by returning birthing services to First Nations communities, [44] 'Birthing on Country' is a metaphor for giving First Nations women and newborns the 'best possible start in life'. [45] Now recommended in national health policy, [3,4] Birthing on Country services are described as community driven maternity services designed to wrap around First Nations women, providing individualised, holistic care. [46] Identified in the RISE framework are four key pillars required for the implementation and continuation of Birthing on Country services; maternity service redesign, workforce investment, strengthening of First Nations families, and embedding First Nation community control. [43] Models underpinned by these principles help to close the gap in perinatal outcomes. One Birthing on Country service in Queensland reported a reduction in pre-term births, increased antenatal care attendance and increased breastfeeding rates. [46] Therefore, it is recommended evidence-based frameworks, such as the RISE framework, are adopted by maternity services to direct the implementation, upscaling and expanding of First Nations caseload midwifery models.

Strengths and limitations

To our knowledge, this qualitative study that includes the views and experiences of 213 women having a First Nations baby is the largest of its kind. However, it should be noted that there was a 38% loss to follow up, therefore the views of may not be representative of all women recruited to the original cohort. As First Nations women should have substantial involvement in the evaluation of First Nations birthing programs, [35] another strength of this study is the lead author has drawn on both her lived experience and her knowledge of cultural issues as an Aboriginal woman. This is important because First Nations people should be where possible, leading research about First Nations communities. [47] Additionally, the co-designed approach with the project AAC means that every effort was made to ensure that the research process contributes to achieving the aspirations of the First Nations community, and to dismantle any power imbalances between the researchers and the 'researched'. [48] Our findings echo those of studies involving First Nations women from other areas of the continent, increasing the generalisability of the findings. Efforts were made to minimise the risk of recall bias, and the surveys were completed between three and six months postpartum. [49,50].

Conclusion

In response to the disproportionate burden of inequitable perinatal outcomes for First Nations women and newborns, maternity services need to work towards implementing evidence-based, community-led models of care. [3] Three tertiary maternity services in Naarm, Victoria, implemented culturally tailored First Nations continuity of midwife care models, as a partnership project between the state peak body of Aboriginal health in Victoria (VACCHO), and La Trobe University. [6] Women reported feeling 'safe, connected and supported in a complex system'. Given our findings along with the evidence of benefit of culturally tailored care for women having a First Nations baby, the Baggarrook Yurrongi model (or Birthing on Country models) should be implemented and offered to more First Nations women. Evidence-based frameworks such as RISE [43] should be used to facilitate change.

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Author Contributions

P.McCalman – conceptualisation, methodology, formal analysis, investigation, data curation, writing - original draft, visualisation. F. McLardie-Hore – investigation, writing - review and editing, project coordination. M. Newton – conceptualisation, writing - review and editing, writing, supervision. D. Forster – conceptualisation, methodology, writing - review and editing, supervision, data curation, funding acquisition. H. McLachlan – conceptualisation, methodology, formal analysis, writing - review and editing, supervision, funding acquisition.

Conflict of interest

None declared.

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Project artwork

We would like to acknowledge and give thanks to Shawana Andrews for creating the project's artwork. The concept of the artwork featured in this paper (Birthing Tree 2) was based on the Shawana's original artwork for the project, named 'Birthing Tree'. The original artwork and Birthing Tree story is provided below.



'Birthing Tree' by Shawana Andrews. "This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come."

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Chapter 10: Yarning with women: In depth semi-structured interviews

Chapter ten presents the fourth and final publication included in this PhD thesis. The completion of this paper was a significant milestone and added an important dimension to the research. I felt very strongly that in order to fully engage with an exploration of women's views and experiences about their care, it was very important to sit with women, one-on-one and face-to-face.

The purpose of this paper was to deeply explore the views and experiences of First Nations women who gave birth at the health services where the new models had been implemented. From the 213 women who completed the follow up questionnaire, a smaller sample of women were also invited to participate in a face-to-face qualitative interview (see Chapter 5, section 5.2.4). Using an overall framework underpinned by Critical Race Theory and indigenous methodologies, a descriptive qualitative design integrated with 'Yarning' was used.

Ten women participated in an interview and overall reported having very positive experiences of the culturally tailored caseload midwifery models. 'Relationships' (continuity and accessibility of their known midwife), 'trust' (with their midwife and the program) and 'culture' (acknowledging identity and a safe space) were key contributors to the positive experiences. Participants reported ongoing challenges within the broader maternity system, particularly if trust, relationships, or cultural safety were lacking. Women also reported that support and care from First Nations staff was important.

The women in this study endorsed the implementation of culturally tailored continuity of midwife models of care. This paper concludes that 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.

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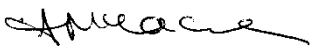
Contribution to the paper:

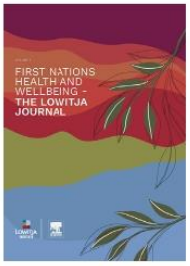
I declare that I have made a substantial contribution to this paper, of which I am the lead author. This includes leading the conceptualisation of the paper and contributing to the design of data collection tool. I conducted all of the data collection and managed the data by transcribing the recordings. Helen McLachlan and I conducted data analysis together. I then drafted the paper. The co-authors contributed to supervision of the data cleaning, data analysis, and editing of the manuscript.



P.McCalman

I declare that Res McCalman made a substantial contribution to this paper. She contributed to many different aspects of the Baggarrook Yurrongi project, model implementation at the study sites, and edited and reviewed the paper.





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

Pamela (Res) McCalman (Noongar)[a,b,*], *Della Forster*[a,c], *Michelle Newton*[a,b], *Fiona McLardie-Hore*[a,c], *Helen McLachlan*[a,b]

[a]Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria, 3086 Australia
[b]School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria, 3052 Australia
[c]The Royal Women’s Hospital, Parkville, Victoria, 3052 Australia

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.

*Corresponding author.
E-mail address: P.McCalman@latrobe.edu.au (P. McCalman).

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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 Victora.

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:

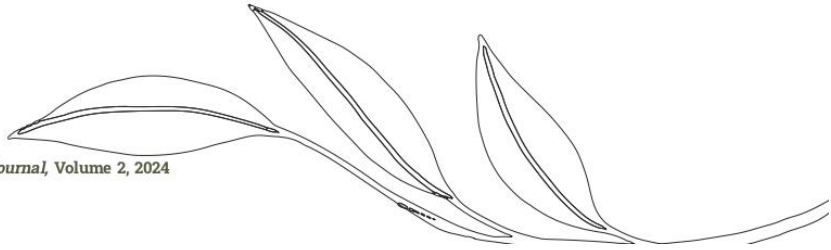
...they were just 'ticking the box'... reading from a script... in some cases I just felt like it was really, really rushed, like, because they've got lots of people to see... I maybe probably didn't feel comfortable asking questions, or, you know, raising issues... when you've got that kind of one-on-one 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).

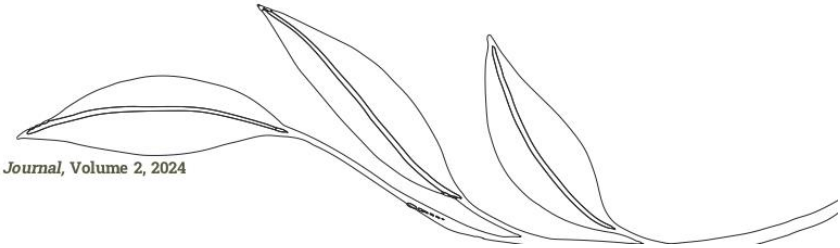
Overall, most women agreed that having a known, trusted midwife, who respected their individual needs had a very positive effect on their birth experience. Ruby explained that she had previously experienced trauma, but described her birth as 'healing':

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':



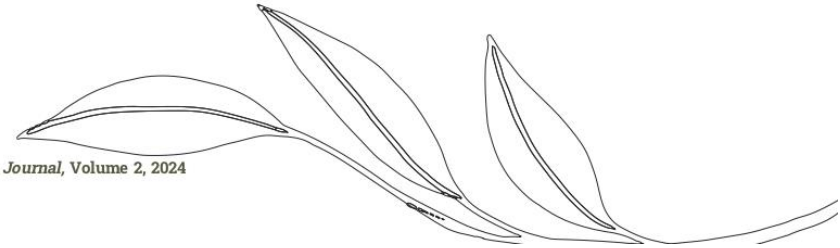
I was really quite lucky actually because I believe she's the only Aboriginal midwife... so just having her there, I just felt like really safe. And I just felt like this connection to her, because, you know, she's Aboriginal as well... her and I were sharing stories. Our stories. And you know, we just 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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Chapter 11: Discussion and conclusion

Aboriginal and Torres Strait Islander ways of knowing, being and doing in relation to pregnancy, birth and early parenting sustained healthy communities for millennia, but have been interrupted since European colonisation (Adams, Faulkhead et al., 2018; Carter, Hussen et al., 1987; Chamberlain and Marriott, 2019; Ramsamy, 2021). Inequitable perinatal outcomes experienced by Aboriginal and Torres Strait Islander women stem from colonisation and are perpetrated by a lack of culturally safe care within the mainstream maternity system, which has been designed with a Western view of health (Carter, Hussen et al., 1987; Hickey, Kildea et al., 2019). As a redress, it is recommended that evidence-based, culturally appropriate co-designed maternity programs are implemented in partnership with Aboriginal and Torres Strait Islander communities (AHRC, 2020; COAG Health Council, 2019; Department of Health and Human Services, 2017; Queensland Health, 2019).

The Baggarrook Yurrongi project was an NHMRC funded partnership project between La Trobe University, VACCHO, and four Victorian maternity services who worked together to implement culturally tailored continuity of midwifery models of care for women having an Aboriginal and Torres Strait Islander baby. This thesis has addressed an important and key secondary aim of the Baggarrook Yurrongi project, which was to explore the views and experiences of Aboriginal and Torres Strait Islander women receiving maternity care at the Baggarrook Yurrongi partner sites. In this final chapter, the findings are brought together, considered, and compared with existing literature, and recommendations made.

Restatement of thesis aims

The key aim of this thesis was to explore the views and experiences of Aboriginal and Torres Strait Islander women receiving maternity care at the Baggarrook Yurrongi partner sites, in the context of new culturally tailored continuity of midwife care models which had been implemented within three of these urban, tertiary maternity hospitals in Naarm:

The research questions were:

- What are the views and experiences of Aboriginal or Torres Strait Islander women having a baby (or women having an Aboriginal or Torres Strait Islander baby) at one of three maternity services in Naarm, Victoria?
- What are the experiences of Aboriginal women in Naarm, Victoria, who received continuity of midwife care through a culturally tailored continuity of midwife care model?

This thesis included the following publications:

- The primary outcome paper of the Baggarrook Yurrongi project, which was a prospective, non-randomised, research translational study design demonstrating that culturally tailored caseload models were successfully embedded and implemented at the three urban maternity services in Naarm (presented in Chapter six).
- An exploration of women's views and experiences using a cross-sectional survey design at two time points, at recruitment (presented in Chapter seven) and then between three-six months postpartum (presented in Chapters eight and nine).
- A qualitative exploration of Aboriginal women's experiences of receiving care in the culturally tailored model using semi-structured interviews and 'Yarning' (presented in Chapter ten).

11.1 Discussion

This thesis addresses a gap in evidence in relation to the views and experiences of Aboriginal and Torres Strait Islander women having a baby (or women having an Aboriginal or Torres Strait Islander baby) in Victorian mainstream maternity services, and where culturally tailored caseload midwifery models had recently been implemented. Prior to the Baggarrook Yurrongi project, access to continuity of midwife care models for Aboriginal and Torres Strait Islander women had been very low, and as such, the findings of this thesis are situated within a context of a major organisational shift in the way many First Nations women located in Naarm were being cared for across pregnancy, labour, and birth, and in the early postnatal period (McLachlan, Newton et al., 2022).

The thesis has provided important information about the context of women's lives and what is important to them, in terms of how maternity care is designed and delivered

(McCalman, McLardie-Hore et al., 2022). Of the large sample of women who participated in a cross-sectional survey completed by 343 women, there was substantial cultural diversity, with women belonging to at least 76 different language or custodial groups from across the continent (McCalman, McLardie-Hore et al., 2022). Other studies involving large cohorts of Aboriginal and/or Torres Strait Islander women describe culturally diverse samples, however, they do not report on the specifics regarding which language or custodial groups were represented (Brown, Weetra et al., 2015; Parker, McKinnon et al., 2014). Life stressors such as grief, loss and illness were common experiences for women around the time of having a baby, both in Naarm (McCalman, McLardie-Hore et al., 2022) and this is also evident for First Nations women in other areas of Australia (Brown, Gartland et al., 2019; Parker, McKinnon et al., 2014).

The follow up questionnaire, which included 213 women and used a cross-sectional survey design (data collected between three to six months postpartum) found that overall, women reported high levels of satisfaction of their care and had positive experiences (McCalman, Forster et al., 2023). Most women had received care through the recently implemented culturally tailored models, and overall women rated their pregnancy, labour and birth and in-home postnatal care highly. Overall, there was a pattern of lower levels of satisfaction in the non-caseload midwifery group (McCalman, Forster et al., 2023). A randomised-controlled-trial not focusing on First Nations women was previously conducted in Naarm and compared perinatal outcomes between women who received caseload midwifery and women who received standard care (McLachlan, Forster et al., 2012). This trial also found lower levels of satisfaction with care in the non-caseload cohort (Forster, McLachlan et al., 2016) and more positive birth experiences in the caseload cohort (McLachlan, Forster et al., 2016).

In this thesis, analysis of free-text, open-ended responses has illuminated the findings of the quantitative papers by providing a deeper exploration of the factors associated with high satisfaction of care, being that women felt safe, connected, and supported (McCalman, Forster et al., 2024a). A previous Australian study has also analysed free-text survey responses regarding women's experiences of caseload midwifery (Allen, Kildea et al., 2017). The authors reported similar findings, though the study did not focus on Aboriginal and Torres Strait Islander women (Allen, Kildea et al., 2017). The evidence of women feeling supported, relaxed and trusting of their midwives in this thesis does echo the voices of other First Nations women, who participated in a previous study that

used focus groups to evaluate an urban-based midwife continuity program in Sydney (Gadigal land) (Homer, Foureur et al., 2012).

Factors that reduced satisfaction of care were also explored. The aim was to also provide women with a safe space to criticise their care, and they told us that the wider maternity system remains complex, fragmented, and unsupportive (McCalman, Forster et al., 2024a). This is not surprising, given that the literature review undertaken for this thesis revealed that the maternity system, overall, is often a challenging space for Indigenous women (see Chapter three). Evidence of positive maternity care experiences was less robust (see section 3.3.2). When reviewing the Australian literature, evidence of negative experiences with mainstream, standard hospital care appeared to feature more strongly than evidence of positive experiences (see section 3.3.2). Detail of the areas to be strengthened, as per the feedback provided by women in this thesis, is provided in section 11.1.2.

11.1.1 Enabling factors of success

Each woman I yarned with during the semi-structured interviews either wanted the culturally tailored midwife continuity models to continue, wanted other women in their community to receive the model, or wanted access to the model for their next pregnancy (McCalman, Forster et al., 2024b). The program was viewed as a positive and important service for the community. The success factors identified in this thesis echo previous studies exploring the maternity care experiences of Aboriginal and/or Torres Strait Islander women who received continuity of midwifery care (Campbell and Brown, 2004; Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Josif, Barclay et al., 2014). Specifically, 'relationships', 'trust' and 'culture' have been identified as factors being key to positive experiences and important for culturally safe care (Homer, Foureur et al., 2012; Josif, Barclay et al., 2014; Kelly, West et al., 2014).

'Trust' was almost unanimously rated as important to the larger group of 343 women (McCalman, McLardie-Hore et al., 2022), and the clear need for Aboriginal and Torres Strait Islander women to feel trusting of health providers is supported in other evidence (Corcoran, Catling et al., 2017; Homer, Foureur et al., 2012; Jan, Conaty et al., 2004; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Massi, Hickey et al., 2023). This thesis demonstrates that having the opportunity to build a relationship with a midwife (and often the backup midwives) was a key factor in how

trusting women felt (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b). The literature stresses the need for increased access to relationship-based care with a midwife for Indigenous women, as access to continuity of midwifery care for Indigenous women is often lacking (Bowden, Toombs et al., 2023; Brown, Varcoe et al., 2011; Buchner, Pearson et al., 2022; Corcoran, Catling et al., 2017; Hanson, 2012; Marriott, Reibel et al., 2019b; Marriott, Strobel et al., 2019; Sivertsen, Anikeeva et al., 2020).

The studies where Indigenous women have been able to access continuity of midwife care and carer highlight that opportunities for women to know their midwife increases trust in both their midwife and their care (Churchill, Smylie et al., 2020; Hartz, Blain et al., 2019; Josif, Barclay et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019). Additionally, the positive impact on women's experiences if the primary midwife is on-call and present during the labour and birth (rather than programs offering antenatal and postnatal continuity only) has been identified in the literature previously (Churchill, Smylie et al., 2020; Homer, Foureur et al., 2012; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019). The findings in this thesis further support that continuity of carer during labour and birth does matter to many women (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b). Other findings in this thesis included that that some women still trusted their 'back up' midwife, due to a perception that all of the midwives working in the culturally tailored models maintained a shared philosophy and approach to midwifery care, while other women wondered whether the absence of their primary midwife impacted negatively on their birth experience (McCalman, Forster et al., 2024b).

As the mainstream maternity system has been implicated in the Stolen Generations and the intergenerational trauma that followed, women also discussed that building trust in the system is a delicate process and takes time. Culturally unsafe practices (Marriott, Reibel et al., 2019b; Marriott, Strobel et al., 2019), racism (Brown, Gartland et al., 2019), and high rates of infant removals (Chamberlain, Gray et al., 2022) persist, so accounts from women of the trust that was built is a significant finding. The women explained that seeing hospital staff during pregnancy sometimes means 'watching their Ps and Qs' (p. 197) or feeling that if they used slang or swear words, a 'red flag' might be put against their name (McCalman, Forster et al., 2024b). Other studies have also touched on this issue (Brown, Weetra et al., 2015; Buchner, Pearson et al., 2022; Spangaro, Herring et al.,

2016). It is known in community that when interacting with the maternity system, Aboriginal women might feel the need to 'code-switch'[10] for fear of being judged by non-Indigenous health care professionals as unfit to parent. This stems from colonial legacy, deficit discourse, and assumptions of European values about parenting as superior (Hine, Krakouer et al., 2022). An interesting finding in this thesis was the level of detail provided by some women about a trusting relationship with a midwife providing a sense of safety in being themselves and expressing honesty about their lives and their health (McCalman, Forster et al., 2024b). They explained that they did not need to change who they were to be treated well, which for some women was a contrast to their previous maternity care experiences (McCalman, Forster et al., 2024b).

