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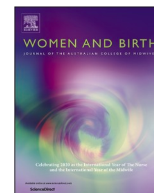

Discussions

Identifying and dismantling racism in Australian perinatal settings: Reframing the narrative from a risk lens to intentionally prioritise connectedness and strengths in providing care to First Nations families☆

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A B S T R A C T

Introduction: The perinatal period is a time when provision of responsive care offers a life course opportunity for positive change to improve health outcomes for mothers, infants and families. Australian perinatal systems carry the legacy of settler-colonialism, manifesting in racist events and interactions that First Nations parents encounter daily.

Objective: The dominance of a western risk lens, and conscious and unconscious bias in the child protection workforce, sustains disproportionately high numbers of First Nations infants being removed from their parents' care. Cascading medical interventions compound existing stressors and magnify health inequities for First Nations women.

Design: Critical discourse was informed by Indigenous ways of knowing, being and doing via targeted dialogue with a group of First Nations and non-Indigenous experts in Australian perinatal care who are co-authors on this paper. Dynamic discussion evolved from a series of yarning circles, supplemented by written exchanges and individual yarns as themes were consolidated.

Results: First Nations maternity services prioritise self-determination, partnership, strengths and communication and have demonstrated positive outcomes with, and high satisfaction from First Nations women. Mainstream perinatal settings could be significantly enhanced by embracing similar principles and models of care.

☆ For the group, the Australian Anti-racism in Perinatal Practice Alliance.** The authors acknowledge the Traditional Custodians of the lands we live and work on, and pay respects to Elders past and present. We recognise First Nations holders of maternity knowledge and wisdom, perinatal practitioners and all First Nations mothers, grandmothers and families.

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Conclusions and relevance: The Australian Anti-racism in Perinatal Practice (AAPP) Alliance calls for urgent transformations to Australian perinatal models of care whereby non-Indigenous health policy makers, managers and clinicians take a proactive role in identifying and redressing ethnocentrism, judgemental and culturally blind practices, reframing the risk narrative, embedding strength-based approaches and intentionally prioritising engagement and connectedness within service delivery.

Introduction

Aboriginal and Torres Strait Islander (herein, First Nations) families embody collectivist notions of wellbeing, emphasising the interweaving of kinship, community and culture, to support and promote belonging, holistic health, purpose and control, dignity, respect, and the attainment of basic needs [1]. First Nations communities across Australia articulate understandings of social and emotional wellbeing which are holistic, but at their core is the prominence of connection to self, including body mind and emotions, identity, culture, art, lore, family, kin and Country [2]. However, a western paradigm dominates the design and delivery of mainstream healthcare services in Australia, with a focus on reactive rather than preventative healthcare and a narrow conceptualisation of health and wellbeing that negates many of the social, cultural, economic, spiritual and political drivers of ill health [2]. This includes perinatal services, where the dominance of a bio-medical model has seen an increase in the medicalisation of birth [3]. While the Australian midwife standards for practice includes acknowledgement of the impact of colonisation and a definition of cultural safety [4], rigorous interrogation of the ways in which midwives and their workplaces translate anti-racist rhetoric into practice is currently lacking. One of the initial barriers [5] is that within the Maternal, Child and Family Health sector, there is limited understanding of individual, structural and ideological racism, and a lack of insight into how these forms of racism manifest in practice with families from First Nations backgrounds. Here we call for urgent transformations to Australian mainstream perinatal models of care to redress systemic racism and improve perinatal outcomes for First Nations women, infants and families.

