



First Nations families' maternity care experiences in the Australian Capital Territory: Kapatı Time Yarning, intergenerational trauma and the case for Birthing with Country

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ABSTRACT

Problem: First Nations women often experience harmful, inequitable maternity care, shaped by intergenerational trauma and culturally unsafe care.

Background: Historical forced removal of First Nations children has created enduring trauma that influences pregnancy and birthing experiences. In the Australian Capital Territory, maternity care is provided through Western biomedical systems, where increasing child protection interventions and fear of surveillance affect women's engagement with care.

Aim: The aim of this study was to explore the maternity care experiences of First Nations women and families in the Australian Capital Territory, and to understand participants' perspectives of culturally safe models of care.

Methods: This study used Kapatı Time Yarning, an Indigenous Research Method based on relational storytelling. Fourteen First Nations women, partners, and family members participated between October 2024 and March 2025. Data were analysed using reflexive thematic analysis.

Findings: Intergenerational trauma was identified as a key theme, with participants describing a persistent fear of child removal, race-based surveillance, and mistrust within maternity services. Pregnancy and birth were experienced as instances of heightened scrutiny, prompting hypervigilance, embodied protective behaviours, and care-avoidance, reinforcing cycles of trauma across generations.

Discussion: Many First Nations people are birthing away from their ancestral Country. The articulation of Birthing with Country offers a pathway to reframe maternity care by bringing Country, cultural authority, and relational care into the maternity space.

Conclusion: Intergenerational trauma linked to forced child removals is actively reproduced within maternal health services. First Nations-led, culturally safe models such as Birthing with Country are essential to disrupt fear and surveillance, build trust, and support wellbeing.

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Introduction

Statement of significance

Problem or Issue	What is Already Known	What this Paper Adds
First Nations women continue to experience maternity care influenced by fear, surveillance, and mistrust, created by the ongoing legacy of forced child removals and intergenerational trauma.	Colonisation, racism and child removal policies have long-term impacts on First Nations women's health, wellbeing and engagement with maternity services.	This study provides qualitative evidence from the Australian Capital Territory showing how intergenerational trauma from child removals is reproduced in maternity care. It identifies Birthing with Country as a restorative model for First Nations families.

The forced removal of Aboriginal and/or Torres Strait Islander (hereafter First Nations) children in Australia has created an enduring legacy of trauma that spans generations and continues to affect First Nations peoples significantly [1,2]. These removals have disrupted family and community structures, cultural knowledge and parenting practices, embedding intergenerational trauma into the lived experiences of First Nations families [2–4]. The practices are not confined to history, nor is the trauma. Instead, this enduring trauma continues to actively influence First Nations women's experiences of maternity care, contributing to cycles of fear, mistrust, and systemic inequity [5].

Pregnancy and birth can be a time of increased vulnerability, particularly for those impacted by child removals. The perinatal period can often reactivate complex trauma, affecting maternal wellbeing, parent-infant attachment, and the capacity to nurture [3]. These experiences are compounded by the cumulative effects of colonisation, racism, discrimination, violence and adverse childhood experiences [6]. Globally, Indigenous peoples experience disproportionate exposure to these forms of trauma, which are associated with elevated risks of perinatal depression, anxiety, and substance use [7, 8, 9, 10, 11, 12].

In Australia, suicide accounted for 10 % of all maternal deaths between 2011 and 2020 [13]. Perinatal mental health concerns are significantly more prevalent among Indigenous populations, exacerbating existing inequities [10,14]. These concerns are closely linked to intergenerational trauma, particularly the legacy and continuation of government-sanctioned child removals [8,15]. In Australia, where First Nations families are ten times more likely to have their infants removed before the age of one [16], child protection is guided by Commonwealth legislation but administered and regulated by individual state and territory laws [17]. In 2024, the rate of First Nations children aged 0–17 in out-of-home care in the Australian Capital Territory (ACT), where this study was conducted, was 57.7 per 1000, compared to 50.3 per 1000 nationally. These rates continue to rise annually [18].