Alongside this, Aboriginal community connection, input, and involvement was also raised by many women (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b), aligning with the views of First Nations women from previous studies (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Kelly, West et al., 2014; Kildea, Stapleton et al., 2012; Magick Dennis and Keedle, 2019; Marriott, Reibel et al., 2019). This thesis identified that women birthing in Naarm are not a culturally homogenous group (McCalman, McLardie-Hore et al., 2022), so it not surprising that women had varying degrees of connection to culture and community, and a range of views about how culture needed to fit into their care (McCalman, McLardie-Hore et al., 2022; McCalman, Forster et al., 2024b). Yet the importance of incorporating culture in care through having opportunities to learn from Elders, connect with community, have unrestricted access to family, having female carers, and displays of culturally appropriate flags and artwork were highlighted (McCalman, McLardie-Hore et al., 2022). Aboriginal staff from the Aboriginal Health Units provided support alongside the midwifery care, which was crucial in providing a space that felt culturally appropriate (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b). Brown, Fereday, and colleagues (2016) noted the importance of midwives recognising Aboriginal and Torres Strait Islander women's culture. It was pointed out in this thesis that even for women who do not actively practice culture, recognition of identity and non-judgemental discourse about cultural needs can feel culturally safe (McCalman, Forster et al., 2024b).

[10] '*Code-switching'* is when a person alters their speech to conform to different cultural norms.

Much of the literature supports community-based maternity care for Indigenous women (Churchill, Smylie et al., 2020; Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Kildea, Gao et al., 2021; Kildea, Lockey et al., 2016; Van Wagner, Epoo et al., 2007; Van Wagner, Osepchook et al., 2012), though one study suggests some pregnant women may choose to attend a mainstream service rather than an ACCHO, due to a perception of greater privacy (Reibel, Morrison et al., 2015). This thesis found mixed responses from women about the importance of having most of their care through an ACCHO (McCalman, McLardie-Hore et al., 2022), but a for a sizeable percentage of women (around 40%) this was important. Therefore, there should be an option for a shared care arrangement, meaning that women are able to choose between all hospital-based culturally tailored midwifery care, or to have this care in a shared care arrangement with midwives, general practitioners and other health workers at a local ACCHO.

11.1.2 Areas to be strengthened

Areas to be strengthened were identified in this thesis, including feedback relating to the model directly (such as if the midwife was not available, or if there was no Aboriginal midwife) or relating to experiences and interactions with hospital staff that were external to the culturally tailored model itself (where cultural safety lacked, there was poor communication, or care felt unsupportive).

In terms of the culturally tailored model itself, some women raised that an area to be strengthened was if the primary midwife was not available as expected (for example, if the primary midwife was difficult to contact, was on leave around the birth, or had ceased working in the model). Due to occupational health and safety requirements (meaning that midwives can only work for a limited time within a 24-hour period) and the unpredictable nature of pregnancy and birth, it is difficult to guarantee that women will have access to their primary midwife one hundred percent of the time. A previous study, which developed an urban maternity service for First Nations women in Queensland, did however recommend reducing midwives' caseload sizes from 35 women per year down to 25 (two to three women birthing per month) (Kildea, Hickey et al., 2017). Adequate leave planning and realistic caseload sizes have also been recommended as part of the overarching Baggarrook Yurrongi project (McLardie-Hore, McLachlan et al., 2023), which would address the issues raised by some of the women, and would also support the sustainability and effectiveness of the models.

Other feedback from women which was specifically directed at the culturally tailored model related to the availability of Aboriginal midwives. Most of the women were not cared for by an Aboriginal midwife, and when the models first commenced, the health services did not proactively seek out Aboriginal midwives to work in the model (which for me as an observer was an uncomfortable experience). Like Aboriginal and Torres Strait Islander women from other areas of Australia (Homer, Foureur et al., 2012; Kelly, West et al., 2014; Marriott, Reibel et al., 2019b), the women identified in this thesis the importance of seeing Aboriginal people working in the maternity programs that are designed for them. This is also recommended in maternity service policy (COAG Health Council, 2019; Queensland Health, 2019) and previous research (Kildea, Hickey et al., 2019). Having Aboriginal midwives as best practice was evident in some of the women's feedback (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b; McCalman, McLardie-Hore et al., 2022;). One participant explained that she felt an added sense of familiarity, connection, and safety in her relationship with her midwife, who was also an Aboriginal woman (McCalman, Forster et al., 2024b). Non-indigenous midwives who had received appropriate cultural training, and who were culturally sensitive, were seen as the next best thing (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b). A sizable percentage of women in this thesis however did not rate having access to Aboriginal and Torres Strait Islander staff as important (McCalman, McLardie-Hore et al., 2022) and a study by Homer et al (2012) reported that not all women viewed having an Aborignal midwife as necessary. As the models have progressed, this issue has been given more priority. Currently across the models at the three services there are four Aboriginal midwives providing care to women.

Aside from these two issues, the majority of negative feedback related to experiences and interactions with hospital staff that were external to the culturally tailored model itself. Much like previous evidence highlighting the challenges of seeing unfamiliar health professionals (Corcoran, Catling et al., 2017; Marriott, Strobel et al., 2019), women often experienced difficulties if they did not have a relationship with other care providers. The most common example given was seeing many different doctors in antenatal clinic or being cared for by many different midwives on the postnatal ward (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b). This could explain the trends of lower ratings of satisfaction with medical care received in antenatal clinics, and the lower ratings of satisfaction on the postnatal ward (McCalman, Forster et al., 2023). Care after

birth in Victoria could be an ongoing area of concern, as both Aboriginal women (Campbell and Brown, 2004) and women from the general Victorian population (Forster, McLachlan et al., 2016; Forster, McLachlan et al., 2006) have also reported lower ratings of satisfaction on the postnatal ward. Feelings of confusion or uncertainty arose for women if opinions or advice from their caseload midwife differed from whichever doctor or midwife they were interacting with when their caseload midwife was not present (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b).

Evidence in this thesis reveals women encountered rude hospital staff, poor communication, questions not being answered, concerns being dismissed, not being told what was happening, feeling judged or stereotyped, and feeling rushed, with long wait times particularly in medical clinics or on the postnatal ward (McCalman, Forster et al., 2024a). These issues have been raised by Aboriginal women previously (Josif, Barclay et al., 2014; Marriott, Reibel et al., 2021; Marriott, Reibel et al., 2019b), and the likelihood of negative experiences are increased outside of continuity of carer models (Corcoran, Catling et al., 2017). The international literature also reflects how challenging the maternity system is for Indigenous women in other countries such as Aotearoa (New Zealand), Canada, and the United States, particularly if opportunities for women to develop trusting relationships with carers are lacking (Brown, Varcoe et al., 2011; Burns, Whitty-Rogers et al., 2019; Hanson, 2012; Lawford, Giles et al., 2018; Makowharemahihi, Lawton et al., 2014; Varcoe, Brown et al., 2013).

Concerningly, specific examples associated with experiences of 'obstetric violence' (Keedle, Keedle et al., 2022) were disclosed by women during the research process, such as *'feeling like just a number'*, *'pain not being recognised'*, *'begging the doctor not to cut me'*, *'feeling coerced'*, feeling *'uninformed'* (McCalman, Forster et al., 2024). The findings of this thesis suggest that the midwives and AHLOs working in the culturally tailored models were providing support and continuity of care that was more likely to be experienced by women as culturally safe, while the wider system remained potentially unsafe (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b).

11.1.3 Linking the findings to Critical Race Theory and Indigenous women's standpoint

Chapter two discussed in detail the historical dispossession of connection to land, language, family, community and culture, which then led to the systematic dismantling of

indigenous birthing knowledge and cultural birthing care for Aboriginal and Torres Strait Islander women. Applying Critical Race Theory as a conceptual framework to this thesis assumes that the issues of power and identity struggles which have historically characterised the relationship between Indigenous women and Western bio-medical maternity systems remain. Critical Race Theory, in the context of this thesis, can be concerned with shifting the power back to Aboriginal and Torres Strait Islander women and highlighting racism, rather than race, as a contributing factor to inequitable perinatal outcomes.

Applying a Critical Race Theory approach to this research highlights that the current maternity system was designed and is delivered with a dominant, bio-medical approach to pregnancy and birth that stems from a Western approach to health and wellbeing. A Critical Race Theory lens suggests that the broader issue to be addressed is that the maternity system must enhance its capacity to meet the needs of First Nations women, and to address the power differentials embedded within the system which perpetuate perinatal inequities and negative experience of care. It appears access to culturally tailored continuity of midwife care models, and the relationships built between women, the midwives, and the AHLOs, facilitate the shifting of power back to the birthing women by facilitating genuine woman-midwife partnerships (Miller and Bear, 2019) and cultural safety (Ramsden, 2002). Evident still are power and identity struggles experienced by women in their interactions with the wider system.

Critical Race Theory also rejects that the researcher should take an objective, neutral approach to the research (Crenshaw, 1989; Delgado and Stefancic, 1998). My standpoint positioning has been declared as Indigenous woman's standpoint theory (Moreton-Robinson, 2013), which reenforces the need to address unique issues of historical of dispossession, the importance of connection to land, and the inherent sovereignty of Indigenous women. This standpoint emphasises research as activism and a political commitment to challenging dominant Western discourse about First Nations women (Moreton-Robinson, 2013). The recommendations in this thesis are rooted in these values.

11.1.4 Thesis limitations

When interpreting the findings of this thesis, there are some limitations to consider. Nine-hundred and twenty-six women who received care during the Baggarrook Yurrongi

project period were identified as eligible to participate in this study. Although over half of these women were able to be approached (479/926, 51.7%), and of those women, 343 (73%) consented to participate, the views of the 447 women who were not approached or did not consent to participate are not reflected in the findings. It should also be noted that with 213 women completing the follow up questionnaire, there was a 38% loss to follow up. Therefore, findings from the postnatal follow up questionnaire may not be representative of all women who were initially recruited. Presented and discussed in Chapter eight, however, is a comparison of participant characteristics between the cohort of women who completed the initial questionnaire and the cohort of women who completed the follow up questionnaire, and the minor differences in demographic characteristics between the two samples were stated (see Chapter eight). Another aspect to consider is that one of the partner sites (the regional maternity service) was not able to implement the model, and based on advice from the Baggarrook Yurrongi project AAC, the research team decided that it was not appropriate to seek to conduct an evaluation of care at the regional site at that time. As such, only the views of women who were booked for maternity care at one of the three urban partner sites had the opportunity to be included.

During the Baggarrook Yurrongi co-design process, members of the Aboriginal community advised that a randomised-controlled-trial was not the preferred option, which was also the view of the broader research team, and offering the new caseload midwifery models to as many eligible woman as possible was preferable. As such, there were low numbers of women who did not receive a caseload midwifery model, which is reflected in the cohort of women who participated in the evaluation of care. Findings in this thesis do support that women preferred the new culturally tailored caseload models to other models of care. For example, for many women who were not having a first baby, they did not have access to a culturally tailored caseload midwifery model with their previous births, and reported that their experience this time was improved. The quantitative findings suggested overall, trends of lower levels of satisfaction in the non-caseload midwifery group. However, as the design of this thesis is not a randomised-controlled-trial, it is not possible to conclude cause and effect.

The use of Critical Race Theory and Indigenist research requires analysis of power relationships (Crenshaw, Gotanda et al., 1995; Parker and Lynn, 2002; Rigney, 1999; West, Stewart et al., 2012). For the recruitment questionnaire, data were most often collected by research midwives in the clinical setting while women were receiving care.

Potential power imbalances at this point in the research process may have impacted on women's willingness to respond truthfully. One possible way of addressing this in future research could be to complete the questionnaire with women via telephone when they are not physically in the clinical setting. However, we cannot know if this was an issue that impacted on the findings, and it is difficult to know if a change in our process would have made any difference. A final consideration is that Critical Race Theory and Indigenist research does aim to be emancipatory (Rigney, 1999), however, I maintain the awareness that this thesis will not liberate all Aboriginal or Torres Strait Islander women from having a culturally unsafe or negative experiences within the maternity system. It can, however, elevate the positive and negative experiences of many women, in order to inform what should be sustained or expanded, and where change within the system could be afforded.

11.1.5 Thesis strengths

With these potential limitations to the findings, there are also many strengths. The inclusion of 343 women makes this the largest study to explore Aboriginal and Torres Strait Islander women's views in an urban Victorian context. A sample size of 213 in the postnatal follow up cohort also makes for the largest study that explores the views and experiences of women having an Aboriginal or Torres Strait Islander baby of their pregnancy, labour and birth, and postnatal care in Australia to date. Adding to the uniqueness of this thesis is that the majority of the women received a culturally tailored model of caseload midwifery. By using a cross-sectional survey design via questionnaires with a large sample of 213 women, as well as qualitative interviews with a smaller sample of women, I have undertaken a process of triangulation (Creswell and Miller, 2000; Gbrich, 2010; Liamputtong, 2016; Thierbach, 2020). The validity and credibility of the qualitative results, which demonstrated high ratings of satisfaction with care (Chapter 8), have been strengthened by the positive experiences identified in the qualitative analysis of free-text questionnaire responses (Chapter 9) and the qualitative semi-structured interviews (Chapter 10) (Schofield and Forrester-Knauss, 2017). The results of each component support and complement each other, which in turn increases trustworthiness of the qualitative findings (Liamputtong, 2016). Section 5.1.3 discussed that using a mixed-methods approach has provided both a broad and deep exploration of the research questions, which I believe have been answered appropriately.

The co-design approach to this thesis, including input from the Baggarrook Yurrongi project AAC, improves the likelihood that these findings will benefit the Aboriginal community in future, as the findings can be used to facilitate well-informed program planning, design, and implementation (AHRC, 2020). Decisions made about this thesis have been based on the recognition that making the most meaningful contribution to the body of evidence about maternity care experiences for Aboriginal and Torres Strait Islander women requires indigenous methodologies and research capacity building for Aboriginal and Torres Strait Islander people (Marriott, Strobel et al., 2019; Simpson, Wepa et al., 2020). I have also made my positionality clear. As an Aboriginal woman, who has used the lens of Critical Race Theory and an Indigenous woman's standpoint, my priority has been to truly centre the views of the women.

Elevating the voices of First Nations women to move forward and improve birthing services is best practice (AHRC, 2020) and is required for the Australian Government to successfully implement maternity service policy (COAG Health Council, 2019). Embedding the priorities of Aboriginal and Torres Strait Islander women into policies and procedures at an organisational level is essential for creating maternity services that could feel culturally secure (Marriott, Strobel et al., 2019). For the findings of this thesis to have a positive impact and benefit on the community, there is an ongoing need to disseminate these findings back to the community, the ACCHO sector, and to the partner hospitals. The findings of this thesis could also facilitate the implementation of culturally tailored caseload midwifery models for women in other areas of Victoria or Australia, however, as Aboriginal and Torres Strait Islander communities are not homogenous this needs to be done with consideration of the unique contexts and needs of different communities.

11.2 Implications for policy, practice, and future research

The following section is a discussion of the implications of the findings of this thesis on policy, practice and future research, and in relation to the broader literature and policy landscape. There are five recommendations arising from the thesis, and each of these is discussed in this way. Following from this is a concluding summary of this thesis and the recommendations made moving forward.

11.2.1 Recommendation 1: Up-scale and expansion of culturally tailored continuity of midwife care models

> *"I really hope that it continues, because it made the whole experience just so much better, I think, than if I hadn't been in that program, and if I gave birth again, I would love to be in the program again, I think it's really important that Aboriginal women and Torres Strait Island women have access to that type of care…I think, like, prioritising that care is actually essential, like, really important." ID 1044*

Policy

This thesis strongly supported that culturally tailored continuity of midwife care models provide positive experiences and make mainstream maternity care feel safer for Aboriginal and Torres Strait Islander women in urban Victoria. These models should be implemented in other urban Victorian maternity services to increase access for Aboriginal and Torres Strait Islander women. As the findings correlate with the views of women from other geographical areas of Australia (Hartz, Blain et al., 2019; Homer, Foureur et al., 2012; Josif, Barclay et al., 2014; Kildea, Stapleton et al., 2012), implementation of these models may also be of benefit to Aboriginal and Torres Strait Islander women who live in Victoria but outside urban settings. As implementation of culturally tailored models are context specific, future work may be required in regional areas of Victoria. As the regional partner service was unable to implement the model during the Baggarrook Yurrongi Project study period, Aboriginal and Torres Strait Islander women living in that region missed out on the opportunity to access to a known midwife through their local maternity hospital.

The findings of this thesis support that trusting relationships with a known midwife increases the likelihood of 'cultural safety' (defined in section 2.1.4) (Ramsden, 2002) in the mainstream maternity system, so it is reasonable to suggest that state and federal governments now have a responsibility to support these models moving forward. The Victorian state Government is well placed develop policies with strategies to increase access to continuity of midwifery care for women having an Aboriginal and Torres Strait Islander baby. Unlike previous policies (Department of Health, 2012), the current strategic plan for Aboriginal health in Victoria for 2017-2027, 'Korin Korin Balit-Djak'

(Department of Health and Human Services, 2017), does not include a dedicated maternal and newborn health strategy. There is instead a broader focus on better access to culturally responsive early years services and support for the expansion of the KMS program, which was established in 2000 as a culturally tailored maternity service for Aboriginal women in Victoria (Department of Health and Human Services, 2017). 'Korin Korin Balit-Djak' is a general Aboriginal health strategy and does not refer to peer-reviewed evidence on maternity care for Aboriginal and Torres Strait Islander women. This signals the potential need for Victorian Aboriginal health policy that focuses specifically on best practice maternal and child health for Aboriginal and Torres Strait Islander communities, similar to Queensland government's Growing Deadly Families strategic directions, which recommends access to continuity of midwife care models for women having an Aboriginal or Torres Strait Islander baby (Queensland Health, 2019).