Needs, strengths and opportunities for women in the perinatal period

For women who have experienced trauma, birth and early parenting can provide an opportunity for healing and recovery, if adequate psychosocial resources and supports are available [6]. The perinatal period is also a time characterised by a transformation in relationships as new parenting inevitably results in changes to roles and interactions both within and outside the family context. The implications for connectedness during pregnancy, birth and early parenting are profound [6,7] and evident in biological, cultural, psychological, and social spheres. There are important cultural mechanisms that can be activated at this time to support mothers with new infants, for example, care, knowledge, and assistance provided by kin, such as grandmothers [8]. The desire to be recognised as a 'good mother' – according to dominant social and cultural norms – is powerful [3,9]. For First Nations women, awareness of conforming to societal norms associated with 'good parenting' sits alongside fear of child protection intervention during the perinatal period. Unfortunately, too often women from a range of backgrounds are marginalised in public discourse, experience rejection, discrimination or judgement when they attempt to connect with service providers, and this may lead to disengagement, loss of hope and feeling helpless, and unsupported. [10] Conversely, families can be compelled to engage with multiple services in a short space of time, each with different models of care and practice frameworks which families often experience as confusing and overwhelming.

The characteristics of positive perinatal models have been investigated and midwifery led continuity of care has been highlighted as one model with demonstrated benefits for all women [11] Models of care that centre the experiences of First Nations women, and adopt participatory approaches, do exist in Australia [12]; the key components of these models need to be incorporated into mainstream settings. Corcoran and colleagues [11] emphasise that in addition to continuity of care, overcoming structural barriers to health service access, celebrating success (through operationalising a strength-based approach) and acknowledging discriminatory experiences First Nations women have had with mainstream services are integral to transforming the perinatal service system.

The Alliance

The authors of this paper have joined to develop the Australian Anti-racism in Perinatal Practice (AAPP) Alliance. The AAPP Alliance is a group comprising eight First Nations and nine non-Indigenous academic and industry experts with an interest in generating knowledge and action to improve First Nations women's experiences and outcomes within the perinatal sector in Australia. Members come from a range of social, cultural and professional backgrounds with areas of expertise including First Nations health and culture, public health, nursing and midwifery, community and clinical mental health, obstetrics, health services research and health economics. Sharing a commitment to culturally safe, anti-racist health and social care practices, and First Nations self-determination, this Alliance recognises that implementing sustainable changes to perinatal service systems necessitates examination of the ways that power and privilege [13] operate within this realm and the impact this has on policy, practice, relationships and interactions. A foundation of respectful collaboration that values diverse "ways of knowing, being and doing" [14] and privileges the perspectives of First Nations peoples' experiences, standpoints and knowledges will be required. It will necessitate persistence, endurance and the courage and willingness of non-Indigenous service providers to overcome white guilt and fragility [15] and to examine and alter longstanding patterns of emotion, cognition and behaviour associated with racial assumptions rooted in social and cultural conditioning [16].

The urgent need to transform the experiences of First Nations women within mainstream perinatal services has been recognised before and was incorporated in the National Maternity Services Plan in 2011 [17]. However, implementation of the plan stalled amidst inadequate federal government commitment, resourcing and support [14] and the 5-year plan which extended to 2015, was neither reviewed nor renewed. This among other deficiencies, has led to the establishment of the AAPP Alliance, to progress and promulgate evidence-based change within mainstream settings.

The process for the development of this discussion paper employed critical discourse informed by Indigenous ways of knowing, being and doing. [14] Major themes and structure were constructed through instigating targeted dialogue with a group of First Nations and non-Indigenous experts in Australian perinatal care who are all co-authors on this paper. The two lead authors (RH & JK) facilitated a series of yarning circles, supplemented by written exchanges and individual yarns with academic and lived experience experts between April and October 2021. Collaborators and co-authors were identified through professional networks and snowballing. Dynamic discussion evolved and themes were shaped and consolidated collaboratively amongst the authorship team.