In the ACT, evidence indicates that First Nations women are experiencing the removal of their newborns while in mainstream hospital maternity care settings [19]. These removals cause profound spiritual and psychological harm, including grief, loss, and anger, and they contribute to long-term consequences, which can include poor physical and mental health, substance use, and exposure to violence [1,2]. They also increase the likelihood of further removals, perpetuating cycles of trauma [20]. Unaddressed perinatal mental health concerns, situated within the context of intergenerational trauma, remain a key driver of these removals [15].

The continued overrepresentation of First Nations children in child protection systems reflects ongoing structural violence and institutional failure [5,20]. Systemic racism and discrimination further intensify these impacts. In mainstream maternity settings, First Nations women frequently report experiences of distress, shame and powerlessness, often linked to racism, culturally unsafe care, limited agency in decision-making, and a lack of understanding of personal and

intergenerational trauma histories among healthcare providers [21,22]. In addition, the fear of child protection notifications is a considerable barrier to engagement with maternity services, leading to avoidance, non-disclosure of social risk factors, and increased anxiety [5,23,24].

Despite this evidence, the dominant model of maternity care in Australia remains the standard public hospital system, delivered by rostered clinicians, with limited continuity of care or cultural responsiveness [8,25,26]. This Western biomedical model routinely excludes holistic, preventive, culturally safe care, contributing to persistent disparities in First Nations maternal and infant health outcomes [8,27]. Research consistently shows that mainstream services fail First Nations women, with widespread reports of culturally unsafe care, ranging from racial profiling, stereotyping and dismissal of pain to exclusion from decision-making and disregard for cultural identity and relational ways of being [3,16,19,28].

In contrast, Birthing on Country (BoC) models of care are increasingly being recognised for their protective effect [20]. Nationally, BoC is described as a set of overarching principles for holistic, First Nations-led maternity care that embeds cultural authority, connection with Country, culturally safe continuity of midwifery care, and wrap-around services [29,30]. Within this national framework, local communities develop models that reflect their needs and circumstances. For example, the urban Australian model, Birthing in Our Community, is one expression of BoC principles, designed specifically for the families and context it serves. This service has demonstrated a significant reduction in newborn removals compared to standard care [20]. Its success is attributed to its culturally governed, continuity-based approach, which strengthens families, interrupts trauma cycles, and addresses the structural drivers of child protection interventions and adverse wellbeing outcomes [20]. In the ACT, the term Birthing with Country is used to describe a model that aligns with the principles of BoC, but reflects the histories, aspirations and service context for this region, consistent with, but distinct from other BoC aligned models.

Transforming maternity care requires an understanding of how the ongoing legacies of invasion and colonisation continue to affect First Nations' birth inequities. Colonisation has disrupted cultural birthing practices, displaced families from Country, and imposed Western health systems that exclude First Nations knowledges and Knowledge Holders. These structural harms, compounded by policies of child removal, have contributed to the disproportionate burden of adverse pregnancy and birthing outcomes experienced today, including significantly higher rates of preterm birth, low birthweight and perinatal loss compared to other families [27]. These enduring impacts highlight the need for culturally governed, community-led models of care that restore cultural authority, embed trauma-informed practice and support First Nations-led solutions that honour the strength, sovereignty and resilience of First Nations families [3,28,31,32].

Methods

Study aim

The aim of this study was to explore and story the maternity care experiences of First Nations women and families in the ACT, to understand their perspectives, to identify the issues and topics that were most important to them, and to envision a culturally safe model of maternity care that enhances First Nations family and community wellbeing.

Research design overview

This was a qualitative study that used an Indigenous Research Method (IRM). IRMs challenge the idea that qualitative research must be neutral or objective, instead centring Indigenous ways of knowing, being, and doing [33]. They enable First Nations communities and researchers to define their own research priorities and processes in ways that reflect cultural authority and lived experiences [33,34]. Rather than

prioritising detachment, IRMs emphasise positionality and relational accountability. Knowledge is co-created through respectful relationships between researchers and participants guided by cultural protocols and ongoing reflexivity [34]. The researcher's identity, values, and lived experience shape how stories are heard, interpreted, and represented. This approach positions connection, reciprocity, and the ethical responsibility to represent participants' voices with integrity at the forefront of the research [34].