Maternity and Aboriginal health policy strongly recommends partnering with local ACCHO sectors (AHRC, 2020; COAG Health Council, 2019; Commonwealth of Australia, 2023). Future policies for implementation and upscale should enable genuine partnerships with Aboriginal communities, including resources for ongoing monitoring of program quality. In the case of the Baggarrook Yurrongi project, using a prospective translational research design that encompassed partnerships with the state-peak body for Aboriginal health (VACCHO) and a local AHS (the Victorian Aborignal Health Service) was key to the success of the model (McLachlan, Newton et al., 2022). Research funding provided the resources required to also address the secondary aims of the project, such as exploring the views and experiences of the women, analysis of clinical outcomes, and the views of key stakeholders.

Future research

If a research framework is required for the upscale and expansion of these models, there should be a paradigm shift from doing research to 'redress Aboriginal and Torres Strait Islander perinatal inequities', to research that addresses self-determination and sovereignty, recognising the inherent rights of Aboriginal and Torres Strait Islander women to reclaim their birth rights and to revitalise cultural birthing. Future research should be underpinned by the appropriate Indigenous methodologies and culturally appropriate and rigorous approaches such as Participatory Action Research (Dudgeon, Bray et al., 2020) and co-design (AHRC, 2020). The principles of 'Indigenous Data Sovereignty' and 'indigenous data needs' (Maiam nayri Wingara Indigenous Data Sovereignty Collective, 2018; Walter, Lovett et al., 2021) should be adopted to ensure

self-determination, governance, the prioritises, goals and the interests of the community are addressed. These approaches require data to be accessible to the community, who are positioned as the decision makers about the data. Future research to upscale and expand culturally tailored continuity of midwifery models must place voices of First Nations women at the centre of program design, planning and evaluation (AHRC, 2020).

"…this time around was definitely better, not having to see a different person every time. I can't say it enough. It's just made such a difference" ID 3031

11.2.2 Recommendation 2: Multidisciplinary continuity of carer and wrap around support

> *"…like, incredibly rude…it made me really grateful to be in the [caseload] program cos I feel like it was a taste of...what the non-caseload care is like, of just being palmed from person to person to person who you don't know and have no, like, necessarily trust in what they're telling you. And they don't have any respect for you cos they've never met you before." ID 1044*

For Aboriginal and Torres Strait Islander women, negative experiences are more likely to occur if care givers are not known to the woman (Corcoran, Catling et al., 2017). Importantly, continuity of carer increases the likelihood of a positive experience, with individualised care that fosters a sense of feeling informed and being in control (Watson, White et al., 2021).

In this thesis, women often linked negative interactions with hospital staff with the absence of a trusting relationship. Culturally tailored caseload midwifery models should be expanded to include continuity of carer with nominated, named multidisciplinary team members (such Obstetricians, social workers and social and emotional health workers). This could increase cultural safety in all aspects of the woman's maternity care journey.

Additionally, the findings of this thesis show that women who are having an Aboriginal or Torres Strait Islander baby in Naarm are often also experiencing significant life stressors around the time of having a baby. Awareness of the need to better understand

the environmental, societal, and structural factors that cause disproportionate levels of maternal stress for black, Indigenous, or women of colour is growing (Lewis, McKeon et al., 2021; Shannon, Clougherty et al., 2020). How maternal stress impacts on perinatal outcomes is also an area of research interest (Burris, Riis et al., 2020; Gerson, McCarthy et al., 2021). Programs must be resourced to adequately address the social determinants of health and the social context of women's lives. High quality continuity of midwifery care models must be provided within a comprehensive, culturally appropriate wrap around service with increased social and emotional wellbeing support (Kildea, Hickey et al., 2019; Queensland Health, 2019).

> *"I'd see a different doctor every time and I'd have to re-explain everything all over again and then I wouldn't have time to discuss what happened between appointments. They were so rushed." ID 3081*

11.2.3 Recommendation 3: Aboriginal women caring for Aboriginal women

> *"Having Aboriginal staff working in this model would be the most appropriate, and if this can't happen non-Aboriginal staff need continuous cultural support…as the learning never stops."* ID 1023

Women identified that Aboriginal people should be present and caring for women in these models. At the commencement of the Baggarrook Yurrongi project, all of the midwives employed to work in the models were non-Indigenous. For many women, this did not appear to be an issue. Being cared for by Aboriginal staff was however rated as important by half of the 343 women who agreed to participate (McCalman, McLardie-Hore et al., 2022). Some women went on to explain that on referral into an Aboriginal midwifery program, they assumed their midwife would be Aboriginal and were surprised to learn they were not (McCalman, Forster et al., 2024a; McCalman, Forster et al., 2024b).

There is currently a shortage of Aboriginal and Torres Strait Islander midwives in Australia. According to the AIHW, 1.5% (6,214) of all nurses and midwives in 2022

identified as Aboriginal or Torres Strait Islander (AIHW, 2023). Focusing only on midwives, data from 2015 shows that there were 230 midwives employed in Australia who identified as an Aboriginal and/or Torres Strait Islander, which represented 1.0% of all employed midwives in that year (AIHW, 2016). This grew to 2.3% in 2023 (AHPRA & National Boards, 2023). If we take the 2021 Aboriginal and Torres Strait Islander birth rate (5% of all births) (AIHW, 2023), there are still far more Aboriginal and Torres Strait Islander women birthing than there are Aboriginal and Torres Strait Islander midwives to care for them.

The need to grow the Aboriginal and Tores Strait Islander health workforce is recognised in both Aboriginal health policy (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2017; Department of Health, 2022) and Australian maternity strategic directions (COAG Health Council, 2019; Queensland Health, 2019). Action across multiple sectors as discussed in the 'gettin em n keepin em n growin em' (GENKE II) report (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2022). However, a shortage of Aboriginal midwives does not mean that there are no Aboriginal midwives available and willing to work in culturally tailored continuity models. During study Baggarrook Yurrongi study period, the number of Aboriginal midwives working in the model grew from zero to two and continues to increase (it is currently four).

Maternity services implementing culturally tailored continuity models must proactively seek Aboriginal midwives to work in the model and plan for First Nations identified positions in the long-term (Kildea, Hickey et al., 2019). This shows that the contribution Aboriginal midwives make in providing culturally safe care is recognised and valued. One possible enabler to continue growing the number of Aboriginal and Torres Strait Islander midwives working in these models could be to provide Aboriginal and Torres Strait Islander midwifery students with clinical placements and mentorship in the models, followed by opportunities to transition into practice as a graduate midwife. Once Aboriginal midwives are working in the models, maternity services also need to ensure they are supported to develop the necessary capacity and leadership skills (Department of Health, 2022).

Growing the Aboriginal and Torres Strait Islander maternity workforce is not limited to midwifery. Culturally tailored caseload midwifery programs should also include dedicated positions for AHLOs, KMS workers, or other culturally appropriate support workers. For example, some programs both in Australia and internationally are exploring

the development of Indigenous doula support programs (Ireland, Montgomery-Andersen et al., 2019; Pandey, Smith et al., 2023). Expanding the scope of the programs beyond midwifery increases opportunities for Aboriginal and Torres Strait Islander employment, increasing the links that the programs have to the local community.

> *"It wasn't until I went through that experience with, um, having an Aboriginal midwife, it just made me feel so much more at ease...it, it does really make a difference…just having someone else there who you can have that spiritual connection with….I just had trust in her."* ID 1152

11.2.4 Recommendation 4: Clear accountability for unprofessional conduct, unethical service provision, and racism in the maternity sector

> *"..the main doctor came in and didn't even say anything to myself of my husband, and she just grabbed the scissors and cut me and started pulling... stitching me up, and I was saying, I can really feel that.. she didn't' even wait for the anaesthetic to come back...and I kept saying I could feel it.. and she said 'just hold your baby, I'm nearly done'."*
>
> *"I can't ever go through that again." ID 3105*

Women have overall expressed positive experiences within the culturally tailored midwifery models, however, this thesis also contains evidence of service provision that directly contradicts the Medical Standards of Practice (Medical Board, 2020) and the Code of Professional Conduct for Midwives (Nursing and Midwifery Board of Australia, 2018). Instances of unprofessional conduct or unethical care provision as per these codes include racism, not listening to women, poor communication, and failing to gain free informed consent for examinations or procedures (Medical Board, 2020; Nursing and Midwifery Board of Australia, 2018; Nursing and Midwifery Board of Australia, 2018; RANZCOG, 2023). Recommendations one, two, and three should be implemented

alongside the strengthening of the mechanisms in place which should ensure accountability and deter unprofessional conduct.

As a gauge of quality, Victorian health service annual reports are required to include results from the Victorian healthcare experience survey (Safer Care Victoria, 2018). For this survey, data regarding women's recent experiences of each public maternity service are collected from random samples of women who have used the service (Safer Care Victoria, 2018). While annual reports may show that services score highly (The Women's, 2023; Western Health, 2023), it is not clear to what degree the Victorian healthcare experience survey addresses unprofessional conduct, unethical service provision or racism. It is also not clear whether Aboriginal and Torres Strait Islander women are represented in the sample.

The analysis of consumer complaints is another method which should drive quality and safety improvement (Australian Commission On Safety And Quality In Health Care, 2021; Safer Care Victoria, 2018). AHPRA is responsible for the administration of the national scheme, which regulates health practitioners for the protection of public safety (AHPRA, 2023). In conjunction with the relevant health practitioner boards, AHPRA receives complaints made about health professionals (with the exception of New South Wales and Queensland, where separate complaints processes are in place) (Walton, Kelly et al., 2020). Determining the effectiveness of this is complex, and a recent parliamentary inquiry into rising rates of 'birth trauma' in Australia (discussed in Chapter two) has highlighted concerns regarding the ineffectiveness of statutory bodies in ensuring health care provider accountability (Select Committee on Birth Trauma, 2024).

During 2022-2023, 168 notifications were made about 135 midwives during 2022-2023, mostly by members of the public about standards of clinical care (AHPRA & National Boards, 2023). Most of the time, no further action was taken. Other outcomes included conditions being imposed, midwives being cautions or reprimanded, or referred to another body (AHPRA & National Boards, 2023). Ten of the 168 notifications resulted in immediate action being taken, five of which related to 'breaches of professional standards'. No further detail is openly accessible regarding the nature of these breaches (AHPRA & National Boards, 2023). AHPRA does not provide information regarding complaints or notifications of medical misconduct in the maternity sector, or of subsequent outcomes. The Royal Australian and New Zealand College of Obstetricians (RANZCOG) complaints policy states information regarding complaints of medical

misconduct are publicly available (RANZCOG, 2023), however only six consumers lodged a complaint to RANZCOG from 2022-2023 (Caballero, 2023). As harmful practices in the maternity sector are prevalent (Keedle, Keedle et al., 2022; Select Committee on Birth Trauma, 2024), it could be that low numbers of complaints reflect an underutilised complaints mechanism, rather than low levels of harm. It is possible that the experiences contained in this thesis may have otherwise gone unheard, which is a problem.

Aboriginal women and industry experts recently called for a non-Indigenous maternity workforce that is held accountable for racism and for practicing cultural safety, signalling that more work needs to be done (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023). The AAPP Alliance recommends collaboration between health, academic and policy sectors to explore how maternity systems can translate anti-racist frameworks into practice with accountability frameworks to measure systemic change (Hine, Krakouer et al., 2022).

The AHPRA cultural safety strategy 2020-2025 identified that increased patient safety for Aboriginal and Torres Strait Islander people (both culturally and clinically) requires more effective monitoring and reporting of AHPRA notifications (AHPRA & National Boards, 2020). Identified initiatives, which have not yet been implemented, include developing, implementing and educating the community about a monitoring and reporting framework specifically for Aboriginal and Torres Strait Islander patient safety (AHPRA & National Boards, 2020). These important initiatives need to progress from policy to practice.

"They were just horrible…they accused me of being a drug user. The midwife [on the ward] just casually said it… I don't know if it was because I had Aboriginal next to my name or the way I look. If [my caseload midwife] wasn't there, it was a totally different attitude…it felt like a prison." ID 3081

11.2.5 Recommendation 5: Moving towards Birthing on Country in Victoria

"A whole Koori space…Can we have our own hospital?... 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.." ID 3053

Working towards the implementation of BoC services in Victoria could ensure women continue to have access to care that is both culturally and clinically safe. As discussed in Chapter two, 'Birthing on Country' is described as a metaphor for the 'best start in life' for Aboriginal and Torres Strait Islander babies, and as a model of care (Kildea, Lockey et al., 2016). BoC is also an international social justice movement to return birthing services back to Aboriginal and Torres Strait Islander communities (Ireland, Maypilama et al., 2021). Aboriginal women and industry experts who attended the most recent national gathering for BoC decided that BoC services provide relationship-based care; First Nations midwives for First Nations women, including a reimagined First Nations maternity workforce; a non-Indigenous maternity workforce that is culturally safe and held accountable for racism; holistic programs; trauma-informed approaches; and indigenous knowledge systems and cultural practices are privileged (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023). BoC services are now recommended in government strategic directions for maternity services (COAG Health Council, 2019). Investing in BoC services is also listed as a strategy in the 2023 Closing the Gap report (Commonwealth of Australia, 2023). Additionally, recommendation 33 in the recent parliamentary inquiry into rising rates of birth trauma in Australia recommended investment in the expansion of BoC models to improve access to culturally safe maternity services (Select Committee on Birth Trauma, 2024).

The establishment of BoC in Victoria can progress concurrently with the previous recommendations made in this chapter. The RISE framework is one example of an evidence-based framework that has been designed to assist with the implementation of BoC services (Kildea, Hickey et al., 2019). I note that the RISE framework also addresses some of the recommendations I have made in this chapter so far, regarding up-scaling and expanding culturally tailored continuity of care programs; wrap-around support; a First Nations workforce; and wider maternity workforce improvements regarding trauma-informed care and cultural safety (Kildea, Hickey et al., 2019).

The information provided in this thesis could be used as a 'first step' framework for the design of a BoC service in Victoria. If applying the RISE framework, the culturally tailored continuity of midwife care models established through Baggarrook Yurrongi project could be considered a 'phase 2' service (Kildea, Hickey et al., 2019). Possible future work could explore community views about progressing models of care to a 'phase 4' birthing on country service, that offers choice of birthplace; an integrated community-

hub; supports strong resilient families (i.e. programs for the whole family); and is owned by the Victorian Aboriginal community (with or without the integration of mainstream maternity services) (Kildea, Hickey et al., 2019).

In terms of offering choice of birthplace, evidence shows that birth centres are safe for women of 'low obstetric risk', with no differences in perinatal mortality rates (Birthplace in England Collaborative, 2011; National Collaborating Centre for and Children's, 2014), improved perinatal morbidity outcomes (Davis, Baddock et al., 2011; Monk, Tracy et al., 2014), improved maternal morbidity outcomes (Kruske, Schultz et al., 2015; Overgaard, Møller et al., 2011), and less birth interventions (Davis, Baddock et al., 2011; Homer, Cheah et al., 2019). While this evidence focuses on women of 'low obstetric risk' and does not focus on Indigenous populations, it does not mean that Aboriginal and Torres Strait Islander women, as a group, should be excluded from access to choice of birthplace as part of a BoC service. Evidence exists which supports positive outcomes for Indigenous women in Canada and New Mexico birthing in their own communities without routine admission to a mainstream hospital (Leeman and Leeman, 2002; Van Wagner, Epoo et al., 2007; Van Wagner, Osepchook et al., 2012). Additionally, the perception of 'high risk pregnancy' as the default for Aboriginal or Indigenous women has been criticised in the literature (Brown, Varcoe et al., 2011; Nelson, Marriot et al., 2021). Data collected during the Baggarrook Yurrongi study period did not support this, as many Aboriginal/Torres Strait Islander women at the study sites were seen to be free of any pregnancy or medical complications (McLardie-Hore, McLachlan et al., 2023).

In terms of mainstream hospital services, a BoC service was established within a mainstream maternity service in Meanjin (Brisbane) and reported lower rates of pre-term births, higher antenatal attendance, and higher rates of breastfeeding (Kildea, Gao et al., 2021). However, no outcomes relating to the women's views and experiences have been published, which would be a beneficial addition to the evidence. For some communities, a BoC service within a mainstream service might be the preferred or only option. Further, culturally tailored continuity of midwifery care is an key component BoC models, and demonstrated in this thesis is that this is critical for care to feel safer.

A BoC service in a mainstream maternity service requires strong local Aboriginal and Torres Strait Islander leadership with clinical and cultural governance oversite embedded (Central Australian Aboriginal Congress and Molly Wardaguga Research Centre, 2023). Building the ACCHO sector and genuine partnerships are now widely recognised as the

best ways forward for improving Aboriginal and Torres Strait Islander health and wellbeing (AHRC, 2020; COAG Health Council, 2019; Commonwealth of Australia, 2023; Department of Health, 2021; Lowitja Institute, 2022). Partnerships between the ACCHO sector and the mainstream maternity sector in Victoria, in the form of MOUs, have long been advocated for (Campbell and Brown, 2004). Governments must now address the current barriers that have been identified which the prevent ACCHOs from establishing and providing BoC services in Australia (Roe, Allen et al., 2024).

Indigenous Elders know that birth is the 'most powerful thing that could happen to a woman'(Kildea, Magick Dennis et al., 2012) (p.7) and it is our 'first ceremony' (Hayward and Cidro, 2021). The United Declaration of the Right of Indigenous People (UNDRIP) states that Indigenous people have a right to self-determination, and to practice, protect, maintain and revitalise our cultural traditions and customs (United Nations (General Assembly), 2007). When contemplating BoC in Victoria, it is worth remembering that prior to colonisation of the Australian continent, an established 'maternity system' was already sustaining healthy communities. Aboriginal and Torres Strait Islander women, supported the men in their community, carried out birthing practices and skills for pregnant and birthing women, on Country. Of this, women have been dispossessed.

The historical, social, and structural challenges that Aboriginal and Torres Strait Islander women continue to face have led me to consider that future directions should include increasing choices for Aboriginal women in terms of *how*, *where* and *with whom*, they give birth, through BoC models of care.

11. 3 Conclusion

This thesis provides clear evidence that culturally tailored continuity of midwife care models make maternity care in the mainstream system feel safer for Aboriginal and Torres Strait Islander women. This is an important finding. Numerous government and Aboriginal health policies state that as a redress to the inequitable perinatal outcomes faced by women which stem from colonisation, evidence-based maternity programs co-designed in partnership with Aboriginal and Torres Strait Islander women are urgently needed. This evidence supports that having a known midwife working in a culturally

tailored caseload model increases the ability of care be woman-centred and experienced as culturally safe.