Health and social impacts of colonisation

Detailed accounts of the atrocities committed during colonisation, if not invasion, of what is now known as Australia have been documented elsewhere [18]. From a First Nations perspective, invasion is a more appropriate term compared with colonisation; invasion refers to the act of intruding into another's sovereign territory by force, whereas colonisation implies a more peaceful process of settlement which discounts the frontier violence and massacre that ensued post-1788. As they pertain to perinatal mental health, many acts of genocide were committed against First Nations peoples during this period. These include the murder of First Nations women and children in the frontier war massacres, [19] forced relocation of peoples onto missions and reserves and separation of First Nations family members due to arbitrary decisions justified under the Half Caste Act (1886) about 'whiteness' and 'cast' under White Australia and assimilation policies [20]. Inhumane, overzealous child protection practices resulting in removal of thousands of First Nations children from their families and cultures to be raised in what were often abusive white foster care placements or orphanages [18,21]. The legacy of historical genocidal colonial practices remains evident through intergenerational trauma from the physical, sexual, emotional, spiritual, cultural and psychological abuse endured by large numbers of First Nations children in settings that were supposed to protect them [18]. Compounding this is the immense and cumulative losses that ensue from the continued removal of First Nations infants and children from their First Nations families, kin, Countries and cultures [12].

The vestige of settler-colonialism remains in the systems and structures of perinatal services. The construction of frameworks and models of care ensures that those deemed to be 'other', who do not conform to predetermined (and often unattainable) social and cultural constructions of a 'good mother' will have their skills, resources and capacity interrogated in the name of enhanced care. Arabena [3] demonstrates the ways in which colonial myths influence birthing experiences for First Nations women through an underpinning imperialist assumption that western medical interventions are most beneficial for First Nations women. Paternalism manifests in decisions to engage medical technologies, which are justified as increasing safety for mother and baby. At times these are entirely necessary; however, a risk adverse system will always err towards intervention, where issues of power are not always examined in medical decision making. Women who resist these interventions are often legally identified as 'declining recommended care', deemed to be placing themselves and/or their child at risk and thereby threatening their claim to be judged a 'good mother' [3].

White middle-class women experience greater privileges within Australian healthcare systems that were designed with them in mind, manifesting in advantageous health outcomes. Conversely, impacts on health and wellbeing for First Nations peoples include grief and loss, unresolved and inter-generational trauma, racism and discrimination, cultural dislocation, as well as disparity and inequity across economic and social factors [22]. Cumulative inequities have serious implications for First Nations women, and antenatal care providers, signalling a failure of Australian healthcare systems to adequately address the social determinants of health for First Nations women.

First Nations women may have higher numbers of children at a younger age [23]. This in itself is not problematic, and may reflect cultural norms. While non-Indigenous women often delay motherhood to pursue career goals, [24] some First Nations women view child-rearing as an aspiration that is prioritised more highly than careers and economic security. For some young First Nations women, motherhood is a choice that brings satisfaction, community respect and an opportunity to strengthen connections with female relatives who provide support and guidance [25]. Young First Nations mothers have highlighted their tenacity and resourcefulness in the face of social scrutiny, frequently with inadequate socioeconomic and personal resources [26]. Many First Nations mothers have spent part of their childhoods in out-of-home care, creating additional barriers to parenting through the trauma associated with being removed, disconnected from family and culture, and lacking opportunities to experience and witness healthy and culturally appropriate parenting practices [18]. Hence, concerted efforts are needed to reorient the healthcare system through making visible the ways in which First Nations women's experiences are erased and interpreted in an individual deficit model that shifts responsibility for poor health outcomes onto the individual and away from services.

The inherent risks of seeing only risks

Acknowledging these layers of disadvantage stemming from colonisation should not equate to an automatic categorisation of First Nations women as universally 'high risk' during pregnancy and birth. Indeed, some First Nations women will have biological and social circumstances that place them at risk, as will women who are non-Indigenous. However, a detailed, nuanced individual assessment is required to ascertain this, undertaken in ways that challenge assumptions and bias. In order to gather the information necessary to make such an assessment, health professionals need to establish trusting relationships with First Nations women and families. Women of kinship can be vital sources of knowledge and support for young First Nations women during pregnancy, and can assist them to access pregnancy care in a timely way [25]. From an Indigenous perspective, women's business includes supporting other women through pregnancy and birth, thus highlighting the inherent strengths of First Nations cultures and kinship systems and creating a supportive environment in which women may feel safer to identify their cultural identity [27].