Kapati Time Yarning

This study employed a Kapati Time yarning method [35], which creates informal, relational spaces for storytelling over a "cup of tea" [35, p. 9]. This distinctly First Nations approach affirms cultural ways of knowing and recognises that people make sense of experiences through "story structures" [35, p. 10]. Kapati Time yarning advances knowledge-building through conversation, trust and the strengthening of relationships [35].

Yarning is recognised in Australia and internationally as a culturally based qualitative methodology in Indigenous health research [33]. It privileges storytelling, honours cultural protocols, and promotes equity through relational accountability [33,35]. By creating culturally safe spaces, yarning generates deep, meaningful data as participants feel comfortable sharing their experiences [36]. Unlike conventional interviews, yarning, which is not time-limited, enables spontaneous, participant-led conversations that may meander between and around topics [33]. The researcher listens for insights relevant to the study while ensuring participants retain agency over their stories, sharing them how they wish [34].

Participants and data collection

The ACT has a diverse First Nations population, including Ngunawal Traditional Owners, First Nations people from other regions residing in or accessing maternity care in the ACT, and those referred from outer regional areas for complex care. All groups were included in the study. Participants were women who had accessed maternity care in a health facility in the ACT, partners, and other family members.

Unstructured Kapati Time yarns were conducted between October 2024 and March 2025 by the first author, a First Nations woman and researcher. Her cultural identity was central to establishing trust and rapport and to informing the themes explored. Recruitment occurred primarily through existing relationships, word of mouth and incidental contact. Flyers distributed via local First Nations community-controlled organisations did not attract any participants, as anticipated, given the impersonal nature of flyers and the importance of relational engagement in Indigenous research. This reflects broader mistrust of exploitative research practices [34,35,37] and an enduring mistrust of "Euro-Western academic hierarchies" [34, p. 19].

The participants were given information sheets outlining the aim of the study, voluntary participation, confidentiality and withdrawal rights. All provided written consent prior to yarning. Fourteen First Nations people participated in the study, sharing their experiences of maternity care in the ACT and giving insights into the type of care they would value. Participants included eleven women, two male partners, and two other family members, one of whom later shared her own experience. The emphasis for this study was on gathering rich, nuanced insights rather than achieving a large sample size. Participants chose the location for their yarn; 12 were held in person, and 2 were held online, each lasting between 40 min and 2.5 h. Participants were offered an AUD\$50 gift card in recognition of their time and knowledge.

Recording and data transformation

With participants' consent, each yarn was digitally voice recorded. It was then transcribed verbatim using transcription software. During

transcription, all identifying information was removed, and participants were allocated pseudonyms, e.g. 'Participant #', to ensure confidentiality. To maintain accuracy, the first author reviewed each transcript line by line against the recordings and made corrections where necessary. Data were stored in password-protected documents accessible only to the research team.

Data analysis

[The first author] listened to the recordings and read the transcripts multiple times throughout the yarning period and again after completion. Analysis followed Braun and Clarke's Reflexive Thematic Analysis (RTA) framework [38], which was used to code and identify themes before iterative refinement. RTA was selected for its relevance to health research and its suitability for exploring lived experiences. Its emphasis on reflexivity, researcher subjectivity and relational knowledge creation and meaning making aligns closely with IRMs such as yarning [35,39]. The approach supports culturally appropriate interpretation without fragmenting the yarns or imposing external analytic categories, making it well suited to the storied, relational nature of Kapati Time yarning. The analysis was led by two Aboriginal authors whose cultural knowledge, lived experience and positionality informed the interpretative process. To strengthen rigour, the second Aboriginal author, [XX], independently reviewed the data and analysis, and multiple review points were conducted over six months to interrogate assumptions and interpretations before finalising themes. A key theme to be presented in the findings section is that of intergenerational trauma linked to the legacy of forced child removals.