The first recommendation of this thesis is to upscale and expand these programs. The Victorian state Government is well placed to implement policies that recommend upscaling and grow these models of care across Victoria, in partnership with the Aboriginal Community Controlled Sector. Victorian maternity services should engage with local communities and local Aboriginal health services to co-design future programs. The potential long-term benefits of this are significant, as equitable maternity services are critical to closing the 'health gap' for Aboriginal and Torres Strait Islander people (Kildea, Gao et al., 2021) and a healthy start to life provides ongoing positive flow on effects into childhood and later life (Kildea, Gao et al., 2021; March of Dimes, PMNCH et al., 2012). Women have also provided important information on which aspects of care need to be improved and as such, specific recommendations based on the women's views and experiences have been made, including: implementing and upscaling continuity of care for Aboriginal and Torres Strait Islander women with midwives and the rest of the multidisciplinary team; Aboriginal women caring for Aboriginal women; accountability for unprofessional conduct, unethical care and racism; and moving towards Birthing on Country in Victoria (United Nations (General Assembly), 2007).

A final word from the yarn I shared with Amber:

"I feel like I actually recovered um, mentally and emotionally a lot quicker the second time around …I really credit the [caseload] team. Um, just from having that, you know, extra support and additional support and care….the word I would use to describe that is, I just felt safe. …like I said to you before, it's just, because I feel like our mob has been through a lot, um, you know, like I said, just for me personally, I can't, couldn't help but to reflect on…'okay, yep I've got this newborn baby but how am I gonna make sure that, what's happened in the past to our mob doesn't happen to this baby?' …they're really big feelings, and really big thoughts….so to have, yeah, the support of the midwives, to help you though those, and yeah… I guess, maybe, take away some of the, you know, …the mental pressure that you put on yourself. I just feel like, it, it really does make such a difference. …I don't know….it was just such a, a warm feeling, just knowing that I had this, this team of people who were caring about me and my interests." - Amber.



Appendices

TABLE 7 - APPENDICES

Appendix	Topic	Included items
Appendix A	Ethics approvals	• La Trobe University • St Vincent's multi-site ethics
Appendix B	Ethics modifications	• COVID-19 Ethics amendment request • St Vincent's multi-site amendment approval
Appendix C	Letter of support	• VACCHO letter of support
Appendix D	Recruitment documentation and data collection tool	• Participant information and consent form • Participants contact details form • Recruitment questionnaire • Information brochure
Appendix E	Follow up documentation and data collection tool	• Telephone contact protocol • Distress protocol • Follow up questionnaire • Generic follow up email
Appendix F	Face to face interview documentation and interview guide	• Participant information and consent form • Face to face interview guide
Appendix G	Participant tracking details	• Participant details tracking data base
Appendix H	Data cleaning documentation	• Data cleaning follow up sheet

Appendix A - Ethics approvals

La Trobe University Ethics Approval

LA TROBE UNIVERSITY

University Human Ethics Committee

RESEARCH OFFICE

MEMORANDUM

To: **Professor Helen McLachlan, School of Nursing and Midwifery, College of SHE**

From: **Senior Human Ethics Officer, Ethics and Integrity**

Subject: **UHEC acceptance of St Vincent's HREC approved project – HREC 195/16 (HREC/16/SVHM/233)**

Title: **Improving the health of Aboriginal mothers and babies through continuity of midwife care**

Date: **30 January 2017**

Thank you for submitting the above protocol to the University Human Ethics Committee (UHEC). Your material was forwarded to the UHEC Chair for consideration. Following evidence of a full review and subsequent final approval by the **St Vincent's HREC**, the UHEC Chair agrees that the protocol complies with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and is in accordance with La Trobe University's *Human Research Ethics Guidelines*.

Endorsement is given for you to take part in this study in line with the conditions of final approval outlined by **St Vincent's HREC.**

Limit of Approval. La Trobe UHEC endorsement is limited strictly to the research protocol as approved by **St Vincent's HREC**.

Variation to Project. As a consequence of the previous condition, any subsequent modifications approved by **St Vincent's HREC** for the project should be notified formally to the UHEC.

Annual Progress Reports. Copies of all progress reports submitted to **St Vincent's HREC** must be forwarded to the UHEC. Failure to submit a progress report will mean that endorsement for your involvement this project will be rescinded. An audit related to your involvement in the study may be conducted by the UHEC at any time.

Final Report. A copy of the final report is to be forwarded to the UHEC within one month of it being submitted to **St Vincent's HREC.**

If you have any queries on the information above please e-mail: **humanethics@latrobe.edu.au** or contact me by phone.

On behalf of the La Trobe University Human Ethics Committee, best wishes with your research!

Kind regards,

Sara Paradowski
Senior Human Ethics Officer
Executive Officer – University Human Ethics Committee
Ethics and Integrity / Research Office
La Trobe University Bundoora, Victoria 3086
P: (03) 9479 – 1443 / F: (03) 9479 - 1464
http://www.latrobe.edu.au/researchers/ethics/human-ethics

ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital
(Melbourne) Limited
ABN 22 052 110 755

41 Victoria Parade Fitzroy VIC 3065
PO Box 2900 Fitzroy VIC 3065

Telephone 03 9231 2211
Facsimile 03 9231 3399
www.svhm.org.au

16 January 2017 (revised 22 March 2017)

Professor Helen McLachlan
School of Nursing and Midwifery
La Trobe University

Dear Prof McLachlan

HREC Reference Number: HREC/16/SVHM/233
St Vincent's HREC Ref: HREC 195/16

Title: 'Improving the health of Aboriginal mothers and babies through continuity of midwife care'

The St Vincent's Hospital (Melbourne) Human Research Ethics Committee has reviewed and approved the aforementioned study.

Approval Status: FINAL

Period of Approval: 16 January 2017 – 16 January 2021

Ethical approval is given in accordance with the research conforming to the *National Health and Medical Research Council Act 1992*, the *National Statement on Ethical Conduct in Human Research* 2007 *(updated May 2015)* and the *Values and Ethics - Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (2003).*

Ethical approval is given for this research project to be conducted at the following sites:

- The Women's Hospital, VIC
- Goulburn Valley Health, VIC
- Sunshine Hospital, VIC
- Mercy Hospital for Women, VIC

Approved documents
The following documents have been reviewed and approved:

Document	Version	Date
National Ethics Application Form (AU/1/4F4A27)	2.2 (2014)	22/11/2016
Victorian Specific Module	-	04/11/2016

Letter of Support from VACCHO	-	21/11/2016
Letter from NHMRC regarding offer of funding	-	Not dated
Study Protocol	1	24/08/2016
List of Routinely collected data	1	29/09/2016
Maternity booking data collection form	1	28/09/16
Participant brochure	1	25/08/2016
Participant information and consent form- Women	2	20/12/2016
Participant contact details form	1	28/09/16
Recruitment interview	1	01/08/16
3 month survey/interview	1	03/08/16
Face to face interview	1	28/09/16
Participant information and consent form- Women's interviews	2	20/12/2016
Key stakeholders interview	1	23/08/16
Caseload midwives interview	1	23/08/2016
Aboriginal health worker's interview	1	22/09/16
Key stakeholder Participant information and consent form	2	20/12/2016
Caseload midwives survey	1	26/10/2016
Aboriginal Cultural Inclusion checklist for Maternity Services	1	22/09/16
CV H McLachlan	-	-
CV D Forster	-	-
CV A Kildea	-	-
CV J Freemantle	-	-
CV J Browne	-	-

St Vincent's HREC-A Protocol number: HREC 195/16
Please quote these numbers on all Correspondence

Approval is subject to:

- The Principal Researcher is to ensure that all associate researchers are aware of the terms of approval and to ensure the project is conducted as specified in the application and in accordance with the National Statement on Ethical Conduct in Human Research (updated March 2014).
- Immediate notification to the Research Governance Unit of any serious adverse events on participants.
- Immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
- Notification and reasons for ceasing the project prior to its expected date of completion;
- Notification of proposed amendments to the study;
- Submission of an annual report, due on the anniversary date of approval, for the duration of the study.
- Submission of reviewing HREC approval for any proposed modifications to the project;
- Submission of a final report and papers published on completion of project;
- Projects may be subject to an audit or any other form of monitoring by the Research Governance Unit at any time.

The HREC wishes you and your colleagues every success in your research.

Yours sincerely,



Ms Leanne Clinch
HREC Secretary
Research Governance Unit
St Vincent's Hospital (Melbourne)

Appendix B - Ethics modifications
Covid Ethics Modification Request

Judith Lumley Centre
La Trobe University
Level 3 George Singer Building
La Trobe University | Bundoora
Melbourne 3086

21/04/ 2020

To St. Vincent's HREC

Re: HREC reference number HREC- 16\SVHM\233.

St Vincent's Hospital Reference HREC 195/16

'Improving the health of Aboriginal mothers and babies through continuity of midwife care: a mixed methods translational study'

Due to changes brought upon by the COVID-19 pandemic, we are writing to an amendment to the protocol of the above-named study. Whilst most data collection for this project can proceed as usual via remote access, or be completed retrospectively, due to the requirement to limit face to face contact, there is a need to make changes in how women are approached to participate in the evaluation of their care.

Our study protocol currently states "our research midwife will approach them in the pregnancy clinic (it may be at the same visit or could be later in the pregnancy if appropriate) and offer them study participation." With most women are now receiving care outside the hospitals, via telehealth or in the community, and with the need to limit face to face contact (particularly in this at-risk population) this is no longer possible. We are seeking permission to approach women via telephone. If women agree to participate, the Participant Information and Consent would be discussed and sent via email. They could sign and either email or post it back to us, or they could choose to consent via an online consent process we have set up.

Our study protocol would then read "our research midwife will approach them in the pregnancy clinic (it may be at the same visit or could be later in the pregnancy if appropriate) or via telephone and offer them study participation."

In addition, we are also asking that secure, end to end encrypted, teleconference be added as an option for the in-depth interviews. This is also in an effort to reduce the face to face contact with women and their families.

We feel that this slight adjustment in protocol will allow us to continue the important work of this NHMRC funded project, with little disruption.

Regards

Helen McLachlan & Della Forster

ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital
(Melbourne) Limited
ABN 22 052 110 755

41 Victoria Parade Fitzroy VIC 3065
PO Box 2900 Fitzroy VIC 3065

Telephone 03 9231 2211
Facsimile 03 9231 3399
www.svhm.org.au

41 Victoria Parade Fitzroy VIC 3065
PO Box 2900 Fitzroy VIC 3065

Telephone 03 9231 2211
Facsimile 03 9231 3399
www.svhm.org.au

05 May 2020

Professor Helen McLachlan
School of Nursing and Midwifery
La Trobe University

Dear Prof McLachlan

HREC Reference Number: HREC/16/SVHM/233
St Vincent's HREC Ref: HREC 195/16

Title: 'Improving the health of Aboriginal mothers and babies through continuity of midwife care'

The Executive of the St Vincent's Hospital (Melbourne) Human Research Ethics Committee (HREC) has reviewed and approved the following amendments:

Amendment Approval Date: 05 May 2020

Approved Documents

Document	Version	Date
Study Protocol	2	21/04/2020

Acknowledged Documents:

Document	Version	Date
St Vincent's HREC amendment request letter COVID 19		21/04/2020

Approval Status: FINAL

Approval is given in accordance with the research conforming to the National Health and Medical Research Council Act 1992 and the National Statement on Ethical Conduct in Human Research 2007 (including all updates)

Approval is subject to:

- The Principal Researcher is to ensure that all associate researchers are aware of the terms of approval and to ensure the project is conducted as specified in the application and in accordance with the National Statement on Ethical Conduct in Human Research 2007 (including all updates)
- The Principal Researcher is to notify the Research Governance Unit of all significant safety issues in accordance with the *NHMRC Guidance: Safety monitoring and reporting in clinical trials involving therapeutic goods (including all updates)*.
- Submit an Annual Safety Report for the duration of the project.
- Immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
- Notification and reasons for ceasing the project prior to its expected date of completion;
- Submit to the reviewing HREC for approval of any proposed amendments to the project including any proposed changes to the Protocol, Participant Information and Consent Form/s, Investigator Brochure and other study materials.
- Submission of reviewing HREC approval for any proposed modifications to the project.
- Submission of a final report and papers published on completion of project.
- Projects may be subject to an audit or any other form of monitoring by the Research Governance Unit at any time.

Project ID Number:
St Vincent's Hospital Reference: HREC 195/16
Please quote these numbers on all Correspondence

This approval will be noted by the full HREC at the next available meeting.

Site-Specific Assessment (SSA)

A copy of this letter must be forwarded to the Principal Investigator(s) and the Research Governance Officer(s) at each participating site covered by this HREC approval.
Please note that, in addition to HREC approval of an amendment, SSA authorisation is required at all sites participating in the project. Each participating site must issue governance approval of the amendment before the amendment can be implemented at individual sites.

The HREC wishes you and your colleagues every success in your research.

Yours sincerely



Ms Leanne Clinch
Research Ethics and Governance Manager
Research Governance Unit
St Vincent's Hospital (Melbourne)

Appendix C - Letter of support

VACCHO letter of support

VACCHO
17-23 Sackville Street
PO Box 1328
Collingwood VIC 3066
P 03 9411 9411
F 03 9411 9599
www.vaccho.org.au

21 November 2016

Dr Tam Nguyen
Executive Officer of Research
St. Vincent's Public Hospital
41 Victoria Parade
FITZROY VIC 3065

Dear Dr Nguyen,

RE: Letter of Support for Improving the health of Aboriginal mothers and babies through continuity of midwife care HREC Application

On behalf of VACCHO, I would like to provide this letter of support for the aforementioned research project that is being led by La Trobe University in partnership with VACCHO and other key stakeholders. The research outcomes will provide invaluable information regarding whether access to midwifery case care models of service delivery improve the health and wellbeing outcomes for Aboriginal women and babies being birthed in Victorian hospitals.

VACCHO has been appropriately consulted by the research team and we are very supportive of the research and our collaboration with all key stakeholders.

Yours sincerely

Jill Gallagher AO
Chief Executive Officer

Cc Ms Louise Lyons, VACCHO
Ms Jennifer Browne, VACCHO

Western Health

'Baggarook Yurrongi' 'Nuraagh Manma Buliana'
Improving the health of Aboriginal and Torres Strait Islander mothers and babies through continuity of midwife care

Western Health

Participant Information and Consent Form (Women)

Sunshine Hospital

This information sheet is for you to keep

Introduction

Thank you for your interest in our study! You are invited to take part in this research project because:

- You, or your partner, have identified as Aboriginal and/or Torres Strait Islander
- You are booked to have your baby at either the Women's Hospital, Mercy Hospital for Women, Sunshine Hospital or Goulburn Valley Health.

This study was put together by a team from:
- La Trobe University

This study is also done in collaboration with:
- Victorian Aboriginal Community Controlled Organisation

Funding from this project has come from:
- The National Health and Medical Research Council

Your story is important

Every woman and pregnancy is different. This is a chance for you to tell your story about your pregnancy journey and help us improve health services for Aboriginal and Torres Strait Islander families.

Your stories and experiences are really important so that we can better understand your experience. We would like to find out what kind of maternity care is best for the health, development and wellbeing of our mums and bubs.

An important feature of this study is that it has been driven in partnership with key Aboriginal Community Controlled Health Organisations. This is important to us, so that our research outcomes reflect the needs and values of the community.

Your questions are important. Don't hesitate to ask at any time. Before you decide if you want to be a part of this research, feel free to yarn with a relative, Elder or local health worker. If you do decide to take part, you will be asked to sign a consent form. Participation in this research is voluntary. If you don't want to take part at any stage, you don't have to. All information you provide is confidential and private. You will not be identifiable by sharing your story.

Western Health

What does it involve?

Information collection

It is important that we collect accurate information to properly tell your story

1. Completing surveys

You will be asked to complete surveys at 2 time points: when you first join the study and when baby is 3 months old.

We will ask you about:

- Pregnancy and maternity care experiences
- Health and wellbeing
- Demographic questions like family background, education, housing
- Life events and worries

The first survey will be face to face interview with one of our research team at the time that you join the study. When your baby is 3 months old, we will invite you to take part in a survey which will take approximately **20-30 minutes** to complete. This can be done face-to-face with an Aboriginal and/or Torres Strait Islander Research Assistant, or you can do it by yourself online on a computer, ipad/tablet, smartphone or on a printed hardcopy.

Do I have to take part in this research project?

Participation in any research is voluntary:

• If you do not wish to take part, you don't have to
• If you start and then later you change your mind, that's okay. You can withdraw at any time
• Your decision to take part or not will not affect your care, or your relationship with staff
• If you decide to leave the study, the researchers will not collect any further information from you. Any information already collected, which has been made non-identifiable, will be kept to ensure that the results of the research project can be measured.
• If you do not want your data to be included, you must tell the researchers when you withdraw from the research project.

Who has checked this research study?

This study has been reviewed and approved by:

• St Vincent's Hospital Human Research Ethics Committee
• The Women's Hospital, Mercy Hospital for Women, Sunshine Hospital and Goulburn Valley Health ethics committees
• The Victorian Aboriginal Community Controlled Health Organisation
• La Trobe University Ethics Committee

What will happen to my information?

Your information will be stored in locked filing cabinets in a locked office. Only the project coordinator and project investigators will have access to the information. Electronic information will be password protected. Any information obtained that can identify you will remain confidential and securely stored. Any information we collect will be kept for 15 years after we have published information from the study in accordance with 2.1.1 of the Australian Code for the Responsible Conduct of Research (2007), which suggests data from clinical trials be kept for this period. All data will then be destroyed in a secure manner.

Possible benefits from taking part

We cannot promise that you will receive any direct benefits from this study Everyone who does participate, however, will be helping us build stronger evidence to improve the maternity care for future generations of Aboriginal and Torres Strait Islander families

Possible risks from taking part

We do not anticipate that taking part in this study will be associated with any risks to you or your baby, although some of the questions in the surveys might cause you to feel irritated or stressed. You can skip questions you don't want to answer if they make you feel uncomfortable.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) and Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander health Research (2003). These documents have been developed to protect the interests of people who agree to participate in human research studies.