A pregnancy deemed to be high-risk results in increased monitoring and intrusive examinations which may necessitate a woman being separated from her family and community. In many cases, rurally based First Nations women are forced to remain hospitalised in urban maternity units until they give birth. Declining the recommended medical treatment and discharging against medical advice, or 'accidentally' birthing on Country by "going bush" in pregnancy until labour has commenced are risky options due to the constant threat of child protection removal that some First Nations parents nevertheless take [28]. First Nations children are nearly seven times more likely than non-Indigenous children to be the subject of a child protection substantiation [29]. High numbers of notifications made in-utero before a baby is born (known as 'unborn reports'), mean that sometimes a child protection practitioner will arrive in the birthing suite to meet the baby before the woman's own family has had the opportunity [9]. This is often the first time the family has been made aware of the notification, negating the opportunity for prevention and early intervention. The intersection of race, medical hierarchy and power are evident and salient in these decision-making processes, but are rarely rigorously examined or critiqued. From direct clinical experience as Aboriginal midwifes and health professionals, the authors have seen protocols that have been designed to support First Nations women and families, undermined or openly contravened. This behaviour is rarely challenged, and so becomes part of the organisational culture even when progressive policies and practice guidelines are in place.

Many First Nations women (similar to non-Indigenous women) express a preference for birthing in hospital and indeed, 81% of First Nations people live in an urban or regional setting in Australia [30]. However, for First Nations women who live in rural or remote locations, being hospitalised in an urban setting may prevent the rich and intimate opportunity of birthing 'on Country', isolating her from family supports, normative activities, the chance to prepare her home for the birth and other children, also necessitating an interruption to cultural customs and practices.

The impact of systemic racism within perinatal services is eloquently articulated by First Nations woman Cammi Murrup-Stewart [31] in a moving account of the primary fear she held surrounding the birth of her

first child "that someone in the hospital who knows of my Aboriginality, will find some reason, some cause, some excuse to rip this child from my arms. To declare that my identity makes me unfit to mother. To jump straight to harmful and false stereotypes of black motherhood." (p1).

First Nations birthing knowledge and expertise

Throughout colonisation, First Nations women have been tenacious and innovative in their survival, and their resistance. As strong and resilient mothers, grandmothers and community leaders, and "as the primary carers of their families and extended families, the wellbeing of Indigenous women is central to the wellbeing of the community." 2(p1).

This resistance and accompanying knowledge, manifests in innovative and successful First Nations birthing and parenting programs [32]. Emphasising connectedness, these programs share a strength-based foundation informed by principles of First Nations self-determination. Bolstering the Indigenous workforce within mainstream perinatal settings is another goal of national maternity policy [33] however, these settings are rarely culturally safe workplaces for First Nations midwives, nurses or First Nations health workers.

Next steps: identifying and dismantling racism in perinatal healthcare settings

These realities along with the failure of successive governments to invest in changing the culture of non-Indigenous (mainstream) perinatal services in any meaningful way, warrent reframing the narrative around risk for First Nations women. Intentionally prioritising anti-racist practice and connectedness will improve maternal (and family and community) social and emotional wellbeing. This leads to questions regarding the most effective pathway for creating such a shift. As one of the key universal health care providers for families in the perinatal period, Maternal, Child and Family Health services are a prime setting for responsive care. Maternity units are another important site. The documented barriers to nurses and midwives building connectedness with First Nations women who experience social and emotional wellbeing challenges include a lack of cultural humility and competence, [33] limited knowledge of cultural safety and policies to facilitate it; [34] inadequate social emotional wellbeing knowledge and confidence, [35] competing work demands, practitioner attitudes and attributes and the physical environment [36]. These need to be urgently overcome through re-prioritisation, policy development and implementation, education and adequate sustainable resourcing. The preventative impact of redressing power imbalances to build trusting relationships with women in the perinatal period makes this of crucial importance.

Harnessing the knowledge and experience of a collaboration of experts from industry and academia who can plan the pathway for systemic change in this sector, is a much-needed step to progress this work. This has already been called upon by numerous First Nations academics, nurses and midwives [37] Identifying the priority issues and needs, before defining a process for implementing structural and cultural change within perinatal health settings is a process that must be driven by First Nations peoples, with authentic collaboration between First Nations and non-Indigenous health experts, perinatal health academics, policy makers and clinicians. This includes First Nations Units within hospitals, particularly maternity hospitals that already provide cultural oversight, training of mainstream staff, support for other First Nations health practitioners, and advocacy work on behalf of First Nations women and their families.