Ethics

Ethics approval was obtained from [Institution, approval #XXXXX]. The study adhered to the National Health and Medical Research Council's guidelines for ethical conduct in health research involving Aboriginal and Torres Strait Islander peoples [40]. A protocol for recognising, managing and responding to participant concerns or distress was developed prior to data collection. The study upheld the principles of Indigenous Data Sovereignty, recognising First Nations peoples' rights to control their cultural and intellectual property, communities, resources, and Country across all stages of research, including data creation, collection, access, analysis, interpretation, management, dissemination, and reuse [41]. The research was supported by Ngunawal Elders and First Nations community-controlled organisations, and data were collected by a First Nations researcher. The study was intentionally designed to promote community self-determination and uphold cultural integrity throughout.

Findings

The theme of intergenerational trauma, as a legacy of forced First Nations child removals, featured prominently in participants' experiences of maternity care. Participants' stories revealed how the history of child removals is not confined to the past but continues to exert lifelong impacts, influencing maternal identity, family relationships, and engagement with health systems across generations. This enduring trauma was evident in the way participants approached pregnancy, birth, and early parenting, often with fear, mistrust, and protective responses. Analysis of this theme classified the experiences into three interconnected subthemes that demonstrate how trauma is enacted and reproduced in maternity care. In keeping with RTA, selected quotations are used illustratively to support analytic interpretation [38].

Intergenerational trauma

1. Intergenerational fear of child removal

Intergenerational fear of child removal was a significant concern

for participants. Women described how the trauma of forced removals in previous generations continues to influence their own experiences of maternity care, creating a perception that the risk of child removal is amplified in the current generation and driving hypervigilance. One woman connected her grandmother's experience to her own vulnerability as an Aboriginal mother. She described her father's removal as a baby, rejecting the notion that forced removals are firmly in the past, emphasising that she feared the same for her own baby:

"I guess I've always had this fear, and I think it's definitely warranted, of the worst thing that can happen is [Child Protection] turning up at your door, especially 'cause my Aboriginal nan, having her son taken away, and I'm an Aboriginal woman and, I just feel like you're more at risk. The statistics still show that. I definitely feared that the same thing would historically happen to me because it was, people think Stolen Generations, they think, 'Oh, that happened so long ago'. That was my dad. And then you have my baby. And then boom, you're just more at risk. It's like they just don't believe Aboriginal people know how to look after their children. Makes you mad. Yeah, it's just a thing that, you know, you can just be taken away like that. It's just awful. And to kind of be hyper-vigilant just because of your race is not a nice thing." – Participant 5

Others recounted overt attempts to remove children from their families, with one describing adoption papers being prepared in advance:

"It happened to my mother. It's in all our stories. That's our history, our history is modern history. It was a lot more overt...they had adoption papers all printed out ready for her signature. That plays on your mind." – Participant 12

This fear of having her baby taken was so intense for one participant that she decided to give birth in another jurisdiction. Her decision reflects how intergenerational trauma and mistrust of local systems can influence birthing choices, with women seeking safety in alternative areas to avoid the risk of child removal:

"I didn't know if I had Bub here, what happened if [baby] got taken off me. That also worried me." – Participant 13

These stories demonstrate how individual experiences are embedded in family histories, transmitted as collective memory and fear. This creates a belief that the state is a continuing threat, influencing contemporary maternity care experiences and instilling fear into pregnancy, birth, and parenting.

2. Racial profiling and surveillance in maternity care

The fear of having a baby removed was intensified by racial profiling and surveillance, where participants described maternity care interactions as marked by suspicion and scrutiny rather than support. One woman described feeling interrogated, believing midwives were assessing her fitness to parent rather than offering care:

"When [the postnatal midwives] came out [to the participant's home], it just felt like an interrogation. I just felt like they could have been more like, 'What do you need? What questions do you have? How are you feeling? I would have said, 'Oh, well I don't know if I'm breastfeeding right', [but] by this stage when they've torn everything apart, the last thing I'm gonna do is [say], 'Oh, I don't know if I'm breast feeding right', 'cause I thought they were trying to build a case to say I wasn't a good mum'" – Participant 5

Another participant recalled being erroneously referred to as a client of Child Protection, generating fear that a report had been lodged simply because she was young, single, and Aboriginal:

"One of my biggest memories during [labour], when that midwife walked in and said, 'Oh, so you're part of care and protection.' And I just thought, someone's put a report on me or has said something that I had not known about until this point. In my mind, I was like that paranoia of, have they

put a report in because I'm a single mum? I haven't done anything wrong. And that fear immediately ...you're put in a box because you're Black." – Participant 10