Who can I contact for further information or to make a complaint?
If you want any further information about his project, or if you have any problems which may be related to your involvement in the project, you can contact the Chief Investigator:
Professor Helen McLachlan
T: 03 9479 5955
E: h.mclachlan@latrobe.edu.au

Or
Mr Bill Karanatsios
Manager, Western Health Office for Research
T: 03 8395 8073
E: ethics@wh.org.au

Or
St Vincent's Hospital HREC
T: 09231 3930
E: research.ethics@svha.org.au

What happens when the research project ends?
This study will end in 2021. We can keep you informed of the study findings by sending you newsletter updates and a summary when we've finished. We will also share our study learnings with health professionals and Indigenous organisations so they can help Aboriginal and Torres Strait Islander families. This will include writing papers for academic journals, presenting findings at conferences and writing newspaper/magazine articles.

Any publication or presentation using the info you have provided will be written so you and your family cannot be identified.



Birthing Tree: artwork by Shawana Andrews

This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come.

Western Health

Participant Information and Consent Form - Sunshine Hospital

Version 1: January 2017

Full Project Title: Woman's Journey - Baggarrook Yurrongi & Nurragh Manma Buliana: Improving the health of Aboriginal mothers and babies through continuity of midwife care

I .....(Participant's name)

understand the purposes, procedures and risks of this research project as described within it and I have;

- read or have had this document (Participant Information Version 1, dated 15th September 2016) read to me in a language that I understand;
- had any questions or queries answered to my satisfaction;
- understood the purposes and procedures of the research project;
- been informed of the possible risks and benefits to participation;
- understood that participation will not affect other care options available to me;
- been informed that the confidentiality of all the information provided and collected will be maintained and safeguarded;
- been assured that I am free to withdraw at any time without comment or penalty;

☐ I agree to participate in the research project.

Participant's Name (printed) .....

Signature Date

Declaration by researcher or representative: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) .....

Signature Date

LA TROBE UNIVERSITY VACCHO the women's GV Health Mercy Health Care first Western Health

Western Health

Withdrawal of Consent

Full Project Title: Woman's Journey - Baggarrook Yurrongi & Nurragh Manma Buliana: Improving the health of Aboriginal mothers and babies through continuity of midwife care

I wish to withdraw participation in the above research study.

I understand that my withdrawal from will not affect the care given to me or my baby, and nor will it affect my relationships with Staff.

Name (printed): .....

Signature: .....

Date: .....

If you wish to withdraw for the study, please complete this form and give it to your maternity care provider, or return it to Professor Helen McLachlan (Chief Investigator)

Professor Helen McLachlan

Judith Lumley centre

La Trobe University

215 Franklin St

Melbourne, 3000

Email: H.McLachlan@latrobe.edu.au

Woman's Journey – 'Baggarrook Yurrongi' 'Nurragh Manma Buliana'

Contact Details

Mother ID



Place BRADMA here

Sometimes it is difficult to find women after their birth or when the baby is three months old, so we'd like to get some other phone numbers from you, e.g. your mother or someone who is unlikely to move house.

- check number on bradma is correct and try to get 3 extra numbers
- needs to be recorded separately – not on questionnaire

Who	Name	Number
Mother		Phone
		Mobile
		Work
Email		
Partner /family		Phone
		Mobile
		Work
Email		
Friend		Phone
		Mobile
		Work
Email		

"Birthing Tree" Artwork by Shawanna Andrews.
This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come"

Version 1 28_09_2016



Birthing Tree:
Artwork by Shawana Andrews

This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come.

After consultation with community elders the name of the study was chosen.

"Baggarrook Yurrongi" is the Woiwurrung translation for "Woman's Journey".

"Nuraagh Manma Buliana" is the Yorta Yorta translation for "all of us working together during pregnancy"

More information

You can contact the Woman's Journey team on 94798779 or email the Women's Journey study coordinator at :
F. McLardie-Hore@latrobe.edu.au

LA TROBE UNIVERSITY
VACCHO
the womens
Western Health
GVHealth
Mercy Health
Care first

Woman's Journey: Baggarrook Yurrongi Nuraagh Manma Buliana

Improving the health of Aboriginal mothers and babies through continuity of midwife care



Woman's Journey: Baggarrook Yurrongi Nuraagh Manma Buliana

Having a yarn about your experience of care.

We are interested to know about Aboriginal & Torres Strait Islander women's thoughts and experiences of maternity care. We would like to talk to Aboriginal and Torres Strait Islander women to see what they think about the care they received during pregnancy and birth.
We want to know if women are given choice, and why, they chose the type of care they received. We want to know how acceptable the sort of care was.

What is involved?

If you are interested and agree to participate in the study, we will ask you to complete an interview with a research midwife when you first join, and again when baby is 3 months old. Participating in the study is entirely up to you, and you will still receive the same care whether you participate in the study or not. You can yarn with an Aboriginal midwife, if you wish.

Who can be in the study?

All Aboriginal women, Torres Strait Islander women, or non-Aboriginal women having an Aboriginal or Torres Strait Islander baby, attending for pregnancy care.

Why be in the study?

We cannot promise that you will receive any direct benefits from being in this study. Everyone who does participate, however, will be helping us build stronger evidence to improve the maternity care for future generations of Aboriginal and Torres Strait Islander families.

How do I join the Woman's Journey: Baggarrook Yurrongi & Nuraagh Manma Buliana study?

If you are interested in this study, you could tell your midwife or Aboriginal Health worker. She will then give your contact details to a research midwife, who will contact you and give you more information and answer your questions.

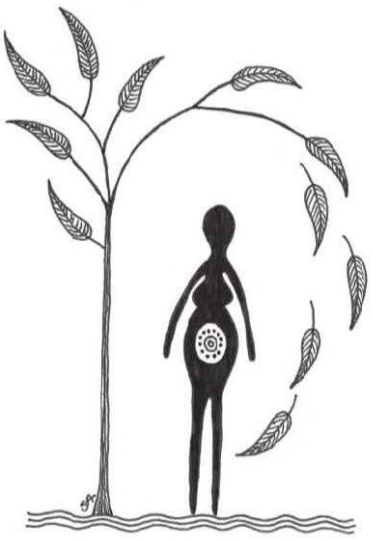
This study is being conducted La Trobe University in partnership with the Victorian Aboriginal Community Controlled Health Organisation, the Royal Women's Hospital,
Mercy Hospital for Women, Western Health-Sunshine Hospital and Goulburn Valley Health.

Baggarrook Yurrongi
Woman's journey

Nuraagh Manma Buliana
All of us working together for pregnancy

Exploring your views of care in pregnancy

Recruitment interview



Birthing Tree, Shawana Andrews 2016

"This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come".

LA TROBE UNIVERSITY

VACCHO

	Date of booking visit___/____/_____	
	Date of interview____/____/____	
	Interview method	
	☐1	**Face to face**
	☐2	**Phone conversation**
	☐3	**Self-completed**
	Interviewer's details:	
	In this section we would like to know about your pregnancy	
1.	**How many weeks pregnant are you today?**	
	☐☐ weeks, or	
	☐☐ months	
	☐ Not sure	
2.	**What date is your baby due?**	
	☐☐/☐☐/☐☐☐☐	
3	**Is this your first baby?**	
	☐1	Yes
	☐2	No
	If no, how many children do you have?	
	☐☐	
4	**Are you of Aboriginal and/or Torres Strait Islander origin ?**	
	☐1	No
	☐2	Yes, Aboriginal
	☐3	Yes, Torres Strait islander
	☐4	Yes, both aboriginal and Torres Strait islander
	If yes. Which Aboriginal language group or community do your people come from?	

5	**Is the father of your baby of Aboriginal and-or Torres Strait Islander origin?**	
	☐1	No
	☐2	Yes, Aboriginal
	☐3	Yes, Torres Strait Islander
	☐4	Yes, both Aboriginal and Torres Strait Islander
	☐5	Unsure/Don't know
	If yes, which Aboriginal language group or community do his people come from?	
6	**Do you speak any Aboriginal language?**	
	☐1	**Yes**
	☐2	**No**
	If yes, please name the language:	
7	**What language do you speak at home?**	
	☐1	English
	☐2	Another language
	Please name other language/s	
8	**How many weeks pregnant were you when you first saw a health provider about this pregnancy? (This includes your GP, Aboriginal Health Service or at the Hospital etc)**	
	☐☐	Weeks or
	☐☐	Months
8 (a)	**What made you decide to go then?**	

8 (b)		
	Was there anything that stopped you going sooner?	
9	**Before you were pregnant, did you have a regular health service or a doctor's clinic? e.g G.P, VAHS public hospital etc.**	
	☐1	Yes, to Aboriginal health service
	☐2	Yes, to mainstream health service
	☐3	No
	☐4	Other
10	**Have you been receiving antenatal care so far during this pregnancy? Tick all that apply**	
	☐1	No, this is my first visit
	☐2	Yes, Aboriginal and Torres Strait Islander Community health service (describe in other)
	☐3	Yes, Victorian Aboriginal Health Service (VAHS)
	☐4	Yes, General Practitioner (GP) (shared care)
	☐5	Yes, hospital (name here)
	☐6	Yes, private obstetrician
	☐7	Yes, private midwife
	☐8	Other (describe
11	**Were you given options about the type of care you have for this pregnancy? e.g Caseload, hospital care, G.P, VAHS etc.**	
	☐1	**Yes**
	☐2	**No**
	☐3	**Don't know/unsure**
	Do you want to comment on anything more?	

12	**"If I may, I'd like to ask some questions about your pregnancy care, and what is important to you" Thinking what that makes you feel most comfortable, which of the following are important to you for the care you will receive during your pregnancy? With 1 being not important and 5 being very important (Please select the best response on the scale)**						
a	**Having culturally appropriate posters, brochures, artwork & Aboriginal and Torres Strait Islander flags**						
	Not important	1	2	3	4	5	Very important
b	**Respecting my privacy & confidentiality**						
	Not important	1	2	3	4	5	Very important
c	**Home visiting from a midwife for check ups**						
	Not important	1	2	3	4	5	Very important
d	**Having an Aboriginal/Torres Strait Islander worker on home visits**						
	Not important	1	2	3	4	5	Very important
e	**Having as many people as I want in the birth room**						
	Not important	1	2	3	4	5	Very important
f	**Able to have as many people as I want to visit me after baby is born (postnatal ward)**						
	Not important	1	2	3	4	5	Very important
g	**My other children/partner/family can come to my check ups**						
	Not important	1	2	3	4	5	Very important
h	**Having care in labour and birth from female health providers**						
	Not important	1	2	3	4	5	Very important
i	**Having most of my care at an Aboriginal community controlled health service**						
	Not important	1	2	3	4	5	Very important
j	**Having transport to check-ups**						
	Not important	1	2	3	4	5	Very important

k	**Meeting other Aboriginal and Torres Strait Islander women who are pregnant**						
	Not important	1	2	3	4	5	Very important
l	**Opportunities to learn about birthing from Elders**						
	Not important	1	2	3	4	5	Very important
m	**Feeling I can trust the health staff**						
	Not important	1	2	3	4	5	Very important
n	**Being cared for by Aboriginal and Torres Strait Islander staff**						
	Not important	1	2	3	4	5	Very important
o	**Opportunities to learn about parenting from Elders**						
	Not important	1	2	3	4	5	Very important

13	**Pregnancy can be a time of change for many women. We would like to ask a few questions about what has been happening in your life.** **Have you experienced any of these during the last 12 months?**				
			Yes	**No**	**NA**
	☐1	Serious illness	☐	☐	☐
	☐2	Serious accident	☐	☐	☐
	☐3	Mental illness	☐	☐	☐
	☐4	Serious disability	☐	☐	☐
	☐5	Overcrowding at home	☐	☐	☐
	☐6	Divorce or separation	☐	☐	☐
	☐7	Getting back together with a partner	☐	☐	☐
	☐8	Serious illness of a family member or close friend	☐	☐	☐
	☐9	Death of a family member or close friend	☐	☐	☐

14	**Please tell us if you have experienced any of these additional worries during this pregnancy. If you prefer not to answer I will go to the next question.** **Please tick all that apply.**					
			Yes	No	NA	Prefer not to answer
	☐1	Money worries	☐	☐	☐	☐
	☐2	Health worries	☐	☐	☐	☐
	☐3	Worries at work	☐	☐	☐	☐
	☐4	Worries about my partner	☐	☐	☐	☐
	☐5	Worries about my kids	☐	☐	☐	☐
	☐6	Worries there could be something wrong with baby	☐	☐	☐	☐
	☐7	Worries about the birth	☐	☐	☐	☐
	☐8	Worries about adult members of my family	☐	☐	☐	☐
	☐9	Worries about problems at home	☐	☐	☐	☐
	☐10	Any other worries (please describe)	☐	☐	☐	☐
	Other worries described					

15	The next questions are about how you've been feeling in general over the last four weeks. In the last 4 weeks, about how often...:				
a	**Did you feel calm and peaceful?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
b	**Have you been a happy person?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
c	**Did you feel full of life?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
d	**Did you feel you have a lot of energy?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
e	**Did you feel nervous?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
f	**Did you feel without hope?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
g	**Did you feel restless of jumpy?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
h	**Did you feel everything was an effort?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
i	**Did you feel so sad that nothing could cheer you up?**				
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
16	**If I may, I'd like to ask you some questions about how you plan to feed your baby.** **How do you plan to feed your baby?**				
	☐1	Breastfeed			
	☐2	Breastfeed and formula			
	☐3	Formula only			
	☐4	Other			

17	**If breastfeeding, how long do you plan to feed your baby breast milk?**	
	☐1	☐☐ MONTHS
	☐2	12 months or longer
	☐3	6 months or longer
	☐4	4 to 6 months
	☐5	1 to 3 months
	☐6	Less than one month
	☐7	A few days
	☐8	I plan to breastfeed but have no plans for how long
	☐9	Other (please describe)
17 C	**How old are you? years**	
18	**Are you currently in a relationship?**	
	☐1	Yes
	☐2	No
19	**Are you....?**	
	☐1	Married
	☐2	Living with partner
	☐3	Have partner but do not live together
	☐4	Separated or divorced
	☐5	Widowed
	☐6	Single
20	**What was the highest level of education you completed?**	
	☐1	Primary school
	☐2	Year 8 or 9
	☐3	Year 10
	☐4	Year 11 or 12
	☐5	Cert III & IV, Diploma
	☐6	Some university but not graduated

	☐7	Bachelors degree
	☐8	Masters, doctorate or other postgraduate degree
	☐9	Other
21	**When you first found out you were pregnant, were you studying?**	
	☐1	Yes, part time
	☐2	Yes, full time
	☐3	No
22	**When you first found out you were pregnant, did you have a paid job?**	
	☐1	Yes, part time
	☐2	Yes, full time
	☐3	No
23	**Is a pension or government benefit the main income for your household?**	
	☐1	Yes
	☐2	No
24	**Do you have a health care concession card?**	
	☐1	Yes
	☐2	No
25	**Do you have private health insurance?**	
	☐1	Yes
	☐2	No
26	**Do you have a car or some other way of getting around?**	
	☐1	Own car
	☐2	My partner's car
	☐3	Use someone else's car
	☐ 4	Use public transport

	☐5	No transport	
	☐6	Other	
27	**What is the postcode for your home address, i.e. the place where you usually live?**		
28	**Which best describes where you are living now?**		
	☐1	Own house/paying off mortgage	
	☐2	Renting	☐Flat/apartment
			☐House
	☐3	Living with family/friends (Someone else's home)	
	☐4	Temporary accommodation (e.g. hostel, motel, refuge, homeless)	
	☐5	Other (please describe)	
29	**How long have you lived there?**		
30	**Before becoming pregnant, approximately how many cigarettes did you smoke a day?**		
	☐1	None	
	☐2	1 – 9	
	☐3	10 – 19	
	☐4	20 – 29	
	☐5	30 – 39	
	☐6	More than 40	
31	**Approximately how many cigarettes did you smoke a day now?**		
	☐1	None	
	☐2	1 – 9	
	☐3	10 – 19	
	☐4	20 – 29	
	☐5	30 – 39	

	☐6	More than 40
32	**Does anyone in your home smoke around you?**	
	☐1	Yes
	☐2	No
33	**What are you looking forward to most about being a new mum?**	
34	**How are you feeling about your pregnancy today?**	
	Very poor ☹ ☐1	Poor ☐2 Mixed ☐3 Good ☐4 Very good ☺ ☐5
35	**How are you feeling in general today?**	
	Very poor ☹ ☐1	Poor ☐2 Mixed ☐3 Good ☐4 Very good ☺ ☐5
36	**Is there anything else you would like to tell us about your pregnancy?**	

Appendix E - Follow up

Telephone contact protocol

WOMAN'S JOURNEY TELEPHONE PROTOCOL

Conducting interviews
Women are informed when they are recruited to the evaluation of care that there will be 1 follow up telephone questionnaire; at 3 months after the birth.

Contact procedure- (Remember to enter all comments in Redcap comments (data entry)

1st attempt at contact
Engaged signal ⇒ Enter 'Phone engaged' and date in Redcap comments
Phone rings out ⇒ Enter 'No answer' and date.
Phone contact made with women, but requested a call back- "requested call back" (leave specific time if applicable)
Answering machine/voicemail ⇒ Enter no answer (or NA) and date. Don't leave a message yet.

2nd attempt at contact
If goes to voicemail/answer machine, leave a message indicating that you will call back. Example of dialogue:

"Hello, I'm ____Research Midwife/Research Assistant from the Pregnancy Care study that ____(mother's name) is part of. I'm calling to ask if I can carry out the 3 month Questionnaire. I will call you again in the next few days"

Enter "1st message left" and date on Redcap.

Phone rings out ⇒ Enter 'N/A' and date on database
Engaged signal ⇒ If the engaged signal persists enter "phone engaged" and the date of the call on the database.(If a mobile number and engaged tone may mean the phone is disconnected: see below)
Phone contact made with women, but requested a call back- "requested call back"

3rd attempt at contact
One message already on answering machine? ⇒ try again, leave another message, ask them to call us back on ###### Enter **"2nd message left"** and, date and time on Redcap.
Example of dialogue:
"Hello, I'm ____Research Midwife/Research Assistance from the Pregnancy Care study that ____(mother's name) is part of. I'm calling to ask if I can carry out the 3 month Questionnaire. Please can you call us back on #### and we can arrange a time to chat"

Try alternative phone contact, explain that you are a researcher and ____ has provided this number as a back up. Ask if the message could be passed on to her, that we are trying to contact her and she can call us on ####

Phone rings out ⇒ If email contact given, send a follow up email. Enter ' follow-up email sent' and date in to Redcap.