First Nations communities have identified perinatal social emotional wellbeing as a critical domain with the potential to create immense wellbeing benefits [6]. It is incumbent on all levels of government policy makers, along with those who work in mainstream perinatal services, to recognise and redress the deficits within the system that perpetuate ongoing health inequities. Non-Indigenous health professionals must take responsibility for developing their own critical self-awareness as a prerequisite for proactively addressing unconscious bias and cultural blindness. [38] Deepening understanding of First Nations cultural norms and providing creative, inclusive, flexible, warm engagement that promotes cultural safety is paramount.

Repositioning therapeutic engagement and connectedness at the centre of health care frameworks will require dedicated and strategic implementation. A core component is building a culture of critical self-reflection on whiteness and power that enables practitioners to engage in dialogue around what needs to change in order to identify and dismantle racist policies and practice that may currently be invisible to those with privilege. This reflective decolonising work could be operationalised through clinical supervision and peer mentoring processes, as well as team-based learning and reflection prompted by activities such as journal clubs. Many white health professionals have been socially conditioned in low context communication cultures, cultures whereby explicit verbal communication is emphasised and delivered with little reliance on environmental context or non-verbal cues [40]. Developing capacity for nyernila – a word meaning to listen continuously in Wergaia/Wotjobaluk language [39] – in health professionals is another step in the long and winding pathway towards creating cultural security within mainstream perinatal health care settings [41].

Conclusion

Colonial perceptions of First Nations peoples as non-human have created the genocide, displacement and deprivation of First Nations peoples and ultimately the creation of a web of policy frameworks that led to the Stolen Generations and continues today to perpetuate high rates of child removal of First Nations children from their families, communities and cultures. Providing surveillance cloaked as support compounds existing stressors, separates women from family, kin, supports and Country and contributes to social and cultural dislocation, as well as triggering a cascade of medical interventions. It alienates women from mainstream healthcare, contributes to intergenerational trauma, grief and cumulative loss, and adverse health and wellbeing outcomes. It must change. There is compelling evidence to demonstrate that identifying and addressing individual needs in culturally safe and responsive practice frameworks that prioritise engagement and connectedness reduces barriers to access and promotes help seeking behaviours. Provision of sensitive maternity care services can accommodate reclaiming of "rich ancestral wisdom… bringing culture and spirituality back into birth to enrich our contemporary health care systems to foster a nurturing birth environment to support parents through this important transitional life event" [14].

The perinatal period presents an opportunity for enhancing engagement for First Nations women with mainstream healthcare systems, providing culturally safe and responsive care that is purposely designed around First Nations knowledges and protocols, grounded in deep listening, addressing individual needs and emphasising self-determination and strengths. Empowering First Nations voices and leadership is part of redressing systemic barriers that arise from policies and practice that are entrenched in derogatory and prejudiced assumptions. It is also substantiated on economic grounds, but more importantly, failing to address this fundamental human need represents a pillar of ongoing systemic oppression and racism and violates human rights as expressed with the United Nations Declaration on the Rights of Indigenous Peoples [42].

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References

[1] G. Garvey, K. Anderson, A. Gall, T.L. Butler, L.J. Whop, B. Arley, et al., The fabric of Aboriginal and Torres Strait Islander wellbeing: a conceptual model, Int. J. Environ. Res. Pub. Health 18 (15) (2021) 7745, https://doi.org/10.3390/ijerph18157745.

[2] P. Dudgeon. Aboriginal and Torres Strait Islander women and mental health. In Psych. 2017;39(1) Available from: https://www.psychology.org.au/inpsych/2017/february/dudgeon/2017/february/dudgeon〉.