Another described her cousin's agitation when nurses approached her baby in the humidicrib:

"[Cousin] was very calm when we were just there with [Baby], but she was very agitated about nurses. [Her] agitation, and her suspicion, she didn't want them near [Baby]." – Participant 4

Participants' stories pointed to ongoing systemic racism, showing how colonial justifications for child protection interventions persist in maternity care. One participant recounted her grandmother's experience, with similar experiences repeated in her mother's generation, and the impact that has had on her:

"My nan...just got told her baby died, and she never, ever saw [baby]; they took [baby], her firstborn baby. Can you imagine the trauma that would do for the rest of her life? She was always thought of as the 'angry Black woman'...and she never got to see her baby...that rips my heart out when I think of that. But these are the things that are our trauma as well. And it's, it's not ancient history. These are real experiences to people that are closest to us. These are the people that have shaped us...and then [they tried to take] Mum[']s firstborn. There was no reason for them to [do that], and that's just bullshit anyway, for them to say, you know, [removing children] is for your own good...that's that same policy that they've been throwing at us our whole lives." – Participant 12

These experiences illustrate how maternity care encounters can replicate child protection surveillance. Structural racism and the stereotyping of First Nations mothers as inherently at risk of failing their children were recurring stories, which informed the way women interpreted and endured their maternity care. Suspicion of health professionals was not simply an individual phenomenon but was based on intergenerational trauma and the long-standing link between maternity services and child removals. Fear was not only about having their children taken, but about being mischaracterised because they are First Nations people.

3. Hypervigilance, self-policing and embodied protective behaviours as coping mechanisms – everyday anxiety

In response to this heightened surveillance and scrutiny, some participants described becoming hypervigilant in their parenting, constantly monitoring their behaviour to avoid an intervention. Fear of child protection involvement extended into daily life, turning ordinary tasks into sources of anxiety and reinforcing race-based double standards. The need to anticipate and pre-empt scrutiny shows how systemic inequities filter into everyday family life, feeding ongoing stress and mistrust.

Some participants stated they felt compelled to focus on appearances, such as keeping their homes and children impeccably clean, to avoid being reported to Child Protection. They contrasted these actions with non-First Nations families who do not live under the same scrutiny:

"I'll do stuff so I don't get reported. I'll try to keep the house clean just in case someone comes over, [to] not get reported. Make sure the kids' hair's brushed. To be hyper-focused on that, it's just ridiculous. I don't see White people going, 'Oh, I've gotta keep my hair clean, my kids' hair clean 'cause you know, I might get a doctor's report'. That is on mine and [partner]'s radar all the time with our kids now. We're super hyper-focused." – Participant 6

"So when [the home-visiting postnatal midwife] come. I would clean the day before. I'd clean where she wouldn't even be going into because I thought, 'Oh my God, she's probably gonna say I'm dirty', so I'd clean." – Participant 5

Another worried about her preschool-aged child's bruises, fearing they could generate an intervention:

“Well, you always worry, if [child]’s got bruises, you always think, ‘Oh, what are they going to do to us?’ You’ve got to be careful if [child]’s got bruises. it’s a very real thing that we face.” – Participant 12

These stories illustrate how intergenerational trauma leads First Nations mothers to engage in relentless self-surveillance and boundary setting to minimise the risk of child protection interventions. Their actions reflect internalisation of risk and translate into constant anxiety in everyday parenting, where participants perceive normal childhood experiences as potential risks for child removal.

These strategies of hypervigilance and self-policing also arise in the birthing space, where participants’ actions reflected both cultural strength and profound mistrust of staff. Intergenerational trauma was expressed through embodied protective behaviours during labour, birth, and early parenting.