Phone contact made with women, but requested a call back- "requested call back" Ask woman when the best time for us to call her might be.

Check messages over the next week.
Keep trying woman's phone number if she has requested a call back. Leave no more than 2 voice messages.

Partner/other contact person

If other contact person answers, ask if they could pass on a message to ask the mother to call us.
If goes to voicemail leave message requesting that they ask woman to call us on ####.

Example of message to partner/contact person:

"Hello, I'm_____ a midwife/research assistant with the* Pregnancy Care study. *I have been trying to contact_____about the follow up telephone 3 month questionnaire. Could you suggest a good time that I might try to contact her or would you please ask her if she would contact me on ####?"

Enter partner/ other contact person contacted message left etc and date on Redcap.

Other Issues

Woman unavailable (someone else answers)⇒ leave a message that you will call back at a convenient time. Enter date/details in Redcap

Wrong number ⇒ check contact sheet and/or hospital IPM to verify. Enter wrong number, date and time. Try email and/or contact person if available

Telephone disconnected ⇒ enter telephone disconnected and date. Try email/contact person as above.

Text messages ⇒ okay if phone contact with woman has already been made (e.g arranging a time to call her)

Interview Process

Introduction

Follow instructions on the front of the questionnaire

Conclusion of interview

Thank the women and ask her if she is happy for further contact in the future.

Summary

Leave up to 2 messages on voicemail/answer machine- no more.
Ok to keep trying, but not leave a message.
Send only one "follow-up email" in total.
Contact partner/contact person once only (if unable to get through to woman)
Text messages to arrange a phone call okay (if previous phone contact with woman has been made)

Referral resource for researchers

Women who have concerns regarding their care in hospital

Refer women to Aboriginal Hospital Liaison Officer at the specific hospital:

Royal Women's Hospital- (03) 8345 3047
Sunshine Hospital: Phone: 8345 0952 Mobile: 0466 499 825
Mercy: Phone: 03 8458 4393 Mobile: 0407 285 446
Shepparton: Ph: (03) 5832 2450

Women who request health information or advice

Discuss with the woman possible avenues for information and assistance, see below.

Women who become distressed or upset
Refer to distress/disclosure protocol

SUGGESTIONS FOR WOMEN REQUIRING REFERRAL
Australian Breastfeeding Association ***1800 mum 2 mum /*** **1800 686 2 686**
Local GP
Local Maternal & Child Health Nurse
Maternal and Child Health Line **13 22 29**
PANDA Perinatal Anxiety and Depression Australia helpline **1300 726 306**
Lifeline **13 11 14**
Beyond Blue **1300 22 4636**
Royal Children's Hospital **9345 5522**
Safe steps **1800 015 188, 24 hours per day**





Woman's Journey distress protocol



This protocol is used for responding where participants become distressed **at any stage** during interviews.

Before commencing interview, researcher will inform woman that the interview may be interrupted, paused, or concluded at any time should the participant not wish to continue. (Example: To attend to baby, to have a break, if participant becomes uncomfortable or for any reason does not want to continue the interview) The interviewer will also offer the woman to nominate a "safe word", where the woman can safely terminate the interview, if she is no longer in a private space.

The interviewer will explain that sometimes talking to a researcher about personal experiences may mean that the woman would like to talk further about any issues that have been raised. Resource cards will have been given at recruitment with referral options.

- If a participant becomes distressed, the researcher will suspend the research process, support the participant, and offer assistance to contact other support services. Support will include:

  1. Listening empathetically to the woman's account of how she is feeling.
  2. Determining what the woman identifies as the reason for her distress.
  3. Allowing the woman to determine the appropriateness of continuing the research process (either then or at a later occasion), or to opt out of the project all together.
  4. Planning for support and contact around follow-up/community supports/referral.

- In the event that there is spontaneous disclosure at any stage during the research process of the woman being in current danger:
  1. The researcher will enquire out the safety of the woman at the point of such disclosure.
  2. Refer the woman to the appropriate services as needed (i.e "If you are feeling that you are in danger right now, I strongly recommended that you call the police.")
  3. If child sexual abuse is disclosed, mandatory reporting laws oblige the researcher to contact police.

Useful contacts:

Victoria Police, Family Violence unit: 03 9865 5100
DHS child protection: 13 12 78
Sexual Assault Crisis Line: 1800 806 292
National Sexual Assault and Domestic Violence Helpline: 1800 737 732
Safe Steps Family Violence Response Centre: 1800 015 188, 24 hours per day
Lifeline: 13 11 14
Aboriginal Family Violence Prevention and Legal Service: 1800 015 188, 9am-5pm
Elizabeth Morgan House: (03) 9482 5744, 9am-5pm





Generic follow up email

Dear, _____

Congratulations on your new baby, we hope things are going well.

You are receiving this e-mail regarding the Woman's Journey pregnancy study, where you signed up to participate in a 3 month postnatal interview, which is all about the care that you received in hospital. Our records tell us that your baby is about 3 months old. One of our research team members will call you soon, to carry out the postnatal questionnaire over the phone. If we ring you at a busy time, it is okay to ask the team member to call you back later. Alternatively, you can ring #### #### to arrange a time that it convenient for you.

We thank you again for agreeing to share your story with us.

Warmest,

the Woman's Journey team.

ID ☐☐☐☐

Baggarrook Yurrongi
(Women's Journey in Woiwurrung)
Nurragh Munma Buliana
(All of us working together in pregnancy in Yorta Yorta)
'Birthing Tree' artwork by Shawana Andrews

Exploring your views of care (interview about three months after birth)

Start the interview by introducing yourself. Inform the woman that you are calling about the study about pregnancy care at La Trobe University, which she is participating.
Ask if the time is convenient, discussing an alternative time if she would prefer. Explain that the interview will take around 40-60 minutes, and that you would like to talk to her while she is in a private and comfortable space.

"Thank you for agreeing to take part in this study. There are no right or wrong answers. We are really interested in your experiences and thoughts about the care you had when you were pregnant, and during labour and birth, and since then. Your answers are confidential, and you will not be identifiable by sharing your story. If you would like to stop or ask any questions at any time during the interview let me know. If there are any questions you would prefer not to answer, please let me know, and I can skip over them. I will be asking some sensitive questions. Please let me know if you are not able to speak to me in a safe and private space today, and I can contact you at a later time."

Interviewer initials ☐☐☐

Interview date ☐☐ ☐☐ ☐☐☐☐

Section 1: Pregnancy	
The interview is in several different sections – a bit about your baby, some on your pregnancy and birth, and some questions about how you have been since then. Firstly…a few questions are about your baby and your pregnancy care..	
1.	**What is <u>your</u> date of birth?**
	☐☐/☐☐/☐☐☐☐
1.a	**How many babies did you have <u>this pregnancy</u>?**
	☐1 one (singleton) ☐2 two (twins) ☐3 three (triplets) ☐4 four or more
2.	**How old is your baby now?**
	☐☐ weeks OR
	☐☐ months
3.	**Did you have a girl or a boy?**
	☐1 Girl
	☐2 Boy
4.	**What was your baby's date of birth?**
	☐☐/☐☐/☐☐☐☐
4.a	**What is your baby's name?** _____
5.	**Where were you originally booked for your birth?**
	☐1 Mercy Hospital for women
	☐2 Royal Women's Hospital
	☐3 Goulburn Valley Health (Shep)
	☐4 Western Health (Sunshine)
	☐5 Other (describe)
6.	**Where was your baby born?**
	☐1 Same as above
	☐2 Other (describe)

"I just want to check where you had your check-ups in pregnancy and who you had them with" (e.g. with the same midwife each time, at the hospital, at the community health service etc) **7.Do you remember about how many pregnancy check-ups you had <u>altogether</u>?**		
	☐☐ visits OR	
7.a	☐1	Less than 5 visits
	☐2	5 to 10 visits
	☐3	More than 10 visits
	☐4	Not sure
7.b	If you had less than 5 pregnancy check-ups, can you tell me why?	
8.	We'd like to know who you mainly saw during pregnancy, where that usually was, and about how many visits you had with each person (or service) ** CHC= community health centre	

	Who did you see?	**Where (usually)?**				**9. # of visits**	
						Write #	Did not see
a	☐ My hospital midwife – same one each time (MGP, Caseload etc)	☐i Hosp	☐ii Home	☐iii CHC	☐iv Other (describe)		☐v
b	☐ My hospital midwife's back-up(s) (MGP, Caseload etc)	☐i Hosp	☐ii Home	☐iii CHC	☐iv other (describe)		☐v
c	☐ Hospital doctor	☐i Hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v
d	☐ Hospital midwife (standard care)	☐i Hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v
e	☐ Midwife from Aboriginal Community Health Centre	☐i hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v
f	☐ Local (family) doctor	☐i hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v

G	☐ KMS midwife or health worker	☐i Hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v
h	☐ Hospital-based Aboriginal Health worker (Liaison officer)	☐i Hosp	☐ii home	☐iii CHC	☐iv other (describe)		☐v
i	☐ Other pregnancy care provider ☐ did not see	If other pregnancy care provider seen, please describe..					

10.	**When you first booked in at the hospital, did you feel like you were given a choice about who would be providing your pregnancy care?**	
	☐1	Yes
	☐2	No
10.a		Would you like to tell us anything more about that?

12.	**I have a list here of some things that some women have said about their <u>care in pregnancy,</u> and after each statement, please rate how much you agree or disagree with each statement on a scale of 1 to 5, with 1 being strongly disagree and 5 being strongly agree.**						
		Strongly Disagree	**Dis agr ee**	**Neither agree nor disagree**	**Agree**	**Strongl y Agree**	**N/A**
a	At my check-ups I was always asked whether I had any questions	☐1	☐2	☐3	☐4	☐5	☐
b	The **midwives** always kept me informed about what was happening	☐1	☐2	☐3	☐4	☐5	☐
c	The **doctors** always kept me informed about what was happening	☐1	☐2	☐3	☐4	☐5	☐6
d	I was always given an active say in decisions about my care in pregnancy	☐1	☐2	☐3	☐4	☐5	☐6
e	I always felt my worries, anxieties or concerns about the pregnancy and the	☐1	☐2	☐3	☐4	☐5	☐6

	baby were taken seriously by the **midwives**						
f	I always felt my worries, anxieties or concerns about the pregnancy and the baby were taken seriously by the **doctors**	☐1	☐2	☐3	☐4	☐5	☐6
g	The **midwives** provided reassurance when I needed it	☐1	☐2	☐3	☐4	☐5	☐6
h	The **doctors** provided reassurance when I needed it	☐1	☐2	☐3	☐4	☐5	☐6
i	At my check-ups the **midwives** often seemed rushed	☐1	☐2	☐3	☐4	☐5	☐6
j	At my check-ups the **doctors** often seemed rushed	☐1	☐2	☐3	☐4	☐5	☐6
k	My care in pregnancy was provided in a competent way	☐1	☐2	☐3	☐4	☐5	☐6
l	I was happy with the physical care I received in pregnancy from **midwives**	☐1	☐2	☐3	☐4	☐5	☐6
m	I was happy with the physical care I received in pregnancy from **doctors**	☐1	☐2	☐3	☐4	☐5	☐6
n	I was happy with the emotional support I received in pregnancy from **midwives**	☐1	☐2	☐3	☐4	☐5	☐6
o	I was happy with the emotional support I received in pregnancy from **doctors**	☐1	☐2	☐3	☐4	☐5	☐6
p	I got adequate information during pregnancy about caring for my baby	☐1	☐2	☐3	☐4	☐5	☐6
q	I got adequate information during pregnancy about breastfeeding	☐1	☐2	☐3	☐4	☐5	☐6
r	I got adequate information during pregnancy about caring for myself after the birth	☐1	☐2	☐3	☐4	☐5	☐6
s	I got adequate information during pregnancy about labour and birth	☐1	☐2	☐3	☐4	☐5	☐6
t	I got adequate information during pregnancy about community services	☐1	☐2	☐3	☐4	☐5	☐6
u	I was informed about how long I would stay in hospital after the birth	☐1	☐2	☐3	☐4	☐5	☐6
v	I was happy with the cultural support I got in pregnancy	☐1	☐2	☐3	☐4	☐5	☐6

11.	**Thinking back to your pregnancy care.. Not including the midwives, how did the other hospital staff behave towards you?**				
		Not at all	**Sometimes**	**Always**	**N/A**
a	Talked to me in a way I could understand	☐ i	☐ ii	☐ iii	☐ iv
b	Listened to me	☐ i	☐ ii	☐ iii	☐ iv
c	Treated me with kindness	☐ i	☐ ii	☐ iii	☐ iv
d	Treated me as an individual	☐ i	☐ ii	☐ iii	☐ iv
e	Treated me with respect	☐ i	☐ ii	☐ iii	☐ iv
13.	**Overall how would you describe your care during pregnancy? Please rate on a scale of 1 to 7 where 1 is very poor and 7 is very good.**				
Overall my care in pregnancy was…		**Very poor** 1 2 3 4 5 6 **Very good** 7			
13. a	**Was there anything about your pregnancy care that you were particularly happy with?**				
13. b	**Was there anything about your pregnancy care that you were particularly unhappy with?**				

Section 2: Your labour and birth experiences

	The next few questions are about the care you received when you were <u>in the hospital for the birth of your baby.</u>						
14.	**What type of birth did you have?**						
	☐1	Normal birth					
	☐2	Forceps birth					
	☐3	Vacuum birth					
	☐4	Caesarean birth (Planned)					
	☐5	Caesarean birth (Unplanned)					
15	**During your labour and birth, were you cared for by a midwife who you had met during pregnancy?**						
a.	☐1	No (skip to question 16)					
b.	☐2	Yes, one or more midwife/midwives					
15.i	**If yes, how many times had you met each one?**						
a.	☐1	First midwife I knew – had met at ☐☐ visits					
b.	☐2	Second midwife I knew – had met at ☐☐ visits					
c.	☐3	Third midwife I knew – had met at ☐☐ visits					
16	**During your labour and birth, were you cared for by an Aboriginal Health worker who you had met during pregnancy?**						
a	☐1	No (skip to question 17)					
b	☐2	Yes, one or more Aboriginal health worker/s					
16.i	**If yes, how many times had you met each one?**						
aa	☐1	First AHW I knew – had met at ☐☐ visits					
b.	☐2	Second AHW I knew – had met at ☐☐ visits					
c.	☐3	Third AHW I knew – had met at ☐☐ visits					
17.	**Can you tell me how much you agree with this next set of statements – you can say: never, occasionally, sometimes, mostly, always, or not applicable**						
	During labour and birth…	**Never**	**Occasionally**	**Sometimes**	**Mostly**	**Always**	N/A
a	The midwives explained what was happening	☐1	☐2	☐3	☐4	☐5	☐6

b	The midwives used words I could understand	☐1	☐2	☐3	☐4	☐5	☐6
c	The midwives were kind and understanding	☐1	☐2	☐3	☐4	☐5	☐6
d	The midwives were there when I needed them	☐1	☐2	☐3	☐4	☐5	☐6
e	I was given a say in decisions about my care	☐1	☐2	☐3	☐4	☐5	☐6

18.	**And now there some questions about how you actually felt and coped during labour and birth…they are all on a scale of 1 to 7…**							
a	During labour and birth I was…	Not at all anxious						Very anxious
		1	**2**	**3**	**4**	**5**	**6**	**7**
b	During labour and birth I felt…	No pain at all						Worst imaginable pain
		1	**2**	**3**	**4**	**5**	**6**	**7**
c	My experience of pain was…	Much worse than expected						Much better than expected
		1	**2**	**3**	**4**	**5**	**6**	**7**
c.i	My experience of pain was….	Very negative						Very positive
		1	**2**	**3**	**4**	**5**	**6**	**7**
d	During labour and birth I felt…	Completely out of control						In complete control
		1	**2**	**3**	**4**	**5**	**6**	**7**
e	Physically I coped…	Much worse than I expected						Much better than I expected
		1	**2**	**3**	**4**	**5**	**6**	**7**
f	Emotionally I coped…	Much worse than I expected						Much better than I expected
		1	**2**	**3**	**4**	**5**	**6**	**7**
g	When looking back at my labour and birth I feel…	Not at all proud of myself						Very proud of myself
		1	**2**	**3**	**4**	**5**	**6**	**7**
h	Overall, my experience of giving birth was…	Very negative						Very positive
		1	**2**	**3**	**4**	**5**	**6**	**7**

19.	"I have already asked you about your experience of care from the midwives during your labour and birth, but I would also like to know about your experience with the other health care staff.." (if applicable). **Thinking about your care during labour and birth overall – how did the other hospital staff (not including the midwives) behave towards you?**

		Not at all	Sometimes	Always	N/A
a	Talked to me in a way I could understand	☐ i	☐ ii	☐ iii	☐ iv
b	Listened to me	☐ i	☐ ii	☐ iii	☐ iv
c	Treated me with kindness	☐ i	☐ ii	☐ iii	☐ iv
d	Treated me as an individual	☐ i	☐ ii	☐ iii	☐ iv
e	Treated me with respect	☐ i	☐ ii	☐ iii	☐ iv
20.	**Overall, my <u>care</u> in labour and birth was**	**Very poor** 1 2 3 4 5 6 **Very Good** 7			
20.a	**Things you were really happy with?**				
20. b	**Things you were particularly unhappy with?**				

SECTION 3: you care after the birth – in hospital and at home		
21.	**During your stay in hospital after the birth. did you see any of the midwives who cared for you during pregnancy or in labour?**	
	☐1	No
	☐2	Yes- midwife/midwives from pregnancy checkups only
	☐3	Yes- midwife/midwives from my labour and birth only
	☐4	Yes midwife/midwifes from **both** pregnancy and labour/birth
22.	**How long did you stay in hospital after your baby was born?** (preferably find out hours but otherwise whatever seems best fit)	
a	☐☐ hours OR	
b	☐1	Less than 24 hrs
	☐2	Between 24 – 48 hrs
	☐3	2 – 4 days
	☐4	5 days or more
23.	**Who decided when you should go home?**	
	☐1	I decided when to go home
	☐2	I decided together with the hospital staff when to go home
	☐3	Hospital staff told me when to go home
	☐4	Not sure/can't remember
24.	**In your opinion was your hospital stay:**	
	☐1	About right
	☐2	Too long
	☐3	Too short
b	**Do you have any other comments about how long you stayed in hospital?**	