[3] K. Arabena, Preachers, policies and power: the reproductive health of adolescent Aboriginal and Torres Strait Islander peoples in Australia, Health Promot J. Aust. 17 (2006) 85–90.

[4] Nursing and Midwifery Board of Australia. Midwife Standards for Practice. Australian Health Practitioner Regulation Agency. 2018. Available from: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx.

[5] J. Grant, P.B. Guerin, Mixed and misunderstandings: an exploration of the meaning of racism with maternal, child, and family health nurses in South Australia, J. Adv. Nurs. 74 (12) (2018) 2831–2839.

[6] C. Chamberlain, N. Ralph, S. Hokke, Y. Clark, G. Gee, C. Stansfield, et al., Healing the past by nurturing the future: A qualitative systematic review and meta-synthesis of pregnancy, birth and early postpartum experiences and views of parents with a history of childhood maltreatment, PLoS One 14 (2019) 12.

[7] R. Lee, S. Robbins, Measuring belongingness: the social connectedness and the social assurance scales, J Couns Psychol 42 (2) (1995) 232–241.

[8] P. Dudgeon, A. Bray, Indigenous relationality: women, kinship and the law, Genealogy 3 (2) (2019) 23.

[9] J.M. Ussher, R. Charter, C. Parton, J. Perz, Constructions and experiences of motherhood in the context of an early intervention for Aboriginal mothers and their children: mother and healthcare worker perspectives, BMC Public Health 16 (620) (2016) 1–12.

[10] R.H. Hine, D. Maybery, M.J. Goodyear, Challenges of connectedness in personal recovery for rural mothers with mental illness, Int. J. Ment. Health Nurs. 27 (2) (2018) 672–682.

[11] P.M. Corcoran, C. Catling, C.S. Homer, Models of midwifery care for indigenous women and babies: a meta-synthesis, Women Birth 30 (1) (2017 1) 77–86.

[12] C. Chamberlain, G. Gee, S. Brown, J. Atkinson, H. Herrman, D. Gartland, et al., Healing the Past by Nurturing the Future – co-designing perinatal strategies for Aboriginal and Torres Strait Islander parents experiencing complex trauma: framework and protocol for a community-based participatory action research study, BMJ Open 9 (6) (2019 1) 1–11.

[13] C. Mayes, White medicine, white ethics: on the historical formation of racism in Australian healthcare, J. Aust. Stud. 44 (3) (2020 2) 287–302.

[14] R. Marriott, C. Chamberlain, Change is in the air: reclaiming ancestral wisdom through Birthing on Country in Australia, Women Birth 32 (5) (2019) 381–382.

[15] D. Bargallie, Unmasking the Racial Contract: Everyday Racism and the Impact of Racial Microaggression on "Indigenous Employees" in the Australian Public Service, Aboriginal Studies Press, Canberra, 2020.

[16] A. Moreton-Robinson, The White Possessive.. Property, Power and Indigenous Sovereignty, University of Minnesota Press, Minnesota, 2015.

[17] Australian Health Minister Conference. National maternity services plan. Australian Government. 2011. Available from: 〈https://www.health.gov.au/internet/main/pub- lishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/$File/maternity- plan.pdf〉.

[18] R. Wilson, Bringing them Home: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their Families, Human Rights and Equal Opportunity Commission, Sydney, 1997 (Available from), 〈https://bth.humanrights.gov.au/the-report/bringing-them-home-report〉.

[19] Culture Victoria. Massacre Map. 2016. 〈https://cv.vic.gov.au/stories/aboriginal-culture/indigenous-stories-about-war-and-invasion/massacre-map/〉.

[20] A. Moran, White australia, settler nationalism and aboriginal assimilation, Aust. J. Polit. Hist. 51 (2005) 168–193.

[21] J. Seran, Australian aboriginal memoir and memory: a stolen generations trauma narrative, Humanities 4 (4) (2015) 661–675.

[22] S. Zubrick, P. Dudgeon, G. Gee, B. Glaskin, K. Kelly, Y. Paradies, et al., Social determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, in: N. Purdie, P. Dudgeon, R. Walker (Eds.), Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, Commonwealth of Australia, Canberra, 2014.