One participant described family-led protection as a response to fear and mistrust of mainstream services, resulting in limited antenatal care. During labour and birth, protection intensified with her mother maintaining a constant presence to guard against perceived risk within the hospital environment. The absence of her grandmother, who could not face entering the hospital, further emphasises the depth of fear associated with mainstream maternity care:

“My nan was always very protective of me through that pregnancy. And I didn’t go to the doctors or anything. I went to [facility] a couple of times, but Nan was like, ‘You don’t trust them’. We all just had that fear and anxiety, you know. When I did end up going into labour, and I went up [to the hospital], Mum didn’t leave my side, and Nan couldn’t even bring herself to come up there.” – Participant 7

Another participant described the urgency of ensuring her partner held their newborn immediately after birth, a behaviour influenced by internalised intergenerational fear that if he did not physically claim the baby, the infant might be taken by the state:

“Maybe it is an Aboriginal thing or maybe it’s just a mother thing. But there is ... a fear that if it’s not you, like if you don’t grab your baby or your husband doesn’t hold your baby. It just kicks in.” – Participant 12

Child removal fears were most pronounced during labour and birth. The protective responses described reflect the embodied effects of intergenerational trauma, with families drawing on collective memories of harm to prioritise safety through the close presence of a family member, rather than reliance on clinical systems. This illustrates how trauma is not only carried across generations but is lived and reproduced in the present.

These findings show how the enduring, lifelong impact of intergenerational trauma from forced child removals continues to influence First Nations women’s experiences of maternity care in the ACT. Participants described a persistent fear of intervention, racial profiling, hypervigilance in parenting, and protective instincts during labour and birth. They highlight the urgent need for maternity services that are First Nations community-led, culturally safe and trauma-informed, particularly in relation to the lived experiences of First Nations families.

Discussion

In the ACT, where Ngunnawal families live alongside First Nations people birthing away from their ancestral Country, a distinct articulation has evolved. Called *Birthing with Country*, an expression first coined by [Author] [42] and subsequently adopted and promulgated by local senior First Nations women, the distinction between ‘on Country’ and ‘with Country’ is especially critical in urban contexts where most First Nations people live, many of whom have been displaced by historical events, including forced removals. The term explicitly recognises that Country is not only a physical place but also a “continuum, without beginning or ending” [43, p. 1], inseparable from the self [44] and encompassing concepts of identity, Law, Knowledge, spirituality,

language, kinship, and belonging [44–46]. Birthing with Country, therefore, brings Country into the maternity space through cultural practices, community governance, and relational care, which contribute to the health and wellbeing of First Nations people. Grounded in First Nations cultures and leadership, this approach ensures that First Nations women receive holistic care, and First Nations babies are born into environments of cultural safety and strength, regardless of place of birth, and where restorative responses to intergenerational trauma disrupt systemic racism and the ongoing trauma and fear of child removals, critical for rebuilding intergenerational wellbeing.

Far from being limited to historical child removal, intergenerational trauma is a living, continuous reality. Almost two decades after the Australian Government’s 2008 Apology to the Stolen Generations [47], First Nations infants in the ACT are still removed at disproportionate and ever-increasing rates [18]. This trauma continues across generations, resulting in fear, mistrust and protective behaviours that extend beyond the perinatal period. Participants described maternity services as places of surveillance rather than support, echoing broader evidence of systemic racism and racial profiling in health care [8,28]. Participants’ stories demonstrate how trauma is enacted in maternity care, influencing maternal identity, parenting practices, and engagement with maternity services in ways that perpetuate cycles of fear.

Findings from the Kapatī Time yarning signal a clear requirement for a model of care that is holistic, supportive, culturally safe and free of racism. Research has shown that continuity of midwifery care, particularly when provided and led by First Nations midwives, improves maternal and infant health outcomes and protects against child removals [20]. Nevertheless, mainstream maternity services continue to be based in Western paradigms that fail to take account of the enduring effects of colonisation and intergenerational trauma and continue to impact maternity care experiences in harmful and unacceptable ways [8].

The participants in this study described hypervigilance in parenting and protective instincts during birth as strategies to resist surveillance. However, these responses also highlighted the deep mistrust of maternity and other health services that persists today. While this was a small study, the findings align with broader literature on trauma-informed care, which emphasises the need for restorative, anti-racist models that disrupt punitive judgments and embed cultural authority in maternity services; models such as Birthing on Country [48].