25.	**Now just a few questions about your care in hospital after the birth…. Please rate each one of a scale of 1 to 5, 1 being strongly disagree and 5 being strongly agree.**					
		Strongly Disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a	I was given the advice I needed with breastfeeding	☐1	☐2	☐3	☐4	☐5
b	I was given the advice I needed about how to handle, settle or look after my baby	☐1	☐2	☐3	☐4	☐5
c	I was given the advice I needed about my own health and recovery after the birth	☐1	☐2	☐3	☐4	☐5
d	The midwives were encouraging	☐1	☐2	☐3	☐4	☐5
e	The midwives often seemed rushed	☐1	☐2	☐3	☐4	☐5
26.	**Overall**, how would you describe the care **YOU** received in hospital after the birth	**Very poor** 1	2	3	4	5	6	**very good** 7
27.	**Overall**, how would you describe the care **YOUR BABY** received in hospital after the birth	**Very poor** 1	2	3	4	5	6	**Very good** 7
28.	**Is there anything else you would like to tell me about your care in hospital after the birth?**							

	SECTION 4: The first week or two after the birth						
	The next few questions are about the care you received from the hospital after you were discharged home and how you felt in the first week.						
29.	**Were you and your baby discharged home together?**						
	☐1 yes (go to Q 31) ☐2 no						
30.	**If your baby did not go home with you, can you tell me why not?**						
30.a	☐1	Baby was unwell and in the special or intensive neonatal care unit					
	☐2	Child safety reasons					
	☐3	Other - please tell me, if that's ok					
31.	**When you went home, did you have any visits from a <u>hospital midwife?</u> (Not including your Maternal and Child Health Nurse)**						
	☐1	Yes					
	☐2	No					
31.a.	☐3	If no, can you tell us why? (describe) (skip to q 36)					
32.	**How many home visits did you have?**						
a	☐☐ visits						
b	☐1 Can't remember						
33.	**Were any of these visits with a midwife you had met before?**						
	☐1	Yes					
	☐2	No (go to question 35)					
34.	**How many visits did you have with a midwife you had met before?**						
	☐☐ visits						
35.	**On a scale of 1 to 7, 1 being very poor and 7 being very good, OVERALL, how would you describe the care you and your baby received <u>from</u> <u>hospital midwife</u> at home, after the birth?**						
	Very Poor						**Very Good**
	1	**2**	**3**	**4**	**5**	**6**	**7**

36.	**Did you have a visit from an Aboriginal Health Worker in the week after you left hospital?**				
	☐1	Yes			
	☐2	No			
	☐3	I can't remember			
36.a	Would you like to add anything about this?				
37.	**I am going to ask you a few questions about your experiences during your hospital care, and how important you think some things are to have a good experience.**				
b	**Did you feel your privacy and confidentiality was respected?**		☐1 Yes	☐2 No	☐3 Not sure
b.i	How important is this to you? not at all important **1** **2** **3** **4** **5** very important				
c	**Did you have home visits from a midwife for any pregnancy check ups?**		☐1 Yes	☐2 No	☐ Not sure
c.i	How important is this to you? not at all important **1** **2** **3** **4** **5** very important				
d	**Did you have an Aboriginal health worker at any of your pregnancy check ups?**		☐1 Yes	☐2 No	☐ Not sure
d.i	How important is this to you? not at all important **1** **2** **3** **4** **5** very important				
e	**Were you able to have as many people as you wanted in the birth room?**		☐1 Yes	☐2 No	☐ Not sure
e.i	How important is this to you? not at all important **1** **2** **3** **4** **5** very important				
f	**Were you able to have as many people visit you after the baby was born?**		☐1 Yes	☐2 No	☐ Not sure
f.i	How important is this to you? not at all important **1** **2** **3** **4** **5** very important				

g	**Were your other children/partner/family members welcome to come to your check ups?**	☐1 Yes ☐2 No ☐ Not sure
g.i	How important is this to you? not at all important very important **1 2 3 4 5**	
h	**Were you cared for during labour and birth from female health care providers only?**	☐1 Yes ☐2 No ☐ Not sure
h.i	How important is this to you? not at all important very important **1 2 3 4 5**	
i	**Did you have any care at an Aboriginal community-controlled health service?**	☐1 Yes ☐2 No ☐ Not sure
i.i	How important is this to you? not at all important very important **1 2 3 4 5**	
j	**If you required transport assistance to get to your checkups, was it available?**	☐1 Yes ☐2 No ☐3 Not needed
j.i	How important is this to you? not at all important very important **1 2 3 4 5**	
a.	**Did you see any culturally appropriate posters, brochures, artwork or Aboriginal & Torres Strait Islander flags around the hospital?**	☐1 Yes ☐2 No ☐ Not sure
a.i	How important is this to you? not at all important very important **1 2 3 4 5**	
k	**Did you have the opportunity to meet other Aboriginal or Torres Strait Islander families who were also having a baby?**	☐1 Yes ☐2 No ☐ Not sure
k.i	How important is this to you? not at all important very important **1 2 3 4 5**	
l	**Were you cared for by staff who identified as Aboriginal or Torres Strait Islander?**	☐1 Yes ☐2 No ☐ Not sure
l.i	How important is this to you? not at all important very important **1 2 3 4 5**	
m.	**Please feel free to comment further on any of these things mentioned above. (next page)**	

38.	**Do you feel that there was ever a time during your care, where you were judged or treated poorly by healthcare staff? For example, your age, weight, or culture?**			
	☐1	Yes		
	☐2	No (Go to question 41)		
39.	**Do you believe you were judged or treated badly because of one or more of the following?**			
		Yes	No	Not applicable
a	Your age	☐1	☐2	☐3
b	Being Aboriginal and/or Torres Strait Islander	☐1	☐2	☐3
c	Your partner being Aboriginal and/or Torres Strait Islander	☐1	☐2	☐3
d	Your weight	☐1	☐2	☐3
e	Your smoking	☐1	☐2	☐3
f	Your visitors (e.g. too many, too loud etc)	☐1	☐2	☐3
g	Your disability (if applicable)	☐1	☐2	☐3
h	Your religion or cultural practices	☐1	☐2	☐3
i	Something else	☐1	☐2	☐3
j	(please describe)			
40.	**Here I have a list of actions some women might decide to take about this. After you were treated poorly, what did you do about it? (tick all that apply):**			
	☐1	Accept it as a fact of life		
	☐2	Try to do something about it		

	☐3	Talk to your partner, friend or family member about it
	☐4	Talk to an Aboriginal Health Worker or Liaison Officer about it
	☐5	Talk to a non-Aboriginal staff member about it
	☐6	Report it or make a complaint
	☐7	Keep it to yourself
40.a	☐8	Other (Please tell me about it if you would like)

41.	"The next set of questions ask about any potential worries that you might be experiencing in your life. Some people might find these questions to be sensitive. You do not have to answer all of the questions. If you would like to skip any, please let me know. If you need to stop the interview, please let me know." ** Note: good to confirm again if woman is in a private space** **Please tell us if you have experienced any of these worries, since the birth of this baby?**				
		Yes	No	Not applicable	Prefer not to answer
a	Money worries	☐1	☐2	☐3	☐4
b	Health worries	☐1	☐2	☐3	☐4
c	Worries at work	☐1	☐2	☐3	☐4
d	Worries about my partner	☐1	☐2	☐3	☐4
e	Worries about my kids	☐1	☐2	☐3	☐4
f	Worries about adult members of my family	☐1	☐2	☐3	☐4
g	Worries about problems at home	☐1	☐2	☐3	☐4
h	Worries about Child Safety Services	☐1	☐2	☐3	☐4
i	Any other worries	☐1	☐2	☐3	☐4
j	(please describe)				

42.	In the last 12 months, has your partner, ex-partner, or anyone in your family:				
		yes	no	Prefer not to answer	Not asked
a	Made you feel unsafe or afraid?	☐i	☐ii	☐iii	☐iv
b	Controlled your daily activities (e.g. who you see, where you go)?	☐i	☐ii	☐iii	☐iv
c	Threatened to hurt you in any way?	☐i	☐ii	☐iii	☐iv
d	Hit, slapped, kicked or otherwise physically hurt you?	☐i	☐ii	☐iii	☐iv
e	If so, who? Partner ☐1 Ex-partner ☐2 Someone else ☐3				

Section 6: Your baby (ONLY INCLUDE IF BABY IS IN MOTHER'S CARE)

43.	Has your baby had any health problems since she/he came home from hospital following the birth?	
	☐1	Yes
	☐2	No (go to q. 45)
43.a	☐	Baby not in mother's care
44.	Please describe her/his health problems (tick all that apply)	
	☐1	Upper respiratory disorders e.g. colds, coughs, runny nose
	☐2	Minor skin disorders e.g. rashes, eczema
	☐3	Infections e.g. umbilical cord, viral, chicken pox
	☐4	Renal/kidney problems e.g. urinary tract infection
	☐5	Sticky eyes/minor eye or ear infections
	☐6	Clicky hips
	☐7	Jaundice
	☐8	Reflux
	☐9	Other (please describe)
45.	Have you needed to bring your baby to a hospital, since going home after her/his birth?	
	☐1	Yes
	☐2	No (go to question 49)
45.a	How many times have you taken your baby to a hospital?	
	☐☐ Times	

	Can you tell me the reason for each visit to hospital, your baby's age at the time, how long she/he stayed and in which areas of the hospital you baby was cared for?			
			46.a Length of visit/stay	**46.b** Baby's age at visit
46.	1st visit reason:		☐☐ Days or ☐☐ Hours	☐☐ Days or ☐☐ Weeks
46.c	☐1	Emergency department at a hospital		
	☐2	The postnatal ward		
	☐3	The newborn intensive care or special care		
	☐5	Outpatient clinic (please describe)		
	☐6	Other (please describe)		
47.	2nd visit reason:		**47.a** ☐☐ Days or ☐☐ Hours	**47.b** ☐☐ Days or ☐☐ Weeks
47.c	☐1	Emergency department at a hospital		
	☐2	The postnatal ward		
	☐3	The newborn intensive care or special care		
	☐5	Outpatient clinic (please describe)		
	☐6	Other (please describe)		
48.	3rd visit reason:		**48.a** ☐☐ Days or ☐☐ Hours	**48.b** ☐☐ Days or ☐☐ Weeks
48.c	☐1	Emergency department at a hospital		
	☐2	The postnatal ward		
	☐3	The newborn intensive care or special care		
	☐5	Outpatient clinic (please describe)		
	☐6	Other (please describe)		
48.e	If there were other visits, please describe them here (next page)			

The next few questions relate to how you have been feeding your baby…		
49.	**In the last 24hrs, what milk have you been feeding your baby?**	
	☐ 1	Fully breastfeeding
	☐ 2	Breastfeeding + expressed breast milk (EBM)
	☐ 3	EBM
	☐ 4	Breastfeeding + formula
	☐ 5	Breastfeeding + EBM + formula
	☐ 6	EBM + formula
	☐ 7	Fully formula feeding
49.a	☐ 8	Other (please describe other milk you have used)
50.	**We would also like to know all the different ways you have been feeding your baby milk since birth?**	
	☐ 1	Fully breastfeeding
	☐ 2	Breastfeeding + expressed breast milk (EBM)
	☐ 3	EBM
	☐ 1	Breastfeeding + formula
	☐ 1	Breastfeeding + EBM + formula
	☐ 1	EBM + formula
	☐ 7	Fully formula feeding
50.a	☐ 8	Other (please describe other milk you have used)
51.	**Has your baby ever had any infant formula at all since birth?**	
	☐ 1	Yes
	☐ 2	No (go to question 53)
52.	**What was/is the reason your baby had/is having infant formula (tick all that apply)**	
	☐ 1	Nipple trauma/damage
	☐ 2	Nipple pain
	☐ 3	Felt there was not enough milk/did not know if baby had enough milk
	☐ 4	Unable to get baby to attach/suck/difficulties attaching baby to the breast
	☐ 5	Baby unwell or very premature

	☐ 6	Baby had low blood sugar
	☐ 7	Excessive weight loss
	☐ 8	Lack of help/support/supervision with breastfeeding
	☐ 9	So someone else could feed the baby
52.a	☐ 10	Other (please describe)
53.	**For how long after she/he was born did your baby have only breast milk? (that is no other fluids or foods) (At what age did you baby first have formula?)**	
	☐☐ days OR	
	☐☐ weeks OR	
53.a	**OR**	
	☐ 1	Still having breast milk only (go to question 56)
	☐ 2	Never had breast milk only
	☐ 99	Not sure/can't remember
54.	**(IF BREASTFEEDING GO TO Q 56)** **If you started to breastfeed and have stopped, how old was the baby when you stopped?**	
	☐☐ days OR	
	☐☐ weeks OR	
54.a	☐ 99	Not sure/can't remember
55.	**Why did you decide to stop breastfeeding (or giving breast milk)?**	
	☐ 1	Did not want to breastfeed/did not want to breastfeed any longer
	☐ 2	Nipple trauma/damage
	☐ 3	Nipple pain
	☐ 4	Felt there was not enough milk/did not know if baby had enough milk
	☐ 5	Unable to get baby to attach/suck/difficulties attaching baby to the breast
	☐ 6	Baby unwell or very premature
	☐ 7	Lack of help/support/supervision with breastfeeding
55.a	☐ 8	Other (please describe)
55.c	**Of the reasons you have given, which would be the most important reason for deciding to stop breastfeeding? (Write number from above question in the box)** ☐	

56.	**What was your original plan for breastfeeding?**	
	☐☐ days OR	
	☐☐ weeks OR	
	☐☐ months OR	
56.a	☐1	As long as I could
	☐2	As long as my baby wanted to
	☐3	Not sure/can't remember
	☐4	Didn't have a plan/set idea
	☐5	Never planned to breastfeed
57.	**Has your baby been introduced to fluids other than breast milk or formula?**	
	☐1	Yes
	☐2	No (go to question 58)
57.a	**At what age did your baby commence fluids other than breast milk or formula?**	
	☐☐ days OR	
	☐☐ weeks OR	
58.	**Has your baby had any solid foods?**	
	☐1	Yes
	☐2	No (go to question 59)
58.a	**At what age did your baby commence solids?**	
	☐☐ days OR	
	☐☐ weeks OR	
58.b	**Can you tell me what types of food?**	
	☐1 fruits ☐2 vegetables ☐3 cereals/grains/bread ☐4 yoghurt/cheese/milk ☐5 meats ☐6 other	
Section 7: Your feelings, emotions and physical health		
59.	Thinking about your own health and how you have been feeling since your baby was born, can you tell me if any of the following have been a problem for you: (tick all that apply)	
a	☐1	Soreness where you had a tear of episiotomy
b	☐2	Pain from caesarean wound

c	☐3	Feeling tired and exhausted
d	☐4	Constantly reliving your labour or your baby's birth
e	☐5	Incontinence (loss of bladder control)
f	☐6	Constipation
g	☐7	Loss of bowel control
h	☐8	Hemorrhoids
i	☐9	More coughs, colds or other minor illnesses than usual
j	☐10	Back pain
k	☐11	Anxiety
l	☐12	Heavy bleeding or bleeding that has worried you
m	☐13	Mastitis (fever caused by infection in your breasts – no medical treatment)
n	☐14	Mastitis (treated with antibiotics)
o	☐15	Sore nipples
p	☐16	Problems in your relationship with your husband/partner
q	☐17	Problems with having sex
r	☐18	Depression lasting two weeks or more
s	☐19	General feeling of being unwell
t	☐20	Other (please describe)

60.	**Have you been admitted to hospital since going home, for yourself? (Not boarding with baby)**	
	☐1	Yes
	☐2	No (go to q. 65i)

If YOU have been admitted to hospital:

		Date you went in	**How many days in hospital**	**Reason for admission**
	1st admission	**61.a)**	**61.b)**	**61.**
	2nd admission	**62.a)**	**62.b)**	**62.**
	3rd admission	**63.a)**	**63.b)**	**63.**
	4th admission	**64.a)**	**64.b)**	**64.**

65i	**Have you seen the Maternal and Child Health Nurse since the birth?**			
	☐1	Yes		
	☐2	No		
	☐3	Not sure/can't remember		
65ii	**If no**, can you please tell me why?			
65.	**How much contact have you had with the Maternal and Child Health Nurse?**			
	☐☐ home visits (number of)			
a.	☐☐ visits to the MCH centre			
b.	☐☐ phone calls to MCH nurse			
c.	☐☐ phone calls to MCH telephone hotline			
66.	Have you used any other (non-hospital) health services for **YOUR BABY'S** health (apart from routine things such as home visit(s) from a midwife and visits with your maternal child health nurse and visits for vaccinations) since your baby was born? Services to include: GP, telephone help lines, Mother/baby unit, paediatrician, lactation consultant (not at the hospital), psychologist, chiropractor, naturopath, osteopath			
	☐1	Yes		
	☐2	No (skip to question 66.b)		
	☐2	Not sure/can't remember		
	If yes:			

66i		Service	No. visits	No. calls	Not sure
	☐1		☐☐	☐☐	☐1
	☐1		☐☐	☐☐	☐1
	☐1		☐☐	☐☐	☐1
	☐1		☐☐	☐☐	☐1
	☐1		☐☐	☐☐	☐1
	☐1		☐☐	☐☐	☐1

66.a	Are you able to make an estimate of how much you have spent in total (after any rebate) on these visits? (We are trying to get an estimate of how much these visits have cost you overall in terms of having to pay fees or medication costs (that you didn't get back from Medicare or Insurance), as well as in travel, costs of petrol to and from visits and maybe childcare or other costs …)
	☐☐☐ $$