[23] Australian Institute of Health and Welfare, Antenatal care use and outcomes for Aboriginal and Torres Strait Islander mothers and their babies 2016-2017. Cat. No. IHW 237, AIHW, Canberra, 2020.

[24] M. Kingsley, The influence of income and work hours on first birth for Australian women, J. Population Res. 5 (2018) 107–129.

[25] T. Reibel, L. Morrison, D. Griffin, L. Chapman, H. Woods, Young Aboriginal women's voices on pregnancy care: factors encouraging antenatal engagement, Women Birth 28 (1) (2015) 47–53.

[26] J.M. Ussher, R. Charter, C. Parton, J. Perz, Constructions and experiences of motherhood in the context of an early intervention for Aboriginal mothers and their children: mother and healthcare worker perspectives, BMC Public Health 16 (1) (2016) 1–2.

[27] P. Daylight, M. Johnstone, Women's business: report of the Aboriginal Women's Task Force. Service, Australian Government Publishing, Canberra, 1986.

[28] C. Felton-Busch, Birthing on country: an elusive ideal? Contemporary Nurse 33 (2) (2009) 161–162.

[29] Australian Institute of Health and Welfare. (2021). Child protection Australia 2019–20. Child Welfare series no. 74. Cat. No. CWS 78. Canberra: AIHW. Retrieved from 〈https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2019–20/summary〉.

[30] Australian Institute of Health and Welfare. Profile of Indigenous Australians. 2019. Available from: 〈https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians〉.

[31] C. Murrup-Stewart, 9 months pregnant and Aboriginal, The Guardian (2021) 10 (Available from), 〈https://indigenousx.com.au/9-MONTHS-PREGNANT-AND-ABORIGINAL/〉.

[32] O. Best, B. Fredericks. Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care, third ed., Cambridge University Press,, Melbourne, 2021.

[33] S. Kildea, S. Tracy, J. Sherwood, F. Magick-Dennis, L. Barclay Barclay, L. Improving. maternity services for Indigenous women in Australia: Moving from policy to practice M J. Australia 205 8 2016 375 379.

[34] S. Kruske, S. Kildea, L. Barclay, Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians, Women Birth 19 (3) (2006 1) 73–77.

[35] S. Elsom, B. Happell, E. Manias, Expanded practice roles for community mental health nurses in Australia: confidence, critical factors for preparedness, and perceived barriers, Issues Ment. Health Nurs. 29 (7) (2008) 767–780.

[36] N. Setola, E. Naldi, G.G. Cocina, L.B. Eide, L. Iannuzzi, D. Daly, The impact of the physical environment on intrapartum maternity care: identification of eight crucial building spaces, HERD 12 (4) (2019) 67–98.

[37] L. Geia, K. Baird, K. Bail, L. Barclay, J. Bennett, O. Best, et al., A unified call to action from Australian nursing and midwifery leaders: ensuring that Black lives matter, Contemp. Nurs. 56 (4) (2020) 297–308.

[38] S. Hickey, Y. Roe, S. Ireland, S. Kildea, P. Haora, Y. Gao, et al., A call for action that cannot go to voicemail: Research activism to urgently improve Indigenous perinatal health and wellbeing, Women Birth 34 (4) (2021) 303–305.

[39] Couzens V. Mother Tongue. In: Victorian Aboriginal Corporation for Languages, editor. Nyernila: Listen Continuously: Aboriginal Creation Stories of Victoria. Melbourne: Creative Victoria.

[40] K.L. McKay-Semmler, High- and low-context cultures, in: Y.Y. Kim (Ed.), In The International Encyclopedia of Intercultural Communication, 2017, https://doi.org/10.1002/9781118783665.ieicc0106.

[41] J. Coffin, Rising to the challenge in Aboriginal health by creating cultural security, Aborig Isl Health Work J. 31 (3) (2007) 22–24.

[42] United Nations General Assembly, United Nations Declaration on the Rights of Indigenous Peoples, United Nations, 2007. 〈https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html〉.