The Birthing on Country movement had its genesis in women in remote communities’ desire to return birthing to their communities. Many believe that birthing on their traditional Country will improve maternal and infant health outcomes and contribute to healing from intergenerational trauma [29], whereas birthing in hospitals, away from traditional Country, compromises their relationship to the land and leaves them feeling culturally unsafe [29,49,50].

Importantly, at a national Birthing on Country workshop held in the Northern Territory in 2012, participants noted that Country is not limited to a person’s ancestral Country. They discussed the appropriateness of the term, which could be misunderstood as birthing in the bush without support [29]. An alternative suggestion was Birthing in Country. Nevertheless, it was agreed that Birthing on Country would be retained as a ‘metaphor for the best start in life’ for First Nations babies, with the focus being not so much about the place of birth, but about birthing in culturally safe environments [29]. Despite this, the term is often not well understood [51], and according to Haora and colleagues (2023), it encompasses a range of interpretations, which limits the effectiveness of the approach and highlights the need for clearly defined models.

Conclusion

This study demonstrates that the legacy of forced child removals continues to impact First Nations women’s experiences of maternity care in the ACT. Intergenerational trauma remains a living influence on

pregnancy, birth, and early parenting, influencing maternal identity, family wellbeing, trust in health systems, and continuing inequity. Participants described maternity services as places where the threat of child protection intervention was ever-present, prompting fear, vigilance, and protective behaviours born of trauma spanning generations.

Within this context, the ACT articulation of Birthing with Country offers a meaningful and critical pathway for change. By recognising Country as relational, continuous, and inseparable from identity, and by embedding First Nations cultural authority and governance within maternity care, *Birthing with Country* repositions care as culturally safe for women, babies and families regardless of where their ancestral Country is. This approach supports women in engaging with maternity care from a place of cultural strength rather than fear, affirming their identities.

Significantly, culturally safe, First Nations-led models reduce the need for First Nations women to undertake constant self-monitoring and precautionary behaviour because of fears of scrutiny and intervention, burdens not borne in the same way by non-First Nations women. By addressing the systemic conditions that produce these fears, rather than locating risk within women themselves, Birthing with Country enables more equitable, culturally safe and trusting maternity care.

Ultimately, the findings highlight the urgent need to transform maternity services into places of safety, justice and intergenerational wellbeing. Embedding First Nations-led, culturally safe, trauma-informed models of care in the ACT, such as *Birthing with Country*, is essential to disrupt cycles of harm, fear and mistrust. Moreover, if appropriately supported, these models will mitigate the harms of the ongoing effects of child removals and will ensure that First Nations women and families experience maternity care that fosters their long-term wellbeing. Importantly, these models offer the opportunity to ensure that every First Nations baby is born into a culturally safe environment, strong in health, identity, and belonging.

Strengths, limitations and recommendations

Strengths

First Nations led, using Kapatī Time yarning to centre First Nations women's and families' maternity care experiences within the ACT context.

Limitations

The study was conducted in a small jurisdiction and reflects retrospective accounts from a small number of participants; the experiences of those unwilling or unable to participate may not be represented.

Recommendations

Findings indicate the need to embed First Nations governance, strengthen continuity of care, and support the development of a Birthing with Country model that is responsive to First Nations families and communities.

CRedit authorship contribution statement

KW: Conceptualisation, methodology, investigation, formal analysis, writing – original draft, writing – review and editing. SH: Supervision, conceptualisation, formal analysis, writing – review and editing. RB: Supervision, conceptualisation, writing – review and editing. AP: Writing – review and editing. HN: Supervision, conceptualisation, writing – review and editing. All authors read and approved the final manuscript.

Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used the Paperpal AI Tool in order to check for grammar and readability. After using this tool, the author(s) reviewed and edited the content as needed and take full responsibility for the content of the publication.

Ethical approval

Ethics approval for this study was granted by the University of Canberra Human Research Ethics Committee, approval #13302, on 16 August 2024.

Submission

Birthing with Country as a restorative response to intergenerational trauma

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Declaration of Competing Interest

The authors declare they have no conflicts of interest.

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Data availability

Study participants were assured raw data would remain confidential and would not be shared.

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