	☐1 Not sure				
66.b	Overall can you estimate what you have paid out-of-pocket (after any rebate) in total on **your own health** since your baby's birth?				
	☐☐☐ $$				
	☐1 Not sure				
	On the same topic, can you estimate the amount you have spent in total on equipment and other requirements **for feeding your baby** (e.g. breast pads, pump hire, bottles, formula)? (If breastfeeding and formula feeding then think about that e.g. bottles)				
67.	Breastfeeding 'equipment' cost (pads, pump, bottles, breast pump hire, etc.)				
	☐☐☐ $$				
	☐1 Not sure				
68.	If applicable, same for formula feeding 'equipment'? cost (formula, bottles, steriliser, etc.)				
	☐☐☐ $$				
	☐1 Not sure				
	The next few questions are about how you're feeling				
69.	How are you feeling about your baby today?				
	Bad	Not very good	mixed	good	Very good
	☹		😐		☺
	☐1	☐2	☐3	☐4	☐5
70.	How are you feeling in general today?				
	Bad	Not very good	mixed	good	Very good
	☹		😐		☺
	☐1	☐2	☐3	☐4	☐5
71.	**For the following few questions please choose the option that seems closest to the way you have felt over the last four weeks. Over the last four weeks, how often …**				
a.	**Did you feel calm and peaceful?**				
	☐1 All of the time				
	☐2 Most of the time				
	☐3 Some of the time				
	☐4 A little of the time				
	☐5 None of the time				
b.	**Have you been a happy person?**				
	☐1 All of the time				

	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
c.	**Did you feel full of life?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
d.	**Did you feel you had a lot of energy?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
e.	**Did you feel nervous?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
f.	**Did you feel without hope?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
g.	**Did you feel restless of jumpy?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time

h.	**Did you feel everything was an effort?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
i	**Did you feel so sad that nothing could cheer you up?**	
	☐ 1	All of the time
	☐ 2	Most of the time
	☐ 3	Some of the time
	☐ 4	A little of the time
	☐ 5	None of the time
	The next few questions ask about smoking and any changes you have made since having your baby….	
72.	**Which of the following statements best describes your smoking?**	
	☐ 1	I have never smoked
	☐ 2	I quit smoking before I got pregnant and haven't smoked since
	☐ 3	I quit smoking while I was pregnant and haven't smoked since
	☐ 4	I quit smoking before I got pregnant but started again after my baby was born
	☐ 5	I quit smoking for a while when I was pregnant but started again before my baby was born
	☐ 6	I quit smoking while I was pregnant but started again after my baby was born
	☐ 7	I didn't smoke before I got pregnant, but I've started smoking since my baby was born
	☐ 8	Other:
72.b	**If you smoke now, how many cigarettes do you smoke per day on average?**	
	☐☐ cigarettes	
73	**Does anyone in your household smoke around you or your baby?**	
	☐ 1	Yes
	☐ 2	No
	☐ 3	Not applicable – don't live with other people
	☐ 4	Other – please comment more if you want… (next page)

	Now just a final few questions about how things are for you now….			
74.	**Do you have a paid job now?**			
	☐1	Yes, part-time		
	☐2	Yes, full-time		
	☐3	Paid maternity leave		
	☐4	Study		
	☐5	No		
	☐6	Other:		
75.	**What sort of place are you living in at the moment?**			
	☐1	Own house/paying off mortgage		
	☐2	Renting	Apartment/flat ☐1	House☐2
	☐4	Living with family/friends (Someone else's home)		
	☐5	Temporary accommodation (e.g. hostel, motel, refuge, homeless)		
	☐6	Other (please describe)		
75.b		**How long have you lived there?**		
		☐☐ Months		
		☐☐ Years		
76.	**If you were to have another baby, would you choose the same type of care again?**			
	☐1	Yes		
	☐2	No		
	☐3	Not sure		
77.	Do you want to add anything about this for example, why/why not?			

77. a	**We are also interested in the impact of the COVID 19 pandemic on women and families when they are having a baby.** **Can you please tell me about that and if and how, the pandemic has affected your experience?**	
78.	**Are there any further comments that you wanted to make about what we have spoken about today, or about the study?**	
79.	**Thank you very much for taking the time to complete this interview and participating in the study. We may look at further research into the effect of this model of care for women. Would you be happy for us to contact you if we wanted to ask more questions about your experience?**	
	☐ 1 **Yes** ☐ 2 **No**	
80.	**Any other comments/referrals by interviewer**	
	☐ 1	No
	☐ 2	Referred to GP
	☐ 3	Referred to MCHN (Maternal Child Health Nurse)
	☐ 4	Referred to Royal Children's Hospital
	☐ 5	Referred to ABA (Australian Breastfeeding Association)
	☐ 6	Referred to Hospital Consumer Advocate
	☐ 7	Referred to Health Services Commissioner
	☐ 8	Referred to breastfeeding/lactation clinic or lactation consultant
	☐ 9	Safe Steps
80.a	☐ 11	Other referrals (Please describe)
81.	**Comments from the interviewer:**	

		You can speak to our project co-ordinator (ph: Fiona McLardie-Hore 9479 8779) or you can email Fiona at F.McLardie-Hore@latrobe.edu.au.

Appendix F - Face to face interviews

Participant information and consent form



Participant Information and Consent Form - Women's Interviews
Royal Women's Hospital

This information sheet is for you to keep.

Introduction

Thank you for your interest in our study! You are invited to take part in this research project because:

- You, or your partner, have identified as Aboriginal and/or Torres Strait Islander
- You may have completed a survey about your maternity care at one of the four participating hospitals (the Women's Hospital, Mercy Hospital for Women, Sunshine Hospital or Goulburn Valley Health)

This study was put together by a team from:

- La Trobe University

In collaboration with:

- Victorian Aboriginal Community Controlled Organisation

Funding from this project has come from:

- The National Health and Medical Research Council

Your story is important

Every woman and every pregnancy is different. This is a chance for you to tell your story about your pregnancy journey and help us improve health services for Aboriginal and Torres Strait Islander families.
Your stories are really important so that we can better understand your experience. We would like to find out what kind of maternity care is best for the health, development and wellbeing of our mums and bubs.
An important feature of this study is that it has been driven in partnership with key Aboriginal Community Controlled Health Organisations. This is important to us, so that our research outcomes reflect the needs and values of the community.

Your questions are important. Don't hesitate to ask at any time. Before you decide if you want to be a part of this research, feel free to yarn with a relative, Elder or local health worker. If you do decide to take part, you will be asked to sign a consent form. Participation in this research is voluntary. If you don't want to take part at any stage, you don't have to. All information you provide is confidential and private. You will not be identifiable by sharing your story.

What does it involve?

Information collection

It is important that we collect accurate information to properly tell your story

Interviews

We will be asking a small number of women to participate in face to face interviews, asking them to tell their story of their pregnancy, their birth experience and the few days after birth. This interview can be conducted by an Aboriginal interviewer if this is preferred. The interview will take between 30minutes to an hour, and will take place at a time and place that suits you. Please feel free to have a family member or friend be with you during the interview.

We would like to audio-record the interview with your permission, and then later write out what was recorded (called a transcript) so we can use this information, along with information from other women, to explain how women have found their care. You will not be identified in any way in telling your story.

Do I have to take part in this research project?

Participation in any research is voluntary:

- If you do not wish to take part, you don't have to
- If you start and then later you change your mind, that's okay. You can withdraw at any time
- Your decision to take part or not will not affect your care, or your relationship with staff
- If you do not want your information to be included, you must tell the researchers when you withdraw from the research project.

Who has checked this research study?

This study has been reviewed and approved by:

- Royal Melbourne Human Research Ethics Committee
- The Women's Hospital, Mercy Hospital for Women, Sunshine Hospital and Goulburn Valley Health ethics committees
- The Victorian Aboriginal Community Controlled Health Organisation
- La Trobe University Ethics Committee

Privacy and confidentiality

All information you provide is confidential and private. Audio files and electronic information will be password protected and interview transcripts will be stored in locked filing cabinets in a locked office. Only the project coordinator and project investigators will have access to the information.

If you give us your permission by signing the Consent Form, we plan to publish the results in relevant professional journals. In any publication, information will be provided in such a way that you cannot be identified. Your privacy will be maintained. A false name will be used for any direct quotes used. You and your family will not be identifiable by sharing your story.

Possible benefits from taking part

We cannot promise that you will receive any direct benefits from this study Everyone who does participate, however, will be helping us build stronger evidence to improve the maternity care for future generations of Aboriginal and Torres Strait Islander families.

Possible risks from taking part

We do not anticipate that taking part in this study will be associated with any risks to you or your baby, although some of the questions in the surveys might cause you to feel irritated or stressed. You can skip questions you don't want to answer, if they make you feel uncomfortable. If discussion of sensitive issues causes discomfort or distress then we will ensure appropriate support services are made available, if you would like. If discomfort or distress occurs during an interview, the interview can be stopped at any stage if that is what you prefer.

What happens to my information?

Audio files and electronic information will be password protected and interview transcripts will be stored in locked filing cabinets in a locked office. Only the project coordinator and project investigators will have access to the information.

Any information we collect will be kept for 15 years after we have published information from the study in accordance with 2.1.1 of the Australian Code for the Responsible Conduct of Research (2007). All data will then be destroyed in a secure manner.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) and Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander health Research (2003). These documents have been developed to protect the interests of people who agree to participate in human research studies.

Who can I contact for further information or to make a complaint?
If you want any further information about his project, or if you have any problems which may be related to your involvement in the project, you can contact the Chief Investigator:

Who can I contact for further information or to make a complaint?
If you want any further information about his project, or if you have any problems which may be related to your involvement in the project, you can contact the Chief Investigator:

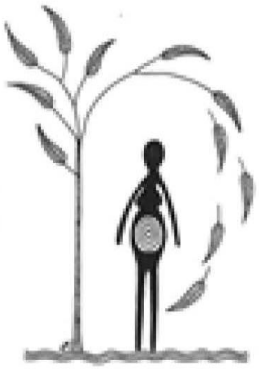
Professor Helen McLachlan
T: 03 9479 5955
E: h.mclachlan@latrobe.edu.au
Or

The Consumer Advocate
Royal Women's Hospital
Telephone: 03 8345 2900
Or

St Vincent's Hospital HREC
T: 092313930
E: research.ethics@svha.org.au

What happens when the research project ends?
This study will end in 2021. We can keep you informed of the study findings by sending you newsletter updates and a summary when we've finished. We will also share our study learnings with health professionals and Indigenous organisations so they can help Aboriginal and Torres Strait Islander families. This will include writing papers for academic journals, presenting findings at conferences and writing newspaper/magazine articles.

Any publication or presentation using the info you have provided will be written so you and your family cannot be identified.



Birthing Tree: artwork by Shawana Andrews

This image represents Aboriginal pregnancy and birthing with support and trust. The tree's branch and leaves curve to represent the 'holding' of women through their pregnancy and birthing experience. The flowing water represents ancestors past and the rivers Dunghala and Birrarung on Yorta Yorta and Wurundjeri country, respectively, to acknowledge the project's place. The circles represent baby and generations to come.

Participant Information and Consent Form – Women's Interviews

Version 1: 15th October 2016

Full Project Title: Woman's Journey - Baggarrook Yurrongi, Nurragh Manma Buliana. Improving the health of Aboriginal mothers and babies through continuity of midwife care

I …… (Participant's name) understand the purposes, procedures and risks of this research project as described within it and I have;

- read or have had this document (Participant Information Version 1, dated 15th September 2016) read to me in a language that I understand;
- had any questions or queries answered to my satisfaction;
- understood the purposes and procedures of the research project;
- been informed of the possible risks and benefits to participation;
- understood that participation will not affect other care options available to me;
- been informed that the confidentiality of all the information provided and collected will be maintained and safeguarded;
- been assured that I am free to withdraw at any time without comment or penalty;

☐ Agree to participate in the research project.

☐ I would like to check the transcript of my interview so, if I want to, I have the opportunity to make changes to what I have said

Participant's Name (printed) ……

Signature Date

Declaration by researcher or representative: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature Date

Withdrawal of Consent

Full Project Title: Woman's Journey - Baggarrook Yurrongi, Nurragh Manma Buliana: Improving the health of Aboriginal mothers and babies through continuity of midwife care

I wish to withdraw participation in the above research study.

I understand that my withdrawal from will not affect the care given to me or my baby, and nor will it affect my relationships with Staff.

Name (printed): .....

Signature: .....

Date: .....

If you wish to withdraw for the study, please complete this form and give it to your maternity care provider, or return it to Professor Helen McLachlan (Chief Investigator)

Professor Helen McLachlan

Judith Lumley centre

La Trobe University

215 Franklin St

Melbourne, 3000

Email: H.McLachlan@latrobe.edu.au

Appendix 3f: Women's interview Final version- Feedback has been sought from Aboriginal Advisory Committee.

Project: Improving the health of Aboriginal women and new-borns through continuity of midwife care: a multi-site mixed methods translational study
Face to face Interview Format (Themes and related questions)

Aim 2: Related to women's views and experiences - Empowering Aboriginal women and their families.

Introduction to self: History, work experience, current role, study, Country, family connection, why I do midwifery **(social yarning)**
Interview rules: (research yarning)
Questions will be about their experience and perceptions of care.
Permission to not answer any question & Permission to stop tape at any time
All names or identifying statements will be changed to protect anonymity
Transcript will be provided to participants for validation (Respondent validation)
I will also provide my contact details (add mobile number) should they wish to follow-up at a later time or think of anything else that they would like to say.

Now start tape

Theme	Questions (research yarning)	Prompts
Exploring the woman's care	Just to start, I am really interested in your recent experience having a baby at __ hospital, and your experience in the ___ program. Would you mind telling me about your experience at x?	The model of care The midwife Usability of the model Perceptions of support The midwife/? known midwife
The relationship between the women and her midwife	How was your relationship with the midwife?	Perceptions of support Level of continuity Difference made?
Exploring the woman's care outside of the model	Apart from the ____ program midwife, was there any other care that you received? How was your experience with that care?	Level of continuity Feelings of safety Community-based services Previous birth

Cultural safety	I am interested in how culturally safe Aboriginal/Torres Strait Islander women/families feel in the care that they receive. Can you tell me about your views/experience?	Racism Power differentials Feelings of safety Traditional ceremonies/customs
Wrap up	Thank you so much for sharing your experience with me today. That is the end of my questions. Do you have any other questions/ comments you would like to tell me?	

*Collaborative yarning/therapeutic yarning consistently occurs time during the interview process.

Appendix G – RedCap

Participant details tracking data base

Participant tracking

Record ID	_____
Participant ID	_____
Recruitment site	◯ 1. Womens ◯ 2. Sunshine ◯ 3. Mercy ◯ 4. Goulburn Valley
Recruitment midwife	◯ PMc ◯ FMc ◯ RM ◯ RH ◯ LM ◯ IH ◯ ZL ◯ SL ◯ JJ ◯ CR ◯ FH
Recruitment date	_____
Hospital number	_____
Participant date of birth	_____
First name	_____
Surname	_____
Street	_____
Suburb	_____
Postcode	_____
Participant phone	_____
Participant email	_____

Other contact name	_____
Other contact phone	_____
Other contact email	_____
Added notes re contacts	_____
Estimated due date	_____
Baby date of birth	_____
Baby hospital number	_____
Three month interview due	_____
Three month interview completed	◯ Yes ◯ No
Date three month interview completed	_____
Three month interview comments	_____
3 month lost to followup	◯ Yes ◯ No
Recruitment interview entered	◯ Yes ◯ No
Three month interview entered	◯ Yes ◯ No
Withdrawn from study	◯ Yes ◯ No
Reasons withdrawn from study	_____
Withdraw all data	◯ Yes ◯ No
Withdraw followup data	◯ Yes ◯ No

Comments

Appendix H – Data cleaning

Data cleaning follow up sheet

3-month interview – October 2020

Red check with Della/Fiona

Yellow to be amended/converted

Green resolved

Question/variable	Issue	Study Id
Study_ID	Duplicate study IDs 2027- record 61 is correct, 2027 record 182 study ID not correct. 3024- check questions: 16, 18, 27, 37, 46, 50, 52, 54, 72, 75. 3065- 37, 39, 41, 45, 46, 47, 56, 71. 3068- 2/3 of interview entered under one record number, the other 1/3 entered under another record.	+-------------------------+ | group: obs: qstdvid | |-------------------------| | 1 60 2027 | | 1 181 2027 | | 2 113 3024 | | 2 120 3024 | | 3 160 3065 | |-------------------------| | 3 174 3065 | | 4 162 3068 | | 4 180 3068 | +-------------------------+
Qdteint (date of interview)	Missing data	+---------+ | qstdvid | |---------| 162. | 3068 | 178. | 1150 |8/5/2020 180. | 3068 | +---------+
q1mother_dob (mother's DOB)	Missing data	3058 | 162. | 3068
*QUESTION ONE-A - How many babies	Missing	| qstdvid | |---------| 14. | 2012 | 43. | 2017 | 50. | 1055 | 74. | 2037 | 81. | 1090 | |---------| 101. | 1110 | 108. | 1102 | 118. | 1101 |one 162. | 3068
*QUESTION TWO - ~~ba's~~ age (weeks)	Both weeks and months are missing *	+---------+ | qstdvid |

		|---------| 162. | 3068 |
*QUESTION TWO- A baby's age (months)	See above	
*QUESTION THREE Baby sex	Missing	| qstdvid | |---------| 49. | 1066 | 162. | 3068 | +---------+
*QUESTION FOUR - Baby's date of birth	Missing	+---------+ | qstdvid | |---------| 63. | 2023 | 64. | 2036 | 140. | 3058 | 162. | 3068 | +---------+
*QUESTION FIVE- where were you originally booked for your birth?	missing	162. | 3068 |
*QUESTION FIVE A- if other, describe		
*QUESTION SIX - Where was your baby born?	missing	3068
*QUESTION SIX- A- if other, please describe		
*QUESTION SEVEN - number of pregnancy appointments (numerical)		
*QUESTION SEVEN A - number of pregnancy check ups (radio buttons)		3068- both options missing
*QUESTION SEVEN B- if less than 5 visits, why?	Free-text	
*QUESTION EIGHT - Who did you mainly see? A - my hospital midwife	Missing	1057
*QUESTION EIGHT B - caseload back ups	Missing	|---------| 53. | 1057 | 55. | 2006 | 63. | 2023 | 162. | 3068 | +---------+
*QUESTION EIGHT C - hospital doctor	missing	| 2006 | 59. | 1060 | 62. | 2028 | 63. | 2023 | 162. | 3068
*QUESTION EIGHT D- hospital midwife (standard)	missing	+---------+ | qstdvid | |---------| 55. | 2006 | 57. | 1074 | 162. | 3068 | +---------+
*QUESTION EIGHT E- midwife from ACCHO	missing	. | 1015 | 47. | 2016 | 51. | 1056 | 52. | 2004 |

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